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The game that shows why value-based payments are doomed

By Paul Levy | April 10, 2017

Those of us who teach negotiation often use a game, developed by Harvard Business School professor Michael Wheeler, called "Win As Much as You Can." It is the ultimate exercise in how difficult it is to achieve sustainable cooperation within a structure that pushes people to behave selfishly.

The game pits four players against another. In 10 successive rounds, each participant plays an "X" or a "Y" card. The payout to each player depends on his or her choice in that round, as well as the choices made by the other three players. Your chance of winning as much as you can for yourself depends on persuading everyone in the group to play "Y," but the structure of the game provides an overwhelming incentive for each individual to play "X." So players often engage in betrayal as they attempt to convince others that they will play "Y," while they then play "X."

Wheeler's game has implications for the healthcare policy arena — and helps explain why ambitious changes in payment structure haven't worked yet, and probably never will.

Good intentions, flawed assumptions

A key element of President Obama's healthcare policy was a push for "value-based pricing," using the authority of the Centers for Medicare and Medicaid Services to experiment with pricing incentives to reduce overuse in clinical care. Private insurers were likewise encouraged to pursue this direction. It's possible, though hardly certain, that the Trump administration will maintain this focus.

Let's review the concept. The status quo in the U.S. for years has been "fee-for-service" pricing, in which doctors and hospitals were paid for piecework. Believing that the persistent rise in healthcare costs in the United States was driven by overuse resulting from this financial incentive, some policy analysts decided that doctors and hospitals should be given a countervailing financial incentive to reduce certain kinds of diagnostic tests and to avoid medically unnecessary procedures.

The predominant form of value-based pricing to emerge from this policy assumption was the so-called "global payment." Medicare or private insurers

would give each health system (now called an accountable care organization or ACO) an annual number of dollars per year per patient, based on the risk profile of that system's population. If the health system could treat the patient for less money, it would keep the surplus. If its spending exceeded that budget, it would suffer a loss.

In essence, the plan consisted of CMS and private insurers trying to transfer the actuarial risk of patient care to providers, counting on the new financial incentive to change behavior.

Did the global payment regime have a chance of success? Let's go back to Michael Wheeler's game. The Obama folks were trying to get doctors and hospitals to play "Y," but the structure of the business inevitably pushes people to play "X." Sustainable cooperation is highly unlikely.

"Do you choose to play 'Y' and be a good team player over time, or do you choose to play 'X' because the incentive to cooperate is so weak and distant from your needs?"

Let's see why

Say you are a gastroenterology doctor in an ACO anchored by an academic medical center. You are paid in great measure by how many endoscopies you perform. Your health system has signed a global payment contract with its insurers, looking at data which suggests that many of these procedures can be avoided by "tincture of time," dietary advice, and observational treatment overseen by the primary care doctors in its network.

You are skeptical, but you're willing to be a team player because you've been told that, should a surplus emerge at the end of the year, you'll get a bonus on your paycheck. At the end of year one, your clinical volumes have declined because of the new care management protocols adopted by your health system. Your bonus arrives, but you notice that your net income is less than before because the bonus has been shared across the health system, with a portion being given to those primary care doctors in return for their diversion of procedural cases.

Now, let's imagine you're a PCP in the network. A patient shows up with gastric distress in the fee-for-service era. Had you said to the patient, "Let's just watch your diet for a few weeks and see if the symptoms subside," the patient might likely have said, "Don't you think I should see a specialist?" With your 18-minute appointment drawing to a close, you take the path of least resistance and refer the patient to a GI specialist, who some percent of the time will perform an unnecessary endoscopy to see if there is an underlying pathology that needs treatment.

Under the global payment plan, the PCPs, like the GI specialists, have been told that avoiding such procedures will likely yield a surplus for the health system. You are skeptical, but you're willing to be a team player because you've been told that, should a surplus emerge at the end of the year, you'll get a bonus on your paycheck.

At the end of year one, the time you have spent seeing patients has increased because of the new care management protocols adopted by your health system. You've received no extra payment for that time spent, and you discover that your share of the surplus is tiny relative to your previous income, while your quality of life has declined because you're spending more time in the clinic.

Whether you're the GI specialist or the PCP, do you choose to play "Y" and be a good team player over time, or do you choose to play "X" because the incentive to cooperate is so weak and distant from your needs?

If the premise of global payments is that doctors are economically rational creatures who will respond to financial incentives, then the financial incentives have to be substantial, immediate, and transparent to be effective. Under a global payment regime, however, the incentives are minor, delayed, and fuzzy. Even those doctors who might want to be good corporate citizens will find themselves inexorably pushed to play "X," and thereby will undermine the hoped-for results.

Thus global payment regimes are hoisted on the petard of their own underlying assumption: The rationality of the participants.

In the case of CMS, the global payment plan was doomed for other reasons. For one thing, early versions had no downside: While there was the potential to garner surpluses, health systems were protected against losses. Further, under federal law, Medicare patients are mobile: They have no obligation to stick with one health system if they feel they can get more of what they want from another.

The real problem with fee-for-service

But let's go back one more step: Why is the overwhelming focus of U.S. policy based on removing fee-for-service payment schemes? In virtually every other sector of our economy, we employ fee-for-service pricing. As consumers, we evaluate the value of something against the price per unit that we will pay for that service or good. No one questions this payment regime in the rest of society. Why do we do so in healthcare?

Perhaps because, in healthcare, consumers don't make the purchase choice, or are not informed of prices, or do not have a good sense of the underlying value of what they're buying. Intermediaries usually make those decisions for them. Given these challenges, value-based pricing, however well-intentioned, is likely to be an energy-sapping distraction, while we fail in the major task of addressing the disenfranchisement of consumers in their treatment decisions.

While policymakers fuss with ill-conceived centralized policy initiatives, entrepreneurs in the healthcare sector will focus on disintermediation. That's where we may truly find value — and rational choices for all involved.

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