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Case Report Open Access

Increasing Physician Earnings through Bundled Payments

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The Case for Change

The case for changing physician reimbursement from an insurance based fee for service model to a less complicated and timelier payment system is obvious to most physicians. As employers shift more healthcare costs to their employees, patients are having an increasingly difficult time paying their bills. The combination of higher insurance premiums and rising out of pocket costs have greatly reduced a patient's ability to pay their doctors. This means that once "well insured" patients are now becoming collections risks. Making the situation worse is the fact that some practices spend as much as 40% of their commercial reimbursement getting paid.

While alternatives to employer based health plans such as a single payer system or socialized medicine have been proposed, these solutions are as complex as they are controversial. Instead of venturing into a theoretical debate over long term healthcare financing solutions for the US, this article focuses on a practical solution that physicians can implement today.

Dissecting the Commercial Insurance Dollar

According to the Healthcare Trends Institute, for the fifty percent of Americans who receive health coverage through their employer or purchase it directly from an insurer, their insurance dollars are spent as follows (Figure 1):

Thirteen percent of the commercial insurance premium dollar is consumed by claims administration (10%) and insurance company profits (3%). While these costs increase the premiums paid by employers and their employees, they do not directly impact physician reimbursement. What directly affects physicians is the cost of obtaining reimbursement. The average cost for doctors to receive commercial insurance reimbursement averages twenty-seven percent. This includes items such as personnel to copy insurance cards, register patients, verify coverage, obtain authorizations and pre-certifications, collect deductibles and co-pays, file claims, check on claim status, deal with suspended or denied claims, and collect fees. It also includes the cost associated with revenue cycle systems and clearing houses [1].

A 2009 study published in Health Affairs estimates that physician practices' interactions with insurers cost $23.2 billion to $31 billion a year. The study found that the average physician spends 43 minutes per workday, more than three hours a week, dealing with health plan administrative requirements. The time physicians, nurses and other practice staff spend interacting with insurers costs an average of $68,274 per physician per annum [2]. Very few other businesses have revenue cycle costs this high. The expense and hassles associated with claims administration has been a major reason that many physicians decided to leave private practice and become health system employees over the past decade. Providers in other modern nations do not incur there administrative costs because their services are either government funded or paid directly by their patients. This is one of many reasons that the US healthcare system costs twice as much per person as the average modern nation that utilizes socialized medicine, a single payor system and/or a self pay system.

Social Juggernaut

In addition to high administrative costs, the trend toward high-deductible health plans is causing customarily well insured patients to experience skyrocketing out of pocket costs and/or higher premiums while traditionally uninsured people are gaining better coverage at low costs. A recent common wealth fund survey found that four out of ten working-age adults did not access needed healthcare services due to their out of pocket costs. The portion of workers with annual deductibles has risen from 55% eight years ago to 80% today, according to research by the Kaiser Family Foundation. Meanwhile the size of the average healthcare deductible more than doubled in the same eight years, from $584 to $1,217 for individual coverage. A recent Mercer study showed that between 2013 and 2014, enrollment in "high-deductible plans" jumped from 18% to 23% of all covered employees [3].

At the same time, co-pays, co-insurance and the price of drugs and procedures not covered by insurance has also increased. During this same time period, employers have shifted a larger percentage of the cost of professional services to individuals. In fact, many plans now have deductibles in excess of $5,000 per member before reimbursement occurs for non-wellness-related physician care. In the best scenarios, patients have some form of healthcare savings or spending accounts. In the worst scenarios, patients have no means to pay their deductibles and go without care or their physician goes without payment. For many workers, commercial insurance has become more like a self-pay discount program with a major medical backstop than the health insurance they once held. The trend toward higher out of pocket expenses is now impacting 150 million working-age Americans for whom full coverage or low deductible plans have long been the gold

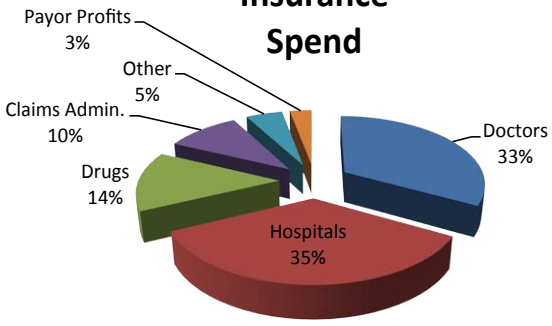

Figure 1: Breakdown of private insurance spend.

