

# 2021



## State of Health Care –

Large Employer Strategies  
to Combat Rising Costs



CBIZ

CBIZ Employee Benefits

As an employer, you know it's critical to provide health care benefits that keep your employees productive, healthy and loyal. However, you also know that managing increasing costs in today's health care landscape can be challenging.



Hear more from our Health Innovations Lead Strategist as he reviews the [“Top 5 Things to Know About the State of Health Care”](#) in this 5-minute video.

In this guide, we'll address the [underlying challenges of employer-sponsored health care](#) for large employers – where we are today and where we seem to be headed. We'll provide pertinent information about need-to-know topics, including:

- Rising premiums and overall costs
- High deductible gap
- Functionally uninsured populations
- How and why health care cost increases have been resistant to intervention

Then, we'll take a look at [strategies large employers like yours can implement to help combat rising health care costs and manage your bottom line](#).

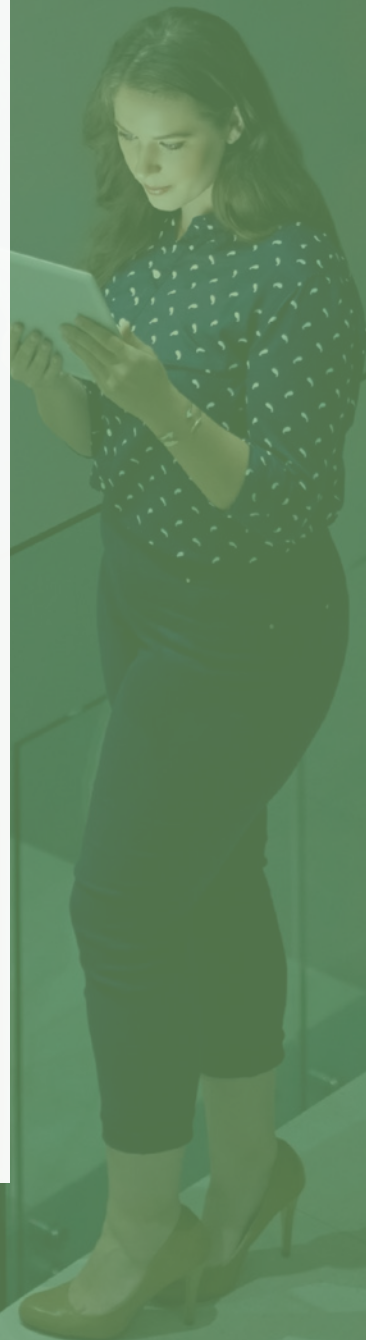
Your organization has more control than you may think when it comes to the rapidly evolving health care landscape. This guide provides information to help you develop benefits programs that mitigate health plan risks and manage costs, while promoting positive change for your employees' health care experience.

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*This CBIZ Guide was curated with a focus on employers, research organizations and other entities that draw interest in understanding the current mechanics and methodologies of private health care purchasing. It is the confidential and proprietary work product of CBIZ Benefits & Insurance Services, Inc. (CBIZ) and cannot be reproduced or disseminated to third parties without the prior express written consent of CBIZ. This Guide is intended to provide insight into viable concepts and strategies that may invoke alternative approaches to health care financing. Supporting evidence indicates that these approaches may lessen the fiscal burden of health care costs for employer-sponsored health care for both current and future consideration.*

*The information contained herein is not intended to be legal, accounting, or other professional advice, nor are these comments directed to specific situations. The information contained herein is provided as general guidance and may be affected by changes in law or regulation. The information contained herein is not intended to replace or substitute for accounting or other professional advice. Attorneys or tax advisors must be consulted for assistance in specific situations. This information is provided as-is, with no warranties of any kind. CBIZ shall not be liable for any damages whatsoever in connection with its use and assumes no obligation to inform the reader of any changes in laws or other factors that could affect the information contained herein.*



# A Foreword Regarding COVID-19

**This guide is intended to address the systemic issues with health care that employers are challenged to face, both pre- and post-COVID-19.**

**COVID-19 may have a few effects on health insurance premium rates, which broadly fall into two categories:**

1. The impact of a new disease on previously established rates

- Treatment costs for COVID-19 can vary substantially, ranging from a few hundred dollars or less for low-severity cases to potentially over a hundred thousand dollars for cases that require inpatient hospitalization.
- Current rates were established before COVID-19 was known, so there will be health care services provided that were not factored into 2020 renewal rates. Since most COVID-19 cases are mild and low impact, on average the impact from COVID-19 would be a few percent. This percentage may vary if there are significantly more hospitalizations than expected or if testing and other low-cost preventive services are performed much more than expected. For example, a business such as a nursing home may test all employees not only once but on a regular basis to safeguard their tenants due to the increased risk of infection particular to their operation.

2. The impact of the lockdown disruption on plan rates, reserves and financial statements

In March 2020, many states implemented lockdowns and stay-at-home orders that have prevented a large number of health care services from being performed due to:

- Providers closing
- Provider or member cancellations to avoid risk of infection; many members may continue to avoid services after stay-at-home orders due to the fear of infection
- Hospital closures and facilities only open to COVID-19 or emergency patients

**COVID-19 has changed the way many Americans view and use health care, and there are a number of changes with lasting presence, such as:**

- Increased safety measures and precautions regarding contagious diseases
- Increased use of telemedicine and technology platforms for delivery of care to maintain safe distancing and work around lockdown restrictions
- Consolidation of providers, in particular hospitals, due to the financial impact of lockdowns on facilities that could not withstand the loss in cash flow

## A Foreword Regarding COVID-19

### The Families First Coronavirus Response Act (FFCRA)

The Families First Coronavirus Response Act (“FFCRA” H. R. 6201, Public Law 116-127) enacted on March 18, 2020 and the Coronavirus Aid, Relief, and Economic Security Act enacted on March 27, 2020 (“CARES Act” H. R. 748, Public Law 116-136) address many of the legislative issues surrounding COVID-19. Specific to employee benefits, these laws provide for mandated health coverage for coronavirus testing and related services, emergency paid sick leave, and emergency family and medical leave, as well as tax credits for providing emergency leave and continuation of health coverage for employers impacted by the COVID-19 situation.

The FFCRA, as amended by the CARES Act, requires individual and group health plans, including insured, self-funded plans and grandfathered health plans to provide first-dollar coverage for testing of COVID-19, including FDA-approved tests, as well as tests provided by labs on an emergency basis, state-developed tests and any other tests determined appropriate by the Department of Health and Human Services (HHS). To assist in determining approved tests, the (FDA) provides a list of FDA-approved laboratories and manufacturers offering COVID-19 tests.

Further, the DOL/HHS FAQs provide that serological testing (antibody testing) must be covered at no cost to participant once it becomes available, as well as screening for other respiratory illnesses that is performed at the time the individual is being assessed for coronavirus.

In the fourth quarter of 2020, two vaccines for COVID-19 were approved. Both require a two-dose regimen over the span of a few weeks. Both are 94 to 95% effective, according to the manufacturer press releases, while a third vaccine by Astrazeneca/Oxford currently is under review by the regulatory agencies. There are high hopes for this vaccine due to its lower cost and easier storage requirements. The distribution will be directed by the States and Federal Government with the aid of the Department of Defense. Phase 1 distribution is targeting health care workers, essential workers and patients at higher risk of severe disease, including patients in long-term care (LTC) facilities. Phase 2 distribution will be for the masses and other critical populations.



## A Foreword Regarding COVID-19

### The CARES Act

The CARES Act provides that approved vaccines and other preventive measures are deemed preventive service and covered without cost share in accordance with the ACA's market provisions within 15 days of it being recommended by the U.S. Preventive Services Task Force (USPSTF) or vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). The intent of this provision is to ensure immediate coverage of a preventive service without waiting the one-year delay that is typically required before a plan is obligated to cover it. For the duration of the emergency, even out-of-network vaccine administration must be covered at no cost to the individual. Generally, the ACA only requires first-dollar coverage of preventive services provided in-network. At this time, it is advisable that both the medical and the pharmacy benefit, if applicable, cover the vaccine.

On Dec. 16, 2020, the Equal Employment Opportunity Commission (EEOC) added a new subsection K to its guidance – [“What You Should Know about COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws”](#) specifically relating to the coronavirus vaccine. This is highly recommended reading for any employer contemplating a vaccine strategy. Topics discussed are:

- ADA and Vaccinations
- ADA and Title VII Issues Regarding Mandatory Vaccinations
- Genetic Information Nondiscrimination Act (GINA) and Vaccinations

In a nutshell, if the employer's vaccine policy is to encourage voluntary engagement and if the vaccine is obtained from an independent third party, it is not a prohibited act for an employer to request proof that an individual has received a vaccination. If, however, the employer asks for an explanation of why an individual has not received a vaccine, this would implicate the ADA and any questioning must be job related and consistent with business necessity. This standard would also apply for vaccine pre-screening offered by the employer or its designee, which would occur if the employer is administering vaccines itself.

The guidance addresses the need to engage in the interactive process in the event a reasonable accommodation might need to be made for a disability or religious-based reason. Notably, if it is determined that no reasonable accommodation can be made and if it is determined that not being vaccinated creates a direct threat to the health or safety of the individual or others in the organization, the employer can exclude the individual from the workplace but cannot necessarily terminate the individual.



# The Underlying Challenges of Employer-Sponsored Health Care

## RISING PREMIUMS & RISING OVERALL COST

Over a 20-year period, the cost of an employer-sponsored health plan has drastically increased.<sup>1</sup>

Cost Segment	1999	2009	2019	% Increase from 1999
Single Coverage; Premiums	\$2,196	\$4,824	\$7,188	227.32%
Single Coverage; Worker Contribution	\$318	\$779	\$1,242	290.57%
Family Coverage; Premiums	\$5,791	\$13,375	\$20,576	255.31%
Family Coverage; Worker Contribution	\$1,543	\$3,515	\$6,015	289.83%

FIGURE 1

For employer-sponsored health insurance, the average 2019 annual premium for single coverage was \$7,188 and \$20,576 for family coverage. That's a 4% and 5% increase, respectively, compared to 2018. At the same time, wages increased by 3.4% and inflation by 2%.<sup>1</sup> Employees are responsible for paying a smaller portion of the full amount, roughly 30% of costs on average, but this portion is steadily increasing. Single individuals paid \$1,242 last year, on average, while families paid \$6,015, an increase of 71% in the past decade. Earnings have grown by 26% during the same time frame.<sup>1</sup>

For 2020, large employers predicted the total cost of covering health insurance for workers and their families would increase to an average of \$15,375. This is a 5% increase from \$14,642 in 2019, according to a survey by the National Business Group on Health. While employers will cover close to 70% of costs, workers will cover about \$4,500 in expenses, according to the survey.<sup>2</sup>

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## The Underlying Challenges of Employer-Sponsored Health Care

### THE HIGH DEDUCTIBLE GAP & FUNCTIONALLY UNINSURED POPULATIONS

As premiums have steadily risen, so has the share of insureds who pay a deductible. In addition to their monthly premiums, workers who have deductibles must pay thousands of dollars out of pocket, on average, on top of their monthly premiums before their coverage begins.

- Over the past 10 years, the percentage of employees who have deductibles on employer-sponsored insurance has increased from 63 to 82%, and the deductibles have risen from \$826 to \$1,655, on average.
- Additionally, the share in High Deductible Health Plans (HDHPs) – a deductible of at least \$1,350 for single coverage and \$2,700 for family coverage – is also increasing.
- The percentage of workers with an annual deductible of \$2,000 or more for single coverage has grown from 18 to 28% over the past five years.<sup>1</sup> Among firms offering health benefits, 26% offered an HSA-qualified HDHP in 2019.
- Large firms (200 or more workers) are more likely than small firms (3 to 199 workers) to offer an HDHP. 23% of covered workers were enrolled in HSA-qualified HDHPs in 2019.

