

MANAGED CARE

OUTLOOK

The Insider's Business Briefing on Managed Healthcare

ASPEN PUBLISHERS

Volume 22, Number 3 • February 1, 2009

Six Predictions for 2009 Herald Challenges for U.S. Health Care Industry

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Casey Stengel's eye for baseball talent often was as keen as his wit. Early in his managerial career with the New York Mets, he was asked about the future prospects for two of his 20-year-old players. "In 10 years, Ed Kranepool has a chance to be a star," said Casey. "In 10 years the other guy has a chance to be 30."

Following humbly in the tradition of Casey Stengel, and as I have done in years prior, I share six predictions for the U.S. health care industry for the new year. I do so with the caveat that these and other developments, while evident in 2009, will be in great respect embryonic and experience years of gestation.

Prediction One

Comparatively more aggressive investment in electronic health records (EHRs) and workflow applications by providers will meaningfully reignite the challenge for health plans to be recognized as "health care systems organizers."

On a per-member or per-patient basis, we are seeing levels of investment in EHRs by hospital systems that dwarf the spend by health plans in similar instruments called payer-based health records, or PBHRs. (These are also called PHRs.) During the past few years, most hospital systems have allocated an average of 25 percent of their capital spending on health information technology (IT) generally.¹ Again, this exceeds what we are

seeing on the payer side in both absolute and relative terms.

If we are to meaningfully improve health care access and affordability in America, health care IT must figure prominently, and physician groups and hospital systems must be applauded for investing in EHRs and workflow applications. My concern, however, is the investment lag in the payer community.

Granted, over the past decade, health plans have invested significantly in IT to improve core administration, which is fundamental to enabling effective care management along with health and wellness programs, but payers need to stop counting adoption rates of static PHRs and step up their investment in applications that use the PHR and rules engines to align information workflow and incentives among all health care constituents, particularly among consumers and providers. If health plans fail to systematically coordinate benefits and care, they risk disintermediation, and worse, real improvement in access, cost, and quality will prove elusive.

Health plan information systems are the single richest repository of benefits and care information in the entire U.S. health care system. Therefore, I continue to believe payers are best positioned to serve as health care systems organizers, and I advocate their investment

in applications that link to and among constituents.

Prediction Two

The scarcity of primary care physicians (PCPs) will spur higher growth in those health plan models that can systematically and effectively extend physician-patient physical interaction with evidence-based medicine (EBM) medialinstruction whether virtual (e.g., over the Internet) or in facilities.

Primary care doctors in the United States are overworked, and nearly half plan to either cut back on how many patients they see or quit medicine entirely.² This reality reflects the shortage of internal medicine and family practice doctors in this country, notwithstanding an abundance of specialist physicians.

An unfortunate consequence of this is that PCPs operate under tight time constraints when they see and treat patients. Brief office visits make it difficult for doctors to examine, diagnose, present efficacious treatment options, and determine with their patients plans to manage health or illness. There is the additional pressure of public opinion; payers, patients, employers, and policymakers all vigorously call upon the provider community to reduce errors and unwarranted variability in medical care.

Information systems will provide a pathway to some relief. Innovative payers will take the lead with health plan models and clinical decision-support systems that put EBM protocols at doctors' and patients' fingertips, while aggregating consumer populations with similar needs (e.g., frail, elderly, or oncology patients undergoing chemotherapy and radiation therapy) into targeted benefit and delivery models.

This will simultaneously drive innovative ways for specialty physicians to repurpose into primary physician roles and establish "advanced medical homes" while making it more practical for doctors to quickly cull and systematically apply EBM protocols and inform the patient/consumer.³ Ultimately, health plans' ability to bring together like-kind

consumers with physicians who have both the training and facilities to meet patients' needs will result in better outcomes, with not only higher efficiency but more human touch.

Prediction Three

Federal and state budgetary pressures will impede meaningful health care policy reform prior to 2010; however, HCIT enablement/standardization containing a provider bias will be popularized in multiple bills.

The two items atop President Barack Obama's very long list are (1) to invest hundreds of billions in a federal stimulus package to augment the government's \$700 billion Troubled Assets Relief Program in an effort to revive the nation's economy and (2) to reduce the budget deficit and national debt, which is more than \$10 trillion. Given this financial reality, the writing on the wall is clear: Significant federal investment in health care reform will be challenging at best.

That said, we will see health care legislation in Washington and at the state level, and these bills will have a provider bias. One reason for this is very basic. Legislators are like the rest of us in that they have visited hospitals and doctors' offices when they have required care. Few, though, have walked the halls of health plans.

Lawmakers know doctors write prescriptions by hand and that physician offices are heavily paper- and manual-based, but they know less of the enormous potential in IT to tap the benefits and care data in payer organizations to engage health care constituents and improve both access and affordability. Not surprisingly then, a provider bias will prevail in public policy.

An approximately \$50 billion investment proposed by Obama would finance EMR and other IT developments in the provider community.⁴ On the state level, in June 2008, 12 states were selected to participate in a new federal incentive program that makes 100 small and medium-sized medical groups eligible for as much as \$295,000 in additional Medicare payments if they adopt computerized

systems that connect to laboratories, hospitals, pharmacies, and other doctors' offices.⁵

Prediction Four

A decade (post-1997) of expected annual increases in medical unit cost trends will give way to a decade or more of selective unit cost decreases in discrete items (e.g., pharmaceuticals, devices, common imaging and lab tests, specialty care procedures, and basic bed-days) combined with new types of process-compliant reimbursement methodologies.

Much like the recent housing market bubble, there is now a health care market bubble, and just as people believed that housing prices would only rise, so too do pundits say that health care costs will continue to climb. I take a contrarian view: The health care bubble will burst. Too much spending for too little value cannot persist indefinitely. Fully insured premiums in 2011 will be less than 2010 rates, and even in 2010, some individuals and many groups may pay less for health insurance than they will in 2009.

