Navigating payer heterogeneity in the United States: lessons for primary care

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ABSTRACT

With most providers accepting private and public funding, the US exemplifies hybridization, which results in both systemic benefits and harms. While this practice stimulates innovation, encourages practices to be efficient, and increases choice, it has also been linked to gaps in patient safety and overtreatment. We propose three lessons from the US for navigating a public and private system: hybridization allows for innovation; hybridization leads to administrative complexity; and if the costs of participation outweigh the benefits, practices may undergo dehybridization.

The US Health Care System

At nearly US$9500 per capita in 2015, US health-care spending is both exceptionally high and remarkably balanced between public and private sources.[1,2] For every public dollar the US spends on health care, US$1.02 is spent privately, compared to US$0.38 for all other Organization for Economic Cooperation and Development (OECD) countries.[2] The tremendous level of spending does not translate to better outcomes, with the US life expectancy falling below the OECD average.[3]

Public spending primarily consists of Medicare (for the elderly) and Medicaid (for the impoverished), but this care is most often delivered in private settings with the government directly employing less than 3% of all US physicians.[4,5] Across all employers, nearly all (9 out of 10) primary care physicians accept Medicare.[6] While a similar percentage also accepts private insurance, payments from private insurers constitute a greater proportion of practice revenue compared to Medicare (53 vs. 31%).[7]

As with other industries in the US, there are benefits to being businesslike. The profit motive stimulates innovation, encourages the efficient delivery of services, and increases choice. In a market-based system, providers compete to retain patients. Wanting to match the convenience and cost of retail-based clinics, primary care offices have expanded hours, started walk-in clinics, offered video visits, and become more price transparent.

Despite embracing free market principles, the US system is plagued by inefficiencies. Variation in spending is disturbingly high, and higher spending rarely translates to better outcomes.[8,9] Due to widespread adoption of expensive medication and legislation banning Medicare from negotiating pharmaceuticals, drug spending is higher in the US than in other countries.[10] To increase market share, hospitals have also consolidated, leading to higher prices.[11,12]

There are limits to efficiency, as the drive for profits can clash with patient safety. The current US fee-for-service system incentivizes visits and procedures, resulting in overdiagnosis, overtreatment and harm to patients, according to some.[13] For example, concurrent surgery is the practice of scheduling overlapping or simultaneous cases. While this practice is important for training and providing access to specialised surgeons, it has also been criticised for potentially leading to harm and increasing charges.[14,15] Strategies that enhance revenue, such as concurrent surgery, are not unique to for-profit entities. More than half of US hospitals are non-profit organisations, yet they are criticised for businesslike practices

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with chief executive officer salaries averaging nearly US$600,000 and non-profit organisations accounting for seven of the top 10 most profitable hospitals.[16–18]

While some non-profits use businesslike practices to thrive,[16] others depend on a hybridized business model to survive. In exchange for residing in underserved communities and seeing all patients regardless of ability to pay, Federally Qualified Health Centers receive federal grants and have become a critical component of the primary care safety net, serving 24 million Americans.[19,20] On average, 39% of health centre patients have Medicaid, while 36% are uninsured. While the majority of health centres have positive, albeit narrow, operating margins, one-quarter operate at a loss.[21] To remain financially viable, health centres rely on grants and contracts and have diversified their services to increasingly include mental health and dental services.[21]

Changes to Medicare

Publically financed, Medicare influences private insurers due to its sheer size. Started in 1966, Medicare is a national social insurance programme, administered by the government, and provides coverage to more than 55 million Americans who are 65 years or older, disabled, or have end-stage renal disease.[22,23] The *Medicare Access and Child Health Insurance Program (CHIP) Act* (MACRA) of 2015 changes how Medicare pays for services, by transitioning from volume- to value-based models.[24] The resultant Quality Payment Programme adjusts payment based on quality and cost, and comes with substantial reporting requirements.[25]

Lessons from the US

During this period of rapid change, there are numerous lessons to share from our experience navigating the duality of public and private payers.

