IMPLEMENTING HEALTH REFORM

Innovation Center to Focus on Pilot Projects

Next year, the federal government will launch the Center for Medicare and Medicaid Innovation, a new department to oversee the portfolio of payment pilot projects called for under the Affordable Care Act.

As part of its charge, the innovation center will develop and evaluate pilot projects for new and old payment ideas that include accountable care organizations, patient-centered medical homes, bundled payments, and capitated payments.


STUART GUTERMAN

Officials at the new center, one of the Centers for Medicare and Medicaid Services (CMS), will have the authority to extend or expand projects that show the potential to improve quality or cut costs.

Stuart Guterman, who studies payment policies for the Commonwealth Fund, explains the potential and the challenges for officials leading the new innovation center.

FAMILY PRACTICE NEWS: Why did lawmakers create this innovation center as part of the Affordable Care Act? Is it necessary?

Mr. Guterman: I think it is necessary. I think, in fact, it may turn out to be one of the most important provisions in the law. It focuses the attention of the CMS, which runs the two biggest health programs in the country, on the notion of innovation. It emphasizes the idea that we need to try new approaches to both payment and delivery of health care to get out off the path that we're on, which is leading to ever-growing health care costs and more pressure on the health care system.

We already spend 50% more than any other country in the world on health care. Everybody points to the amount of waste in the system. But it's harder to identify ways of actually getting rid of it and making the health care system work better for people. That's what this innovation center was intended to do – to focus the attention of the federal government on that issue and to bring in the other parts of the health care sector to collaborate on better ways of providing care and better ways of paying for care.

FPN: Some of the concepts – such as medical homes and capitated payments – have been tested before. What makes this effort different?

Mr. Guterman: Capitation was tried in the 1990s, but the world was a different place then. In the 1990s, we didn't have the kinds of measures of health system performance that we have now. Also, the notion of capitating payments so that you provided a strong incentive to reduce costs got separated from the notion of providing care in an effective, efficient way. So we started out with a managed care movement that was focused on providing coordinated care for patients and we ended up with a movement that was focused primarily on reducing the costs, sometimes in arbitrary ways. Today, I think we have the tools to avoid going off that track. We may not get all the way to capitation, but there are bundled payments and other strategies that get us away from the current fee-for-service system.

In terms of the medical home, models are being tested by various private payers, Medicare is developing a demonstration project, and Medicaid is testing several models. But those efforts are fragmented, just like the rest of our health care delivery and financing systems. If we conduct these pilots individually, they are much less effective than if they can be coordinated and focused, using the same kinds of measures.

FPN: What are the keys to making the innovation center successful?

Mr. Guterman: We need to bring together all of the health care system's stakeholders. We are currently projected to spend between $30 trillion and $35 trillion on health care over the next 10 years. The issue is not what to cut, it's how to use some reasonable amount of money to buy the kind of health care we think our system should produce. That requires the involvement of everyone – providers, patients, and public and private payers.

FPN: What challenges will officials at the innovation center face in rapidly testing new payment concepts?

Mr. Guterman: It's easy to say that everyone ought to be involved, but right now people tend to look at change as something that threatens them. We need to overcome that. We also need to have patience. A lot of these projects will take time to develop and implement, and to adjust as they go along. But Congress and the American public also need to have patience and realize these strategies will take awhile to unfold.

FPN: Is the innovation center's work likely to significantly lower costs?

Mr. Guterman: Yes, though it's hard to predict just how much. You've got a system now that pays for more care, more complicated care, and more invasive care, but not more appropriate and efficient care. So you've got to figure that if you change the focus from more to better and from more invasive to more appropriate, that you can make some difference in lowering costs. ■

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Most of 2010 Premium Increases Passed on to Employees

BY NASEEM S. MILLER

For the first time in several years, U.S. workers are footing nearly the whole bill for the premium increases associated with their employer-provided health insurance. According to a nationwide survey, employers are declining to take more than a tiny share of the load.

