The Health Care Benefit Crisis, Twenty Years Later: Part 3

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ABSTRACT

Twenty years have passed since the article, "Health Care Benefit Crisis: Cost Drivers and Strategic Solutions," appeared in this Journal (Parmenter, *Journal of Financial Service Professionals* 58, no. 4 (2004): 63-78). And nearly 10 years have passed since Part 1 and Part 2 of "The Health Care Benefit Crisis, Ten Years Later," were published in 2015 (Parmenter, *Journal of Financial Service Professionals* 69, no. 2 and no. 3 (2015): 67-83; 83-91), evaluating the state of employer-sponsored self-funded health benefits in the decade from 2004 to 2014. In this current three-part series, Part 1 examined how the drivers of cost have evolved over the past two decades since those original articles were published. Part 2 summarized the viewpoints of employers, employees, and consultants from survey data, along with contemporary employer actions. Part 3 proposes a new set of legislative initiatives that align incentives to improve the cost and quality of health care for key stakeholders.

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The Path Forward

As detailed in Parts 1 and 2 of this series,[1] the past two decades have witnessed continued increases in costs for employer-sponsored health benefit plans, higher than wages and the general rate of inflation.[2] As a result, employer actions have shifted to an increased focus on strategies that help employees navigate the complex and costly health care ecosystem with a focus on value, quality, and affordability. These strategies, however, assume that the status quo of the regulatory and delivery system framework remains largely the same.

This article, Part 3 of the series, presents recommendations for consideration for a new regulatory and delivery framework requiring a collaborative effort from all key stakeholders, including government, providers, payors, pharma, and employers. Each proposal is in concept form and lacks granular-level policy, legal, and operational details that would need to be developed by appropriate stakeholders if these ideas were adopted. An act of Congress signed into law by the president of the U.S. would be required for these concepts to become real. While these proposed ideas are based on common sense and are not considered to be liberal or conservative in nature, the chances of adoption in a deeply divided and divisive political environment are low. Nevertheless, these ideas are intended to generate discussion, which could lead to a more meaningful alignment of incen-

tives in health care delivery and the ultimate health improvement for Americans.

Qualified Health Care Corporation

The first component of a new regulatory and delivery framework requires a change in the federal tax code. Hospitals and health systems are incorporated as one of three primary types of entities: (1) not-for-profit organizations; (2) for-profit organizations of which some are publicly traded and others are privately held; and (3) government-owned entities, like the Veterans Administration (VA) hospitals. A proposed new type of corporation is a qualified health care corporation (QHC). A QHC creates new incentives for health systems to abandon fee-for-service (FFS) reimbursement while creating incentives for owners, including physician and employee stakeholders, for equity-based compensation and wealth creation while providing higher-quality patient care. The following are key pillars of the QHC:

1. QHCs issue stock that may be owned by investors, management, and employees.
2. QHCs would have a new federal tax structure in which their net income is nontaxable, like current nonprofit health systems.
3. Dividends and capital gains would either be tax-free, like municipal bonds, or taxed at a reduced rate compared to other investments subject to capital-gains taxation.
4. For a health system to be qualified as a QHC, it must meet a set of standards established by a governing body, such as the Department of Health and Human Services (HHS), with regulatory authority, including:
    a. elimination of FFS reimbursement and adoption of approved value-based reimbursement models
    b. achievement of established quality standards, adjusted every year
    c. provision of a minimum level of patient care service lines for primary, secondary, and tertiary care. Systems offering quaternary care can also achieve QHC status.
    d. adherence to data security, transparency, interoperability, and medical record standards
    e. adherence to patient protections of data and financial protections to avoid financial hardships
    f. staff compensation may take the form of salary, hourly rates, and equity compensation, such as stock grants and stock options. Bonuses can be paid based on performance but must have a meaningful health care quality component and may not be tied to volume-based measures such as the number of tests and procedures.
    g. provision of charity care consistent with rules for non-QHC entities
    h. may not be a payor, pharmacy benefits manager (PBM), or network entity primarily but a hospital/health system

This tax-efficient organization will be able to compensate medical professionals and other employees in a way that provides the wealth creation opportunities that for-profit health systems provide, but with the added incentive that nonprofit organizations enjoy by avoiding taxes. Given that quality health care is essential for all citizens and that healthier nations will enjoy greater productivity, this structure is a societal investment.

