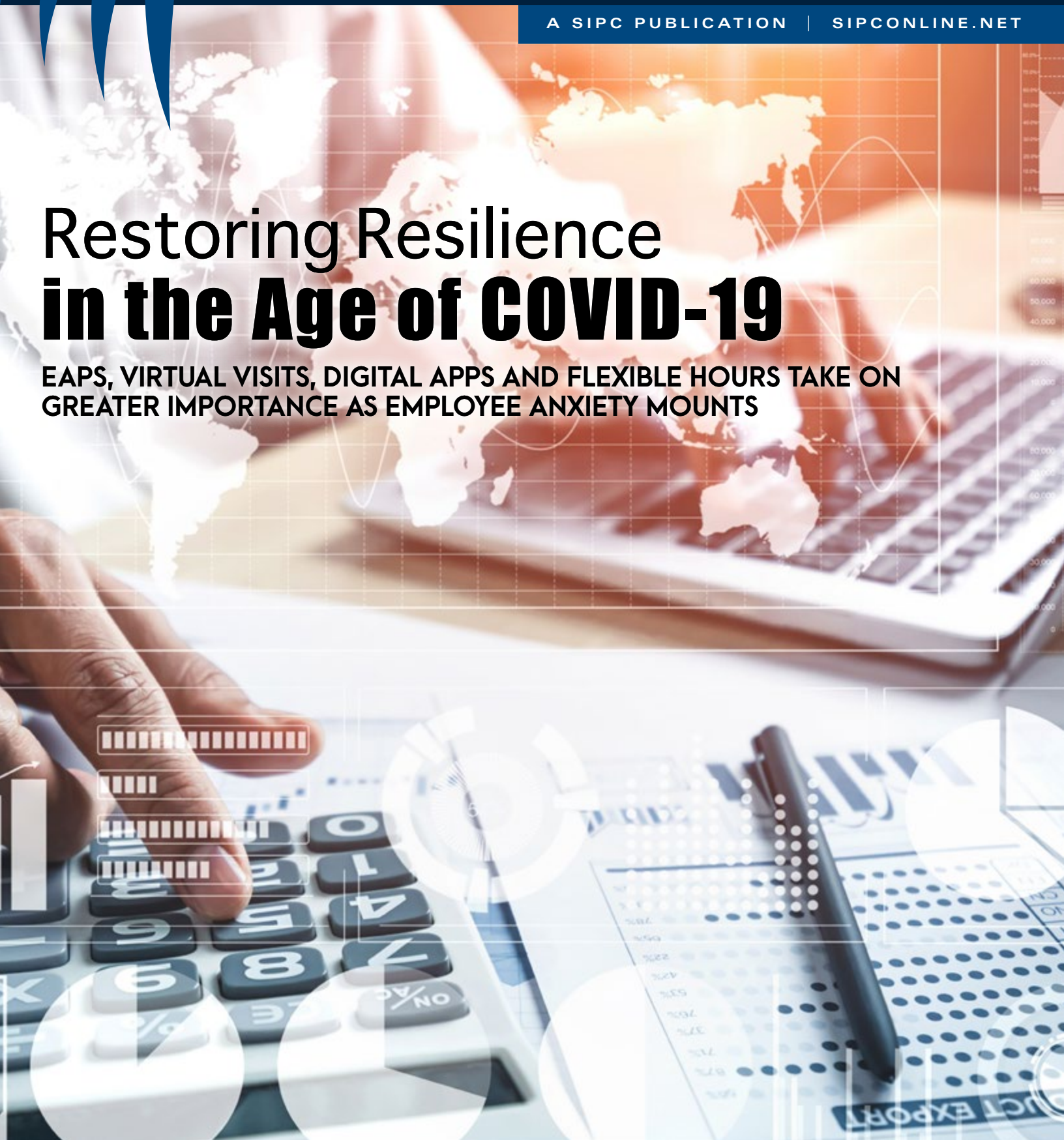
SEPTEMBER 2020

THE Self-Insurer

A SIPC PUBLICATION | SIPCONLINE.NET



Restoring Resilience in the Age of COVID-19

EAPS, VIRTUAL VISITS, DIGITAL APPS AND FLEXIBLE HOURS TAKE ON GREATER IMPORTANCE AS EMPLOYEE ANXIETY MOUNTS

HOW TO DECREASE YOUR HEALTH PLAN COSTS

Written By Scott Roloff

Now is the time to innovate to decrease your health plan costs. Doing so is a two-step process; finding the best doctors and getting your people to them.

