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A Requiem for Value-Based Care

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Abstract

What is the message? Value-based care models still dominate discussion at the policy level and across private health insurance markets. Yet, there is little evidence that value-based payment has had a meaningful impact on healthcare delivery. To address its deficiencies, policymakers need to take on a holistic, market-level view of the U.S. health system's value payment program.

What is the evidence? Academic literature and studies, insurance documents, and U.S. government data.

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The Evolution of Value-Based Care

Healthcare delivery in the United States has long been characterized by high costs and inconsistent quality of services for patients. A little over a decade ago, policymakers designed an innovative solution to these challenges: they would shift payment models from the *provision of services* (often described in a derogatory manner as payment for volume), to a new concept called *value.* If we paid for services based on value, then the delivery system would respond by reorienting the business model to lower-cost, higher-quality services. (1) Leading advocates of this new model were certain that it would finally drive to a higher-performing healthcare system. An article in a business magazine reflected this perspective, "The Strategy That Will Fix Healthcare." (2)

Value-based healthcare (VBC) was adopted by the Centers for Medicare and Medicaid Services (CMS) through the Affordable Care Act and later, by the private healthcare market. Value would be driven by: a) financial models such as Accountable Care Organizations (ACOs), b) value-based care demonstration models across service lines such as oncology and orthopedic surgery, and c) new programs offered by the CMS Innovation Center. In the private sector, most major health insurers have value-based payment models. For example, United Healthcare touts, "…we are accelerating the transition from a fee-for-service to a value-based system of care delivery. Value-based care arrangements are designed to manage health care costs and improve the patient experience." (3) Aetna has a different take on the model: " VBC's triple aim is to improve the health care experience, improve the health of individuals and populations and reduce the costs of health care. To do this, VBC moves beyond sick care and adopts a proactive, team-oriented and data-driven approach to keeping people healthy." (4)

Value-based care models still dominate discussion at the policy level and across private health insurance markets. Yet, there is little evidence that value-based payment has had a meaningful impact on healthcare delivery. Evaluations of the ACO program found little evidence of benefit from hospital-based ACOs, and at best, extremely modest evidence of benefit from other models. (5) Even proponents of these policies have begun to acknowledge this failure. (6)

"Apart from conceptual reservations, a decade of empirical evidence on the effects of pay for performance is not encouraging. Less charitably, it is damning. There have been some scattered gains, but studies of major programs have consistently found little to no improvement—even on targeted measures—and revealed plenty of cause for concern." (7) The government's

assessment is consistent with these assessments, albeit with an optimistic spin: “CBO concluded that some ACO models produced small net savings.” (8)

How could such a perfect solution result in such disappointing results? From the beginning, the policymakers promoting value ignored the business model of the U.S. healthcare delivery system. Hospitals embarked on a strategy of scale starting in the late 1990’s, finding that scale at a local level would provide significant pricing leverage in negotiations with private health insurance plans. This strategy was successful, driving up prices for those with private health insurance, and driving up the costs of healthcare delivery as hospitals competed for profitable, privately insured patients with newer and more elegant facilities. While the American Hospital Association reported that private health insurance paid only a modest premium to Medicare in 2000, (9) a 2022 study from RAND found that private health plans now pay 224% of Medicare prices, and in 19 states, health plans pay more than 300% of Medicare prices for outpatient care. (10)

The premise of value actually allowed hospital systems to double-down on this strategy of consolidation by extending their leverage over physician services. In 2012, only 6% of physicians worked directly for hospitals. (11) But federal policy shifted to a value framework that ignored the impact of hospital consolidation on prices in the private healthcare market. In the name of “value,” we witnessed relaxed anti-trust enforcement, CMS’s pursuit of hospital-friendly payment policies including generous facility fee payment models, and expansion of the 340B drug purchasing program for outpatient hospital-based services. At the same time, physicians struggled to adapt to new rules of electronic health records and the cacophony of “value” payments models in the market. The net result saw physicians flock to hospital-based employment. By 2022, 52% of physicians were hospital employees. (11)

Where Are We Today?

