The Future of Effective Health Care

What Employers Must Understand and Prepare For

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While medical care dates to the dawn of mankind, the concept of an employer paying the caregiver for the services rendered is a phenomenon new to the 20th century. Historically there are several examples of health care models funded by employers, including the health care sponsored by Henry Kaiser at his construction company and the very first Blue Shield plan in the world here in the logging communities of Washington State, but it wasn't until the wage controls of World War II that employer provided health insurance became ubiquitous. Twenty two years later, in 1965 Congress created Medicare and extended health insurance coverage to nearly all Americans age 65 and older. So in less than twenty five years, the United States population went from being nearly universally personally self insured, to being covered by a third party payer. The result has been that nearly 95% of documented Americans are covered by insurance. Unfortunately the system did not anticipate the massive cost increases over the last half century. The result is that we are once again looking to reform the system with an eye towards quality and affordability.

Cost Drivers

There are several reasons for health care costs increasing but there is little debate about the major drivers. Technical advances in treatment protocols, device capabilities and distribution, radical gains in the pharmaceutical industry, and an increase in life expectancy and resulting aging of the general population are all major contributors to the total cost of health care.

In addition to these indisputable factors, there is widely held belief that the current entitlement system enables poor health by curtailing the financial impediments associated with the consumption of services, as well as undermining the impact of neglectful or poor lifestyle decisions. Others argue that physicians operate under a perverse incentive, one that pays them not for improving health but merely for providing more health care.

Different Models

The present system is a result of decades of trial and error. The most common form of health insurance is provided on a fee for service basis. Simply put, when services are rendered, the provider submits a claim and is reimbursed for the service. The most common fee for service model is provided through Preferred Provider Organizations that have negotiated fee discounts with the insurance companies.

An alternative to this model is the capitation model where a physician or system is paid a monthly fee and accepts the risk associated from patients who visit infrequently to people with chronic illness that see their physician routinely. Typically seen in Health Maintenance Organizations, capitated models extend all the way to organizations like Group Health Cooperative, where the insurance company is also the health care provider and the physicians are employees of the health plan.

With rising health care costs, there has been tremendous pressure on all of the payment models to better control costs, generally through care management and utilization management. Examples of care management are nurse case management and disease management, where high cost individuals are identified and followed through the health care system in an effort to reduce redundancy and support best practices health care. Utilization review and population management are data driven, systems wide initiatives employed to identify new programs, support and enhance existing programs, and reduce cost through oversight and rationing of care.

Government Intervention

The problem of rising health care costs is nothing new. Congress has passed several major pieces of legislation to control the rising costs of health care including the HMO Act of 1973 that created HMOs, the Employee Retirement Income Security Act of 1974 that defined and validated self funding, the Medicare Modernization Act of 2003 that created Health Savings Accounts, and most recently PPACA, for one very clear reason- all attempts to control cost have failed. Starkly, health care costs have continued to increase at a rate that averages about 3X the rate of inflation over the last decade.

As the insurance system has attempted to rein in cost through provider contracts and health management, feeling the pressure from an increasingly dissatisfied public, Congress continues to create additional layers of compliance and oversight. With HIPAA and its amendment HITECH Act, Congress has created very specific requirements pertaining to privacy and Electronic Data Interchange. With Electronic Medical Records, health information is quickly going digital and EDI is intended to enable this encrypted data to be transmitted between all relevant parties.

With the passage of the Patient Protection and Affordable Care Act, Congress intervened in an entirely new way. Mandating health insurance for all American citizens, PPACA also mandated the coverage to be provided, the definition of affordable health insurance, the definition of quality coverage, and provided the mechanism for providing access to coverage through the yet to be created health insurance exchanges. In addition to the central tenets of mandated coverage and the "play or pay" tax, PPACA also provided for the extension of and creation of several new taxes to fund several initiatives including the evaluation of Accountable Care Organizations, evidence based medicine, and additional quality and health incentives.

Evidence Based Initiatives

Providers, employers, and insurers are working collaboratively to ensure the care they pay for is consistent with commonly accepted medical standards referred to as best practices or evidence based, the care is performed at the appropriate, least costly location, and quality and coordination is maintained throughout the entire cycle. The medical community has been working with private insurers and employers to address population health management and the perverse incentive that doctors are paid more when their patients consume more health care. Nationally the Leapfrog Group and locally the Puget Sound Health Alliance are attempting to change the way providers are paid for improving their patient's health.

Patient Responsibility

Routinely, patients have neither the incentive, nor the ability to evaluate health care for quality, cost, or effectiveness. Companies like Avvo are providing web based information about patient satisfaction levels with their physicians, a movement will only gain momentum. And insurance companies are moving towards providing specific costs for specific procedures performed by specific providers. Both of these steps will provide more transparency in the system and will allow patients to make more conscious decisions about the value of the health care they receive. Of course, quality care is difficult to quantify and communicate. Addressing this challenge, additional data reporting and aggregation coupled with advanced analytics will provide more clarity around quality health care.

Provider Incentives

Providers of health care are going to see substantial changes in the way their practices operate to stay relevant in the changing landscape as well. The cost of complying with EDI and EMR standards, the increasing pressure from insurance companies to reduce fees, and the need to operate in an evidence based environment will put tremendous pressure on individual and small practices to merge with larger delivery systems that can deliver everything from primary care to inpatient care. These larger systems will likely enter into some form of risk sharing arrangement with the insurance companies with the goal of being rewarded for improving the health of their members. Regardless of size though, all doctors are going to be held to a new level of accountability from both their patients when it comes to cost, and the insurance companies as it pertains to evidence based best practices.

Conclusion

Employers of all sizes that make a conscious decision to continue to sponsor a health plan in the future will need to expend more time and energy to understand the series of decisions and the implications therein. Gathering and analyzing complex data to make value based decisions will take on an entirely new significance. And while employee consumers are accustomed to selecting from large PPO networks, employers will have a vested interest in their employees receiving the highest quality care at the lowest cost. In the near future this will mean evaluating plan designs and networks that have far more limited PPO networks with even more stringent utilization review based on best practices medicine. As an employee benefit, employers will need to effectively communicate the value of such arrangements in order to prevent employees from believing that their freedom and flexibility is being reduced or eliminated. As in all things, communication regarding these kinds of decisions is absolutely paramount in achieving the best results.