



BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Impact of Increasing Consumer Cost Sharing on Physician Organizations: The Good, the Bad, and the Inevitable

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Overview



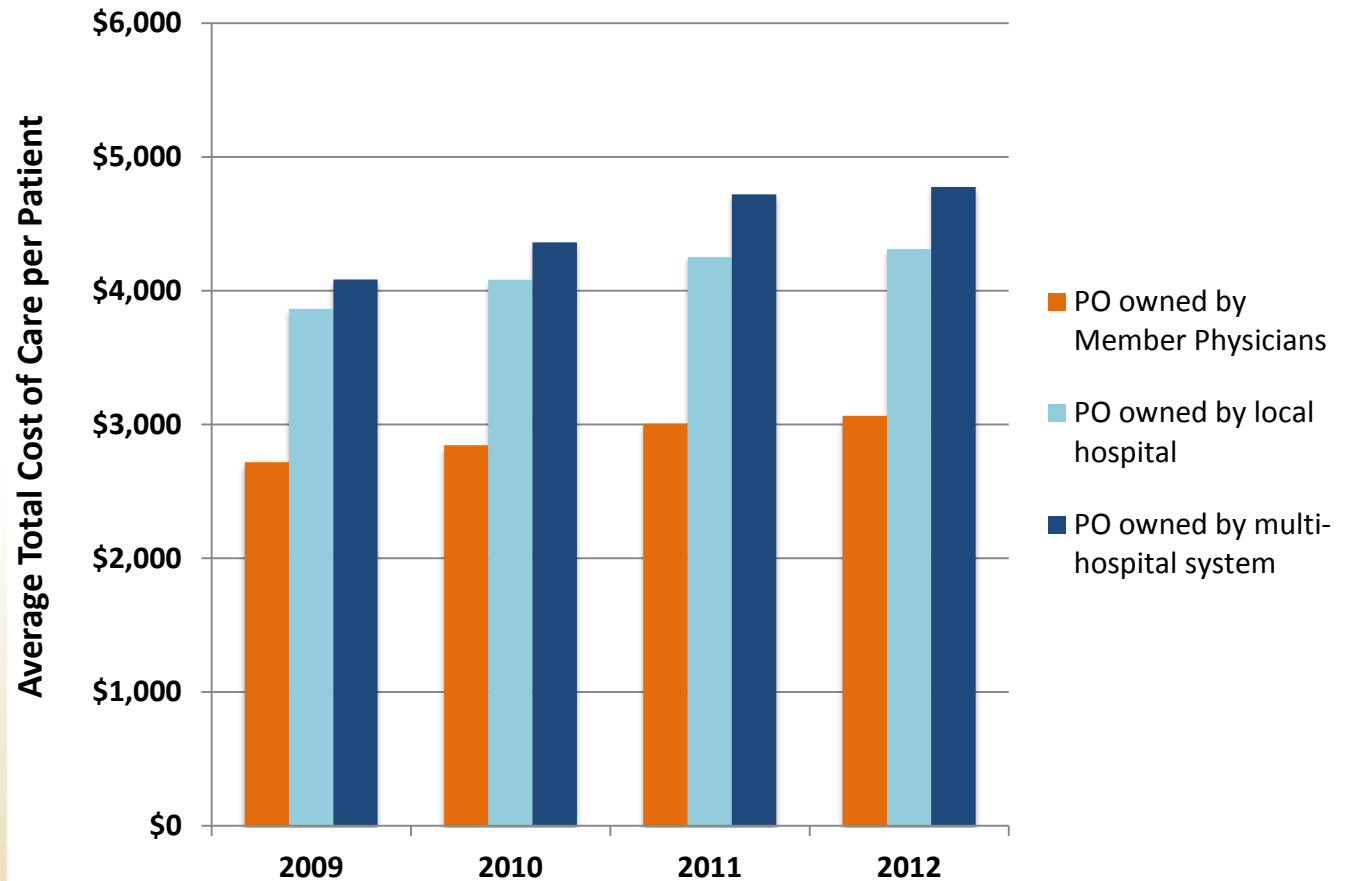
- Coordination is necessary, not sufficient
- The re-design of health insurance
 - High cost sharing
 - Narrow networks
 - Reference pricing
 - Price transparency
- Aligning consumers with providers

