

# ITUP

---

# Health Reform Newsletter

By Adam Dougherty, MPH

September 2009

## Value Based Purchasing

Research has shown that one of the biggest drivers of cost growth in the health care system is centered on the volume-based, fee-for-service payment structure. Under the current arrangement, the extent to which providers are paid is generally based upon how many services they can deliver in a workday; the more high priced billable services, the more reimbursement.

Numerous pilot programs in both the public and private sector have experimented with new payment models in an attempt to promote quality of care through value based purchasing. Several programs in Medicare have attempted to incentivize quality through required hospital data reporting and denying payment for “never” events like hospital acquired infections and certain readmissions. The Medicare Physician Group Practice (PGP) Demonstration has shown marked success by creating pay-for-performance incentives to coordinate care across physician groups and meet quality of care benchmarks. Organizations like Kaiser Permanente, Intermountain Health Care, and others have shown significant strides in care



**ITUP**

**INSURE THE UNINSURED  
PROJECT**

The ITUP Health Reform Newsletter Series will give our constituents a deeper look at some of the major policy implications being considered over the coming months. The newsletter will analyze topics more comprehensively than the accompanying ITUP blog, and include useful resources for reference. It will also investigate the effects of potential legislation specifically towards California and its unique demographic and social landscape.

coordination and quality through provider payment incentives and salaried physicians. Insurers are also increasingly turning to medical home models for treatments of chronic diseases, where treatments and referrals are coordinated through the medical home to improve the quality and value of care.

The health reform proposals aim to more aggressively promote innovative payment models, specifically through modifications to Medicare and Medicaid. Below are the most popular incentive structures being discussed.

#### *Accountable Care Organizations (ACOs)*

ACOs are groups of providers (hospitals, physician groups, and other caregivers) that are jointly responsibly for the quality and cost of health care services and are subject to shared payment bonuses or penalties. Where HR 3200 provides \$2B for an ACO pilot project, the Finance Committee's America's Healthy Future Act allows groups who voluntarily meet certain criteria to be recognized as ACOs and be eligible for incentive bonuses in Medicare. These provider groups could include primary care physicians, specialists, nurse practitioners, physician assistants, clinical nurse specialists and others determined by the Secretary of HHS as appropriate. In addition, CMS would assign Medicare beneficiaries to ACOs based on their past service use.

#### *Pay for Performance (P4P)*

All the proposals include strategies to promote innovative payment mechanisms that focus on quality targets and care coordination. HR 3200 and the HELP Committee bill allow the Secretary of HHS to utilize these strategies through the Public Plan Option. The Finance Committee bill instead links payment to quality through the existing Medicare program. Building on the successes of the pay-for-reporting quality data programs in Medicare, the bills call for Medicare to pay for actual performance on these measures. Incentive payments would be based on health outcomes and other quality measures, applied to both qualifying hospitals

and physicians. The bills will also take the first steps towards value-based purchasing by establishing quality reporting programs for long-term care facilities, rehabilitation centers, and hospice. All three proposals stress the importance of public availability of quality data and require reporting websites to develop more user-friendly platforms. The Finance Committee's Innovation Center within CMS would test additional payment reform to incentivize quality over quantity.

#### *Payment Bundling*

The two comprehensive proposals, HR 3200 and the Senate Finance Committee draft, establish voluntary three-year pilot programs for hospitals, physician groups, and post-acute entities interested in assuming shared patient responsibility in return for financial incentives. In the programs, one bundled Medicare payment would cover the acute care inpatient and follow-up outpatient hospital services, physician services, and post-acute care for a qualifying patient. The patients in this program are those with a mix of acute and chronic conditions, a mix of surgical and medical conditions, high volume conditions, or those conditions with significant variation on readmission and spending rates. If evaluation of the program finds significant success, the Finance bill would require the Secretary of HHS to submit an implementation plan to establish its permanence in the Medicare program by 2018.

#### *Partial Capitation/Global Budget*

The House bill contains a provision for the secretary of HHS to experiment with payment mechanisms through the Public Plan Option. One of those provisions is up-front 'budgeted' payment, which may incentivize efficient use of the dollars allocated. As this could result in lower quality care (since the less amount used on care, the greater the profit) the bill suggests a partially capitated structure, where providers would be paid by a combination of fee-for-service and a fixed amount.