A recent study from GoBankingRates indicates that in 2019 69% of Americans surveyed had less than \$1,000 in savings, with a staggering 45% having \$0 in savings. From these statistics, we can conclude that the majority of employees may not have the capacity to absorb the costs associated with covering high-deductible costs before health insurance kicks in.

To compound the issue, 51% of women and 53% of middle-aged people (ages 45 to 54) indicate they have \$0 in savings.<sup>4</sup> We know that women typically utilize health care at a higher degree than men. We also know that middle-aged populations are highly rooted in their work careers and at an age where health risks begin to permeate into disease, which increases their demand for health care services. If these populations are on an HDHP and have no savings to cover medical expenses until deductibles have been met, nor do they contribute sustainably to an HSA, they fall into an ever-growing gap of employees known as the “functionally uninsured.” According to Commonwealth Fund survey in 2018:

- 28% of adults with job-based plans were underinsured.
- 41% of underinsured employees said they delayed needed care due to cost (compared to 23% of people with adequate insurance coverage), and 47% reported medical bill and debt problems (compared to 25% of those who are not underinsured).



The percentage of employees with employer-sponsored insurance who have deductibles has increased from 63 to 82% in the past 10 years, and the deductibles have risen from \$826 to \$1,655, on average.



## The Underlying Challenges of Employer-Sponsored Health Care

- The findings also revealed that half of Americans who get job-based coverage said that, within the past year, they or a dependent of the health plan have put off going to the doctor, not filled a prescription or delayed some other kind of medical care because of cost concerns.
- Many individuals putting off care due to high deductibles are people who should be going to the doctor – those with serious conditions such as diabetes, heart disease and cancer. As a matter of fact, insured individuals with chronic conditions are about twice as likely as other insured individuals to report problems paying medical bills (36% versus 16%).<sup>5</sup>
- In evaluating the macroeconomic and historical trends of employer-sponsored health care, it can be surmised that while costs have increased rapidly compared to other sectors of the American economy, either:
  - Very little has been altered regarding the procurement process of employer-sponsored health benefits; and/or
- The methodologies that employers use under the presumption that these tactics and strategies will lower health care costs do not factor in the economic needs and behaviors of employee-patients.



# The Underlying Challenges of Employer-Sponsored Health Care



**WATCH  
NOW**

Our Health Innovations Lead Strategist explains [why health care costs are resistant to intervention](#) in this 5-minute video.

## HEALTH CARE COST INCREASES HAVE BEEN RESISTANT TO INTERVENTION

Within the 20-year timespan in which premiums and contributions have risen over 200% in each cost segment in Figure 1 on page 7, the most utilized cost-containment solutions have included plan design and cost-shifting endeavors, such as tobacco surcharges, spousal surcharges, premium differentials for wellness program engagement and the utilization of high-deductible health plans. Additional cost-containment solutions have focused on the appropriateness of health care access and therapies, including tiered formularies and networks, in addition to increased telemedicine access. With those strategies being deployed, employers and employees are paying well over 200% more for health care coverage than they did before the turn of the century. Over a similar period, the stock prices of health insurance companies rose by 272% from January 2014 to 2018, resulting in improved profitability and outperforming the S&P 500 by 106%.<sup>6</sup>

Borrowing a term from the study of behavioral disorders, “resistance to intervention” is a function of a number of factors, including the severity, chronicity, generalization and tolerance of an existing process or behavior, as well as the strength, acceptability, integrity and effectiveness of the proposed interventions that are intended to alter the process or behavior toward a more favorable outcome.



# The Underlying Challenges of Employer-Sponsored Health Care



The resistance to intervention as related to health care costs can be defined in the following concepts:

Factors	The Health Care Situation
1. Market behaviors and objectives of the supply side of health care	As both employers and employee-patients pay more toward medical and pharmaceutical expenses, through both premiums and claims, that additional payment translates into higher revenue for the health care industry. Therefore, health care entities will lose out on existing and future revenues if employers and their employee-patients develop a strategy that results in paying less for health care services. As a means to prevent this from occurring, the health care industry develops and deploys creative ways to extract newer and higher revenue streams from commercially insured populations. There is little distinction between the revenue goals of nonprofit, private equity and publicly traded entities in this regard.
2. Market behaviors and objectives of health care intermediaries	As both employers and employee-patients pay more toward medical and pharmaceutical expenses, through both premiums and claims, that additional payment translates into higher revenue for the health care industry, which in turn translates into higher revenue for health care intermediaries, such as carriers, brokers, specialty vendors and other professionals who are indirectly involved in the purchase and placement of health care services but not directly involved in care delivery.
3. Misapplied or overvalued tactics	Because most employers access the supply side of health care via the use of health care intermediaries, the tactics that employers are exposed to the most are the ones that would be misapplied or overvalued, as those processes would have only a minor and limited effect on the overall cost of care. In most cases, the tactics that have been recommended historically did not account for the actual macroeconomic drivers of health care – variance in quality of care; variance in cost of care; clustering of claims cost in a few members; medical and pharmaceutical advancements compounding the cost of treatment, fraud, waste and abuse; health care conglomeration and vertical integration; a lack of evidence-based medicine applications; and several other factors that would not be affected or addressed by cost-shifting tactics, wellness programs or other commonly adopted yet minimally impactful strategies.
4. Employers are not properly exposed to undervalued or appropriately valued tactics	The supply side of health care and the intermediaries of health care seek higher revenues, and the primary recommended and adopted tactics that employers are exposed to are overvalued because of their limited impact on lowering claims trajectory and curbing claims trend. Alternatively, the tactics that could effectively lower claims trajectory and curb claims trend would be seen as disruptive and a threat to the revenue levels of both the supply side of health care and their intermediaries.
5. Undervalued or appropriately valued tactics are perceived as disruptive	Assumptively, if an employer is receiving advisory services from someone whose revenue is directly tied to the outcome of health care expenses rising, certain pertinent strategies may not be brought to the employer or the employer is left to believe there is only a simple dichotomy to consider – continue forward with the same or similar strategies while paying more for the same coverage year after year or deal with employees and internal benefit personnel who will be discontent with some degree of change in terms of the cost, quality, access and structure of the health benefit plan.

FIGURE 2

# The Underlying Challenges of Employer-Sponsored Health Care



“Resistance to intervention” is a function of a number of factors, including the severity, chronicity, generalization and tolerance of an existing process or behavior, as well as the strength, acceptability, integrity and effectiveness of the proposed interventions that are intended to alter the process or behavior toward a more favorable outcome.

## SPECIFIC FACTORS THAT HELP CREATE THE “RESISTANCE TO INTERVENTION”

### Vertical Integration: Consolidating Health Care Supply for Marketplace Leverage

Vertical integration raises employer-sponsored health care costs each year due to the tactics and strategies put in place by the demand side of health care to drive costs upward. U.S. employers have witnessed multiple mergers focused on vertically integrating the health care supply chain. In the past five years, the pharmacy solutions company, CVS Health, purchased a leading health insurer, Aetna, while Cigna acquired another pharmacy benefit manager, Express Scripts. Coinciding with this, UnitedHealth Group finalized several key acquisitions, including that of DaVita Medical Group.

Simultaneously, hospital mergers and acquisitions increased at a rapid rate. During the first half of 2018, 483 health care sector deals with a combined value of \$100 billion were announced, according to PwC’s tally.<sup>7</sup> Additionally, hospitals have been annexing physician practices at a record rate. Since 2012, there has been a 100% increase in hospital-owned physician practices, indicating those medical groups may be struggling to maintain independence in a health care landscape that is increasingly geared toward larger, integrated systems.<sup>8</sup>

In 2018, hospital mergers and acquisitions (M&A) reached historic highs in both revenue and number. Hospitals being bought by other entities averaged annual revenue of \$409 million with 92 M&A transactions in total. In 2019, that trend dipped and the average annual revenue of companies being acquired was \$278 million with 90 M&A transactions. The 2019 trend toward partnerships between financially strong health systems continued from the year prior. Three announced transactions were “mega mergers” (transactions in which the smaller partner by revenue had more than \$1 billion in annual revenue), and in an additional 11 transactions the smaller partner had annual revenue between \$500 million and \$1 billion. In five transactions, the smaller partner had an “A” credit rating or higher. The number of financially distressed sellers remained low at 20% (the same as in 2018). A state-specific focus on M&A activity became less relevant as health systems increasingly look across state lines or leapfrog geographies for growth opportunities in new markets. Four transactions in 2019 involved cross-state transactions.<sup>9</sup>

Another prime driver of hospital M&A was the desire of health care systems to act as the “front door” to health care, allowing all-inclusive enhancements to focus on patient convenience and having all comprehensive services within the spectrum of care needs all under one umbrella, while still having the patient within the controls and confines of the parent hospital system.<sup>9</sup> This requires health care systems to acquire multi-faceted components – primary care physician practices, specialty care physician practices, home health, digital health, telehealth, rehab and therapy, and behavioral health services. As a result, this approach to health care adds value in regards to keeping all continuum of care transactions within the scope and scale of the hospital system and the system sees smaller volumes of patient and revenue leakage to health competitors.

## The Underlying Challenges of Employer-Sponsored Health Care

In total, the business objectives for the acquisitions are centered on complementary synergies of:

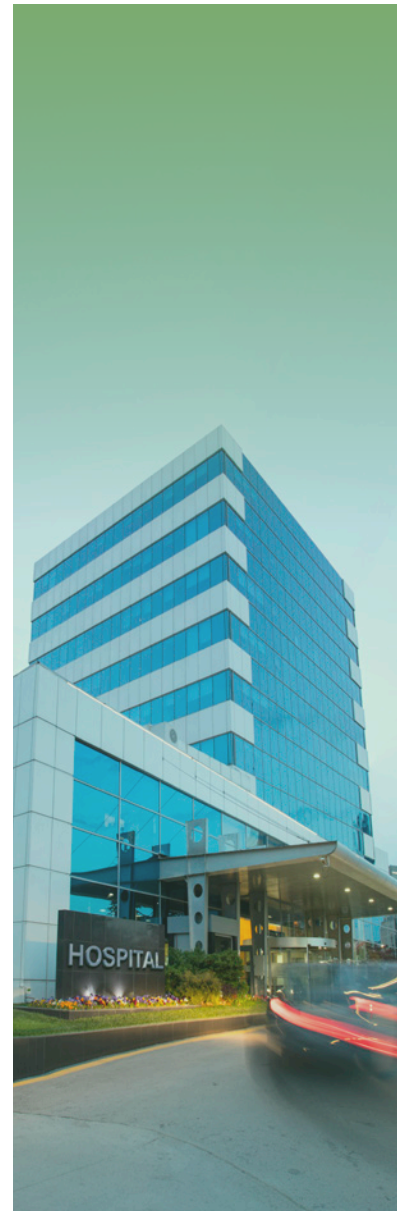
- Merged partners
- Revenue opportunities
- Market posture relative to other competitors and negotiation leverage with claims payers
- Capital strategy and health care access points
- Efficiency and quality of care delivery

As health care systems make adaptations to assimilate competitors into constituents, this process has a twofold effect. First, it increases market share for the health care entity while diluting the local, regional or national pool of competitors. Second, this market reconfiguration allows the health care entity to have further controls on pricing and negotiation of health care services. The resulting conflict of the data unveils an interesting dichotomy – hospital studies and reports state that mergers and acquisitions create favorable outcomes in terms of quality and cost, while independent researchers pose different observational outcomes.

The September 2019 report, “Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis - An Update,” which provided an analysis of interviews with 10 health systems, had key findings that indicate:<sup>10</sup>

- Due to increased scale, mergers decrease costs and are associated with a statistically significant 2.3% reduction in annual operating expenses.
- Mergers often facilitate quality improvement through updating clinical operations across a health system, implementing consistent best practices and enhancing the promise of technology and data analytics.
- Revenues per admission at acquired hospitals decline by a statistically significant 3.5% relative to non-merging hospitals, which suggests that “savings that accrue to merging hospitals are passed on to patients and their health plans.”

