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Private Payer Roles in Moving to More Efficient Health Spending

PAUL B. GINSBURG

Developments in private insurance have direct and indirect effects on the federal budget and therefore strongly influence the degree to which measures to slow the growth of federal health spending can be successful. The private sector is even more important with respect to the broader goal of slowing the growth of total national health spending.

Direct and Indirect Effects

The direct interactions between private payers and the federal budget are mostly on the revenue side. The exclusion from taxation of employer contributions to employment-based health insurance is one of the largest tax expenditures in the federal budget. For fiscal year 2007, this expenditure is projected to total $146.8 billion. The Office of Management and Budget projects an increase of 45 percent between 2007 and 2011, substantially higher than the OMB's projection of increased total federal revenue of 26 percent over the same period.[1] Additional tax expenditures come from the deductibility of self-employed persons' purchase of health insurance coverage, employer or individual contributions to health savings accounts, and the medical expense deduction—also growing faster than federal revenues.

Direct subsidies for the purchase of private health insurance are becoming more important as well. In Medicare, beneficiaries can opt to obtain their coverage through a Medicare Advantage plan, which is administered by a private insurer, rather than through the traditional Medicare program. The recently implemented Medicare Part D program subsidizes the purchase of private coverage for prescription drugs. Some Medicaid programs, through federal waivers, subsidize the purchase of private coverage for categories of persons whose incomes are low but not low enough to qualify for regular Medicaid coverage. The federal government matches the cost of these subsidies.

Federal spending is also affected by the degree to which employment-based coverage is available to those who meet the qualifications for the Medicaid program. As employer-based coverage erodes over time, especially for relatively low-wage workers, more employed people (or at least their children) will be enrolling in Medicaid. To the degree that remaining employer-based coverage becomes less attractive to employees, both because contributions for coverage are higher and more patient cost sharing is required, more low-income workers with offers of coverage will nevertheless enroll in Medicaid.

A less direct and more speculative relationship concerns the degree to which higher costs and reduced access to private coverage will lead to political pressure for a major effort by the federal government to either expand public coverage or offer increased subsidies to private coverage. Although expanding health insurance coverage is not high on the federal policy agenda at this point, in a few years public demand could push the federal government to expand coverage along the lines of the recently enacted program in Massachusetts or actions of some other states.[2] The implication is that pressure for spending still more federal resources on health care may very well be on the horizon, spurred by increases in health spending that exceed people's ability to pay for care.

Less widely perceived are the indirect effects of developments in private insurance on federal spending for health care. Private insurance and the Medicare, Medicaid, and TRICARE programs all finance medical services from the same providers of services, including hospitals, physicians, freestanding outpatient facilities, and pharmaceutical manufacturers.[3] Although some providers, such as public hospitals and community health centers, treat low-income patients predominantly, most providers treat substantial numbers of patients covered by private insurance, Medicare, and Medicaid. Providers, for the most part, treat patients with different types of coverage the same way. If a hospital invests in expanding its facilities for high-end medical imaging, it is likely that care for both privately and publicly insured patients will include these services.

As a result of this common delivery system, it is likely that strong initiatives by one type of payer will influence the care for most patients, even those with distinct coverage. Although little research has been published, it is likely that the strong shift in enrollment among the privately insured to restrictive managed care products during the early 1990s had a spillover effect on Medicare and Medicaid. The authorization requirements of managed care plans for hospital admissions likely influenced physicians' admitting decisions for all of their patients. Hospitals may have put expansion plans on hold as a result of declining rates of admissions, at least for managed care patients. The need to offer greater discounts on rates to managed care plans may have made hospitals more cautious about spending for new technologies.

Moreover, overall trends in practice patterns in medical care affect all payers. If new medical technologies are covered by private payers, then a public payer will find it very difficult to not pay for them. The notion that public payers will only support a lower level of technology than is the norm in medical practice would violate long-held principles. As a practical matter, however, restriction of new technologies probably happens in Medicaid because providers are operating in difficult financial environments (many uninsured in addition to Medicaid patients).

