# ST. LOUIS HEALTH CARE INDUSTRY OVERVIEW

## 2018

## Volume 1: Health Plan Quality and Financial Overview

St. Louis Area bhc
BUSINESS HEALTH COALITION
*employer partners in healthcare*

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# Message to the Community – Affordability crisis, the top challenge

**Public policy uncertainty and demographic shifts were key influencers** of the U.S. commercial health plan industry in 2016:

- **The U.S. hit a new low as the percentage of Americans without health insurance decreased to 8.8%**. While the number of uninsured has declined since 2013, coinciding with coverage expansions of the Affordable Care Act (ACA), **the 2016 decrease was driven by more people aging into Medicare, the Census Bureau said**. Large national carriers incurred losses on public exchange products, yet **fared well financially, capturing a disproportionate share of industry profits**. Despite this, most reduced participation on the exchanges.
- **Medicare and Medicaid managed care became essential to the business purpose** of the nation's largest health insurers, accounting for **60% of revenue** in 2016. Increases in Medicare enrollment and Medicaid expansion through the ACA spurred growth in government plans, while commercial plan enrollment declined (p. 2). While generating a larger share of revenue, medical costs were higher and garnered lower margins compared to commercial health plans.
- Health care cost pressures on consumers, employers and government continued to mount. **Consumers used the same amount of health care services or less in 2016, compared to the prior year. Still, they paid more for less as prices increased**. Nationally, health care expenses increased 4.3% overall, driven by growth in private health plan spending.
- **High claim costs edged health insurance industry profitability down slightly.** Operating margins were 7% in 2016, down from 7.5% in the previous year (p. 3), driving medical loss ratios up slightly across the individual, small group and large group markets.

**In Missouri, fully-insured commercial health plan membership declined 9% for insurers operating in St. Louis**. Enrollment decreased across market segments. Individual plans saw the largest decrease (14%) followed by large group plans (7%) and (5%) for small groups. **Aetna's Coventry and UnitedHealthcare saw the sharpest declines in enrollment**. In aggregate, premium revenue per enrollee grew 4.4% while claims costs increased 3.8% and medical loss ratios increased (p. 2).

Medicare Advantage (MA) plan membership grew by 7.6% nationally. Approximately one-third of Medicare members nationally and locally are enrolled in an MA plan. **In Missouri, Aetna, Humana and UnitedHealthcare dominated the market, enrolling 79% of MA members statewide**. The Star Ratings system provides a consumer-friendly way to compare the quality of MA plans. More than half of local plans were rated four stars and above, similar to the previous year (p. 6).

A core tenet of value-based payments is that fee-for-service (FFS) inadequately controls costs or drives improvements in care quality. Value-based payment (VBP) models align provider performance and care quality to have meaningful transformation of care delivery. Nationally and locally, financial incentives in MA plans are more likely to include quality bonuses and value-based incentives which reward clinicians for results. Not surprisingly, **local MA plans continued to outperform commercial plans** on health outcomes such as controlling high blood pressure, glucose control for people with diabetes and reducing readmission rates (p. 7-9).

**St. Louis private health plans' use of VBP gradually increased during 2015 and 2016**. Pay-for-performance and medical home models were the most prevalent, paying bonuses for care quality and/or efficiency and care coordination fees. However, payment is based on FFS. Still, shared risk arrangements that include upside and downside (1 and 2 sided) risk such as accountable care organizations (ACO) are increasing. Locally, Anthem's Enhanced Personal Health Care program is the largest commercial ACO.

**It is too early to tell whether growth in value-based incentive programs is playing a role in better quality outcomes for commercial health plans**. However, the quality gap between MA and commercial plans has begun to narrow. Five out of seven St. Louis commercial plans improved care for privately insured people with diabetes, scoring above the national average in controlling blood sugar (p. 8).

Nationally, employers comment on a lack of standardized reporting on commercial ACO performance on quality and savings, underscoring the need for greater transparency.

For the second consecutive year, nationally only 75% of customers gave their health plan a score of "8, 9 or 10" in 2016. In St. Louis, Anthem's PPO offered in the Federal Employees Health Benefit Program was the only plan that performed above the 90th percentile. **Affordability is a top concern among enrollees and may play a role in lower health plan customer experience scores, research finds** (p. 5). It seems that the public is beginning to recognize that higher costs do not mean higher quality. Increased spend may actually result from complications or simply higher prices. Many employers and plans provide transparency services and explore new ways to help enrollees discern those providers who offer top quality for a fair price.

**In recent years, the silos in the U.S. health care system have started to blur as health plan, care delivery, pharmacy and other sectors have begun to converge.** The most definitive example of this is the proposed purchase of Aetna by CVS, announced in December 2017. However, UnitedHealth Group (UHG) has been expanding its footprint in the provider space. It aims to provide primary and ambulatory care in 75 markets, representing two-thirds of the U.S. population (p. 3). By the end of 2016 it had acquired clinical practices in 26 markets. SSM and Ascension Health's recent announcement that they will manufacture some generic drugs, could bring health plans much needed lower and stable generic drug prices. The looming Amazon-Berkshire-JPMorgan non-profit venture announcement has garnered much enthusiasm from purchasers and pause from industry players, given Amazon's widespread customer base and Warren Buffett's recent comments about health care cost being the "tapeworm" of American competitiveness.

It is too soon to tell how these and other convergences will impact the U.S. health care system. The top drivers of the system's underperformance and staggering cost seem to be their target. These include the overuse of low-value services, unwarranted high prices and fragmented, poorly coordinated care. While these are beyond any one organization's ability to solve, the collective impact of these disruptors offers hope for a better health care future. Paired with the public's growing concern over high health care costs and the consequences on their already tight budgets, these developments have the potential to move us toward the health care system Americans want and deserve.

