



The  
Gantry  
Group

The Gantry Group, LLC  
150 Baker Avenue, Suite 301  
Concord MA 01742

Tel: 978 371 7557  
Fax: 978 287 0043  
www.gantrygroup.com

## ***Gantry Insights: How Payers Are Bending the Trend***

In past years, Payers invested broadly in a range of diverse initiatives that promised cost control and reduction, including business process automation, disease management, health coaching, member education, nurse advice lines and many other programs. However, lackluster and/or ambiguous returns from some of these programs caused Payers to scale back the breadth of their investment allocations. (See [The Changing Care Management Landscape](#).) Payer research conducted by Gantry Group in July 2011 found that Payers are achieving cost control objectives by targeting resources on successful deployment of a few initiatives that concentrate on the biggest drivers of healthcare cost:

- Controlling hospital admissions
- Averting hospital readmissions
- Averting ER visits
- Averting high-cost diagnostics/procedures
- Architecting new provider fee-for-service reimbursement models
- Swapping high cost brand drugs for lower cost generics

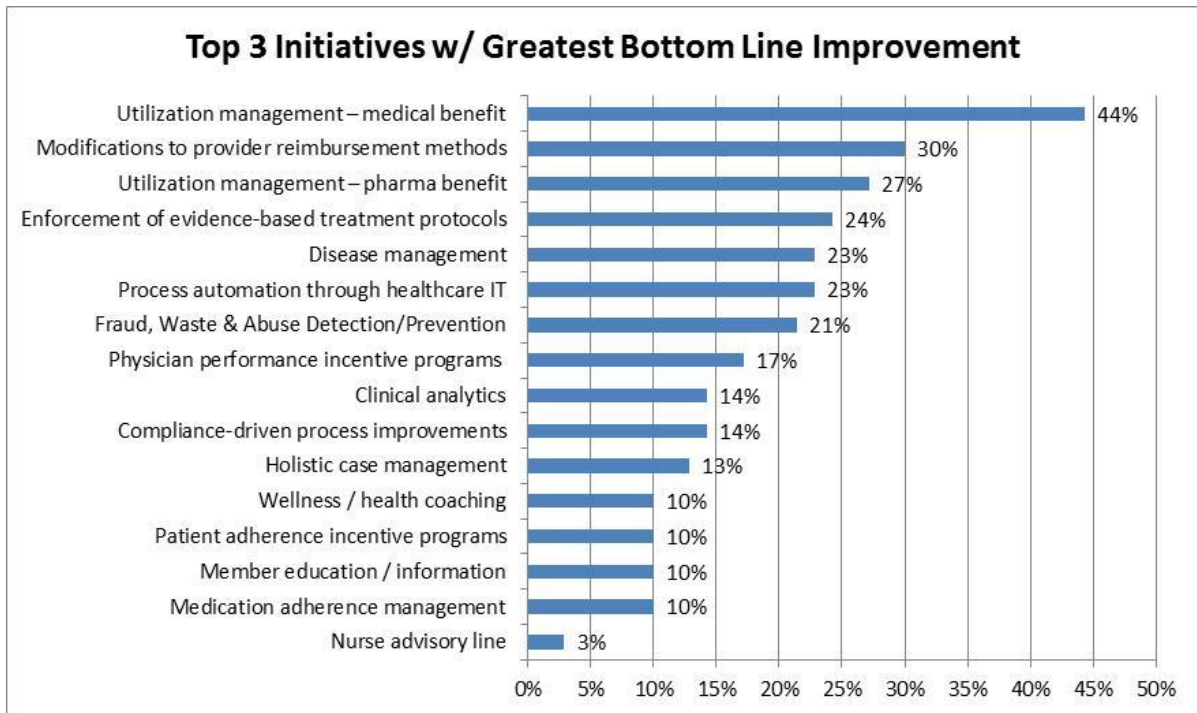
Although mandated to invest in numerous IT initiatives to comply with Healthcare Reform, U.S. Payers are using this targeted approach to effectively “bend the trend” of healthcare costs

### **How Do Payer Initiatives Stack Up?**

Disappointed by poor financial return from a plethora of cost-cutting and outcomes initiatives, many Payers retrenched their non-mandatory program investments in 2011. Gantry research has identified a growing trend among all Payers types (e.g. health plans, IDNs, ASOs) toward program “simplification”: re-focusing mitigation resources on the components of the healthcare delivery chain that wield greatest impact on cost. Findings from Gantry’s Payer research in July 2011 suggest that this approach is paying off.

