IS RISK SHARING FEASIBLE FOR ADMIN AND MANAGED CARE CONTRACTS?

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HEALTH WARNING

This is not a presentation – it is a discussion!

OVERVIEW

- My part:
  - Some definitions
  - International experience
  - Some quality assurance concepts
  - Some questions

- Your part:
  - WHAT STRUCTURES ARE FEASIBLE?
  - WHAT ARE CURRENT HURDLES TO IMPLEMENTATION?
  - IS THIS USEFUL?

REFERENCES

Frank RG, McGuire TG, Newhouse JP (2013) Risk contracts in managed mental health care. Health Affairs, 14(3)

Peterson LA, LeChauncy DW, Urech T, Daw C, Sookanan S (2006) Does Pay-for-Performance Improve the Quality of Health Care? Annals of Internal Medicine Vol 145(4)

Nicolle E, Mathauer I (2010) Administrative costs of health insurance schemes: Exploring the reasons for their variability. WHO Discussion Paper Number 8 - 2010

WHO: HEALTH INSURANCE ACTIVITIES IMPLYING ADMINISTRATIVE COSTS

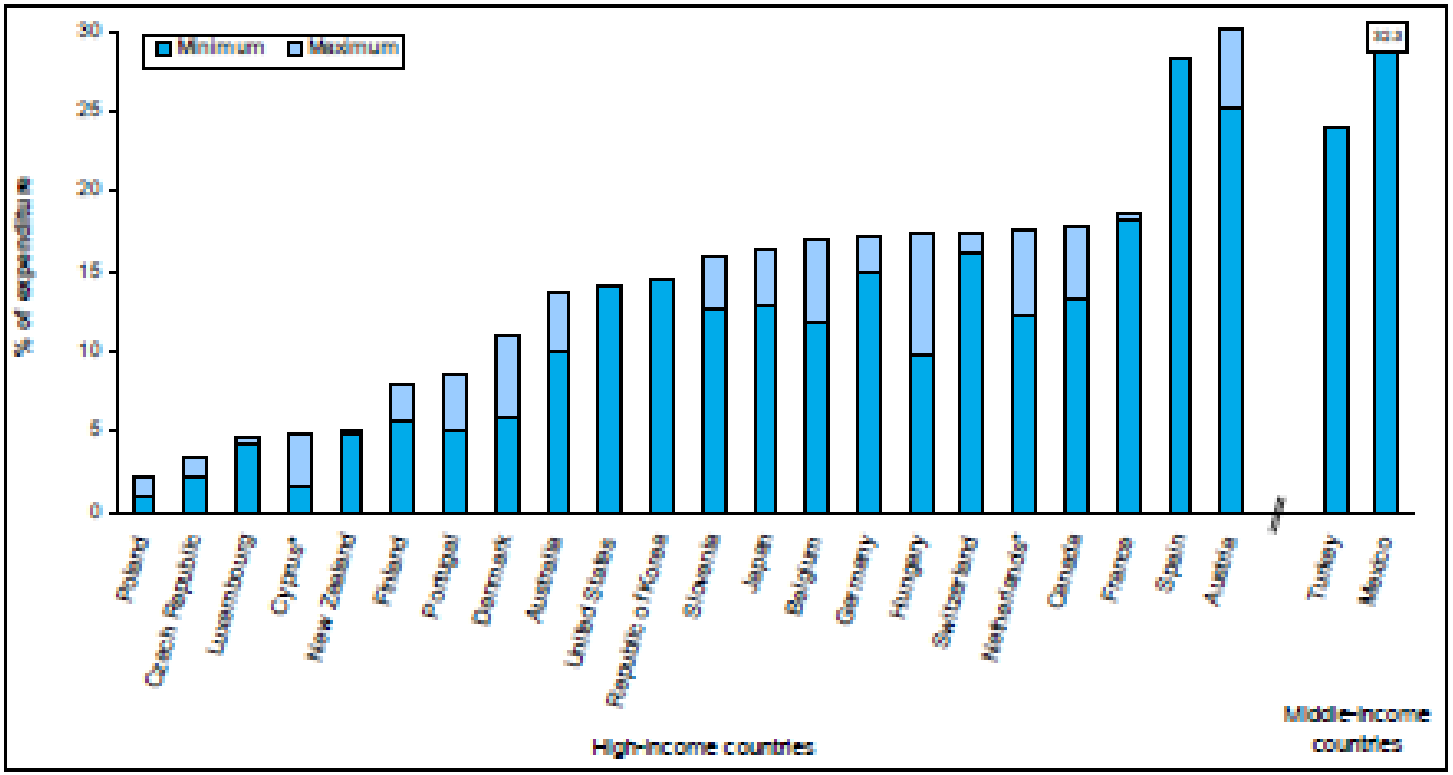
Health financing function	Administrative activity
Resource mobilisation	Providing information
	Identifying members
	Registering, enrolling members
	Billing, collecting contributions
	Managing exemptions
	Advertising, marketing, selling
	Underwriting
Pooling	Pooling and transferring resources
	Managing risk equalisation
Purchasing	Selecting, negotiating with health providers, purchasing, contracting
	Managing accreditations, quality assurance
	Processing claims, paying providers/reimbursing patients
	Care co-ordination (disease management, gatekeeping…)
Stewardship and overall management	Providing customer services (members, providers) and consumer education
	Appeal mechanisms
	Human resource management including staff training
	Executive management, governing institutions and board supervision
	Policy-making, planning, scheme design
	Surveillance at all stages: monitoring, statistics
	Actuarial analysis, financial management, budgeting