GOOD HEALTHCARE COSTS LESS

Healthcare is not a commodity. We all think that our doctor is the best-or at least above average-but we don't live in Lake Wobegon where all the children are above average. Exactly half of all children are above average, and exactly half are below. It's the same with doctors-and the specialists and surgeons that they refer us to, and the hospitals that they put us in.

Although it seems counter-intuitive, going to a good doctor costs less overall than going to a bad one. 30% of healthcare costs are unnecessary, the result of poor or ineffective care and good doctors don't incur those excess costs.

Good doctors make fewer errors, perform fewer unnecessary procedures, experience fewer patient complications and get their patients better faster.

But how do you find the best doctors? The best doctors have the best outcomes.

MEASURING QUALITY IN HEALTHCARE

Many purport to measure healthcare quality and identify the best doctors, and every insurance company has a "narrow network" listing the best doctors in their network, but you have to ask what they're measuring to do so?

What they're measuring are proxies for a good outcome that they hope will predict one, such as:

- Whether the doctor complies with a checklist of recommended processes and procedures?
- Whether patients "like" the doctor?
- Whether the doctor went to a prestigious medical school?
- And thrown into this mix is what the doctor charges for an office visit or procedure?

To find the doctors that achieve the best outcomes, you have to measure the outcomes.

QUANTIFYING OUTCOMES

There are two ways to quantify healthcare outcomes. Which one you use depends on who you are and what data you have.

Occupational Outcomes

If you're an employer that self-insures your health plan you own your claims data; and you can combine those claims with your human resource (HR) and absence data.

Begin by defining a "good outcome" as an ill or injured employee being at work. You then measure all the costs to get the employee back to work and/or keep them there over the entire continuum of care. For serious illnesses and injuries, those costs are not only the claims paid to the doctors and hospitals, but the absence costs while the employee was out, which can be even more.

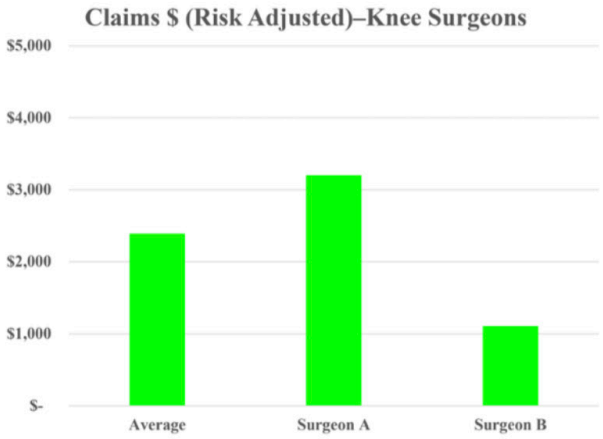
You can then rank each provider by root diagnosis, from the best with the lowest average risk-adjusted cost (claims + absence costs) when treating employees with that condition, to the worst with the highest–and you can use those employee-derived rankings to move everyone to better care.

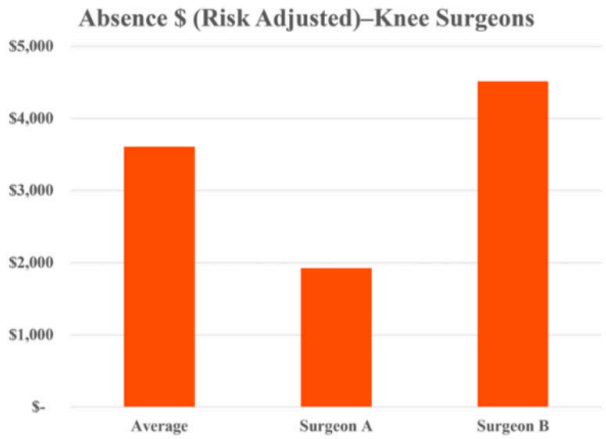
The charts below compare two knee surgeons against each other and the average for the group of knee surgeons in a provider network. The chart on the top left in green compares