## Medicare & Medicaid

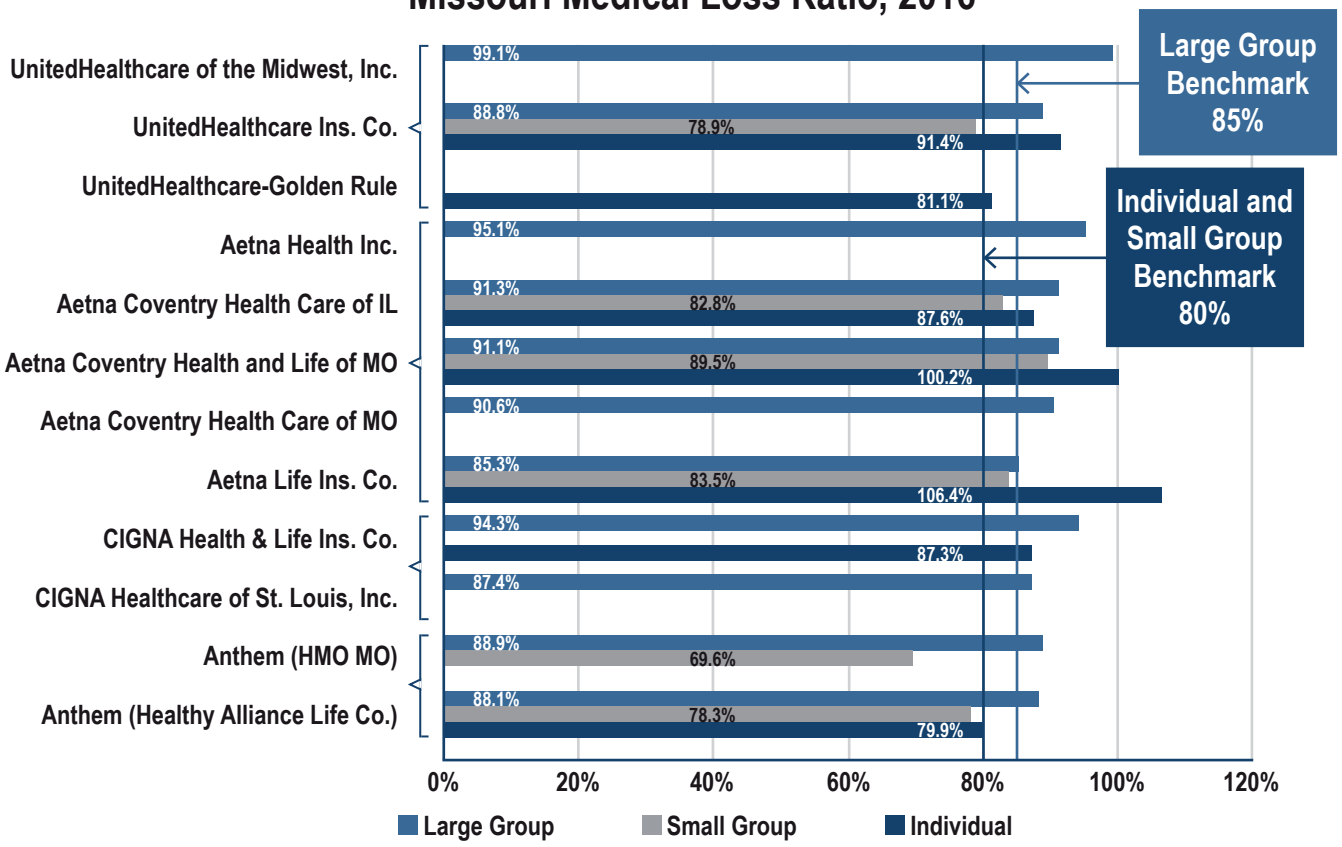
**The nation's largest health plans earn more revenue from Medicare and Medicaid managed care plans than from commercial plans.**

More people aging into Medicare and the expansion of Medicaid through the Affordable Care Act (ACA) have spurred the growth in government plans, while enrollment in individual and group polices declined.[1]

**The U.S. hit a new low as the percentage of Americans without health insurance decreased to 8.8% in 2016,** driven by an expansion of Medicare coverage.[2] In Missouri, the percentage of adults and children lacking coverage decreased to 9.3%, down from 10.2% in 2015, the Census Bureau said.

**In 2016, customer rebates required by the ACA increased to $446.9 million nationally,** up from $396.7 million the previous year, a **13% increase**. However, the number of customers owed rebates decreased nearly 19%, coinciding with a slight increase in medical loss ratios across market segments.[3] Under ACA regulations, insurers are required to pay rebates to fully-insured customers if the average medical loss ratio (MLR) falls below 80% for individuals and small groups or 85% for large groups. **Health care expenses grew 4.3% overall, driven by growth in private health plan spending as prices increased and utilization held steady or declined.**[4]

### National Health Plans
### Missouri Medical Loss Ratio, 2016




Source: The Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight (CCIIO).

**In 2016, Missouri fully-insured commercial health plan enrollment decreased 9% for carriers operating in St. Louis.** Individual plans saw the largest decline (14%). Membership decreased 7% for large group and 5% for small group plans. **Aetna's Coventry and UnitedHealthcare saw the sharpest declines in individual and large group plans.**

In aggregate, **premium revenue per enrollee grew 4.4% while claims costs increased 3.8%.** Medical loss ratios increased 7% for individual plans, 3% for small groups and decreased (3%) in the large group market. **Local plan rebates to customers decreased to $13.7 million,** down from $21 million in 2015, **a 34% decrease**. The percentage of people receiving rebates declined 11%.

- Anthem paid more than $10.6 million in refunds to individual and small group market customers in 2016, down 23% compared to the previous year, and the largest paid by a local plan for the fourth consecutive year. Refunds accounted for 0.6% of earned premiums.
- UnitedHealthcare paid over $3 million in refunds to small group members, down from $6 million in 2015 or 0.3% of earned premiums.

[1] C Schoen, S Collins "The Big Five Health Insurers' Membership and Revenue Trends: Implications for Public Policy," Health Affairs, December 1, 2017.
[2] L Radnofsky, "Uninsured Rate Fell in 2016 as More People Aged Into Medicare," Wall Street Journal, September 12, 2017.
[3] The Center for Consumer Information and Insurance Oversight. Retrieved from: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Medical_Loss_Ratio_2016_Annual_Reportpdf.pdf
[4] M Hartman, A Martin, N Espinosa, A Catlin, et.al., "National Health Care Spending In 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions," Health Affairs, 37:1, January 2018.

# Largest carriers maintain profits as overall industry profitability declines

**7%**

Nationally, health insurance industry operating margins were 7% in 2016, down from 7.5% the previous year. The nation's **largest carriers captured a disproportionate share of industry profits**, a recent study found.[1]

**11%**

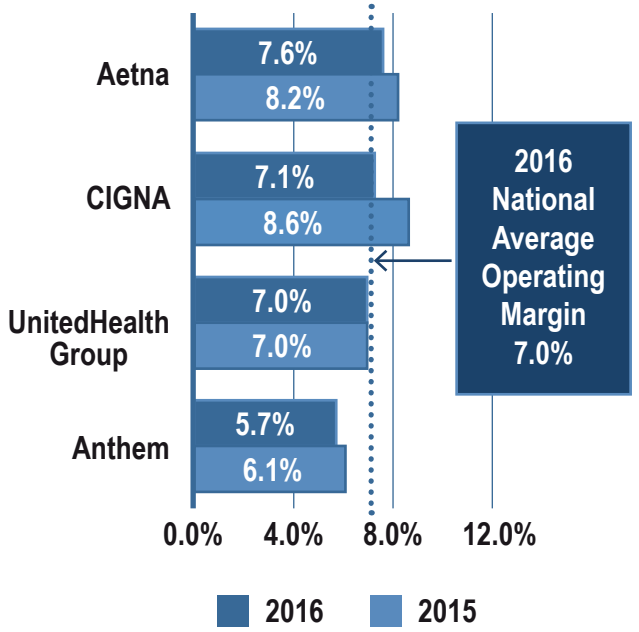
Operating revenues for the nation's four largest health plans grew 11% as overall enrollment increased 3%. For the second consecutive year, **Aetna, Anthem and UnitedHealth Group have collected more premium revenue from Medicare and Medicaid managed care plans than private insurance. Still, government plans accounted for only 20% of their total enrollment.**