New Government Protections against Catastrophic Health Care Costs

The political debates over the decades about fixing the health care system have been characterized by polarization. Representatives on one pole advocate for a single-payer system, while those on the opposite pole advocate for a free-market system. Some have advocated for something in-between, such as an option for individuals to buy into Medicare before they are eligible, called a public option. The following represents a

balanced approach to address some of the structural weaknesses of the current regulatory matrix.

1. Mandated rate structure, not rates. The prices of health care are opaque despite new rules around transparency for providers and payers.[3] Many prices are expressed as a percentage of an arbitrary and inflated rate called a discount. This top-down approach makes comparisons of prices difficult. A bottoms-up approach, such as a percentage of Medicare rates, levels the playing field. If all medical fees were required to be pegged to the standard price matrix, real transparency could more readily be achieved. For instance, one hospital may charge commercial rates of 175 percent of Medicare for a knee replacement while another may charge 125 percent. Since the Medicare rate is known and published, those conducting data analytics and contract negotiations will work within a common framework. Of course, value-based pricing is preferred to FFS pricing as called for in the QHC above. However, for those organizations that retain an FFS approach, this new rule would have the ability to shine additional light on pricing, in furtherance of the goal of transparency and potentially encourage the move to become a QHC, where FFS rates are not allowed.
2. Stop-loss pools for catastrophic claims. Some medical procedures and ongoing care journeys generate millions of dollars of claims for a single patient. While many employers with self-funded plans purchase stop-loss insurance, these costs are reflected in premiums and premium renewals, and often, exclusions and limitations put employers in financial hardship. A government catastrophic pool could be established, funded through a relatively small payroll tax of approximately 1 percent that would cap the cost of claims per individual, perhaps at $1 million to $3 million. Stop-loss carriers could sell stop loss below these levels without lasering and exclusions at more affordable rates. This provision is one way to protect employers against the high cost of gene therapies, some of which are priced at over $1 million per treatment.
3. Mandate that plan sponsors of self-funded health benefit plans have access to plan data. This may seem like an unnecessary mandate since the data should be considered the employer's data in the first place. However, many employers are told by their payors that only limited data is available.
4. Address the catastrophic costs of patented pharmaceutical drugs. While a full discussion of the high cost of patented drugs on employer plans is complex and outside the scope of this article, this is an area where a balanced approach between the private sector and government needs innovative solutions.

New Models to Address High-Cost Drugs and Gene Therapies

Experts agree that the solution to address high-cost drugs and gene therapies is not a one-size-fits-all approach. One attempt at cost control for these treatments originated from former President Biden's Executive Order on Lowering Prescription Drug Costs for Americans, in October 2022. The Centers for Medicare & Medicaid Services (CMS) created The Cell and Gene Therapy (CGT) Access Model in response. This model aims to support "outcomes-based agreements between states and manufacturers that will provide for treatments within a framework that lowers prices for states and ties payment to outcomes."[4]

The intent of an outcomes-based payment model is to allow payers to connect reimbursement to a drug's real-world performance.[5] Real-world performance metrics are vital as many high-cost drugs and gene therapies are coming to market via the FDA's Accelerated Approval process, where long-term clinical benefit may be unknown at the time of approval.[6]

Today, regulatory barriers and the need for improved data systems that can efficiently track health outcomes tied to these treatments have made it difficult to design and implement outcome contracts.[7] Participation in the CMS CGT Access Model was set to begin in January 2025. If CMS can successfully execute outcomes-based agreements between participating states and manufacturers of gene and cell therapies, it could provide a framework and new standard practice for plan sponsors to follow suit.

