Happy New Year: Higher Patient Financial Responsibility Risks More Provider Debt

written by Theresa Hush | December 23, 2015

A few weeks ago, we learned that the rate of health care spending has escalated, with a 5.3 percent gain in 2014—accounting for 17.5 per cent of the U.S. Gross Domestic Product. And, according to the Kaiser Foundation, this predicted upward trend shows no signs of abating anytime soon.

At some point, this cost burden on the economy is unsustainable. So where is the outcry? The relative silence around the trend, compared with prior decades, reveals a shift in financial responsibility from employers to individuals, which just might crack the foundations of the health care system.

Consumers are Paying More for Less Health Care

It's not news that businesses have mitigated some of their increasing health care costs by altering benefit plans, dropping coverage and pushing employees to exchanges. While business costs are going up, however, employee costs are going up even more. Premium costs are skyrocketing; employees have experienced an 83 percent increase in premium contributions over the past 10 years. The problem is compounded by the lag in wages: within the last five years, employees' premiums have jumped 27 percent, compared to an average wage increase of only 10 percent during the same period.

And this increase in consumer health care costs isn't limited to higher premiums. What's even more significant is the change in benefit plans. More than a quarter of employers now have High Deductible Health Plans (HDHP), some including Savings Options. There is a major trend toward adopting this kind of benefit plan, essentially catastrophic coverage, among employers who can't afford to provide full coverage. Even among PPO plans, deductibles and copays are going up, and a $6,000 annual individual out-of-pocket cap is not unusual. The bottom line:

consumers are paying more for less health care.

Narrow Networks Limit Access to Care for the Sickest Patients

But the story doesn't end there. The effect of higher deductibles and copays on employee costs is compounded by actions that health plans have implemented to keep premiums from rising even higher: the institution of "narrow networks." In Chicago, one plan has dropped nearly all tertiary and academic centers as "high cost" providers so that they become out-of-plan providers. Really sick or emergency patients who receive care in specialized centers get stuck with even higher deductibles and copays for going out-of-network.

Can we really expect consumers to bear 40 per cent of the cost of the $117,094 in average hospital fees and $45,000 minimum for physician fees for a coronary artery bypass? Think about the long-term, high cost of patients with cancer, and what this will mean for both patients and providers. Without enough income to pay for their care, individuals have only two choices: go without and get even sicker (with associated higher costs for eventual treatment), or default on their medical bills.

Patients Bear More Financial Responsibility for Care, but Can't Control Resources

Many have championed the idea that individuals should be more financially responsible for health care in order to encourage lower resource use. That was how copays became attached to office visits and higher copays tied to Emergency Room usage.

But is this what we had in mind? Under many employee benefit plans—and the plans under the Affordable Care Act (ACA)—as high as 30 or 40 per cent of hospital fees are the patient's responsibility, as well as a substantial portion of outpatient care. Yet patients control few if any resources in an inpatient stay. Diagnostic tests and other treatments are similarly ordered by physicians with few, if any, options for the patient.

Deductibles under most health plans start at $1,500, but are more typically close to $3,000 per individual and $12,000 per family. On a more global scale, some Medicare reform initiatives call for defined benefits, otherwise known as vouchers. The idea is to allow beneficiaries to shop around for the lowest cost and operate under a health care budget. That's an idea borrowed from employers who have done the same, directing their employees to HDHPs on insurance exchanges. But employees don't have access to enough accurate, understandable information to make good choices.

Market Fluidity Undercuts Patients' Ability to Cultivate Trusting Relationships with Providers

Why aren't consumers in revolt? Do individuals understand what is happening to their insurance coverage and how it will affect them? It's doubtful. According to a just-published study of how consumers evaluate and choose health plans, only 14 percent could answer four simple, multiple-choice questions regarding the definition of cost-sharing features, even when provided with some explanatory information. As networks are changing day-by-day, the ability of an individual to determine whether his or her provider is in network is nearly impossible. Sometimes even the provider's staff don't know.

Industry experts appear perplexed that methods of "Patient Engagement" to better connect with providers are not working. Real partnership between patients and providers is the element that Value-Based Health Care and various risk models require to generate better outcomes at lower cost. But we are driving patients away from the system! Not only is affordability the issue, but also the ongoing changes in networks and plans make it impossible for consumers to cultivate relationships and trust.

The path we are on is unsustainable. Both patients and providers will be crushed by the burden of unpaid services, as consumers' inability to pay for the more expensive care will simply increase provider debt. The underlying health issues will not be addressed and lead to worsened public health, as well as greater, unavoidable health care expenses.

Can Provider Action Mitigate the Crisis?

A solution to these problems is unlikely to come out of business or government, or from health plans, at least for now. Even if economic and political barriers didn't exist, the stakeholders' understanding of all these issues is murky. But providers must already be experiencing increases in their Patient Accounts Receivable. And, since consumers can simply not pay, health care providers are at significant financial risk. Here are a few basic steps toward building better commitment and trust with patients:

> Clarify insurance affiliations for patients. It is inexcusable for patients to receive out-of-network charges to a provider when that information was not conveyed to them in the first place. Proactively advertise your network affiliations at the point-of-care sites and include them in consent forms for treatments.
> Enforce the use of in-network providers when treating patients. Patients will understandably be angry if they use an in-network provider who deploys out-of-network anesthesiologists, radiologists, hospitalists and emergency room staff. With narrow networks, providers must pay attention to the alignment of all specialists who touch the patient, or face financial or legal repercussions.

Treat patients like real customers. Building loyalty and partnership in a program to maintain health entails a huge shift in culture across the entire health care system. This requires more than a “patient-centric system” as in an EMR; it requires a patient-centric Health Care System in all aspects of receiving, communicating, treating and following up with patients. Variability in individual patients’ wants and needs must be documented and addressed. Nothing less will do than placing patients first, because, in the new competitive environment, they have more options.

Correct the pricing. If you want patients to see you, don’t charge high fees for essential connections like providing history during physicals or getting a basic workup. Patients are more willing to pay you for something they can’t do. Figure out how to help them maintain a good lifestyle without extra out-of-pocket costs. Really examine your pricing structure, and make sure that consumers can—and do—understand it. That means getting rid of charges that make consumers crazy, like Tylenol on hospital bills. And don’t ask them to come back for check-ups if you can use an alternative, like telemedicine.

Help physicians and direct providers learn how to do shared decision-making with patients, and/or facilitate a primary-care-powered, shared decision-making process for major treatment plans. This isn’t learned in medical school and may be undervalued by top-notch clinicians—but good results with savings depend on the shared decision-making between patient and physician. Your primary care physicians, often iced out of the process of care that has been referred to specialists, can play a critical role in providing a balanced and trusted perspective, with less risk of conflict of interest. This will take education and training.

Change your measures of performance. If you are evaluating your physicians by admissions, revenues and rigid patient satisfaction surveys, your strategy needs an update. Your measures must be in line with both patient and market expectations of performance, and should incorporate clinical process performance, outcomes and more measurement of what is important to the patients.

Treat your employees like partners, so that they will do the same with patients.

While you can’t completely fix the economics of a complex and difficult system, you can do much to help your organization survive while the system is in transition. Treating patients like valued customers—especially if they are expected to share the costs of care—is the place to start. After all, a trusting relationship, based on effective, affordable health care, is what we’re all striving for, right?

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