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How Primary Care, America's Best- Kept Secret, Can Reduce Health Care Costs

for Self-Funded Employers

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Payors could make greater and wiser use of primary care health care providers resulting in healthier employees, lower costs and increased employee morale.

This article is directed to the payors—especially self-funded employers and TPAs—that seek to improve the health of the populations they cover in addition to administering the plan. Greater use of primary care is one way to better manage the health delivery. The results should also impact costs in a measurable way.

Primary care is America's best-kept secret for keeping costly conditions from happening in the first place. Primary care is the ideal coach or liaison to coordinate and oversee the specialty care that often operates in silos.

What is Primary Care?

Primary care includes family medicine doctors, general practitioners, pediatricians, nurse practitioners and physician assistants. Generally, these professionals treat acute conditions, and to some degree, chronic conditions. While many health care provider groups (specialty, pharma, hospitalization) experience double-digit cost increases, the group of primary care providers lags with an average three-percent annual increases. The result is pushing more and more primary care physicians into specialty care where reimbursements are greater.

Our payment systems pay more for specialty care. Our case management will often not permit procedures unless ordered by a specialist. The focus of our stop-loss community is on high-cost hospitalization and associated high-cost specialty care. While our focus is justified, it causes us to focus on specialty and hospitalization care, and gives little or no time and effort to promote the values of primary care.

Primary care is America's best-kept secret for keeping costly conditions from happening in the first place. Primary care is the ideal coach or liaison to coordinate and oversee the specialty care that often operates in silos. Patients will often have two or three specialists with each focused solely on their "special" part of the body or condition. Specialists prescribe medication to treat their focus often without knowledge of other specialty care being administered, whether treatments or medication. The primary care provider can serve as coordinator, patient advocate, and patient educator. The result can be vastly improved care, better coordination of treatments and medications, improved communication and education with the patient.

As few years ago, a 38-year-old female cafeteria worker with the self-funded assisted living facility management firm, American Retirement Corporation, said she was looking forward to seeing the onsite clinic physician because she was taking eight medications prescribed by three specialists. She had been diagnosed with high blood pressure, diabetes, and had a heart attack two years earlier. Her out-of-pocket on the medications alone was over $300 a month.

Several months later when visiting the clinic, she found me in the company cafeteria. With tears in her eyes, she pulled on my arm to step away from my colleagues at the table. She said, "I just want you to know that I love Dr. Gross (the onsite primary care physician). He has helped me reduce to only three drugs. I only need two of my three specialists now. My out-of-pocket is now only $80 a month. My headaches have stopped and I have never felt better."

It is not that Dr. Gross was necessarily any smarter than the specialists. But his care coordination and patient education made a huge difference, improving the health of this employee/patient and lowering the costs for both her and her employer.

Much of Specialty Care Spending is Unnecessary

Specialty care in the United States is the envy of the world. Dedicated professionals spend decades in education to refine their knowledge, skill and application to make a significant difference in

The report argues that the health care system must focus greater attention on developing care processes for the common conditions that afflict many people. A limited number of such conditions, about 15 to 25, account for the majority of health care services and cost. According to the IOM report, the 15 priority conditions are:

- Cancer
- Diabetes
- Emphysema
- High cholesterol
- HIV/AIDS
- Hypertension
- Ischemic heart disease
- Stroke
- Arthritis
- Asthma
- Gall bladder disease
- Stomach ulcers
- Back problems
- Alzheimer's disease and other dementias
- Depression and anxiety disorders

Most of these conditions have fewer than 10 key markers or tests that can easily be followed by primary care providers instead of specialists. The primary care provider can easily refer to specialty care when one of these markers changes and merits the action.

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For example, the predominant diabetes markers include glucose, weight, HbA1C, and triglycerides. The primary care provider can monitor the marker levels. Treatment including diet, medications and education can be adjusted in response to changes in the markers. If satisfactory responses are not achieved, then the specialists can become an active participant in the treatment process.

