Loyale Healthcare, a Leading Healthcare Financial Company Explores Healthcare in America: Which Model is Best for Delivering Quality, Affordable Patient Care

Americans and Americans continue to struggle with access to affordable healthcare. Whether the solution is multi-payer private, single-payer, integrated delivery or a new model entirely, sustainability will only be achieved when the interests of patients, providers, payers and employers are all aligned.

LAFAYETTE, Calif. ([PRWEB](http://prweb.com)) September 26, 2018 -- Across the United States, there is one issue of common concern to most Americans - In almost every survey on issues of concern to Americans, the availability and cost of healthcare is at the top of the list. As healthcare costs continue to rise, better solutions are being sought and new models are evolving - all with the goal of delivering high quality and effective healthcare at a reasonable cost. In this article, we'll examine models for the delivery and payment of healthcare in modern, industrialized economies, and explore the dynamics that are driving fundamental change here in the U.S.

In the United States, healthcare has always been an adversarial arena for participants – providers, payers, clinicians, administrators, employers and patients. The economic incentives for each of these constituencies do not align. The payer insurance company is focused on controlling costs and managing premiums, the provider is focused on the best possible care at any cost, the employer is looking to manage its expenses and exposure to risk, and the patient just wants to get well without incurring unbearable personal expense.

Historically, the economics behind the American healthcare industry have wrongly incentivized volume-based fees-for-service over value-based care delivery at a mounting cost to the American economy, costs that affect every stakeholder. Consequently, payers, providers and patients are all looking at new models to achieve high quality health services at “reasonable costs.”

Incremental adjustments to the U.S.’s traditional multi-payer model are being attempted, but so far they have fallen short of meeting the objectives for a sustainable, affordable healthcare delivery and payment model.

Matt Bierbaum, VP of Managed Services and Enterprise Partnerships at Philips stated that “With (the market’s) revised expectations for quality and value comes a need for higher degrees of coordination and new models of strategic partnership among all participants in the healthcare economy. Many hospitals, payers and community organizations are already finding ways to work together as partners to deliver new care delivery options or payment choices to patients. However, in most of these "partnership" arrangements, the parties are simply trading better long-term prices or more broadly scoped service and purchasing agreements. While these types of collaborations can make near-term incremental improvements, they are still not aligned to meet the long-term challenges of the new healthcare economics”.

A Comparison of Healthcare Financial and Delivery Models

Multi-Payer System - The American Model

The United States has no single nationwide system of health insurance. Health insurance is purchased in the private marketplace or provided by the government to certain groups. Private health insurance can be purchased
from various for-profit commercial insurance companies such as United Healthcare or from nonprofit insurers such as Blue Cross/Blue Shield. Approximately 61% of health insurance coverage is employment related, largely due to the cost savings associated with group plans that can be purchased through an employer.

The United States possesses a multiplayer system in which a variety of third-party payers are responsible for reimbursing health care providers. Thus, we face the first disconnect, where the insurance company is focused on reducing patient care outlays and the provider is focused on delivering the highest quality of patient care which, coincidently, generally increases the profit of the healthcare provider whether that provider is a doctor, hospital or pharmaceutical company.

In addition to private health insurance, nearly 26% of the U.S. population is covered by public health insurance. The two major types of public health insurance, both of which began in 1966, are Medicare and Medicaid. Medicare is a uniform national public health insurance program for aged and disabled individuals. Administered by the federal government, Medicare is the largest health insurer in the country, covering about 13% of the population.

According to the Kaiser Family Foundation's survey of employer health benefits, health insurance premiums have been rising faster than wages. Between 2012 and 2017, workers' earnings grew by 12 percent, while premiums went up by 19 percent. Between 2007 and 2012, premiums increased twice as fast as workers' earnings.

Former Apple CEO John Sculley, now the chief marketing officer for RxAdvance, a health tech company, has observed that “The U.S. health-care system is unsustainable in terms of its costs, and the entire debate by political leaders — whether it is Democrats or Republicans — has focused on repairing and replacing Obamacare and the ideological differences.”

