Introduction to Business Health Care Group's High-Performance Health Plan

December 16, 2020
Webinar

Executive Summary

Representatives from the broker and consultant community gathered virtually to attend a webinar on December 16 that detailed BHCG's new, groundbreaking high-performance health plan solution. BHCG leadership, including members of its Executive Steering Committee and senior executives from Centivo (BHCG's administrative partner to support the new high-performance model) presented information and answered questions regarding:

- BHCG's strategic vision for the new health plan solution; key health plan elements of the model
- Timelines for next steps in the engagement and development process
- Centivo's support for brokers and consultants in incorporating and implementing high-performance solutions for employer's health plan offerings in 2022 and beyond

Introduction – Jeff Kluever, BHCG Executive Director

- **The business community is striving to make Wisconsin a great place to do business and to demonstrate responsible corporate citizenship – high quality, cost effective health care is a key element**
  - WI has high quality health care and great access, but it costs too much
    - Unsustainable for employers, employees and their families
    - Can't continue to shift costs onto employees, either through premium or plan design (e.g., deductibles, co-insurance, etc.)
- **BHCG is a mission-driven organization, not a purchasing organization**
  - Mission is to create value through innovative shared strategies to improve health care quality and cost efficiency – not only for employers, but their employees, family members and the community
- **BHCG has developed best in class strategic partnerships with a number of organizations**
  - Adding Centivo to its portfolio

- A rigorous assessment process (lasting over 18 months) resulted in Centivo's selection – utilized consulting expertise from three leading national organizations
- Will offer the Centivo high-performance plan in conjunction with a national network offering(s) for multi-state employers

Lisa Mrozinski Director of Total Rewards, Baird (BHCG Executive Steering Committee Member)

- **BHCG's key priorities address three issues in the eastern WI health care market**
  - Local costs are high but, in many cases not associated with any measurable difference in quality of service or outcomes
  - Many people have a limited or no relationship with a primary care physician (medical homelessness) to help guide them and make good decisions
  - Payment model is not well-aligned to achieve our desired goals
    - Need to devote more financial resources to physicians and hospitals that provide lower costs and higher quality care while also reducing financial barriers to getting the right care
      - The money used for overpriced, inappropriate care can then be used to pay for better care for all stakeholders
- **Time for employers to be more actively involved in driving positive change**

Cara Olson – Human Resources Director, Sendik's Food Markets (BHCG Executive Steering Committee)

- **Need new health care model that meets the needs of business, people and health care providers**
  - Well-aligned system that:
    - Pays appropriately with clear expectations between those paying for the services and those providing them
    - Offers resources for people to make really good decisions while asking them to be accountable

Dave Osterndorf – Actuary, Centivo; BHCG Strategic Consultant

- **Centivo solution – a combination of a high value network with additional aligned elements that combine to deliver three desired outcomes**
  - Great member access that is primary care-driven with strong partnerships between patients and providers
    - Lack of barriers (operationally and financially) to get primary care quickly
    - Starting place to get care is through primary care provider (not ED or specialist, for example)
  - Improved overall quality
    - Have the right kind of structures, patient flow and financial incentives in place
    - Identify high quality specialists to guide referrals
    - Provide sufficient patient and provider data to providers to maximize good patient management

- A cost picture that is far more sustainable
  - Uses financial resources as effectively as possible
  - Recognizes that every dollar employers save is lost revenue for a provider system – can't just reduce pricing
    - Have a dialogue about how to take out revenue while reducing provider expense burden to partner effectively on the total cost of care