SCHEME SERVICES

Admin	?	Management
• Membership • Claim adjudication • Financial mgmnt and reporting • Customer service	• Pre-auth /cert • Case mgmnt	• Protocol development • Disease management

INTERNATIONAL EXPERIENCE

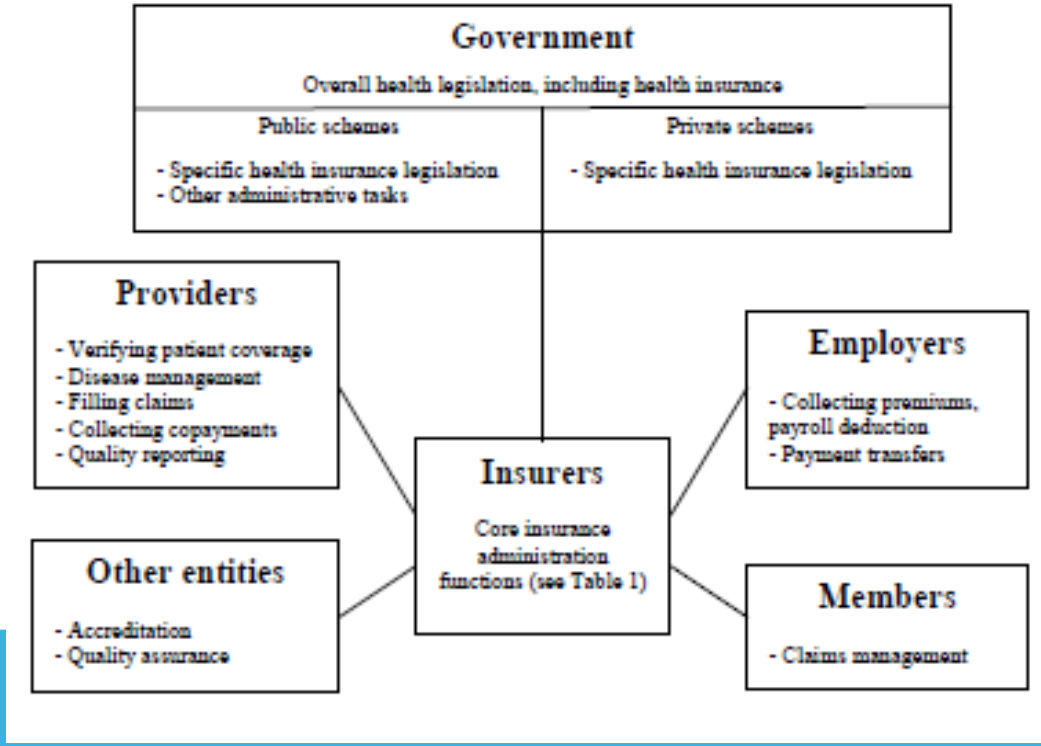
Graph 3. Private insurance administrative costs over 1999-2007 in OECD & EU countries



Source: SHA data, * NHA data

REASONS FOR DEVIATION

- Different definitions and methodologies applied
- Different health administration functions being undertaken
- Context determinants
- Insurance design



