PUBH 6564, SECTION [course section]

Private Purchasers of Health Care: Roles of Employers and Health Plans in the Care System
Fall/2018

COURSE & CONTACT INFORMATION

Credits: 2
Meeting Day(s): Mondays, September 10 – December 10, 2018
Meeting Time: 1:25 – 3:20 PM
Meeting Place: D199 Mayo

Instructor: Jon B. Christianson
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Office Hours: By Appointment
Office Location: 15-225 Phillips Wangensteen Building

COURSE DESCRIPTION

Add course description] Payments received from private insurance companies are critical to the financial survival of most health care providers. These funds come for the most part from employers that pay insurance companies to manage their employee health care expenses (considered to be part of employee compensation). The purpose of this course is to help future health care managers understand the goals of their best customers and how health plans and employers pursue these goals. The course examines the role of employers and health plans in the health care system and, specifically, how the payers of the bills for health care develop and implement strategies to achieve their organizational and health care system goals. Topics covered include measurement of provider performance, health benefit design, efforts to support consumers in their health care decisions (provision of information to inform choice of providers, choice of treatment options and providers, management of chronic illnesses, and engagement in health promotion activities), provider contracting and utilization management, and provider payment.

COURSE PREREQUISITES

Students must be admitted to the University of Minnesota's Master in Healthcare Administration Program or have consent of the instructor.

COURSE GOALS & OBJECTIVES

Specific goals and learning objectives are listed in for each class period.

METHODS OF INSTRUCTION AND WORK EXPECTATIONS

Each class will include a didactic presentation on the part of the instructor; significant issues will be identified and discussed, referencing the readings for the class period. There are no required readings for the course. The starred readings are a good starting point for students to begin exploring each topic. The amount that students learn in this course, and their performance on assignments, will depend to a large degree on the time and effort they devote to the readings for each topic. In most class periods, students will present or discuss results from individual or group assignments. Students will be expected to engage with the readings prior to class, participate in the discussion during class, and complete group and individual assignments as scheduled. Further readings are provided as starting points for students who wish to explore specific topics in greater depth and to assist in the completion of individual and group assignments.

COURSE TEXT & READINGS

COURSE OUTLINE/WEEKLY SCHEDULE

Week	Topic	Readings	Activities/Assignments
Week 1 - September 10, 17	• **Evolution of Employer Involvement: Consistent Goals and Shifting Strategies**	• **Readings**	• **Presentation of Group Assignment 1 (10 pts.) – September 17**
Week 2 - September 24	• **The Nature and Role of Health Plans**	•	•
Week 3 - October 1	• **Measuring Provider Performance: The Foundation of Purchaser Strategies**	•	• **Discussion of Individual Assignment 1 (15 pts.)**
Week 4 – October 8	• **Using Benefit Design to Influence Consumers' Choice of Providers and Use of Services**	•	•
Week 5 – October 15	• **Supporting Consumer Use of Quality and Cost Information for Provider Choice**	•	• **Discussion of Individual Assignment 2 (15 pts.)**
Week 6 – October 22	• **Providing Employees/Enrollees with Information to Use in Choosing Treatment Options**	•	•
Week 7 – October 29	• **Providing Programs That Help Employees/Enrollees Maintain and Improve Their Health**	•	•
Week 8 – November 5	• **Providing Programs That Help Employees/Enrollees Manage Chronic Illnesses**	•	• **Discussion of Individual Assignment 3 (15 pts.)**
Week 9 – November 12	• **Provider Contracting and Payment Fundamentals**	•	•
Week 10 – November 19	• **Utilization Management Under Provider Contracting Arrangements**	•	• **Discussion of Individual Assignment 4 (15 pts.)**
Week 11 – November 26	• **Moving Towards Value-based Payment**	•	• **Discussion of Individual Assignment 5 (15 pts.)**
Week 12 – December 3	• **New Payment Arrangements: Bundled/Episode-based Payment**	•	• **Discussion of Individual Assignment 6 (15 pts.)**
Week 13 – December 10	• **New Payment Arrangements: Global Contracts and Population Health Management**	•	•

SPH AND UNIVERSITY POLICIES & RESOURCES

The School of Public Health maintains up-to-date information about resources available to students, as well as formal course policies, on our website at www.sph.umn.edu/student-policies/. Students are expected to read and understand all policy information available at this link and are encouraged to make use of the resources available.

