Emerging Health Care Trends and the Effects on Payers

Remaining competitive in the new care delivery landscape with analytics and predictive modeling
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Withstanding recent court rulings on the constitutionality of the Patient Protection and Affordable Care Act (PPACA), the law’s unprecedented changes will create serious challenges for the health insurance marketplace—increased competition for the group market, burgeoning numbers of insured patients, cost restrictions, complex compliance requirements, and new models of care. Understanding these changes and trends and then using analytics and predictive modeling will allow health plans to develop the products and services needed to remain competitive in the new health care landscape.

We must begin to understand the effect of the new law by placing it in the context of the “Triple Aim” that Dr. Donald Berwick, the administrator of the Centers for Medicaid and Medicare Services (CMS), has decided will be the central focus of CMS. The Triple Aim was described in an article by Dr. Berwick, et. al. for Health Affairs entitled The Triple Aim: Care, Health, and Cost.

As described in the Health Affairs article, the Triple Aim consists of three overarching goals:

- Better care for individuals, described by the six dimensions of health care performance listed in the Institute of Medicine’s 2001 report Crossing the Quality Chasm: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.
- Better health for populations, by attacking “the upstream causes of so much of our ill health,” such as poor nutrition, physical inactivity, and substance abuse.
- Reducing per-capita costs.

The goal of the PPACA is aligned with the Triple Aim and its influence is clearly seen in the Act. Better care, better health, and lower costs are drivers of the PPACA. The question is how can better care, better health, and lower cost be simultaneously achieved when many view them as mutually exclusive?
This is the essence of the challenges for payers shaped by the PPACA and it is also where the opportunities arise!

Another entity that must be understood is a by-product of the American Recovery and Reinvestment Act (ARRA), specifically the Health Information Technology for Economic and Clinical Health (HITECH) sub-act, which created/expanded the idea of Health Information Exchanges (HIE).

An HIE is “the process of reliable and interoperable electronic health-related information sharing conducted in a manner that protects the confidentiality, privacy, and security of the information\(^1\).” HIEs exist at the state-level and are in development at the federal/ regional level. They can also exist within a health system.

Collectively, the Triple Aim and government sponsored HIEs set the stage for a real transformation of health care practices and policies in the USA.

The challenges and opportunities thus presented need to be understood and actions/reactions to them must be available for payers to remain competitive in today’s market. Let us examine a few of the new topics and how payers will be impacted in the new landscape.

**Expanded Coverage: Health Benefit Exchanges and Expanded Medicaid**

Unlike Health Information Exchanges, where data is shared for the joint use of patient care and analysis of care, benefit exchanges are a new model of delivery, by which consumers can have access to shared information on offers of health insurance coverage. The PPACA establishes two types of benefit exchanges – one for the individual market and one for the small group market. By 2014 most Americans will be required to have health insurance, if current laws are not repealed.

Individuals who do not have access to employer plans will be able to purchase insurance through state-based American Health Benefits Exchanges.
Plans in the Exchanges will have to meet minimum standards with four levels of coverage that vary in premiums, out-of-pocket costs, and benefits. Exchange plans must offer catastrophic coverage. (4)

New private health plans will be required to provide a minimum set of services. Caps will be placed on out-of-pocket spending for essential benefits, cost-sharing with members for preventive services will be prohibited, annual limits will be phased out and lifetime limits eliminated. (4)

All plans will be required to reduce waiting periods to 90 days or less and will be prevented from denying coverage for any reason and from charging higher premiums based on gender or health status. (4)

Medicaid coverage will be extended to anyone under age 65 whose income is up to 133% of the federal poverty level (FPL). (4)

**What Does This Mean for Payers?**

The Congressional Budget Office estimates that as many as 32 million Americans will be newly insured by 2014, taxing the ability of payers to enroll, assess risks, and make underwriting decisions. The ranks of the insured will include greater numbers of members with pre-existing chronic and serious health conditions that are expensive to treat.

While the pool of non-chronic or serious health condition members will be larger, allowing the increased costs to be spread amongst more members, the financial burden on payers to treat the newly acquired members with serious health issues is expected to be large.

