The Delay of the Affordable Care Act Employer Mandate: What Employers Can Do Now to Prepare for 2015

Webinar Transcript
The employer mandated provision of the Affordable Care Act (ACA) has been delayed until January 1, 2015. What does it mean for employers and how can they use 2014 to prepare?
The employer mandated provision of the Affordable Care Act (ACA) has been delayed until January 1, 2015. This delay has left businesses to consider how they can use the additional time to plan for this significant change.

In September 2013, Castlight Health hosted a webinar, *The Delay of the Affordable Care Act Employer Mandate: What Employers Can Do Now to Prepare for 2015*, to help companies consider the options and opportunities this additional time affords them. Here are seven highlights, with 1-3 giving an overview of the ACA and 4-7 indicating what employers should do:

1. **The ACA tackles three big health care problems: access, cost, and quality.**

   Core provisions of the ACA include:
   - **Expanding access** through state exchanges, greater coverage from federal programs, and consumer protections
   - **Controlling costs** by changing the Medicare fee-for-service payment system to other systems that award doctors for improving quality and lowering costs
   - **Improving quality** by penalizing poor performance in hospitals, creating incentives for wellness and prevention programs, and investigating new approaches for better, lower-cost care

2. **ACA provisions roll out over the next decade.**

   Health care reform is a process. Some important dates include:
   - **October 2013:** The open enrollment period begins for buying health insurance through exchanges
   - **January 2014:** The individual mandate takes effect
   - **2015:** Important cost provisions are enacted, including the hospital-acquired condition fee for complications and bundled payments
   - **2018:** The “Cadillac” tax plan takes effect, which imposes an excise tax on high premiums to create parity between using pre-tax employer dollars and individual dollars on exchanges
What is a frozen carrot?
“We have been providing an incentive for doing the health assessment and biometric screening. This year we are going to eliminate it. Instead we are going to raise the deductible and if the employee and their spouse does the biometric screening and health assessment we’ll provide the difference back on an FSA card.”

The effects of ACA on employers and recent administrative changes.
The ACA has both a direct and an indirect long-term effect on companies. Recent administrative changes have delayed employer mandates.

Recent Administrative Changes
- Delaying employer mandate until 2015
- Delaying employers out of pocket maximum of $12,700 for a family until 2015
- No individual mandate penalty where Medicaid not expanded and no access to Exchange plans

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Build a culture that fosters employee engagement.
Best practices to engage employees in better health care decision-making include:
1. Communicate advocacy and support, not directives
2. Improve consumer decision-making and lower costs through use of transparency
3. Utilize sticks to drive results, despite employee preference of carrots
4. Do not rely on health plans, as they have been ineffective at marketing, engaging consumers and changing behavior

ER Avoidance Strategies
“One that has never worked for us is the nurse line because they always tell patients to go to the ER. We're really going to focus on telemedicine and web medicine where people can access a doctor.”
Act as a Good Consumer

Understand Personal Health and Well-being

Be Medically Literate

Increase employee accountability to drive outcomes.

1. Act as a Good Consumer
2. Be Medically Literate
3. Understand Personal Health and Well-being

Accountability is Key

Set priorities for cost management.

Companies should have a team focused on streamlining cost management in a prioritized fashion. Here are the top 4 areas Comcast has identified:

1. **Eliminate Waste** — Ensure employees get the right care at the right price in the right setting from the right provider to improve outcomes and efficiency
2. **Use the Frozen Carrot** — Set an actuarial plan that requires employees engage in specific actions before they receive the full actuarial value of their plan
3. **Utilize Cost Sharing** — Increase the percentage of the premium paid by the employee out of their paycheck
4. **Decrease Actuarial Value** — Increase the amount a member pays at the point of service

Top ways for all employers to reduce costs and improve quality:

1. Encourage the use of urgent care instead of emergency room
2. Provide transparency to help employees understand the financial implications of their decisions
3. Educate employees about provider selection, such as not using a low volume provider when volume matters
4. Motivate employees to fill prescriptions through mail, never at retail pharmacies, and don’t cover branded drugs when a generic is available
5. Encourage employees to get imaging and labs performed at low cost providers, never at hospitals
6. Implement a network management process to limit out-of-network claims
7. Implement a claims overpayment review process to hold carriers accountable
8. Increase access to primary care to direct patients to the right facility and provider
Introduction

Lisa:
Welcome to the Castlight Health webinar. Our topic today is the delay of the Affordable Care Act employer mandate and what employers can do now to prepare for 2015.

Allow me to introduce our panel of expert speakers. We’ll first hear a few introductory comments from Peter Isaacson, Castlight’s Chief Marketing Officer. Then Peter will hand things off to our two featured speakers, Bob Kocher and Shawn Leavitt.