The University of Minnesota has official policies, including but not limited to the following:

- Grade definitions
- Scholastic dishonesty
- Makeup work for legitimate absences
- Student conduct code
- Sexual harassment, sexual assault, stalking and relationship violence
- Equity, diversity, equal employment opportunity, and affirmative action
- Disability services
- Academic freedom and responsibility

Resources available for students include:

- Confidential mental health services
- Disability accommodations
- Housing and financial instability resources
- Technology help
- Academic support

EVALUATION & GRADING

[Enter a detailed statement of the basis for grading here. Include a breakdown of course components and a point system for achieving a particular grade. Include expected turnaround time for grading/feedback. Please refer to the University's Uniform Grading Policy and Grading Rubric Resource at https://z.umn.edu/gradingpolicy]

Grading Scale
The University uses plus and minus grading on a 4.000 cumulative grade point scale in accordance with the following, and you can expect the grade lines to be drawn as follows:

% In Class	Grade	GPA
93 - 100%	A	4.000
90 - 92%	A-	3.667
87 - 89%	B+	3.333
83 - 86%	B	3.000
80 - 82%	B-	2.667
77 - 79%	C+	2.333
73 - 76%	C	2.000
70 - 72%	C-	1.667
67 - 69%	D+	1.333
63 - 66%	D	1.000
< 62%	F	

- A = achievement that is outstanding relative to the level necessary to meet course requirements.

- B = achievement that is significantly above the level necessary to meet course requirements.
- C = achievement that meets the course requirements in every respect.
- D = achievement that is worthy of credit even though it fails to meet fully the course requirements.
- F = failure because work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed and there was no agreement between the instructor and the student that the student would be awarded an I (Incomplete).
- S = achievement that is satisfactory, which is equivalent to a C- or better
- N = achievement that is not satisfactory and signifies that the work was either 1) completed but at a level that is not worthy of credit, or 2) not completed and there was no agreement between the instructor and student that the student would receive an I (Incomplete).

Evaluation/Grading Policy	Evaluation/Grading Policy Description
Scholastic Dishonesty, Plagiarism, Cheating, etc.	You are expected to do your own academic work and cite sources as necessary. Failing to do so is scholastic dishonesty. Scholastic dishonesty means plagiarizing; cheating on assignments or examinations; engaging in unauthorized collaboration on academic work; taking, acquiring, or using test materials without faculty permission; submitting false or incomplete records of academic achievement; acting alone or in cooperation with another to falsify records or to obtain dishonestly grades, honors, awards, or professional endorsement; altering, forging, or misusing a University academic record; or fabricating or falsifying data, research procedures, or data analysis (As defined in the Student Conduct Code). For additional information, please see https://z.umn.edu/dishonesty The Office for Student Conduct and Academic Integrity has compiled a useful list of Frequently Asked Questions pertaining to scholastic dishonesty: https://z.umn.edu/integrity. If you have additional questions, please clarify with your instructor. Your instructor can respond to your specific questions regarding what would constitute scholastic dishonesty in the context of a particular class-e.g., whether collaboration on assignments is permitted, requirements and methods for citing sources, if electronic aids are permitted or prohibited during an exam. Indiana University offers a clear description of plagiarism and an online quiz to check your understanding (http://z.umn.edu/iuplagiarism).
Late Assignments	[Instructor to set policy]
Attendance Requirements	[Instructor to set policy]
Extra Credit	[Instructor to set policy]
Intellectual Property of Instructors' Material	The MHA program prohibits any current student from uploading MHA course content (e.g., lecture notes, assignments, or examinations for any PUBH 65XX or PUBH 75XX courses) created by a University of Minnesota faculty member, lecturer, or instructor to any crowdsourced online learning platform.

CEPH KNOWLEDGE DOMAINS

Knowledge Domain	Course Learning Objectives	Assessment Strategies
Discuss the science of primary, secondary and tertiary prevention in population health including health promotion and screening.	To understand strategies and programs that employers use to support employees in choosing providers, choosing treatment options, managing chronic illnesses, and maintaining wellness.	Individual and group (oral and written) assignments.
Explain the social, political and economic determinants of health on population health and health inequities.	To understand employer and health plan programs and payment approaches as they impact population health.	Individual assignments.