Payers will need efficient and comprehensive data analytics capabilities to stratify risk and motivation and efficiently prioritize preventive and chronic care initiatives to develop benefits that align with each group’s health care needs.

A key to success will be the need for payers to respond to the accompanying demand for better products, service, information and overall value, and to focus on real cost drivers.
New Models of Care

Accountable care organizations (ACOs) are networks, partnerships, or joint ventures of hospitals, group practices, and other health care entities that provide care across a continuum of services to a defined patient population. Networks will be defined differently in the future. An ACO could be its own network, embracing and accepting the risk for a specific population. The network will be accountable for the cost and quality of care and will receive payment for all care for which they have taken risk.

ACOs are required to build a technology infrastructure to support clinical coordination, collaboration, and continuity of care. The model seeks to promote evidence-based medicine and patient engagement, and to report on quality and cost measures. Incentives are designed to promote disease and care management, and physician compensation is performance based, focused on quality, efficiency, and financial performance.

The patient-centered medical home (PCMH), a primary component of ACOs, is an approach to care that facilitates partnerships between patients and personal physicians who manage a care plan and coordinate with specialists. The personal physician leads a team of health care providers who collectively care for the “whole” patient throughout all stages of life and types of care—preventive services, acute and chronic care, and end of life.

Health information technology (HIT) facilitates the transmission of care data among physicians and care givers, across all care settings. Incentives and shared savings models are designed to promote better care coordination, resulting in wellness, targeting reduced disease management and more proactive health care. The ability for physicians and care givers to understand all of the pieces of the whole patient is paramount to managing the risk in an ACO network, and results in truly holistic care. Compliance with evidence-based guidelines is increasingly important in value-based reimbursement systems.
What Does This Mean for Payers?

The collaborative, integrated care approach of PCMHs, ACOs or any other emerging care delivery model requires highly developed technological infrastructure; access to accurate, timely, and comprehensive data; and integrated clinical and financial analytics. Tracking meaningful results for the patient population and per-capita spending will be critically important in charting the success of these approaches.

Payers have an opportunity to partner with ACOs because they have the critical claims data that ACOs need to better monitor patients’ health, identify gaps in care, and manage risk. Reimbursement within these models requires a different kind of tracking system for payments than that used for fee-for-service. Rather than paying for individual services, plans will increasingly reimburse for improved member health and wellness, coupled with demonstrated cost savings.

This type of reimbursement model requires greater transparency and sharing of health information as well as better methods for tracking to improve decision support and better methods for tracking compliance with evidence-based guidelines. Payers who can provide analysis of quality initiatives and care delivery in real-time will become the partners of choice for ACOs who need to meet quality-of-care performance thresholds as defined by CMS.

Medical Loss Ratio (MLR)

MLR is defined as the percentage of premium dollars an insurance company spends on medical care rather than administration or profits. Starting in 2011, payers must meet the new MLR ratios or refund the difference to policy holders beginning in 2012. Large group plans must have an MLR of 85% while small group and individual plans are required to have an MLR of 80%.

What Does This Mean for Payers?

Payers will need to implement or redesign internal processes to help decrease administrative costs and increase spending on medical care. They must be able to demonstrate how the funds were spent on medical care. As administrative functions are eliminated in favor of a greater focus on medical care, it is critical that payers have
HIT to support those administrative tasks previously supported by humans. Payers also have to adopt the right strategic model to approach and engage consumers evaluating the correlations of factors that indicate how some of them are more amenable to an intervention than others. This can only be accomplished by leveraging some very refined data mining, predictive analytics and modeling tools that help transform information into strategic assets, representing an assessment of the motivation of the individual members to participate in their own care (preventive or otherwise), facilitating better decision making, and building a competitive advantage through appropriate financial delegations for quality care services.

**Greater Individual Responsibility**

As employers seek new ways to control rising premiums by sharing more health care costs with employees (higher deductibles/co-pays, and restricted retiree benefits), individuals will be forced to assume more responsibility for managing and paying for health services and planning for the future.

Financial health care planning is expected to be provided by “health infomediaries,” that is, entities who help consumers navigate the insurance, channel, and service options.

