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Session 62PD, Health Care Affordability and Bending the Cost Curve

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2018 SOA Health Meeting

Chris Schmidt, FSA, MAAA, Lauren Onderisin, FSA, MAAA, Ryder Riess, Mike Selvage

Session 62: Bending the Cost Curve

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Panel Introductions

Ryder Riess – McClean, VA



Ryder is a Senior Manager in the Monitor Deloitte Strategy practice with strong experience in Corporate Strategy, Customer Experience, Growth and M&A. He has deep experience evaluating competitive dynamics and assessing the economic impact of strategic options. His recent work has focused on creating tangible strategic options and evaluating operational capabilities for Provider clients shifting to population health as well as building clinically integrated networks. Ryder has a proven ability to build, leverage and develop teams to create deep insights and innovative thinking. He has worked in and advised clients in multiple industries including health care, life sciences, retail, energy and financial services.

Mike Selvage – Austin, TX



Mike is a Manager within Deloitte Consulting's Health Care practice, serving provider and health plan clients. He played an early role in developing Deloitte's market position in Value Based Care, helping clients to understand the strategic and financial implications of shifting from volume to value. Mike has engagement experience related to physician network adequacy and optimization, ACO/PCMH strategies, MACRA readiness, and Case Management / Utilization Management program design.

Chris Schmidt – Minneapolis, MN



Mr. Christopher A. Schmidt has over 16 years of consulting experience. Mr. Schmidt's focus has been in the area of health actuarial and data analytic services. He has worked with Federal, State and local government agencies, large national and regional health plans, and providers. He has expertise in a variety of areas including issues such as Value Based Care analysis, Value Based Care program design and implementation, payer/provider reimbursement analysis and contracting strategy, Medicaid capitation rate setting, and Medicare pricing and bid development.

Lauren Onderisin – New York, NY



Lauren is a Manager in Deloitte's Health Actuarial practice with a focus on pharmacy economics and analytics. She works with health plans, PBMs, and providers to perform pharmacy claims experience analyses and financial modeling and identify potential savings opportunities. In addition, Lauren regularly consults regional, mid-sized, and national health plans in their pharmacy contract renegotiation and RFP processes with PBMs by preparing pricing and underwriting analyses, performing market benchmarking, and offering end-to-end strategic support.

An Affordability Point-of-View

Why is Affordability Important?

When compared to 10 developed countries, the US ranks last in overall health care performance, highlighted by per capita spending that is 50% greater than the next country and last place rankings in efficiency, equity, and healthy lives

Comparative Performance Metrics

U.S. Rankings among 11 Countries

COUNTRY RANKINGS	Top 2		Middle		Bottom 2												
																	
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US						
OVERALL RANKINGS ('13)	4	10	9	5	5	7	7	3	2	1	11						
Quality Care	2	9	8	7	5	4	11	10	3	1	5						
Effective Care	4	7	9	6	5	2	11	10	8	1	3						
Safe Care	3	10	2	6	7	9	11	5	4	1	7						
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6						
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4						
Access	8	9	11	3	4	7	6	4	2	1	9						
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11						
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5						
Efficiency	4	10	8	9	7	3	4	2	6	1	11						
Equity	5	9	7	4	8	10	6	1	2	2	11						
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11						
Health Expenditures/Capita ('11)	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508						

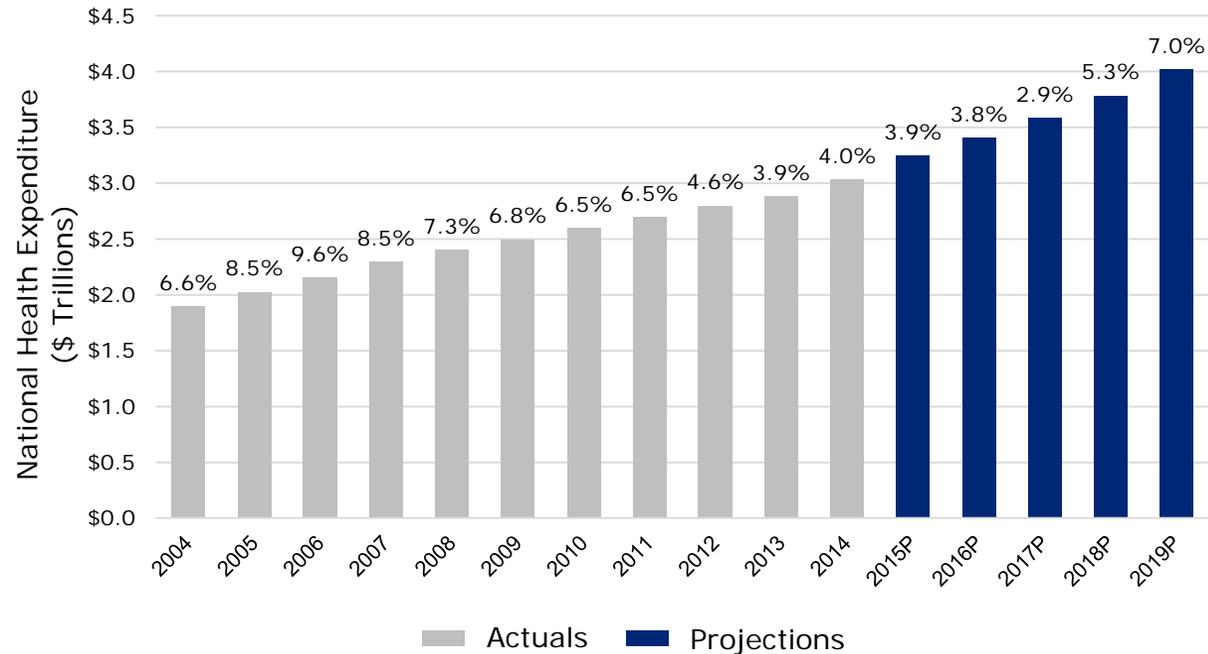
Source: Commonwealth Fund 2014
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Why is Affordability Important to Health Plans?

