Medical Management (Cost Control) Trends

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Topics

- Definition
- Trends vs. cycles
- Options
- Influencers
- Limits

Medical Management Cost Control Defined for This Presentation

- Benefit limits
  - Cost sharing (CDHC, high deductible plans, tiered co-pays)
  - Other coverage limitations/exclusions
- Utilization management
  - Medical necessity & contractual compliance review - prior auth (PA), inpatient concurrent review (ICR), drug utilization review (DUR)
- Condition management
  - Case management (high cost, catastrophic, etc)
  - DM, population management
- Network management
  - PFP
  - Tiered, specialty and “closed” networks
  - Risk transfer (case rates, capitation, “shared” risk)
  - Quality*** (medical errors, etcs)

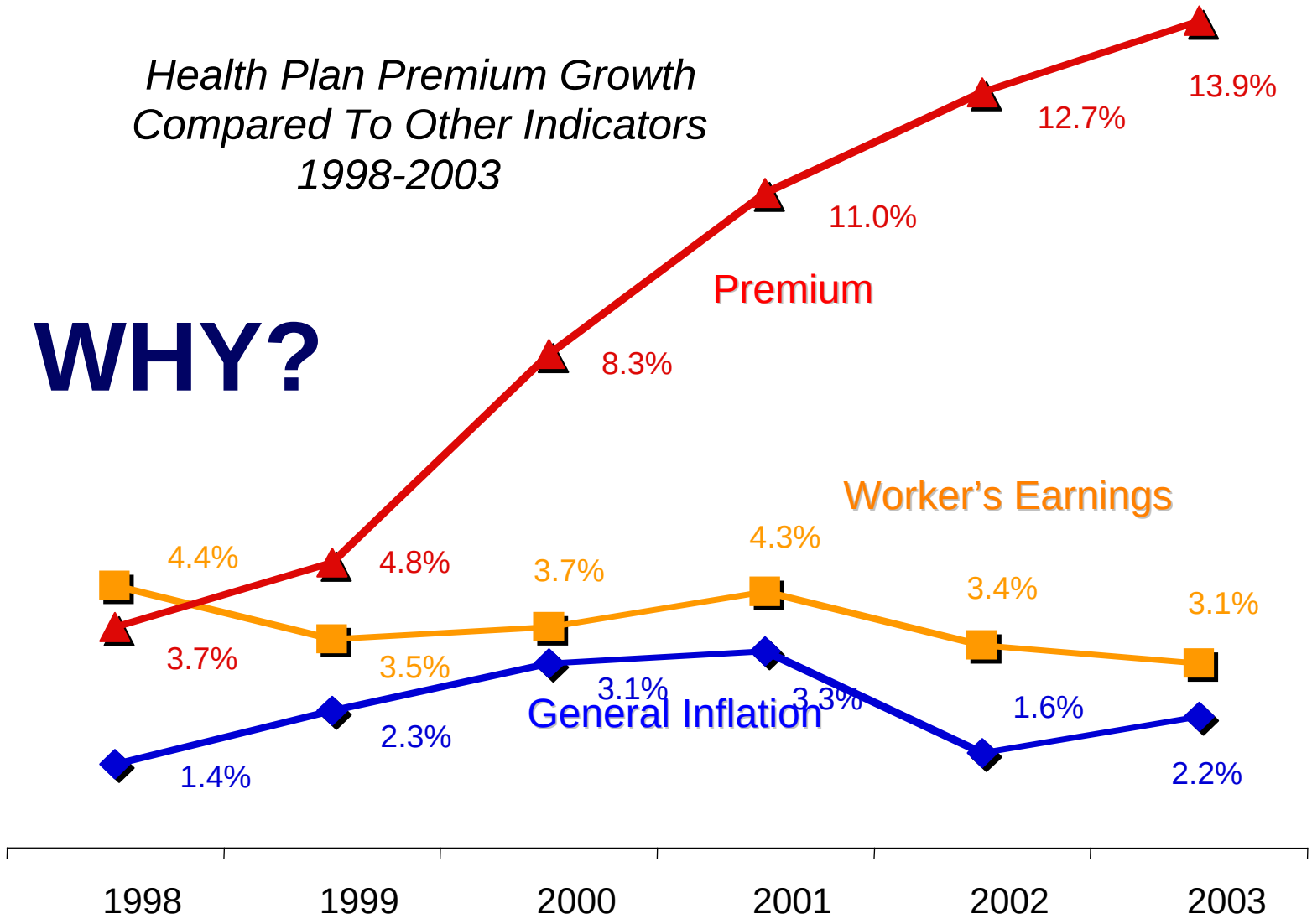
Trends vs. Cycles

- Trends in cost control practices often are cyclical due to;
  - Demand (need) for savings
  - Program cost
  - Popularity
  - Politics
  - Sex appeal (such as having sparkles, being highly technical, producing lots of reports, has only positive impacts, costs a lot or maybe is a new cost)
- Some interventions produce one time savings but fail to alter underlying trends (for example, lower provider fee schedule)

