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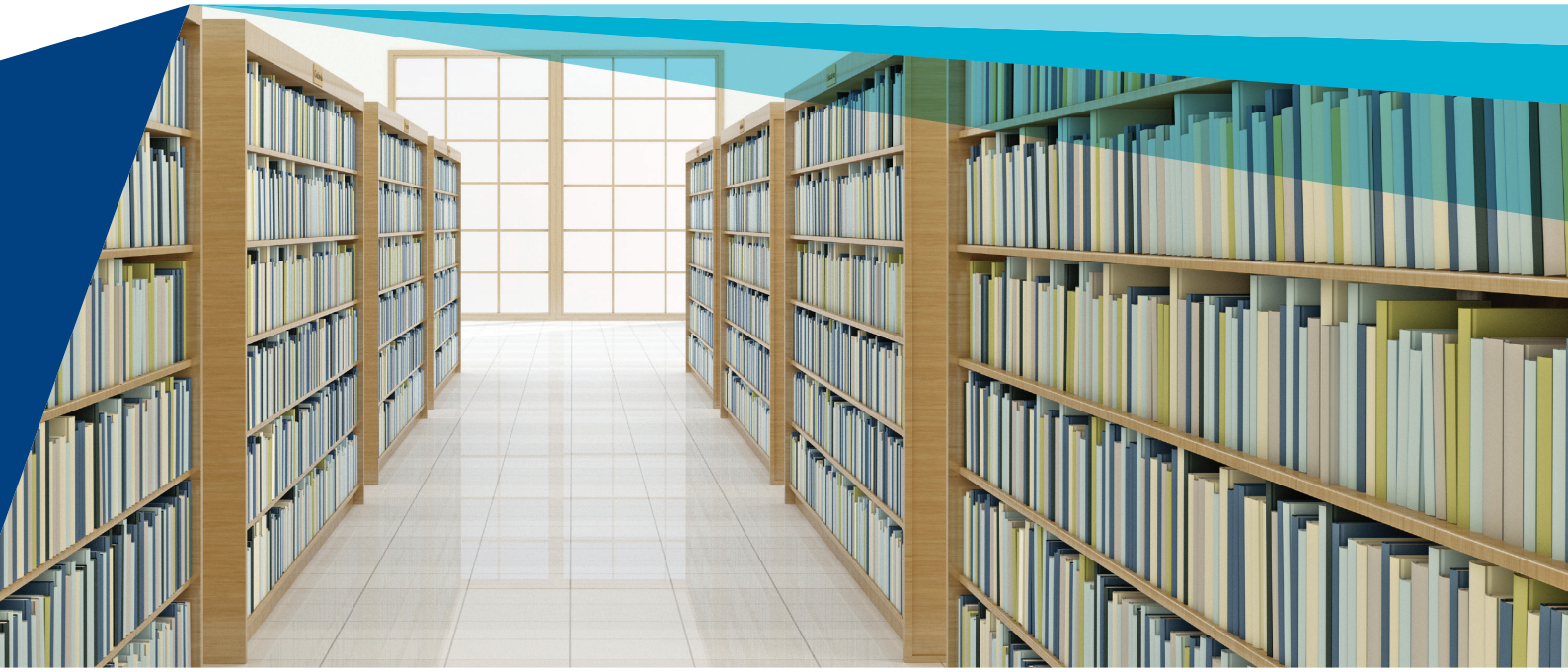
MAKING YOUR HEALTH BENEFITS DATA COUNT

USING EMPLOYEE HEALTH BENEFITS DATA TO TRANSFORM HEALTH CARE DELIVERY IN ASIA



MARSH & McLENNAN COMPANIES

SOMETHING HAS TO CHANGE — AND FAST

As a region, and in stark contrast to much of the world, Asia is enjoying a rapidly emerging economy. Yet with this change comes unprecedented challenges in health care utilization and delivery.

Medical inflation in Asia continues to outpace general inflation,[1] and while the gap between these two types of inflation is now contracting in the West, the opposite is occurring in Asia. Alarmingly, medical inflation in this region is likely under-reported, and a big reason for that is that data capture for health cost and utilization is often incomplete and not used in an optimally integrated manner across various sources.