Escalating costs and decreasing affordability continue to pose the primary challenge in U.S. healthcare as cost pressures are increasing for all who pay for healthcare: health plans, governments, employers, and consumers

National Health Expenditures and Annual Growth Rates¹

Actuals 2005-2014, Projections 2015-2019



Source: ¹Centers for Medicare and Medicaid Services (CMS) "NHE Tables" and "Historical and Projections 1960-2024"; ²SNL Financial Benchmarking Data; ³"The Facts on Medicare Spending and Financing," Kaiser Family Foundation; ⁴"Medicaid's Share of State Budgets," MACPAC; ⁵ Kaiser/HRET Survey of Employer Sponsored Health Benefits

Impact on Health Care Payers

Health Plans



From 2010 to 2015, the average health plan medical loss ratio increased from 86% to 90%²

Government



The Medicare Hospital Insurance trust fund is projected to be depleted in 2029³

From 2010 to 2015, Medicaid's share of funded state budgets increased from 12% to 16%⁴

Employers



From 2010 to 2015, average employer contributions to employee premiums increased by 28% from \$9,733 to 12,591⁵

Consumers

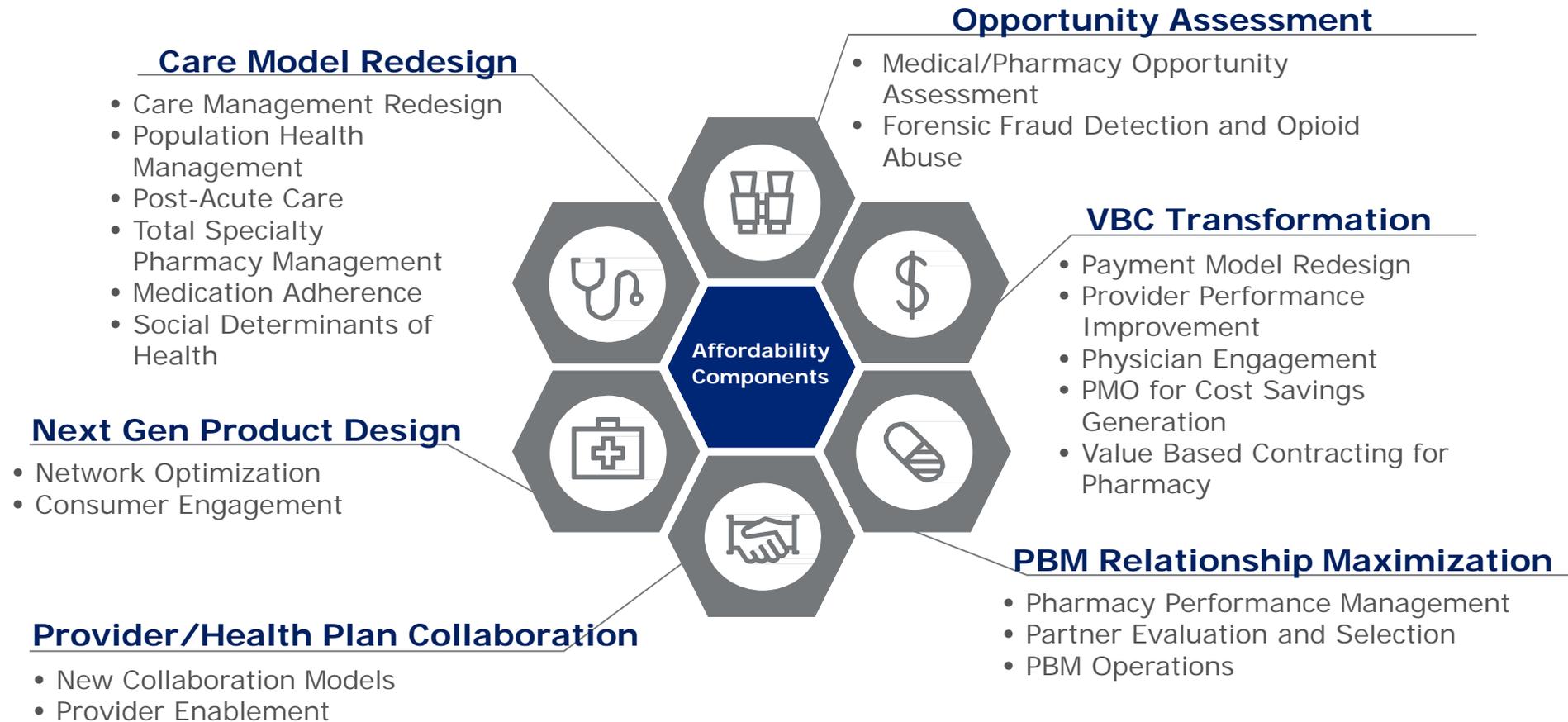


From 2010 to 2015, average employee contributions to premiums increased by 24% from \$3,997 to \$4,955⁵

If industry actions do not meaningfully restructure the healthcare system to tame costs, there is a growing risk to the future of the viability of the standalone health plan business due to potential disruptive government policies that could lead to the disintermediation of the health plan value proposition and a shift to a less profitable book of business

Key Affordability areas available for bending the cost curve

Six key components are recurring themes to address the unsustainable increases in medical cost, premiums, and cost-sharing

