Thought Leadership Unit

2018 Case Study

Bending the curve
Part 2: Making networks work

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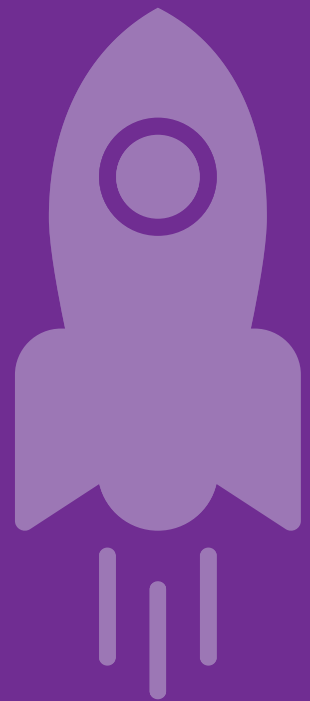
The key to making a quality international network work for customers is global expertise and deep local knowledge.



Skyrocketing health care costs, which are borne by individuals, employers and governments alike, make it increasingly difficult for people to access quality, timely care, resulting in poorer health outcomes.

How fast are costs rising?

According to a survey by consultancy Aon, the cost of medical care worldwide is expected to **increase 8.4 percent in 2018, more than double the general inflation rate of 3.1 percent**.

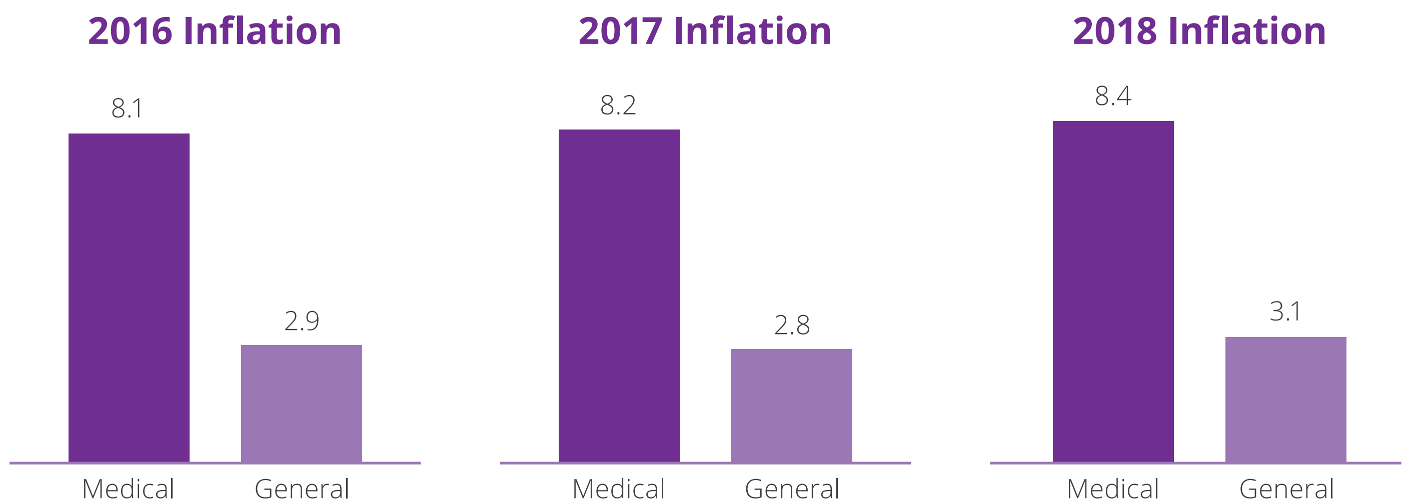
Moreover, according to a survey by consultancy Willis Towers Watson, nearly six in 10 insurers expect the cost of care to keep rising in the coming years, while just 4 percent expect costs to drop. [1,2]

Addressing the cost of high medical inflation

To address the rising costs in health care and ensure individuals experience healthier, longer lives, many health care players are implementing value-based prevention and intervention strategies with a focus on the best health outcomes.

At the same time, employers are implementing high deductible plans and annual benefit limits to share costs with employees. They are increasingly looking to partner with health and wellness providers that reward value-based care models. In this way, employers are able to manage the risk and cost of the health care demands of their employees and can help educate their employees by building a link between health and wealth. The option of a high-deductible plan can have a positive impact on most consumers' health care premiums.