BASIC FLAWS IN CURRENT APPROACH

Schemes are in the hands of administrators

Providers are rewarded for over-servicing

There are no measures or rewards for outcomes

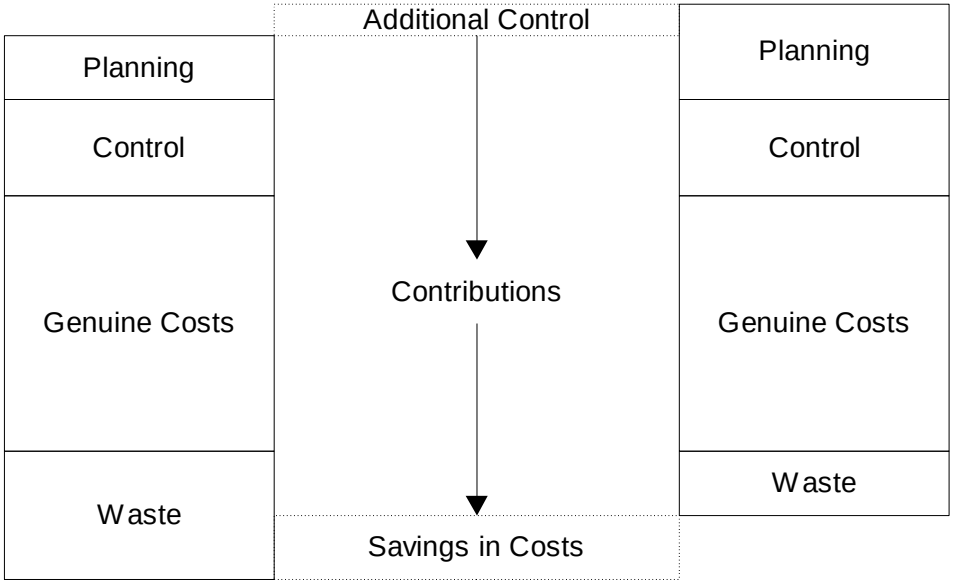
Hospitals target specialists not members

Cost reduction = Risk shifting

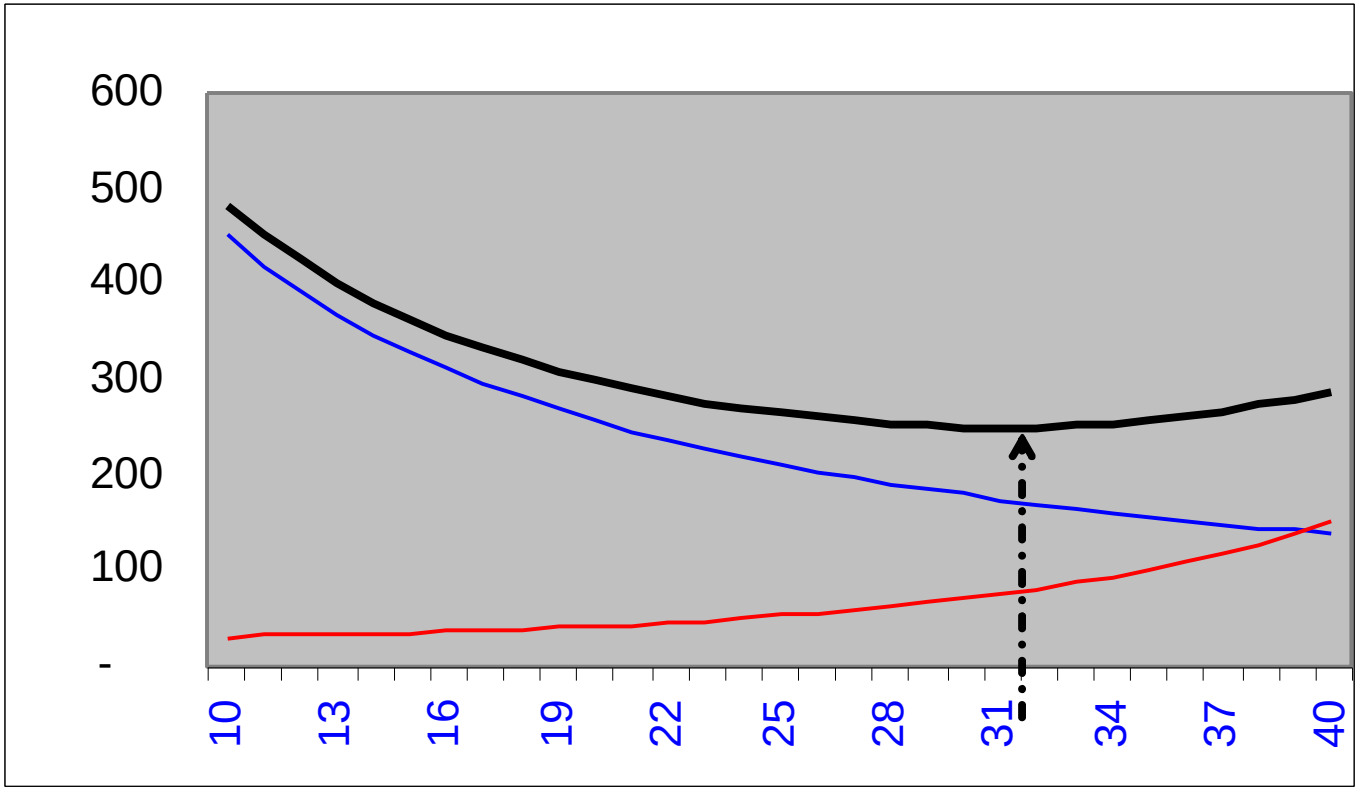
(Tony Patz, 2003)

