Universal Access to health care sometime in this decade is inevitable. To reach this objective, however, will take monumental changes not only in the health care delivery system but in society's total value system.

The decade of the '80s has been labelled by some as the decade of “excess.” A line from a popular motion picture described the thinking succinctly, “greed is good”!

Unfortunately, some individuals still subscribe to this mind set. Greed is defined as an “inordinate or excessive share or profit.” Both the medical and insurance industries have been accused of being “greedy” and the primary culprits for out-of-control health care costs.

The general public and, in turn, each of the respective industries point at the other as being the culprit. The atmosphere has been one of finger pointing and allegation, rhetoric and name calling with little tangible being done to help those who are in need.

The last several years have shown a world in upheaval. Events that few, if any, could have envisioned have come to pass. The dissolution of the USSR, a “blitzkrieg war” in the Middle East, the Atlanta Braves winning the National League West: The climate is ripe for change.

Health care is but a single thread in the fabric of societal problems. Education, environment, crime, housing, employment, and all the other threads that make up the fabric of society are interwoven and connected. Pull a single thread the wrong way and the fabric can wrinkle and tear. On the other hand, pulling in the other direction might smooth the wrinkle and prevent the tear.

Health care is a logical starting point in reconstruction of society's fabric and foundation. A healthy population is the prime requisite for any nations' aspirations. With health, dreams are possible; without it, there is extinction.

Universal Access to health care, though inevitable, will take time. Political wrangling and special interests will see to that. In the interim, there must be a concerted effort to help those individuals who are being irreparably harmed by the procrastination and suspicion. There must be an elimination of the wasteful distrust and non-communication between payors and providers. Both are groping for a common means to provide appropriate levels of health care with diminishing resources. Cooperation, rather than self-serving defensive posturing, would be much more practical and beneficial to all concerned.

Managed care is receiving widespread acceptance as the means for providing improved access to health care services. Managed care is defined as “the organized process designed to ensure the medical necessity and cost effectiveness of a proposed service.”

Employers, in ever increasing numbers, are contracting with managed care organizations (HMOs and PPOs). By contracting for their employees' entire package of health care services, employers hope to curb escalating utilization and costs.

The basic care provided by these organizations is generally more than adequate and, in fact, is much more sensible than the traditional indemnity plans because of the emphasis on preventative medicine.

The access and provision of basic care is not at issue. Like traditional indemnity coverage, problems are encountered when serious or catastrophic illness or injury arises.

Group health insurance, be it under managed care or traditional indemnity, is not intended to address protracted periods of treatment. There are very few health care reimbursement contracts with unlimited benefits. The majority are restricted by a specific schedule or time, e.g., a specific number of days or type of service. Most are capped with a “not-to-exceed” lifetime dollar amount.

Advances in life-sustaining technology have far outstripped any one segment of society's ability to adequately finance long-term or chronic care. “Blended” or cooperative funding between health care financing entities in the private and public sectors and selected health care providers would appear to be a sensible approach to servicing the growing catastrophically injured population.

The Dilemma

The growth of managed care, and advances in life saving and sustaining technology, have contributed to a growing population of underinsured. “... a 1985 estimate, based on data projected from the 1977 National Health Care Expenditures Study, was that 26% of the nonelderly population or approximately 56 million people in 1984, were inadequately protected against the possibility of large medical bills.”

In January 1991, HMO membership was estimated to be in excess of 35.3 million, as opposed to 34 million in January 1990. Though considered to be “adequately” covered, a growing number of these managed care enrollees who are, or will become, catastrophically ill or injured may eventually be relegated to the public sector for health care benefits because of specific policy limitations or simply by exhausting total benefits.

For many of those who are approaching exhaustion of their benefits, it will be difficult to “swallow” the prospect of “going
on welfare,” especially when it was “understood” that they were fully covered. For the literally hundreds of thousands that will be told that their benefits are about to be terminated, there is a method of cushioning the impact while ensuring continuity and quality care.

Blended Funding

“Blended funding” is a vehicle that allows payors, both private and public, to work cooperatively with health care providers, to ensure quality outcomes. This cooperative effort can benefit their respective clients, in particular, and society, in general.

