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THE STATE OF HEALTH CARE TODAY:

HOW PHYSICIANS, CONSUMERS, AND EMPLOYERS VIEW HEALTH CARE COSTS, OUTCOMES, AND REFORM EFFORTS

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HIP HEALTH INTELLIGENCE PARTNERS

EXECUTIVE SUMMARY

As health care spending in the U.S. reaches unsustainable levels, the value-based reform movement seeks to rein in costs and improve quality. Amid these reform efforts, it is necessary to assess the current state of health care and how different stakeholders approach health care's challenges and solutions. Leavitt Partners surveyed physicians, employers, and consumers across the nation to better understand their perspectives in today's complicated, challenging, and changing health care system. Physicians, employers, and consumers all agree that fundamental changes are needed to make the U.S. health system work better; however, physicians and employers disagree on which payment reform efforts will work, who is responsible for driving reform, and which are the most important barriers to overcome. Consumers express the need for fundamental, systemic changes to the health care system, yet report satisfaction with their individual health care, including their health insurance plan. Understanding where these groups agree and disagree enhances our knowledge of the state of health care today and the best next steps for tomorrow.

INTRODUCTION

Health care dominated the national conversation in 2017 and promises to remain a central focus in 2018. In 2017, per capita health care costs climbed to over $10,000 and health care spending consumed nearly 18 percent of gross domestic product.[1] Meanwhile, the U.S. continues to lag behind other industrialized countries on quality measures and public health outcomes. While enormous gains have been made in coverage, 28.1 million Americans (8.8 percent) still lack health insurance.[2]

SAMPLE SIZE

Physicians	621
Employers	538
Consumers	5,031

To address these challenges, the Institute for Healthcare Improvement established the "Triple Aim," a framework for enhancing performance within the health care system through three components: improving the experience of care, improving the health of populations, and reducing per capita health care costs.

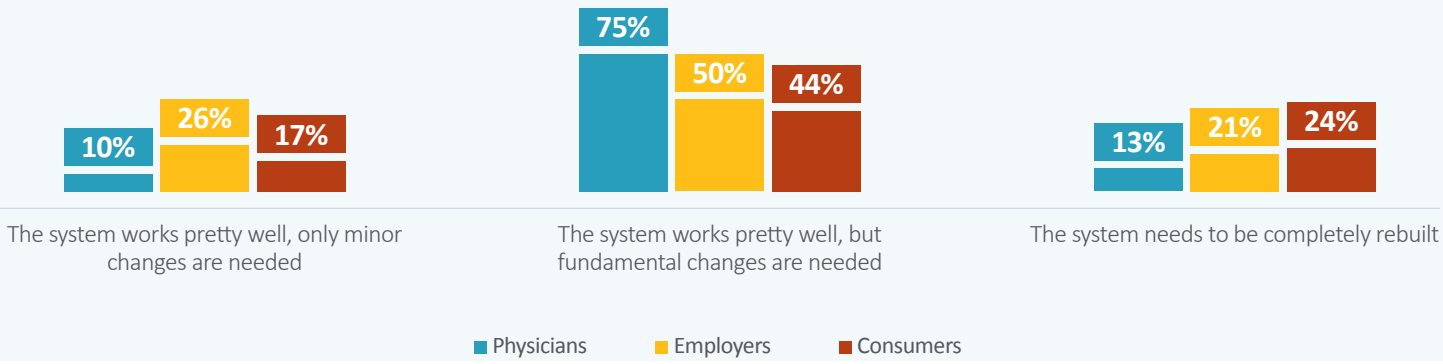
It is important to step back and assess progress toward the Triple Aim amid various payment and delivery reform efforts to contain costs and improve quality. The Leavitt Partners Health Intelligence Partners (HIP) 2017 surveys offer unique insight into what the country thinks of our health care system through the lens of three stakeholder perspectives: physicians, employers, and consumers. These groups approach health care from sometimes complementary and other times conflicting angles. In general, physicians, employers, and consumers agree that the health care system requires change; however, they disagree on what changes are needed, who is responsible for making changes, and which reform efforts hold the most promise. Understanding these divergent perspectives can help hone efforts to achieve the goals of the Triple Aim.

IN GENERAL, PHYSICIANS, EMPLOYERS, AND CONSUMERS AGREE THAT THE HEALTH CARE SYSTEM REQUIRES CHANGE; HOWEVER, THEY DISAGREE ON WHAT CHANGES ARE NEEDED, WHO IS RESPONSIBLE FOR MAKING CHANGES, AND WHICH REFORM EFFORTS HOLD THE MOST PROMISE.

