



The Role of Healthcare Performance Management in Controlling Costs and Improving Quality in an Enterprise Environment

*A Report on How Senior Executives are Re-Establishing
Control of Healthcare Resources in Their Organizations*

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Executive Summary:

In this report, we explore a new corporate discipline called healthcare performance management (HPM) that is achieving the dual objectives of reducing costs while improving healthcare outcomes. HPM is a technology-enabled business strategy that tackles the challenge of health care in much the same way that enterprises have approached the optimization of customer relations, supply chain management and enterprise resource management.

- In 2010, many employers who take responsibility for offering health insurance benefits to their workers will see premiums increase significantly. And as the cost of healthcare rises, executives will see the quality of the services offered to employees decline. In many cases, the reduction in service quality will be accompanied by a cost-shift to employees (often manifested as increased premiums and co-pay policies). The forces behind these cost and performance trends are many. One of the most important — and addressable — factors revolves around existing business models in the industry that hinder the effective sharing and management of information among key constituencies (employers, members, healthcare providers and insurance carriers).
- Despite these issues, enterprise leaders can take concrete steps to head off spiraling costs and new bureaucracy. There is a growing body of evidence that strongly suggests employers can achieve savings and better results for their companies and their employees by implementing proactive, hands-on business management strategies for employee healthcare benefits plans. Success, however, will depend on a complete re-evaluation of the current assumptions and business models that underpin healthcare administration practices.
- HPM applies proven business and management principles to company-provided healthcare benefits by giving C-level executives visibility and control over company healthcare benefits spending trends and risk management postures, while scrupulously protecting individual employee privacy. Companies that have effectively adopted HPM methodologies are reporting that their health benefits plan costs are stabilizing after years of unchecked growth, while improving the delivery of healthcare services to employees.

To better understand the principles and promise of HPM, the editors of BizTechReports.Com interviewed experts and executives associated with the recently formed Healthcare Performance Management Institute (www.hpminstitute.org). The institute is a research and education body dedicated to promoting the use of business technology and management principles that deliver better and more cost-effective healthcare benefits.

The Limits of the Current Healthcare Model

America's C-level executives are faced with an intimidating array of challenges when it comes to providing high-quality, cost-effective healthcare benefits to their companies' employees. Among them are:

- Many U.S. employers reported increases of more than 10 percent in their medical benefits expenditures in 2009, according to HR trade publication *BLR*.
- Industry analysts at HR consulting firm Towers Perrin project an increase of 7 percent in 2010. The cumulative effect of ongoing cost increases combined with the current economic climate is creating significant affordability challenges for both employers and employees. Analysts report that many employers are preparing to take action by embracing new approaches to benefits management that have the potential to fundamentally transform the current model of healthcare delivery.¹
- The third-party payment system, whereby employers pay all or most of the healthcare costs — often with little thought as to how much services cost — has been harmful for businesses. Any time third-party payments are the norm, costs increase and insurance company profit margins rise. For example: Lasik surgery is not a covered procedure; consumers must pay out-of-pocket for it. Because of competition in the market, costs for Lasik went from \$5,000 to \$1,500 within a few years. On the other hand, MRIs are covered procedures, paid for by third parties, and their cost has doubled over the past 10 years.²
- Health-risk mitigation programs often have limited uptake and adoption, leaving participation rates hovering between 20 and 30 percent for non-financially incentivized programs. In contrast, adoption rates see a different trend — experiencing participation rates between 70 and 90 percent when financial

¹http://www.towersperrin.com/tp/showdctm.doc.jsp?country=global&url=Master_Brand_2/USA/Press_Releases/2009/20091008/2009_10_08.htm ; <http://hr.blr.com/HR-news/Benefits-Leave/Healthcare-Insurance/Many-Employers-Report-2009-Healthcare-Cost-Increas/>

² Health Affairs, News Release, November 10, 2008

support is offered to encourage healthy lifestyle changes.³

Businesses are often prevented from making the most basic comparisons with regard to their healthcare costs, since insurance carriers do not provide timely information in a format that is understandable or usable. As a result, executives cannot manage what they are unable to measure.

