

The Trend Towards Consumer-driven Healthcare

The cost of healthcare in the US is rising at an unsustainable rate and this cost is being transferred directly to the consumer. However, up to 30 percent of all healthcare expense pays for administration of billing, collection and payments processing. Consumer-driven healthcare is one key way of countering excessive administration costs and a high-deductible health plan is central to this approach. This is aimed at providing more transparency on how the consumer's money is spent.

By Catherine Warren, Bank of America — January 10, 2006

Structural Improvements to Heal an Ailing Health System

In 2004 healthcare expense in the United States reached \$1.7 trillion, approximately 15 percent of GDP. The price tag continues to climb at an unsustainable rate. Projections indicate that if nothing were to change within the industry, the cost would reach \$3.6 trillion by 2010, or 19 percent of GDP. The US dedicates the highest percentage of GDP to its healthcare system of any major industrialized country. In spite of this, a staggering estimated 45 million Americans lack any healthcare coverage whatsoever.

The healthcare industry has long faced intense pressure to lower expense, with key participants — payers, including the largest payer, the US government; providers and employers — driving most cost-reduction efforts over the past 40 years. The movement towards a consumer-driven-healthcare (CDHC) model brings consumers into the cost-management equation. It is a fundamental shift in healthcare management that holds great promise for driving structural changes to disrupt the current cycle of spiraling costs.

The Spiraling Cost Cycle: Paying the Price for a System in Crisis

A key dynamic of rising costs is the inability of employers to pay for employee health insurance. Small businesses — which represent an amazing 99.7 percent of U.S. employers — account for just over half of the private sector work force but many struggle to afford providing healthcare insurance. And while most large companies must offer benefits to compete in the labor



Catherine Warren,
Senior Vice President — Bank of America

Catherine Warren is a senior vice president at Bank of America and the Healthcare Industry Strategist for Global Treasury Services (GTS). In her current role, she is responsible for identifying current and future needs unique to the healthcare industry, development of the Treasury Management strategy for healthcare, and champion for the industry on behalf of GTS clients across the Bank of America enterprise. She has been a principle member of the team developing the Bank's Healthcare Savings Account initiative, and has developed and executed the strategy for web-based delivery of EOB information on Bank of America's Global Advice platform. Catherine has over 15 years in financial services including roles in credit and debit card management, consumer online banking and treasury management services. She has membership in the Healthcare Financial Management Association and is a Certified Treasury Professional.

market, the associated expense has a tangible impact on bottom-line performance. The result is an excessively high number of uninsured workers. Added to the uninsured are the underinsured — whose partial coverage often results in delayed or inadequate care or discourages preventative care — and indigent patients who rely on Medicaid as a safety net.

One study estimates that 55 percent of emergency-room visits serve as a form of immediate but non-urgent (and more expensive) treatment for the uninsured¹. Those

¹ Center for Disease Control and Prevention, 1997

who seek outpatient care in the emergency room but fail to pay have shifted the cost burden within the system to providers. Hospital write-offs form part of the provider's component of the expense equation. Expensive new technology and medicine, cuts in Medicaid and Medicare payments, challenges in collections from both payers and patients all contribute to rising expenses for providers.

One of the most significant drivers of expense in the industry is administrative expense. Billing, collection and payment processes may account for up to 30 percent of healthcare expenditures, or one-third of the \$1.7 trillion total healthcare expense. A recent study by PricewaterhouseCooper² demonstrates that the time involved to process the paperwork for a patient may be, in some cases, equal to the time spent caring for the patient.

Meanwhile, hospitals have undergone consolidation, and larger, more competitive hospital groups have acquired greater leverage in negotiating higher reimbursement rates from health insurers. In turn, health plans are passing back these price increases to employers. The financial health concerns at General Motors Corp., which pays \$6bn annually to provide health coverage for 1.1 million current and past employees, underscores the problem. At the other end of the spectrum are those large employers that offer limited healthcare benefits. This contributes to a greater reliance by the uninsured on Medicaid, which, in turn, drives up the cost of benefit payouts by state governments.

Historically, a majority of consumers have been largely insulated from rising costs. While the price of healthcare has been minimized for many, an increasing number of employees and retirees are beginning to see an erosion of benefits in the form of higher co-payments, insurance premiums and deductibles.

These examples underscore the problem with merely shifting growing healthcare costs among payers, providers, employers and consumers rather than changing the underlying drivers of cost dynamics. And although cost-saving initiatives by payers, providers and

employers are keeping some expenses in check, they are individual efforts that do not provide systemic change.

From Shared Burden to Shared Responsibility

The introduction of consumer-driven healthcare is a significant step towards disrupting this cost cycle. At the heart of the consumer-driven model is the philosophy: Give a man a fish; you have fed him for today. Teach a man to fish; and you have fed him for a lifetime. The approach recognizes that behavioral change is a key driver of the structural change needed to alter cost dynamics. CDHC increases consumer awareness of the cost and quality of healthcare while giving consumers greater control over personal health management. A high-deductible health plan is central to the approach, but CDHC is not just about shifting a greater portion of costs to consumers. By making previously hidden costs transparent to consumers, a higher deductible aims to instill greater ownership in consumer healthcare choices. In turn, consumer-driven choice introduces a free market dynamic. Patients will be more likely to carefully weigh cost and quality of healthcare when making choices.

