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Healthcare Solutions for Employer Groups

Breaking the Bonds of *Status Quo*

"*Status Quo*, you know, is just Latin for "the mess we're in".

- Ronald Reagan

Ah yes, *Status Quo*. It's a demagogue's standard operating procedure and a CEO's nightmare. Nothing can be more frustrating than doing the same thing over and over, expecting a different result. Yet in healthcare, many employers still think in terms of group insurance as the solution to cost containment. The latest grasp at cost containment is wellness programs. Insurance companies, TPA's and large employers are going to great lengths and expense to encourage employees to "get fit" as a way of improving their health and filing less claims. Yet how many employees actually change their unhealthy habits? What is the cost of the wellness program amortized against the ones that actually change? Wellness programs are just fine but how do you quantify their results? And from the employer's perspective, how do you monetize the wellness program as an asset?

Here's my point – wellness programs and case management are examples of cost containment. And cost containment is *status quo*. It's a noble effort to try to reduce the cost of a known expense. But it's retrospective, hard to quantify and hard to monetize.

Employers are experiencing dramatic increases in the cost of health insurance whether self-insured or fully-insured. Insurance companies look at past claims experience as it relates to expected losses and then applies increases to cover the loss, cover the current expected claims and their profit margins. In other words, retrospective, reactionary pricing on a pass-through basis – *a model that's clearly not working for employers.* And that's no slap at the insurance industry – it's just *status quo*.

Defining the issue

There are the two main contributors to insurance overutilization that drives up costs: acute illnesses based on frequency of claims and chronic illnesses based on severity of claims. Both are hard to predict and skew the actuarial metrics when either or both are out of balance with expected losses. And in an effort to be competitive, insurance companies tend to price new business on an optimistic basis knowing full well that they'll make up the difference upon renewal. As stated above, retrospective, reactionary pricing on a pass-through basis.

The solution is not solely "cost containment" of either type of claim (acute or chronic). The solution is filing far fewer insurance claims to begin with – less utilization - notwithstanding the prevalence and frequency of acute illness and chronic disease. ***Now stay with me* – remember, we're not talking *status quo*.**

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Accessing healthcare outside health insurance

The terms "healthcare" and "health insurance" have become somewhat (wrongly) synonymous in our current lexicon. "Healthcare" is based on access. "Health insurance" is based on risk and entitlements. And while they may be synonymous in the minds of many people, they are very different with respect to pricing and affordability.

As technology, legislation and healthcare have changed, alternative methods of accessing healthcare have emerged that provide more convenient, less expensive, quality care than the traditional, expensive insurance model that is adversely affected by utilization. The key to employer acceptance is stepping out of *status quo*. The key to employee acceptance is *incentive* (more on this later).

Telemedicine and Telehealth for Acute Illness

Many employers already use some form of acute care telemedicine service as a product in their group benefit plan. Employees can contact a physician by phone and get a consultation for acute, non-emergency illnesses with prescription medication if needed. This is an outstanding service and is essential to reducing insurance utilization. The problem is that most employers offer this service with $25 - $40 copays per consultation. The employee has a choice of going to their family doctor, an urgent care clinic or calling for a physician telephone consultation – all at basically the same out-of-pocket costs. Given no difference in *incentive*, health insurance will be utilized over healthcare because it's *status quo* and there's no incentive not to. Acute care telemedicine should be utilized through incentive with $0 out-of-pocket costs vs. being perceived as just another product that employees can choose. In other words, telemedicine should be a strategic way to reduce insurance utilization instead of just another product offering.

Let's do the math. Let's assume a group insurance plan of 1,500 employees. Half are employee only and half are employee plus family. Each office visit for an acute, non-emergency illness has a $35 copay to the employee and an additional $140 to the self-insured company (total $175 office visit). If between employee only and employee and family, there are 9,000 office visits over the course of the year, the self-insured company has an expense of $1,260,000 in acute care office visits. If 50% of those visits were utilized through telemedicine, the employer would save $540,000 to the bottom line (even after paying for the benefit) and the employee would have an incentive ($0 out-of-pocket cost) for the convenience of on-demand, 24/7 healthcare. The employer saves tremendous amounts of cash and at the same time lowers utilization on their health insurance. Everyone wins.

Telemedicine and Telehealth for Chronic Illness

In study after study, roughly 20% of any group is responsible for approximately 80% of the overall healthcare spend. Knowing this hasn't materially changed the way chronic disease is managed. *Status*

quo is getting case management involved as soon as the insurance company becomes aware of the claim (retroactive and reactionary).

Chronic disease care in America goes something like this…..a person gets to feeling a little bad and goes to the doctor. The doctor runs a series of tests and diagnoses a chronic disease (ie: diabetes). The doctor has a conference with the patient about losing weight, exercising and taking their medication. At that point, the conference is over and an appointment is made in six months for follow-up lab testing. The patient then goes to his local retail pharmacy, purchases medication and then goes home and tries to get in a "new normal" frame of mind. The patient does their best to change their lifestyle but over a short period of time, they fall back into their usual habits. Many times they self-medicate to save money or take their medication only when they start feeling bad. The chronic condition gets worse causing far more insurance utilization with the potential for living in a serious disease state. And the cycle continues.

That common scenario happens every day in America. And it costs employers and employees tremendously in time, money, productivity and quality of life.

Here's some empirical data that is the root cause of poor outcomes in chronic disease patients:

- 30% of prescriptions never get filled[1]
- 50% of Americans have difficulty understanding and acting upon health information[1]
- 213B or approx. 10% of healthcare spend is avoidable[2]
- 68% of avoidable healthcare spend stems from medication non-adherence[2]
- 15% of patients account for more than 75% of healthcare spend[3]

The solution is two-fold: 1) Chronic disease and medication management and 2) patient education and accountability. Both must be built on relationship and trust. The patient (employee) must be a willing participant vis-à-vis education so they understand their disease state, how it impacts their physiology and why it's important for them to become compliant and adherent to their clinical treatment.

Chronic disease and medication management is the process by which clinical outcomes drastically improve through education, accountability and adherence and compliance with treatment protocols. With monthly consultations to ensure adherence, 24/7 access to your clinicians, consultations between the clinical pharmacologist and physician if needed, copay assistance program if needed, no hassle medication refills and monthly, pre-packaging of medications sent to your home free of shipping charges. And in the process, clinical outcomes are drastically improved, overall healthcare spend is reduced and the patient gets better, feels better and stays better.

Or, you could stand in line at your local retail pharmacy and live with *status quo*.

With chronic disease and medication management, patients drastically improve and the root causes of poor clinical outcomes are addressed: approximately 90% reduction in hospital readmissions, reduced first-time admissions, fewer doctor visits, fewer emergency room visits, measurable improvement in medication adherence and associated lab results and a measurable reduction in overall healthcare spend.

Prospective. Forward-looking. Lower utilization. Lower healthcare spend. It's time to break out of *status quo*.

[1] Institute of Medicine of the National Academies

[2] IMS Institute for Healthcare Infomatics

[3] Parata Systems

Jim Jones is President of Wellspring Benefits Group located in Colleyville, Texas. He is a visionary leader with an eye for emerging markets in a changing healthcare environment. Through Jim's 30 years in the insurance and healthcare industry, he has developed a business model that integrates healthcare services that lowers insurance utilization, improves clinical outcomes and lowers overall healthcare spend. Jim can be reached at jim.jones@wellspringbenefitsgroup.com.