

The Future of Payment Reform

Michael Chernew

1970s



1980s



1990s



2000s



Health spending exceeds income growth by:

2.2%

3.2%

1.6%

2.7%

Perspective Matters

- Total spending

- Most comprehensive measure of health system performance

- Government spending

- Most relevant for taxes

Medicare's Challenge

Excess spending growth per beneficiary (percentage points)	Medicare share of GDP in 2035 (%)
2	8.0
1	6.6
0.5	6.0
0	5.4

Share in 2015 was 3.6 percent. To remain at 3.6 percent of GDP in 2035, real demographically-adjusted Medicare per beneficiary spending needs to grow at a rate of 2 percentage points below GDP. Faster GDP growth would imply slightly lower Medicare shares for any amount of excess spending growth.

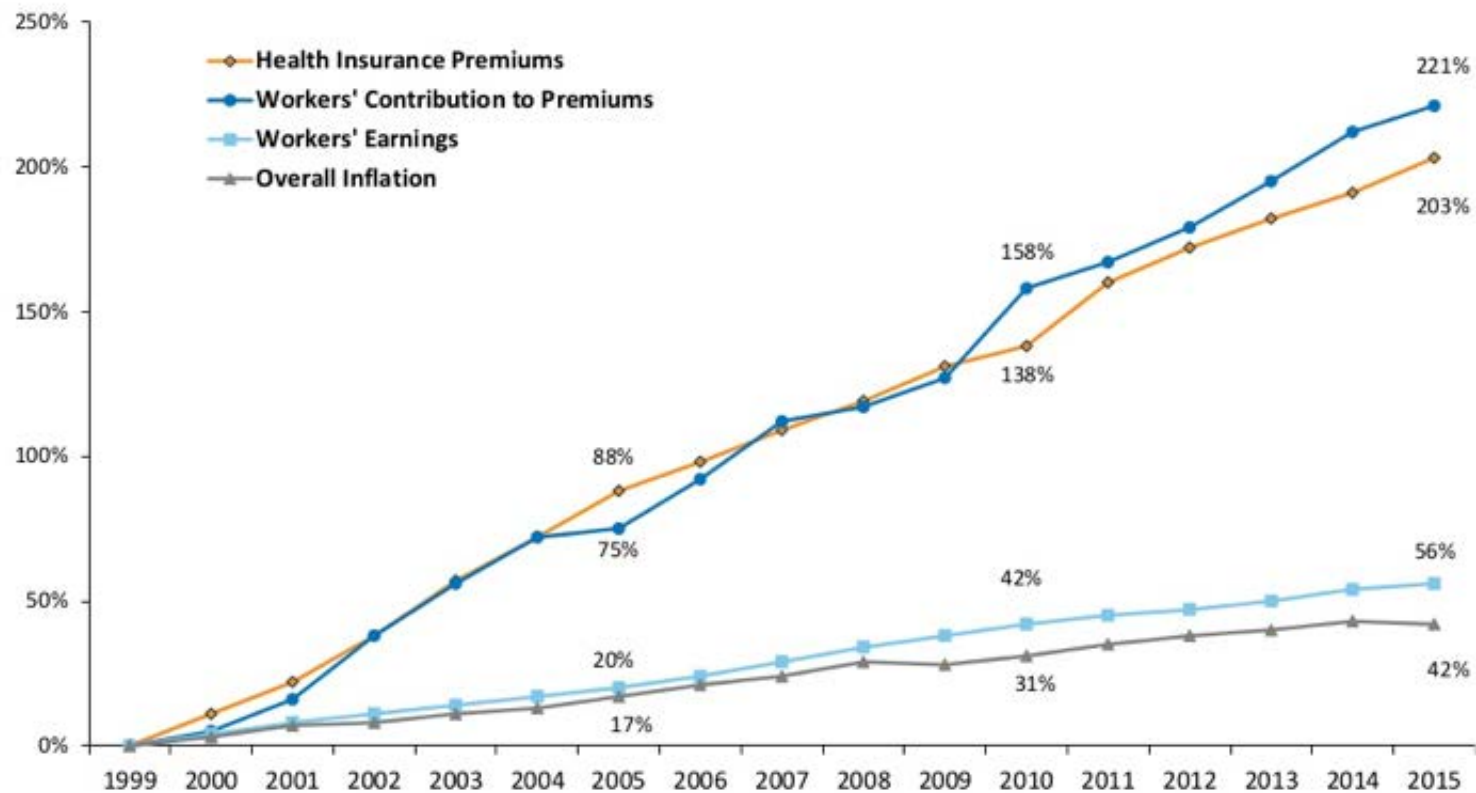
Sources: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

Total state spending on Medicaid now surpasses K-12 education



Private Health Care Spending is not Sustainable

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).

