

Moving Beyond Managed Care

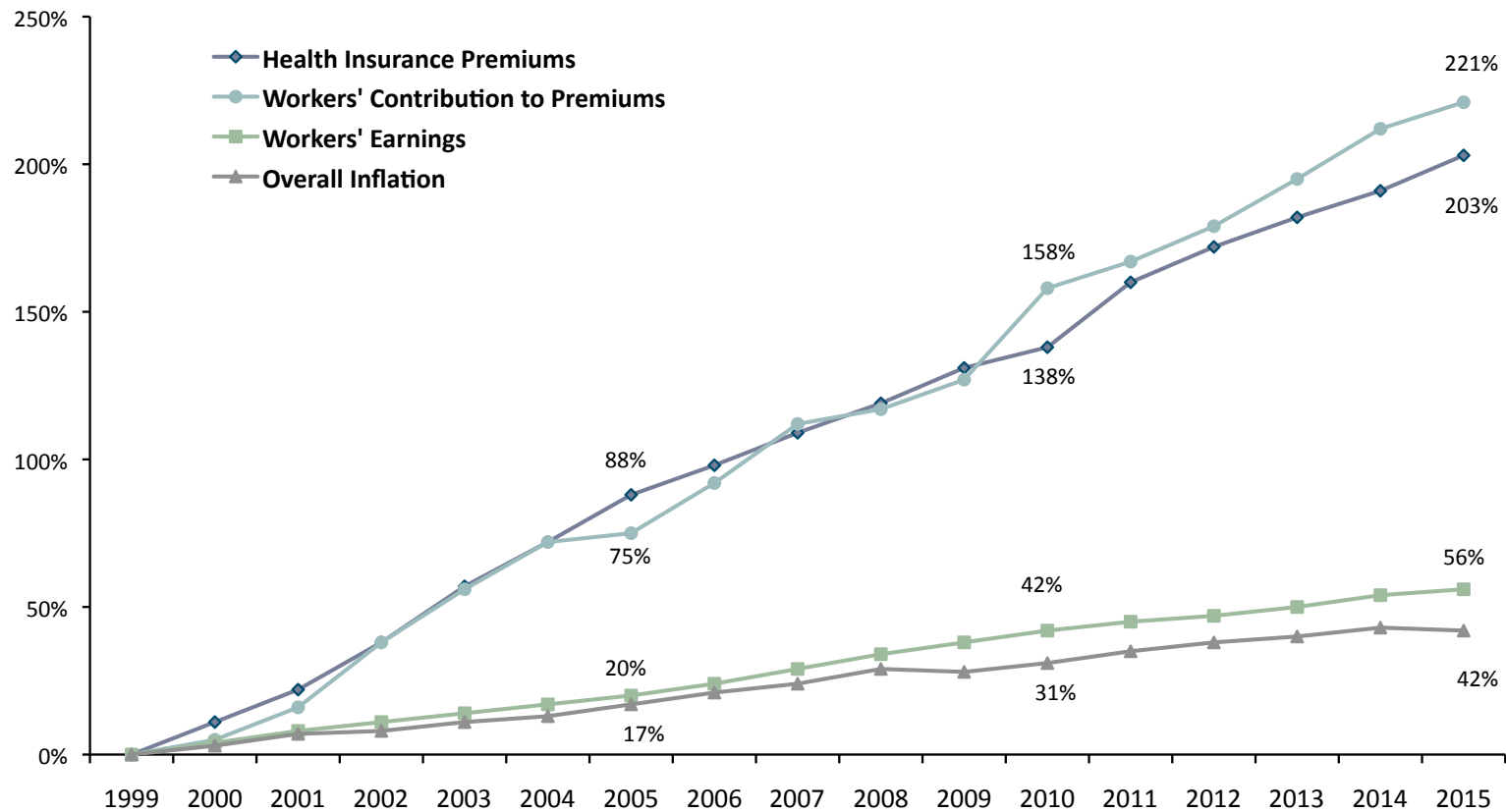


**HOW EMPLOYER MEDICAL PLANS
CAN REDUCE MEDICAL COSTS,
NOT BENEFITS OR ACCESS TO
CARE**

**Sally Covington, PhM
Community Campaigns for Quality Care**

Under Managed Care, Costs Have Soared

2



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).