# Underwriting Reform: Premium Rating Variation

One of the central elements of health reform is making health insurance affordable, especially when you are sick and need it the most. Under current law, insurance companies are able to perform a practice known as underwriting in order to avoid ‘costly’ individuals based on beneficiaries’ characteristics. Persons with pre-existing conditions, employees with hazardous jobs, and older individuals are all subject to much higher premiums or no coverage at all because they are considered high risk. Those in the individual insurance market experience particularly severe underwriting exclusions. Whole departments of health insurance companies are devoted to this practice. Health reform attempts to modify these practices by setting levels for premium rating. Below are rating variation provisions from the two most comprehensive pieces of legislation.

Rating variations	HR 3200	Finance Committee Draft
Age	Max. 2:1	Max. 4:1
Lifestyle (Tobacco Use)	N/A	Max. 1.5:1
Family status	Allowable	Max. 3:1
Allows variation by	Community/Geography	
Prohibits variation by	Gender, health status, pre-existing conditions	
Max. variance	N/A	7.5:1

## ABOUT THE AUTHOR

Adam Dougherty is the Research Director at Insure the Uninsured Project. He is currently stationed in Washington, DC acting as the ITUP correspondent on federal health reform. In addition to this newsletter, Adam also maintains a daily blog with updates on reform efforts from the nation’s capital and can be accessed at: [www.itup.org/blog](http://www.itup.org/blog)

Setting explicit rating ratios is a useful way to control premium variation and establish affordability for certain high-risk groups, but unfavorable cost shifting can result. For example, if the maximum variance for age is relatively low (as is seen in HR 3200) we will see younger individuals subsidizing a substantial amount of the premium costs for older and more frequent users of health care. Due to their relatively good health, the young already have the highest rates of being uninsured as the costs of coverage often outweigh the perceived benefits. Any substantial cost shift from older to younger individuals would add to the costs of coverage expansion efforts, as more of the uninsured are young adults. A higher ratio, one closer to the Senate version perhaps, would limit the potential shift of health care dollars from the young to the old, though affordability concerns for older age groups and sicker individuals would need to be carefully mitigated through the premium subsidies of the Exchange.

Value based purchasing, delivery system reform and care coordination should be used in combination with premium rating ratios and the Exchange’s subsidies of premiums and cost sharing to improve affordability and quality for high frequency users.

The Finance Committee’s rating variation for lifestyle choice sets an important social

precedent for prevention and wellness. This mechanism can prove troublesome, though, as it is conceivably much easier to elude a tobacco rating variation compared to one's age on an insurance application by simply not checking the "I use tobacco" box. In this case, a tax or fee at the point of sale for tobacco alcohol, soda, or certain food products may be more appropriate if the government is serious about addressing healthy lifestyles. Conversely, premium discounts for wellness programs, gym memberships, or even food purchases could prove useful in this effort. Revenue for financing the reform effort could be accessed through such fees on unhealthful products, though a majority of lawmakers have insisted that financing comes exclusively from within the health care system.

For more information and useful resource material visit [www.itup.org](http://www.itup.org)

Or contact us at:

Insure the Uninsured Project  
2444 Wilshire Blvd. Suite 415  
Santa Monica, CA 90403  
(310) 828-0338  
[info@itup.org](mailto:info@itup.org)

## *The Role of Prevention in Health Reform*

Prevention efforts are key to long-term cost containment and improved health outcomes, and insurance coverage is central for access to these services. Prevention currently accounts for only 2 to 3 percent of health care spending, though the reform proposals invest significant resources for future preventive interventions.

Below are excerpts from the Alliance for Health Reform report entitled "The Case for Prevention: Tales from the Field."

- The American Recovery and Reinvestment Act of 2009 provides **\$1 billion** toward prevention. Of this amount, some **\$650 million** will go for community-based prevention and wellness programs, and **\$300 million** to expand immunization programs.
- Implementing proven clinical smoking cessation interventions would cost an estimated **\$2,587** for each year of life saved, the most cost-effective of all clinical preventative services.
- Kaiser Permanente's ALL tertiary prevention program for high-risk diabetics is projected to save as much as **\$38 million** annually and avoid **8,000** hospitalizations when fully implemented.
- The Congressional Budget Office has **declined** to attribute savings to prevention provisions in leading health reform proposals.

The full report can be accessed here:

[http://www.allhealth.org/publications/Public\\_health/The\\_Case\\_for\\_Prevention\\_90.pdf](http://www.allhealth.org/publications/Public_health/The_Case_for_Prevention_90.pdf)