Temperatures Rising

Blame Reform Uncertainty, Flawed System

By Rebecca Patrick

If Benjamin Franklin were alive today, he might be inclined to add health care angst to his famous phrase about how nothing in life is certain except death and taxes.

The last decade-plus has seen premiums skyrocket while a significant number in the country remain uninsured or under insured. Last year, the national "cure-all" known as the Patient Protection and Affordable Care Act (PPACA) was set in motion in Washington, with provisions slowly being phased in.

The trouble is that many people don't feel any better now about their health care – some maybe even worse – and consumers and industry leaders alike are downright skeptical of how the reform plan is going to play out. Add to that the growing sentiment – one that the PPACA didn't address – that the health care system itself is flawed and something has got to give.

To discuss where we go from here, what improvements still need to be made and what positive steps some employers can take are:

Participants:

- **Bryan Mills,** president and CEO, Community Health Network, Indianapolis
- **Mike Ripley,** vice president of health care policy, Indiana Chamber of Commerce, Indianapolis
- **Chris Schrader,** global vice president, Author Solutions, Bloomington
- **Shelly Sondgerath,** sales executive, Brown & Brown Insurance, Carmel

Wild cards

Even beyond the aspects of the federal health care reform left as "to be determined," there are specific provisions in the plan that are clear red flags to our panel.

"There's a lot of risk baked into the mutual interdependencies of so many bureaucracies that will exist in the national health care system," Schrader proclaims. "You can never really forecast how each bureaucracy will interpret its mandate."

He also cites the "unprecedented power given the secretary of health and human services in this bill, to be able to grant waivers, to be able to make decisions" as something that gives him pause.

But without question, the group cited one cornerstone of the PPACA as the biggest uncertainty: How to get the state health exchanges to work. By 2014, each state is required to have such an exchange – an organization of sorts where buyers and sellers of health care coverage come together. It's up to each state to decide if it wants to run its exchange or have the federal government oversee it.

"Quite frankly, I think they're going to have trouble getting exchanges off the ground for two reasons. I think they aren't going to find a whole lot of people willing to commit to them, and then there's going to be a gross disparity between the states that say to the feds, 'here you do it,' and the states that say, 'let me take it on,' " Schrader theorizes.

"That said, given a choice between the feds doing it or Hoosiers doing it, I'll take Hoosiers every day and twice on Sunday."

Ripley concurs. "We think it makes more sense for the state to do it – to take the bull by the horns – instead of letting the feds do it because the kind of regulations that we probably would get from the federal government would likely stifle innovation.

"In addition to that, if employers don't want to participate in the exchange, you can see adverse selection and things like a death spiral because you're going to get more folks who may be in the high-risk category in the exchange. So insurance carriers may not participate in the process," he offers.

"Carriers have indicated exactly that to me – that they might not participate in it if it's not going to look like a viable market for them."

Adds Schrader, "If I were an insurer, I could completely see a rationale for 'let's see if these

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shake out and see how this works before we commit ourselves.' "

Employer effect

The wait-and-see approach is also evident in the business community. While implementations of mandated provisions of the PPACA are obviously occurring to meet effective dates, the general uncertainty of the new plan and its costs are top of mind.

Ripley has heard from Indiana Chamber members statewide who find the new federal program unsettling. "We have seen numbers predicting anywhere from a 3-15% increase for premiums. The concern with employers I talk to – large and small – centers on will they be able to continue to provide coverage for their employees.

"While there is a definite employer benefit to providing health care, to try to attract the best quality employees, at some point it may become easier and necessary financially to push folks into the health exchange. That decision may come when they have more information and can do a cost-benefit analysis," he determines.

Sondgerath labels what she's hearing from employers as a "tad bit of fear. There are laws in place that don't really have set rules. How do you plan long term when we don't know what you're even planning for? Do you take this path, the second path or the third path?

"Whether it's blue collar or white collar workers, if they truly understand how to use a consumer-driven plan, how it affects them and the pre-tax savings, they will do it and they will love it."