These health infomediaries are expected to provide expertise in healthy lifestyle/behavior choices, health benefits, provider pricing and quality, comparative cost-effectiveness, care coordination, and financial and insurance planning.(6)

**What Does This Mean for Payers?**

Consumer engagement will drive more transparency of costs of care. Because they have access to consumer health information, payers will be in a good position to serve as health infomediaries, but they will face competition from health care providers and financial planners who could provide similar services.

Payers must strive to become trusted sources of information for members. Plans that can deliver a more personalized experience, provide timely analytic data that consumers can act upon, and differentiate their products and services will be better able to compete in the changing landscape.
Competition

The competitive landscape is changing: more benefit plans might be sold to individuals rather than group purchasers, creating more market segmentation and a need for more flexible products and services. Competition will come from regional, national, and nontraditional institutions (e.g., financial).

The basis for competition will shift from price, coverage, network size, and claims processing/ responsiveness to personalized, actionable information for consumers and products and services that are targeted across a wider range of health care needs and delivery channels.

What Does This Mean for Payers?

Innovation is needed to provide personalized products and services and cover specialty networks and new models of care. Payers will need to shift to a retail mindset in which the consumers, along with employer groups, are the primary customers. Important capabilities will include:

• Empowerment of members to assume greater accountability with data-driven tools to address health and wealth decision making, especially preventive services

• Collaboration with providers to achieve success in a value-based reimbursement environment by providing comparative effectiveness data and streamlining administrative processes

• Innovation in products and services through a shift in mindset and development of partnerships and collaborations with other stakeholders

• Optimization of operational efficiencies to reduce costs, improve service levels, and maximize margins through comprehensive data analysis and predictive modeling

• Development of strong business intelligence capabilities through flexible and efficient transaction systems and robust analytics that use clinical and claims information to advise members and providers

Innovation is needed to provide personalized products and services and cover specialty networks and new models of care.
How Can MEDai Analytics Help Payers Meet These Challenges and Opportunities?

Identification and Stratification of Risk
Instead of a simple “risk score,” MEDai focuses on the facets of population health management through a data agnostic approach that includes member-level insight around:

Prediction
- Forecasted Medical cost
- Forecasted Rx cost
- Forecasted acute utilization
- ER visits
- LOS
- Propensity for predicted acute utilization to be impactable [through medical management and other payer initiatives]
- Propensity for chronic guidelines to be impactable

Identification
- Members with evidence-based medicine (EBM) guideline gaps
- Members experiencing a large increase/ decrease in their costs/ utilization (movers)
- Members with the propensity to engage with clinicians and self-manage
- Members missing pharmaceuticals

Prioritization
- Priority diagnosis assignment
- Condition-specific contributions to forecasts (risk drivers)
- Medical management status

Analysis of Cost and Utilization and Prediction of Trends
Quick and easy access to cost and utilization trends, outlier forecasts, and identification of diseases/conditions that will most likely affect future costs.

Provider Performance
Analyze compliance with evidence-based guidelines within a population of members and physician networks to form improvements in care coordination and to manage costs.

Use flexible benchmark comparisons of provider efficiencies and enable collection of data across ACOs and other networks that are required for quality-performance reporting and value-based reimbursement.

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Partnership Support
Provide the data support that providers and payers need to move from traditional fee-for-service to pay-for-performance, incentive based and shared savings initiatives and other payment models through shared monitoring of compliance with guidelines and their corresponding effect on patient health status.

Promote a shift in care from disease focus to wellness focus by providing the data analysis needed to assess where interventions will make the most impact on patient outcomes.

Bibliography/Citations
1. Donald, M. Berwick, Thomas W. Nolan, and John Whittington, ‘The Triple Aim: Care, Health, and Cost’, Health Affairs, 27, no. 3 (May, 2008), pp. 759 - 769,


3. AHIMA, Health Information Exchange, web page.


For more information:
Call 800.446.3324 or visit www.medai.com

About MEDai
For over 20 years, MEDai, has been developing and delivering medical and health information leveraging the industry’s most data and technology solutions. MEDai started with one simple idea: the incredible volume of data that flows through health care organizations holds the secret to improving care and reducing costs. The key to success is being able to turn that data into action. MEDai combines sophisticated data mining technology with advanced analytics to enable health care organizations to make better decisions and improve the quality of health care outcomes and operational efficiencies.

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