Solutions

What will slow spending growth

- Payment reform
- Consumer strategies (benefit design)

Payment Reform

- Pay less

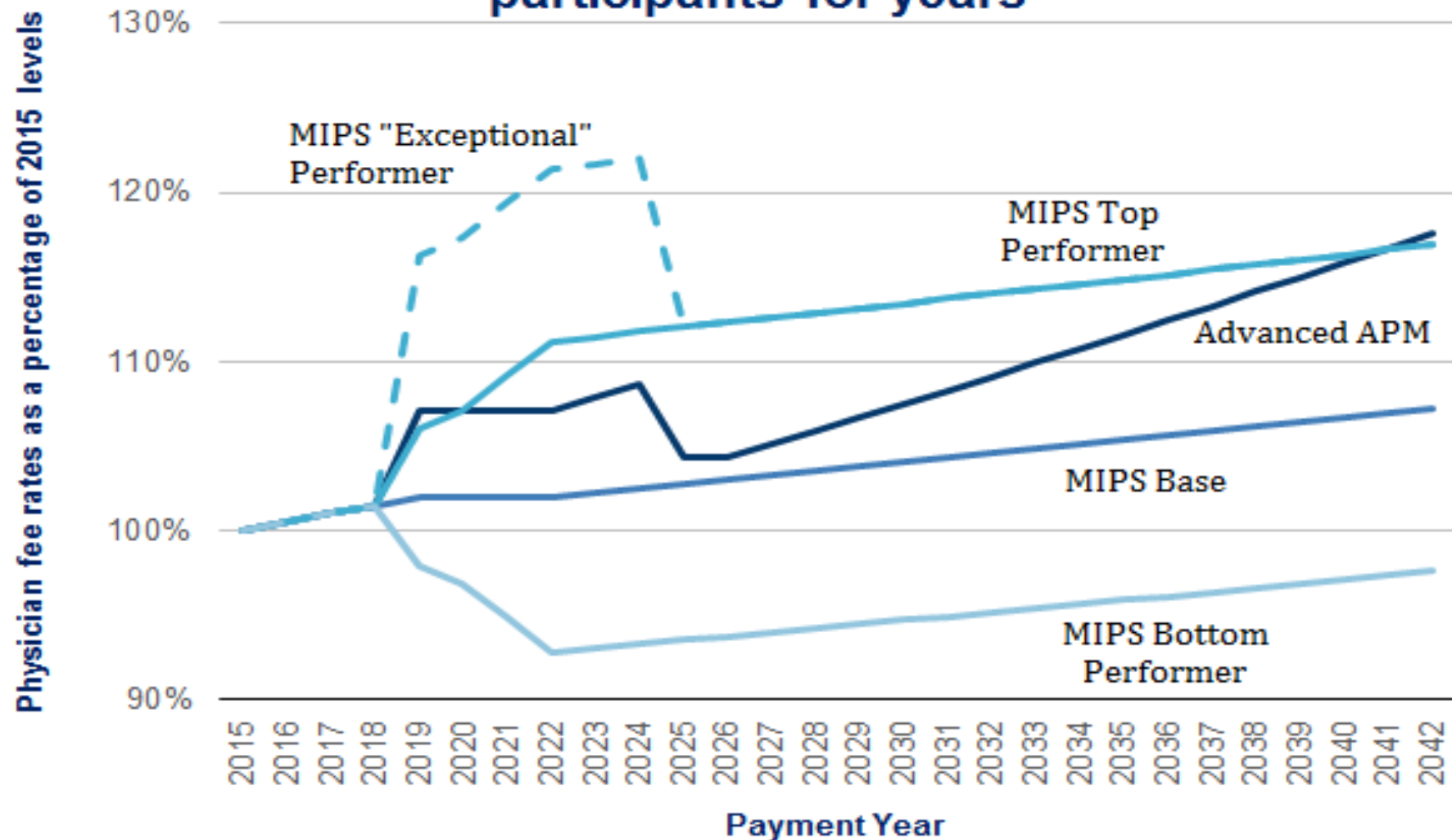
- Reductions in payment to providers

- Move away from FFS

- Episode bundles

- Population based payment (ACOs)

Top MIPS performers could out-earn APM participants for years



Source: Data compiled based on fee update and performance-based bonuses and penalties under the two incentive programs outlined in the Medicare Access and CHIP Reauthorization Act of 2015.

