Shared Decision-Making on Health Care Risks

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Risks in health care typically fall into two major buckets: economic and clinical. Health insurance coverage involves both buckets. How risks are determined, managed, and paid for creates numerous opportunities for confusion or conflict among key stakeholders. This column will explore the purpose behind managing risk and determining how conflict around care cost management can occur, including through the use of pathways.

MANAGEMENT OF RISK

There are five basic principles of risk management that are typically found in health insurance, workers' compensation, and disability injuries. These include: (1) risk identification, (2) risk analysis, (3) risk control, (4) risk financing, and (5) claims management.[1] A plan sponsor should take steps to analyze, assess, and address the best strategy for managing identified risks in their employee health care plan. An employer must decide whether to fully cover the self-insured plan risk or use a third-party administrator to manage their risk. This decision directly impacts their operating cost and/or financial bottom-line profitability.

These risks can be reduced, dispersed, or avoided by the employer, their insurer, or third-party administrator by using different strategies. One strategy, which is the most common marketplace decision, is to transfer the risk to an insurance entity that can offer different types of insurance. The resulting insurance policy is an indemnity contract between two parties.[2] In turn, the financial implications around the plan's cost of care is primarily managed by a third-party administrator.

- For a fully insured employer, all annual health risk costs are shifted through an insurance policy taking on that expected risk, which may or may not include catastrophic claim exposure coverage.
- For self-insured employers, health risk costs are retained (owned) by the employer while administration shifts through structured payments through the third party to include catastrophic claim exposure.

LEGAL AND HEALTH INSURANCE PLAN RISKS

Proximate cause—a key principle in insurance contract legal determinations—refers to the immediate or most direct reason for an insurance loss. Minimization of harm (ie, loss) is a duty of the insured to take reasonable steps to prevent loss to the extent possible. Known as mitigation of loss,[3] this is one of the insurance principles that transcends strategy and tactical management of health benefit insurance plans. The benefit design and implementation are intended to minimize health risks for the plan sponsor and its plan members.

Proximate cause of harm influences insurance principles by determining coverage eligibility, whereas root cause is more relevant for addressing underlying issues and preventing future loss.[3] This difference is also helpful in explaining the use of care pathways in care management for quality improvement vs utilization review and risk management.

By applying these principles, especially the first four, health insurance plan sponsors (employers or insurers) can determine the best options for managing health care case risks involving their plan members. In addition, care pathways can be used for certain clinical conditions and actions taken to manage those conditions medically or therapeutically.

Contemporary development of clinical and economic pathways, however, is typically done independently from one another. How they influence clinician decision-making for hands-on care or therapy utilization depends in part on their source, along with contractual obligations beyond Hippocratic or other professional codes of conduct. This can set up a conflict between the intent of different pathways.

LEGAL CHALLENGES TO EMPLOYER HEALTH BENEFIT PLANS AND POTENTIAL IMPACTS

Employers seek to provide competitive health benefit plans that help retain or recruit employees to their business. However, the plaintiffs' bar is seeking to change employer engagement in their plan decisions. This sets up potential conflicts for businesses, who, as employers, are also health plan sponsors.

Most large employer plan sponsors have long outsourced the management of their self-insured health benefits programs to independent consulting firms under the Employee Retirement Income Security Act of 1974 (ERISA). Recently, plaintiff law firms have alleged that employers have exercised little oversight into how those third parties secure employer-based health benefit plans. As a result, those firms are asking employees to question the costs of their health insurance and are suggesting that these members could have claims.

These law firms have targeted plans from major employers

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such as Target and Lockheed Martin, and, more recently, have begun recruiting employees of firms using LinkedIn and other consumer sites. The firms plan to file class-action suits against other large US companies for allegedly failing to comply with a 2021 law requiring them to find cost-effective health plans that meet their employees' needs. In amending ERISA in 2021 with the Affordable Care Act (ACA; **Box**),[4] the US Congress placed more responsibility on employers to ensure that they're spending their employees' money in cost-effective ways.

Some legislators say lawsuits were not envisioned in the 2021 law and that Congress intended to give companies new tools to seek better insurance deals, not encourage the plaintiffs' bar; yet, the unintended effect remains.[5] This legal trend matters for employers and other health stakeholders if the law firms' efforts succeed. Health industry experts say it could result in significant changes in how companies purchase and administer health benefits, potentially leaving employers on the hook for tens of millions of dollars.

Box. Key Amendments to ERISA.

- Consolidated Omnibus Budget Reconciliation Act
- Health Insurance Portability and Accountability Act
- Newborns' and Mothers' Health Protection Act
- The Mental Health Parity Act
- The Women's Health and Cancer Rights Act
- The Affordable Care Act
- The Mental Health Parity and Addiction Equity Act

Abbreviation: ERISA, Employee Retirement Income Security Act.

While there has been much change in ACA benefits post-pandemic, commercial insurance coverage had remained mostly reliably unchanged. That is now threatened by the latest plaintiffs' bar attack on employer plan sponsors. Many would argue that third-party administrators along with consultants have caused employers to depend on them for decision-making, resulting in higher plan costs. Certainly, employer decision-makers need to be engaged in all aspects of their benefit plan decisions, but how best to go about improving engagement remains controversial.

CONCLUSION

The development of care guidelines and clinical pathways for clinical performance or economic risk considerations will continue. The purpose for those pathways and who develops them are important aspects of how shared decision-making can occur. Increasingly, the intersection of economic and clinical purposes is likely to clash due to different perspectives. Clinical research, care delivery performance reporting, and provider adherence to usual and customary care are embedded into risk-management tactical tools. The indirect exchange of clinical care information is often augmented through advisory groups, specialty referrals, and center of excellence programs by economic stakeholders such as employers or insurers.

Improving clinical performance is the focus within the tenets of quality improvement, not just for assessing the care given but also for improving care from past experience. Likewise, based on established experience, health care provider stakeholders use care pathways for risk management and near or real-time decision-making case determinations on care coverage. Such determinations are rooted from benefit plan contracts and turn into actionable medical policy that surrounds care coverage or case management.

Clinical pathways remain an important tool for all health insurance plan types and are not likely to change due to the principles in law and insurance. When it comes to decision-making, who is engaged in it and at what stage remains controversial as regulation or legislation evolves. For employers and other health provider stakeholders, it is prudent to remain aware of the principles of insurance. In addition, staying aware of changes in the marketplace that can impact the economic aspects intersecting with the use of various care pathways will increase in importance for all concerned.

Reader questions, feedback, and suggestions are always welcome and can be directed to JCPEditors@hmpglobal.com. ◆

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