CHAPTER 4

# REFORMING THE FINANCE AND PAYMENT SYSTEM

## Introduction

This section describes recommended finance and payment system strategies to ensure universal financial access to a uniform benefits package and to control expenditures for those benefits. As presented in Chapter 1, these recommendations focus on insurance as a key financial access mechanism and emphasize four key policies:

1. The service delivery system should offer individuals a choice of types of providers and systems from which to obtain health services, and offer practitioners a choice of work environments. Managed care strategies and systems should continue to be an important characteristic of the service delivery system.

2. The system should enhance portability of coverage and "smooth the seams" of coverage that may occur as the result of changes in job, financial status, or place of residence. The need for individuals to change health plans and care providers should be minimized, consistent with prudent cost control measures.

3. Behaviors or decisions that discriminate based on health status should be minimized. The system should minimize incentives for employers to employ only healthier workers, for providers to serve only healthier individuals, and for health plans to enroll only healthier people. In other words, health plans, service providers, and insurance sponsors (e.g., state programs, employer-sponsored plans) should not be able to control their own costs by shifting costs to others.

4. Individuals, employers, governments, and other health insurance sponsors should be able to purchase coverage for benefits that are not part of the uniform benefits package or to purchase such services directly. Unless otherwise stated, finance and payment mechanisms and relationships regarding these "supplemental" benefits are left up to the individuals or organizations involved in financing, paying for, providing, and using such benefits.

### FACTORS DRIVING UP HEALTH COSTS

Chapter 1 points out that spending on health services in Washington state has been increasing at two to three times the general inflation rate. Neither the regulatory programs of the 1970s nor the market strategies of the 1980s appear to have slowed this rate of spending growth.

What drives the cost of health care up so fast? The federal Health Care Financing Administration (HCFA) defines four categories of cost drivers: population changes (e.g.,

increasing proportion of older adults), general inflation (price increases in the economy at large), medical inflation (price increases for health services and products over-and-above general inflation), and other factors (e.g., new technologies, increased demand, increased rates of testing or procedures *for each patient*, increased administrative complexity). Figure 2 shows how important these four factors have been in health care spending increases for selected years from 1965 to 1988.

One overarching explanation for continuing spending growth, which takes into account the four HCFA categories, is that buying and selling health care -- the health care market -- does not work like other competitive markets to hold down costs. Experts point to one or more of the following "market imperfections" and other major causes of increasing health system expenditures:

•Methods of paying providers place few limits on and, in fact, give economic incentives to use more services, to do all that is possible for each patient, and expand capacity for health care, regardless of cost or benefit.

•Providers of services are also often decision makers about the amount, frequency, and type of services used. Consumers and purchasers lack sufficient information to prudently choose among providers or service options.

•Consumers demand more and higher quality health services, in part due to insurance coverage that shields individual consumers from having to directly pay most costs.

•New and expensive medical technologies and treatments are rapidly developed and used, often without evaluation of their relative costs and benefits. Providers and consumers both demand to use these new technologies.

•The costs of administering public and private health programs and provider services are increasing rapidly due to duplication, competition, and expanding efforts to manage care.

•The supply of physicians continues to grow, rising from 1.6 per 1,000 people in 1970 to 2.4 per 1,000 in 1990.

•The aging population means an increasing need to treat chronic illnesses.

•Policy and management responsibilities are defuse and fragmented, making coordination, access, and cost control difficult.

•Information regarding costs and benefits of many medical treatments, services, and practice patterns is inadequate.

•The health care liability system may contribute to rising costs: high insurance premiums may

push prices for services higher; clinicians may order unneeded tests or treatments to protect against possible liability claims or lawsuits; the insurance and civil justice processes may be inefficient in determining liability and providing compensation for negligence-injured patients.

•Competitive insurance practices have lead to higher costs for some purchasers than others, based on the medical risk of the insured group and the market power of the purchaser.

