THERE IS NOW A FUNDAMENTAL FLAW THAT THREATENS EVERYBODY'S HEALTH CARE, AND A SOLUTION

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"Medicare [alone] is well on its way to bankrupting the nation" (Robert Reich, President Clinton's Labor Secretary).[1]

Worse, there is now a fundamental flaw that threatens everybody's health care in the U.S., including Obamacare, Medicare, Medicaid and employee health benefits. It results from a profound factual change that has slowly taken place over the last 50 years.

"In the past 50 years, chronic disease replaced acute disease as the dominant health problem:"[2]

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[1] Reich, Critical Care, *NYT Book Review* (Sept. 6, 2009).

[2] Halstead Holman, "Chronic Disease—The Need for a New Clinical Education," *JAMA* (Sept. 1, 2004), p. 1057.

- “Chronic disease is now the principal cause of disability and use of health services and consumes 78% of health expenditures [now 86%, detailed below].
- “The differences between acute and chronic disease are substantial.
- “Acute disease is episodic….Chronic disease is continuous.
- “the nature of care changes…. Because of the many facets of a chronic illness, management is best provided by a coordinated team of health care professionals (e.g., physician, case manager, patient educator, social worker) whose members can deploy the appropriate service when needed. Over time, the patient may see many physicians and other health care professionals.
- “continuity and integration of care are essential.
- “the role of the patient changes. Because the patient must usually engage in unending treatment, make behavior changes, and adjust to consequences of the disease, the patient inevitably becomes a principal caretaker.
- “the sites of care change. Chronic disease treatment occurs primarily in ambulatory settings and consists largely of changes in medications and behaviors. It can often be provided well by different members of the care team in the home, schools, and community centers or by telephone, e-mail, or group educational programs.”

The fundamental flaw is that what has not changed is how insurers and providers are paid and incentivized.

The dominant method of paying insurers and providers is short-term for acute care: 1-year rating for insurers and Fee-for-Service (FFS) for providers.

Short-term payment incentives are inherently in conflict with the long-term interests of the chronically ill.

None of the Republican, Democrat and think tank health care proposals identify, let alone fix, this fundamental flaw in how we pay and incentivize providers and insurers for the chronically ill. This paper elaborates how this fundamental flaw threatens everybody’s health care, and presents new directions of a solution

The Fundamental Flaw

The fundamental flaw, as noted, results from the fact that chronic disease has replaced acute disease as the dominant health problem. This year the U.S. will spend 86% of $3.5 trillion in health care spending on people with

chronic conditions, $3 trillion.[3] Medicare's chronic disease's toll is even higher: 94% of spending is for people with two or more chronic conditions.[4]

For patients with heart disease, diabetes and most chronic diseases, the episode of care is usually the rest of their life. The chronically ill need good outcomes for both the "near-term and longer-term," and "outcomes [and payment to providers] should be measured for periods long enough to reveal the sustainability of health and the incidence of complications and need for additional care."[5]

The fundamental flaw that threatens everybody's health care is that the incentives for insurers facing 1-year rating cycles by necessity are short-term, and, in turn, use short-term provider reimbursement models that are contrary to the long-term interests of the chronically ill, so that:

(1) Insurers and providers under Fee-For-Service (FFS) are not paid if they improve chronically ill patient outcomes over the rest of their lives.
(2) Worse, they are punished, as their revenue drops when a patient's condition improves. Insurers under risk adjustment are paid less because their payment codes for healthier patients are less. Providers are paid less under FFS because healthier patients require fewer services and thus no revenue.
(3) Instead, insurers are incentivized to focus on upcoding, e.g., Medicare Advantage Hierarchical Condition Category (HCC) codes,[6] and through adverse selection to avoid sick patients.

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3 *AHRQ Multiple Chronic Conditions Chartbook 2010*, p. 7.

4 *CMS Chronic Conditions Among Medicare Beneficiaries Chartbook 2015*, Table 13.