Blended funding acknowledges the finite resources available through private health care reimbursement and the stringent eligibility requirements to access the available public-sector funding. This concept also recognizes the respective self-interest of the parties by offering incentives beneficial to all. The incentives are:

<table>
<thead>
<tr>
<th>Patients/ Clients</th>
<th>Private Sector Payors</th>
<th>Public Sector Payors</th>
<th>Health Care Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to necessary care</td>
<td>Long-term benefit savings</td>
<td>Short- and long-term benefit savings</td>
<td>Reasonable reimbursement</td>
</tr>
<tr>
<td>Access to benefits information</td>
<td>Improved public image</td>
<td>Improved public image</td>
<td>Increased referral volume</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Reduced litigation potential</td>
<td>Reduction of welfare rolls</td>
<td>Decreased paperwork</td>
</tr>
</tbody>
</table>

The Blended Funding Project

Since June 1991, representatives from public-sector reimbursement, HMOs, case management, and health care providers have met on several occasions to explore the possibility of working cooperatively to streamline delivery and reimbursement for individuals who have suffered catastrophic illness or injury. The following “model” was presented and continues in a developmental stage.

The “Lead” Case Management Model

One definition of case management is “... the process of assessing, planning, coordinating, monitoring, and evaluation of the services required to respond to an individual’s health care needs to attain the goals of quality and cost effective care.”

Although many payors utilize “case managers,” only a few can follow a patient with a catastrophic injury through to what all parties would consider a success. Withdrawal of case management services usually precedes that success because of end of liability, benefit exhaustion, or other fiscal reasons, rather than because of goal attainment or recovery.

When case management is withdrawn, patients may be left to fend for themselves in order to access the services they require. There can be a bridge or a gaping chasm, depending upon the communication links developed by the case manager between providers and the public sector.

The premise being put forth is that a qualified case manager can and should be assigned to catastrophic cases to ensure continuity and access to all levels of care, regardless of the funding source.

In other words, there would be development of detailed treatment, discharge, life care, and contingency plans, at the earliest possible date. This would entail development of formal lines of communication, policies, and procedures, and possibly lines of authority if “co-funding” could be arranged.

The rationale for development of such a model is to streamline the administrative and fiscal components of health care delivery and to better plan and implement the clinical delivery of services. From a moral and ethical viewpoint, ability to pay should not dictate availability of services. However, in reality, it does. This model acknowledges that fact and will attempt to provide quality service within the bounds of finite resources and unbridled expectations.

Flexible Plan Benefit Utilization

The “lead case management” model gives primary responsibility to the initial payor, or managed care entity, for identifying potential candidates for case management services. Pre-authorization for acute hospitalization provides an excellent “trigger” for these services.

There is growing recognition that severe illness and injury requires specialized handling from both a medical and a reimbursement perspective. Two to 5% of catastrophic and chronic claims account for over 30% of the total dollars expended.

These catastrophic cases require a very complex, protracted course of treatment which may last for months, years, or even a lifetime. This treatment will, in many instances, extend far beyond the limits of the private health coverage in both time and dollars. Therefore, sensible, realistic planning must be initiated at the earliest possible stages, not only in anticipation of long-term management, but to make the most efficient use of time and dollar benefits that are currently available.

The blended funding concept is to have an understanding of how all the respective plan benefits will be utilized to gain the most from both a therapeutic and a fiscal perspective.

Example: John is a 24-year-old, single male who was involved in a motor vehicle accident. He sustained a severe head injury in a motor vehicle accident. He sustained a severe head injury and multiple fractures to both lower and upper extremities. John is a member of a progressive HMO and his benefits are as follows:

<table>
<thead>
<tr>
<th>Hospital Room and Board</th>
<th>ICU or semi-private, 365 days if deemed to be medically necessary</th>
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<tbody>
<tr>
<td>Rehabilitation</td>
<td>60 days lifetime benefit</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>90 days, following 5 consecutive days of acute hospitalization, up to 1/2 semi-private room rate</td>
</tr>
<tr>
<td>Outpatient Benefits</td>
<td>as medically necessary but not to exceed $5,000 total per calendar year</td>
</tr>
<tr>
<td>Home Health</td>
<td>as medically necessary but not to exceed 100 visits per calendar year</td>
</tr>
</tbody>
</table>
John’s injury was recent; he has not yet been terminated from his job. However, this could happen at any time. Therefore, it can be assumed that he has less than two years of coverage, based on COBRA. John will be eligible for Medicare, if he does not recover sufficiently to return to gainful employment. After two years of disability, John will also be eligible for Medicare.