Shelly Sondgerath
Brown & Brown Insurance

"That's the number one question that we see for clients coming into renewal season for 2011 and going into the next couple of years."

Between the employer mandates in the bill and the expected rise in coverage costs, Sondgerath agrees with Ripley on the reality that some Hoosier businesses will wash their hands of health care.

"In general, employers are sitting back and trying to calculate out what it's going to cost me to take on these increases versus what it's going to cost me to pay the penalty and get the heck out of the market of health care altogether."

But she believes that act is a last resort. "Most employers I find don't want to do that; they care about their employees. Plus, their retention rate is important to them and they can't recruit without a decent package."

Consumerism rise

Going forward, the group contends inherent changes are going to have to happen to make health care more viable for employers, providers and users. One way is through the product side.

"We have to find new and better ways to bring additional offerings to an employee plan. That might mean ways to help them shop for health care. Employers are going to have to help their employees become true consumers and that's something that we have failed immensely at so far," Sondgerath assesses.

"People don't know what accountability in health care is; they have no clue. They don't know how to shop for it; they don't know how to choose the right doctor and so on. They don't know how to really look for that information and how to ascertain where they should be getting their care and what it should be costing them."

Turning that corner and getting more consumers informed, however, won't happen overnight. It's a philosophy change that relies on employers and those in all aspects of the health care industry providing better education.

Schrader is an exception to the norm. That message reached him several years ago and he has since driven home the benefits of consumerism with his employees.

"Five years ago, I introduced HRAs (health reimbursement accounts) at the company with high deductible plans. The consumer-directed model drove the employee costs down to only 20% of what they had been before (in a classic $500 or $1,000 deductible indemnity plans) and got almost everybody back into the plan. Then, I steadily ratcheted up deductibles as the employee HRA balances grew," he explains.

A $4,000 deductible plan is the current model, with $3,000 in HRA credits and only $1,000 exposure for the employee.

"I was able to pull this off because my workforce is very atypical for Indiana; the average age is 28, 89% have a college degree – so I had a lot of folks for whom I basically had coverages right up their alley.

"It's been remarkably successful here and a lot of my folks are quite concerned about the health care bill because they are worried about their HRA balances and will we be able to have a plan like this," Schrader notes. "And I must say that in my reading of the federal health care bill, they are not particularly kind to innovative designs like mine."

Adds Sondgerath, "No, they're not at all. You've done what I wish

"We know for certain that nobody pays us what we charge – nobody. And the way the systems are set up, our price and fee schedules are so out of whack, and they are out of whack based upon our response to the reimbursement system over 30 or 40 years."

Bryan Mills
Community Health Network

all HR directors would do, which is lots of education. Whether it's blue collar or white collar workers, if they truly understand how to use a consumer-driven plan, how it affects them and the pre-tax savings, they will do it and they will love it.

"We don't see people switching back off once they've been there. … When you're trying to be innovative and create something for a plan design that's forward-thinking, the HSA (health savings account) and HRA are your two best components," she offers.

"Long term, these plans will have an impact on costs, but right now people are just learning some of these new ways of doing things."

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Mike Ripley
Indiana Chamber of Commerce

Foundation cracking

But no matter the changes made on the consumer side, it will not mask the health care system's inherent flaws of how providers get paid and the current billing model.

As a matter of course, those paying for their own insurance – the commercial market – pay not only for their health care but also the subsidies for government coverage (Medicaid and Medicare). What's happening is the government market is increasing while the commercial market is decreasing, Mills says.

"That puts more pressure on those premiums, and this is not sustainable," he asserts. "This issue has been highlighted or exacerbated due to health care reform, but the fundamentals were there anyway. We've got an issue to deal with, and it's here to stay."

Mills explains that it's a big problem that only the governmental side is seeing usage increases, given how much hospitals get paid on services rendered to those individuals.