- **What's driving the problem?**
  - Unaffordability of health care is unsustainable – i.e., almost half of insured adults say they can't afford their deductible
  - Consumerism hasn't worked very well – health care decisions are emotional and complex and most consumers don't feel equipped to make purchasing decisions effectively
  - Most people just listen to what their physicians tell them
    - Should incentivize provider community to align with strategy to bring down overall costs
- **What do health care providers say?**
  - It's hard to be accountable for what they can't control; don't like a retroactive process to look at data at the end of the year – no incentive to change (ineffective process)
    - Better to work proactively with an assigned panel of known patients for whom they are accountable
    - Equip them with tools that help patients be more compliant with primary care advice for a far better chance for success
  - Providers understand measurement is necessary, skepticism can be overcome with a transparent and consistent process
  - Significant agreement among health care providers a primary care-centered model will be valuable in reducing costs (Centivo book of business has about a 9% decrease in total cost of care) and increasing satisfaction
  - Providers are getting used to the idea of value-based care (about half of payments have a value-based element currently)
- **Identifying high-performing PCPs**
  - Can they give us access and a strong patient experience?
    - Same day appointment for sick care
    - Take advantage of good virtual care integrated with mental health
  - Look at process measures (e.g., how are they using nurse practitioners or other extended team to manage routine care, etc.?)
    - Uses survey and *BHCG/GNS Physician Value Study* as part of the evaluation process
  - Measure care appropriateness
    - *Practicing Wisely* measurement system
    - Also use self-report data, use of electronic health records and other clinical management tools
  - Ensure strong baseline quality measures – compliance with evidence-based medicine standards
    - Captured in *Physician Value Study* – must meet minimum standard to be in high-performing category (pass/fail)
- **GNS *Physician Value Study***

- Uses AI-based machine learning algorithm to look at
  - Cost efficiency – how well do individual PCPs perform in terms of episode cost by type and patient characteristics compared to what it should be expected to cost?
  - Quality – how well do individual PCPs perform in terms of compliance with evidence-based measures
- ***Practicing Wisely***
  - Evaluates the appropriateness of care based on numerous quantitative measures
    - Inappropriate use of medications and imaging
    - Approach to prevention and wellness services
    - How well are chronic disease patients being managed?
      - All get rolled up into a score for an individual provider
      - Larger practices tend to have higher scores vs. smaller practices
- **Connecting patients to PCPs**
  - Activation at beginning of plan year (has to be easy to accommodate)
    - Select a PCP team
    - Understand the program and how to access care through your team
    - Initiate an interaction with PCP team (virtual or in-person)
  - Preferred benefit design (will not dictate benefits to plan sponsors)
    - Hard push for free or near-free primary care to eliminate barriers to access
    - Highest level of benefits is when care is coordinated through PCP
    - Substantially higher cost sharing If patients go on their own and not through a PCP

Andrea Markofski, Sales Engineer, Centivo

- **What does the member experience look like?**
  - Two main goals
    - Help facilitate and establish relationship between member and PCP
    - Make sure it is as easy to navigate and understandable as possible (e.g., visuals and easy to understand language)
  - Communication support
    - Open enrollment handouts and other materials (can be customized with employer key messages and branding)
    - Guides
    - Can attend meetings/webinars
    - Provider directory
  - Member will receive
    - Confirmation email
    - Welcome kit – drive to activate plan/select PCP team
      - Stats show 80% of members activate the plan within two weeks of enrollment (90% within 6 weeks); will send out reminders to activate
      - Can activate online, via phone app or call
      - Provided with education and help to find a PCP team
    - ID card

- Physician will receive roster of all patients that have selected them and templates of welcome communications for members
- App/tools will facilitate referrals and finding resources (spending summary, etc.)
- Concierge for members to reach by phone or email
- Ongoing, year-round communication to help members do what they need to do when they need to do it – to get the most out of the plan