This notion applies to public providers of care as well. The norms of care in private hospitals influence the expectations of the public for care in public facilities as well. For instance, Veterans Administration hospitals need to provide care comparable to that in private hospitals lest the Veterans Administration be accused of providing lower-quality care to our veterans.

Provider payment policies of private insurers may also influence what public insurers pay providers. Hospital administrators and insurers perceive that changes in payment rates by one major payer influence rates paid by other payers, although economists have puzzled over how this "cost shifting" can occur.[4] One reason is that private nonprofit hospitals often keep prices below those that would maximize revenues. They do this because of their nonprofit mission, the presence of community leaders on their boards, and concern about their image in the community. For-profit hospitals, however, which do not have these motivations, may be constrained by the rates charged by their more numerous nonprofit competitors.

On the one hand, if public payers reduce payment rates to hospitals and market conditions give hospitals enough power, then the hospital can offset the losses, at least in part, by raising rates to private payers. On the other hand, if hospitals do not have much power, as was the case in the mid-1990s when purchasers of insurance accepted narrow provider networks, then a reduction in rates by public payers might induce hospitals to reduce their costs instead of raising rates to private payers.[5]

Cost shifting can work both ways. Although most discussions have focused on the impact of Medicare and Medicaid payment policies on rates that private insurers pay, the relationship might go the other way. Public policymakers setting payment rates for Medicare or Medicaid are likely influenced by the financial status of hospitals. They are often called on to bail out foundering hospitals that are well regarded in their communities. The Medicare Payment Advisory Commission's annual tracking of trends in margins of hospitals is closely followed in Congress. Lower private rates could force hospitals to cut their costs to maintain their financial position. But if many hospitals experience deterioration in their financial position, it could influence public payers to be more generous. So if private payers are able to squeeze hospital rates, public payers might partly offset this by paying higher rates. Whether a cut in rates paid by private payers leads to higher or lower rates paid by the public programs depends upon whether hospital cost cutting, which would permit lower rates by public payers, or the policy response to deteriorating hospital financial positions predominates.

The relationship between private and public payment rates for physician services is distinct from the situation for hospital care. Public policymakers for the most part are not concerned with the financial status of physician practices, but they are concerned about physician acceptance of patients covered by public financing programs.[6] If private payment rates are high, this could either discourage or encourage acceptance of patients from public programs. Higher rates would make public patients relatively less attractive. But physicians often speak in terms of "target incomes," suggesting that higher rates for private patients could lead to greater ability to treat less lucrative patients with public coverage.

Provider reimbursement policies of private payers have been heavily influenced by Medicare policies and in turn have influenced Medicare policies. For physician payment, private payers have largely incorporated the Medicare structure of relative payment for different services. This has meant that changes in Medicare payment structures have the potential to have broader impacts on patterns of medical practice. But private payers' following the Medicare structure has probably also allowed the Medicare program to push further toward its goal of pegging its structure of payments based on its estimates of relative resource use because large discrepancies between public and private payment rates for specialties or categories of services are less likely to arise.

In recent years, the health care system has seen increasing examples of how innovations on the part of either private or public insurers influence the other. Private payers' experimentation with pay-for-performance (P4P) for physician services has increased public policymakers' interest in developing such a mechanism for the Medicare program. At about the same time, large employers and the Medicare program each experimented with the "centers of excellence" approach, which encouraged enrollees to use those providers with high quality of care ratings (with the private experience likely influencing the Medicare initiative). Unfortunately the approach has so far proved to have less potential than anticipated in both environments.[7] As another example, the experiences of private employers and insurers with disease management have influenced the Medicare program to pursue demonstrations of this approach. Indeed, expertise in disease management for employment-based coverage is easily transferable to

Medicare demonstrations, since vendors of disease management services as well as providers of care who have invested in this approach can be engaged in Medicare.