NCHL HEALTHCARE LEADERSHIP COMPETENCIES FOR CAHME ACCREDITATION PURPOSES

Competency	Course Learning Objectives	Assessment Strategies
Knowledge of Population Health, Healthcare Delivery and Financing.	To understand the role that employers and health plans play in maintaining the health of their employees, influencing the delivery of care, and paying for care in the U.S. healthcare system.	Individual and group (oral and written) assignments.
	To understand the challenges of measuring health care quality and using measures to improve dimensions of quality of health care delivery.	Individual assignments.
	To understand the design and implementation of payment strategies to support and encourage value-based care.	Individual assignments.
Professionalism	To enhance ability to use written and oral communications effectively.	Individual assignments.

OVERVIEW OF EMPLOYER/HEALTH PLAN ROLES IN HEALTH SYSTEM

September 10, 17, 2018

Evolution of Employer Involvement: Consistent Goals and Shifting Strategies

The two-decade period from the mid-1970s through the mid-1990s marked the ascendancy of a particular type of health plan – the managed care organization – in the private health care marketplace and also as a contractor to Medicare and Medicaid. Responding to pressures from employers and government to control health care costs, these organizations (in collaboration with risk-bearing provider systems) instituted a variety of supply-side mechanisms, financial and non-financial, to influence provider behavior. Accompanying steps were taken to manage access to care on the part of plan enrollees. The result, eventually, was managed care backlash on the part of consumers and providers, precipitated in part by a redefinition by employers of their health benefit designs. In this first session, we will describe the transition over the past 15 years to a new "post backlash" employer paradigm for employee health benefits, emphasizing an expanded role for consumers, and more recently, an evolving "value-based" approach to paying providers

Learning Objectives

Students should be able to:

1. Describe the origins and evolution of managed care organizations.
2. Explain the origins and nature of the managed care backlash of the 1990s, and its influence on the ongoing development of the new employer paradigm for health benefits.
3. Explain the factors influencing present employer demands on the health care system, and the impact of these demands on health plans, consumers, and America's health care system as a whole.

Suggested Readings

The Evolution of Employer Involvement in Health Care

1.* Christianson JB. Managed care. *Encyclopedia of Health Economics*, Elsevier, United Kingdom, 2014. (posted on Moodle).
2.* Reinhardt UE. The illogic of employer-sponsored health insurance. *The New York Times*, July 1, 2014. http://www.nytimes.com/2014/07/03/upshot/the-illogic-of-employer-sponsored-health-insurance.html?_r=0
3.* McLellan RK. Work, health, and worker well-being: Roles and opportunities for employers. *Health Aff.* 2017;36(2):206-213. http://content.healthaffairs.org/content/36/2.toc
4.* Warshawsky MJ, Biggs AG. Income inequality and rising health-care costs: A worker who today makes $30,000 has had to forsake a 26% salary increase since 1999 as employer costs rise. *The Wall Street Journal*, October 6, 2014. https://search.proquest.com/pdnwallstreetjournal/docview/1940549015/pagelevelImagePDF/AD60C32FA59F43BFPQ/1?accountid=14586
5. Galvin RS. Still in the game — harnessing employer inventiveness in U.S. health care reform. *N Engl J Med.* 2008;359(14):1421-1423. https://www.nejm.org/doi/pdf/10.1056/NEJMp0805021 '
6. Grover D. Costly drugs to weigh on U.S. employers' expenses in 2018: survey. Reuters, September 18, 2017. https://www.reuters.com/article/us-usa-healthcare-survey/costly-drugs-to-weigh-on-u-s-employers-expenses-in-2018-survey-idUSKCN1BT1FR
7. Irwin N. Envisioning the end of employer-provided health plans. *The New York Times*, May 1, 2014. http://www.nytimes.com/2014/05/01/upshot/employer-sponsored-health-insurance-may-be-on-the-way-out.html
8. Levitz E. Amazon should not be in charge of solving our health-care crisis. *New York Magazine*, January 30, 2018. http://nymag.com/daily/intelligencer/2018/01/amazon-shouldnt-be-in-charge-of-fixing-health-care.html
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10. State Health Access Data Assistance Center. State-level trends in employer-sponsored health insurance, 2011-2015. Author, February 2017. http://shadac.org/publications/state-level-trends-employer-sponsored-health-insurance-2011-2015-chartbook-and-state
11. Snowbeck C. Employer health costs rising faster in Minnesota. *Star Tribune*, May 7, 2018. http://www.startribune.com/employer-health-costs-rising-faster-in-minnesota/481974291/
12. Farr C. Employers don't understand the 'black box' behind rising drug prices, and are fed up. cnbc.com, April 22, 2018. https://www.cnbc.com/2018/04/22/rising-drug-prices-big-topic-at-national-business-of-health-conference.html

