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Beyond the Public Plan:
A Pathway to Contain Costs and Transform the Delivery System

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SUMMARY AND OVERVIEW

The current focus of the health reform debate is rightfully beginning to shift to the need to transform the delivery system to contain the long run growth in costs. Although much of the debate still focuses on the role of a public plan, this ignores the need for fundamental change. None of the options on the table will transform the delivery system. If passed, the best the current proposals could do is to expand enrollment and perhaps contain federal costs, but on its own the public plan will be unable to make the delivery system more efficient.

To control health care costs, I propose a publicly chartered major risk pool, or MRP, that will allow plans to pool risk, thereby eliminating the need for wasteful underwriting and selective marketing costs. Participation in the MRP by both providers and insurers is voluntary. It can be combined with any public option in an exchange implemented at the federal or state level; it can even work without a public option. After a brief transition period, the MRP requires no federal funds and will not be "on budget." By allowing private plans to play a role in a transformed insurance and delivery system, the MRP can be politically attractive to a broader constituency than any of the current proposals.

The MRP addresses a key component of comprehensive health reform: restructuring the delivery system. It is not a simple reinsurance pool that *reimburses* health plans for high cost claims. Instead, it creates a *reformed payment system* for both inpatient care and outpatient chronic care that will encourage efficiency and quality. The MRP will cover inpatient and similar short but expensive episodes, as well as chronic illness management. Its new payment approaches will achieve the efficiency goals promised by proposals for hospital medical staff-focused Accountable Care Organizations, but in an organizationally more plausible manner. Hospitals and physicians who focus on inpatient care and voluntarily form Care Delivery Teams will receive bundled episode-based payments, but the MRP will pay providers regardless of whether they belong to a Care Delivery Team, although at less attractive rates. Providers in these teams can use their bargaining power to charge the primary insurers more than the MRP pays. The MRP's payments for monthly chronic illness management will give health plans and primary care physicians the incentives, flexibility, and information to more effectively compensate clinicians for the care they deliver and coordinate. By being publicly chartered, but independent of Congress, and by allowing options for all players, the MRP will be able to sidestep the ability of special interests to block change.

RECOMMENDATIONS

1) **Establish a publicly chartered major risk pool (MRP) to cover (a) all inpatient and interventional episodes of care and (b) chronic illness management.**
    - The MRP should have a publicly appointed, representative board with long terms and independence.
    - The MRP should be permitted to use Medicare fee schedules and have rapid access to linkable Medicare claims data.
    - Health plans that participate in the exchange should be required to buy into the MRP at fair demographic rates within geographic areas.

- Health plans and self-insured employers outside the exchange should be permitted to purchase coverage from the MRP at demographic rates similar to exchange-based plans but in separate risk pools.

2) **Create Care Delivery Teams (CDTs) composed of inpatient care providers and the facility where they practice, and pay the CDTs for inpatient episodes on a bundled basis (analogous to diagnosis-related group payments (DRGs)).**
   - Payments should be based on the average charges of those CDTs with better than average outcomes, adjusted for regional price variations.
   - Physicians and hospitals not in CDTs should be paid at Medicare rates and "balance billing" of health plans or patients should be prohibited.
   - Transition funds should supplement Medicare payments while new CDTs are forming in an area.
   - CDTs may negotiate with health plans for payments above those offered by the MRP.
   - CDTs and health plans should use their expertise and discretion to combine services and products that will achieve the best outcomes for their patients.
   - For a small administrative fee, health plans and self-insured employers outside the exchange should have access to MRP rates to pay CDTs for episodes of care.

3) **Require health plans and Medicare to deliver claims data to the MRP to facilitate cost controls.**
   - The MRP should base its chronic illness management payments on plans that achieve above average outcomes for their patients, adjusted for local prices.
   - Health plans may provide additional data to demonstrate their patients are sicker than average or have better than average outcomes.
   - The MRP should pay separately to cover experimental services and products for people enrolling in studies that will be in the public domain.
   - The MRP should link claims data and provide plans with HIPAA-compliant data for analysis.
   - Health plans may use such data to identify and seek out physicians who provide high value care and through a trusted intermediary negotiate mutually acceptable rates and new fee schedules to join preferred networks.

4) **Establish new Medicare Advantage Reinsured (MAR) plans that offer Medicare-Advantage-type coverage to Medicare beneficiaries.**
   - MAR plans will have less incentive to select against Medicare by buying reinsurance from the MRP.
   - The MRP should cooperate with Medicare to determine appropriate risk-adjusted payments for MAR plans.

THE CURRENT OPTIONS UNDER DISCUSSION

Although the debate in Washington, D.C. and nationally continues to focus on whether a public plan option should be a component of health reform, attention is beginning to shift to the ability of any of the reform proposals to slow the rate of growth in overall health care expenditures. Current public plan proposals focus largely on expanding the population with coverage and on controlling federal costs. The proposal I am putting forward here is compatible with coverage expansions and the outlines of the overall reform package that appears to be taking shape. It provides, moreover, a way to transform the system to slow the growth in *all* health care costs. By offering realistic ways to slow the long-term rate of growth in costs for everyone, it makes possible the additional federal expenditures needed to ensure coverage for everyone.

All discussions of a public option (and many proposals without a public option) envision some type of an exchange allowing individuals to access a wide range of insurance options with transparent price and actuarial information, uniform rules about basic benefits, guaranteed issue and renewal clauses, premiums not based on health status, and risk adjustment across plans. None of these exist in the current market and establishing an exchange will be a significant improvement, with the following caveats. In contrast to the relationship the Centers for Medicare and Medicaid Services (CMS) has with Medicare Advantage plans, management of the exchange should be independent of that of the public plan. There should also be a requirement that everyone enroll in some plan with subsidies for those for whom this would be too expensive. All of these are good ideas and all are compatible with the proposal below. The weak links in the exchange component of the current proposals are (a) the risk adjustment mechanisms and (b) the determination of the basic benefit package. The proposal below addresses those two aspects. It does not, however, include all the details needed for comprehensive health reform—it is intended as a supplement to ideas currently on the table. Rather than a blueprint for a specific hybrid vehicle, it is a description of how a gas and electric engine can work together to make a more efficient vehicle of any variety. This proposal is intended to change the way we think about health reform.

