Article

Trends That Aim to Reduce Costs, Improve Outcomes and Ensure Health Care Benefits for Your Workforce

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Prior to the Covid-19 pandemic, health care spending was a rapidly increasing percentage of the U.S. economy, yet the increase in spending was not producing better outcomes for patients. This issue has only been highlighted by the pandemic, leading private companies, along with the government, to examine the causes in hopes of developing and implementing a solution.

One component of the industry's overspending is due to improper incentives. For example, under the traditional fee-for-service (FFS) model, health care providers make more money if their patients are sick than if they are well.

The Affordable Care Act (ACA), was a major step in trying to move away from the traditional FFS model. This was achieved through Accountable Care Organizations (ACOs), which are health care organizations comprised of providers whose reimbursement is tied to quality metrics and reductions in the cost of care.

The model is based on capitation, which has been adopted by other payers besides Medicare. With capitation, the provider is paid a fixed amount per person over a defined time period that covers all health care services. It is adjusted for each patient's needs and the providers remain responsible for high-quality outcomes. This payment system is meant to align providers' financial incentives with the goal of eliminating waste and reducing cost without compromising the quality of care.

A changing landscape

This trend of a changing health care landscape and various new payment models have not gone unnoticed by health care executives and investors. Payers, such as United and Humana, have subsidiaries actively acquiring primary care practices with large Medicare Advantage patient populations. These payers also have proprietary software allowing them to closely monitor their patients' health. With these more innovative care models, the traditional fault lines between "payer" and "provider" are blurred as payers have more influence over the costs of care.

Some employers have set-up their own wellness clinics on site to provide basic care to their employees and employees' families. Not only do employees appreciate the benefit, but it also saves employers in both out-of-pocket medical expenses and in lost productivity from employees taking unplanned paid time off (PTO).

No surprises act

The lack of transparency regarding pricing is another reason for spiraling costs. In no other industry do you buy into a service or purchase a product without knowing the price in advance. Providers have put the blame on insurance companies, arguing that they — the providers — don't know what they will get paid at the time of treatment, and therefore are unable to accurately inform patients of the costs.

In the closing days of 2020, Congress passed the No Surprises Act. The new law protects consumers by ensuring they are not held responsible for the cost of unanticipated, out-of-network medical bills. Surprise bills often arise in emergencies – when patients typically have little or no say in where they receive care. They can also arise in non-emergencies – when patients at in-network hospitals, or other facilities, receive care from ancillary providers (such as anesthesiologists) who are not in-network and whom the patient did not choose.

The No Surprises Act goes into effect for health plans beginning on or after Jan. 1, 2022. The new law applies to nearly all private health care plans offered by employers (including grandfathered group health plans and the Federal Employees Health Benefits Program), as well as non-group health insurance policies offered through and outside the marketplace. The new law also contains other related provisions, including a requirement for health plans to keep network provider directories up-to-date.

Meanwhile, new businesses are forming to address the lack of transparency in pricing for health care services. At www.healthcarebluebook.com, patients can learn prices for tests, procedures, images, etc. before they receive medical care. The idea is that more transparency should eliminate surprises, create competition and lower prices.

Direct contracting

Many large employers are taking cost savings into their own hands by establishing contracts directly with providers.

Rather than pay premiums to traditional health insurance companies to accept unknown carrier network pricing, employers are contracting directly with providers to be their preferred points-of-service for employees' health care needs. Many times, employers prioritize contracts for the highest-cost and most frequent health care needs. The practice can be considered an extension of narrow networks, making a smaller number of high-value providers available to employees.

Different contract types exist within direct contracting, such as (i) traditional FFS, (ii) risk-based (using capitation or other global payment methods), (iii) service level agreements, and (iv) in some cases, medical tourism. One popular example of direct contracting is Walmart's arrangement with the Cleveland Clinic for cardiac surgery. The retailer also partners with Johns Hopkins Hospital in Baltimore for joint replacement surgery and the Mayo Clinic for transplants and cancer care.

While these are enterprise-level programs, it is important to note the same opportunities can exist on the local level.

Providers are typically only willing to consider direct contracting if they know their patient population or services will increase throughout the contract period, and that competing providers are eliminated from the network. In other words, the deal has to work for both parties.

Consolidations

Consolidation, and lack of competition that it can cause in the marketplace, is another reason for the rising costs. While Texas does not require one, most states require a certificate of need (CON) demonstrating a community needs the infrastructure of services to be provided before they approve expanding or developing a hospital, clinic, or ambulatory surgery center.

In Texas, the belief is that if the market does not need the hospital, or other facility, the project will either be unable to receive funding or it will fail. However, more than 35 states feel otherwise. These states take the view that if there are more hospitals, doctors will find reasons to keep them full. Yet, this goes against the concept of

competition and the free market. With the added safeguard of value-based arrangements, there is little reason to fear the addition of new facilities. Rather, the new facilities should increase supply and help lower prices.

Improving workforce health and wellness

The mental and physical well-being of a company's workforce (and arguably their families) cannot be overemphasized. However, traditionally, an employer's only role in health care was relegated to contracting (through a broker) with an insurance company to pay for that care. Year after year, the goal has been to stop the bleeding and manage the ever-growing costs associated with health care services.

For the reasons identified above, and as a result of the currently shifting reality, now more than ever before, we see opportunities for employers to play a more active role in the delivery of health care, with ultimate goal of improving workforce health and managing expenses.

It may be too early to predict with certainty what the Biden administration's approach to health care issues such as these will look like. However, judging from the recent nominations to the Department of Health and Human Services leadership, including a former policy official who played a key role in guiding the Affordable Care Act as the new administrator for the Centers for Medicare and Medicaid, it will likely be very different than the previous administration's outlook.

Learn more about Munsch Hardt's Health Care Practice.

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