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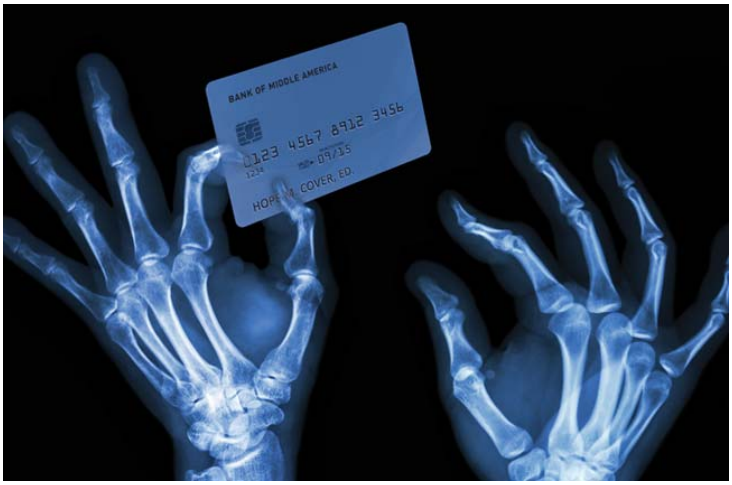
Medical Exam

TECH-ENABLED TRANSPARENCY IS A MAJOR STEP IN REGAINING CONTROL OF HEALTHCARE COSTS.

BY Sandy Laycox (http://leadersedgemagazine.com/about/staff/sandy-laycox) | JUNE '17



If you want to understand business trends, you're often told to follow the money. We watched more than a billion dollars pour into insurance technology companies in 2016, and one of the most heavily funded insurtech areas was healthcare.

If you're following the money, what does that mean to you?

According to startup research firm Venture Scanner, startups that are designed to help people search for healthcare solutions (including providers and plans) have raised $2.5 billion to date, startups that provide employee benefits platforms have raised nearly $1.4 billion, and startups that focus on health management have raised $2 billion.

These companies perform a variety of services. After all, our healthcare system is complicated, with a lot of pain points that need fixing. One of the most pressing issues is the unsustainable cost trend. According to a PwC Medical Cost Trend report released earlier this year: "In the early 2000s, price and utilization were both major contributors to healthcare trend growth. Since then, the utilization trend has declined while the price trend grew…. Health benefit costs will be unsustainable in the long run."

FAST FOCUS

Among the most pressing issues facing the healthcare industry: the unsustainable pace of rising costs.

Yet even as consumers pay more, most have no idea what they're spending.

Insurtech startups are diving in with potential solutions to price transparency, but uptake is low.

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Yet while costs rise, most consumers have no idea what they're spending. "While the escalation of the high costs of large claimants is a major economic problem in the system, still there is too much waste and variability in what things cost," says Brad Plummer, senior vice president of the employee benefits practice at Cottingham & Butler. "When you connect the consumer to the provider with transparent costs and remove the opaque PPO/carrier system, you get efficient markets."

How does insurtech propose to help? Price transparency is just a start.

Nothing "Consumer" About It

In response to the healthcare cost trend, employers have begun to shift more of the burden to employees. According to PwC, "63% of employers offer a high-deductible plan with a health savings account, and 25% offer a high-deductible plan as the only health insurance option to their employees." But as consumers bear more of the upfront, out-of-pocket costs of their healthcare, cries for a more realistic, consumer-like experience are growing.

“With the rise of consumer-driven health plans, the need for price transparency has become even more critical,” says Seth Cohen, vice president of sales and alliances at healthcare tech company Castlight Health. “It’s debatable how important that information is when every member has a $20 co-pay, but when a member has a $3,000 deductible, then that information becomes really critical. And so, a lot of people say there’s nothing ‘consumer’ about a consumer-driven health plan without consumer-like information.”

Consumers certainly have a right to ask. Many research studies, for example, have shown wide variations in prices for the same procedure. And Castlight Health’s own price map shows that a lower back MRI in Miami costs from $714 to $3,164, while prices for a mammogram in Miami range from $96 to $510.

Cohen says it goes beyond medical, with pharmacy pricing playing a critical role.

“Price transparency in pharmacy is really important,” Cohen says. “A lot of people don’t know that the price of a pharmaceutical actually varies pretty significantly depending on whether you’re at Costco or Walgreens or Walmart or CVS.” The amount consumers spent at their pharmacy—while still a relatively small portion of employer health benefits—had the steepest rise in the share of employer health costs (a 21% increase since 2007) in PwC’s Medical Cost Trend report.