By way of background and context, the two current public plan options originally debated are sometimes labeled the "strong" and the "weak" versions, referring not to the strength of the proposals, but the power of the public plan. As ideas have moved from concept to legislative proposals, characterizing the public plan proposals as "strong" and "weak" is increasingly misleading and less relevant. But to have an informed stake in the debate, it helps to understand the underpinnings of the current proposals as well as their strengths and weaknesses.

The "strong" version of the public plan, as originally advocated by Jacob Hacker,[i] among others, is a near clone of Medicare made available to those under age 65. Its critical aspect is its use of Medicare's buying power in setting fees for provider services, thereby keeping down the cost of coverage relative to private plans without such leverage. Not surprisingly, both providers and private insurers vigorously oppose the idea. They see the plan as inevitably leading to a "Medicare for all" single payer system because by passing on the lower fees, the public plan will attract an ever-increasing share of the population. The proposal has other important features that promise improvements in quality, such as shifting the relative

fees paid for primary care or identifying medical innovations worth implementing, but these require legislative action that has so far eluded policymakers in the Medicare program. Most importantly, even if passed a "strong" public plan will not on its own transform the health care system.

The current version of the Tri-Committee House bill (H.R. 3200) includes a national public plan that initially builds upon the Medicare fee schedule (offering 5% more than Medicare) and begins with Medicare participating providers as its network. It does not, however, require that providers agree to be in the public plan in order to maintain their Medicare eligibility. This uncoupling markedly weakens the ability of the proposed public plan to force fee concessions, especially by primary care physicians who are in high demand and would have little reason to accept the new fee schedule of the public plan. This version of a national public plan is unlikely to lead to a single-payer system, regardless of the rhetoric used.

Medicare already has the ability to force down physician fees. This may shift costs to other payers or reduce provider incomes, but it has no impact on improving efficiency in the overall use of services. A good argument can be made that the current Medicare fee structure contributed significantly to the unpopularity of primary care as a profession. Yet, other than constraining the federal share of physician payments, Congress has failed to generate payment reforms that would slow the overall growth in costs. When legislative changes must be budget-neutral, modifications to the *status quo* are opposed by those interest groups fearing a loss of revenue. The recent reaction of specialists to proposed fee increases for primary care is a case in point. Even competitive bidding for durable medical equipment raised vigorous opposition from certain quarters. The problem with the "strong" plan, on its own, is not its economics but that any measures it will need to take to reduce overall rate of growth in costs will inevitably be hamstrung in the U.S. political environment.[1]

A "weak" public plan, as proposed by Nichols and Bertko,[ii] would compete with private insurers by being transparent, non-profit, and well-intentioned. Such a plan could formally be public, or it could be a cooperative. It would follow all the rules required of private plans and not leverage Medicare's buying power. If the failures of the current payment system were simply excess profits and high management salaries, this could be a useful strategy. Such a plan will, however, need significant public funding to get started, and if public, will face public contracting, employment, and other constraints. Public enterprises are not known for being nimble; a public plan competing with private ones is unlikely to succeed in the medical care environment's rapidly changing technologies, practice problems, and the need by payers for ever smarter ways to process data. An alternative to the "build your own" version of the "weak" plan is what many states have developed for their employees—a public entity that designs benefits, creates provider networks, and carries risk, but contracts

[1] Single payer advocates fail to recognize that for these reasons the ultimate version of a "strong" plan—the single payer model—might work in a parliamentary system, but not here. Some analysts have argued that MedPAC (the Medicare Payment Advisory Committee) should be given authority to make significant changes in Medicare payment structures and regulations. The willingness of Congress to delegate this much authority is a key test of the potential ability of the strong public option to transform the system. If Congress gives up its implicit line by line veto of the types of changes MedPAC has been suggesting, then the strong public option could be a very attractive policy. If Congress is unwilling to grant the plan such autonomy, then at best the plan will be able to control federal expenditures largely by cost shifting.

out the administration to private insurers or administrators. Either way, a "weak" public option will not be very effective in disciplining private plans though competition.

This is not to excuse the current behavior of private health insurance plans. They spend enormous amounts on marketing and underwriting and they often make money by denying claims or creating such cumbersome claims processes that some providers and patients just walk away from pursuing legitimate payments. They design their provider networks to be unattractive to those most in need of care. They have failed to be the innovators they claimed to be. Profits should reward firms that increase value, not those simply able to exercise market power. Market advocates believe competitive forces lead to better outcomes. This is only true, however, if markets are structured appropriately—which is not the case for health care in the U.S. Nevertheless, my proposal will allow them to function far better than is now the case. It reduces the problems of risk selection when small groups and individuals are enrolled by providing necessary new structures. More importantly, it adds features that help to reorganize the delivery system in a way that no other plan is addressing.

The original "strong" version, which linked Medicare and public plan participation by providers, does not figure in the Committee versions of the bill. It may therefore be most useful for this discussion to term the options the "national plan"—i.e., a federally controlled public plan with nationwide scope—and "local alternatives" that include state-based public plans and cooperatives. The former maintains the vision of a national structure for coverage and administration; the latter addresses the desire for new, transparent and publicly-focused health plans that can provide alternatives to what are seen by some as the evils of the health insurance industry. The legislative proposals currently on the table still need to address the problem of risk selection. They also need mechanisms that will address the twin goals of cost containment and delivery system reform. The following proposal responds to these needs.

THE MAJOR RISK POOL

I propose an alternative that avoids the weaknesses of both existing public programs such as Medicare and the current operation of private insurance plans, while building on the strengths of each. What I propose goes beyond simple reinsurance and creates a new payment system. This proposal is *not* intended to be comprehensive; expanding coverage to everyone will require mandate and subsidy provisions beyond the scope of this paper. This proposal *is* designed to lay the foundation for the transformation of the delivery system to increase quality while enhancing efficiency, and to do so in a viable way in the context of the American political system. As it incorporates an important role for private health plans and choices for providers and patients, it may attract a broad political constituency.

The new alternative I propose should be a publicly chartered, but not a publicly controlled, entity. It needs enough independence from direct Congressional oversight to avoid being hamstrung by special interest groups who may be threatened by specific decisions. It should have a publicly appointed board with long terms, similar to the Federal Reserve Board, with high expectations for transparency. Aside from some start-up funding, the plan will be self-financing. Without a long-term draw on public funds, limiting Congressional oversight should be politically tolerable.

