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

Average Total Cost of Care per Patient

- PO owned by Member Physicians
- PO owned by local hospital
- PO owned by multi-hospital system

2009: $3,400
2010: $3,600
2011: $4,000
2012: $4,500
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

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Subsidy Eligible</th>
<th>Unsubsidized</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>24%</td>
<td>36%</td>
<td>26%</td>
</tr>
<tr>
<td>Silver</td>
<td>66%</td>
<td>30%</td>
<td>62%</td>
</tr>
<tr>
<td>Gold</td>
<td>5%</td>
<td>13%</td>
<td>6%</td>
</tr>
<tr>
<td>Platinum</td>
<td>4%</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>1,222,320</td>
<td>173,609</td>
<td>1,395,929</td>
</tr>
</tbody>
</table>

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?

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

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)

- 38% Ultra-narrow
- 30% Broad
- 32% Narrow

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

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

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

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

- CalPERS HOPD
- Anthem HOPD

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

CalPERS
Anthem

Reference Price Implementation

2009  2010  2011  2012  2013
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
Web-based and mobile applications allow consumers to “shop” for health care with real time information on price, quality and location of providers.
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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