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Reducing Medical Cost Trend With Concierge Services and Enhanced Digital Tools

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Best practices in medical trend analysis and projection break trend down into two components: unit cost and utilization. It is well-documented in pricing manuals that increasing member cost sharing will reduce utilization. Another working assumption is that the complexity of the health care system has a dampening effect on utilization. Actuaries often see lower initial utilization in groups newly added to a company's program, and as members learn how to use their benefits, utilization increases to each group's normal level. Some studies suggest that new programs are making care easier to access, resulting in higher utilization.

These principles may seem fundamental, but the way people access, navigate and engage with health care is changing every day. From concierge services to on-site clinics to enhanced digital tools, the health care system seems committed to making care as convenient as possible. In fact, in the last seven years alone, Rock Health's 2017 year-end funding report shows that \$23 billion has been poured into digital health to test the role technology plays in this new health care economy.¹ The question is, will making care easier to access automatically result in higher utilization and higher costs? One recent study, *Controlling Employer Health Costs: A Collective Health Book of Business Trend Analysis*, suggests that technology, coupled with a concierge service approach, may enhance patient care while reducing costs by helping members navigate their options more intelligently.²

THE CONVENTIONAL TAKE ON CONVENIENT CARE

According to PwC's 2017 *Behind the Numbers* report, "Forces inflating medical cost trend stem from increases in access to care, particularly primary and behavioral health services. Convenient care settings, such as retail clinics, provide consumer satisfaction at a low unit cost. Yet their success has led to greater utilization and more spending."³ Another study conducted by the Rand Corporation came to a similar conclusion, claiming that 58 percent of retail clinic visits for low-acuity conditions

represented new utilization and that retail clinic use led to an increase in spending.⁴

These studies tell us that making care more convenient is inflating medical cost trend and aggravating the problem of waste in the health care system. According to a 2012 *JAMA* report published in the *Harvard Business Review*, 35 percent of health care spending in the United States can be attributed to waste.⁵ Researchers have identified a number of categories in this waste, including but not limited to failures in care delivery and care coordination as well as overtreatment. We see specific examples of these failures in things such as the overutilization of emergency room (ER) visits. According to a 2013 study by Truven Health Analytics, 71 percent of ER visits made by patients with employer-sponsored insurance coverage are for causes that do not require immediate attention in the emergency room or are preventable with proper outpatient care.⁶ Similarly a 2016 study in *JAMA Internal Medicine* by Frank S. Drescher and Brenda E. Sirovich reports that advanced imaging, such as the use of computed tomography, has increased dramatically over the last 10 years among patients with the least chance of benefitting from it.⁷

Various strategies have been tried to eliminate waste in the system, and they have had a modest impact at best. From mandatory second opinions and required precertifications to narrowing networks, plan design changes and voluntary programs to help members better understand their options—these new strategies are not moving the needle in a meaningful way. One thing they have done, however, is make the health care system more complex and frustrating than ever before.

An important observation at the heart of this problem is that members want to avoid unnecessary utilization too. They don't want unnecessary tests, unnecessary surgeries, unnecessary diagnostic procedures or unnecessary hospital stays. However, members lack the information and tools to avoid these situations.



Systems of well-coordinated care such as the Geisinger Health Plan in Pennsylvania have a long record of guiding members through the system, and Geisinger has often been held up as a model for eliminating waste. Kurt Wrobel, FSA, MAAA, chief financial officer and chief actuary of the Geisinger Health Plan points out that its clinics provide same-day access, which allows patients to see a physician quickly without going through the typical appointment process. This convenience is an effective triage for patients within the system, where their records are easily available. Same-day access avoids duplicate tests and unnecessary ER visits.

But is Geisinger’s approach the only way to make care convenient for members while eliminating waste?

INTELLIGENT NAVIGATION: HOW A HIGH-TECH, HIGH-TOUCH APPROACH OPTIMIZED CARE AND LOWERED COSTS

New research also suggests that more informed members who better understand their plans make better care decisions. Today, plan sponsors are investing in a mix of better online tools, on-site clinics and third-party programs—all supported by high-touch, concierge member services to help members navigate the health care system more intelligently.

