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AMERICAN COLLEGE OF MEDICAL PRACTICE EXECUTIVES
PROFESSIONAL PAPER MANUSCRIPT
Exploratory

An exploration of reimbursement methodologies and the cost structure of healthcare delivery in the United States

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This exploratory paper is being submitted in partial fulfillment of the requirements for ACMPE certification.

This paper will explore the problems related to increasing healthcare costs, identify and elucidate some of the root causes, and suggest some specific directions that might ultimately lead to positively reforming the system. Using published studies and data on prices, spending, and use, it will show how current healthcare delivery models and provider reimbursement methodologies fuel inefficiency and lead to inequities in care. By combining evidence from simulations and case studies with stakeholder opinions as reported by the popular press, it will argue that the current reform bill treats the symptoms of a flawed system while ignoring its causes. It will conclude by proposing alternative methods for delivery and reimbursement that might pave the way to achieving affordable health care in the long-term.

As the current legislation begins to take effect, medical practice managers and physicians have a vested interest in educating themselves about the cornerstones of healthcare reform. By providing a multitude of perspectives on reform coupled with evidence-based evaluations, this paper offers an objective review of the effects of current initiatives. Such an approach will enable practice owners to understand how to gain market share and reduce cost in the advent of change. At the same time, it will arm practice managers with ideas to engage in discussions with key stakeholders—physicians, the medical community, and business and government leaders—to work together to find ways to help affect change and improve our national system.

BACKGROUND

This section will review the underlying problems in the health care system and principles of reform that have shaped the most recent national debate. This review will

provide a lens to evaluate current strategies from the perspective of government policy and will highlight the political hurdles to achieving comprehensive health care reform.

The passage of the Patient Protection and Affordable Care Act in March 2010 marked a significant, but tentative, step towards comprehensive health care reform. Focused on expanding insurance coverage in the short-term, the legislation failed to remedy the underlying causes of rising costs. These include abuse and waste, overutilization of care, overreliance on prohibitively expensive hospital-based medicine, and underfunding or misallocation of funds for government-based healthcare initiatives including Medicare. Without overhauling current physician payment methods and correcting fundamental problems in the delivery system, costs will continue to rise at unsustainable rates.

HISTORIC REFORM EFFORTS

Efforts to regulate the health care market began during the early 20th century, when the public's trust in physicians began to erode in entrepreneurial physicians rife with conflicts of interest. According to the legal historian Mark Rodwin, most physicians at the time were "self-employed practitioners" that made treatment decisions based on the risk of financial loss and potential profits.[i]

The conflict between their profit motive and the need for adequate patient care, combined with skyrocketing prices led to the formation of two forms of not-for-profit insurance emerged to increase access and control cost. On the one hand, Blue Cross and Blue Shields offered medical benefits through independent hospitals and physician; the other insurance model, the prepaid group practice (PPGP), controlled costs by employing physicians or paying them per capita.

Although the Blues were initially the predominant form of insurance in the United States, a series of legislative initiatives enacted during the 1970s adopted the PPGP model. Spearheaded by President Richard Nixon, these initiatives promoted the formation of Health Maintenance Organizations (HMOs) that attempted to control costs by issuing paid fixed premiums for each person.

Although the majority of HMOs were initially non-profit entities, deregulation efforts during the 1980s promoted the growth of for-profit HMOs and by 1985, more than half of all HMOs operated on a for-profit basis. As HMOs flourished, traditional indemnity insurers began to adopt principles of managed care—for instance utilization review and preferred provider networks—to remain competitive.

During the 1990s, the practices of for-profit HMOs came under scrutiny in a public debate over health care reform. Although embraced in previous decades as the cornerstone of reform, HMOs became the target of public outrage as politicians and the press criticized the methods used by for-profit insurer to increase profits: coverage denials, reductions of beneficial services, and inadequate provider payments.

This so-called "HMO backlash" led to patient protection laws. These laws set standards for adequate coverage and called for the formation of independent medical reviews through which individuals could appeal insurers' decisions to deny coverage. Since they make their decisions on an individual basis, these independent medical reviews proved ineffective as instruments of systematic change in the health care market.[ii]

SPENDING MORE FOR LESS

Despite decades of public outcry and numerous attempts to curb growth, health care costs in the United States continue to grow at an inexorable pace. Since 1970, health care costs have consistently outpaced growth in the GDP by an average of 2.4 percent.[iii] Although the rate of increase slowed during the 1990s, expenditures are once again skyrocketing with 2009 spending estimated at 2.47 trillion dollars. This marks the largest year-on-year increase since 1960—from 2.34 trillion in 2008—and bolsters the Centers for Medicare and Medicaid Services (CMS) predictions that total spending will reach 4.5 trillion by 2019.[iv]

These levels make the United States a notable outlier in health care spending worldwide. Accounting for 17.6 % of the GDP, the United States spends approximately twice as much on health care than other major industrialized countries, more than 56% per capita than predicted by income.[v] Despite spending more on health care than any other industrialized nation, the U.S. consistently ranks in the bottom half of industrialized countries in relation to access, infant mortality, life expectancy, and mortality from amenable conditions.[vi]

THE COVERAGE GAP

In recent years, health insurance premiums have consistently grown faster than inflation and workers earnings. Cumulative growth in premiums was 119% from 1999-2008, compared to the cumulative inflation rate of 29% and the wage growth rate of 34% (Appendix 1).[vii] At this rate, the cost of family insurance will soon reach 27,000, taking a fifth of every dollar earned.[viii]

These rising premiums have also had devastating effects on employers, who provide the largest source of coverage in the United States. If costs continue to rise at the same

rate, businesses will see their health coverage expenses rise from ten percent to seventeen percent.[ix] According to Warren Buffett, health care has consequently become "a tapeworm eating at our economic body," as the cost of providing coverage for employees places U.S. companies at a competitive disadvantage in the global economy. [x]

As a result of rising premiums, there has been a steady decline in insurance coverage amongst the non-elderly since 2000 (Appendix 2).[xi] The recent economic recession widened the gaps in coverage to levels deemed "unconscionable" by the press.[xii] As companies struggled to stay afloat, they cut health care benefits, while layoffs led to record numbers of uninsured workers; from May 2007 to July 2009, the uninsured rate jumped from 12.3 percent to 16.4 percent.[xiii]