Consumers do not have a clear idea of future health care costs. They are trying to make healthy lifestyle decisions and are naturally keen to divert their income into their pockets instead of their health care premiums. They are responding to the availability of personalised health pathways that will keep them fit and well for longer, while ensuring the best health outcomes if they do fall ill. This approach can help members manage unforeseen medical expenses and ease the burden of medical and non-medical financial responsibilities.



Sources: Aon 2017 Global Medical Trend Rates, Aon 2018 Global Medical Trend Rates

1 http://www.aon.com/attachments/human-capital-consulting/2017_GB_Trends_brochure_20170105.pdf
2 https://www.willistowerswatson.com/-/media/WTW/PDF/Insights/2017/12/2018-global-medical-trends-pulse-survey-report-wtw.pdf

Factors that drive increased utilisation

Volume-based provider remuneration (fee for service), which rewards providers for ordering more tests and treatments instead of achieving better outcomes

Physician and hospital practises versus individual's health care needs

Increasing risk for disease in an ageing population

Consumers' increasing demands for more health care

Consumer-driven demand (direct-to-consumer advertising)

Supply-driven demand (provider-targeted advertising)

Innovation (new drugs and technologies)

Focussing on health outcomes

Restructuring health care models

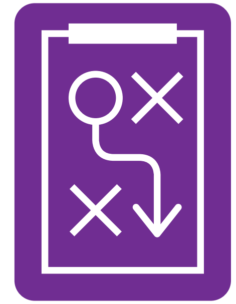
A paradigm shift is underway. As the National Center for Biotechnology Information (NCBI) explains, this means shifting, "from a disease model of treating episodic illness, without attention to quality outcomes, to a focus on health and systems that reward providers for quality outcomes and intervening to prevent illness and disease progression — in keeping populations well." [3]

Implementing strategic solutions

A number of strategies can play a key role in reining in the rising cost of health care. Among them: 1) proactively helping individuals take an active role in their own care and 2) understanding when, where and why individuals are receiving care. Proactive employers can work with their international private medical insurance (iPMI) providers — as well as health and wellness partners like Aetna International — to ensure that workers are getting the right care in the right setting at the right price.

3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5266427/

How employers can lower health care risks and costs



1.

Encouraging behavioural change

Proactive employers can work with their iPMI providers to predict, prevent and intervene in their employees' medical issues, leading to better health outcomes for individuals and more cost-effective results for employers.

- Review and lower utilisation rates including medical management negotiations
- Implement health & wellness services and encourage participation by employees, including on-site health fairs and utilisation of virtual health
- Manage high-dollar claims
- Respond to critical conditions through data and risk analysis
- Predict costs

2.

Analysing data

When it comes to lowering utilisation rates, employers can benefit from working with iPMI providers with a robust network strategy that:

- Reviews where employees/individuals are receiving care (in or out of network)
- Monitors the performance of the network to ensure it only comprises an array of quality, cost-effective health care providers (doctors, specialists, hospitals)
- Analyses claim trends that are condition specific (e.g., increases in musculoskeletal that may indicate a health safety issue)

Health systems and companies like Aetna International are addressing these factors by:

- Shifting from sick care to health care models — emphasising prevention over cure
- Regarding members and patients as health care 'consumers' and investing the time in educating members to make smarter health choices, be it providers with better health outcomes, obtaining preventative care and ensuring that patients stick with their health care goals and treatment protocols
- Developing interoperable digital platforms and health and wellness solutions powered by big data

Making networks work

Of critical importance to any health plan is a robust provider network that comprises an array of quality, cost-effective health care providers, including primary care doctors, specialists and hospitals. Network providers are selected based on:

- Their ability to provide quality care
- Their willingness to see members of the health plan
- Their agreement to charge contracted rates

Network management exists to ensure access to care at a competitive price. Network managers combine a global perspective with a deep knowledge of local health care practises and the local regulatory environment.

Network management is an ongoing process. By analysing utilisation rates and addressing unit cost issues, managers can bend the trend curve.

Network benefits

When networks function well, everyone benefits:

Individuals
can be confident that providers have been screened and credentialed for quality and competence.

Employers
have tools for managing risk, lowering costs and ensuring a happy, productive workforce.

Providers
receive education and strategic support.

Insurers
keep costs predictable and under control, allowing them to offer lower premiums to customers.

Aetna International customers also receive:

- Letters of authorisation/guarantee of payments prior to a hospital admission and/or procedure
- An easy claim submission process via email or online through the secured provider portal
- Prompt, direct payment in multiple currencies

At Aetna International, we have embarked on a medical cost management initiative that not only addresses fast-growing health care burdens but also focuses on access and quality. This move places us at the forefront of health management ecosystem development work with a suite of personalised services and products that benefit brokers, clients and individual customers.