Private Payer Initiatives

Most private coverage is obtained through employment. The U.S. Census Bureau reports that 88 percent of private health insurance was obtained through employment in 2005.[8] In the absence of a public program for universal coverage, there are many strong reasons for linking private coverage to employment. Tax treatment of employment-based coverage confers a large subsidy to obtaining coverage through employment, with the subsidy generally greater for those with higher marginal income tax rates. Employers can obtain more favorable premiums than can individuals because employers are purchasing in bulk and because payroll deduction is a much lower-cost method of collecting regular payments from individuals than is monthly billing of enrollees. Employers' purchasing insurance for the majority of employees and their families permits them to vary employee contributions only by family status (single versus family coverage), meaning that older employees or those with chronic disease in their families are more likely to be able to afford coverage. Finally, employers provide valuable assistance to employees in navigating the purchase of a highly complex financial product.

The degree to which employers take major steps to contain the costs of the coverage they provide appears to be cyclical. During the early 1990s, when a deep recession led to low profits and slack labor markets, employers aggressively shifted their health benefits to managed care. In the late 1990s, with high profits and very tight labor markets, complaints about restrictions in managed care led to a shifting to less-restrictive versions. Authorization requirements for hospitalization or referral to a specialist or obtaining a major procedure were scaled back. Provider networks were expanded in response to demands for greater choice. It was or should have been clear that these steps would lead to higher costs. But health care premium trends were low at the time, and the urgent need was to address employee concerns.

Because of subsequently increasing premium trends and their recent experience with a recession, employers began to pay more attention to costs. Many stated that improved quality was the key to cost reduction, influenced perhaps by two landmark reports of the Institute of Medicine.[9] But employers continued to have concerns about antagonizing employees with aggressive management. Indeed, despite the enthusiasm of employers for the efforts of the Leapfrog Group, which promulgated quality standards for hospitals that employers should push for, many were unwilling to drop from their provider network those hospitals not meeting the standards.

Beginning in 2002, however, employers began to increase patient cost sharing in their health benefits plans. They increased deductibles, coinsurance, and co-payments but did not change the percentage of premiums contributed by employees. Their goal was to avoid discouraging enrollment while using shifts in financial responsibility to change behavior. Employers did not return to restrictive managed care, although authorization requirements were added to address specific problem areas, such as high-end imaging and specialty pharmaceuticals. This shift in cost sharing can be interpreted in two ways. One is that employers perceive the long-term outlook for labor markets to be relatively tight, especially for those with high skills, and shifting costs is more acceptable to those employees most difficult to retain than are administrative restrictions on care. The other is that society's attitude has shifted in favor of individuals making the key decisions in their health care as opposed to institutions, such as employers or insurers.

Patient Financial Incentives

The major thrust of cost containment strategies by employers today is to increase reliance on *patient financial incentives,* such as deductibles, coinsurance, and co-payments. Although good data to summarize the magnitude of change are not available, reports from Wall Street analysts that I have catalogued over time suggest that from 2001 to 2006 the actuarial value of private health insurance policies declined by more than 10 percent, with small employers experiencing larger declines in their policies.[10] Prescription drug benefits have perhaps changed the most. The norm has become a three-tiered structure with incentives to use generic drugs and those brand name drugs on a preferred list (brand name drugs not on the preferred list being the third tier). Some plans created a fourth tier for drugs that are deemed more elective than others (for example, drugs for erectile dysfunction) and for biologics, which are often so expensive that co-payments associated with the third tier are seen as having little impact on incentives. Over the course of this period, co-payments have increased, and coinsurance has been used increasingly instead of co-payments, with emphasis on increasing the magnitude of the incentives to favor the lower-cost tiers. Deductibles for both hospital and physician services have increased as well.