At the same time, the 2008 presidential election drew attention to the human side of rising costs. As newspapers and public debates described the devastating effects of losing health care coverage, reports furnished evidence on the cost of the insurance gap.[xiv] For both the uninsured and underinsured, medical care can be financially disastrous: medical expenses has been shown as the cause of over half of all bankruptcy filings.[xv]According to a report on health insurance and mortality in the U.S., lack of insurance in United States causes 18,000 unnecessary deaths every year; a 2009 study from Harvard estimated a much larger number, 44,800, of excess deaths due to the lack of health insurance in the United States.[xvi]

HEALTH CARE REFORM PRINCIPLES

The election of President Barack Obama precipitated a national dialogue over health care reform. This debate centered on the best method to expand coverage and

increase quality while lowering costs. While there was a general consensus that the current system was "broken," there was little agreement on how to achieve reform.

President Obama spearheaded the health reform debate beginning with his remarks on the White House Health Care Forum. Tying the need for reform into the exigencies of the fiscal crisis, he argued that:

"…the greatest threat to America's fiscal health is not Social Security, though that's a significant challenge; it's not the investments that we've made to rescue our economy during this crisis. By a wide margin, the biggest threat to our nation's balance sheet is the skyrocketing cost of health care. It's not even close."[xvii]

In June 2009, President Obama proposed a strategy for reform based on cost-containment that included electronic record-keeping, preventing expensive conditions, reducing obesity, refocusing doctor incentives from quantity of care to quality, bundling payments, and reducing defensive medicine.[xviii] In the year that followed, a variety of proposals for reforming the health care system were brought forward including a list of "fifteen ways to cut costs," a population-based program to increase physical activity, and a government-run single-payor system.[xix]

As President Obama's remarks conveyed, the fiscal crisis focused politicians, analysts, and the public alike on curbing costs. Most of the "legitimate" proposals attempted to expand coverage and curb cost in the short-term. According to Harvard Economist David Cutler, policy proposals used three basic strategies to achieve these dual aims:

1) Develop a single-payor system with hard-budget constraints that would allow the federal government to limit spending and technology acquisition. Although internationally the most common method of cost

containment, the single-payor system was not included in any serious legislative proposals.

2) Increase consumer choice by limiting tax exclusion to encourage less-generous plans or pushing consumers into high deductible plans.

3) Use the leverage of Medicare payments to change provider incentives throughout the medical system. [xx]

The philosophy of the final legislation most closely reflected the third strategy. As enacted, the legislation focuses on expanding coverage in the short-term and regulating the private insurance industry's coverage protocol. It also includes a variety of pilot programs and demonstrations to explore alternatives in healthcare delivery and payment reimbursement. The major provisions of the Patient Protection and Affordable Care Act contribute to the broader reform goals of expanding coverage, decreasing costs, and improving quality, albeit limited in scope.

The new legislation will expand coverage by increasing regulatory oversight of commercial insurers, using the tax code and subsidies to mandate coverage, and creating state-based exchanges to improve the accessibility, transparency, and efficiency of insurance markets.

Beginning in 2010, lifetime and annual limits on policies will be disallowed along with policy cancellations in the individual market. At the same time, tax credits will be provided for small employers with low-wage workers to subsidize benefits, and children under age 26 will be allowed to stay on their parent's plan. Also effective immediately will be temporary state-based high-risk pools for those who lost their insurance coverage

within the last six months. The high-risk pool will remain in place until 2014 and will sets premiums at a standard rate that can vary by no more than 4:1 by age.

In 2014, insurers will be required to accept and renew every individual or employer applying for coverage regardless of health status or utilization. They will also be required to limit variance among premiums to a ratio of 3:1 according to family size, geography, and actuarial value of policy, tobacco use, and age. These insurance reforms will be coupled with an individual mandate that will use the tax code to require legal residents to enroll in qualified health plans or face penalties. The individual mandate is intended to counter the potential for adverse selection, increased costs, and the "financial death spiral" associated with increasing coverage to high-risk individuals and expanding benefits.

Individuals and small businesses will be able to purchase plans through state-wide marketplaces administered by the government or non-profit entities with federal start-up funding. States will exercise a great deal of control in designing and implementing the systems, however the PPACA does provide for some guidelines in the design of benefit coverage. The pools will provide a choice of plans and benefit categories based on actuarial value and categorized as bronze, silver, gold, and platinum. Insurers will be required to meet QHP certification by offering a full range of services, charging the same premium for policies in and out of the state's exchange, and providing at least one plan in the silver and gold benefit tier.

To ensure that individuals can access these new plans, there will be financial assistance for those with incomes between 133 and 400 percent of federal poverty level.

This subsidy is intended to help low and middle income individuals purchase insurance by limiting the cost to percentage of income.

Small businesses will also be eligible for subsidies: initially this will consist of a 35 percent subsidy for the purchase of insurance premiums, and after 2014, employers purchasing coverage through the state exchange will receive a tax credit of up to 50 percent of their cost.

Effect on Cost

The insurance reforms provisions target those groups that are largely uninsured and, as such, attempt to counter the financial burden of uninsurance in the current system. The extension of dependent coverage to children up to age 26 targets young Americans for whom the cost of insurance is prohibitively expensive. The new marketplaces will also benefit those ages 55- 65 by providing health care security as they transition to retirement and before they are eligible for Medicare. Beyond providing an alternative option for coverage, provisions to limit variance in premiums according to age will offer this demographic the greatest reduction in premiums. .

MISSED OPPORTUNITIES FOR REFORM

Like the debate that precipitated it, the final legislation focused on expanding coverage and reforming the insurance industry. Focused on short-term cost containment, the bill fails to act upon the long-term savings that realign provider incentives and improve health care delivery promise. While it attempts to expand coverage to 32 million Americans, it appears to lack the wide-scale reforms necessary to “bend” the cost curve and enable more universal affordability. Moreover, the lack of definition in certain terms

may create expensive liabilities for certain services. Equally importantly, the funding for these current coverage expansions is uncertain.

