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The Role of Private Payers in Payment Reform

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In September, one of California's largest private payers, Anthem Blue Cross, joined 7 Los Angeles health systems in a new managed care contract with savings and risks shared among the payer and health systems. In a state where premiums have increased at a rate 5 times faster than inflation over the past decade, the new partnership aims to slow spending through mutual price control and clinical coordination among the narrow network of prior rivals, while offering employers and individuals lower premiums and zero deductibles.

This is the latest in an increasing trend toward joint efforts between private payers and delivery systems to control health care spending in major urban markets. Although policy attention has largely been focused on Medicare spending, private health care spending for populations younger than 65 years has quietly returned to 4% annual growth in the years after the recession, with coverage expansions under the Affordable Care Act potentially poised to steepen this trend.[1] Combined with the sizeable share of US health care spending deemed wasteful, slowing the rate of increase of health care costs becomes increasingly important.

In response, private payers are increasingly banding with delivery systems to move away from fee-for-service toward bundled or global payment contracts, with approximately 12 million covered lives in the United States now under private accountable care organization (ACO) arrangements.[2] Private ACO contracts mirror those in Medicare by giving physicians and hospitals a risk-adjusted budget and quality incentives for the care of a defined population of enrollees.

Yet private ACO contracts also differ from their public counterparts in important ways. First, global budgets from private payers tend to involve more risk—the prospect of claims in excess of the budget that do not garner full reimbursement—whereas most Medicare ACOs (the majority of ACOs in the Medicare shared savings program) have thus far been protected from risk. Second, delivery systems in private ACO contracts are more likely to receive a prospectively defined population of enrollees, enabling them to know exactly

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whose care they are responsible for before a contract year, whereas the majority of Medicare ACOs are assigned beneficiaries retrospectively based on the plurality of a patient's primary care spending.

In addition, ACOs in private contracts have several unique levers for cost control that are absent under public contracts. They have the ability to obtain price discounts through referrals to less-expensive physicians or hospitals since the negotiated price of a given medical service can vary substantially in the private insurance market (whereas Medicare prices are standardized). With the average age of privately insured populations in their 30s, clinicians serving these younger populations may find more opportunities for prevention and behavior change as compared with older populations. Moreover, with younger patients more likely to incur spending in the outpatient setting, investments in primary care and mental health may have more opportunities to generate savings than investments in the inpatient setting, where older patient populations receive a larger share of medical services.

Private payers are using other levers as well, such as reducing copayments for certain high-value services (eg, preventive care) and placing physicians and hospitals into preferred and nonpreferred tiers based on cost and quality—with lower cost sharing for the former. They are maintaining supply-side managed care techniques such as prior authorization and utilization review, but also adopting other demand-side incentives such as high-deductible health plans that attract enrollees through lower premiums. According to the National Center for Health Statistics, enrollment in plans with annual deductibles of at least $1250 for individual coverage and $2500 for family coverage increased from 17% in 2008 to 36% in 2014 for privately insured persons younger than 65 years.[3] In addition, private payers are creating narrower network plans to better dictate referral patterns, such as in California, Arizona, and Connecticut, and in some cases even purchasing or consolidating with delivery systems entirely, aligning incentives for cost and quality directly rather than through a payment contract.[4]

Even though they lack the scale of Medicare, examples of payment reforms initiated by private payers are increasing across the United States. In some states, such as Massachusetts, the largest private payers all began to move away from fee-for-service within a few years of each other. In other areas, the movement has been more gradual. The Massachusetts experience has offered a few initial lessons. Physician groups' responses to global payment can be varied. Some may focus on referral patterns, some on volume, and others on acquisitions and expansion. Incentives for quality can improve process measures rather quickly as was the case in Medicare Pioneer ACOs over the first 2 years.[5] In addition, initial savings on claims spending, reflecting meaningful behavior change, may be offset by shared savings under the budget and quality bonuses, such that net savings may take longer to realize.[6]

Despite its growth, private sector payment reform faces challenges. From the contractual standpoint, setting the budget growth rate for multiyear contracts can be difficult. Setting too low of a spending target may require clinicians to change practice patterns too much too soon, whereas high target spending may not provide enough incentive for behavior change and may delay delivery system reforms. From a market perspective, payers are facing

increasing integration among physicians and hospitals, which affords delivery systems more market power to bargain for higher prices or spending targets.[7] Surveys show that the proportion of independent physicians has declined below 40% in the United States, with consolidation in urban markets increasing particularly fast.[8] Private payers might respond by enhancing their own market power through acquisition, consolidation, or other means of growing their membership. In half of US states, the largest private insurer has more than 60% of the large group insurance market and most often commands the majority of the small group and individual markets as well.

On a broader policy front, private payers will also need to work with federal efforts to stimulate reforms in the private sector, such as through the Centers for Medicare & Medicaid Innovation's Multi-Payer Advanced Primary Care Practice and Comprehensive Primary Care Initiative.[9] In many states, private payer involvement is considered central to state-level payment reform. For example, Maryland's all-payer program requires the state to keep annual all-payer hospital cost growth to less than the gross state product growth (3.6%). In the State Innovation Models Initiative, 25 states have received $300 million from the Centers for Medicare & Medicaid Services, with another $730 million planned to stimulate new payment models that require coordination between public and private payers. These initiates range from testing established models in states such as Arkansas and Oregon to designing new models in states such as New York. The complexity of contracting across multiple payers and delivery systems can be formidable, requiring both technical expertise in budget design and risk dissemination as well as managerial acumen in bridging stakeholders, as exemplified by the Integrated Healthcare Association's experience in implementing episode-based payments in California.[10]

As millions of previously uninsured individuals begin to receive care under the Affordable Care Act and discretionary spending recovers after the recession, the need to slow private health spending may increasingly mirror that for public spending. Therefore, while still in its nascent stages, payment reform for the privately insured—the largest sector of the insured population in the United States—may become an increasing focus of health policy. Going forward, policies that encourage partnership between public and private payers might yield a favorable balance between regulatory and market-based approaches to slowing spending. Such coordinated efforts may also help physicians and hospitals merge delivery system reforms for patients across payers.

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