Redesigning Insurance Benefits and Consumer Cost-Sharing for High-Cost Surgical Services

James C. Robinson, PhD
Leonard D. Schaeffer Professor of Health Economics
Director, Berkeley Center for Health Technology

Kimberly MacPherson, MBA, MPH
Program Director, Health Policy & Management
Associate Director, Berkeley Center for Health Technology

School of Public Health, University of California, Berkeley

The Integrated Healthcare Association is coordinating an episode of care payment initiative involving prominent health plans, hospital systems, and physicians organizations in California.

IHA
INTEGRATED HEALTHCARE ASSOCIATION

www.iha.org

Published by Integrated Healthcare Association and sponsored by the California Healthcare Foundation

The fragmentation of payment methods undermines efficiency and quality of care due to its effects on both providers and consumers. This effect is especially pronounced when considering high-cost surgical procedures that encompass multiple caregivers and facilities. On the provider side, each physician now typically is paid individually regardless of the total cost and final outcome of the patient's care, while the hospital is paid per discharge or based on the number of days the patient is in the facility. The care provided before and after discharge often is even more fragmented and involves an additional cast of providers and facilities. Under this contemporary scheme, there is little incentive for any one caregiver to pay attention to the outcome of the patient's entire course of care, as distinct from each caregiver's individual contribution. One major objective of shifting to bundled payment for all services provided during the episode of care (EOC) is to create incentives for collaboration among all participants.

On the consumer side, there currently is almost no impetus or ability to compare price and quality across alternative clinical treatments and provider organizations. The consumer's out-of-pocket cost-sharing responsibility typically is comprised of a confusing mix of deductibles, coinsurance, copayments, and annual out-of-pocket payment maximums that do not promote informed, cost-conscious choice. Consumers often must pay out-of-pocket for at least part of the ambulatory services that might forestall the need for expensive surgery, but then often bear no responsibility for the cost implications of whether to have surgery, where to have it, and which implantable device to use as part of the procedure. In this sense, consumers are both under-insured and over-insured for high-cost hospital and ambulatory surgery procedures such as orthopedic surgery, cardiac angioplasty, and bariatric surgery.

The Integrated Healthcare Association (IHA) is coordinating an episode of care payment initiative involving prominent health plans, hospital systems, and physician organizations in California. In order to support that initiative, it is also sponsoring a project to explore the state of innovation in benefit design and how those emerging designs could support EOC payment methods. This Issue Brief describes the need for benefit redesign and the principal obstacles that must

be overcome. A subsequent Brief will highlight the most promising new benefit structures.

THREE MAJOR CHOICES FACING THE CONSUMER

There are three types of consumer-facing decisions that should be considered with respect to complex acute care services, which may be conceptualized in the form of a decision tree. First, which course of treatment is the most appropriate? Second, given the choice of treatment, which physician and delivery organization should provide the care? Third, given that the choices of treatment and provider have been made, which drugs, devices, and tests should be used in the process of care? Each of these decisions has implications for benefit design and cost-sharing.

INCENTIVES FOR TREATMENT SELECTION: APPROPRIATENESS

The first decision concerns choice among alternative treatments. Depending on the patient's condition and ability to adhere to a protocol, therapeutic alternatives may include watchful waiting, behavior modification, drug management, endovascular intervention such as angioplasty, or any of several surgical strategies. There may be clear evidence on the value of each alternative for each type of patient, but often authoritative clinical guidelines are not available. The appropriateness of a particular treatment for a particular patient also depends on his or her preferences with respect to risk, pain tolerance, convenience, financial cost, burden on family members, and other factors.

This first set of decisions, which for present purposes may be termed decisions with respect to treatment appropriateness, are best made by the informed and cost-conscious patient in collaboration with physicians and other caregivers. A variety of formal and informal programs have emerged to support this collaborative decision-making under the rubric of "shared decision-making" (SDM). These can include educational initiatives as well as mandated participation in case management programs. Benefit design changes that promote SDM are important in the present context since no one favors simply improving the efficiency of procedures that are not consistent with the clinical evidence and the patient's preferences.

Insurance benefits and consumer cost-sharing should be designed to promote access to SDM and should not impose penny-wise-but-pound-foolish copayments that would discourage use. Office visit copayments and coinsurance should be waived for patient participation in shared decision making programs. This approach is consistent with the general principles of value-based insurance design (VBID), which assert that consumer cost-sharing requirements should not inadvertently discourage use of services that have been proven to be especially effective either in improving health or in reducing costs.

Special cost-sharing consideration for SDM requires that the SDM programs be formalized and evaluated with respect to their effectiveness in promoting patient understanding and engagement. Not simply any conversation between a patient and a physician should count as "shared decision making" for purposes of special exemptions from copayments.

INCENTIVES FOR PROVIDER SELECTION: CHANNELING

The second set of choices facing the consumer concerns which clinician or clinical organization should provide the treatment, once the choice has been made as to which treatment to pursue. For high-cost acute services such as those subject to EOC payment, this typically involves choice of both physicians and facilities, and could also be defined to encompass additional post-acute providers.