Employer Strategies for Changing the Health Care System

1.* Galvin R, Milstein A. Large employers' new strategies in health care. *N Engl J Med.* 2002;347(12):939-942. http://www.nejm.org/toc/nejm/347/12
2.* Christianson JB, Ginsburg PB, Draper DA. The transition from managed care to consumerism: a community-level status report. *Health Aff.* 2008;27(5):1362-1370. http://content.healthaffairs.org/content/27/5/1362.full.pdf+html
3.* Millenson ML. Paradigm, not pill: The new role of patient-centered care. NIHCM Foundation, February 2014. http://www.nihcm.org/pdf/Patient-Centered_Care_EV_Millenson_2014-1.pdf
4.* Hiltzik M. The myth of 'consumer-driven healthcare' comes to life again. *The Los Angeles Times*, December 14, 2015. http://www.latimes.com/business/hiltzik/la-fi-mh-the-myth-of-consumer-directed-healthcare-20151214-column.html
5.* Delbanco S, Caballero AE. The payment reform landscape: For employers, keep pushing ahead. *Health Aff.* Blog, April 21, 2017. http://healthaffairs.org/blog/2017/04/21/the-payment-reform-landscape-for-employers-keep-pushing-ahead/

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9. Orszag PR, Gluckman D. Orszag, Gluckman: The medical marketplace is changing fast. Bloomberg, April 10, 2018. https://www.bloomberg.com/view/articles/2018-04-09/the-medical-marketplace-is-changing-fast
10. Bernard TS. High health plan deductibles weigh down more employees. *The New York Times*, September 1, 2014. https://www.nytimes.com/2014/09/02/business/increasingly-high-deductible-health-plans-weigh-down-employees.html
11. Frost A, Newman D, Quincy L. Health care consumerism: can the tail wag the dog? *Health Aff.* Blog, March 2, 2016. http://healthaffairs.org/blog/2016/03/02/health-care-consumerism-can-the-tail-wag-the-dog-2/
12. Meyer H. Blog: Why consumerism is no panacea for our healthcare problems. Modern Healthcare, March 8, 2016. http://www.modernhealthcare.com/article/20160308/BLOG/160309857
13. Hancock J, Luthra S. Studies: Employer Costs Slow as Consumers Use Less Care, Deductibles Soar. Kaiser Health News, September 14, 2016. http://khn.org/news/studies-employer-costs-slow-as-consumers-use-less-care-deductibles-soar/
14. Peterson Center on Healthcare. New initiative to help employers become more effective purchasers of healthcare. Press Release, May 2, 2017. http://petersonhealthcare.org/new-initiative-help-employers-become-more-effective-purchasers-healthcare

The Role of Self-Insurance

1.* Weaver C, Mathews AW. One strategy for health-law costs: self insure. *The Wall Street Journal*, May 27, 2013. https://search.proquest.com/docview/1355641943/fulltext/67705D6B9D264496PQ/1?accountid=14586
2.* Freeman GA. Self-insurance options continue to draw employers. HealthLeaders Media, May 3, 2017. http://www.healthleadersmedia.com/health-plans/self-insurance-options-continue-draw-employers
1. Bazar E. For millions of insured Americans, state health laws don't apply. Kaiser Health News, November 16, 2017. https://khn.org/news/for-millions-of-insured-americans-state-health-laws-dont-apply/
2. Catalyst for Payment Reform. MYTHBUSTER: Employers are getting out of the business of buying health insurance. Author, December 19, 2017. https://www.catalyze.org/employers-exchanges/
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4. Cutler D. Building a better health care system: the work ahead. *JAMA* Forum, March 30, 2016. http://newsatjama.jama.com/2016/03/30/jama-forum-building-a-better-health-care-system-the-work-ahead/