The Employer Health Benefits 2010 Annual Survey shows that the average annual premium for employer-provided family health insurance is $13,770 this year. Of that, employees are paying an average of $3,997, an increase of $482, or 14%, from 2009, according to the survey, which was conducted by the Kaiser Family Foundation and the Health Research & Educational Trust.

"It's the first time that I can remember seeing employers cope with rising health care cost by shifting virtually all of the cost to the workers and it just speaks to the depths of recession and the pressure that employers have been under to hold the line on cost while trying as best as they can to avoid layoffs," Drew Altman, Ph.D., president and CEO of the Kaiser Family Foundation, said during a press briefing.

The survey authors note that employer-provided health insurance is one piece that has not received enough attention in the health reform debate. They predicted that the increased out-of-pocket cost for employees is not going to stop in the next few years, despite implementation of the Affordable Care Act.

"The longer term trend is that what workers pay for health insurance continues to go up much faster than their wages, while at the same time their insurance continues to get less comprehensive," Dr. Altman said. "So the insurance that workers get just looks less and less like the more comprehensive coverage that their parents got."

The survey was conducted between January and May 2010. The findings are based on a telephone survey of benefit managers for 2,046 randomly selected, nonfederal public and private companies with three or more employees.

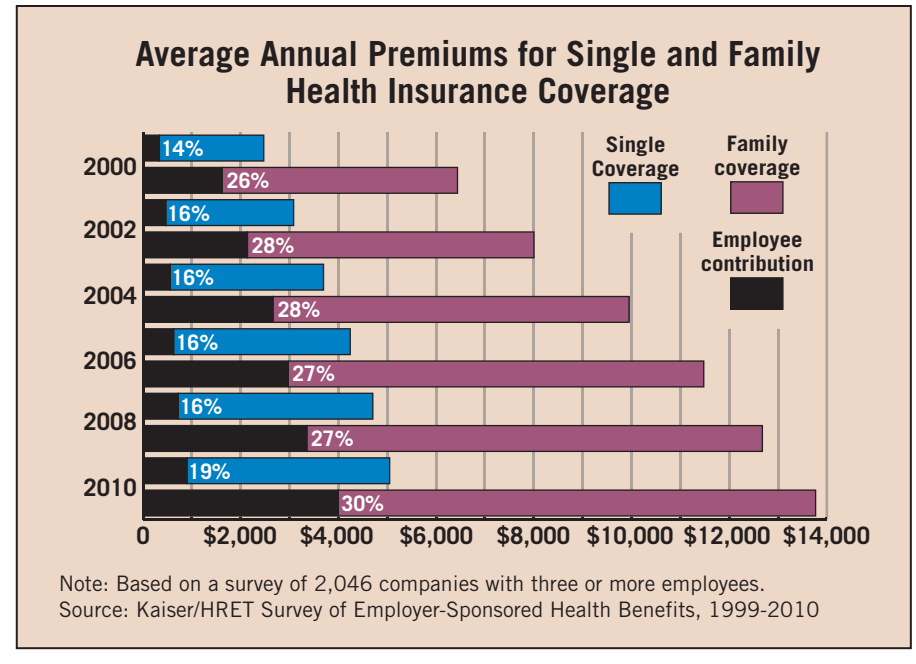
The survey findings show a modest increase in premiums from last year: The average annual cost of premiums for single coverage was $5,049 in 2010, up 5% from 2009. The average premium for family coverage rose 3% to $13,770.

The average primary care office visit copayment increased from $20 in 2009 to $22 in 2010, and from $28 to $31 for a specialist office visit, according to the findings.

Among the surprising findings of the survey was a significant increase in the percentage of companies offering health benefits in 2010 (69%) compared with 2009 (60%). The researchers attributed the increase to the fact that a greater percentage of very small companies – those with 3-9 employees – offer health insurance as a benefit.

Why the increase occurred was unclear, they noted. One possible explanation was that more very small companies that previously did not offer health insurance as a benefit have failed, shrinking the pool of companies to measure.

More than 150 million nonelderly Americans have employer-sponsored health insurance, making it the leading source of coverage. ■



Note: Based on a survey of 2,046 companies with three or more employees.
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010

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