

Issue Brief

Findings from HSC



PATIENT COST-SHARING INNOVATIONS: PROMISES AND PITFALLS

by Sally Trude and Joy M. Grossman

Over the next decade, health plans and employers will refine patient cost sharing to encourage workers to seek more cost-effective care, according to a panel of market and health policy experts at a Center for Studying Health System Change (HSC) conference. Instead of using a single, large deductible, employers and health plans will likely vary patient cost sharing by choice of provider, site and type of service, so patients choosing less effective care options pay more. Employers also will try to limit financial hardships for low-income workers by, for example, varying cost sharing based on workers' income. However, significant obstacles could hinder the effectiveness of emerging cost-sharing strategies, including inadequate information on quality of care and provider resistance.

Patient Cost-Sharing Trends

To slow health insurance premium increases, employers in recent years have increased patient cost sharing through higher deductibles, copayments and coinsurance. Nationally, employers are estimated to have raised patient cost sharing to reduce average health insurance premiums by 2 percent to 3 percent in 2002 and an additional 3 percent in 2003.¹

Panelist Arnold Milstein, M.D., national thought leader at Mercer Human Resource Consulting, said employers' enthusiasm for cost sharing stems from two main desires: to restore patient cost sharing to comparable levels before the advent of managed care or to give workers a greater financial stake in care decisions through higher out-of-pocket costs.

Switching from a \$5 or \$10 copayment to coinsurance, where patients pay a percentage of the total cost of care, will capture patients' attention quickly, said Robert Berenson, M.D., a senior fellow at The Urban Institute. "It was only when I went from copays to coinsurance when I changed jobs recently that I really understood the price of the drugs that I was being asked to pay for," he said.

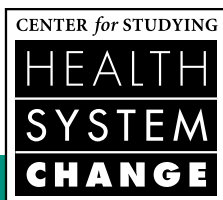
Helen Darling, president of the National Business Group on Health, said employers are increasing cost sharing to get workers' attention about the large increases in total health care costs, and if steps aren't taken to rein in spending, people will lose coverage. "We will have vastly more people with no coverage because employers can't afford to

provide coverage without cost sharing," she said.

How far and how fast employers increase cost sharing will depend on the strength of the economy and the pace of rising health care costs. In a slow economy amid rapidly rising health costs, employers will risk employee rancor by aggressively increasing cost sharing but will back off when the economy improves and labor markets tighten, Milstein said.

Refinements Ahead

Increased patient cost sharing can be a powerful—but blunt—tool to raise patients' awareness of the true costs of care. As the move toward higher patient cost sharing continues,





“The good news is we’re on the way to being able to identify the high-quality, efficient providers...but we’re not quite there.”

– John Bertko, Humana

“It’s wrong to push patients around with big economic incentives at the point of care when they’re sick and most vulnerable.”

**– Mark Chassin,
Mount Sinai School of
Medicine**

“We don’t want overuse, we don’t want errors, but we also don’t want underuse of needed care.”

**–Karen Davis,
The Commonwealth Fund**

“We need cost sharing to at least change some of the incentives within the system.”

**– Helen Darling,
National Business Group on
Health**

employers and health plans will refine cost-sharing approaches, Milstein said. Without refinements, patients will cut back on both needed and discretionary care when faced with higher out-of-pocket costs.² As a result, seriously ill and low-income workers may face financial and medical hardships.³ “This refined approach to cost sharing—where patients are given incentives to select more cost-effective and higher-quality options—is likely to predominate in the longer term, because it prevents much of the unintended negative consequences of higher cost sharing,” Milstein said.

Still stinging from the managed care backlash, most employers are likely to increase cost sharing while maintaining broad patient choices, said John Bertko, senior actuary of Humana Inc. As cost sharing increases, plan designs will grow more complex, and consumers will have to shoulder more responsibility for identifying and making cost-choice trade-offs.

“Consumers are going to have to do more work to find out where the best site for them is and where the most affordable care is,” Bertko said. Milstein predicted the biggest bang for the buck will come from varying cost sharing by patients’ choice of provider, participation in disease management and wellness programs, and choice of where and what care they receive.

HSC President Paul Ginsburg pointed out that these are the same opportunities for efficiency gains that managed care was expected to capture but that patients rebelled against. “The same thinking is going on here, but always through incentives and letting the patients choose, hopefully with the support of their physician,” Ginsburg said.

