ESSAYS ON ISSUES
THE FEDERAL RESERVE BANK OF CHICAGO
AUGUST 2010
NUMBER 277b

Chicago Fed Letter

How can payment reform improve the health care value chain?

by Martin Lavelle, associate economist

On April 26–27, 2010, the Federal Reserve Bank of Chicago and the Detroit Regional Chamber co-sponsored their fourth annual forum on health care. This year's program focused on how payment reform within the health care value chain can improve health care delivery. It also explored the role of employers in promoting better health among their employees.

Materials presented at the conference are available at www.chicagofed.org/webpages/events/2010/detroit_health_conference.cfm.

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and it will soon change the health care landscape in the U.S.[1] How will payment reform, as part of this new landscape, add value to the health care delivery system while reducing its costs? Must other policies be implemented in order for payment reform to have a greater effect throughout the entire system? Also, what can employers do outside of government reform to promote best payment practices with respect to health care? And what can employers do to encourage better health among their workers in general? The 2010 Health Care Forum brought together health care practitioners, insurers, academics, and policymakers to explore these and other related questions.

Impact of the Affordable Care Act

Karen Davis, The Commonwealth Fund, argued that the Affordable Care Act of 2010 will fundamentally alter the way health insurance and health care are provided in the U.S. One of the problems with the U.S. health care industry is that its costs are rising exponentially. In 2007, 72 million Americans indicated they had problems paying their medical bills or paying off their accrued medical debt, said Davis. This problem is exacerbated by continually rising health insurance premiums, which are projected to constitute 24% of the median family's income by 2020, up from 18% in 2008 and 11% in 1999.[2] The Affordable Care Act aims to raise revenues and lower costs by instituting an individual mandate (i.e., the requirement for everybody to purchase health insurance or face a penalty) and requiring employers with 50 or more employees to provide health insurance. The act also fundamentally changes how medical services are paid for: It moves us toward a system in which medical providers receive payment for patient outcomes or "bundled payments" (payments for a bundle of related services), rather than one in which they are paid for each individual service.

These new reforms will be implemented over the next eight to ten years, said Davis, beginning with the extension of dependents' coverage on their parents' health plans until they are 26 years old and the elimination of health care insurance exclusions for children with preexisting conditions. The individual mandate to buy health insurance and the employer requirement to provide health insurance will not come into effect until 2014. And the "Cadillac plan" taxes (taxes on high-priced employer-sponsored health insurance policies) will not be imposed until 2018. The revenue from the Cadillac plan taxes and the cost savings from payment reforms are expected to slow the rate of increase in national health expenditures and reduce the federal budget deficit. Under

these new provisions, employers are expected to maintain their role as the primary source of health care coverage. Small businesses, which are classified as firms with fewer than 50 employees, will receive tax credits for providing health insurance to their employees.[3] Davis said that the biggest challenges related to the new health care legislation will be figuring out effective ways to bring payment reforms to market and implementing cost savings while maintaining the quality and quantity of employer-based health coverage.

The Affordable Care Act of 2010 fundamentally changes how medical services are paid for.

Payment reform

A panel of speakers examined how payment reform could lower costs and increase the value of health care delivered. Peter Hussey, RAND Corporation, indicated bundled payments would lower health care costs by the greatest percentage when compared with other reforms such as further implementation of new health information technology, disease management programs, and benefit plan designs.[4] The biggest roadblocks to bundled payments are resistance from health care providers, who question how this particular payment reform will be implemented and whether it will be effective, and consumers, who want to keep the type of health care insurance they currently carry. Each leading payment reform model, including the bundled payment model, contains quality standards and incentives that can be developed quickly. Hussey argued that if the right incentives for changes in payment strategy are applied, health care delivery will be reorganized. That reorganization would include practice management redesign, staff and clinical retraining, and increased doctor–patient interaction.

Thomas Simmer, Blue Cross Blue Shield of Michigan (BCBS), talked about the new BCBS payment model. Unlike this new model, traditional fee-for-service models tend not to improve health at the population level because they don't incrementally reinvest in parts of the health care infrastructure, such as health care technologies, facilities, and doctor training programs, nor do they manage costs. According to Simmer, payment reform of the health care system should aim to be flexible enough to deliver the services that are of the highest value to patients. This reform should also seek to be profitable by keeping people healthy, and it should lower payments while decreasing the number of patients lost through lower-quality care. Payment reform should also be structured, Simmer said, so that there is no need to cross-subsidize population groups who buy health care and so that providers who care for sicker patients receive higher payments.

