BY HARRIS ALLEN

"There has been a little bit too much silence on the part of the business community around health care reform," Dr. Donald M. Berwick, the former chief administrator of federal health care programs, has lamented. And Dr Berwick is right on the money: While the numbers of workers covered by employers has been edging downward for decades, business still pays for one-third of all health care expenditures and 40 percent of all spending on prescription drugs.

Moreover, in the past, businesses played a key role in efforts to make health care cost-effective. To take just two examples, employer support has been pivotal to the evolution of the Healthcare Effectiveness Data Information Set, a bureaucratic mouthful that is the national standard by which the performance of health plans is now measured. Conversely, efforts to set up regional health-information centers across the country to promote the exchange of clinical data have, with a few exceptions, stalled, in large part because financial support from employers has fallen far short of expectations.

Yet despite the extensive skin they still have in the game, private-sector health insurance purchasers have maintained a low profile in this round of health care reform. The Affordable Care Act is breathtaking in the scope of the changes it mandates. Nonetheless, there is little in the law that seeks to capitalize on the knowledge that private-sector employers have acquired (and continue to acquire) as stewards of their employees' medical benefits. Nor is there any sense that the law has been shaped by insights about the incentives driving private-sector health care expenditures.

The consequences of this disconnect could be grave. The success or failure of the new law to accomplish its goals – wider coverage that improves Americans' health in cost-effective ways – could well turn on cross-pollination between the federal and state bureaucracies administering the new law on the one hand and the thousands of businesses still offering health care coverage. In particular, it would be a great pity if the experience and expertise that employers have acquired in their ongoing efforts to maintain the health of their beneficiaries while cutting health care costs were not used in fine-tuning the law.

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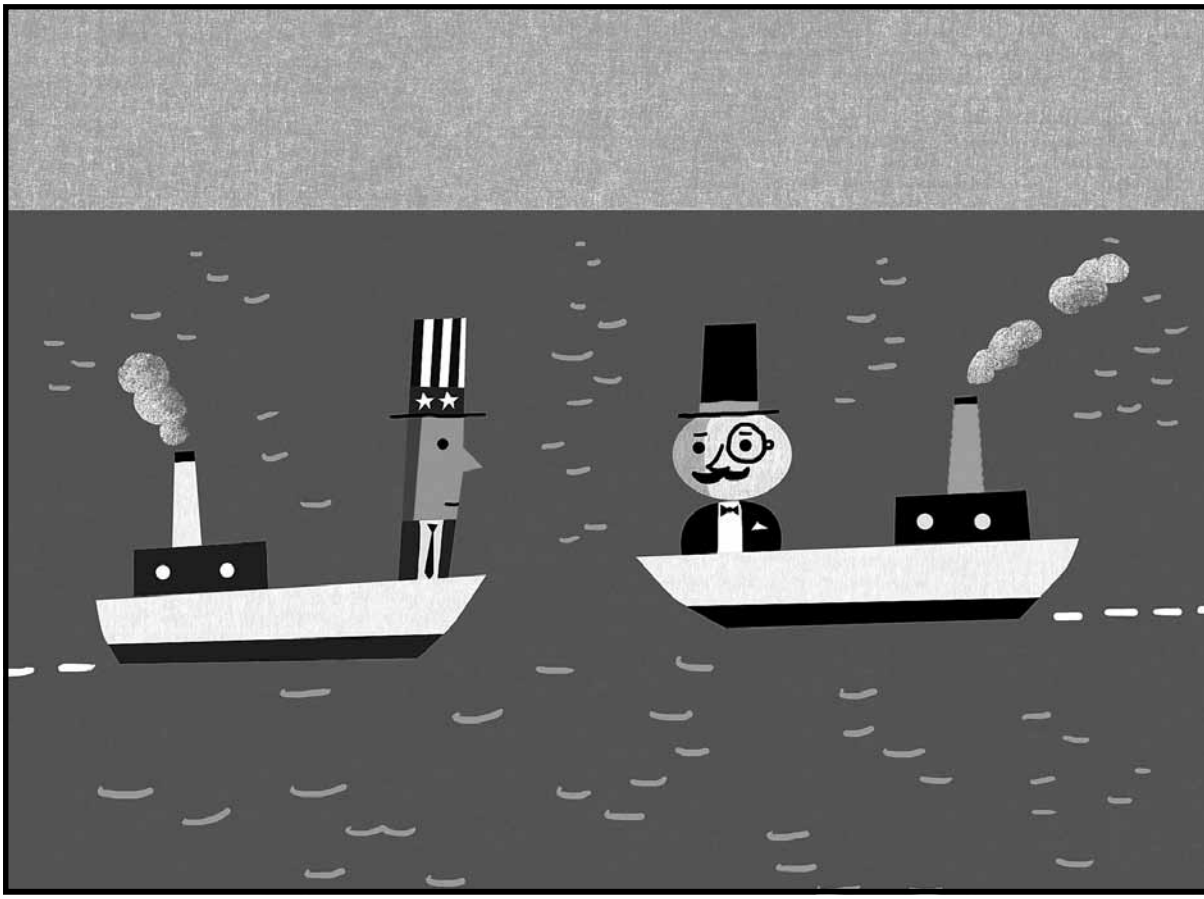
NUTS AND BOLTS

