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Research Note

The American Health Care System

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Abstract: This paper delves into the complex and most recent evolution of the American Health Care system, and the subsequently evolving risks associated with the Patient Protection and Affordable Care Act of 2010. The growing complexities of this critical sector have added to the existing risks of an already complicated landscape.

As the world's strongest economy continues to boast strong growth, one of the sectors that continues to be fraught with issues is the Health Care & Services sector. Even with President Obama's last successful campaign centered on establishing a robust health insurance exchange platform, the effectiveness of its implementation remains debatable till date.

Without further ado, let us look at the new stakeholders in the system, and analyze the vulnerabilities and concerns for each of these. With the recently implemented Patient Protection and Affordable Care Act of 2010 ("**ACA**"),[i] the health care landscape changed dramatically. We shall discuss the evolution of this sector to understand the new landscape and examining the

[i] Also referred to as "Obama Care"

inherent risks and how to mitigate them.

By the late 2000s the American health care system was essentially managed by the states themselves, bifurcating into specific divisions for different services offered. Each state had its own DHHS that would be responsible for supporting recipients in the low-income bracket, in need of medical assistance.[ii] Each state would identify its own metrics of aid categories and then decide the eligibility of members for coverage under this Medicaid program. Recipients qualified under these programs would often go to doctors of their choice and the bills (also known as 'claims processing') would be submitted directly to state government.[1]

As the economy went through turbulent times during the 2005 housing bubble and shortly thereafter, the sub-prime mortgage recession in late 2007-2008, a far larger population emerged that was unable to pay their medical bills as jobs were lost and more recipients increasingly kept getting qualified for Medicaid.[2] The year of 2008 highlighted the difficulty of the 'fee for service' model that the state governments had adopted as state budget deficits skyrocketed with medical coverage costs.[3] The need for an overhaul of the entire framework became transparent. The private healthcare insurers were very much cognizant of these changing times and offered a great solution - the government could allow recipients to pick a 'private health plan'. These health plans would be designed in such a way that they would negotiate subsidized fee contracts with doctors, clinics, hospitals etc. in exchange for offering a higher volume of patients/clients for a subsidized fee that the health insurer would pay the doctor/clinic. The health care service providers were happy with timely payments unlike state governments

[ii] More commonly grouped under the umbrella term of 'Medicaid'

that became notorious for late payments under increased financial pressure.[4]

The model worked. Across the country, state governments scrambled to allow recipients to be enrolled into health care plans. This was by no means a small initiative. Numerous factors that come into play, which unknowingly paved the way for further risks. Despite technology advancing at a pace far beyond our imagination, the government continued with legacy and ancient mainframe systems to determine eligibility for members with ever changing eligibility/ demographic data/healthcare details. To aid them in the process, separate independent entities were appointed by State governments to enable recipients to independently choose a health plan with far more sophisticated technologies posing for inevitable systems and processes risks due to integration and several other issues.

While the model seemed extremely promising, the inherent need for each state government to implement, maintain and run their own independent systems was an overkill.[5] President Obama convinced Congress to establish a central 'Federal Exchange' which allowed State governments to replace their systems and integrate them with the Federal Exchange which would then administer Medicaid programs. The scale at which the Federal Exchange was planned was extensive, including multiple programs such as Medicare (for senior citizens), CHIP (Children Health Insurance Program), LTSS (Long Term Services & Supports), insurance claims processing etc.[6] The ACA broadened the coverage for Medicaid up to 133% of poverty line, and also extended the coverage to a larger segment of the populace through federal government subsidies.

While being widely hailed as a great solution, the ACA turned out to be double-edged

sword in itself. As a federal program it allowed States some breathing room as they would be able to sway federal subsidies. However, on the flip side, it took away the autonomy of the States to administer health care for themselves. So with this evolution in the last few years, we are at a stage where we have grown from two stakeholders, the 'doctor/clinic' and the 'patient' to one where we have four key players, 'the service providers', 'the insurance companies', 'the government' and 'the recipient'.[7] The ACA framework has its own significance and risks for each of these entities, which we will eventually look to mitigate.

