

## P E R S P E C T I V E

**Hot Potato Endgame**

No health-sector stakeholder wants to hold the hot potato of biomedical technology–fueled margin reduction.

by **Arnold Milstein**

**ABSTRACT:** Other stakeholders and events will influence whether health insurers' current postmerger prosperity will lead to U.S. health benefit programs that are predominantly sponsored by the private or public sectors. Large employers are encouraging three complementary health benefit innovations to improve the affordability and quality, or "efficiency," of clinical services: portable spending accounts, provider pay-for-performance, and tiered plans. If health insurers prefer private-sector health benefit sponsorship, they will need to implement these innovations robustly, despite the risks they pose to insurers' current but predictably temporary prosperity. Clinical efficiency gains can also sustain access to biomedical innovations for low- and moderate-income Americans.

**A**LL STAKEHOLDERS in the flow of health insurance dollars seek to improve their margin between income and spending. Facing steep rates of increase in medical costs, insurers pursued mergers that improved their bargaining power with customers and suppliers and that captured administrative economies. Both of these scale-dependent improvements increased barriers to entry. Insurers thrived; employers, workers, retirees, and taxpayers suffered. The "hot potato" of margin reduction had again changed hands.

James Robinson observes that margin improvements built on diminished competition are inherently unstable. Although predicting change in complex adaptive systems is difficult, his formulation of a two-scenario endgame for insurers is credible: rejuvenation via innovations that deliver affordability, quality, and access; or domestication in a world of publicly funded and specified health benefits.<sup>1</sup>

■ **Private-sector rejuvenation.** Large

commercial insurance purchasers—mainly private and public employers and union-administered Taft-Hartley trusts—are actively facilitating insurer rejuvenation. Despite their increased economic pain, most are predisposed toward market solutions and believe they can effectively manage health benefit programs. Reinforcing this predisposition are surveys indicating that employees value their employer as an ally in dealing with insurers and providers.

These facilitation efforts among purchasers center on three complementary approaches to improving the efficiency of health benefit spending: portable spending accounts, provider pay-for-performance, and tiered plans. By "efficiency," most purchasers mean the ratio of quality (defined ultimately as utility-weighted, health care-mediated gain in enrollees' health status) to cost-efficiency (defined as aggregate health benefit spending by employer and employee over the course of an acute illness episode or a year of chronic ill-

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*Arnold Milstein (Arnold.Milstein@mercer.com) is medical director of the Pacific Business Group on Health, cofounder of the Leapfrog Group, and a physician consultant at Mercer Human Resource Consulting.*

ness). Purchasers' three approaches fit within a simple model: (1) new insurance options that better reward providers for superior performance and enrollees for informed selection of high-performing providers and health risk-reduction behavior; and (2) a consequent compelling business case for direct and indirect providers of care to continuously reengineer, to capture efficiencies that offset the inflationary effects of increased demand for biomedical innovations and population aging.<sup>2</sup>

■ **Portable spending accounts: the blunt instrument.** Most large employers intend to add higher-deductible plan options paired with tax-advantaged health reimbursement accounts (HRAs) or newly enacted health savings accounts (HSAs). Early reported yields have been favorable: They include higher rates of health risk-reduction behavior and price-conscious service substitutions such as generic drugs and ambulatory surgeries. Most report an initial reduction of five to ten percentage points in premium growth compared with the concurrent or preceding trend, net of any reduction in plans' actuarial value. These reports have not been confirmed by health services researchers.

Few large employers regard spending accounts as stand-alone vehicles for continuous improvement in health benefit efficiency. More than half of health benefit spending is for sicker enrollees, who rapidly exhaust their spending accounts and exceed out-of-pocket plan limits. These enrollees are also least amenable to switching to new plans. In addition, the RAND Health Insurance Experiment documented that giving consumers blunt incentives to avoid care impairs health because few can distinguish useful from useless clinical services.<sup>3</sup> Finally, stimulating provider efficiency capture via spending accounts requires usually unavailable comparisons of provider cost-efficiency. Most large employers have not strongly motivated their enrollees to select spending accounts, preferring to monitor small-scale tests of their impact on health insurance trend, quality, and employee relations, especially for sicker enrollees.

■ **Pay-for-performance: the “you go**

**first” stand-off.** Long-established, cost-efficiency-based, pay-for-performance (“P4P”) programs among health maintenance organizations (HMOs) include capitation payment, fee-for-service withholds, and bonus programs. Partly in response to purchasers' leadership, more than sixty quality-based P4P programs have been recently implemented, mostly by insurers. While evidence is inconclusive on whether quality has improved, many attribute this to a lack of coordination among insurers, leading to divergent provider performance measures or insufficient incentives. Some purchasers remain optimistic about P4P, although its uptake remains stuck in a “you go first” stand-off.