The Affordable Care Act, which was passed in 2010 and upheld by the Supreme Court in June, includes:

• Mandates for insuring the uninsured, either through state-based private insurance



JAMES YANG

exchanges or state Medicaid programs – and providing subsidies for those who can't afford the premiums.

• A slew of innovations in the delivery of health care and the design of payments meant to improve the quality of care and slow the rate of growth in spending.

• Regulations intended to broaden and stabilize private coverage, ranging from extending dependent coverage on parents' policies to prohibiting exclusions for pre-existing conditions to capping lifetime coverage outlays.

• Funds for new prevention programs to augment state and local efforts to tackle costly chronic diseases, detect and respond rapidly to health security threats and reduce injuries.

• Beefed-up antifraud provisions to combat improper payments in federal and state health programs.

• New sources of revenue to help pay for these provisions, including an excise tax on the premiums of so-called Cadillac employment-based health plans.

ON THE SIDELINES

What's missing from the list are provisions that explicitly seek to engage companies already sponsoring and paying for the lion's share of coverage for their beneficiaries. This holds true even where a higher profile role for business is just common sense.

Take the lack of employer involvement in the law's encouragement of accountable-care organizations. They are local organizations, each comprised of groups of providers often linked in one way or another to a health plan,

that agree to be held accountable for the cost and quality of care delivered to a defined beneficiary population, and, in return, to be compensated according to their success. Spurred by the new legislation's provisions encouraging their use, a host of these organizations has emerged. As of July, some 300 of them have been licensed, with nearly half aimed at adults who are not old enough to be eligible for Medicare.

The viability of many of these accountable-care organizations will be heavily influenced by whether businesses that offer insurance encourage their employees to enroll. Yet the new law includes no incentives (or even guidelines) for involving employers in the management of accountable-care organizations or for encouraging employers to steer their beneficiaries to use accountable-care organization providers.

Or consider the state-level health insurance exchanges. Under the new law, the exchanges are serving as marketplaces for individuals and small businesses to buy health care coverage that meets minimum government standards, often with the help of federal subsidies. Exchanges are not insurers because they do not bear risk themselves, but they determine eligibility for plan inclusion. Their job is to promote insurance transparency, facilitate increased enrollment and the delivery of subsidies and help spread risk to ensure that the costs incurred by those with high medical needs are shared by large groups of insured people.

