

## Improving health care affordability

Helping health plans bend the cost curve

# What's at stake?

After years of escalating costs, US health care has become unaffordable for many. Industry stakeholders, including health plans, are making strides to improve health care affordability. In fact, there are so many efforts underway that narrowing in on the right ones can be a challenge unto itself—the path forward for individual organizations is not always clear.

Why is affordability such a hot-button issue? When compared to 10 developed countries, the United States' per capita spending on health care is 50 percent greater than the next most expensive country. Yet more spending doesn't necessarily produce better outcomes; the United States ranks last in overall health care performance (efficiency, equity, and healthy lives) (figure 1).

# Why is affordability important?

**Figure 1. US health care spending and performance**

When compared to 10 developed countries, the United States ranks last in overall health care performance, highlighted by per capita spending that is 50 percent higher than the next country and last place rankings in efficiency, equity, and healthy lives.

		Comparative performance metrics US rankings among 11 developed countries										
		AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
<b>Overall rankings ('13)</b>		4	10	9	5	5	7	7	3	2	1	11
<b>Quality care</b>		2	9	8	7	5	4	11	10	3	1	5
	Effective care	4	7	9	6	5	2	11	10	8	1	3
	Safe care	3	10	2	6	7	9	11	5	4	1	7
	Coordinated care	4	8	9	10	5	2	7	11	3	1	6
	Patient-centered care	5	8	10	7	3	6	11	9	2	1	4
<b>Access</b>		8	9	11	3	4	7	6	4	2	1	9
	Cost-related problem	9	5	10	4	8	6	3	1	7	1	11
	Timeliness of care	6	11	10	4	2	7	8	9	1	3	5
<b>Efficiency</b>		4	10	8	9	7	3	4	2	6	1	11
<b>Equity</b>		5	9	7	4	8	10	6	1	2	2	11
<b>Healthy lives</b>		4	8	1	7	5	9	6	2	3	10	11
<b>Health expenditures/capita ('11)</b>		\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Country rankings ■ Top 2 ■ Middle ■ Bottom 2

Source: Commonwealth Fund 2014

Cost pressures are increasing for all who pay for health care: health plans, governments, employers, and consumers.

- **Health plans**—From 2010 to 2015, the average health plan medical loss ratio increased from 86 percent to 90 percent.<sup>1</sup>
- **Government**—The Medicare Hospital Insurance trust fund is projected to be depleted in 2029.<sup>2</sup> From 2010 to 2015, Medicaid’s share of funded state

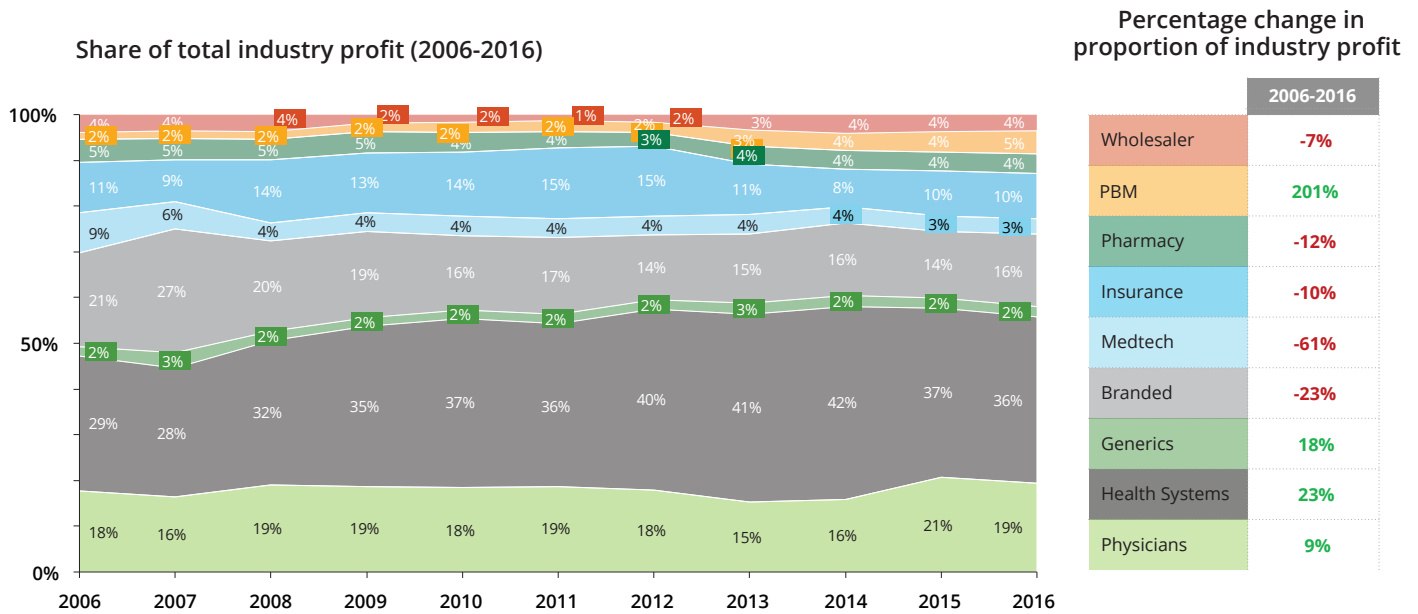
budgets increased from 12 percent<sup>3</sup> to 19 percent.<sup>4</sup>