Today’s speakers

Implications of the ACA:
How you can act now to prepare for 2015

Peter Isaacson
Chief Marketing Officer
Castlight Health

Bob Kocher, MD
Former Special Assistant to the President for Health Care Policy
Venrock

Shawn Leavitt
SVP, Global Benefits
Comcast
Bob Kocher is a partner at Venrock and focuses on health care IT and services investments. Prior to Venrock, Bob served in the Obama administration where he helped shape the Health Care Reform legislation by focusing on cost, quality and delivery system reform. Shawn Leavitt is the SVP of global benefits for Comcast. An industry veteran with reputation for innovation, Shawn is responsible for delivering retirement, health and welfare and health services programs in support of Comcast’s 126,000 employees.

With that, let’s begin our presentation. Peter, please take it away.

Castlight Health Overview

Peter:
Hi everyone, this is Peter Isaacson, Chief marketing Officer at Castlight Health. I just want to give a very brief overview of Castlight before I hand it over to Bob and Shawn. We’ve got a lot of new participants here attending the webinar. I thought it’d be helpful just to give a quick overview of Castlight Health. Really in a nutshell, Castlight Health helps employers and companies reduce health care spending while improving the quality of care for employees. We do this by giving customers really hyper accurate pricing information and we combine that with quality data and other information such as educational materials and patient reviews. Combine this together so that people can make better decisions about their health care.

Now what we’re really proud of is some of the results that we’ve been able to drive with companies. We’ve been able to help companies achieve up to 80% engagement rates with their employee population, which is really unheard of in
the benefits space. We’ve also been able to translate those high levels of engagement into really meaningful savings for employers, sometimes up to 13% versus the projected trends that they had. So we’re really not just about providing the information, we’re about making some meaningful change in terms of the engagement rates and driving those engagement rates into significant savings for employers.

Really, Castlight is about much more than just providing price and quality information. On this chart you can see that price and quality information and just the basic shopping tool is almost table stakes right now. Very useful information but the value that we’re providing customers goes well beyond this. Really we think the next frontier of just beyond the price and quality shopping experience that you can provide is driving true engagement and consumerization within your employee population. Once you get an engaged employee population, you can really start driving true behavior change with them. That’s where you start to see real results happen within your benefit program.

We’re really quickly moving just even beyond that basic level of engagement and consumerization into more of a benefit management platform. We’re really creating a true platform that helps make a company’s full benefits portfolio more effective. So not just changing the shopping experience, not just giving them access to the price and quality, not just driving engagement but really using that engagement to get people much more engaged in the full benefit experience, and use all of the different programs that the company has to offer, whether it’s case management or wellness or other programs and make those programs even more effective.
That's really the next frontier for benefits and health care in the United States. Castlight Health is very happy to be leading the way there. Now, with that, as I said, I just wanted to give a quick overview and then hand it over to the meat of today's presentation. So I'm going to transfer it over to Bob Kocher. Bob, take it away.

What Happens Next? The Implications of Health Reform on Employers

**Bob:**

I'm Bob Kocher, it's a pleasure to talk to you today about the Affordable Care Act and its implication on employers. I appreciate your interest and your help engaging your workers to improve health and health care. The Affordable Care Act was designed to tackle three things at once. Why is that? Because they really stick together to drive a system that will grow more slowly over time, deliver better care and frankly, be much more engaging and a better experience for all involved. First goal is to extend access to the roughly 50 million uninsured Americans, and that will be done through a combination of offering subsidized commercial insurance on new state exchanges and Medicaid expansion.

This will be funded by a combination of improving quality and averting complications and unnecessary, wasteful care, and slowing the rate at which costs grow. We spend an astonishing amount in America on U.S. health care, actually more than France. We spend about $800 billion more than we need to spend. There's a fair amount of waste in the system. The way the ACA works is through a combination of...
We spend an astonishing amount in America on U.S. health care, actually more than France. We spend about $800 billion more than we need to spend.

The ACA is Designed to Tackle Access, Cost, and Quality

- **Access**: 50 million Americans are uninsured and without access to affordable care. Goals: Extend coverage, protect consumers, increase choice.
- **Cost**: 2x more per capita spent in the US than any other country. Goals: Reduce cost growth, eliminate waste, reduce federal deficits.
- **Quality**: 100 thousand Americans die each year due to medical errors. Goals: Align incentives for better care, improve IT and transparency.

programs, which tackle access, cost and quality. On the access side as I mentioned state exchanges will be launching shortly and those will be websites where you can buy commercial insurance without the burden of being underwritten, and finding an agent. Also with the confidence that what you’re buying is high quality and comprehensive insurance. They will organize by medal level — bronze, silver and gold — which will equate to actuarial value.

