TBGH-DFWBGH 2013 Benefits & Wellness Forum White Paper

Prepared by Steve Jacob, 1/10/14

More than 400 healthcare, corporate benefits and wellness executives gathered in Dallas on December 5, 2013 to hear industry experts share success stories and insights about healthcare's future. The Ninth Annual Benefits & Wellness Forum, co-hosted by Texas Business Group on Health (TBGH) and Dallas-Fort Worth Business Group on Health (DFWBGH), covered a broad range of strategies and trends to help businesses navigate a fast-moving healthcare reform environment.

This White Paper recaps a baker's dozen healthcare trends that attendees gleaned from conference sessions.

1. Chaotic healthcare pricing drives transparency

The persistently vast difference in billed charges and contract rates will continue to fuel the engine of healthcare price transparency, according to Wally Gomaa, chief executive officer of Dallas-based ACAP Health Consulting.

For example, hospital chargemaster rates for cardiac imaging in Dallas-Fort Worth range from $1,361 to $9,219, compared with a Medicare rate of about $700. Similarly, he said billed rates for a major joint replacement range from $28,263 to $160,832 locally, compared with a Medicare rate of slightly more than $15,000.

Prices, not utilization, are driving healthcare costs. The utilization rate was nearly flat between 2010 and 2012 because high-deductible health plans deterred consumers from seeking care. Price pressure is expected to continue for commercial payers because the ACA will cut Medicare payments by $741 billion over the next decade, and Medicaid rates have been cut by Texas and other states, resulting in a cost shift by hospitals from government to private insurers. Medicare currently pays 86 percent and Medicaid 56 percent of a hospital's average cost of care, compared with 144 percent paid by private insurers.

Employers were urged to shop for the best healthcare values because contracted rates "are all over the place." Current price transparency efforts were characterized as "first generation" and widespread reference-based pricing for common procedures was predicted for the near future.

Eric Bricker, MD, chief medical officer of Compass Professional Health Services in Dallas, pointed out the seemingly arbitrary differences in prices within markets. Some examples:

- An arthroscopic knee surgery was $1,900 with an overnight hospital stay, compared with $7,000 for the same surgery at an outpatient facility in Houston.
- A procedure by the same surgeon cost $1,900 in an ambulatory surgery center and $6,600 at a hospital. The same company owned both facilities in Austin.

- The charge for an orthopedic procedure by the same surgeon cost $18,800 at Hospital A, $13,500 at Hospital B, and $7,200 at Hospital C in Austin. The hospitals were located within two miles of each other

Mike Haefner, senior vice president of human resources at Atmos Energy, said his company saved more than $250,000 in claims costs in third quarter of 2013 and has saved more than $3 million since it began using Compass, one of the nation's largest price transparency companies, in April 2011. He said his company's claim costs have risen only 1.3 percent since 2010 despite having only 3 percent of employees using high-deductible plans.

The most frequent Compass services are physician recommendations based on cost and quality, reviewing bills and providing price estimates. He said employees "are completely outraged" by the enormous differences in provider price quotes.

2. Payers are becoming more comfortable with narrow networks

Affordable Care Act (ACA) has been a catalyst for the creation of narrow provider networks. National and regional insurance carriers are developing smaller networks to compete on public and private exchanges. Mike Taylor, senior vice president at Aon Hewitt, noted that there has been significant provider re-contracting to include value-based reimbursement and greater risk sharing.

However, the savings of narrower networks are not significant. Taylor pointed out that a 40 percent decrease in network size only produces a 5 percent savings, and a 75 percent increase translates to a 25 percent savings.

Employers are more willing to trade limited access for improved cost and quality as healthcare costs continue to rise. According to the 2013 Aon Hewitt employer survey, about 1 out of 4 are steering patients to high quality providers, but more than 4 out of 5 plan to do so in 3-5 years.

2. Domestic tourism has replaced international medical tourism

The fear a few years ago was that foreign healthcare facilities would steal business from U.S. providers. Although foreign medical tourism has not really gained traction as expected, its threat did bring down the price of many procedures. The competitive pressure has now switched to the domestic front.

