

# Consumer-driven cost solution

by William C. Short



**President Barack Obama outlined a plan** to cut \$313 billion in government health care spending, which would be used to help pay for the administration's new plan of offering coverage to the uninsured. Obama "found" these extra dollars by reducing payments to providers and hospitals, making cuts in both Medicare and Medicaid, and extending the payment of outstanding reimbursements. >>

But the \$313 billion pales in comparison to the estimated \$1 trillion to \$1.9 trillion that will be required to actually bring this new plan to fruition. Not to mention, the plan may also completely miss the point when it comes to addressing the core problem.

The biggest reason behind the rising cost of health care is a misalignment of stakeholder incentives. As it stands, each stakeholder (from consumers to providers to payers) is incentivized to deliver solutions that are counter-productive to others in the system – and no amount of cash that we can throw at this problem will deliver a viable and sustainable solution if the stakeholders are not operating on a common foundation upon which incentives are properly aligned.

## HOW DID WE GET HERE?

Since World War II, nearly 170 million people in the United States have obtained health care benefits through their employers. Employer-offered health benefits became the standard during the war as a means to attract and retain employees when wage hikes were frozen; since then, tax benefits for employers who offer health insurance coverage to employees have done the job of preserving the employer-based health care coverage system.

The problem with this arrangement? For the most part, employers are not experts in the delivery of health benefits. Yet as health care costs continue to rise, employers have been forced to seek out different plan options in a futile attempt to maintain rich and competitive benefit offerings that don't destroy their bottom line.

The clear incentive for employers to offer health benefits is market-driven: rich benefits make an employer more competitive and favorable tax treatment provides an important financial benefit. These incentives must remain in place in order for employers to continue offering health benefits. If overregulation and/or misalignment of other stakeholders' incentives make it financially unreasonable for an employer to offer health benefits, the employer will be left with no choice but to eliminate these offerings. So, in order for the employer-based model to work, there must continue to be inherent and real value for the employer as a stakeholder, which can be fostered through favorable tax policy that encourages benefit offerings, and benefit plan options that effectively curtail the rising cost of health insurance.

## WHY RISING HEALTH CARE COSTS?

Anyone who has followed the health care debate, however, knows that curtailing the rising cost of health insurance is no easy task. But what is the real cause of rising health care costs? Misalignment of incentives, as previously discussed, which has negatively influenced the behaviors of all stakeholders in the system: patients, providers and insurance carriers. Patients in the traditional (non-consumer driven) health plans that make up the majority of health plans offered today have little to no incentive to be smart medical "consumers." Their cost remains the same regardless of their usage, and there is no financial reward back to the consumer for cost-conscious behavior. This situation has created a population of consumers who are incentivized to be heavy users because they are removed from the payment system and blind to the true cost of care.

Providers, for their part, are forced to deal with the burden of extended account receivables arising from a cumbersome reimbursement process. The overhead for providers and hospitals should be focused on delivering patient care, but instead, physicians have been pushed into a position where they must allocate ever-greater time and resources toward submitting claims and managing account receivables. Providers are motivated (whether consciously or not) to focus on cash flow. And let's not forget the prevalence of malpractice lawsuits, which has given providers an even greater incentive to order unnecessary services and procedures (both as a means to reduce the threat of litigation and as a way to recoup additional income).

Carriers, which are extremely effective at managing insurance for low-probability, catastrophic events (such as open heart surgery), struggle with the efficiency of insuring below-deductible, high-probability medical events. Further complicating management of these smaller medical events for the insurance carrier is the fact that, as a third party, the carrier is removed from the doctor-patient relationship but still forced to make decisions related to the payment of these claims. The inefficiency of handling smaller claims has greatly increased overhead costs for insurance carriers, which in turn feeds into the payments dilemma whereby carriers have a financial incentive to delay payment to providers for as long as legally possible in order to maximize cash on hand.

If we attempt to make sense of this tangled web of opposing interests and misaligned incentives, the core problem underlying our

CDHPs grew  
at a rate of  
**33.9%**  
this past year

CDHPs  
cover more  
employees  
than HMO  
plans (15.4%  
versus 13.6%)

The average  
cost increase  
for all CDHPs  
at 6.3 % was  
slightly lower  
than that of  
the average  
of all plan  
types, which  
increased  
7.3 % this  
year.

Source: 2009 UBA Health  
Plan Survey

health care system becomes obvious. Consumers pay into a plan that encourages heavy health care usage and doesn't reward efficient consumer behavior.

Providers are motivated to support the pattern of heavy usage and have no incentive to encourage patients to be smart health care consumers. Carriers keep raising costs to offset the inefficiency of handling the growing number of small claims that arise from increased health care consumption. It's easy to see why heavy and expensive usage has become the norm within our health care system, reinforced by misaligned incentives (or lack of incentives) for patients, providers and carriers. In short, we've created a system where the "buyers" and the "sellers" are motivated to make wasteful and inefficient decisions.

## WHERE TO BEGIN

Identifying the problem is only one small part of the equation. The question now becomes, how do we realign incentives for all players in order to modify inefficient behaviors and reduce health care costs? To begin with, let's make one thing clear: it's not about spending more money.

Employers should still play an integral role in the delivery of health care benefits. Removing the employer's role from the health care system would eliminate an important competitive advantage that employers have used for decades to enhance their position within the marketplace. To ensure that employers are motivated to continue providing these benefits to their employees, they should have access to creative coverage solutions that reduce their costs and maximize their tax savings. Consumer-driven plans (high-deductible insurance coverage combined with a tax-advantaged account like an FSA or HRA) are a good way for employers to provide the same caliber of benefits to their employees while also reducing premiums and involving employees in the cost of coverage.

## WHY CDHC MAKES SENSE

Involving consumers is key when it comes to modifying behaviors and reducing inefficiency.

Right now, patients do not think about health care until something happens to them because they pay into a plan without having any clue as to how much their care may cost. At the same time, no one wants to have to worry about comparing costs when they experience a major medical event that puts their life on the line. For that reason, the best way to give consumers a

**“How do we realign incentives for all players in order to modify inefficient behaviors and reduce health care costs? To begin with, let's make one thing clear: it's not about spending more money.”**

financial incentive to be smart health care users is to focus on below-deductible items. This could be accomplished by providing catastrophic coverage for complicated, expensive and unexpected medical events, while rewarding patients for making responsible decisions on below-deductible expenditures through a tax-advantaged, consumer-driven plan.

Encouraging the use of consumer-driven plans will have a positive effect on providers as well. If patients pay for health care services in "cash" (using pre-tax funds in an FSA or HRA, for instance), providers will not be subject to the same lengthy, burdensome payments cycle – overhead will decrease and the accounts receivable problem will be substantially reduced. As is the case within any market-driven system, providers will eventually have an incentive to compete for these cash-paying customers, which in turn will drive down costs, improve delivery of care, and offer greater benefits back to the patient.

Insurance carriers should focus on what they do best: managing claims for large, catastrophic events. Carriers would no longer have to expend resources toward the inefficient management of small claims, their operational costs would go down, and therefore insurance premiums would stabilize.

Of course, behaviors can't be changed overnight. And there will inevitably be segments of the population that, for a variety of reasons, will not fit within the structure of a market-driven health care system. But, considering that the majority of Americans are already capable of making informed, cost-conscious decisions in other areas of their life (when provided with the appropriate tools and incentives to do so), can we afford to ignore the possibility that this same principle may provide the cure to our nation's ailing health care system? **E**



William Short is president and CEO of AmeriFlex. He can be reached at [wshort@flex125.com](mailto:wshort@flex125.com).