The known health care challenges are vast:

- A relatively young, yet rapidly aging, population.
- Growing incidence of chronic disease, particularly among those in their 30s and 40s.
- A population that is living longer but with more illness.
- Providers and facilities that do not have the capacity and technology to meet the growing demand.

These issues have the potential to quickly undermine what initially made this region a burgeoning economic hub, particularly where low-margin, low-cost workforces have driven mass global investment. The value gained from lower costs of business is already eroding in part because of the emerging health and medical challenges.

WHAT THIS MEANS FOR EMPLOYERS

As medical benefits remain a large expenditure for businesses, employers need to take a hard look at what's working — and, equally, what's not working — in their health programs and develop new strategies. Employers often limit themselves to market studies and industry comparisons, but there is also a greater opportunity for reform and cost improvement by examining the untapped potential of health data and information. From a business standpoint, the current system of health care utilization and provision is not optimized in a way that ensures accountability or, more important, drives change. Employees and their dependents consume the services of health care providers, who pass their financial demands on to an intermediary (insurance company, HMO, or third-party administrator), which then in turn looks to corporate employers for reimbursement. In this cycle, employers often seem to have no choice but to pass costs to employees and cut and restrict benefits to influence consumer behavior. But in many cases, the decisions behind these actions are not being made from an informed position and do not achieve the desired impact. The use of data — and determining how to get the right data — will be key to reducing waste in the system and bringing about a fully aligned and integrated approach to delivery and health management. This paper explores five key areas with the greatest opportunities for transformation:

- Managing intermediaries to drive change.
- Planning and funding employer-sponsored health care around cost drivers and risks.
- Targeting wellness initiatives.
- Influencing employee behavior.
- Managing your supply chain.

[1] Loong LH. *Opening Address: Towards Better Health for All* (April 2013). Speech presented at the World Health Summit Regional Meeting, Asia. Available at: www.worldhealthsummit.org

MANAGING INTERMEDIARIES TO DRIVE CHANGE

Vendors, including insurers, HMOs, and third-party administrators, operate in an overly transactional manner and are rewarded on volume of claims, which is a counter incentive to the objective of employers and plan members.

If we look to the West to see why that region has done better in narrowing the inflation gap,[2] a key reason is that improvements in health outcomes are measured and managed consistently and formally through advanced data tracking and risk predictions. In Asia, the role of vendors is largely transactional in nature and, as a result, intermediaries are measured by the volume of claims, when in fact they should be measured by –the quality of how the claims are recorded, tracked, and measured and the sustainable outcomes. In Asia, the percentage of every health care dollar spent by employers and allocated by insurers for administration and expected cost-management services is less transparent than in the West, so they may be doing less for more.

The imperative moving forward must be to transform the role of intermediaries from a "middle man" paid simply by the transaction into an active participant that helps manage both patient care and delivery of services. To do this, payment-incentive models have to evolve and be aligned with employers' and members' desired outcomes. The existing "cost plus" arrangements — in which insurers get paid, essentially, by a percentage load on total spend — result in higher administration costs for employers and inflated profits for the intermediary when health care costs skyrocket. In other words, these are not the right incentives for intermediaries, who should be rewarded for more positive outcomes, such as performance metrics (reduced member utilization) and development of evidence-based approaches to care delivery.

The immediate challenge is that the data needed to support this evolution (or revolution) are rarely being captured nor measured, meaning there is no baseline from which to measure program efficacy. While international data standards may already exist, this region needs to get beyond simply measuring the number of diagnoses and start enforcing the capture of related procedure codes.

The first step in driving change is for vendors to start reframing their own network agreements with health care providers to create positive incentives or alternate payment terms for the accurate provision of desired data. We need to know not just *why* people receive care but also *what* kind of care was received and the measured *outcome.* The latter two parts of this equation are unfortunately not sufficiently captured today throughout much of the region.

Although business needs are rightfully creating demand for measurable outcomes to maximize investments in employee health, we cannot manage what we cannot measure. Expectations for providers to support a change in mindset are likely to be contingent on rewarding for the *right care at the right time in the right setting*.

