CONCIERGE
Third Party Administrator

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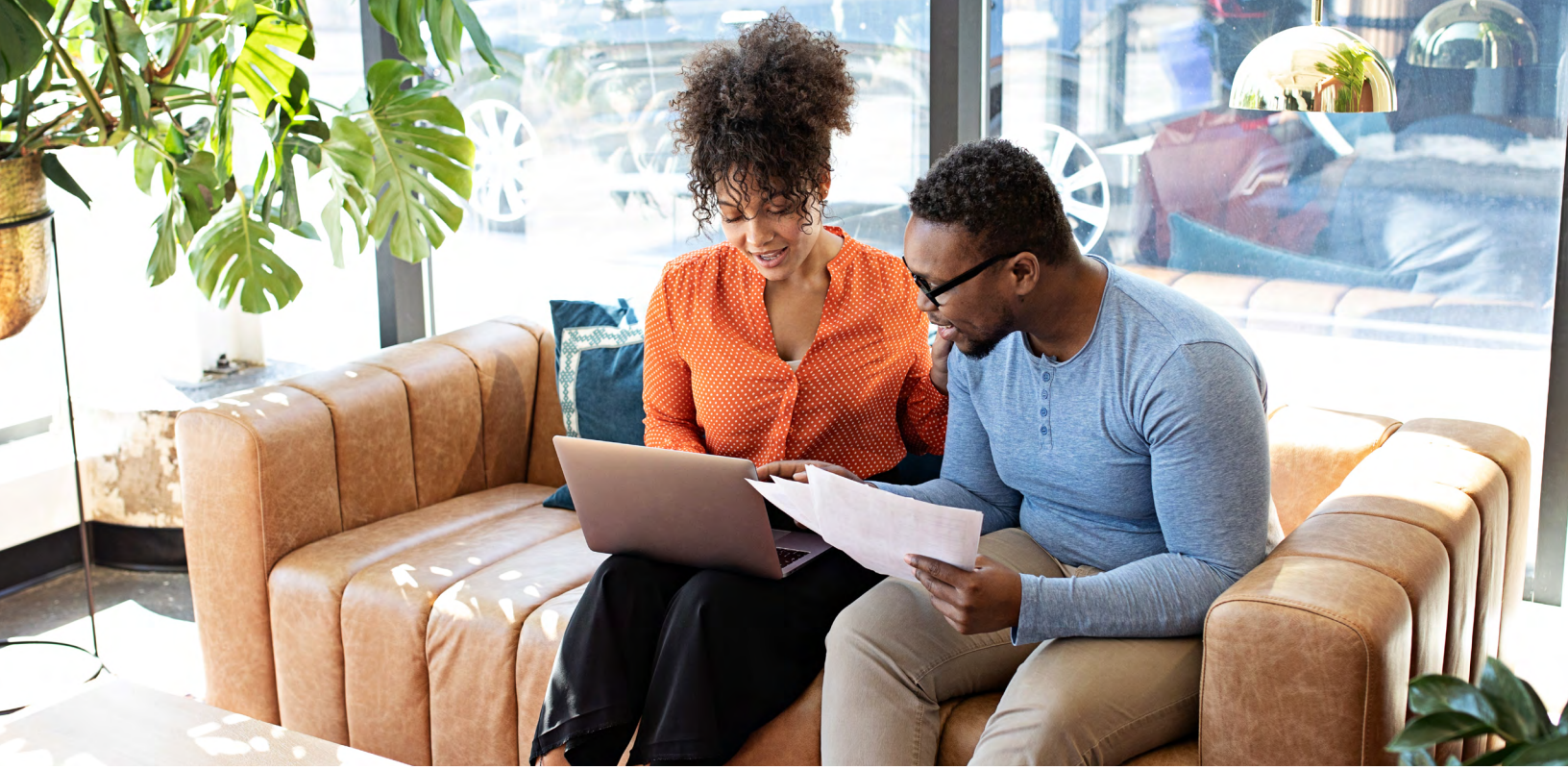
People: The One Constant in an Industry of Change

A Look at Healthcare Accessibility Throughout History

Table of Contents

Introduction 2
The Evolution of the Insurance Industry... 3
Defining a People-Centric Approach 5
Facing the Challenges 6
A Holistic, Humanistic Future 8
About Concierge 8



INTRODUCTION

The healthcare industry is always changing. It faces constant shifts driven by new technology, regulatory changes, and market demand. But amidst all the changes, there remains one constant: people.