The primary role of the new entity will be to manage a major risk pool. The pool will not itself offer insurance directly to consumers, but instead offer reinsurance for hospitalization and chronic care—the most expensive components of health care—to health plans. The plans, which may be private insurers, HMOs, self-insured employers, or new public or cooperative entities, build on the risk coverage of the pool and offer comprehensive packages for their enrollees. From the perspective of the enrollee, the risk pool is in the background. It simply makes it possible for insurance to be more affordable. In my book, *Total Cure: the Antidote to the Health Care Crisis*,[iii] I use the term "Universal Coverage Pool" (UCP) to describe an entity with most of these functions. The comprehensive model for health reform that I call "SecureChoice" in *Total Cure* incorporates mechanisms for income-based subsidies and other features that may or may not be included in the current discussion. In this discussion, I use the term Major Risk Pool, or MRP, to describe this more narrowly construed function.

The rationale for the MRP is two-fold. (1) By pooling risk for the most expensive and financially precarious components of health care, it spreads risk broadly and markedly simplifies the role of exchanges in dealing with risk selection. Allowing health plans to buy coverage at simple demographically-determined rates eliminates a substantial portion of administrative and marketing expenses, significantly lowering the cost of obtaining this necessary coverage.[2] (2) By paying in new ways for the services it covers and providing broadly-based but identity-protected data, it will transform the delivery system.

Hospitalization and chronic illness costs account for over 60% of all medical costs incurred by privately-insured individuals. Some hospitalizations are totally unpredictable accidents and thus technically insurable, but many are related to chronic illness. Paradoxically, health insurers seek to avoid risk. People with chronic illnesses have higher than average costs and thus are the enrollees health plans like to avoid. Plans incur substantial underwriting, marketing, and administrative costs attempting to avoid such people—those who are actually most in need of coverage. Such costs add no societal value. Even if plans do not actively avoid high risk enrollees, biased selection occurs simply through the geographic location of plans and selective inclusion of providers in networks. Well-meaning plans often get saddled with the high risk enrollees. Addressing the legitimate concerns plans have about adverse selection will markedly reduce this waste.

All proposals for coverage expansion include the concept of an exchange through which enrollment will occur, independent of a person's health status. The exchange is supposed to adjust premium payments across plans to compensate for differences in risk so that patients can make their choices based on quality and cost, independent of the health care needs of those enrolled in each plan. Such risk adjustment is conceptually simple to describe, but extraordinarily difficult to implement, especially via prospective adjustments to premiums. Without going into the details, the underlying problem is that most medical costs are attributable to a small number of people; this is true even *within* narrowly defined diagnostic groups such as patients with congestive heart failure, cystic fibrosis, or HIV/AIDS.

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[2] In essence, this is modified community rating; premiums would not vary by health status. It is a policy choice whether premiums should rise with age. Doing so will allow much lower premiums for younger people, who comprise the majority of the uninsured, and will therefore make it easier for them to be covered. Income-based subsidies can offset the increased burden this approach would impose on the elderly and enhance equity.

Predicting who will need expensive medical care is very difficult; even after patients begin care, predicting which cases will be very high cost is almost impossible.

Designing a way to transfer dollars to offset selection differences is difficult even in the best of circumstances. When the transfers must occur *among competitors*, and may make the difference between profitability and loss, those plans experiencing higher profits due to unmeasured favorable selection will claim the losses of others are due simply to inefficiency. If some plans are public or socially oriented and seek to do the "right thing," they are likely to attract higher risk enrollees than their private competitors. The exchange is charged with risk adjustment, but if it cannot accomplish this quickly and accurately, the public or local alternative plans will go out of business and be seen as inefficient failures.

The best way to effectively address such selection problems is through a reinsurance pool that spreads risk across a wide range of—preferably all—plans. Other proposals for reinsurance pools have surfaced over the years. For example, Senator John Kerry proposed a reinsurance plan in his 2004 Presidential campaign. The House Tri-Committee bill includes a reinsurance plan for early retirees that would reimburse the health plans for 80% of the enrollee costs between $15,000 and $90,000. However, this is largely intended as a subsidy for employer-based plans with a large number of early retirees.

The MRP, however, differs markedly from reinsurance that simply reimburses insurers after they have incurred unusually high costs for certain individuals or groups. Classic reinsurance generates no incentives for more efficient behavior by either providers or the insured and, by offloading risk to a passive "reimburser," it actually blunts incentives for insurers to attempt to manage high cost cases. As described below, the primary purpose of the MRP is to change payment incentives for providers, and it can be most effective in doing so by attracting the high cost cases.

The MRP will bear most of the risk associated with the presence of chronic illness, thereby reducing the fear insurers face when approached by individuals and small groups. Establishment of the MRP *could* be coupled with a mandate that everyone have coverage for hospitalization and chronic illness, either (indirectly) through the MRP or through a private or public plan with comparable coverage. Such a mandate will further lower the average cost of coverage by bringing in those who believe they are healthier than average. An individual mandate, however, must be accompanied by federal subsidies making such a mandate affordable to people with low incomes.[3]

By not providing insurance directly to consumers, the MRP sidesteps the need to define a basic benefit package. Thus, it can work as effectively with a national plan offering uniform

[3] This distinction offers another important political advantage. If the mandate for coverage is only for chronic illness and hospitalization, the cost of the mandated coverage and necessary subsidies is much lower than for a comprehensive benefit package that includes many desirable, but less critical services. For example, vision care is certainly desirable, but including it in the mandated benefit package will reduce market pressures for lower cost vision services. If the concern is about ensuring access for those with very low incomes, it would be far better to offer separate programs for those add-on services with a different subsidy program. As will be discussed below, the distinction being made here is not between primary and specialty care. Much of the care needed for managing chronic illness, which is covered by the MRP, is delivered by, or coordinated through, primary care practitioners.

benefits as it can with local alternatives adhering to state-based mandates. The MRP will typically pay a bundled amount for the care of chronic conditions or episodes of illness, leaving it up to providers to decide exactly what services they need to use. Thus, it will rarely need to make decisions about paying for specific items and services, avoiding the fraught choices Medicare faces in making coverage decisions. Both issues attract lobbying by provider groups and manufacturers of specific products. Benefit packages, moreover, are often subject to state insurance mandates that may be difficult to override at the federal level. In contrast, the MRP simply provides funds for certain broad types of illnesses (major acute and interventional care requiring a facility and care for chronic illnesses). It is up to the clinicians involved and the health plans providing the wraparound coverage to decide what services and products will efficiently achieve the best outcomes. [4]

The health insurance industry has already expressed its willingness to have legislation with guaranteed-issue requirements coupled with an individual mandate for coverage. While this is a good first step, such a proposal leaves many details to be addressed. Carriers may still have substantial ability to tinker with their benefit design or network of providers to avoid high cost enrollees. Adhering to guaranteed-issue, moreover, does nothing to reduce selective marketing and other administrative costs that add little value to the coverage provided. A more effective way to pool risk across plans is therefore needed. The MRP does this.