Single Payer - Government Sponsored Systems

A single-payer system is a single public system that covers the costs of essential healthcare for all residents. It is this characteristic that distinguishes most of the industrialized world’s systems from the United States’ multiplayer system in which private, qualified individuals or their employers pay for health insurance with various limits on healthcare coverage via multiple private or public sources.

Single-payer systems (also referred to as socialized medicine) may contract for healthcare services from private organizations (Canada) or may own and employ healthcare resources and personnel (United Kingdom). These systems generally fall within one of three models: The Beveridge Model (UK) the Bismarck model (Germany), and the National Health Insurance Model, which contains elements of both the Beveridge and Bismarck models.

In any of these three models, healthcare providers and consumers deal with a single, governmental payer, which may own and operate its own healthcare delivery system, or may engage with private healthcare providers and payers with powerful government oversight. In each instance, universal coverage is assured with costs and care delivery closely managed by the government entity charged with the system’s administration. The programs are funded either by taxes (Beveridge), Employer/Employee private insurance (Bismarck) or Government run insurance (National Health)

The lower costs and universal coverage provided by many single payer systems have led to successful
employer-sponsored experiments here in the U.S. At present, it may be these or similar models that prove to be the solution to America’s seemingly intractable healthcare challenge.

Privately funded, multi-payer systems: Managed Care – an Integrated Delivery System (IDS)

An Integrated Delivery System (IDS) is a health system with a goal of logical integration of the delivery of health care rather than a fragmented system or a disorganized lack of system. The term has sometimes been used in a broad sense with reference to Managed Care in general (as opposed to fee-for-service care), but in the United States it now more often refers to any specific network of health care organizations constituting a corporate group that attempts to integrate care to some degree.

One of the most successful of the Managed Care systems in the United States started during World War II.

In 1942, 20,000 Kaiser Shipyard workers were provided healthcare services through the Kaiser Permanente Health Plan. Workers paid a very small premium (6 cents a day) and healthcare was provided at the job site, thereby minimizing healthcare costs and improving healthcare services to workers. Last but not least, it also reduced employee absence time through on-the-spot healthcare services. Kaiser Permanente has remained a very large and successful healthcare delivery model, combining the services of a payer and provider across several states.

Today, other efficient integrated healthcare systems generally are found in large multi-specialty medical group practices with transparent links to hospitals, labs and pharmacies. These organizations provide complete care—from the doctor's office to the hospital to home care, and everything in between. They often have their own insurance arms and work under contracts in which they agree to deliver comprehensive medical services to consumers for a fixed-dollar amount.

The relative success of a Managed Care model evolves around two propositions:

1. The system has moved from a linear structure to a closed-loop model. In traditional models, care and costs associated with equipment, services, and software are considered as separate, isolated events at every step in each patient’s journey. In the Managed Care model, there is full transparency providing visibility to the all players in the continuum of care.

2. Partners share risk (and reward) for outcomes. This is a particularly critical component as our healthcare market shifts from a volume- to value-based model. In the most innovative business models, risk (financial, clinical or operational) is appropriately distributed to each partner to ensure a shared focus and contribution to the joint goals of the partners.

Strategies to mimic the Managed Care Model in Traditional Care Delivery Environments

Due to the success of Kaiser’s and other Managed Care models, many hospitals and health systems are making merger and acquisition moves to implement value-based care, manage costs and sustain profitability. It’s easy to see why. According to a 2016 HFMA report, “The transition from volume to value and the corresponding move to population health management require major capital investments and sophisticated management expertise of the sort that may prompt even the most independent-minded hospitals and health systems to consider their consolidation options.”
The Managed Care model has recently accelerated in growth as the result of the dramatic increase of mergers and acquisitions across industry verticals. Payers (insurance companies) have entered the provider (hospital business) and drug store companies have acquired payers.

These companies are moving into an industry where the lines between traditionally distinct areas, such as pharmacies, insurers and providers, are increasingly blurry. CVS Health’s deal to buy the health insurer Aetna for about $69 billion is just one example of the changes underway. Separately, Amazon’s potential entry into the pharmacy business continues to rattle major drug companies and distributors.