From policyholders to administrators, people are the most critical asset in the healthcare benefits industry. A people-centric approach to benefits administration can lead to sustained success and innovation.

But it's all easier said than done. Maintaining a people-centric approach that puts members first is not without its challenges. It's important to recognize common obstacles Third-Party Administrators (TPAs) and other players face—and have practical strategies to overcome them.

In this whitepaper, we cover the historical evolution of the benefits industry, highlighting the irreplaceable value of people and the power of relationships. We also delve into how stakeholders—TPAs, brokers, employers, and employees—collectively drive the self-funded industry's growth and resilience, and what the future of people-centric care looks like.

The Anatomy of a People-Centric Approach:

- Prioritizing member needs, preferences, and well-being.
- Providing accessible, equitable, and high-quality coverage.
- Empowering members to make informed decisions.
- Ensuring seamless coordination of care.
- Continuous improvement based on feedback and outcomes.

THE EVOLUTION OF THE INSURANCE INDUSTRY

The journey of healthcare coverage in the United States is a testament to the power of relationships and the enduring value of people in an ever-changing industry.

In the US, one can see a clear trend of making healthcare more accessible over the years. From early pre-paid insurance plans in the 19th century to the expansion of employer-sponsored health insurance in the mid-20th century, reaching more people has always been a top priority. This reflects a continual push towards a people-centric approach, ensuring that policies and services are responsive to the needs and preferences of individuals. This emphasis on human connection remains pivotal, emphasizing inclusivity and quality of care.

One of the most significant milestones occurred in 1965 when Medicare and Medicaid were introduced.[1] This landmark legislation was not just about policy change—it was about recognizing and addressing the needs of millions of elderly, disabled, and low-income Americans. It showed that when we prioritize the health and well-being of people, we can create programs that become pillars of support for generations.

The late 1970s presented new challenges as economic recession and rising healthcare costs forced a shift in focus toward cost containment. This period reinforced that even amid financial constraints, the priority should always be the people who rely on these services.

In more recent times, the Affordable Care Act (ACA) and subsequent modifications highlighted the ongoing desire to make healthcare accessible and affordable for all. The ACA's requirement for individual health coverage aimed to ensure that no one would be left without the protection they need. Although later changes modified this mandate, the focus on transparency and ending surprise billing continued to prioritize individual empowerment and protection.[2]

The COVID-19 pandemic further emphasized the critical need for accessible healthcare, including behavioral health services. Legislators and policymakers were compelled to reevaluate care access and utilization, highlighting the importance of ensuring that everyone could receive care in times of crisis. Technological advancements like telemedicine services, which saw a surge in use during and after the pandemic, have also made healthcare more accessible for many.

While there will always be a need for some public health coverage for the elderly, disabled, and people who are otherwise unable to provide for themselves, the promotion of a taxpayer funded system that will somehow fix things is misguided and unrealistic. The focus should be on prevention, expanding telehealth and in-home services, introduction of more integrative medicine approaches, value based care, addressing geographic and demographic disparities in care, and integrated delivery systems that improve patient outcomes and streamline care delivery.

When we follow a people-centric approach, we create a healthcare system that is resilient, responsive, and truly valuable.

THE HISTORY OF HEALTH INSURANCE IN THE US[1]

1912
During his presidential campaign, Teddy Roosevelt endorses social insurance, including health insurance.

1929
Baylor Hospital introduces pre-paid hospital insurance plans for schoolteachers.

1944
FDR outlines 'Economic Bill of Rights,' which includes the right to adequate medical care.

1959-1964
Private plans begin to set premiums based on experience with health costs. Health reformers refocus efforts on the elderly.

1965
President Johnson signs Medicare and Medicaid into law under the Social Security Act, contributing to the passage of the most significant healthcare reform of the 20th century.

1975-1979
President Carter prioritizes cost containment over expanding coverage. National reform efforts stalled in the face of a recession and uncontrollable healthcare costs.