Core ACA Provisions

- **Access**: Extends coverage through state exchanges, expands coverage from federal programs, protects consumers through market regulations.
- **Cost**: Reduces Medicare Advantage payments, reduces growth of hospital payments to reflect productivity, incentivizes bundled payments, ACOs, and shared saving models of reimbursement, streamlines administrative processes.
- **Quality care**: Penalizes poor performance in hospitals, incentivizes wellness and prevention, funds Center for Innovation to investigate new approaches for better lower cost care.
Most states are expanding Medicaid and that will offer those who are in the lower income industries to access generous health care. On the cost side, most of the cost savings are coming from two programs. One is reductions in the Medicare Advantage program, which is the program which is the alternative to Medicare that some seniors choose, which currently costs more on a beneficiary basis than the traditional pay per service Medicare program. Those overpayments are being reduced gradually over time. The second major bucket of cost savings comes from reducing the rate at which hospital payments grow. This is really being done to capture back some of the productivity that will come from increasing occupancy in the hospitals.

I think most importantly for employers is a series of new payment models including bundled payments, accountable care organizations, patients in the medical homes, which changes the system of payment from one that rewards activity necessary and unnecessary activity in fee for service systems more to those that reward providers that are better managing risk and better delivering reliable outcomes. From the quality side we’re seeing some promising signs. A reduction of readmissions from roughly 20% to 17% just in the last year. As a result of payments and the attention that came from the penalties the Medicare program has enacted. Next year will be a program to reduce incentives for hospital to allow for acquired conditions. Lastly I’m really interested in a $11 billion innovation center that’s been created which allows Medicare to test and pilot in a much more rapid cycle in a way to incorporate new systems and new approaches to care — anything that reduces cost and improves quality can be now scaled across the Medicare program.

The ACA is Implemented Over a Decade

As you would expect, the Affordable Care Act is implemented over a decade, and I think actually over many decades, because I think our health care system will continue to evolve and there will be necessary regulatory change and reform rollouts and I think it will get better over time. Many of the insurance market reforms have
already been put into place, but some important ones begin this January. And those are the ones that guarantee issue, community ratings so there is no more individual underwriting, and the creation of the state exchanges that I mentioned, which will allow people to more easily buy health plans. I think importantly, the fact that there will be exchanges will really change the way health plans are designed to be more engaging for individuals, and make all of us more comfortable with shopping for health care — not just health plans, but actual health services. In 2015, a hospital acquired condition fee goes into effect, and in 2018 the Cadillac tax goes into effect, and that’s a tax that over time will create parity between using pre-tax employer dollars to buy health insurance and individual dollars on exchanges.

### ACA Effects on Employers

#### Direct
- Employer responsible for providing coverage and relationship to individual mandate
- Requirements for minimum value of coverage and benefits
- Incentives and guidelines for wellness programs
- New fees, taxes, and compliance requirement for employers

#### Indirect
- Creation of subsidized public exchanges for individuals and small groups, and introduction of risk adjustment
- Increasing interest in private exchanges and defined contribution for employers
- Impact of public delivery system reform efforts and payment model changes on cost growth and the employer market

There’s a variety of effects that health care reform has on employers, both direct and indirect. The direct ones are fairly straightforward. Employers are responsible for providing qualifying health coverage to their work groups. Qualifying is defined as an actuarial value of 0.6 and inclusive of all the essential health benefits.

They also have more incentives now under HIPAA for very premium services for employers interested in wellness programs which I think is an important lever that employers can have to help engage workers, generally both in things that make them healthier, but also value consciousness throughout the health system. There are some compliance requirements for employers most notably that they document that their health benefits qualify and they make sure that their workers who do not have affordable options have access to the subsidized government plan. The indirect consequences I think are more interesting. The creation of exchanges I think will lean towards a broad consumerization of the health system, such that products and services are redefined to be engaging and compelling to individuals. I believe that all Americans will be more interested and able to shop for health care, both health benefits and health care services. They will also become more familiar with defined contribution, effectively the state exchanges are a defined contribution mechanism that makes it that someone who is getting a subsidy from the government can buy
from a broader selection of health plans than most people are able to access today. And very importantly the new payment models, which shift away from volume-based payments towards outcome-based payments, should enable employers to adopt many of these and reduce your exposure to complications and create stronger incentives for providers to deliver reliable, higher-quality and better experience to health care for your employees.

**Administrative Changes**

1. Delaying employer mandate until 2015
2. Delaying for employers out of pocket maximum of $12,700 for a family until 2015
3. Not enforcing individual mandate penalty on people in states that do not expand Medicaid and do not have access subsidized Exchange plans

There’s been a handful of administrative changes as well, which many have taken note of, but most importantly the employer mandate penalty, the $2,000 tax for employers that do not offer health benefits, has been delayed until 2015. For complexity reasons, the out of pocket maximum is also not going into effect until 2015. This is because the $12,700 tax is inclusive of both pharmacy and provider spending, and the systems to actually combine those are complicated, so this gives a year to work out some of the kinks and to test those systems such that you can be confident that that’s going to work smoothly. And then lastly, individuals and states that choose not to expand Medicaid are not in jeopardy to pay the individual mandate penalty will not be enforced for individuals at the lower end of these distributions below federal poverty do not have a Medicaid option.