Key Contributing Factors

3

No Price Transparency

- Prices are hidden
- Pricing structure is irrational. A single insurer may negotiate 50 different rates for the exact same service

No Price Competition

- Providers set charge master (price list) as starting point for negotiating rates
- Rates are privately negotiated and reflect market clout of negotiators

Big Inefficiencies

- Thousands of provider contracts and service prices impose substantial billing, claims adjudication and collection costs on providers
- For every one physician, there are 10 healthcare administrators

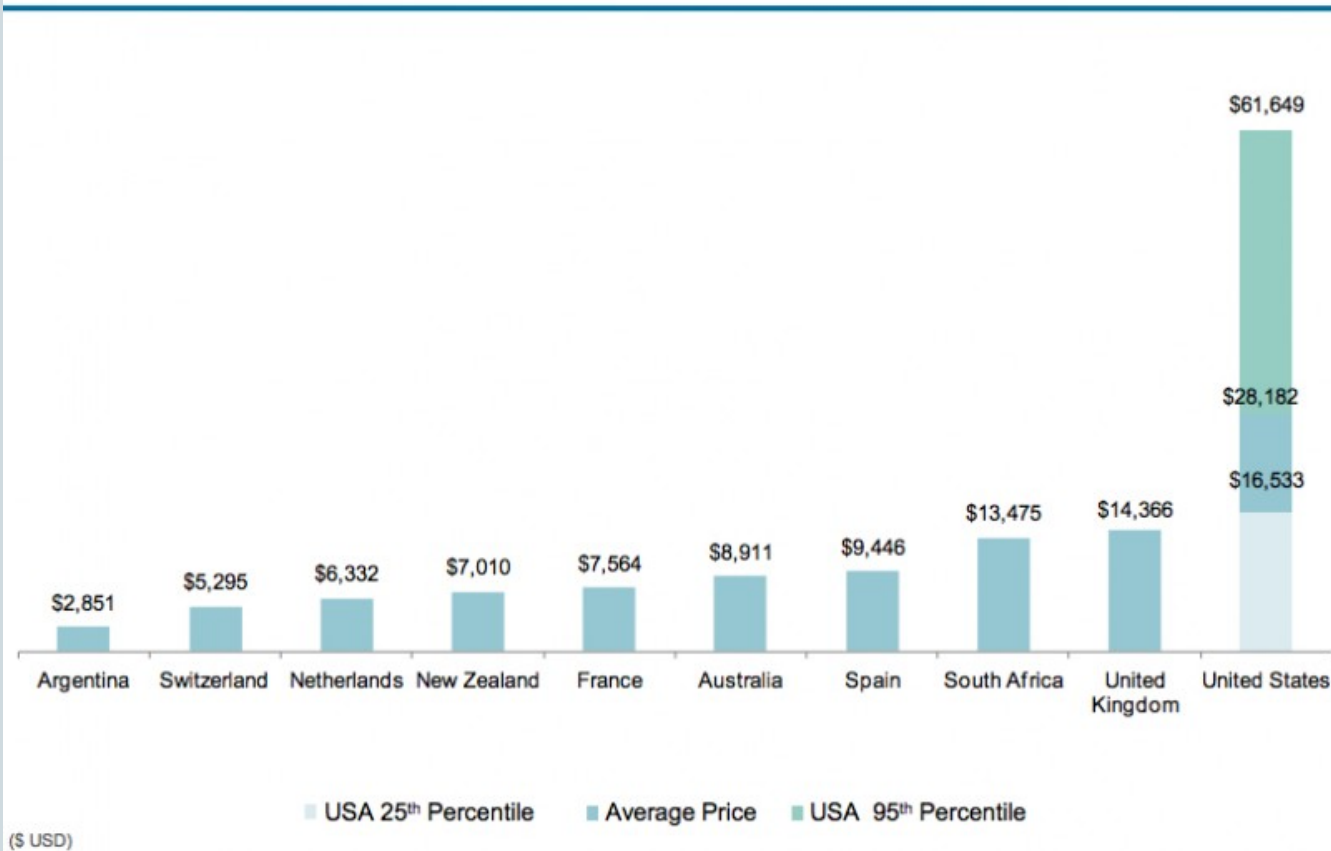
Market Consolidation

- Providers and managed care companies seek negotiating leverage over the other by getting bigger
- Consolidation results in price inflation

