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The U.S. Health Care Revolution

Give Me an Incentivized Provider Payment System or Give Me Death!

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The health care expenditures in the United States are currently more than two and a half times that of the average of other developed countries, and for the most part, we don't get what we're paying for. Our quality measures such as life expectancy and infant mortality lag behind those of these same countries. The two main goals of the recent health care reform legislation were to cover the millions of people lacking health insurance and to curb the long term growth of health care costs. However, according to the chief Medicare actuary, the legislation is actually expected to increase costs. The legislation is also going to make the world's most complicated health care system even more complicated. The time is ripe for a U.S. health care revolution that will lower costs and simplify the system. Provider payment reform is likely the best way to address this. Why? To quote a phrase that is incorrectly attributed to bank robber, Willie Sutton, "because that's where the money is."

Current State of the Provider Payment System: Taxation without Representation

Let me see if I have got this straight. You have this Fee for Service (FFS) system where a physician can maximize his profits by making sure that I stay sick. Then you have this discount system where the largest commercial insurers get the biggest discounts from providers thereby shutting the smaller players out of the market so there is less choice for consumers. Neither the providers nor the patients know what the prices are because there are so many different networks and payment arrangements. On top of this, the government gets the biggest discounts of all for older, disabled and low income people. When this government's group grows from high unemployment or aging Baby Boomers, cost shifting occurs. Since providers deem the government's rates to be inadequate, they shift or increase charges to the commercial insurers, employers and taxpayers to make up for the shortfall. Finally, the

uninsured, who may be the ones that have the least ability to afford to pay for health care, are expected to pay 100 percent of the provider's rates (no discount). What am I missing? When you step back and think about it, why would any country create such a convoluted system? I think that it is definitely cause to start dumping tea in Boston Harbor again.

Who actually sets the prices under this system? Good question. Maybe understanding who pays is the first step in figuring this out. The government pays 50 percent of all health care costs and everyone else (insurers, employers, consumers, etc.) pay the other 50 percent. Since the providers are not happy with what the government pays, it looks like the government is setting the price for their 50 percent. Since the others negotiate prices with providers, it appears that the payers are more influential in setting the prices than the providers. Does this mean we don't have a free market? Some will say that health care is akin to a product like electricity whose price should be regulated. Others point out that we are the only developed country that doesn't have a budget for their health care expenditures. Who wants to sign a blank check for health care? These issues should be kept in mind as you read the rest of this paper.

National Fee Schedule: The "Shot Heard 'Round the World"

The health care revolution could start with a national fee schedule. Why not take some of the people across the country working for payers and providers who are busy every day negotiating fee schedules and have them create a single national fee schedule. The fee schedule would be a living document in that it would be evaluated and updated on a regular basis. It could have adjustments built in for things such as regional cost differences, types of provider, treatment complexities, etc. The fee schedule would be available at the offices of all providers and posted on the internet for all to see.

One of the major advantages of a national fee schedule is that we will finally know what our health care costs us. It would not be much of a leap from here to have physicians obtain our cost share information when they check our eligibility before we arrive, or even provide it for our considered treatment before we leave. We give up the convoluted system that shuts competition out of the insurance market and shifts costs from the government to everyone else. The uninsured will now pay what everyone else pays. A national fee schedule should simplify provider billing and the payment of claims as multiple fee schedules no longer have to be loaded into the systems of providers and payers. Usual, Reasonable and Customary (UCR) databases and balanced billing will also be things of the past.

Promoting Primary Care Physicians (PCPs): The Battle of Bunker Hill

Is anyone here a doctor? Fifty years ago, the percentage of PCPs was 50 percent. Today, 75 percent of physicians are specialists and fewer than two percent of today's medical school students are choosing to become primary care physicians. PCPs are not a happy bunch. Their compensation has actually been decreasing while their responsibilities and the required amount of paper work have been increasing. So many physicians are considering career changes that there are now consultants out there who are making a living helping unhappy physicians transition to other occupations. On top of all this, 34 million additional people are expected to be eligible for insurance and services in 2014. Can we help these physicians out before they become extinct? How about we take that national fee schedule and move some money away from the specialists to pay the PCPs more? I know of at least one other country where specialists make less in relation to PCPs than the United States, and I suspect that this is probably the case in other countries as well. Medicare has discovered that areas with a higher concentration of PCPs versus specialists actually have lower health care costs without a



reduction in quality. While the physicians' share of health care costs is only 10 percent, they have control over 80 percent of the health care costs. Therefore, it is critical to enlist the help of the PCP to control health care costs.

Expanding the Primary Care System: Minutemen and Minute Clinics

We see many people using emergency rooms for conditions that should be addressed through the primary care system or for conditions that end up as emergency situations because of the lack of a good primary care system. How about further modifying the national fee schedule to support clinics and alternative providers such as nurse practitioners and physician assistants? Not all conditions need the diagnostic expertise of a physician. I realize that it may take more than just adjusting fee schedules to

make this happen as this has to do with how medicine is practiced, but I would think that any alignment of monetary incentives should help.

