A Halting March Toward Value-Based Benefit Design

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As health care costs have continued to increase, patients are assuming a greater share of medical expenses. Higher levels of cost sharing are evident in the growth of high-deductible health plans, which combine low premiums with deductibles of at least $1,200 for an individual plan and $2,400 for family coverage, often significantly higher. According to the Kaiser Family Foundation, the proportion of single-coverage workers with a deductible greater than $1,000 increased from 10% in 2006 to 34% in 2012. (http://kff.org/health-costs/issue-brief/snapshots-the-prevalence-and-cost-of-deductibles-in-employer-sponsored-insurance/)

Coping with medical costs under high-deductible plans is a source of great stress for many families of limited means.

If patients are going to pay a higher share of medical costs, can we at least be smart about it? For example, benefits can be adjusted to require patients to pay a higher share of costs for medical services of limited or unproven value and a lower share for care that brings clear clinical benefit. Minimizing out-of-pocket spending for services that help control chronic disease could avoid costly down-

![Figure 1. Patient Financial Responsibility for Physician Services by Specialty, 2009 – 2012](Dollars Owed per Visit and as a Percentage of Allowable Charges).
stream hospitalization and emergency department utilization. This is the idea behind value-based benefit design, a concept articulated by Fendrick, Chernew, and others, that calls for changing benefit structures to improve outcomes and encourage cost-effective behavior on the part of patients. (http://www.sph.umich.edu/vbidcenter/registry/pdfs/AJMC_06speclFendrick6p.pdf)

The desire to improve benefit structures was also the motivation behind Section 2713 of the Affordable Care Act, which stipulates that nongrandfathered health plans must allow patients to receive a wide range of preventive services at no out-of-pocket expense to the patient. (http://www.bricker.com/services/resource-details.aspx?resourceid=484) This provision, which became operational on September 23, 2010, applies to all health services with a grade of A or B from the U. S. Preventive Services Task Force. The intent is to reduce out-of-pocket expenses for preventive care.

We recently undertook an effort to measure how out-of-pocket patient expenditures for medical care are changing for physicians’ services. Focusing on commercial insurers, we analyzed 12.5 million claims for physician care from 2009 and 13.2 million claims from 2012. These claims were submitted by 15,069 physicians in 795 practices in 40 states. The claims were managed by athenahealth, a health care information technology and services firm with physician clients around the country. All practices used athenahealth software over the study period.

Figure 1 shows out-of-pocket expenditures by patients for physician services in 2009 and 2012 by physician type – adult primary care physicians, pediatricians, and specialists. Overall, patient responsibility for physician services increased 14.8%, from $27 per visit in 2009 to $31 per visit in 2012. However, this aggregate trend masks considerable variation by specialty. Patient obligations for primary care increased very slightly, from $22 to $23 per visit. Out-of-pocket obligations for pediatric care were nominally flat ($16 per visit) but decreased substantially as a percentage of total allowable charges. Specialty care accounted for virtually all of the overall increase in patient payments, with payment per visit increasing by nearly 20%, from $41 to $49. On a proportional basis, patient financial obligations for specialty care increased from 17.7% to 20.7%. Thus, the high-level view is that patient obligations are decreasing for pediat-
rics, increasing for specialty care, and remaining constant for primary care. We are encouraged that out-of-pocket costs for pediatric are decreasing and those for primary care holding steady. But it is difficult to evaluate the increase in patient obligations for specialty care: it is likely that this trend leads some patients to think twice about receiving care of limited value, while causing others to delay or forgo treatment they need.

A closer look at changes in patient cost sharing for specific procedures reveals a murky picture (Fig. 2). For example, average patient obligations for colonoscopy decreased from $53 to $32 between 2009 and 2012. We view this as a clear positive, given studies documenting the benefits of colonoscopy in detecting and preventing the progression of colon cancer. Other shifts, however, are more ambiguous. For example, the cost of a well visit decreased 80% while the cost of a general office visit increased 15%. We question the value of making a well visit free for a healthy person, while the chronically ill (including the chronically ill of limited means) need to pay more to receive care for serious existing problems. The significant increase in patient obligations for magnetic resonance imaging (a 25% increase to $165 per visit) and for knee arthroscopy (a 33% increase to $226) are good examples of the increased costs of specialty care. To the extent that these changes encourage patients to wait until problems self-resolve, they could be viewed as beneficial. However, there may also be cases where patients delay clearly needed and appropriate diagnostics and services owing to cost.

The path toward value-based benefit design will be long and difficult. We are encouraged that the financial burden for children is diminishing and that out-of-pocket expenditures for primary care are flat, at least for the moment. However, current efforts feel like a club when surgical precision is needed. We would welcome further efforts to design patient obligations where they are most likely to have the greatest effect – reflecting the inherent value and cost-saving potential of the service, given the clinical needs of individual patients.