The Bottom Line UK Version

Health Plan Premium Growth
Compared To Other Indicators
1998-2003

WHY?



Increased Cost Sharing

- CDHC (High Deductible Plans-HSAs – "Consumerism")
  - Growth from 2000 – 2004 – 100% per year (1,176,000)[1]
  - Wal-Mart, GM[2], DaimlerChrysler[3]
  - 5.2% of total premium in 2005
  - 7 to 15% lower utilization

[1]Forrester [2]DaimlerChrysler [3]Atlantic Information Service

The Story

- Specific utilization management (UM) processes, if done aggressively, can reduce claims cost
  - Sherwood Report for BCBS Association
  - Professional experience
- The trend is increasing number of Health Plans adopting the UM processes that reduce claims cost and performing these aggressively

What is an Active and Aggressive UM Process

Process	Payment Denials[1] as % of Cases Reviewed
Inpatient Hospital Review	> 5 %
Precertification	> 5 to 10 %
Medical Necessity Review	Criteria/Guidelines used for most reviews
Steerage	Varies

- [1] Denials may include true avoidance of services

What Works

Services	Process	Cost Impact
All	Network Management , Provider Contracting	30% reduction
Inpatient Hosp	PA & ICR	10% reduction
Outpatient Procedures (OP Surgeries)	Prior Authorization	5% reduction
High Cost Outpatient Diagnostic Tests	Prior Authorization	5% reduction
Drugs	Drug Utilization Review	15% reduction
Chronic Disease	Disease Management & Ambulatory Case Management	? 1% reduction
Total		30% to 50% reduction

Claims Cost Management
What Doesn't Work

Service Area	Process	Cost Impact
All	Ambulatory Case Management	0% reduction
All	Predictive modeling for future high cost individuals	0% reduction
Total		0% reduction

Inpatient Admission Review Typical Results

% of Admits Reviewed	**50%**
% of Admits Reviewed That Are Denied/ Diverted	**5%**
% of Denials Overturned on Appeal	**9%**
% of Admits Deferred Until Later	**25%**
Net Reduction	**1.7% Reduction in Admissions**

Inpatient Continued Stay (LOS) Review Typical Results

% of Days Reviewed	**80%**
% of Days Reviewed That Are Denied/ Diverted	**15%**
% of Denials Overturned on Appeal	**9%**
Net Reduction	**11%**

An aggressive inpatient concurrent review program may downgrade an additional 10% of acute hospital days to a lower level of care (e.g., observation, skilled or subacute)

WHAT ABOUT THE REST?

- Predictive modeling (for identification of high cost cases)
- Case management/Care coordination
- Population & Disease management

Predictive Modeling

- Used to identify individuals to receive interventions
  - SOA study shows R2 (0.1 to 0.23) too low to accurately perform this task
  - Survey info (health risk assessments) being added to predictive models to improve effectiveness – to date no evidence showing improved results

Case Management/Care Coordination

- What do we know?
  - Probably effective only in very loosely managed indemnity programs, in most managed care programs unlikely to reduce costs beyond that achieved by UM
  - At best, offers very small overall cost reduction
  - Should be viewed as quality improvement function
  - All reported cost savings are “soft” and are losing credibility

