Employment-Based Health Benefits And Public-Sector Coverage: Opportunity For Leadership

The shift toward public-sector health coverage could move us a few steps forward in resolving the U.S. health care coverage dilemma.

by Helen Darling

ABSTRACT: In this commentary, Helen Darling, speaking from the large-employer perspective, responds to James Robinson’s paper on the mature health insurance industry, which faces declining opportunities with employer-based health benefits and growing but less appealing public-sector opportunities for management and other services. The similar needs of public and private employers and payers provide an opportunity for leadership, accelerating innovation and using value-added services to improve safety, quality, and efficiency of health care for all. [Health Affairs 25, no. 6 (2006): 1487–1489; 10.1377/hlthaff.25.6.1487]

Health care spending has nearly doubled since the early 1990s.1 When this spending rise is coupled with global competition and a slowing economy, business leaders, politicians, and other policymakers express rising concern about the unsustainability of the current health financing situation and the possible demise of employment-based health benefits for 174 million Americans. Some wish that this historically accidental but sixty-year-old mode of coverage would fail so that a single-payer, national health insurance-type program could be established in its place. Others wish that we could extend the existing system through an employer mandate that would force all employers, mostly small ones not providing coverage now, to provide comprehensive health benefits and would use regulatory action to deal with the high costs that would result. In between are the many people who suspect, for a variety of practical reasons, that we will stumble along with our imperfect health system, trying out new financing methods, payment reform, and assumed cost moderators such as consumer-directed health care, evidence-based benefit design, decision support tools, and value purchasing as well as continuing with older approaches such as more cost sharing, tiered benefits, and other plan changes. Virtually all agree that the more than forty-six million uninsured Americans should have adequate coverage, but consensus melts away when specifics are discussed including what would be reimbursed and, most importantly, who would pay for it.

James Robinson discusses the health insurance industry as it faces a future with a decline in the proportion of Americans under age sixty-five covered by employer-sponsored health benefits and an increase in opportunities for private insurers to participate in public programs, as evidenced by private insurers’ major role in Medicare Part D.2 He notes that

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“there is no publicly administered drug coverage, no fall back from the private plans.” State Medicaid programs are increasingly seeking to outsource management of their programs. Profits will be harder for health plans to earn. But, he believes, health insurers have no choice but to serve the growing public sector.

Clearly, we are seeing more willingness to serve public-sector customers, which will have a sizable effect on the industry, generating increased interest in transparency and efficiency. At the same time, changes could have a positive effect on these governmental customers, who lag behind the best private employers in management and innovations, such as clinical care management; data warehouses for better analysis and program design; personal health records; higher-quality, safer care; and e-visits. Aggregating all-payer claims data into regional and national information centers will improve statistical power and accelerate our ability to assess the quality and appropriateness of care across all age groups, especially if claims are available much faster than they are now in government programs.

■ Federal subsidy to employers. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 offered another interesting “carrot” for policy thinkers to consider. For the first time, the federal government is making payments to private corporations (up to 28 percent of costs) to enable employers to provide retiree medical coverage. No employer could offer this coverage if it didn’t have the ability to support the other 72 percent, and most that could change retiree medical coverage have already done so, but the subsidy certainly helped some employers. From a policy perspective, it is an interesting precedent. If the natural experiment works, and a partnership with the federal government proves to be not so risky, there may be interest in other experiments in which public funds subsidize employee cost sharing for low-wage employees or certain employers, such as nonprofit child care centers in low-income areas.

■ Cost challenges. We will continue to see a complicated mix of private and public coverage with more private management and delivery, paid for by different public payment schemes, payments from employers, and more from individual consumers in out-of-pocket payments. Public expenditures — approaching 50 percent by 2015, when the industry reaches $4 trillion, double what we now spend — will change the industry even more.1 Put another way, total public-sector spending will be roughly the same as that of the entire health industry today. With global competition, the economic effect of a huge national debt, and slower growth of the U.S. economy, the public sector will be challenged to raise taxes and pay for the promised coverage to those it insures plus its employees, retirees, and dependents.

■ Value-added services. Health plans are in strong positions to be aggressive leaders in the patient safety and quality movement because they and their customers would benefit greatly from the reduction in waste and costly harm to patients. Health plans can do even more for our growing country to demonstrate how to improve consumers’ health, reduce health disparities, find the right balance between cost sharing and coverage, and improve a patient’s ability to navigate the variable health system. Health plans can distribute consumer-friendly information (based on trusted groups such as the American Academy of Pediatrics and Consumers Union) and help patients know what kind of care they should be getting. Personalized medicine will make the solutions more complicated but perhaps even more effective and cost-effective. The private sector can be an engine of change and creativity, and it can move quickly. Insurers that innovate will likely be rewarded with market share when they efficiently deliver high-value services.

■ Leveraging technology to improve patient care. In addition to paying claims, the health insurance industry has the potential to make even more of a difference in the quality, safety, effectiveness, appropriateness, and efficiency of health care delivery and financing, as Blue Cross Blue Shield of Massachusetts has done with its support of the 100,000 Lives Campaign. If the industry does become more enmeshed in the public sector, it could move
public purchasing to a more sophisticated level and help beleaguered public officials get a better return on their investments. Health insurers have the capital and other resources, including vast stores of data, to track medical care to identify less than optimal treatment and follow up with physicians and patients to encourage best practice care. As health IT expands and information is reported in real time, the ability to move quickly and change behavior will accelerate. Storage of clinical information will enable health plans to continuously update practice patterns and use those experiences to feed back to researchers what is happening after new treatments, technologies, or drugs have been used by many people. They can track the impact of existing treatments, many of which have never been examined despite widespread use, to determine their effectiveness and health impact. A health plan could send out information or provide incentives to encourage or even reward hypertension screening at every visit; the plan could quickly see that it is receiving reports with blood pressure screening checked with the screening results. The same system could also flag failure to report and automatically send electronic notices to patients and physicians’ offices. The inability to detect an effect after launching a new program could also send a health plan back to the drawing board. Everyone has a stake in ensuring that evidence-based medicine is the foundation for care delivery in the United States. Investments in research to improve practice and developments in clinical guidelines to eliminate waste and improve quality should be supported by all payers on a proportionate basis since they are “public goods.” As the demand for transparency in the health system increases, so will the demand to match price and quality information to help consumers and employers make better decisions about care. Payers can use this information to determine which providers are the most efficient.

The health insurance industry has substantial resources and intellectual capital already committed to these objectives. As the industry evolves and faces different challenges as suppliers to the public as well as the private sector, as Robinson describes, the insurance industry will be most successful if it stays focused on the value-added services that help us buy a lot more real health, not just more health care, at ever-rising rates. In fact, more rapid spread of these practices and programs and faster turnaround on the ineffective would be more than welcome. Those who continue to have employer-sponsored coverage and those who have individual coverage, possibly through some new pooling methods, are a lot like those in Medicaid, Medicare, and the State Children’s Health Insurance Program (SCHIP), in their need for quality and safety protections, information about best treatment outcomes, and help with navigating the health system and making healthy lifestyle choices. Health plans can help employers and government deliver the cost-control message and devise cost-saving solutions. If we do not act soon and turn around the cost juggernaut, fewer and fewer people will have good health care coverage. All of us lose if that happens. To be efficient and effective, all employers, health plans, insurers, other purchasers, providers, consumers, and politicians have to work together for the good of all, no matter what the financing method. We can't afford to waste more resources or continue to leave people unprotected.

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