Employer Perspectives on Health Care Reform

1.* Galvin R. How employers are responding to the ACA. *N Engl J Med.* 2016;374(7):604-606. http://www.nejm.org/toc/nejm/374/7
2. Furman J, Fiedler M. The Cadillac tax — a crucial tool for delivery-system reform. *N Engl J Med.* 2016;374(11):1008-1009. http://www.nejm.org/toc/nejm/374/11
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6. Hancock J. Employers eye moving sickest workers to insurance exchanges. Kaiser Health News, May 7, 2014. http://www.kaiserhealthnews.org/stories/2014/may/07/shifting-employees-to-exchanges.aspx

Further Readings

1. Tozzi J. Trump's health chief wants to change how doctors do business. Bloomberg, March 21, 2018. https://www.bloomberg.com/news/articles/2018-03-21/trump-s-health-chief-wants-to-change-how-doctors-do-business
2. Wingfield N, Thomas K. Amazon, Berkshire Hathaway and JPMorgan team up to disrupt health care. *The New York Times,* January 30, 2018. https://nyti.ms/2GuXbBp
3. Blumenthal D. Employer-sponsored health insurance in the United States – origins and implications. *N Engl J Med.* 2006;355(1):82-88. http://www.nejm.org/doi/pdf/10.1056/NEJMhpr060703
4. Blumenthal D. Employer-sponsored insurance – riding the health care tiger. *N Engl J Med.* 2006;355(2):195-202. http://www.nejm.org/doi/pdf/10.1056/NEJMhpr060704
5. Robinson JC, Ginsburg PB. Consumer-driven health care: promise and performance. *Health Aff.* 2009;28(2):w272-w281. http://content.healthaffairs.org/content/28/2/w272.full.pdf+html

September 24, 2018
The Nature and Role of Health Plans
Health plans represent employer interests in the health care system, competing for contracts with employers. They structure their products and actions to gain and retain the business of employer clients, which is critical to their own financial success. In doing so, they provide a wide range of products and services in addition to traditional health insurance. In this session, we trace the development of the health insurance industry and describe its current state. We discuss market concentration, premium setting, and differences among health plan products; describe how plans are evaluated by employers and consumers; and discuss public perceptions of the health insurance industry.

Learning Objectives
Students should be able to:

1. Describe the structure of the health insurance industry and how it is changing.
2. Distinguish among different types of health plans and health plan products.
3. Explain how employers assess health plan performance and choose among health plans.
4. Identify major current issues relating to health plan performance from the perspective of employers and the public.

Suggested Readings
Overview of the Health Plan Industry

1.* Grant C. Why health insurers are the new 800-pound gorillas. *The Wall Street Journal*, March 22, 2016. https://search.proquest.com/docview/1774998768/5B58C0AB8A754952PQ/1?accountid=14586
2.* Archer D. Private insurance is bankrupting Americans: is Congress paying attention? *Health Aff.* Blog, June 26, 2012. http://healthaffairs.org/blog/2012/06/26/private-insurance-is-bankrupting-americans-is-congress-paying-attention/
3.* Morse S. Majority of employer-insured Americans are satisfied with their health plan. Healthcare Finance News, February 6, 2018. http://www.healthcarefinancenews.com/news/majority-employer-insured-americans-are-satisfied-their-health-plan
4.* Morse S. AHIP follows the money: Here are the factors driving insurance premiums higher. Healthcare Finance News, May 22, 2018. http://www.healthcarefinancenews.com/news/ahip-follows-money-here-are-factors-driving-insurance-premiums-higher
5. Schoen C, Collins SR. The big five health insurers' membership and revenue trends: Implications for public policy. *Health Aff.* 2017;36(12):2185-2194. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0858
6. Weixel N. UnitedHealth expects $1.7B windfall from tax law. The Hill, January 16, 2018. http://thehill.com/policy/healthcare/369147-unitedhealth-expects-17b-windfall-from-tax-law
7. Japsen B. Anthem's new CEO looks to Medicare, technology investments for growth. Forbes, January 31, 2018. https://www.forbes.com/forbes/welcome/?toURL=https://www.forbes.com/sites/brucejapsen/2018/01/31/anthems-new-ceo-looks-to-medicare-technology-investments-for-growth/&refURL=https://www.google.com/&referrer=https://www.google.com/
8. Hetzel A.. Why Blue Cross Blue Shield of Michigan's nonprofit status is important to our members. News Release, MI Blues Perspective, March 1, 2018. https://www.mibluesperspectives.com/news/why-blue-cross-blue-shield-of-michigans-nonprofit-status-is-important-to-our-members-2/
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10. Mangan D. Obamacare's Medicaid expansion leading to health insurance boom in some states. CNBC, July 20, 2016. http://www.cnbc.com/2016/07/20/obamacares-medicaid-expansion-leading-to-health-insurance-boom-in-some-states.html
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14. Evans M. Big hospital operator retreats from health-insurance foray. *The Wall Street Journal*, December 15, 2016. https://www.wsj.com/articles/big-hospital-operator-retreats-from-health-insurance-foray-1481814003
15. Sommer J. Gripes about Obamacare aside, health insurers are in a profit spiral. *The New York Times,* March 18, 2017. https://nyti.ms/2me5Thb