- **Employers**—From 2010 to 2016, average employer contributions to employee premiums increased by 32 percent, from \$9,733 to \$12,865.<sup>5</sup>
- **Consumers**—From 2010 to 2016, average employee contributions to premiums increased by 31 percent, from \$3,997 to \$5,277.<sup>5</sup>

Health plans, in particular, are in a vulnerable position if industry actions do not meaningfully restructure the health care system to tame costs. As health care costs continue to rise, employers likely will continue to decrease or drop coverage; as a result, health plans’ traditional books of business will shift toward less-profitable segments including Medicaid and health insurance exchanges.

As costs and the number of insured lives continue to increase, health systems and physicians have captured more of the health care industry's total profits at the expense of health plans (figure 2). Meanwhile, government policies to transfer more financial risk to providers have prompted health systems to take on traditional health plan capabilities, particularly care management.

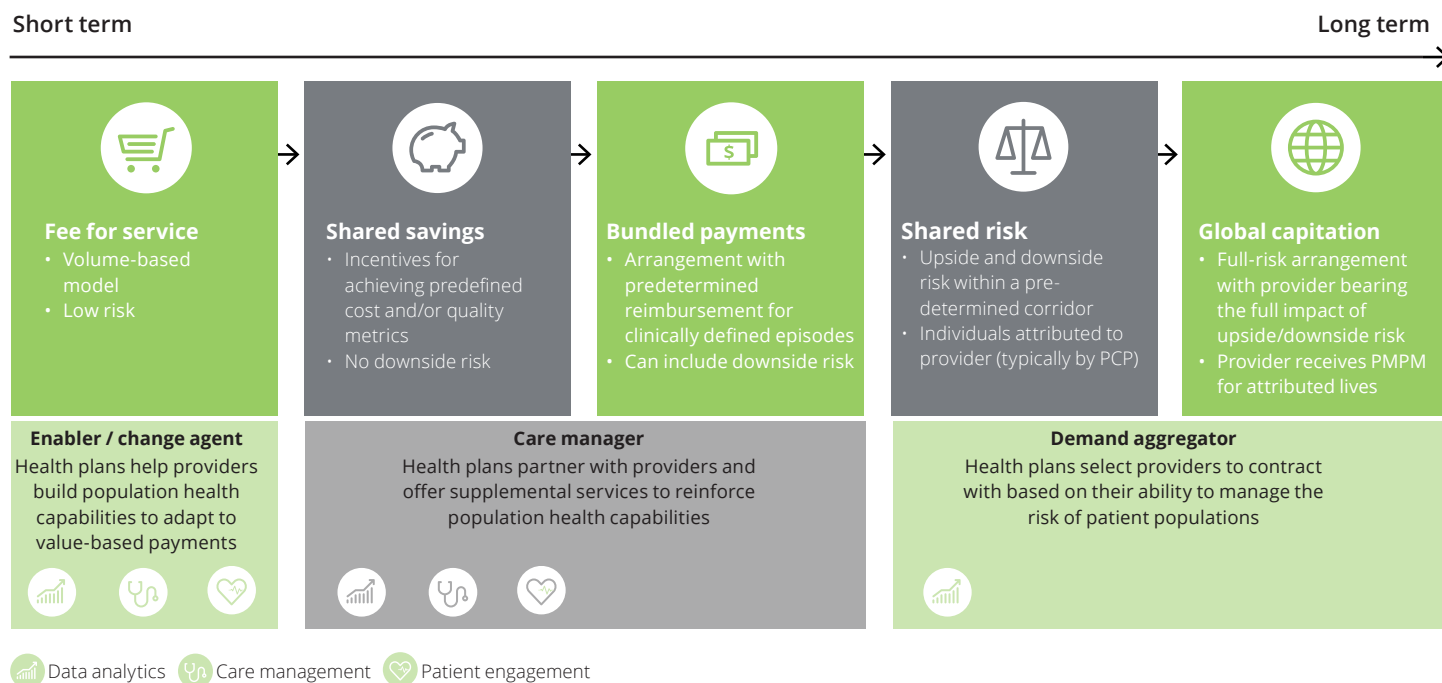
**Figure 2. Health care industry share of revenue and profit by sector**



Source: IBIS World; Capital IQ; Monitor Deloitte Analysis. Note: US market; EBITDA used as a proxy for profit.  
 Note: Due to a methodology change implemented in the 2016 report, historical data has been restated for the generic and branded biopharma sectors.