To offset the price of increased coverage, the bill calls for Medicare payment reductions and excise taxes. According to the Congressional Budget Office (CBO), these measures will reduce the deficit by 124 over the next ten years. However, such payment reductions will not yield savings in the long-term; "overpayments" can only be corrected once, while slowing the pace of Medicare fee updates cannot continue indefinitely.[xxi] Moreover, most analysts agree that the Sustainable Growth Rate, which is used to determine Medicare fee updates, must be fixed if reform is to be enacted. The CBO estimates that fixing these problems will itself offset the potential savings, costing approximately $215 billion to $350 billion in the next ten years.[xxii]

While the public debate over health care reform and the subsequent legislation focused on *what* physicians are paid, achieving affordable health care in the long term requires changing *how* they are paid. In fact, compared to rising costs, real physician income has declined.[xxiii] This disparity is a function of the misaligned incentives of reimbursement methodologies and a faulty delivery system that fuels provider-induced demand, overspecialization, and the unnecessary use of technology.[xxiv]

PROBLEMS WITH THE CURRENT SYSTEM

This section will address the structural problems inherent in the contemporary health care market from the perspective of third-party payors, providers, and patients. Beginning with a discussion of the systematic differences in government, for-profit, and not-for-profit plans, it will show how the current system creates administrative waste,

before focusing in on methods used by for-profit plans to generate revenue. Using Medicare reimbursement methodologies as a functional example, it will then address how faulty incentives to providers contribute to rising costs. Throughout this section, the effect of third-party payors and providers on access to and quality of care will be discussed.

THE PAYORS

Health care is paid for in the United States by some combination of the patient, the provider, and a third-party payor. Currently, out of pocket expenses account for 14.2 percent of all health expenditures, while third-party payments made by the government account for 46.5 percent, with the remainder paid for through private health plans.[xxv]

In a third-party payer system such as the United States, the mechanisms used to structure access to and payment for care, rather than prices and demand, create the behavioral environment for the supply of services. As they employ different methods to structure payment to providers and access to care, both the government and private insurers contribute to rising costs and increasing disparities in access to and quality of care.

The Political Economy of Health

Before delving into the unique characteristics of government and private payors, it is necessary to examine how the contemporary multi-payer third-party payer system emerged as a function of the economics of health care.

In his seminal article "Uncertainty and the Welfare Economics of Medical Care" Kenneth Arrow laid the basis for the study of health economics and future attempts at reform by isolating the unique features of the health care market. According to Arrow,

productivity norms in medical care are governed by the concept of uncertainty: the consumer's uncertainty about the value of medical care and their belief that the physician has greater knowledge. He concluded that unlike other commodities, the relationship between the consumers and producers of health care is "colored by" the consumers' trust that the provider has knowledge that "is necessarily very much greater than that of the patient, or at least so it is believed."[xxvi] Third-party payors, whether private or public, reduce this quality of uncertainty: they enhance patients' trust in medical, while facilitating profits for providers

Arrow also points out that the normative goals of the Pareto efficiency, in which no party ends up worse than he began, is only a theoretical prediction under an assumed set of conditions. In reality, societies must reconcile how much efficiency they are willing to trade for equity, a particularly pointed question when it comes to health care. In the United States, the government works to counterbalance these inequities in its' role as a payor through the Medicare and the Medicaid programs.

Medicare

Medicare is a social insurance program that provides health insurance for 47 million disabled and elderly individuals. It consists of four parts: hospital insurance (Part A) which also includes coverage for nursing facility care, hospice, and home health care, supplementary medical insurance (Part B) which covers physician and other health related services as well as hospital outpatient care, Medicare+Choice (Part C) which permits beneficiaries to enroll in MCOs, and prescription drug coverage (Part D).

Medicare benefit payments are expected to amount to 504 billion in 2010 and account for 23 percent of national health care spending. Total spending is highly

concentrated in hospital care: Part A, which is funded primarily from Social Security Taxes, will account for 39 percent of this total while Part B, which is funded through general revenues and enrollee premiums, will accounts for 27 percent of expenditures.[xxvii]

Medicare spending is also highly concentrated amongst its beneficiaries with the top 10% of beneficiaries accounting for 58 percent of total spending. This reflects, among other things, the high utilization of medical services during the last year of life; Research has found that approximately 30 percent of expenditures are devoted to individuals in the last year of life, with 11 percent of expenditures attributed to the last month of life. [xxviii]

Medicare sets nationwide rules about rates of payment to qualified plans and providers. Payments to physicians, hospitals, and health plans are generally calculated according to characteristics of the patient (age, new/established patient), the provider (teaching/non-teaching hospital, physician specialty), and the activity conducted (procedure, surgery, imaging). These rates are then adjusted annually in relation to general economic growth.

These payment rates are known in advance, and providers can chose to provide coverage based on these fees. Unlike the private insurance market, both Medicare and Medicaid accept any provider who is willing to supply at these rates; hospitals decide whether or not to provide care at all, whereas physicians might decide on a practice or service-by-service level. [xxix] Those physicians who "opt out" of the Medicare program are required to cap charges to beneficiaries at 115% of Medicare allowable fees.

Although it is administered by the Centers for Medicare and Medicaid Services, the government contracts with private companies that operate as "fiscal intermediaries"

by accepting bills and writing checks to providers, before being reimbursed by the Medicare trust funds.

Medicaid

Medicaid is a means-tested, needs-based social welfare program that provides coverage to certain subgroups of low-income individuals and families. Unlike Medicare, which is universally accessible to those over age 65, Medicaid must be applied for. As the CMS website explains:

"Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the designated eligibility groups."[xxx]

Generally, these individuals fall into four categories—children, their parents, pregnant women, and people with disabilities. Impoverished elderly individuals receiving Medicare coverage also receive financial assistance through the Medicaid program. The specific requirements for eligibility are determined on a state-level and, as a consequence, coverage varies widely from state to state.