LIMITATIONS ON COVER AND MANAGED CARE

- Most controls are of a financial nature
- Costs are controlled through denial of care



OPTIMAL FUNCTIONAL CONTROL

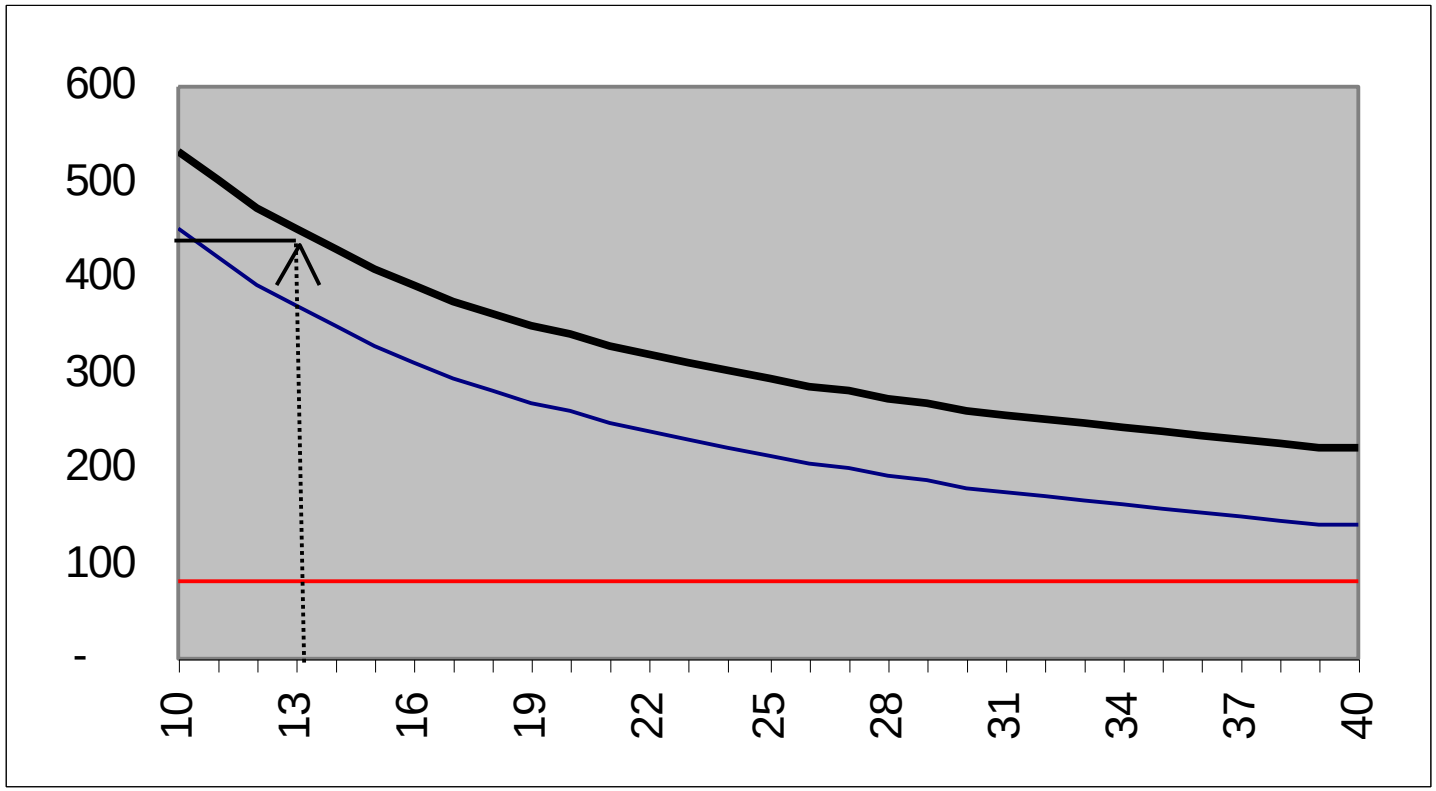


Red: Control cost

Blue: Delivery cost

Black: Combined

CONTRACTED PROVIDER



Red: Control cost

Blue: Delivery cost

Black: Combined

FOCUS ON PRICE

While cost is made up of Price x Frequency

An avoided event costs nothing

PRICE NEGOTIATION REQUIRES:

Large enough to matter

Able to negotiate

Able to monitor

FREQUENCY IS REDUCED VIA:

Eliminating unnecessary service

Reducing errors

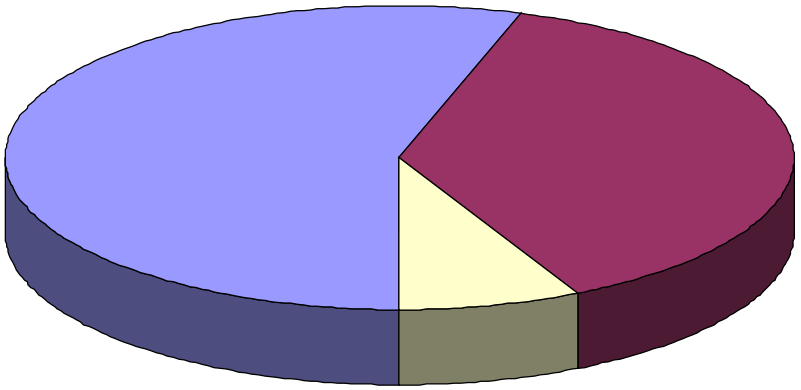
OVER-SERVICING IS REDUCED:

Through

Incentives

WASTAGE – DIMINISHING RETURNS?

Optimal



Waste

Cost of control

THE SCHEME RETAINS CONTROL BY

Setting service levels

Accrediting service suppliers

Contracting with suppliers

Monitoring performance

Accumulating Knowledge

OPPORTUNITIES

Identify opportunities for efficiency (total)

The role of technology

DOES PAY FOR PERFORMANCE PROMOTE EFFICIENCY?

- How effective are financial incentives for quality?
- Are pay-for-performance programmes cost effective?
- What types of clinical conditions or healthcare services should be the target of financial incentives to improve quality: chronic diseases, acute care, or one-time preventative services?
- Within what type of payment structures (i.e. fee for service, salaried, capitation, blended arrangements) are financial incentives most effective?