Price and quality vary in meaningful ways among alternative providers and provider organizations, and consumers should have both the tools and the incentives to make meaningful and responsible choices among the alternatives.

The role for consumer choice can be especially important for non-emergency acute care services such as those subject to EOC payment, since the consumer often has the time to "shop" the market. This shopping already occurs commonly for maternity and for cosmetic surgery. Now shopping is beginning to occur for a broader range of services for which there exists quality information on the Internet.

Until recently, however, insurance benefits and consumer cost-sharing were not designed to motivate patients to take price as well as quality into consideration. The cost of these orthopedic and cardiac procedures invariably exceeds the deductible and annual out-of-pocket maximum payment and therefore the patient is indifferent to variation in the prices charged by competing providers.

Insurance benefits need to be redesigned to make the patient sensitive to both provider quality and price differences, in what may be termed incentives for channeling or directing appropriate care to avoid unwanted variation. Two dimensions of channeling are important. Prices differ across provider organizations, e.g., across competing hospitals for the same type of inpatient procedure. Prices also differ across sites of care, e.g., between hospital-based outpatient surgery centers and freestanding ambulatory surgery centers (ASC). Benefit design should be structured to motivate cost-conscious choice in both dimensions.

"Reference pricing" is one possible benefit design incentive for motivating patients to pay attention to the price as well as the quality of care offered across different physicians and hospital systems. Under reference pricing, the health plan or employer ("plan sponsor") establishes a maximum amount it is willing to pay towards the cost of a particular procedure, such as a knee replacement surgery. This limit is selected after examining the variation in procedure prices across the market and suffices to cover the costs of efficient providers.

The health plan can first apply a quality screen to ensure that all considered providers perform well on processes of care, clinical outcomes, and patient satisfaction prior to be assessed based on price. If the patient selects a provider whose prices fall at or below this benefit limit, the health plan's traditional cost-sharing provisions apply (the patient may be held responsible for 20% coinsurance, for example). However, if the patient selects a provider whose price is above the defined benefit limit, the health plan pays only up to that limit (minus the 20% coinsurance) and the patient is required to pay the remainder.

This is a very strong incentive for the patient to pay attention to provider prices, since he or she will pay 20% of the benefit limit plus 100% of any excess of price above that limit. Consumer cost-sharing payments above the benefit limit would not count towards the annual out-of-pocket maximum.

INCENTIVES FOR PRODUCT SELECTION: FORMULARY

The third set of choices facing the consumer concerns which drug regimen, device implant, or imaging modality should be used, once the choice has been made with respect to treatment and provider. For some forms of care, clinical inputs are not salient since their costs are low or alternatives are lacking. But for many of the acute care services subject to EOC payment, drug, device, and imaging prices are high and vary widely among alternatives. Patients may play an important role in selecting among regimens, implant types, and testing modalities based on their values, preferences, and choice of physician.

Benefit design has not been structured to encourage price-consciousness on the part of the patient, thereby leaving the choice to the physicians and the often-complex professional and financial incentives that influence their preferences. While most physicians select products based on their clinical effects, many also face financial incentives that influence their choices based on economic factors.

For example, physicians infusing chemotherapies for cancer or immune disorders often purchase the drugs from distributors and then charge a marked-up price to the insurer, earning a greater mark-up on expensive than on economical drugs. Surgeons selecting implantable orthopedic or cardiac devices for their patients often receive consulting honoraria from the manufacturers of those devices, often based on an implicit commitment to brand loyalty. An increasing number of specialty practices now own advanced imaging modalities and earn substantial revenues from use of those imaging tests even in contexts where there is no evidence of clinical benefit.

Health plans have applied cost-sharing to clinical products most extensively in the domain of drugs, rather than implantable devices or imaging tests. Indeed, patients are almost always required to contribute to the cost of ambulatory drugs purchased at the pharmacy, with the level of copayment being lowest for cheap generic drugs and highest for branded drugs where the insurer has not been able to negotiate a price discount from the manufacturer. This "tiered formulary" strategy has been extended to cover complex self-injected biopharmaceutical drugs such as many for rheumatoid arthritis and other immune disorders. Some observers have suggested that an analogous formulary approach could be applied to categories of implantable devices where there is meaningful variation in prices but equivalent clinical performance across competitors.

For example, knee replacement implants are manufactured with a variety of materials and functional specifications and sold at often quite different prices, with substantial direct-to-consumer advertising for the most expensive variants. A formulary approach could associate

a copayment to the device itself, above or instead of copayment for the procedure itself (as variation in the cost of the procedure is due principally to variation in the cost of the implanted device). There are some examples of this approach in the domains of durable medical equipment (e.g., electric wheelchairs) and eye lens implants.