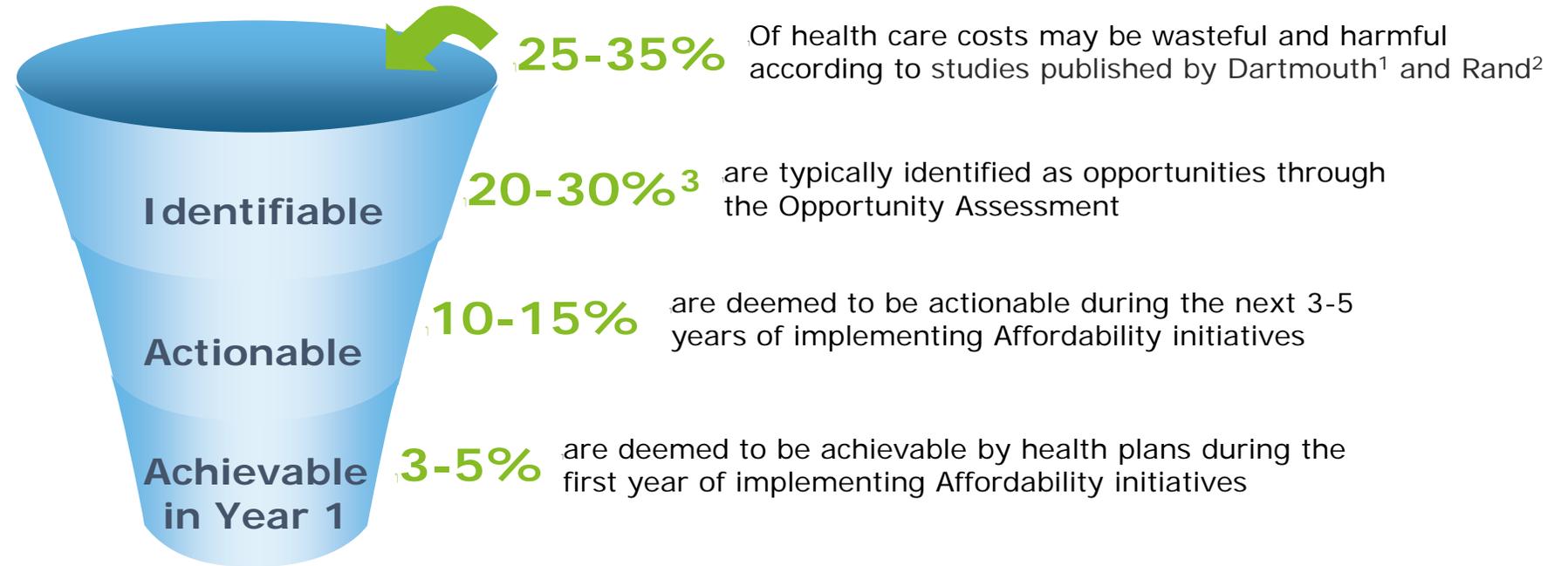




Opportunity Assessment

Through claims data analyses, the universe of opportunities and actions can be narrowed down to the right combination of initiatives that will provide strong ROI in the near term

Deloitte's experience with health plans has indicated the following...



...based on industry knowledge and observation

¹ Institute for Health Policy and Clinical Practice: "Reflections on Geographic Variations in U.S. Health Care"

² Berwick and Hackbarth: "Eliminating Waste in US Health Care"

³ This is analogous to the 25-35% published by Dartmouth and Rand



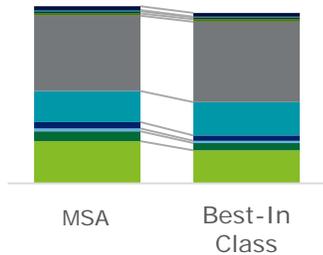
Opportunity Assessment Approach

Opportunity assessment analytics can be applied to identify potential opportunities to reduce medical and pharmacy costs while maintaining quality of care

Medical Approach

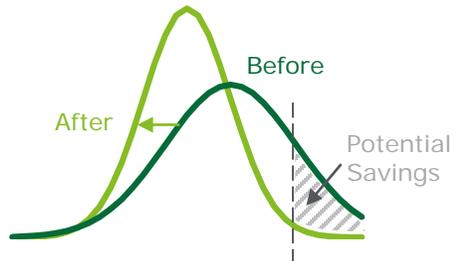
Background

Utilization Analysis



MSAs are compared against Best-in-Class MSAs to determine utilization management opportunities

Episode Analysis



Analyses based on identifying unusual variation within episodes inform condition specific targeting and opportunity quantification

Site of Service



Opportunities are identified to shift services to a more cost effective setting, suggesting new ways to approach care

Pharmacy Approach

Background

Rx Comparison to Market



Cost and utilization metrics compared against Best-in-Class MSAs to determine if gaps or opportunities exist

Distribution Channel Analysis

Retail 30/Retail 90/Mail



The distribution of scripts dispensed through retail vs. mail order is compared against Best-in-Class metrics to gauge the savings opportunity from directing utilization to more efficient channels

PBM Contract Benchmarking



The current PBM contract's pricing, terms, and conditions are compared against a blinded, market-based sample of comparators to identify areas of focus for future contract negotiation

Therapeutic Classes



The top drug therapeutic classes for a population are identified, and tailored approaches are developed to optimize and manage costs