Coordination is Necessary, not Sufficient, for Success

- We all are committed to improved clinical, financial, and cultural coordination to improve efficiency and quality
- But coordination does not lead to savings if purchasers do not shop on the basis of price (as well as quality)
- Many large, integrated, coordinated health systems have high costs and charge high prices
- Purchasers are disenchanted with consolidation
- They are redesigning their strategies to promote price-conscious choice
- Let's talk about that
- But first, one visual:



Total Cost of Care per Patient in Physician Organizations (PO) in California



Re-Designing Health Insurance

- Traditionally, health care has been purchased by groups (insured populations, employee populations) but now, increasingly, will be purchased by individuals
- This is good, in that it aligns better with the preferences and pocketbooks of the consumer
- But people buy health care differently when they purchase for themselves than when they purchase as part of a group
- This has major implications for physicians and other care providers



Individual Choice

- When purchasing insurance as a group, people often want comprehensive coverage (little cost sharing) and comprehensive choice (broad provider networks)
- When purchasing as individuals, however, most people are willing to accept:
 - Limited coverage (high cost sharing)
 - Limited choice (narrow networks)
 - Ability to 'buy up' (reference pricing)
 - Responsibility for choice (transparency)
- Individual choice will transform health insurance and, indirectly, will transform health care delivery

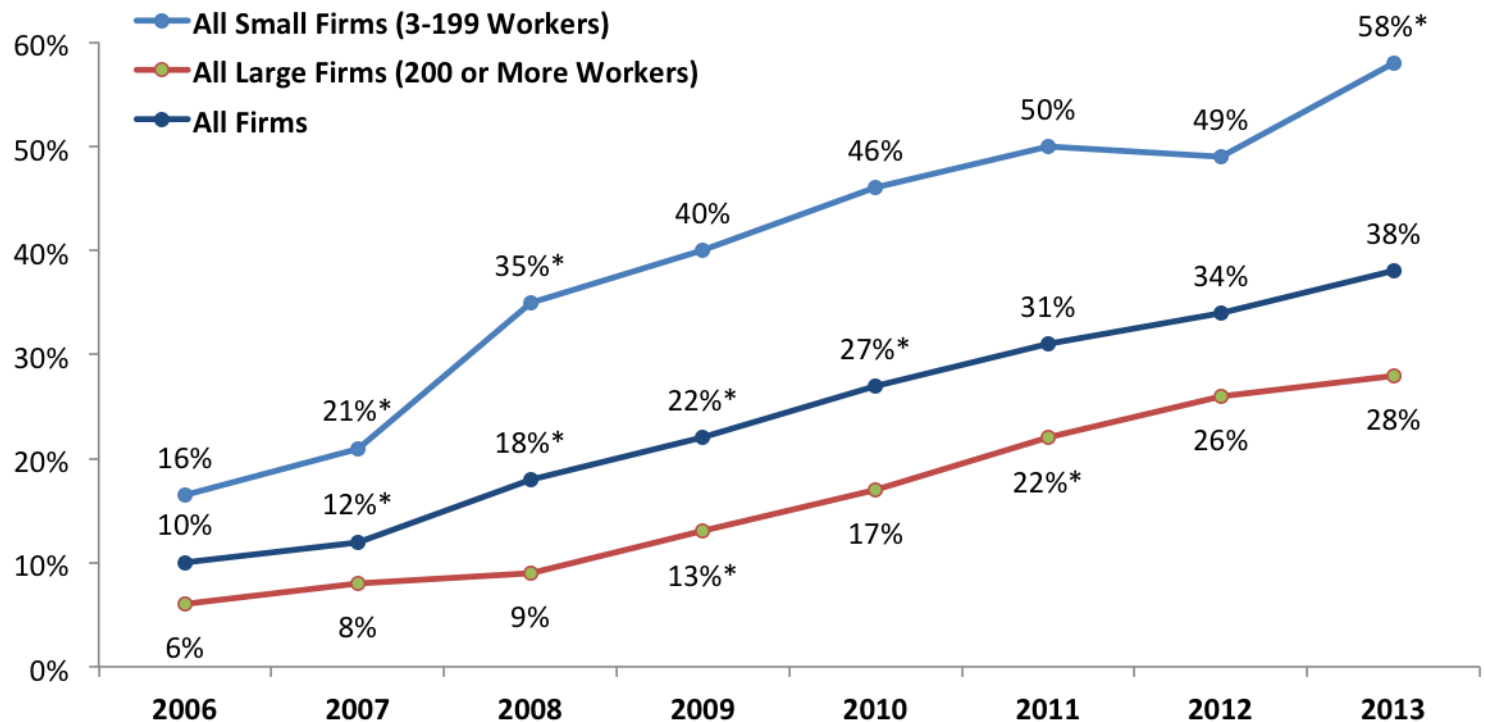


High Cost Sharing

- To reduce premiums, employers and insurers are increasing consumer cost sharing and defined contributions
- High deductible health plans (HDHP) in the employment-based market
- HDHP growth in Health Insurance Exchanges under Obamacare