CONTEMPORARY BENEFIT DESIGNS DO NOT SUPPORT INFORMED CHOICE

Many of the important choices in health care are complex and thus delegated by consumers to physicians and other clinical experts. However, consumers play an essential role in health care decision-making because they know their values and preferences better than anyone else. They have both the right and the responsibility to make the most important choices in the often difficult context of scientific uncertainty, emotional anxiety, and financial burden. In principle, health insurance is designed to promote attention to the price as well as the quality of care by obliging the enrollee to pay a share of the costs incurred on his or her behalf. In practice, health insurance products impose a convoluted set of deductibles, coinsurance, copayments, exclusions, and payment maximums that hinder rather than promote informed choice.

Examples of the complexity of insurance benefits and their implications for EOC payment include:

- **Annual deductible**
  Most PPO products impose an annual deductible, ranging from $250 up to $10,000, that must be paid by the patient before the plan begins paying; most lie in the range between $500 and $1,000. These are structured on a calendar year basis rather than linked to episodes. Deductibles require the patient to pay out of pocket for primary care, physical therapy, and shared decision-making programs, which are precisely the relatively low-cost forms of care that might forestall need for expensive surgery.

  Once the patient has decided he or she needs surgery, the deductible provides no incentive for where the procedure should be obtained or which form of implantable device should be used, since the cost variation among surgeons, facilities, and device types is all above the deductible limit.
- **Annual out-of-pocket (OOP) maximum**
  Most health insurance designs include a limit on the total amount the enrollee can be expected to contribute in out-of-pocket cost-sharing over the course of the year. For an individual, these OOP maximums tend to cluster around $1,000 for HMO plans and $3,000 for PPO plans, though some can go much higher. As a practical matter, the OOP maximum serves as a cost shift from the plan to the enrollee but otherwise does not provide incentives for informed choice in the context of acute care procedures.

  The cost of these procedures is so high that any level of coinsurance, even 10%, will bring the consumer to the OOP maximum at which point there is no more incentive to pay attention to the cost implications of where the procedure is performed or with which implantable device.
- **Office visit copayments**
  Many PPO products require dollar copayments for visits to physicians and some other caregivers such as physical therapy, for example $25 per visit. If the patient is paying 20% coinsurance on the episode, he or she should not also be paying $25 for episode-related visits before or after the procedure (if the definition of the episode is expanded beyond the current IHA definition). It often will be difficult to ascertain, however, whether a particular visit was related to the episode or not.

  Clearly the extent of this difficulty is influenced by the definition chosen for the episode. If the episode is defined as beginning at hospital admission and ending at hospital discharge, as with the Medicare ACE initiative, the role of office visit copayments is minimal, but if the episode is defined as including recovery time after discharge (physical therapy, physician follow-up visits) then copayments must be adjudicated. Some plans waive office visit copayments within a specified date range following the procedure.
- **Limits on number of visits**
  Some PPO products impose limits on the annual number of covered visits, such as for physical therapy. Some patients will have used some of those visits for non-EOC services prior to receiving the EOC procedure, while others will not but may need them after the procedure even for non-EOC services.

- **Facility fees**
  Recovery for major acute procedures such as those covered by EOC payment not infrequently involves a stay in a non-acute care facility such as skilled nursing facility (SNF), inpatient rehabilitation hospital, or sub-acute unit of an acute care facility. Different benefit designs impose different mixes of special copayments or limits on numbers of days for these post-acute services.
- **Special copayments for admissions or tests**
  Some PPO products charge additional copayments for admission to hospital facilities, distinct from the annual deductible and coinsurance, and some charge additional copayments for particular high-cost imaging and genetic diagnostics tests. Some of these services will be related to the episode of care covered by EOC payment, while others will not.

CONCLUSION

Contemporary insurance benefit designs fail to support price-conscious and quality-conscious decision-making. Consumer choice among alternative treatments, providers, and clinical products is complex and fraught with concerns over the patient's ability to understand incentives and to pay out-of-pocket for services that are not fully reimbursed by insurance. Important dimensions of these choices therefore legitimately are shifted from consumers to insurers or to providers of care. However, shifting costs away from consumers also implies shifting the responsibility for managing those costs and the related decision-making authority away from consumers to third parties whose values and preferences may not align well with those of the patient.

There is a strong trend in the U.S. health care system for the consumer and patient to have more information and accountability for health care choices, partially displacing the once-unquestioned role of the physician. While the physician remains a key decision-maker, the consumer is taking an ever more active role in evaluating the appropriateness of alternative treatments, in selecting the physician and hospital where care will be obtained, and in expressing preferences with respect to the drug, device, and imaging inputs that will be used during the course of care.

Incentives directed at the caregivers, such as bundled episode of care payment, are important, but incentives directed at the consumers also are important. Most immediately, insurance benefit design should not frustrate the pursuit of efficiency and quality by providing insufficient coverage for high-value services and overly generous coverage for low-value services.

Over the longer term, however, insurance benefit designs need to be restructured so that they are consistent with and support shared decision-making, bundled EOC payment, and evidence-based guidelines for selection of drugs, devices, and imaging tests.

This project was supported by grant number R18HS020098 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.