With that I want to offer a couple of closing thoughts. I believe that health insurance and the health care reforms are creating real opportunities for employers to take advantage of slowing health care trend. New payment models that will allow you to capture much better value and experience for your workers, and the broad consumer strategies that payers and providers are taking will have the corollary effect of helping your workers become more engaged and more interested in shopping and capturing value. So with that I want to thank you for your time and attention and I’m going to turn it over to my good friend and colleague Shawn Leavitt.
Shawn:
Thank you Bob. First I'll share a little bit about Comcast just to give you a sense of who we are. We are one of the largest entertainment companies in the world. We own NBC Universal, which includes the Universal theme parks. It includes television channels like E! Entertainment, Bravo, The Golf Channel. We also own Telemundo, which is the second largest Spanish language network in the world and, of course, NBC, one of our flagship organizations.

And as an organization we are a little bit unique because we are primarily non-union. It’s an organization with over 120,000 employees and we have on our Comcast health plan about 250,000 lives and an annual health plan spend of around a billion dollars — slightly over a billion dollars actually. It is a big number for us as an organization. As we take a look this opportunity given to us by the delay of the employer mandate. For the most part, we have a bulk of our population covered.

About Comcast

Our Company
Comcast brings together the best in media and technology. We drive innovation to create the world’s best entertainment and online experiences.

Comcast Cable
- Comcast Cable applies the latest innovation and technology to entertain, inform and connect people in new ways. Providing households and businesses with the ultimate in video, Internet, voice, home management and business services.

NBCUniversal
- NBCUniversal — one of the world’s premier media and entertainment companies. Continually bringing new television, movie and theme park experiences to a global audience.

Our People and Business
- Over 126,000 employees (Comcast and NBCUniversal)
- $62.6 billion in revenue for 2012
- 51.3 million video, high-speed Internet and voice customers in 2012

There’s not a lot of work for us to do around determining are we going to make changes to coverage for part-timers or do we have a small populations out there that aren’t currently eligible for benefits. We have some of those. We were pretty much ready for 2014 and so 2015 really just buys us extra time to actually start thinking more about 2018 and what Bob mentioned in terms of the Cadillac tax rolling in.
So how are we going to think about that? Well I first thought I would start by sharing a little bit about what I’ve learned over the years and then talk about the philosophy we’re going to implement here at Comcast. So what have we learned over time? A couple of different things. First, really around kind of the debacle of the HMO days and how employees got really frustrated with having claims denied, having someone in a back room making a decision about whether or not something was medically necessary.

What our employers are looking for I believe is advocates. They’re looking for people who will help them and support them through a process and that’s what they respond much better to. Also learned that the lack of transparency, whether it’s price transparency or quality transparency or even transparency of billing patterns or practice patterns has really led to very poor consumers. Our employees continually make decisions on very critical treatment decisions or treatment options with limited information. That is really continues to be a problem that drives a significant amount of health care costs for us.

What Have We Learned?

Also we’ve learned that while employees really like the idea of the incentives, while they like the idea of getting something they don’t respond as well to it as we would like. We have found that the stick approach tends to be a little bit more powerful and tends to actually work a little bit better. It has some negative employee relations issues that come with it. Then finally, the last thing I’ve learned is that health plans, and I’m not talking about carriers per se. I’m actually talking about the health plan that we have here at Comcast or the health plan you might have at your company that health plans themselves have not been tremendously effective at marketing, at engaging people, in processes or programs and certainly in changing behavior.

When we think about our companies, we think about the businesses that we run, there’s no question that some of the products that we put out, if they had the same engagement rates that some of our programs that we have in our health plan has, it would be gone from the shelf faster than we could even imagine. It’s fascinating to me that we haven’t taken that same approach and that same kind of dedication to ensuring that the product is right and marketed properly in our health plans. That’s a huge opportunity that we’ve identified.
I’ll talk now about our philosophy that we are going to be implementing through 2014. It’s really this philosophy of accountability. Really introducing the need for our employees to become accountable. We really feel like this accountability thing coupled with a couple of other things we’re going to work on is going to drive us into a good position about being ready for the Cadillac tax in 2018. This concept is we want our employees to be accountable for their own health and wellbeing. We think it’s important that individuals take accountability for that. We also want them to be accountable for being medically literate. We define medical literacy as understanding a diagnosis and engaging in a process of determining how to treat that diagnosis, so active participation.

Then finally, we want people to become accountable for being a good consumer. Really, the way we decide to define consumer is rather than being a receiver of health care, it’s being an active participant in deciding what health care to receive, when to receive it, where to receive, et cetera. It’s really about having engagement. One of the things I’ll talk about next is really that we have decided to reshape how we’re going to manage costs from Comcast’s perspective.