EMPLOYER OPPORTUNITY

Redesign intermediary incentives to reward for quality of outcomes and management of appropriate utilization.

[2] Mercer National Survey of Employer-Sponsored Health Plans, October 2013. Available at: http://www.mercer.us/press-releases/1557830

PLANNING AND FUNDING EMPLOYER-SPONSORED HEALTH CARE AROUND COST DRIVERS AND RISKS

Measurement of the loss ratio as a performance metric shifts the focus to funding, distracting employers from fully understanding existing cost drivers, emerging risks, and the need for intervention.

In Asia, the primary measure of success or failure in insured corporate health care plans currently is the loss ratio (total claims ÷ total premium) — that is, how much of every premium dollar collected is converted into a paid claim. But dependence on the loss ratio as a measure of plan performance is a flawed approach. Claims costs simply do not provide enough detail for robust analysis, and premium amounts can be reported and distorted in many different ways. Furthermore, gauging success or failure via the loss ratio does not set an appropriate baseline for the ultimate question: "How are health care claims trending, and what is driving this trend?"

From the intermediary and employer perspectives, negotiations and planning are defensive in nature and too focused on dealing with the outcomes of the prior year. The data typically presented in the annual renewal process are simply aggregated information with insufficient detail for most people to make informed, evidence-based decisions.

To set a better go-forward benefits strategy and plan more wisely for the future, effort must be refocused to drill down into what is truly driving cost today and what is likely to emerge in the future. The employer's measurement of plan performance must look closely at claims rather than the loss ratio, with the appropriate measurement vehicles built in from the outset. Redirecting the focus to claims will enable analysis and proactive follow-up response to issues related to emerging diseases, provider behavior, treatment patterns, clinical efficacy, and referral volumes while also helping to identify opportunities to develop new offerings and, ultimately, identify inherent perverse incentives in the delivery chain.

In terms of claims, it is tough to determine the appropriate mix of inpatient and outpatient claims, but at minimum, employers and intermediaries should further assess the appropriateness *and* setting of care, including:

- Is outpatient deliverable care taking place in an inpatient setting?
- Are we seeing overt levels of diagnostics?
- How much volume is being unnecessarily driven by unnecessary repetition?
- Are expensive specialists playing the role of general practitioner?
- Are there differences in consumption between employees and dependents?
- Which parts of health care expenditure are volume-driven versus severity-driven?
- How much care is being delivered appropriately?
- Are there perverse incentives driving the wrong provider behavior?
- Do any plan design elements drive members to seek care in more expensive facilities due to a perception of better care?

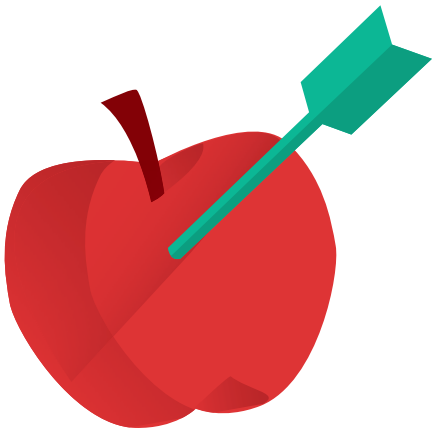
Employers must tackle these kinds of questions to investigate *what* is driving care before they can truly address *how* to manage it — if they do not do this, efficacy and sustainability will be impossible to achieve. When examined carefully and correctly, however, employers can rapidly transform their approach from one that is reactive to one that is conscientious and proactive.

In addition, the contractual terms of other income sources for the intermediary should be transparently informed. Only then can an employer truly understand the actual cost of appropriate health care funding and cost.

EMPLOYER OPPORTUNITY

Conduct a robust diagnostic to identify today's cost drivers and emerging issues to better support future health strategies and future claims cost expectations. Funding of those claims and supporting elements, such as claims administration and network management, should be treated as contractual and with complete transparency.

"Conduct a robust diagnostic to identify today's cost drivers and emerging issues to better support future health strategies and future claims cost expectations."