Broken Business Models

The health insurance and benefits management services on which nearly all employers rely to cover their employees' healthcare needs offer few strategies for dealing with these challenges. The annual procurement cycle on which most health benefits services are re-negotiated offers executives little opportunity to make adjustments to health benefits plan performance. Every company needs to be informed about where it is spending its money, in addition to finding out:

- What's driving the corporate healthcare costs?
- What strategies may be implemented to reduce those costs?
- What can be done to pinpoint and engage employees with high medical costs so that they become healthier and cost the enterprise less?
- How can the results of cost-saving programs and healthcare improvements be measured?

Unfortunately, the business model that currently underpins how most people receive healthcare benefits — namely, through employers — is counter-indented with regard to reducing costs.

"The current model of managing employee healthcare benefits relies on reactive measures," says Bill Lavis, a veteran of the employee health benefits industry who heads up the employee benefits practice at Sitzmann Morris & Lavis (SML), an Oakland, Calif.-based firm that advises companies on employee benefits and insurance matters.

³ O'Donnell, Michael P. "The Genetic Information Non-Discrimination Act — A Wake-Up Call: Great Intentions, but a Setback for Health Impact and Cost-Effectiveness of Workplace Health Promotion." *American Journal of Health Promotion* 24.3 (2010): iv-v. Web. 20 Jan 2010. <<http://www.healthpromotionjournal.com/publications/journal/en2010-01.htm>>.

After a year of negative performance, he says, this reactive approach leaves C-level executives with only unattractive options, such as rate and deductible increases.

"Indeed," Lavis explains, "most employer groups look at plan design as their main lever for healthcare programs, which is a primitive tool for cost control. That is, company executives can reduce the benefits their plan is offering, they can change the employer and employee contributions to their plan, or they can change the vendors who run their plan. If these changes were the best answer, why do they continue to make the same ones year after year? All of these are short-term fixes," he says.

Moreover, when such changes are made, they often result in disruption and frustration for senior executives, human resources (HR) professionals and employees. The limited array of choices often results in pitting different constituencies within the enterprise against each other.

The process many enterprises use to procure healthcare benefits services for their employees sidesteps proven management principles that guide executive decision making for other business processes. One of the key challenges is an almost complete inability to integrate systems that track, on an ongoing basis:

- The health profiles of covered employee groups
- The risk to which employers are exposed
- The actions taken to manage the health of high-risk participants in a group using best healthcare practices

Instead, most companies purchase Preferred Provider Organization (PPO) and Pharmacy Benefit Management (PBM) services on an annual basis. Executives are provided with a report on how the group consumed services in the previous year and are then told what the new premiums will be, based on a projection of the events that had taken place the previous year.

"Most companies just outsource the management of their health benefits," explains Henry Cha, president of Healthcare Interactive, a Glenwood, Md., company that is developing enterprise applications that enable HPM strategies. "They leave important business decisions about the performance of their plans to PPOs and PBMs."

The C-suite's lack of access to integrated data impedes sound business decision making regarding employees' healthcare benefits plans.

For organizations that adopt a "fully insured" strategy, insurance providers are typically under no obligation to offer any meaningful operational statistics at all.

Those employers that pursue a self-insurance healthcare management strategy, however, do have a somewhat easier path to accessing healthcare benefits plan data. However, because of the highly fragmented and complicated nature of both claims management and clinical data, it has been difficult to capture, aggregate and analyze data in a meaningful manner so that effective cost-cutting and outcome-enhancing initiatives can be put in place.

In short, there is a severe absence of information transparency. As a result:

- Organizations are hard pressed to truly understand what their actual healthcare spending profile looks like.
- Executives cannot compare and contrast their risk profile to regional or national trends.
- Enterprises have no way of projecting how their cost curve will evolve. More importantly, they cannot effectively identify key variables that can be managed to bend the curve.