More attention has gone to *consumer-driven health plans,* which I define as plans with substantial patient financial incentives, a health savings account or health reimbursement account to pay medical bills, and consumer information tools on price and quality. Although enrollment has increased rapidly and surveys suggest that many large employers are offering or expect to offer such a plan, enrollment is still very small in relation to that of current employer-based coverage. America's Health Insurance Plans estimates that 3.2 million persons were enrolled in high-deductible health plans that were eligible for health savings accounts (HSAs) in January 2006.[11] In contrast, the Census Bureau estimates that 198.9 million had private insurance in 2005.[12] Much of the HSA coverage was in the market for individually purchased coverage, where the HSA is the only tax incentive that applies to those obtaining health insurance separately from employment. It is risky to extrapolate from a brief period of rapid growth of a new product.

Without doubt, increased patient financial incentives will reduce spending. The question is the magnitude of the impact. For example, if one compares standard actuarial assumptions with the 10 percent reduction in actuarial value noted above, the impact on spending might be around 2 percent—or 0.5 percent per year. Such an impact is not insignificant but is still relatively small in relation to the gap between spending trends and income trends, which historically has been 2.5 percentage points per year.[13] And there is a limit to the number of years that reductions in actuarial value can continue before insurance no longer provides substantial financial protection.

But the impact of increased financial incentives is likely greater than the standard assumptions would suggest because some of the response to the incentives is focused on choosing lower-priced providers. This was especially the case with prescription drugs, where cost sharing is structured to provide incentives to increase the use of generic drugs and those branded drugs that are in a preferred tier. Thus the response to higher drug co-payments in three-tiered structures would involve additional savings by shifting to less expensive drugs. However, benefit structures are not as oriented toward choosing hospital and physician services with lower prices, and information for consumers is very limited. This could change over time.

Nevertheless, a major question exists concerning the long-term impact of this core private-sector strategy. We know that health care spending in any year is concentrated in a minority of enrollees who have very large expenses. Ten percent of the population accounts for 69 percent of spending during the course of a year.[14] This means that a large proportion of spending will fall beyond the reach of patient financial incentives. These people will have exceeded their deductibles and limits on out-of-pocket spending. Should society continue in the direction of emphasizing patient financial incentives, benefit structures will need to evolve so that consumers can take more actions in the context of taking on a certain amount of financial risk.

These directions are starting to appear, although they are developing slowly. I believe that the direction offering greatest promise is to emphasize patient choice of provider. If a patient can be induced to choose a more efficient provider for an episode of care, then the incentive will have affected all of his or her spending for that episode—perhaps $100,000 worth of services rather than only the first $1,000.

A few years ago, insurers developed tiered hospital networks to create financial incentives to choose lower-cost hospitals. But hospital resistance (prominent hospitals threatened to leave networks unless they were placed in the preferred tier) and lack of employer interest have resulted in limited development. But *high-performance networks,* which focus on physicians in selected specialties, have had a much warmer reception by employers and are not as vulnerable to provider interference.

In a high-performance network, network physician practices in a specialty are sorted into two subnetworks. Patients are given financial incentives to favor those designated high performers. Typically, quality screens are used, then those practices passing the quality screens are ranked on the basis of costs per episode of care. These costs can include services beyond those provided by the physician, such as hospital costs, outpatient facility costs, and prescription drug costs. Direct savings are obtained when patients choose more efficient practices. If a significant share of the market adopts this tool, important indirect savings could be realized when those practices that are not high performers become more efficient to protect their patient volume.

This phenomenon is already happening in some areas. In Seattle, Aetna informed Virginia Mason Medical Center (VMMC), a large, integrated delivery system, that many of its specialties did not make the efficiency cut.[15] The two organizations began to work together to increase VMMC's efficiency so that it could remain in the preferred subnetwork, with Aetna providing analyses from its claims files and VMMC broadening its ongoing adoption of the Toyota Production System to focus on costs per episode.

