

Top Insurance Exec Talks ACA

The chief medical officer of BCBSIL explains how physicians should prepare for more change

By Bruce Japsen

AS THE TOP doctor at Blue Cross and Blue Shield of Illinois, the state's largest insurer, Stephen L. Ondra, MD, is at the epicenter of the coming changes facing physicians across the state. A neurosurgeon, veteran of the Iraq War and former health advisor to President Obama, Dr. Ondra last year left his position as senior vice president and chief medical officer at Northwestern Memorial Hospital to take a similar post as senior vice president and chief medical officer of Health Care Service Corp. (HCSC), which has more than 14.2 million health plan subscribers, operating Blue Cross and Blue Shield plans in Illinois, Texas, Oklahoma, New Mexico and Montana. The Illinois Blue Cross plan has 7.7 million members.

Chicago Medicine posed several key questions to Dr. Ondra about how physicians should prepare for the next round of initiatives under the Affordable Care Act (ACA) and how organized medicine should brace for other changes coming to health care from insurers, employers, other payers and the public at large.

Here's what he had to say:

CM: What is the biggest thing doctors should prepare for when it comes to health insurers with plans on Illinois' or other exchanges under the ACA? Are there different things they need to know?

SO: The good news for physicians is that many patients who lacked insurance will have more access to the health care system. Physicians have always cared for the uninsured, but the expansion in access to coverage leads to greater overall certainty of reimbursement. However, this is a big change that also presents some challenges for physicians.

Many newly insured patients have no previous experience with health insurance and are unfamiliar with deductibles or how to use insurance. Although this should not be a major problem in most cases, some patients will need extra assistance to educate them about the health insurance process, which may put some strain on physicians' front offices.

The three-month grace period for premium payment is a more significant issue. The ACA includes a provision that gives enrollees who

receive exchange subsidies a three-month grace period to pay their premium, provided they have already paid at least one month's premium in full. During the second and third months of the grace period, the insurer will typically pay the claims the member incurs. If the member does not pay the outstanding premium in full within the grace period, the insurer will send a request for a refund to the provider for claims paid for services rendered in months two and three. This rule only applies to patients who receive exchange subsidies, but the subsidy status of a patient will not always be known to the physician.

HCSC is committed to working with physicians and their staff to ensure verification of eligibility status and notification if a patient enters the last two months of the grace period, as required by the Centers for Medicare and Medicaid Services (CMS). Verification is much easier with patients who have electronic health records that accommodate a HIPAA-compliant electronic transaction, since the patient's eligibility can be checked at the time of the appointment.

While this sounds like a large undertaking, it is important to keep the problem in perspective. Subsidized patients will be the smallest part of most practices. Most patients will continue to rely on unsubsidized private insurance, Medicare and Medicaid. Early reports also suggest that the premium payment rate for exchange patients is not dramatically different than for other groups of consumers. This makes the risk of bad debt under the three-month grace period even smaller. Still, it is in doctors' interests to put procedures in place to verify eligibility and manage it in ways similar to what they have done for other patients who have lost insurance.

Physicians will also likely see a greater number of patients with higher deductibles, which increases the risk of bad debt. This trend was occurring even before the ACA. If the law works as planned, any increase in bad debt from higher deductibles will be offset by a decrease in bad debt from uninsured patients.

CM: Under the health law, insured plans, which are sold mostly to individuals and small groups, have to spend at least 80% of the premium on medical care. Will this benefit physicians in any way?



SO: Absolutely. The focus on medical care and quality improvement activities will help reduce administrative overhead and the cost of health insurance, thus stimulating an even more consumer-centered health care system. It will help keep insurance affordable and enable physicians to care for more patients who are covered by insurance. That is good for everyone.

CM: You hear a lot about accountable care organizations, or ACOs, but most doctors do not belong to one. Is it only a matter of time before most physicians join an ACO? If so, how should they prepare for this new order?

SO: ACOs are only one of a portfolio of approaches that will help to shift the reimbursement model from fee-for-service to fee-for-value. The

fee-for-service model rewards volume over efficiency by paying for the number of services provided. Cost is only partially controlled through cuts in reimbursement. The only way for physicians to make up that lost revenue is to treat more patients, which leads to further reimbursement cuts. Doctors have to run faster and faster to keep up.