Drug-Level Analysis

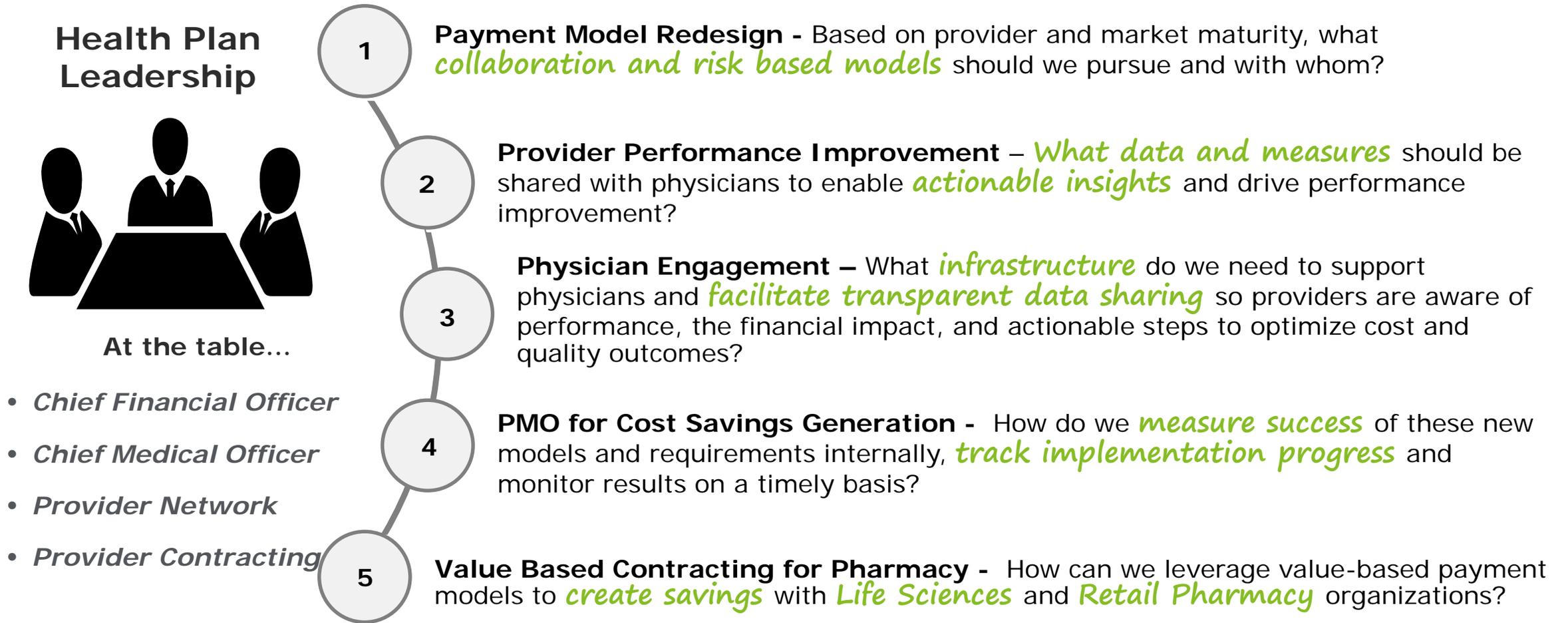
Details	Figures	
# of Units	10,589	
Physician's office	1,882	Assume you can move 50% of units to PO setting
Hospital	8,697	
Others (Infusion Center)	10	
Covered Charges / Unit	\$625	
Physician's office	\$565	13% price difference that can generate \$323 - \$50k in savings
Hospital	\$639	
Others (Infusion Center)	\$896	

For high cost drugs, a deep dive is conducted into whether opportunities may exist from shifting utilization between the medical and pharmacy benefits or between sites of care



VBC Transformation: Health Plan Challenges in the Shift from Volume to Value

Several strategic questions must be answered by health plan leadership in order to drive successful transition to a value based care business model





VBC Transformation: Provider Issues and Trends

As the market shifts from volume to value, providers are facing increased challenges with unmet capability needs and partnership options

Unmet Provider Needs

- Providers currently deploy population health mgmt. resources (e.g., care mgmt. and analytics) resources in an ad-hoc manner due to **operational and financial limitations**
- **Unmet needs** remains across provider segments (health systems, physician groups etc.), especially in interoperability and actionable population health analytics
- Providers have difficulty **with change management** of clinical operations at the practice level

Provider Perception on Partnership

- Providers are actively seeking for **opportunities to enhance population health capabilities and reduce cost**, and recognized they cannot achieve the goals by themselves
- **Partnership with health plans** is promising, but entails challenges to build the trust and identify a truly differentiated partner

Population Health Enablement Market

- The provider population health enablement marketplace is still open with **no clear winner or defined model of success**, although some players (i.e. Optum and Epic) are starting to rise to the top
- Most **National Plans and some Blues plans** are actively evolving their enablement solutions to support various models of provider partnerships

Leveraging capabilities and resources, Health Plans have the opportunity to diversify their revenue streams under the pressure of shrinking profitability in the traditional insurance market



Payment Models: Provider Partnership Models

The inherent risk to the provider in a value-based care arrangement affects their willingness to invest in and focus on population health management

"Traditional" Health Plan Led Models

(75% of 2020 Payments)

FFS & Upside Only Gain Sharing

	Chronic	Optimize	Highly
Wellness	Condition	Episodes	Complex
	Management	of Care	Care



"Hybrid" Provider / Plan Facilitated Models

(~20% of 2020 payments)

Bundled Payments

	Chronic	Optimize	Highly
Wellness	Condition	Episodes	Complex
	Management	of Care	Care



Shared Risk

	Chronic	Optimize	Highly
Wellness	Condition	Episodes	Complex
	Management	of Care	Care

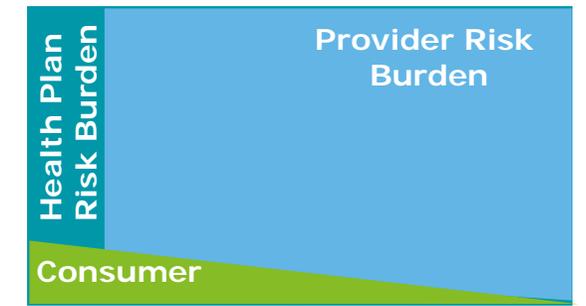


"Delegated" Financial Risk Model

(~5% of 2020 payments)

Global Risk

	Chronic	Optimize	Highly
Wellness	Condition	Episodes	Complex
	Management	of Care	Care



Note: Health plans will continue to conduct sentinel utilization management in Hybrid and Provider Led models

A Health Plan must ensure it has the internal capabilities to support provider partners in managing risk in order to create a successful collaboration