The eligibility requirements of the Medicaid program exclude many individuals who cannot otherwise afford health insurance. As a consequence, adults at the poverty level experience the highest levels of uninsurance, with 24.5% of individuals in households with income below 25,000 lacking plans. Another large group of uninsured patients are eligible for Medicaid but do not apply because of enrollment hurdles. Coupled with state variation in eligibility requirements, this system has created, what the prominent health care analyst John Iglehart described as “the greatest inequity” in the

health care system “not between the nonpoor and the poor” but “the insured poor and the uninsured poor.”[xxxi]

In 2008, Medicaid spending, which is jointly funded from state and federal tax-revenues, totaled about $339 billion. Although each state must meet certain requirements to receive federal funds, federal law gives states wide discretion over payment levels and methods. As a consequence, Medicaid funding is highly effected by the economy, as states cut coverage when faced with financial pressures.

Medicaid is the nation's primary payor for long-term care, with more than 30% of total spending concentrated in this sector. By comparison 5% to 20% of Medicaid funds are spent on acute care. As such, Medicaid might be the single largest purchaser of personal care, adult day care, some mental health services, and services for people with intellectual disabilities in a state.

Medicaid’s role in the long-term care market reflects the special needs of its beneficiaries, amongst whom spending is highly concentrated. Although the elderly and people with disabilities comprise one- quarter of Medicaid enrollees, they account for roughly two-thirds of Medicaid spending; In 2007, Medicaid expenditures were about $14,500 per disabled enrollee and $12,500 per elderly enrollee, while they averaged $2,100 per child and $2,500 per non-elderly adult.[xxxii]

Private Health Insurance

66.7% of Americans have some form of private health coverage, with 58.5% of Americans receiving coverage through their employers as part of their benefits package. Those without employee-sponsored health insurance are able to purchase individual

plans; according to the U.S. Census Bureau, approximately 9% of individuals were covered by independently purchased plans in 2008. [xxxiii]

Employers buy directly from health plans often through a broker and the prices of these plans reflect bargaining and different risk distributions from different employers Typically, an employer pays around 85 percent of the insurance premium for employees and 75 percent for their dependents, while the employee pays the remainder, typically with tax-exempt earnings.

Non-group insurance is a weak alternative to employer-sponsored plans. As a function of risk pooling and the ability of insurers to vary premiums according to age and health status, these plans are prohibitively expensive for most individuals.

The U.S. has a joint federal/state system for regulating insurance, although states exercise most regulatory control by regulating the content of policies and requiring coverage of specific types of medical services or providers. These mandates do not apply to those health plans offered by large employers due to the pre-emption clause of the Employee Retirement Income Security Act.

Today, the predominant type of insurance network is the Preferred Provider Organization or some form of it. PPOs are networks of physicians and providers who agree to provide services at discounted rates and/or agree to certain utilization protocols while Enrollees are given financial incentives to use network providers.

PROBLEMS WITH GOVERNMENT PLANS

An oft-cited solution to the outcry for a more efficient and cost-effective insurance plan is a government-operated option. Proponents of this use Medicare as an example of something that "works." Government plans, however, have their own breed

of issues that include how reimbursements are set as well as oversight and management of care.

Reimbursement rates

Attempts to curb Medicare and Medicaid spending have led the government to continue to propose lower reimbursement rates that either trail the prevailing state/regional private markets or are argued by providers to undervalue services. Adapting to these disparities have led physicians to limit the amount of their practice they devote to government beneficiaries and hospitals to “shift” costs to the private market.

Physician reimbursement for Medicare is approximately 78% of private insurance rates. Although these disparities are beginning to effect physician access amongst Medicare beneficiaries, the flexibility of Part B coverage has meant that, overall, 97% of practitioners still accept Medicare patients. [xxxiv]

In 2008, Medicaid reimbursement averaged approximately 72% of the rates paid by Medicare. Since there are no pathways for further compensation, it has been approximated that only one-third of physicians will accept new Medicaid patients at this time. Describing his decision to stop providing for this market, one Michigan doctor, where Medicaid payments are amongst the lowest in the nation, explained that he lost money every time a Medicaid patient walked in his exam room.[xxxv] The poor availability of physicians combined with the specific attributes of the Medicaid population contributes to the overutilization of emergency rooms, which has led to a greater drain on the system’s more expensive healthcare delivery methods.

Within the hospital market, the disparity between Medicare and the private market has led to a phenomenon known as “cost shifting.” From 1999-2007, average payment to

cost ratios for Medicare patients fell from 107% of allowable costs to 94%. This process was accelerated as real costs rose much faster than the 3% increase in Medicare payment rates; by contrast, the average payment-to-cost ratio for privately insured patients rose from 116% to 132%. [xxxvi]

Many believe that this disparity exists because hospitals depend on private insurers to cover the losses they sustain from treating Medicare patients. Some have pointed to this as a central force driving higher premiums. For instance, an Economist from Stanford, Daniel Kessler, analyzing California hospitals found that while the uninsured led to a 1.4% increase in private premiums, this paled in comparison to the 10.8% escalation due to the uncovered costs of MediCal and Medicare. [xxxvii]

Other studies have been less conclusive on the causes and effect of these disparities in payment rates. As one researcher Jeffrey Stenisland pointed out, traditional cost-shifting arguments assume that hospitals cannot control their cost when, in fact, hospitals with strong market power who can reap higher revenues from private payors have weaker costs controls. As a consequence, these hospitals have higher costs per unit of service and narrower margins on Medicare business.[xxxviii]

Fraud

Another concern about the government system is its current inability or lack of funding to address the prevalence of fraud and abuse. Although it is difficult to estimate the full cost of health care fraud, the Federal Bureau of Investigation estimates that fraudulent billings to public and private health care programs account for 3-10 percent of total health spending, or $75-$250 billion in 2009.[xxxix]

Federal health care programs operate under a "pay-and-chase" model. The majority of claims for federal payment are submitted electronically, processed based on predictable edits applied to representations on the claim, and paid claim by claim with limited verification that the services were actually provided or were necessary. As a consequence, additional analysis is needed to determine whether a series of claims, each of which may appear legitimate by itself, demonstrate a pattern of potential fraud or abuse when taken together. For-profit managed care companies by contrast take a much more aggressive stance towards review of claims, as well as auditing.

Problems with Private Insurance

Although private insurance is able to be more responsive to consumer demand and has been more innovative with cost-curbing measures as a result of the profit-motive, the private insurance market has also contributed to the rising cost of healthcare and its systematic inequities.

