Self-Insured Employers — The Payment-Reform Wild Card

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Each year, U.S. health care becomes less affordable. Medicare and Medicaid account for an ever-increasing share of the federal budget, commercial premiums continue to rise, and consumers pay higher copayments and deductibles. We cannot solve this spending crisis without substantial changes in the way care is delivered. But widespread delivery-system restructuring will not occur as long as fee for service is the dominant method of health care payment.

Since the Affordable Care Act was passed in 2010, Medicare has shifted provider payment into alternative payment models (APMs) — mainly accountable care organizations (ACOs) — covering more than a third of its beneficiaries. Medicare ACO savings have been modest — about 1% annually, and a portion of that is offset by bonuses for successful ACOs.[1,2] The initial Medicare ACOs have improved over time, however, achieving greater savings the longer they've been in the program.[2] These initiatives have also begun to spur some delivery-system changes that provide a foundation for continued improvement in the quality and value of care.

But many commercial health plans have been slow to adopt APMs, largely because their biggest customers — self-insured employers — have not demanded it. Provider systems will not make major changes until a critical mass of their revenues come from payment systems that reward lower spending and better quality. Whereas traditional fee-for-service Medicare accounts for about 15% of national health spending, employer-sponsored insurance accounts for 31%, and self-insured employers pay the largest share of that. That makes self-insured employers the payment-reform wild card.

Publicly available data on commercial APMs are limited. A recent survey of 80 large multispecialty group practices and integrated networks — the groups most likely to participate in APMs — revealed that 29% of commercial insurance payments were made through APMs, a majority of which were arrangements in which providers shared in savings but not losses and 4% of which were full-capitation models. Among independent and loosely organized providers, APM participation levels are much lower. In addition, more than half the medical groups responding to the survey reported that most commercial payers in their markets did not offer risk-based contracts.[3] Therefore, health plans' readiness to move into APMs merits examination.

In fact, the business case for health plans to implement APMs is far from clear. Implementing new payment models is expensive. Many health plans have aging information-technology infrastructure, including multiple claims systems that often cannot communicate with one another. Committing to APMs requires large investments for information-system upgrades, as well as personnel who can design, negotiate, and monitor global budget–based or episode-based contracts.

Health plans also have no easy mechanism for incorporating shared-savings payments into self-insured contracts. Plans must explicitly charge self-insured customers when they pay bonuses, which can be problematic if the amounts are large. To avoid explicit charges, some plans incorporate shared-savings bonuses into future provider-rate increases. But then the bonuses are neither immediate nor salient, which reduces their effectiveness in encouraging behavior change.

The most important barrier for health plans, however, is that their biggest customers have not demanded the use of APMs. Employers have traditionally focused on managing the demand side of health care through benefit design because they have less expertise in supply-side issues such as financial arrangements with providers. Benefit changes have dampened the impact of cost increases on companies' bottom lines, but there is scant evidence that employees have become healthier or smarter health care consumers. A return to higher-cost inflation and a tightening labor market in which attractive health benefits are needed to recruit skilled workers are causing employers to consider supply-side strategies such as payment reform. A recent survey of large self-insured employers by the National Business Group on Health indicated that 21% of companies plan to direct payments to ACOs in 2018 and that the number will double over the subsequent 2 years.

In attending to the supply side, self-insured employers that want to interface successfully with health care providers will have to adapt their approach to cost control and lengthen their time hori-

zon for seeing a positive return on any extra money that's paid for improved value. Many U.S. provider organizations are working toward systems necessary for delivering better value, but they cannot change providers' practice patterns overnight. Employers will need to overcome their reluctance to pay providers bonuses for eliminating unnecessary services. Large employers that have agreed to participate in ACO arrangements frequently cap providers' shared-savings bonuses at around $5 per member per month, or slightly more than 1% — reducing incentives for major restructuring that could eliminate waste. Finally, provider organizations will expect companies to invest in communicating with employees about the value of integrated delivery systems and alter benefit designs to steer employees to them.

Other factors inhibit employers' use of APMs. For example, companies with a geographically dispersed workforce may lack a sufficient concentration of workers in local markets for APM programs to be actuarially stable and administratively feasible. Given the challenges, some employers may prefer to free-ride on payment-reform incentives from Medicare or other private payers. When physicians modify their practice style in response to new payment models, they don't do so selectively — utilization changes spill over to other payers.[4] Anecdotally, some benefits consultants advise clients to let others do the heavy lifting and wait until utilization rates drop before committing to sharing savings with providers.

Will self-insured employers reverse their historical inability to use their purchasing power to reward higher-value care? Recently, some large employers have banded together to support APMs in particular markets, aiming to drive volume to a limited number of more efficient health systems.[5] Such arrangements have been tried before, but companies haven't exhibited the patience necessary to change a slow-moving system like health care. However, the recently announced initiative by Amazon, JP Morgan, and Berkshire Hathaway may herald a new kind of employer activism in the health benefits arena. Amazon in particular is known for its willingness to invest in long-term strategies without getting distracted by short-term results and for its ability to engage customers, eliminate unnecessary middlemen, and drive price competition among suppliers. Over time, such strategies could have many positive effects, from improving employees' medication adherence to directing them to the most effective and efficient providers. Silicon Valley firms have tried to change health care in the past and failed. But given Amazon's track record of disrupting various sectors of the economy, it's too soon to count them out.