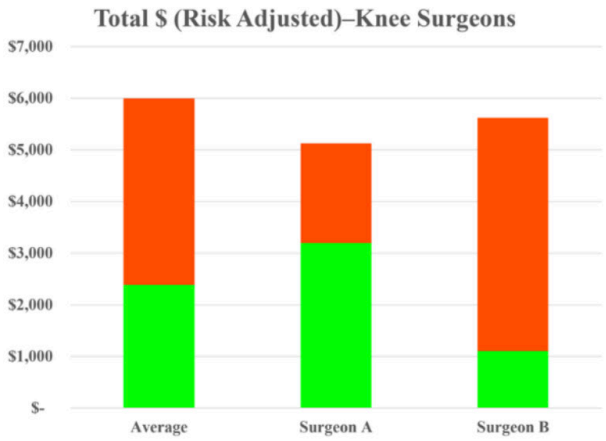
the average risk-adjusted claims costs. Surgeon A is above the group average, while Surgeon B is below. Stopping here—and everyone else does—Surgeon B is the best choice.

Now moving to the right, we see their absence costs in orange—the average risk-adjusted amounts that the employer paid to each surgeon's patients while they were out sick. These are not only real costs to the employer, but double as an indication of the effectiveness of the care. The quicker the surgeon got the employee better and back to work, the more effective the surgeon was. Here Surgeon A is much better than average, while Surgeon B is worse.

The bottom chart combines the two. Both Surgeon A and Surgeon B are better than average, but Surgeon A is the best. Something you would never have seen by just looking at the claims.





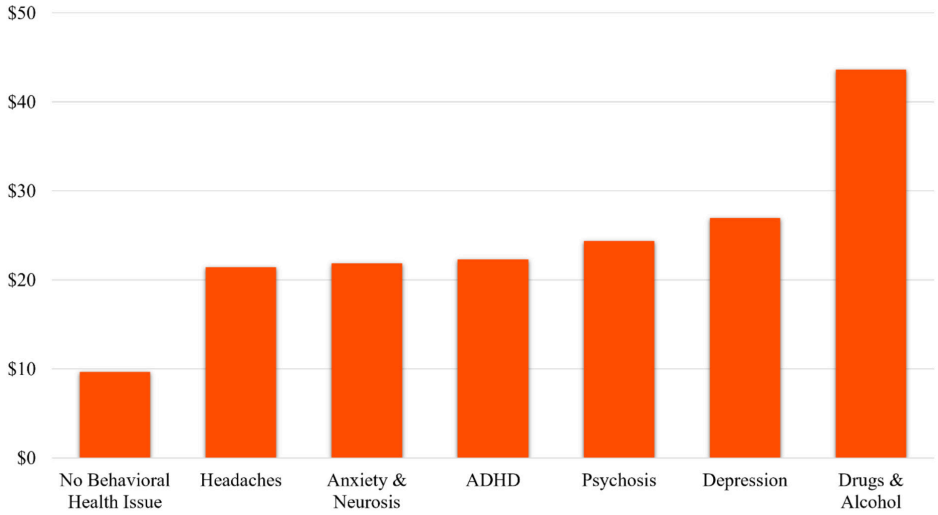


Clinical Efficiency

If you're a health insurance company or just don't have HR data to match against the claims, including an employer quantifying the outcomes for the spouses and dependents in its plan, you can measure the outcomes using just the claims. Instead of asking how much it cost and how long it took to get and/or keep an employee at work, now ask how much it cost in claims to keep a person well?