**5%**

Operating profit grew slower at 5%, as health benefits expenses and medical loss ratios increased (see p. 2). Aetna was the only carrier that posted operating margins above the national average (see graph at right). Still, earnings more than offset losses on marketplace exchange plans across companies.[2]

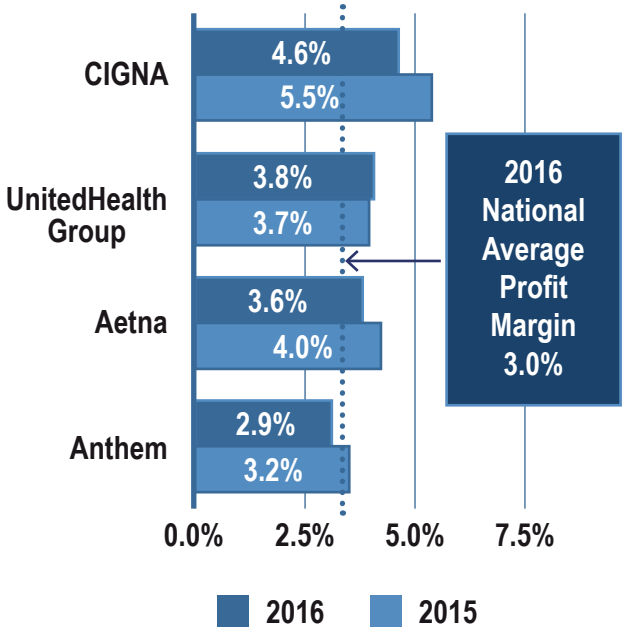
While Medicare and Medicaid now generate a larger share of plan revenue, health care costs are higher. Government plans garner lower margins as compared to commercial insurance products.

## National Health Plan Operating Margins 2015 - 2016




Source: SEC Health Plan 10-K Statements and CSI Markets national statistics

## National Health Plan Profit Margins 2015 - 2016




Source: SEC Health Plan 10-K Statements and CSI Markets national statistics

**3%**

In 2016, average health plan profit margins nationally decreased to 3.0% in 2016, down from 4.6% in the previous year. **Profit margins for three out of four large carriers were above the national average**, as shown in the graph at left. For the fifth consecutive year, CIGNA was the most profitable.

**Acquisition expenses impacted income, particularly those linked to the failed Aetna-Humana and Anthem-CIGNA deals.**

Anthem paid $915.3 million in interest and $14.6 million in higher taxes related to the CIGNA purchase.[2] As of January 2018, Anthem had not paid the $1.85 billion break-up fee to CIGNA pending litigation.

Aetna spent $775 million in transaction and integration-related fees, and paid Humana a $1 billion break-up fee.[3]

UnitedHealth Group aims to provide primary and ambulatory care in 75 markets, representing two-thirds of the U.S. population. By the end of 2016, it had acquired clinical practices in 26 markets.[4] This contributed to a 22% increase in operating costs in 2016.

[1] "Health plan financial trends, 2011-2016," Deloitte Center for Health Solutions, 2017.
[2] Form 10-K, Securities and Exchange Commission.
[3] S Livingston, "Health insurer CEOs score 2016 pay raises despite uncertain future," Modern Healthcare, April 27, 2017.
[4] A Mathews, "UnitedHealth's Optum to Acquire Surgical Care Affiliates for $2.3 Billion," Wall Street Journal, January 9, 2017.

# Local health plan value-based payment programs are taking hold

In St. Louis, fee-for-service (FFS) continues to dominate provider payment methods among the four largest commercial carriers. Still, **value-based payment (VBP) programs gradually increased during 2015 and 2016.** Locally, the size and mix of VBP programs varied across health plans, which can be categorized in four general areas:

## 1 Pay-for-Performance Programs

**Pay-for-performance** programs provide financial incentives or penalties based on a provider's ability to meet or exceed certain quality of care and/or efficiency measures or reward performance over time. Often implemented as a performance-based bonus on top of usual compensation methods, it is the most common VBP program.

## 2 Patient-Centered Medical Home

**The Patient-Centered Medical Home (PCMH) is a team-based model in which clinicians work with patients and families toward defined health goals**. A PCMH practice may be paid a blend of FFS payment, care quality incentives and a management fee for care that falls outside of the office visit. The PCMH is consistent with the goals of shared-risk arrangement models such as **Accountable Care Organizations** (ACO) discussed below. In St. Louis, the majority of ACOs are recognized as PCMHs by the National Committee for Quality Assurance.

## 3 Shared-Risk Arrangements

**Shared-risk arrangements** include upside and downside (1 and 2 sided) risk. One example of a shared-risk arrangement is an ACO in which physicians, hospitals and other providers work together and are accountable for both the quality and cost of care for a defined population. **The largest commercial ACO in the St. Louis region is Anthem's Enhanced Personal Health Care program.**

**In the U.S., there are nearly 1,000 ACOs covering more than 32 million lives (approximately 10% of the population).**[1] If you are an employer or health care purchaser, you likely are or will soon be participating in an ACO. Depending on the health plan, ACO care management or reward incentives may be incorporated into the employer's fees.

Medicare ACOs report improvements in care quality, yet bonus payments to providers outpaced savings. Nationally, **employers report a lack of standardized reporting on commercial ACO performance on quality and savings, underscoring the need for greater transparency.**[2]

## 4 Bundled and Episode-Based Programs

A bundled or episode-based payment is a single payment made to providers, health care facilities or jointly to both for all services to treat a condition or provide a procedure as well as costs associated with preventable complications. **With the exception of UnitedHealthcare, bundled and episode payment programs were largely unavailable to self-insured plans.**

[1] V Lewis, E Fisher, C Colla, "Explaining Sluggish Savings under Accountable Care," NEJM, November 9, 2017.
[2] "Time to push health plans for the real story on ACOs," Catalyst for Payment Reform Blog, October 16, 2017.

**Nationally more than 54% of family practice physicians participate in value-based payment models,** a recent study found. However, physicians report barriers are stifling progress, such as lack of staff time, transparency between payers and providers and **standardized reporting among insurers.**[3]

**In St. Louis, health plan VBP reporting also lacks standardization.** The number and types of quality metrics by program used to measure and reward clinician performance varied widely among health plans, as shown in the table to the right.