HPM in Action

SML's Lavis is confident that employers can overcome these obstacles to reining in healthcare benefits costs. "The best solution to skyrocketing healthcare benefits costs," explains Lavis, "requires top-level executives to be engaged in the day-to-day management of their companies' benefits plan performance."

The promise of HPM lies in developing systems and strategies that mine and manage healthcare benefits plan data.

"Executives know more about how many pencils and pads of paper they have in their organizations than they do about how employees are using healthcare resources," observes Cha.

Senior executive involvement in healthcare benefits management is largely absent today. Organizations have far more insight and control over:

- How customers are served — by applying customer relationship management (CRM) applications to determine what each client buys and how long it takes to address a customer complaint
- The performance of suppliers in meeting contractual and operational obligations — by using supply chain management (SCM) technologies to monitor pricing trends, delivery histories and current shipment status

The disposition of enterprise resources by using enterprise resource planning (ERP) systems to ensure that the right assets are at the right place at the right time in the organizations to enable them to meet mission-critical objectives

Monitoring, Measuring and Managing

At the heart of each of the above initiatives lies the principle of tracking, measuring and managing key performance indicators.

Currently, most senior executives aren't equipped with the right information technology tools and accompanying skill-sets to take control of their companies' employee healthcare program costs.

"That's because the business intelligence tools that executives need to do HPM are only just now coming online," says Todd Thompson, chief technology officer and director of engineering and technology in Lockheed Martin's financial services and human capital practice.

Thompson is intimately familiar with some of the largest healthcare benefits management challenges — such as those run by large federal government agencies for government employees and entitlement recipients.

Thompson explains further: "It took some successful, easy-to-implement software offerings, like PeopleSoft and SAP, for other business intelligence disciplines to take off."

"What HPM software tools offer to employers," Thompson continues, "is visibility into benefits plan data previously held exclusively by insurance companies and PBMs."

Keith Lemer, president of Philadelphia-based WellNet Healthcare, a company that specializes in health plan management for corporations, concurs.

"When you give technology to the entity paying the bills that has the greatest motive to find waste, overcharges, lower prices or effective alternatives, you provide an opportunity to become more competitive in the marketplace," he says.

According to a 2010 Pricewaterhouse- Coopers (PwC) study, employers are already seeking more meaningful and higher-quality data to help them control costs and keep their employees healthy.⁴

"HPM extends the principles of information transparency and enterprise-wide asset management," says Cha. "This provides company executives with data tools to constantly review and update the design of their healthcare benefits plans to meet shifting needs and markets.

"These data tools allow the executives to take positive, impactful action and make on-the-fly adjustments to plan design and administration."

For example, if a significant number of members of a company's health plan take a brand-name prescription drug that has a less expensive generic substitute, company executives would be alerted to the potential savings by their HPM data tools.

Executives could then take swift action — via an education-and-information campaign promoting the benefits of generic drugs or informing employees of a cash-back incentive to plan members — that would immediately result in lowered costs to the plan.

Alternatively, HPM data tools can alert company executives to take low-cost, high- impact measures in response to patient risks.

Typically, a relatively small fraction of plan members are assessed as "high risk" and account for a larger percentage of the overall healthcare costs of the organization.

Many risk factors can be identified when members are prescribed specific drug types, or when they are diagnosed for serious, but treatable conditions — such as high blood pressure, high cholesterol or a family history of diabetes; these are risk factors that can be managed. Company executives, for instance, can engage a third-party wellness provider to

⁴ 2010 PricewaterhouseCoopers Study: What Employers Want from Health Insurers. Survey profile of 100 large U.S.-based companies and 130 privately held small businesses. Large companies had an average of 11,000 employees, and small employers had a workforce of less than 200 employees.

develop a plan to improve the high-risk members' health outcomes.

This could entail referral of the plan member to a program that uses a combination of in-person, telephone and online coaching to encourage plan members to take full advantage of treatment regimes and available resources — physician visits and tests, prescription benefits and lifestyle services — to mitigate their health risks.

Such an approach can dramatically improve the outcome for the employee/plan member while saving the overall plan the expense of costly intervention later.