According to Gantry’s study, the top 3 initiatives that Payers believe to have greatest impact on the bottom line directly address the top 3 cost drivers of healthcare:

1. **Medical Utilization Management** - to provide authorization review and oversight on admissions, as well as costly procedures and diagnostics. *(44% of study participants)*
2. **Modification of Provider Reimbursement Methods** - to replace traditional unconditional fee-for-service with methods that compensate for delivered value, performance, and quality of care. *(30% of study participants)*
3. **Pharma Utilization Management** - to provide oversight on medication costs by replacing brand pharmaceuticals with equally effective, but lower cost generics. *(27% of study participants)*



Source: Gantry Group, LLC 2011

Notable, are the initiatives that are not considered by Payers to have strong bottom line impact, such as nurse advisory lines, wellness / health coaching, patient adherence incentive programs, medication adherence management, and member education. In most cases, these programs *are not* viewed by Payers as being ineffective paths to cost reduction; rather many of these programs are simply in the early stages of deployment, in part due to the lack of availability of the technology solutions required to administer them on a larger scale. This is particularly true for “gap-in-care” programs such as medication adherence management and patient adherence incentive programs, which are designed to keep patients on their treatment regimens to avoid costly acute care events. Such programs are just emerging and are still hampered by manual, administration. Gaps-in-care management programs show future promise as a method to mitigate risk and cost, particularly when patients’ providers can be alerted in real-time through their EMR systems.

In addition to the newness of programs and the availability of technology solutions to administer them, Payers have also traditionally been challenged to create performance measurement methodologies that credibly quantify program benefits. Some programs, like member education and communication, are difficult to connect to bottom line savings. Other programs, like wellness coaching and member adherence incentives, operate on a longer payback timeframe and will take several years to produce definitive results.

### How Does Medical Utilization Management Pay Off?

Overutilization of high cost medical services is a lynchpin to the control of healthcare cost. With no incentive to do otherwise, providers generally opt first to recommend costly surgery, CT Scans, and hospital admission rather than giving full consideration to lower cost alternative care protocols. Informed by evidence-based care guidelines on best care practices, Payers can recommend alternative care protocols that promise equal or better outcomes at a lower cost. Through authorization review, Payers intervene to assess the appropriateness of hospital admissions, procedure, and high-cost diagnostics. By comparing a patient’s case to applicable evidence-based,

care protocols, Payers are enabled recommend alternative care orders to physicians without incurring additional risk (e.g., x-rays over CT Scans, physical therapy over surgery).

Another way to curb hospital and ER admissions is to enroll members in wellness and disease management programs that are designed to encourage healthy behavior and manage chronic disease, respectively, so that the incidence of costly catastrophic events is mitigated. Ideally, programs aimed at changing the behavior of both provider and patient will synergistically result in lower healthcare costs.

## **Reining in the Spiraling Cost of Prescription Medication**

Many Payers are concentrating care management efforts on Pharma Utilization Management and medication adherence, using a variety of approaches. Pharma Utilization Management refers to a set of restrictions and tools intended to control prescription protocols:

- Establishment of tiered “formularies” that list those drugs a Payer will agree to cover. Co-pay varies based on what tier a drug falls under. Generics are typically in the lowest tier with lowest or no co-pay.
- Enforcement of limits on quantity, dosage, and re-fills paid for by the Payer. These restrictions vary with formulary tier and limit the total amount a Payer will spend on a particular drug.
- Provider “prior authorization” requirements before a Payer will cover a drug. This restriction requires a provider to gain special approval for prescription of certain drugs, typically involving paperwork and delays of several days. This restriction is meant to be a deterrent to providers from prescribing selected drugs.
- Step-therapy requirements are a protocol set by the Payer to encourage use of generics. With step-therapy patients must begin treatment with cheaper “preferred” drugs to prove that the more expensive, higher tier drugs are medically necessary.