Provider / Health Plan Collaboration

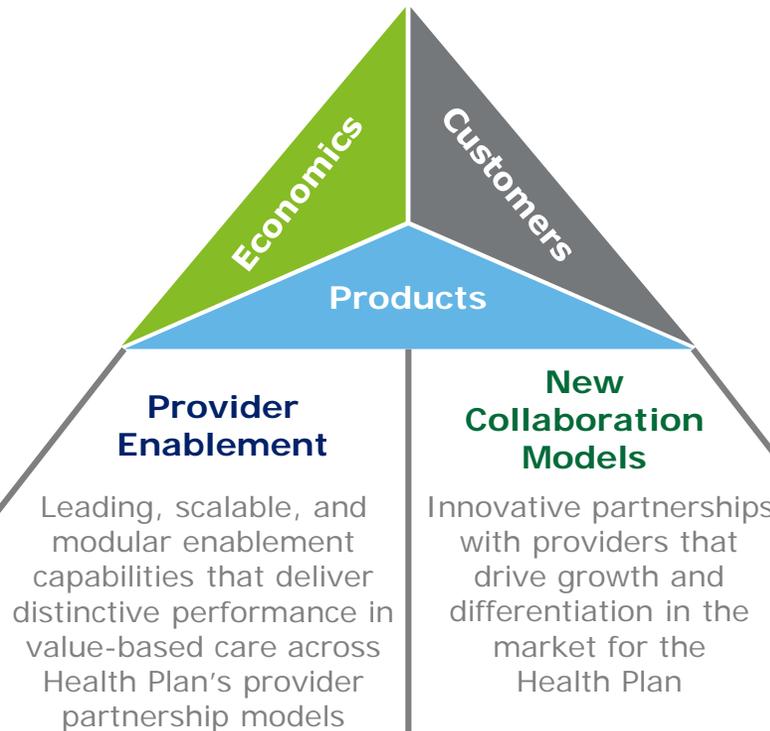
Providers and Health plans need to work together to achieve optimal cost savings

Provider Enablement: Assess and develop health plan capabilities to better address provider unmet population health needs and support provider partnerships across the payment model spectrum

Scope includes:

- Strategy and Business Model Development
- Provider Segmentation and Needs Assessment
- Population Health Capability Assessment
- Build / Buy / Partner Options

A capability-driven approach to help health plans address unmet provider needs and diversify revenue streams



New Collaboration Models: Evaluate and form strategic and financial health plan / provider partnerships, and implement integrated operational models that improve delivery system performance

Scope includes:

- Conceptual Partnership Framework and Model
- Strategic and Financial Assessment
- Joint Business Plan and Operational Blueprint

Innovative, executable model that will reduce cost and drive shared benefits to improve overall performance

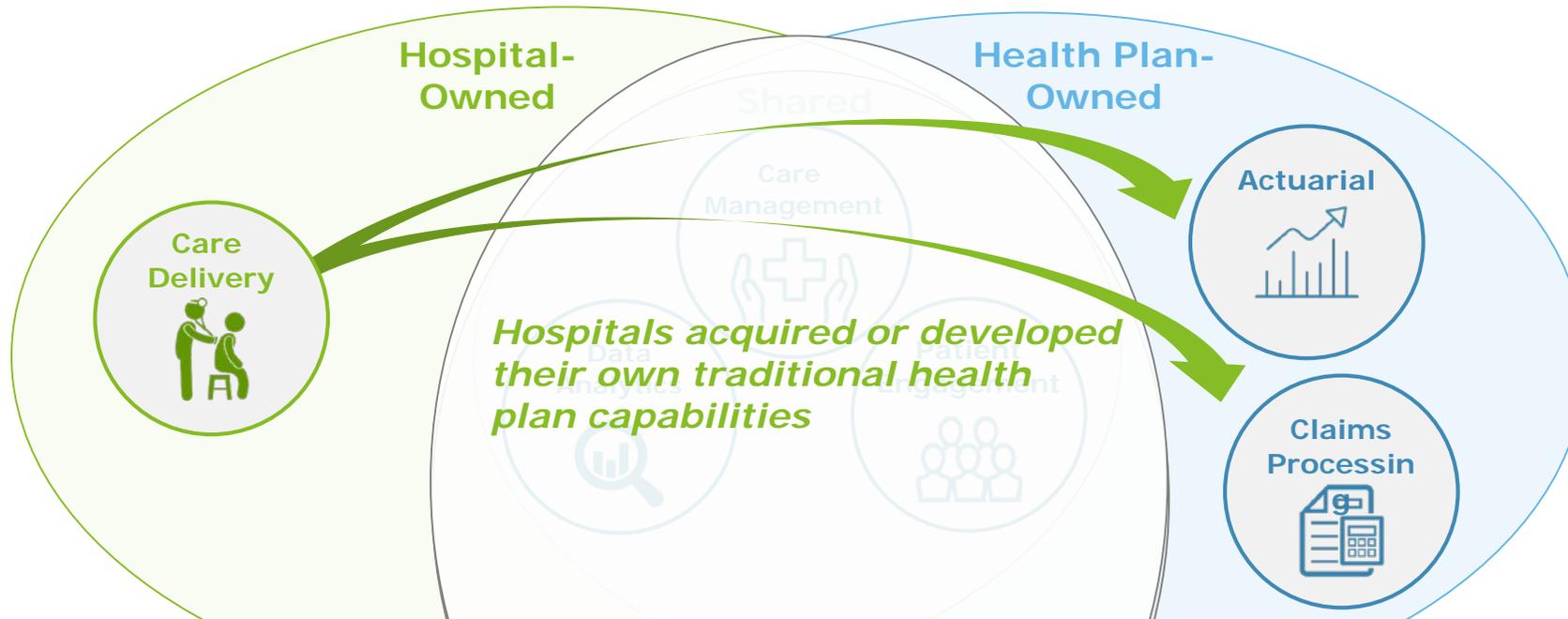
Provider / Health Plan Collaboration



Providers Developing Risk Management Capabilities

Government policies to transfer more financial risk to providers have led providers to try to develop traditional health plan capabilities (i.e. Actuarial); however, results have been negative to date

Health Plan and Provider Capabilities



Examples of Provider Systems Taking on Health Plan Capabilities

"Of the 17 provider-sponsored health plans started since 2010, **none made a profit in 2016** and just two eked out a small profit in the first half of **2017...at least six have already either gone out of business or are in the process of doing so...**"¹



PBM Relationships Maximization: Trends

Five years ago, four key trends were anticipated for Health Plan pharmacy management organizations. Some of these trends have proven to be more prevalent than others