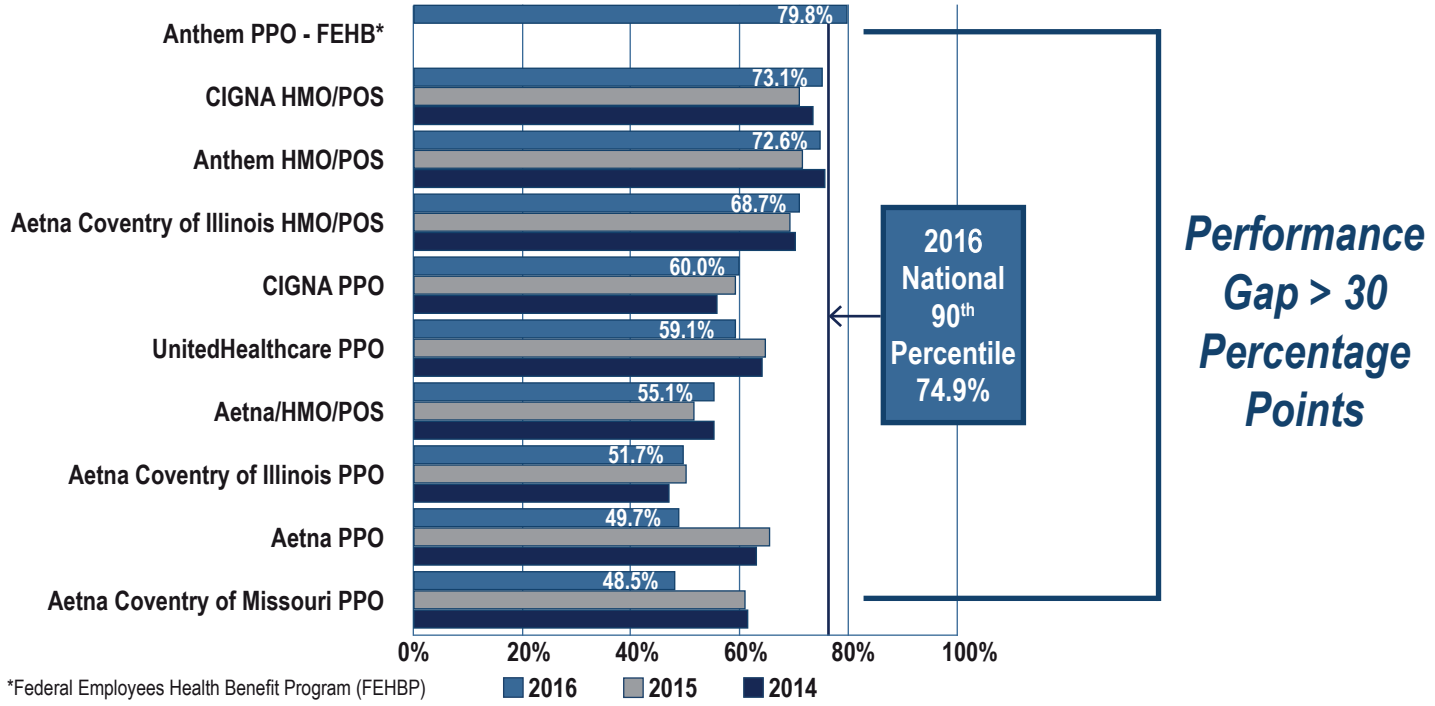
[3] "2017 Value-Based Payment Study," AAFP and Humana, November 2017.

**St. Louis Health Plans 2015-2016 Value-Based Payment Program Quality Metrics**

| | Accountable Care Organization | Pay for Performance (Physicians) | Pay for Performance (Hospitals) | Patient-Centered Medical Home |
|---|---|---|---|---|
| | Number of Quality Measures by Program | | | |
| Aetna | 10-15 | 10-15 | NA | 10-15 |
| Anthem | 44 | NA | 53 | 44 |
| CIGNA | 17 | Number varies by Specialty | Number varies by Contract | 44 |
| UHC | 15 | 21 | 14 | NA |

## Customer Experience Performance Gap Grows

**Percent of enrollees who rated their health plan a top score of 8, 9, or 10, St. Louis Area Health Plans, 2014-2016**




Source: National Committee for Quality Assurance (NCQA), Quality Compass, St. Louis Metropolitan Area, used with permission of NCQA. Quality Compass is a registered trademark of NCQA. The HEDIS® measures and specifications were developed by and are owned by the NCQA. The analysis, interpretation, and conclusions based on these data are solely the responsibility of the BHC.

**Nationally, for the second consecutive year only 75% of customers gave their health plan a score of "8, 9 or 10" in 2016.** In St. Louis, there was a mix of modest gains and falling scores that widened the gap between high and low performers, as shown in the graph above. **Anthem's PPO offered in the Federal Employees Health Benefit Program (FEHBP)** was the **only local plan performing at or above the 90th percentile with a score of 79.8%,** shown for the first time in this report. **These results may have been influenced by a recent initiative launched by the FEHBP in 2016** which links measures of health outcomes, customer experience and resource use to financial incentives. In 2017, these incentives will be enhanced to include rewards for performance improvements.

Affordability is a top concern among employers and enrollees in their search for the best health plan value. Notably, plans that are leaders in customer experience tend to grow revenue faster and can charge more for their products, thus it pays to improve.[1]

How can plans better satisfy members? Here are three takeaways on improving the customer experience:

**Improve Affordability**

It has become increasingly clear to the public that higher costs do not ensure higher quality care. High cost may result from complications or rework or simply higher prices. Many employers and plans provide sophisticated transparency tools and are exploring new ways to help enrollees discern those providers offering safe, high quality care at a fair price.

Enrollees of all age groups are squeezed by high health care costs. In a recent event to discuss health insurance with millenials, one panelist said, "We joke, but it's not really a joke, that if one of us gets hurt to call an Uber, not an ambulance, because it is too expensive."[2]

**Offer Personal & Timely Customer Service Support**

Plans can better connect to customers by offering concierge-like services such as phones quickly answered, representatives who easily understand the member's coverage and health care needs and deliver clear, relevant information.

**Provide Ease of Access to Information**

Communicate through multiple channels such as text, chat, email, phone, website and social media. Also, give the customer the ability to request a call-back.

[1] K McCarthy, F Adams, "The US Health Insurance Customer Experience Index, 2017," Forbes, October 11, 2017.
[2] B Rosen, "Millennials Throw Shade, Offer Savage Tips for Health Plans," healthsparq.com/blog, October 4, 2017.