In stark contrast, a January 2020 special article in the New England Journal of Medicine, “Changes in Quality of Care after Hospital Mergers and Acquisitions,” which sampled 246 acquired hospitals and 1,986 control hospitals, indicated that hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Acquired hospitals had a significant differential improvement in performance on the clinical-process measure but could not be conclusively attributed to acquisition.<sup>11</sup>



## The Underlying Challenges of Employer-Sponsored Health Care

With respect to costs, a study by the National Council on Compensation Insurance (NCCI) stated that acquired hospitals reported reductions in operating costs between 15 and 30% through the economies of scale. However, lower operating costs do not always equal lower prices for patients and employers paying for hospital services. The same NCCI report claimed hospital mergers increased the average price of hospital services by 6 to 18%.<sup>12</sup> The disparity of findings in these studies could largely be attributed to biases between those on the supply side of health care and those on the demand side.

Anticipatory reactions to these changes in the health care landscape all have a common theme – vertical integration as a means to control the delivery systems and maintain strength in negotiations with other health care payment and financing stakeholders. Insurers are playing defense by buying doctor groups, specialty practices and freestanding, independent medical facilities. By doing so they are able to reduce their spending by exerting more control over how those physicians practice medicine, where they refer patients and what medications they prescribe. On the other hand, when hospitals buy physician practices, they are able to keep patients in their health systems and protect their revenue. Conversely, hospital systems are making forays into vertical integration, as well, by offering their own insurance products and reducing or eliminating insurance offerings from other health insurers.<sup>13,14</sup> This process would be in direct competition with the strategies insurers are using.

### Payment Integrity: Billing Errors Paid by Employers Are a Source of Health Care Revenue

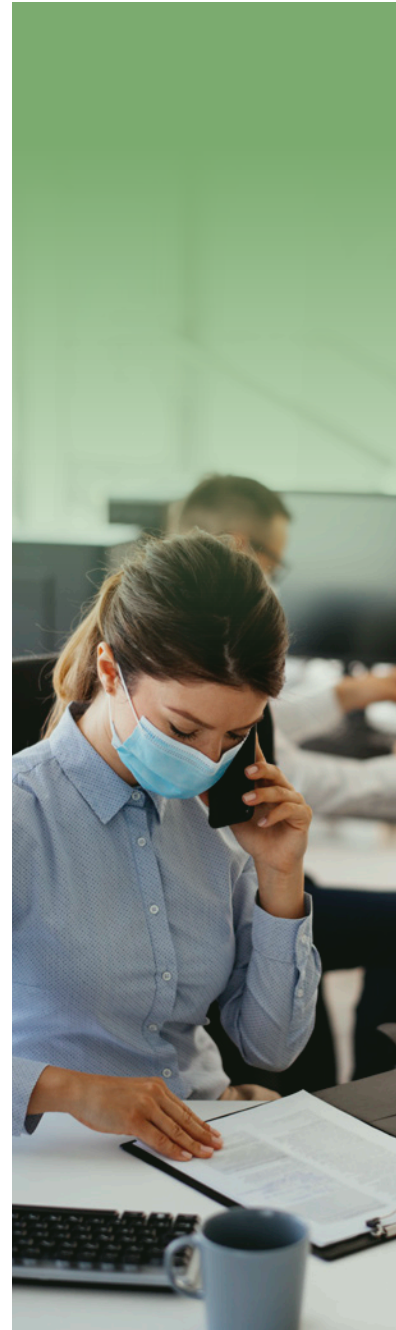
The second factor that raises employer-sponsored health care costs higher each year is the impact of billing errors and irregularities from health care entities, largely attributed to the three specific types of error – fraud, waste and abuse (FWA).

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. § 1347).

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions but by the misuse of resources.

Abuse is payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment. Centers for Medicare and Medicaid Services (CMS) categorizes fraud and program integrity issues into four categories:

1. Mistakes resulting in administrative errors, such as incorrect billing
2. Inefficiencies causing waste, such as ordering excessive diagnostic tests
3. Bending and abuse of rules, such as upcoding claims
4. Intentional, deceptive fraud, such as billing for services or tests that were not provided or that are undoubtedly medically unnecessary (and sometimes harmful to the patient)<sup>15</sup>



## The Underlying Challenges of Employer-Sponsored Health Care



The Federal Bureau of Investigation estimates that fraudulent billing – the most serious of program integrity issues – constitutes 3 to 10% of total health spending, contributing to inefficiency, high health care costs and waste.<sup>13</sup> Fraudulent billing directly impacts both cost and quality as reflected in higher premiums, more expensive services and patients’ potential exposure to unnecessary and risky interventions, such as being prescribed a medication or undergoing surgery without medical necessity.<sup>16,17</sup> Most employers would love to reduce their health spend by 3 to 5%, especially if it does not entail reducing benefits, not allowing spouses on the plan or making employees pay more for their health insurance. For a \$100-million company, this could mean \$5 million in savings without a change in benefits.

### 12,000 Member Health Plan Billing Study of Fraud, Waste & Abuse (FWA)

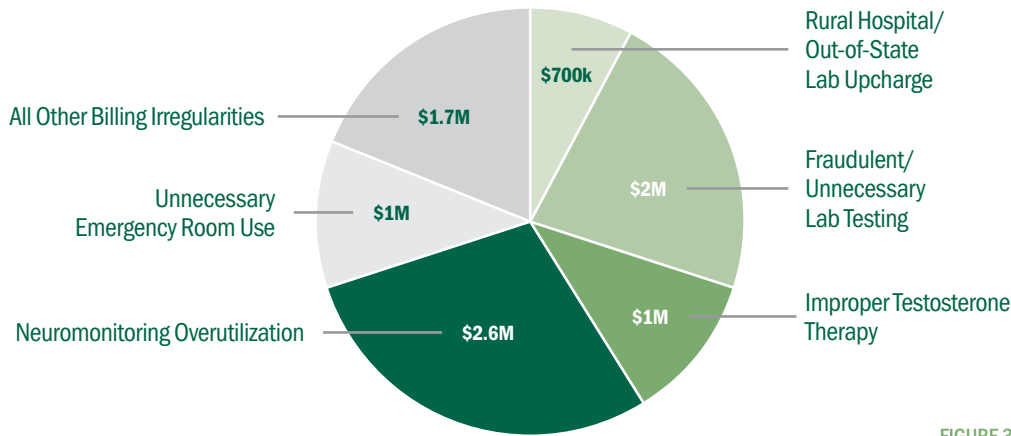


FIGURE 3



## The Underlying Challenges of Employer-Sponsored Health Care

In an analysis of 27 months of paid-claims data for 12,000 people covered in a city municipality health plan, up to 40% of spending in the analysis was FWA, rather than mistaken billing. The overspending via FWA occurred in the following manners<sup>18</sup>

- Around \$700,000 in overspending resulted from pass-through rural hospitals that received higher reimbursement rates from insurers and made arrangements with out-of-state labs to bill for services. The hospital kept a portion of the reimbursement and sent most of the money back to the out-of-state laboratory or management company.
- Over \$2 million in fraudulent lab testing, where in-network physicians ordered drug screenings that weren't necessary and billed for them, getting a kickback from out-of-network labs to do so.
- Over \$1 million was clustered in the misuse of testosterone therapy treatment, which was prescribed for patients under dubious criteria, and some physicians may have been billing for a weekly office visit when a patient was merely receiving an injection, adding to the waste.

- \$2.6 million in overspending due to intraoperative neuromonitoring (IONM). Certain financial arrangements between an IONM provider and a referring physician/surgeon, whether direct or indirect, have the potential to endanger patient safety. Specifically, kickbacks and self-referrals create the potential for overutilization and substandard patient care when a physician/surgeon refers a case to an IONM provider based on financial considerations.<sup>19</sup>

- Over \$1 million in wasteful spending due to unnecessary emergency room utilization in which 47 plan members accounted for 969 emergency room visits.

For low- to-moderate-cost claims, the burden of FWA largely falls on the shoulders of an employee who pays those inappropriate costs via their deductible and out-of-pocket expenses. For the higher cost claims, the burden of FWA largely falls on the shoulders of an employer who pays for those inappropriate costs as the incorrect claims breach specific stop-loss policies. This breach has a twofold effect – first, an increase in erroneous claims that incur a specific stop-loss reimbursement for the current year and, second, that overstated risk carries over into underwriting considerations for future year stop-loss premiums.



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# The Underlying Challenges of Employer-Sponsored Health Care

## The Prevalence of the Unmitigated Catastrophic Claim

The third factor that raises employer-sponsored health care costs higher year after year is the magnitude and frequency of the high-dollar, catastrophic claim. The rise of the catastrophic claimant (those incurring over \$500,000 in medical and/or pharmacy claims in a plan year) over the past two years has been alarming. 64% of surveyed employers stated having a claimant of at least \$500,000 in plan spend within the past

two plan years, which is up 8% from the previous year. Additionally, 31% of respondent employers stated having a claim of \$1 million or more, with 6% of respondents having a claimant in excess of \$2 million.<sup>20</sup> Aggressive hospital billing tactics and the rise of specialty and orphan drug utilization were listed as factors in the survey. Moreover, in a 2019 Stop-Loss Research Report, merely ten conditions represented 51.2% of all claims that resulted in a stop-loss reimbursement, with only three conditions representing 31.3%.<sup>21</sup>

## Top High-Cost Claim Conditions

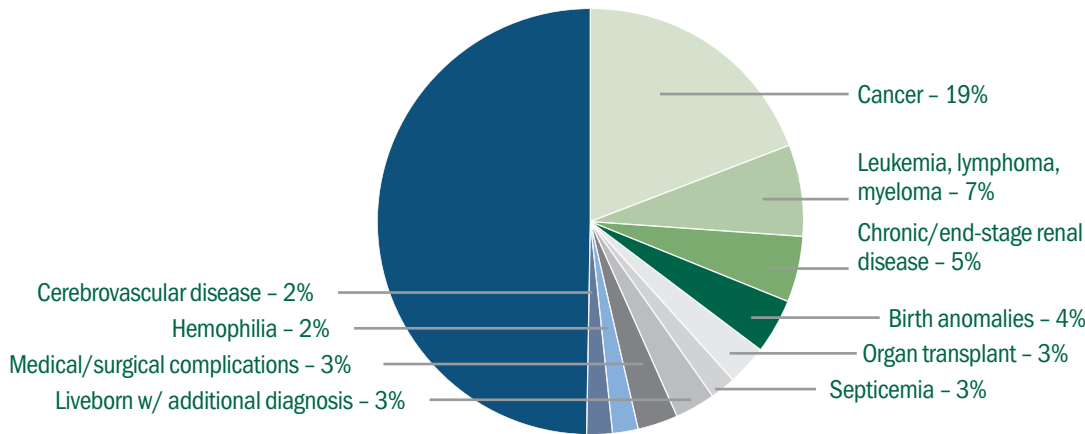


FIGURE 4



## The Underlying Challenges of Employer-Sponsored Health Care



A contributing factor to the increased catastrophic claim prevalence is the rise of specialty medications, injectable medications and orphan drugs. In 2019 commercial insurance, 31% of pharmacy patients using specialty drugs represented 96% of pharmacy spend. Oncology medications represented 43% of that spend due to a rise in prescriptions for two medications – Keytruda and Opdivo.<sup>22</sup>

Corresponding with the increase in overall pharmacy costs is the rise of genomic medications. Already, genomic medicine is making an impact in the fields of oncology, pharmacology, rare and undiagnosed diseases, and infectious disease.<sup>23</sup> Pharmacogenomics involves using an individual's genome to determine whether or not a particular

therapy, or dose of therapy, will be effective. Currently, more than 100 FDA-approved drugs have pharmacogenomics information on their labels. The most expensive drug to hit the market in 2019 was Zolgensma, with a price tag of \$2.125 million per dose, to treat spinal muscular atrophy, which affects about 400 babies per year.