Yet according to public policy advocacy group Public Agenda, 51% of those who have not pursued price information before getting care indicate they are not sure how to do so.

Sometimes, even providers are not so sure. When we talk about the healthcare delivery system, says Rod Cruickshank, president and CEO of The Partners Group, “none of the actors know what the price is, nor are they interested. If we are trying to create transparency in healthcare purchases, we have to understand the problem from the delivery side’s perspective.”

The Rise of Value-Based Payments

There is an expectation that, if costs are made readily available to consumers, they will use that information to choose a lower-cost provider. Higher-cost providers will then begin to lose market share and lower their prices.

This notion has a considerable amount of buy-in. “About eight years ago…there were very limited efforts by health insurance companies but nothing meaningful,” Cohen says. “We encountered a lot of resistance initially to it. But I think now price transparency has kind of been accepted almost universally as a must-have. I have yet to encounter any employer, any broker, any consultant who would say price transparency is not important.”

A lot of people say there’s nothing ‘consumer’ about a consumer-driven health plan without consumer-like information.

Seth Cohen, VP of sales and alliances, Castlight Health

Wade Olson, national practice leader of employee benefits for BB&T Insurance Services, agrees. “There’s always been Medicare data that’s given us some basic elements of price and quality transparency but never really on the commercial side,” he says. “Over the last four to five years, there’s been a lot more focused effort from technology companies and technology platforms to align cost and quality outcomes.”

Underlying factors help drive this change. The healthcare community has recognized for a number of years now that our system doesn’t work. Throughout the 1990s, healthcare leaders, policymakers and even the public began to acknowledge the system is costly, inefficient, even potentially unsafe. A 1999 Institute of Medicine report found perhaps as many as 98,000 people die in hospitals each year as a result of preventable medical errors. It called for leadership, measured improvement, and mandatory quality reporting. The report helped catalyze the already burgeoning quality movement, and patient safety and quality care rose to the forefront of industry conversations.

It would have been impossible to truly change healthcare delivery without changing the fee-for-service system, which exacerbates quality-of-care issues by rewarding providers for volume and intensity of services.

Thus began the movement toward a value-based payment system.

At first, the Centers for Medicare & Medicaid Services (CMS) and state governments used demonstration projects, such as voluntary public reporting of quality data, to work toward this goal. But in 2010, the Affordable Care Act put many of those reforms into law, including the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program.

Those ACA mandates, both of which incentivize quality care through Medicare payments, have been an important part of fostering change in pricing transparency because they help change the focus of payment to value and outcomes instead of the number of patients seen.

“Before the ACA…the discussion among physicians and hospitals and payers to collaborate on quality and risk were really, really rare,” Cruickshank says. “But everybody now is at the table talking, so that’s movement.”

That collaboration among players is critical for change. “The ACA places a focus on wellness and outcome-based results versus discounted fee-for-service activities,” Olson says. “The carriers are adopting fee-for-value payment programs, and the health systems are recognizing the need to have outcome-based incentives as a key part of their revenue generation model.

“So, if I’m paying a provider less on a discounted fee-for-service activity and more on an incentive to deliver value to that membership, it has to be supported by the insurance carriers as well as the health community,” Olson says. “You have companies like Mobile Health Consumer, Castlight, and many others that focus on transparency of cost and quality. That is being integrated into the insurance carrier’s model to incentivize the members to leverage that data and control their own consumption based upon the cost and quality information they see.”

Not Price But Value

While the industry has made improvements in getting pricing information more publicly available, the same can’t necessarily be said for information on quality—and one without the other is useless. In fact, some argue that price transparency itself is not a good thing, because price information alone could do more harm than good.

According to Health Affairs, a leading journal of health policy issues, evidence suggests consumers associate high cost with value in healthcare, believing that more care is better and that higher-cost providers provide higher-quality care. “The potential hazard of only publicly reporting cost data is that consumers will use the cost information to select higher-cost providers,” Health Affairs reported. “Overcoming the ‘more is better’ belief and communicating that lower cost is not compromising on quality are key challenges in publicly reporting cost data.”

“No one wants the cheapest doctor,” Cohen says. “I think this is where insurance companies still have the biggest challenge—they’re really hard-pressed to show meaningful, quality information. “If you are an insurance company responsible for contracting with a network, with a provider, how can you turn around and tell your members that provider you just contracted with is below average? They’re in a really difficult spot to objectively distinguish lesser and better performers.”