# Medicare Advantage membership grows, quality gains smaller

**7.6%**

**Medicare Advantage (MA) plan membership grew by 7.6% nationally (1.3 million Medicare beneficiaries) in 2017.**

*Private insurers that administer MA plans generally offer more benefits at lower levels of enrollee cost-sharing to attract customers, as compared to fee-for-service Medicare.*

**31%**

**of Medicare beneficiaries in Missouri signed up for Medicare Advantage in 2017, up from 29%.**

*UnitedHealthcare, Aetna and Humana dominated the market, enrolling 79% of MA members statewide.[1]*

**Star Ratings make it easier for Medicare beneficiaries to compare MA plans.**

*Ratings summarize multiple aspects of care that impact patient outcomes, patient experience and access to care (listed in the box below).*

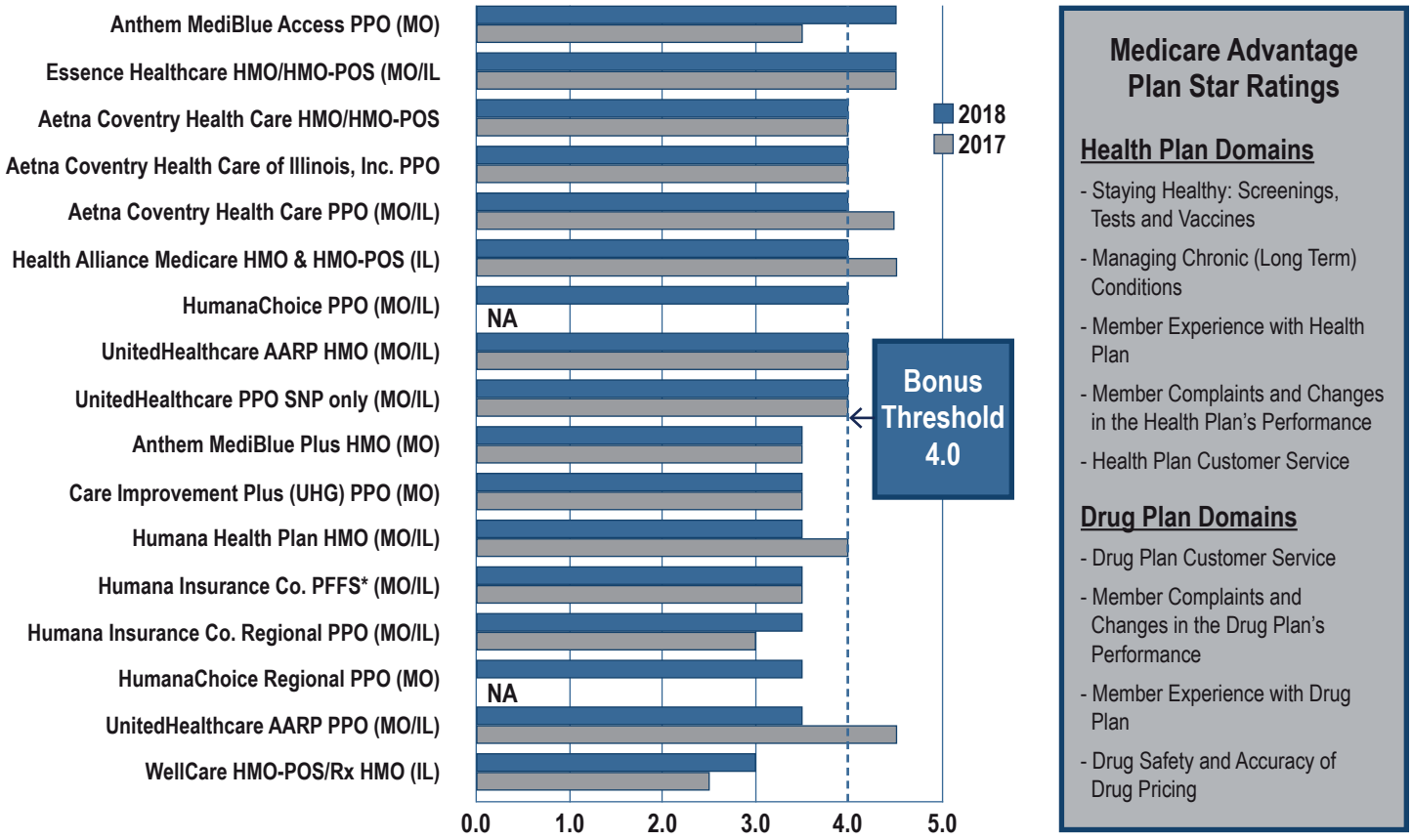
**$$$**

**Medicare rewards MA plans with a 5% bonus in capitation payments for a 4-star rating and above.**

*In 2018, more than half of local (MA) plans were rated four stars and above for 2018 enrollment, the same as in 2017, shown in the graph below.*

## St. Louis Metropolitan Area
## Medicare Advantage Plan Star Ratings, 2016-2017

*Over the past year, a small number of metrics showed poorer results and less than one-fourth of measures improved. Still, those that improved are tied to outcomes and are more heavily weighted in the star rating system, such as improvement in blood pressure control and glucose control for people with diabetes. Medicare Advantage continued to outperform commercial health plans on these metrics (see pgs.7-8).*




### Medicare Advantage Plan Star Ratings

**Health Plan Domains**

- Staying Healthy: Screenings, Tests and Vaccines
- Managing Chronic (Long Term) Conditions
- Member Experience with Health Plan
- Member Complaints and Changes in the Health Plan's Performance
- Health Plan Customer Service

**Drug Plan Domains**

- Drug Plan Customer Service
- Member Complaints and Changes in the Drug Plan's Performance
- Member Experience with Drug Plan
- Drug Safety and Accuracy of Drug Pricing

Source: The Centers for Medicare and Medicaid Services. * Private Fee-for-Service (PFFS).

# Millions more will need to lower blood pressure under new guideline

Approximately 103 million Americans have hypertension, a **14% increase** over previous estimates, based on **new definitions and treatment targets issued in 2017** by the American Heart Association and the American College of Cardiology. The change **means that 46% of the adult population will meet the criteria for high blood pressure, up from 33% under the former guideline.**

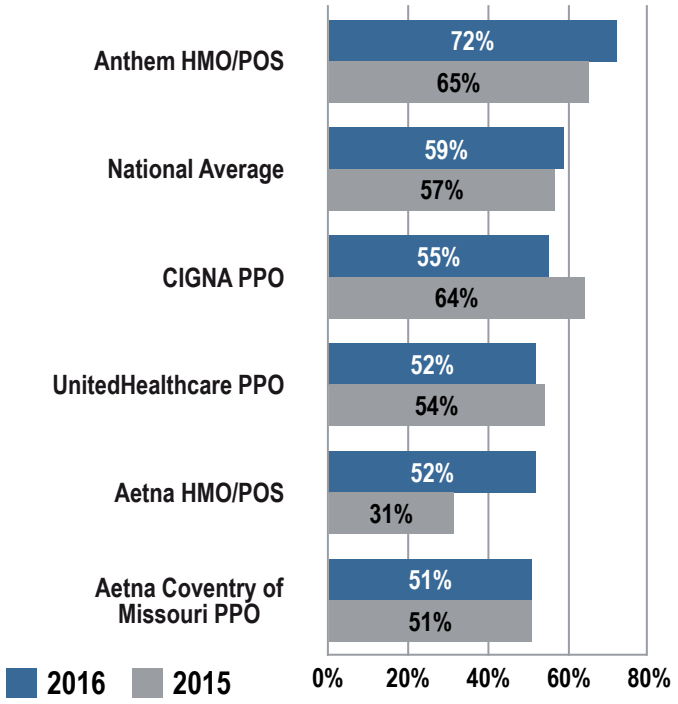
## What Changed?