A primary care provider can easily measure prothrombin time and INR for anticoagulant patients taking the blood-thinner, Coumadin or Warfarin, even on a stat basis. If the results merit a call to the cardiologist, the primary care provider can talk physician-to-physician to decide what next steps are in the best interest of the patient. The patient saves a trip to the Cardiologists and the self-funded health plan pays significantly less for a primary care visit instead of a specialty care visit.

How We have Encouraged the Growth of Specialty care

TPAs, self-funded employers and other payers have encouraged the drive toward specialty care, creating a huge imbalance in health care overpayments.

For specialty and optimization care, our financial incentives encourage the overuse of acute care hospital services and the proliferation of medical specialists. That is, we are willing to pay many times more to specialists, which drives more physicians to become specialists. Generally, we pay hospitals based on utilization instead of case rates. Imagine paying for car repairs based on the number of days the car is in the shop. Hospitals responded with outpatient facilities. Now, in many cases, outpatient costs exceed inpatient costs.

While payments for primary care as a health care component have declined relatively, our payments for specialty care have increased making specialty care much more attractive for physician salaries. The median income of specialists in 2004 was almost twice that of primary care physicians and the gap is widening. Data from the Medical Group Management Association indicate that from 1995 to 2004, the median income for primary care physicians increased by 21.4 percent (2.2 percent per year), while that for specialists increased by 37.5 percent (3.6 percent per year).

A 2006 report from the Center for Studying Health System Change reveals that from 1995 to 2003, inflation-adjusted income decreased by 7.1 percent for all physicians and by 10.2 percent for primary care physicians.

Essentially, we are promoters of higher cost specialty care when lower cost primary care is being overlooked and not rewarded. In fact, experience and studies are showing that primary care can deliver adequate quality health care in vastly more situations.

Primary Care Is At Risk of Collapse

The Primary Care component of the portfolio of health care providers is not doing well.

Fewer graduating medical students are seeking careers in primary care. In 2005, only four out of 100 University of Tennessee medical school graduates chose primary care careers according to Family Medicine Department Chair, J. Mack Worthington, M.D. Further, on average, only two of the four physicians entering the primary care arena will remain after 10 years of practice.

The New England Journal of Medicine reported, "The American College of Physicians recently warned that "primary care, the backbone of the nation's health care system, is at grave risk of collapse."

Yes, the great majority of patients prefer to seek initial care from a primary care physician rather than a specialist, but their unhappiness with their primary care experience is growing according to Wennberg. Patients are increasingly dissatisfied with their care and with the difficulty of gaining timely access to a primary care physician.

Compensating and Promoting Primary Care

We need to search for ways to reward and provide profit incentives for primary care providers to thrive and grow. With advances in accessing evidence-based medical guidelines on real-time systems, primary care providers can often rival and bypass the current state-of-the-art knowledge level of their specialty colleagues. Payors should have reimbursement systems to compensate and promote the use of these systems.

Reimbursement based primarily on the quantity of services delivered, rather than on quality, forces primary care physicians onto a treadmill, devaluing their professional work life. The short, rushed visits with overfilled agendas that cause patient dissatisfaction also breed frustration in physicians.

A growing number of patients report that they cannot schedule timely appointments with their physician. Emergency departments are overflowing with patients who do not have access to primary care. The majority of patients with diabetes, hypertension, and other chronic conditions do not receive adequate clinical care partly because half of all patients leave their office visits without having understood what the physician said.

Primary Care Providers as Heroes

Even as primary care spirals further into crisis, studies have demonstrated that a primary care-based health care system has the potential to reduce costs while maintaining quality.

The hospitalization rates for diagnoses that could be addressed in ambulatory care settings are higher in geographic areas where access to primary care physicians is more limited.

How TPAs and Self-Funded Employers Can Invest in & Promote Primary Care

There are several areas where the self-funded community could consider promoting primary care and encouraging providers to remain and thrive in the primary care arena. With each of these considerations, it is critically important to monitor health outcomes of the employee population to measure progress and identify key areas of concern.

The list below is not exhaustive and the considerations are not mutually exclusive. That is, a combination of considerations will often achieve the best results.

Better Payment Reimbursements for Primary Care Providers

- Pay primary care providers more; it will be a minor cost compared to the health plan costs. It can start the process to get the attention of key primary care providers to take a greater role in the self-funded plan.
- Pay based on population outcomes and shifts in improved health status.