CHANGE IS NEEDED

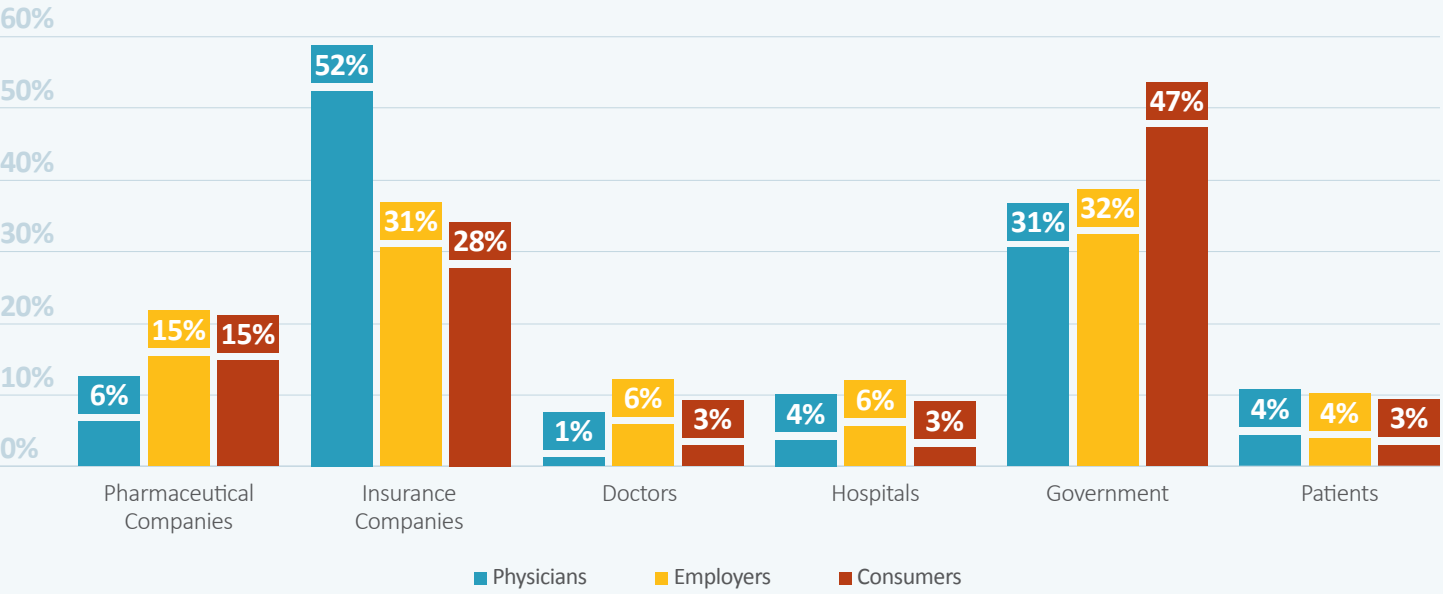
Overall, physicians, employers, and consumers agree that there are some positive aspects of the health care system in the U.S., but they also recognize that fundamental changes are needed (Figure 1). Only 10 percent of physicians think the system works reasonably well and only minor changes are necessary, while one-quarter of employers and 17 percent of consumers think only minor changes are needed. Meanwhile, 90 percent of physicians and around 70 percent of employers and consumers think that fundamental changes or a completely rebuilt system are needed. While all survey groups overwhelmingly agree that fundamental changes are needed, employers and consumers are more likely to think our health care system needs to be "completely rebuilt."

FIGURE 1. Respondents' Overall View of the U.S. Health Care System



Physicians, employers, and consumers generally agree on the groups most to blame for problems in the health care system, though they disagree on the degree to which those groups are responsible. All three groups place the most responsibility on insurance companies and the government, while few blame hospitals (3-6 percent), doctors (1-6 percent), or patients (3-4 percent) (Figure 2). Half of physicians (52 percent), one-third of employers (31 percent), and 28 percent of consumers blame insurance companies for the problems in our health care system. One-third of physicians (31 percent) and employers (32 percent), and nearly half of consumers (47 percent) blame the government for health care's problems. Because respondents put little blame on themselves, it appears they see health care problems as beyond their control. There is also likely significant variation in how different survey respondents define problems; some may see them as problems of finance, regulation, or delivery of care.