We have always believed medical cost management is a discipline, not just an activity; it's a holistic approach to looking at costs before, during and after a health episode, as opposed to simply reactively managing customers' care or conditions or establishing strong fraud, waste and abuse practices. The management of our health care provider network underpins many of our cost management strategies.

About our provider network

Aetna Connections

- Aetna Connections comprises more than 1 million providers supporting 800,000 members
- Spans more than 190 countries
- Brings together more than 160 years' experience to deliver:

Global cohesion:
global oversight and management

Global control:
governance of provider certification, cost containment and discounts

Local expertise:
co-located network and clinical teams

Aetna International's core strengths come to the fore in the management of our global network:

Global best practices

which enhance our regional networks

Local insights

which raise the global standard

Relationship management excellence

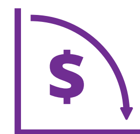
which results in a broad network that offers more in-network care with direct settlement

Rigorous governance and certification

which ensures clinical expertise with local knowledge for highly-relevant regional care

Strategic flexibility

which helps us meet individual customer needs



Cost savings

which benefit our customers as well as the business

> **Our network** provides an integrated global-local solution that is second to none. Aetna Connections provides our customers with access to a quality network of care providers and unparalleled support in more than 190 countries. In this way, we empower our members to achieve their health goals and build their healthiest lives, wherever they are in the world.
>
> — **Patrick Blackburn**,
> Head of Americas' Network Management, Aetna International

How Aetna Connections benefits members:

Quality care

Access to quality care network in more than 190 countries

Skilfully negotiated rates

Network discounts that help reduce medical costs

Financial stability

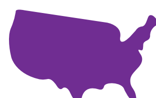
Reduced out-of-pocket expenses

Convenience

Direct provider claims settlement in 75 percent of cases (99% in the U.S., and 70% outside the U.S.)

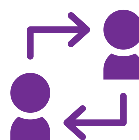
Worldwide support

Anytime, anywhere care



Global-meets-local expertise

Clinical knowledge and local network expertise combine to meet distinct regional requirements delivering a better customer experience



On-the-ground teams

Regional teams understand the local health care delivery systems, provider behaviours, custom influences, cost structures and unique market requirements

Regional know-how

Improved claims experience for members and improved claims settlement for providers

A network management case study

A real-world example demonstrates the value of rigorous network management.

The country involved and certain other details have been made masked, but otherwise the case study is accurate.

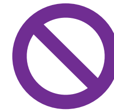
Quarterly, Aetna International analyses regional medical trends to see what's happening with providers, customers, and members. As an example, we look at provider procedures and correlated drug spend and then compare that to regional and global historical benchmarks and best practices. These types of analyses help us identify issues we can then proactively work through with provider and clients. In one recent case, a poignant problem was identified.

2-3x more tests given

Members were being given tests and procedures 2–3x what would be considered normal (increasing costs 2–3x for certain procedures).

Claims upcoded

Members claims were being upcoded to the maximum possible reimbursement levels (making them 1.25x more expensive).



Incorrect classifications

Member claims were being submitted with incorrect classification for where the procedures took place (making them 1.5x more expensive)

Total costs 1.6x more

Total impact of all of these were costs for standard pre, during and post procedure treatments were 1.6x expected. A typical case cost $6,000 USD, but in this case it was costing $9,600.

What we found

In reviewing country by country claims data, one specific country stood out. When we drilled down to see what was going on, we identified three major issues:

- Utilisation of a particular procedure was considerably higher than expected or necessary under any best practice guidelines. No matter the patient's age, no matter the situation, the procedure was happening incredibly frequently.
- Costs for the condition leading to the procedure were higher than expected and billing had been inconsistent.
- Hospital charges unrelated to the procedure in question were higher than expected per admission.

What we did

Once that provider was identified, our network management, account management, operations and international special investigations units swung into action. Among the steps they took were:

- Our network management unit met with the provider to share best practices and explain to them what we were seeing.
- Our account management unit re-educated and communicated with customers seeing this provider as to the benefits that their plans covered (and those that were not covered).
- Our operations and investigations units created system flags to ensure that inappropriate claims would not be paid.
- Our operations and investigations units modified claim procedures and began special reviews of all claims submitted henceforth.

Case study results

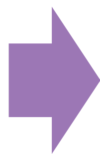
In addition to ensuring that members weren't getting and paying for an unnecessary procedure, we were able to significantly reduce medical expenditure for groups in this country and as a result of that, future premiums for these groups. In fact, year-over-year premium reductions amounted to $1m U.S.