The most important function for the MRP, however, is in transforming the delivery system. It is not a simple reinsurance pool that *reimburses* health plans for high cost claims. Instead, it creates a *reformed payment system* for both inpatient care and outpatient chronic care that will encourage efficiency and quality.

Paying for Inpatient Care

For inpatient care (including major interventional procedures provided in ambulatory settings[5]) the MRP will be a direct payer offering two options, illustrated in Figure 1: One is simple fee-for-service and diagnosis-related group (DRG)-based payment at Medicare rates, comparable to what the national public plan option contemplates. This will provide some pressure for providers to participate in Care Delivery Teams, yet allow a viable alternative for those who do not.[6]

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[4] These issues are discussed in much more detail in *Total Cure*. In brief, the incentives of the proposed system will generate a demand by clinicians for unbiased information on what interventions work most effectively. Such comparative effectiveness (and related) studies might be funded federally, but past experience suggests interest groups may attempt to influence the topics addressed or even the publication of such reports. The public availability of detailed data from the MRP will, however, provide the raw material for independent analysts to develop the observational evidence base on what works well. *Total Cure* describes how such information would be kept in the public domain. To help in the assessment of new drugs and devices, the MRP would offer separate coverage for all patients willing to participate in appropriate trials and/or registries.

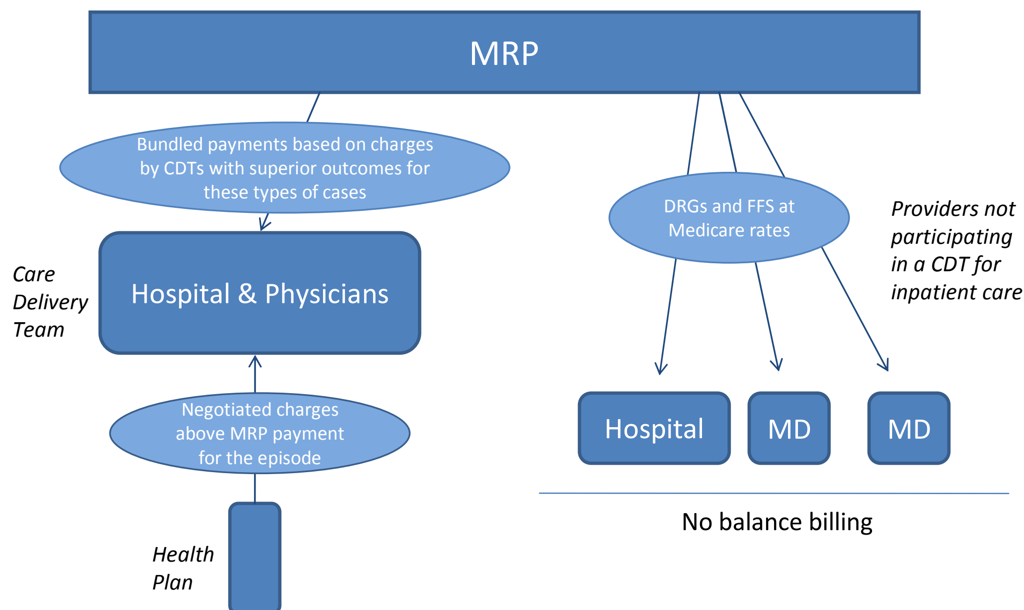
[5] An increasing number of services can be shifted from inpatient to ambulatory facility settings. The bundled payments should be focused on the nature of the intervention, not the licensure of the facility. An initial rule of thumb is that if the episode involves a facility fee and/or anesthesia, it will be considered a major interventional procedure.

[6] As described below, these Medicare-based payments may be substantially subsidized during a transition period allowing the Care Delivery Teams to form.

The second payment option is a bundled amount for an episode of care including not just facility and physician costs, but also appropriate pre-admission work-up and post discharge follow-up care. This bundled payment will be made to newly organized Care Delivery Teams.

The Care Delivery Team (CDT) would be a new entity, willing to accept responsibility for delivering or paying for all the necessary care during an episode. CDTs will be composed of those physicians and hospitals voluntarily choosing to participate. The CDTs will establish their own governance rules, thereby addressing physician fear of excessive hospital power. Clinicians need not be employees of the CDT; they might be paid on an hourly, per service, or other basis. They may also share gains (and losses) realized by the CDT.

Figure 1: Payments for Inpatient Care to Care Delivery Teams (CDTs) and Non-Participating Providers



Unlike the Accountable Care Organizations proposed by Elliot Fisher and others at Dartmouth,[iv] CDTs will focus only on physicians whose work is largely *within* the participating facility. That is, the CDT should be at risk for what goes on during the inpatient episode (and to a small degree, subsequently) but not for the initial decisions to admit the patient. Those decisions are often complex and involve multiple parties; they are addressed below in the context of how the MRP pays for chronic illness management. CDTs, moreover, need not include all the physicians practicing at the hospital—just the willing participants. For patients not reinsured by the MRP, physicians (and hospitals) involved in CDTs will continue to be paid under conventional arrangements.

Providers choosing to stay with fee-for-service will be paid Medicare rates by the MRP for its enrollees, and as with Medicare patients, cannot charge more (balance bill) if they choose this method. In contrast, CDTs are free to set their own prices for each type of episode of care, or expanded DRG. The MRP will pay them an amount, after adjusting for regional input cost differences, equal to the average prices set by those CDTs nationally with *better than average outcomes* for similar patients. Currently, most hospitals set their charges well above what Medicare pays. Some health plans pay these charges, but most have negotiated rates well below "list price" but usually above Medicare rates. If the CDT charges more than the MRP payment, some or all the difference could be paid by whatever insurer the patient has chosen, based on negotiations, much like those occurring today.[7] If the CDT charges less than the MRP payment, the CDT can keep the difference or share it with the health plans to attract more patients.[8] This pricing flexibility will make joining CDTs attractive to clinicians.