Anticipated Trends in 2012 & 2013

- 1 **Increased Government Coverage**
- 2 **Specialty Pharmacy Growth**
- 3 **New Payment Models**
- 4 **Increased Consumer Choice**



How Those Trends are Playing out in 2017 & 2018

- 1 **YES!** Medicare and Medicaid enrollment has increased at a CAGR of 4.9% from 114M in 2012 to 138M in 2017
- 2 **YES!** Specialty Drug spend has increased at a CAGR of over 15%
- 3 **Not Really...** Numerous models are emerging but still in an experimental phase with limited consensus on what works
- 4 **No!** Consumer choice has been controlled by more restrictive networks and formularies

While Government membership and usage of high cost specialty drugs has increased, no consistent new reimbursement models or plan designs to increase consumer choice have emerged



PBM Relationship Consolidation

Massive retail and PBM consolidation makes PBMs ripe for disruption and vulnerable to direct attacks on traditional PBM value drivers. Health Plans have an opportunity to demand better economics and service

Forbes

The CVS/Target Deal Is Just The Beginning: Why Retail Is Ripe For More Mergers And Acquisitions

The New York Times
Walgreens Calls Off Deal to Buy Rite-Aid
Instead Rite-Aid will sell 2,186 stores out of a total of 4,600

HEALTHCARE FINANCE

Cigna teams with CVS Health in collaboration to rival urgent care clinics
Roughly 45 percent of urgent care facility visits by Cigna members could be conducted at retail healthcare clinics, insurer says.

The Washington Post

Anthem sues Express Scripts over prescription drug pricing
Health insurance company Anthem is suing Express Scripts, the largest prescription drug benefit provider in the U.S., for allegedly charging too much for drugs.

The New York Business Journal

Pharmacy lines may feel shorter with Zipdrug

Forbes

Why Pharmacies Really Should Fear Amazon Invading Their Market

Potential Pharmacy Scenarios

- 1 Attempts at retail pharmacy consolidation will continue, with retail commanding better reimbursement levels and threatening PBM profits from spread pricing
- 2 As the major health plan outsourcing deals mature, health plans move to insource value by taking functions back from the PBMs
- 3 Non-traditional players continue to attack profitable PBM channels such as Mail Order and Retail
- 4 Health plans look beyond the PBM for help managing Specialty Drug spend on both the medical and pharmacy benefit



PBM Relationships Maximization

Health Plans should consider the following tools and approaches to maximize the value of their PBM relationship

Pharmacy Performance Management

Detailed Cost & Trend Driver Analysis



- Claim Summary Review
- Top Therapeutic Class Review
- Claim Cost Trend Analysis
- Network Performance Analysis

Performance Management Services



- Claim-Based Plan Design Review
- Claim Payment and Financial Accuracy Validation
- Rebate Remittance and Collection Review

Product Analysis & Evaluation



- Plan Design Review and Intent Validation
- Design Strategy and Analysis
- Valuation, Pricing, and Rate Tiering

Partner Evaluation & Selection

Pharmacy Operating Model Analysis



- Current State and Functional Sourcing Assessment
- Document Pain Points, Gaps, and Inefficiencies
- Steady State Recommendations

Partner Selection & Evaluation Services



- Request for Information (RFI)
- Request for Proposal (RFP)
- Renewal Negotiation and Support

M&A Synergy Analysis



- Base Financial Synergy Calculations
- Incremental Synergy Valuation
- Financial Analysis and Price Underwriting

Migration Planning & Execution



- Customer Profiling and Book of Business Analysis
- Migration Strategy and Planning
- Operational Readiness and Execution

PBM Operations

Contract Review & Benchmarking



- Competitive Economics and Pricing Analysis
- Performance Guarantee Review
- Evaluation of Contract Terms & Conditions

Performance Auditing



- Rebate and Retail Network Auditing
- Claims Payment Accuracy Review
- Performance Guarantee Audit