**Blood pressure (BP) of 130/80mm/Hg or more is now defined as hypertension** for anyone with cardiovascular disease (CVD) or at significant risk of heart attacks or strokes. Lifestyle changes, like diet and exercise, and medication can help reduce BP below 130/80mm/Hg. The **previous guideline defined hypertension as 140/90mm/Hg** and was in control if held below this level.

In formulating the guidelines, the expert committee found **that people with blood pressure above 130/80mm/Hg carried double the risk of heart attack, stroke, heart failure and kidney failure**, compared to those with lower blood pressure.

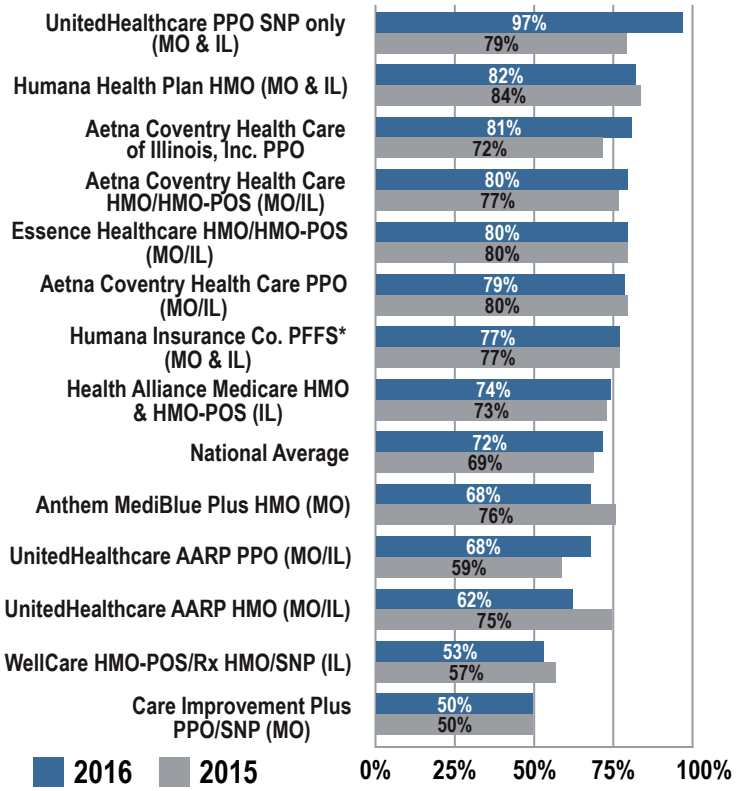
**Nationally, control of hypertension in commercially insured patients increased to 59%** in 2016, up slightly from 57% the previous year based on the former, more lenient standard of BP below 140/90mm/Hg. In St. Louis, control of hypertension in **commercially insured patients was below the national average at 56% in 2016. Two local plans improved performance, Aetna and Anthem**, shown in the graph to the right.

## % of Patients with Blood Pressure in Control St. Louis Commercial Plans, 2015-2016




Source: National Committee for Quality Assurance (NCQA) Quality Compass 2016 based on the previous guideline to keep blood pressure below 140/90mm/Hg.

## % of Patients with Blood Pressure in Control St. Louis Medicare Advantage Plans, 2015-2016




Source: Centers for Medicare and Medicaid Services based on the previous guideline of keeping blood pressure below 140/90mm/Hg.

***The gap in blood pressure control between Medicare Advantage and commercial health plans was 13 percentage points.***

**Medicare Advantage (MA) plans nationally continued to outperform commercial plans on hypertension control at 72%.** Locally, UnitedHealthcare's PPO Special Needs Plan (SNP) plan, that covers patients living in skilled nursing facilities, had the highest score among local MA plans.

**What is different?** For the first time, Anthem's commercial HMO/POS enrollees had better control of hypertension than MA members. **"In our successful Enhanced Personal Health Care program we work with physician practices on a regular basis to identify high-risk members and then work closely with physicians to better coordinate care to help members manage chronic conditions," Anthem said.**

Primary care visits and wellness screenings will be more important than ever given the larger percentage of the people expected to have hypertension. Drug treatment will likely be recommended for more people. Given that prior treatment strategies have not been successful in getting many patients to goal, heart experts urge doctors to find more effective ways to engage their patients in lifestyle changes to support achievement of the new targets. Successful implementation of the new guideline will likely result in a substantially lower BP in the general population with a commensurate reduction in morbidity and mortality from CVD.[1]

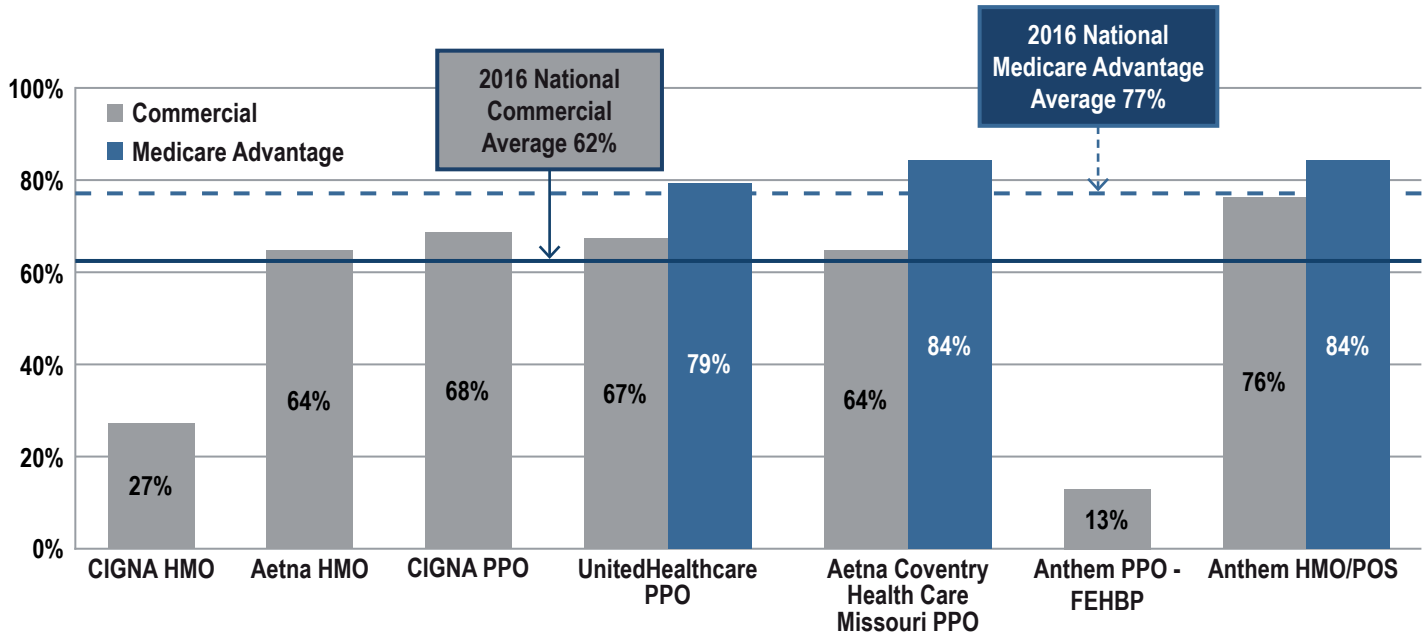
[1] P Whelton, R Carey, "The 2017 Clinical Practice Guideline for High Blood Pressure," Viewpoint, JAMA, November 20, 2017.