Prices Under Managed Care Model

4

2012 Total Hospital and Physician Cost: Angioplasty

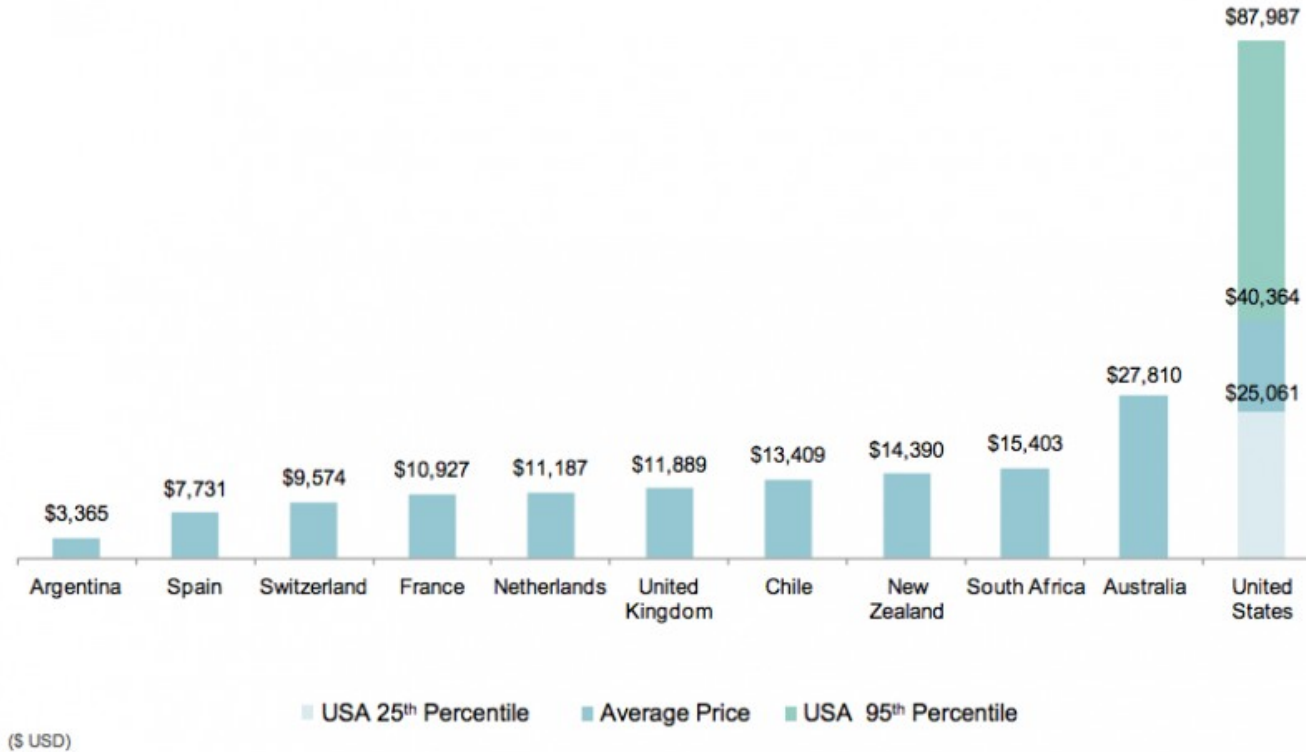


Source: International Federation of Health