TARGETING WELLNESS INITIATIVES

Employer efforts today are often focused on maintaining a healthy employee population and stabilizing those with minor, easily treatable conditions. However, claims costs are often driven by a small group of employees with acute and chronic conditions. Careful case management can yield significant health benefits cost savings while ensuring the best level of patient care.

Most employers today have some level of investment or, at the very least, express an interest in wellness programs. While this is a great initiative, employers must have appropriate expectations for outcomes. They also need to stay mindful of the fact that the majority of health care cost emanates from the dependent pool — a group to whom employer wellness programs do not typically penetrate.

The goal of a typical wellness program is to keep the healthy population healthy while additionally managing at-risk groups. The heaviest focus usually is on targeting the populations for whom health care claims and costs have not yet started to manifest, and employers do this by placing a lot of emphasis on lifestyle programs, health risk assessments, seminars, and education tools. As such, expectations have been focused on future *cost avoidance* and not necessarily *costs savings*.

Currently, 83% of employers with wellness programs in Asia are offering annual health check-ups to their employees,[3] but participation is often low and employers are not maximizing the use of these check-ups by driving action based on the findings. Another flaw is that these programs help identify health risks only in employees, not dependents — many of whom typically drive more aggregate cost than the employees. Furthermore, employers tend to rely on employee self-reporting on health risks (such as alcohol consumption) and base their decisions on these kinds of data, even though experience shows that employees tend to under-report any health risks or illness and over-report their positive behaviors (such as exercise routines).

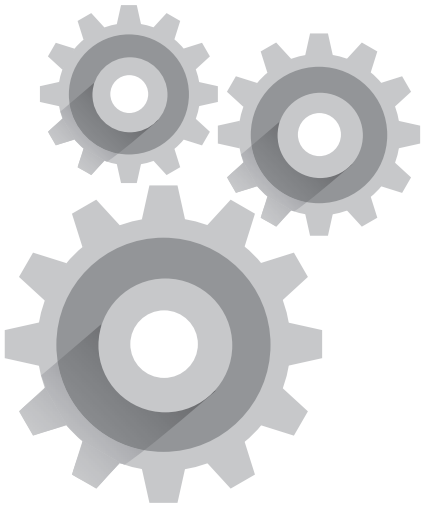
Employers can bolster their current wellness efforts with some additional actions. An important step is to include approaches that more effectively manage costs within acute and chronically ill populations, as failure to do so increases health care expenditures and absenteeism rates while decreasing productivity. In spite of this, only 10% of employers are offering any form of chronic disease management — and among the employers who are doing this, their programs are typically not targeted and are voluntary in nature.[4]

Care management for these populations is a key opportunity for all employers, but this is another key area where data matter. Deep-dive claims analytics are necessary for employers to build much more robust case, care, and cost-management strategies. This kind of analysis can offer much higher levels of potential efficacy than the strategies in use today.

EMPLOYER OPPORTUNITY

A deep-dive claims diagnostic can quickly uncover opportunities to help build a broader health (think beyond just wellness) strategy that may provide better outcomes for plan members with lower associated health risks, at a lower employer cost. Baselines can be identified, and return on investment can be readily calculated through ongoing measurement of actual outcomes over a much shorter time horizon.

[3] Mercer Marsh Benefits Asia Total Health and Choice in Benefits 2013 Survey.
[4] Ibid.



CREATING CHANGE BY INFLUENCING EMPLOYEE BEHAVIOR

Employers are looking to plan members to be better "consumers" of health care through elements such as copays. In reality, these behaviors tend to provide simple cost-shifting outcomes to employees with little reduction in overall consumption patterns. Employee-focused strategies are readily eroded by very strong provider behaviors that are utilization, instead of outcome, focused.

Employers today are increasing their efforts to modify the behavior of employees and their dependents through financial incentives (or penalties) and education on the benefits of "consumerism." While this approach does have a role to play, it is more likely to operate as a pure cost-shifting mechanism rather than as a real shift in the overall consumption patterns of health care services. This should continue, but employers must be realistic about the limits on the outcomes this can achieve, as education is likely to produce only short-term gains.