Medicare fee schedules for physicians are usually below those of private payers. Legislation establishing the MRP should therefore incorporate a transitional subsidy allowing the MRP to increase its fee-for-service-based payments to those providers at hospitals that have not formed CDTs. The total amount of the subsidy needed will be positively related to the growth in MRP enrollment and negatively related to the speed with which CDTs are formed. The availability of "balance billing" to the primary insurer (not the patient) and the inherent efficiency and gainsharing aspects of the bundled payment will encourage CDT growth.[9] The transition subsidy should be phased out over time.[10]

The MRP will not immediately have good measures of risk-adjusted patient outcomes to determine which CDTs provide above average quality care. Consistent with its public charter and commitment to transparency, the MRP will engage panels of patients and professionals in identifying what outcomes matter to patients and how these outcomes can be measured. This could be done using existing data or new data to be separately collected,

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[7] Although negotiations would occur between plans and CDTs, it is likely they will focus on the simple question of what multiplier should be used with the MRP payment. CDTs (and plans) could save significant contract negotiation and administrative costs by focusing on the "markup" rather than on separately pricing all the components of care.

[8] This discussion does not focus on how people choose health plans. One can easily imagine simpler systems than our current employment-based approach, and *Total Cure* discusses how that might work. The MRP, however, is designed to work with currently preferred policy options based on retaining, at least in the interim, employer-sponsored coverage. Most workers would be in specific plans selected by their employers, usually the large ones availing themselves of the ERISA exemption. Most individuals and small employers would obtain coverage through an exchange that fosters competition among plans based on roughly comparable benefits. These plans, which may include publicly sponsored options playing by the "weak plan" rules, or co-ops, would exert pressure on CDTs charging more than the MRP payment to demonstrate to enrollees that their extra costs are worth the price. A "strong public plan" leveraging Medicare rates might choose to use that option rather than buying into to MRP.

[9] This would also require changes in the law, the discussion of which is beyond the scope of this paper.

[10] The exact nature and funding of the transition supplement will be subject to substantial political negotiation. It may be entirely federal, or may include some recharges to the health plans buying into the MRP. The MRP is not designed to be a fee negotiator—in the long run it simply sets the payments to the CDTs based on averaging the charges reported by the superior quality CDTs, and uses Medicare rates for non-CDT payments. Differences between what CDTs want to charge and what payers are willing to offer are negotiated between CDTs and plans. The uniform fee adjustment aspect is designed to quickly get the system up and running. Keeping the MRP out of fee negotiations will allow the market to force changes that special interest groups would otherwise resist.

such as patient self-reports on functional status. Until outcome data are collected, each CDT's outcomes for each expanded DRG category are assumed to be average, so the MRP's payment is based on national average charges, adjusted for regional price differences.

Health plans will attempt to steer patients preferentially to CDTs with lower prices. CDTs will gain margin and/or patients as they bring their costs down relative to the MRP payment. In most instances, CDTs will reduce costs not by targeting the share paid to their physician members, but by reducing the inputs used in an episode of care and by avoiding complications. For example, orthopedic surgeons in CDTs are likely to agree on a much smaller set of prosthetic devices, allowing the CDT to negotiate more effectively with manufacturers. Radiologists in the CDT will identify outpatient providers whose CT and MRI scans are reliable enough that new ones do not have to be routinely done. Members of the CDT will collaborate to design and enforce "best practices" amongst themselves to minimize infections and complications. This will often involve more creative and empowering use of both clinical and non-clinical staff.

Under HIPAA-compliant data use agreements, the MRP will make available its data to researchers and other analysts developing risk models and other analytic tools (with appropriate protection of pricing data to avoid price fixing by CDTs). CDTs will use the results of such analyses to identify new processes leading to higher quality at lower cost. As more and more CDTs improve their processes, overall costs will fall as excess resource use is squeezed out of the system. Manufacturers, from pharmaceuticals to device makers, will find increased demand for cost-reducing technologies that enhance or maintain quality.

Covering Chronic Illnesses

By paying directly for all types of inpatient and interventional episodes (except purely discretionary ones such as cosmetic surgery already excluded under most public and private coverage), the MRP does not need to determine whether the episode represents an acute rather than chronic condition. Chronic illness management, however, is often deeply intertwined with acute care. An office visit initiated for an ankle sprain may also involve a blood pressure check and ongoing monitoring of a patient's diabetes. Thus, a different payment model is needed for outpatient services, recognizing that these services are delivered by both primary and specialty care providers.

As illustrated in Figure 2, each month the MRP will transfer to those health insurers buying its coverage an amount for the chronic illness management (CIM) of their enrollees with chronic illnesses. These risk-adjusted CIM payments will be based on the average costs incurred by those plans or groups of providers achieving better than average outcomes for their patients, again adjusted to reflect regional input costs but not utilization differences. Although the monthly payments per case are set in advance, the number and mix of patients with chronic conditions in each health plan is adjusted monthly.[11] To be reinsured, plans must share with the MRP their billing and other data files to allow it to determine eligibility, cost updates, and the quality of care. These data already include enough information to

