The Future of Payment Reform

Michael Chernew
Health spending exceeds income growth by:

- 1970s: 2.2%
- 1980s: 3.2%
- 1990s: 1.6%
- 2000s: 2.7%
Perspective Matters

- Total spending
  - Most comprehensive measure of health system performance

- Government spending
  - Most relevant for taxes
**Medicare’s Challenge**

<table>
<thead>
<tr>
<th>Excess spending growth per beneficiary (percentage points)</th>
<th>Medicare share of GDP in 2035 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>1</td>
<td>6.6</td>
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<tr>
<td>0.5</td>
<td>6.0</td>
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<td>0</td>
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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

Source: National Association of State Budget Officers (NASBO). State Expenditure Reports.
Private Health Care Spending is not Sustainable

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

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.
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

What Is Value in Health Care?
Michael E. Porter, Ph D.

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

The Strategy That Will Fix Health Care
by Michael E. Porter and Thomas H. Lee

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 \(\sim 20\%\) (incl. SNFs, IRFs, Home Health) \(^3\)
  - BPCI saved \(\sim 4\%\) on orthopedic episodes \(^3\)

- Savings may be offset by increased episode volume \((\text{Fisher, 2016})\)

- No consistent quality impact BPCI\(^1,2\)

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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