MMC Perspectives
on Health Care Reform

Number One

The Rest of Reform

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Introduction

For the past several months, the debate over reform of the US health care system has commanded our attention. Now that legislation has been produced by Congress, Americans may be lulled into the impression that the end of the reform effort is at hand.

Nothing could be further from the truth.

At Marsh & McLennan Companies (MMC), we are confident that true health care reform—better care for more people at lower cost—can be achieved. Our belief and optimism are grounded in the many years our companies have worked closely with employers, health care providers, insurance companies, and governments.

It is crucial to recognize, however, that the efforts discussed so far have focused almost exclusively on health insurance reform, with a goal of reducing the number of uninsured Americans. While expanded coverage is a critical element of any system overhaul, it does little to improve quality of care, make people healthier, or reduce costs. Those goals will require an entire second wave of reform that should alter the way health care is delivered and how clinicians are paid, while creating a system of incentives and consequences for patients to begin taking a more appropriate level of responsibility for their own health.

At MMC, our companies speak every day to current and future players in the reform of the US health care system. Accordingly, we are launching a series of white papers under the banner of "MMC Perspectives on Health Care Reform." This paper—"The Rest of Reform"—was authored by Oliver Wyman, the international management consulting firm that combines deep industry knowledge with specialized expertise in strategy, operations, risk management, organizational transformation, and leadership. In the coming weeks and months, additional views on health care reform will be presented from across the MMC enterprise.

Our nation stands at the threshold of health care reform. Major changes in the current health care delivery and financing models will be required to achieve sustainability. We hope that sharing MMC's points of view, which are shaped by many years of working with the health care industry, will contribute to a more informed and insightful debate on the crucial issues that face us all.

Sincerely,

Brian Duperreault
President and CEO
Marsh & McLennan Companies, Inc.

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The Rest of Reform

After a long, arduous process, the US may be on the verge of expanded health insurance coverage. Now legislators need to turn their attention to the real core of reform: cost and quality of health care.

If in the weeks and months to come Congress successfully passes a law bringing health coverage to 35 million currently uninsured Americans, it will be a big step forward. But it will not solve all the country's health care problems.

At the head of the list of problems yet to solve is cost. US health care already faces a looming crisis of affordability. The United States spends more on health care than our peer countries, and the total expenditure is growing at a rate that exceeds the growth of GDP by a factor of two or three. And unaffordable health care goes hand in hand with our expanding gaps in access. Indeed, if health care were already more affordable, a significant portion of the coverage problem might never have developed. The link works the other way as well, so that reform as currently conceived is almost certain to have a major, negative impact on the cost of health care.

High costs and poor quality cannot be fixed by mandating coverage, arbitrary reductions in reimbursement, or taxes on "Cadillac" plans. We need to restructure the economic underpinnings of US health care.

When reform takes effect, tens of millions of previously uncovered patients will flood the system. Government will likely attempt to pay for a portion of their care by ratcheting down Medicare fee-for-service rates. In practice, long experience suggests that clinicians will work to offset what they lose on Medicare patients by shifting costs to patients with employer-sponsored insurance. This in turn will lead to further erosion of employer-sponsored health benefits that now pay almost half the cost of US health care. Meanwhile, the proposed shift to "community rating" will make health care more affordable for the less healthy by shifting costs to the healthy—possibly causing healthy individuals to leave the insurance market. There is reason to fear that costs will spiral out of control.

This does not mean that we should abandon uninsured Americans. It does mean, however, that we should begin—and quickly—to focus on the rest of reform. As we will see, high costs, poor quality, and poor value are built into the very structure of our health care system. They cannot be fixed by mandating coverage, by arbitrary reductions in reimbursement rates, or by taxes on "Cadillac" plans. Instead, we need to restructure the fundamental economic underpinnings of US health care.