Growth of High Deductible Health Plans in the Employment-based Insurance Market



Percentage of Covered Workers Enrolled in a Plan with a Deductible of \$1,000 or More for Single Coverage

Growth of High Deductible Health Plans in the Health Insurance Exchange

Metal Level	Subsidy Eligible	Unsubsidized	Total
Bronze	24%	36%	26%
Silver	66%	30%	62%
Gold	5%	13%	6%
Platinum	4%	14%	5%
Total Enrollment	1,222,320	173,609	1,395,929

Source: Covered California enrollment, 10/1/13 – 3/31/14.

Data includes individuals who finished applications and selected plans through April 15, 2014.



What is a Bronze, Silver, or Gold Benefit?

Service	Cost Sharing (Gold)	Cost Sharing (Silver)	Cost Sharing (Bronze)
Deductible	None	\$2,000	\$5,000
PCP Office Visit	\$30	\$45	\$60 (3 per year)
SCP Office Visit	\$50	\$65	\$70
Urgent Care Visit	\$60	\$90	\$120
ER Visit	\$250	\$250	\$300
Lab Test	\$30	\$45	30%
X-ray	\$50	\$65	30%
Generic Drug	\$19	\$19	\$19
Brand Drug	\$50	\$50	\$50
Max OOP: Individual	\$6,350	\$6,350	\$6,350
Max OOP: Family	\$12,700	\$12,700	\$12,700

Source: Covered California *Plan Options Participant Guide*.



Implications of High Consumer Cost Sharing for Medical Groups

- Fewer patient visits
- Reduced patient compliance/adherence
 - Drug prescriptions, lab tests, imaging
- More physician time needed to explain cost of treatment options
- Greater collection risk
 - Bad debt and litigation
- Adverse publicity on prices



Narrow Networks

- To reduce premiums, insurers in Exchanges are restricting hospital and physician participation as a means of negotiating lower provider fees
- This targets hospitals first and foremost, but also affects medical groups and physicians affiliated with hospitals
- Insurers care both about prices and about total costs of care



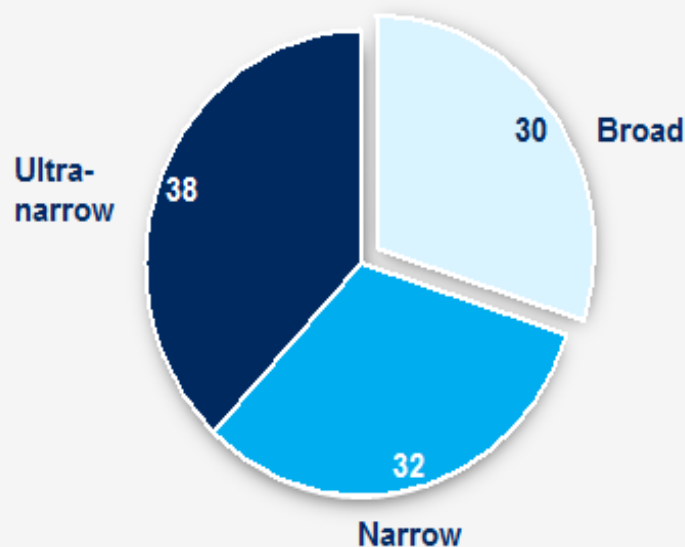
National Prevalence of Narrow Networks

EXHIBIT 1

70 percent of hospital networks on exchanges are narrow or ultra-narrow

Distribution of networks by network breadth¹

2014 individual exchange – Percent of analyzed silver networks (n = 120²)



¹ Broad networks: less than 30% of largest 20 hospitals by number of beds are not participating, Narrow networks: 30-69% of largest 20 hospitals are not participating, Ultra-narrow networks: at least 70% of largest 20 hospitals are not participating

² Networks offered in silver in Atlanta, Bridgeport, Dallas, Nashville, Houston, Salt Lake City, Miami, Tampa, Louisville, Indianapolis, St. Louis, Los Angeles, San Jose, Pittsburgh, Denver, Philadelphia, Seattle, Chicago, Washington D.C., and Portland, ME

