Concerns with Episode Payment

- Breadth / adjustment for multiple concurrent episodes
- Induced use
Population Based Payments
Population Based Payment Evidence

- Population based payment models reduce spending (by a small amount)
  - Private sector models do better
  - Results improve over time
  - Independent physician groups do better

- Savings get shared

- Provide incentives for providers to be more efficient and promote flexibility
Caveats

- Details Matter
- Execution Matters
Everything is Relative

• We want

• We have

• We can build
Episodes vs Population Based Payment

- Both lower spending
- Episodes are narrower (harder to get PMPM savings)
- Not all areas can support population based payment
- Episodes engage specialists better
Should Payment Reform Continue

- MACRA is current law
  - APMs are favored
  - Difficult to add more money

- When money gets tight; providers likely want to control the money
Benefit Design
Insurance Balances Risk with Incentives
Why the cost sharing?

- To lower premiums  
  ❌

- To tax the sick?  
  ?

- To improve incentives  
  – Reduce ‘excess use’
  – Encourage price shopping  
  ✔
Benefit Design Options

- Higher copays, co-insurance or deductibles
  - HDHPs w/ HSAs or HRAs
- Reference pricing
- Tiered networks
- Value Based Insurance Design (VBID)
  - Align copays with value
Benefit Design Results

- Patients clearly respond to cost sharing
  - Shift sites of care
    - Reference Pricing:
      - Potentially meaningful shift in volume
      - Smaller $ effects
    - Tiered network: 5% of total PMPM
  - Reduce use
    - HDHPs: 5%-14%
    - VBID: Depends on details.
Benefit Design Concerns

- Reductions in appropriate use same as for inappropriate use (Sui et al. 1986)
  - Copays reduce use of preventive services
  - Copays reduce use of ‘valuable’ pharmaceuticals

- How much risk do we transfer?

- How does this affect disparities?
Keep It Simple
The road to success is always under construction.

Lily Tomlin