Nine Health Care Megatrends, Part 1: System And Payment Reform

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We are all futurists. We all have to make predictions—even if only implicitly—about the future to shape our lives: to determine what job we take, where to live, whether to buy a house, whether to get additional education or training and in what subjects, and on and on. The same is true for the 22 million people <https://www.census.gov/library/stories/2021/04/who-are-our-health-care-workers.html> employed in health care in the US as well as health investors and government policy makers. Thus, it is essential to periodically consider trends in the health care system, to figure out how to benefit from them, to assess how to bolster

beneficial trends or to impede those that seem unhelpful or even harmful. What does the future hold for health care?

In this three-part article, I present nine "megatrends" that I believe will characterize US health over the rest of this decade. They follow on the trends I identified eight years ago in my book *Reinventing American Health Care*. Below, in Part 1 of this article, I discuss the megatrends I predict related to system and payment reform. Part 2 will cover trends related to system reconfiguration, and Part 3 will focus on patient care trends.

As with everything, how these trends play out—especially how extensively and rapidly they are implemented and develop—will depend on government action, the overall economy, and commitment by those in the health care industry. As I discuss, not all of the trends I predicted in 2014 developed in the time frames I envisioned. But in my judgment, the trends I lay out in this article represent what is likely to happen.

At least for the foreseeable future, substantial federal government action—on the order of the Social Security Amendments of 1983 that created prospective payments for hospital inpatient care or the Balanced Budget Act of 1997 that created Medicare Part C, much less the Affordable Care Act (ACA)—is unlikely. After the Inflation Reduction Act, there is unlikely to be significant new health care legislation for the rest of the decade unless a crisis precipitates the need to do more to rein in costs. The only other major issue requiring legislation will be the impending insolvency of the Medicare trust fund, now projected for 2028 <https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/> . But none of the options to address this issue are attractive, so procrastination reigns. Consequently, much of the future of the health care industry lies in Centers for Medicare and Medicaid Innovation demonstrations projects and the decisions of the private sector.

Megatrend 1: Merging Of Payers And Providers—Amplifying Value-Based Payments

General and medical cost inflation are causing ever more pain, even among the insured. Premiums are stratospheric, with family plan premiums averaging just below $22,500 per year in 2022 and individual plans nearly $8,000. These cost increases have not been accompanied by any evidence of systemically improved quality. Instead, there has been a worsening <https://www.forbes.com/sites/debgordon/2022/11/28/60-of-americans-have-had-a-recent-bad-healthcare-experience-new-survey-shows/?sh=1cd72e572adf> of patient experience <https://www.fiercehealthcare.com/providers/leapfrog-group-patients-are-reporting-more-potentially-dangerous-hospital-experiences> , not to

mention growing dissatisfaction <https://www.nejm.org/doi/full/10.1056/NEJMp2207252> and burnout among clinicians and other health care employees. Employers have reached their limit, too: Average deductibles in employer-sponsored plans have nearly doubled <https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/> since passage of the ACA, from $1,025 for a single person to $2,004 in 2021.

In 2014, in *Reinventing American Health Care*, I predicted the end of insurance companies as we know them. I imagined hospitals would move to fuse payment and delivery of care, supplanting insurers. I was wrong. It turned out that hospitals did not take the initiative to merge payment and delivery. They proved unimaginative and demurred from being the leaders of transformation. Instead, it was insurers that changed their nature and became the disrupters by moving into health care delivery. We see that with United-Optum; Walgreens-Village MD; CVS-Aetna-Oak Street Health; and Humana buying various primary care groups <https://www.bain.com/about/media-center/press-releases/2022/new-models-of-primary-care-will-capture-30-of-the-us-market-by-2030-as-retailers-payer-owned-providers-and-advanced-primary-care-disruptors-gain-traction/> and recently entering a risk agreement with Aledade, as well as various mergers, acquisitions, and integrations by other payers.