Mergers and Acquisitions

1.* Dafny LS. Good riddance to big insurance mergers. *N Engl J Med.* 2017;376(19):1804-1806. http://www.nejm.org/doi/pdf/10.1056/NEJMp1616553
2.* Abelson R. Failure of 2 health insurer mergers is unlikely to stop the efforts. *The New York Times*, July 20, 2016. http://www.nytimes.com/2016/07/21/business/failure-of-2-health-insurer-mergers-is-unlikely-to-stop-the-efforts.html?_r=0
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wants-be-in-your-neighborhood-because-zip-codes-powerfully-shape-peoples-health/?noredirect=on&utm_term=.fd70fbf0254a

4. *The Times* Editorial Board. CVS and Aetna say their massive merger is needed to keep prices down. That remains to be see. *The Los Angeles Times*, December 11, 2017. http://www.latimes.com/opinion/editorials/la-ed-cvs-aetna-20171211-story.html
5. Grant C. Anthem may win by sitting out wave of health insurance deals. *The Wall Street Journal*, April 6, 2018. https://www.wsj.com/articles/anthem-may-win-by-sitting-out-wave-of-health-insurance-deals-1523016903
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10. O'Donnell J. Hospitals, doctors funded consumer opposition to insurance mergers. *USA Today*, July 21, 2016. http://www.usatoday.com/story/news/politics/2016/07/21/hospitals-doctors-funded-consumer-opposition-insurance-mergers/87387476/

Competitive Strategies of Health Plans

Care Delivery

1. Snowbeck C. Future looks bright for startup insurer Bright Health. *StarTribune*, May 17, 2018. http://www.startribune.com/startup-insurer-bright-health-getting-bigger/482967681/
2. Weaver C. Health insurers opening their own clinics to trim costs. Kaiser Health News, May 4, 2011. http://www.kaiserhealthnews.org/stories/2011/may/04/insurers-turn-to-clinics-for-cost-control.aspx?referrer=search
3. Snowbeck C. UnitedHealth's Optum Unit Makes Big Push into Urgent Care in Minnesota. *Star Tribune*, September 13, 2016. http://www.startribune.com/unitedhealth-s-optum-unit-makes-big-push-into-urgent-care-in-minnesota/393327791/
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October 1, 2018
Measuring Provider Performance: The Foundation of Purchaser Strategies
Efforts on the part of health plans and employers to measure provider performance have intensified over the past decade, with performance measurement assuming a key role in almost all employer/health plan strategies. Health plans construct or employ measures of performance to: select providers for inclusion in networks; create tiered networks; structure provider incentive payments; and produce provider performance reports for their providers, members, and the general public. These measures also can be used in disease management and wellness programs. The way in which performance measures are constructed and used has been a point of contention between employers/health plans and providers as has the cost to providers of constructing measures. Consumers also have criticized these measures as lacking in relevance for their decision making. In this session, we describe the efforts of employers and health plans to measure provider performance, common issues in measure construction, the use of risk-adjustment techniques, and alternatives for attributing patients to providers.

Learning Objectives
Students should be able to:
1. Describe and contrast different approaches to performance measurement.
2. Discuss strengths and weaknesses of these approaches.
3. Discuss the role of risk adjustment techniques and how they are applied.
4. Discuss alternatives for attributing patients to providers for measurement purposes.
5. Contrast how measurement challenges differ for quality vs. cost/efficiency measures.
6. Discuss potential adverse consequences of performance measurement.

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INFLUENCING CONSUMER BEHAVIOR

October 8, 2018

Using Benefit Design to Influence Consumers' Choice of Providers and Use of Services

Employers pursue a variety of benefit design options to influence consumer purchase decisions, such as cost-sharing, network design, coverage limitations, and incentives regarding plan choice. In this session, we describe these efforts, their implementation and evidence of their impacts.