As a measure of the profit margin for private insurance, the five largest health insurance companies posted a 56% gain in profits in 2009 over 2008. This came as 2.7 million Americans lost their coverage as a result of the recession.[xl]

Medical Loss Ratio.

The "medical loss ratio" (MLR) is the percentage of every dollar taken in premiums that goes towards payment for care. Historically, the MLR for non-profit and government plans has been around 95 percent, with almost every dollar collected in premiums put towards payments for care. For-profit plans, however, typically have MLRs that range from 65 to 75 percent; and in some markets are as low as 60 percent.[xli]

Rather than competing for customers, private insurers compete on the basis of the MLR to attract shareholders and provide an adequate return on investments. As one former health executive recalled an insurer's stock price “fell by more than 20 percent in a single day because the first-quarter medical-loss ratio had increased from 77.9 percent to 79.4 percent.”[xlii] Since for-profit publically traded insurance companies have a fiduciary responsibility to maximize profits, maintaining these low levels of MLRs is fundamental to their existence. Operating with a MLR above the 80-85 percent mark arguably puts a company at a serious disadvantage.

In the face of rising costs, private insurers have maintained their MLR, and, in fact, generated record-breaking profits, by increasing premiums and cutting back coverage. Price increases have consistently outpaced the rate of growth in costs, with premium yields 1.5% to 2.0% above cost trends since 2000.

In addition to raising premiums, companies have also cut back on coverage. As Drew Altman, President and CEO of the Kaiser Family Foundation explains, the insurance industry has coupled premium hikes with “buy downs” where the company offers lower-priced plans with less coverage. Consequently, amongst individually purchased insurance 52% of expenses were paid out of pocket from 2004-2007, as compared to the 30 percent out-of-pocket share for employer-sponsored coverage. As a result, the average deductible for family plans in the individual market increased from $2,760 in 2008 to $3,128 in 2009. The trend also held true in employee-sponsored coverage, especially in smaller firms where the percentage of workers in plans with high deductibles skyrocketed from 16% in 2006 to 40% in 2009. [xliii]

Administrative Waste

A major source of waste in the industry is the cost of private insurance administration. The cost of insurance administration in the United States was 156 billion in 2007 and is expected to double by 2018. At these levels, the McKinsey Institute estimates that the U.S. wastes 91 billion more per year than other countries on health care administration.[xliv]

Between 2000-2005, the administrative overhead of insurance companies (difference between premiums and claim) grew 12 percent per year faster than average growth of health care expenditures. While estimates of the total cost of administration vary according to the definition of “administrative” costs, the disparity between the private and government insurance market is consistent, with private insurance seeming to incur 12% in administrative costs compared to 3-5% in Medicare and Medicaid programs.[xlv]

The differences in administrative costs between the government and private health insurance industry reflect both the profit motive of private insurers and the difference in economies of scale. According to the McKinsey Institute over 85% of the administrative cost of private insurance can be traced to activities such as product design, underwriting and marketing. At the same time, the percentage of premium attributable to administration runs from 5 percent to 40 percent depending on the market and state: 5-40% of premiums in individual market; 15-25% in companies with fewer than 50 employees; and 5-15% in those with more than 50 employees.[xlvi] Nonetheless, insurance companies spend a great deal on underwriting and product design, as evidenced by the

fact that the largest health insurance companies averaged 13-18% in administrative costs in 2008.[xlvii]

A great deal of administrative waste is also generated by the cost of interacting with all these payors. One study found that on average, physician practices spent $68,274 per physician per year interacting with health plans. When this average is multiplied by the number of physicians practicing in the United States, the total cost of physicians' interactions with health plans is $31.0 billion.[xlviii]

Fragmented Purchasers

Whereas the government yields enough market power to influence provider practices, the private market is characterized by the multitude of payors and the diversity of purchasers. In this complex buying environment, the relationship between all actors involved lacks transparency and no single purchaser yields the power necessary to effect comprehensive change.

Attempting to combat these shortcomings, a small group of large employers banded together in 2000 to form the Leapfrog Group. Together, they developed purchasing principles intended to improve the value of health care and targeted towards both health plans and providers. These initiatives called for the free flow of information about providers to educate consumers and a performance-based payment system.

Despite its large group membership, clear goals, and national recognition, the Leapfrog Group failed to achieve its aims as participating employers failed to change their purchasing practices. A study of the group's long-term impact published in *Health Affairs* pointed to the fundamental diversity of buyers' purchasing and contracting practices to explain employers' reluctance to adopt Leapfrog's practices. While some

companies, the ultimate purchasing decision lies with human resource professionals who do not have the particular expertise necessary to effect change within the complex health care market, others outsource the decision to consultants who have little financial interest in cooperating with their competitors. Furthermore, employers faced with the drain of near-term health-care costs have been reluctant to allocate more of their budgets to pay-for-performance, despite the long-term savings such a payment mechanism might yield.[xlix]

REIMBURSEMENT METHODOLOGIES

This section will review the two primary payment mechanisms used by Medicare to reimburse physicians to shed light on opportunities for additional reform.

Diagnosis Related Groups (DRG)

Medicare Part B uses a prospective payment method to reimburse providers for hospital care. In a prospective payment system (PPS), providers are reimbursed using rates that have been established in advance of the episode of care and based on the historical resource needs for the average patient given a set of conditions or a disease.

Implemented to curb the explosive growth in inpatient hospital costs after the implementation of Medicare, PPS shifts risk to providers, incentivizing them to reduce the quantity of care. Unlike the fee-for-service (FFS) system, which fuels provider-induced demand, the PPS system leads to supply-side decision-making.

Medicare uses Diagnosis Related Groups to classify episodes of care. Developed by Barclay Fetter and John Thompson of Yale University, DRGs classify hospital cases using codes that group homogenous units of activity to binding prices, regardless of the specific attributes of the patient.

Before being implemented on the national level, the DRG model was tested in New Jersey where it was gradually adopted by all hospitals in the state over a three-year period beginning in 1980. The New Jersey experiment was designed to measure how DRGs could reduce the share of hospital revenues furnished by Medicare payments. Despite less than conclusive results, however, legislation called for the use of DRGs to pay all hospitals treating Medicare patients in 1983. [l]

In 1987, New York State passed legislation to expand DRGs to non-Medicare patients. After Medicare DRGs proved inadequate for this population, the state commissioned a series of studies to develop DRG modifications. These modifications eventually resulted in APDRGs (All-Patient DRGs) that include support for the needs of an array of patient types—for instance, high-risk obstetric care and pediatrics.