Define being well in terms of healthy days, which you can see in the claims. Healthy days are days that the person does not spend in the healthcare system (e.g. hospital stays, doctor's visits, etc.) or at home in a non-functional state (e.g. recuperating or otherwise unable to carry out their normal activities). You can then rank each doctor by root diagnosis, from the best with the lowest average risk-adjusted claims per healthy day, to the worst with the highest.

The chart below illustrates this concept with behavioral health issues. If a person doesn't have any behavioral health issue, it takes $10 per day to keep them healthy (i.e. almost everyone will have some claims and unhealthy days during a year).



On the other hand, if a person has headaches it doubles to over $20 per day, and if they have a drug or alcohol problem it doubles again to over $40.

RISK SCORES

You'll notice that the above methods refer to "risk-adjusted" claims and absence costs. Risk scoring is critical when quantifying outcomes. If you ask any doctor why their costs are more than another doctor's, they'll always give the same answer. "Because my patients are sicker." And sometimes they're right.

Sicker patients cost more and take longer to get better. If you have two patients with the same back injury, one of them young and otherwise healthy,

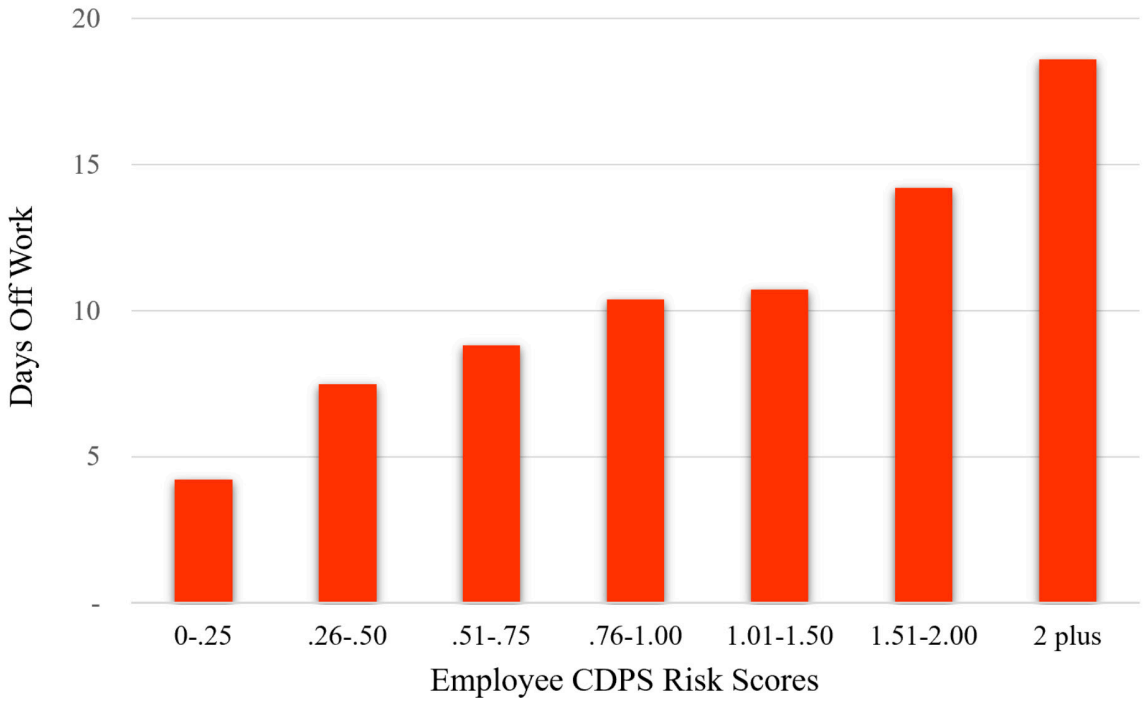
while the other older, overweight and diabetic, the older patient is going to cost more. So you need to adjust for comorbidities by assigning each patient a risk score. That way the provider rankings are based solely on the doctors' performances, not the patients that they treated.

A good risk scoring system to use is CDPS (Chronic Illness and Disability Payment System). CDPS is an open source system designed by the University of California, San Diego and employed by many Medicaid programs around the country.