There’s a part of me that is growing a little bit weary of all the conversation about bending the cost curve. The big question is well is that where the big dollars are or are the dollars really in this big bucket of waste that we continue to talk about and we continue to see the studies around. We’ve decided that our approach and we’ve put together a strategic health initiatives team that’s going to focus for the next two years on eliminating waste from our health plan. That’s going to be our number one priority and our number one focus from a cost management perspective. It’s really about ensuring that our employees have the right care at the right price, in the right setting, from the right provider.
Four Categories of Cost Management — Prioritized

1. **Eliminate Waste** — the right care, at the right price, in the right setting, from the right provider; all leading to improved outcomes and a more efficient plan.

2. **Frozen Carrot** — financial impact to those who do not exhibit behavior that is considered beneficial to the plan.
   - Can be used to reduce the actuarial value of the plan for lack of engagement.
   - Can be used to pass along the cost when a participant chooses to utilize more expensive providers that may be more convenient or have a higher perceived value but are identical in quality to lower cost providers.

3. **Cost Sharing** — increasing the percentage of the premium paid by the employee out of their paycheck.

4. **Actuarial Value** — increasing the amount a member pays at the point of service.

With those four key elements, we’re really going to focus on taking cost out of the health plan. Our second area of cost management that we’re going to focus on is around a concept of the frozen carrot. This is really born from the idea that people like carrots but they don’t necessarily react to them as well as they have a stick. We have an actuarial plan value that we target every year. Our objective is for our employees to receive that actuarial plan value from a plan perspective.

What we want to do though is ensure that our people take action and do things that we know will support them and help us improve our plans and also improve outcomes. We’re going to ask our employees to do things before they can actually receive the full actuarial plan value of the plan. That’s why we’re calling it a frozen carrot. What used to be our number one way of managing costs for the organization, cost sharing, has now jumped down to number three. Finally, our very last area of opportunity is around the actuarial value of our plan. The reason for the actuarial value being so low on the list is at Comcast our employees are very much invested in the health plan.

They really like the plan and they like the fact that it’s rich. It’s something that we receive very high marks for on engagement survey and our other pulse surveys we do throughout the year. A lot of it has to do with the price point of the plan and the earning power of our employees and what income level they’re at that it’s much easier for them to plan out of a paycheck than it is trying to make decisions around say a high deductible or things along those lines.
This is the way that we're focusing our priorities going forward. 2014 for us is going to focus a lot on working through eliminating waste and identifying opportunities in the frozen carrot. It's also going to do a little bit of work around understanding those final few populations that we need to address under the employer mandate part of the ACA. From a long-term perspective, we have a primary question that we're going to focus on and that is a hypothesis that the waste that we can eliminate is potentially even more valuable than the network discounts that we've been chasing for so many years.

Our question and a big focus of our long term strategy is going to be answering this question and trying to understand should we be willing to step away from some of the bigger discounts and actually build a plan that is much more directive and provides more advocacy and is much more wrapped around the individual, and ensures that the individual gets the right care, at the right setting, from the right provider at the right price and achieves a better outcome. Is that a better approach than being focused on network discounts? That's a big question for us and what we will be focusing on in the next couple of years.

With that, I'd like to say thank you.

What is More Valuable?

Eliminating Waste or the Network’s Discount

Audience Q&A

*Bob:*

Great. Thank you Shawn. Why don't we turn to the first question now as people begin submitting their questions. I'm curious Shawn, given your experience at a series of employers what are the table stakes that every employer should be doing today regardless of the ACA to get started?
Shawn:
That was a great question and there are quite a few things that I would argue that people should focus on. These are really just core things that when you look at your plan you make sure that are being done and being done effectively. A lot of it can be done through marketing; some of it needs to be done through plan design. Here are some of the things. One is we should always be looking at our emergency room utilization. We should have strategies to try and drive decision making and help people with decision making so they know when to go to an urgent care center, when to go to actually speak to a provider. The fact that short of going to the emergency room in a hospital, it’s pretty rare that you should ever go to an emergency room. How do we create education around that? How do we design our plans to support that? Do we put in programs like telemedicine and web medicine to help our employees understand that, I think that’s really critical.

Clearly, transparency is important, especially for those of us who have high deductible health plans. Helping people understand the financial impact of their decisions can be critical. Helping educate people about provider selection. Not using a low volume provider or facility for a service where volume does matter. Whether that’s introducing centers of excellence or thinking about how you support employees, I think it’s critical. The next couple of things on the list are things like doing prescriptions through mail or using imaging and labs at lower costs providers.
I would submit that we actually have a fiduciary responsibility as a plan to ensure that this happens. That allowing our employees to use high cost lab services or to use higher cost pharmacy refills simply because it's more convenient to them, that’s not really solid fiduciary plan management. There’s no reason not to allow them to do it. You can force them to pay the difference in some way and make up for that cost. The price of convenience shouldn't fall to the plan. I would argue that’s a fiduciary responsibility that we should all be paying attending to.