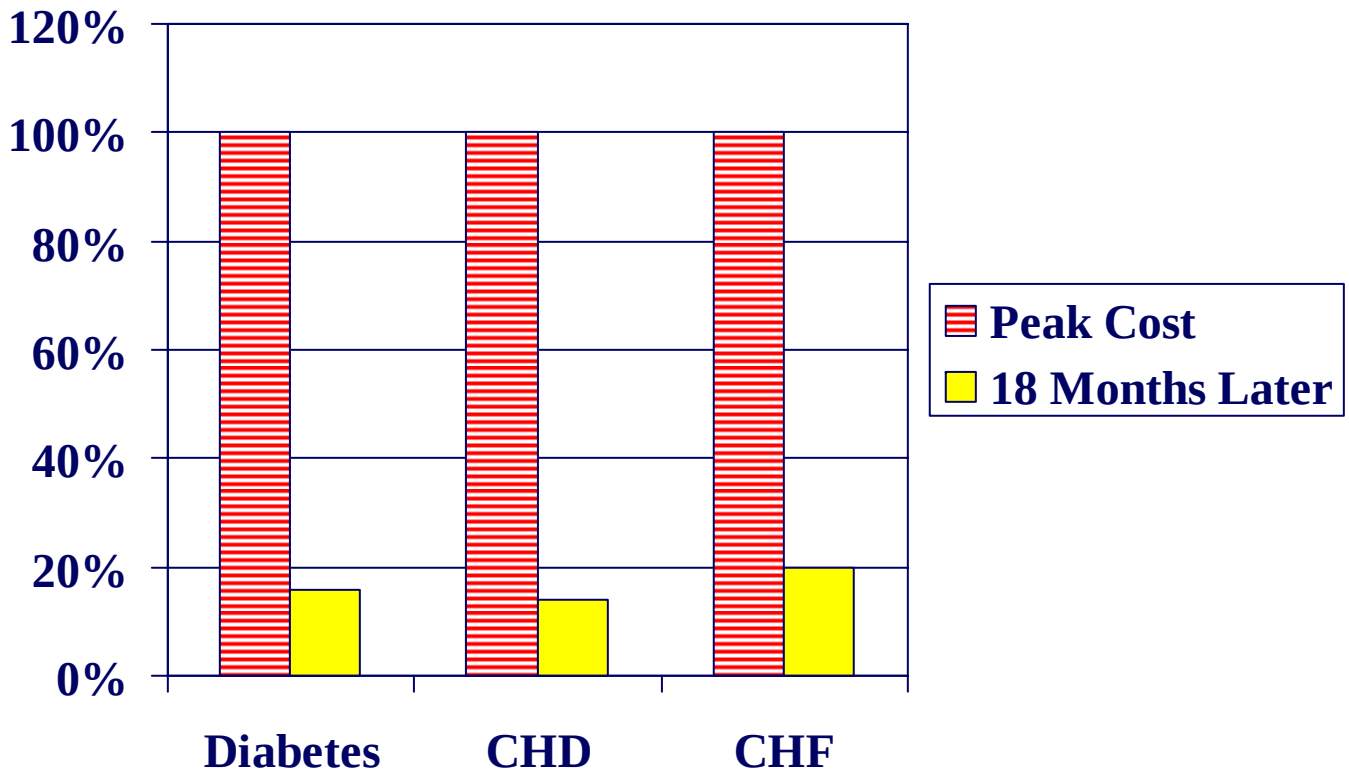
Population & Disease Management

- What do we know?
  - Does not include Service carve outs – at core, most of these are UM programs and should be evaluated as such
  - Demand management – cost savings doubtful outside of staff model settings
  - Disease or condition management programs
    - Popular, although now being critically scrutinized
    - Original contracts with DM vendors have flawed methodologies for calculating savings
    - Little but growing credible support for true cost savings
    - May be a replacement for non-effective UM programs

Why Traditional Disease Management Doesn't Reduce Costs in US or Western Europe

- Treating elevated cholesterol to prevent heart attacks, strokes and cardiac death example; (US population based)
- For every avoided heart attack or stroke, about 100 people must receive a full years treatment with cholesterol lowering drug
- For every avoided cardiac death 500 people must receive a full years treatment with cholesterol lowering drug