1996
The Health Insurance Portability and Accountability Act (HIPAA) restricts the use of pre-existing conditions in coverage determinations and sets standards for medical record privacy.

2010
President Obama signs the Patient Protection and Affordable Care Act (ACA) into law. It required all individuals to have health insurance by 2014.

2016[2]
President Trump eliminates the individual mandate section of the ACA and removes the monetary penalty for not having health insurance. He calls for action to end surprise medical billing and improve price transparency.

2020[2]
COVID-19 requires legislators and policymakers to take a closer look at healthcare access and utilization.

2023[2]
President Biden takes action to lower the cost of care and insurance enrollment using the healthcare marketplace.

DEFINING A PEOPLE-CENTRIC APPROACH

A people-centric approach to healthcare benefits administration emphasizes prioritizing the shifting needs, preferences, and well-being of individuals in the design, implementation, and delivery of insurance services.

For TPAs, the focus is on creating a system that is accessible, equitable, responsive, and supportive to ensure that all members receive appropriate, timely, and high-quality healthcare.

Key components include:

Patient-Centered Care: Tailoring benefit plans and services to meet the unique needs and circumstances of each member, making sure they receive the right care at the right time and at the right price.

Accessibility: Ensuring that coverage is easy to understand, obtain, and use, with clear information and support for navigating their benefit plans.

Equity and Inclusion: Addressing disparities in healthcare access by providing equitable coverage and support for diverse populations.

Coordination and Integration: Facilitating seamless coordination between different healthcare providers and services to improve overall care quality and efficiency, reducing fragmentation and duplication of services.

Empowerment and Engagement: Encouraging active participation of individuals in their own healthcare decisions by providing them with the necessary information, tools, and resources to make informed choices.

Transparency and Accountability: Maintaining openness in insurance policies, procedures, and decisions, and being accountable for the quality and effectiveness of the services provided.

Continuous Improvement: Regularly assessing and improving insurance policies and practices based on feedback from members and healthcare outcomes to better meet evolving needs.

By focusing on these principles, a people-centric approach aims to enhance the overall experience and satisfaction of individuals with their healthcare insurance, ultimately leading to better health outcomes and a more sustainable healthcare system.

FACING THE CHALLENGES

Resistance to healthcare reform has often stalled, making it difficult to implement comprehensive changes. Aside from ERISA (that has proven to be a very effective public policy framework), the lack of a comprehensive approach to public health policy has resulted in a patchwork of regulation that often overlaps or has gaps that promotes a lot of the cost and inefficiencies of the current system.

Another consequence of a lack of a comprehensive public health policy is a lack of competition in the system. Healthcare is the largest segment of our economy where competition is non-existent. That has to change. We have some of the finest medical training and technology in the world, yet the current patchwork of regulation defeats the potential of these significant advantages. We need to harness the undisputed power of our economic system to drive reform that leads to improvements in health outcomes while promoting competition to drive out inefficiency, waste, and graft, and promoting innovation, efficiency and improved outcomes.

Other challenges in the healthcare industry often stem from balancing business needs with maintaining a people-centric approach. Payors, such as TPAs and other plan providers, must deliver quality service while ensuring operational efficiency and profitability.