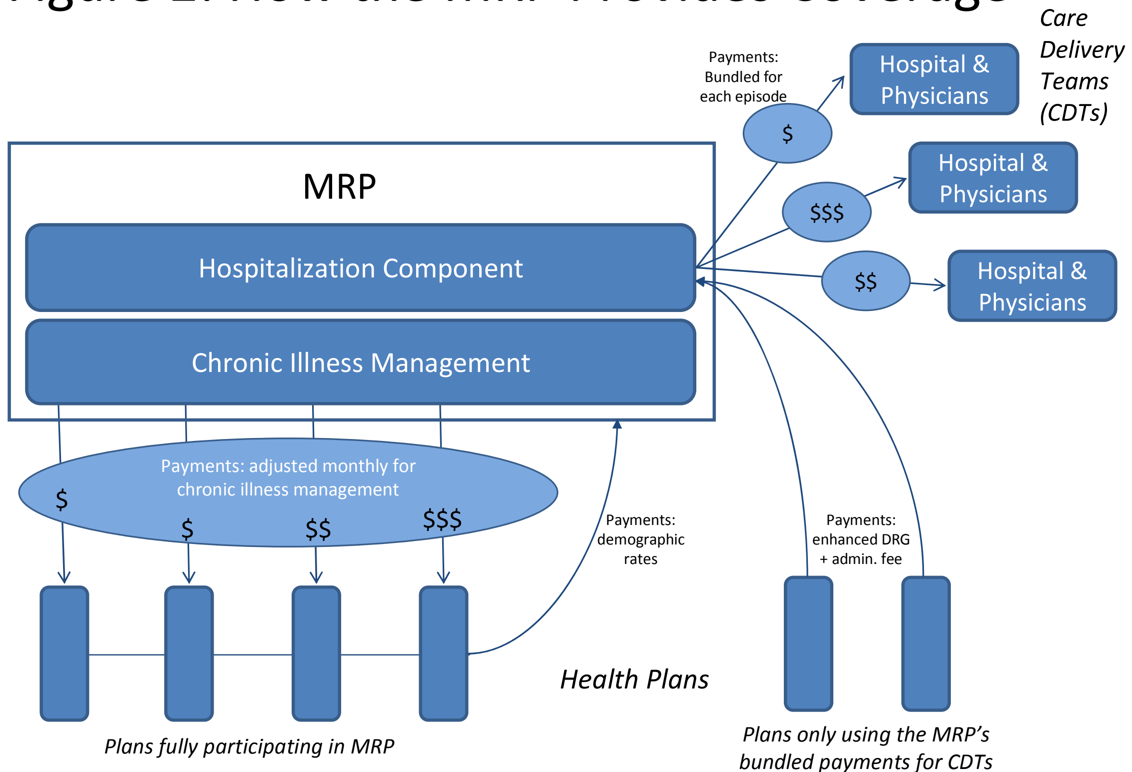
[11] By paying directly for inpatient episodes and paying plans monthly for chronic illness management as conditions are identified, the MRP addresses the risk-adjustment issues that an exchange would otherwise need to consider. Concurrent adjustment is much better than anything that can be done prospectively, yet it retains most of the important incentives for plans and providers to improve care.

know which patients have what chronic conditions. As with the inpatient data, the MRP will make available linked data for all enrollees. The MRP will assume outcomes are average until plans can demonstrate that their providers have outcomes that are better than average, leading to continuous development of better measures and better data. Some providers or plans will claim to have sicker patients within a chronic condition. The MRP will add appropriate risk adjustments as the plans forward the clinical risk factors (usually laboratory findings). These adjustments simply reallocate payments among plans within risk cells; unlike the risk adjustment with Medicare managed care plans, there is no residual payer. As health plans submit such indicators to the MRP, the pooled data will become even more valuable for quality measurement and improvement.

Health plans could choose to bundle together the experience of all the patients for whom they are purchasing reinsurance, or subdivide that experience by patients associated with subsets of providers, such as specific multispecialty groups or physicians in the area surrounding a certain hospital. In this manner, physicians providing higher quality care can be recognized and rewarded for their expertise.

This approach is roughly equivalent to the outpatient component of Fisher's Accountable Care Organizations. As with the CDT model for inpatient care, it is highly feasible to establish because it does not require participation by all physicians in an area. It can easily include non-physicians, such as psychologists and physical therapists, who can impact the need for hospitalization and yet do not have medical staff privileges.

Figure 2: How the MRP Provides Coverage



Effective management of chronic illness is likely to reduce the need for expensive hospital episodes, but it may require transferring resources to outpatient settings. As the MRP is carrying the risk for both types of care and simply needs to break even, such transfers are to its advantage. For most chronic conditions, hospitalization reflects poor, rather than high quality care. Consistent with Fisher's approach, the MRP payments for high quality chronic illness management care may be higher if admission rates for those patients are lower. Unlike a budget neutral system, efficient physicians will have the potential to negotiate more attractive rates with health plans based on their initial performance, not just further improvements.

There is good evidence that effective primary care can reduce costs and improve quality. It is also generally recognized that primary care physicians are undercompensated for their time and coordination of care. Health plans, either directly or through contracts with groups of providers, will be able to develop new payment arrangements that better reward primary care providers. Unlike a public plan seeking to establish new national schedules that may find the development of such fee schedules stymied by the lobbying of those who might lose, independent health plans will have much more flexibility.

The MRP and the Plans

The MRP will operate largely "in the background," offering a superior form of reinsurance to all plans—private or public. Ideally, health plans offered through the exchange would be required to participate in the MRP; but participation can also be structured as an option rather than a mandate, especially for people insured outside the exchange.[12] No inpatient provider will be forced into CDTs that accept its newly structured payments. Reinsurance, however, will make coverage much more affordable for the sick. Eliminating the need for underwriting and reducing the costs of selective marketing will even reduce coverage costs for the healthy. The real payoff, however, will be through increasing numbers of patients choosing more efficient providers. This will occur in several ways.

Innovative private or public plans will use the MRP to drive efficiency. The reinsurance option will be available to all plans at uniform demographic rates within each geographic area. The MRP payments to all CDTs in an area will be the same. CDTs able to keep down their own costs, yet demonstrate high quality, will be those most attractive to health plans. Because much of the cost in inpatient care is associated with the overuse of services, net income to providers can increase even with low overall costs. CDTs will be in a much better bargaining situation vis-à-vis plans than hospitals with independent physicians who have little incentive to lower overall resource use. Plans, however, can benefit only if they develop ways to steer patients to lower cost CDTs, and benefit even more if their ability to do so attracts more enrollees. Thus, plans will need to reduce their net premiums or provide other incentives to attract more enrollees and steer them to the right CDTs. If the private market does not jump at these new opportunities, public plans can lead the way and the competition will create incentives for private plans to follow.

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[12] One might expect insurers with healthy risk pools to eschew participating in the MRP. Offering MRP coverage at demographic and geographic rates will reduce their motivation to do so. Furthermore, such insurers pursuing a "cherry picking" strategy will incur the extra costs of underwriting and selective marketing avoided by their competitors who decide to join the MRP.

With the MRP, the role of health plans will shift from underwriting to innovating. Health plans currently spend significant sums avoiding enrollees likely to incur high cost; the MRP will eliminate the need for such behavior. Instead, plans stand to gain by offering their analytic expertise to CDTs in helping them improve their care processes. More importantly, health plans—using MRP data—can play a critical role in the interface between outpatient and inpatient care and in improving quality and efficiency.

Such data-driven quality and efficiency improvements are sorely needed. There is ample evidence of wide variation in medical practices that reflects neither patient risk factors nor quality, but instead a dearth of information for clinicians and inappropriate payment incentives. I discuss these issues and solutions to them in *Total Cure*. In brief, patients need information and incentives to select primary care providers and specialists that deliver high quality care efficiently; and clinicians need better information on how they can improve their practices and a payment structure that rewards such improvement.

