Health Insurers: Revamping the Physician Payment Model

By Don Urbanowicz, Urbanowicz Consulting

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With Major insurers reforming payment plans to focus on care at the Primary-Care Physician level, care patterns are expected to change and may impact medical device companies.

The Impact

As the insurance industry starts moving toward new physician payment models and away from fee-for-service compensation, **delivering quality outcomes cost effectively will become even more important**.

Device companies will need to contend with — and plan for — structural changes that will affect access (including impact on health care utilization/procedural volume) and the way business is conducted.

Insurers will likely focus on post-marketing data to determine the comparative effectiveness of different treatment methods. This will result in increased scrutiny on existing and potential future treatments and products. **Data collection will be mandatory; and without data, devices will not be covered or paid for**.

Device companies must include large insurance carriers as "key customers" — just like the surgeons, hospitals and patients. By understanding the business models and thought processes of insurers, device company executives will be in a better position to understand "the way payers pay" and how surgical procedures are affected, and then pro-actively work with insurers to secure optimal reimbursement values.

The Trend

Three of the largest U.S. health insurers — UnitedHealth Group, WellPoint and Aetna — have recently announced programs that could overhaul how physicians and hospitals are paid. After many years of discussing how best to promote the use of primary care, each insurer has promised what some physicians say has been lacking from past efforts — effectively, a pay increase for primary-care physicians (PCPs).

WellPoint — the largest health insurer by membership — was the first to roll-out a revamped payment model by offering PCPs a fee increase of about 10% and a chance to share savings that result from improved patient outcomes.

Aetna followed by announcing payment reform plans that would allow PCPs to earn quarterly bonus payments for meeting certain standards for improving care.

UnitedHealth — the largest health insurer by sales — then became the latest carrier to overhaul its fee structure with plans that stretch beyond primary care to include hospitals and physician groups in other specialties. UnitedHealth is looking to create new contracts with physicians and hospitals that would financially reward them for care considered high quality and efficient.

The proposed nationwide expansion of the programs follows similar efforts by the government to reduce medical costs by transitioning away from payments based on services provided by physicians.

The Rationale

1. **Too Little Value Placed on Primary-Care:** The U.S. health care system has long been criticized for placing too little value on primary-care, which has traditionally been front-line medical work. A study in the January 2011 Journal of Internal Medicine found that PCPs spent 20% of their day on care management tasks that are mostly unpaid.

2. **Primary Care Physicians Are Under Paid and Under Reimbursed:** Critics suggest that the U.S. health care system underpays PCPs. Based on 2010 data from Medical Group Management Association, annual median physician compensation by specialty is listed below:

- Primary Care (including Family Practice without obstetrics, Internal Medicine and Pediatric/ Adolescent Medicine) — $202, 393
- Emergency Medicine — $277,229
- Opththalmology — $330, 784
- Urology — $372, 455
- Dermatology — $430,874
- Radiology: Diagnostic — $471, 253
- Orthopedic Surgery (General) — $514, 659
- Cardiovascular — $560, 659

In addition, inadequate reimbursement has led many PCPs to see as many patients as possible each day to stay ahead financially. This situation has either prevented them from conducting care management — or significantly reduced the amount of time they do.

3. **Re-Establish PCPs as the "Quarterback":** Although specialists will continue to play an important role in the health care system, carriers are hoping to reposition PCPs as the quarterback of care management.

4. **Current Fee-For-Service System Is Flawed**: Industry experts believe that the current payment system has flaws. Hospitals and physicians are paid more by delivering higher volume, not necessarily better, health care that frequently leads to overutilization. In addition, no one tracks patients to ensure they get proper preventive and/or outpatient care or acts as a coordinator to avoid duplication. The experts argue that the end result is higher costs and less quality patient care.

5. **Potential Cost Savings:** The carriers are betting that spending more now for better primary care can save money in the future in the form of fewer emergency room visits and hospital stays. The hope is that aligning the financial incentives of physicians, hospitals and the insurers translates into potentially better health care and at a lower price.

The Details

Aetna: Insurer is planning to give some primary care physicians (about 55,000 across its network) an extra monthly payment to help them better manage care. The Company will pay physicians in practices that qualify as Patient-Centered Medical Homes (PCMH) an additional $2 to $3 per member per month — with the stipulation that the practices must be recognized as medical homes by the National Committee for Quality Assurance. Physicians in a PCMH track and coordinate all of their patients care across disciplines, including drafting outpatient care plans after hospital stays. They also communicate with patients between visits and act as the central contact-point between specialists, nutritionists and others.

Insurers and supporters of PCMH say the concept will improve care for people with complex medical conditions like diabetes, which may reduce expensive forms of care like hospital stay. They also claim that the concept will help prevent patients from developing chronic health conditions.

