

## Section 1: Avoiding the Mistakes of the Past

One of the fundamental flaws in past and existing payment models within an insurance-based health care payment system has been the misallocation of risk between insurers, providers and consumers. With the advent of traditional managed care, theorists came to the correct conclusion that FFS leaves physicians in a riskless environment where they are shielded from the economic consequences of their decisions and indeed benefit from increasing costs to others. But the same theorists jumped to the wrong assumption for distributing the risk (discussed below). Because of that incorrect assumption, they formulated a concept of risk that alienated both consumers and physicians. Consumers were given limited choice in closed provider panels and through gatekeeping, while physicians found no clinical logic and the wrong risk in capitation. Given that lesson from managed care, when considering potential sustainable funding for Medical Homes, ideally one would find a reimbursement mechanism that delegates risk appropriately, while at the same time preserving patient choice.

Today, we find three major ways to pay for care. The table below lists them with their attendant incentives, organizational effects and effects on consumerism. They are:

1. Fee for Service
2. Capitation
3. Global Fees, Case Rates, for Episodes of Medical Care

Payment Mode	Core Incentive	Organizational Effect	Consumer Shopping Effect
Fee-for-Service	Increase volume	Favors fragmentation	Can only shop for individual services
Capitation	Decrease volume	Favors consolidation	Can only shop for "systems"
Episode	Decrease volume w/in episode, increase volume of episodes	Favors some consolidation... at the disease/procedure level	Can shop for "care packages" – relevant price transparency

In exploring the specific effects of each payment method, it is important to understand that the nature and apportionment of risk in each is different. How different types of risk are distributed amongst the three main stakeholders—patients, providers, payers—has profound implications on their incentives and actions.<sup>1</sup> As the recent financial crisis has shown, misunderstanding risk and how to adequately price and manage it can wreak havoc. This insight about apportionment of risk should guide policymakers in their deliberations of payment reform and help mitigate the negative effects of any proposed incentive scheme.

<sup>1</sup> For an in-depth discussion of risk, please see Appendix A – Discussion of Risk Bifurcation in Health Care, by Douglas Emery

Because many of the chronic conditions addressed in the ECRs are being addressed by others as well, finding measures to score physicians on those conditions was not so difficult.

The predictability of risk manifests itself through variation in the price of services and goods. The less predictable risk is, the greater the variation in prices, because those who have to bear that risk will demand adequate compensation. As study after study has shown, there is tremendous variation in the total price of care, not simply from region to region, but within regions throughout the country.<sup>vi</sup> However, that variation is neither one-dimensional nor homogenous.<sup>viii</sup>

Prior research reveals that it is possible to identify three types of risk that drive this underlying variation<sup>viii</sup>: the risk that any patient at any point in time will develop an illness, have an accident or generally require medical services; the risk that physicians, hospitals and other health care services providers will make the wrong decisions and follow the wrong treatment pathways in managing patients; and the risk that patients will make the wrong decisions in seeking care or

deciding upon which treatment pathway to follow. While there are clearly some inter-dependencies between these three types of risks, we believe that the function of each stakeholder in the health care system suggests the following pattern for an appropriate distribution of risks:

Type of Risk	Payer	Patient	Provider
Risk that a medical event will occur	80%	10%	10%
Risk related to choices made by patients	10%	80%	10%
Risk related to choices made by providers	10%	10%	80%

While creating such an ideal balance is likely to take time and many experiments, it is important for payment reform proponents to understand how their models will impact the distribution of risks in the table above, and it is just as important to understand how current provider, payer and patients incentives impact the distribution.

The patient’s portion of the risks will depend largely on their benefit design. For example, patients with high co-insurance will carry a significant portion of the risks that a medical event will occur, the risks related to the choices made by providers, and their own choices. Several experiments have shown that the choice of services is highly dependent on the price paid for the service—higher price leads to lower consumption.<sup>ix</sup> The risk created by patient choice is also manifest in what the Dartmouth University researchers have termed “preference-sensitive care.”<sup>x</sup>

There are many provider actions that create variation in total cost of care and create incremental risk. We know from many studies that there are significant defects in the

production of care services.<sup>xi</sup> These defects range from the seemingly benign—the failure of providing a recommended preventive screening—to the headline-grabbing tragedy—the graft of an incompatible blood-typed organ in a transplant patient. Other research has shown that demand for a specific treatment can be induced by the physician’s preference for a certain pathway, even when that pathway is not consistent with the patient’s needs.<sup>xii</sup> A well-designed payment model should shift the majority of these risks to providers.

Finally, to a certain extent, the likelihood of a costly medical event can be influenced by the actions (or inactions) of payers and purchasers. For example, the lack of patient education and activation might lead to more plan members becoming ill or acquiring a chronic disease. Similarly, creating barriers to accessing preventive care services or medication for the management of a chronic illness can greatly increase the severity of an episode of medical care. Importantly, and more simply, the risk that a medical event will occur is a core function of insurance, and the reason why consumers are willing to pay premiums. As such, it is the core risk that should be borne by payers and should not be shifted to the delivery system. A well-designed payment model should shift this risk to payers.

There are many factors in today’s health care marketplace that significantly increase these three risks, and therefore inflate the total price of care. One such example is in the incentives created by the benefit design of most health insurance programs (not least the Medicare program). For the most part, they continue to make the consumer almost completely insensitive to the actual price of care services, and distorts their choices.

Similarly, FFS places the cost of all health care utilization into the hands of the payer and distorts technical risk. And the combination of FFS and non-value-based benefit design is the reason why costs of care have continued to outpace inflation. Conversely, capitation places the cost of the variation caused by both probability and technical risks in the hands of providers. In addition, capitation creates an inherent conflict between providers and patients because traditional capitation requires providers to control for both probability and technical risk, while blocking the expression of choice by patients.<sup>xiii</sup>

No matter how well intended, the effort to capitate providers radically lowers the total choice sets for consumers. We argue that to the extent that Medical Home funding is based on capitation, simply relabeling those narrowed sets of consumer choice as Medical Homes won’t help at all. Consumers will ultimately rebel. If past is prologue, attempts to channel patients towards optimal care pathways that do not permit their choice utilities to be taken into account will likely fail.

The patient has an important role in helping to hold the delivery system accountable for variation in costs. Unfortunately, the efforts to maximize the patient role will require more than simply using incentives to “steer” patients to reengineered Medical Homes.