Learning Objectives

Students should be able to:

1. Understand differences in health benefit designs and their influence on consumer use of services.
2. Discuss the pros and cons of limited and tiered provider networks.
3. Discuss common issues relating to health plan coverage limitations.
4. Describe the motivation for employers to offer access to health plans through private benefit exchanges.

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October 15, 2018

Supporting Consumer on Quality and Cost Information for Provider Choice

Providing consumers with timely, useful information about the performance of providers is one way that purchasers hope to engage consumers. Their intent is that consumers use this information, in combination with financial incentives, to seek out lower cost, higher quality providers and to inform their conversations with providers. And, it is hoped that providers will improve their quality and reduce their costs when faced with public comparisons with their peers. The present health care system, some argue, does not provide information that is truly useful to consumers in making cost/quality tradeoffs when choosing providers, or that is credible to providers. Employers have been strong supporters of recent efforts to publicly report information comparing providers. We will describe these efforts as well as the evidence regarding the influence of this information on consumer and provider decisions.

Learning Objectives

Students should be able to:

1. Describe the recent efforts to increase the amount and quality of information available to health care consumers about providers.
2. Discuss the responses of providers to these efforts.
3. Assess the evidence regarding the impact of comparative provider performance data on consumer decisions, quality of care, and health care costs.

Suggested Readings

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Providing Employees/Enrollees with Information to Use in Choosing Treatment Options

There is growing support for the need to provide consumers with information necessary to evaluate treatment options and select the option that is the best fit for their individual circumstances and preferences. Consumer decision aids have been

developed to address this issue. We discuss how decision aids function, evidence of their effectiveness, and the roles of employers and health plans in encouraging their use. We also discuss the challenges that low health literacy and numeracy pose for the use of shared decision making generally, and specifically how it relates to consumer choice of treatment options. We describe efforts by payers and health plans to address this issue.

Learning Objectives

Students should be able to:

1. Describe different approaches being used to support consumers in their choice of treatments.
2. Discuss the problems faced by employers and health plans in implementing decision aids.
3. Evaluate the evidence regarding the effectiveness of these decision aids.
4. Assess the challenges that low health literacy and numeracy pose for informed consumer decision making.

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Providing Programs That Help Employees/Enrollees Maintain and Improve Their Health

Increasingly, employers are instituting programs and financial incentives that support employees in maintaining and improving their health. The expectation is that these efforts will reduce the rate of increase in health care costs over time by reducing or delaying the onset of chronic illnesses. Employers also hope that wellness programs will reduce absenteeism and increase worker productivity. Payers use both rewards and negative incentives to encourage healthy behaviors, and both health plans

and independent vendors deliver program content. The employer role in promoting these wellness programs has been controversial as it relates to use of positive versus negative incentives and the protection of personal employee information.

Learning Objectives

Students should be able to:

1. Describe the rationale for employer/health plan support for healthy lifestyle programs.
2. Assess the strengths and weaknesses of different program designs.
3. Evaluate the evidence that these programs have been successful in achieving their goals.
4. Discuss the impediments to the successful implementation of these programs.
8. Discuss the aspects of these programs that can make them controversial.

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November 5, 2018

Providing Programs That Help Employees/Enrollees Manage Chronic Illnesses

Employers are strong supporters of programs that help employees self-manage care for chronic illnesses. The general idea is to place the consumer in a much more central role in medical care treatment. By educating consumers in appropriate treatment methods for their illnesses and supporting their efforts to manage their illnesses, payers and health plans hope that the progression of chronic illnesses can be delayed, and the number of acute flare-ups of chronic illnesses can be minimized. If successful, these efforts would improve the quality of life for employees, reduce emergency room and hospital use, and restrain growth in costs. In this session, we discuss efforts of payers and health plans to support consumers in chronic care management and the contexts in which they have been successful.

Learning Objectives

Students should be able to:

1. Explain the concepts of patient self-management and disease management in their different forms.
2. Discuss the various ways in which employers and health plans are supporting employees and plan enrollees in chronic illness management.
3. Assess the evidence of their effectiveness in various settings.
4. Describe the obstacles payers and health plans face when implementing programs to support chronic illness management by consumers.