## PAST ATTEMPTS AT COST CONTROL

There are many examples, both past and present, of strategies that have tried to resolve each of these supply and demand cost-drivers. And some of these strategies have, in fact, "worked" to the extent that a specific symptom may have been alleviated for a specific program. For example, diagnostic related groups or DRGs, the prospective payment method created by Medicare in 1983, was developed to control hospital expenditures, the largest category of health care spending. The DRG system pays hospitals a fixed fee for a given patient, regardless of how long that patient is in the hospital or how many services s/he uses. By putting hospitals at financial risk, DRGs created incentives for greater efficiency. As a result, Medicare hospital lengths-of-stay have decreased and inpatient hospital spending increases were moderated. However, the program's out-of-hospital expenditures seem to have accelerated, meaning Medicare's "bottom-line" may not have changed.[i]

A second example of targeted cost control strategies is the certificate-of-need program (CON). CON attempted to control the proliferation of, among other things, high cost diagnostic technologies (e.g., magnetic resonance imagers, CAT scanners). In Washington state, as in nearly all states, CON regulations concerning the purchase of new high cost equipment applied only to hospitals. While the program may have moderated the proliferation of certain technologies by *hospitals*, these diagnostic machines were instead purchased by *physicians* and other non-hospital entities. As with the DRG example, CON appears to have shifted rather than controlled costs.[ii]

A final example comes from the private sector. In the past decade, as awareness of "the health cost problem" grew within the business community, employers undertook various strategies to control their costs. These efforts were targeted, in part, at increasing the cost-sensitivity of employees as they made decisions about when and how to use health care (by increasing the employee's share of costs) and, in part, to induce more efficient service delivery by providers and health plans (through greater use of managed care strategies). According to a U.S. General Accounting Office report,[iii] the percentage of firms that paid full premiums for their employees fell from 74% in 1980 to 55% in 1988 for individual coverage plans, while for family coverage plans the rates fell from 54% to 37%. During 1982-88, average monthly employee contributions nearly doubled (from $9 to $18 for individuals, $27 to $52 for families), exceeding the 23% economy-wide inflation rate during that time. Between 1980 and 1988, the proportion of

employer-sponsored plans with a deductible of $150 or more rose from less than 10% to 40%.

Employers also increased their use of managed care systems: by 1988, more than 70% of workers covered through their work place were enrolled in such systems.[iv] Firms also implemented care management techniques of their own, including mandatory second opinions for surgeries and pre-hospital admission review. Over 60% of employer plans in the U.S. had preadmission review requirements in 1988. Yet, in spite of the rapid expansion of managed care and the trend towards greater employee cost sharing, employer health care spending increases have continued to outpace inflation by 100-200% each year.[v]

Commission members studied and discussed the reasons that these various targeted strategies have not been successful in controlling the health system's financial appetite. The Commission concluded that the many cost-drivers and the complex relationships among them require a *comprehensive approach* with complimentary strategies to ensure financial access, control total expenditures, and infuse incentives for efficiency and effectiveness. In other words, rather than focus on controlling only certain specific cost drivers, the Commission decided to address the "finance and payment system," the incentives and rules that govern the relationships between funding sources, purchasers, service providers, and consumers. In addition to service users/consumers/patients, the elements of the finance and payment system include:

- **"Financers"** are the *origins* of funds used to purchase services, including individuals/households, employers, and local/state/federal taxes.

- **Purchasers** are entities that pay service providers directly, including individuals, self-funded employers, private insurance plans, certain managed care plans, and public insurance programs. In some cases a purchaser may also be a financer; for example, an individual or self-funded business that pays service providers directly.

- **Providers** are individuals and organizations that provide health services to individuals or communties. Providers include facilities (e.g., hospitals, nursing homes), health care practitioners (e.g., physicians, dentists), private organizations (e.g., pharmacies, home care agencies, community health centers), and public agencies (e.g., local health departments).

In order to guide its development of a comprehensive approach to reforming the finance and payment system, the Commission developed a set of cost control criteria.

# Cost Control Criteria

The following cost control criteria will be used by the Washington Health Care Commission to evaluate the strengths and weaknesses of alternative financing and payment systems in controlling health service costs:

## CRITERIA TO CONTROL HEALTH SERVICE COSTS

Does the proposed financing and payment system:

(1)Comprehensively address all elements of the health system so as to control total health system expenditures?

(2)Minimize unnecessary administrative costs by encouraging simplicity and cost-effective administrative activities at all levels of the system?

(3)Promote the efficient delivery of appropriate and effective health services (including the appropriate and effective service, timing, location and setting, type of provider, and payment level) with safeguards to prevent inadequate, unnecessary, or harmful care?

(4)Encourage the use of appropriate, effective, and timely health services by consumers and discourage inappropriate use of those services?

## COST-RELATED CRITERIA

Does the proposed financing and payment system:

(5)Promote health, healthy behaviors, and disease/injury prevention through financing decisions?

(6)Ensure adequate financing of operating, capital, and professional education/training so as to support an efficient system of appropriate and effective health services?

(7)Encourage the equitable distribution of financial burdens, so they do not fall disproportionately on particular individuals, employers, employees, providers, private insurers, communities, or governments?