Aetna will pilot its program in Connecticut and New Jersey before launching nationally later in 2012.

WellPoint: The Carrier is planning to give PCPs (about 100,000 in its network) a raise of about 10% with the opportunity of additional payments that could increase compensation by up to 50% for treating patients the insurer covers. The new approach could mean an additional $1 billion invested into primary-care. The Company plans to roll-out the primary-care pay raise by market starting in the fall of 2012.

A portion of the 10% represents an increase for specific services that are already paid. However, WellPoint will initiate reimbursement for tasks that aren't currently paid for, such as care management for chronically ill patients. It will also offer physicians an opportunity to share in select savings when improved patient care leads to a reduction in costs.

WellPoint will not require that a practice become certified as a PCMH. However, they will require practices that participate in the program to adopt "patient-centered practice principles". At the end of 2011, the Carrier had nine PCMHs. WellPoint expects about 70% of PCPs in its network to join its new program by the end of 2014. The Company's up-front payment in primary-care could reduce its projected medical costs by up to 20% by 2015 by improving patient health and reducing the need for costlier medical services.

UnitedHealth: The Insurer plans to pay physicians based on the quality of their care. New payment models are focusing on three main categories of health-care providers, including PCMH, PCPs and Accountable Care Organizations (ACO's). Providers will enter into new contracts willingly and not be forced into them.

The Company plans to use various structures to transition toward what it calls "value-based contracting" across the U.S. Under one model, a portion of a provider's payment could be a bonus, or withholding of expected increases if certain goals are not achieved.

UnitedHealth hopes to have 50 to 70% of its commercially insured members affected by these contracts by 2015, up from 1 to 2% in 2012. The Carrier expects to save twice as much as it spends on incentive payments to physicians "because patients will be healthier".

The Insurer's service business, which includes the sale of hardware, data and consulting to providers, expects to benefit from new payment models.

Successes to Date

UnitedHealth launched its PCMH pilot program in five states in 2009. It reported an initial 29% drop in emergency room visits, an 11% drop in preventable hospitalizations and 6% fewer office visits for members served by those initial medical homes.

Several early medical-home pilot programs have also shown signs of improved quality and patient satisfaction. Some regional carriers like CareFirst Blue-Cross BlueShield have moved forward with broader programs.

Concerns Voiced

"There is no strong evidence of cost savings yet with new models, at least based on short-term results published so far."

"**WellPoint's savings projections are based largely on its own data from medical-home pilot programs**."

“A big question is whether higher payments from any one insurer can change the way physicians work, given that many patients will still have more traditional coverage.”

“If you only have 10% of your practice that you’re getting paid extra for, that’s not enough to get your attention.”

“Efforts to reform healthcare will always draw skepticism when they involve higher guaranteed costs up front – in the uncertain hope that savings will come down the road.”

“It will still take a couple of years of big investment, especially in electronic medical records, for a practice to switch to a PCMH.”

“**Let’s hope the insurers aren’t paying for their primary-care programs by reducing what specialists make.**”

“**Primary-care physicians are likely to refer fewer patients to orthopedic surgeons. Orthopods will need to reach out to primary-care physicians and help them understand the value the orthopods provide**.”

Moving Forward

There may be more questions than answers:

What is the end-game for insurers and what do they want to achieve with these payment models? Is it to effectively reduce pay for specialists, provide better health care at lower prices or something else?

Could this be a fundamental shift that negatively impacts elective surgeries?

Will a focus on PCPs have a more positive impact on pharmaceutical (versus device) sector?

Is this another speculative and supposedly better payment model that seems to always fail?

Here’s What’s Certain

Insurers are at least attempting to drive transformation within primary care by seeking to pay PCPs more fairly for the new activities they are being asked to undertake. An opportunity exists to fundamentally change the relationship between insurer and PCP – and on a scale much bolder than previous programs.

In addition, all the major insurers are mining their billing data and attempting to more accurately measure costs and compare them with outcomes. The cumulative affect of all the proposed modifications to the insurers business model could potentially change the reward and payment system. Insurers remain hopeful that will eventually translate to better care and better health at lower costs.

Don Urbanowicz is Principal of Urbanowicz Consulting (UC), a medical device advisory firm with a musculoskeletal focus seeking to enable clients to achieve strategic and transaction-related goals by capitalizing on market opportunities. UC offers a unique perspective on how large global companies approach strategy, valuation, negotiations, due diligence and integration, and a thorough understanding of achieving success throughout all phases of the transaction process. Please learn more online at ***www.urbanowiczconsulting.com*** *, and contact Don Urbanowicz at durbanowicz@du-llc.com.*