The MRP will also drive efficiency for ambulatory care physicians outside CDTs. Some health plans have tried to develop tiers of outpatient-based preferred providers and offer patients incentives to use them. These efforts appear focused largely on attracting providers with lower fees rather than higher value—lower overall cost relative to quality. Fee information is easy for health plans to obtain; they typically do not, however, have enough patients in a physician's practice to develop valid estimates of overall resource use and quality. In contrast, the MRP will require claims data for all the patients it reinsures, not just those admitted to hospitals. It will therefore have much better data and make it available to plans and others developing better risk-adjusted measures of resource use and quality. Outpatient physician identities, however, will remain confidential in the raw MRP data. Plans seeking the most efficient ambulatory-based physicians will need to offer them more attractive payments. This would be done through a trusted intermediary that obtains the physician identifiers from the MRP and conveys contracting offers from the plans to the providers; when a "deal is struck" the physician's identity is revealed and added to the plan's preferred list.[13] The enhanced payments arrangements to these newly-identified efficient providers may be more than just higher fee schedules, but also payments for services that save money but are not currently reimbursed, such as extended consultations, telephone consults and care provided directly by non-clinicians. They reward physicians who are more innovative and efficient in overall resource use.

For these ambulatory care providers, contracting and payment approaches that may work well in places with many group practices like California and Minnesota will be very different than approaches that work best in urban areas with few such groups, or in rural areas. Physicians with efficient practice styles may form group practices without walls, connected electronically and sharing in higher payments. Entirely new entities may enter the field, simply offering high quality information to clinicians on how to improve their practices.

Figure 3 illustrates the relationship between plans and the MRP. The MRP's standard reinsurance is for both the risk of hospitalization and the management of chronic illness

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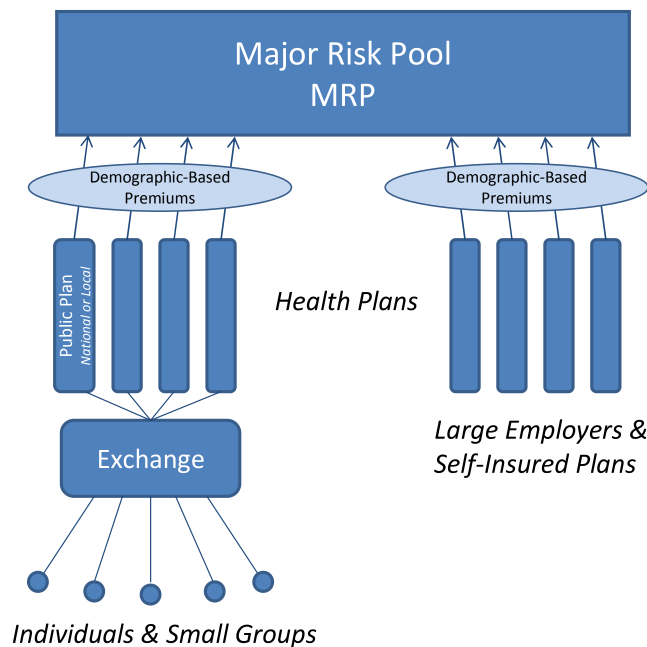
[13] The trusted intermediary needs to be an organization that physicians and plans can trust. It is transmitting highly confidential pricing and contract information between the parties. It must, however, be sufficiently transparent and structured to ensure trust and that the information is not used for price fixing.

care. The MRP pays for hospital episodes directly, but its coverage for chronic illness involves only a monthly transfer to the plan for each patient with chronic illnesses.[14] Plans will use these payments to partially offset the costs incurred within a more comprehensive benefit package that can include minor acute care and other services. The insurer will continue to be subject to state insurance regulations and other requirements. The MRP sells its reinsurance on a break-even basis (including its administrative costs) yielding immediate system savings.[15] The MRP, however, cannot let insurers keep the low risk cases for themselves while passing on the high risk cases *within* demographic cells. It will therefore only sell coverage to insurers for a whole line of business and refuse to do business with insurers who create lines of business designed to get around this requirement.

Figure 3: How Health Plans and Others Engage with the Major Risk Pool (MRP)



One rationale for the MRP is to make coverage more accessible for individuals and small groups. Large employer-based groups, the source of coverage for most people who now have private insurance, can also be an important market for the MRP. By serving them, the MRP will increase its enrollment, thereby strengthening the business case for hospitals and physicians to form CDTs. This will help speed the MRP-driven transformation of the delivery system. ERISA-governed plans generally design their own coverage packages and

[14] The monthly amount per patient is a risk-adjusted amount for each condition, or constellation of conditions. Unlike a risk adjusted capitation amount, the MRP payments can be adjusted each month based on the new identification of chronic illnesses. Moreover, these payments do not need to include the cost of inpatient care, which the MRP covers directly.

[15] The particulars of federal and state oversight of the reinsurance product remain to be determined.

benefit structures, so the MRP will offer them two types of reinsurance: its standard inpatient plus chronic illness package and inpatient-only.[16] (See Figure 2.)

The MRP will also allow any insurer (private or public) or self-funded (ERISA) plan to access its bundled payment arrangements with CDTs as an administrative service *without* providing reinsurance. The employer (or insurer) would use the MRP as an intermediary for inpatient episodes with participating CDTs. (This need not occur for all cases. To avoid adverse selection *within* types of cases, however, the MRP would not allow plans or employers to use this coverage option for a specific patient after the episode has begun.) Because the MRP bears no risk, it will simply charge the employer or health plan what it pays the CDT plus a small administrative fee to cover its costs. Employers and health plans thereby get access to CDTs that both measure their quality and agree to bundled payments. CDTs will be free to ask the plan for more than the MRP payment, most likely a negotiated percentage adjustment. Using the MRP saves plans administrative costs in the billing and payment of claims across the many providers involved in the case. Furthermore, the incentives inherent in bundled payment will result in true efficiencies, lowering costs in the long run. From the CDT's perspective, moving toward uniform incentives for all similar cases will facilitate internal process changes.

