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International Society of Certified Employee Benefit Specialists

Lowering Health Care Costs…

We can lower health care costs by changing our paradigms to focus on wellness instead of illness. While this shift has been introduced by wellness programs, it needs to accelerate and fully impact both the health care delivery systems and employee benefit plans. Our goal needs to be rewarding health care providers for keeping patients healthy while putting them at risk for the cost of illness.

While this is a novel idea, it is not new. The Chinese first thought of this approach for their nobility in 500 B.C.. Back then, the physician was very well paid when the patient was healthy. Payments stopped when the patient became ill. In the event the patient died, the physician shared the same fate.

While it went too far, this approach places emphasis where it belongs, on maintaining good health.

But how do we achieve the shift of paradigms in the health care delivery system? The answer is; by using payments from our employee benefit plans to achieve the desired shift. This is possible because of the dependency the health care delivery system has on employee benefit plan revenue. Let me explain.

My employee benefit plan promotes wellness

My employee benefit

… By Changing Our Paradigms

There are three major revenue sources available to the health care delivery system: Medicare, Medicaid and employee benefit plans. Private pay is insignificant.

Medicare has reduced its cost by reducing their payments to providers. For every $1.00 of billed charges, Medicare pays about 50 cents. The remaining 50 cents is paid by cost shifting.

Medicaid pays about 80 cents on the $1.00 shifting 20 cents. Those who are uninsured become charity cases adding 2 cents to 7 cents to each $1.00 0f provider cost.

And where does all this shift to? The answer is employee benefit plans. This gives employee benefit plans tremendous power to direct the focus of the health care system, something never done historically.

The first step in seizing this power is to stop thinking of payments from our employee benefit plans as payment of

uncontrollable expenses. Instead, we must consider these payments as compensation for a cash starved health care system.

With this new perspective, we can then approach this expense as any other form of compensation, developing performance criteria that will drive the shift in paradigms from focusing on illness to focusing on wellness.

This compensation should have at least two components. The first would be a monthly capitation fee that will allow the provider to shift the focus to wellness. With revenue streams no longer dependent on treating illness, the focus can now be directed to maintaining health. Healthier patients are easier to treat than those who are ill and, therefore, more profitable.

The second component would be periodic cash payments generated for achieving specific objectives in certain time frames. These payments would need to relate to both the quality and cost of health care, with quantifiable performance standards, such as economic profiling of providers with targeted objectives.

The health care system can be managed. Consider the impact utilization review (UR) has had. The health care system has reduced the number of inpatient hospital days utilized in response to UR controls. However, the cost for these fewer days is still higher in the aggregate. Procedures shifted from an inpatient to an outpatient basis often cost more after the shift. In addition, we have put another layer of administrative cost and profit into our health care costs. Through approaches such as UR, we are treating only a symptom of the problem.

To treat the problem, incentives need to focus on the primary care physician (PCP). The PCP is the linchpin of the medical delivery system. While hospital costs represent 60% of our medical costs, these expenses are incurred only if ordered by a physician. Prescription drugs, by definition, are ordered by the physician. Yet, currently, physicians have no financial incentive to seek out less costly, but similar quality, alternatives.

I believe no physician enters medical school anticipating that he or she will become driven by the economics of our society. However, when physicians graduate - sometimes in their mid-30s and almost always with substantial medical school loans to repay - economics becomes a powerful motivator. Physicians worry about paying their bills like the rest of us, only they have more bills to pay. The result is: Medical practices have done what they were paid to do - treat illness. Now is the time to provide these physicians with incentives to promote health and get paid for it. With 50% of costs related to health or life style issues, employee benefit plans have a financial incentive also.

What needs to be developed is a new form of "partnering" between employee benefit plans and physicians, with the physician becoming much more responsible for achieving measurable cost and quality objectives. The employee benefit plan, in turn, needs to become much more sensitive to designing a plan of promoting health in support of the physician. This would result in a uniting of goals, with financial incentives to achieve lower costs through improved health.

To measure and direct this new partnership, employee benefit plans will also need to shift their focus from those who are ill to those who are well. We have great analytic ability when it comes to the ill; we must now develop a parallel ability to understand those who are well. What characteristics do the well have in common? Can these characteristics be replicated? How do we measure the health of a group?

In addition, we must learn to define health in terms other than a current lack of illness. For example, good health might be defined as leading a well balanced life complete with good nutrition, exercise/recreation and spiritual development, promoting a lifestyle that is currently free of illness and has patterns that minimize the risk of future illness.

To achieve these results, we can use various existing structures, such as HMOs or insurance companies, or we can develop new structures. The structure of the solution will vary geographically. Obviously, a locale with 10,000 employees working at 8,000 employers will develop a different solution that a locale with 10,000 employees at a single employer.

Regardless of structure, we need to view payments from our employee benefit plans as compensation to our health care delivery system and expect to use this compensation to drive the agendas we need driven. The overall agenda needs to be to shift our health care system from focusing on illness to focusing on wellness and good health.

About the Author

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