Client support

Putting our differentiated network offering into action

Our dedicated network specialists offer end-to-end support to help our clients and their employees access quality health resources and personalised support around the world.

Our client has **43,545 employees** in locations around the world.



Last year, **88% of their employee claims** were paid directly via health care provider (compared with 24% in 2016). This keeps employee out-of-pocket expenses to a minimum.

These employees have access to **165,000** providers outside the U.S. including **116,000** we added in 2017 alone.

In 2017, we helped our client save over **$1.2m** in claims costs for their young employees, and over **$1.4m** for their older employee base.

We have since analysed our client's $9m 2017 spend on in-patient and out-patient claims. Through risk analysis, we have been able to tailor wellness services to meet their needs, such as wellness webinars and one-nurse-one-employee outreach to at-risk customers. We have also been able to drive utilisation of health and wellness benefits helping to deliver the promise of healthy … anytime, anywhere. This helps to keep employee productivity up and our clients' expenses down.

Key network competencies of health and wellness partners

- Review and lower utilisation rates through provider network negotiations: Reviewing where employees/individuals are receiving care (in or out of network), and what type of care and why. In depth network analysis should include, but is not limited to:
  - Analysis: average discounts
  - How many members use in-network discounts
  - Utilisation analytics
  - Out of network cost management programs that reviews claim sizes and diagnoses, for example
  - Identifying claims early on to coordinate with the carrier on the best outcome
- Ensure the network comprises an array of quality, cost-effective health care providers (doctors, specialists, hospitals)
- Implement wellness services
- Manage high-dollar claims
- Respond to critical conditions through data and risk analysis
- Predict costs
- Credentialing of hospital and provider facilities

Questions to ask a prospective health insurer

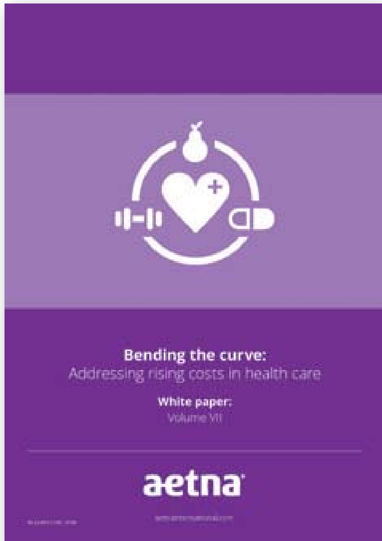
For employers

- **How robust** is your network?
- Can you create an **individualised cost containment** strategy?
- What are your **data analytics capabilities**?
- What steps can you take to **mitigate risk and costs**?

For individuals

- **How extensive** is your network?
- Are my **preferred providers** in the network?
- What will my out-of-pocket costs be?
- How many health care providers in your network can **settle my bills directly** with you?
- What support do you provide **when I am overseas**?
- What happens if I want to **keep my current doctor**?

Further reading



Bending the curve: Addressing rising costs in health care

In this white paper, we outline the main influencers of medical inflation — utilisation and unit cost — and share some of Aetna International's medical cost containment (MCC) strategies, which temper the impact of fast-growing health care burdens.

Bending the curve: Part 1: Tackling fraud, waste and abuse

Billions of dollars in health care spending are lost each year to fraud, waste and abuse (FWA). FWA affects everyone. Global medical inflation rates in 2017 were nearly three times general inflation rates, and FWA is a cause of premium hikes and reduced benefits.

Aetna International is working to build a culture of health and well-being within our communities to transform the member experience and address many of the acute challenges facing health care today. Our zero-tolerance approach to FWA underpins this mission.

At Aetna International, we provide access to quality health care — locally and virtually — focusing on health outcomes while containing costs and keeping premiums in check. Our network management strategies help us to deliver on the promise of healthy ... anytime, anywhere.

Appendix

Cost containment

Effective cost containment is holistic, not reactive.
Here's Aetna International's three-pronged approach:

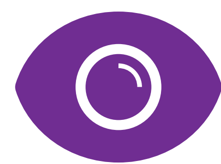
Pre-episode

- We leverage our worldwide networks to understand the variance in cost and quality around the globe.
- We provide new tools like vHealth by Aetna to connect patients and providers.
- We reach out to at-risk members through our In Touch Care program.
- We offer condition-management and support programs.
- We ensure members are getting the appropriate screenings.