Plans 2012 Comparative Price Report

Prices Under Managed Care Model

5

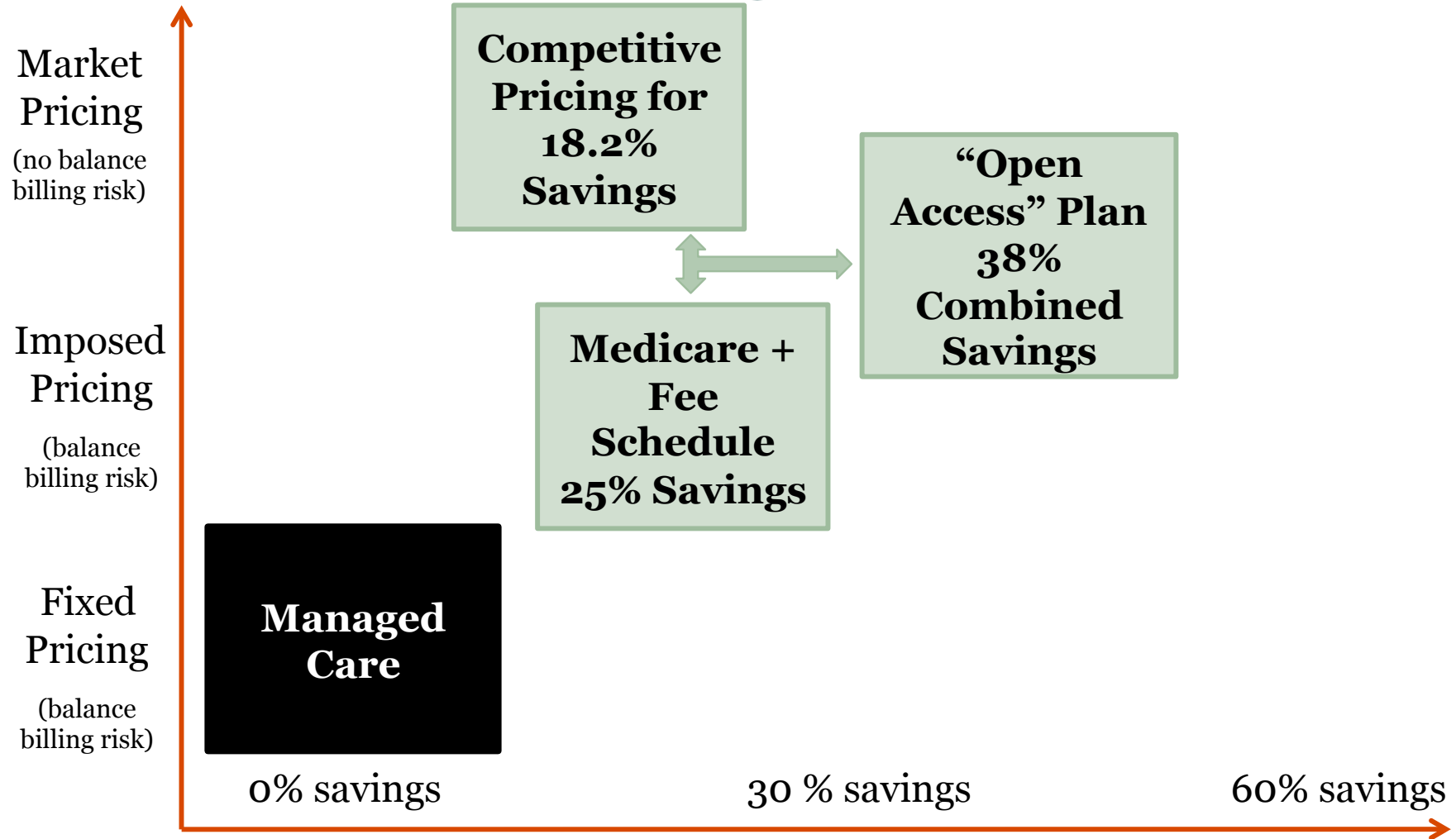
2012 Total Hospital and Physician Cost: Hip Replacement



