

Six Ways to Fix Our Healthcare System by Samuel H. Fleet

The fever for healthcare reform is running high in Washington, D.C., and politicians are lining up on different sides to offer treatment plans. The Democrats are pushing hard for a “public plan,” with talk of connectors like those in Massachusetts, broker disintermediation and efficiency. The Republicans have little leverage, as they strive to protect free-market options and worry about the runaway costs of yet another entitlement.

The prognosis? Not good. The diagnosis is faulty, and the treatments are aimed at the wrong symptoms. In short, policy makers are missing many of the key opportunities to address what is really broken about the system. If we want effective reform, we must insist that our representatives make an honest assessment about what is happening today, as well as agree on a realistic prescription for getting to the roots of our sick system and building a healthy one in its place.

The objectives of healthcare reform are to improve access (providing coverage for the uninsured) and affordability (lowering the cost of health insurance).

There are only a few reasons that individuals are uninsured:

- They can't afford insurance
- They can afford it, but choose not to buy it because they are willing to gamble on their health or they know that if they need care, they can show up at any emergency room and get it
- They are uninsurable

For those that choose not to buy it there are two alternatives in forcing them to buy coverage.

First, we can deny them care when they show up at the Emergency Room (not likely) or second, we can mandate that they buy it. Mandates are the preferable solution. The mandates could come in the form of forcing employers to offer insurance (at least to some minimum level) to full-time employees and individuals could buy into a guaranteed issue pool. Today, we see more and more companies opting out of the system, which only makes the problem worse.

While we regularly hear that 47 million Americans don't have health insurance, I believe this issue is more of a red herring. If we drive down the cost, mandate those who can afford it to buy it, and provide a social safety net (not the ER) for those that can't afford it, we can resolve this issue quickly, albeit it at a significant cost to the taxpayer.

To address the issue of affordability, we need to look at this problem honestly; and there is one fact that it is critical to keep in mind: Health insurance cost and overall healthcare cost are two distinct issues. All of the rhetoric coming out of Washington is focusing on the 12-20% of health insurance premiums that make up administration costs and not the 80%-88% that pays healthcare claims. No one's plan takes on the biggest contributor to healthcare inflation: physician and hospital payments. Experts on all sides of the healthcare reform debate

acknowledge this system is wasteful and inefficient. But no one is addressing this key driver of healthcare costs, or any of the other factors that contribute to the healthcare crisis.

How to Fix It

Here are six things we need to address if we expect healthcare reform to make a difference:

1. Our Health – NOT Healthcare – Crisis
2. Restore competition in the market
3. Enable the American consumer to become an astute buyer of healthcare
4. Eliminate hidden revenue streams
5. Facilitate administrative efficiency
6. Protect the risk pool

Our Health – NOT Healthcare – Crisis

Our nation is sick. Our behavioral norms are no exercise, terrible eating habits, excessive drinking, etc. The nation is hysterical over 18,000 cases of the Swine Flu, yet we have 100 million obese people in this country and no one notices. The country needs public policies that address this issue head-on. For example:

- Create an aggressive public campaign to encourage good health similar to the successful programs with wearing seatbelts and quitting smoking
- Restore funding for physical education in schools
- Advertise about the health risks of diabetes and obesity to the same degree that commercials spread the word about the little blue pill's effectiveness for erectile dysfunction
- Engage the food industry in a public-private partnership to offer healthier foods. If they won't, we need to use tax policy to shape the discussion. We have to regulate sodas in schools, the types of food provided at school lunches, etc.
- Encourage and facilitate the use of prevention-based healthcare, with regular health risk assessments and checkups that intervene earlier to stop diseases before they become chronic
- Allow health plans to offer aggressive financial incentives to encourage health and mandate disease management. There are some very successful models, such as Wellness Coaches, American Healthway, and Healthcheck360.

If we provide publicly financed healthcare with no discrimination in rates based on health, how will we incentivize people to get healthy and pursue preventative care? Every psychologist will tell you that the vast majority of people need both carrots and sticks, as well as support, to make changes. We need flexibility around the tools that will help consumers see that the cost of care is tied to their healthy lifestyle efforts.

Restore competition in the market

We need to break up the BUCA monopoly. In most states, the #1 carrier has 60-70% market share. In any other industry, this would raise antitrust concerns, but for healthcare no one seems concerned. The reality is that the Blue Cross/Blue Shield, United Healthcare, CIGNA and Aetna dominate the market. In addition, they partner across states to create a difficult business climate for competitors.

Why is this oligopoly a problem? These carriers get discounts from healthcare providers that are significantly better than other payors can get. Historically, this grew out of the PPO movement, which promised providers patient steerage in exchange for lower prices. But today, the oligopoly basically has 99% of all providers in the network. They are not steering patients to providers – rather providers could be faced with bankruptcy if they don't accept their rates.

Insurance carriers and managed care organizations charge two to three times for network access fees and administration fees than the amounts charged by local TPAs and PPOs. Many in the industry claim the carriers are inefficient, but that is simply not true. They leverage their better discounts from providers which often drives up fees for customers considerably. Thus, the lower provider prices don't lead to significantly lower consumer prices, just higher profits for the carriers.