A recent study by Collective Health, a technology company that serves as an alternative to traditional health plans for self-funded employers, suggests that plan sponsors can adopt these high-tech, high-touch strategies to achieve cost savings—leveraging trust and familiarity to reduce unnecessary utilization and waste.⁸

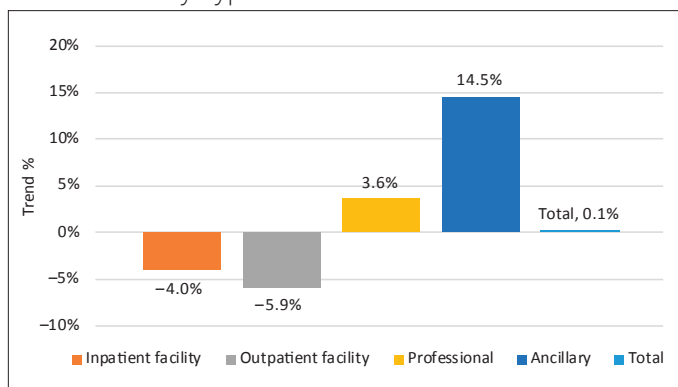
Overview of Analysis

Collective Health analyzed medical trend across its book of business. The overall calculation was completed by Frank Cheung, ASA, MAAA, head of analytics for Collective Health, and Sophie Kim, ASA, actuary for Collective Health, and peer reviewed by Susan Pantely, FSA, MAAA, who heads Milliman’s office in San Francisco. Collective Health performed an additional analysis to assess utilization and care optimization—and it came to an encouraging conclusion. The organization’s technology, platform, and member advocacy model, which leverages member trust and enables more informed, value-based choices, actually reduces medical cost trend. What’s more, the study found that Collective Health was able to achieve these results through care optimization rather than care avoidance.

Process and Methods

Specifically, the analysis focused on all self-funded clients who were live with Collective Health as of January 1, 2016. It

Figure 1
PMPM Trend by Type



Data from Collective Health. Used by permission.

compared their medical spending and utilization in the first half of 2016 with that across the first half of 2017.

The subset of employer customers examined included 33,332 members during the study period. All claims were included, and the model allows the user to normalize for demographics, geography (area) and changes in benefit design, and to truncate large claimants that exceed a defined threshold. That means the model is presented both with and without adjustments to remove the effects of an aging population, new members in areas with lower (or higher) health care costs, and changes in benefit design, among other changes.

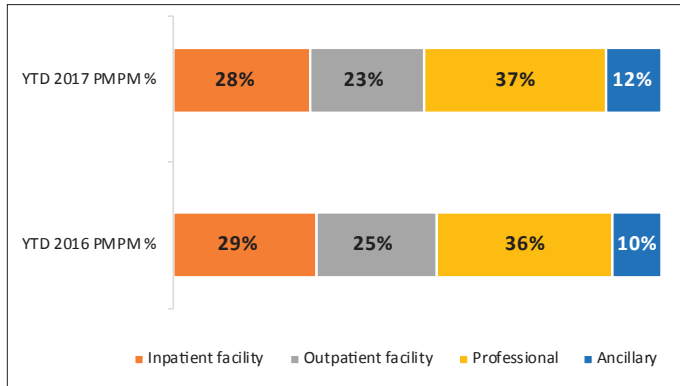
Medical Trend Results

The raw data, without normalization, revealed an overall medical trend of 0.1 percent (see Figure 1). Normalizing for demographics (aging of the population), the overall medical trend was -0.5 percent. When normalizing for demographics, geography (area) and benefit design changes, the overall medical trend was 0.0 percent (see Figure 2). These figures were significantly lower than historical client trends and market trends, which the analysis approximated to be about 5 percent.

Engagement Results

Forty-eight percent of members engaged with Collective Health during the first half of 2017. They had a medical trend of -2.0 percent with normalization and -0.7 percent without normalization. These members, who drive the majority of medical spending, are responsible for the improvements in trend over baseline, as the medical trend of non-engaged members was 6.7 percent. This finding suggests that Collective Health leverages member trust and enables more informed, value-based choices.

Figure 2
PMPM Percentage by Type



Data from Collective Health. Used by permission.

Utilization Results

The analysis showed that the medical trend was driven by care optimization, not care avoidance. Collective Health members optimized their utilization in two ways, as shown in Table 1. First, they reduced their use of four categories of services, such as advanced imaging and ER visits, that have a history of overutilization. Managed care plans have used many “tactics” (such as preauthorization) to reduce such overutilization. Second, members increased their use of behavioral health care and urgent care facilities. The underutilization of these services has historically contributed to higher overall costs as members turn to more expensive alternatives.

Table 1
Changes That Optimized Member Utilization

Services	Utilization Rate
Advanced imaging	-12%
ER visits	-5%
Radiology	-9%
Specialist visits	-8%
Behavioral health	+13%
Urgent care	+4%

CONCLUSION

Plan sponsors are investing in a mix of better online tools, on-site clinics and third-party programs—all supported by high-touch, concierge member services to help members navigate the health care system more intelligently. While these initiatives have proven to increase member satisfaction with health benefits, they are also showing the potential to be effective cost reduction strategies. Plan sponsors that provide better online tools to navigate the health care system combined with a concierge approach to member services may help achieve two legs of the “Triple Aim” of health care—enhanced patient care and reduced cost—even as they provide easier access to care. ■



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ENDNOTES

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