An Evolving Fourth Model

During the last two years, a new model has emerged, the result of employers tackling the problem of healthcare accessibility and cost. Employers are using their considerable purchasing power to influence provider and health plan behavior and discovering new means to control healthcare costs. If implemented, these initiatives would help inaugurate the transformation critical to the industry's financial survival.

Many large employers are now negotiating payments to providers based on the value of the services provided. They’re also offering incentives and information for consumers to allow them to choose high value providers thereby aligning private purchaser actions with public purchasers’. Leveraging their market and cultural influence, these employers are, in effect, applying the same economic pressures wielded by government payers in single-payer and our own Medicare/Medicaid systems.

Recently three corporate behemoths — Amazon, Berkshire Hathaway and JPMorgan Chase — announced that they would form an independent health care company for their employees in the United States. The alliance was a sign of just how frustrated American businesses are with the state of the nation’s health care system and the rapidly spiraling cost of medical treatment. It also caused further turmoil in an industry reeling from attempts by new players to attack a notoriously inefficient, intractable web of doctors, hospitals, insurers and pharmaceutical companies.

Will more companies adopt an Amazon - Berkshire Hathaway -JP Morgan Chase model? Or will they join the model where the employer is the payer and provider of healthcare services? Will the Amazon triumvirate begin to acquire hospital systems, pharmaceutical companies and healthcare technology providers?

Does the Model Really Matter?

Essentially, this is a question without an answer. Each model has its benefits and costs. Single payer proponents will argue that the United States should adopt this model and follow the European model. The American model delivers choice and convenience. The Managed Care model is efficient and comprehensive and the new evolving Amazon model is untested.

Whatever the model, payers, providers and patients can work together to build a better “mousetrap” by focusing on several key objectives and solutions:

Patient Level Initiatives:

- Simplify and standardize health care administration, such as codes and billing, across health care industries.
• Offer incentives for processes that improve patient care such as electronic health records.
• Streamline the Patient Registration Process.
• Together with the patient, create a Custom Patient Financial Plan.
• Incorporate Estimated Patient Share financial tools into the patient financial management process.
• Incorporate a Patient Financial Assessment into the registration process.
• Incorporate Estimated Patient Share financial tools into the patient financial management process.
• Consolidate and democratize patient medical and financial information
• Ensure that information technology enables self-management by improving patients’ access to personal health information.

Provider and Payer Level Initiatives:

• Implement comparative effectiveness studies for treatment practices.
• Develop a national initiative to reduce preventable hospital admissions and readmissions.
• Expand hospice through support to community-based programs.
• Reduce relative values for services undergoing high rates of growth in volume.
• Promote bundled payment covering all providers for acute episodes of care and post-acute care.
• Fund research to identify key elements of effective self-management programs.
• Support self-management through benefit design such as using financial incentives for patients to encourage the use of care that is proven to be effective and discourage care that has less evidence of success.
• Support self-management through provider incentives, linking payments to increases in patient activation.
• Ensure that information technology enables self-management by improving patients’ access to personal health information.
• Promote provider support for patient-centered care.

Organizations are seeking new capabilities for a value-based, consumer-oriented health system. These capabilities include data analytics and care coordination across the healthcare continuum. Whatever the model or initiative, the patient must remain at the center of the discussion. Quality service at a reasonable cost is achievable under any model if we can move healthcare out of the political discourse and begin to change the adversarial arena of the participants to one of mutual benefit and cooperation.

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About Loyale Healthcare

Loyale Patient Financial Manager™ is a comprehensive patient financial engagement technology platform leveraging a suite of configurable solution components including predictive analytics, intelligent workflows, multiple patient financing vehicles, communications, payments, portals and other key capabilities.

Loyale Healthcare is committed to a mission of turning patient responsibility into lasting loyalty for its healthcare provider customers. Based in Lafayette, California, Loyale and its leadership team bring 27 years of expertise delivering leading financial engagement solutions for complex business environments. Loyale currently serves approximately 2,000 healthcare providers across 48 states. Loyale recently announced an Enterprise level strategic partnership with Parallon including deployment of its industry leading technology to all HCA hospitals and Physician Groups nationwide.
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