Source: International Federation of Health Plans 2012 Comparative Price Report

New Pricing Models, Big Savings

6



Alternative Pricing Models

7

Competitive Bidding for Non-Emergency Services (Cash payment – no claims)

- Medical specialists set their own service prices in a competitive environment
- Patients who request bids receive information on provider prices, credentials, experience, and quality
- Patients decide whether to choose a bidding provider (or not).
- When patients choose a bid, their plan pays providers in cash at time of service and shares the savings

Medicare Plus Rates for Non-Competitively Bid Services (Claims submitted and paid)

- Plans adopt a “Medicare Plus” fee schedule and indemnify patients
- Under the fee schedule, providers are paid the same base rate for the same service
- The base rate is adjusted for differences in patient severity, provider characteristics, and the cost of local market inputs
- The “plus” amount is a plan policy decision (e.g., Medicare rate plus an additional 20 or 30%)

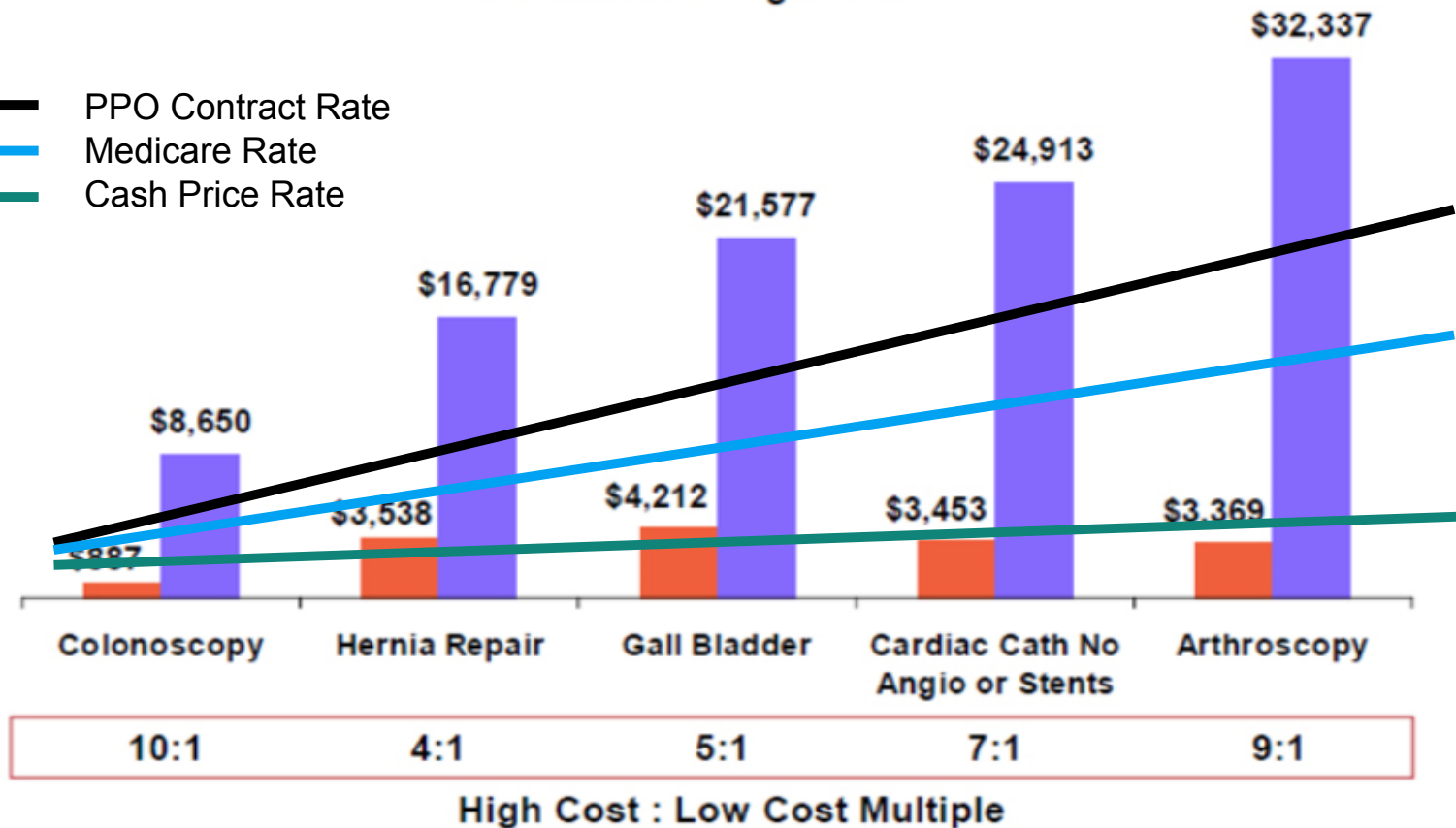
PPO, Medicare and Cash Rates

8

Cost Per Procedure (\$) - Greater SF Bay Area MSA

Low Cost High Cost

— PPO Contract Rate
— Medicare Rate
— Cash Price Rate



PPO and Cash Rates: MRI Scan

9

SF Bay Area Facility	Insurance Rate for Non-Contrast MRI	Cash Price Rate for Non-Contrast MRI
Alta Bates Summit Medical Center, Summit Campus	\$1,346	\$466