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standard. This trend is causing many commercially insured patients to avoid doctor visits, delay medical procedures, drop prescriptions and/or ration pills in much the same manner that the uninsured have traditionally done. Around the country many physicians are witnessing a polar shift in their practices as poor, long-uninsured patients are getting coverage through Medicaid or the Affordable Care Act and are coming in for care, while commercially insured patients are increasingly staying away.

Praveen Arla, M.D., a family practice physician in Hillview, KY said, "It's flip-flopped, patients tell me that, my deductible is so high. I'm trying to come to the doctor as little as possible.… What is the minimum I can get done?' They're really worried about cost" [3].

Today many patients struggle to pay their out of pocket expenses. Others complain that providers cannot even tell them how much their services will cost. What they repeatedly request is:

a. To know their out of pocket costs before a procedure is performed, be able to budget

b. To have a single comprehensive fee for service with no surprises

c. Discounts for paying cash

d. More flexibility in the care receive, i.e. care plans that better fit their needs

e. Medical financing to help pay over time

A More Excellent Way

For the 53% of physicians (beyond residency training) who remain owners of their practices [4], there is an acute need to change the game. Changing the game requires a departure from line item fee for service reimbursement to a form of reimbursement that allows greater physician autonomy, lower administrative costs, lower patient costs and the ability to improve the patient experience. Bundled payments represent a logical approach to achieve all of these objectives.

A bundled payment is simply a single payment for a defined set of professional services. For example, a bundled payment could be developed for an annual physical with lab tests, one year of medical management of a chronic disease such as diabetes, a normal vaginal delivery or a surgical procedure.

Across the country a number of physicians are now creating bundled payments for their most common services. In every case reviewed, this alternative payment arrangement has resulted in lower administrative costs, lower patient out of pocket costs, higher physician incomes, improved patient experiences, and greater flexibility in care delivery. In contrast with traditional fee for service models that dictate professional fees and define which services are reimbursed, bundled payments eliminate the twenty seven cents of administrative costs consumed in the commercial insurance reimbursement process while encouraging physicians to innovate and improve care. Professional bundled payments also meet the needs of the growing number of "insured poor" whose high out of pocket costs are barriers to receiving necessary care.

Savvy physicians are also using bundled payments as a strategy to increase practice volume and margins by catering to patient demand. Some physicians are even using bundled payments to contract directly with employers. The result is generally a ten to thirty percent reduction in administrative cost and much greater flexibility in the services being rendered.

Developing Bundled Payments in the Physician Practice

The basic steps to building a professional bundled payment are to select an episode of care, define inputs and costs, develop contractual terms, conduct financial analysis, and redesign/improve care. These steps are detailed below:

Select an episode of care

Episodes of care in a physician practice can include any set of services that patients want to purchase on a fixed price basis. There is no limitation to what can be included. This means that the doctor is free to develop a treatment plan that best meets patient needs.

Examples of professional services that have been bundled include:

a. An office visit with labs

b. The professional component of a surgery with follow up visits

c. A wellness bundle that includes a physical, two sick visits and labs for up to one year

d. A diabetic care bundle covering professional services and labs for one year of care

e. A physical therapy bundle that covers outpatient PT for six weeks

f. A chiropractic bundle with up to twelve adjustments in a one year period

g. A normal vaginal delivery including nine prenatal visits

h. Weight management for twelve weeks

i. Mohs Surgery

j. A round of chemotherapy including drugs

k. Concierge medical care for 12 months

Self pay bundles allow the physician to leave the bounds of fee for service reimbursement and move toward improved patient care management and lower administrative costs. It changes the game from saying "what will the plan reimburse?" to asking "what will benefit my patient the most?" In many cases, physician service bundles result in lower costs to patients, a better patient experience, and enhanced clinical outcomes.