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare
Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of
11.15.2013

McKinsey & Company

Implications of Narrow Network Designs for Providers

- Greater risk of network exclusion
 - Favored providers grow, others shrink
 - Provider consolidation will continue
 - Competition among hospital systems, health plans, and medical groups as consolidators of physician practices
- Lower provider payment rates for Exchange insurance products than for commercial insurance products



Reference Based Benefits (RBB)

- Sponsor establishes a ***maximum contribution*** (reference price) it will make towards paying for a particular service or product
 - This limit is set at minimum or median of the price range charged by comparable providers
- Patient must ***pay full difference*** between this limit and the actual price charged by the provider
 - Patient payment is not limited by OOP max
 - Provider price is the negotiated “allowed charge” not the arbitrary list price
- Patient chooses his/her cost sharing by choosing his/her service or provider
 - Patient has good coverage for low priced options but ***full responsibility for choice***



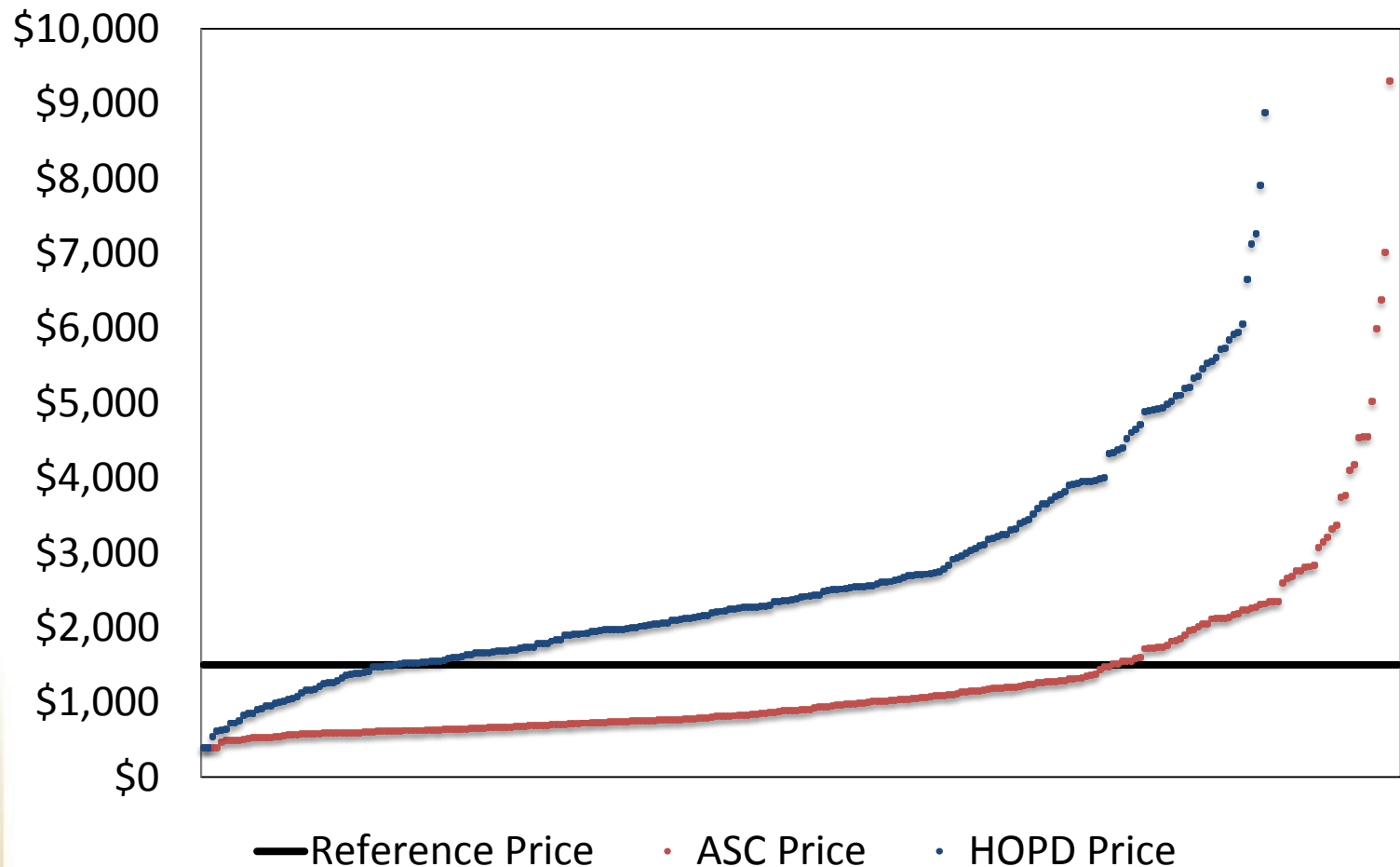
Example: Expansion of RBB to Ambulatory Procedures