As enacted today, Medicare uses DRGs to determine reimbursement rates according to clinical profiles and requisite resources. DRGs classify cases according to similar diagnosis and treatments, consumption of resources, and length of stays with higher weights yielding higher payments.

On the national level, Medicare PPS immediately led to across the board decreases in length of stay and admissions. With "quicker but sicker" discharges, there was an increase in the use of post-hospital services like home health care and nursing facilities. Although the implementation of DRG immediately led to large increases in hospital profits, it eventually gave way to substantive losses for hospitals as Medicare fees began to trail costs.[li]

Despite the theoretical benefits of using a Prospective Payment System, problems with the administration of the program have offset these gains. For one, as initially

designed, DRGs failed to account for patient differences that drastically affect the care necessary for a given diagnosis: for instance, the severity of the condition or the general health of the patient prior to admittance.

Although CMS has since implemented a variety of mechanisms to attempt to account for these factors, the current codes still fail to adequately reimburse providers for uncontrollable variations in the amount of care necessary for a given episode. As with APDRGs, the CMS has been unable to collect a set of data that can be applied universally and accurately accounts for these variations

Furthermore, the delayed review process, in which current fees reflect historical data from two years prior, also mean that by definition DRG adjustments do not reflect the cost of new technology. As a consequence, the system does not reward providers for adopting effective new technologies and therapies. Although this mechanism has helped to curb the inappropriate use of expensive technology, according to Nancy Reaven, it also creates a "paradoxical" system for innovation. She argues that if a new procedure is less time-consuming, requires fewer clinical personnel, or uses less expensive equipment or supplies, the re-imbursement will still be less, even if the outcome is better.[lii]

Another problem with the system resides in how claims are filed. Critics have focused on how hospitals developed practices to "game" the system through "upcoding" or "upgrading" the seriousness of the problem by filing a claim using a DRG code with a higher level of reimbursement. Beyond systematic practices such as "upcoding," however, DRG leads to inflation in more innocuous ways. For instance, if a patient is admitted on a DRG of a heart attack, but it is later determined that he/she does not need to be treated on an inpatient basis, a physician could file an amendment to the claim. But

doing so is often prohibitively burdensome, and as a result, the physician might chose to continue treating the patient in the hospital to avoid it.[liii]

Fee-for-service

The traditional fee-for-service model reimburses providers on the basis of each specific service provided. These services are listed on a claim and sent to a third-party payer. The FFS model is a retrospective payment method meaning that a third party payers reimburse providers for costs or charges previously incurred. By privileging volume over value, the FFS system creates waste by discouraging physician cooperation, encouraging overutilization, and devaluing primary care services.

As one analyst pointed out, in theory there is nothing wrong with the conceptual grounding of FFS, in fact most businesses are founded on this model. However, what is being "purchased" and "sold" in healthcare is much different than most businesses. Within the health system there are a variety of "products": physicians sell skills, hospitals sell time and beds, pharmacies sell drugs. In this system, the physician becomes the manager of inputs, since the patient lacks the expertise necessary to assess the value of specific inputs in achieving the desired outcome. However, since there is nothing in FFS to influence integration, each physician acts as his/her own provider and has no incentive to influence others to cooperate/streamline care.[liv]

The FFS system rewards providers for attention to immediate specialized need without regard for the longitudinal outcomes related to the health of the "whole person." As such, it does not encourage provider collaboration, and, in fact, rewards for additional treatment incurred from the lack of communication between providers. The "norm" of care in the United States has thus become a disjointed mechanism in which patients

receive uncoordinated treatments from a variety of providers.

Moreover, under the FFS model, fee reductions have been ineffective in achieving long-term savings. For every 1% reduction in Medicare physician fees, the volume of physician services increases by 0.56%.[lv]

Another problem related to the FFS system has been its insufficiency in rewarding primary care doctors. As one physician noted, most FFS payment models were established when the focus of attention during office visits was acute illness. However, in recent years there have been a growing number of items needing attention during visits: including greater number of preventive services, more patients with chronic illnesses who can benefit from long-term management interventions, direct-to-consumer advertising of health care services, and health information Internet queries.[lvi] Analysts show that physicians are now woefully short of time to discuss preventive medicine, or chronic illness care.[lvii] Since they aren't paid to deal with patients "after hours", more patients are ending up in the Emergency Room. At the same time, the current definition of office visit in the FFS system has been described as an "out-moded" model for delineating the "clinical decision-making" process: doctors now employ a variety of methods to communicate with their patients including e-mail and electronic messaging systems. Although they are critical for providing comprehensive care, FFS does not adequately reward primary care physicians for engaging in these activities.[lviii]

PROPOSALS FOR REFORM

This section will propose initiatives that might be undertaken to counterbalance the current system-wide inefficiencies created by public and private payors as well as

physician reimbursement methods. In doing so, it will evaluate the provisions of the Patient Protection and Affordable Care Act.

PRIVATE INSURANCE REGULATION

A key to reforming the system resides with regulating the private insurance industry. As discussed earlier, companies compete in the current private insurance market by reducing their MLR to yield higher stock–market earnings. As a result, they have lost sight of the primary function of a third-party payer: to provide a meeting ground for providers and patients. Instead, they are accountable to neither and instead to their stakeholders. Further complicating the issue is that insurance company reserves go primarily unregulated and actuarial analyses non-standardized.

Increasing the transparency and accountability of private insurers resides with regulating the Medical Loss Ratio. A minimum MLR demands that insurers spend at least a specified percentage of the premium dollars they collect directly on medical care rather than on administrative costs, marketing, and profits. Such regulation not only facilitates high-value coverage, but, since individuals and small businesses have less negotiating power over premium rates compared to large employers, helps protect purchasers in the non-group market.