FIGURE 2. Responsibility for Problems with the U.S. Health Care System



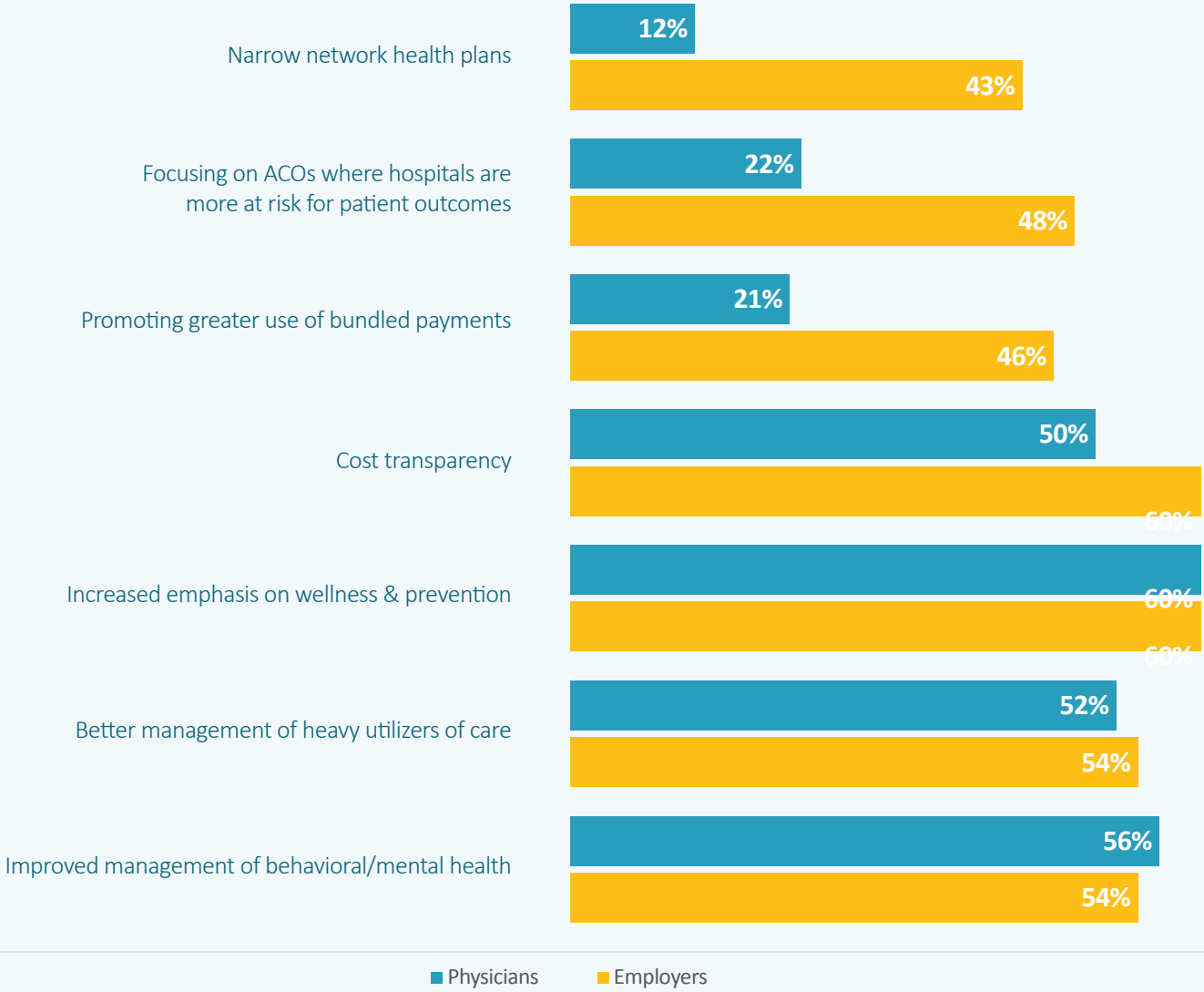
While few from each stakeholder group think the health care system works well, there continues to be disagreement on what needs to be done and who is responsible. Specifically, some disagreement exists on how to contain costs, improve quality, and implement reform efforts.

COST

Since the U.S. spends more money per capita on health care than any other industrialized country, it is important to understand stakeholders' perspectives on health care costs.[3] Physicians and employers both believe that cost transparency tools and an increased emphasis on wellness and prevention would help contain health care costs. Just over half of physicians and employers (52 percent and 54 percent, respectively) also believe that better management of heavy utilizers of care and of behavioral and mental health would work well to curb costs (Figure 3).

However, physicians and employers disagree on the efficacy of some measures to contain costs. While 46 percent of employers believe bundled payments can lower spending, only 21 percent of physicians agree. Similarly, nearly half of employers (48 percent) see accountable care organizations (ACOs) as a promising way to lower costs, compared to just 22 percent of physicians.

FIGURE 3. Percent of Physicians and Employers Who Believe the Following Efforts Will Work Extremely or Very Well to Contain Health Care Costs



Overall, employers are more optimistic on various ways to contain costs. Compared to physicians, employers place more importance on promoting value-based payment reforms including ACOs and bundled payments. Given physician and employer beliefs, reforms must emphasize the areas of agreement, including wellness and prevention, better management of heavy utilizers of care, improved management of behavioral and mental health, and availability of cost transparency tools. Physicians are more optimistic about reforms that involve patient engagement and less optimistic about reforms that impact their payment. Thus, there is a need to create incentives for physicians to transition away from a fee-for-service environment and toward value-based payment models. A business case for value must be made and continual engagement with providers on reform efforts and care delivery transformation is important.