Synergies Between the MRP and Medicare

Although the MRP will be independent of the Centers for Medicare and Medicaid Services (CMS), the legislation establishing the MRP should facilitate cooperation between the two entities. The MRP should be allowed to use the Medicare fee schedules and DRG payments for providers wishing to be paid on a fee-for-service basis. The MRP should also be able to enforce Medicare prohibitions against balance billing—charging more than the Medicare payment—for those choosing the traditional methods. Medicare fees are typically below those of most health plans and as the MRP comes into being there may be few duly constituted CDTs able to accept bundled payments. Thus, the MRP should be granted additional funding by Congress to allow it to pay substantially above Medicare rates to providers during a transition period.[17] Use of CDTs by the MRP is based on provider choice; over time as these transition supplements disappear, it is unlikely many providers would continue to choose Medicare payments rather than bundled payments through CDTs. The MRP should also have immediate access to data on Medicare beneficiaries treated by CDTs. These additional data will help in developing risk-adjusted quality measures.

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[16] The exchange proposals require roughly comparable benefits and coverage for plans using exchange services. Large employers, however, have substantial discretion under ERISA to tailor their benefit packages. This may differentially affect their need for reinsurance across demographic cells. If the MRP reinsures plans with markedly different benefit packages, these plans should be placed in different risk pools. Payments from the MRP, however, need not make this distinction. Thus, while the age-sex-specific rate of a category of admissions may vary between plans that offer extensive first-dollar benefits and those that have substantial co-payments, the payment to a CDT for that type of episode need not depend on the risk pool from which the patient came. This will prevent those with one type of coverage from implicitly subsidizing those with another type of coverage.

[17] The amount and details of this subsidy would have to be worked out in legislation and regulation. It is unlikely that a uniform "markup" will be politically acceptable to providers and Congress because various health plans have widely differing rates in different areas. One starting point might be the fees used in the health plans with the largest number of Federal employees.

The MRP is intended to be more nimble and innovative than Medicare, but cannot do so without some cooperation from CMS. With the exception of pediatric and maternity care, most inpatient care episodes occur in both the Medicare and non-Medicare populations. Physicians and hospitals choosing to form a CDT and accept a bundled payment from the MRP for non-Medicare patients should also be able to do so for Medicare beneficiaries. This could occur if Medicare adapted its payment scheme to mirror how the MRP pays the CDTs. But such a change may be politically fraught and could ultimately be unnecessary.

Medicare may not need to change its payment scheme because Medicare beneficiaries can benefit directly from the new approach by opting out of Medicare fee-for-service and enrolling in a managed care (Medicare Advantage) plan. Medicare Advantage plans currently bear full risk for their enrollees, but the accuracy of the risk adjustment is controversial and many believe the plans are being overpaid. Pursuant to its public charter, the MRP governing board will cooperate with Medicare in developing risk adjustment methodologies and rates that the MRP will receive for people who choose new Medicare Advantage Reinsured (MAR) plans. These MAR plans will be similar to current Medicare Advantage plans, but are premised on reinsuring their enrollees with the MRP for hospitalization and chronic illness. Because the MAR plans off-load most risk to the MRP, they have much less incentive to seek out the healthiest enrollees.

The rationale for new MAR plans is that they are likely to have much more flexibility than traditional Medicare in developing new payment arrangements with providers.[18] For example, not being bound by political constraints, they will be able to offer primary care providers much higher fees and pay for services and care coordination not covered by Medicare. Specialists joining CDTs may be attracted to them because the CDTs do not need to rely on fee-for-service payments to capture savings achieved through inpatient process redesign and reductions in unnecessary services. Many of the new MAR plans will be regional and thus be able to implement payment and other arrangements that need not be acceptable in all areas.

The MAR plans can be designed as PPOs, with incentives for beneficiaries to use the preferred providers and higher copayments for those using other providers. Such plans are likely to be attractive for all beneficiaries, except those strongly attached to physicians unwilling to join CDTs or physicians with such high-use profiles they do not get invited to join any network. Over time, this may leave Medicare fee-for-service with just high cost providers, and unless Congress alters the Sustainable Growth Rate formula, increased downward pressure on fees. It is also why the risk-adjusted payment by Medicare to the MAR plans will not always be what those enrollees would have cost in Medicare fee-for-service. The expectation is that MAR plans will become increasingly more efficient than classic Medicare.

A Necessary Component for Cost Containment

The appropriate rationale for a public option is to bring a long-term public perspective to covering *and* delivering care. Relative to the proposals currently on the table, the MRP emphasizes delivery system reform, a critical goal for long-term sustainability, and perhaps also short-term political acceptability. It is, moreover, compatible with various subsidy and

[18] Again, the argument here is based largely on the political insulation of the MRP and the MARs.

mandate programs to expand coverage—increasing efficiency in delivery will make such subsidies affordable. It is also compatible with most of the options currently being debated in Washington.

Through its direct relationship with providers, the MRP does a better job of improving health care quality and achieving efficiency than a public plan on its own. The local alternatives will not have enough marketshare to transform the system, and the national plan is likely to face rear-guard political action by providers whose revenue streams are threatened. By operating in the background and providing a continued, but transformed, role for private plans that opt into its reinsurance, the MRP curbs costs without posing a threat to the plans' existence. In theory, the MRP could be a wholly private entity, but this is extremely unlikely to happen because of both the negotiations that would be needed and the unwillingness of players to trust such a private entity with all the sensitive information it needs to operate. No existing "player" could fill that role.

Having the MRP publicly chartered allows it to receive some initial public start-up funding, to be not-for-profit in the long run, and to operate transparently with a publicly appointed board. It also facilitates its use of Medicare leverage with those providers wishing to stay with a fee-for-service model. The long-term goal of the pool, however, is transforming the delivery system. The bundled payments it makes directly to new CDTs gives them incentives to improve efficiency and quality. The chronic illness management payments channeled through existing plans reduces their risk while allowing them to develop creative new payment arrangements with ambulatory care providers. Both types of innovations would likely be stymied by politics if attempted directly though a public plan.

A publicly chartered reinsurance pool can be designed to work well with private plans and public options. A carefully crafted policy incorporating both can be more effective than either approach alone.

NOTES

[i] Jacob S. Hacker, "Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement" (Berkeley: Center on Health, Economic & Family Security, 2009).

[ii] Len Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Health Plan" (Washington D.C.: New America Foundation, 2009).

[iii] Harold S. Luft, *Total Cure: the Antidote to the Health Care Crisis* (Cambridge: Harvard University Press, 2008) (for various commentaries and applications, see http://www.SecureChoice.info).

[iv] Elliott Fisher and others, "Fostering Accountable Health Care: Moving Forward In Medicare," *Health Affairs* 28 (2) (2009): w219-w231.

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