Dave Osterndorf

- **PCP payment model**
  - Moving away from pure fee-for-service
  - Provide patient management fee to encourage PCPs to spend more time with patients that need it
  - Looking to affect the total cost of care and reward for performance over the long term
    - Also looking at prescribing and referral patterns, inclusion of behavioral health services, access and clinical management structures
    - Ensuring data sharing process is in place
  - In Centivo book of business, for every dollar spent in primary care services, three dollars are saved in downstream care
  - Look at benefit design structures to give a known cost to a patient (seen as a significant satisfier for patient)
    - Drives better collection process
  - High performing PCPs affiliated with lower total cost of care systems are put at the top of the list in activation process (people tend to choose from the top of the list)
    - Health systems have incentive to encourage cost efficiency in exchange for larger volume
- **Contracting process**
  - Moving forward relatively quickly; good response from systems/providers in our service area
  - Bringing valuable commercial population business that represents about 30% of revenue and 125% of margin for health systems
  - Dual network structure for high-performance solution
    - Broad-based network with most providers in the community that agree to the primary care model and rates consistent with best in market rates
    - Narrow network solution – if one of limited number of providers or dominant provider in your area will expect significantly better rates from them
      - Will consider competition factors in setting rates
      - Looking for narrow network structure that will work best for employer community
  - Want to bring in value-based provisions
    - At minimum, primary care performance metrics; ultimately want to get to total cost of care
    - The more health systems assume risk, the more flexibility will be offered to work with them
      - Will be collaborative process with a lot of back and forth
- **Savings**

- Will be very direct in how savings are determined
- Unit cost savings – getting the same services from the same provider at a lower cost
- Care redirection – redirect care to lower cost providers from higher cost providers
- Impact of primary care model – spending more money on in-office primary care and less money on downstream care
  - Includes prescription drugs (will have to coordinate with PBM)
- Important to show sources of savings to broker/consultant and employer (actual cost impact of all the different pieces)
  - Will look at actual allowed cost in a typical health plan (PMPM) and where the savings might be from
    - Redirecting care from high cost providers
    - Better unit price position
    - PCP management process
  - Lay out expectations relative to the cost picture for a particular employer, as well as plan design implications

- **Preferred plan design structure**
  - What drives behaviors (e.g., virtue of copay structures, no cost primary care visits)?
  - Ultimately plan sponsor decisions – no mandate
- **Support for advisors and clients**
  - Will be as transparent as possible about contractual terms
  - Financial analysis of expected changes in allowed charges
  - Support in the development of premium equivalent rates
  - Benefit design templates with actuarial values attached
  - Case studies of how model has worked in other places
  - Connections to stop loss carriers who understand the model
- **Centivo compensation**
  - BHCG pre-negotiated base ASO rate (three tiers based on employer size)
  - Incentive fee – based on actual cost of employer's experience relative to target cost
    - Will have access to data through portal
  - Adviser compensation can be accommodated through directed fees or other arrangements that employer agrees to
    - Transparent approach – no undisclosed payments to advisors
- **High-performance model summary**
  - If providers take accountability for total cost of care, will receive panel of patients motivated to follow their guidance and substantial additional data (clinical and economic information) to make the best decisions
  - Employees will take accountability for choosing PCP by going through the activation process and working with PCP in order to get a trusted guide through the system and a stronger benefit program and known costs
  - Employers who agree to undertake and work with program requirements will receive a cost effective, competitive benefit program with high levels of employee satisfaction
    - Resulting in making WI a better place to do business
- **Timelines**

- Targeted March 31 for completed agreements with health systems (to allow time for employers to make decisions for 1/1/22)
- High expectation things will be up and running for 1/1/22 activation date (good support and operational follow-through from health systems so far)
  - Bit of delay on getting financial terms due to COVID, but still on track on getting out info