As employers face the challenges relative to catastrophic claims, it is important to recognize the conditions and treatments that correlate to high costs. By better understanding the catalysts for catastrophic claims, employers can identify tactics and strategies that reduce the burden these types of claims have on their overall health care spend.



A contributing factor to the increased catastrophic claim prevalence is the rise of specialty medications, injectable medications and orphan drugs.

### Top Commercial Disease States Treated by Medications

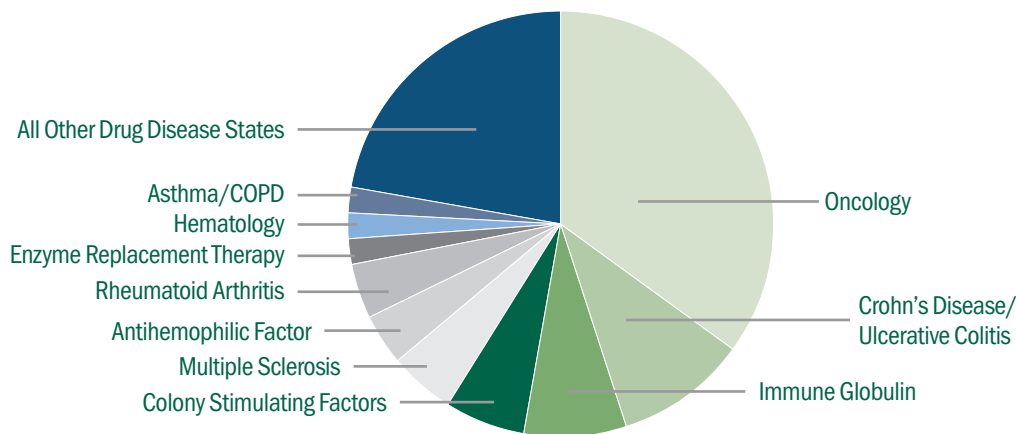


FIGURE 5



# How Employers Can Adapt To & Overcome Health Care Challenges

## ADJUSTING TO THE EVOLVING MARKET

In section one of this report, we addressed the limiting agents that prohibit health care sustainability, which were largely attributed to how the supply side of health care functions to bolster revenue at the expense of the employer and employee-patient. Because most employers access the supply side of health care via the use of health care intermediaries, the tactics that employers are exposed to the most are the ones that would be misapplied or overvalued, as those processes would have only a minor and limited effect on the overall cost of care. In most cases, the tactics that have been recommended historically did not account for the actual macroeconomic drivers of health care – variance in quality of care; variance in cost of care; clustering of claims cost in a few members; medical and pharmaceutical advancements compounding the cost of treatment; fraud, waste and abuse; health care conglomeration and vertical integration; a lack of evidence-based medicine applications; and several other factors that would not be affected or addressed by cost-shifting tactics, wellness programs or other commonly adopted yet minimally impactful strategies.

To acclimate to the health care market and deploy strategies to address these changes, employers will begin to demand more flexibility from their claims administrators in order to tackle ever-changing problems with adaptive solutions. Because of this, we will likely see a higher application of third-party administrators (TPAs) providing unbundled solutions and programs that are pertinent and unique to each client's claim profile. This allows for a higher degree of inclusion of decision-support tools, concierge-level guidance and employee support.

All of these solutions and functions will have a trickle-down impact on how stop-loss carriers will have to underwrite risk in a more precise but client-specific manner in order to remain competitive in the marketplace. Additionally, as automation and artificial intelligence (AI) become commonplace, employers will likely consider outsourcing some elements of the HR function as benefit design will become more mappable in a digital schematic sense. This will alleviate the need for benefit decisions to be pondered and administered at the human level.

In terms of other related benefit offerings, employers will likely consider expanding the role of personalized plans with options to purchase enhanced benefits, particularly with features in the non-health benefits space. Such benefits might include credit monitoring, subscription-based grocery shopping and delivery programs, improved maternity/paternity leave, and other work-life integration strategies.

## How Employers Can Adapt To & Overcome Health Care Challenges



For more cost-mitigation strategies, watch our on-demand webinar, [“Population Health Management Using Data Analytics: How to Increase Health Care Quality & Decrease Costs.”](#)

With these complex and sweeping changes, employers must respond by focusing less on insurance modification strategies and more on ecosystem and claims management, whole-health and whole-person benefit plan design, and granular strategies for specific issues. The greatest impact in curtailing rising benefit costs will be had by developing a thorough understanding of the health care supply chain and the stakeholders that may positively or negatively impact the costs that both the employer and employee will face.

### COST MITIGATION

Most employer health care ecosystems are composed of several parts. Generally, the components are:

- a collection of doctors that members have access to at an agreed-upon rate (professional network)
- a collection of medical facilities that members have access to at an agreed-upon rate (facility network)
- a methodology that ensures medical procedures are necessary and meet coverage criteria (precertification and prior authorization via utilization management)
- a means to interact with ongoing and costly member illnesses (case management and disease management)
- the rules by which a claim is to be paid and how the member is to properly access the medical benefit (summary plan description or SPD)
- a claims administrator and payer that adjudicates and pays claims to the terms the employer has set in the SPD (insurance carrier or TPA)

Merely having these components in the overall health care ecosystem is not sufficient to effectively manage costs, as these specific components are the catalysts in which costs proliferate due to some of the challenges explained in section one of this guide. However, employers have the capacity to amend, replace, remove, add and create new ecosystem components to address specific needs, objectives or opportunities in their employee benefits landscape.

This section of the guide aims to address the leverage an employer has not only to create a more succinct and efficient health care delivery system based on overall affordability but also to create a more abundant and appealing benefits package to recruit and retain employees.

## How Employers Can Adapt To & Overcome Health Care Challenges

When an employer's health care ecosystem is constructed to be nimble enough to align cost, quality and access parameters, the corollary effects compound in a manner that yields synergistic benefits to both employer and employee. Cost-containment solutions reduce and manage overall risk to the plan, which produces lower overall premium and budgetary pressure. These solutions lead to more innovative plan design, which creates steerage incentives to drive employee-patients to better overall outcomes. In order for an employer's health care ecosystem to achieve these outcomes, the employer's plan should include tactics that:

- Protect against unnecessary spending due to fraud, waste and abuse
- Provide structured and reasoned access to primary care
- Guide minor acute care to efficient and low-cost sites of care (telemedicine, urgent care)
- Construct a care coordination methodology that handholds patients through health care navigation and care-delivery decisions for both routine and complex matters, as well as creates a 360-degree composite view of the patient as a unique individual
- Promote value-based care for situational diagnoses (low back pain, diabetes, dialysis)
- Align benefit deliverables with evidence-based medicine and proper diagnosis for high-dollar and catastrophic conditions (birth abnormalities, cancer, autoimmune conditions)
- Account for health care system outliers and have a plan to negotiate and contest their impacts on overall health spend
- Manage the pharmacy contracting and purchasing process to ensure the best overall drug procurement strategy
- Collect and analyze ongoing data to deduce patterns, trends and opportunities regarding overall ecosystem performance



# How Employers Can Adapt To & Overcome Health Care Challenges

## THE “HEALTH CARE HOME”

For the remainder of this guide, we’ll use the metaphor of a home to describe the form and function of future employer-sponsored health care delivery. In the below figure of an employer’s “health care home,” we present tactics employers can use in a manner that promotes logistical function and reasoned action.

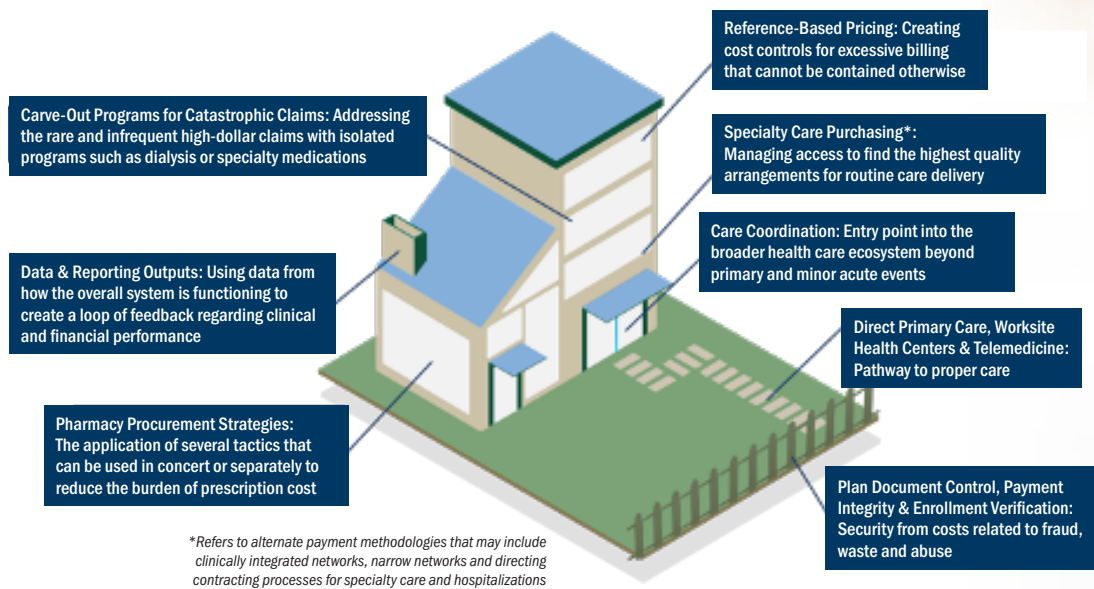
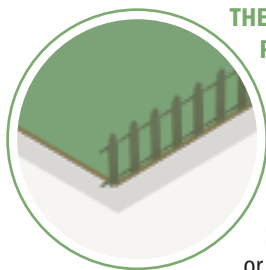


FIGURE 6

These primary cost-mitigation options that are marbled within the health care ecosystem are segmented into different categories:

**WATCH NOW**

Learn more about “**The Fence**” as part of the health care home in this 5-minute video.



### THE FENCE: PROCEDURAL SECURITY TACTICS THAT OBSTRUCT THE ORIGIN POINTS OF HEALTH CARE WASTE

#### Summary Plan Document (SPD) Control

With any self-funded plan, there are multiple points of connectivity, including the plan document, the stop-loss policy, the network contract and contractual relationships with other health care vendors. As these points of connectivity interact, it is common to find “gaps” – a misalignment or misinterpretation of verbiage – between the plan document and any supporting document or policy. By proactively aligning all plan components and ensuring proper verbiage and flow, employers can prevent gaps that may originate between these multiple points of connectivity.

## How Employers Can Adapt To & Overcome Health Care Challenges

The following is a prime example. A plan incurs an in-network claim billed at \$50,000. The SPD provides the plan the responsibility to audit all claims, and an audit reveals that the Usual and Customary (U&C) appropriate payable rate for this claim is \$30,000. Meanwhile, the network contract provides a 10% discount on billed charges for this particular claim. This results in the plan paying \$30,000 based on the SPD but owing \$45,000 as the network rate. When this issue occurs, the employer may agree to adhere to the terms of the network contract over the terms listed in the SPD. However, the dilemma may not be over since stop-loss presumably has underwritten coverage based on the assumption that the plan's U&C rate will be paid. This, in turn, results in the stop-loss carrier's coverage possibly denying the \$15,000 paid in excess of the plan's U&C rate. Even though a network contract exists and the plan may have no choice but to pay the claim, the chance that the stop-loss policy will define its payment on other terms may occur.