The promise of these tech-driven healthcare companies, such as Castlight, is to be that objective third party that can provide that extremely important information on quality of care. “We don’t have a conflict of interest with the provider community,” Cohen explains. “We are able to tell you this provider is really bad and you should stay away from them.” Castlight works with numerous partners to provide more objective information on quality of care, including The Centers for Medicare & Medicaid Services, The Leapfrog Group, the NCQA and other regional groups.

By adding quality-of-care information alongside pricing information, you can then have a conversation about value. “You don’t know if a lower cost is a good thing or a bad thing unless you know how that ties to the outcomes from a health perspective,” Olson says. “A higher-cost setting with high quality of care, improved outcomes and lower infection rates all factor into the value proposition of that provider. Ultimately, that higher cost setting can deliver much greater value for the member and plan sponsor than a lower-cost, lower-quality facility.”

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Government Leads the Way

The Affordable Care Act represented a significant legislative push toward a value-based payment system. How that will continue is uncertain, but as Olson says, “Long term, this change to value in payment is definitely going to be a key component in the revenue model for carriers and healthcare providers. I think the health systems and the doctors offices will have a transition period…but I think as they start understanding fee for value and the outcome-based rewards they receive, they will start shifting more and more of their operating model to those outcomes. This operating focus on value from the providers is ultimately best for the consumers as well as for the financial integrity of the healthcare system overall.”

The government has continued to play a role in increasing price transparency at both the federal and state level. For example, a 2014 West Health Policy Center analysis notes that in April of that year, the Centers for Medicare & Medicaid Services “made a massive Medicare physician claims dataset freely available online.” This was in response to a Freedom of Information Act request by Consumers’ Checkbook, a nonprofit consumer organization. The goal of releasing such a large volume of claims data with physician identifiers is to help stakeholders gain an understanding of “the efficiency and treatment patterns of individual physicians and physician groups.”

For a number of reasons, it’s important that CMS continues to push in this direction. “What has historically happened is that nobody adopts anything unless CMS adopts it first,” Cruickshank says. “As a provider, you know that if something gets installed through Medicare, it’s eventually going to play out in the other lines of business at some point.”

It helps to understand how healthcare is delivered. “Most of the money that runs through the delivery system is coming from the over-age-65 group, and that’s Medicare,” Cruickshank says. “That’s why we’ve got to remember when we’re talking to payers, if we’re only talking about employer-sponsored healthcare, we are not being heard. We are not their number one revenue source. The minute I start talking about Medicare, Medicaid and commercial…now I’ve got their attention, and we can conduct change.”

State governments have also made movement toward price transparency. According to the 2016 Report Card on State Price Transparency Laws, compiled by two independent health policy organizations, “Most states have approached the subject of price transparency at the legislative level, as only seven states have no statutes addressing it. But in 37 other states, the lack of transparency comes from weakness in the design and implementation of their laws.”

The report card, produced by the Health Care Incentives Improvement Institute and Catalyst for Payment Reform, notes a trend in proposed state legislation that directs providers or insurers to give consumers price information prior to care. The report card acknowledges that, while this is a step in the right direction, this type of legislation alone is not robust enough. Pitfalls to this approach include the fact that providers and insurers do not use a consistent approach to calculating and presenting pricing information, “making it very difficult to comparison shop.” Instead, the report card rewards states with a mandated all-payer claims database (APCD) and states that publish those data on a well-designed, state-mandated website. All-payer claims databases collect data on paid amounts for services from a range of sources, from private insurers to Medicaid to self-insured employer plans.

While this information is intended to improve price transparency, consumers aren’t the only stakeholders who could benefit. The West Health Policy Center notes, “Patients may occasionally consult APCD-based hospital price reports, but they are not the primary audience. The more significant audiences for these price reports are employers, health plans and policymakers. Employers can use the price data to identify high-price providers and, with health plans, develop strategies to steer patients away from these providers. Policymakers can use the price reports to assess the level of competition, or lack thereof, in the market for hospital care.”

Another key takeaway from the report card is the importance it places on the presentation of the information—not just the collection of it. As report card contributor Judith Hibbard of the University of Oregon writes, “The benefits of transparency are only realized, however, if consumers attend to and use the information in making choices. We know from years of experience and decades of research with health care quality transparency efforts, that the way in which information is displayed and presented can make a difference in whether it is understood and used.”

This is a critical point—and a key focus of some healthcare tech companies. As many are learning, just because you put the information out there doesn’t mean consumers will use it.

According to a 2016 study in the Journal of the American Medical Association, “Low utilization is the most commonly reported challenge to price transparency initiatives by insurers who offer tools.”