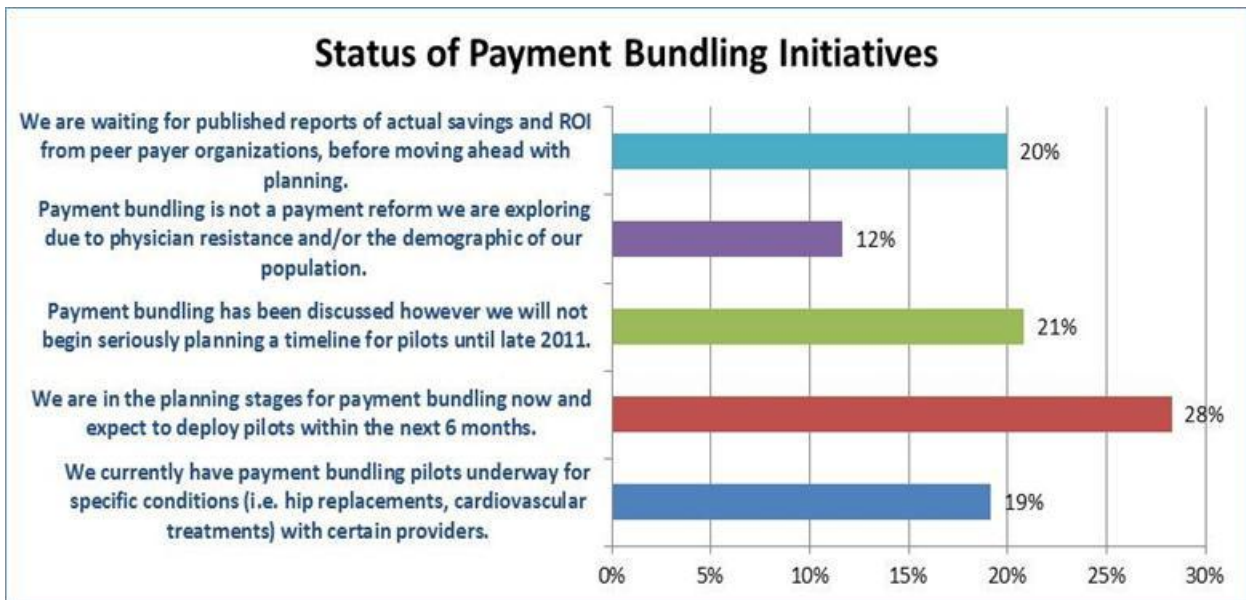
The purpose of formularies and Utilization Management restrictions is to manage the choices and behavior of providers and members, ultimately steering them to lower cost treatments that have been clinically proven to have equal or better effectiveness. Drugs can be moved on or off the formulary at various times, shifted between tiers, or be subject to changes in Utilization Management restrictions as deemed by the payer.

In addition to Utilization Management Payers also use incentive programs for providers and members. Providers received financial incentives for prescribing generic drugs. Patients are financially rewarded for using generic drugs through the reduction or removal of co-pays, which is dually intended to encourage medication adherence by making drugs more affordable. By helping members comply with their medication regimens, Payers can avoid acute care episode costs, while offsetting the increased pharma costs through increased use of generic drugs. In a study conducted with Gantry’s in-house Payer research panel early 2011, almost 50% of Payers identified the reduction of member co-pays or premiums based on adherence to generic medication regimens (an essential component of value based insurance design, or “VBID”), as a highly effective method for lowering their pharma spend.

## Searching For Alternatives to a Broken Provider Reimbursement System

Payers unanimously agree that the currently dominant provider payment model, “fee-for-service” is broken and is a major catalyst and enabler to soaring healthcare costs. Payers are experimenting with several new provider reimbursement methods to assess which ones will yield better align Provider and Payer business objectives, and be easy to administrate without creating provider loopholes. The following alternatives payment schemas are all based on the concept of shared risk between Payers and Providers including:

- Bundled or global payments that pay providers on a single “fixed price” basis for all services provided for specific care episodes (i.e. hip replacements, angioplasties) which include any treatments for post-episodic complications within a specified time period.
- Value-Based Reimbursement (VBR) that pays a portion of provider bills according to provider achievement of specified outcomes and quality metrics.
- Capitated payments that pay providers a contracted annual rate per patient within a defined population, regardless of the number of services provided throughout the year.



Source: Gantry Group, LLC 2011

A Gantry study conducted with Gantry’s Payer research panel in May 2011 revealed that 47% of Payers are already deploying or planning to deploy payment bundling initiatives; another 21% are planning to begin payment bundling pilots at the end of this year. The fact that Payers are already realizing a positive financial impact from trying out alternative reimbursement models is promising and underscores the failure of the fee-for-services model.

## **Summing it all up**

After years of funding myriad cost reduction initiatives, Payers have set their sights on those programs that attack the bulk of the underlying cause for stratospheric healthcare costs. The tightening effect of Healthcare Reform on Payers' already shrinking margins has fueled health plans to invest in initiatives that address over-utilization of costly protocols and admissions, over-utilization of branded drugs, and provider reimbursement schemes that place the payment burden squarely on Payers. As the realization of the savings potential of alternative provider reimbursement models and utilization management programs gains momentum in the Payer sector, the demand for technology that automates and enables large scale administration of these initiatives represents a significant and growing opportunity for vendors with solutions that facilitate their implementation.

*Gantry Group is a global strategic marketing and research company that specializes solely in the healthcare market. With exclusive focus on the healthcare industry, Healthcare IT vendors engage Gantry to further inform strategic decisions with market intelligence. For over 12 years, Gantry's reputation for executing primary research that exposed industry trends and business opportunities is further distinguished by our ability to dissect, expose, and transform underlying market drivers into effective and often pivotal business guidance. HIT vendors' repeated reliance on Gantry's comprehensive research panels for payers, providers, physicians, TPAs, PBMs, ASOs, members and consumers is further testimony to Gantry's delivered value.*