REFORMS MUST EMPHASIZE THE AREAS OF AGREEMENT, INCLUDING WELLNESS AND PREVENTION, BETTER MANAGEMENT OF HEAVY UTILIZERS OF CARE, IMPROVED MANAGEMENT OF BEHAVIORAL AND MENTAL HEALTH, AND AVAILABILITY OF COST TRANSPARENCY TOOLS.

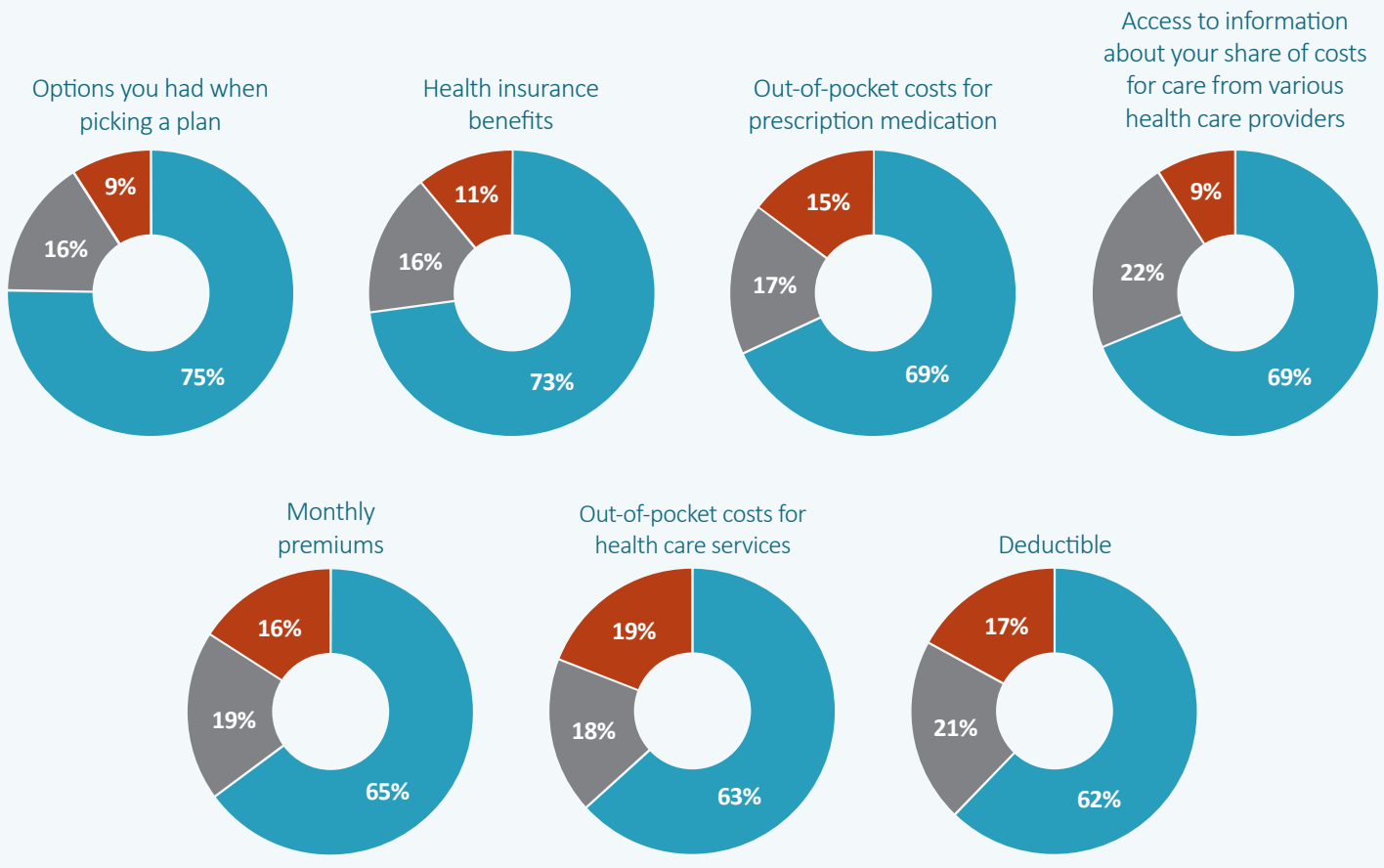
Consumers are, perhaps unsurprisingly, most likely to be dissatisfied with cost when it comes to their health insurance. Consumers' number one reason for choosing their health insurance plan was the inclusion of low monthly premiums. However, more than one-third (36 percent) of consumers would not accept a 15-20 percent decrease in their monthly insurance premium in exchange for various insurance plan restrictions, such as restrictions on the brand of medications that can be prescribed, restrictions on which pharmacies to use, restrictions on which imaging centers and/or labs to use, a requirement to get a referral before seeing a specialist, or a limited network of preferred doctors.