Why? Many find the information difficult to understand or irrelevant to their situation. Or they just aren’t used to shopping around for healthcare providers and services.

If You Build It, Will They Come?

Cohen says Castlight worked hard in its early years to obtain and publicize information about healthcare costs, a process he calls “a really big challenge.” He said the company figured as long as it made that information freely available on a consumer-friendly site, consumers would flock to it. “If you’re responsible for the first $3,000 out of pocket, well, of course you’re going to want to know how to spend that money wisely,” he says. Yet that “hypothesis,” Cohen says, had a “mixed result.”

“It’s not just a given people will use this information,” he says. “In fact, it’s really, really hard. Healthcare is a very emotional purchasing decision…. And unwinding those habits…it’s a really hard behavior change.”
Cruickshank agrees. We could create all of the transparency in the world, but ultimately, he says, “Nobody cares about transparency until they are going to be a user in the system. What’s the number one response to a $5,000 deductible I don’t want to spend? I don’t go to the doctor until I have to. We’re delaying care.”

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>
> Seth Cohen, VP of sales and alliances, Castlight Health

Noting the rapid rise of high-deductible health plans, Cruickshank asks, “Is it good?” He’s not sold on the value of these benefit designs for employers or members, and he questions whether the experiment is working, whether the system itself can yet handle the trust necessary for consumerism to work. And yet, he provides a clear picture of how, once a movement gains momentum—once people trust it—we can, indeed, change.

“Remember when no one bought anything on the Internet?” he says. “And there were the early adopters who said, ‘No, I trust the Internet, and I’ll make purchases.’ But for a while there, it was a big unknown. Will anyone use it? Will they give up their credit card number to this system? And we watched adoption move slowly, slowly, slowly until we jumped over this cliff to where now everybody buys everything on the Internet. As soon as convenience is given without risk, people will do it.”

Incentives and Accountability

One group that has a significant amount of control—and may not be leveraging it—is employers. According to a 2016 report by the Kaiser Family Foundation, employer-sponsored insurance covers about 150 million people in the United States, more than half of the non-elderly population. And, as Olson explains, “the employer has a pretty strong influence over how members consume medical goods and services.”

“Medicare and Medicaid aren’t sensitive to consumerism,” Cruickshank says. “So when it comes to what are we going to do as a country to have more affordability, it probably is going to be that we’ve got to do something that lowers the cost of the employer-sponsored plan. That’s the one that seems to be visible and seems to be absolutely out of control.”

One of the ways employers can influence consumer behavior is with plan design, and this means more than just offering a high-deductible healthcare plan. “I think the future success of employer-sponsored health plans should really focus more on how the employer can position the program to influence the membership as the key stakeholder in driving positive change,” Olson says. He likens it to the auto and home insurance industries, where riskier insureds—e.g., 19-year-old male drivers—pay more. “If you’re a smoker and you become a nonsmoker, you should get a discount on your premiums. If you improve your BMI to a targeted level, you should be rewarded for that behavior and lifestyle change that improved your health and reduced your future risk of incurring claims.”

Obviously, this requires data about employees’ health. And for companies that don’t have the resources to collect, mine and communicate about the data themselves, “It’s really the broker/consultant who should be partnering—either internally or externally—with an effective data analytics company and linking individual member data with an effective outreach program to

drive lifestyle and behavior modification at the member level," Olson says. "[Using] claims data from the insurance carriers in such a way…is the key leverage point for an integrated data system."

Yet the matter of engagement persists. You can't tell people that they will be penalized or incentivized for XYZ and then just walk away. At the same time, how do you incentivize healthy people—those who won't benefit from lifestyle incentives—to engage at all? One possible answer is to meet them where they are.

Building a Community

When Castlight Health realized people weren't just going to start using their hard-earned pricing information automatically, the company shifted its approach. "What we have to do is really provide a more comprehensive platform to help people engage in their healthcare needs and benefits holistically," Cohen says. So the company became a healthcare information destination, answering questions ranging from "What is a deductible?" to "How do I lose weight?" The company believes the more comprehensive approach is critical to engaging more consumers.

Cohen says timing also poses one of healthcare insurtech's biggest challenges. Instead of targeting the generic open enrollment period, he says, "let's stop communicating a bunch of stuff to people when they don't need it." Instead, use the data they have to send timely, targeted messages. That could mean using pregnancy claims data to determine when people may be looking for other labor and delivery information or sending checkup reminders based on doctor visit history.

Olson believes another key part of fostering engagement is helping people become comfortable with communicating via the technology, which could require some incentives.

