

Bundled payments for self-insured employers: an alternative to traditional cost controls

Pamela M. Pelizzari, MPH
 Suzanne Taranto, EA, MAAA
 Eric A. Buzby, FSA, MAAA



In an environment of increasing health care costs, organizations providing health care coverage are increasingly looking towards cost control mechanisms. In recent years, we have seen a great deal of activity in bundled or episode-based payments driven by the Center for Medicare and Medicaid Innovation (CMMI) models for the Medicare population, which involve setting a fixed price or target for a collection of services (a clinically- or temporally-defined 'episode') that may be variable across patients. These have shown promise in reducing cost and improving the quality of care and may provide plan sponsors with an opportunity to leverage the arrangements many provider organizations have implemented for the Medicare population.

In this paper, we explore whether bundled payments are a reasonable alternative to traditional cost controls for employers and plan sponsors. We also consider relevant factors for an employer selecting episodes for a bundled payment program.

Background

Historically, employers have attempted to manage the rate of cost increases by either shifting a portion of their liability to employees or by reducing their combined liability.

The two traditional cost-shifting methods have been to:

1. Reduce benefit richness, putting a larger share of the cost of utilizing the plan on to employees through higher deductibles, out-of-pocket maximums, or point-of-service costs (through higher coinsurance or copays), or
2. Increase employee's contributions, either through increased payroll deductions or surcharges, such as for smokers or for spouses enrolling in the plan who are eligible for coverage elsewhere.

To reduce their liability, employers have regularly looked to pay less for medical services by issuing RFPs to third-party administrators (TPAs) to find the highest discounts in geographic areas specific to their employees. They have also introduced narrower networks or tiered networks encouraging employees to go to higher quality and/or lower cost providers. On the pharmacy side, employers have increasingly been issuing RFPs and evaluating group purchasing opportunities that negotiate better discounts and rebates with their PBMs and more consistently market-check deal terms to ensure they are keeping pace in a quickly moving industry.

Employers have also implemented disease and care management programs to better manage the health of their employees, and wellness incentives to encourage employees to manage their own well-being. These wellness incentives are often tied to a savings vehicle associated with the medical plan, such as an HSA or HRA that are intended to encourage employees to be better stewards of health spending.

Even with all these cost control measures, healthcare costs have been trending at an unsustainable rate, significantly higher than the rate of inflation, so most employer plans are continuously looking for new methods to manage costs.

Contracting with providers has typically been part of the TPA selection, with the employer choosing the health plan or combination of health plans that reflects optimal cost and care management for that organization's members. However, this limits the employer's ability to control its own cost, and in this environment, to the extent possible, employers should be considering all opportunities to manage cost. The CMMI-inspired uptick in provider organizations' willingness and ability to manage episode-based payments creates new opportunities for employers to pursue direct contracting strategies to reduce their costs and enhance the value of their benefit offerings.

Alternative cost control measures

CMMI has piloted several alternative payment models including accountable care organizations (ACOs), bundled or episode-based payment models, and primary care transformation that may be relevant to the commercial sector. This paper focuses on bundled or episode-based payments and discusses why they may be an opportunity for employers, what services may be appropriate to target, and challenges they may face during implementation.

BACKGROUND ON CMMI BUNDLED PAYMENTS

Over the past five years, Medicare has rolled out several episode-based payment models within the Medicare fee-for-service (FFS) program. Under these models, CMS sets a target price for a collection of services, and entities that enroll in the program (or are mandated to participate, in some cases) are financially rewarded if they provide those services for less than the target price. For example, the popular Bundled Payments for Care Improvement (BPCI) Advanced model has hundreds of

active sites across the country. Under this model, participants agree to assume financial risk for an episode that includes an inpatient admission and all clinically related services that occur within 90 days post-acute (including skilled nursing facility services, readmissions, home health care, inpatient or outpatient rehabilitation, and a number of other service types). Throughout the performance period of the model, CMS pays all claims under its normal payment schedule. At the end of each performance period, CMS compares the cost of all services provided to the target price, and either pays money to or recoups money from the program participant depending on whether the total costs were below or above the target price.

These programs have been popular among providers for various reasons, including facilitating relationship development between different types of providers and driving down costs while maintaining quality of care.¹ Because of this popularity, there has been enthusiasm about leveraging this opportunity for commercial or direct-to-employer arrangements. However, certain key differences between Medicare and non-Medicare populations and benefit designs should be recognized when structuring a bundled payment program within a non-Medicare population to improve the chances of success.

SERVICES TO TARGET

When determining which services to target for bundled payments, we considered three criteria:

1. The service is not better managed through another method;
2. There is a sufficient volume to warrant the effort, administrative burden, and cost of setting up and managing the payment model; and
3. There is sufficiently high variability in cost to demonstrate savings potential.

When considering #1, we focused on procedural services, such as surgeries, because medical conditions (e.g., asthma and diabetes) are often better managed through utilization management (UM) programs designed to avoid admissions.² As an illustration of how to examine #2, we summarized all claims from the 2018 MarketScan database for the Nassau-Suffolk, New York-Jersey City, and New York-White Plains MSAs by DRG to determine which DRGs may have enough services, both in terms of number of cases and total allowed dollars, to warrant setting up a bundled payment model. For those same claims, we looked at the average cost, standard deviation, and coefficient of variation (standard deviation ÷ average) to validate #3, if there is enough variability to prove savings potential. The results of this analysis are shown in Figure 1.