Finally, one of the things that I think we have not always focused as strongly on as we should is really effective program management. We should be managing our plans just as we manage any other program in our organization or any other product in our organization. We should be really focused on who our partners are, working with them, measuring their effectiveness, holding them accountable and really understanding what our network issues are and managing our in and out of network utilization and being very much on top of it. The standard reporting that comes from our carriers doesn’t share with us things like an out of network surgery center that is abusing the out of network benefit. We have to go ask for this information. Being on top of these things I think are really critical.
Bob:
I’m curious Shawn, you mentioned your four categories of cost management and the first priority was eliminating waste. I’m curious, you not only talk about the table stakes, what’s next on the menu for eliminating waste for you all?

Discussion

1. What are the core things you think all employers should do to reduce costs and improve quality?
2. What are the next set of actions you plan to take to reduce cost growth and why?
3. What are your most important goals for 2014?
4. What are the top ACA-related issues for 2014?
5. How do you balance your efforts and investment between reducing demand and accessing better value supply?

Shawn:
Yes, I think one of the things that’s really next on the menu for us is really this focus on primary care. We are concerned and this also can potentially be an answer for a later question. We’re very concerned about access to primary care. When I talked about earlier how important it is to drive individuals to the right facility and the right provider, if we continue to see a constriction of access to primary care, this is going to be a major problem. We’re going to kick off some pilots where we are actually putting in place primary care networks or primary care clinics that are near site that will guarantee access to our employees essentially for 12 to 14 hours a day, including weekends. Also, availability by phone and by web and guaranteed 24 hour appointments because we do believe primary care is a care is a key access point and a key driver to really effectively managing cost going forward.

Bob:
Do you have any perspective yet on how you identify the right types of primary care physicians that are going to lead towards that kind of service level and also better quality? How do you identify or recruit them or hire them or bring them to Comcast?
Shawn:
Yes, you know what, it is a little bit about identifying the types of clinics that really build primary care processes and adhere to them. One of the things we’ve done is we’ve looked at a clinic group that’s going to be doing a pilot for us and when you compare their emergency room utilization to our emergency room utilization in this particular market their book of business emergency room utilization is like 80 ER visits per thousand per year, where ours is 250. If we can just cut that in half, I don’t know if we’ll ever get to 80 but I’d be thrilled if we could get to 125. It’d make a huge difference for us in the marketplace.

One of the markets we’re also looking at in the northwest, of our spend in that market a full 53% of it is on primary care services when you do the breakdown. It’s been a market where we have been relatively good from a claims perspective on high cost claims. Fifty-three percent of our claims are primary care-related, only about 26 – 27% of those actually come through primary care physician. We have so much stuff being done in setting that it shouldn’t be done in.

Bob:
Stepping back a year from now Shawn, how will know if you’ve been successful this year. What type of metrics are you thinking about or how would you know if everything’s working?

Shawn:
I think that there’s a couple things. We’re actually transitioning and creating a new kind of a new way of looking at goals. Our goals are going to be around engagement and behavior change. When I talk about behavior change I’m not saying that we want to try and change people from smokers to nonsmokers or having everybody eat a healthy lunch or everybody get out and exercise. Yes we believe in all that, we want that to happen but our focus is going to be on really setting goals about the types of behavior we want to change. We want practice patterns to change.

We want to reduce the number of single field antidepressants where the script is written by a primary care physician. We want to reduce the number of emergency room visits and we’ll look at it by market by market and we’ll put programs in place to drive that change. We’ll measure actual changes in behavior in terms of how people use services. We’re going to make a change in our pharmacy plan and we will be looking at how many people actually change their behavior around using their prescription drug coverage. We’re very much focused on engagement and behavior change that we know will change ultimate outcomes and that’ll change people into better consumers and better utilizers in health care services.
**Bob:**
You’re somebody who I’m sure gets lots of questions about the ACA and employer issues. What are the things that gnaw at you or you are paying attention related to in the ACA in 2014?

**Shawn:**
As I mentioned earlier, the biggest thing for us is primary care. We already know we have challenges for our employees to access primary care. We’re implementing both tele and web medicine for 2014 as a way to start addressing that. As I mentioned, we’re also looking at primary care clinics and primary care networks that we can walk in certain access requirements to. That’s our first big thing around the ACA. Our second is really actually getting ready for 2015, especially around prescription drugs and how that’s going to factor in to our deductible.

