



What's Next? An Executive Summary

What's next in US healthcare pricing and how do we prepare ourselves? There is value in this exercise as we can all be sharpened by the dialogue. So let us turn our gaze towards the future and examine emerging trends and their potential ripple effects on the international payer and their agents.

Here comes a recession

Depending on who you read, the US is either in or sliding into a recession. This will not be a problem for healthcare providers who have a proven track record of being “recession proof.” Provider profits will still remain high, and this will be a building time -- the highest hospital construction boom since 1960. Invariably, these costs will be transferred to the payers. The only risk is that providers may have difficulty securing credit. Recent changes to Medicare reimbursements (MS-DRG) will create some “losers,” and so expect some re-structuring, consolidation for hospitals, and legislation concerning physician owned hospitals. History shows that healthcare providers will perform well even when the overall market does not.¹ Currently, hospitals are enjoying the highest profit margins since 1997.²

The same cannot be said for the payer community (government, employers, insurers and the under or uninsured). Insurers heavily invested in healthcare will have a further pressure to consolidate to cover growing healthcare expenses. Reductions in mainstream policy benefits and higher copayment and deductibles for consumers are very possible scenarios. There will also be a spike of uninsured people due to a likely increase in unemployment and fewer employers offering meaningful benefits.

Due federal gridlock on key issues, and the difficulty to initiate a federal program; look for many states to experiment with programs to have their population insured. Initial attempts have been met with resistance and funding problems (e.g. Massachusetts). Despite the enormous interest generated by the presidential candidates, more change will come at the state level than federal, which should temper speculations about the impact of the coming elections.

More cost shifting

As there have been over two decades of steady cost-shifting, the easiest prediction is to say that this will continue. The government has decided to no longer reimburse so-called “never-events” which include hospital-borne infections, surgeries on the wrong body part and so on.

As the population continues to age, there will be an increasing utilization of healthcare services by Medicare patients. This is of particular concern, as many analysts predict that Medicare will become financially insolvent by 2019, but this number has dropped from original predictions.³

¹ *Medical Cost Trends*: PricewaterhouseCoopers health research Institute June 2008 p. 14

² American Hospital Association aha.org cited in *By the Numbers* Modern Healthcare Supplement 2007-2008 Edition p. 16

³ Medicare | *Medicare's Hospital Trust Fund Will Be Insolvent by 2019, According to Trustees Report*



The government has recognized that improved IT infrastructures and electronic medical records will reduce administrative costs. For providers, however, there is no ROI for these programs beyond the obvious process efficiencies. As such, expect the government to launch pilot programs that give providers more reimbursement if they have these programs in place. After a year, the reimbursements should return to normal, but a fee reduction (negative incentive) for providers without these programs will likely be introduced.⁴

All of the aforementioned variables will mean more cost shifting, higher costs, and fewer people who can afford insurance. This will result in more uninsured, which means more cost shifting and so the broken record keeps playing. This will exacerbate billing and collection problems, as providers will look to outsource more components of the management of their receivables. We are already seeing specialized credit cards positioning themselves for this emerging market.

An interesting note about uncompensated care (charity) hospitals is their disclosure of the regular charges they write-off versus the actual cost or the market rate of such services. The true write-off is at least half, and for many facilities under a quarter of the disclosed contribution. In fact, despite the increase in the uninsured population, the cost for this sector has remained virtually the same since 1997 at approximately 5.8% of total expenses.⁵

Transparency (more than a buzz word)

PPO contracting has come under scrutiny and a handful of states have enacted legislation towards more transparent contracting. The American Medical Association (AMA) has drafted a Model Act that is being pushed at various state levels for approval (e.g. SB 1012 for Florida). The Act is designed to protect providers from unilateral amendments and re-contracting by the PPO.⁶ The Act also includes standards for dispute resolution. This is similar to the prompt pay initiatives from a few years back; expect that over 40 states will have a variation of the AMA Model Act within the next 2-3 years. Arguably, the biggest change will be for the PPOs themselves, as the burden for compliant contracting will be on them as the gate keepers of the discount and steerage requirements. This, along with recent and continuing consolidation, will result in payment transaction problems.

We will see round two in hospital pricing transparency. The first round consisted of public disclosure of charge master prices and posting discount policies for the uninsured (California). Round two will be more of the same, but we will also see hospitals disclosing a set price for services designed to attract the individual consumer market, creating some debate (and legislation) about variable rates for “insured” and “uninsured” persons.

KaiserNetwork.org. March 26, 2008

⁴ See *HHS Secretary Mike Leavitt discusses the tough changes necessary to fix healthcare*, modernhealthcare.com Executive Interview Podcasts

⁵ American Hospital Association aha.org cited in *By the Numbers Modern Healthcare Supplement 2007-2008 Edition* p. 20

⁶ 2008 Legislative Update First Health Network p. 1



It is also to be expected that not-for-profit hospitals will come under more scrutiny for their community contributions (or lack thereof) to justify their tax-exempt status. The Internal Revenue Services (IRS) have a new reporting standard (form 990), which may reveal some abuses in this sector.

Employee group health plans (160 million lives) will have to be more transparent regarding healthcare benefits. This will be an extension of burgeoning discussions on usual, customary and reasonable rates.⁷ Expect to see health plans introducing very specific formulae for payment based on the Medicare rate calculations or a variation of a maximum allowed amount, which could eventually replace the use of PPOs altogether.

Despite initially strong expectations for consumerism in healthcare, growth here will still be moderate, but will be in direct proportion of the transparency and availability of meaningful pricing and quality of care data.

What does all this mean to us?

Despite many consulting firms declaring slowed inflation, this does not apply to the PPO payer market, which will still have inflation of costs nearing 11%.⁸ In short, this will mean higher charges and lesser discounts. More than ever, international insurers will need strong support to be able to pay a fair market rate for healthcare. Attentive policy revisions, stronger case management and competent, professional repricing initiatives will be required to curb the effects of inflation.

Lastly, expect that in the coming years much will be made about private versus universal healthcare. The truth is that the US already has a fragmented form of universal coverage, as providers must treat people irrespective of their ability to pay, and these costs are borne by all. Whether it takes 2 years or 20, it is to be expected that the US will eventually acknowledge this, and turn their attention to determining the most efficient and cost-effective way to make healthcare accessible to all their citizens.

⁷ See *Stewart Scharfman, Zev and Linda Wachtel and Renee McCoy v. Health Net* Civ. Docket No. 2:05-cv-0301.

⁸ 2009 Segal Health Plan Cost Trend Survey. p. 2