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CONTRACTING WITH AND PAYING PROVIDERS

November 12, 2018

Provider Contracting and Payment Fundamentals

A major factor in health plans' success in securing employer contracts is their ability to negotiate favorable terms when contracting with providers and to effectively manage provider networks in ways that do not provoke enrollee backlash. In this session, we discuss the basics of provider contracting, including payment fundamentals and the way in which health plans and providers attempt to exert leverage in the contracting process.

Learning Objectives

Students should be able to:

1. Describe the basic reimbursement approaches used by health plans in contracting with providers.
2. Discuss the nature of the contracting process from the health plan and provider perspectives.
3. Describe areas of friction between providers and plans that arise during the contracting process.

Suggested Readings

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November 19, 2018

Utilization Management under Provider Contracting Arrangements

Reminders, clinical decision-support systems, predictive modeling, guidelines, and rules are all used by health plans to influence the amount and type of care that providers deliver to patients. Reminders prompt physicians about a patient's care needs prior to, or at the time of, the treatment visit. Clinical decision-support systems typically involve software designed to assist the physician's clinical decision-making. Predictive modeling uses large claims databases to identify patients who may be at risk of specific illnesses in the future and alert clinicians prior to the patient visit. Guidelines, or pathways, assist physicians in taking the appropriate treatment steps, given a patient's condition, and often are applied when treating patients with chronic health problems. They can be incorporated in clinical decision support systems. Rules are used by health plans to intervene more directly in the care process. This session will address the different ways that health plans attempt to influence the delivery of care by providers, including the manner in which these techniques are being employed and evidence of their effectiveness.

Learning Objectives
Students should be able to:

1. Describe the most common practices used by health plans to influence the delivery of care.
2. Explain the barriers to their effective implementation.
3. Assess the strength of the evidence supporting their effectiveness.
4. Describe recent trends in their use in conjunction with other efforts to influence physician behavior.

Suggested Readings

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November 26, 2018
Moving Towards Value-based Payment

During the 1980s through the mid-1990s, most provider payment arrangements employed by health plans were designed to influence providers to reduce unnecessary service utilization. Then, responding to consumer backlash, plans and employers largely reverted to fee-for-service payment. However, over the past decade, health plans and purchasers have initiated a variety of new payment approaches that have broader behavioral change goals, including improving quality of care, implementing evidence-based medical practices effectively, and supporting the restructuring of care delivery. Some of these approaches blend traditional fee-for-service with payments related to provider performance. Recently, Medicare and some Medicaid programs have instituted payment reforms with similar objectives. We will discuss employer and health plan first steps toward value-based payment methodologies. We also describe parallel payment initiatives by Medicare that supplement these private sector efforts. In subsequent sessions, we will discuss payment approaches that shift more financial risk to providers.

Learning Objectives

Students should be able to:

1. Understand what is meant by value-based payment.
2. Describe the different types of pay-for-performance and health care home payment initiatives being undertaken as health plans and purchasers move toward value-based payment.
3. Describe how these approaches differ in their design, as well as the challenges they pose for implementation, in

comparison to previous payment arrangements between health plans and providers.

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December 3, 2018
New Payment Arrangements: Bundled/Episode-Based Payment
Private sector plans and Medicare are experimenting with provider payments that bundle related care activities, sometimes in conjunction with reference pricing. These payments place more financial risk on providers but also offer providers the potential for financial gains. While attractive for some services, bundled payments have proven difficult to implement in practice. Nevertheless, momentum behind bundled payments in the private sector (and in Medicare) seems to be growing.

Learning Objectives
Students should be able to:
1. Understand the basic design features relating to bundled payment.
2. Discuss the obstacles to implementing bundled payment arrangements.
3. Understand the evidence regarding the impacts of bundled payment.
4. Discuss Medicare support for bundled payment.

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December 10, 2018
New Payment Arrangements: Global Contracts and Population Health Management
Total Cost of Care, also called Global, contracts between health plans and providers are growing in popularity. Under these contracts, providers agree to deliver services to a defined group of individuals for one global payment. Typically, providers can agree to assume some degree of risk in return for the chance to share in savings, assuming adequate performance on quality metrics. In Medicare, this approach involves contracts with "accountable care organizations" or ACOs.

Learning Objectives
Students should be able to:
1. Describe the basic features of comprehensive, global contracts between health plans and providers.
2. Discuss the obstacles to implementing global payment arrangements.
3. Discuss Medicare support for global payment.

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