Under the new health reform law, starting next year insurers must spend at least 85% of subscriber premiums on medical costs in group coverage plans and at least 80% of premiums on medical costs for individual plans. Insurers that don't meet this requirement must give the dollars back to members in the form of rebates. While a great deal of attention was given during the debate to the level at which these ratios were established, experiences in states that implemented similar measures and the early

responses to these guidelines suggest that rather than simply establishing a minimum MLR, a key to reform is providing clear guidelines and reporting measures on what is included in calculating the ratio.

Such regulation would include a definition of what constitutes as an administrative cost. Since the current legislation lacks such guidelines, insurance companies have already begun to exploit this loophole. WellPoint, as an example, has already "reclassified" more than $500 million of administrative costs as medical expenses "in its bid to stampede regulators into accepting its preferred formula." Such reclassification efforts might increase WellPoint's corporate-wide MLR by 1.7 percentage points without improving the value of its plans. [lix]

Evaluating the current legislation, the Medical Group Management Association has encouraged legislators to include claims payment administrative expenses incurred by providers to be included as an element of the insurer's administrative costs. Such a measure would ease the administrative burden on private practices, ultimately facilitating long-term savings, and prevent insurers from passing more administrative duties onto providers as they strive to maintain a minimum MLR. [lx]

Another sticking point of the current legislation has been the vague definition of "activities to improve healthcare quality." In the absence of specific guidelines, there has been vast disagreement over what activities improve patients' quality of care. Whereas the American Hospital Association advocates a strict definition of such activities, the insurance lobby America's Health Insurance Plan and Blue Cross and Blue Shields have identified at least thirteen categories of activities that they argue should be included in

this category (Appendix 3). [lxi]

PUBLIC PAYMENT SYSTEM

The current methods for establishing fees and administering claims through the government have led to insufficient reimbursement rates and exposed the system to fraud. Many of these issues relate to the time-delay embedded in government systems: claims are filed on a "pay and chase" basis, while current fee schedules reflect historical data. By comparison, private insurance companies, who negotiate directly with providers to determine fees and purchasers to determine benefits, have been more responsive to market needs. They have also been more efficient at finding and remedying billing and claims problems to avoid fraud.

Although the current legislation includes some provisions to help remedy the payment problems associated with Medicare and Medicaid, it lacks specific measures to target these inefficiencies. Instead, it calls for an institute to be formed to study the payment system and make recommendations.

Fixing the flaws in the government system depend on facilitating a process that would allow the government to be more responsive to their market and would allow providers to file and adjudicate claims in real-time. Lessons from other industries show that computer systems can be highly effective in allowing global companies to respond to local markets. Therefore, using these successful examples from other industries, the government should utilize health information technology to ensure that payments are distributed efficiently and reflect real-time costs.

PHYSICIAN REIMBURSEMENT

As mentioned earlier, the current legislation does not address the faulty incentives embedded in predominant physician reimbursement methods. Although it does include pilot programs to test health care delivery models, such as bundling and accountable care organizations, through Medicare and Medicaid, its failure to address the problem on a global basis has been pointed to by many as a critical flaw. Gail Willensky for instance has written that as a consequence, the legislation will "just continue the same dysfunctional incentives that reward more and more complex rather than high-quality outcomes at efficiently produced prices."[lxii]

Others have seen the government pilot programs as a promising step in paving the way for broader reforms. Atul Gawande, writing for the New Yorker, for instance, pointed out that lasting reform can only occur through the testing and implementation of new methodologies on a piecemeal basis. [lxiii]

In praising the exploratory approach of the current system, however, Gawande and others have missed a simple measure that might pave the way for more comprehensive reform. The new delivery models being tested all seek to coordinate and integrate care while rewarding physicians for value. Studies of pay for performance, however, have consistently pointed to the difficulty of measuring and reporting value as well as the likelihood that physicians might begin to "treat for the test" or cherry-pick patients for whom meeting quality guidelines is easier.[lxiv] Others have voiced concern that experiments in bundling and accountable care are unrealistic, as their successful implementation requires fundamental changes to payer-provider culture. [lxv]

At the same time electronic medical records have been shown to be highly effective in coordinating care amongst providers and managing transitions in care settings.[lxvi]

These records, when used effectively and frequently, have helped practices cut down on duplicated tests and unnecessary procedures. Building on the success of EHR in individual practices, the American Recovery and Reinvestment Act of 2009 called for a nationwide, interoperable, secure, and private electronic health information system. The bill also incentivized physicians to adopt this technology by providing $44,000 to practices that adopt a "certified" system under Medicare and $63,750 under Medicaid.

Many have voiced concern that the system might have overly burdensome requirements and that needlessly complex administration will discourage practices from participating in the program.[lxvii] However, beyond the question of whether or not physicians adopt the technology, is whether or not they use it. One doctor writing in the Wall Street Journal explained that even though his practice employed electronic health records, he often called other physicians to retrieve test results because it was simply "easier.[lxviii]" His statements corroborate the fact that adopting a electronic health record system does not in itself yield greater integration and cooperation amongst physicians.

As such, physicians should not only be incentivized to adopt these electronic health record systems, but they should be rewarded for using them in an effective manner to communicate with other physicians in facilitating care. Rewarding physicians for using such a system as part of the FFS system would create the culture of compliance necessary to realize the full potential of electronic health records.

CONCLUSION

The passage of the Patient Protection and Affordable Care Act marked a major milestone in the struggle to reform the health care system. While it includes

unprecedented measures to regulate the insurance industry and expand coverage, the legislation does not address the systematic inefficiencies that have led to spiraling health care costs in recent years. In treating the symptoms of these rising costs—the high levels of the uninsured—it misses out on measures that might make health care affordable in the long-term. Unless the current systems for health care delivery and physician reimbursement are addressed, health care costs will continue to drain the system without providing sufficient care or widespread quality coverage.