- What proportion of health care payments should be dependent on performance?
- Within what types of practice settings (i.e. multispecialty group practice, hospital-based setting) are financial incentives most effective?

DOES PAY FOR PERFORMANCE PROMOTE EFFICIENCY (2)?

- What are the optimum magnitude, frequency and duration of financial incentives for quality?
- To whom should such incentives be directed: the patient, the healthcare provider, the provider group or all of these?
- What types of quality measures should be rewarded: process of care, outcomes or both?
- Are financial incentives to prevent the overuse of services (e.g. antibiotics for uncomplicated upper respiratory illness) effective?
- Should performance targets be designed as an absolute threshold (e.g. 75% of patients with up to date immunisation status), a relative performance goal (e.g. 30% improvement from baseline), payment for each instance of a service regardless of the overall performance, or some combination?

DOES PAY FOR PERFORMANCE PROMOTE EFFICIENCY (3)?

- What is the optimum “package” of nonfinancial interventions (if any) to include with financial incentives for quality (e.g. audit and feedback, recognition, clinical reminders, academic detailing, or information technology support)?
- Can we expect that the effect of financial incentives may persist after they are stopped?
- Because any effective intervention will have some unanticipated effects, will important patient care activities that are not rewarded financially be neglected?

WHAT STRUCTURES CAN WORK?