BCBS's new payment model rewards physician organizations based on performance metrics at the group level as opposed to the individual level, said Simmer. This model includes a commitment to treating individual patients across their different stages of care and life. The new model steers patients to high-performing providers and gives privileges for certain services, such as the use of new technologies, to high-performing providers with known track records for responsible use. The new model also shares savings with providers, supplies payments to provider organizations for investments in performance improvement, and bundles payments.

Steven Grant, Detroit Medical Center, argued that payment reform will be ineffective unless primary care delivery is restructured. He said that health care reform will cost more than anticipated because under the new legislation, more uninsured and underinsured patients[5] will seek care from primary care physicians, who will have to bill (and likely raise prices) for the needed services. In many instances, service costs borne by primary care providers are already greater than the reimbursements they are offered by government-provided health care programs, and such gaps will tend to increase as the new health care laws take effect. Citing a recent article in the *Journal of the American Medical Association*,[6] Grant argued that recent reforms will result in higher demand for primary care physicians at a time when their numbers are decreasing nationwide. Medical school graduates are discouraged from becoming primary care physicians because their compensation pales in comparison with that of specialists. In addition, Grant said he was not sure how payment reform could be implemented when it is difficult to measure the quality of health care delivered to some patients.

Paul Ginsburg, Center for Studying Health System Change, looked at how health care is purchased and how future purchasing arrangements could improve health care quality and curb rising costs. Under the current health care structure, consumers inadvertently send "bad" signals to providers about what type of care is most highly valued through the overuse of well-reimbursed, highly technological, unrelated procedures.[7] Because of these bad signals, providers place a greater emphasis on high-volume care procedures, increasing capacity for those particular procedures. Payment reform, such as bundled payments, should result in rates that better reflect the cost of care and services that consumers demand. Using bundled payments would bring multiple providers under the same health episode. But how would the payment groupers, which create these bundled payments, work out what to charge for an episode? For instance, would they adjust the charge for multiple conditions in an episode and account for their different degrees of severity? According to Ginsburg, a promising approach to solving this problem is to use high-performance networks at an early stage of an episode. High-performance networks rely on payment groupers across various specialties to evaluate all claims costs, find the best providers, and steer patients toward those providers. Currently, high-performance networks are encountering problems, including a lack of transparency about the cost and quality of treatment,

inadequate claims data to make assignments to the appropriate provider, and inconsistent bundled payment rates across similar health episodes. As the number of providers who adopt bundled payments increases, these issues should be resolved and consumers' ability to choose efficient providers should improve, said Ginsburg.

Changes to Medicare and elements of the new health care reform legislation are helping to reduce price distortions, said Ginsburg. Medicare is leading payment reforms because it carries clout and credibility with providers, most visibly with specialists selling their services to hospitals. Ginsburg said that Medicare should invite private insurers to collaborate on pilot reforms and increase the incentives for all health care entities to become involved in cost-effective restructuring. The pilot reforms should remain insulated from political interference. Another important factor in payment reform is improving the tracking of patients and providers. Given Medicare's clout within the medical community, pilot payment programs within Medicare could serve as the model for wider reform. However, these pilot programs in Medicare need to work relatively quickly in order for the model to be adopted successfully by Medicaid, state plans, and private sector payers.

Employer health initiatives

Cyndy Nayer, Center for Health Value Innovation, explained that her organization's mission is to help improve the efficiency and efficacy of health care plans and related programs sponsored by employers. The center promotes value-based programs, which help increase the value of every dollar invested in the health of companies' employees. It seeks to help companies change their employees' behavior—the key to sustaining value over the long run. According to a recent survey conducted by her organization, value-based programs—such as health management and wellness programs and chronic care management programs—help improve employees' health outlook; and these programs have proven to be economically sustainable, even during the recent recession.

Employee satisfaction about such programs is higher when senior leadership is visible in promoting them in the workplace. The conditions typically covered under chronic care management programs include diabetes, asthma, and depression. As part of these programs, consumers may visit nurses and walk-in clinics in their provider network and see reductions in their co-pays in exchange for utilizing the lowest-cost appropriate site of care—such incentives help move the system toward paying for outcomes. All successful adoptions of value-based programs, said Nayer, are linked to clear, consistent, and frequent communications between all parties involved. For example, providers need to educate consumers about the importance of preventive care and how careful management of chronic health conditions leads to better quality of life, as well as lower health care costs over time. These programs are more likely to be adopted when they offer clear health and financial incentives to both employees and employers.