(8)Promote organizational structures that encourage efficient management and delivery of appropriate and effective health services at the local level?

(9)Encourage the creation and appropriate dissemination of effective and efficient innovations and developments?

## Responsibilities and Authorities

The Commission studied operating and proposed health systems from a number of countries and states, including Hawaii, Oregon, Massachusetts, New York, British Columbia, Germany, and Japan. Combined with the lessons learned from past cost control efforts in Washington, this review helped the Commission members develop a range of possible strategies that could successfully control system expenditures and ensure universal financial access, consistent with the cost control and access criteria.

The Commission's comprehensive approach to reforming the finance and payment system begins with certain *key desired characteristics* drawn from the recommendations and policy statements presented in Chapters 1-4:

•**Stakeholders** - All stakeholders -- consumers, employers, employees, providers, insurers, communities, and governments -- should participate in developing and implementing system reform.

•**Choice** - Consistent with responsible cost control, individuals should have a choice of efficient and economic service delivery systems, and providers within those systems. Service providers should have a choice of practice environments.

•**Shared Financing Responsibility** - Financing the health system should be equitably shared by individuals/households, employers, and governments. Shared (or pluralistic) financing ensures each sector has a direct stake in the system, providing checks and balances against the economic dominance of any one interest or perspective.

•**System-wide Cost Control** - Cost control mechanisms must be comprehensive so as to control total health system expenditures.

•**Efficiency and Innovation Through Incentives** - Health costs should be controlled in significant part by incentives (for payers, providers, and consumers) to reduce the provision and use of inappropriate and ineffective health services. Incentives should promote integrated organizational structures that efficiently manage and deliver appropriate and effective health services at the local level. The system should encourage the creation and appropriate dissemination of effective and efficient innovations and developments.

Based on these desired characteristics, the Commission defined a set of nine "responsibilities and authorities" that would, when implemented, create strong incentives to control total system spending, enhance the efficiency by which services are delivered, promote prudent use of services by consumers, and equitably distribute the financing of the health system.

**UNIFORM BENEFITS PACKAGE**

In order to ensure universal financial access, the finance and payment system must first identify the set of services for which all state residents will have coverage. All state residents should have insurance coverage for at least a uniform benefits package, determined within criteria and other parameters set by the State Legislature. The package should be more comprehensive[a] than lean, leaving a relatively small portion of total health service expenditures outside the package. Mechanisms to ensure that the package remains comprehensive over time, consistent with controlling total expenditures for the package, must be implemented.

## TOTAL EXPENDITURES

To avoid the failures of past targeted cost control strategies, total system expenditures for the uniform benefits package must be controlled; that is, controlling the costs incurred by only certain providers, payers, or financers is not sufficient. The finance and payment system must include a mechanism to define and control the **maximum** resident/month premium that payers/insurers will be allowed to charge -- or that managed care plans will be paid -- for the package. Different maximum premiums could be defined for different situations (such as urban or rural, or groups with higher than average medical risks). The premium and/or target or budget expenditure level should be adequate to fund the package through an efficient and effective service delivery system and be based on an analytic process.

## INDIVIDUAL FINANCIAL PARTICIPATION

Individuals must help finance their uniform benefits package in order to promote prudent service use and purchasing decisions, but not to the extent that financial participation becomes an access barrier to appropriate and effective health services.

To this end, the finance and payment system should include a mechanism to:

- determine levels and limits of individual financial responsibility for premium sharing and point-of-service cost sharing (copayments, deductibles, coinsurance, and maximum out-of-pocket spending) based on an individual's ability to pay (for example, income and/or asset-based sliding scales);

- apply point-of-service cost sharing primarily as an incentive for appropriate use of services and secondarily as a means of financing the uniform benefits package;

- determine whether absolute levels, maximums, or ranges of individual financial participation are

[a] "Comprehensive" in this context refers only to the **array** of health services covered, not to the level or distribution of financial coverage for or other limitations on services (for example, number of visits and levels of coinsurance, deductibles, and copayments), which may vary by service and type of beneficiary.

appropriate for premiums and point-of-service cost sharing; and

•ban or limit the extent to which supplemental benefits are allowed to cover cost sharing provisions intended as incentives for appropriate use of uniform benefits.

**PROVIDER PAYMENT METHODS**

To promote efficient service delivery and the use of appropriate and effective services, the finance and payment system should encourage the development of payment methods that eliminate charge-based fees and move toward prospective payment methods that shift a greater portion of financial risk to providers. A mechanism should exist that will determine provider payment methods, including the authority to limit the number of allowable methods and to ban certain methods, for both uniform and supplemental benefits.