Companies are linking patients with national providers, such as children’s hospital networks, cancer center networks, and Mayo Clinic and Cleveland Clinic affiliations.

Examples of the "centers of excellence" include Lowe's use of the Cleveland Clinic for heart surgeries; PepsiCo's use of Johns Hopkins for cardiac and joint replacements, and Wal-Mart uses six health systems for heart, spine and transplants. Large employers typically select high-cost procedures, pay travel expenses and employees pay little or no cost.

BridgeHealth Medical, EmployerDirect and others are creating networks and benefits to support travel to certain domestic centers for knees, hips, and back procedures. Medibid finds physicians who accept

cash funds for care. However, domestic players also also need to provide concierge services and travel benefits to spouses to succeed.

3. The growth of ACOs has slowed

A *Health Affairs* blog indicated ACO expansion seems to have lost some steam. After the Centers for Medicare and Medicaid Services (CMS) announced 106 new Medicare ACOs in January 2013, only 35 new commercial ACOs were announced in the subsequent 10 months.

Blogger David Mulestein of Leavitt Partners, which tracks ACO formation, pointed out several reasons for the slowdown. Most of the early adopters were already in the program, there is a lack of widespread acceptance of the model by commercial insurers, and there is no clear model for success. Many healthcare organizations are waiting to see if ACOs renew their contracts with commercial payers, which would signal whether they are succeeding.

The initial CMS Pioneer ACO program yielded poor results. Aon Hewitt's Taylor said his recent discussions with health systems indicate that they want to hang onto the fee-for-service system as long as possible. Organizations are more likely to accept bundled payments and shared savings than accountable care programs that include shared risk and capitation.

Nonetheless, more than half of Americans live in areas served by ACOs. In spring 2013, 52 percent of U.S. patients lived in primary care service areas served by ACOs, compared with 45 percent just six months earlier. About 30 percent lived in areas served by two or more ACOs, which was double the rate six months earlier.

4. Delivery system transformation: How tomorrow will look like yesterday

The HMOs and integrated health networks in the managed care era of the 1990s shared characteristics with the current wave of delivery reform, including capitation, performance bonuses, restricted provider networks and rudimentary quality measurements. Employers back then wanted to reduce costs and manage quality, as they do today.

Key provisions of the ACA include insurance exchanges, value-based contracting and clinical effectiveness. Responsibility for population health management is shifting from payers to providers. Patients also have significant "skin in the game" through consumer-directed health plans.

Speakers predicted a resurgence of third-party administrators (TPAs), which have consolidated and become more flexible over the past decade. Aetna, Cigna and United Healthcare have used provider networks of TPAs to fill in geographic gaps. The spread of ACOs and the possible re-emergence of

provider-sponsored health plans would create demand for TPA networks, claims management and care management.

5. Major insurers are evolving their payment models

Health plans are focusing more on paying for outcomes and quality. Payment reform and competition for consumers on the health insurance exchanges are creating more local and regional plans.

The major national insurers are carving out niches nationally. Aetna has focused on ACOs and developing patient-centered medical homes (PCMHs), and facility-based and specialty-based markets. Blue Cross Blue Shield has focused its payment models on outcomes-based results through ACOs, PCMHs, pay for performance and Bridges to Excellence. The Blues have maintained more of a local market focus in contracting. Cigna's payment model focuses on individual consumers and has paid more attention to hospital payment reform, rather than physicians. United Healthcare has taken a broader approach than the other major carriers have, and has focused its payment models on outcomes-based results.

Insurers have ambitious plans to move a significant percentage of their spending to value-based payments. For example, Cigna expects to have 60 percent and Anthem plans to have 70 percent of total outlays in accountable care by 2016. Regional payers such as Health Partners and Harvard Pilgrim in Massachusetts already have half of their spending tied up in value-based payments. About half of health systems with at least $1 billion in annual revenue are gearing up to accept value-based payments as well.