For a capitalist economy trying to wade its way out of recession, amassing capital in order to reform a struggling health care system (an estimated 50 million uninsured citizens before President Obama took office)[8] would of course be a challenge. Given the extent to which the Affordable Care Act was extending the Medicaid program, the financial hit of funding this program was considerably large. For the year of 2015, the net cost of the ACA was $76 billion.[9] Even a resurgent and strong economy like the U.S. can be weighed down by heavy deficits and debts.

The next and natural step to fund these deficits was by imposing higher taxation. The first winners to higher taxes were high-income individuals. The next big fish for the government was the pharmaceutical industry. When the Affordable Care Act was initially rolled out, it was done with the support of the pharmaceutical industry. But with government deficits widening unendingly, the next step of raising taxes for specialty drugs, was quite like a boomerang. Something waiting to hit the system back. With the government wanting to increase its revenue to offset deficits, the pharmaceutical industry decided to continue growing by pursuing a policy

of higher drug pricing.[10] And that is what you see happening today which can be categorized as another operational risk is bordering on financial instability. In fact, these extra 'Obama Care taxes' will in all probability, eventually lead to increasing the overall end costs for health care. A short term fix, certainly. A long-term cure? Not.

Even as the government passed a 1,000-pages long ACA the actual implementation was no mean feat. The sheer scale of this effort was unprecedented and continues to remain a work in progress as the government learns the lessons of risk management the hard way. After a grand launch in October 2013, the first week of being operational, the website had enrollments for only one percent of the estimated population target.[11] There were issues with enrollments as health plans that received forms through the portal were missing necessary information to complete the job of enrollment. The response time of the website was publicly criticized since it was agonizingly slow. Officials later released reports saying the actual web traffic was closer to 250,000 simultaneous users against an earlier estimate of 50,000 users.[12]

First impressions are worth millions. And the implementation of ACA did not exactly leave the best one. The system development costs were initially charted out to be around $600 million[13] split between several information technology ("**IT**") firms. The lack of coordination and planning between these agencies is another classic example of a systemic risk which resulting into a complete website failure. Ignoring technology as a crucial component is a people risk. Even though some of these firms were relieved of their duty (e.g. CGI Federal),[14] the lesson was learnt the hard way. It is estimated that the actual cost of implementing the website[15] through 2014 was closer to $2.1 billion against the $800 million estimated initially by the

Department of Health and Human Services ("**DHHS"**).[16] This also highlights the fact that no sector can function entirely on its own. The Health Care sector is extremely reliant on several other critical sectors for continuity of operations and service delivery, including: Communications, Emergency Services, Energy, Food and Agriculture, Information Technology, Transportation Systems, and Water and Wastewater Systems.[17] In our present study we focus on the dependency on the IT sector and how management must always factor this as a key point in their decision-making.

While some of the concerns have been identified, there are several additional risks that continue to plague the system. The system established in the Affordable Care Act in essence is facilitating enrollments into private health plans. Since recipient data and conditions continue to keep changing, the continuous evaluation and determination of eligibility is a big risk. There continue to be cases where wrong eligibility determinations have led to early/late plan coverage enrollments/terminations. As a recipient of health care benefits this is not the kind of problem you'd want to be worrying about during a health problem.

Handling of health care related data in America is governed by the Health Insurance Portability and Accountability Act, 1996 ("**HIPAA**"). Even as initial concerns of the exchange website not being HIPPA complaint were addressed,[18] the inherent nature of making such sensitive data available at this scale through the web has significant security risks. Whether there is one platform i.e. the Federal Exchange, or State-owned systems for the 17 states that decided *not* to be part of the Affordable Care Act implementation, it is essential to make these systems resilient and robust towards any kind of cyber warfare.

Even as the government continues to evolve and make slow but steady progress, the private health insurance companies face their own risks and challenges. And some of these risks are exactly opposite in nature. They are similar to the ones that generally accompany an activity associated with fast growth and rising expenses. As health plans see a growing influx of recipients, the overall cost of medical care for the population has also constantly been rising across the board. Since premiums negotiated with the government have been stagnant, numerous reports indicate that health plans are offsetting their rising expenses with an increase for private health care coverage. This introduces an inherent risk of attrition within health plans. The churn in itself is not an issue, but it is a huge blow to a recipient at the end of the day who may have to keep switching providers.