These payer-provider mergers (what might be called the “Kaiserification” of US health care, something I did predict) are aimed at putting what businesspeople call “asset lite,” value-based primary care at the center of health care (see megatrends 4 and 6): care offerings structured around multiple convenient, digital channels for relatively healthy patients to access advice and care, and longer in-person visits for chronically ill patients that deliver more integrated care—behavioral health and social service support, supplemented by home care (see megatrends 5, 7, and 9). This combination works by preempting office visits with digital interactions and avoiding emergency department visits, hospital admissions, and re-admissions for exacerbations of chronic conditions.

The success of this merging of payer and provider will further accelerate the replacement of fee-for-service by alternative payment models (APMs) that put risk on providers. Providers are the key to controlling costs and ensuring quality of care. After all, physicians control the decisions about hospital admissions and orders for tests and treatments. And hospitals control the efficiency of operations and negotiate commercial prices. If providers were to eliminate inefficient and unnecessary care, it is estimated <https://jamanetwork.com/journals/jama/article-abstract/2752664> the savings could range from $86.8 billion to $164.1 billion—about $250 to $500 per American. And if they

were to provide more proactive care for patients with chronic illness, additional billions could be saved.

The past decade has seen a lot of talk about value-based payments, accountable care organizations (ACOs), bundles, capitation, and the like. However, compared to the rhetoric, implementation has been plodding. But the fusing of payers and providers across the US health care system finally seems to be at a critical inflection point and will drive expansion of APMs.

The Centers for Medicare and Medicaid Services (CMS) has pledged <https://innovation.cms.gov/strategic-direction-whitepaper> to have all fee-for-service Medicare patients in some kind of APM or ACO by 2030. Leading payers, such as UnitedHealth and Humana, are implementing more <https://www.unitedhealthgroup.com/newsroom/research-reports/posts/global-capitation-research-403552.html> APMs, especially prospective payments and capitation. Finally, APMs are taking hold <https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/2021-infographic/> not just for primary care providers but also for specialists. Bundles for orthopedic and other surgical procedures and value-based payments related to renal and oncology care are proliferating. And now cardiology groups are organizing to manage patients with serious cardiac conditions and receive risk-based payments.

The trend toward implementation of APMs seems unstoppable. To be successful, the incentives will need to be well designed, infrastructure better developed, and performance information readily available. (The “three I’s,” with a hat tip to Victor Fuchs for the framing.) In the decade since the ACA, we have learned a lot about what does not work, enough to design and deploy reasonably effective—if not optimal—APMs.

Small incentives across a broad range of outcomes fail to motivate <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2800747> changes in patient care. Instead, behaviorally informed incentive design <https://www.acpjournals.org/doi/10.7326/M15-1330?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed> for physicians can change physician practice and increase savings. More importantly, it takes more than just payment incentives to effect change—it also requires relevant information and infrastructure: Information such as which lab, imaging center, or ambulatory surgery center (ASC) is the lowest cost, and which physicians perform better than others; infrastructure such as accreditation at an ASC and relationships with the anesthesiology group. In addition, patience is necessary. It takes a few years to implement and refine workflows to institutionalize efficiencies and savings.

A major barrier to expansion of APMs that received relatively little attention is the Relative Value Unit (RVU)-driven, fee-for-service financial infrastructure at the heart of US health care. (RVUs are the basic component of the Resource-Based Relative Value Scale, used by CMS and private payers to calculate physician payment.) Providers are addicted to this model. Physicians and health systems have good RVU-based benchmarking data; they know how many patients they need to see per hour and have honed their practice to those metrics. Similarly, payers have an entire coding/billing/prior authorization infrastructure. Supplanting RVUs with APMs will require different financial models and different payment platforms—those built on capitation and bundles, global budgets, and financial incentives for quality and cost savings. Changing financial models and having systems that can deliver APMs will be important for realizing better care through the merging of payer and provider roles.