High-performance networks are an example of a blending of consumerism and managed care. The managed care plan uses its data and analytical resources to assess the performance of providers and creates relatively simple financial incentives for consumers. But consumers can continue to access the providers who are not in the high-performance network and still benefit from negotiated payment rates and the lower cost sharing associated with using network providers.

The likely outcome—or at least the hoped-for outcome—of high-performance networks is that many providers will improve their efficiency and that public programs will benefit from the greater efficiency of providers who are treating their beneficiaries.

However, to the degree that the volume of services shifts toward the more efficient providers and that those providers do not expand their volume but instead respond by increasing the proportion of their patients with private insurance, spending by public programs could increase.

The federal government has an opportunity to spur development of this tool. A significant limiting factor for insurers is not having enough claims data for many practices to make reliable assessments of quality and efficiency. If the federal government provided access to Medicare claims data that identified the physician but not the beneficiary (other than a scrambled code to permit grouping of claims into episodes), insurers could use this tool more extensively. The federal government could also create a mechanism for private insurers to pool their own data for the purposes of having a larger sample with which each could make its own assessments of provider efficiency and quality.

Other potential strategies for implementing patient financial incentives would involve additional differentiation of cost sharing by type of service. The aim would be to avoid discouraging or burdening patients who use services that evidence suggests have substantial benefits and to place additional cost sharing for those services with small or uncertain benefits. Small steps are being taken in this direction. Some employers are reducing or eliminating cost sharing for services that are part of standard regimens for the management of chronic diseases—at least if the patient is participating in a disease management program. A well-known initiative is Pitney Bowes's reduction of drug co-payments to the rate for generic drugs for all drugs used in the treatment of diabetes, hypertension, and asthma. At the other end of the spectrum, some employers or insurers are setting higher coinsurance rates for certain procedures, such as bariatric surgery.

Employers' strategies that emphasize increasing financial incentives for patients will likely have impacts on federal programs. Medicaid enrollment will likely increase, especially for children, as parents see the virtue of substituting Medicaid for employment-based coverage. More extensive patient cost sharing could also increase political pressure to apply these changes to Medicare and Medicaid, given the contrasts between the benefit structure for Medicaid beneficiaries and that for those with somewhat higher incomes who have private coverage with extensive cost sharing. Hospitals are experiencing more bad debt from their patients who have more cost sharing. To the degree that policy on Medicare payment rates is based in part on the financial condition of hospitals, increased cost sharing in private insurance could lead to higher outlays for Medicare.

In theory, the Medicare and Medicaid programs could benefit from the development by private insurers of tools like high-performance networks and varying patient cost sharing by type of service. But they are not likely to transfer well. Congress has often discouraged the Centers for Medicare and Medicaid Services (CMS) from exercising the flexibility and judgment involved in initiatives like these, since some providers who are constituents perceive an entitlement to participate in these programs. In the case of Medicaid programs, low incomes of beneficiaries limit how extensively patient financial incentives can be used, although the current administration has been more open to such incentives, particularly for those beneficiaries with relatively high incomes. An important question concerning the Medicare program is the degree to which Medicare Advantage plans can incorporate some of these features without violating the rules on benefit structures.

If the use of patient financial incentives increases substantially, it could have some long-term impacts beyond direct responses by patients. For example, on the one hand, physicians would likely become more aware of affordability issues experienced by their patients and thus essentially increase their scope as agents for their patients, paying more attention to the patient costs for different drug alternatives or being less aggressive in ordering expensive diagnostic tests. On the other hand, if higher cost sharing leaves physicians less busy, they might prescribe their own services more readily.