This is a large task, but far from impossible. After studying and advising a wide variety of insurance plans and health care providers, large and small, for many years, Oliver Wyman has seen abundant evidence that health care spending in this country can be reduced by 10 to 15 percent—and in some cases by 30 to 40 percent. Medical trend—the rate at which costs increase—can be brought down to match the rate of growth of the Consumer Price Index. Moreover, these savings can be achieved not by rationing care and cutting benefits, but by coordinating care, focusing resources correctly, and aligning the interests of payer, patient, and health care provider.

Reform on this scale will be long, difficult, and disruptive, but change can be introduced gradually, and savings from early phases can help pay for later rounds. Besides, there is little choice. Unless we address cost and quality, we face a future of cutbacks, rationing, and unaffordable care.

This is not to criticize the efforts that have gone into health care reform so far, but rather to point out the obvious: No matter what emerges from Congress and the Obama administration in the weeks and months to come, it will be only the beginning of health care reform. We know from our conversations in Washington, DC, that a significant number of senior leaders in Congress and the Obama administration are already well aware of the points we make here. They realize that for the health care system to be sustainable there must be major changes in the way care is delivered and paid for. It is time for a wider audience of Americans to become aware of the steps we must take next.

Reform, round two

The reform debate has generated an overwhelming volume of criticism of American health care. In our work with employers, health care plans, and providers, though, we have learned that four issues are central to solving the cost/quality conundrum:

Medically complex patients make up less than 10 percent of the non-elderly patient population, but they account for half of all medical expenditures. Someone needs to take the role of "quarterback" in their care.

Medically complex patients need coordinated care

The health care system has grown much more complicated in recent decades. The armamentarium of treatments and diagnostics has expanded radically, and care is distributed in new settings: urgent care centers, retail clinics, infusion centers, specialty surgical centers, home-based biometric monitoring, and many others. On the whole, this growth is good for the economy and stimulates investment in health care innovation. But it also creates the potential for duplication, waste, and error, contributing to rising costs.

The key to controlling these costs is coordination of care. And that is especially true in the case of medically complex patients. These patients tend to suffer from multiple late-stage chronic diseases. They make up less than 10 percent of the non-elderly patient population, but they account for roughly half of all medical expenditures. One would expect that someone would take the role of "quarterback" in their care, to eliminate duplication, set priorities, guard against conflict, help patients make informed choices, and ensure that the insights of multiple providers are melded into a unified plan. In practice, that rarely happens.

Care needs to rely on evidence-based medicine

A major contributor to high health care costs is unwarranted variation in care. Studies completed by the Wennberg Institute[1] and RAND[2] looked at patients with the same diagnosis and similar levels of acuity and found that physician practice variation exceeded 40 percent. It is difficult for physicians to stay current on best practices, and there is variation across medical schools and other training programs. But practice variation costs money and compromises quality.

1 See, for example, Sirovich B, Gallagher PM, Wennberg DE, Fisher ES. Discretionary Decision Making by Primary Care Physicians and the Cost of US Health Care. *Health Affairs*, 2008; 27: 813-23.

2 McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*, 2003; 348: 2635-2645.

Electronic health record systems with built-in evidence-based practice guidelines offer an opportunity for physicians to narrow variation, reducing costs and improving quality of care. Many physician groups across the country have already made this move.

Payment needs to be tied to outcomes

The predominant payment model in American health care is fee-for-service. It is a model with a deep intrinsic flaw: It rewards clinicians for the volume of services they deliver rather than for how well their patients fare.

Economic incentives tend to work, and under fee-for-service the health care system has churned out billions of tests, prescriptions, and procedures. There is virtual unanimity that many of them produce little or no value for patients, but they continue to be ordered because they create revenue for health care providers. And, unfortunately, services that we vitally need—counseling, patient education, care coordination, etc.—are underprovided because they are not paid for. More important from the patient perspective, fee-for-service means that the interests of doctor and patient are frequently at odds. As a society, we strive to eliminate conflicts of interest in areas that affect public well-being, and it is hard to regard fee-for-service medicine as anything but a conflict of interest.