Questions

- **Who is Centivo renting their network from?**
  - This is a Centivo-negotiated and owned network (contracts directly with Centivo and not owned by another party) available to BHCG members
- **What do you do if a member does not activate?**
  - Member will have more cost-sharing (second tier of benefits); employer decides on differential
- **How does the BHCG high-performance model coordinate with other BHCG best in class partners (e.g., Quantum, Navitus, etc.)?**
  - Because Quantum has substantial interaction with patients (very complementary to the model), it's important to have consistent messaging – need to have access to the same data provided to PCPs
    - Because Quantum takes phones calls (primary conversations with patients), there is a $5 PMPM reduction in ASO fees for clients that have Quantum
  - Navitus is Centivo's preferred national PBM (like their fully transparent, pass-through model); can coordinate with all PBMs but Navitus really works will within the high-performance model
- **Will the Centivo plan be available to any size employer and is there any minimum participation requirement? Available to both fully-insured and self-funded employers?**
  - A solution available only to self-funded employers (Centivo not a risk-bearing entity)
    - Do have lots of stop loss solutions available (some for relatively small groups) – no minimum size employer
  - No minimum participation requirement – can be used side by side with other options
- **What savings guarantees will Centivo agree to (any ROI or other savings)?**
  - Base ASO fee is relatively low and ability to make a profit is dependent on incentive fee (have to perform effectively to be financially effective internally)
    - Must meet targets for employers – advisers will be involved
    - Centivo not risk-bearing, so no financial guarantee in terms of a cap and costs
    - Stop loss carriers will offer discounted rates for the model
- **Has the WI Centivo network been built or is 1/1/22 the target date for completion and 2021 the time period for development?**
  - Network being built as we speak – coming to you early in the process to build awareness and get additional input
  - Process overseen by BHCG Executive Steering Committee

- Networks should be completed by March 31, 2021and you will be informed about what is in the structure and who is participating (information to support 1/1/22 planning – may also be available in time for off-year renewal planning)

- **Any insight into how the health systems are viewing the narrow network?**
  - A number of health systems are looking forward to competing on that basis
  - Three key messages heard over and over again in health system conversations
    - Like the model and the patient information available to them to integrate clinically
    - Like that the savings goes back to the employer and employee (not interested in generating more insurance company profits)
    - Worked through the narrow network concept and what it means for them to be trading lower price points for volume and control
  - Some creative approaches – deploying some of their assets in a different way
  - Centivo is very optimistic as the rates start coming in that it will be an attractive solution
- **Does Centivo have the same meaningful UHC discounts to deliver to the employer for complex patients seeing specialists?**
  - Expectation is rates will be the same or better than UHC levels – don't expect to see any backsliding relative to best of market rate (these are the kind of patients health systems have to have); financially motivated to work with us after COVID especially
- **How will the new ACA price transparency rule affect this process?**
  - Creates a positive outcome that gets away from "secret deals" that have created some challenges
  - Will help to bring down total cost and bring quality and unit price data together to get a much better new equation – don't believe the fear that low cost providers will increase fees
- **How can broker/consultants jump on board as quickly as possible? Is there a representative we can meet with?**
  - Contact Jeff Kluever – BHCG has been a very good partner involved in all aspects of development and would like to add the broker voice into the process

Jeff Kluever

- **Closing comments**
  - Some common themes in conversations with providers
    - Strong alignment between health systems/provider groups and this high-performance solution
      - They believe it will be beneficial not only for the employer community but also for health systems and their provider groups and other stakeholders
    - Not interested in increasing health insurance carrier profitability – want to see cost structure realigned to reward them for value and reduce employer and employee family expense
      - Have heard UHC has said BHCG is disparaging their profitability
      - UHC has reported record profitability as of the second quarter of 2020

- The reasons for selecting Centivo
  - Employers need administrative partners who are committed to better data sharing and transparency, more efficient payment models and a willingness to progressively move the market away from the status quo to benefit employers and their employees
    - These partners should be committed to and rewarded for creating this positive change, rather than protecting the current system
- UnitedHealthcare has chosen to discontinue its relationship with BHCG, rather than play that role
  - UHC is not aligned with BHCG and will not be a partner on an ongoing basis. The reasons?
    - Limited contracting for value (volume vs. value)
    - Limited innovation
  - UHC has provided incentives to BHCG member employers to terminate with BHCG 12/31/20
    - However, the termination of the BHCG relationship does not impact the administration agreements currently in place (terms will remain in place through the employer's next renewal)
- BHCG is completely in alignment with Centivo's commitment to the items we require of an administrative partner
- Enthused about the value the model will bring to our current member employers, prospects and eastern WI and working with you and member employers and prospects