

# Aligning Consumer Cost-Sharing with Episode of Care (EOC) Provider Payments

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*The Integrated Healthcare Association is coordinating an episode of care payment project for knee and hip replacement surgery, which will be expanding into other diagnostic and surgical procedures.*



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The Integrated Healthcare Association (IHA) is coordinating a bundled episode-of-care (EOC) payment project for knee and hip replacement surgery, which will be expanding into other diagnostic and surgical procedures. It bears many similarities to, though also some differences from, Medicare's Acute Care Episode (ACE) payment demonstration for orthopedic and cardiac surgery. As organized to date, the IHA project changes the way hospitals and physicians are paid by health plans but does not alter the structure of the patients' cost-sharing obligations. This omission represents a meaningful limitation of the project. The IHA now is re-examining consumer benefit design in light of the move towards EOC provider payment.

This Issue Brief describes the need for benefit re-design in the context of the movement towards EOC payment methods. It gives examples of benefit options specifically for the types of high-cost acute care procedures that are the focus of the IHA initiative. These options include coinsurance with a high annual out-of-pocket maximum, reference pricing, and "Centers of Excellence" contracting. The Brief concludes by considering the extent to which payment reform and benefit redesign can supplement one another and also be used as substitutes for one another.

## THE NEED FOR BENEFIT RE-DESIGN

The principle that insurance benefits should be redesigned to be compatible with and supportive of EOC payment is supported by the health plans and provider organizations participating in the IHA episode payment initiative, albeit for somewhat distinct reasons. The principal goals and potential challenges expressed to date by the stakeholders around EOC payment include:

- **Channeling patient volume to reward provider participation in EOC payment**

The move from fragmented to bundled payment imposes meaningful administrative costs on participating provider organizations and threatens to sharpen internal disagreements over the division of revenues between physicians and the hospital organization. Some provider organizations participating in the bundled payment project feel they need to gain new patient volume in order to defray the costs and com-

plications of moving to the new structure. They advocate that cost-sharing be reduced if the patient selects a provider organization that has transitioned to bundled payment. This perspective is consistent with EOC payment evolving into a component of “Centers of Excellence” that would document quality and efficiency in return for a channeling of patient volume.

- **Incentives for patients to select providers charging lower EOC prices**

Bundled payment gives incentives to physicians and hospitals to collaborate and reduce the cost of care but not in any direct sense to reduce the prices they charge to insurers. Indeed, the enhanced collaboration and integration among providers may strengthen their ability to negotiate for higher, rather than lower, reimbursements. If consumers do not pay more out-of-pocket to use providers that charge high bundled prices than they do to use providers that charge low bundled prices, there is no incentive for price competition among providers. Some health plans therefore favor changes in cost-sharing provisions that shift to the patient some of the differential charged by high-priced providers relative to low-priced providers.

- **Incentives for price transparency**

The cost and quality of care vary significantly among hospitals and physicians yet consumers historically have not had the information or incentives to shop, even for major non-emergency procedures. For shopping to occur, patients need to have access to comparative information across competing facilities. This transparency, in turn, requires that the providers set their prices on a bundled EOC basis, since consumers will never be able to understand and make decisions based on the confusing multiplicity of fees for each individual service. If patients are to use newly transparent prices in their choices among providers, their out-of-pocket payment obligations must be linked to the negotiated EOC prices in a manner that facilitates apples-to-apples comparisons.

## **INSURANCE BENEFIT DESIGN COMPONENTS THAT SUPPORT EOC PROVIDER PAYMENT**

The interest in redesign of consumer cost-sharing to support bundled provider payment occurs in the context of

larger debates over the optimal structure of insurance benefits. Some health plans and employers are experimenting with forms of “value based insurance design” (VBID) that would reduce cost-sharing for particularly effective services and increase cost-sharing for services that lack comparable evidence of effectiveness. Others are increasing the consumer’s out-of-pocket payment responsibility simply as a mechanism to slow the increase in the premium charged to the employer.

There are three principal options for benefit redesign that would support EOC payment in making the consumer more aware of and responsible for price as well as quality differences among competing provider organizations. These include:

- Coinsurance with increased annual out-of-pocket (OOP) payment maximum
- Reference pricing
- Center of Excellence (COE) contracting

As a baseline for purposes of comparison, we begin with a benefit design that is common among contemporary insurance products. We consider the patient’s out-of-pocket responsibility at this starting point and then consider how it would change under each of the alternatives. The contemporary health insurance market includes numerous variants on these basic alternatives; minor variations will be ignored to focus on the important incentive changes.

