

Utilization Review Management makes \$8 million difference for JCWS Health Plan

Utilization Review Management Situation

Like many US companies, the rising cost of healthcare was significantly impacting Johnson Controls World Services (JCWS). Their self-funded health plan trust encompassed 14,000 employees who are spread out over more than 70 US locations and at least 10 international locations. The population was divided in half with approximately 50% of the members assigned to government contracts and 50% to commercial. The health plan was facing DCAA direction to segregate the trust assets into separate government and commercial accounts, had no reliable claims experience, was experiencing extraordinary large claim expenditure, and was projecting a 2.1 million dollar shortfall on 12 million dollars in claims.

Once the assets were segregated the balance in the government portion of the trust started to deplete at an alarming rate. Investigation of the cause led to several points of concern. First, the commercial side of the trust had apparently been subsidizing the federal and the federal population appeared to have a much higher risk profile. Secondly, 31 individual claimants accounted for 39.4% of the annual claim experience in 2003. Two individual claimants accounted for 8% of the plan's annual claims increase. Over the same time frame, individual claims in the \$20-49K range had increased by 61%. Each of these issues ran JCWS's average claims costs 24% above their TPA's book of business. This was an unacceptable rate for any group to face.

To address the situation, the Company instituted weekly monitoring and reporting of trust assets, monthly executive reviews, advanced trust payments, and made mid-year adjustments to the plan. The erosion of benefits and increasing premiums were not well received with this population who had bathed in the comfort of stable premiums for two years. Even with these remarkable efforts in place, JCWS still endured double-digit inflation, an anticipated \$3.6 million dollar short-fall, and 40% Collective Bargaining Agreements, as well as growing employee dissatisfaction in a highly competitive market.

Solution Description

In an effort to find some way of reversing the skyrocketing costs that to date had only been slowed, the plan decided to refocus by recognizing and embracing some basic health plan and health care principles. The plan acknowledged what they titled "basic truths about health care":

- Quality Care Costs Less
- Most Participants Don't Have a Clue on Picking Quality Providers
- Patients with Advocates in the HealthCare System Have Better Outcomes
- Non-Compliance is Dangerous and Expensive

- A Small Percentage of the Population Accounts for a Large Percentage of the Overall Cost (Beginning/End State)
- Most Diagnoses is Done via Lab Work
- The First Piece of Clinical Data is via Lab Work or Rx
- Prevention Costs Less Than Treating Disease
- Most Chronic Diseases Have Predictable Patterns
- People Will Take the Path of Least Resistance, Including the Path of Lowest Cost
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The plan embarked on a mission to locate a partner who could address these issues. The fundamental premise was to follow the data to identify the specific areas that required attention. The objectives included improved employee satisfaction, improved healthcare quality, decreased absenteeism, increased productivity, and finally overall control of health care costs. Ault International Medical Management (A.I.M.M.) was selected to partner with the health plan to provide PC3M®, a unique Patient-Centric Comprehensive Care Management model of medical management services.

The PC3M® service focuses on improving health care quality through patient education and empowerment as a means of decreasing the self-funded health plan's claims costs. The usage of evidence-based clinical care guidelines was executed in a step-wise approach allowing the health plan to realize opportunities for immediate impact and reinvestment of saved resources into additional services. This new approach yielded steady progress toward meeting JCWS's goal: a population that is well-educated, and empowered to utilize preventative health strategies, early intervention for health issues, and best-in-class medical care. Resources were able to be allocated to areas of highest need through the specific, actionable results of data mining. Outbound calls started with the top 1% of claimants in cost and/or risk.

Once the 1% was completed, the top 5% were addressed. Additional condition specific areas where JCWS's occurrences and or spending were out of proportion to national averages/benchmarks were addressed. The group's covered members were provided with one-on-one interactions with RNs. Members asked questions and offered informative details that RNs used to further assist them in becoming educated, empowered consumers. Consistent, dedicated communication between AIMM and members developed a relationship and trust in the plan that was rare in previous years. The use of the PC3M® model also provided the ability to measure the impact of interventions from a clinical quality stand-point, a patient satisfaction stand-point, and from a financial stand-point.

Results

JCWS was grossly aware of the deficits in their health plan. The first step to securing their future was initiation of Utilization Management, Case Management, and Maternity Management. Not until results of this first claims analysis were they able to visualize the depths of the previous deficits. This inaugural step was able to decrease the projected claims by \$54.11 PMPM. The number of hospitalizations per 1000 members was down,

as well as the length of stay for each of those admissions. The second step was to identify and rank the plan's issues with a now-solid database. Individual members and general trends were identified and interventions were put in place to evaluate and alleviate projected costs. Step three of the Step-Wise Method of Implementation of PC3M® was to sit down and do something with the facts on hand. Registered Nurses start touching individual patients through outbound phone calls and mailings. These nurses have been trained to not only educate the member on the condition that identified them but also on any other facts that present themselves through thorough evaluation.

Risk Indicators and overall claims dollars spent were used as "triggers", not just the top conditions as in older medical management models. Population Management Initiatives were developed based on data mining results. These included a six-month drive on key issues identified in this population as well as direct mailings to high-risk members. The next step was to identify risk using data and surveys. This simple and relatively inexpensive step had several unexpected results.

Members actually reported making lifestyle and health behavior changes based solely on the survey. A better understanding of lifestyle behavior issues that were driving the health conditions in the population was revealed through claims mining as well as the ability to begin predicting the next year's issues and proactively address them in hopes of averting them. This self-assessment also brought to light the impact corporate culture had on health care costs.

At the end of year one of these interventions, the self-funded health plan had gone from a 3.5 million dollar deficit to a 4.5 million dollar surplus! ER visits almost disappeared, and premature babies virtually disappeared. The savings were used to enhance benefits, and the plan now offers preventative health services at NO COST to members. The financial results from year 2 interventions will soon be through the auditing process. In year 3 the plan will continue their current services with A.I.M.M. and will enhance those services to take an even more assertive stance on preventative health initiatives. Medical claims costs for the self-funded health plan continue to decrease and the plan has completely avoided all cost escalation for 3 years, even with increased coverage and benefits, and no increase in employee cost-sharing.

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