Population Health & Insurance Risk: Making Employees Part of the Equation

Making the transition into a value-based care and reimbursement model can be daunting for healthcare providers. The good news, however, is that providers can learn to act like insurers and manage health risk by starting with their own employees, BENAT Consulting’s Ryan Smith told some 150 CEOs, Chief Medical Officers and Chief Information Officers at Valence Health’s further 2014 conference.

Regardless of whether the population served is small or large, the requirements of coordinating care, improving care quality and driving down costs are the same. By experimenting with a self-funded health plan for their employees, providers can gain firsthand knowledge of their population and better control many of the factors that drive up costs. This experience can set the foundation for them to take on greater financial and clinical responsibilities for other defined populations.

First, employers must gauge the “big risks” that can make or break the bottom line. Risks, from an insurer’s perspective – or an employer paying for its employees’ insurance – are “uncontrolled drivers of cost and things you need to understand before managing population health,” Smith explained.

Understanding employee health risks starts with a thorough knowledge of their demographics and socio-economic factors, which make up the actuarial prediction of how employees will use care. The next step is to look at healthcare delivery and insurance elements across a population that can increase expenses. High-cost diagnostics, emergency department visits and medication noncompliance represent the most-often examined clinical cost-drivers. However, unmanaged benefits and poor plan designs also can impact cost and utilization.

Often, a smart benefit design is a key lever to managing expenditures. The best plan designs balance the right deductible, co-pays and co-insurance to encourage preventive...
care, but discourage overuse. “Individual deductibles of $750, family deductibles of $1,500 and $35 office visit co-pays quite often hit the mark,” Smith said.

Next, providers possess the unique knowledge to develop benefits packages that incent needed medical care for people with chronic diseases. With the added levers and interaction points an employer has with its employees, a provider organization can often obtain better compliance with its employees than the general population.

So-called “domestic utilization” is key, whether managing employees or patient populations under some types of risk arrangements. Because of the high rate of fixed costs at most provider organizations, the cost to provide care within the provider organization, is only the variable cost – often only 30-40 percent. By contrast, care delivered outside of the organization, places 100 percent of the cost on the payor.

Most self-funded, employer-sponsored health plans use a third-party administrator to provide the infrastructure and administrative capabilities, such as sending out identification cards, developing a formulary, paying claims, conducting disease management programs and setting up a customer call center.

Whether done internally or externally, it is important that analytics and reporting exist to clearly see trends and outliers, so the hospital or health system can identify savings and optimization opportunities.

Finally, the employer-insurer will want to set up an integrated risk management system to understand and manage risks throughout the continuum of care. The best systems include intentional plan design, care management, a clinical population health adviser, disease management programs and practice pattern management. A partner like Valence Health can provide consulting, third-party administration and infrastructure support, taking on 85 percent of this work, while still allowing an employer-insurer to understand the full spectrum of services needed to manage costs and outcomes.

In addition to incenting prevention through your benefit design, you can help put the right wellness services at your employees’ fingertips. Smoking cessation or weight management support can be offered at the times and places that are most convenient to high-risk employee plan members.”

Ryan Smith
Lead Partner
BENAT Consulting

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“Finding someone who can help you integrate all of this into one management system is a huge advantage,” Smith said.

In sum, optimizing an existing self-funded health plan is a tremendous way for providers to ramp-up their capabilities to transition to value-based models. Whether a hospital manages a health plan for its own employees or a defined patient population, the key success factors remain the same. When thinking about other discrete populations that providers may want to manage, it may make sense to offer a managed care plan to Medicaid patients or a collection of municipality workers. By starting with a smaller group, for whom they are likely already financially “at risk,” healthcare organizations can gain the critical experience needed to take on full value-based care arrangements.

ABOUT VALENCE HEALTH

Valence Health provides value-based care solutions for hospitals, health systems and physicians to help them achieve clinical and financial rewards for more effectively managing patient populations. Leveraging 20 years of experience, Valence Health works with clients to design, build and manage value-based care models customized for each client including clinically integrated networks, bundled payments, risk-based contracts, accountable care organizations and provider-sponsored health plans. Providers turn to Valence Health’s integrated set of advisory services, analytical solutions and outsourced services to make the volume-to-value transition with a single partner, in a practical and flexible way. Valence Health’s 600 employees empower 39,000 physicians and 130 hospitals to advance the health of 20 million patients.

For more information, please contact us at:
E: information@valencehealth.com
T: 888.847.0250
www.ValenceHealth.com