Provider Reimbursement Methods

Private insurers have not been as innovative when it comes to provider reimbursement as has been the case in developing patient financial incentives. For the most part, insurers have adopted Medicare methods, screened billed charges for reasonableness, or negotiated discounts from charges. For example, with physician services, most private insurers use fee schedules based on the Medicare relative value scale. For small practices, insurers' fee schedules are a percentage of Medicare rates, with the percentage varying widely by market. Fee schedules for larger practices tend to be negotiated but are also based on the Medicare structure. For inpatient care, diagnosis-related groups (DRGs) are not used extensively by private insurers. Payment tends to be either a discount from billed charges or a per diem payment. Like Medicare DRGs, per diem systems have a provision for additional payments for patients who use much greater amounts of services than the norm. Virtually all payment rates to hospitals are negotiated. Private insurers have slowly adopted prospective payment systems for other types of providers, as Medicare has developed them.

Interviews with provider relations executives at insurers revealed that few resources are devoted to innovating provider payment.[16] Many insurers believe that they do not have the clout to depart from either billed charges or Medicare methods, believing that providers would not agree to another structure of rates. But the fact that many insurers do follow Medicare methods means that Medicare reimbursement policies can more aggressively depart from established patterns of billed charges. It also means that when Medicare policies have a particular objective in mind, such as encouraging or discouraging types of services, their impact on the delivery system can be greater.

Incentives to Promote Higher Quality of Care

Increasing evidence that quality of care is not as high as it should be has spawned efforts to measure and report more indicators of quality and to incorporate quality into provider payment. For hospital care, Medicare has taken the lead in measurement and reporting through its voluntary hospital reporting standards. Hospitals now report on a series of measures specified by CMS, which are available to the public. Interviews with hospital officials have indicated that having these hospital quality measures publicly reported has motivated hospitals to improve quality.[17] Hospitals envision a future when private insurers use the information to steer enrollees to hospitals with higher quality scores.

For physicians, some private insurers are paying more when quality indicators are met. Pioneering work in pay-for-performance has been done in California by the Integrated Healthcare Association. Under the auspices of this voluntary organization, physician organizations and insurers collaboratively developed a uniform series of measures of quality on which each insurer would base its schedule of performance incentives. At this point, substantial payments are being made to practices that score higher.

A key challenge for private insurers has been coordinating the choice of measurements. Physicians understandably object to different sets of measures from each insurer. They also want a role in choosing the measures so that they have a degree of confidence in the standards on which payments will be made.

In the Boston area, P4P is used by each of the three major insurers without a need to coordinate on measurements of provider performance. This is because the insurers have limited their assessments of quality to information already available in standard claims data. Indeed, an important part of P4P in Boston is based on measures of cost, such as rates of imaging services ordered and the proportion of prescriptions that are for generic drugs. Boston insurers envision their system as not just a device to encourage better quality but also as something to replace the extensive use of capitation payments that had rapidly fallen out of favor.

The need for the coordination of measurements points to a significant potential role in this area for the Medicare program. Currently, CMS is conducting a number of demonstrations of P4P in Medicare. Congress has been debating whether to use P4P in the Medicare program and decided to pay physicians to report data on quality. It is likely that private insurers will coalesce around the specific reporting measures chosen by Medicare. Medicare's process of developing measures will certainly involve organized medicine, thereby making such measures more likely to be credible to practicing physicians. Indeed, the possibility that Congress might direct Medicare to pay on the basis of performance has spurred many specialty societies to develop measures relevant to their specialty that Medicare could adopt. With early versions of P4P focused mostly on primary care, specialists are strongly motivated to ensure that they also have opportunities for additional payments.

Should Medicare take the lead in P4P, followed by private payers, changes in physician incentives would be substantial. But the implications for spending are not clear. P4P in its early stages would likely include only bonuses for good performance and not penalties for poor performance. Changes in physician behavior in response to these incentives would likely improve quality, although how strong is the connection between process quality measures and outcomes is open to debate. But it is much more uncertain what the impact on spending would be. In addition to the P4P bonuses, some additional services that are paid separately would be performed more frequently. The unknown is whether some of the quality improvements would reduce the need for future services. Over time, it seems inevitable that a system with a series of bonuses but no penalties would erode the base payment rates—that is, payment rates, before performance incentives are paid, are likely to be increased less in the future in response to the cost of bonuses.