San Mateo Medical Center	\$2,690	\$585
UCSF Medical Center	\$1,690	\$1,628
Seton Medical Center	\$5,061	\$1,752
Washington Hospital, Fremont	\$5,113	\$1,770
Mills Health Center	\$5,662	\$1,960
CA Pacific Medical Center, Pacific C.	\$7,791	\$2,697
Marin General Hospital	\$7,826	\$2,709

Source: insurance rate estimated from paid claims data (Jan 2013-Oct 31 2014) provided by Northern CA employer self-funded medical plan. See “Digging Deeper on ‘As Hospital Prices Soar, a Single Stitch Tops \$500’ from the NY Times,” for cash price rates, available at: blog.pricinghealthcare.com.

Patient-Level Case Example

10

Orthopedics: OP Arthroscopy and Menisectomy (Bundled Service)

CPT 29881 ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG			
OUTPATIENT HOSPITAL			
ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG			
ICD-9 Code 71596 - OSTEOARTHROSIS UNSPEC WHETHER GEN/LOC LOWER LEG			
Date of Service 6/2/2014	PLAN PAID	MEMBER PAID	TOTAL
ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	\$12,826	\$1,371	\$14,197
ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	\$1,366	\$0	\$1,366
PPO contract price	\$14,192	\$1,371	\$15,563
Medicare discount price	\$7,436	\$795	\$8,231
Cash discount price	\$4,967	\$0	\$4,967

•The patient case examples are based on actual amounts paid (PPO contract rate) by a self-funded health plan in Northern California. Medicare and cash price rates are estimates based on ratios developed from published data.