It’s very difficult and so as we’ve thought about how you communicate to employees that oh well now because your co-payments count towards your out of pocket maximum, we need to raise your out of pocket maximum, right. There’s not a single communication strategy around that that we have come up with that we think is actually going to work. We’re trying to figure out should we package this with other changes. This will be a huge project for us in 2014 to really try to understand wow, we just want to improve the actuarial value of our plan or do we want to keep the actuarial value the same and try to make a variety of changes that helps make this more palatable for employees. That is a big ACA related issue for us.

**Bob:**
I would love to get your take on the right balance in the portfolio of things that you would do related to health on reducing demand and there’s a bunch of really interesting behavioral economic and activity based and programmatic things that we are seeing gain some traction. With the strategy that you talked about related to primary care and much better access to high quality provider systems and value when it comes to eliminating waste, how do you think about the balance there between the driving end and end overall, versus procuring a lot better health care supply?

**Shawn:**
Actually, to me they’re actually interrelated. I started to really believe that if we develop processes around managing demand that we will do a better job of improving the value of what is supplied. What do we mean by that? Earlier in the conversation I said that employees don’t like to be dictated what to do. They don’t like to be told what to do but boy they certainly would like help. If you think about it, one of the ways to reduce demand but at the same time provide better value is to actually get an employee to the right provider.
If I can do some network optimization or do some way of understanding who are the right providers for a certain service. Let’s pick a market in Minneapolis and maybe we’ve got access to quality data and we’re able to do some network optimization that determine that if you are in Minneapolis and you have low back pain, here are the six doctors that we should steer you into. I put in a program in which you need to get a referral to a specialist and so that we get you to the right specialist. Not only do I get better value but I likely reduced demand of services downstream because that doctor is more efficient and effective at managing that care and we get better outcomes.

**Bob:**
Shawn, you had an intriguing term called frozen carrot. Can you talk about what a couple frozen carrots are?

**Shawn:**
Yes, absolutely. We will be looking at multiple ways of introducing this. For this first year, what we’re doing is we have been for years providing an incentive for doing your health assessment and biometrics. That incentive has garnered us 12% engagement by employees and 2% engagement by spouses. If that were a television channel, it would no longer be on or a television show for that matter it would no longer be on. What we’re doing this year is we are going to take that incentive and eliminate it. Instead we’re going to raise the deductible and if the employee and their spouse does the biometric screening and take their health assessment. We’ll provide them that back on an FSA card. For them to get the actuarial plan value and our richest plan is at 88% actuarial plan value. For them to get that full 88% plan value they need to engage in that activity. Down the road we’re looking at setting up processes for things like medical decision support, things for second opinion services. Where if you don’t participate in those programs and one of my favorites is a host discharge management program. Where if you don’t participate in one of those programs then your plan of value goes down. That’s where we’re looking at it from a frozen carrot perspective.

**Bob:**
Why don’t I turn it over to Peter who I know has been organizing our audience questions. Peter.
**Peter:**
Here’s one Bob, this is on the ACA and maybe a little bit more directed towards you. The question is could you tell me if every aspect of the ACA has been delayed until 2015 and is there any employee notification that needs to be done in 2014?

**Bob:**
The employee notification requirement of 2014 is in effect and actually virtually every aspect of the Affordable Care Act is in effect now and much of it has already been implemented. I would describe the delays as details and not programmatic changes. The big aspects of it which are the launch of the state exchanges and expansion of insurance to get insured with the individual mandate so that there is coverage that all begins in October on schedule. I think it would be prudent to plan for ongoing implementation of the law, as most employers have and there might be administrative things here and there which are delayed to make them work better, but a lot of stuff is going into effect.

**Peter:**
This question is what are your thoughts on how to communicate the cost of the ACA to plan participants?

**Shawn:**
This is a challenge. Our philosophy is to be transparent and our communication philosophy is to be transparent and honest with our employees. For us without making any changes to our plan design the ACA’s worth just over three percentage points. That’s because a copay that’s going towards the out of pocket maximum and then the various fees. As we’re designing our communication materials this year we are going to talk about the fact that the plan just got richer because your copayment does not count for your out of pocket match, so the plan got more valuable to you and because of that the price of the plan has gone up. We’re going to lay out what the impact is in the various fees. We’re also going to share that one of the biggest fees is one that will step down over time, the reinsurance fee. We’re just being transparent about here’s it is and the fact that we are taking the same increase that you’re taking as a company because we share that increase equally.

**Peter:**
Which ER avoidance strategies have you seen be most effective or most successful?
I think that one of the most effective avoidance strategies of all time has been the old well if you go to the emergency room and you don’t get admitted your copayments might be $500. It’s amazing how money talks.

**Shawn:**
I think that one of the most effective avoidance strategies of all time has been the old well if you go to the emergency room and you don’t get admitted your copayments might be $500. It’s amazing how money talks. We, of course, have a lot more challenges because of ACA around how we try to manage emergency rooms. There’s a big question about whether or not we can still do that old tried and true method. I think the second most effective one that I’ve seen work is really an all out communication strategy and marketing strategy around who are the urgent care centers in your neighborhood or your network and tying that into a telemedicine and web medicine provider so that individuals have different alternatives.