Chuck Haas, City of Cincinnati, presented details about the city's Healthy Lifestyles Program. Over the period 1999–2004, the city's health care costs almost doubled. In response, the city developed the Healthy Lifestyles Program—a wellness incentive program that rewards City of Cincinnati employees and their spouses for making positive choices for better health. Employees and their spouses who participate in this program can each earn up to $500 every calendar year in financial incentives, which are credited to health reimbursement accounts; program participants can manage their out-of-pocket health care expenses with the funds accrued in these accounts. Further financial incentives are provided to those who take part in biometric measures and exercise programs, preventive care screenings, and other related programs and events, such as personal training programs and health fairs. Haas said that the total participation rate in the program and the number of employees and their spouses taking personal health assessments (questionnaires about their family history, nutrition and fitness habits, and other health factors) have increased each year. On average, cholesterol, blood sugar, and blood pressure readings have fallen for city employees. Almost all participants report they would recommend the program to other employees and their spouses. Haas said that the program has been successful thus far in achieving better health for program participants and reducing health care costs for the city.

Howard Weyers, Health and Benefit Strategy, shared how employers can take control of their health care costs and promote wellness and prevention programs that will improve the company's bottom line. Weyers argued that personal health habits are the biggest factor in quickly escalating health care costs and employers need to be proactive in influencing their employees' health behavior. During his tenure as CEO at Weyco, Weyers instituted a zero tolerance smoking policy among his employees, both on and off the job. The company mandated random smoking tests for all employees. Weyers said that all employers should install health plans that reward positive behavior and punish negative behavior. For wellness and prevention programs to succeed, he said, the chief executive should lead by example.

Agreeing on the need for employers to be proactive, Dee Edington, University

ISSN 0895-0164

of Michigan, contended that we should view reforming health care and promoting healthy workplaces as economic strategies, not just health strategies. Businesses should adopt the strategy of maintaining high-performing and healthy employees instead of focusing on treating illnesses among their employees once they develop. First, senior leadership must create a vision and commit to a healthy work culture, connecting new health initiatives within the company to the business's core strategies. Next, operations management must implement and brand the company's new health policies and programs so that everyone willingly participates, leading to a work culture that values good health. As more employees participate, more rewards and incentives should be introduced to positively reinforce this process of transforming the work culture.

Conclusion

The 2010 Health Care Forum yielded informative discussions about the challenges and opportunities presented by payment reform in the health care system, especially given the requirements of the new health care legislation. It also explored several ways in which the private and public sectors are promoting wellness among their employees to reduce health care costs and support a healthier, more productive work force.

[1] The Health Care and Education Reconciliation Act, amending certain provisions in the Affordable Care Act, was signed into law on March 30, 2010.

[2] K. Davis, 2009, "Why health reform must counter the rising costs of health insurance premiums," *The Commonwealth Fund Blog*, August 18, available at www.commonwealthfund.org/Content/Blog/Why-Health-Reform-Must-Counter-the-Rising-Costs-of-Health-Insurance-Premiums.aspx.

[3] Small business employees fall under the individual mandate. These tax credits might motivate small businesses to increase the availability of employer-sponsored health care plans.

[4] P. Hussey, C. Eibner, M. Ridgely, and E. McGlynn, 2009, "Controlling U.S. health care spending—Separating promising from unpromising approaches," *New England Journal of Medicine*, Vol. 361, No. 22, November, pp. 2109–2111.

[5] The individual health insurance mandate requires a person to purchase insurance unless it costs more than 8% of his or her monthly income. It is assumed some individuals will choose to pay the penalty rather than pay for insurance because of the cost. See M. Trumbull, 2010, "Obama signs health bill: Who won't be covered?," *Christian Science Monitor*, March 23, available at www.csmonitor.com/USA/2010/0323/Obama-signs-health-care-bill-Who-won-t-be-covered. Also, the mandate only requires the purchase of minimal insurance coverage, under which some conditions will not be covered.

[6] R. Brook and R. Young, 2010, "The primary care physician and health care reform," *Journal of the American Medical Association*, Vol. 303, No. 15, April 21, pp. 1535–1536.

[7] H. Pham, P. Ginsburg, T. Lake, and M. Maxfield, 2010, "Episode-based payments: Charting a course for health care payment reform," Policy Analysis, National Institute for Health Care Reform, No. 1, January.