Portable Health Record Owned by Individuals

The cornerstone of making patient health records portable is interoperability—the ability of one electronic health record (EHR) system to talk to another and allow patients and providers to exchange health care information with minimal time and effort. The goal of interoperability was first enshrined in policy in the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, which specified that one of the required capabilities of a certified EHR system was "health information exchange." The 21st Century Cures Act, passed in 2016, required that certified EHR systems be interoperable and considered Certified Electronic Health Record Technology (CEHRT).[8]

Despite this legislation impacting health care providers, portable electronic health records have not been implemented. While hospitals, health systems, and physicians have adopted electronic medical records on a widespread basis in the U.S., additional legislative steps are needed to require that the ownership of the content about the medical history of the patient within those records belong to the patient and can be easily accessed by any qualified provider, with the patient's permission.

The key to this legislation is the patient's ownership of the health record, not the doctor, hospital health system, or other medical provider. The providers will own the infrastructure or major software systems as they do now, but the data within the medical record will be owned by the patient. The patient can give permission to any qualified medical provider, doctor, hospital, lab, or organization that provides individual care management, health coaching, or other health care support. The patient can also give permission to a caregiver, such as a spouse or family member, to act on the patient's behalf under certain circumstances, and parents and legal guardians will give permission for minor children.

Deeper Adoption of Transformational Value-Based Care

Value-based care is a transformational change designed to shift from a predominantly FFS reimbursement environment, wrought with problems of waste and access, where providers work independently from one another to care for individuals. Value-based care models align incentives for teams of care providers to take ownership of managing the health, cost, and outcomes of specific populations. Value-based care is a more effective, efficient, equitable, safe, timely, and patient-centered delivery model for health care.

The 2014 article, "The Health Care Benefit Crisis, Ten Years Later," called for employers to adopt value-based care to manage costs and improve health care quality and outcomes.[9] The past decade has seen strong adoption of value-based care in Medicare but much lower adoption in the commercial employer market, where more than 55 percent of payments remain FFS, not tied to quality. The move away from FFS models, even those with a value-based component, is lowest in commercial employer plans than in government plans, as shown in Table 1. Alternative payment models (APMs) include structures such as global capitation budgets and/or prospective or retrospective bundled payment arrangements that combine entire episodes of care, such as maternity, including one price.

Many of the ideas outlined below were articulated in the article a decade ago, but adjustments have been made to adapt to the current health care and health benefits landscape. The most important lesson learned from the past two decades of attempt-

ing to manage health care costs is that many of the actions and strategies that employers have deployed have failed to produce meaningful improvements in cost and quality because the underlying structures are fraught with misaligned incentives. Independent health care navigation companies have demonstrated success at improving the member/patient experience and lowering the cost and trend of health benefit plans, but these savings have been achieved by eliminating much of the waste in the system rather than changing the system itself. Point solutions, such as those focused on mental and behavioral health, oncology, chronic disease, musculoskeletal, and other issues, have produced savings and improved outcomes, but employers are looking for ways to incorporate effective point solutions into a cohesive benefit platform, or they may serve to create more fragmentation in an already fragmented health care system.

This cohesive integration is another role that independent navigation companies play by creating a single point of contact for members/patients to guide them through the complex employee benefit and health care ecosystems. Yet, value-based care fundamentally attacks one of the biggest problems in the cost and quality of health care—FFS reimbursement.

Fundamentally, greater use of value-based care models is needed, with aligned incentives for all stakeholders based on value, not volume. The new QHC and patient protections outlined above represent ideas to remove barriers to value-based care and realign key stakeholders' incentives, which could catalyze deeper adoption of value-based care models. However, value-based care can and does work in the current environment, and a broader application of value-based structures will drive lower costs and higher-quality outcomes.