Note: Advanced APM line excludes contract performance and MIPS excludes the use of a conversion factor that can magnify a MIPS bonus or penalty by as much as three times to ensure budget neutrality.

BROOKINGS
USC Schaeffer

Leonard D. Schaeffer Center
for Health Policy & Economics

Alternative Payment Models

Basic Features

- Transfer risk to providers
- Include P4P
- Data support

Value Based Payment

From Volume to Value

Transforming Health Care Payment and Delivery

THE WALL STREET JOURNAL.

Employee Benefits

Produced in Cooperation with the Employee Benefit Research Institute and the International

[Tough Responsibilities in a Tough Era](#)

[The Future of Retirement Plans](#)

In Tough Economic Times, Employers Turn to Value-Based Health Care



Harvard Business Review

STRATEGY

The Strategy That Will Fix Health Care

by Michael E. Porter and Thomas H. Lee



The NEW ENGLAND JOURNAL of MEDICINE

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Perspective

What Is Value in Health Care?

Michael E. Porter, Ph.D.

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Reconciling Prevention And Value In The Health Care System

Michael Chernew, J. Sanford Schwartz, and A. Mark Fendrick

Why Do We Call It “Value Based Payment”



Episode Payments

■ Some evidence of savings

- Some lower spending in episodes with post-acute care^{2,3}
 - PAC spending decreased ~20% (incl. SNFs, IRFs, Home Health)³
- BPCI saved ~4% on orthopedic episodes³

■ Savings may be offset by increased episode volume (Fisher, 2016)

■ No consistent quality impact BPCI^{1, 2}

¹ Econometrica, Inc. "Evaluation and Monitoring of the Bundled Payments for Care Improvement Model 1 Initiative." July 2015.

² Lewin Group. "CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report." February 2015.

³ Dummit et al. "Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes." JAMA. 2016;316(12)

Concerns with Episode Payment

- Breadth / adjustment for multiple concurrent episodes
- Induced use

Population Based Payments

Population Based Payment Evidence

- Population based payment models reduce spending (by a small amount)
 - Private sector models do better
 - Results improve over time
 - Independent physician groups do better
- Savings get shared
- Provide incentives for providers to be more efficient and promote flexibility