Define inputs and costs

Once a package of services, a service pack, is identified, an analysis of clinical inputs and their associated costs is conducted. This review includes items such as the number of visits involved, time per visit, place of service, patient care provider (PA, NP, MD), diagnostic tests (lab, radiology, therapy), supplies, drugs and any other relevant data. A good source of this information is the practice's revenue cycle and accounting systems. Key items such as procedure codes, diagnosis codes, practice costs and reimbursement per procedure are all helpful when building the financial model. Once all inputs are identified, and their associated costs assigned, this information is placed in a spreadsheet for further analysis (Table 1).

Develop contractual terms

Bundled payments require careful attention to key contractual terms including: start and end points for the episode of care (admission through discharge, number of visits, time period), outlier payments or additional costs (if number of visits exceeds 3, then a fee of $50 per

Obstetrics bundle						
Input	**Volume**	**Service**	**Cost/Item ($)**	**Current insurance model ($)**	**Bundled payment with 100% self pay ($)**	**Notes**
Office visits	8	MD	38	300	300	1
Supplies	8	Office Supplies/Visit	15	120	120	2
Vaginal delivery	1	Average MD Time/ Vaginal delivery	450	450	450	3
Follow up visit	1		38	38	38	4
Billing and insurance admin.	1		450	450	-	5
Sub total				1,358	908	
Overhead	30%			407	407	6
Total cost / OB bundle				1,765	1,315	7
Physician margin / profit				250	500	8
Cost to patient				2,015	1,815	9
Notes:						
1	Assumes $300,000 MD salary and benefits divided by time allocated to patient visits. (bonus not included)					
2	Supply costs, laundry, sterile paper, cleaning instruments, other direct supplies.					
3	Assumes 3 hours per average MD vaginal delivery and $300,000 / year / MD. ($150 per hour of MD time)					
4	Assumes $300,000 MD salary and benefits divided by time allocated to patient visits					
5	Average cost of collections at 30% of insurance reimbursed amount. Used actual total revenue cycle costs.					
6	Overhead includes malpractice, rent, utilities, clinical staff, office supplies, insurance, marketing, etc.					
7	Without insurance administrative costs and revenue cycle costs the practice eliminated $450 in non-beneficial costs.					
8	The practice gained $250 more contribution margin / profit. This is above the fees allocated for physician services listed above in the spreadsheet.					
9	The patient price is $200 less for services under the bundled payment *vs.* commercial insurance.					

Table 1: Comparison between commercial insurance and self pay bundle.

additional visit is required, etc.), carve outs for high cost drugs or supplies (human growth factors, upgrades in supplies (gel *vs.* saline breast implants), additional services such as patient housing, any guarantees (no additional fees for infection care, re-dos) and standard terms and conditions (payment terms, process for patient referral and acceptance, normal legal terms and conditions). The key is being clear about what is and is not included. While contracts should be kept as simple as possible, it is vital to clearly define the service pack and any terms and conditions. Malpractice and various regulatory requirements must also be included in these contracts (HIPAA).

Conduct financial analysis

Once all inputs and their costs are defined, a financial analysis is conducted. This analysis considers direct costs, overhead costs, contingency, and profit margin per service pack. A good starting place is to look at current collections for these services by payor. Other relevant inputs include average margin per procedure (all payors), cost of insurance administration (use 27% or actual cost, if known). In cases where patient volume increases because of the advantages of having bundled payments, practice overhead costs per service pack decrease and margin increases. Bundled payments are generally paid in cash in advance of service. This eliminates most billing and collections expenses and allows the practice to save 27% (or actual claims administration costs). For patients wanting to use their healthcare spending accounts, health care savings accounts or obtain insurance reimbursement, the practice can provide a statement that includes the bundled fee, diagnosis code(s), procedure code(s), dates of service and other needed information. This same information can also be used by patients to file their own insurance claims.

