# What Will Healthcare Reimbursement Look Like in the Future?

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Based upon the past and the current state of affairs in healthcare, healthcare reimbursement will change dramatically in the future. I believe that reimbursement based upon fee-for-service will gradually disappear and be replaced by models based upon the ability to better manage patient diseases and conditions. That is, reimbursement will be based upon the quality of service delivered by the provider. For insurers, whether private or governmental, I believe that this is the only viable approach for them to take.

Let us look at the present state of affairs briefly. A March 28, 2012 article on the Wharton School of Economics website, *Looking for Solutions in a Rapidly Changing Healthcare Environment* (http://knowledge.wharton.upenn.edu/article.cfm?articleid=2963), several important facts were stated about the present state of healthcare:

> Glenn D. Steele, CEO of Geisinger Health System, stated that recent studies showed "that more than 50% of health care spending in the U.S. is wasted or actually harmful." Robert Pearl, CEO of The Permanente Medical Group stated that the survival of the U.S. depends upon reigning in health care costs. He added that "Costs have been rising 7% to 8% a year; health care is 18% of GDP this year, and it is set to double again, to 36% GDP, by 2030….That leaves no money for education, infrastructure, police and fire."

Couple these grim facts with the common knowledge that employers are providing less coverage of care to their employees as the cost of policies increase dramatically to them and that copays and deductibles for employees are increasing and one can see that insurers cannot afford to reimburse to providers as they have in the past. The fee-for-service model is simply unsustainable economically to insurers; private insurers will not be able to continue to sell policies based upon fee-for-service if they wish to provide policies that individuals and companies can afford and CMS will not be able to spend its tax revenues in this manner.

So what might we expect in the near future? Before I look into that, let me first provide a very brief history of healthcare insurance in the U.S. The first private hospitalization insurance sold was Blue Cross in the 1930's. In the 1930's hospitals as we presently know them were beginning to take shape; surgeries that were formerly done in homes were now being done in hospitals as standardization of care started to take root under the direction of the American Hospital Association and the American College of Surgeons. The hospitals as a group wanted prospective patients to be able to pay for services. So, they formed Blue Cross so that individuals could prepay for care at any hospital in the Blue Cross Network. Blue Cross as a non-profit prospered.

Physicians did not want to be reimbursed by an insurance group as they wanted to retain the ability to charge as they saw fit. Eventually, as they saw how well Blue Cross was doing and fearing a takeover by hospitals, they formed the non-profit Blue Shield, which also prospered.

Private insurance firms stayed on the sidelines fearing that they could not make a profit, believing that only individuals with existing problems would buy policies. They eventually got around this adverse selection problem by designing policies to be sold to employers. They prospered with this model. This model became more robust in WWII as the U.S. government allowed businesses to provide health insurance benefits to employees; wage increases were frozen at the time.

Over the time that private insurance was emerging, there was a political movement to provide universal healthcare through the national government. However, advocates were not able to succeed until the 1960's under President Kennedy; Medicare legislation was passed mandating that anyone 65 or older be enrolled in Medicare Part A, the hospitalization segment of Medicare. As we know, Medicare and Medicaid have grown larger ever since, to the point where almost half of all medical services now are paid by one or the other. Looking back, one can see that the healthcare insurance business has steadily grown; private insurers have provided policies from which they can profit. I believe they will continue to find products that meet their customers needs while making a healthy profit.

So what might the future look like for healthcare reimbursement? Rather than offer just my own opinions based upon pure judgment, I will offer a forecast based upon a methodology highlighted in the April 2012 edition of *Smithsonian* magazine. The method is based upon the idea that the future is already upon us, that the future is already happening in niches directed by risk takers and explorers and it is very accurate.

Looking at the niches of reimbursement we find several models. One is Accountable Care Organizations. CMS just formed 27 new ACO's with hospital and private physician groups under its new regulations. There have been ACO's formed in alliance with private payers for some time and this model is being adopted by more insurers.

Private insurers are also contracting with physicians to reimburse them at higher rates if they form patient-centered medical homes. Recently Aetna and WellPoint have begun PCMH programs. CMS has pilot PCMH programs. In Michigan, Blue Cross/Blue Shield has been reimbursing physicians for forming PCMH's for several years now.

Bundled payment contracts seem to be expanding. CMS has used bundled payment programs for some time now in organ transplant programs across the U.S.

If you are at all familiar with the above programs you know that they are based upon providing quality outcomes for patients. The goal is to reduce the cost of providing healthcare to patients enrolled in the programs while improving the outcomes for individuals. Containing the costs for the 10%-15% of patients who account for 65%-75% of all healthcare costs is a must.

Will insurers and CMS be able to control costs by focusing on quality outcomes or will programs such as those mentioned above go the way of HMO's, which still exist but which have failed to contain costs as expected originally? Private insurers seem to be betting that providing reimbursement based upon quality outcomes will become a tenable model for them. If their recent development and deployment of such reimbursement models prove successful then quality

outcomes with contained costs will be the future of reimbursement for providers. I bet that this will be so.