As providers start to choose health plan partners to manage the risk of certain populations, health plans will need to assume different roles across the payment model spectrum in the coming years (figure 3):

**Figure 3. Payment model categories and the role of health plans**

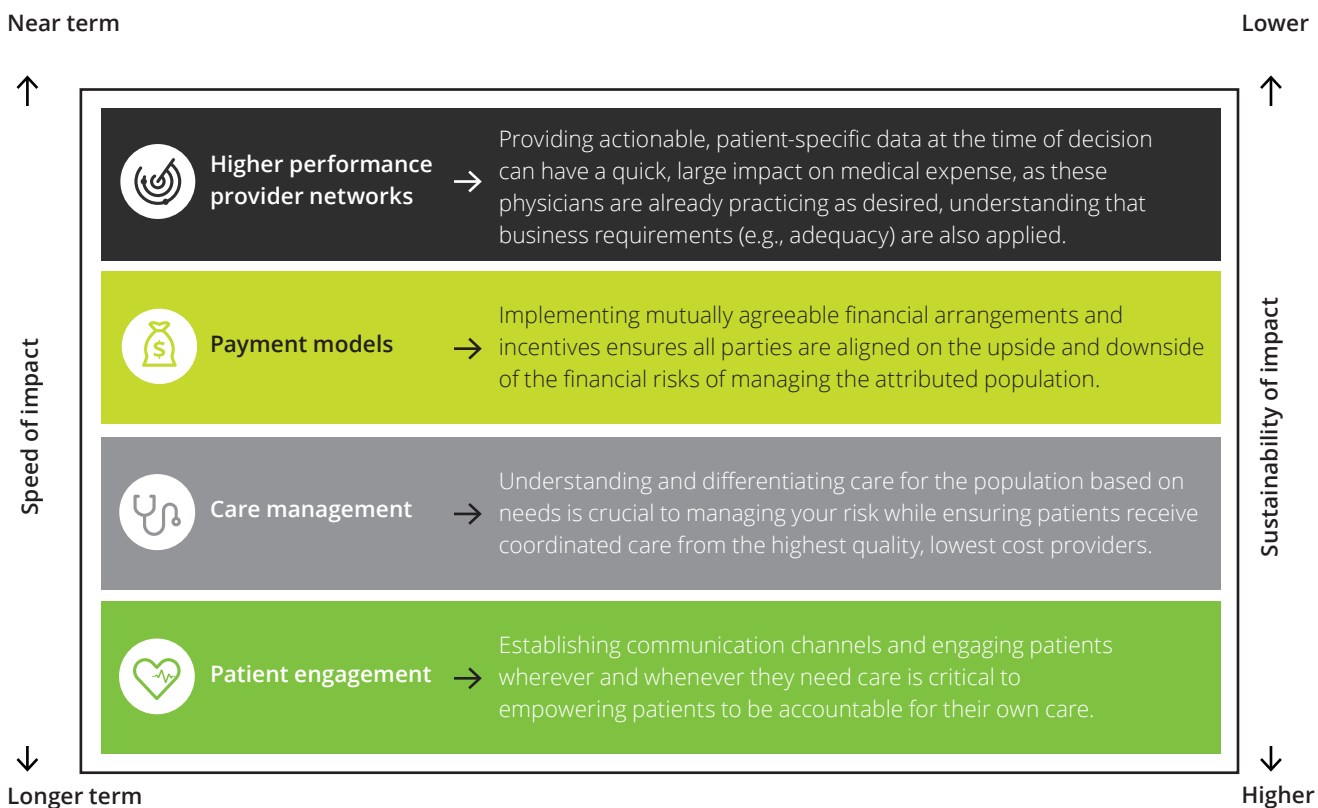


If health plans cannot offer value-added services to enable collaboration and partnerships with providers across the payment model spectrum, they run the risk of potential disintermediation in the long term. Now is the time for health plans to demonstrate a strong value proposition by impacting the affordability of health care.