Operational Performance Improvement

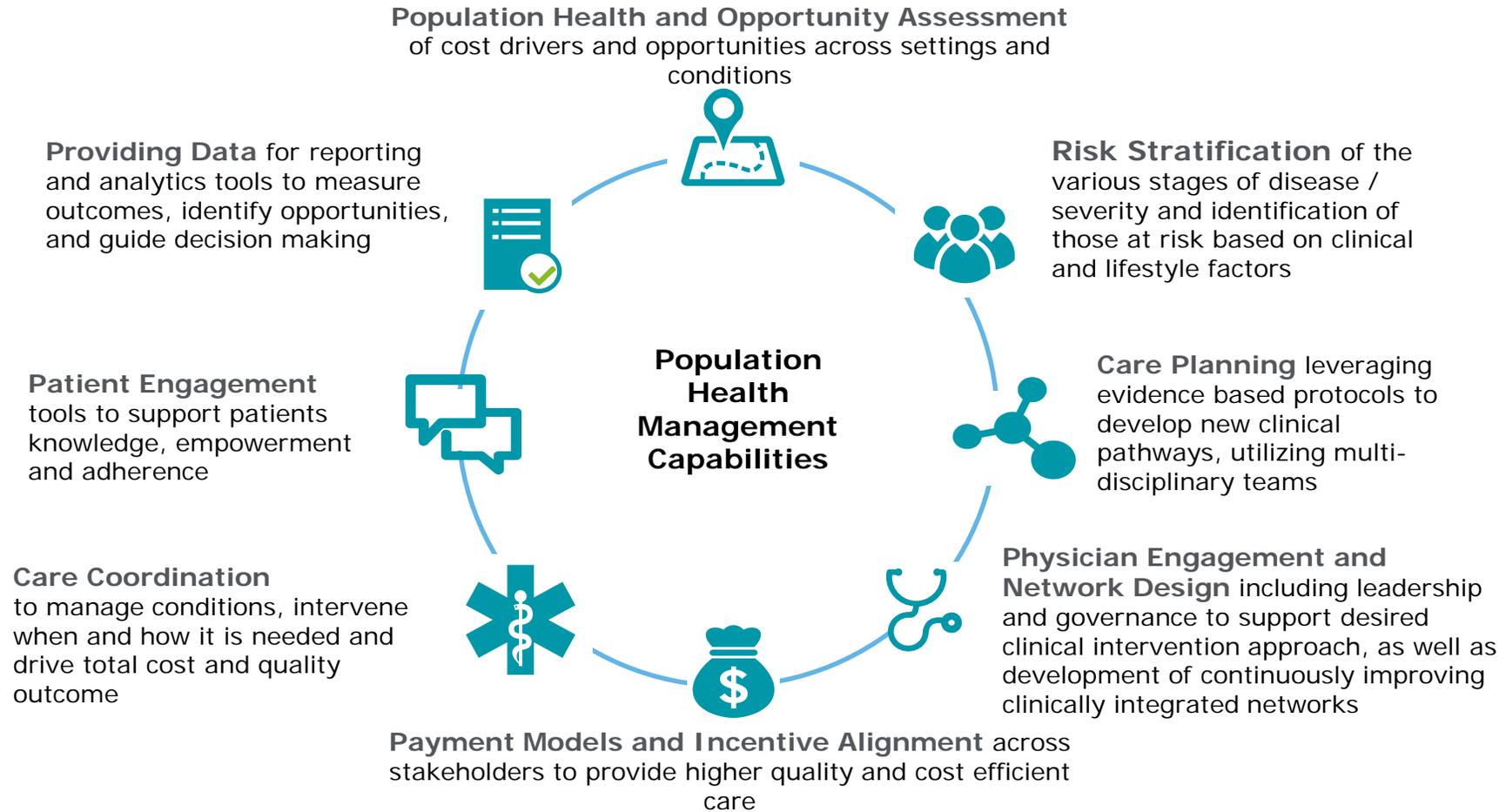


- Benefit Loading and Testing
- Process Enhancement and Automation
- Capability Assessment and Innovation



Care Model Redesign

Health plans can define a broader portfolio of population health offerings to help provider partners succeed under VBC arrangements



Health Plans should continue to strengthen existing strengths and capabilities in provider analytics and reporting, care management, and risk stratification in order to entice provider partners

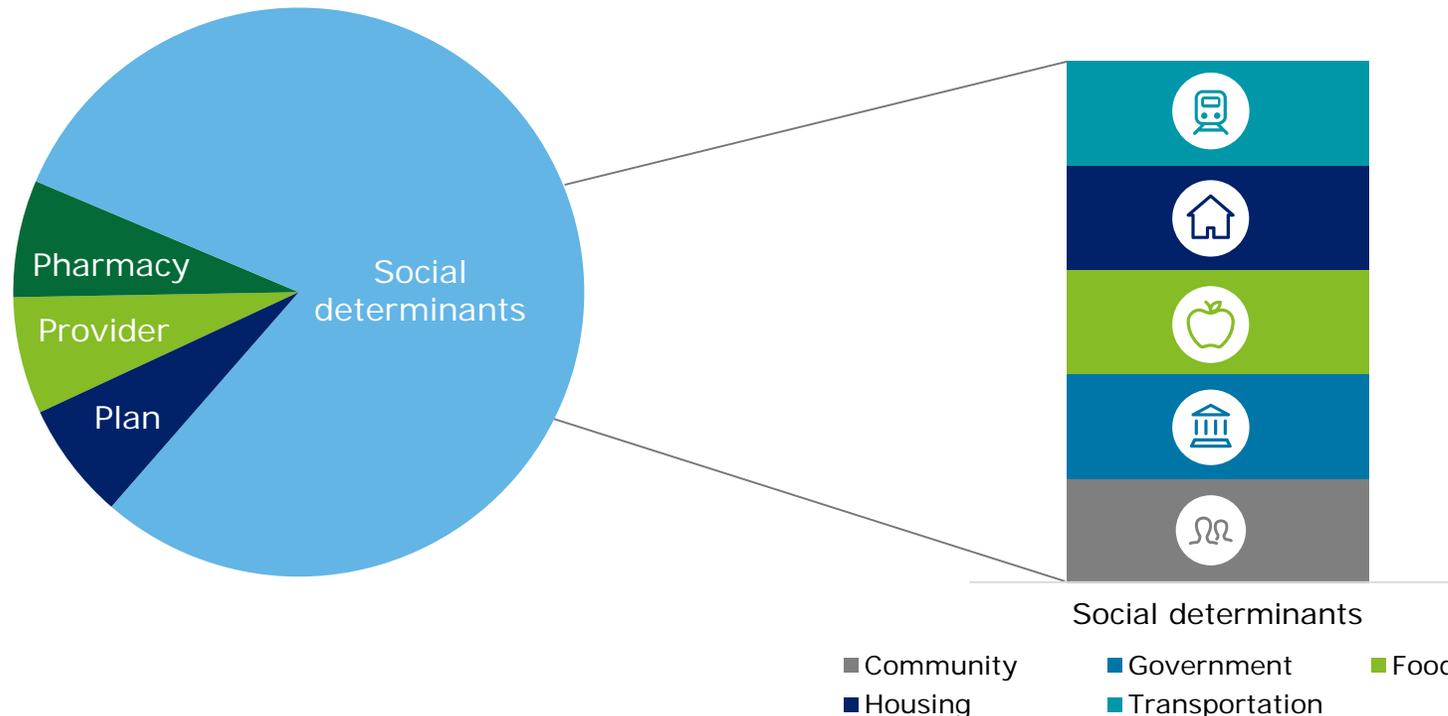


Care Management: Social Determinants of Health

Environmental and social factors greatly impact patient health, but they are often not addressed or prioritized by the health care system

20 percent of health outcomes are determined by clinical care, yet this accounts for **88 percent** of health care investment

80 percent of health outcomes are determined by environmental and social factors, yet few players understand these factors or are able to integrate relevant services into their treatment protocols