We briefly assess each benefit design option in terms of:

- Effect on consumer’s cost-sharing responsibility
- Need for assessment by the health plan of quality at different facilities
- Need for disclosure (transparency) of negotiated price levels
- Need for communication of benefit design characteristics to consumers
- Restrictions on consumer’s breadth of choice
- Ease of implementation
- Effect on providers’ desire to participate in bundled payment

## BASELINE CASE (STATUS QUO)

To highlight the tradeoffs among design options, we focus on a single procedure that is included in the IHA's bundled payment project, knee replacement surgery, which exhibits physician and hospital allowed charges that range from \$20,000 to \$100,000 in California. We assume that providers will be able to negotiate bundled EOC prices at approximately the same level as the allowed charge levels they are able to negotiate prior to the implementation of bundled EOC payment. Indeed, all the participating provider organizations are clear that they are not willing or able to accept lower payment levels as part of a shift to the new bundled payment structure.

For illustrative purposes, we will consider Provider A whose negotiated EOC price is \$25,000, and Provider B whose EOC price is \$50,000. We assume that the EOC payment covers the knee replacement episode of care as defined in the IHA project: all facility charges and physician and device charges for the admission where the knee replacement surgery takes place, plus related readmissions, but not for other services such as pre-admission testing or post-discharge rehabilitation.

Consider as the status quo, a common PPO benefit design that imposes 20% coinsurance up to an OOP maximum of \$5,000 and how this influences choice between provider organizations A and B.

**Provider A** (EOC price \$25,000):  
Consumer pays  $(0.20 \times \$25,000) = \$5,000$   
Plan pays:  $\$25,000 - \$5,000 = \$20,000$

**Provider B** (EOC price \$50,000):  
Consumer pays  $(0.20 \times \$50,000) = \$10,000$ ,  
but only \$5,000 due to OOP max  
Plan pays  $\$50,000 - \$5,000 = \$45,000$

This very simple example highlights how differences among providers in EOC prices have a major financial impact on health plans but often no impact on consumers, whose out of pocket cost-sharing does not vary according to which hospital and physician are chosen. There is no reason for the provider organizations to charge a low EOC price, since lower prices do not change the consumer's out-of-pocket responsibility and hence have no effect on their choice of facility.

In this status quo benefit design, there is no variation in cost-sharing depending on the benefit design, there is no variation in cost-sharing depending on the quality of the hospital chosen and no disclosure of price to patients (no need for price transparency).

Consumers may understand that their out-of-pocket payment responsibility is 20% but have no ability to understand their financial liability prior to choosing their provider and going through the procedure. There is no restriction on the patient's choice of provider (beyond the modest limits placed by the PPO insurer via exclusion of a few providers from the contractual network).

## RE-DESIGN OPTION ONE: COINSURANCE WITH HIGH OOP MAXIMUM

In this option, coinsurance remains 20% but the annual OOP maximum is raised to \$15,000. Cost-sharing is significantly different for these patients. However, it is still the plan that pays the vast majority of the difference between Providers A and B in EOC price. Now consumer cost-sharing is:

**Provider A** (EOC price \$25,000):  
Consumer pays  $(0.20 \times \$25,000) = \$5,000$   
Plan pays  $\$25,000 - \$5,000 = \$20,000$

**Provider B** (EOC price \$50,000):  
Consumer pays  $(0.20 \times \$50,000) = \$10,000$ ,  
Plan pays  $\$50,000 - \$10,000 = \$40,000$

### Quality assessment

There is no need for plan to assess quality of care at A and B, as choice remains that of the consumer.

### Communication

Communication needs are modest (raising of OOP max will be considered a takeaway, but is otherwise easy to understand).

### Price transparency

This option has a strong need for disclosure and transparency of the negotiated EOC price for each provider, in order for the consumer to make a price-conscious choice. Without prior disclosure, the consumer will face post-surgical financial surprises but not change behavior. This undermines incentives for the provider to moderate its prices.

- **Access restrictions**

There are no restrictions on the consumer's choice of facility.

- **Ease of implementation**

This is very easy to implement, offering the greatest immediate impact and least administrative expense among the three options.

- **Provider incentives**

There is no incentive here for the provider to participate in bundled payment. There is no reason for a provider to believe that negotiating on an EOC basis will bring greater patient volume, even if the price is low, since prices at competing providers are paid on a fragmented basis that cannot be compared on the basis of price with those that are paid on an EOC basis.