Enable the American consumer to become an astute buyer of quality healthcare

A California patient who needs a chest X-ray is charged anywhere from \$120 to \$1,519; in fact, within a few blocks in Sacramento, the price climbs from \$451 to \$790 from one hospital to the next. A simple blood count ranges from \$47 to \$547.

In the world of consumer products, such price variations would be unsustainable if they involved refrigerators, cameras or even paper towels. Shoppers would compare quality and cost and then vote with their pocketbooks for the product that gave them the best deal. But in the world of health care, costs continue to escalate in stealth mode while frustrated consumers stand on the sidelines, wondering why they can afford neither insurance nor direct care.

It's a pretty simple fix: Bring transparency to pricing. Every provider must disclose the net prices that they charge (after PPO deals). No back-end kickbacks either. Once providers are mandated to disclose to the patient that they charge Customer X \$100 and Customer Y \$200, the pressure to bring prices into realistic order will show up.

In addition, consumers need to know how to find high-quality care. This can be achieved by forcing all providers to provide outcome data. Give each provider a quality grade once a year and make them display their grade for all to see. This solution may highlight some of the 7,000 patients that die from drug errors each year or the 90,000 people that die of hospital-acquired infections annually. Not many people want to talk about these issues yet it's estimated that due to poor-quality of care, \$2,000 per insured worker is added to the cost of healthcare.

Finally, mandate data availability for employers. Most insurance carriers today won't share claims costs or data with plan sponsors. This is ridiculous; if you want consumers of healthcare to make smart choices, companies have to provide the data that can identify trends and issues.

Eliminate hidden revenue streams

The amount of fragmentation in the healthcare delivery system results in many middlemen making exorbitant profits. Pharmacy Benefit Managers (PBM's) make money off spread pricing and rebates (kickbacks), which are rarely disclosed to clients. Drug companies heavily incent doctors to prescribe their pills. Doctors own the MRI and CT-scan facilities. Insurance companies charge hidden network access fees. There are a lot of firms getting fat off of the sick system. Some solutions:

- Require PBMs to fully disclose all sources of revenue and profit
- Block doctors from owning the diagnostic machines they refer their patients to
- Ban trips, money, etc. from drug companies to doctors
- Require insurance companies to fully disclose all administrative sources of revenue they receive
- Force hospitals to disclose profitability and markup on implant devices. Some hospitals mark up implants to twenty times what they paid.

Facilitate administrative efficiency

Our system is filled with inefficiency. The conventional wisdom is that we have too many payors and too many providers, and so we need consolidation to eliminate the transaction costs. Politicians claim that a public plan will save us. They say that Medicare has only a 4% administration cost vs. private plans' 12-20%. Yet not all costs associated with the running of Medicare are included in the 4%, such as salaries for administrators at CMS.

Real savings can be realized by instituting the following:

- Government should define a standard for claims submission between providers and payors

- Intermediaries should emerge to facilitate data translation between providers and payors. This is where the government can play a key role. The data is captured and published online to promote true consumerism in healthcare.
- Drive a set of rules for dealing with pended claims that makes sense

Protect the risk pool

The only way to make universal coverage work is to make sure it is universal. The first step: Mandate that all employers offer insurance or force them to contribute to a government fund. We have to stop employers from opting out.

Just as importantly, we need to limit coverage to basic minimums set nationally. We cannot continue with the tyranny of state-mandated benefits that force all insurers to cover elective procedures just because of a single strong interest group.

Finally, to make sure that everyone can afford coverage, we should require carriers to pool risk above a certain amount per claimant. Insurers should not be allowed to charge extra premium for individuals with ongoing risk. Every covered employee will pay a small premium to offset the potential shock claim risk. This will bring sanity to renewals, ensure an affordable cost of care for the unfortunate few who have had bad luck, and spread risk broadly.

Reform that Works

No one is arguing that reform is unnecessary. But for reform to work, it has to address the correct symptoms and get to the underlying causes. We can all be pleased that the administration and congressional leaders are taking on this important issue, and there are many worthwhile and far-reaching reforms that should be achievable this year. The much-discussed public health insurance plan is all too likely to create an uneven system, undermine what works in the existing employer-provided group health insurance marketplace and cost future generations trillions of dollars. It is up to all of us to make sure that what is achieved leads to an effective system and a healthy America.

About Samuel H. Fleet

Fleet is the president of AmWINS Group Benefits of Warwick, R.I., a leading wholesale broker of comprehensive group insurance programs and administrative services. In 2008, AmWINS Group Benefits earned over \$1 billion in premium from nearly 10,000 employer group clients in the private and public sectors. With more than 20 years of health and benefits experience, Samuel Fleet has proven his unmatched expertise with the rapid rise of his company from a small regional organization to one of the most successful insurance wholesalers in the country. Fleet, over the last several years, has positioned AmWINS Group Benefits as the leading industry administrator and authority on group medical programs.