Managed Care Trends

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Managed Care Economics

A typical day at work.............
BSWH Managed Care

Baylor Quality Alliance – all below plus 2,300 specialists
Hospitals - 14
Ambulatory Surgery Centers – 35
Free-Standing EDs (Emerus) – 7
Outpatient Imaging (Touchstone) – 28
Inpatient Rehab Hospitals (Select) – 5
Outpatient Rehab Clinics (Select) – 45
HealthTexas Provider Network – 600
Home Care Agency
Retail Pharmacies - 12

Scott & White Healthcare

• Hospitals – 10
• Outpatient Centers - 78
• Joint Venture Facilities – 3
• S&W Physicians – 1,200
• Scott & White Health Plan
• Home Care Agency
• Home Infusion
• DME
• Hospice
• Dialysis
• Retail Pharmacies

BSWQA: Combined contracting oversight for a total of 44 hospitals, 500 care sites, 1,800 employed physicians, and one ACO

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1. Market Segment Population
2. Control/Reduce Costs through Reimbursement
3. Control/Reduce Costs through Benefit Plan Design
4. New Delivery and Approaches
5. Other Market Trends
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1. Market Population - almost all employer-based; less than 10% individual plans
   - **Losses** - Losing covered lives as 10,000 Baby Boomers age into Medicare every day from 2011 until 2030 (U.S.)
   - **Gains**
     - Public Exchange individual plan enrollment in DFW in 2014 was 182,000. Overall commercial enrollment increased by same amount suggesting increase came from the Exchange. Exchange is still a small percentage (5%) of total managed care commercial business in DFW (3.7M)
     - DFW job market is growing and adding to commercially insured – other parts of Texas negatively impacted by oil industry glut
   - **Pending** - Employer mandate delays in 2014 delayed shift to Exchange, but expect some transition from small group market to public exchange in 2015 and 2016.

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2. Control/Reduce Costs through Reimbursement
   - **Case Rates** instead of percent of billed charges
   - **Fee-For-Value** instead of fee-for-service
   - **Bundled Pricing** – in early stages in DFW
   - **Shared Savings/Pay-for-Performance**
   - **Coding “tricks”** – payors downcode bills based on vendor software vs. contract terms
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3. Control/Reduce Costs through Benefit Design

- **Shifting More Costs to Patient** – Higher premiums for smoking/obesity; Higher and more types of deductibles, ($6,350/$12,700) now comprise 25% of employer plans offered; Reference pricing caps benefit amount – patient pays anything over coverage limit
- **More Restrictive Benefit Plan** – surgeries require more non-surgical treatment; more authorizations or step-therapy; more services/drugs considered experimental; tiered drug pricing; excluding bariatric surgery
- **Moving to Defined Contribution** versus Defined Benefit – where employees take lump sum and purchase own plan offered by Employer, or through Public or Private Exchange
- **Network Design** – moving away from broad PPO-type networks
  - Accountable Care – accountable for health of patient population to minimize medical claims
  - Narrow Networks – fewer providers in exchange for lower reimbursement; providers counting on increased volume to offset lower price
  - Employer-based – SmartE Network (Wal-Mart); payors and employers developing
  - Payor’s Centers of Excellence now driven by low cost, not quality (payors’ COEs, not ours)
  - Domestic Tourism/Specialty Networks – used by Employers Lowe’s (cardiac), Wal-Mart (cardiac and spine); and Providers (Cleveland Clinic) – patient willingness to travel unproven
  - Physician-only networks – ELAP

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4. New Delivery and Approaches

- **Private Exchanges** - no consistent definition; most led by brokerage firms (Aon Hewitt, Towers Perrin, Mercer, etc); could use narrow networks or ACOs; moving retirees and >65 employees off group plans to Medicare Advantage exchanges; currently 3 million out of 150 million in private exchanges; 32% of employers considering as option; expect slower growth than headlines suggest as employers “watch and wait” for proven cost reduction
- **Shift From Business to Consumer** - Managed Care companies must develop “consumer-centric” processes and services, along with existing business-to-business model.
- **Electronic/Telehealth** – rapid movement making this the new norm. Mobile apps, Google glasses; consults via phone/text; payors paying for Teledoc, etc.
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5. Other Market Trends

- Providers/Health Systems Adding Health Plans
- Health Plans Adding Providers
- Network Aggregators - attempt to avoid contract obligations and shop for best contracted price per claim
- Cost-Containment Firms – audit bills for errors; negotiate discounts on OON claims

Blue Cross Still Dominates DFW Commercial Market

July 2014- Commercial Market Share (not Medicare Advantage plans or Managed Medicaid)
Managed Medicare Overview - DFW

Original vs. Medicare Advantage

- Original Medicare, 70%
- Medicare Advantage, 30%

Medicare Advantage Market Share

- United, 57%
- Humana, 13%
- Aetna, 14%
- 14 Others, 16%

17 Total MA Plans – top 3 account for 84%

Public Exchange Market Share

DFW 2014

- Blue Cross, 64%
- Cigna, 34%
- Molina, 3%
- Aetna, 0.3%

2014 Membership

- BCBS – 116,132
- Cigna – 61,281
- Molina – 3,894 (new to comm’l mkt)
- Aetna – 695 (highest premiums)

July 2014- Public Exchange Market Share; HealthLeaders Interstudy
### Health Insurance Exchange - Texas

#### Highlights of 2014
- Exchange plans boosted membership of BCBS and Cigna – negatively impacted Aetna’s and United’s market share.
- Of 182,000 Exchange members in DFW – approximately 84% used federal subsidy dollars to help pay premiums.
- Patient gets 90-day grace period — only applies if subsidies were used.
- Most plans had high out-of-pocket costs patients ($6,350 ind/$12,700 fam).

#### Changes in 2015
- **Three additional plans added** to North Texas Exchange market: SWHP, United and Assurant.
- Percentage of Exchange members using federal subsidies increased to 87%.
- Don’t expect dramatic increase in Exchange members until 2016 when uninsured penalties increase to $695 per adult in household.
- Enrollment ended February 15 so final statistics not published yet.

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“Ready to walk the Reimbursement Maze?”