5 Michael Porter, "What is Value in Health Care?," *NEJM* 2477 (Dec. 23, 2010), Appendix 2, pp. 2-3.

6 See, e.g., Walsh, "Scheme Tied to UnitedHealth Overbilled Medicare for Years," *N.Y. Times* (Feb 17, 2017)(litigation alleging United Health coding manipulation cost Medicare billions by upgrading HCC codes).

(4) Providers are incentivized under FFS to provide more services, resulting in an estimated 30%-40% of care that is unnecessary and to focus on upcoding DRG and other payment codes to increase revenue.

Accordingly, everybody's heath care is threatened because every government and private health benefit program, and all of the Democrat, Republican and think tank proposals are fundamentally flawed because their short-term insurer and provider payment incentives are inherently in conflict with the long-term interests of the chronically ill that now account for 86% of health care spending.

What is needed, but doesn't exist, is a new provider payment system that pays for treating the chronically ill for good outcomes, on a recurring basis over time that aligns the interests of the chronically ill, their provider team and payers over the long-term. Then providers also would be strongly incented to learn effective new medical treatments much sooner than the 17 years studies show it usually takes effective new treatments to be widely adopted.

Solution? New directions of payment are needed, such as the following among many that are likely to be developed.

The Long-Term Payer Incentive Payment Solution for the Chronically Ill 86%

1-Long-Term Payers

Are there any long-term payers with a financial interest that aligns with long-term interests of the chronically ill? As noted, it is not insurance companies subject to 1-year rating. They are short-term payers.

Are there any long-term payers, financially interested in better health outcomes and lower costs, not just this year, but usually for the rest of life for the chronically ill 86%? The three most prominent are:

- Self-insured employer and union health benefit programs that have low turnover. They cover about 100 million under 65 and 10 million with Medicare supplements, about 2 ½ times the number covered by Medicare FFS.[7]
- Kaiser Permanente and similar organizations with a low turnover and long-term commitment to their members.
- Medicare FFS, which covers about 40 million (not Medicare Advantage because they face 1-year insurance rating).

2-Recurring Long-Term Provider Payments for Chronically Ill Outcomes

The needed breakthrough is to have a long-term time horizon for the chronically ill patient and provider. Thus the opportunity is to develop and implement with long-term payers a recurring payment system for providers treating the chronically ill. Not a single bundled or FFS payment, but recurring payments for good outcomes year after year for the rest of life.

How to rigorously predict and put a dollar value on future patient outcomes, costs and savings?

3-Have Actuaries Calculate the Recurring Payments and Determine the Metrics

What has never been done to our knowledge is to use those who are specially trained to predict future outcomes, costs and savings, and to choose the best metrics to use (and not use) – actuaries. Obviously actuaries do many things in health care, e.g, insurance rating for one-year cycles, risk adjustment, Accountable Care Organization bonuses, evaluation of wellness programs' ROI.[8] But actuaries have not done this type of payment calculation and selected the patient's metrics to use as far as we know – yet.

Actuaries have a special expertise in determining what patient metrics to use and not use, such as BMI, total cholesterol, LDL, A1c, biomarkers, guidelines, exercise,

[7] Haislmaier & Gonshorowski, "Health Insurance Enrollment," *Heritage Issue Brief* (July 26, 2017), p. 1. The 10 million with Medicare supplements is the author's calculation.

[8] See, e.g., Am. Acad. Actuaries, Issue Brief: Risk Assessment and Risk Adjustment (May 2010).

nutrition, genomics, new tests and other big data, and to then calculate the initial and recurring provider payments for a chronically ill person's outcomes, costs and savings over time.

Actuaries also have a major advantage with long-term payers like self-insured employer and union plans, Kaiser and government programs when it comes to putting a credible dollar value on their calculations. These payers are used to relying on actuaries to put dollar values on pensions and many things.