# Plans improve diabetes care for privately insured

Nationally, 62% of commercially insured people with diabetes had blood sugar in control in 2016, about the same as the previous year. A far larger percentage, 77% of people with diabetes covered by Medicare Advantage (MA) plans had glucose in control, a 15 percentage point difference.

**In St. Louis, 68% of privately insured people with diabetes had blood sugar in control, a 16% increase over the prior year.** Five out of seven scored above the national average as shown in the graph below, the best performance since 2014. Furthermore, **the gap in performance between commercial and MA plans decreased.** After years of falling scores, these improvements for local commercial plans are encouraging.

## Commercial vs. Medicare Advantage Plans
## % of Diabetic Patients with Blood Sugar Controlled, 2016




Source: National Committee for Quality Assurance (NCQA) Quality Compass 2017 and Centers for Medicare and Medicaid Services.

In 2016, **76% of Anthem commercially insured members with diabetes had blood sugar in control, the best performance among local plans for the second consecutive year.** Anthem increased the number members served by its **Enhanced Personal Health Care program** which offers shared savings to participating providers in its commercial network that achieve quality of care goals (p. 4). Anthem and Aetna's Coventry MA plans had comparable performance in glucose control for patients with diabetes. Anthem is moving MA plans to a more value-based design model that encourages chronically ill seniors to use high-value services, lowers out-of-pocket costs and offers shared savings to providers. Aetna's MA plan provider incentives include care management fees, quality bonuses and shared risk.

Insulin is a hormone that converts blood sugar (glucose) to energy in the body. About 5% of people have Type 1 diabetes and do not make enough insulin. **Type 2 accounts for 95% of diabetes cases.** While a person with Type 2 makes insulin, his or her body does not use it properly. This is called insulin resistance.[1]

**Without effective treatment, glucose builds up in the blood.** The consequences of uncontrolled glucose are severe, damaging blood vessels and nerves, increasing the risk of heart attack, stroke, kidney failure, blindness and amputations. **A test called hemoglobin A1C measures how well glucose is managed over time. An A1C value over 9 indicates glucose is out of control.** The right combination of diet, lifestyle changes and/or medication can get glucose under control and prevent or delay complications.

**30 Million**

In the U.S., ***if diabetes were a state, its population would be*** bigger than Texas, bigger than Florida, and bigger than New York. ***Over 30 million people have diabetes, or 9.4% of the population***, the American Diabetes Association said.

Thus far, medical treatment of Type 2 diabetes has focused on medication and lifestyle strategies that delay and/or manage complications, yet few achieve remission. In recent years, multiple studies have demonstrated that a substantial percentage of people with Type 2 diabetes can reverse the disease, reducing or eliminating the need for medication, through targeted interventions that include intensive and individualized nutrition programs, biometric feedback and behavioral and peer support.[2,3] Taking note of this, St. Louis Area Business Health Coalition employers are gearing up to learn more about these opportunities to support their employees with diabetes in realizing their best health outcome in 2018.

[1] National Diabetes Statistics Report, Centers for Disease Control, July 26, 2017
[2] S Steven, et.al., "Very Low-Calorie Diet and 6 Months of Weight Stability in Type 2 Diabetes: Pathophysiological Changes in Responders and Nonresponders," Diabetes Care 2016 May; 39(5): 808-815.
[3] A McKenzie, et al, "A Novel Intervention Including Individualized Nutritional Recommendations Reduces Hemoglobin A1c Level, Medication Use, and Weight in Type 2 Diabetes," JMIR Diabetes, July 3, 2017.

# Readmissions decline, effective communications matter

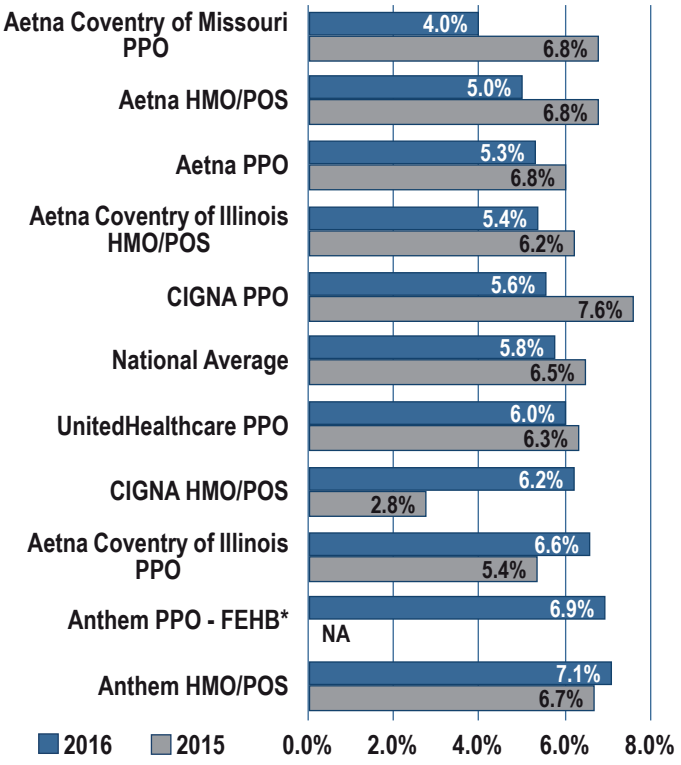
In 2016, national **readmission rates for commercially insured patients decreased to 5.8%**, down from 6.5% the previous year. Unplanned return visits to the hospital within 30 days of discharge for half of local health plans declined as shown in the graph at right. **Aetna's Coventry PPO had the lowest rate of 4%**, down almost half from the prior year.