**BILLING, CLAIMS, AND UTILIZATION MANAGEMENT**

The finance and payment system should contain a mechanism to determine uniform billing and claims policy and procedures, and utilization management policy for both uniform and supplemental benefits. Utilization management policy should promote uniformity and simplicity to the extent it does not interfere with the development and application of cost-effective utilization management techniques. Utilization management techniques should be used when they cost-effectively reduce unnecessary and inappropriate health services.

**MEDICAL RISK DISTRIBUTION**

The finance and payment system should include a mechanism to distribute the financial effects of medical risks equitably among all insurers/payers and providers. This mechanism is necessary to reduce the incentives to reduce costs by avoiding medical risks.

**HIGH COST TECHNOLOGY**

The finance and payment system should include a mechanism to control the proliferation of high cost technologies. Such a mechanism is necessary, because high cost technologies -- especially diagnostic tests -- are a strong driver of health care spending increases: medical tests represent about 7% of total expenditures; 20-60% of tests may not contribute to diagnosis or treatment; technology may account for 25-75% of hospital cost increases.[vi]

**PROVIDER CONFLICTS OF INTEREST**

The finance and payment system should include a mechanism to prohibit or restrict provider investments that present conflicts of interest (e.g., an X-ray laboratory partially owned by a physician who refers patients to that lab).

## HEALTH PLAN CERTIFICATION

The finance and payment system should include a mechanism to ensure that health plans are "certified"; that is, that a health plan is capable of providing uniform benefits coverage consistent with policies promulgated as a result of these responsibilities and authorities.

# State Authority

After determining the health system responsibilities and authorities necessary to ensure financial access and control costs, the Commission discussed the need for an entity or entities to carry out those responsibilities. The multifaceted nature of our current health system provides strong incentives for each stakeholder to further its own interests, minimizing its own financial burdens in part by avoiding risks and shifting costs. The Commission believes these shortcomings require some entity to guide the system in the public interest. Members considered entities in both the public and private sectors, as well as those at the federal, state, and local levels. Emphasis was placed on independence from existing state bureaucracies, an arms-length relationship to the Legislature, and accountability. The Commission concluded that a permanent, independent state board or commission would be best able to coordinate and guide the efforts among the numerous public and private entities involved in financing, purchasing, and delivering health services to Washington residents.

Therefore, the Washington State Legislature should establish a permanent and independent state board or commission (referred to in this document as "the authority") that carries out the "Responsibilities and Authorities" described in the previous section. The authority should have the following characteristics:

## COMPOSITION

The authority should comprise five to nine full-time paid members, appointed by the Governor and confirmed by the State Senate for defined terms. Members should represent the public interest and have no fiduciary tie to any health service activity during their terms. The authority should include members with experience in various elements of the health system. The authority should have independent rule-making authority which, pursuant to state law, requires formal public involvement in its decision-making process.

## STAKEHOLDER ROLES

The authority should be required to establish structures and processes that allow formal participation of stakeholders (including business, labor, government, providers, insurers, and consumers) in its decision-making processes. For the specific purpose of developing and updating the uniform benefits package, the authority should implement a stakeholder process that incorporates at least the following functions:

- collate national research on health service effectiveness and appropriateness;
- provide access to and collate data on health service appropriateness and effectiveness in Washington;
- set priorities for assessing the appropriateness and effectiveness of health services;
- identify data needs for necessary assessments;
- assess how well specific health services meet technical criteria;

•disseminate information about the degree to which health services are appropriate and effective;
•assess public values necessary to determine to which health services all residents should have access;
•recommend revisions to the uniform benefits package applying Washington-specific values (non-technical criteria) as well as technical criteria; and
•assess how well the uniform benefits package achieves expected health system outcomes.

# Finance and Payment System Model

The Commission's recommendations to reform the finance and payment system in Washington state come together in a system "model," a description of the desired relationships among financers, payers, providers, and consumers of health services. Figure 2, "Financing and Payment System Model," shows these desired relationships, including the state authority and its responsibilities and authorities. Descriptions of specific parts of the model are presented below.

## COMPETING HEALTH PLANS

A defined uniform benefits package means that some entity or entities must manage the package and ensure that covered services are, in fact, available and provided when needed. Two general options for packaging benefits and delivering services exist: (1) the state or an agent/contractor of the state, or; (2) two or more intermediaries or "plans." The first option defines a British Columbia-like system in which the state has direct contractual relationships with individual practitioners, facilities, and other service providers. This means the elimination of what we call managed care systems (although, the state could be considered **the** managed care system). The Commission's recommendations concerning choice, efficient management and service delivery, and managed care systems are contradictory to this option.