Cost-Sharing Innovations

Going forward, employers are likely to adopt layers of deductibles, copayments and coinsurance instead of offering health plan options with a single, high deductible, according to Bertko and Milstein. Degrees of patient cost sharing will be tied to choice of provider, the site of service and the type of service. These innovations will include cost-sharing tiers to encourage patients to use the most efficient hospital and physician

networks. Higher copayments and coinsurance will be specific to the site of care, for example, with lower out-of-pocket costs to encourage physician office visits—where care is less expensive and better coordinated—and higher patient cost sharing for hospital emergency department visits. Patient cost sharing also will vary by type of service. Imaging services, for example, might have higher cost sharing than office visits, with an aim of reducing inappropriate use of new technology, according to Bertko.

In the past, potential cost savings depended on workers’ annual choice of a health plan. Innovations in patient cost sharing, in contrast, emphasize choice at the point of service and do not require a yearlong commitment by the patient. For many common decisions, such as a choice of drugs, providers and some services, a patient could first choose a lower-cost option but switch to the higher cost option if dissatisfied. For example, a patient might choose between a less costly X-ray and more expensive magnetic resonance imaging (MRI) for a joint problem.

To design cost-sharing tiers for provider networks, health plans are developing increasingly sophisticated measures of cost and quality to rank providers based on efficiency—providers’ ability to provide quality care at a lower cost. Instead of depending solely on the number of service units used, such as radiology and other diagnostic tests, efficiency measures will reflect average service provision per patient over longer time periods or an episode of illness. In addition, a health plan might define a tier consisting of providers in the top 25 percent of efficiency and quality.

In addition, tiered-provider networks may become service specific, according to Bertko. Currently, health plans tend to contract with hospital systems for their full range of services despite the fact that one hospital system may excel at cancer treatment while another excels at cardiovascular care. In the future, health plans may match tiers and cost-sharing arrangements to specific hospital systems and types of services, similar to current centers of excellence.

Health plans also are improving the information available to consumers, such as what is available on Web sites like Aetna’s Health Navigator and Humana’s Wizard.

These data sources allow consumers to identify providers within particular geographic areas and find hospital quality information, including rates of surgical complications and hospital-acquired infection rates. Because of contractual arrangements with providers, health plans cannot post price information but can provide broad rankings similar to dollar-sign ratings used to classify restaurants to give consumers insights into cost differences.

Health plans also are developing tools to help patients make cost-effective choices on an ongoing basis. For example, Bertko described a Humana program where the health plan scans a prescription drug claims database to look for patients who have a choice of either a lower-cost brand drug or a generic drug. Through an interactive voice response system, a computer calls patients and explains that the person can save money by taking a substitute drug. Humana found that 19 percent of these automated calls prompted patients to move to a lower-cost drug.

Tying Cost Sharing to Income

If employees choose a less cost-effective option, employers will pass on almost all of the additional cost associated with that choice, Milstein predicted. To temper concerns that lower-income workers may be unduly penalized, employers may vary cost sharing by income. One approach would be for employers to set maximum annual out-of-pocket spending limits based on income. Darling noted that employers used to have different cost sharing for hourly and salaried workers, but those distinctions disappeared under managed care where there was little or no cost sharing. As cost sharing increases, companies are likely to reintroduce earning-level differentials.

However, how to establish cost-sharing differentials based on earnings may be somewhat complicated. For dual-income households, the family income may be a better measure than the employee's earnings, but this information is unavailable to employers. Bertko noted that small employers are unlikely to introduce cost-sharing differentials based on earnings because the firm's owner—the person establishing the benefit—would likely face the highest cost sharing. Also, small firms typically don't have the payroll systems to administer these types of options.

Federal tax policy also could be revised for low-income workers who face financial and medical hardships when employers move aggressively to higher cost sharing without adequate financial protections. Karen Davis, president of The Commonwealth Fund, suggested that income-related tax credits could replace the current tax deduction for medical expenses that exceed 7.5 percent of adjusted-gross income. She suggested a tax credit of 75 percent to 90 percent of expenses over 10 percent of income for those with low incomes.

Patient Education Challenges

Despite employers' interest in patient cost sharing, the panelists agreed that the infrastructure for supporting patient decision making is still under development. "We would hope that we could get better at communicating the complexity and also getting people's attention to realize that they have to be active consumers," Darling said. Likewise, Berenson noted that "if we go into patient cost sharing in a big way, there needs to be a lot more informed consent from physicians to patients about trade-offs. Prices would need to be much more transparent than they are now to permit informed decisions."