### Enrollment Verification

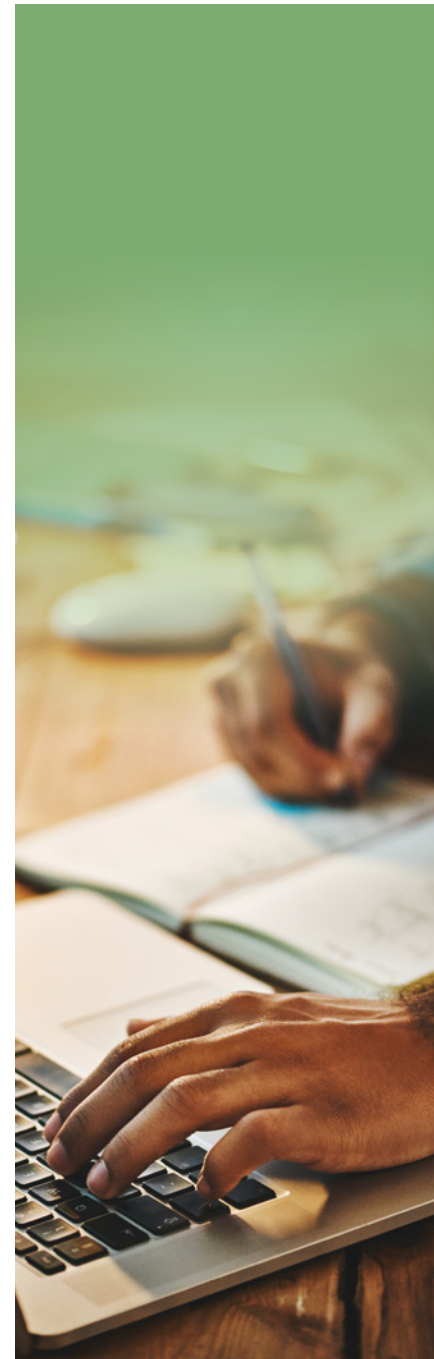
An eligibility audit is a type of voluntary compliance review that compares a plan's eligibility rules to the dependents actually enrolled in the plan. The purpose of a dependent eligibility audit is to identify dependents who should no longer be covered on the plan. Examples include children who have met the maximum age limit, divorced spouses and children impacted by changes in custody arrangements, among others. Removing those ineligible dependents from the health care plan can translate into cost savings for employers, especially if eligibility problems are already known to exist.

If employers fail to comply with plan eligibility rules as provided in the plan documents, they risk noncompliance with ERISA. An audit will help reveal not only eligibility issues but also may reveal important tax and revenue issues.

Health care reform includes a rule providing that a group health plan cannot rescind plan coverage with respect to an enrollee once the enrollee is covered, except with respect to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan. The plan may not cancel the coverage except with prior notice to the enrollee. What this means is once an enrollee is covered, employers will not be able to remove that individual unless they performed an act or practice that constitutes "fraud" or made an "intentional misrepresentation" of material fact as prohibited by the terms of the plan. Ineligible dependents, such as ex-spouses, girlfriends/boyfriends, nieces, nephews, parents, etc., could remain on the health plans if there is not a process to retain and maintain the employer's right to remove ineligible plan participants. Employers can use the dependent audit process to clearly define what they consider to be an act of "fraud" or "intentional misrepresentation," as well as the dependent eligibility requirements, to protect the plan from unintended covered dependents.

### Payment Integrity

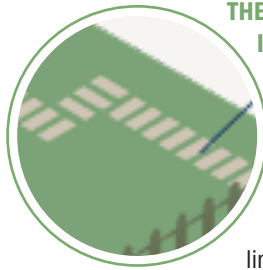
Payment integrity is essential for ensuring a health claim is paid per contract terms and without waste, abusive practices or fraudulent intent. Instead of merely paying medical claims as requested by the medical professionals and facilities billing for services, payment integrity ensures the claim accurately represents the services rendered. Detecting aberrant patterns in health care claims is key to defending against the threat of fraud, waste and abuse. This allows employers to be aware of potentially fraudulent claims before the claim is processed and paid, increasing the efficiency of administrative operations and lowering costs.



# How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about [“The Pathway”](#) as part of the health care home in this 5-minute video.



## THE PATHWAY: SERVICES THAT ESTABLISH HEALTH CARE ACCESS & INITIATE PROPER CARE DELIVERY

### Integrated Primary Care Concepts

As background, with the growth of medical insurance and other intermediary entities, primary care physicians (PCPs) began to see their role as gatekeeper being diminished due to numerous factors, including burdens related to filing insurance claims in a fee-for-service arrangement, limited reimbursement and the need to be within a broad medical network in order to have a patient pipeline.

As a result of this and other variables, access to primary care and primary care’s role in the health care delivery system have been greatly reduced. Studies indicate that the percentage of total U.S. health care spending allocated to primary care ranges from 5.8 to 7.7%, and even among high-performing health plans, primary care spending varies widely.<sup>24,25</sup>

Underinvestment in primary care gives rise to patient access and workforce issues. A significant financial incentive for physicians and other clinicians to choose other areas of specialty undermines primary care. A byproduct of this issue was identified in the 2017 Marriot Hawkins Survey of Physician Appointment Wait Times. The results were telling; in 2017 the average wait time to access primary/family care in 15 major metropolitan areas was 29.3 days, an increase from 19.5 days in the 2014 iteration of this study. When the results were applied to 15 mid-sized metropolitan areas, the average wait time in 2017 was 54.3 days to see a primary care/family practice setting.<sup>26</sup>

One way for employers to address this pertinent health access issue is to consider the use of direct primary care (DPC) or workplace clinics (onsite or near-site). In the DPC model, instead of being in a medical network and receiving a payment for each procedure under a fee-for-service arrangement, DPC doctors charge a monthly membership fee, usually between \$50 and \$100 per month, depending on the geographic market. In the workplace clinic model, the concept has similarities, with key differences being employer-centered locations and a more integrated process with workers’ compensation claims issues. Additionally, workplace clinics have a lower per-person unit cost but are generally reserved for larger employer groups.

## How Employers Can Adapt To & Overcome Health Care Challenges

In either model, the DPC and family physicians become the gatekeepers for a patient's health care decisions. On average, DPC and worksite clinic providers have 70% fewer patients to care for than a traditional primary care practice. Physicians can therefore spend the time needed with their patients to discuss their health concerns and history and develop a trusting relationship.<sup>27</sup> These models also improve access to care; for example, 95% of urgent visits in DPC/worksite clinics are scheduled the same or next day, and 85% of visits had a wait time of less than five minutes. Conversely, in traditional primary care office appointments, 85% of patients reported wait times of 10 to 30 minutes.<sup>27</sup>

In terms of outcomes, a 2019 study in the *Journal of the American Medical Association (JAMA)* that compared 49,286 adults with primary care and 21,133 adults without primary care revealed that patients who routinely use primary care received significantly more high-value care (4 of 5 composites), an example of which would be appropriate age and gender cancer screenings; received slightly more low-value care (3 of 4 composites), an example of which would be prescribing antibiotics for the flu virus; and reported significantly better health care access and experience.<sup>28</sup>

Most recently, a study released in May of 2020 by the Society of Actuaries found significant positive effects of DPC offerings compared to traditional insurance offerings after risk adjustment.<sup>48</sup>

- DPC members' overall claim costs were lower by 6.41 to 18.87% compared to traditional insurance.
- Total use of medical services (inpatient stays, outpatient services, specialty practice usage, urgent care, ambulance, home health and prescriptions) was lower by 12.64%.
- Emergency room utilization was 28.52 to 52.60% lower compared to traditional insurance.

- Inpatient admission rates showed no statistical significant differences between DPC and traditional insurance.
- Depending on utilization modeling, under the high-DPC-savings scenarios, the DPC option saved 5.2% of total non-administrative plan costs. Under the low- and mid-DPC-savings scenarios, the DPC option increased costs for the employer by 7.8% and 1.3%, respectively, of total non-administrative plan costs.

All of these services are covered by the monthly subscription fee with no additional co-pays. The net benefit to the employer is the ability to provide a capitated fee to PCPs who are singularly focused on the care and health of fewer members, with a greater attention to detail. When a DPC practice or worksite clinic provider is engrained with an employer, it creates the capacity to:

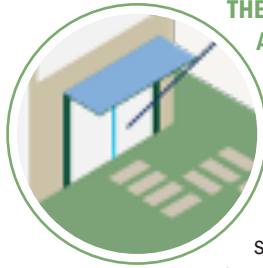
- Create stronger measurement of improved health outcomes for chronically ill members with lifestyle-related conditions.
- Triage medical services to the appropriate levels of care so that chronic condition maintenance and high-risk condition management take priority. Minor acute and episodic care needs can be handled via integrated telemedicine or over the phone for the patient's convenience.
- Drastically reduce medical plan costs related to fee-for-service charges that have wild variance in pricing.
- Avoid unnecessary costs related to specialty care. In some cases, the employer's cost and quality tools are used in concert with the DPC practice or worksite clinic to help steer the member to doctors and facilities that create better health care purchasing value for larger ticket medical expenses outside the scope of primary care.



## How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about [“The Front Door”](#) as part of the health care home in this 5-minute video.



### THE FRONT DOOR: COORDINATING CARE & CENTRALIZING ADVOCACY SERVICE

Care coordination refers to the organization and integration of information across providers and settings, enabling a more personalized experience for the patient. In the employer health care model, care coordination typically takes on the role of precertification, prior authorization and verification of benefits. By assuming these responsibilities care coordinators can help steer patients to better overall treatments through the use of higher quality facilities, medical second opinions and centers of excellence (COEs).

While data shows that care coordination can improve delivery and lower costs for all patients, it's especially important for individuals managing chronic diseases that require the ongoing support of multiple providers.<sup>29</sup> The benefits of care coordination across clinicians, specialties and settings have been a central focus of health care payment and delivery system reforms. Better care coordination, it has been argued, is a remedy for a fragmented health system and could lead to improved health outcomes, superior patient experiences and lower costs.

However, in practice, this process becomes complex . . .

- 70% of Americans don't feel compelled to get a second opinion or do additional research upon their doctor's recommendation.
- 20% of patients are sent to see a specialist without any formal communication from the first doctor.<sup>31</sup>
- 75% of specialists have received at least one “clinically inappropriate” referral in the past year.
- 7.8% of all referrals are considered “clinically inappropriate,” which equates to 42 mismatched patients to specialists per year and 19.7 million clinically inappropriate referrals annually, nationwide.
- 65% of clinically inappropriate referrals were either sent to the wrong specialist or subspecialist (48%) or did not require a referral at all (17%).<sup>30</sup>

## How Employers Can Adapt To & Overcome Health Care Challenges

Therefore, it becomes paramount for proper diagnosis and continuity of patient care to avoid costly critical-care situations that could otherwise be avoided by clinical adherence and oversight.<sup>31</sup>

Clinical integration has long been a goal of many health care providers in order to improve quality, coordination and efficiency. In an example of care coordination, Medicaid patients receiving acute care interventions had lower emergency department use and fewer follow-up visits, resulting in savings of \$4,295 per beneficiary episode (inpatient stay plus 90 days following hospitalization) compared with a control group drawn from neighboring hospitals.<sup>32</sup>

Recent data shows that Americans want their providers to better coordinate their care to improve connectivity across care settings. In fact, 62% of Americans believe that information sharing (such as electronic medical records) across care settings has a positive impact on health outcomes. Furthermore, 84% of Americans say it is important for their providers to utilize technology to communicate with one another, including pharmacists and retail health practitioners.<sup>33</sup>

The employer's role in this endeavor is to ensure the proper channels are created to coordinate care via the alignment of the third-party administrator (TPA), pharmacy benefits manager (PBM), care management vendor and the provider network focused on the patient. This includes tight regulations of the prior authorization and pre-certification processes along with a designed workflow for specific conditions and treatments to ensure care protocols are being fulfilled. By building a specific plan for care delivery, using integrated vendor relationships, employers can avoid costs related to waste, overtreatment, improper referrals and redundancies in care, as well as gaps in care.