Part of the shift away from FFS to value-based care focuses on eliminating waste. By most accounts, the amount of waste in health care is enormous. Waste can include spending on services that lack evidence of producing better health outcomes compared to less-expensive alternatives, inefficiencies in providing health care goods and services, and costs incurred while treating avoidable medical injuries, such as preventable hospital infections.[10] It can also include fraud and abuse. The estimated cost of waste in the U.S. health care system ranged from $760 billion to $935 billion, accounting for approximately 25 percent

TABLE 1
Share of Payments Made by Payer and Payment Category (2018)[a]

	FFS, Not Linked to Quality or Value	FFS, Linked to Quality or Value	APMs Built on FFS Architecture	APMs Using Population-Based Payment
Overall	39.10%	25.10%	30.70%	5.10%
Medicare	10.20%	48.90%	36.50%	4.40%
Medicare Advantage	39.50%	6.90%	36.40%	17.20%
Medicaid	66.10%	10.60%	17.40%	5.90%
Commercial	55.70%	14.20%	27.60%	2.50%

[a]R.M. Werner et al., "The Future of Value-Based Payment: A Road Map to 2030," University of Pennsylvania Leonard Davis Institute of Health Economics, February 17, 2023.

of total health care spending, and the projected potential savings from interventions that reduce waste, excluding savings from administrative complexity, ranged from $191 billion to $286 billion, representing a potential 25 percent reduction in the total cost of waste. Implementing effective measures to eliminate waste represents an opportunity to reduce the continued increases in U.S. health care expenditures.[11]

Another key component of value-based care is improving access to appropriate medical care at the right time, place, cost, and result. This includes telemedicine and walk-in clinics during evenings, weekends, and other off-peak times. In addition, direct primary care can serve as an organizing model for value-based care in a patient-centered medical home (PCMH).

Employers who contract directly with provider groups or with payers that have accountable care organization (ACO) payer-provider models will become active participants in the movement from volume to value and reap the rewards of lower cost and better clinical results over time.

Essential elements of an employer-based ACO include:

1. a commitment by the employer to build a robust and sustained culture of health that focuses on the well-being and productivity of employees through workplace food options, vending machines, ergonomics, and leadership values
2. health and pharmacy benefit plan design that encourages the use of high-value care and discourages low-value care, provides incentives to participants to use providers in high-performance integrated networks, encourages smart decisions at the point of care, and encourages dollar conservation through account-based plans
3. health benefit navigation that provides high-touch and high-tech support to members/patients as they embark on complex and challenging patient journeys and that provides a single phone number, app, or portal to ensure a high-touch, high-value patient experience
4. powerful data management and measurement warehouse, with stratification, analytical, and work-rules technology that connects high-risk, chronically ill, and complex-case patients with a physician-led care team and the evidence-based programs listed above. This data engine must also provide experts, those with legal privacy clearance, with the ability to mine and analyze the data to determine drivers of cost, program effectiveness, and ROI, and to inform changes in strategy.
5. a high-performance network of health system facilities and providers paid through value-based care models to deliver coordinated care, including primary care providers (PCPs) and specialists and facilities. This includes the use of direct primary care or a similar PCMH.
6. multiple access points to value-based providers, including traditional office visits, telemedicine connected to the same panel of providers and medical records as traditional visits within the value network, urgent care clinics, a digital experience through smartphone apps integrated within the same value-based system, and in-home care like old-fashioned house calls
7. wrap-around mental and behavioral health support through face-to-face, telemedicine, and digital connection options with coaching and support services between visits and coordination with PCPs[12]
8. an integrated clinical prescription drug management model with effective clinical programs, low-net-cost purchasing power, use of biosimilars and other evidence-based clinical equivalents as alternatives to high-priced drugs and aligned formularies with appropriate clinical protocols
9. well-designed and managed health promotion or workplace wellness strategy that

aligns incentives for participants to engage in decision-support structures such as health assessments, biometric screenings, and a broad spectrum of tailored and targeted health improvement and management programs. These include evidence-based clinical programs such as complex care advising, transitions care, and gaps in care driven by stratification data. These programs coordinate with PCPs to help people comply with treatment plans and healthy lifestyle behaviors and use engagement technology to connect individuals with the right resources based on their health profile and when care is needed to drive the right care at the right time, at the right place, at the right price, with the right outcome.