36 percent of consumers are unwilling to accept various insurance plan restrictions in exchange for a **15-20 percent** decrease in monthly insurance premiums

There is a disconnect between how consumers view the health care system generally and how they view it personally. The majority of consumers report being at least somewhat satisfied (between 62 percent and 75 percent) with a variety of aspects of their health insurance plan (Figure 4). Most consumers (72 percent) report that their health insurance plans meet their family's needs very or extremely well.

CONSUMERS APPEAR TO HAVE A GENERALIZED DISSATISFACTION WITH THE HEALTH CARE SYSTEM AND A BELIEF THAT FUNDAMENTAL CHANGES ARE NEEDED, YET EXPRESS CONTENTMENT WITH THEIR INDIVIDUAL HEALTH CARE PLANS.

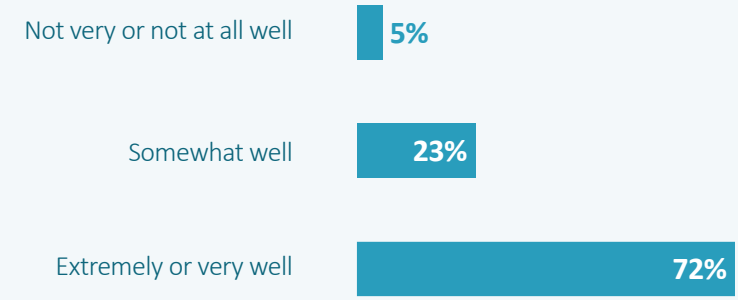
FIGURE 4. Consumer Satisfaction with Health Insurance



Meanwhile, only five percent responded that their health insurance plans met their family's needs not very well or not at all (Figure 5). Consumers appear to have a generalized dissatisfaction with the health care system and a belief that fundamental changes are needed, yet express contentment with their individual health care plans. However, these are aggregate findings and further research is needed to determine whether these views are shared by consumers with different types of insurance (Medicare, Medicaid, and commercial) and different levels of cost sharing.

> **PHYSICIANS ARE MOST OPTIMISTIC ABOUT PAY FOR PERFORMANCE (P4P) AND PATIENT-CENTERED MEDICAL HOMES' ABILITY TO IMPROVE OUTCOMES.**