### REDESIGN OPTION TWO: REFERENCE PRICING (BENEFIT LIMIT)

Here the employer or insurer establishes a benefit limit or "reference price," say \$30,000, for this procedure. The limit is established based on a retrospective evaluation of the distribution across provider organizations of allowed charges for the specific procedure in the prior year.

With reference pricing, the consumer pays 20% of the EOC price up to a defined benefit limit of \$30,000 and then 100% of the difference between the EOC price and that limit (for providers where the EOC price is above \$30,000). There is no OOP maximum that applies for the procedure.

**Provider A** (EOC price \$25,000):  
Consumer pays  $(0.20 \times \$25,000) = \$5,000$   
Plan pays:  $\$25,000 - \$5,000 = \$20,000$

**Provider B** (EOC price \$50,000):  
Consumer pays  $(0.20 \times \$30,000) +$   
 $(\$50,000 - \$30,000) = \$26,000$   
Plan pays  $\$50,000 - \$26,000 = \$24,000$

Compared to the base case, the consumer's cost share remains at \$5,000 if Provider A is chosen but has increased from \$5,000 to \$26,000 if Provider B is chosen. The health plan's payment remains at \$20,000 if Provider A is chosen but falls from \$45,000 to \$24,000 if Provider B is chosen.

- **Quality assessment**

Reference pricing requires some assessment of quality by the health plan in order to ensure that the providers with EOC prices below the benefit limit have good quality relative to those above it (in order to preclude charges of channeling consumers to low price, low quality organizations).

- **Communication**

The communication needs to consumers for reference pricing are very significant due to the high potential cost-sharing if they go to high-priced providers.

- **Price transparency**

There is little need for disclosure of prices for those providers whose prices are below the benefit limit of \$30,000 unless there are shared savings with the consumer. Consumers choosing providers with EOC prices above the benefit limit have a strong need for disclosure if they are to make a value-based choice.

- **Access restrictions**

This design does not limit the consumer's choice of provider directly. However, high cost-sharing for providers with prices above the benefit limit will lead many consumers and observers to consider this a tiered benefit plan design. The limit creates two tiers, those for whom consumer cost-sharing is limited and those for whom it is unlimited. The plan typically sets the benefit limit to ensure that a sufficient number of providers in each geographic region are in the limited cost-sharing tier.

- **Ease of implementation**

Reference prices must be set differently for each individual procedure and perhaps for each different geographic market, based on the health plan's assessment of how many providers will set their prices below each possible reference price benefit limit. This will require research by employers or health plans and should take risk adjusted measures and quality indicators into consideration.

A rigorous process will still likely result in a shared reliance on some type of formula (e.g., set the reference price such that half the providers have EOC prices above and half below) plus judgment (e.g., how to flex the benefit limit since some geographic regions have no providers with EOC prices below the reference price).

- **Provider incentives**

In order to induce providers to participate in EOC payment, the plan could give ‘extra credit’ to participating providers when the plan is developing its list of which ones are included in the tier where the consumer’s out of pocket costs are capped at 20% of \$30,000, versus those where out of pocket costs are uncapped. If a provider participated in EOC payment but its EOC price were far above the benefit limit of \$30,000, however, it would still be placed in the uncapped tier.

For example, if a provider participates in EOC but charges a bundled EOC price of \$35,000, the cost-sharing could be set at  $0.20 \times \$30,000 = \$6,000$ , with the plan paying  $\$35,000 - \$6,000 = \$29,000$ . For Provider B charging \$50,000, however, the reference pricing would be enforced, with the patient paying \$26,000 and the plan paying \$24,000.

### **REDESIGN OPTION THREE: CENTER OF EXCELLENCE (COE) CONTRACTING**

Here the plan’s network is limited to one or a few providers that have demonstrated good quality and whose EOC prices are reasonable from the perspective of the plan. When the consumer uses the COE, cost-sharing can be either the basic coinsurance required of all services (20%) or can be set to zero. If the consumer uses a provider that is not the COE, he or she pays the full EOC price.

In the typical HMO benefit design, there is no coinsurance but sometimes an admission copayment. HMO product purchasers may prefer the COE strategy to the reference pricing strategy as it is easier for them to exclude coverage altogether for high-cost providers than to shift the extra costs of those facilities onto the patient, as is the case with reference pricing. In this sense, reference pricing is more compatible with PPO product designs while COE contracting is more compatible with HMO benefit designs. It is important to note that some states do not allow plans to exclude coverage for an out-of-network provider.