Under a lead case management protocol, John’s entire recovery process would be assessed. Assessment includes not only diagnosis and prognosis, but also benefit package analysis—what will be paid for and under what circumstances. Knowing what is available and what isn’t is crucial in the development of specific treatment, discharge, and life care plans. Private sector payors (HMOs and PPOs included) have a degree of flexibility within their own contracts. Interpretation differs from payor to payor as to what is to be considered within the contract and what is outside the contract. This is significant as some payors will see fit to go “outside” of the strict interpretation of their contracts if it will benefit the patient and, in turn, be cost effective to do so. Other payors will “creatively flex” within their own contracts—trading benefits of one type to pay for services that might be more appropriate, e.g., skilled nursing benefit days for home health care days. The case manager has the opportunity to bring all of this type of information together to construct a coherent plan.

It should be noted that the treatment of the catastrophically injured individual has become very big business, sometimes at the expense of the patient. The competition for “paying” patients is fierce. The acute hospital, even the Emergency Room, is under intense pressure sometimes to discharge patients prematurely to various other levels of care, even though the patient is not “quite” appropriate. This may empty a bed or keep average lengths of stay artificially low, but it does the patient a disservice by utilizing other limited benefits (rehabilitation, SNF, etc.) and can, at its extreme, have dire consequences. Case managers who understand disease, disability, priorities, sequence, and access will be able to lay out the parameters in which effective treatment can take place. They are not making the rules or creating the benefits, merely interpreting them. By doing this, treatment can be prioritized, with expectations of the patient, family, and treatment team kept at realistic levels. Knowing benefit limitations also provides the opportunity to tap alternative sources of funding from charitable or other private sources, and can, in fact, reduce potential litigation. Litigation, in many instances, is caused by unmet expectations or “surprises.” A cardinal rule in case management is, “No surprises.”

In John’s example, then, treatment planning should begin after case identification, benefit plan analysis, review of appropriate records, and discussion with John, if able, and John’s family, attending physician, and acute care treatment team (other involved parties, attorney, employer when allowable, etc.). The case manager can then make recommendations to the family as to the most appropriate transfer site.

Selection of the treatment site following acute hospitalization is a “landmark” decision point. Appropriate placement is imperative as the “clock” will start to run on most services available after discharge from the acute facility, i.e., 60 days of rehabilitation, or 90 days of skilled nursing facility benefits.

Assuming that the appropriate placement is made, plans can be implemented to utilize John’s remaining non-acute hospital benefits in order to maximize the recovery process at the most appropriate cost levels. The incentive for the payor to utilize these benefits is that there will usually be acute hospital benefits remaining. Acute hospital days are the most expensive to use. Inpatient hospital rates can exceed $2,000 per day while acute rehabilitation or sub-acute will often not exceed $1,000 per day. Therefore, therapeutic intervention that keeps a patient out of the acute hospital setting is almost always the avenue of choice.

The degree and rate of recovery will dictate therapeutic intervention and placement. If it is determined that benefits will be exhausted, plans must be made to transition the patient to the appropriate public sector entity with as little disruption as possible.

This can be achieved if the lead case manager has established the necessary links to the public sector agencies that will be involved. It is imperative that all eligibility requirements be satisfied and that all forms be completed.

Conclusion

There is much more involved in the development of this “lead case management” model and the concept of “blended funding.” It is being presented to show that private- and public-sector financing entities are attempting to work together with health care providers and case managers to help solve the problem of escalating costs and decreasing care.

Like the Middle East peace initiatives, they are all sitting around the same table and talking—it’s a start.

REFERENCES

3. Friedman E. The uninsured from dilemma to crisis. JAMA;265:2491-95.