Therefore, the Commission envisions two or more "health plans" that would manage uniform benefits. These plans would have direct financial (and, perhaps, contractual) relationships with service providers. Health plans could be sponsored by existing private insurers, health maintenance organizations, other managed care plans, state or local governments).

## SHARED FINANCING RESPONSIBILITIES

The Commission recommends that governments, businesses, and individuals must equitably share the burden of financing the health system. The question is not whether each sector will pay, but *how and how much*. Commission members agree that the following policies should govern how financing burdens should be shared:

- Individuals must share in uniform benefits package premiums, co-payments, deductibles, and co-insurance, except if such sharing poses a barrier to appropriate and effective health services.

- Government must be the primary financer of coverage for people who are unemployed and must also help finance coverage for low income, part-time, and seasonal employees and employees of some businesses (e.g., small or start-up firms).

- Employers must be the primary financers of coverage for their employees and dependents.

## STATE AUTHORITY

As presented above, the Commission recommends that a permanent state authority be the responsible body to carry out the responsibilities and authorities necessary to control costs and ensure financial access. In defining the "Responsibilities and Authorities", the Commission has said that the system of financing, managing, and delivering services/benefits needs to exhibit certain uniform characteristics. In order to control total spending and produce these uniform characteristics, the Commission recommends that the authority ensure that health plans are "certified" to cover the uniform benefits package consistent with the authority's policies and procedures.

## UNIFORM BENEFITS PACKAGE SPONSORSHIP

### Employers

The remaining variable in the Commission's finance and payment system model is whether employers will (continue to) sponsor uniform benefits packages -- remembering that the Commission has stated that employers must, in any case, help finance these benefits. From one point of view, this is a question of the relative benefits and costs of having employers involved in making or restricting the choices of health plans available to individuals (in addition to the authority doing so through a certification process). From another angle, it is a question of whether emploeyrs can exert pressure on the system to control costs, over and above the other system features defined by the Commission (capped premiums, uniform billings and claims, provider payment methods, etc.). In addition, political and labor/management issues are central to the question of employer involvement.

Some **arguments for allowing employers to sponsor** uniform benefits include:

•If an employer wants to offer supplemental benefits, it may be more efficient to purchase both uniform and supplemental benefits in one package.

•Many employers already have the administrative mechanisms in place to offer the uniform benefits coverage, minizing the amount of system "retooling" necessary.

•Policies of the state authority could provide incentives for businesses to seek value and efficiency. Employers could in turn create incentives for employees and the combination could create continuous pressure on health plans (who would compete for enrollment) to be more and more efficient.

•Health benefits are an important part of employer-employee relationships today and such relationships could be traumatized if employers are taken "out of the loop."

Some **arguments against allowing employers to sponsor** uniform benefits:

•Businesses would continue to be an added layer of administration in the system.

•The experience, to date, of employers exerting pressure for greater system value and efficiency is equivocal.

•If employers sponsor uniform benefits, then the system will continue to have a "seam" defined by one's employment status, forcing changes in an individual's health plan or care provider.

The Commission decided to continue its study of the pros and cons of employer sponsorship of uniform benefits coverage before making a final recommendation. The question mark in Figure 2 represents this unresolved question.

**Single State Plan**

While not yet deciding about employer sponsorship, the Commission did discuss who should sponsor uniform benefits for residents not covered through their places of work *if employers do sponsor these benefits*. The Commission recommends that a "single state plan" cover state residents who do not have employer-sponsored coverage, including people who are now uninsured, Medicaid recipients, enrollees in the Basic Health Plan, and Medicare enrollees.

## Endnotes

i.See David, Carolyne K. et al, "The Impact of DGRs on the Cost and Quality of Health Care in the United States," Health Policy, 1988; 9:117-121; and Rosko, Michael D, "A Comparison of Hospital Performance Under the Partial-Payer Medicare PPS and State-All-Payer Rate-Setting Systems," Inquiry, 1989 Spring, 26:48-61.

ii.State of Washington Legislative Budget Committee, "Sunset Review of the Washington State Hospital Commission and Hospital Cost Containment," p.58-61, 1988.

iii.United States General Accounting Office, "Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting," May 1990.

iv.United States General Accounting Office, "Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting," May 1990.

v.Foster Higgins, "Health Care Benefits Survey," 1989.

vi.Friedman, David, testimony to the Health Care Commission's Cost Control Committee, March 7, 1991, Travelers Health Network.