In CBIZ client case studies, care coordination efforts resulted in 98.8% engagement with patients who had annual claims costs of more than \$50,000. Over 53% of those interactions were not with the high-dollar patient but instead with their panel of medical providers. 72.2% of members with a chronic condition were actively engaged in this coordination model. During the annual observation period, the employer's annual plan costs only increased 1.9% compared to the previous year, while national medical trend averages for employers in 2019 were 6%.<sup>34</sup>

Acting as the front door of health care, care coordination aids the member in accessing the broader health care market as it relates to their benefit plan options and rules. The value of this process is ever-growing. In a study published in the American Journal of Managed Care, of the more than 140 million health plan members across 31 different commercial plans who had access to price-transparency tools, only 2% used them. Many members did not know the tools existed at all.<sup>35</sup> Care coordination is the typical setting in which care coordinators use these price-transparency tools, alongside the member in the patient's time of need, which increases utilization.

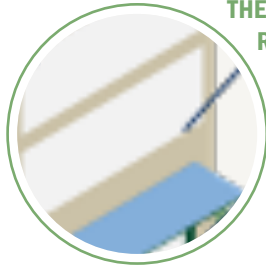
Secondly, care coordination can assist members with issues navigating both the medical ecosystem and the insurance ecosystem. In an advocacy role, care coordination can assist with billing issues, medical appeals and other functions where insurance and health care intersect. Further, care coordination can help alleviate the humanistic issues surrounding care delivery, such as transportation challenges, logistical hurdles with returning home after hospitalization, and other social and behavioral issues associated with the upheaval a sensitive health care diagnosis can cause in a patient's daily life.



## How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about  
“[The 1st Story](#)” as  
part of the health  
care home in this  
5-minute video.



### THE 1ST STORY: UTILIZING COST & QUALITY INFORMATION TO RECONFIGURE HEALTH CARE PURCHASING

As employee-patients develop symptoms that exceed the expertise of primary care and/or minor acute care practitioners, the more costly care becomes. This is not exclusively due to the increasing severity of conditions but also the opacity of cost and quality information regarding specialty care and facilities, which often has wide-sweeping variances.

Even for the non-emergent, transactional portions of care delivery, such as labs and imaging, price disparities can vary greatly. For example, in Nashville, a heart perfusion imaging procedure has an in-network price disparity of 721% between competitors in the same zip code for the exact same service. In Chicago, a knee arthroscopy has an in-network price disparity of 1,268% between competitors 13 miles apart for the exact same service.

In a study published in 2018, researchers used insurance claims data from three of the largest commercial insurers in the U.S. to observe that health care prices vary nationally. A representation of this data is listed in Figure 7. They found that the highest cost provider charged three times more than the fees charged by the lowest cost provider. (Until recently this data was not made available for public research use.) The data includes hospitals’ transaction prices, with substantial variation in prices across hospitals, even for identical services like lower-limb MRIs. Moreover, a significant amount of the national variation in prices occurs within hospitals. This suggests that insurers’ bargaining leverage influences the prices they negotiate with hospitals. Market structure appears strongly associated with hospitals’ price levels and contract structure. When compared to hospitals located in quadropoly or greater markets, monopoly hospitals are associated with 12% higher prices, 10% more cases paid as a share of charges and 11% less of their prospectively paid cases set as a percentage of Medicare payments.<sup>36</sup>

In regards to quality, outcomes metrics for reimbursement are already being tied to more refined performance measures dependent upon more comprehensive documentation and coding than what drives Medicare Severity-Diagnosis Related Groups (MS-DRGs) or severity of illness.<sup>37</sup>

## How Employers Can Adapt To & Overcome Health Care Challenges

For employers, this largely creates an opportunity to identify higher performing physicians and hospitals in the following measurement categories:

- Overall Mortality
- Overall Complications
- Overall All-Site Readmissions
- Inpatient Quality
- Patient Safety

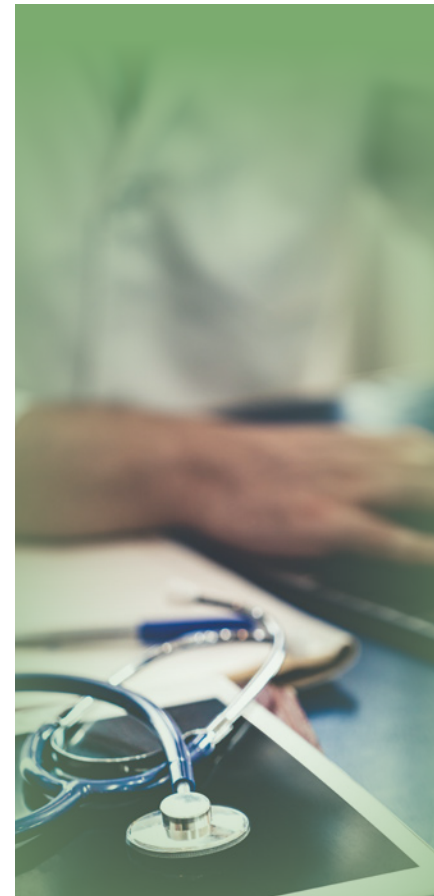
From these categories, quality ranges are determined for multiple categories of care (segmented by categories such as cancer care, orthopedic care or cardiac care) and rated in the following manner:

- 10% receive “highest” quality rating
- 15% receive “high” quality rating
- 50% receive “average” quality rating
- 15% receive “low” quality rating
- 10% receive “lowest” quality rating

In an analysis of cost and quality of medical facility options, the three medical systems within a top 150 metropolitan statistical area in the Southern U.S. were evaluated for cost and quality using the metrics listed above.

Each of the three hospitals had significant variance in both their quality scores for different types of specialty care as well as their billing rates as a ratio above what Medicare pays for those services. Within the metropolitan area, the voluntary nonprofit hospital that charges 25.88% less for medical services is only 7.76% lower in overall hospital quality compared to the medical facility owned by a corporation. However, when evaluating broader hospital choices within a 35-mile radius of the metropolitan area, better overall quality options are available in terms of orthopedic care and overall hospital excellence scores.

This invites discussion regarding how health care quality is dispersed by each unique hospital, the category of specialty care being received and proximity to the patient, and how those variables are perceived within the context of overall cost of care. Even though employers are the largest purchasers of health insurance, they typically don't apply this information or leverage their influence to encourage improvements to the health care they buy.



Hospital Type*	Billed Multiple Above-Medicare Rates	Overall Hospital Score	Overall Medical Score	Overall Surgical Score	Cancer Care Score	Orthopedic Care Score	Cardiac Care Score
<b>Proprietary Corporation</b>	5.89x	73	98	27	71	43	82
<b>Voluntary Nonprofit</b>	4.54x	67	98	23	21	42	93
<b>Academic Medical Center</b>	5.14x	47	16	38	17	12	13
<b>Other Hospitals within 35 Miles</b>	Varies	82	81	70	37	81	47

\*Quality data on a 0 - 100 scale, rounded to nearest whole number

FIGURE 7

## How Employers Can Adapt To & Overcome Health Care Challenges

When properly armed with this cost and quality information, employers can then configure their health care purchasing philosophy to gain better utilization of higher quality and lower overall cost facilities that results in the collective unification of “high value health care.” There are several methodologies an employer can choose from to configure the health care ecosystem to obtain the highest value care. Regardless of methodology, the intent of this process is to achieve a contracted rate that would be lower than the price an employer would receive through a traditional medical network. After all, the employer is funneling more health care volume to fewer overall service providers, who happen to perform with higher quality, in return for a favorable pricing agreement. There are several preexisting programs that aggregate multiple employers for competitive purchasing in the open market so that an employer doesn’t have to be involved in the contract development process.

An employer can utilize and integrate multiple methodologies at once, but the basic methods involved are:

- **Direct contracting, pre-negotiated rates and case-rate pricing** in which providers and employers agree on a defined rate for services, which is usually based upon some multiple of Medicare. Alternately, the compensation is determined via negotiation, based on the hospital’s areas of specialty and medical quality. This also will apply to domestic medical tourism and condition-specific carve-out programs, such as for dialysis.
- **Value-based care, utilizing alternative payment models**, including accountable care organizations (ACOs) and clinically integrated networks that focus on tighter care coordination tactics in which the care providers have a vested interest in both the clinical and cost outcomes and share in the savings created by more efficient health care utilization.

### ■ **High-performance but narrower networks**

focused on medical quality outcomes to determine which hospitals and physicians are included in the network. For infrequent, atypical and high-dollar procedures/conditions, a centers of excellence (COE) program can be used to direct members to hospitals nationally regarded as best in class.

### ■ **Direct Contracting**

The administrative benefits of a traditional contracting process, using insurance carriers and TPAs to design and maintain health care provider networks instead of contracting directly with the providers themselves, come at a price to employers. In having a traditional contracting process, employers cede much of their ability to control costs to those insurance carriers and TPAs. In a direct contracting situation, employers sidestep health insurers and contract directly with providers. Currently, only 6% of employers contract directly with providers, but 22% of large employers considered including this option in their 2019 benefit plans.<sup>42</sup>

The three common kinds of direct relationships between employers and providers are:

- Accountable care organizations (ACOs) for an entire employee population, largely clustered in a tight geographic area near the chosen contracted health system
- A bundled payment, carve-out or center of excellence (COE) for a defined condition, such as cancer, spinal surgery or transplants
- An advocacy role, such as meeting with hospital leaders to advocate for quality initiatives or payment reforms



## How Employers Can Adapt To & Overcome Health Care Challenges

With each new provider reimbursement strategy, employers should carefully consider their overarching goals and preferences – cost, quality, access or a combination of all three – and test augmentation of their benefit plan designs and underwriting processes to properly evaluate and measure expected outcomes of these strategies. Additionally, a key emphasis of either direct contracting strategy is to identify providers with the capability, willingness and performance record to accept these alternative performance structures for health care services.

### Alternative Payment Models – ACOs & COEs

Large self-insured employers are increasingly contracting for services with doctors and health systems directly in order to combat unmitigated employee access to underperforming providers in a broad network. Direct contracting with ACOs and high-performance networks jumped from 3% in 2018 to 11% in 2019. Direct contracting with COEs increased from 12 to 18% in that same time period.<sup>38</sup> With financial pressures growing and the focus placed on quality outcomes, alternatives to traditional fee-for-service (FFS) reimbursement are gaining in popularity. With this focus on cost-effective, efficient and quality services, new payment methods such as bundled payments, patient-centered medical homes, COEs, employer-sponsored narrow networks and ACOs are becoming more prevalent. These models of care emphasize elimination of wasteful spending, better health information management and improved clinical outcomes.

ACOs are comprised of groups of doctors, hospitals and other providers that come together voluntarily to provide coordinated, high-quality care to their patients. High-performance networks limit in-network doctors, clinics and hospitals to providers that are highly rated for cost and quality of care. Similarly, COEs are highly rated facilities shown to offer high-quality, cost-effective care, often focused on specific diseases or conditions.

As public and private payers begin to link payments to quality, outcomes and costs, the market repercussions for providers and health systems are significant and far-reaching. In the increasingly value-based health care economy, only those organizations that can demonstrate positive clinical outcomes across episodes, while safely reducing costs, will prevail. In regards to employers, creating network customization, benefit plan design and patient communication regarding hospital and physician choice is critical in order to address the additional cost burden of misdiagnosis, medical error, waste and readmissions.

To optimize their clinical and financial performance in value-based care models, physicians and hospitals must prove they are meeting or exceeding quality standards, achieving better clinical outcomes and controlling costs. Since hospital systems are focused on revenue generation, not employer cost containment, accuracy of source data and stronger transparency in clinical documentation are essential for proving quality to external stakeholders, sustaining high quality and advancing performance improvement in emerging value-based health care models.