Over the next several years, a confluence of developments will exert a downward pressure on price. We will see public/private programs that bring the uninsured or under-insured into organized systems of care. By increasing the size of the insured pool, unit costs will go down. Further, as an actuarial matter, the larger pool of insured will spread risk and hence make it possible to reduce premiums.

We will continue to see slower spending growth for prescription drugs as fewer blockbuster pharmaceuticals come to market, some come off patent, and others move to over-the-counter status. Tiered formularies will become ubiquitous in health plan design, and marketing campaigns encouraging the use of generics versus brand-name drugs will continue to prove impactful. We also will see intensified public pressure on medical device manufacturers as well as pharmaceutical companies regarding pricing. Supply-driven tests such as imaging will be particularly hard hit. When the health care bubble bursts,

all of these developments will have been contributing factors.

The largest factor, however, will be a push toward process-compliant reimbursement by health plans and the government. Mathematical proof that decreasing unwarranted variation in care saves money and improves health status will become broadly accepted and will guide private and public policymakers.

The notion that has served every other industry — that a well-engineered, systematic set of inputs and processes can produce higher-quality results at lower cost — is beginning to enter the psyche of the U.S. health care industry. Increasingly, doctors and facilities will be reimbursed for providing “whole-patient care,” and payer organizations will modify health plan designs and information systems to stipulate reimbursement based on evidence of such care.

Systematically, whole-patient care addresses the psychological and social (psychosocial) problems associated with illness. For instance, while state-of-the-science biomedical treatment can help cancer patients, whole-patient care seeks to remediate depression and other emotional problems, lack of information or skills needed to manage the illness, lack of transportation or other resources, and disruptions in work, school, and family life — factors that can increase suffering, weaken adherence to prescribed treatments, and compromise patients' ability to return to health.

Prediction Five

Growth in off-shore medical procedures will be constrained by the development of more comprehensive and effective informed-consent methodologies to weigh risks and benefits and assess liability.

Wouldn't it be ironic if the next great U.S. export were medical malpractice litigation? Excitement about recently reported “medical tourism” pilot programs is understandable, given the comparatively higher cost of care on our shores. Providers in Cuba, for instance, advertise a total hip arthroplasty for a total

cost of \$5,845, a fraction of the procedure's cost in the United States.⁶

But there are risks – risks from infectious diseases to which recovering Westerners have no natural immunity, risks from varying quality in post-operative care overseas, and the most obvious risk, that of botched procedures in countries with legal and cultural frameworks far different than our own. Specifically, medical liability laws vary significantly among countries, and patients cannot assume they will receive the same legal protections in India, Malaysia, or elsewhere that they receive at home.

There is no way to avoid all risks associated with treatment decisions and treatment execution either domestically or in other countries. An eyes-wide-open methodology, however, for describing treatment options and known risks, along with a consent mechanism that reasonably shows patients understand both, is necessary. The demand for non-U.S. based treatment will drive the need for a more advanced informed-consent framework. In this matter, physicians' and health plans' interests will be fully aligned, and a new standard of informed-consent aided by EBM protocols will appropriately govern malpractice litigation.

Prediction Six

Health plans and brokers will be required to significantly drive down distribution costs of benefit plans to consumers to catch up to the efficiency of operational administration and shift a higher percentage of premium dollars toward care and wellness management.

Over the years, information systems have enabled payer organizations to drive down their administrative costs from historical highs of 18 to 22 percent of the premium dollar to just 10 percent today.⁷ Their challenge, going forward, will be to tackle costs in the distribution of health plans, a staggering \$23 billion annually.⁸ This amount is roughly equal to the revenue generated from all retail electronic sales in the United States, double the sales from alcohol sold at bars and restaurants,

and equal to the revenue from sales of women's clothing.⁹

Watch for the debut of online exchanges that reduce these distribution costs dramatically, provide payers a straight-through processing environment, and enable brokers and employers to quote, enroll, and receive member identification (ID) cards for health insurance directly over the Web. This quote-to-card capability at the broker desktop will significantly differentiate and drive more business to participating health plans. Further, it will eliminate a significant number of ID card and eligibility issues that now frustrate customers, and it will give brokers and benefit consultants more time to sell.

It was Mark Twain who said, "The art of prophecy is very difficult, especially with respect to the future." While we may be uncertain about the timeline of these predictions, I am most certain that the U.S. health care industry is up to meeting these challenges head on and vastly improving the delivery of benefits and care in our country. ■

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Endnotes:

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2. Fox, Maggie, "Many Doctors Plan to Quit or Cut Back: Survey," news story reporting on 2008 survey by Physicians' Foundation, Reuters Limited, Nov. 18, 2008.
3. The advanced medical home model is a "physician practice that provides comprehensive, preventive and coordinated care centered on their patients' needs, using health information technology and other process innovations to assure high quality, accessible and efficient care. Practices would be certified as advanced medical homes, and certified practices would be

eligible for new models of reimbursement to provide financing commensurate with the value they offer. These practices would also be accountable for results based on quality, efficiency and patient satisfaction measures. The advanced medical home would be particularly beneficial to patients with multiple chronic diseases—a population of patients that is growing rapidly and that consumes a disproportionate share of health care resources.” (Source: “The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care,” American College of Physicians, Jan. 30, 2006. Available at www.dhhs.gov/healthit/ahic/materials/meeting03/cc/ACP_Initiative.pdf.) The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The American Academy of Family Physicians and the American College of Physicians have since developed their own models for improving patient care called the “medical home” (AAFP, 2004) or “advanced medical

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