THE COLD WAR OVER HEALTH PRICES: THE VALUE-BASED CARE GAP AND STEPS FOR EMPLOYERS TO MAXIMIZE PLAN VALUE WHILE REDUCING EXPENSES

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The long-term struggle over the price of health care services between providers and payers is a tale as old as time. On one side, providers want to preserve the status quo, fee-for-service payment (FFS) system, which triggers unnecessary treatment and wasteful health care spending.

Meanwhile, payers have been consistently pushing new payment models that attempt to tie spending with results. Collectively, these models are often referred to as "value-based care" (VBC) or "alternative payment models."

In 2020, 40.9 percent of all health care payments in the U.S. were paid through some form of VBC model – an all-time high – according to the Health Care Payment Learning & Action Network (LAN).

Traditional Medicare and Medicare Advantage plans were the main drivers of this achievement, as 85 and 62 percent of their payments, respectively, were value-based.

Meanwhile, with only 49 percent of payments tied to VBC, employers and commercial payers lagged significantly behind Medicare. The survey did not measure the difference between self-insured employer plans and large commercial plans like UnitedHealth, but employer VBC payments are likely lower than the LAN survey suggests.

This gap translates into real-world disparities between Medicare and group plans including:

- Group plans pay hospitals double the Medicare rate for inpatient services and triple the rate for outpatient services;
- Inpatient hospital prices for groups grew 42 percent from 2007 to 2014, while physician prices for inpatient care grew 18 percent;
- Employer dollars spent per employee for healthcare increased twice as fast as Medicare after the ACA was passed in 2008.

THE REASONS FOR THE VBC GAP

The chief causes of the VBC gap have nothing to do with a lack of trying from within the self-funding industry and boil down to basic principles of market position and bargaining power.

At the highest level, self-funded groups must lease provider networks through one of a few national carriers, which impose mandatory FFS rates and prevent plans from steering patients to better value in-network providers or directly contracting with outside providers.

A 2013 antitrust lawsuit against a California-based provider network, Sutter Health, provided an up-close example of how these practices work. The plaintiffs accused Sutter Health of using coercive contracting practices to require group plans to penalize (either directly or through forfeited discounts) participants for using non-network providers or risk being completely frozen out of the in-network rates.

One of the contract provisions at issue was:

> Sutter Health shall require each group health payer accessing Sutter Health providers through the [health plan] network to actively encourage members obtaining medical care to use Sutter Health providers … If Sutter Health or any provider learns that a payer … does not actively encourage its members to use network participating providers, … Sutter shall have the right … to terminate that payer's right to the negotiated rates … [The] terminated payer shall pay for covered services rendered by providers at 100% of billed charges until … Sutter reasonably believes that the payer does in fact actively encourage its members to use network participating providers …

Anti-competitive network language like this is commonplace and generally legal; Sutter Health won its case.

Unless a plan is willing to cut all network ties (which has its own drawbacks), most group plans must tolerate all-or-nothing network agreements. The bargaining power of group plans in these arrangements today is akin to one person trying to negotiate Apple's terms and conditions.

Provider demands underpin these one-sided networks agreements. Increasingly-consolidated provider chains are the main source of high prices and resistance to VBC. Today, nearly 90 percent of all U.S. metro areas are "highly concentrated" in terms of provider competition.

For context, the U.S. soda market between Coke and Pepsi is also considered "highly concentrated." Large providers leverage their monopolization of regional markets to demand higher reimbursements and one-side contract arrangements from the networks, which then offset the costs upon group plans.

Medicare has always counteracted these forces because of its market position as America's largest health insurer (by enrollees) and political power. That is a major reason why Medicare has historically paid lower prices than groups plans. In recent years, though, the disparity between the two has accelerated because Medicare has gradually deployed VBC reforms that have helped curb rapidly rising health care prices.

Providers cannot do much to stop Medicare's VBC efforts aside from lobbying Congress. Meanwhile, group plans must tolerate unilateral network agreements or find alternative solutions that may increase the risk of balance billing on plan members.

By this point, it might seem impossible for group plans to overcome coercive network agreements and provider monopolies – especially for mid-to-small-size employers. There is light on the horizon, however. Group plans and employers can still contain health costs and boost coverage with a balance of available VBC solutions and thoughtful plan design.