In addition, measures needed to assess and compare the quality of care provided by individual physicians remain "at an extremely rudimentary state of development," Milstein said. The next step will be to determine overall rates of compliance with evidence-based guidelines from administrative data. Bertko raised concerns that having too few claims for each physician may prevent health plans from profiling individual physicians reliably except in markets where the health plan has substantial market share. Giving health plans access to Medicare physician-level claims data, unavailable to the private sector since 1984, would "go a long way to solving problems of low sample size that plague physician-profiling efforts," Milstein said.

Bertko also noted that health plans currently can measure cost of care by episodes, but that "quality measures are still emerging." He recommended an incremental approach that uses available measures of provider efficiency, adding quality measures as they are developed instead of waiting for perfect data and measures.



"We assume that health care choices are interchangeable commodities like cell phones, when in fact, they are probably not."

**—Robert Berenson,
The Urban Institute**

"If employers thought they could rely on professionalism or tighter managed care or government regulation to reduce health care costs, they would happily do so."

**—Arnold Milstein,
Mercer Human Resource
Consulting**

"The real improvement in quality is going to come from physicians or hospitals changing how they practice when they lose patients or are embarrassed because of the low scores they're getting."

—Paul Ginsburg, HSC

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This Issue Brief is based on an HSC conference—*Patient Cost Sharing: Promises and Pitfalls*—held Dec. 3, 2003, in Washington, D.C. A full transcript of the conference is available at www.hschange.org.

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Some panelists were concerned that forcing patients to make cost-choice trade-offs at the time they need care would always be a problem because patients might be too sick to make an informed choice. “A patient may know they have heart disease, but one provider may have the best record for heart failure, while another has the best record for coronary disease,” said Mark Chassin, M.D., chairman of the Department of Health Policy at Mount Sinai School of Medicine in New York. Milstein was more optimistic that education could occur earlier for people at risk, such as when they are first diagnosed with a heart condition. Patients could learn about the differences in efficiency and quality across hospitals before needing hospitalization. Milstein described how employers’ use of financial incentives for centers of excellence has significantly increased patients’ use of them for organ transplants.

Aligning Provider Incentives

Providers also will play a crucial role in cost-sharing innovations. As cost sharing increases and becomes more complex, patients will look to their practitioners for guidance in making cost-effective medical decisions. Patients will need to talk with their caregivers about cost-sharing requirements and their ability to pay.

“The new ideas about cost sharing would promote prevention and reduce discretionary and overused services, circumventing some of the distortions in utilization and charges we saw under traditional insurance,” Berenson said, cautioning, however, that while cost sharing has worked well for prescription drugs, cost sharing in the doctor’s office is more complicated. For example, to collect coinsurance, the physician must know up front how much the health plan will pay for a particular service. Bertko countered that one health plan is developing technology that would allow physicians to determine a patient’s cost-sharing requirements as simply as swiping a credit card.

Furthermore, the effectiveness of cost-sharing innovations may be limited by

providers’ own financial incentives. At the same time that the pendulum is swinging back to higher cost sharing, provider payment trends are returning to fee-for-service arrangements, creating financial incentives for practitioners to provide more services.

Davis noted that the current system of hospital payment leads to an expansion in capacity for profitable services and that “if Medicare would tackle this,” there would be a ripple effect through the private sector as well.

“There are enormous economic disincentives for providers to invent ways to reduce overuse. There’s absolutely no reason in favor and every reason against a hospital figuring out how many bypass surgeries are totally inappropriate and getting rid of them,” Chassin said. Employers and health plans need to work to align cost-sharing innovations with efforts to change provider payment incentives through such measures as pay for performance, where providers receive bonuses for meeting certain quality standards.

“We do not have economic incentives that reward excellence,” Chassin said. “Instead we have a completely fragmented and multidirectional set of incentives from different payer groups that act in different ways on different parts of the delivery system.”

Physicians also remain reticent about sharing information on the quality or cost of care they provide. “In terms of the quality of their own care, 7 percent of physicians think their quality data should be made available publicly,” Davis said. ●

Notes

1. Strunk, Bradley C., and Paul B. Ginsburg, “Tracking Health Care Costs: Trends Stabilize But Remain High In 2002,” *Health Affairs*, Web exclusive, www.healthaffairs.org (June 11, 2003).
2. Newhouse, Joseph P., *Free for All? Lessons from the RAND Health Insurance Experiment*, Harvard University Press, Cambridge, Mass. (1993).
3. Trude, Sally, *Patient Cost Sharing: How Much is Too Much?*, Issue Brief No. 72, Center for Studying Health System Change, Washington, D.C. (December 2003).