# Our take

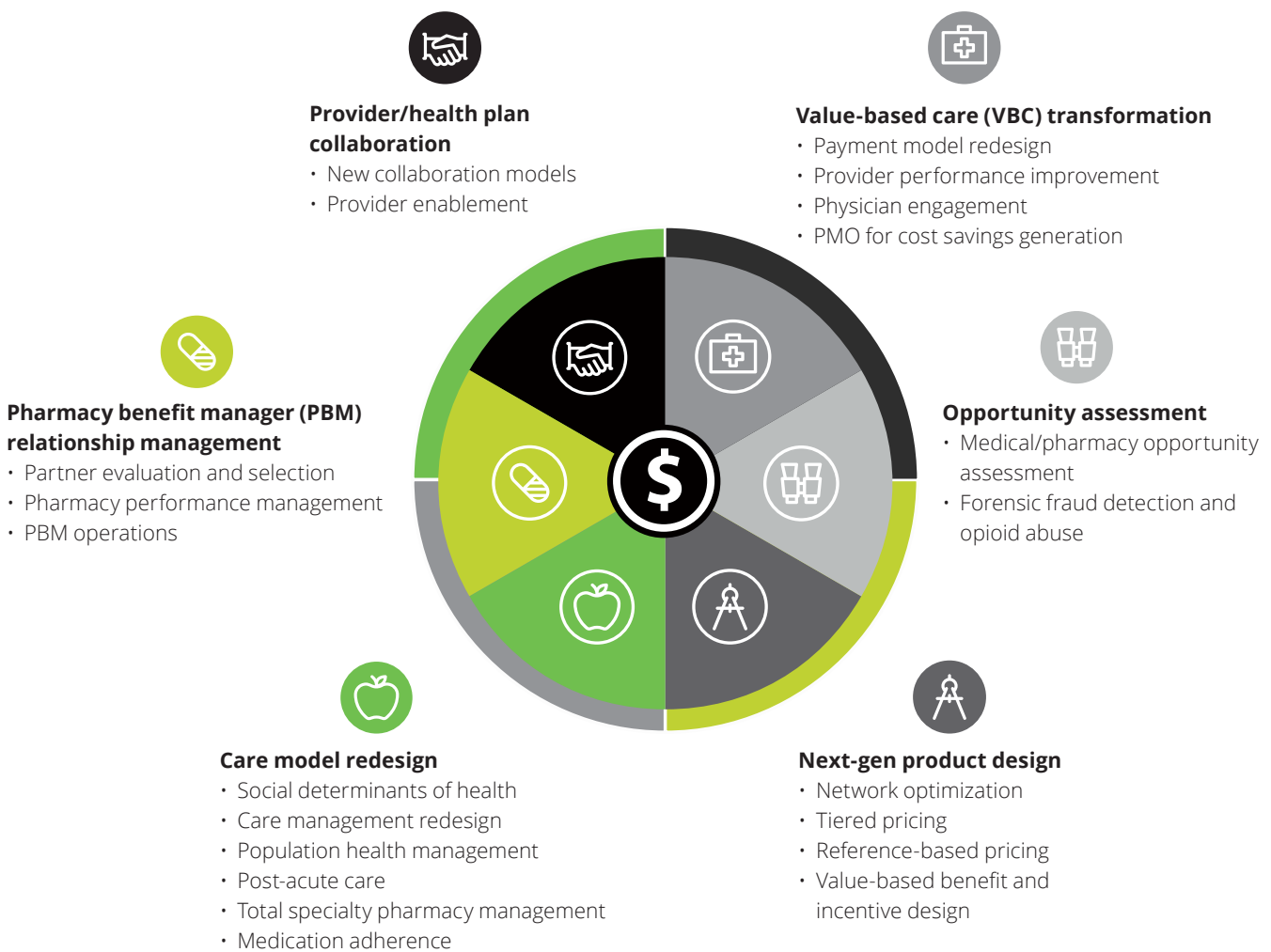
Based on Deloitte’s decades of experience across all health care sectors, we see that both health plans and risk-taking providers are facing similar constraints in attempting to bend the cost curve while retaining and improving quality (figure 4).

**Figure 4. Affordability value drivers**



It is critical that health plans’ strategies to improve affordability address medical and pharmacy expenses. Although there might be opportunities to improve administrative expenses, these have a small impact on affordability relative to spending on medical and drug expenses. Both Dartmouth and Rand have published studies that indicate more than 30 percent of all health care spend is inefficiency. Opportunity assessment projects Deloitte has done for clients indicate similar waste. An important first step is to quantify and prioritize these cost-curve bending opportunities so that efforts can be focused on the areas of largest potential impact. Deloitte’s six affordability platform offerings are constructed to help health plans target efforts and then pull the appropriate levers to generate the savings (figure 5).