Projected Savings: “Reference” PPO Plan*

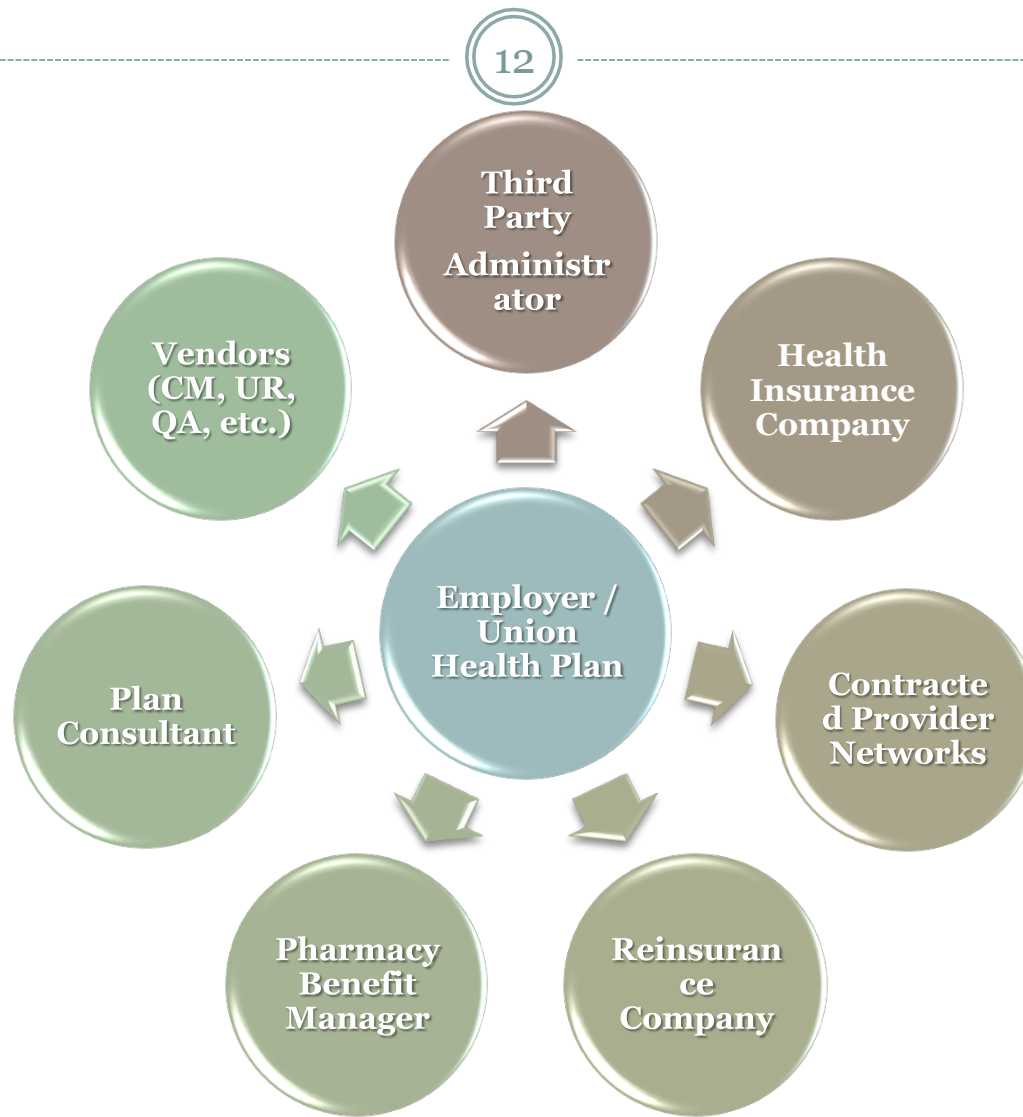
11

Northern CA ESHP, 22 months paid claims data	Baseline PPO Spending	Total Spending under Medicare+	Savings from Medicare+ fee schedule \$ and %	Savings from Comp Bidding at cash price rates, \$ and %	Combined Savings \$ and %
All claims	\$471,463,258	\$354,278,748	\$117,184,509 (25%)		
Comp bidding, 50% patient participation				\$85,756,588 (18.2%)	
Total Combined Savings after repricing			\$117,184,509 (25%)	\$64,354,734 (18.2%)	\$181,539,243 (38.5%)

•Northern California private sector Employer-Sponsored Health Plan, Jan 2013-Oct 2014)

