

Hospital Payment Systems: Will Payers Like the Future Better than the Past?

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Outline

- Why payers care
- What employers want
- What insurers want
- Private sector payment experiments
- Scenarios for hospital payment systems

Why Payers (and Hospitals) Care

- Employers as a whole pay 30% of hospital bills, same as Medicare
- Hospital payments make up 34% of claims paid by employer-sponsored insurance
- Hospital costs most responsible for recent health care cost growth
- Health care cost growth rates are unsustainable

What Employers Want

- Low premiums and satisfied workers
- Simplicity
 - ◆ Discounts off charges \neq conversion factor of RBRVS
 - ◆ Too many prices, poor FFS incentives \Rightarrow per diems, DRGs, capitation
 - ◆ Efficient marginal cost of bundles that add value
 - ◆ P4P is a pathway, to help identify and reward better providers
- Transparency
 - ◆ Publicly available and comparable quality, use, and cost data
 - ◆ Need publicly available data to convince workers

What Insurers Want

- Insurers are middlemen, with valuable specialized knowledge
 - ◆ Risk pooling + care management, claims processing
- Enhance and preserve their ability to add value for non-specialist buyers
- Simplicity
- Transparency *if* data are privately held

Private P4P experiments

- 35 private, 2 CMS
 - ◆ 7 employer led, 28 insurer led
- Not budget neutral
 - ◆ Incentives 1-15% off old base
 - ◆ Some hospitals reward CEOs or staff
- Wide variation

Limitations of current experiments

- Risk adjustment for outcomes measures
- Measurement difficulties
 - ◆ Coding differences affect “denominators”
 - ◆ Definition/Locus of control for some process measures
- Scale of bonuses relative to effort, IT required
- Outcomes of experiments not reported (yet)
 - ◆ Incentive structure proprietary ?
- Small and rural hospitals are special cases
- Low resource providers at disadvantage
- Tiering now may be premature

Scenarios for future hospital pricing systems for group insurance

- Nirvana
- Continued small steps
- Rejection of publicly reported comparative performance data

Scenario 1: Nirvana

System-wide performance based payment

- Good performers earn cost of efficient provision of valuable services
 - ◆ Consistently poor performers wither away
- Base price system would be DRGs or capitation
 - ◆ Need discipline to encourage only those new technologies that are cost effective
- Performance differentials eradicated
- In effect, hospitals would bid by DRG

Barriers to Nirvana

- Local hospital market power vs. typical group buyers
 - ◆ Coordination with Medicare essential
- Scale of performance-based experiments today; 1-3% of 15% of spending
 - ◆ Spread of QI to unmeasured domains?
- Prohibitions on gain-sharing

Scenario 2: Continued small steps

- Early evidence encouraging, may spread in some markets
 - ◆ BUT, measured hospital quality not essential for marketing in most markets
- Concrete examples of quality and efficiency gains will be compelling, if revealed enough to be replicable
- Professional ethics will also drive improvements, but slowly
- Medicare's decisions are still key

Why Medicare and Private Group Buyers need each other

- Medicare can compel measurement and reporting
- Private sector can experiment more freely about payment incentives and comparative data exchange

Scenario 3: Rejection of publicly reported comparative performance data

- Employers are desperate, and Plan B has arisen
- Health plans support keeping quality and efficiency data proprietary
 - ◆ Market share-based discount strategy is profitable
- People may not really want efficiency
 - ◆ Some local hospitals might close
 - ◆ Elites and patients differ on “waste”
 - ◆ One person’s cost = someone else’s income
 - ◆ Easily led into fear and rejection of change

Conclusion

- Performance-based payment system will occur only if we find will and leadership
- Do we want equity?
 - ◆ If so, then we must make system more efficient, performance-based
 - ◆ If not, then we can muddle along and most of us will have access for most of the first half of this century
- Provider-led revolution is possible...