Accordingly, it is demographically appropriate for a working age population. In contrast, if you are working with a Medicare Advantage plan you might use the HCC risk scoring system (Hierarchical Condition Categories) used in Medicare.

The CDPS system looks at various demographic and clinical data, including age, gender, diagnoses, and the prescription drugs that a patient is taking, and assigns the patient a score: 1.00 being an individual of average health, below 1.00 healthier than normal (the lower the score, the healthier), and above 1.00 sicker (the higher the score, the sicker).

The chart below shows the relationship between an employee's risk score and the number of days that they miss from work. As you would expect, the higher the risk score, the more time that they miss.



GETTING FOLKS TO THE BEST DOCTORS

Quantifying the outcomes and ranking your network's doctors based on the outcomes that they achieve is only half of it. Now you have to get your folks to them. There are a number of ways to do so.

Network Design

The most obvious answer is to design your provider network to include the best doctors for each root diagnosis, or at least eliminate the worst. And it's the worst doctors, who often see only a few of patients, that cost the most. You can think of this in terms of Malcolm Gladwell's "10,000-hour rule," his hypothesis that you must practice something for 10,000 hours to become an expert at it. If a doctor sees only a few back patients a year, that doctor probably won't be very good at treating back patients.

The takeaway is that eliminating the worst doctors from a network, who may be seeing only a few patients anyway, can make a big difference!

If you're a health insurance company, that's your answer–unless you've contracted with a health system that precludes you from excluding any of its doctors.

What if you're a self-insured employer? You have a contract with an insurance company to provide you with a network of doctors and process your claims, i.e. a TPA–Third Party Administrator. Will the insurance company let you add and delete doctors from the network? The answer is almost always "No." Next.

Stratify the Network

If you can't choose the network, stratify it. Decrease or eliminate co-pays and out-of-pocket costs when plan members go to the best doctors. Properly structured, you'll save more in decreased claims and absence costs than you'll lose by giving up those co-pays and deductibles.

If you have a HDHP (High Deductible Health Plan) coupled with HSAs (Health Savings Accounts) you can do essentially the same thing by contributing to the employees' HSAs when they go to the best doctors. Be careful with those HDHPs, however.

Is shifting upfront costs to your employees causing them to defer care? When a problem arises, an employee will go to the doctor if they know that all they will pay is the co-pay. They might not go, however, if they'll have to pay the entire doctor's bill. Make sure you're not saving a little on the front end, only to pay a lot more later, when a problem that could have been remedied early festers into a much larger problem.

Case Managers

You have case managers who work with your high cost and chronically ill members. Give them a list of the best doctors for each diagnosis so that they can help those members get the best care. You can provide this list to the case managers interactively over an internet portal.

You can give the doctors in your network, and even your members themselves, similar portals to look up the best doctors. Primary Care Physicians (PCPs) often don't know the best specialists and surgeons to whom to make referrals. Now they can just look them up. And you can give your plan members a portal to look up the best doctors for what they need themselves. The problem will be getting them to use it.

Your plan's members will only make up a fraction of any doctor's overall patient load. Will the doctor change their routine for your members and stop to look up the best specialist or surgeon when referring them?

On the other hand, patient steering tools have a notoriously low participation rate. Not without good reason, patients suspect that they're being directed to the cheapest option. And if you have a sick child you don't want cheap, you want the best. These analytics identify the best, but it takes some effort to educate the members so that they understand that.

Wellness Programs

We've concentrated on quantifying the outcomes achieved by doctors, but these analytics can quantify the outcomes for other things too, like wellness programs. Everyone knows that generic lifestyle wellness programs don't work.

For every $1.00 spent on them, they save 50¢-a negative return of 50%. On the other hand, targeted wellness programs do work, those specifically for patients with diabetes, hypertension, etc. For every $1.00 spent, they save an average of $3.80. These analytics can identify which wellness programs are right for an employer's population, and then quantify the outcomes those programs achieve and calculate the ROI.

WORKERS' COMPENSATION

We've been focusing on health plans-a word about workers' compensation programs. In most health plan settings, you can only encourage someone to go to the best doctor. They can go to whoever they want.