With Medicare (health care for people primarily over 65), the hospital gets paid about 85% of what it costs to provide its services. With Medicaid (health program for eligible individuals and families with low incomes and resources), the hospital gets covered for about 55% of its costs. "Not what we charge, but what it costs us for our services," Mills emphasizes.

With that comes the reality that hospitals are not suddenly going to get paid more for what they do. The only alternative is to find a way to offer the same health care at a reduced cost.

"I've got to provide a service based upon what the market will pay. All of these rates are migrating. Whether it's due to the population aging or general conditions of the economy, they're migrating to a government payment. So we've got to find ways to improve efficiencies in our organization to reduce the cost that it takes us to provide that care," Mills notes.

The Community Health Network is currently working on how that can be achieved.

"We're in the midst of an initiative to take $100 million (of cost) out of our network, and I'm very confident we can do that. … We will have this fully implemented by the middle of 2011, and that's the first phase of what we need to do to get where we need to be," he surmises.

"And I'm very, very confident that we're not sacrificing quality or safety in the things that we're doing, but it's through better coordination of care and doing things in a far more efficient manner."

The sustainability issue is such a vital one that he believes it can help take down the communication barriers that exist between health care and insurance providers. Mills and Sondgerath both see a need to make pricing more transparent and reflective of what consumers actually pay.

"That's why I personally dislike national health care so much. Here I am trying to be innovative, trying to do the best I can for my employees, working hard to keep my company's costs in line … and I've got the federal government hanging over me while I'm trying to do it."

Chris Schrader
Author Solutions

"I think we can and need to collaborate on this because we've priced ourselves for the third party. We have these mechanisms for how we're being paid that are shielded from the consumer," Mills acknowledges.

"Like the consumer who takes accountability and says I need to start shopping, we have an obligation too. I have an obligation to show and deliver my product and make sure they know what they're buying and what's they're paying for. That's not been done. In the past, consumers paid what was left over after this mysterious thing happened."

He characterizes the task of changing the provider pricing structure as "monumental."

"We know for certain that nobody pays us what we charge – nobody.

And the way the systems are set up, our price and fee schedules are so out of whack, and they are out of whack based upon our response to the reimbursement system over 30 or 40 years. So all of sudden to stop on a dime and say we're now going to price it based upon what a consumer is paying is a huge shift," Mills stresses.

"That's not saying we don't have to do it, but that's where we need to partner with the insurance community and the business community to better do that."

For Sondgerath, the key is educating the client bases. "That's such a massive undertaking. It's almost like you're scrapping everything and starting over because from a cost containment perspective – from how things work – everything will be affected by it.

"And we know the communication level between the delivery systems is not where it needs to be, and that will be a big undertaking as well."

Down the road

Looking further ahead to five years from now, to where else the health care arena could be headed, Schrader took the floor.

"The PPACA as we know it has been found unconstitutional by the Supreme Court. A new structure takes place; it is a national health plan that has bipartisan support. It is targeted primarily at those who are uninsured or too poor to be able to purchase insurance," he predicts.

"The insurance industry looks different than it does today, both in its relationships with the people and with the providers. So you're going to see the trend line of organizations, entities and units of all kind working to directly contract for services to deliver results."

After this initial and well-received forecast, Mills quips, "I think Chris is the Secretary of Health in five years."

Chimes in Sondgerath, "If you could help get that thrown out completely and let's just start over, I'd vote for you for sure – no questions asked. It's certainly making my job a lot tougher."

Ripley asks Schrader on what point he believes the PPACA will be found unconstitutional.

"It's going to be the individual mandate, and I base that on what I expect the composition of the court to be. I can't see anything in the Commerce Clause about the federal government having the authority to direct me to purchase a commodity or service from any established entity by the government, and last I checked the 10th Amendment is still sitting there," Schrader explains.

"So, rights of government – power of government – are enumerated. Everything else, unless specifically enumerated, belongs to the people."

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(In mid-December, one month after this discussion, a Virginia judge ruled a portion of the health care law to be unconstitutional).