Most providers are wary of programs funded by reduced annual base payments or explicit penalties for poor performance. The first attempt by the Centers for Medicare and Medicaid Services (CMS) to initiate a budget-neutral program with Premier drew a minority of eligible hospitals and skepticism from the Office of Management and Budget (OMB). Purchasers and plans facing steep cost increases are equally wary about “going first” by paying more to current high performers. Purchasers with core businesses that sell clinical performance improvement services and technologies are understandably more enthusiastic. Four Leapfrog employers in New York and a GE-led group of purchasers in four communities have attempted to end the stand-off via programs in which purchasers share with providers the actuarially estimated savings from high quality. However, neither program has been applied by insurers to their insured enrollment that accounts for most insurer payments.

Some programs are nearing the size required for adequate salience to providers. One is sponsored by the market-dominant Blue Cross plan in Hawaii. In California, Pacific Business Group on Health (PBGH) employers sparked a program that includes all major managed care plans except Kaiser. After a three-year stand-off, the program was initiated by the Integrated Healthcare Association (IHA), an alliance of HMOs and their medical

groups, activated by shared concerns about managed care's declining image and enrollment. Although quality bonus pools will amount to almost \$100 million for 2004 medical group performance, as a percentage of individual physicians' total revenue it remains far below the 10 percent believed necessary to trigger robust improvement efforts. The PBGH and the Leapfrog Group now advocate adding provider cost-efficiency measures to P4P programs, to justify larger bonuses.

■ **Tiered plans: the oligopoly-challenged precision tool.** While many regard portable spending accounts as the defining feature of consumer-directed health plans, the predominant form is tiered benefit coverage based on the quality or cost-efficiency rating of the provider, medication, or personal health risk-reduction programs selected by enrollees. The majority of tiered plans continuously vary consumers' cost sharing on their selections at the point of care, although some fix it annually. Examples include a lower premium or deductible in exchange for a year-long enrollee obligation to use providers in the top-rated tier exclusively. "Narrow network" forms have generated percentage savings in the mid-teens.<sup>4</sup> In some cases, tiered plans are combined with spending accounts to further intensify consumers' value-consciousness.

Tiered plans may represent the best hope for insurer rejuvenation because they simplify employees' identification of better-value selections and spare insurers the risks of unproven provider-improvement hypotheses or perceptibly reducing providers' fees. However, insurers' margins mainly depend on nontiered options; many worry that tiered plans will alienate providers and trigger fee increases or withdrawal from plans less sensitive to provider performance. Another challenge is that valid service line-specific quality and cost-efficiency measurements of individual providers and their transformation into P4P or tiered plans that ensure adequate access usually require pooling of claims data across insurers. Pooling stirs concerns that it may compromise insurers' confidential negotiated unit price advantages. In markets such as Massachusetts

and Missouri, where insurers overcame these concerns, some oligopoly providers have refused to participate in performance-tiered plans or insisted on measurement or tiering methods that improved their tier placement. This has kindled purchasers' calls for stronger antitrust regulation.

■ **Double endgame.** The insurer endgame of rejuvenation or domestication will likely be resolved by unpredictable events and other stakeholders that are indifferent to market solutions. These include U.S. economic growth rates, labor markets, providers, legislators, antitrust regulators and courts, and especially insurers' willingness to risk their inherently unstable new prosperity for a nondomesticated future. The insurer endgame is one element of a broader societal endgame also offering two alternatives: large continuous efficiency capture via robust clinical reengineering; or limiting biomedical technology's bounty to the rich. To avoid social divisiveness, more allies will likely join purchasers' quest for clinical efficiency. To avoid domestication, insurers must more robustly support this quest, especially via tiered plans that are highly sensitive to provider performance differences.

#### NOTES

1. J.C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 11-24.
2. Aggregating research on current static savings and quality improvement opportunities, purchasers discern capturable improvements of fifty percentage points in quality reliability and thirty to forty percentage points in per capita health care spending. Arnold Milstein, Pacific Business Group on Health, Witness Testimony, Senate Committee on Health, Education, Labor, and Pensions, 28 January 2004, [labor.senate.gov/testimony/milstein.html](http://labor.senate.gov/testimony/milstein.html) (16 August 2004).
3. A.L. Siu, "Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans," *New England Journal of Medicine* 315, no. 20 (1986): 1259-1266.
4. Samuel Ho, PacifiCare Health Systems, testimony before House Committee on Ways and Means, Hearing on New Frontiers in Quality Initiatives, 28 March 2004, [waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=135](http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=135) (16 August 2004).