The fee-for-value approach encourages physicians to serve patients as efficiently as possible. By maintaining quality of outcomes and rewarding efficiency, the approach aligns the business incentives of the health care system with the consumers' needs. Patients want to get well as quickly as possible, without tests or treatments that they do not need. The shift from volume to efficiency alters the business model that most doctors and their staff have known their entire careers. The change is even more complex in a multi-payer environment

Dr. Stephen Ondra believes the future of medicine is very bright, saying that we are on the cusp of amazing changes that will improve how physicians care for individuals and the population as a whole.

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involving multiple incentive models. To succeed, this transition will require payers and providers to collaborate in new ways.

The shift also changes the dynamic between physicians and payers by creating shared risks and rewards that will encourage new and more productive collaboration. Rather than being a care regulator and the sole risk holder, the payer is now a care facilitator and a shared risk partner. Payers have more incentive to help physicians and other providers partner efficiently to deliver high-value care to their patients. All parties benefit when quality care is delivered with greater efficiency and lower cost.

CM: You have been a noted neurosurgeon at Northwestern Memorial Hospital in Chicago and in the military before that. Do you see more quality measures coming to specialist disciplines? Currently, most of the quality measurements are related to primary care physicians and the kind of medical care they deliver. How could this work in more specialized medicine?

SO: Work is underway to simplify, improve and codify the current quality measures. It would help immensely if different stakeholders (physicians, other providers, payers, consumers and others) would come together to develop new measures that are even more relevant to the outcomes that define quality. This needs to be done at a macro level and at a more granular patient-treatment level. Patient-level measures will be particularly helpful in guiding decisions about physicians, treatments and facilities. Relevant, reliable and transparent quality measures can become a powerful force for health care delivery improvement.

Quality and cost transparency will give patients the tools they need to assess the value of their treatment and delivery options. For the first time, they can behave as informed health care consumers. Nothing will have a more profound impact on the economics of our health system.

HCSC is working with physician organizations on better ways to assess the quality of the treatment received by our members. We won't be able to do this for every specialty right away. Our strategy is to start with those who have already done the most work in quality measurement and assessment, and then scale it to other specialties and treatments.

CM: No matter whether ACOs become more predominant in the delivery of health care, it's becoming increasingly clear that health insurers and government payers are—and want to—move away from fee-for-service medicine, perhaps entirely. Do you agree with this? Do you think fee-for-service medicine will go away?

SO: Much of the debate about reimbursement models has been about which will be the model of

the future. This is not the right discussion. Health care is too diverse for a one-size-fits-all solution. A young healthy patient should not be managed in the same way with the same incentive model, as a patient with a newly diagnosed cancer.

An ACO is a terrific tool for managing populations, especially those with chronic conditions. Efficiently managing those populations can have a profound and broad impact on the overall value that is delivered by our health care system. However, it is not the most practical or efficient way to manage everyone.

The resources of an ACO are not well used when managing a substantial number of healthy people who need little care. It may be far more efficient to deliver their care through a fee-for-service model. A complex patient with multiple chronic conditions may benefit from an intensive medical home until they are well enough to be managed through an ACO or HMO. Some specialty treatments are single events of high impact and cost. This might be best managed through a prospective or retrospective bundled care approach.

In the end, the solution is not any one of these approaches alone, but fitting them together like the gears on a machine to create a “Value of Care Organization.” Creating a portfolio of incentive model options in a practical and adaptable approach is the best way to meet the needs of a community, while encouraging higher quality, efficiency and integration. Establishing the management infrastructure for this type of integration is difficult and requires collaboration among stakeholders to develop capabilities that align with consumer needs.

CM: What is the biggest concern for physicians as they move forward in a world of medicine that is moving away from fee-for-service?

SO: Doctors have to be prepared for more public scrutiny and accountability. We are already seeing that in the area of reimbursement. There will be increasing pressure to measure outcome quality, and the measures of quality will become more transparent in terms of treatment and physician performance. Physicians should embrace this process and collaborate with other stakeholders to create measures of quality that are fair, accurate and meaningful, and can be collected with minimal administrative burden. Sitting on the sidelines is not an option and doing this invites others to craft measures without the needed physician input. The measures will not be perfect, but perfect should not be the enemy of good—especially when quality measures are inevitable.