- In 2011 PERS expanded RBB to ambulatory procedures, with intent of convincing beneficiaries to select lower-price ambulatory surgery centers (ASC) over hospital outpatient departments (HOPD)
- Reference based limit was set for HOPD at average price for ASC

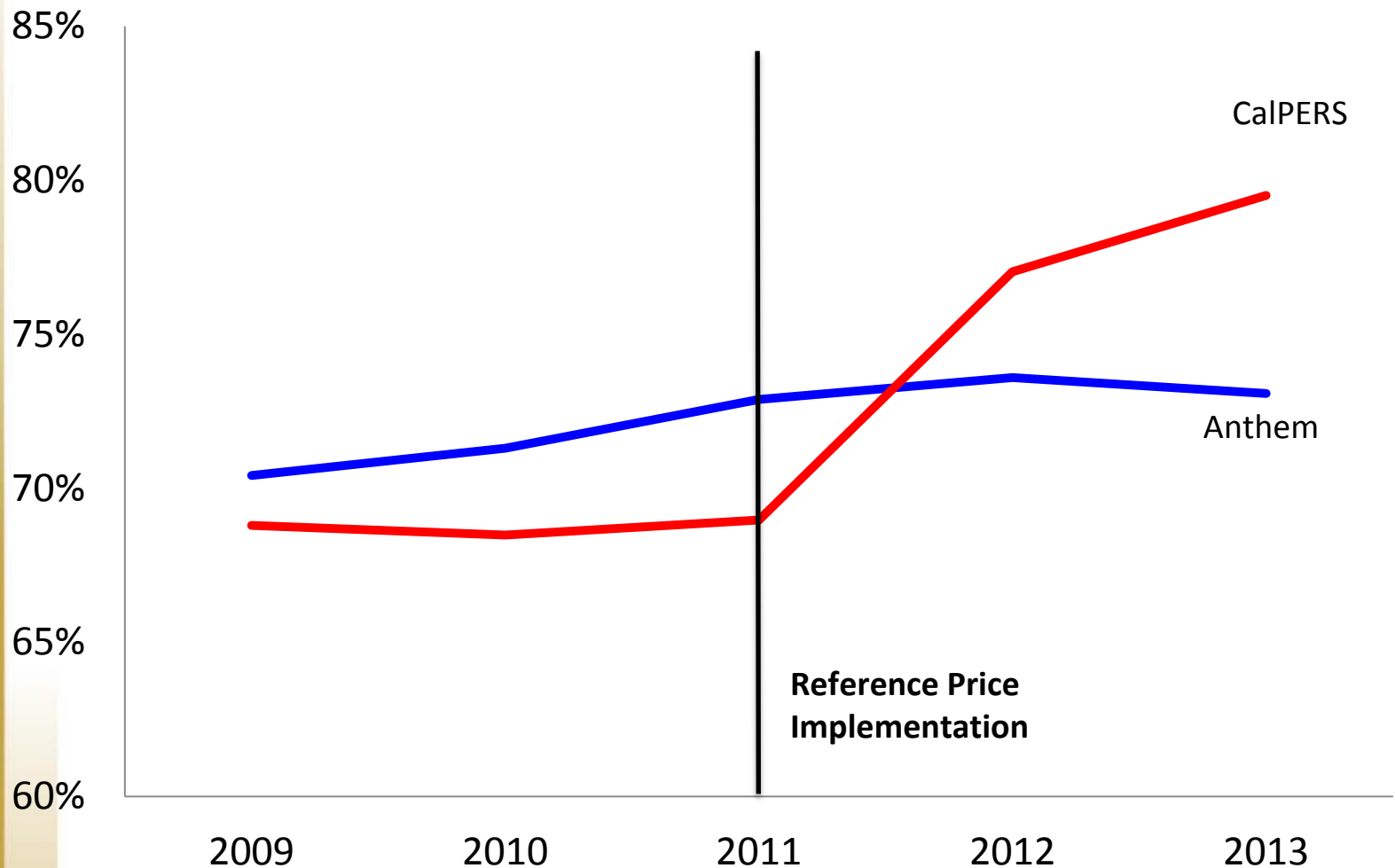


Prices For Same Service Are Highly Variable

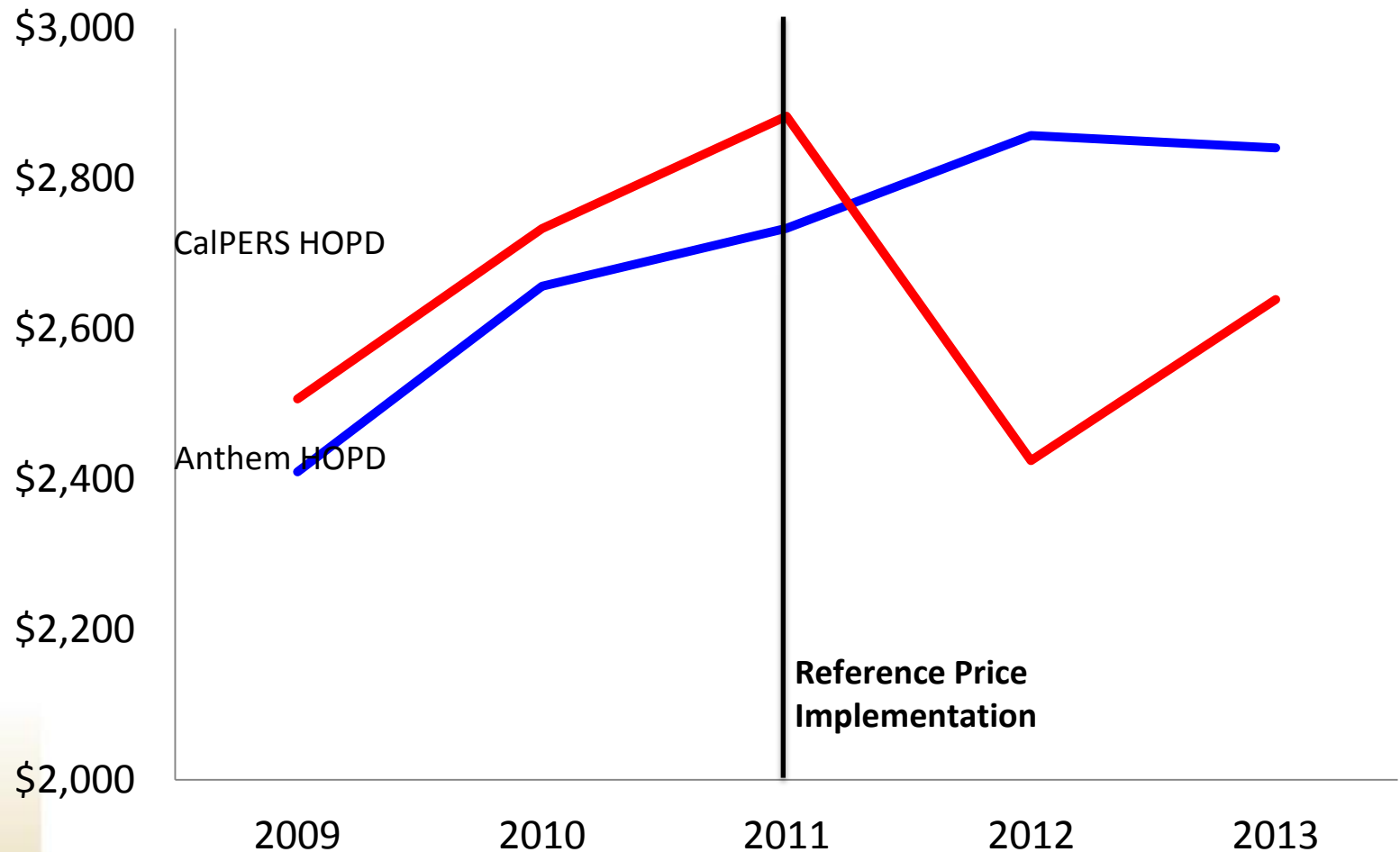
Range in Colonoscopy Prices Across California HOPDs and ASCs in 2011