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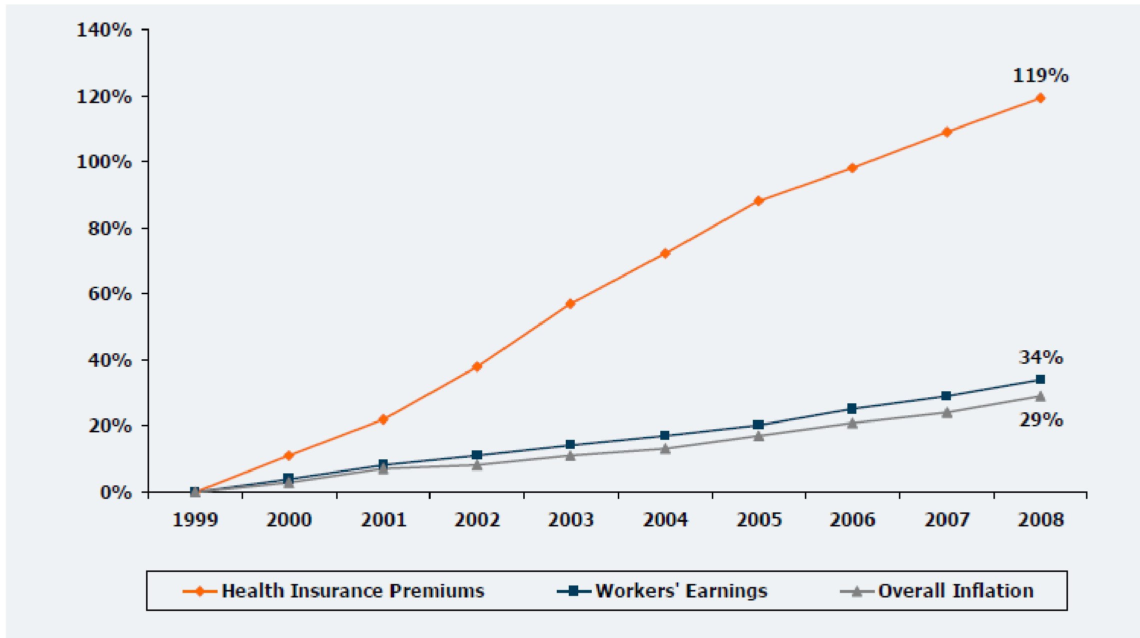
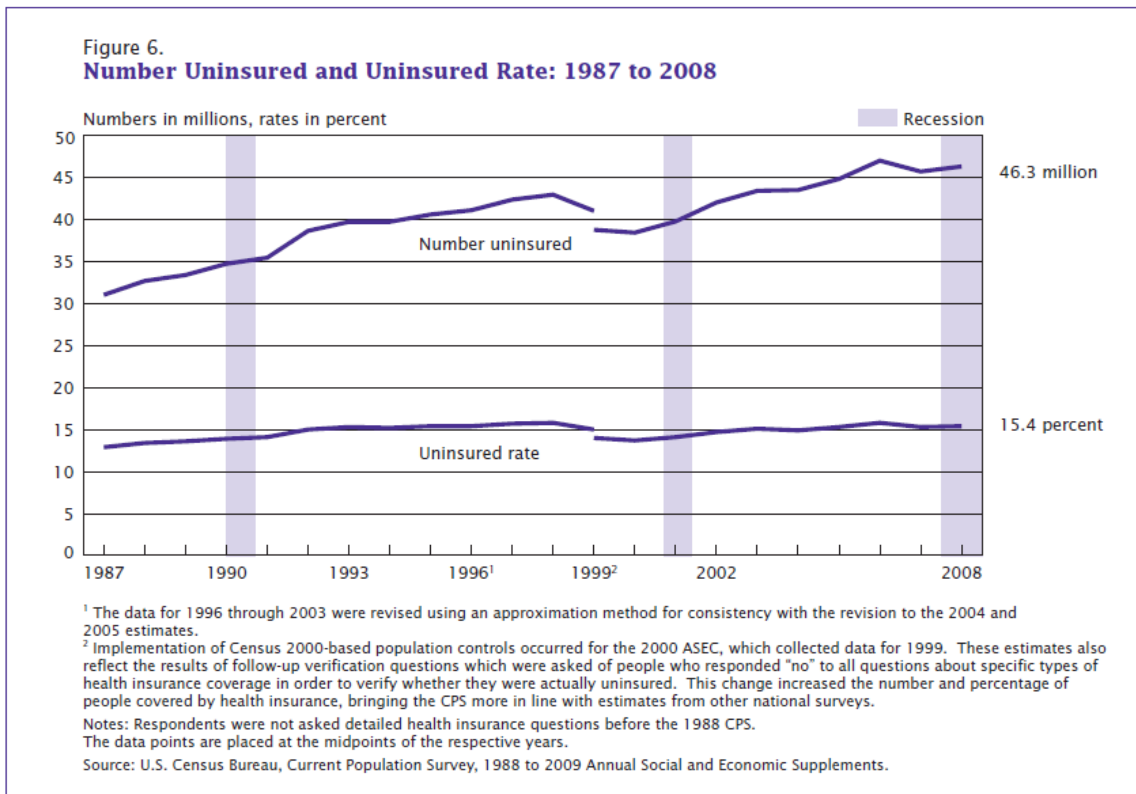
Appendix A
Cumulative changes in Health Insurance Premiums, Inflation, and Worker's Earnings.



Source: Kaiser Family Foundation. "Trends in Health Care Costs and Spending."

Appendix B
Rate of those Lacking Health Insurance



Source: U.S. Census Bureau: Income, Poverty and Health Insurance Coverage in the United States: 2008.

Appendix C
Defining Quality

In statements to the Department of Health and Human Services, America's Health Insurance Plans said the following activities should count as quality improvement efforts, not administrative costs, when HHS calculates an insurer's medical-loss ratio:

- **Care and case management, disease management programs, care coordination and patient monitoring.**

- **Care improvement activities.**

- **Consumer education programs.**

- **Costs associated with provider credentialing.**

- **Review programs that ensure patients receive effective, timely care.**

- **Investments in health information technology, personal health records.**

- **Maintenance and development of patient-centered medical homes.**

- **Nurse call lines.**

- **Programs designed to ensure prescription drug safety.**

- **Quality programs that would qualify a plan for accreditation.**

- **Quality research and reporting designed to educate providers.**

- **Value-based purchasing initiatives, including pay-for-quality.**

- **Wellness and prevention programs.**

Source: Vesely, R. "Detail Oriented: Medical Loss-ratio Definition Needed by HHS." Modern Healthcare, 40.21 (2010): 8-9.