Find Real Health Care Reform

Demand adaptation and innovation

By Greg Loudon

The Patient Protection and Affordable Care Act (PPACA) of 2010, also known as health care reform, is receiving mixed reviews from both advocates and opponents of the bill. Some provisions have proven difficult to implement and regulators are slowly rolling out guidance. As health plans have their first renewals following Sept. 23, 2010, we are seeing the removal of lifetime maximums, and the phase-out of annual maximums. The law eliminates pre-existing condition exclusions for children under age 19. Children can now stay covered to age 26, and new plans are paying for expanded preventive care.

By early February 2011, rulings were released in four federal court cases on different lawsuits brought against the federal government challenging the constitutionality of the PPACA. Two of the cases were decided in favor of the federal government, and two have ruled that the individual mandate – the requirement that everyone in the country purchase insurance – is unconstitutional. The State of Alaska joined Florida and 25 other states in a suit in Federal District Court challenging the individual mandate as a violation of Congress' Commerce Clause powers. U.S. District Judge Roger Vinson ruled that not only was the individual mandate unconstitutional, but because the PPACA lacks a severance clause, the entire law must be thrown out. From a practical standpoint, Vinson is correct. With no individual mandate, then the entire bill is in jeopardy. All of the popular provisions within PPACA cost money. In 2014, pre-existing condition limitations will be eliminated for everyone, not just children. We can only afford this if everyone is included in the insurance pool. If you are allowed to wait to purchase health coverage until you need it without any penalty, most rational people will wait until they are sick – driving up costs for everyone else.

Regardless of one's opinion on the specifics of the PPACA, the necessity of reforming our health care industry is paramount. Our current spending on health care is unsustainable.

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) reports the following data regarding U.S. spending on health services.

This steady increase in health care spending limits employers' ability to invest in other areas and may threaten their viability. More businesses face the difficult decision to sacrifice the quality of health coverage provided to their employees, or eliminate it altogether. Cost-shifting through increased deductibles and out-of-pocket costs, or increased employee contributions is common.

So why have we lost control of health care costs? What, or who, is driving the rampant cost increases? Complicated regulatory and pricing environments, provider shortages, technology advances allowing treatment of more complicated diseases, an aging population, chronic diseases like diabetes, heart disease, obesity … all result in a tremendous increase in cost.

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Broken Delivery and Payment Model

Most consumers are disconnected from the financial purchase of their care. We have grown to expect that a doctor visit only costs $25 (our co-pay), or that our antibiotic costs $35 – oblivious that the doctor is really being paid $250 for that office visit, several hundred more for the chest x-ray, and our medication costs more than our monthly car payment.

Our current model of health care delivery in Alaska is called fee-for-service. A provider performs a service and we pay for it. Fundamental economics, willing seller and willing purchaser – this should be an efficient model, but it's not.

We have difficulty figuring out the price of our care, but it is equally difficult to determine the quality of care. To purchase a new car, you rely on readily available statistics to make an informed decision, and you understand the quality difference between the $80,000 Mercedes and the $20,000 Kia. Armed with information, you weigh price and quality and make a determination of value.

How many have called different providers and shopped prices on an annual physical? Even if you knew that a visit to Dr. A costs $350, and a visit to Dr. B $2,000, which one offers the best value? With your health at stake are you going to buy the low bidder? Maybe. If you knew that outcomes were similar, you may choose the lower cost.

Why do Dr. A and Dr. B charge such different amounts for a similar service? Before handing out a script for a statin, Dr. A pushes her patients to lose weight and start exercising more. She would rather lose a patient then give in to a patient's desire for the newest drug. Dr. B's approach is different. He chooses to order more extensive services up front or gives in to his patient's request for the newest medication.

Is Dr. A more virtuous? Not necessarily. But people do exactly what they are incented (paid) to do. Run more tests – you have a lower chance of being sued, your patients think you're thorough and you get paid more in fees. Before you know it, defensive medicine, patient demand, increased technology, higher overhead and more staff have changed the way that you run your practice.

Add to this mix a provider shortage and the lack of competition and it yields yet higher prices.

How Do We Change The System?

In 2003, health savings accounts (HSAs) joined an alphabet soup of personal health accounts (FSA, HRA) supporting the consumer-directed health plans (CDHP) concept. CDHP plans feature a large deductible, which can be funded from the employee's health account. Employees spend their own money from health accounts or from their pocket until the deductible is met. Variations allow employees to own the money outright, or carry it over from year-to-year. The concept is simple: we behave differently when our own money is at stake.

Remember some of the factors driving our health care costs – chronic diseases? These few conditions drive the majority of all health care spending. Ironically, you can save more money on these conditions by spending more money – early on.

Wellness plans and disease management programs address this problem directly. Keep people healthy and they won't get sick. Unfortunately, we don't always engage in behaviors that keep us healthy. We don't sleep or exercise enough, we eat and drink too much, and generally don't pay attention to our health until we are forced to go to the doctor. Doctors get paid to perform services. In fact, they are paid more if we stay unhealthy because they must perform more services. Wellness plans create incentives and opportunities to stay healthy. There has to be a strong

employer commitment to wellness to be effective, but data shows a good wellness program delivers a positive return on investment.

Disease management (DM) focuses on the segment of the population having chronic disease, with proactive treatment mitigating expensive hospitalization. A DM vendor identifies patients through review of claim data. DM nurses provide patients regular monitoring, coaching and assistance to manage their disease.

These two programs are so effective that nearly every major insurer offers some form of them as a way to reduce costs. But more often, it is the large self-insured employers that are driving these programs. Why? Insurers have a job to do for their clients, but they also have to remain profitable. Because employers often change insurers based on pricing, insurers may have a more volatile turnover rate than a large employer. The insurer wants to keep patients healthy for the next two or three years, but they have less incentive to focus on changes that will yield results 10, 15 or 20 years down the line. An employer with a steady work force may have an employee for their entire career. Keeping that employee healthy saves money. The incentives are aligned.

New Models?

In parts of the country, large employers are building their own clinics on campus and hiring their own medical providers. By having medical services available at the work site, employees spend less time away for an appointment. The employer pays only for the direct salary of the doctors and nurses that provide the care and rent for the space. While there are few employers in Alaska large enough to make this pencil out, we may see it in the coming future. Other health plans are adopting alternative care models such as collaborative care or the patient-centered home. While these programs aren't available in Alaska today, they may be developed in the future

Even if you can't participate in one of these alternative care models – you can demand more from your providers. Question the care you receive. I am optimistic most physicians will welcome the opportunity to enlighten their patients and discuss their treatment plan. If your physician doesn't, find someone else.

President Obama is right – health care costs have grown to an unsustainable level and they have to be brought under control or our country will suffer. The PPACA doesn't appear to provide the right kind of health care reform, and our current delivery system cannot adapt and innovate unless you demand it. Your business, and the future prosperity of America require it. ❑

About the Author

Greg Loudon is an employee benefits account executive for Parker, Smith & Feek, one of the 100 largest insurance brokerage firms in the nation. Responsible for the design and implementation of employee-benefit programs for a variety of governmental, Taft-Hartley and private-sector clients to provide health and welfare consulting and brokerage services. Loudon is an active in Alaska legislative issues and an experienced, invited speaker on employee benefits topics.