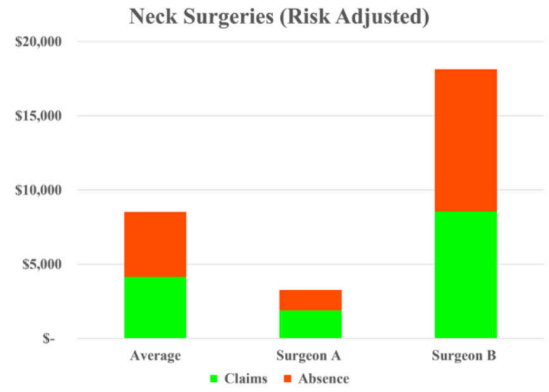
Workers' compensation is different. In many states, an employer can direct care and require an injured employee to go to the provider that the employer selects, the one that these analytics identify as the best doctor for that type of injury. Accordingly, although the numbers are smaller, an employer can capture a much larger percentage of the potential savings, while getting its injured employees better care.

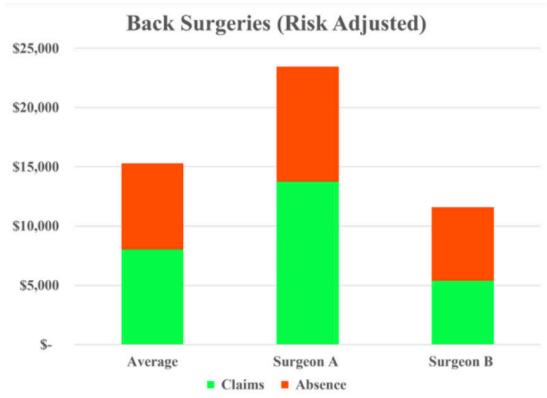
A FINAL THOUGHT: THE TALE OF TWO SURGEONS

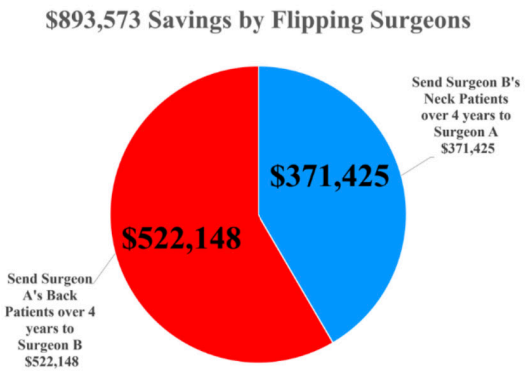
One of the more interesting insights involved one employer's network of orthopedic surgeons, which included Surgeon A and Surgeon B. Both surgeons did neck surgeries and back surgeries. The chart on the next page compares their neck patients over four years. Surgeon A was very good at neck surgery, and Surgeon B was very bad.

The chart on the right compares their back patients over this same four years. Here it was reversed. Surgeon A was very bad at back surgery, while Surgeon B was very good.

The chart on the bottom shows that this employer could have saved $893,573 over these four years by flipping each surgeon's patients to what that surgeon was good at–Surgeon A handled Surgeon B's neck patients, and Surgeon B handled Surgeon A's back patients.







Doctors aren't all good or all bad. They're good at some things, and not so good at others. These analytics find out what they're good at and exploit it to everyone's advantage.

BETTER CARE AT LOWER COSTS

By sending the plan members to the doctors that achieve the best outcomes–claims will go down. Good healthcare costs less overall than bad healthcare as 30% of claims are unnecessary, the result of poor or ineffective care. The best doctors deliver superior care for less, wringing out those excess costs. Absence costs will go down too because the best doctors return employees to work faster. And maybe most importantly of all, now everyone will receive better care. ■

Scott Roloff is the President of IntegerHealth Technologies, which combines advanced analytics with medical expertise to quantify healthcare outcomes for health plans and workers' compensation programs Driving down the costs, while improving the care. Scott can be reached at (817) 849-9402 and sroloff@integerhealth.com.