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Consumers need to enter discussions on reform

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Health care reform in Massachusetts continues to evolve. There is no question that Massachusetts achieved its initial and primary goal of near universal coverage in the state, at almost 97 percent. There has been an intentional and measured distribution of financial sacrifice to help fund the costs of the program in its early stages. Small employers have perhaps had the most direct adverse impact, as the blending of the individual and small group insurance markets have hit small group health premiums with additional percentage points on top of trend in each of the past two years.

Massachusetts taxpayers, providers and insurance carriers have all paid in to the pool in various forms. But in order for Massachusetts reform to succeed in Phase 2 — cost control — we need to add the most critical player to the equation in a significant way: the consumer.

For the past several years, carriers, employers and intermediaries have talked about the term health care “consumerism.” The Bush administration’s passage of Health Savings Account legislation was designed to give “consumers” the ability to take more risk and make better buying decisions with their health care dollars.

Companies trying to control ever rising health care costs looked to these high-deductible programs as a possible panacea for rising costs. Unfortunately many studies are now bringing to light what many predicted early on. Without real access to provider and facility costs and outcomes data, and without real financial teeth built into the plan design, the consumer will continue to make decisions on treatment based on perceived reputation and prestige of the facility.

Most high-deductible plans fail in the attempt to engage the consumer in that any surgery or hospitalization that would make a financial difference is going to cost that same deductible maximum, and the plan then reverts to a first-dollar plan for the rest of the year.

What is needed in Massachusetts, therefore, are plan designs that provide significant cost sharing at “site of service” or time of care. For example, the state plan, or Group Insurance Commission, has worked creatively with the carriers over the past few years to develop tiered networks with co-pays or even premiums tied to the cost and outcomes of the hospitals or practice groups.

More importantly, there are currently programs being developed outside of the Group Insurance Commission that would place significant co-pays on use of facilities where costs can be over 50 percent higher than other nearby facilities with comparable outcomes.

The successful rollout of these plans faces several hurdles. The state insurance laws currently restrict plans from having co-pays more than \$1,000, so employers are stuck accepting double-digit rate increases and passing the costs on to their employees in the form of contributions.

This does not engage the consumer. The state needs to allow plans — similar to what we see in most other states in the country — in which the consumer shares the costs more significantly. In fact, the 100 percent plans we see in Massachusetts are not even available in most areas of the country where 80 percent in network coverage is the standard. But knowing that lower cost doesn't mean lower quality is the key.

In Massachusetts, the Health care Quality and Cost Council, established as part of the reform legislation, is quietly developing a useful database of costs per procedure and quality measures of Massachusetts hospitals and doctors. Although the information is still sparse for many procedures, it identifies significant cost disparities amongst Massachusetts hospitals.

The key is to get this data in the hands of the consumer and, more importantly, to make it matter. Health care reform, in order to be true reform, must address cost.

Give the private system the tools it needs to change the economics of the buying cycle, and the free market will take care of the rest.

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