Crisis in Corporate America: How to Reduce Healthcare Costs

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Introduction

Businesses that fully insure their employees are almost always over-insuring their employees. That is, they pay far more in premiums than the medical care of their employees actually costs. For this reason, many businesses are moving to a self-insurance model where they pay the cost of their employees' medical costs directly and have a stop-loss to mitigate against catastrophic medical expenses.

This is an excellent strategy, not just because it's cheaper than being fully insured but also because any medical cost savings their employees achieve are passed directly on to the employer. The main questions employers want to ask then is what's driving the increase in healthcare costs and what can they do to counter it?

Healthcare Overutilization

One of the biggest drivers of rising healthcare costs is unnecessary healthcare utilization: unnecessary ER visits, specialty referrals, x-rays, MRIs, CT scans—even unnecessary hospital admissions, one of the most costly healthcare expenses there is. Why do people overutilize healthcare? There are four main reasons:

- Fee-for-service payment structures motivate doctors to provide more services (to collect more fees).
- Fear of being sued—especially prevalent in emergency rooms where patients have no pre-existing relationships with physicians to diminish their inclination to sue—leads physicians to order more rather than fewer tests to protect themselves.
- Patients frequently demand tests and procedures they don't actually need (MRIs for back pain, antibiotics for viral infections, and so on) and physicians are often reluctant to refuse for fear of angering or alienating them, or simply have too little time to explain why such tests or procedures are unnecessary.
- Primary care physicians especially have too little time to spend with each patient and work in systems that put up too many barriers between them and their patients, leading to more testing, specialty referrals, ER visits, and hospital admissions than are often necessary.

The impact of overutilization on the nation's healthcare bill is enormous. In 2010, for example, $29.7 billion[1] was spent in hospitalizing patients for potentially preventable complications of conditions such as diabetes, congestive heart failure, and osteoarthritis. Better managing—or even preventing—these complications could therefore dramatically reduce the cost of caring for patients with these diseases and therefore the direct cost to self-insured employers.

Inadequate Healthcare Access

Unfortunately, however, cost isn't the only issue that companies need to worry about. They also need to worry about healthcare access. If their employees can't get in to see their doctors, small problems are more likely to become bigger ones, and absenteeism is likely to rise. Just how hard is it to get access to primary care in America? According to a study conducted by Merritt-Hawkins in 2017 in multiple cities across the U.S., the average wait time for an appointment with a primary care physician is approximately 24.1 days.[2] This represents a 30% increase from 2014. Also, according to Becker's Hospital Review, even in Urgent Care centers (specifically designed to get patients in to see providers quickly) once patients arrive at their appointments almost 30% have to wait 21-40 minutes to be seen.[3] What's more, the average length of time primary care appointments last is only 15.7 minutes.[4]

For simple issues like ankle sprains or back pain, this might be enough. But for patients with multiple, complex issues it's completely inadequate—and further leaves no real time to address important topics that require extended dialogue (for instance, end-of-life care in terminal cases). Further, dealing effectively with important emotional issues—stress, anxiety, depression, and so on—in such a timeframe is nearly impossible, as are meaningful and effective discussions surrounding preventive care.

Too Much Healthcare Access

Clearly, reduced access to care impinges on the quality of care. But paradoxically *too much* access—that is too much care—does as well. Every test and every intervention, from a routine blood draw to major surgery, carries with it a set of predictable risks. And though these risks are usually acceptably low at the level of the individual (or at the very least outweighed by the benefits), when viewed at the level of whole populations their impact becomes considerable. By some estimates, almost 1 million people die each year (Table 2)[5] in the U.S. due

to complications from medical interventions. Certainly these interventions save far more lives than they take (otherwise we wouldn't perform them), but the take home point is clear: tests and procedures that are *unnecessary*, and which therefore expose patients to *unjustified* risk, must be avoided at all costs.

So what can an employer do to combat poor healthcare access, reduced healthcare quality, and unnecessary overutilization of healthcare resources that drive up healthcare costs?

The Solution

Direct primary care, or concierge medicine, is a new model of healthcare that's been shown to address all of these problems. In direct primary care, or concierge medicine, physicians charge a monthly or annual retainer fee to patients directly in exchange for offering 24/7 access and same-day or next-day appointments that start on time and last as long as they need to. In one study, researchers evaluated the cost-benefit of the largest direct primary care, or concierge medicine, practice in the U.S. (MDVIP). For states in which sufficient patient information was available (New York, Florida, Virginia, Arizona, and Nevada), decreases in preventable hospital use resulted in $119.4 million in savings in 2010 alone. On a per capita basis, these savings ($2,551 per patient) were greater than the payment for membership[6] in the medical practices (generally $1,500-$1,800 per patient per year).

Further, in 2010 (the most recent year of the study), MDVIP patients experienced 83% fewer elective admissions, 56% fewer non-elective admissions, 49% fewer avoidable admissions, and 63% fewer non-avoidable admissions when compared to patients in traditional fee-for-service practices.[7] Additionally, members of MDVIP were readmitted 97%, 95%, and 91% less frequently for acute myocardial infarction, congestive heart failure, and pneumonia, respectively.

Data[8] from Qliance, the second largest direct primary care, or concierge medicine, practice in the U.S. shows that, compared to patients in standard fee-for-service primary care practices, their patients had:

- 59% decrease in ER visits
- 30% decrease in number of days admitted to the hospital
- 62% decrease in specialty referrals
- 65% decrease in radiology exams

- 80% fewer surgeries
- *115% increase in primary care visits*

—yielding a $1,486 savings per patient per year compared to traditional fee-for-service practices.

A direct primary care, or concierge medicine, model where retainer fees are covered by the employer, by the patient, or by some combination of the two also makes the cost of primary care far more predictable, thus reducing barriers to patients seeking primary care early, and thus reducing healthcare overutilization. Further, because the retainer fee is a deductible business expense, the actual cost to a business will be reduced by a percentage equal to its total corporate tax rate.

A number of businesses have already recognized the potential for cost savings inherent in the direct primary care, or concierge medicine, model. A clause in the ACA states that "the Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan."

For self-insured employers concerned about rising healthcare costs, direct primary care, or concierge medicine, represents a solution that offers three benefits at once: increased employee satisfaction, improved quality of care, and decreased cost. And though the decreased cost requires an increased upfront expenditure, for large groups of patients (that is, employees) the data strongly suggests that the old adage one must often "spend money to save money" is highly likely to hold true.

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[1]https://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf
[2]https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Pdf/mha2017waittimesurveyPDF.pdf
[3]http://www.beckershospitalreview.com/lists/25-things-to-know-about-urgent-care.html
[4]http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2254573/
[5]http://www.webdc.com/pdfs/deathbymedicine.pdf

[6]http://www.ncbi.nlm.nih.gov/pubmed/23286675
[7]Ibid.
[8]http://stateofreform.com/news/industry/healthcare-providers/2015/01/qliance-study-shows-monthly-fee-primary-care-model-saves-20-percent-claims/