One problem that continues to impact educational efforts and compound the problem is the supply chain's major focus on profit motivation. This often readily negates the positive efforts of the other three constituents in the health care consumption cycle — intermediaries, employers, and employees/dependents — as efforts toward behavioral change are (perhaps unintentionally) circumvented by the supply chain. Maternity care in much of the region is one example of this: Rates of caesarean sections among working women are, in some instances, five times those recommended by the World Health Organization.[5] To a large extent, this trend has roots tied to some perverse incentives in care algorithms, encouraging the wrong provider behaviors.

It is also symptomatic of some of the cultural issues faced in Asia, where questioning of doctors is frowned upon yet data suggest that this line of thinking is outdated. There needs to be a greater level of accountability by those having the largest impact on outcomes.

EMPLOYER OPPORTUNITY

Better plan member education is needed around appropriateness and delivery of care, as opposed to a cost-shifting approach. Opportunities to improve outcomes while addressing plan utilization and employer cost concerns may be achievable though a more patient centric model with a care advocate (for example, a primary care physician) rewarded on managing individuals' utilization to counter the existing provider mindset around "volume."

[5] World Health Organization, *Background Paper, 29, Determinants of Caesarean Section Rates in Developed Countries: Supply, Demand and Opportunities for Control* (2010).

MANAGING YOUR SUPPLY CHAIN — FROM VOLUME TO VALUE

The "supply chain" of doctors, diagnostics, and facilities is often rewarded positively for greater volumes of overall consumption of services. However, a focus on profit over care is manifesting in higher rates of confinement, high levels of diagnostics, high volumes of repeat visits with specialists, and waste through a lack of care coordination.

The next major frontier for tackling the cost and quality of health care delivery in Asia is in ensuring effective supply chain management. Arguably the single biggest opportunity going forward, the supply chain has until now had the least amount of attention. In its current state, the supply chain is showing a tendency to focus on profit over care, which leads to higher rates of confinement in inpatient settings, increased use of diagnostics, high volumes of repeat visits to specialists, and waste due to a lack of care coordination.

Providers — from general practitioners to specialists, all the way through to hospitals — need to be held accountable for their actions. The system needs a greater focus on evidence-based delivery that places facts and data at the core of decision-making processes. In many markets, too little specific information is provided to truly justify the reimbursed levels of consumption, yet the practice continues.

Where data are robust and available, the troubling issues are emerging. In particular, volumes of care in outpatient settings are rising rapidly — and not for positive reasons. Also concerning is that inpatient care is becoming more expensive as the duration of care treatments gets longer, rather than efficiency and care delivery improvements driving care duration down.

Providers need to be required to go beyond documenting why they are seeing patients and provide more justification for what they have done to address the issues, rather than focus only on cost outcomes. While the quality of data on diagnoses has improved, too little information is given on the procedural and justification sides of the equation. Intermediaries, and the corporate employers who rely on them, can play a key role in forcing an uptick in the quality and volume of data being passed through.

EMPLOYER OPPORTUNITY

Greater accountability, from all parts of the supply chain, will shift attention back on patient-centered care. Existing perverse incentives that drive care today, through a volume approach, need to be identified through diagnostics and addressed, or ideally removed, to move rewards for supply chain back to focus of "right care at the right time in the right setting."

MAKING YOUR HEALTH BENEFITS DATA COUNT

High-quality, readily accessible data have, to date, been widely underutilized in Asia but are vital to changing the outcomes of care delivery and — more important — improving the financial and care-quality outcomes.