Caveats

- Details Matter
- Execution Matters

Everything is Relative

- We want



- We have



- We can build



Episodes vs Population Based Payment

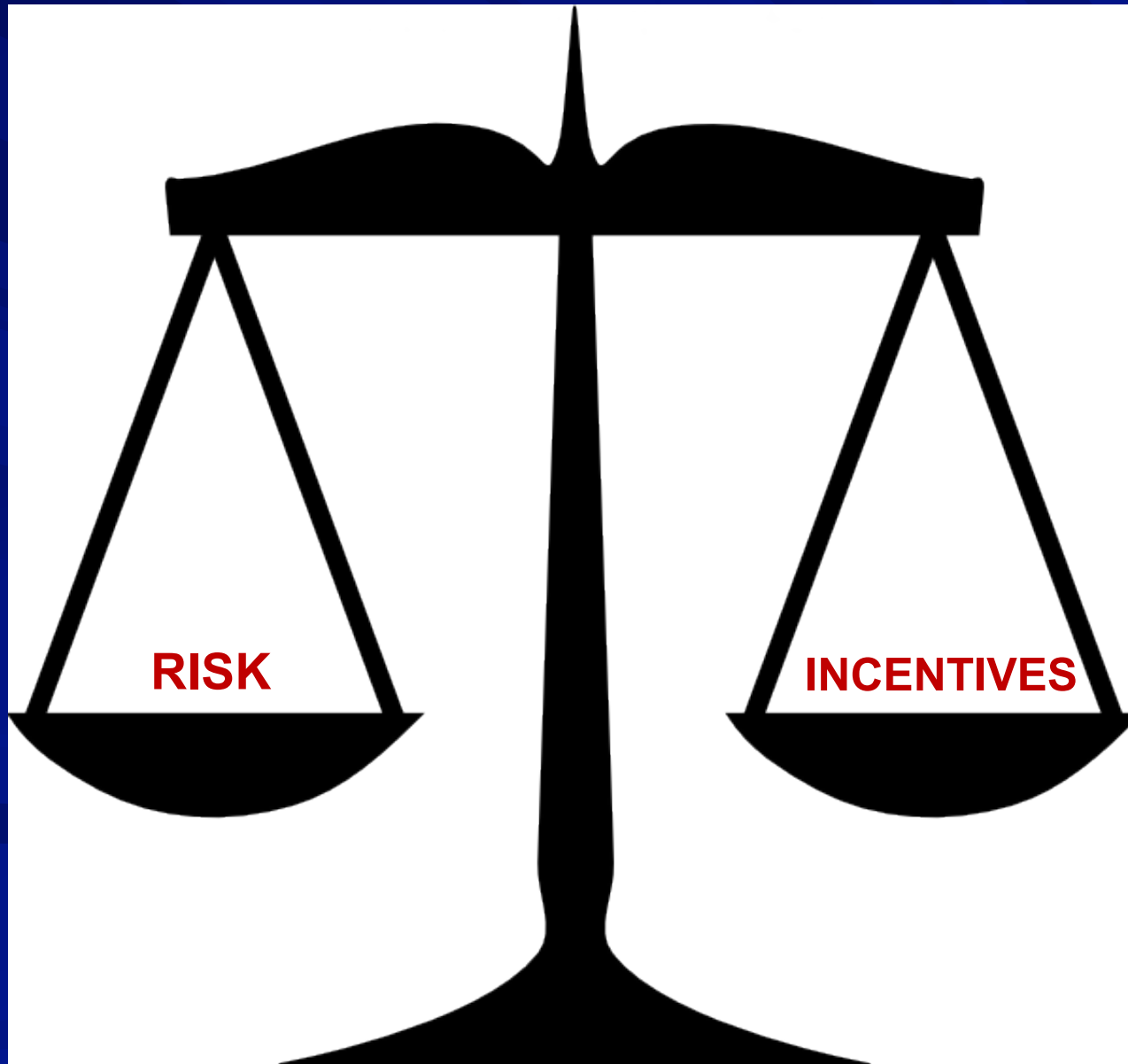
- Both lower spending
- Episodes are narrower (harder to get PMPM savings)
- Not all areas can support population based payment
- Episodes engage specialists better

Should Payment Reform Continue

- MACRA is current law
 - APMs are favored
 - Difficult to add more money
- When money gets tight; providers likely want to control the money

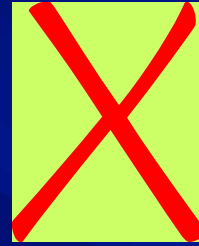
Benefit Design

Insurance Balances Risk with Incentives



Why the cost sharing?

■ To lower premiums

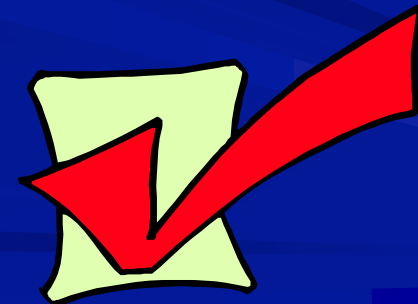


■ To tax the sick?



■ To improve incentives

- Reduce 'excess use'
- Encourage price shopping



Benefit Design Options

- Higher copays, co-insurance or deductibles
 - HDHPs w/ HSAs or HRAs
- Reference pricing
- Tiered networks
- Value Based Insurance Design (VBID)
 - Align copays with value

Benefit Design Results

- Patients clearly respond to cost sharing
 - Shift sites of care
 - Reference Pricing:
 - Potentially meaningful shift in volume
 - Smaller \$ effects
 - Tiered network: 5% of total PMPM
 - Reduce use
 - HDHPs: 5%-14%
 - VBID: Depends on details.

Benefit Design Concerns

- Reductions in appropriate use same as for inappropriate use (Sui et al. 1986)
 - Copays reduce use of preventive services
 - Copays reduce use of 'valuable' pharmaceuticals
- How much risk do we transfer?
- How does this affect disparities?

Final Thoughts

Keep It Simple





The road to success is always
under construction.

Lily Tomlin

quote fancy

END