The value movement is steamrolling ahead unabated despite its dismal record. Even negative evaluations of value programs in academic literature suggest that these programs require time to mature rather than recognizing them for what they are — a failure. This policy battle is not without cost. The real cost of private health insurance has risen from 13% of median family household income in 2000 to 25% in 2021, (12) and our life expectancy has fallen to a rank of 33 among 49 nations tracked by the OECD, with average U.S. life expectancy now 6.5 years

lower than in Switzerland. (13)

How did policymakers get this whole concept so wrong? In August of every year, U.S. economists meet in Jackson Hole, Wyoming for the Jackson Hole Economic Symposium. There, looking at the grandeur of the mountains, attendees fiercely debate economic data and policy, and the outlook for the coming year.

We have no such gathering in healthcare. We have experts in pieces of the elephant — experts in Medicare policy, experts in Medicaid, experts examining hospital consolidation, and experts examining the pharmaceutical market. One state Secretary of Health explained that they were in charge of Medicaid and the state employee health plan. They did not even know about the alignment of hospitals and physicians in the state.

Some of these experts meet at different disciplinary conferences to present their research, but nowhere are all of these perspectives brought together to achieve an overarching economic understanding of the market and the inter-relationships between hospital strategy, payment models, and health outcomes. Rationally, how could a “value” payment program even be considered in one sector of the market when it is not in sync with, or is possibly even in conflict with, value models in other sectors of the economy, and still hope for changes in the market?

The U.S. healthcare system is a market, and our policymakers need to take on a market-level view and understanding. Yet, we have no such mechanism for market oversight in place. (14) The Biden administration competition policy initiative could have provided the rationale for such an effort. The Trump administration market disruption agenda could also provide a impetus for this wholistic approach. We could tackle this entire agenda, or start with the segment of the market with the greatest potential for leverage, by focusing on the payment process. (15) By examining all of the pieces of the market concurrently, we can begin to understand the strategies driving disparate actors and develop market and regulatory solutions to drive the market in the direction of value for individual patients.

References

1. Burns LR, Pauly MV. Transformation of the Health Care Industry: Curb Your Enthusiasm? Milbank Q. 2018 Mar;96(1):57-109.

2. Porter, M., and Lee T. “The Strategy That Will Fix Health Care.” Harvard Business Review 91, no. 10 (October 2013): 50–70. https://search-ebscohost-com.ezp-prod1.hul.harvard.edu/login.aspx?direct=true&db=heh&AN=90325428&site=ehost-live&scope=site
3. https://www.unitedhealthgroup.com/driven-by-our-mission/what-we-do/value-based-care.html
4. https://www.aetna.com/employers-organizations/resources/value-based-care.html
5. McWilliams JM. Pay for Performance: When Slogans Overtake Science in Health Policy. JAMA. 2022 Dec 6;328(21):2114-2116.
6. Schulman KA, Richman BD. Reassessing ACOs and Health Care Reform. JAMA. 2016 Aug 16;316(7):707-8.
7. Song Z, Fisher ES. The ACO Experiment in Infancy–Looking Back and Looking Forward. JAMA. 2016 Aug 16;316(7):705-6.
8. https://www.cbo.gov/system/files/2024-04/59879-Medicare-ACOs.pdf
9. Schulman KA, Milstein A. The Implications of “Medicare for All” for US Hospitals. JAMA. 2019 May 7;321(17):1661-1662
10. Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O’Neill, and Aaron Kofner, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1144-1.html.
11. Bowling D 3rd, Richman BD, Schulman KA. The Rise and Potential of Physician Unions. JAMA. 2022 Aug 16;328(7):617-618.
12. Schulman KA, Narayan, A. Employer-Based Health Insurance and Employee Compensation. *JAMA Health Forum*. 2023;4(3):e225486.
13. https://data.oecd.org/healthstat/life-expectancy-at-birth.htm
14. Burns R. The U.S. healthcare ecosystem: payers, providers, producers. New York : McGraw Hill. 2021.
15. Richman, Barak D. and Schulman, Kevin, Healthcare Administrative Costs and Competition Policy (May 2023). Competition Policy International Antitrust Chronicle, (May 2023), Duke Law School Public Law & Legal Theory Series No. 2023-36, Available at SSRN: https://ssrn.com/abstract=4488625

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