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- Pay for e-mail consults between patient and primary care provider.
- Help primary care providers to use systems that access evidence-based medical guidelines as part of the process during the patient evaluation and management process.

While in its infancy, pay-for-performance (P4P) is growing in importance as a valuable means of paying providers and improving health. The various methods go beyond the scope of this article. Nevertheless, the P4P concept is consistent with the fundamentals of self-funding. That is, self-funding forces greater responsibility for management of plan assets. In a similar way, P4P forces greater responsibility for healthier outcomes.

The health care sector may reap a significantly positive return on investment by fostering a more effective primary care sector ...

Monitoring the clinic progress of the self-funded plan is important. The Health Risk Assessment is an important tool to report the health of the individual, but also measure the health of the population. Taking before and after "snap shots" of key clinical values will measure and define progress. Further, key areas of concern can be identified so that the self-funded employer can respond with plan design changes, adjustments mix and payments in provider networks, and most importantly, providing the individual employee a "report card" progress report of what is happening in their body. A well-designed Health Risk Assessment will help the individual relate lifestyle choices, taking medications, and following doctor's orders with changes in their personal values such as cholesterol, chemistry, liver, blood (serum and pressure values), and other clinic values.

Advances have also taken place with industry analysis tools and predictors such as those offered by Benefit Informatics, D2Hawkeye, Healthx, Ingenix, MEDai, and others. TPAs and self-funded employers must move beyond mere financial and utilization analysis and start monitoring overall health and clinical factors as well.

Plan Design Changes

- Redesign the PPO network to favor primary care providers.
- Redesign the employee incentives through reduced co-pays and deductibles that favor primary care providers

It is important to educate the employee/patient to understand that primary care providers can often meet treatment needs as well as specialty providers can. When an employee accesses the provider network online or via booklet or phone, the response should take inquiry opportunity to explain the benefits and offerings of primary care providers.

Employee co-pays and deductibles can be among the tools used to get the fastest response. Reducing co-pays and deductibles to increase access to primary care providers can be accomplished fairly easily with measurable results.

Onsite Medical Clinics

- Many self-funded employers are embracing onsite care, where a primary care physician becomes a trusted ally in providing care for employees and dependents.
- The onsite physician often becomes an advisor in addition to providing health care to employees and family members.

Onsite clinics are a consideration I favor and promote. While I have a vested interest, given that I own an onsite medical clinic, I strongly believe that onsite clinics produce results significantly beyond other initiatives. For example, measuring trend on a per employee per year (PEPY) basis, a self-funded county enjoys overall health care cost trend of less than two percent per year as the plans completes three years of having onsite clinics. Another self-funded organization experienced a PEPY health care cost decline. A self-funded printing firm in Wisconsin consistently runs $1,000 PEPY less than its business peers in the same area as reported in the Feb. 11, 2005, issue of the *Wall Street Journal*.

An onsite clinic is often the ideal environment for primary care providers to flourish by treating employees and dependents onsite. The areas of finances, operations, health and clinical outcomes, employee productivity and morale are being measured with favorable results.

Collaborate with Local Primary Care Physicians

- Develop a trusted relationship with a primary care physician to explore how primary care be access more by the health plan.
- Request the primary care physician to identify sources of educational material based on the key health concerns of the population.

- Use the primary care physician to work in concert with the disease/case management firm to help forge a more collaborative relationship between D/CM and other providers.

TPAs and self-funded plans who want to "touch the water before diving in" should consider forming a relationship with one or two primary care providers who currently treat employees covered under the plan. While all discussions will be mindful of HIPAA privacy and confidentiality, much can be explored in how to improve the perceived and delivered value of primary care providers.

Conclusion

The health care sector may reap a significantly positive return on investment by fostering a more effective primary care sector that will reduce health care costs and improve quality and patient satisfaction.

Ignoring the opportunities with primary care, we are subject to consequences of higher costs and lower quality as patients find themselves in a confusing, fragmented and over-specialized system in which no one physician accepts responsibility for their care, and no one physician is accountable to them for the quality of care provided. ■

Sources

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