"We have lots of data from across the industry," says Cha. "We know for a fact that a high percentage of patients don't appropriately take the medications they are prescribed for the most common risky conditions. Many, we know, should seriously consider lifestyle/health changes. By not engaging with high-risk employees, more risk and cost is added for everyone in the employer's total health plan."

Putting Privacy Concerns to Rest

According to George Pantos, former deputy undersecretary of commerce and executive director of the HPM Institute, singling out risky patient conditions for intervention or additional attention doesn't mean that employers can discriminate against or otherwise take action against individual employees based on information captured about their health.

"Employers know they can be heavily penalized," says Pantos. "It is against HIPAA [Health Insurance Portability and Accountability Act], civil rights law and various employment laws for employers to hire or fire employees based on health issues. HPM decisions are based on anonymous and aggregated data. All the C-level executive needs to know is that there are high-risk plan members — not who they are."

The actions taken to engage with plan members are undertaken by a third-party healthcare services provider funded by the employer, but whose fiduciary and privacy responsibilities accrue to the plan member. The objective is to identify planwide risks, and then take action to improve the health outcomes of individual plan members.

"We are using data to get a big-picture look for the enterprise and then help plan members to improve their health and get better treatment," says Harry Kovar, CEO and founder of WellNet Healthcare. "We take HIPAA and other privacy requirements very seriously. What is really innovative is how we use data to make life better, both for our clients — who are employers — and for individual plan members. Responses from both the clients and the plan members are very positive."

Kovar explains that the massive amounts of data that drive the HPM process have always existed. It is just that companies often have not had reliable means for accessing their own plans' data. "Data about healthcare plan performance is usually controlled by plan service providers and other intermediaries," he explains. "They use it to formulate annual rate increases and protect their margins. That is another way of saying these entities don't really have an incentive to save their clients' money."

That is why getting a handle on real-time information about how the enterprise is actually using healthcare resources is so important.

"Some PPO and PBM carriers are resistant to handing that data over to the companies whose plans they service," cautions WellNet's Lemer. Nonetheless, self-insuring companies are generally entitled to their plans' performance data. But if a service provider balks at providing plan performance data, it may be an indication of significant performance and management problems in the plan.

Bending the Cost Curve

Once an enterprise opts to implement an HPM strategy, executives can expect to see at least modest cost reductions right away. Healthcare Interactive's Cha estimates that the initial analysis of benefits plan data takes two or three working days and can start yielding decision-support data almost immediately.

"Pharmacy data alone is a very productive indicator," says Cha. "It can give company executives valuable decision-making insights early on in adopting an HPM strategy."

The next step is to develop a platform that allows all key constituents (employers, members, healthcare providers, for instance) to get on the same page.

"Healthcare Interactive's HPM dashboard, for instance, gives executives and HR an up-to-date readout on the performance of their company's health benefits plan," Cha explains. "We host the HPM dashboard on our own secure servers, which are already compliant with HIPAA and other relevant privacy regulations, so the technology investment for a company starting off with HPM is very low."

The payoff for this new kind of executive involvement in employee healthcare plans has already been proven. WellNet has documented

more than \$350 million in HPM-related savings for its corporate customers.

Regardless of what changes come out of the national healthcare policy debate, HPM stands to make a positive contribution to stabilizing healthcare by helping employers use data to apply sound management principles to employee healthcare plans.

About the HPM Institute

The Healthcare Performance Management Institute (HPM Institute) is a research and education organization dedicated to promoting the use of business technology and management principles that deliver better and more cost-effective healthcare benefits for employers who cover their employees. The institute's mission is to introduce and develop a new corporate discipline called healthcare performance management (HPM) — a technology-enabled business strategy that tackles the challenge of controlling healthcare cost and quality in much the same way that enterprises have optimized customer relations, supply chain management and enterprise resource management. HPM provides C-level executives with visibility and control over company healthcare benefits spending trends and risk management postures, while protecting individual employee privacy. For more information, visit www.hpminstitute.org.

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