In addition to actuaries, others are sure to enter this entirely new market of developing and implementing initial and recurring payments to providers for outcomes treating the chronically ill over the long-term.

How would this work in practice?

Example #1. Diabetes, as is well known, is epidemic in the U.S. and worldwide. What is not well known are the stunning long-term costs of diabetes, which not only involves ongoing expensive drug costs but down the road often leads to heart disease, kidney failure, amputations and blindness. United Health reported "this one disease [diabetes] accounts for 40% of all health care claims for our customers."[9]

Assuming HbA1c is actuarially determined to be an accurate predictor of health care costs, and that:

- a patient before treatment had an HbA1c of 9.0 that was actuarially determined for a long-term payer to cost $15,000 annually,
- after treatment had an HbA1c of 6.5 that was actuarially determined for this payer to cost $7,500 annually and
- the 6.5 level was maintained for four years,

then a recurring incentive payment to the provider team for this outcome computed as a percent of payers saving could be as follows:

[9] Tully, "Can United Health Really Fix the System?," *Fortune* (May 20, 2013), pp. 187, 194.

	TREATMENT YEAR				
	1	2	3	4	5+
Diabetic patient HbA1c	9.0	6.5	6.5	6.5	6.5
Expected Annual Health Cost	$15,000	$7,500	$7,500	$7,500	$7,500
Payer Savings Relative to Year 1		$7,500	$7,500	$7,500	$7,500
Incentive Payment to Provider Team @ 20% Savings		$1,500	$1,500	$1,500	$1,500
Net Payer Savings Relative to Year 1		$6,000	$6,000	$6,000	$6,000

Thus, unlike the current short-term payment models, this shows the long-term breakthrough that aligns the chronically ill person's needs for the rest life with the long-term payer's financial interests and justifies a recurring incentive payment, say every year, if the outcome is that the person maintains an HbA1c of 6.5 or lower.

Example #2. Consider a self-insured employer that paid an average of $75,000 for people with Coronary Artery Disease and $67,000 for diabetics. If providers were paid to reverse or stop these conditions, now and for the rest of their life, they would have powerful incentives to continuously find the latest and best treatments that improve these chronically ill patient outcomes and thereby also share the savings – not just once, but periodically over the patient's lifetime.

Legal Flexibility. There is also good legal news. For decades efforts to change provider reimbursement with capitation and risk have been hobbled by the fact they are usually treated as a form of insurance. The good news is this method of provider reimbursement innovation is not insurance and does not require having an insurance license, working with licensed insurers or worrying about 50 states different insurance laws. Thus innovation can happen fast and much less expensively.

Virtual Integrated Delivery Systems. It also creates the opportunity to establish, quickly, a new type of delivery system nationally and internationally – Virtual Integrated Delivery Systems that pay providers for results, not volume, over time for chronically ill patients. The key is separating how providers are paid, for outcomes

rather than putting providers at insurance risk which subjects them to 50 states' insurance regulation. Freed from the barrier of state insurance regulation, doctors can do what they do best and be paid for patient results and not as insurers.

How to get this enormously politically and technically complex task of developing, revising and implementing enough of about $3T in provider reimbursement to have a real impact, soon?

Getting It Done Significantly Soon

The Administration, Congress, states and the private market should take two actions:

First, take to the bully pulpit to advocate and facilitate this long-term payer incentive payment solution for the chronically ill that account for 86% of health care spending.

Second, develop and implement new reimbursement and incentive systems with a long-term focus on the chronically ill in public and private health benefit programs.

Conclusion

The fundamental flaw that threatens everybody's heath care is the short-term insurer and provider payment incentives that are inherently in conflict with the long-term needs of the chronically ill that account for 86% of health care spending.

The solution is to develop and implement with long-term payers a new system of long-term provider and others payment incentives and methods that align with the needs of the chronically ill, such as actuary determined predicted recurring payments for improved outcomes and savings over time in the private market and by government.