

## Harvard Business Review

### Smarter Consumer Cost Sharing Using Clinical Nuance

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NOVEMBER 15, 2013

There is strong bipartisan consensus that our current level of health care spending does not deliver sufficient value in terms of individual or population health. Since there is more than enough money in the system, our attention should turn from how much we spend to how well we spend our health care dollars. To encourage a shift from volume to value, insurance benefits and payment models must be redesigned with the basic tenets of clinical nuance in mind. These tenets recognize that 1) medical services and providers differ in the amount of health produced, and 2) the clinical benefit derived from a specific service depends on the consumer using it, who provides it, and where it is delivered.

Most efforts to control costs or improve quality of care have focused on provider-facing “supply-side” initiatives. These efforts have addressed the infrastructure, processes, and financing (e.g., accountable care, medical homes) of care delivery. Far less attention has been devoted to “demand-side” programs that directly engage consumers (e.g., price transparency) in the dual objectives of enhancing quality and containing costs.

One typical consumer-facing initiative that insurers use to control health care spending is cost shifting – requiring beneficiaries to pay more in the form of higher premiums, larger deductibles, and increased cost sharing at the point of service. Most health insurers — including Medicare — implement consumer cost sharing in a one-size-fits-all way such that beneficiaries are expected to pay the same out-of-pocket amount for every service within each category of care (e.g., office visits, diagnostic tests, or formulary tiers of prescription drugs). In nearly every instance, consumer cost sharing is based on the type and price – not the clinical value – of the service provided.

Increases in consumer cost sharing, however, lead to decreases in the use of both nonessential and essential care. For example, when consumers are asked to pay more for high-value cancer screenings, clinician visits and potentially life-saving drugs, they use significantly fewer of these services. For example, when cost sharing was increased for office visits in Medicare Advantage plans, patients visited their physicians less often, as expected. However, individuals with increased cost sharing for office visits were also hospitalized more frequently, and their total costs outpaced those of patients whose out-of-pocket costs did not rise.

Two common clinical examples demonstrate how a clinically nuanced cost sharing approach can improve the outcomes and efficiency of health care. Screening for colorectal cancer is an important life-saving service that is provided with no cost sharing under the preventive health provisions of the Affordable Care Act, because it is recommended by the U.S. Preventive Services Task Force (USPSTF). The task force recommends screening only for adults of average

risk between the ages of 50 and 75 (and states that screening beyond the age of 85 is generally harmful). This recommendation demonstrates the crucial principle of clinical nuance, in that the value of a service depends on the needs of those who receive it. In contrast, patients outside the recommended age range should not be eligible for zero cost sharing unless they have a family history of colorectal cancer (for those under 50) or have had precancerous polyps on prior screening exams (for those over 75). Such a nuanced approach ensures that patient cost sharing is eliminated or substantially reduced when a service is clinically necessary, while allowing health plans to impose higher copayments for services that lack strong clinical evidence to support their use.

Another example of using clinical nuance to make health plans more efficient is the evidence-based recommendation that individuals with diabetes undergo routine eye examinations. While it is not clinically appropriate for everyone to receive such exams, the delivery of this evidence-based service to patients with diabetes is a frequently employed quality metric. In a nuanced design, cost sharing for eye exams would be substantially lower for those with diabetes than for those without.

Although clinical evidence and specialty guidelines frequently determine treatment recommendations for specific diagnoses (e.g., asthma, cardiovascular disease, depression), most benefit designs do not tailor consumer cost sharing to specific conditions. This lack of clinical nuance in cost sharing levels may reduce short-term medical expenditures through reduced utilization. However, lower rates of adherence to evidence-based recommendations — especially by specific patient groups most likely benefit — can lead to inferior health outcomes and, in certain circumstances, higher overall costs. This undesirable effect of higher cost sharing on high-value services in targeted populations demonstrates that the aphorism “penny wise and pound foolish” applies to health care. Conversely, when cost sharing is set too low — as in certain Medicare supplemental insurance plans — those who do not have an appropriate clinical need may overuse services that are potentially harmful or provide little clinical value, resulting in wasteful spending.

To encourage consumers to take better advantage of high-value services and actively participate in decision making about treatments that are subject to misuse, private-sector payers began to implement the value-based insurance design (V-BID) concept more than a decade ago. The basic V-BID premise calls for a clinically nuanced benefit structure that reduces consumer cost sharing for evidence-based services and high-performing providers. V-BID programs that lower cost sharing for targeted services have consistently demonstrated improved adherence with no net increases in aggregate expenditures when compared with plans without such clinically nuanced cost sharing.

More recently, V-BID programs have incorporated nuanced disincentives to discourage the use of low-value care. Key stakeholders, such as the medical professional societies participating in the Choosing Wisely initiative, agree that discouraging the misuse or overuse of identified low-value services must be part of the strategy. These “stick” programs, while more difficult to implement, are substantially more likely to achieve short-term cost savings.

To build public support, efforts to bend the health care cost curve must be linked with a focus on patient-centered, high-quality care. By basing consumer cost sharing on the clinical value – not the price – of services, payers can actively engage consumers in seeking high-value care and foster more regular conversations with providers regarding low-value services. Moreover, as provider-facing initiatives are implemented, it is critically important to align these supply-side programs closely with approaches intended to assist consumers. The potential impact of such carefully aligned approaches to contain costs and improve quality will be far greater than any single strategy can achieve.