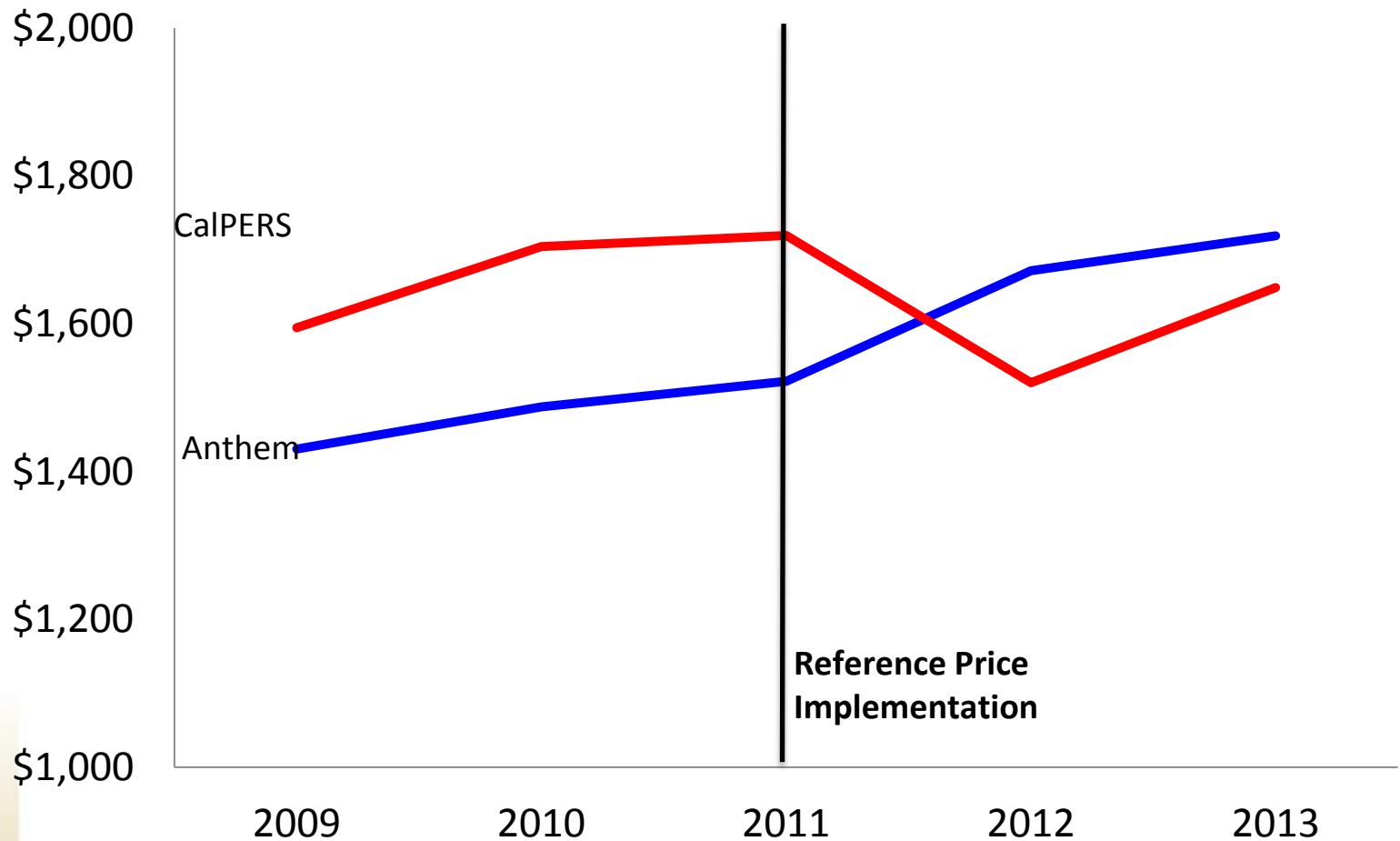
Percentage of Colonoscopy Patients Choosing ASC over HOPD before and after Implementation of Reference Pricing



Colonoscopy Prices in HOPD Selected by Patients Before and After Implementation of Reference Pricing by CalPERS



Payment per Procedure for Colonoscopy Before and After Implementation of Reference Pricing by CalPERS