Physicians are also likely to find themselves in a world of shifting reimbursement models, with multiple payers moving in slightly different directions at different speeds. This creates a challenge in offices set up to work with the current

fee-for-service system. This pressure is clear not only from pilot studies from CMS and its Center for Medicare and Medicaid Innovation, but also from private payers, employers and others. It is even present in the recently proposed fix for the Sustainable Growth Rate and will no doubt be a part of future approaches to controlling health care costs from across the government and payer spectrum.

CM: Is there anything that worries you about the future of medicine?

SO: The future of medicine and our health care system have never been brighter, but navigating the change will be daunting. Historically, collateral damage is inevitable in any major shift. We need to focus on reforming the system and mitigating any potential downside for groups and individuals.

Physicians and others also have a legitimate concern that growing consumer demand will swamp the relatively fixed physician supply. That will happen if we hang onto the current delivery model. We can't let that happen. We need to reinvent our care model to bring the right resources to each patient, rather than approaching diverse needs with the same model in every case.

We can overcome any access gap and improve care by adopting alternative delivery platforms, using technology in new ways, and expanding how we think about and use tele-health services, as well as how we incorporate allied health professionals into a more personalized system of care delivery. Doing this will free physicians to focus on the things that they are uniquely trained and qualified to do—and where they are most needed—while using other resources to deliver the greatest value and best experience to the patient.

It is also important to remember that with transitions of this scale, often the most vulnerable do not benefit from the advances of the system. In fact, from the perspective of health care disparities, we've learned that a rising tide does not necessarily lift all boats. We will have to be attuned to this issue and to ensure health and health care improves for all Americans.

Helping everyone understand that involves empowering providers, not disenfranchising anyone. And that will be a challenge, as culture changes always are.

CM: As a clinician who has worked as a military surgeon, in private practice, and in academic practice, and is now the top doctor at the nation's fourth-largest insurance company, what excites you about the future of medicine?

SO: There is a lot of pessimism among physicians and a general angst in the public about the future of the health care system. That is not unexpected with all the changes the industry is facing. Fear of the unknown is a common and understandable reaction,

even when the status quo is undesirable. As for me, I have never been more excited or optimistic about the future of health care.


We are on the cusp of amazing changes that will improve how we care for individuals and the population as a whole. By centering care on the patient, we can shift from providing care the way the system wants to deliver it, to providing care the way the patient wants to receive it. We are also in the process of creating a better professional work environment for physicians by finally offering a pathway to get them off the hamster wheel of reimbursement cuts, longer days and less time with patients to a reimbursement model that rewards professionalism and the value of the services they deliver.

As both an insurance executive and physician, I am also excited about the chance to redefine the relationship between the payer and provider. By aligning incentives, we can create a more productive, satisfying and collaborative relationship that will allow us to work together to benefit not only each other's interests but most of all, the patients we serve. HCSC is eager to work with physicians and others, to help refine and shape health reform and our health care system.

In addition to the policy and business changes that will improve both patient experience and provider careers, we are in the midst of an amazing technological revolution that is improving health and health care for everyone involved. The amount of data that is being generated is massive and growing exponentially. As we seek even greater ways to increase the value of care, there will be an incentive to aggregate and analyze this data to improve patient care and care efficiency.

By combining this data with rapidly advancing computing power, physicians, other providers and patients will transform how care is assessed, received and delivered in ways we cannot yet fathom. The ability to personalize medicine at the level of the genome can combine with big data to dramatically improve health and health care. This is only one example of how technology will be a part of creative disruption as we reform our health and health care system.

I think that this is not only the most exciting time in the history of health care, it is also a time of great opportunity and promise for those willing to embrace and shape the future while remaining true to the timeless values and ethics of the medical profession.

Bruce Japsen is an independent Chicago health care journalist and writer for Forbes magazine and contributor to the New York Times. He is also a regular television analyst for WTTW's Chicago Tonight and radio analyst and commentator for several radio programs including WBBM radio 780-AM and 105.9 FM. He teaches writing at Loyola University Chicago School of Communication. He can be reached at brucejapsen@gmail.com. 

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