I am going to talk today about why we need to change the way we pay for health care.

But before I get into the weeds, I’d like to start at 30,000 feet, looking at health care’s role in the economy and how our health care system performs.

Spending for health care in the U.S. hit $2.9 trillion in 2013. If the U.S. health care system were a country, it would be the sixth largest economy in the world.

Health care spending is projected to rise to $5.4 trillion in less than 10 years, at which point it will account for about 1 in every five dollars of gross domestic product.

It’s not a good economic policy to spend one of every five dollars on health care. It is not only imposing an undue burden on employers and their employees, it is preventing us as a country from making much needed investments elsewhere.

Our health care system’s high cost is helping drive a discussion about changing the way we *pay* for health care, because many experts believe the way we pay for health care is a serious roadblock to delivering care that is smarter and more efficient.

The Bipartisan Policy Center issued a report a few years back that cataloged what it said were the top 10 drivers of health care costs. You know what was at the top of the list?

“Fee-for-service reimbursement.” Now what in the world, you might ask, does that mean?

Fee for service is the term used in the health care sector for the way we pay for the majority of the health care delivered in this country. As the name would imply, this means we pay for each individual service that is delivered, such as a visit to the doctor, a test or a procedure. And it means we pay for each service regardless of the quality and outcomes it achieves. A misdiagnosis or a treatment plan that doesn’t work only generates more revenue.

Let me quote you what the Bipartisan Policy Center said about the incentives fee for service creates:

“Reimbursement under the fee-for-service model generates a strong incentive to perform a high volume of tests and services, regardless of whether those services improve quality or contribute to a broader effort to manage care.”

Fee for service also means each doctor, hospital, and other healthcare provider involved in a patient’s care gets paid separately. This often results in paying for duplicative tests and services as you move from one provider to the next.

It also means there is no incentive for individual providers to coordinate the services they provide patients. Medicare and most health plans will not pay your primary care doctor to coordinate care with a specialist by telephone or email. But they will pay for the problems lack of care coordination creates, like duplicate tests or medicines that don’t work mix well.

What’s worse, this payment system often penalizes health care providers if they provide better quality care because they lose money if they make fewer mistakes and do not provide unnecessary care. And if their patients stay healthy, they don’t get paid at all, because healthy people don’t need health care.

Now that’s what I’d call a perverse set of incentives.

When people ask me why health insurance is expensive, I tell them it because health care is expensive. And when it comes to the high cost of health care, everybody has their favorite scapegoat. For some it is insurance companies. For others drug companies. Some blame it on medical malpractice lawsuits. Others point to expensive technology. Others to the high cost of medical services themselves.

But there is one cause that is inescapable: the soaring prevalence of chronic disease.

* 86% of our healthcare spending is for patients with one or more chronic conditions, like diabetes, hypertension, asthma or depression.
* 71% of healthcare spending is for patients with multiple chronic conditions.

That’s right, 71¢ of every dollar of healthcare spending goes to treating people with multiple chronic conditions.

In fact, 31.5% of all Americans, almost a third of the population, are now living with multiple chronic conditions.

Many of these conditions are preventable and can be routinely managed outside of the hospital.

But if they are not managed well, these patients can end up in and out of the emergency room and the hospital.

Unfortunately, our payment system is geared more toward paying for you to go to the hospital than it is to paying for the care management that can help keep you out of the hospital.

Let me give you an example. Let’s say you are a doctor who takes steps to identify your high-risk, and potentially high-cost, patients. You hire an extra nurse, a patient educator, or a nutritionist to help them manage their conditions. And you have one patient who has trouble making it to your office because she doesn’t have a car. So you send a taxi for her, because she has diabetes and really needs her checkups. Good luck getting paid for any of this, even though every this doctor wants to do will help his patients from having to use the hospital.

Now, let’s say our same doctor tells his patients to email or call with problems that require only a quick consultation because it will save everyone time and trouble. Good luck getting paid for that, because most health plans won’t reimburse for emails or phone calls. Fee for service favors delivery models that rely heavily on face-to-face encounters between patients and doctors.

I hope you are beginning to get the picture. The picture I am painting is of a payment system that does not provide financial support for doctors, hospitals or other health care providers to do things differently to deliver better care more efficiently.

The good news is that is beginning to change. An evolution is underway from a payment system based primarily on the volume of services provided to one based on the value of services provided. I say evolution because it is not happening everywhere or uniformly but in small pockets of experimentation. Providers are being rewarded for coordinating and managing care. They are being penalized for poor performance. And there are purchasers using reimbursement incentives to people toward high quality, efficient providers.

These new payment reform strategies can take many forms. Let me talk about five.

First, we can reward care coordination through what are known as a “medical homes.” Providers who operate a medical home receive extra reimbursement for coordinating a patient’s total care.