In our example, Provider A is selected as a COE facility while Provider B is not.

**Provider A** (a COE facility):

Consumer pays  $(0.20 \times \$25,000) = \$5,000$

Plan pays:  $\$25,000 - \$5,000 = \$20,000$

If cost-sharing is eliminated completely at

COE facilities: Consumer pays \$0; Plan pays \$25,000

**Provider B** (a non-COE facility):

Consumer pays \$50,000; Plan pays \$0

- **Quality assessment**

High. The provider organization needs to score high on the various metrics of performance and, as an obvious starting point, be willing to collect and report on these dimensions of performance.

- **Communication**

Moderate. The plan informs enrollees concerning the identity of the COE facilities but does not need to communicate their specific prices, and in this sense faces fewer communication needs than under reference pricing. However, there are strong communication needs in telling consumers about the importance of selecting a COE provider and the criteria by which the plan selected particular providers as a COE.

- **Price transparency**

There is no need for price transparency since the plan, rather than the consumer, is making the price-conscious choice. If there are multiple COE facilities, the plan’s payments will vary but the consumer’s cost-sharing will not, and so price transparency is not necessary.

- **Access restrictions**

Very high. For this reason the plan will need to make extra efforts at quality assessment, communication, and sharing savings with the consumer. The plan can shift consumer sentiment from negative to positive by selecting ‘brand name’ providers for the COE, by adding a travel benefit, and by reducing or eliminating cost-sharing relative to the baseline level of coinsurance required of all services (20%).

- **Ease of implementation**

Many health plans already have designated particular hospitals or provider organizations as especially high quality and cost effective options within the broader

provider network for at least some services, ranging from organ transplantation to bariatric surgery to cardiac bypass surgery. A COE strategy for a larger category of orthopedic and cardiac procedures would use similar data and criteria for designation and would not pose major new difficulties.

The most important challenges could come from state regulatory agencies that respond to complaints from non-designated providers that they be treated similarly with respect to consumer cost-sharing. Multi-hospital systems may demand that all their facilities be considered COE for benefit design purposes if the health plan wants to have any be included or that a hospital designated as a COE for one set of services, such as orthopedic surgery, also be designated as a COE for other services, such as interventional cardiology, regardless of the quality and price of those latter services.

▪ **Provider incentives**

Selection of a provider as a Center of Excellence would be based on its participation in EOC pricing (and its negotiating an acceptable EOC price), as well as on quality metrics. The possibility of more plans shifting more services to Center of Excellence contracting is the strongest current incentive for a provider to participate in EOC payment, as a means to prepare itself for successfully competing for Center designation.

**SHARING THE SAVINGS FROM EOC PAYMENT WITH THE CONSUMER**

A challenge facing reference pricing is that the EOC prices charged by each provider must be transparent to the consumers since they face very high out of pocket cost-sharing if they select a high-priced option. This raises difficulties both in terms of the price non-disclosure clauses negotiated by providers and health plans and in terms of the inherent difficulty in communicating pricing information to consumers. One solution is for the plan to identify the providers whose prices are at or below the benefit limit (\$30,000 in our example) and to set a low, uniform out-of-pocket payment obligation for consumers choosing any of these providers. The consumer's payment obligation for providers charging more than this reference price would continue to vary according to their actual price.

For example, the plan could set a fixed out of pocket payment requirement of 20% of the reference price limit of \$30,000 = \$6,000 for all providers falling under the benefit limit, even if the actual EOC price were below \$30,000.

**Provider A** (EOC price \$25,000):  
Consumer pays  $(0.20 \times \$30,000) = \$6,000$   
Plan pays:  $\$25,000 - \$6,000 = \$19,000$

**Provider B** (EOC price \$50,000):  
Consumer pays  $(0.20 \times \$30,000) + (\$50,000 - \$30,000) = \$26,000$   
Plan pays  $\$50,000 - \$26,000 = \$24,000$

This gives the consumer no incentive to care about the provider price so long as it falls beneath the \$30,000 benefit limit. This would motivate providers to set their EOC price no lower than \$30,000.