Information will play a critical role in empowering educated consumer choice and facilitating behavioral change. For example, as plan providers offer centralized, information-rich Web sites and telephone hotlines (e.g., nurse, pharmacy), consumers will have access to high-quality, low-cost resources for obtaining help with common ailments and price information.

Within the healthcare arena we are moving towards a greater recognition of shared responsibility and closer collaboration among all parties — providers, employers, payers and consumers. Unions and employers will work more closely together, as unions concede that change is inevitable and become agents for positive change. Non-union employers will need to make choices that disrupt the cost cycle or accept the changes imposed upon them.

² Patients or Paperwork? The Regulatory Burden Facing America's Hospitals

Shifting to a Consumer-Driven Model: Transformational Tools

Consumer-driven healthcare complements current solutions that focus on reducing cost within the system and enhancing the revenue cycle. All CDHC products are structured to raise consumer awareness and put choice and spending controls into the consumer's hands. The most significant trends to watch are the growth of Healthcare Savings Accounts and the introduction of new tools to facilitate Point of Service efficiency.

Healthcare Savings Accounts

The Healthcare Savings Account (HSA) is one tool for disrupting the cost cycle by enabling consumer ownership over healthcare choices. By providing a means of saving tax-free funds for current and future healthcare expenditures, it represents the next step in the evolution towards employee control in pretax, healthcare-related financial products. Whereas Healthcare Reimbursement Accounts are employer-funded and employer-controlled, and Flexible Savings Accounts are employee-funded and employer-controlled, the Healthcare Savings Account is employee-owned and funded either by the employer or the employee.

An HSA is available only if the account holders have a high-deductible health plan (HDHP). By reducing expenses of a health plan by as much as 50 percent, for employers, the account enables many more small businesses to provide some level of insurance. At the same time, by allowing employees to spend the dollars when and how they choose, as well as providing incentive for saving, the HSA motivates patients to make responsible choices in the level of care needed (e.g., when to use a specialist versus general practitioner), as well as focus on well care.

While most HDHPs encourage and provide for well care, they also ensure coverage in case of emergencies. Hospital visits will typically exceed a deductible, causing coverage to kick in at the plan level, thus reducing hospital write-offs. A reduction in emergency-care losses helps hospitals stabilize prices, which in turn supports payers in containing health-plan expenses and minimizing price hikes to employers. A key to the

successful adoption to HDHP/HSA plans is offering 100 percent coverage on the HDHP once the deductible is met. This provides security to the employee that their financial future is not at risk, as well as reassurance to the healthcare provider that payment will be received.

As a vehicle for transferring healthcare-benefits ownership from employer to employee, some have likened the HAS's potential impact to that of the 401(k). One obstacle under the existing account structure, as defined by the Department of the Treasury, is the annual contribution limit on permitted savings. If consumers could fund their HSAs up to the annual maximum out-of-pocket expenses then HSAs would become an even more attractive option for both employees and employers, many of whom are cutting retiree healthcare benefits. Alternately, the HDHP should cover 100 percent of expenses after the deductible is met, effectively setting the maximum annual out of pocket at the same level as the deductible.

Point of Service Solutions

While HDHP/HSAs encourage patient payment responsibility, our current system of claim submission to third party payers continues to create a revenue lag for providers. Under the current conditions, HSAs could exacerbate this cash flow challenge for providers, creating additional collections and bad debt. By discouraging patient payments at point of service in order to ensure proper patient billing through a claims process, providers will drive an increase in days in accounts receivable.

As a result, there will be an increasing demand for tools and information access to assist providers in identifying patient responsibility immediately, capability to support recurring payments, and data capture in a single transaction with the payment posting. As these tools become available, more service providers will begin to attempt to address the holy grail of healthcare payment processing: real-time claim adjudication and payment processing at point-of-service.

An alternate and arguably more cost-effective scenario is one in which healthcare providers determine discounted pricing for patient cash payments is a sustainable and profitable business model. Without the

cost of submitting a claim and waiting for adjudication and payment, discounted cash pricing should be at least a break-even model.

Towards Integration

The shift to a consumer-driven model requires new infrastructure. Service providers have begun to understand the size of the opportunity, and as a result, many new players are jumping into the healthcare arena with a plethora of revenue-cycle-management offerings. In the short-term this overabundance of suppliers is driving fragmentation and sowing confusion for payers and providers. What the industry needs is fewer intermediaries rather than more, simplified solutions rather than complicated offerings, and companies that are focused on streamlining the system.

As an existing trusted financial intermediary between patients, payers and providers, banks will play a significant role in providing solutions to all of the participants in this dynamic marketplace.

A Fundamental Shift

The consumer is the most influential and powerful market driver of change, which is why CDHC will have such a powerful impact at a systemic level. As an enabler of change, the introduction of Health Savings Accounts is one of the most significant changes in healthcare in the past 40 years. Everyone stands to win in consumer-driven healthcare, but the transformation requires a shared responsibility in which we all participate.