One of the most mature medical home programs is run by CareFirst BlueCross BlueShield, in the greater Washington D.C. metropolitan region. Before the program’s inception in 2011, CareFirst experienced overall rates of increase in medical spending that averaged 7.5 percent annually. By 2014, the overall rate of increase slowed to 3.5 percent. Even more dramatically, the rate of increase for the more than 1 million CareFirst members covered by the program dropped to an unprecedented 2 percent.

How did they do it? A key reason for the decline has been an unprecedented, 20 percent drop in inpatient hospital use and tightened control over drug costs. Meanwhile, patient satisfaction scores are high, and primary care physicians who meet cost and quality targets received an average of $41,000 in additional revenue in 2014, on top of the additional fees they earn for participation.

Second, we can pay for episodes of care—paying once for the total package of treatments necessary for a medical condition, rather than paying separately for each service. For example, a person would get a single bill for a knee operation that covered the hospital facility, the surgeon, the anesthesiologist, the physical therapy and so forth. This way the patient can find out up front what it will cost for surgery and follow-up care. These so-called bundled payments can also change the behavior of health care providers. A single payment dissuades providers from delivering more of the services covered by the bundle, and encourages them to coordinate their services.

Third, we can pay providers to be accountable for the overall costs and quality of care for the populations they serve—and share in the savings they create by improving quality and slowing spending growth. In some of these “accountable care organizations,” providers are also at financial risk if they do not meet their budget targets.

There is a good example of this approach at work in Northern California, which is a highly consolidated market that includes Kaiser Permanente, an integrated delivery system with a 40 percent market share. One of the largest health care purchasers in the Sacramento market is the California Public Employees’ Retirement System, known as CalPERS.

To compete more effectively with Kaiser for CalPERS business, Hill Physicians, a large independent practice association (IPA) that organizes multiple independent physician practices, joined forces with Dignity Health, a large Catholic hospital system, and Blue Shield of California, a health insurer. The trio formed an accountable care organization for 41,000 public sector employees and retirees covered by CalPERS. The partners agreed to share in the savings and Hill Physicians and Dignity Health were at risk of losing money if they went over budget.

The ACO partners’ goal was to reduce spending and bring Blue Shield’s premiums for CalPERS members below those of Kaiser’s. They set a target of reducing spending by $15.5 million in the first year using several strategies, including focused attention on 5,000 patients with chronic illness who accounted for three-fourths of all costs.

The results were impressive. The ACO reduced spending by $20 million its first year. $15.5 million went to offset any increase growth in Blue Shield’s premiums for CalPERS members. The other $4.5 million was shared among the three partners. Over three years, the ACO reduced Blue Shield premiums for CalPERS beneficiaries by $59 million, or $480 per member per year.

Fourth, we can establish standard prices for medications, procedures, and packages of treatments that insurance companies agree to pay and certain providers are willing to accept. In turn, we can require health plan members to cover any care above and beyond the standard price. This encourages both providers and patients to become more conscious cost. And to make it work, we have to make sure the providers meet certain quality standards as well.

Fifth, we can be smarter about the way we design benefits. We can use patients’ out-of-pocket costs, such as co-payments and premiums, as a set of carrots and sticks. We can encourage the use of high-value services, including preventive services and certain prescription drugs, by offering low or no co-payment. For example, we want people with diabetes to take their medications and get routine eye and foot exams. So we can waive those co-pays for these services for these patients as an incentive. At the same time, we could use of low-value care, such someone who has an initial bout of lower back pain getting an MRI right out of the box.

What these five strategies all share is they all seek to change the way health care is delivered by changing the way providers get paid or how patients share in the cost.

Within each model there are incentives and disincentives and positives and negatives.

And there are three things we especially need to keep an eye on.

First, we need to make sure that the quality of care does not suffer if provides are rewarded for containing costs. This fear drove the backlash against managed care in the 1980s. Managed care plans were accused of denying people care they needed to control costs. Some say we’re heading back to that future with some of the payment reforms I just discussed. But this isn’t the 1980s. Today we can better measure and monitor the quality of care and compare providers. We can also build incentives for high quality care into the payment structure.

Second, we need to make sure providers don’t cherry pick healthy people. We need to make sure providers, who serve high-risk, high-cost people aren’t penalized if we hold them accountable for the total cost of care. We can do this by adjusting payments based on how sick the population is they serve.

Third, we need to keep an eye out for market concentration. Payment models that emphasize provider cooperation, coordination, efficiency and financial risk could, ironically, be driving prices up, not down. This is because hospitals and health systems are merging and buying doctors’ practices at a furious rate. If fewer, and larger providers dominate markets, they will gain significant bargaining power with health plans.

So, there is a good side and a bad side to most, and each method can be improved upon. While there are some promising early results from payment reform, there are also some flops.

There is no perfect way of doing this. But one thing that is clear to me is if we continue on the same path we’ve been on, we’re likely get the same results—the world’s most expensive health care.

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# **Talking Points**

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