One possible solution is for the plan to share with the consumer the savings if the consumer chooses a provider that charges less than the benefit limit of \$30,000. For example, if the plan shares half of any such savings with the consumer (in the form of reduced cost-sharing), the distribution of payments would be:

**Provider A** (EOC price \$25,000):  
Consumer pays  $(0.20 \times \$30,000) - [0.5 \times (\$30,000 - \$25,000)] = \$3,500$   
Plan pays:  $\$25,000 - \$3,500 = \$21,500$

**Provider B** (EOC price \$50,000):  
Consumer pays  $(0.20 \times \$30,000) + (\$50,000 - \$30,000) = \$26,000$   
Plan pays  $\$50,000 - \$26,000 = \$24,000$

▪ **Quality assessment**

Same as with reference pricing.

▪ **Communication**

The communication needs to consumers are much lower than for traditional reference pricing. The main message is that the consumer would be wise to select from

among the providers charging an EOC price below the reference price limit. Choosing a provider whose EOC price is above that limit will expose the consumer to a large and unknown out-of-pocket payment responsibility. If there is shared savings with the consumer, this will need to be communicated but can be a positive message: how to get a partial refund on coinsurance payments if a low-priced provider is selected.

- **Price transparency**

This increases the need for price transparency for provider organizations with EOC prices below the reference price limit, as this will be the basis for shared savings. Consumers choosing providers with EOC prices above the benefit limit would have a strong need for disclosure, as above.

- **Access restrictions**

The high cost-sharing for providers with prices above the benefit limit will lead many consumers and observers to consider this a narrow-network plan design. The limit creates two tiers, those for whom consumer cost-sharing is limited and those for whom it is unlimited.

- **Ease of implementation**

Reference prices must be set differently for each individual procedure and perhaps for each different geographic market, as above.

- **Provider incentives**

The shared savings component creates an additional incentive for the provider to participate in bundled pricing if it only applies to those that participate. For example, if a provider did not participate in bundled payment but had allowed charges of \$25,000, the consumer's out-of-pocket responsibility would be \$6,000, but if that same provider charged a bundled EOC price of \$25,000, the consumer's out-of-pocket responsibility would be just \$3,500.

## **CONCLUSION**

Incentives for providers from EOC payment and incentives for consumers from insurance benefit design are equally important to stimulate movement towards to a value-based health system. Ideally, provider payments and consumer benefits would be revamped in concert to enhance each

other's impact. For example, a health plan could shift to EOC payment for acute hospital services and restructure the consumer's benefit design around reference pricing principles. EOC payment would facilitate the consumer's efforts to compare price and quality across competing providers while reference pricing would reward the more cost-effective providers with higher patient volumes.

Alternatively, hospitals could compete to be designated Centers of Excellence, offering quality guarantees and EOC pricing in exchange for being the only facility covered for particular procedures in their geographic market. Here, acceptance of bundled payments would be one requirement for COE designation since the health plan would want to be sure of the total cost of care at its preferred Centers. Limiting insurance coverage to use of the COE would then guarantee that providers who accepted bundled payment and offered documented evidence of quality would receive the majority of the health plan's enrollees who need the service in question.

While EOC payment and benefit redesign are complementary and strengthen each other, some purchasers and plans are emphasizing payment redesign while others emphasize benefit redesign. Both incentive changes are complex and require considerable administrative resources to implement. In this sense, payment redesign and benefit redesign may be substitutes as well as complements.

Different sets of organizations may choose to emphasize different tactics due to their relationship with the organizations' capabilities and larger strategic goals. Some employers and health plans may focus on benefit redesign through changes in the OOP maximum or reference pricing, since they have unilateral control over benefits but must open negotiations to make any changes in payment structure with providers. Moreover, they have only a secondary interest in the effects of bundled EOC payment on alignment of incentives between physicians and hospitals.

In the immediate term, purchasers and plans care about the level of provider prices, not the efficiencies by which costs are lowered in order to support lower prices. EOC payment fosters the alignment of incentives between physicians and hospitals and thus supports the strategic goals of efficiency and quality. Changes in the structure of provider payment must be negotiated with health plans, which may be reluctant to change from the status quo due to difficulties with incumbent claims payment systems, but the largest implementation challenges for EOC payment lie

within provider organizations themselves. Moreover, providers have no direct influence over benefit design and typically worry that consumer cost-sharing of any type may lead to increased bad debt.

Bundled EOC payment changes the incentives facing physicians and hospitals, offering the potential for retention and sharing of savings from improved coordination, lower input prices, reduced errors, and streamlined care processes. Redesigned insurance benefits change the incentives facing consumers and patients, offering the potential for lower

out-of-pocket payments if patients choose more appropriate treatments, efficient providers, and cost-effective drugs and devices. Each has an important role to play in moving the health care system to one that encourages use of high-value services and discourages use of low-value services.

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