## How Employers Can Adapt To & Overcome Health Care Challenges

### Narrow Networks & Centers of Excellence

Some health care institutions are seeking to differentiate themselves by establishing niche programs focusing on particular areas of medicine, delivering world-class care and attention to their selected fronts.<sup>39</sup> Known as centers of excellence (COEs), these programs create many advantages for health care institutions and their served markets in addition to employers and their employees.<sup>40</sup> When an employer decides to offer access to only those physicians and facilities that are high performing but not clinically connected in their operations (as in the ACO model), then the employer is engaging in a narrow network. While these narrow networks have high-performing medical professionals, the network itself is markedly smaller than a traditional insurance carrier network given that it only incorporates the best local and regional facilities and physicians.

Notably, by differentiating themselves as institutions of specialized expertise, medical providers increase their opportunities to attract patients. They also have the ability to deliver enhanced quality through the application of innovative devices, technologies and techniques, which improves outcomes. Further, COEs can benefit institutions financially by increasing efficiencies and improving reimbursements, while providing better clinical outcomes for employee-patients through reductions in readmissions, proper diagnosis and other quality of care metrics for their particular areas of specialty.<sup>39,41</sup>

Employers' use of some form of COE jumped from 79% in 2016 to 88% in 2019, according to NBGH's "2019 Large Employers' Health Care Strategy and

Plan Design Survey" of 170 large U.S. employers. And, while most of these contracts are between providers working with health plans, the survey indicated that direct contracting between employers and COEs is "rising rapidly" from 12% in 2019 to 18% of employers in 2020.<sup>38</sup> Among employers, COEs were first used for workers who needed transplants, with 74% of employer-sponsored health plans contracting for such procedures. Increasingly, though, employers are tailoring COE programs for other "conditions or procedures, such as bariatric surgery (58%) and surgical procedures to treat musculoskeletal problems (38%)." COE growth has increased across a number of procedures/conditions over the last two years, but COEs for cancer (up 10%) and fertility treatments (up 7%) will experience the greatest growth after 2019.<sup>38</sup>

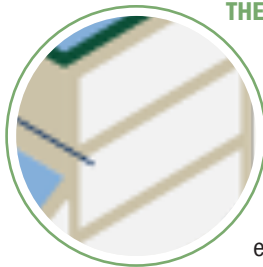
For employers, the strategy of deploying a narrow network or COE program begins with identifying how many procedures are related to high-dollar conditions/procedures that a COE strategy could improve. This largely means evaluating claims data to identify surgical procedures such as spine, heart/valve, knee, hip, cancer, transplants and stem-cell therapies. The second measure is to ensure a procedure is medically necessary, as misdiagnosis and lack of application of evidence-based medicine techniques may hinder cost and outcomes for both the member and the plan. By offering, at minimum, a second opinion with a COE, the employer is using the COE to ensure the diagnosis was accurate and that conservative therapies had been considered and implemented before surgeries were recommended.



## How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about [“The 2nd Story”](#) as part of the health care home in this 5-minute video.



### THE 2ND STORY: ISOLATING THE RISKS RELATED TO CATASTROPHIC CLAIMS

Of the top high-cost conditions that result in stop-loss claims, many high-cost elements of cancer treatment, organ transplants, birth anomalies, medical/surgical complications, major orthopedic surgery and wellness-sensitive medical events can be tempered via various combinations of integrated primary care, care coordination and improved purchasing methodologies, such as the use of direct contracting, narrow networks and COEs. However, some specific elements of these conditions remain independently expensive, such as the cost of medications or procedural processes required for treatment. Additionally, for other illnesses, such as end-stage renal disease, hemophilia, autoimmune and inflammation-related disorders, and growth hormone and genomic-focused conditions, the whole cost of treatment is independently expensive for the same reasons; the cost of medications and/or the procedural process of delivering medical services to the patient is high.

In most catastrophic claims, an overwhelming majority of the cost is clustered in a single, sentinel procedure. In a significant volume of catastrophic claims, the medication itself is the sentinel expense, often times representing 30 to 90% of the overall cost. As an example, a specific stop-loss claimant suffering from inflammatory bowel disease (in the form of ulcerative colitis) totaled over \$215,000 in claims cost, with nearly \$206,000 coming solely from the cost of Stelara, a multi-faceted specialty medication that can be used in the treatment of moderate to severe cases of ulcerative colitis, Crohn’s disease, psoriatic arthritis and psoriasis. In other scenarios, such as end-stage renal disease (otherwise known as chronic kidney disease or chronic renal failure), a specific stop-loss claimant incurred over \$577,000 in claims of which \$543,000 originated solely from weekly dialysis procedures.

Circumstances in which a sentinel procedure drives the majority of costs are viable opportunities to look at alternative purchasing models, otherwise known as carve-out programs. When the sentinel procedure is earmarked for carve-out, it is intended to be purchased outside of any network arrangement via an alternative medium at a cost significantly lower than any contracted network rate.

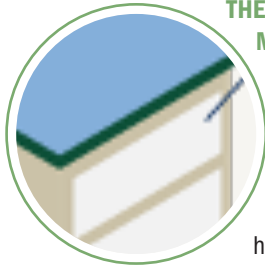
For high-dollar specialty medications, a very narrow set of qualifying disease states represents the majority of not only those drug costs but also drug costs specific to catastrophic claims. 45% of specialty drug costs originate from cancer and biologic drugs for autoimmune disorders (BDAIDs) alone.<sup>22</sup>

For catastrophic claims in which pharmacy expense is not the sentinel driver of cost, the procedural process of delivering medical care is typically the sentinel cost driver. In those cases, ensuring patient adherence to the standard of care is paramount and should only be altered in a manner that improves convenience and access, as opposed to disruption that may reduce adherence to a care plan, such as limiting provider choice or creating financial burdens on the patient. In that regard, most alternative payment strategies do not alter the place of care but rather change the mechanics of how the cost of services is negotiated. Such negotiations may include tactics that incorporate utilization of Medicare rules and reference-based pricing (RBP) as the antecedents for change. In other cases, the strategy is to intentionally change the place of care from a facility to in-home therapy, creating a better experience for the patient. This in-home transition, when appropriate, drastically lowers the cost and creates convenience for the patient, while ensuring better adherence to care.

## How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about “[The Attic](#)” as part of the health care home in this 5-minute video.



### THE ATTIC: A MEANS TO EXPEL ADDITIONAL RISK WHEN ALL OTHER METHODS ARE EXHAUSTED

The primary purpose of attic or roof ventilation is to expel solar-heated hot air in order to lessen the building cooling load, which if left unmitigated would drive up the cost of cooling the home in the hottest part of the year. In health care, the purpose of RBP is to expel other extreme sources of health care costs in scenarios where all other cost-containment measures have been exhausted or are simply not applicable to the circumstance. This could apply to a myriad of scenarios:

- Specifically for out-of-network claims or claims in which no agreement exists with medical providers
- To confront medical providers with egregious billing tactics
- When hospitals have created a limited-area oligopoly and an employer is attempting to restructure the reimbursement rates to reset the business landscape to be reflective of true fair-market value
- When an employer requires a more simplified, streamlined method of medical reimbursement and/or has significant logistical constraints with respect to budget or administrative burden

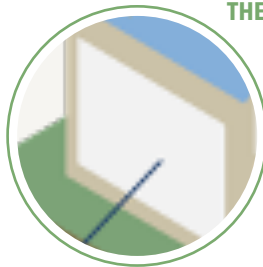
### Reference-Based Pricing (RBP)

Despite the overwhelming variance in costs for the same procedures in the same geographic area, most employers are not adopting strategies that directly address this issue, namely the use of RBP.<sup>24</sup> Under RBP, the health plan determines a “reference price” – generally some percentage above Medicare reimbursement rates (usually 120 to 200% of Medicare rates in a geographic area) – for a given medical service, and the plan will cover medical expenses for that service up to that price. If a patient receives care from a provider whose negotiated payment is above the reference price, the patient is responsible for paying all medical costs above that price (i.e., balance billing) along with all other cost sharing. RBP is applied only to select medical services, typically those that are non-emergent and for which patients have a choice of providers. To date, the largest employer plan confirmed to utilize this method for most of their claims payment processes is the State of Montana. The state transitioned to a RBP model in 2016, with the state reimbursing providers 234% of what Medicare offers. Under the new plan, Montana has saved \$13.6 million in three years.<sup>43</sup> During that time, executives from the Montana Hospital Association stated that Montana hospitals have had “reasonable financial performance” and that no area hospitals have been struggling under the new state contract.<sup>44</sup>

# How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about “The Garage” as part of the health care home in this 5-minute video.



## THE GARAGE: STOCKPILING TOOLS TO EFFECTIVELY MANAGE PHARMACY COSTS

There are generally six stakeholders in the supply and demand of prescription drugs – pharmaceutical manufacturers, health insurers (including self-insured employers), PBMs, pharmacies, wholesalers and patients. In the past four years, the medical and pharmaceutical industries have assimilated into a merged, vertically integrated model. During this timeframe, either a major insurance carrier has acquired a major PBM or vice versa.

<b>Insurer:</b>	United Healthcare	Aetna	Cigna	Anthem	Humana	BlueCross BlueShield
<b>PBM:</b>	Optum Rx	CVS Caremark	Express Scripts	Ingenio	Humana Pharmacy Solutions	Prime Therapeutics
<b>Specialty Pharmacy:</b>	Briova Rx	CVS Specialty	Accredo	CVS Specialty	Humana Pharmacy	AllianceRx

FIGURE 8

While this conglomeration creates efficiencies for the merged entity, how it affects the employer’s health spend is varied.

In a carve-in pharmacy scenario, the employer’s pharmacy benefits are purchased and integrated through the insurance carrier relationship. Because of this, administrative function is more automated and succinct. There is one overall ID card for members, and data sharing between the medical and pharmacy benefits is consolidated. This allows for synchronization with carrier condition management programs and care coordination efforts with providers.

In a carve-out scenario, the tradeoff is that the employer can now attain greater visibility and control over the clinical programs, as well as the contractual stipulations and plan performance. Employers can also obtain flexibility with considerations on plan design and network enhancements. Additionally, it allows them to adopt more innovative clinical and steerage programs for greater medication adherence

and financial outcome opportunities. This is largely driven by the fact that carve-out PBMs have to justify the financial investment to overcome the administrative advantages typically perceived with having a carve-in pharmacy arrangement.

Carve-out PBMs all have varying business models, with each PBM having different preferences of levers to lower overall cost. These differing levers are actually widely dispersed tactics. Some focus on rebates and contractual guarantees alongside strict formulary management. Others focus on the purchasing efficiencies with particular pharmacies that have favorable contracts. Some simply charge an administrative fee with no markup on the cost of procuring medications. A few highlight the use of programs that maximize the use of nuanced savings strategies, such as co-pay coupons, patient assistance programs or other progressive strategies. And finally, some leverage bulk purchasing as a means to aggregate economies of scale and negotiate with pharmacy entities.

# How Employers Can Adapt To & Overcome Health Care Challenges

## Pharmacy Coalitions

Coalitions act as a means to aggregate mid-market employers in a manner that allows those entities to leverage their total volume and pharmacy spend in order to receive pricing that would typically be reserved for large employers. Just as PBMs differ greatly from each other, coalitions all have unique business objectives. Some purchase directly through one PBM entity, while others negotiate with multiple PBMs. Coalitions may have a regional, market-size or industry-specific focus, and some may charge membership fees or have rigid contracts with employers.