To further promote the primary care system by providing people with scheduling alternatives, how about paying a surcharge in the national fee schedule for treatments that occur outside of the normal Monday to Friday 9 a.m. to 5 p.m. hours?

If we are successful in creating a robust primary care system, it should help satisfy the demand for health care and rein in health care costs. Then our emergency rooms can return to what they were meant for, urgent care.

Integrated Health Systems – “Common Sense” by Thomas Paine

Let’s get back to that faulty FFS system. How about we create a system that properly incentivizes providers? We should start by looking at the history of Medicare’s Diagnostic Related Groups (DRGs), which is a single shared payment for each condition. This system originated in the 1980s when hospital costs were rising at unprecedented rates. Medicare decided to change their payments to DRGs where hospitals would get a single payment for a patient’s entire hospital stay. The DRG payment covers room charges, medicines, physical therapy, blood tests and more. This change to DRGs resulted in a drop in cost and length of stay without any decline in quality of care. Physician payments were not included in DRGs.

Perhaps it makes sense to go one step further and create a single payment that would be shared by both hospitals and physicians. In 1992 to 1996, Medicare conducted a single payment demonstration project with seven hospitals for bypass surgery. The physicians received fixed fees and sometimes a percent of profit as well. Medicare savings were ten percent higher than expected through shorter hospital stays including shorter ICU stays. They also experienced lower drug costs. This demonstration appeared to be successful as they experienced a lower mortality rate and found that patients had higher satisfaction rates. Everyone involved in this project worked together as

a team. However, in some instances, surgeons resisted the changes and savings were less. My understanding is that this could work seamlessly for some common diagnoses such as pneumonia, heart attack and congestive heart failure but may be more challenging for outpatient services as they require multiple doctors, radiology and lab services. If it can be successful in managing chronic illnesses, it would be addressing 78 percent of all the health care expenses in Medicare.

There are examples around the country (e.g., accountable care organizations, patient centered medical homes and other integrated hospital/physician systems) where this concept is in place and producing good results. How about we use our national fee schedule to promote these? We could make payments more lucrative for the providers under these arrangements versus the payments for those working under the status quo. The maximum payments could be reserved for the most comprehensive systems (i.e., systems that have a large number of and varied types of providers so that patients can receive all of the care that they need within the system). Moving towards a single shared payment system would help align the incentives to keep our health care costs under control.

Evidence Based Medicine: One if by Land, Two if by Sea

It has been demonstrated that implementing best practices saves money and leads to more effective treatment. An example of this is what Geisinger Health System in Pennsylvania does for heart bypass surgery. Therefore, another way to properly incentivize the health care system would be creating higher payments for more effective treatments. A program like this would also be very beneficial with prescription drugs even though it exists in some plans already through tiering. Providers would make less for treatments that are not as effective, and hopefully this will mean that the additional costs will make their way to consumers in order to change behavior. However, I think that it is most critical to make sure that the greater payments for more effective treatments and medications result in lower cost sharing for patients. Aligning the savings incentives to impact

both the provider and patients must be done to make this work properly.

Pay for Performance: The Incentives are coming!

To complete the goal of an incentivized system, how about we implement a pay for performance program for providers? Monies could be set aside to pay for success such as quality measures, error reduction, successful diagnosis/treatment, etc. It would create a stream of additional income for providers when they engage their patients more and encourage healthy behavior such as checkups and flu shots. Hospitals would be rewarded for efficiencies such as low infection rates.

Risk Sharing Mechanism: The First Continental Congress

The last finishing touch on our new health care system developed through provider payment reform is a risk sharing mechanism for providers. This equalizing mechanism would consist of a risk transfer payment system so that providers will neither benefit from treating the mostly healthy nor get hurt from treating a large number of patients with chronic illnesses.

Putting it all Together: We hold these truths to be self-evident....

The transition to the new health care system using the above mentioned changes to the provider payment system will not be an easy task. We are talking about developing multiple programs that take today's health care payment dollars and moves them around in a lot of different ways. We will need to take from the resources that exist today in the provider community, insurance companies and government agencies to help create the system to make this happen. It will likely require some quasi-governmental agency to oversee this. In order to ensure that total payments do not exceed what we pay today, we will need the help of actuaries along with other statistical and financial people. The good news is that the system is set up to be self correcting if it works out as planned. The more we spend on

these programs, the more likely we will see savings in our health care costs.

I expect that the greatest challenge in implementing the new health care system will be the resistance from those who are currently profiting from the existing system. They will likely bring up the same flashpoints that incited the public during last year's health reform debate: rationing, death panels, and interference with the physician/patient relationship. I think it would be best to continue to draw attention to what life will be like under the new health care system in order to push it through:

- Price simplification and actually knowing what the costs are.
- A robust primary care system that offers patients a lot of choices and is convenient to everyone's schedules.
- No more waiting for hours in emergency rooms.
- Physicians, hospitals and other providers who are more concerned about my continued health because they make more money when I am healthy.
- Less consumer cost sharing for more effective treatments and medications.

And finally, the item that we most urgently need in this country: Lower Health Care Costs for All! ■

“The time is near at hand which must determine whether Americans are to be free men or slaves.”

- George Washington

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