The one that has just never worked for us has been trying to use the nurse line because every time they call the nurse line the nurse line tells them to go to the emergency room. We’ve really started to say that we’re going to turn off and we’re going to really focus on the telemedicine, web medicine through where people can get to and speak to a doctor who can then really help them triage and plan for a visit coming forward. We also offer the service of making appointments for our employees so if they reach out to us on our telemedicine or web medicine, we will go through a process of getting them an appointment the next day if they need to go in and see a provider. We’re hopeful that that’s a strategy that’s going to be effective.

**Peter:**
Would completely free primary care for the participant not just for prevention but completely free primary care be an effective tool?

**Shawn:**
We’ll come back to the answer on that in March 2015. One of our pilots for a metro area is to implement us a group of primary care clinics that have a very concierge feel in terms of how they take care of the patients. We are going to go with no copayments and we’ll also provide some maintenance medications for free when they’re prescribed through that clinic. We’re going to test it. We’re going to see whether or not removing that barrier. In that same situation we’re also looking at 7:00 am to 7:00 pm hours and weekend hours to really create a relationship opportunity that we hope will change that group’s utilization of emergency rooms, even urgent care centers and certainly of specialty care.
**Bob:**
This is Bob. I would say that data for the Medicare Managed program is promising with this regard. There have been many capitated Medicare vendors and providers who offer seven day retail type access to primary care and in some cases daily visits between patients and primary care doctors and free medications. They’ve seen really meaningful reductions in hospital utilization, ER utilization and costs. I think the best example is a group from south Florida which published a health affair paper in August about their model and their rather astonishing improvement but I think there’s reason to think for employers that taking primary care and chronic medications, at least generic ones, prove likely to savings than patient engagement and better adherence.

**Peter:**
Does Comcast think it will work directly with physicians and hospitals? If so, what might that look like or are you already doing that?

**Shawn:**
We are picking up pilots from a physician perspective in terms of using these clinics. Yes, I think we will start building relationships like that, especially where on the primary care side where we could see ourselves getting better access for our employee population. It’s one of the powerful things of having the scale that we have. In terms of hospitals, I’m not as convinced that that is the right way to go. From a volume perspective, we don’t have the ability to deliver the kind of volume that anybody else can. I think we’re probably more interested in centers of excellence and doing those through partners than necessarily doing those directly ourselves.

**Peter:**
What are your main approaches for covered retirees?

**Shawn:**
Well, it’s called the exchange. For us it’s going to be very simple. We’re a little bit fortunate because our retiree population currently receives a stipend that they can use toward the purchase of health care. We’ve had almost a private exchange in place with Untied for the last five years. In fact, tomorrow is a big day for us in terms of really trying to finalize the retiree strategy for ’14 and beyond. I think we’ll wait a little bit until we understand how effective the exchanges are going to be or how everything works from signing up, et cetera. Then we’re likely to allow our retirees to use that stipend to use to go into the exchange.
Peter:
I know that we've gotten this question in a couple of different ways but there's definitely some interest in reference-based pricing, what your thoughts are on it and whether you're planning on implementing that or are you considering it for Comcast?

Shawn:
Yes, absolutely considering it. It is one of the issues I didn't raise under ACA that there is a little bit of concern about how are the rates going to come out and are they going to allow for reference pricing. I think reference pricing is a powerful tool and I have said before and I will always continue to say that in certain circumstances, whether it's labs, whether it is medications, I believe that we have almost a fiduciary responsibility to implement a program like that. It is unacceptable to have example for the Bay Area in 2000 — this is from 2010, 2011 where that in the Bay Area you could get a lipid panel done from Qwest Lab Corps in the $10 to $12 range. You'd be off to Stanford for $54. You'd go to John Deer Hospital for $84 and you'd go to a Sutter facility for $118 using the same machine and the outcomes the same. So I don't understand how we can say that we're doing our fiduciary responsibility if we allow for someone to go to some place that expensive for a lipid panel simply because it's more convenient or because they perceive it to be a better value. Our health plan should never be built that way.

Peter:
Great answer and a great final comment to close on. There are some other questions. We're going to do our best to follow up in writing to the questions. There are a lot of them but we really appreciate everyone's engagement on this topic. Now I'm going to turn it back over.

Lisa:
Thank you Peter. Excellent presentations. I want to thank Bob and Shawn for their presentations. For folks in the audience that still have remaining questions you can email us at marketing@castlighthealth.com. Thanks again everyone for joining and we look forward to seeing you on future Casting Health webinars.
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Castlight Health, Inc.
San Francisco, CA
(415) 829-1400
info@castlighthealth.com
www.castlighthealth.com

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