Figure 5. Deloitte affordability platform offerings



# Path forward

## Opportunity assessment

Identify targeted opportunities for improvement and cost savings (e.g., medical, pharmacy, fraud detection)

**Problem:** Runaway medical and pharmacy costs eroding profitability

**Sample value generated:** Identify 5-15 percent of medical costs that are deemed to be achievable by health plans

## Provider/health plan collaboration

Explore new collaboration models and ways to enable providers

**Problem:** Need to integrate plan and provider capabilities, assets, and resources

**Sample value generated:** Enable better management of the delivery system by aligning the interests and capabilities of a provider and a health plan

## Pharmacy benefit manager (PBM) relationship management

Manage performance and operations of PBM and evaluate potential partners

**Problem:** Increasing drug prices, particularly for specialty and on-patent medications

**Sample value generated:** Reduce cost of goods sold ranging from 8-20 percent over the life of the new contract

## Value-based care (VBC) transformation

Engage physicians and provide them with incentive to shift from fee-for-service (FFS) to fee-for-value

**Problem:** Business model shift from volume to value

**Sample value generated:** Increase VBC reimbursement and physician engagement

## Care model redesign

Implement programs that target opportunities to avoid waste and improve quality through the care model

**Problem:** Care models are not optimized due to a lack of coordination between health plans and care systems

**Sample value generated:** Redesign of care models to leverage the best capabilities between health plans and care systems powered by analytics

## Next-gen product design

Enable consumer behavior to drive quality and cost-effective decisions

**Problem:** Plan designs that do not appropriately engage consumers and networks that are not designed to provide the most value

**Sample value generated:** Engaged consumers and optimized networks, which can lead to more affordable products

## Affordability transformation in action

A large health plan faced the challenge that traditional evaluations of fee-for-service (FFS) do not adequately capture the performance of providers. More robust cost measures are needed, balanced with measures of quality and accurate coding. Complicating this affordability struggle is the fact that patient care is provided by an array of primary care physicians, specialists, hospitals, and ancillary providers. As such, a holistic view of costs across episodes of care is required. Equally important are the connections and interactions among providers and the impact those have on member care and network performance.

Deloitte implemented a phased approach to identify and implement targeted interventions focusing on cost efficiency, clinical quality, and coding accuracy.

- The efficiency analysis focused on bundling claims into episodes of care

then comparing the costs of attributed episodes for each provider to similar episodes treated by peers at both an individual and a group level.

- Providers' connection to other providers, as evidenced by shared patients, were also analyzed to gain insight into the overall impact of network composition. The algorithms highlight where naturally occurring communities of care were taking place and visually demonstrated these clusters of care to provide insight into how numerous variables affect care pathways (e.g., geography, specialty, facilities, employment, practice affiliation). Predictive modeling supplemented this analysis to reveal potential drivers of performance.
- A full suite of reporting via Tableau was developed to provide transparency and help providers understand their results with actionable insights to improve.

- Lastly, results were incorporated into tools that simulate the performance of alternate networks and the impact of modifications to existing networks via sophisticated algorithms. This tool takes advanced mathematical techniques to develop numerous network scenarios to achieve various targets: cost savings, design a narrow network (e.g. "who would need to remain in the network"), create tiered pricing ("physicians can remain but X percent more should be charged to members to accommodate for choice"), develop a high quality network, and minimize member disruption.

This analytics solution greatly enhances the health plan's ability to improve member care and reduce costs by developing high-performing networks, modifying care patterns, engaging and educating providers to enhance performance, improving transparency, and identifying opportunities to implement alternative payment models.



# Bottom line

A Deloitte-led affordability transformation can help health plans position themselves to significantly reduce medical and pharmacy expense and improve health plan profitability. In addition, health plans can work toward becoming a preferred partner for providers as they move to a value-based world. Deloitte can help clients achieve an improved value proposition through more affordable products and better provider relationships.

# Endnotes

1. SNL Financial Benchmarking Data
2. "The Facts on Medicare Spending and Financing," Kaiser Family Foundation
3. "Medicaid's Share of State Budgets," MACPAC
4. Kaiser Commission on Medicaid and the Uninsured based on NASBO's Nov 2016 State Expenditure Report
5. Kaiser/HRET Survey of Employer Sponsored Health Benefits
6. Kaiser/HRET Survey of Employer Sponsored Health Benefits

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