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The Self-Insured Employee Benefit Plan as a Foundation for Risk/Population Health Management

Hospitals and health care systems have always been in a unique position when it comes to health insurance benefits for their own workforce. Often, hospitals self insure their plans with the idea of driving expenditures within their own health system and reducing expense as it relates to premium dollars and/or claims paid to their competitors. Through plan design and/or cost shifting; health care employers provide incentives to stay “domestic” and the plan experiences only the incremental costs of providing these benefits. The underlying concept is that the health care employer is managing the “risk” of their employee population in a way that the future vision of health reform would have the health of the nation managed. However, health management of the hospital’s employees and dependents typically stopped there.

Health systems have not – to a very large degree – sought to leverage the expertise under their own roof to improve the overall health and well being of their workforce. Often times, the hospital campus fails to “advertise” health – food choices are not healthy; staff smoke at the hospital entrances and more than half the workforce is overweight or obese¹.

In thinking about why this is so – one comes back to how the business of health is “rewarded.” In a fee-for-service environment – incentives on the health provider side are not aligned with managing the health of the population. The payment methodology is still tied to delivering health care services and not with managing the health of the population. Health care organizations who wish to be “cutting edge” and prepared for possible changes struggle with doing so under a payment system that, in essence, penalizes efficiency.

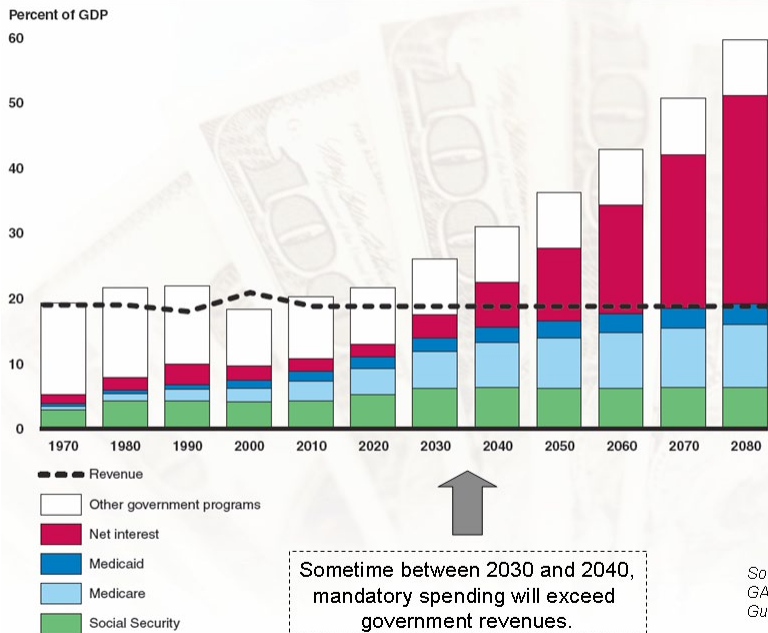
Industry news draws attention to organizations that declare they are forming an Accountable Care Organization (ACO). Physician practices are focused on patient-centered medical home initiatives. Health leaders are trying to figure out what this all means to their business, while dealing with encumbrances that are often at odds with the objectives health reform seeks to drive. Payment methodology, the legal restrictions imposed by anti-trust or anti-kickback regulation, and the fragmented health management delivery system stand in the way. All these factors oppose an integrated system of health management that actually rewards health care organizations for delivering high quality health care and preventing disease at an efficient and affordable price.

The question remains – are health care employers managing the health of their workforce and their dependents in a way that they can, in turn, “sell” to employers (commercially insured) or the government (Medicare and Medicaid) under risk arrangements? Do health care employers demonstrate a success story with their own employee population that can provide the foundation upon which to build their risk management business?

This achievement has rarely been accomplished. Typically, even in a self-insured arrangement – and even under some risk arrangements – health care employers have delegated population health management services back to the insurance carrier. The health insurance carrier provides services like utilization management, large case management and most importantly, disease management. These services are frequently divided amongst different groups, and at times, subcontracted to other specialty vendors, creating a fragmented health management framework. Limited access to data obfuscated what was happening among the population. The services will need to be delivered through a seamless and integrated care management platform with technology that provides tools for decision support and access to data that can be analyzed for results if health reform is to achieve its stated objectives.

The business case for managing health has an unprecedented sense of urgency.

The Risks of Growing Entitlement Spending



Source:
GAO Citizen's
Guide 2007

As a nation, we cannot sustain the cost increases in our entitlement programs. According to a recently published article in the journal “Health Affairs²,” in

2011 spending on government programs will account for more than half of all U.S. health-care spending, for the first time – some of which is the result of the weak economy and job loss pushing more people into Medicaid and slowing the growth of private insurance³.

According to the Centers for Medicare & Medicaid Services, National health spending for 2008 was \$2.33 trillion and represented 47% of the public share. That percentage is expected to grow to more than 50% in 2011, a figure that exceeds government estimates that predicted the 50% share would not be reached until around 2016.

New projections estimate that one out of every five dollars spent in the United States will be spent on health care – an amount that far exceeds any industrialized nation. The Centers for Medicare & Medicaid Services predicts that spending for 2009 will reach \$2.5 trillion which is 5.7% over 2008. This represents 17.3% of gross domestic product (GDP), up from 16.2% in 2008, primarily due to the shrinking economy. By 2019, health spending is expected to reach \$4.5 trillion or 19% of GDP.