FIGURE 1: DRGS BY NUMBER OF CASES

DRG	# OF CASES	ALLOWED DOLLARS			
		TOTAL	AVERAGE	STANDARD DEVIATION	COEFFICIENT OF VARIATION
MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1,365	\$84,061,073	\$61,583	\$22,226	0.361
O.R. PROCEDURES FOR OBESITY W/O CC/MCC	900	\$40,009,947	\$44,455	\$18,858	0.424
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	513	\$14,364,002	\$28,000	\$17,367	0.620
MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	366	\$21,251,103	\$58,063	\$27,869	0.480
PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	363	\$19,759,243	\$54,433	\$20,627	0.379
UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	260	\$10,401,098	\$40,004	\$21,141	0.528
SPINAL FUSION EXCEPT CERVICAL W/O MCC	205	\$31,099,896	\$151,707	\$92,435	0.609
LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	186	\$6,974,015	\$37,495	\$20,450	0.545
MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	183	\$21,672,031	\$118,426	\$259,839	2.194
O.R. PROCEDURES FOR OBESITY W CC	159	\$7,575,637	\$47,646	\$20,144	0.423

Source: 2018 MarketScan

¹ "Two-Year Evaluation of Mandatory Bundled Payments for Joint Replacement," Michael Barnett, Andrew Wilcock, J. Michael McWilliams, Arnold Epstein, Karen Joynt Maddox, John Orav, David Grabowski, Ateev Mehrotra, New England Journal of Medicine, online January 2, 2019, doi: 10.1056/NEJMsa1809010

² While beyond the scope of this paper, we note that provider organizations are beginning to pursue condition-based bundled payment opportunities with similarities to traditional UM programs.

If an employer were considering entering into a bundled payment arrangement, the information shown in Figure 1, recreated for their covered population within a specific geographic area, would be a useful starting point to consider procedures of interest. For the population represented in Figure 1, the procedural admissions drop off sharply, with only seven DRGs having 200 or more cases in 2018. These higher volume DRGs would be a useful starting point to identify potential bundled payment opportunity.

In addition, it is useful to look at the total cost of these admissions and the cost variation within cases. Conditions with low variation in cost may not offer as much opportunity. Conditions with both high cost and high variation (such as Spinal Fusion) may offer more opportunity, as this variation may be controllable based on pricing and other factors. However, it is important to continue this analysis to identify whether or not there are uncontrollable clinical factors driving that variation – those clinical factors may make it difficult to control the variation with contracting alone. There may also be opportunities to shift some of these procedures to less intensive settings (such as hospital outpatient departments or ambulatory surgical centers), which could be incentivized by site-neutral bundled payments.

While the type of analysis shown above is a useful starting point, it does not tell the whole story. Most employers' own datasets will not show such a large number of cases for any given DRG (as these results represent multiple data contributors within an MSA), so they should evaluate how many cases would be needed to make this endeavor worthwhile. The threshold that will make this activity worthwhile for a given employer will vary substantially based on the total cost of the procedure, the presence of opportunities for cost savings, and the administrative burden associated with implementing the arrangement. We'd expect an important follow-on analysis would detail costs within a time period surrounding the admissions still in consideration for bundled payment based on the initial cost and variation analysis. Managing variation in related costs can offer additional opportunity in some cases.

CHALLENGES

There are unique challenges associated with implementing this payment model for employers, which include volume requirements, data collection and reporting capabilities, and contracting.

Employers wishing to bundle specific services will need a sufficient volume of those services in order to be economically viable for all parties. Most employer plan sponsors require either size or geographic concentration to make the exercise worthwhile. It may be necessary for the employer to join others in a similar situation to justify the investments required for success. Sufficient volume may also be attained by pursuing negotiations through the TPA that already has many employers, but this will require the TPA to manage the payment model and may incur additional administration fees.

Data collection and reporting capabilities vary widely among TPAs, so processes must be put in place to ensure information is being collected and tracked to ensure appropriate attribution and payment is made. Some questions to consider are whether data is available to track spending by service, whether the TPA is willing to share data, and how to deal with differences in data feeds by TPA. Claim-level detailed data is needed from the TPA to properly assess the opportunity. Additionally, the employer will need to evaluate this data to assess which services are most appropriate to bundle.

Finally, if the employer pursues direct contracting with certain providers, the employer should consider how that contract will impact the current relationship with its TPA, as the TPA has its own negotiated rates with the provider, and their current contract with the TPAs may not permit this type of arrangement. How will TPAs react to their reduced negotiating leverage and potential competitive disadvantage? Will the TPA be willing and able to administer this external contract? Will the employer have enough volume to negotiate a better deal than what they already have through the TPA?

CONCLUSION

When they are thoughtfully designed, bundled payment programs may offer significant value to employers seeking to manage costs within covered populations. However, bundled payments are complex to design and implement, and a thoughtful analysis of the existing costs and variation within the population as well as the potential costs and complexity of implementing a bundled payment program should be completed before an employer begins negotiating these types of arrangements.



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CONTACT

Pamela M. Pelizzari

pamela.pelizzari@milliman.com

Suzanne Taranto

suzanne.taranto@milliman.com

Eric A. Buzby

eric.buzby@milliman.com

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