FIGURE 5. Consumer Beliefs on Insurance Plan Meeting Family's Health Needs



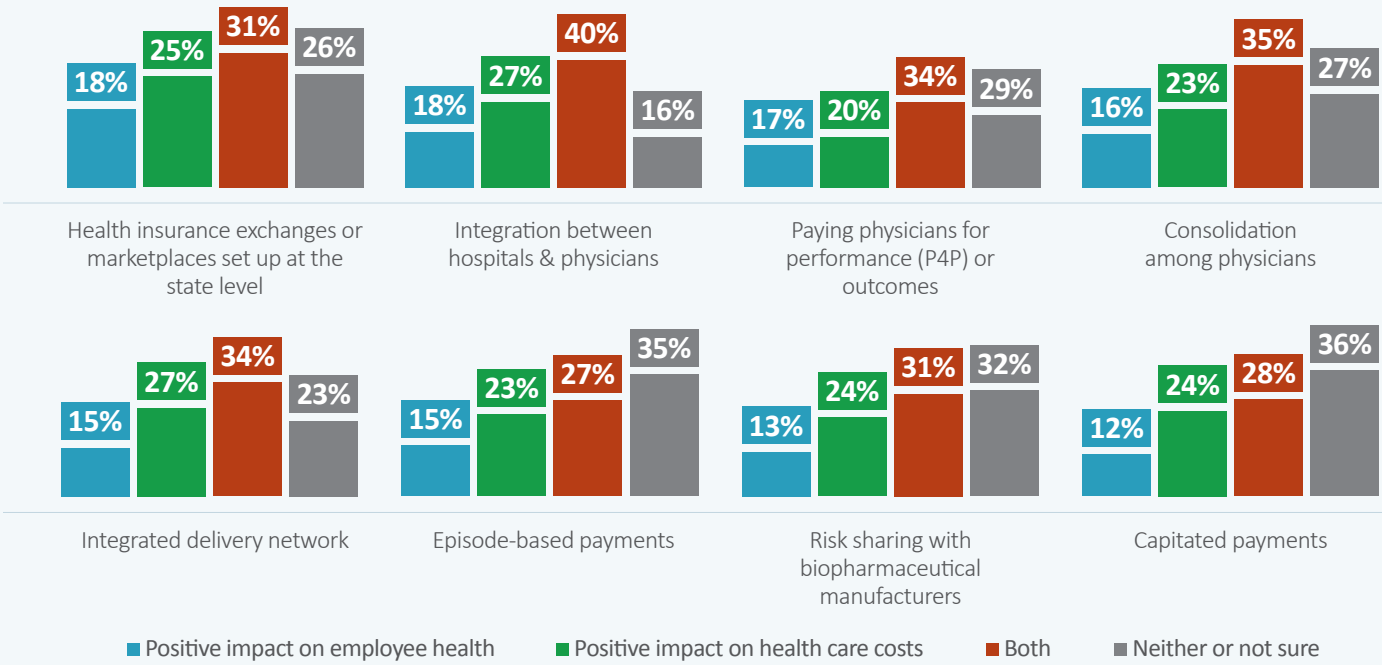
OUTCOMES

The U.S. performs well on certain health care outcomes, including lower in-hospital mortality rates for heart attacks or strokes and breast cancer survival rates, but ranks last among other high-income countries on overall health outcomes including infant mortality and life expectancy at age 60.[4] There is a need to focus attention on improving overall health outcomes in the U.S. population. While we are seeing an increase in adoption of various new payment reforms that encourage value and decrease costs, physicians are skeptical that value-based reforms have a positive impact on patient health outcomes. Physicians are most optimistic about pay for performance (P4P) and patient-centered medical homes (PCMHs), but are less likely to believe capitated, global, or bundled payments will improve outcomes. Overall, between 34 percent and 58 percent of respondents are not yet sure of the impact of these initiatives (Figure 6).

FIGURE 6. Physician Beliefs on the Impact of Payment and Delivery Models on Patient Health Outcomes

While physicians are hesitant about the impact of various value-based payment reforms, one-third of employers also are not sure or disagree that certain value-based payment reforms will have a positive impact on outcomes like employee health and health care costs (Figure 7). These reforms include capitated payments, episode-based payments, and paying physicians for performance (P4P) or outcomes.

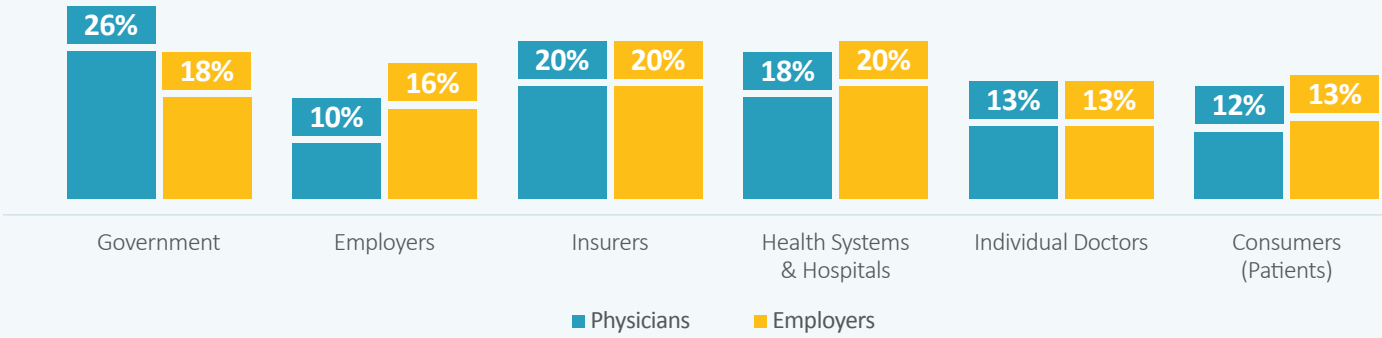
FIGURE 7. Employer Beliefs on Impact of Changes Happening in the Health Care System



REFORM

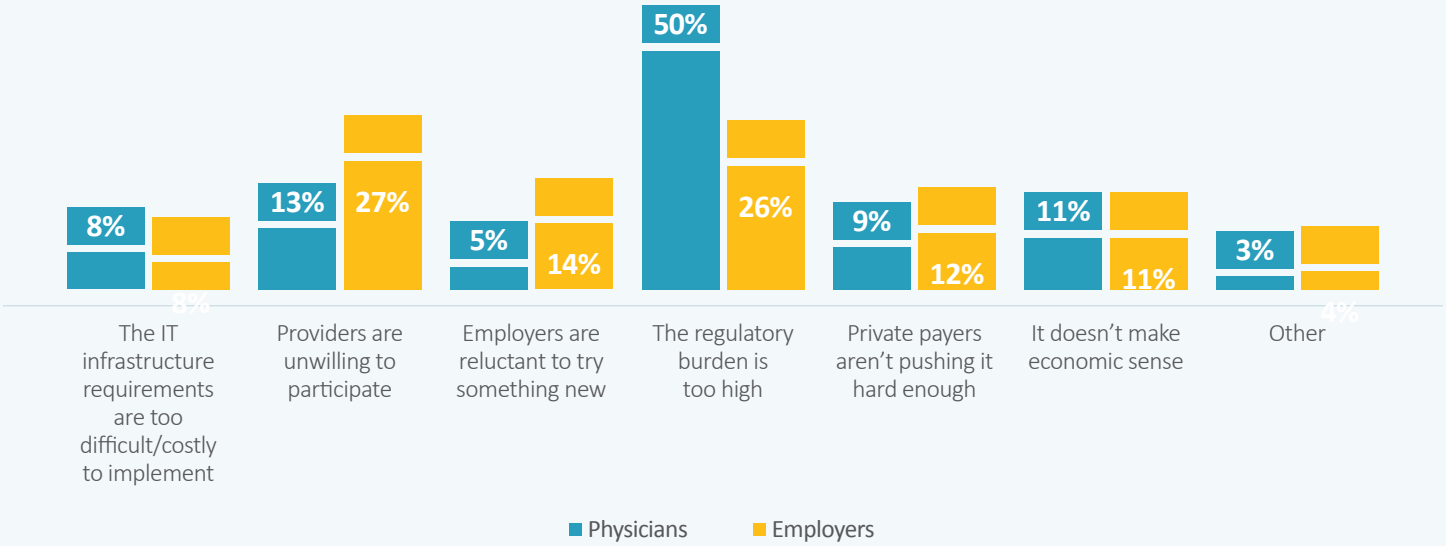
The value-based reform movement is well underway, yet little consensus exists within or between groups on how to keep it moving forward. For example, physicians and employers do not agree on who is responsible for pushing provider payment reform initiatives, which may contribute to the uncertainty physicians and employers have about reform efforts (Figure 8). Physicians and employers identify a variety of groups as being responsible for pushing reform. Lack of agreement both within and between groups on who should drive reform makes progress difficult.