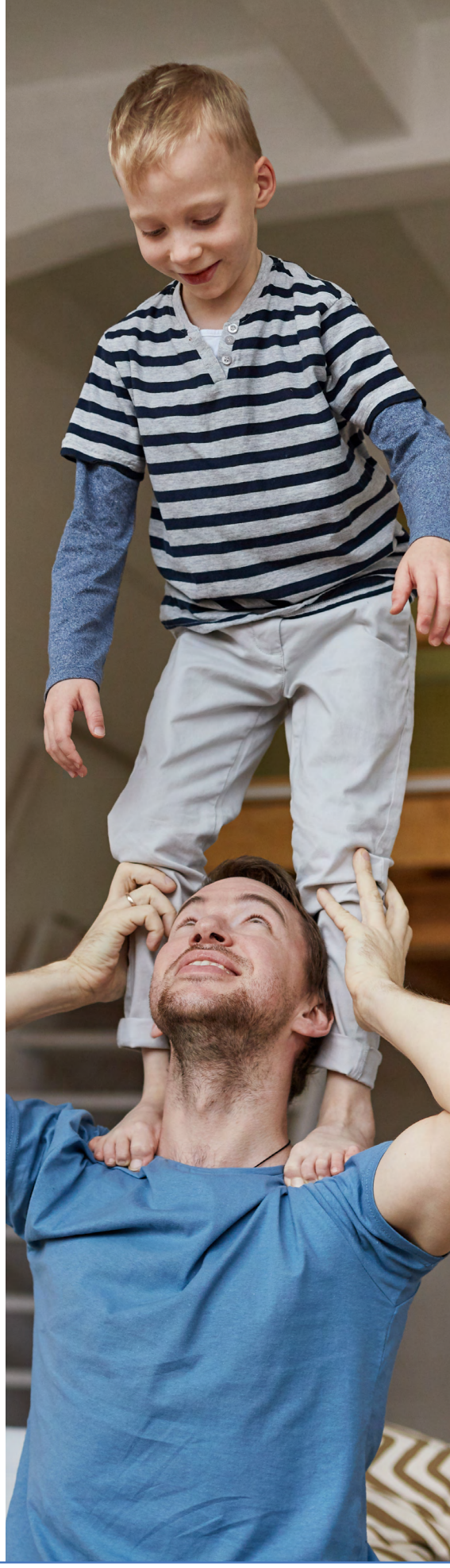
It's important to manage costs while still meeting the complex healthcare needs and expectations of members. Striking a balance between financial sustainability and member satisfaction can be a delicate tightrope act that requires strategic thinking and innovative solutions. The practice of just slapping a discount on a billed charge has run its course.

The healthcare landscape's increasing complexity, including evolving regulations, medical technology advancements, the growing use of Artificial Intelligence (AI) for affordable care, and changing consumer preferences, has also hindered change.

Navigating this intricate environment while keeping the member experience at the forefront can be daunting. Payors must proactively adapt to these changes, invest in technology and infrastructure, and stay agile in responding to emerging trends to ensure they are providing relevant and valuable services to members. Although people should always be the main focus, keeping up with technology is essential to finding new ways to proactively support members and partners.

To effectively deal with these challenges and maintain a people-centric approach, **payors must prioritize communication, transparency, and personalization in their interactions with members.**

Building strong relationships based on trust and open dialogue can help address issues promptly and prevent misunderstandings. Additionally, investing in tools and technology that enhance member experiences, such as user-friendly portals for claims processing or telehealth services for convenient healthcare access, can streamline processes while still prioritizing the human touch. By fostering a culture of empathy, collaboration, and continuous improvement, payors can provide exceptional service that truly puts people at the center of their operations.



A HOLISTIC, HUMANISTIC FUTURE

The future of healthcare accessibility is promising, driven by advancements in technology, thoughtful regulation, and a renewed focus on holistic, humanistic care.

Regulations play a pivotal role in shaping this future by ensuring equitable access, promoting competition, and safeguarding patient rights. Policies aimed at expanding telehealth, incentivizing preventive care, and supporting value-based care (VBC) models will help create a more inclusive and efficient healthcare system.

Technology will be a cornerstone in this evolution, enabling a return to personalized, holistic care reminiscent of the bygone era of local doctors who knew their patients intimately. Direct Primary Care (DPC) models, supported by digital health tools, allow for more time and attention to be devoted to each member, fostering stronger relationships. Advanced data analytics, wearable health devices, and telemedicine platforms empower providers to monitor and manage patient health in real-time, offering tailored and timely interventions. This fusion of technology and traditional care values modernizes healthcare delivery, making it more responsive, efficient, and centered on the whole human experience.

One thing is certain—a people-centric approach will continue to be the cornerstone of success and sustainability.

ABOUT CONCIERGE

Founded in 2014, Concierge has built a team of true industry professionals focused on providing excellent customer support service in the self-funded space. We're a work-horse third-party administrator (TPA), letting our core values guide us in handling health benefits administration for our clients, partners, and members.

Our People Put Your People First

Read Our Story

Sources:
[1] https://www.boosthealthinsurance.com/the-history-of-health-insurance-infographic/
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10810293/