SOLUTIONS AVAILABLE FOR EMPLOYERS

The solutions that help employers contain group plan expenses and increase the value of coverage come in two flavors based on whom they target.

The first category of "supply-side" interventions seeks to change providers' incentives to increase prices.

The second category of "demand-side" solutions targets participants' incentives to choose more efficient care through benefits design and education. Supply-side solutions include many traditional VBC models such as capitation, bundled payments, etc., and can be highly effective in combatting wasteful provider practices, especially unbundling and upcoding.

In the self-funding space, employers who implement supply-side solutions typically agree to prepay providers, often on a per employee per month (PEPM) basis, for the care. Direct primary care (DPC) – where an employer directly contracts with a primary care physician practice that provides comprehensive treatment to eligible employees for a set fee – is probably the most widespread VBC solution among employers today.

Primary care is hardly the only type of medicine where employers can experience significant savings; bundled payments may enable employers to reduce health expenses for certain complex treatments.

For example, recent research by the RAND Corporation showed that self-insured employers save up to 11 percent of health by switching to bundled care services for complex operations – including total knee and hip replacement, spinal fusion, and bariatric weight loss procedures.

Aside from the financial benefits, many supply-side solutions can also boost employee satisfaction with the plan since it usually increases low-cost access to necessary care.

As discussed above, network contracts often block employers from employing these solutions. Employers should carefully examine their network agreement and weigh their own comfort level prior to implementing most VBC solutions.

Aside from networks, participants not utilizing prepaid DPC services or other VBC services can be a financial risk for employers. This can be counteracted by making employees aware of the program and reducing the number of participants enrolled in the program to those who will actually use it.

Additional compliance considerations dependent on the specific VBC program and group plan may also exist and should be analyzed on a case-by-case basis.

A practical consideration for employers interested in DPC, bundled payments, or other supply-side solution is whether the provider contract includes two-sided risk factors.

In other words, employers may want to consider VBC arrangements that financially penalize the provider for poor-quality care and reward them for improved-quality care. These carrot-stick arrangements are already popular with public payers and can help better align plan costs with health outcomes and care quality than PEPM and other set fee arrangements. They also are generally more adaptable to patient demands and surges in care that have become a mainstay in the COVID-19 era.

Next, while supply-side solutions are effective, providers still often cave to patient demands even in the face of a financial penalty. This is why it is crucial for employers to consider the value of health care when designing benefits. A simple way that employers can do this is by tying cost-sharing to the value of specific treatments, which then nudges participants to utilize more clinically and cost-effective health care.

The Phia Group incorporates some of these demand-side nudges into its own plan, such as waiving cost-sharing when a generic alternative exists for a brand-name drug or using urgent care over emergency departments for non-emergent conditions.

Other models have been developed by public health researchers and can already be seen in Medicare Advantage plans and on the ACA Exchanges. Specifically, the "VBID-X Model" offers a good starting point for plans to reference when tailoring cost-sharing to the value of certain services. The basic framework of the plan design is built upon the below principles:

- Favor services with the strongest evidence-based and external validation;
- Favor services that are more responsive to cost-sharing;
- Favor services with a high likelihood to be high or low-value (e.g., services with the least nuance in value are the easiest to implement);
- Considering how the plan design features intersect with related reforms and initiatives (e.g., favor services already rewarded under value-based payment models);
- Focus on areas with the most need for improvement;

- Consider equity, adverse selection, impact on special populations, and the risk pool.

The designers of the VBID-X were able to use these principles to increase the actuarial value of a group plan's coverage without increasing the actual plan costs. Importantly, designing plan benefits based on value is significantly less likely to conflict with network agreements and is the easiest way for employers to decrease plan expenses without decreasing coverage.

Overall, as rapidly rising prices impact employees through rising premiums and deductibles, participants are likely to demand better value coverage. Beginning to implement VBC payment arrangements and high-value plan design can help employers take control of their future health care costs now. ■

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Micah attended college at Oklahoma State University in Stillwater, Oklahoma, graduating with a B.A. in Broadcast Journalism. He earned a joint Juris Doctor and Master of Public Health degree from Boston College Law School and Tufts University School of Medicine, respectively, where he focused on health law and rising health care costs. After law school, Micah worked briefly as an attorney representing harassment and personal injury clients. He is currently licensed to practice in the Commonwealth of Massachusetts.