Many health care innovations ought to save money and improve care but in fact don't. That changes drastically when physicians and patients are motivated to work together through aligned financial incentives.

Numerous models exist for tying pay to outcomes, and more are being developed. Some take the form of guarantees: One major specialty surgical center, for example, provides follow-up surgery for free if the original procedure fails. Others adjust reimbursement to encourage physician follow-up and patient compliance: Many integrate clinical quality and outcomes-based performance measures into a physician bonus program. Still others pay providers on a health risk-adjusted per-episode basis or use a membership model to shift physicians' focus from individual office visits to disease or whole-person care.

The goal is not just to change the payment model, but to provide fundamental economic alignment, so that payers, health care providers, and patients all have strong incentives to produce the right results.

Patients need to be accountable

The unreported scandal of American health care is the tens of billions of dollars wasted on treatments that patients either take improperly or discontinue before they have received any benefit from them. Poor compliance multiplies costs: Health plans and Medicare spend today to pay for treatments that are used improperly or not at all. Then they spend again tomorrow to treat same the disease when it reoccurs or becomes more severe because it was never properly treated. Much of the responsibility for poor compliance necessarily rests with patients. But employers have largely been unwilling (when not blocked by law or regulation) to ask health plans to impose real consequences for failure to take steps to control blood sugar or lower cholesterol, take blood pressure medications regularly, or make lifestyle modifications such as quitting smoking.

Everyone is familiar with the use of high copays or coinsurance to discourage the use of expensive prescription drugs or treatments. When the goal is to *encourage* patients to follow doctors' orders, the most promising approach is Value-Based Insurance Design.

For example, value-based benefits may reward an individual with elevated health risk factors for participating in programs to help him or her lose weight or lower cholesterol. It may create an incentive for selecting a patient-centered medical home and following evidence-based treatment recommendations. Value-based benefits motivate individuals to take personal accountability for their health and help to get physicians and patients on the same page.

These four ideas are the core of a new, more sustainable model of health care known by a variety of names, but most frequently as Integrated Health Management (IHM). The power of IHM is in the integration of aligned incentives, coordination of care, use of care guidelines, and patient engagement. In our detailed survey of the health care landscape, it was clear that integration is the magic ingredient that defines the difference between highly effective and ineffective health care innovation.

The fact is that there are many reasonable-sounding health care innovations that *ought* to save money and improve care—health management programs, wellness programs, primary and secondary prevention programs, and so forth. But there is little evidence that they achieve the results they're supposed to achieve. That changes drastically when physicians and patients are motivated to work together through aligned incentives and real changes in the health care management and delivery model.

In the short run, it is almost unaffordable for physicians to shift from fee-for-service reimbursement to Integrated Health Management. Traditional providers and hospitals will need help in reinventing themselves.

Through extensive research and across multiple client engagements, we identified more than 40 programs that have "bent medical trend" over multiple years while improving quality of care and patient satisfaction. We calculate that if the savings of these programs alone were extrapolated over the 150 million Americans covered by commercial insurance, the savings would amount to more than $700 billion over ten years—more than double the projected impact of Medicare rate reductions. And this figure doesn't take into account savings generated as a result of improved prevention and workforce productivity.

Perhaps the most impressive of these programs is CareMore Medical Group, recently hailed by our colleague Dr. Arnold Milstein as an "American Medical Home Run" in the journal *Health Affairs*.[3] CareMore is the antithesis of the stripped-down, grudging sort of plan many people fear will emerge from health care reform. It is aggressive in caring for its population of frail elders, providing home visits to address environmental issues, 24-hour telephone access to doctors, transportation for appointments, and extensive testing and routine care. The cornerstone of the program is a newly defined physician quarterback role that CareMore calls the extensivist.