6. Employers are embracing reference pricing

The number of employers that plan to use reference-based pricing will grow nearly 10-fold in the next five years, according to the 2013 Aon Hewitt employer survey. Only 8 percent of employers use reference pricing, meaning they would pay a specific amount for a procedure that is considered a fair price for quality care locally. However, that is expected to grow to 70 percent of employers by 2018. Common procedures covered by reference prices include magnetic resonance imaging, computed tomography scans and colonoscopies. Reference pricing is common in Europe's national health insurance systems.

Hip and knee replacement prices at California's most costly hospitals dropped by about one third after the California Public Employees' Retirement System (CalPERS) required its workers and retirees to pay out of their own pockets all costs above the established reference price of $30,000 in 2011. For the 41 California hospitals identified as "value" hospitals that initially charged below the reference price, patients paid co-insurance of $3,000.

CalPERS saved an estimated $2.7 million on joint-replacement surgeries in 2011. Of that, 13 percent was attributed to market share growth at "value" hospitals, while the balance was due to price reductions at all California hospitals in response to the new policy. Aon Hewitt's Taylor called the CalPERS case "a

classic example of transparency and market pressure," and said health plans need to be aligned with the potential growth of reference pricing.

7. The implications of delivery system transformation for employers

Delivery reform held several opportunities for employers. Reform could create cost savings by paying for value instead of volume; greater opportunity for steering employees to high-quality providers and facilities; sharing financial risk with health plans and providers, and leveraging the role of primary-care providers in managing chronic conditions.

Potential drawbacks will be the discomfort of moving away from traditional networks and the unpopularity with employees of narrower networks; the lack of a standard definition of "quality"; the need for provider systems to manage both population and financial risk; the lack of visibility on the pace of healthcare delivery reform, and the uncertainty of the ACA's implications.

Pat Pitsch, director of medical benefits for BNSF Railway in Fort Worth, said the key questions for employers include:

- Will senior management be willing to make employee health and healthcare a business priority before it becomes a crisis?
- Are they willing to adopt creative and unproven plan designs?
- Will companies support "shared savings" arrangements with providers?
- Will leaders emerge to be the voice of the business community to the provider community?

8. The emerging role of private exchanges

Some companies are choosing to offer their employees health benefits via private exchanges — online insurance marketplaces that are separate from the federal system. Employers typically purchase health insurance through the private exchange and employees can choose a plan from participating payers.

Private exchanges often allow companies to move toward a defined contribution model of health insurance. Private exchanges can be customized for any employer group. They also can offer a broader range of insurance choices. Single-carrier exchanges allow employers to preserve a role in choosing a plan design and insurance carrier. Multi-carrier exchanges usually are promoted by third-party brokers or consultants.

Joseph Dizenhouse, senior consultant for health and group benefits at Towers Watson, said private exchanges should be one part of an employer's strategy in providing benefits.

Private exchanges have been used most often for Medicare-eligible retirees whose companies are ending traditional retiree health insurance benefits. Another emerging market for private exchanges is younger retirees under age 65 who are not eligible for subsidies on the public exchanges.

Towers Watson research has found that more than 1 out of 3 employers see private exchanges as a viable alternative to traditional self-managed employer coverage for full-time employees in 2014.

However, 3 out of 4 want more evidence that private exchanges can deliver value and most are uncertain whether to move full-time employees to those exchanges in 2015. Many employers are uncomfortable with losing day-to-day control over benefits.

9. Major advancements in the fight against obesity

There have been several major developments in the last 18 months in combating obesity.

The Food and Drug Administration (FDA) approved two new weight-loss drugs—Qsymia and Belviq—in 2012, which were the first such compounds in 13 years. A third drug is expected to be approved in mid-2014. The American Medical Association (AMA) and the American Association of Clinical Endocrinologists recently supported the medical importance of treating obesity, which could lead to greater reimbursement for providers.

Timothy Church, MD, director of the Laboratory of Preventive Medicine at the Pennington Biomedical Research Center in Baton Rouge, La., said the AMA was correct in calling obesity a disease "because it acts like one. Obesity does not end with weight loss. It is a chronic condition that must be treated for a lifetime. Keeping weight off for 12-18 months and beyond is the key."

About 9 percent of U.S. health spending is directly attributable to obesity. Each 1-point increase in body mass index added an average of 4 percent in medical costs and 7 percent in pharmaceutical costs annually in 2012.