10. a value-based payment strategy that rewards providers, employers, and members alike for high-quality care with excellent clinical and experiential outcomes and upside opportunity and downside risk
11. use of centers of excellence (COE) for high-cost procedures such as cardiology, musculoskeletal, transplants, and several others. Comprehensive, highly ranked health systems may serve as the foundation of an ACO network with built-in COE but may also contract with other COEs as needed to access the highest quality on a shared basis for certain conditions.
12. incorporation of the best principles of behavioral science and behavioral economics to nudge participants in the direction of prevention and healthy habits.[13]

Employers are taking a dual approach to delivery reform, with 41 percent of employers indicating that they are driving delivery system change through value-based and alternative delivery models, plus moving forward with improving access, convenience, experience, and efficiency through solutions, navigation, and concierge offerings.[14]

Most industries compete on value. Health care historically has not competed on value but volume. The application of value-based care differs by population type. For instance, end-of-life issues and palliative care services are more prevalent in a Medicare population, while behavioral health and obstetrics are more common in an employee population. Having said this, the core principles are similar across populations. Greater adoption of value-based care, perhaps with the aid of a new structural framework, promises to improve health and enable the U.S. to thrive in the global economy.

For the last several eras in health care, physicians and hospitals—the true sellers—have contracted with health insurance carriers that negotiate discounts for the volume of patients directed to their system through network plan design. These so-called "discounts" are often at least two to three times higher than Medicare rates whereby employers subsidize Medicare patients and overpay for their employees' services. In turn, the carriers (wrongly called payers by physicians and hospitals) contract with employers, which are the true buyers of health care. This triangle of stakeholders is missing a critical link, a direct relationship between the true buyer and seller of health care. This broken triangle is a big part of the problem with runaway costs and is the problem that needs to be fixed through the realignment of incentives based on value-based accountable care between employer buyers and provider-sellers.[15]

Transactional Next Steps to Value-Based Care

For the transformation of value-based care to work, the following transactional components must take place:

1. Health systems with multispecialty practices and sufficient primary care resources build high-performance networks with population health management infrastructure. These health systems need to manage the balance between traditional FFS reimbursement and compensation structures aligned with man-

aging the cost and quality of populations.
2. Payers expand partnerships with high-performance networks with service contracts to manage a contracted population's health, cost, and outcomes, often called attributed lives or downloaded risk, on a fixed-fee, shared-savings, shared-risk, or other financial model other than FFS reimbursement.
3. Employers implement the components of ACOs described above and enter contracts directly with the health systems or payers with provider partnerships to deliver value-based care.

Conclusion

Anatomy and physiology describe the respective structure and function of the human body. These words can also be used to describe the U.S. health care system, which has all the necessary working parts and a well-developed anatomy but physiology that is not functioning well. The solution lies in the psychology of reprogramming the cognitive and behavioral patterns of the collective system to repair, realign, or create the connective tissue. In health care, there are a multiplicity of systems. It is not any single system that makes things work but the relationship between them that has the power to transform and invent new transformative architectures.[16]

The transition from volume to value has been creeping along for more than a decade but requires a reenergized physiology and psychology for employers, health care providers, individuals, and governments to fulfill the "triple aim," a commonly accepted goal of all who strive to change health care by changing the way it is delivered. The triple aim is:

1. improved health care coordination
2. improved patient experience
3. lowered health care expenditures

In conclusion, "Every system is perfectly designed to get the results it gets."[17] Put another way, the U.S. health care system is not broken; it works perfectly for those who designed it to work this way. Perhaps Atul Gawande was right in 2009, and the same is true today:

> Dramatic improvements and savings will take at least a decade. But a choice must be made. Who do we want to be in charge of managing the full complexity of medical care? We can turn to insurers (whether public or private), which have proved repeatedly that they can't do it. Or we can turn to the local medical communities, which have proved they can. But we have to choose someone—because, in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health-care system in the world.[18]

Employers can be the driving force to make this shift happen and can begin to collaborate with each other, creating more demand for transformational value-based care. ■

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(1) Eric M. Parmenter et al, "The Health Care Benefit Crisis, Twenty Years Later: Part 1," *Journal of Financial Service Professionals* 79, no. 2 (2025): 37-57; Eric M. Parmenter et al, "The Health Care Benefit Crisis, Twenty Years Later: Part 2," *Journal of Financial Service Professionals* 79, no. 3 (2025): 48-55.
(2) Peter Wehrwein, "KFF: Premiums for Employer-Sponsored Insurace Increased 7% in 2023," *Formulary Watch* October 19, 2023.
(3) Stephen T. Parente, "Estimating the Impact of New Health Price Transparency Policies," *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 60 (2023): doi:10.1177/00469580231155988.
(4) Centers for Medicare & Medicaid Services, "Cell and Gene Therapy (CGT) Access Model," cms.gov, January 30, 2024; https://www.cms.gov/priorities/innovation/innovation-models/cgt.
(5) National Pharmaceutical Council, "Value-Based Contracts," npcnow.org; https://www.npcnow.org/topics/alternative-payment-models/value-based-contracts.
(6) U.S. Food & Drug Administration, "Accelerated Approval Program," fda.gov; December 12, 2024; https://www.fda.gov/drugs/nda-and-bla-approvals/accelerated-approval-program.
(7) National Pharmaceutical Council, "Regulatory Barriers & Challenges," npcnow.org; https://www.npcnow.org/topics/alternative-payment-models/regulatory-barriers-challenges.
(8) Peter Jaret, "Electronic Health Records: What Will It Take to Make Them Work?" *AAMC News* August 21, 2018; https://www.aamc.org/news/electronic-health-records-what-will-it-take-make-them-work.
(9) Eric M. Parmenter, "The Health Care Benefit Crisis, Ten Years Later: Part II," *Journal of Financial Service Professionals* 70, no. 3 (2015): 83-91.
(10) Nicole Cafarella Lallemand, "Reducing Waste in Health Care," *Health Policy Briefs* December 13, 2012; https://www.healthaffairs.org/content/briefs/reducing-waste-health-care.
(11) William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings," *Journal of the American Medical Association* 322, no. 15 (2019): 1501-1509.
(12) Eric Parmenter and Mark Attridge, "Can Robots Improve the Mental Health of the Workforce?" *Benefits Magazine* 58, no. 5 (May 2021): 38-45; https://www.researchgate.net/publication/359773922_Can_Robots_Improve_the_Mental_Health_of_the_Workforce.
(13) Eric M. Parmenter, "Choice Architecture: A Tool for Ratcheting up Benefit and Wellness Results," *Benefits Magazine* 51, no. 2 (February 2014): 14-19; https://streamer.espeakers.com/assets/7/29067/125510.pdf.
(14) Business Group on Health, "2024 Large Employer Health Care Strategy Survey," August 23, 2023.
(15) David Saltzman, "Fixing the Broken Triangle of Health Care, Part 1—with Eric Parmenter," *BenefitsPRO* (March 15, 2018); https://www.benefitspro.com/2018/03/15/fixing-the-broken-triangle-of-health-care-part-1-w/.
(16) Thom Mayne, paraphrases from "How Architecture Can Connect Us," TED2005 (February 2005). While this quote was about the power of physical architecture to connect us, the same idea can be applied to health care.
(17) This quote is attributed to a range of people, including Don Berwick, W. Edwards Deming, and Dr. Paul Batalden.
(18) Atul Gawande, "The Cost Conundrum," *The New Yorker* (May 25, 2009).