During episode

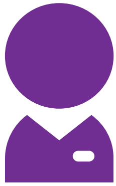
- We use precertification to ensure that easy-to-prescribe procedures are not overprescribed.
- We publish Clinical Policy Bulletins that provide guidance on the medical necessity of medical technologies, experimental treatments and other services.
- We use concurrent review and discharge planning to ensure members are getting the right service in the right setting.
- We coordinate services when members are seeing multiple providers for multiple conditions.

Post-episode



- We ensure claim validity through reactive and proactive fraud, waste and abuse processes.
- We ensure that charges are correct and are reasonable and customary for the setting.
- We ensure that claims are paid by the right carrier, a process known as subrogation.

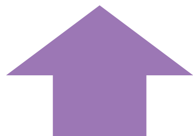
Rising costs have significant impacts for several key stakeholders



Brokers

Deductibles are rising faster than premiums

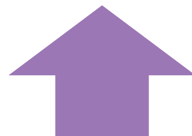
63%
rise from
2010 – 2016



Plan Sponsors

Premiums are rising faster than earnings

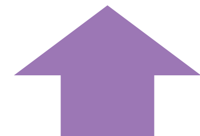
19%
rise from
2011 – 2016



Members

Earnings aren't keeping up

11%
rise from
2011 – 2016



Top 3 employer goals: 2018

Short term (next 12 – 18 months)	Long term (next 5 years)
1 Managing overall cost of health care benefits	**1** Managing overall cost of health care benefits
2 Maintaining current level of benefits offered	**2** Maintaining current level of benefits offered
3 Maintaining productivity of all employees	**3** Attracting high-quality new talent

Source: Wells Fargo survey

Cost drivers: 2018

	Americas	Europe	Asia-Pacific	Middle East and Africa
Top cost drivers	• Hospital costs • Physician services • Prescription drugs	• Hospital costs. • Physician services • Clinics/labs	• Hospital costs • Clinics/labs • Preventative care	• Hospital costs • Prescription drugs • Physician services
Top health conditions (minus maternity)	• Cardiovascular disease • Cancer • Musculoskeletal/ back conditions	• Cancer • Cardiovascular disease • Musculoskeletal/ back conditions • Mental health issues	• Cancer • Cardiovascular disease • Musculoskeletal/ back conditions	• Cardiovascular disease • Cancer • Respiratory illness
Top risk factors	• Obesity • Physical inactivity • Poor nutrition	• High blood pressure • Physical inactivity • Smoking	• Physical inactivity • High cholesterol • High blood pressure	• High blood pressure • High cholesterol
Typical cost sharing approaches	• Annual deductibles • Member coinsurance • Premium cost sharing by employees • Annual limits on out-of-pocket expenses	• Annual deductibles • Annual limits on out-of-pocket expenses • Premium cost sharing by employees • Member coinsurance	• Annual deductibles • Member coinsurance • Premium cost sharing by employees • Annual limits on out-of-pocket expenses	• Annual deductibles • Annual limits on out-of-pocket expenses • Member coinsurance • Premium cost sharing by employees
Cost mitigation methods	• Plan changes (U.S. and Canada) • Cost sharing (U.S. and Latin America)	• Provider networks • Plan changes • Cost sharing	• Cost sharing • Service limits • Provider networks	• Cost sharing • Service limits • Provider networks

Sources: Aon survey[4]

4 http://www.aon.com/russia/files/2018-global-medical-trends-report.pdf

About Aetna International

Aetna International is re-shaping health care across the globe by developing solutions to improve the quality, affordability and accessibility of health care. To this end, we raise awareness of critical health challenges facing the world and examine potential solutions that could help combat and prevent the worsening of some of the world's most serious health care problems.

Global expertise with local touch:

16
Countries where we have employees

160
Year heritage

1,600
Aetna International employees

165,000
Medical providers in our network outside of the U.S.

800,000
Aetna International members worldwide

1.2m
Medical providers in our U.S. network

Thought Leadership Unit details

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2017 Volume I: Globesity: Tackling the world's obesity pandemic

2017 Volume II: Striking the right balance: Global caesarean delivery rates in an era of controversy

2017 Volume III: Expatriate mental health: Breaking the silence and ending the stigma

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2017 Volume V: The Forgotten Killer: Cardiovascular Disease

2017 Opinion Paper 1.0: Pandemic: Controlling infectious diseases before they spread

2017 Opinion Paper 2.0: Endemic infectious diseases: Focusing the world's attention on neglected killers

2017 Volume VI: The ticking bomb: Ageing population

2017 Volume VII: Bending the curve: Addressing rising costs in health care

2018: Volume VIII: Antibiotic resistance: Toward better stewardship of a precious medical resource

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