The so-called “thought leaders” in health care policy have been predicting that a new model of health care contracting will provide the basis for a higher quality, more efficient and less expensive national health care system, i.e., the Triple Aim, for many years. People have mentioned management care contracting, pay for performance contracting, narrow network contracting, and value-based purchasing. Some think the managed care contracting reform started in the early 1990s with the Clinton Health Security Act, but the Federal Health Maintenance Organization (HMO Act) was actually passed in 1973. Medicare was created by the Social Security Act in the early 1960s, so clearly the idea of health care reform has been percolating for quite some time. Although it has been a long time coming, Western Pennsylvania actually may now be ready to take that next step, although it appears that employers rather than providers or patients may be leading that charge.

Early managed care
and anti-trust challenges

The two inherent structural problems with early managed care contracting were (1) that it was based almost solely upon market power and economic leverage, and (2) that the concept was designed to restrict choice and deny services. Even today, with very sophisticated electronic health records (EHR) systems and quality management protocols, there has been little competition based on just quality and cost performance. The deck was previously stacked in favor of the large health care insurers, because even prior to the Clinton attempt at health care reform, there were a host of multi-billion dollar third-party payers, but hospital providers and, even more so, physician providers, were relatively small economic players in the health care business spectrum. Early managed care contracting focused primarily on numbers, i.e., how many covered lives, how many beds, how many providers?

Managed care organizations did not offer transparent pricing or documented quality improvements to drive health care decisions. Instead, primary care physicians (PCPs) were designated to be “gatekeepers” and specialty services needed prior authorization. Patients resented the concept that money was saved by utilization control and that PCPs were paid capitation regardless of whether services were provided, and PCPs resented being the obvious “enforcers.”

Attempts by physicians to organize Independent Physician Associations (IPAs) and by hospitals and physicians to organize physician hospital organizations (PHOs) and preferred provider organizations (PPOs) were largely thwarted by antitrust challenges as conspiracies to fix prices.

Competition was even more constrained in Western Pennsylvania because of the combination of a high percentage of government programs and the early dominance of the commercial market by Pennsylvania Blue Shield, and the then four state Blue Cross plans (Western Pennsylvania, Capital, Northeast and Independence). The merger of some of those plans has further consolidated the insurance market. Coupled with the rise of UPMC as first a dominant health care provider and then as a major health care insurer, the local environment has impeded the ability of the smaller players to compete and discouraged the need for the big players to do so because the status quo was satisfactory to them.

Early attempts by physician providers to create medical practices with sufficient size to play in that arena were preempted by the acquisition of many of those early movers and of many other physicians by the systems. Although hospital physician integration, primarily through employment, was always a national trend, the percentages of physicians employed by all hospitals in Western Pennsylvania is among the highest in the country.

Quality and price transparency

The contractual separation by
UPMC and Highmark/AHN is creating the type of market place disruption that should create the opportunity for health care competition; both systems are now entering into new competitive arrangements, and the entry into the market of new commercial third party payers also is creating new competitive opportunities. Although individual consumerism has been touted as a critical part of health care reform, the resources and data and planning necessary for individual consumerism has always made that a very difficult proposition. Even if individual consumers had the data and the resources necessary to choose among health care providers, (which they usually do not) the fact that many health care events occur on an emergency or at least a time critical basis makes it practically impossible for individual consumers to shop around when confronted with specific health care decisions.

**Pittsburgh Business Group on Health**

Although individual consumers may not and may never have the ability to affect competition, the employers that purchase health care coverage do have the resources to do that “shopping.”

The Pittsburgh Business Group on Health (PBGH) is poised to be a catalyst on behalf of employers in this new health care market place. PBGH is an organization of approximately 75 primarily large employers in Western Pennsylvania, with approximately 400,000 employees (and obviously significantly more covered lives). Eighty percent of those employers are self-insured and they represent a national health care spend of approximately $5 billion and a regional health care spend of approximately $3 billion. PBGH is spearheading efforts to provide both comparison quality data and transparent pricing for health care services to their employer members so that those employers may utilize that data when constructing and offering health care coverage to their employees. This is the type of information necessary to effectively implement narrow network contracting.

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Narrow network contracting

Narrow network contracting is just one of many names health care consultants have used to define a new generation of competitive contracting. We could just as easily refer to it as value-based contracting, direct contracting, or even pay for performance. The concept is simply that the primary purchaser of health care services, employers, are in a much better position to proactively conduct the purchase than individual consumers. This is predicated upon the selection of health care providers, both institutional and individual, who can now provide and be selected on a basis that includes both quality and cost efficiency.

With the type of information that is now available, health care purchasers can now engage in competitive contracting, regardless of how it is labeled. This process is now being discussed as “reference pricing,” which in reality is just a new name for the process of establishing a maximum price a purchaser is willing to pay and communicating that in a “request-for-proposal” (RFP) manner to health care systems as an invitation to agree to accept that price. All of this sounds new, but this is the way most other businesses have routinely conducted business. Many other businesses engage in price comparison, RFPs, and group purchasing organizations to minimize cost and quality variability for the benefit of the ultimate consumers. Employers and health plans are now poised to participate in that same process.

Physician participation

What will be the role of physicians in this process? As usual, the ability of physicians to play a meaningful role will be dependent upon their practice situation.

Independent practices will be better situated to actively participate in this process, and to negotiate for inclusion in the narrow networks, but only if they have the quality data discussed above. Obviously this suggests that independent physicians would benefit from participating in larger practices or voluntary networks, such as Accountable Care Organizations (ACOs) which may be the formal Medicare Shared Savings programs or commercial network of similar design.

Physicians employed by hospitals would not normally have the independent authority to actively participate in these new models, but that does not mean they should not be attuned to the impact of these new contracting models. Since the hospitals or institutional employers will be utilizing the physicians as key pieces of network designs in contracts, those physicians should strive to have their compensation and staffing decisions reflect the contributions that they can make to these networks.

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