P4P could also significantly spur the adoption of information technology by physicians, if Medicare required or strongly encouraged physician reporting of quality measures in electronic form. The indirect result could be savings in other areas, such as reduction in the duplication of tests or fewer medical errors. If large practices, because of their infrastructure, tended to capture much higher rates of P4P bonuses than did small practices, this could accelerate the ongoing movement of physicians from small to large practices, a change that could have positive implications for costs and quality.

Disease Management and Wellness

In recent years, disease management (DM) programs have become a more significant part of the landscape in private insurance. Disease management programs tend to be designed to support physicians with complementary resources, such as patient monitoring and education. Their use has long been driven by employer or insurer demands for evidence that it pays for itself in reduced medical spending. The evolution of DM has involved focusing on patients with a higher likelihood of benefiting, for example, instead of all diabetics, focus on those with more severe disease. It has also involved choosing diseases on the basis of disease patterns in an employer's workforce. The benefits to employers and insurers of disease management are limited by turnover. Returns to these investments are lost when an employee changes jobs or health plans. Some important benefits of disease management are probably ignored because most employers are unable to measure benefits of reduced disability and absenteeism and higher productivity while on the job.

Little research on the effectiveness of DM has appeared in peer-reviewed journals. This could reflect the rapidly changing mechanisms used or a lack of financial support for careful objective studies. It appears that DM companies have been able to present enough evidence to employers and insurers to justify the continuation and expansion of disease management. However, the returns do not appear to be very large. DM might be effective enough to more than pay for itself, but it is unlikely to be a potential solution to the broader health spending issue.

Medicare has been conducting extensive demonstrations in DM for a number of years. There are factors that suggest that the tool could either be more or less effective in Medicare than in employer-based coverage. The low rate of turnover in the Medicare population is clearly a plus, since more of the gains from the investment can be captured by the program. The fact that an elderly population has a higher incidence of chronic disease presents a substantial opportunity for DM to have an effect. However, the gains that employers can realize from reduced absenteeism and disability do not apply here.

Employers have invested in DM on the basis of very limited information on its effectiveness. This could be a problem for Medicare, where officials do not have the opportunities that private-sector benefits managers have to pursue initiatives with only limited research evidence to support it. This helps explain why CMS has invested a lot in demonstrations of DM—it needs successful demonstrations before it can contemplate much broader application.

Further development by private payers of DM tools will have benefits for the Medicare program. The more effective the tools are, the more likely that the Medicare program will be able to employ them. Transferring the technology should not be a problem, since either DM vendors or private insurers who conduct DM with their own staffs can be hired as contractors in Medicare.

Recently, employers have become more interested in promoting wellness in their workforces. However, the field appears to be highly fragmented; it has not coalesced around a small number of tools that are seen as particularly effective. One tool that has recently garnered interest has been the health assessment. Some employers have pushed employees to take the assessment, using either bonuses or penalties. In King County, Washington, the local government has gotten a lot of attention for not only using incentives to encourage employees' taking the assessment, but also for attaching rewards for following the advice given in the assessment. The field of wellness seems to be at a much earlier stage than is DM and is probably less likely to be applied to Medicare in the near future.

Conclusion

The outlook for federal spending on health care is substantially intertwined with developments in private health insurance. Beneficiaries of federal programs and enrollees in private coverage get their care from a common health care delivery system. Federal programs cannot succeed by pushing the delivery system in directions that are at odds with directions pursued by private payers. There are important opportunities for tools used in the public or private sector to contain spending to make similar efforts more effective in the other sector. Public and private insurers today are very familiar with the tools of their counterparts and more open to adapting them than has been the case in the past.