Another risk introduced with health plans is the dependence on insurance. The days where we could walk into a health care clinic are long gone and the days of being unable to afford health care with insurance continue to mar the horizon. The extension of the Medicaid populace helped add coverage to a new subset of individuals. But the rise in cost of healthcare is creating additional risk for the individuals who could have previously been able to afford their own health care. The deductibles for insurance is increasing despite Obama Care's subsidized plans and has reached levels of up to $5,000 for certain plans.[19] The argument being that health plans run the risk of pricing themselves out of affordability for an average American, and losing a large chunk of their current subscribed users base.

Just the way we have systems risks associated with the government, there's a similar risk for private health insurers. Especially in cases where squeezed IT budgets are made to

accommodate highly available systems and interfaces with external clients and vendors like the governments (state and federal), claim processors (typically independent third party processors for regulatory reasons), pharmaceutical partners etc.

All this change is meaningless without the right health care providers backing up the new evolving systems. Health care professionals deal with patients and this is the most crucial part of the process - making sure people are treated with the best possible care and treatment available. Unlike the past, with liberal Medicaid coverage checks from the government, health care is now very closely monitored by health care insurance companies. So when health care providers submit claims for processing it often involves instances of microscopic scrutiny. When doctors and medical professionals are retrospectively probed for the justification of their suggested treatments or diagnosis, it can become problematic. After all there's a fine line between precaution and need, which may not necessarily be best assessed by a claims processor. This makes the system vulnerable to lots of ambiguity. It also involves long financial cycles in many cases, often resulting in arbitration disputes.

Lastly, the most important stakeholders in the health care services are the recipients of medical care. The underlying principle of all health care service is to arrange for quality medical care. This problem is still not completely addressed and is actually one of the biggest risks to the entire health care services industry.[20] With an increasing focus to enroll with independent health plans, recipients are forced to 'pick' healthcare/medical plans instead of having freedom of going to the best medical practitioner. This fundamental change in how this profession now aligns medical care to a plan rather than a medical professional for a recipient is a fundamental change.

This is a major obstacle in cases where a recipient needs to go see different specialists who may not be part of the same health plan.

Going back to BASEL II's definition of 'Operational Risk' as the risk of a change in value caused by the fact that actual losses, incurred for inadequate or failed internal processes, people and systems, or from external events (including legal risk), differ from the expected losses[21] - all the risks identified above fall within the ambit of this definition. Moreover, they have been well summarized by Deloitte as these three: (1) regulatory uncertainty, (2) implementation across various stakeholders and (3) resource availability.[22] As far as a risk mitigation plan is concerned, in 2010 the Department of Homeland Security ("**DHS**") issued an Annex to the National Infrastructure Protection Plan[23] that aims to measure effectiveness by proposing 'Risk Mitigation Activities' along with Appendix Five[24] that together put forward an excellent structure with well laid out steps:

(i) Identification of different entities, associations and their relationships with each other. Who are the primary organizations, the intermediaries and their contractual obligations with one another? Which institution responsible for the information supply chain?

(ii) Prioritization of critical assets as the key supporting infrastructure within a particular jurisdiction and using a consistent criteria for such evaluation. Also keeping in mind infrastructure belonging to dependent sectors that could have national impact (eg. IT, Communications, etc.).

(iii) Conducting period hazard vulnerability assessments in a structured and disciplined manner. Thereafter, matching the risks thus found with the protection goals and objectives. Also charting out impact probability maps and risk cards for dissemination of this information.

(iv) Developing a robust and resilient strategy to be adopted in times of crises. This extensive strategy must be prepared taking into consideration the viewpoints of all stakeholder representatives as well as internal employees in different departments. An important component of this strategy shall be continuous research & development that keeps tabulating all sorts of potential risks that the establishment may face in future and continuously reworks on its crisis management plan.

(v) Last but not the least, the element of communication must be woven into all the above-mentioned steps. Setting a tone of transparency and accountability, especially in financial disclosures and public grievances can go a long way for an institution's working as well as reputation.

The entire process of moving recipients from a 'fee for service' model to enrollment into private health insurance plans mandated coming up with a well-constructed plan which could be flawlessly implemented, along with a plan for incident management and disaster recovery in case something goes haywire, which it did. Let us hope it does not happen again.

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