Megatrend 2: Reducing Upcoding And Other Gaming Of Medicare Advantage

The gaming of Medicare Advantage (MA) has reached crisis proportion. Reports and estimates by the Office of Inspector General, the Medicare Payment Advisory Commission, the Committee for a Responsible Federal Budget, and others have documented <https://www.crfb.org/papers/committee-sends-letter-cms-medicare-advantage> extensive gaming and abuse. Collectively, they suggest that CMS could save from $20 billion to $35 billion per year by eliminating the structural overpayment to MA plans, systematic upcoding, quality gerrymandering, and other manipulations. After years of documentation and commentary, this gaming has finally pierced public consciousness through excellent coverage by the *New York Times* <https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html> and *Kaiser Health News* <https://khn.org/news/article/medicare-advantage-auditors-overcharged-taxpayers/> .

This overpayment is becoming more important. MA currently enrolls about half of all Medicare seniors and is projected to cover 60 percent <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/> by 2030. Overpayment fuels this growth. MA plans attract seniors by offering hearing, vision, and dental services as well as other additional benefits (for example, grocery gift cards, gym memberships) not available in traditional Medicare. These further increase MA insurers' revenue and profits—and the government's cost. But this will not go on unchecked forever. It is an iron law of government: Higher enrollments and higher payments will inevitably focus more scrutiny on the MA program.

The Department of Health and Human Services (HHS) and CMS are feeling pressure to do something—and quickly. Within the past few months, the Biden administration announced a rule that strengthens HHS's ability to audit MA plans and recover overpayments, expected to save $4.7 billion <https://www.federalregister.gov/documents/2023/02/01/2023-01942/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare> over the next decade. They have also issued new rules that change the payment for specific conditions, such as diabetes with complications, commonly used in upcoding. These are signals that the government is getting serious and will likely bring additional sanctions on MA overpayment. Precisely what the additional actions over the next few years will be is not yet clear.

The current actions are blunt. But one obvious and probable place for action is to revise or replace the hierarchical condition category (HCC) risk-adjustment model. It is outdated and needs to be retired. CMS is phasing in small changes <https://www.fiercehealthcare.com/payers/providers-payers-press-cms-get-rid-medicare-advantage-risk-adjustment-changes-entirely> to the risk-adjustment model, including getting rid of more than 2,000 diagnostic codes that are likely to be abused for upcoding. But there needs to be a better alternative—one that is more accurate and objective, ideally based on factors not dependent on clinical codes but on ones that are less manipulable, such as laboratory results, and imaging findings. A dynamic machine learning (ML) model using the same data that goes into HCC scores would be more accurate and less biased at predicting future costs.

The accuracy and equity would likely to be further improved by using more readily available, less manipulable data, such as prescription drug claims, vulnerability index of place of residence, and recent claims. And using ML-informed risk adjustment could also be structured to reduce the impact of future upcoding. (Disclosure: I am engaged in just such a project to improve Medicare's risk-scoring methodology using ML and additional data.)

In the ACA, Congress reduced overpayment <https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar17_medpac_ch13.pdf> to MA plans from about 14 percent to about 4 percent today. (Reducing it to zero would be worth about $9 billion per annum.) Whether Congress will change the MA payment formula again is unclear, but rising costs and overpayment would increase the likelihood of congressional action. Another approach is to eliminate the benchmark and rebate system and just go straight to competitive bidding by MA plans. This would create serious price competition among private plans, reducing

premiums closer to plan costs, thereby spurring efficiencies. It would also mean that savings would not stay with insurers; instead, the government would save significantly. The government savings could be used to postpone Medicare insolvency and to give all Medicare beneficiaries additional benefits such as vision, hearing, and dental services. Given the appeal of these measures, especially as insolvency looms larger, this change seems possible if not yet probable. Whatever the approach, some change is needed in the next few years to keep taxpayers from overpaying.

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