Frail elders are a cohort who frequently run up high bills, but CareMore was able to reduce the cost of caring for its senior population by 15 percent—not by reducing care but by increasing the intensity of services and the speed of intervention for the sickest one-third of patients. And CareMore patients love the model.

3 Milstein A, Gilbertson E. American Medical Home Runs. *Health Affairs*, 2009; 28: 1317-1326

What Congress should do to support long-term health reform

Congress's effort to increase access to coverage for all Americans is important. But by itself it won't cure our true long-term problems. Congress cannot directly legislate more effective, cost-efficient health care, but it can provide a useful push in several areas through oversight of federal health care programs and government-funded studies. Moreover, legislators can remove roadblocks to progress or at least refrain from creating new ones. The goal is reform that leads to sustainable cost savings and significant improvements in care quality. To achieve it will require private/public sector collaboration and a framework that protects important social rights while stimulating investment and innovation.

Remove obstacles to delivering the best care

To reduce costs and improve quality, health plans need to explore a variety of new techniques for changing provider and patient behavior—providing incentives for patient compliance, coordinating care, ensuring that the sickest patients are treated by the most qualified physicians, and giving employers incentives to implement novel approaches. But innovations like these are frequently difficult to implement because of federal and state laws and regulations.

Medicare can help prepare the market for coming change. It can accustom physicians to value-based payment standards and a new role for primary care. It can lead the move toward evidence-based medicine.

While it is unlikely and probably unnecessary that legislators would deregulate the health care industry, they need to give insurers and health care providers leeway to create solutions that work in the real world. One key area where government could remove a barrier is by medical malpractice and liability reform, removing part of the impetus for "defensive medicine." By linking the practice of evidence-based medicine to reduced medical liability, Congress could accelerate adoption of guidelines and reduce unwarranted practice variation.

Support innovation in health care delivery

When we think about health care innovation, we tend to think in terms of technology and science. But as Harvard Professor Clayton Christensen pointed out in 2008, in *The Innovator's Prescription,*[4] what health care needs most today is innovation in its business model.

For all the conservatism of the medical profession, the past few years have been a time of great creativity in health care. We have seen the emergence of new payment models, incentives to improve consumer engagement, risk-sharing contracts for prescription drugs, and new approaches to complex care, including medical homes and accountable care organizations. These new ideas need to be tested more thoroughly, and the best ones adopted—a sort of evidence-based reform parallel to evidence-based medicine. Government support and incentives can clearly be a help here. The funds and incentives provided in the American Recovery and Reinvestment Act of 2009 are a great start—but only a start. In the short run, it is almost unaffordable for physicians to make the crucial shift from fee-for-service reimbursement to Integrated Health Management. Meanwhile,

4 Christensen CM, Grossman JH, Hwang J. *The Innovator's Prescription: A Disruptive Solution for Health Care*. New York: McGraw-Hill, 2008.

traditional providers and hospitals will discover that they need to reinvent themselves to fit into the emerging health care world. Experience says that many of them will need help.

Use government-sponsored programs to build critical mass for best practices

Government directly or indirectly manages a significant portion of the US health care system. Medicare, Medicaid, government military plans, and federal and state employee plans are all opportunities for government-led improvements to cost-efficiency and quality. Medicare in particular has a tremendous ability—and responsibility—to set standards and establish precedent. Medicare can help prepare the market for coming changes. It can accustom physicians to working with value-based payment standards and a new role for primary care. It can and should be a leader in moving toward evidence-based medicine and standardized, interoperative electronic medical records. The great fear at the moment is that far from making Medicare a source of leadership and innovation, Congress will lock into what is perhaps the most destructive idea in current reform proposals: funding coverage for the uninsured by cutting physician reimbursement in Medicare fee-for-service programs. The results, as we argued earlier, could be disastrous.

To move Medicare in a more productive direction will take effort and money. But it will pay rewards for American health care, both public and private.

Better compliance will boost the effectiveness of care of all sorts. This is a goal worthy of publicly supported research. And patient compliance and responsibility need to be built into the health care system.