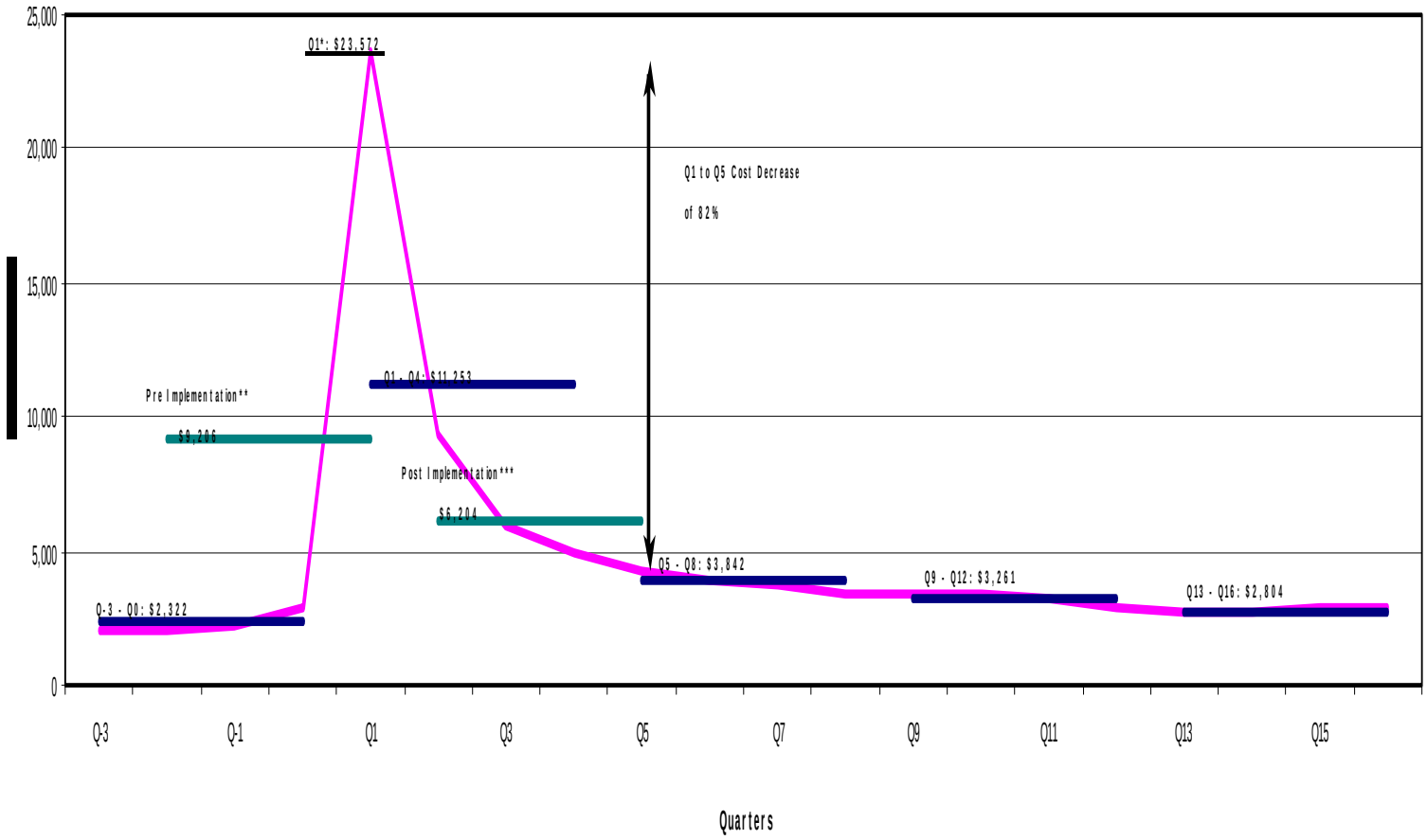
Cost Regression Due to Natural History of Disease



Example of Regression to the Mean

Figure M-1

Medicare Diabetes Average Claim Cost



Health Plan Use of UM Processes

- Facts do not match perceptions or public statements
- Active and aggressive “Managed Care” processes as defined here actually have steadily increased over the past 10 years

Prevalence of Active and Effective UM Processes

Process	Estimated % of Plans Using Process and Judged Aggressive
Inpatient Hospital Review	60 to 75 %
Precertification	5 to 10 %
Medical Necessity Review	50%
Steerage	5 %

Health Plan Use of Aggressive UM Processes (Mirkin Index)

Plan Type	1994	1999	2004
National	Rare	Few	Almost All*
Blues	None?	Few	Most
Regional for Profit	Few	Most	Half to Most
Regional not for Profit	None?	Few	Half to Most

Dave's Expert Opinions

- Utilization Management
  - Payment denial is primary tool
  - Is "sentinel" effect still real – probably not
- Case Management/Care Coordination
  - In our experience there is no good evidence these reduce costs
- Other medical management functions/tools
  - Unlikely to have any stand alone value to control costs - IT solutions are just coming to market, they may have value by reinforcing adherence to clinical guidelines and protocols or reducing the cost per review for UM

Questions?

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