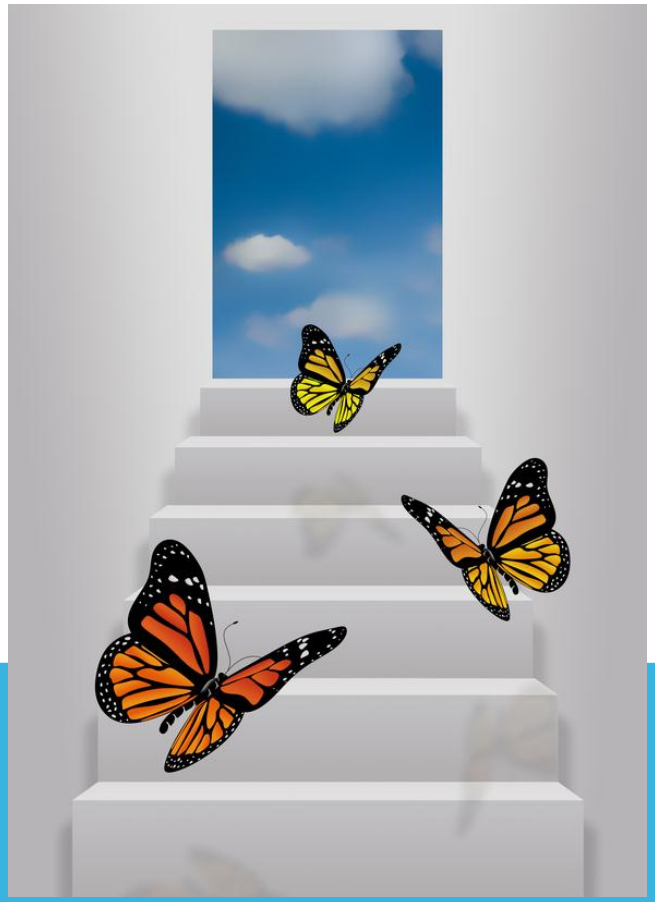
Incentives require careful design

- There will be a response to incentives, but will it be the desired one?
- Incentives to avoid higher risk members
- Incentives to “game the system”

WHY HASN'T THIS HAPPENED YET?

MAXIMISING THE UTILITY FUNCTION:

- Financial incentives
- Professional and social status
- Altruistic concerns
- Intrinsic motivation



HEALTH FINANCING OBJECTIVES

RM : Increased resource mobilisation

EQF : Equity in health financing

FRP: Financial risk protection

EF : Efficiency

Health financing function	Insurance design aspect	Explanation of impact on administrative costs	Impact on administrative costs	Impact on health financiing objectives
Collection	Mandatory membership	Monitoring and enforcement required to avoid evasion		
	Exemptions, subidies	Regulation, identification of members and enforcement required		
	Income-related contribution	Need for income assessment, can be administratively complex		
	Context-adapted revenue collection	E.g. context-adjusted payment schedules intensify administration		
Pooling	Risk equalisation mechanism	Necessary establishment and management of criteria, system enforcement: complex and data intensive		
Purchasing	Transparent benefit package definition	Necessary technology assessments, cost efficiency analyses		
	Provider payment: performance-based	Complex to set-up and manage		
	Gatekeeping	Additional administrative step required		
	Income-related cost-sharing maximums	Additional administrative system required		
Stewardship	Patient appeal mechanism	Additional administrative system required	UP	+

Health financing function	Insurance design aspect	Explanation of impact on administrative costs	Impact on administrative costs	Impact on health financiing objectives
Collection	Underwriting	Administratively intense		
	Contribution ceiling, opting-out option	Additional administrative proceedings required	UP	-
Purchasing	Provider payment: fee for service	Complex management of claims, close monitoring required		
Pooling	Multiple funds	Duplication of administrative structures, procedures, benefit packages	UP	+/-
Purchasing	Comprehensive benefit package	Extensive coverage leads to more claims		
	Selective contracting	Individual contracting requires more administration		
Purchasing	Provider payment: capitation DRG	Can reduce administration required to process claims but control needed to avoid fraud, underprovision	UP and DOWN	
	Single fund	Economies of scale, standardised procedures		+

Health financing function	Insurance design aspect	Explanation of impact on administrative costs	Impact on administrative costs	Impact on health financiing objectives
Pooling	Provider payment: per diem, salary, budget	Simple to manage	DOWN	+
Purchasing	Direct payment of providers	Simpler to manage than reimbursing patients	DOWN	-

CONCLUDING REMARK

"The aim is not to lower non-healthcare costs by all means but to optimise the use of resources to reach administrative efficiency"

WHO Discussion Paper