Lesson one: hybridization allows for innovation

Although fee-for-service remains dominant, payers have long recognised that US health-care spending is unsustainable. The Center for Medicare & Medicaid Innovation is testing 30 non-fee-for-service payment models, including novel ways of paying for nursing home care, hospitalizations, end-stage renal disease, and practice transformation.[26] Private insurers are following suit by experimenting with alternative payment models.[27,28] Because most practices receive public and private funding, US clinicians and patients are exposed to a wide variety of payment frameworks. This allows payers and providers to simultaneously test multiple models, disseminate the ones that are working, and discard the ones that are not.

Lesson two: hybridization leads to administrative complexity

In addition to multiple commercial payers, primary care practices, including health centres, often receive funding from Medicare, Medicaid, and uninsured patients. As each payer has its own reporting system, payer heterogeneity has led to administrative complexity. Administrative costs in the US were US$156 billion in 2007 and are projected to reach US$315 billion by 2018.[29] The National Academy of Medicine estimates that US$190 billion can be saved by eliminating excessive administrative costs.[30] Higher administrative costs are not only wasteful but have also been linked to worse quality.[31] To pay for value, administrative costs have increased, with payers developing processes to assess quality and costs. This reporting infrastructure is expensive, with US primary care physicians spending over US$50,000 per physician yearly to report quality measures.[32]

Researchers have sought to quantify the consequences of payer heterogeneity by assessing measurement alignment across payers. A 2013 study examined measurement alignment among 23 health plans and the Physician Quality Reporting System (a Medicare programme). Of the 546 quality measures used by private insurers, 5% were used by more than half the plans. Only 6% of the 301 Medicare programme measures were the same as those used by the private insurers.[33] With misaligned and occasionally contradictory targets, providers have difficulty determining what changes to make. Nearly half of practices

reported that dealing with similar but not identical measure sets was a significant burden.[32]

The US government has acknowledged the burden measurement misalignment creates and has taken steps to understand its dimensions. The US Government Accountability Office identified three factors driving measurement misalignment: dispersed decision-making among various public and private health-care payers regarding measures, variation in data collection and reporting systems, and a paucity of meaningful measures on which stakeholders can agree to align.[34] In parallel, the Centers for Medicare & Medicaid Services (CMS) launched the Core Quality Measures Collaborative to align measures across public and private payers and develop meaningful measures.

In addition to aligning measures, CMS is aligning payment methods across Medicare and other public and private payers through the Comprehensive Primary Care Initiative. Participating primary care practices receive per beneficiary per month payments (the median payment per clinician was US$51,286 in 2015) in addition to fee-for-service in exchange for providing advanced primary care functions such as risk-stratified care management, expanded access, and increased patient and caregiver engagement.[35] Quality and utilisation data have been mixed, and the evaluation is ongoing.[35]

Lesson three: if the costs of participation outweigh the benefits, practices may undergo dehybridization

While payers have the potential to align payment methods and health outcomes, too much regulation can encourage providers to leave public funding altogether, with the reporting burden leading to real fallout. Those saddled by more administrative burden have reported higher burnout, reduced job satisfaction, and less interest in seeing patients.[36] Due to their lack of technological infrastructure and administrative support, the reporting burden is also thought to disproportionately affect solo and small clinics where more than half of family physicians in the US practice.[37] The US Department of Health and Human Services projects that 87% of US clinicians in solo practice will have a negative adjustment in payment under MACRA compared to 18% of practices with 100 or more clinicians.[24]

Dehybridization (or the process of reducing exposure to public or private insurance or leaving insurance) has already started in the US. Frustrated with administrative burden, a small but growing percentage of the family physician workforce has gravitated towards direct primary care. Direct primary care practices charge a periodic fee for services and do not bill any third parties on a fee-for-service basis. By working outside the insurance system, these providers report that they have more availability, more time per encounter, and lower overhead costs.[38,39]

Conclusion

While the US is plagued by high spending, poor outcomes, and market inefficiencies, there are benefits to its hybrid system. At its best, such as in the recent era of wide-scale health system transformation, hybridization allows safety net clinics to survive and for simultaneous testing of new payment models and delivery systems. The market-based system pushes practices to innovate and compete for patients. At its worst, hybridization is inefficient, as payer heterogeneity creates administrative and reporting chaos. The drive for greater efficiency and higher revenue can push the boundaries of patient safety and quality. For now, hybridization is alive and well in the US, offering both opportunities and challenges for primary care to navigate.

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COMPETING INTERESTS
The authors declare no conflicts of interest.