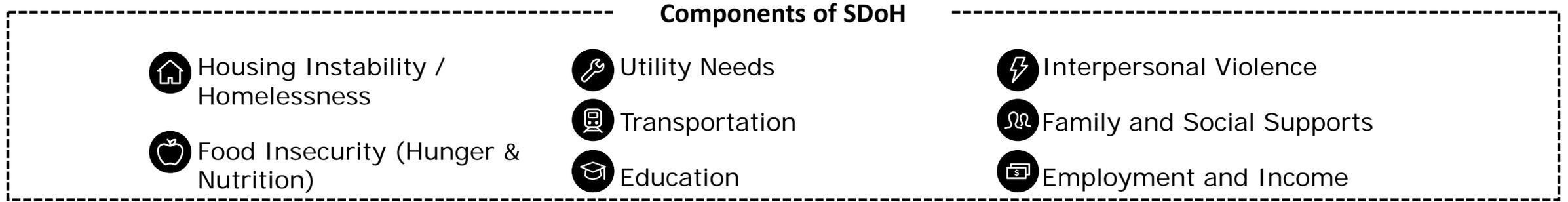


Sources: Health Aff (Millwood). 2010 Sep



Care Management: Social Determinants of Health

There are a few pragmatic ways in which a Health Plan can leverage its own data or 3rd party resources to address many of the components of social determinants of health



Pragmatic Approach to SDoH

#	Description	Rationale
1	Identify and collect SDoH factors on every member (from zip codes to consumer info) and leverage in all programs	Advanced stratification algorithms layer in any number of SDoH variables that factor in social when determining the right program and intervention strategy
2	Deploy Community Health workers in specific markets and populations	Research supports efficacy of peer-based coaching programs (e.g., Peers for Progress) for disease education and self-management of chronic conditions
3	Provide care managers and providers with information and access to available resources	Aggregation platforms, such as Aunt Bertha, provide quick reference to available community programs (housing, transit, financial, etc.) within the patient/members immediate geography



Next Gen Product Design

As health plans look for ways to manage the premiums of their products, their focus has not always been on one of the most important levers they can pull: refining their networks. Health plans have the opportunity to address this challenge by advancing their analytic capabilities

Analytic Capabilities

- Health plans heavily invest in analytic capabilities, however provider relationships are not always data driven and are instead built around relationships, not performance
- Network analytics are typically done by viewing provider relationships on a contract by contract basis, rather than viewing the network holistically

Ways to Measure Success

- A way to measure physician populations (e.g. efficiency, quality, etc.) is not consistently available throughout the industry
- Trade-off discussions aren't always occurring when creating a cost efficient, successful network (e.g. "what premium are consumers willing to pay for a narrow network?", "Is this provider group worth the additional bump in premium I must charge to have them in?")

Typical Product Design

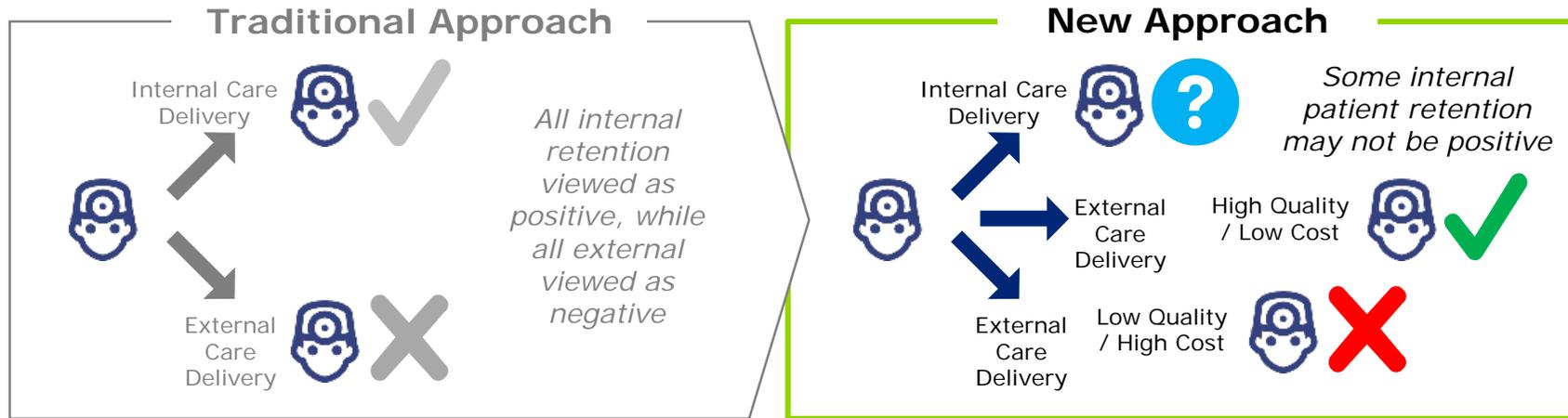
- Traditional focus has been benefit design as a way to control costs, rather than selectively focusing on who's driving and providing the care
- Regulations prevent additional benefit design options and pricing levers have not been flexible enough

By leveraging advanced analytic capabilities to optimize their network, a Health Plan has both the opportunity to create the "right" partnerships and the ability to lower cost of their products



High Performance Provider Network: Patient Retention Analytics

As participation in more VBC deals increases, it becomes critical that the system analyzes patient retention and care patterns – especially since not all leakage is bad and not all “keepage” is good.



Using Care Pattern analytics, organizations will be able to concentrate patient retention efforts in a more efficient and effective manner. For example:

- The **relationship view** visualizes how physicians in the market are interconnected, based on shared patients
 - Can be used to identify potential gaps in the network
- The **care leakage view** identifies organization physicians directing patients out-of-network and displays performance of the non-organization provider
 - Leakage to low-performing non-organization providers represents greatest opportunity for financial impact of retention
- The **care redirection feature** re-evaluates physicians' performance, taking into account their own performance, the performance of closely connected physicians/facilities, influence in the market, capacity, and location (drive time)

Questions?



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