Nationally, **Medicare Advantage (MA) plan readmission rates declined to 10%**, down from 11% in 2015. While two out of three MA plans saw rates decline, commercial health plan readmissions were markedly lower (more than 40%).Still, the **UnitedHealthcare (UHC) Special Needs Plan (SNP)**, which covers patients living in skilled nursing facilities, had readmissions comparable to commercial insurance of 5%. **The UHC SNP program is well-managed by nurse practitioners that closely monitor patients to intervene earlier to avoid potential readmissions.**

**Returning to the hospital for unplanned care disrupts patients' lives, increases their risk of harmful events like healthcare-associated infections and costs more money.** Better care quality improves health outcomes, which helps patients avoid returning to the hospital.

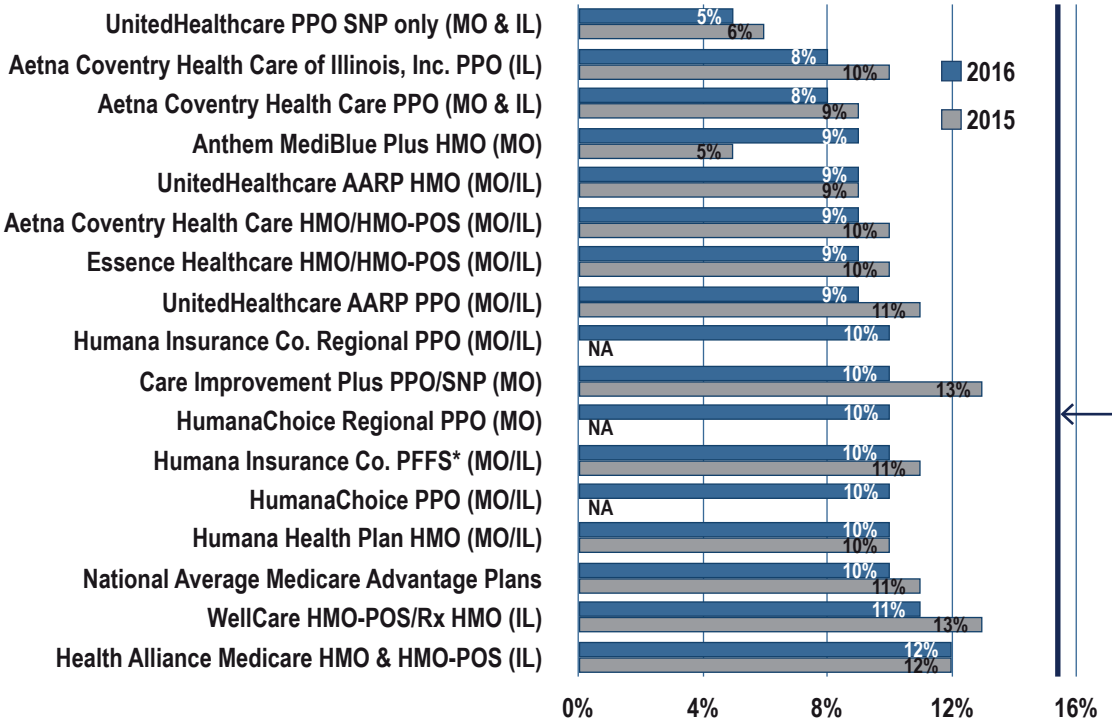
**Higher patient satisfaction has been linked to lower readmissions,** a recent study found. Patients that reported high satisfaction with their care experience were 39% less likely to be readmitted. Patients who reported feeling like their doctors listened to them carefully were 32% less likely to be readmitted.[1] "The reason these patients are not returning to the hospital is because they have better communication with their care team, and because of that communication, they have a better understanding of how to take care of themselves. Overall it is a much more fulfilling experience for them," said Dr. Jocelyn Carter, lead author of the study and an internal medicine physician at Massachusetts General Hospital.[2]

## Plan All-Cause 30-Day Readmission Rates St. Louis Commercial Plans, 2015-2016




Source: National Committee for Quality Assurance Quality Compass 2017

## Plan All-Cause 30-Day Readmission Rates St. Louis Medicare Advantage Plans, 2015-2016




***Patients that reported high satisfaction with their care experience were 39% less likely to be readmitted.***

**2016 National Medicare Fee-for-Service Average 15.3%**

[1]J Carter, et al, "The association between patient experience factors and likelihood of 30-day readmission: a prospective cohort study," BMJ Qual Saf, Nov. 16, 2017.

[2]M Castelucci, "High patient satisfaction linked to lower readmissions," Modern Healthcare, Dec. 15, 2017

Source: The Centers for Medicare and Medicaid Services. Plan All-Cause Readmissions measure steward is the National Committee for Quality Assurance.

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## About the BHC

The St. Louis Area Business Health Coalition (BHC) represents leading St. Louis employers in their efforts to improve the well-being of their employees and enhance the overall value of their health benefit investments. BHC employers seek a transparent health care market where comparative information about quality, cost and outcomes is used to achieve high-quality, patient-centered, and affordable care for all people in the region.

The BHC Foundation is a separate non-profit subsidiary organization to the BHC. The BHC Foundation's purpose is to provide pertinent health care information to the community.

## About this Report

This report analyzes, summarizes and presents information and trends on St. Louis area health plans that include data from fiscal year 2014 through 2016. The report includes data from the following sources: U.S. Department of Health and Human Services HealthCare.gov, the Centers for Medicare and Medicaid Services, Health Plan 10-K reports filed with the Securities and Exchange Commission, the Kaiser Family Foundation, and the National Committee for Quality Assurance (NCQA) Quality Compass, as well as additional information voluntarily submitted by health plans. This report may be downloaded from the BHC website, at www.stlbhc.org.

## Data Limitation and Cautions

BHC has made every effort to provide accurate information. Each health plan was given the opportunity to verify its data. As with any analysis of industry data, a note of caution is advised. BHC depends upon the accuracy of the data sources and cannot guarantee the complete accuracy of all the data in this report. For example, NCQA Quality Compass data may not always report rates from year to year and rates may also be affected by small sample sizes. In this case, data inaccuracies that may remain for individual health plans would have minimal impact on weighted average values and virtually no impact on the overall conclusions. Please read and become familiar with the technical discussion while reviewing or interpreting the data detailed in this report.

## Acknowledgments

BHC would like to acknowledge the health plan representatives who voluntarily provided BHC with health plan data. Health plan representatives and their staff worked extensively with BHC to verify the accuracy of the data. The additional time and effort spent analyzing and verifying the data was invaluable to the project's success.

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