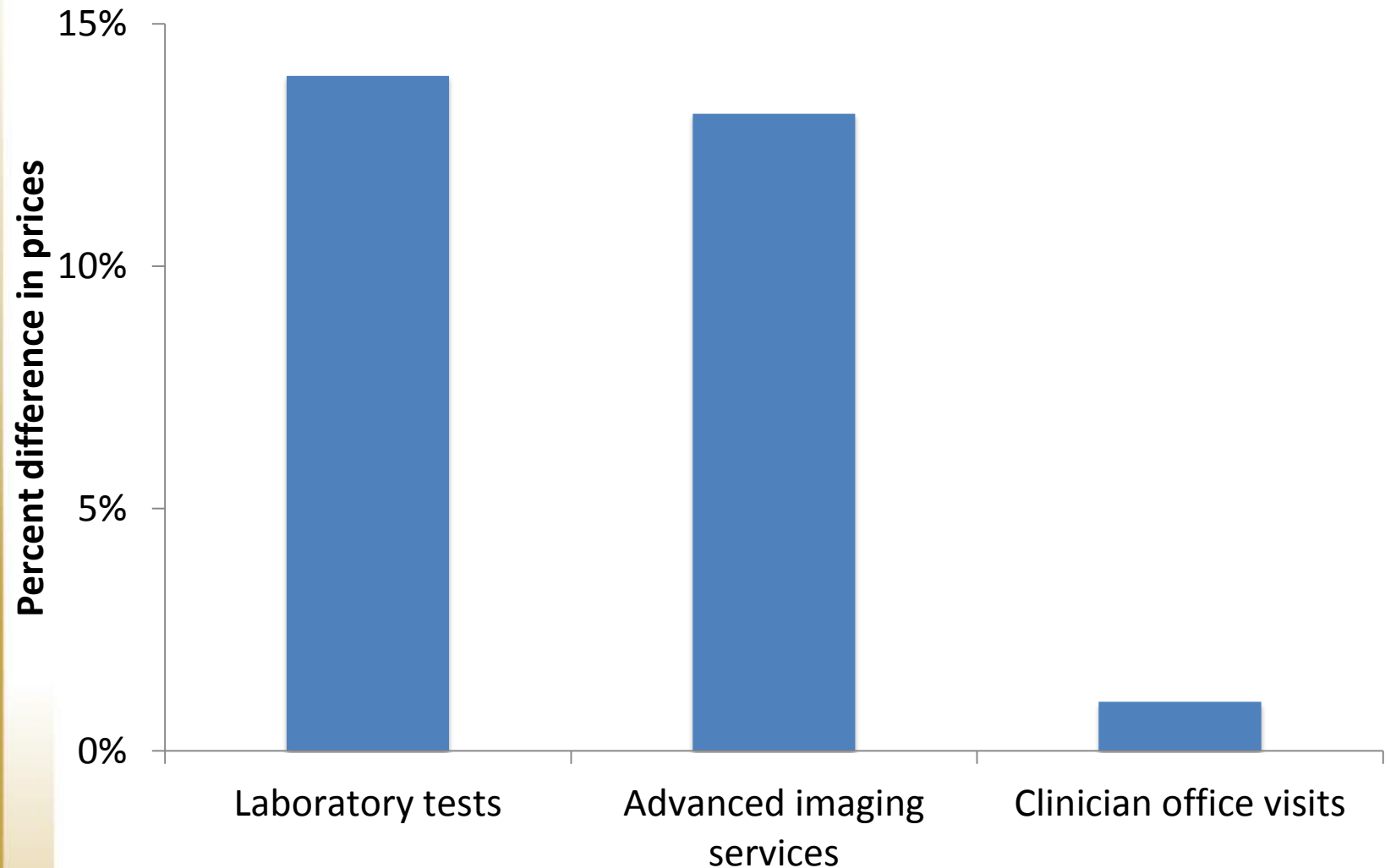


Price Transparency

- Health plan or employer sponsors platform information on how much the patient could expect to pay at each provider, taking into account benefits at individual level (e.g., where patient is in deductible)
- Some insurers/employers add outreach program that offers price data and alternatives to patients identified through prior authorization programs as needing imaging or other intervention



Percentage Savings for Patients Who Searched for Lower Prices



Synergy between Consumer and Provider Initiatives?

- Consumer engagement initiatives do not substitute for provider coordination
- Coordination is essential for efficiency
- But they create a business case for integration that improves efficiency
- For providers to invest in the IT, staffing, administrative capabilities, and care redesign, they need the potential reward of more patient volume
- Otherwise, providers will want to be paid more, not less, to develop ACOs and coordinated care



The System is Changing

- The US has had a platinum/gold system for most, a bronze system for some, and no system for too-many
- It has not been willing to pay the taxes and premiums to support this mix
- It now is moving towards a system that offers consumers choice with accountability and offers providers pay in return for efficiency and quality



The Emerging Health Care System Requires More from Everyone

- Of consumers: cost sharing, engagement, and informed choice
- Of providers: appropriate site of care, process redesign, and efficiency
- Of health plans: benefit designs that align consumers with providers





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