Irrespective of what happens with challenges to health reform and all the possible iterations of change models – ACOs, patient centered medical homes, etc. – it is obvious that no matter what form it takes, change is inevitable. Commercially insured plans provided through private employers cannot continue to absorb the increases hospitals seek in order to offset the losses from government payers on their balance sheets. There is a very real risk that corporate employers will react as they did to the changes to employer sponsored defined benefit pension plans under ERISA, when they responded by getting out of the defined benefit business and offering a defined contribution instead. As health reform creates both a mandate and an avenue for purchasing insurance, large corporate employers could opt out of providing a benefit and instead elect to offer a contribution to offset the individual's purchase cost. The end result would not help us to improve the health of the American population or the communities each of the hospitals serve.

It is fundamentally clear that today's existing system cannot be sustained. The Massachusetts experience demonstrates that there is no simple solution to the health care conundrum. Nevertheless, their industry brethren should take note how health care organizations in the Bay State are managing under state reform. In a recent publication from the Center for Studying Health System Change⁴, the authors cited the following key developments since passage of state reform:

- State policy makers and legislators have been prevaricating, and putting off decisions for reform to control the rate of health care expenditures. Meanwhile, costs go on rising, in part as a consequence of the stature of Boston's celebrated academic medical centers (AMCs), which are strategically positioned to impose higher prices, drawing increasing numbers of patients from community hospitals.
- State regulators and health plans have been locked in controversies over proposed rate increases for the small group market. At the same time, the major plans have been confronting operating losses in the face of escalating medical costs. There have been legislative proposals to curb provider rates by capping them at a percent of Medicare. These did not make it into law and the efforts to curb provider increases were limited to provisions for financially strong hospitals to make voluntary, one-time contributions that would be used to ease the cost burden of premium increases for small employers.
- Boston's historically strong health care safety net is altering its framework. Most community health centers (CHCs) have been taking advantage of coverage expansions, while safety net hospitals have been hard pressed financially. The state has been transferring uncompensated care funding toward insurance subsidies, as a way of broadening coverage.

Additional developments provide some insight into how the market may change under national reform. The forays into global payment by the commercial insurers began in 2009. The Alternative Quality Contract (AQC) was rolled out by Blue Cross early last year, and seeks to set a global payment for providers who sign up based on historical trends, which are adjusted annually for inflation and health risk of the covered population attributed to the provider. Since the payment level is not adjusted annually for costs, any efficiencies they achieve are retained by the provider. An important improvement over prior attempts in this area (i.e., capitation) include performance-based incentives based on process, outcomes and patient experiences to avoid actual or perceived holding back on patient care. Blue Cross already has several hospital and physician organizations (PO) signed to the five year contracts.

We also see continued consolidation of physician practices and shifts in physician and hospital alignment. Tiered networks are being implemented as a cost control mechanism to narrow provider selection and the prevalence of Consumer-Driven Health Plan options is also growing. One area of attention and focus is utilization management – especially in preference sensitive, prescription and imaging services.

All that said, now what? Health care reform has focused new attention on the tension between being a health provider and a provider of health benefits; the emphasis on the objective of health insurance changes from paying for health care to managing health.

The health care employer's self insured health plan is a ready-made platform upon which to experiment, if there ever was one. In essence, it is a pilot project for creating and testing out how to create a health management infrastructure. There is no down side. On the one hand, if it succeeds, the organization will be far ahead of its competitors, who will still struggle with what it means to be an ACO or to have a patient-centered medical home. On the other hand, if it fails, the only loss is to the self insured plan – which, in all likelihood would have suffered the same losses under the old regime of health care delivery.

This platform is not a “wellness program” with return on investment (ROI) metrics that measure participation in HRAs and health related programs. It is a profound change the way business is conducted.

These goals call for organization wide re-engineering. The old way of doing business must give way to a new method of integrating service delivery and managing health outcomes. This transformation will require a commitment from the most senior levels of the organization to a new way of doing business, and will evolve over time. Return on the investment is typically generated incrementally over a three-to-five year period, while sustainability of health management and improvement is a critical challenge. As we work through our series, we will tackle issues the organization must face when seeking to redesign the health delivery system from one that delivers care services, to one that manages population health.

We will review case studies that cover the key factors in implementing and sustaining population health management including:

- Plan governance
- Data, analytics and decision support for:
 - early detection
 - patient engagement
 - clinical outcomes
 - financial optimization

- physician performance
- Technology for analyzing data, selecting patients, managing health outcomes and measuring results
- Health management to drive services within your system and to high performing (clinical and financial) physicians
- “Skin in the game” – plan design and incentives
- Absenteeism and presenteeism – the other cost of poor health management

Endnotes

¹ *Avi Dor, et al, A Heavy Burden: The Individual Costs of Being Overweight and Obese in the United States, <http://www.gwu.edu/~sphhs/departments/healthpolicy/pdf/heavyburdenreport.pdf> (September 2010).*

² *Christopher J. Truffer, et al, “Health Spending Projections Through 2019: The Recession’s Impact Continues,” *Health Affairs* 29, No. 3 (March 2010): 1-10.*

³ *“Public Health Tab to Hit Milestone,” *Wall Street Journal*, 4 February 2010.*

⁴ *Ha T. Tu, et al, State Reform Dominates Boston Health Care Market Dynamics, <http://www.bschange.com/CONTENT/1145/> (September 2010).*