New Year's Prediction: More Cost Sharing for Patients Means Problems for Providers

written by Theresa Hush | December 21, 2016

A year ago we reported on the trend in shifting health care costs to the consumer through higher deductibles, copayments and premium sharing. Fast forward to 2017: expect to see "financial accountability" for patients vastly increase, as health care costs continue their relentless rise and the public policies that support premium subsidies, Obamacare, Medicare and Medicaid expansion, research and innovative provider-based models are weakened or reversed.

In general, the politics of the moment are ushering in simple economic concepts: Reduce the complexity, cap costs, minimize bureaucracy. When government or employers contemplate giving patients a fixed contribution for health care, possibly through vouchers or spending accounts, the message is this: Now it's up to you.

"Patient Empowerment" Has Not-So-Hidden Costs

The outcome is not that simple, of course. The trend toward holding providers responsible will continue, and there will be compromises regarding how much expense patients should bear. Plus, strong interest groups will rally and likely influence the results.

Nonetheless, accelerated movement toward a "Patient Empowerment" agenda built on financial responsibility will have consequences. We don't know all the outcomes of handing the patient the checkbook, except for these:

- When patients face medical expenses beyond their means, they go bankrupt, and providers don't get paid.
- When insurance coverage is lost, patients don't go to the doctor until they are very sick, costing more money and more losses for providers.

Either way, patients lose. But so do providers. If the safety nets disappear, the pain will be shared across the board.

Patients Will Demand Better Information to Make Smart Choices

What are the alternatives? We are headed in the right direction to an answer, but may not realize it. Risk-based delivery models place providers and patients in a financial environment where, with correct controls, costs decrease but outcomes improve. But it will take "flipping the switch" on reimbursement incentives to create a sensible system:

- Patients and providers must be prepared to usher in Risk arrangements again.
  - Health systems thinking about "Pick Your Pace" for MIPS in 2017: Don't take a pass. MIPS is a practice ground for your ACO—or for participating in any other Risk model.
  - Patients will have to get used to the "HMO" concept again, although some of the negative features of the previous model may be unnecessary, such as referrals, if providers close their loopholes and establish procedures for referring patients.
- Find out what patients really want for their health care, and don't assume you know. A new populism is emerging, even in health care. Until patients are required to make a choice of network or health plan (we predict this will happen eventually), new provider strategies to reach out to patients are essential. Patients will be shopping for networks and will have better tools to find them. Patients will not give you loyalty for free.
- Invest in the tools patients will use to make choices. Measure outcomes, control your total per patient costs, transform your practices and invite your providers to participate. There will be websites, companies and other services for patients to compare providers for their results, costs, and customer service. Don't get left behind.
- Develop ways to ensure coverage of total episode costs to patients. One byproduct of embedding contracted "choice" or "preferred" or "narrow" networks into benefit plans is that traditional provider selection is now broken. It often happens that a patient going to an in-network physician will get tests from an affiliated institution that is not covered, making the patient totally responsible for thousands of dollars. Health care systems will

need to develop the mechanisms to ensure the financial security of patients who choose them. This could mean write-offs, but it is preferable to negotiate comprehensive deals with insurers to get everything under the tent.

Engage in customer service. Stories among patients point out the worst that health care systems have to offer—waiting for appointments, duplicate tests, lack of coordination. Evaluate and change your system, and you will guarantee patient flow.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Todd Quackenbush