## Co-Pay Programs & Rebates

In the status quo of pharmacy benefits, pharmaceutical manufacturers provide subsidies to employee-patients, typically in the form of a coupon or debit card, which can be used to pay for out-of-pocket expenses. This allows the member to then purchase a potentially more expensive drug under their benefit plan for the same or lower cost than a lower tier alternative. Because drug manufacturers know the bulk of a drug cost will be paid by the employer, the intent of this program is for the drug manufacturer to absolve the member's cost share, thus incenting them to use the higher cost drug.

While this solely benefits the member, there are many tactics an employer can use to make this mutually beneficial for the employee-patient and the employer. The employer may:

- allow the use of the coupon to absolve the member's cost share; however, the employer prohibits the use of coupon dollars to count toward the member's out-of-pocket expenses.

- introduce the concept of a "variable co-pay program" in which the co-pays are set artificially high to maximize coupons for various medications. This process typically results in savings of \$500 to \$1,500 per drug script.
- set a higher coinsurance to further utilize more of the manufacturer's contribution on behalf of the employee-patient.

Another area of interest within the scope of pharmacy is the use and handling of rebates. Rebates are a form of price concession paid by a pharmaceutical manufacturer to the health plan sponsor or the PBM working on the plan's behalf. Proponents argue that rebates are a result of vigorous negotiations that help lower overall drug costs.

Rebate contract terms are trade secrets and vary widely among brands, pharmaceutical manufacturers and health insurers but tend to be highest for brands in therapeutic classes with competing products.<sup>4</sup> This secrecy makes cost comparisons between competing brands difficult to estimate on the basis of price alone. Rebates therefore create a "black box" in the prescription drug distribution chain. The patient and, typically, the plan sponsor or employer do not know how much the pharmaceutical manufacturers are paying in rebates and how much of the rebates PBMs are keeping before passing the remainder to the health insurer.<sup>46</sup> While rebates average close to 20% of the price, some brands have no rebates and others are believed to offer rebates of over 60%.<sup>47</sup>

While rebates can be perceived as a source of revenue for an employer's drug spend, the intent of any plan sponsor is to achieve patient clinical adherence, condition management

and, possibly, employee satisfaction at the lowest overall price. In following that logic, some pharmacy tactics focus on the lowest cost of procurement, which is a potential contradiction to maximizing rebate dollars, as rebate dollars are returned to the employer after the purchase of the highly rebated drug occurs. Therefore, if the drug is procured in a nontraditional manner at a significantly lower cost, it is not accumulated within the aggregate reimbursement of rebate dollars. However, when a drug does not qualify for alternative procurement, it stays within the formulary to maximize the rebate dollars associated with the drug.

## Alternative Funding Markets

To address the increases in pharmacy spending, the use of advocacy-based programs, utilizing alternative-funding markets, is on the rise. These alternative-funding markets are comprised of private foundations (largely operated or sponsored by pharmaceutical manufacturers), public charities, state access programs or international mail-order programs. By applying these strategies, employers are seeing a reduction in pharmacy costs of 35% or more on high-dollar medications, while greatly reducing the member's cost-share burden.

## Going International

Specifically regarding specialty medications and related carve-out programs, one strategy to avoid the exceedingly high prices of some prescription medications in the U.S. is simply to procure them from elsewhere. Tier 1 countries, including Canada, the UK, Australia and New Zealand, have safety and efficacy standards that equal or exceed U.S. standards. They're also able to offer chemically identical drugs at significantly lower prices than those offered in the U.S.

## How Employers Can Adapt To & Overcome Health Care Challenges

So, why hasn't the U.S. prescription drug market self-corrected due to this international competition? The simple answer is that the practice is illegal. Under federal law, drugs that are manufactured for sale outside the U.S. are not FDA approved as there is no potential for oversight in the manufacturing process. Additionally, FDA guidelines address labeling, storage and transportation.

If importing foreign drugs is illegal, how is it a viable option for cost containment? It's possible, under the right circumstances, due to a well-documented FDA policy of "enforcement discretion." Under this policy, the FDA does not prosecute individuals who import a limited quantity of prescription medications (no more than a three-month supply) for personal use from abroad. So, if an international program is set up correctly, the savings on many costly medications can be huge, with very minimal risk to the employer and patient.

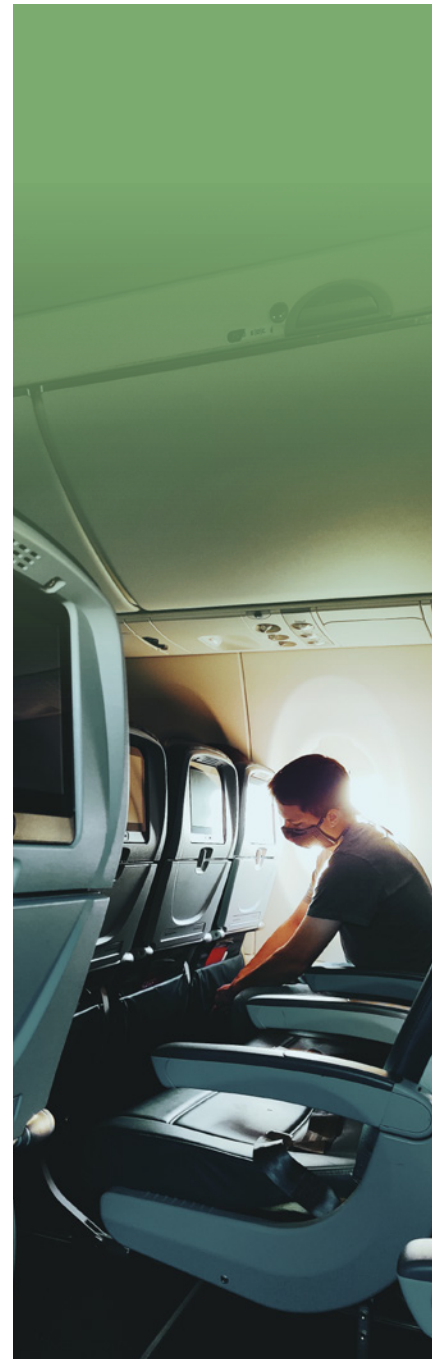
Two important things to consider, though, are safety and plan document design. Regarding safety, it is important to remember that just because a drug comes from a Tier 1 country does not guarantee it is safe. Employers should be aligned with reputable people and pharmacies abroad when implementing this type of program. Occasionally, drugs manufactured in countries with more lax standards have been imported into Tier 1 countries, causing incident. Additionally, some of these drugs have been found to be outright counterfeits. Regarding plan document design, every plan document likely has some existing barriers to making a seamless transition into reimbursing for invalid expenses such as these. Any exclusions or conflicting language must be removed, and these changes should be approved by the plan's stop-loss carrier and TPA (and ideally the PBM as well).

### Medical Tourism

Another trend is specialized medical tourism, both within the country and internationally. More and more providers are gearing their business model to specifically target medical tourism and sometimes even specific conditions/illnesses. When a facility that specializes in certain clinical procedure therapies or treating diseases that are particularly costly begins operating just over the border or just offshore, it's surely no coincidence.

Of course, a medical tourism offering only helps an employer save money if patients are willing to use it. Health City Cayman Islands, a facility that offers a broad spectrum of health care services, understands this. As an example, their hepatitis C program provides the greatest opportunity for potential savings and has been designed to include travel planning assistance, transportation and concierge services, complete with arranging local activities and excursions. The leading prescription hepatitis C medications can cost nearly \$100,000 for a single 12-week course of treatment in the U.S. As surprising as it may seem, it can be significantly less expensive to fly a patient (with a companion) to the Caribbean for treatment, including all ancillary services, testing and prescription medications, than to have the drug dispensed at a local U.S. pharmacy.

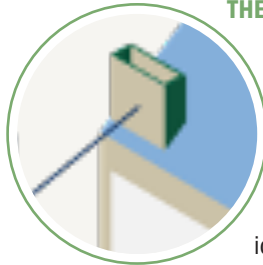
Given the expected burden that specialty medications are going to have on total health plan expense, employers should be aware of all of the potential strategies and the unique characteristics of each as it relates to augmenting the pharmaceutical supply chain and the overall cost of medications. In order to effectively manage pharmacy expense, it's paramount that employers have a toolkit of tactics available to them and the knowledge to execute a plan that is harmonious with their objectives and procurement philosophy.



## How Employers Can Adapt To & Overcome Health Care Challenges



Learn more about [“The Chimney”](#) as part of the health care home in this 5-minute video.



### THE CHIMNEY: USING THE OUTPUT OF DATA TO BUILD FOR THE FUTURE

A chimney is a center of output for a home used to keep the interior of the building warm. In a similar fashion, data generated as a byproduct of medical and pharmacy utilization is valuable in understanding the risks, trends, demands and opportunities within an employee population. Consequently, this data can be used to make projections and identify potential problems, alterations and solutions. Claims-level data can identify unmanaged and unmitigated risk, isolate irregularities in provider billing practices, and categorize prominent cost drivers by factors such as geographic location, age, plan type and other socioeconomic variables.

This output not only becomes the fuel for cost-mitigation strategy but also creates a baseline to test the plausibility of reducing costs through certain interventions. For example, an employer had a high usage of non-emergent local emergency room (ER) facilities in which 45.7% of all ER claims were deemed as preventable, primary care appropriate, non-emergent or behavioral health cases. When analyzing these claims, it was discovered that the ER facilities were used a total of 66 times by less than 54 members of the plan within a 90-day window. Upon further investigation, it was noted that only six of the ER users had established a primary care relationship. A vast majority of members worked second or third shift, which limited their access to routine primary care services. Armed with this data, the employer evaluated the use of an onsite clinic to accommodate shift-workers. The clinic was anchored by PCPs with a flexed working schedule and did not charge members for access. Additionally, it provided outreach to the members who would be better served in a primary care setting.

## Taking It Home

By utilizing data constructively and introspectively, employers have a means to not only understand how their employees utilize care but also how the supply side of health care takes advantage of the employees. In light of escalating costs, providing benefits to employees has become a bottom-line issue for employers. Rising health care costs are further compounded by poor quality of care, catastrophic claims and poor chronic disease management. Surprisingly, while employers have abundant market choices for diffusing health care costs, many do not take advantage of using them. Employers who utilize cost-mitigation tactics will benefit not only in regard to financial competitiveness but also in how they market and appeal to their current and future employees by offering richer benefits plans at a lower cost.

With more innovative care-delivery models, such as the ones referenced in this guide (integrated primary care, specialty pharmacy management processes, determining provider medical quality, streamlined provider reimbursement, the use of centers of excellence, and the deployment of care coordination and clinical integration), plan design elements need to be aligned in a manner that creates natural pathways for employees to have both a financial gain and improvement in health from the employer's redesign of the health care ecosystem. This, in turn, will create more financial flexibility for the employee, remove barriers to care and result in better overall metrics of appropriate health care utilization.



## About CBIZ Health Innovations Practice



CBIZ Health Innovations Practice (HIP) utilizes the combined power of our multi-disciplined expertise and robust data analytics to help you gain control over health plan costs, make more informed decisions and avoid wasted spending. CBIZ HIP has the competitive advantage of providing insight and tactics related to our unified pharmacy, wellbeing, actuarial and clinical consulting experts.

An additional benefit of our consulting process is our acumen regarding the overall health care ecosystem. Our in-depth knowledge of the health care supply chain and how to engineer marketplace impacts helps our clients develop benefits programs that mitigate health plan risks while promoting positive change for their employees' health care experience.

## About CBIZ Employee Benefits



At CBIZ Employee Benefits, we're passionate about providing strategic solutions that will drive employee engagement and build a dynamic and thriving workplace culture. This isn't cookie-cutter consulting. Our team of forward-thinking professionals will collaborate with you to develop an actionable plan designed to help you navigate the complexities of your benefits strategy, addressing your unique pain points and goals. You can count on us – with over 4,500 clients and 500 associates nationwide – as your trusted advisors committed to your success.



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