Provide more time and flexibility for employers to expand coverage

Employers face significant challenges in determining how to comply with proposed health care reform legislation. On the one hand, they must consider how to comply with the requirements for eligibility, design, and contributions, assuming they want to continue providing coverage. But they also face new expenses—an almost certain surcharge of 40 percent—for having "generous" health plans. Our research indicates that this surcharge will affect almost 40 percent of large employers by 2017. For some employers, it may make more economic sense to abandon their role as plan sponsors.

If a majority of employers were to do that, it's doubtful that the currently proposed exchange market could accommodate the influx of uninsured employees and their families. Yet currently proposed legislation provides no positive incentives for employers to remain in the market. Quite the opposite, thanks to new mandates to extend coverage to part-time workers and increase employer contributions for family coverage. An alternative approach might be to phase in potential populations that could seek coverage through an exchange.

Current proposals mandate a zero copayment on any preventive service, regardless of the patient's income. Copayments can be a financial barrier for some individuals, but even a modest copayment reinforces the fact that the visit, test, or prescription has a financial value. Employers need the flexibility to base these decisions on evidence (for example, applying a zero or low copay only to the drug that yields the best outcome or to the specific medical teams that consistently manage high-cost, complex illnesses most effectively).

Invest in training more primary care providers

The current vision of health reform focuses on providing greater access to care. In practice, as tens of millions of additional patients acquire insurance, almost everyone

will likely face access problems, as the flood of new patients overwhelms primary care providers. It is clear that we will need new doctors, nurses, nurse practitioners, and medical assistants as health care reform comes to fruition—and as the population continues to age. The nation should put its resources behind attracting professionals to primary care and guaranteeing that we train an adequate supply of them.

This expansion needs to be accompanied by teaching PCPs how their innovative peers have substantially boosted their productivity and patient panel sizes via better use of non-physician team members and electronic information and communication technologies.

Focus on patient adherence, compliance, and responsibility

Not enough is known about the causes and cures of poor patient compliance, but this is clearly an area that could have greater impact than the discovery of a new wonder drug. Better compliance will boost the ultimate effectiveness of care of all sorts. This is a goal worthy of publicly supported social science research. And patient compliance and responsibility need to be built into the structure of the health care system as a whole.

Support programs that reduce risk factors

Health insurance and doctors are not the only components in reducing spending on health care. In the United States, almost 40 million people have high blood pressure that is either untreated or uncontrolled. More than 43 million adults smoke. More than 34 million have a total cholesterol level of more than 240—the level defined as high-risk. There are 6 million undiagnosed diabetics. Each of these groups is a time bomb waiting to create exploding health costs in the future.

The core characteristics of US health care—fee-for-service reimbursement, lack of coordination, and badly aligned economic incentives—have enormous power. Unless changed, they will make reform unsustainable.

Conclusion

American health care is in a pickle, but no one should forget that it got that way largely because of decades of brilliant medical and scientific innovation. Health care is expensive partly because there is so much worth paying for: new treatments, new drugs, new surgical techniques, and new diagnostic tools. But the way we deliver and pay for care has not kept pace. The core characteristics of American health care—fee-for-service reimbursement, lack of coordination, and badly aligned economic incentives—have enormous power. Unless they are changed, they will make reform unsustainable.

We have focused here on what we think government needs to do. But the enterprise we propose—shifting the very basis of US health care from fee-for-service to a value-based system such as IHM—represents profound and needed change for physicians, patients, health plans, medical device and life science companies, and clinical solution providers. It is no easy task to slow down a $2 trillion snowball rolling downhill. Our greatest hope in the months and years ahead is that public and private entities will work together to create a market structure for health care that promotes positive change, competition, and investment while advancing the social good. Many of the needed integrated health management innovations are already in the marketplace. Let us use the second wave of reform to stimulate the heavy lifting required to make US health care both sustainable and the envy of the globe.

About the authors

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