Innovate

Bundled payments tend to spur the kind of physician innovation that improves outcomes, lowers costs and provides a better patient experience. While bundled payments can reduce revenue cycle costs by allowing an upfront payment for an entire episode of care, the greatest financial rewards generally come from care innovation, volume growth and overhead reduction. The reality is that there are many patients who want an alternative to the current insurance process and will seek out physicians who cater to their needs. These patients range from the working insured to the affluent.

Developing and Analyzing Bundled Payments

Exhibit B provides an analysis of a service pack for a normal vaginal delivery. The spreadsheet includes the services that this OB/Gyn typically provides when caring for a mother who has a normal vaginal delivery. The "Obstetrics Service Pack" includes prenatal visits, supplies, and delivery procedures, follow up visits, billing and insurance costs, overhead and margin. Labs are left out of this sample service pack, but could easily be added. The notes in Exhibit B provide more detail on cost assumptions and data sources.

In this example, the physician practice reduces the costs associated with insurance administration by $450, lowers the cost to the patient by $200 and nets $250 more in contribution margin. The service pack is then offered to patients with high deductibles or no insurance. It can also be offered directly to employers. By knowing the total cost upfront, patients are better prepared to budget for their medical needs or utilize medical financing. Language in this particular service pack contract includes contingency language for additional charges if a C-Section is needed or in the event of complications such as early onset of labor. The services included in the service pack are completely at the discretion of the physician and cash is paid in full upfront thereby reducing the cost of claims administration. Some physicians also offer a payment plan or medical financing options.

The Market for Bundled Payments

The potential market for bundled service packs is approximately 150 million working Americans who have high out of pocket costs. There are also a growing number of payors and employers that are interested in shifting to bundled payments. This is a large potential market for physicians. Already, there are physicians who are so pleased with bundled payments that they have stopped accepting commercial insurance altogether. While this strategy can have significant risks, many physicians are making it work.

The concept of a single payment for a set of services is not as new as some physicians' think. For example, plastic surgeons have long used bundled payments for cosmetic procedures. Almost all physicians practicing "concierge medical" are currently using bundled fees between $2500 and $12,000 per year for their VIP patients. OB/Gyn surgeons have bundled payment arrangements already in place with insurance companies and high deductible or self pay patients. Many primary care physicians and some surgeons are also beginning to offer bundled service packs.

Summary

Bundled payments for defined services can be a useful club in the bag of any physician that wants to simplify payment, lower patient costs, reduce administrative costs, reduce collection risks, enhance income and become more innovative in their service offerings.

With over twenty five years of positive results, bundled payments represent a logical alternative to traditional fee for service models. With 150 million commercially insured Americans seeing their out of pocket costs increase; and a growing and affluent baby boomer population demanding alternatives to traditional fee arrangements; consumer demand for bundled service packs is higher than ever. These factors create an opportunity for doctors to "do good and do well", i.e. earn higher incomes while delivering the same or better outcomes at lower costs. This win/win approach is one of the few strategies for empowering physicians to improve care while lowering costs by eliminating the waste and restrictions associated with traditional fee for service reimbursement.

With the many advantages of bundled fees, some physicians ask, "What's the down side?" The down side risks can include not pricing appropriately, not being clear about what is included in a service pack, and not preparing staff for the changes. The best way to mitigate these risks is to engage an experienced consult who can help develop and implement a successful bundled payment strategy.

In addition to consumers, bundled payments are also receiving interest from employers who are looking for ways to reduce costs while improving care for their employees. A growing number of payers are also looking for ways to limit their medical loss ratios through bundled payments. With approximately 27% of physician reimbursement and three hours of physician time consumed per week in insurance administration activities, bundled payments have the potential to significantly improve the time physicians have available to see patients and develop care plans while also improving professional incomes.

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