At this point in time, greater use of patient financial incentives, coupled with providing patients with information on provider price and quality, is the key strategy of private payers. The public sector is not pursuing such a strategy, and it does not have a clear strategy of its own, except for the current administration's strategy of increasing the use of private insurance in public programs. However, a number of public-sector activities have the potential to facilitate private-sector strategies and possibly have some favorable direct effects on the private-sector delivery system. These activities include revamping provider reimbursement to reduce inadvertent incentives to expand certain services and promoting measurement and reporting of provider quality.

Notes

1. Office of Management and Budget, *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2007* (Government Printing Office, 2006). These estimates refer to foregone federal income tax revenue only and do not include foregone revenue from federal payroll taxes or state income taxes.

2. In 2006 Massachusetts enacted a series of policies designed to substantially reduce the proportion of the population who are uninsured. The policies included an expansion of public coverage for low-income persons, subsidies to purchase private insurance, fees to be assessed on employers who do not provide coverage,

a mechanism to increase the efficiency of the insurance market for small groups and individual purchasers, and a mandate on individuals to have coverage.

3. The TRICARE program provides private insurance for military dependents and retirees.

4. Paul B. Ginsburg, "Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?" *Health Affairs* web exclusive, October 8, 2003: W3-472–W3-479.

5. A network is a listing of medical providers who have a contract with the insurer to provide services to enrollees at a negotiated price. The terms "broad" or "narrow" refer to extensive or limited degrees of provider choice.

6. Policymakers are becoming concerned about how declines in physician income in primary care have resulted in fewer physicians entering into those specialties. Similar concerns in the mid-1980s led to reform of physician payment in Medicare, which was enacted in 1989.

7. Private employers found employee interest in centers of excellence to be much lower than anticipated. Medicare was not able to translate its successful demonstration of the approach for coronary artery bypass graft surgery (CABG) into demonstrations for other procedures, perhaps because the ease in measurement of provider quality and the substantial variation in provider quality are not found in many other important procedures. When variation in quality is small, less is gained by pushing consumers to use the better providers.

8. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement, Table HI01, "Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2005, All Races," http://pubdb3.census.gov/macro/032006/health/h01_001.htm.

9. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington: Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press, 2000); Committee on Quality of Health Care in America, *Crossing The Quality Chasm: A New Health System For The 21st Century* (Washington: Institute of Medicine, National Academy Press, 2001).

10. Although some employer surveys do include detailed questions on the benefit structures of health plans and actuaries have models to summarize this information into an actuarial value, the dynamism of benefit structures leads this approach to underestimate changes. When a new type of cost sharing is introduced, its impact will not be measured during the period from its introduction until it is recognized as pervasive enough to include in survey questionnaires.

11. America's Health Insurance Plans, "January 2006 Census Shows 3.2 Million People Covered by HSA Plans" (Washington: AHIP, Center for Policy and Research, 2006).

12. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement, Table HI01.

13. Calculations by the author from National Health Accounts data published by the Centers for Medicare and Medicaid Services.

14. Marc L. Berk and Alan C. Monheit, “The Concentration of Health Care Expenditures, Revisited,” *Health Affairs* 20, no. 2 (March-April 2001): 9–18.

15. The Center for Studying Health System Change is studying this experience with support from the California HealthCare Foundation. The discussion here is limited to information that has been covered in public presentations by officials from Aetna or the Virginia Mason Medical Center.

16. Paul B. Ginsburg and Joy M. Grossman, “When the Price Isn’t Right: How Inadvertent Payment Incentives Drive Medical Care,” *Health Affairs* web exclusive, August 9, 2005: W5-376–W5-384.

17. Hoangmai H. Pham, Jennifer Coughlan, Ann S. O’Malley, “The Impact of Quality-Reporting Programs on Hospital Operations,” *Health Affairs* 25, no. 5 (September-October 2006): 1412–422.