Public policies that pressure employers to limit growth of health care costs — such as the so-called Cadillac tax — could spur employer action. The tax, a 40% charge for health benefit plans costing over a certain amount, is predicted to affect more than 20% of employers. But its effective date has been delayed from 2018 to 2022, and in the face of bipartisan criticism, it may well not survive.

Another lever for payment reform is public-employee benefit programs. Several state-employee benefit programs have established targets for enrolling members in plans with APM arrangements. State and municipal employees represent a large market for commercial payers, and their size and geographic concentration makes their actions relevant for provider systems. The TriCare program, which covers more than 9 million active-duty military families and retirees, has the potential to influence markets but is just starting to focus on value-based care. The 2017 National Defense Authorization Act authorized changes to the structure of the Military Health System that would enable development of a single integrated system of readiness and health for all the armed services, and the Defense Health Agency is developing a value-based care strategy to guide future health plan procurements.

Commercial health plans trying to make meaningful payment reforms face challenges, including provider hesitance (though a small but growing cohort of medical groups are eager to assume risk), high costs of implementation, and still-limited enthusiasm from customers. For health plans that are making money, changing current payment arrangements may look like a losing proposition. Progress will require action by self-insured employers. Without more private-sector leadership, U.S. health care will remain stuck in a fee-for-service system for the foreseeable future.

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Saving Thyroids — Overtreatment of Small Papillary Cancers

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This year, more than 50,000 people in the United States will be diagnosed with thyroid cancer.[1] Three quarters of these diagnoses will be in women; their median age at diagnosis will be about 50 years (for context, the median age at the time of breast cancer diagnosis is 62). Thyroid cancer has become an increasingly common diagnosis for Americans: over the past 25 years, its incidence has tripled — largely reflecting the detection of small papillary thyroid cancers.[2]

Despite this dramatic rise in incidence, mortality due to thyroid cancer has remained stable, which suggests that there is widespread overdiagnosis — detection of disease that is not destined to cause clinical illness or death.[3] Consequently, efforts to reduce thyroid cancer detection are clearly warranted — for example, refraining from screening for cancers and from biopsying small thyroid nodules, as advocated by the American Thyroid Association.[4] Also needed, however, are efforts to reduce overtreatment. We support the option of active surveillance for selected patients with small papillary thyroid cancers,[5] but we recognize that some patients will prefer to have their cancer removed. In such cases, the question becomes how much thyroid to resect.

The "complete" operation for thyroid cancer is total thyroidectomy. It carries a risk of injury to either recurrent laryngeal nerve (or, rarely, both of them) and a risk of hypoparathyroidism due to damage to all four parathyroid glands; it also necessitates lifelong thyroid hormone replacement. The less extensive operation is thyroid lobectomy, or removal of about half the thyroid gland. This surgery carries a lower risk of nerve damage, avoids the risk of hypoparathyroidism altogether, and preserves thyroid tissue — for many patients, obviating the need for permanent thyroid hormone–replacement therapy. Adjuvant therapy with radioactive iodine (RAI) must be preceded by total thyroidectomy.

It has become increasingly clear that the choice between total thyroidectomy (with or without RAI therapy) and lobectomy has little effect on the risk of death from thyroid cancer. The upper graph shows the 25-year risk of death due to thyroid cancer in patients with localized papillary thyroid cancer (≤2 cm in diameter) treated with either total thyroidectomy or lobectomy (see also the Supplementary Appendix, available at NEJM.org). The graph confirms two facts about small papillary thyroid cancers: first, the risk of death from thyroid cancer is extremely low (roughly 2% over 25 years), and second, that risk is unaffected by the choice of procedure.

Given the additional harms of total thyroidectomy, one would expect that the recognition of similar effectiveness would lead lobectomy to becomei the dominant procedure, especially given the increasing detection of small tumors. But instead, the opposite has happened. The lower graph shows that the rate of total thyroidectomy is, in fact, accelerating faster than the rate of lobectomy. Currently, about 80% of patients who have surgery for localized papillary thyroid cancer (≤2 cm in diameter) undergo a total thyroidectomy.

Why are physicians subjecting patients to the additional risks of hypoparathyroidism and recurrent laryngeal nerve damage? Why are we consigning them to lifelong thyroid hormone replacement?

Patient preference is not a plausible explanation. Patients may have strong preferences for surgery over active surveillance (if that's a choice for them), since the idea of simply watching a cancer is so foreign, particularly given our decades-long instruction on the need to act quickly. But patients are unlikely to have preexisting preferences about which operative strategy to follow; instead, they look to clinicians for advice.

Thus, we are left with provider preferences. Surgeons and endocrinologists may simply believe that total thyroidectomy is the