Health Insurance Cooperative Agency

Community-Based Plans Provide an Answer to the Health Care Crisis

Kansas hospitals are seeing an increase in high-deductible health plans, resulting in an increase in accounts receivable, charity care, and bad debt. Hospitals struggle to keep up with, let alone comply with, the deluge of regulatory requirements.

The impact of the Affordable Care Act on health care providers starts with employer mandates requiring plans to meet standards that have increased deductibles and out-of-pocket costs for many employees participating in employer-sponsored plans. Plans that meet ACA minimum value standards have $6,350 individual or $12,700 family out-of-pocket maximum costs. Often these deductibles and maximum out-of-pocket costs are too high and not within the individual or family budget. Increased premiums to meet ACA guidelines are pushing many smaller employers (under 50) out of the traditional health benefits market.

As the ACA evolves, it is critical that health care plans support the local providers to keep community health care intact

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The solution: community-based health plans

The Health Insurance Cooperative Agency has been working to come up with a health care plan that supports local providers and keeps community health care intact. The solution is community-based health plans that offer lower deductibles and out-of-pocket costs to employees seeking local care. The HIC Agency has developed a model to create health plans that help create a more direct relationship between the community providers and the employer health plans.

David Hickman, President and CEO of the HIC Agency, has developed steps to implement a community-based health care model, starting with utilizing a hospital / physician network that allows steerage to local providers at an enhanced or lower out-of-pocket cost to the community.

How can you create a community based health care model?

1

Utilize a hospital/physician network that allows steerage to local providers at an enhanced or lower out-of-pocket cost to the community. Many times, lowering copays, lowering coinsurance, and covering the mandates such as essential health services only at the local community provider level will create positive steerage. Community leaders have to be engaged and encouraged to participate; this can be accomplished in several ways. Plan design featuring lower out-of-pocket costs for employees utilizing local providers can help keep competitive rates for employers.

2

Third-party administration of the health plan will allow the community plan to be marketed to employer groups, and can also help customize the benefits to meet the needs of each unique group while steering care to the local providers where appropriate. The lower administration cost and streamlined service cost efficiencies of TPAs will help, along with the enhanced benefits locally. The TPA and hospital physician network can monitor any leakage of covered services outside of the community and corrections can be made where appropriate.

3

For prescription drug benefits, it is important to utilize a Pharmacy Benefit Management (PBM) network that works closely with the local providers. Pharmacy compliance with physician orders can help reduce potentially large claims and critical medical occurrences. We often find that allowing local retail fill on 90-day maintenance drugs vs. mail order is a big win for smaller rural communities. PBMs also have strategies that focus on quality and safety first along with cost containment programs. These programs can be tailored based on each employer's specific needs.

4 Focus on health and wellness. Seventy-five percent of all day-to-day health costs is lifestyle driven, and preventable illness makes up 70% of the burden of illness and the associated costs. A community-based wellness initiative will help modify those behaviors that lead to chronic conditions.

5 Implementing a wellness program that shares data with local primary care physicians not only fosters a relationship between employees and their physicians, but also increases the probability of long-term risk reduction and long-term cost savings.

Maximizing employee utilization in wellness services is a win for the employee, a win for the employer, and a win for the community.

The employee becomes healthy while taking advantage of lower deductibles and out-of-pocket costs, the employer realizes increased productivity and reduced health care costs overall, and the community benefits not only from the improved health of its residents but also from the long-term sustainability of the successful local hospital.

Using a community-based health care model, the data obtained through health risk assessment and biometrics results is sent to the selected medical home or local provider. With this data and information, real population management for the communities' specific needs can take place while utilizing the local resources.

The community health care model has to start with the providers. A marketing communication plan has to be implemented, along with health benefit plans that feature community care highlighting the benefits to everyone.

For more information on how a community-based health plan can benefit your hospital network and your community, contact the HIC Agency at 913.649.5500

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