"With Mobile Health Consumer, we can put a health assessment on the mobile tool and require employees to download the app and take their health assessment to be eligible for incentives for healthy consumer activities," he says. Once people have taken that step, he explains, you can use data analytics to understand their health needs and communicate personalized information to them on their phone. As they begin to see value in that messaging, they become part of that community, and you can drive lifestyle behavior modification. "This activity will ultimately help members reduce their claims because they're more engaged in managing their health. Those engaged members know they have a resource they can rely on because it's been a credible tool in the past."

One of the arguments against consumerism in healthcare is that only certain procedures are "shoppable." According to a Health Care Cost Institute study, "At most, 43% of the $524.2 billion spent on healthcare by individuals with [employer-sponsored insurance] in 2011 was spent on shoppable services." These are services such as colonoscopies, lab tests and imaging tests—procedures you can plan for. And it's true in a sense—if you have an emergency and are rushed to the hospital, you'll go where the ambulance driver takes you.

But, as Cohen explains, it's a long-term process of engaging in your care. Whether it's gaps in medication adherence or receiving care in a poor-quality setting or just not at all, "catastrophic claims emerge often because people are not managing their preventative care. And that's a huge priority area for self-insured employers and totally insured companies alike."

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>
> Rod Cruickshank, president and CEO, The Partners Group

Know Your Clients

For a broker, there's a lot to know. First, there's knowing your clients. Olson says good brokers and consultants help clients understand how an employee benefit program design can support their core business strategies. "It's not so much about short-term cost savings as it is about long-term risk mitigation and risk management," Olson says. "The marketplace is not placing much value on a broker or consultant who is just placing product annually then going away. Technology can drive efficiencies but not necessarily effectiveness of solutions.

“We spend 95% of our time at a prospect meeting understanding their business issues and their business strategies. We want to understand how they compete in the market, what challenges they are facing, and how their total rewards system is helping them attract and retain talent. Your business focus and technical expertise has to be much broader in the areas in which you provide advice and guidance for your customers than it was five years ago.”

Then, there’s knowing the options and where to find them. “Part of the job of the consultant or broker is to help clients take advantage of innovation, right?” Cohen says. “And to help them adopt new strategies and tools to address persistent problems in the healthcare space. Given that, I would say the focus of innovation is rapidly moving away from the places we used to see it.”

Healthcare innovation used to lie in carrier headquarters, such as Indianapolis or Hartford, Cohen says. Brokers would see what the carriers were offering and bring it to their clients. Today, Cohen says, many employers are moving to what he calls “best of breed” models. “Instead of relying on single health plans for all of the capabilities you need, let’s take advantage of the proliferation of innovation that is taking place in Silicon Valley or in Austin, Texas, or in Boston.”

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> Wade Olson, national practice leader of employee benefits, BB&T Insurance Services

The point he makes is this: all that funding flowing to health insurance tech companies is not going to carrier headquarters; it’s likely going to Silicon Valley—or, as Cohen says, “to 700 app vendors.” That shift also changes the roles of brokers and consultants, he notes, because procuring a pilot with an app vendor is different from procuring health insurance. Communicating these options is also different. “If you have 17 different programs available to your employees, you need a very different communications plan and platform,” he says. “We have to rethink how we procure and then make the most of this innovation, because I think if we just look at the health plans of health insurance companies, we’re missing it.”

But how do you choose? “You don’t want to just have something to have it,” Olson says. “There’s so many different tools and so many different applications of those tools that I think what you really need to do is step back and analyze what is the core problem we’re trying to solve. Then you need to confirm the key objectives and ask what stakeholders in the delivery model this solution or technology brings value to. Key healthcare stakeholders include the insurance carriers, the health systems, employers, employees and their family members, the government and the consultant/broker. How can we have an integrated approach that’s going to bring value to all stakeholders? Once the goals are defined, you start building that integrated model. If you’re building it with that in mind, you will make better decisions, and you go from where you are to where you want to be in a more effective and efficient way.”

Finally, brokers should know the healthcare landscape. Cruickshank says brokers need to learn more about how public entities such as Medicare, Medicaid and CMS operate. As he says, “Be more fluent in the public domain.”

The mandates imposed by the Affordable Care Act, Olson says, helped align different healthcare stakeholders around better outcomes. As a result, he says, insurtech becomes a key to future success. “The more that insurtech can focus on aligning and integrating the various stakeholders in a way that brings value to each of those in their own way and then collectively produces better outcomes for the member, it is absolutely key,” he says. “It needs to be well understood by the insurance community.

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