FIGURE 8. Responsibility for Pushing Provider Payment Reform Initiatives to Lower Costs



There is also no agreement on the barriers to reform. Employers and physicians place little responsibility on themselves as the barrier to provider payment reform. Physicians overwhelmingly cite regulatory burden as the major barrier to payment reform. While one-quarter (26 percent) of employers agree the regulatory burden is too high, an equal number (27 percent) believe providers' unwillingness to participate in payment reform is a significant obstacle (Figure 9). In the end, there does not seem to be agreement between groups on barriers to adoption of provider payment reform.

FIGURE 9. Most Significant Barrier to Adoption of Provider Payment Reform



Physician uncertainty about value-based payment reforms could be due to insufficient understanding or engagement. Most frequently, physicians reported recognizing the name but not being familiar with the requirements of the Medicare Access and CHIP Reauthorization Act (MACRA). Only four percent of physicians said that they had an in-depth knowledge of the law and its requirements (Figure 10). Frustration on the part of physicians may come from experiencing existing challenges, but not having a sufficient understanding of either the underlying problems or the reform efforts.

In addition to physician unfamiliarity with MACRA and its requirements, the majority of consumers reported not being familiar with terms related to value-based payment and care delivery transformation (Figure 11).

FIGURE 10. Physician Familiarity with the 2015 Medicare Access and CHIP Reauthorization Act (MACRA)

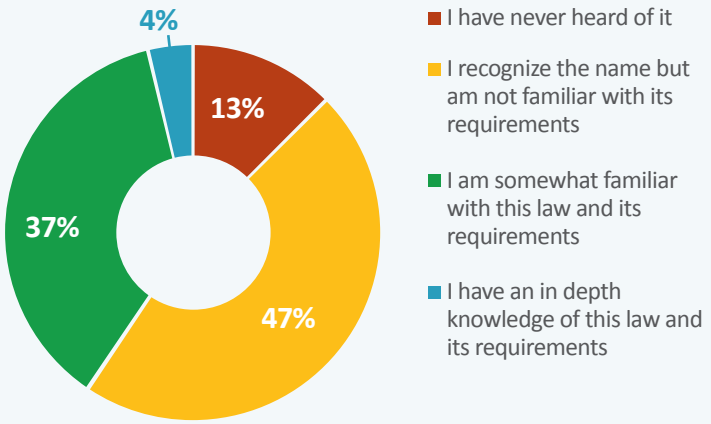
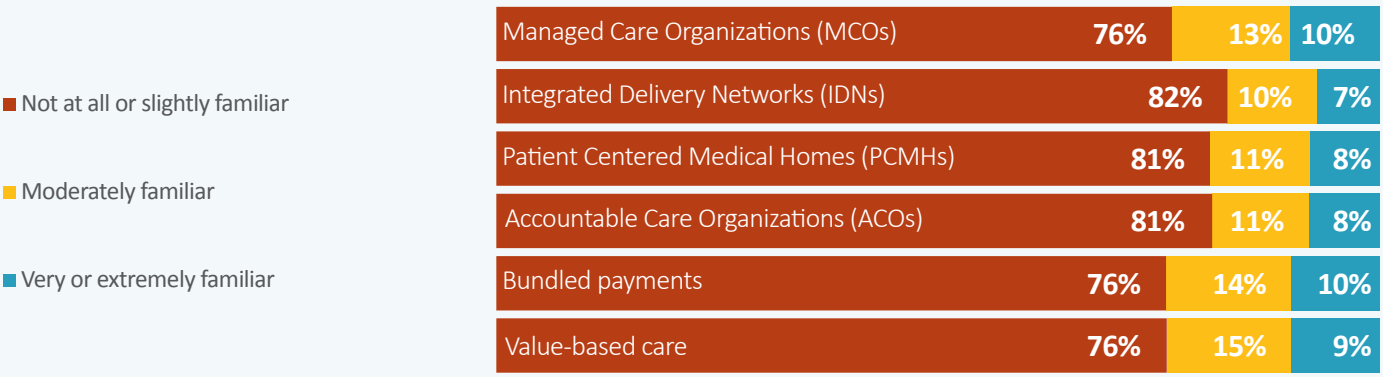