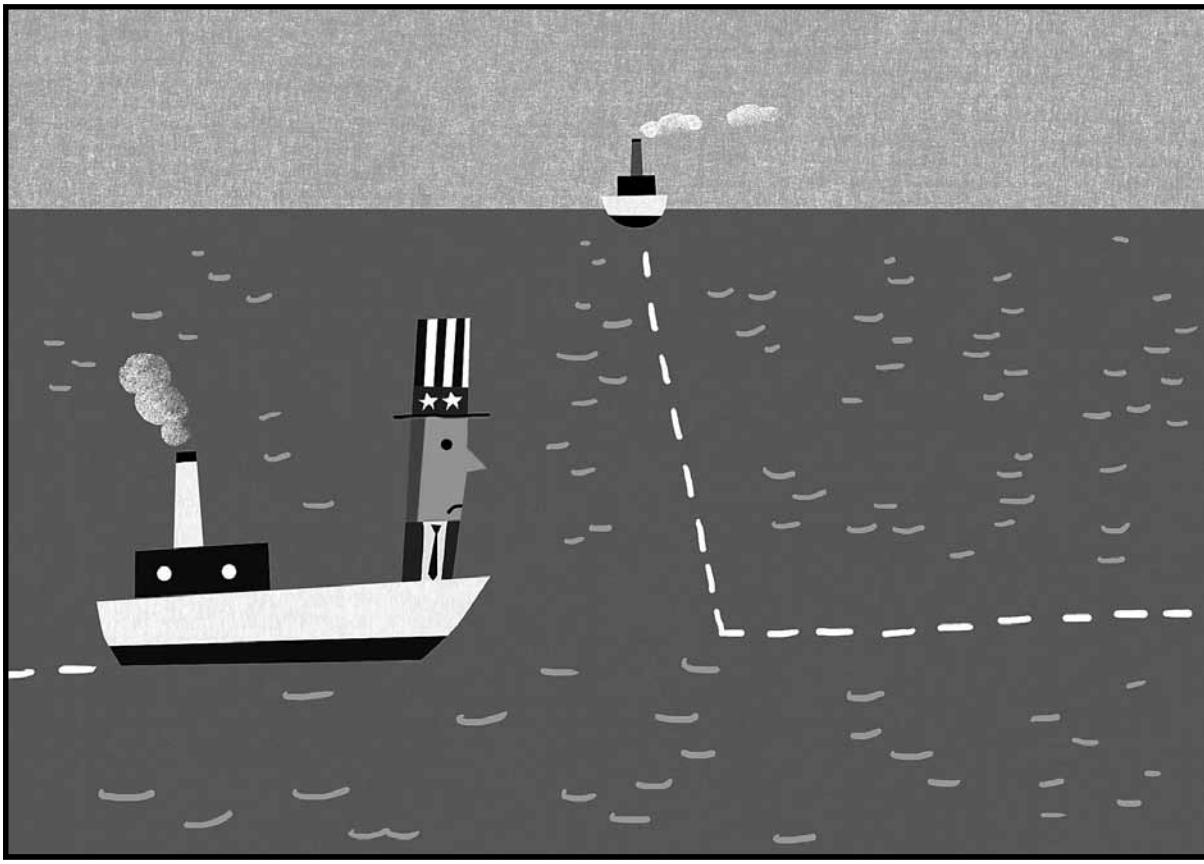
Each state may choose to run its own exchange or join together with others to run multistate exchanges. Alternatively, states may opt out of running exchanges, in which case the federal government will step in and create them.

The basic idea is to give individuals and small groups the competitive marketplace advantages that large groups enjoy by virtue of their size – in other words, for buyers lacking market power to gain parity with large private-sector purchasers. It thus stands to reason that sponsors of large-group coverage have much to offer to the exchanges because they are repositories of the skill and expertise to best exercise these advantages. Yet the Affordable Care Act has no provisions to facilitate such a knowledge transfer or to create incentives for employers to participate actively.

A third area of foregone (or at least significantly underutilized) opportunity is found in the Affordable Care Act's provisions for value-based purchasing. This consists of a family of proven strategies for paying for health care based on the value of services, rather than volume. It entails the use of payment mechanisms that give providers incentives to deliver more effective care at lower cost.

Value-based purchasing has evolved in three major phases, often with leadership from the business community. The first consisted of rewarding providers with bonuses for superior quality based on preventive-care measures. The second involved placing providers at financial risk: they receive lower payments if their performance is below benchmarks and higher payments if their performance exceeds those benchmarks. More recently, paying-for-value strategies have become a centerpiece in structural reforms for how care is delivered, including how accountable-care organizations perform.