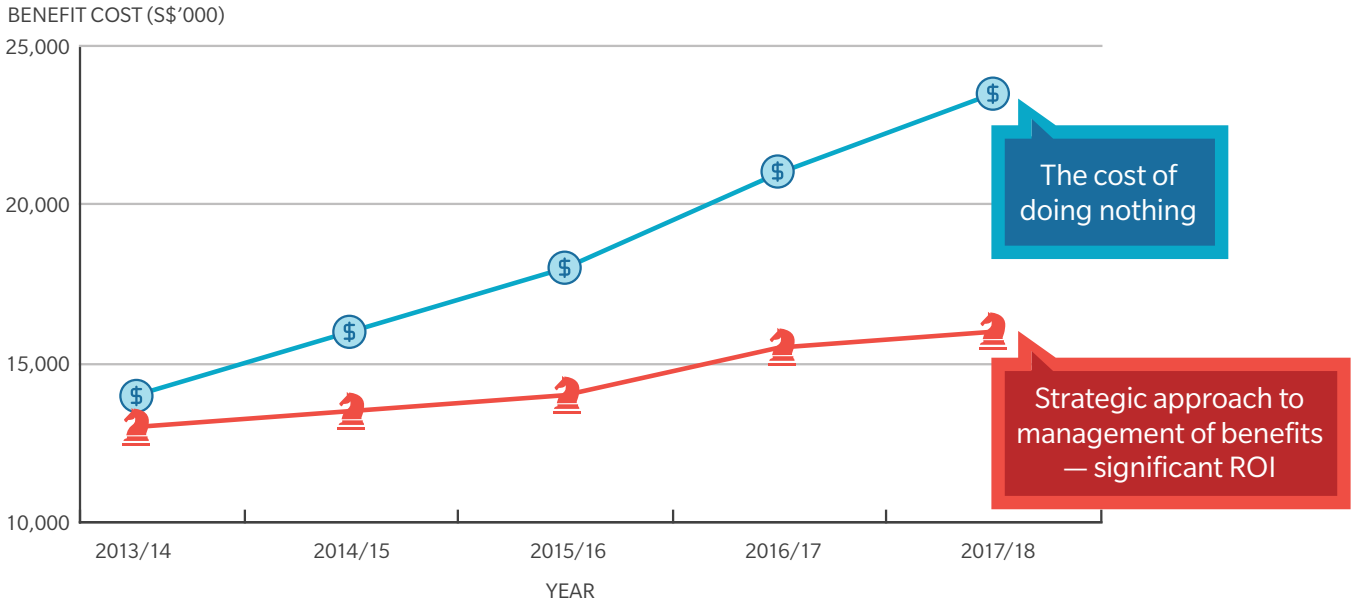
Employers in the region have an opportunity to transform health benefits delivery, by shifting their focus from simply managing costs to truly understanding what can be done to change the outcome itself and reduce future expenses. That will involve not only managing the risks and health of today's population but also carefully planning for emerging challenges. Risks are cropping up in Asia at an unprecedented pace and employers' reactions and thinking needs to match in both speed and ingenuity.

Health benefits solutions that are developed both individually and in aggregate are becoming more reliant on data diagnostics as the opportunity to influence intermediaries, better guide employer planning and funding decisions, enhance wellness initiatives, drive employee behavior, and manage the supply chain becomes real.

Health benefits data, when utilized, provide HR with the ability to drive greater levels of provider accountability and transparency around the real health benefits costs and employee risks. Using data, when managed appropriately, leads to better health outcomes for employees and better business health for organizations, too.

A well designed employer strategy has the potential for real and immediate positive outcomes. While we see an increased focus in the region on demonstration of ROI, we also need to think carefully about how we measure cost and associated returns. The reality is that doing nothing today will have serious and somewhat unknown consequences and, therefore, it is no longer a viable option. Strategies need to be developed from an informed position, baselines need to be measured, outcomes need to be monitored, and employers need to be willing to adapt to changes, which will be ongoing. It's not a passive situation; it needs to be an actively managed one.

COST PROJECTIONS FOR MANAGEMENT OF BENEFITS



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ABOUT MERCER MARSH BENEFITS

Mercer Marsh Benefits provides clients with a single source for managing the costs, people risks, and complexities of employee benefits. The network is a combination of Mercer and Marsh local offices around the world, plus country correspondents who have been selected based on specific criteria. Our benefits experts, located in 135 countries and servicing clients in more than 150 countries, are deeply knowledgeable about their local markets. Through our locally established businesses, we have a unique common platform that allows us to serve clients with global consistency and locally unique solutions.

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