FIGURE 11. Consumer Familiarity with Value-Based Reform



CONCLUSION

Overall, physicians, employers, and consumers agree that while there are some positive aspects of the U.S. health care system, fundamental changes are needed. However, between these three stakeholders, disagreement continues on what needs to be done, on how to contain costs and improve health outcomes, and on who is responsible for reform initiatives. These insights show that the incentives that exist today are not well understood, and not aligned to outcomes in a way that makes clear the responsibility of payers, providers, and consumers. Physicians do not want a reduction in pay, but they understand the need for financial incentives that encourage them to help patients be healthier. Consumers do not want to pay more for health insurance, but they can understand a system that challenges them financially to utilize resources to get healthier. In an economic environment that mandates changes to the health care system, it is especially important to create a strong business case for providers to participate in value-based payment models.

IN AN ECONOMIC ENVIRONMENT THAT MANDATES CHANGES TO THE HEALTH CARE SYSTEM, IT IS ESPECIALLY IMPORTANT TO CREATE A STRONG BUSINESS CASE FOR PROVIDERS TO PARTICIPATE IN VALUE-BASED PAYMENT MODELS.

METHODS

Research findings represent data from three surveys: physicians, employers, and consumers.

PARTICIPANTS

Participants in the surveys included 621 physicians, 538 employers, and 5,031 consumers. Quotas were set to ensure representation from different types of physicians including solo practitioners and specialists that are most likely to write biologic prescriptions, as well as a high-level physician classification as follows:

Primary Care Physicians (PCPs)
Hospitalists
Radiologists, Anesthesiologists, and Pathologists (RAPs)
Surgical Specialists (defined as spending at least 30 percent of their time in surgery)
Non-surgical Specialists

The target population for employers was health benefit decision-makers from all sectors, industries, and sizes of organizations. Minimum quotas were set for various sizes of employers to ensure representation from small (5 to 99 employees), medium (100 to 499 employees), and large (500 to 4,999 employees), to more than 5,000+ employees.

Minimum quotas were also set for consumers to achieve a sample that was loosely representative of U.S. demographics including quotas for gender, race, age, education, income, and geography. Final data were weighted to reflect the true demographics of the U.S. population based on most recent census data.

DESIGN AND PROCEDURE

The survey for physicians was administered online through Qualtrics survey software between June 20, 2017 and July 10, 2017 and the sampling frame was provided by Medscape. The employer survey was also administered online through Qualtrics between June 20, 2017 and July 14, 2017 and the sampling frame was provided by SSI's B2B panel. The consumer survey was administered online through Qualtrics between May 25, 2017 and June 13, 2017 and the sampling frame was provided by Qualtrics.

LIMITATIONS

The survey data has the possibility for several limitations. Perception and self-reported data may be biased based on the respondent's ability to recall information and desire to be socially acceptable, among other reasons. The survey instrument was carefully designed; however, it was not tested for validity or reliability so there may be survey bias and measurement error. Finally, although the respondent groups are large, this was a non-probability sample, so findings may not be generalizable to the large U.S. population.

BIBLIOGRAPHY

1. Centers for Medicare & Medicaid Services. National Health Expenditures, 2016 [Internet]. 2017 [cited 2017 Dec 17]. Available from: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

2. U.S. Department of Health and Human Services. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January – March 2017 [Internet]. 2017. Available from: https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf

3. Davis K, Stremikis K, Squires D, Schoen C. Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally. Commonw Fund [Internet]. 2014; Available from: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

4. Schneider EC, Sarnak DO, Squires D, Shah A, Doty MM. Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care [Internet]. 2017 [cited 2017 Dec 17]. Available from: http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/

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Health Intelligence Partners (HIP) is a trusted health intelligence advisory service that supports decision making in the value economy. HIP is a membership community for health care leaders in strategic roles across policy, advocacy, and business circles, and provides analysis of action and reaction both inside and outside the Beltway. HIP surveys of health care stakeholders add strategic insights by presenting the voices of those living and working in our health care system. HIP surveys were designed and analyzed by Jennifer Colamonico, senior director of Leavitt Partners Health Intelligence Partners, and Kerstin Edwards, a research manager at Leavitt Partners.

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