The new law advances value-based purchasing on several fronts. The Department of Health and Human Services, for example, is authorized to establish guidelines that permit health plans to use value-based insurance design. Likewise, the Centers for Medicare and Medicaid Services has put into place a Medicare value-based purchasing program for inpatient acute care facilities. With this program,



JAMES YANG

a phased-in reduction in base payments for many "diagnosis-related groups" (classifications of patient conditions) will begin in 2013. To "earn back" these payment reductions, hospitals have to demonstrate their success in providing quality care.

Yet the Affordable Care Act overlooks a similar reform with much upside potential for private sector-purchasers. Fee-for-service arrangements – which do not punish inferior quality and may often reward it by paying for unnecessary or inappropriate care – remain by far the most prominent method of payment for private-sector health care. Sadly, though, the new law overlooks the potential for nudging private-sector purchasers toward value-based purchasing by means of tax incentives or cash rebates.

One more example can be found in the Patient-Centered Outcomes Research Institute, which was created by the new law as an independent non-profit organization. The institute's mission is to help patients and their care providers to make more informed decisions. The idea is to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options. Because the research institute is the Affordable Care Act's ongoing arm for comparative effectiveness research, its focus includes quality of life, quality of care and the potential for improved treatment adherence. And there is now momentum to broaden this focus to include direct and indirect benefits to society, patient differences in responses to treatment and clinical comparative effectiveness.

Even in its expanded version, however,

employer-purchaser priorities are being only partially met. These priorities center on consideration of total health burden – that is, both the direct costs in health care services and the indirect toll of poor health on productivity and the costs of workers' compensation and disability insurance. The research institute's intent to empower patients and physicians is not the same as purchasers' need to maximize the return on their investment in health care.

These examples all suggest ways that the reach and effectiveness of the Affordable Care Act could have been enhanced, had its provisions legislated a higher profile for private-sector purchasers with existing midsize and large employee groups. Why, then, didn't midsize and large businesses play a bigger role?

One likely reason is skepticism – arising from the disappointing outcomes of past efforts with which they were involved – that they would be able to make a difference. Another may have been fear that they would be stuck with a greater share of the cost. Still another may have been a reluctance to be caught in the ideological cross-fire. But this alienation was a two-way street: the law's designers didn't seem especially interested in engaging with large employers, either.

WHAT NEXT?

It's one thing to identify the failure of the new law to make good use of the knowledge of employer-sponsors in developing strategies for getting more health care bang for a buck. It's quite another to remedy the error. Congress isn't likely to make mid-course corrections in a law that has somehow become an ideological litmus test. Nor would a new president have the power to wipe out the law with one stroke of a pen.

And large corporations, which ironically were once upon a time the only interests pressing for greater federal involvement in health care, aren't likely to dive into the controversy.

Perhaps the most practical way to raise the profile of employer-sponsors is to focus on the Affordable Care Act's goal of more rigorous measurement of health-intervention outcomes. This would create a less political and more technocratic context for government-business dialogue, one in which the strengths of private-sector purchasers and their priorities become better appreciated.

In particular, employer input could broaden the new law's rather narrow measurement perspective to one that recognizes costs that include, for example, presenteeism (impaired performance while at work), absenteeism, workers' compensation and disability and related indirect costs that businesses seek to defray with their expenditures in health care.

Take, for example, the measurement set for the final rule for accountable-care organizations' performance and payment, which was recently released by the Centers for Medicare and Medicaid Services. Although the bulk of accountable-care organizations' start-up activities to date has been directed toward Medicare enrollees, some insurers and some integrated providers are now also forming such organizations for the private market. Yet the Centers for Medicare and Medicaid Services' measures do not take account of indirect costs that are ultimately highly relevant to payers of all stripes, including the business community and the broader economy.

Of course, the wide-scale logistical, data-collection and analytic challenges posed by the adoption of indirect-cost measures would be considerable. But like it or not, the Affordable Care Act is here to stay. To meet its goals – really, everyone's goals – the law is going to need all the help it can get. M