About 92 percent of diagnosed type 2 diabetes patients also are considered obese. A 6 percent weight loss among those who have metabolic syndrome reduces the conversion to diabetes by 58 percent.

10. Healthcare is primed for mobile technology

The big challenges in healthcare information technology are to harness the explosion of digital data to make it useful for providers and patients, and to engage patients through mobile technology.

More people worldwide will have greater access to mobile devices than they will have to toilets and running water in 2014. Baby boomers comprise a huge telehealth market, with more than half of people 50 and older using or wanting to use mobile technology. An estimated 88 percent of those 50 and over have cell phones.

Nasrin Dayani, executive director of AT&T mHealth and Telehealth Solutions, said, "Patient engagement (with mHealth) is not the issue. They're ready. The desire to live at home as people age will push the technology to enable independent living."

More than 1 out of 3 employers use mobile technology to engage wellness program participants in healthy behavior, according to the 2013 Aon Hewitt employer survey. Nine out of 10 employers say they plan to do so within five years.

The FDA decided in September to limit its oversight of mHealth apps to those used by medical professionals. The agency plans to stay away from consumer-operated apps, such as those that track

personal fitness, prompt doctor appointment reminders or provide drug-dosing schedules. In its ruling, the FDA was attempting to strike a balance between patient safety without stifling innovation.

The new guidelines should make it easier for designers "to push the envelope" for content-rich apps.

11. Indirect medical expenses are the real cost driver

Chris Nicholson, chief operating officer of Humana Wellness, said employer strategies that focus on people who have high direct medical costs often overlook the opportunity to reduce spending on indirect medical costs. Direct medical costs—such as treatment, pharmacy and disability claims—account for less than one-third of a company's health costs.

Indirect medical costs—such as employee absences and lost performance—account for nearly 70 percent of health costs. For example, indirect medical costs outweigh direct costs by a ratio of 10-1 for headaches and 6-1 for allergies. A typical 5,000-employee organization would spend $1.28 million annually on diabetes and its associated complications. This largely preventable condition would cost the company nearly $900,000 in indirect medical costs.

The key to lower direct and indirect costs is active employee engagement in, not simply signing up for, wellness activities. Humana said its unpublished research show that the gold-level participants in its Humana Vitality program had 30 percent lower indirect medical costs.

Employers were urged to tap into each employee's "moment of influence" to help them improve their health when they are the most open to being motivated. That was defined as "delivering the right content, through the right channel at the right time to drive an immediate action."

12. Using data to identify wellness priorities and designing benefits accordingly

Doug Tapp, vice president of healthcare for H&R Block in Kansas City, MO, said his company closely examined its health costs and benchmarked it against similar companies. It found that employees had excessive amounts of late-stage cancer, indicating they were not seeing their primary-care physicians enough to catch tumors earlier and resulting in excessive hospitalizations.

H&R Block developed a wellness program and was able lower its cost trend by 5 percent over four years. Tapp said the key to his company's success was that "we designed the plan around the data."

Lana Raimbault, human resources manager for the City of McKinney, Texas, said its data showed excessive healthcare spending, a lack of employee understanding of the link between health and costs, and a high rate of metabolic syndrome.

The city used a health navigator program to help employees make more cost-effective healthcare choices, saving $190,000 over the first 16 months. It also conducted a team-based 10-week program for weight loss and increased physical activity, resulting in fewer employees with high risk factors. Raimbault said the use of credible data persuaded senior executives to support the initiatives and the

structured method of measuring the results of interventions was critical to the continuing success of these programs.

12. Why this conference matters

Matt Robbins, DFWBGH president and director of compensation and benefits for Atmos Energy, said the forum offered a healthy mix of benefits and wellness-related sessions, augmented by several employer case studies. He said networking with colleagues and industry leaders, as well as learning about the latest resources and tools offered by exhibitors, were added benefits.

"Our goal is to provide an exceptional learning experience that will help each of you succeed in a rapidly changing healthcare marketplace. We know that helping employees get healthy, controlling healthcare costs, and getting the best value for your healthcare dollars continues to be top priorities," Robbins said.