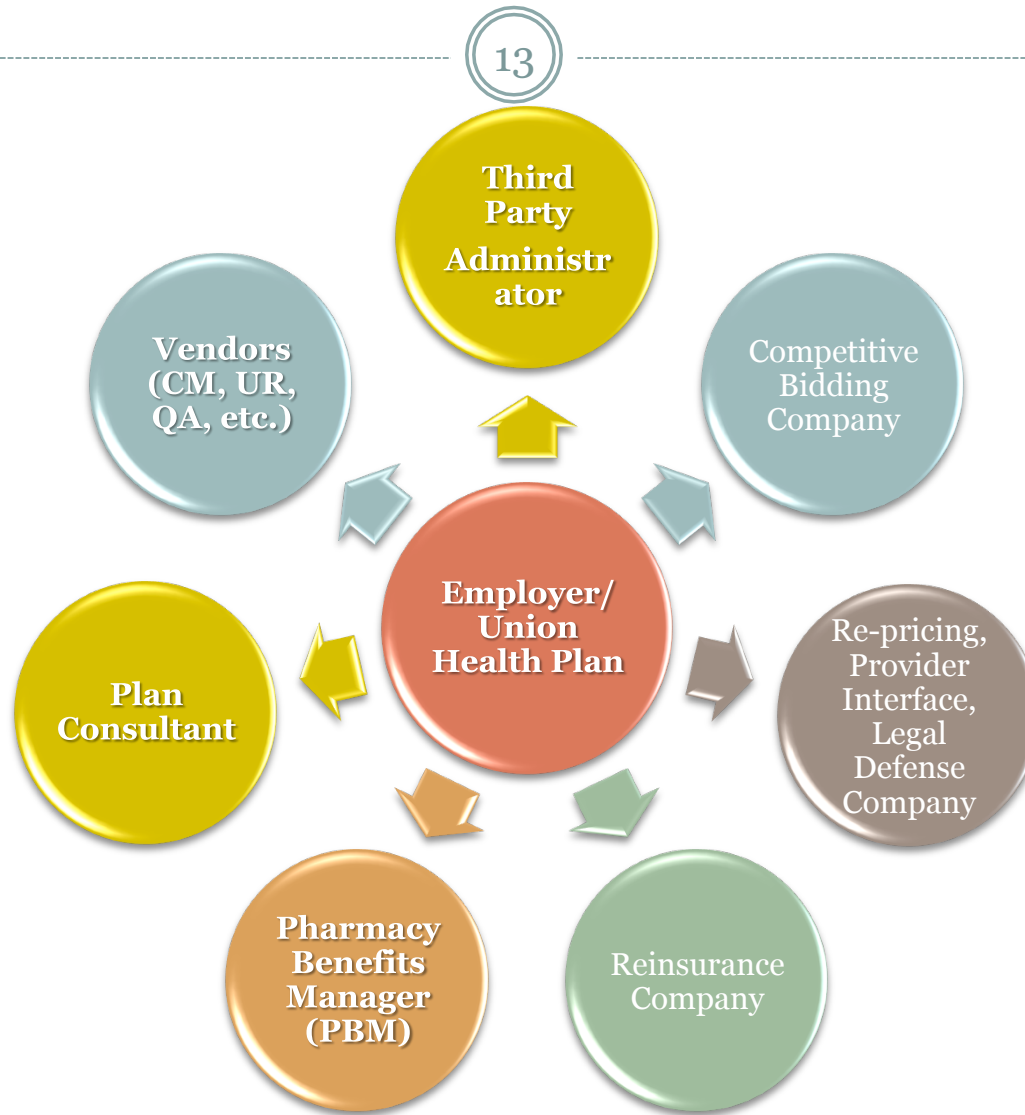
PPO Health Plan Infrastructure

12



Open Access Health Plan Infrastructure

13



Potential Next Steps

14

1. Analyze 12=24 months of paid claims data to project savings from competitive bidding and Medicare Plus
2. Implement competitive bidding pilot
3. Evaluate and share results

Questions?



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COMMUNITY CAMPAIGNS FOR QUALITY CARE