Cost-Sharing Strategies for OHP Medical Services

Background

Question

How might OHP use cost-sharing to generate revenue and control ineffective utilization? What impacts (good and bad) would various strategies have?

Definitions

- ***Cost-sharing*** is defined as patient exposure to out-of-pocket costs associated with health services delivery.
- ***Co-payments*** are a fixed dollar fee per visit or item (drug, supply, etc.), paid at the point of service.
- ***Co-insurance*** is a defined percentage of total charges for a service.
- ***Premiums*** are defined as a set amount of dollars per defined payment period paid to obtain health insurance coverage.
- ***Deductibles*** are flat dollar amounts for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the price of services.
- ***Out-of-Pocket Limit*** is defined as the total amount (except for the premium contribution) of cost-sharing for a period of time, typically for one year.

Principles

- Cost-sharing should be based on ability to pay. The combined impacts of premiums, co-pays/coinsurance should be considered.
- Cost-sharing arrangements affect everyone (enrollees, State, delivery systems, providers). They vary in their impacts. Consider carefully. Monitor appropriately.
- Cost-sharing should target less effective and elective care utilization. Most of cost savings will come from decreased utilization.
- Cost-sharing for targeted services will work as intended only if patient and physician are informed about clinical options.
- Cost-sharing should directly contribute some revenue (no less (?) than currently collected from enrollee premium contibutions).
- Cost-sharing arrangements should be simple to administer.

Expected Impacts of Cost-sharing

Economic Impacts

- Co-payments can decrease costs in the short-run (due to reduced utilization of certain health services) and increase down-stream costs (due to higher hospitalization rates and increased use of emergency rooms)[1,2,3]. These effects would be most pronounced for the poorest people in the OHP if cost-sharing is a barrier to effective care.
- When co-payments are initiated in a Medicaid population, hospitalization rates can increase to levels higher than they were without the co-payments. This is likely to be due to the reduction in early/preventive medical care because of the inhibiting effect of the co-payments[4,5].
- The sicker the individual, the greater the economic burden of co-payments[6].
- Co-payments are not a good primary revenue generator[7]. While co-pays may lead to decreased utilization and therefore to saved dollars, OHP probably can't set the co-pay amounts high enough to have a significant direct impact on the bottom line.
- Potentially, co-payment revenue could be directed to providers to offset the negative financial impacts of treating OHP clients.

Impact on Access/Utilization

- The poorer the individual, the greater the reduction in access to health services, and the greater the deterrent effect on health care utilization[8,9].
- Patients may be more likely to remain with a single medical treatment "home" when co-payments for medical services are not required[10].
- The bulk of relevant research indicates requiring co-payments from a Medicaid population has a deterrent effect on both necessary and unnecessary care[11,12].
- As income increases, co-payments would have less effect on limiting utilization.
- Co-payments can prompt very low-income insured individuals and those from large families to seek free/charity care from safety net clinics[13].

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[1] B Stuart and C Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?," *Health Affairs* 18, no. 2 (1999).
[2] SB Soumerai and D Ross-Degnan, "Determinants of Change in Medicaid Pharmaceutical Cost Sharing: Does Evidence Affect Policy?," *Milbank Quarterly* 75, no. 1 (1997).
[3] MI Roemer and CE Hopkins, "Copayments for Ambulatory Care: Penny-Wise and Pound Foolish," *Medical Care* 13, no. 6 (June, 1975).
[4] Soumerai and Ross-Degnan (1997).
[5] Roemer and Hopkins (June, 1975).
[6] Stuart and Zacker (1999).
[7] CE Hopkins, MI Roemer, DM Procter, F Gartside, J Lubitz, GA Gardner, M Moser, "Cost-Sharing and Prior Authorization Effects on Medicaid Services in California: Part II: The Providers' Reactions," *Medical Care* 13, no. 8 (August, 1975).
[8] Soumerai and Ross-Degnan (1997).
[9] L Ku and TA Coughlin, "Sliding-Scale Premium Health Insurance Programs; Four State's Experiences," *Inquiry* 36, no. 4 (1999-2000).
[10] D Ansell, "Public Health Briefs. Voting with Their Feet: Public Hospitals, Health Reform, and Patient Choices," *American Journal of Public Health* 88, no. 3 (1998).
[11] AA Nelson, Jr, CE Reeder, and WM Dickson, "The Effect of a Medicaid Drug Copayment Program on the Utilization and Cost of Prescription Services," *Medical Care* 22, no. 8 (1984).
[12] SB Soumerai and J Avorn, "Payment Restrictions for Prescription Drugs under Medicai: Effects on Therapy, Cost, and Equity," *New England Journal of Medicine* 317, no. 9 (1987).
[13] CJ Rocha, "Use of Health Insurance in County-Funded Clinics: Issues for Health Care Reform," *Health and Social Work* 1, no. 1 (1996).

- The impacts of co-payments can be unpredictable. These impacts can vary by patient type, by illness, by type of delivery system, and by physician behavior[14].

Health and Social Impact

- Since co-payments can have a deterrent effect on the utilization of necessary care, they could contribute to a reduction in health status for OHP members.
- Health status of the poorest Oregonians would be most negatively impacted.
- According to Empowerment Theory, and substantiated by verbal communication with administrators, providers, and staff from various health safety net facilities in Oregon and elsewhere, co-payments can have several positive effects for clients. They can serve to reduce feelings of dependency, empower clients to participate more fully in the health care experience, and allow clients to have higher expectations of the health care services which they receive[15].

Administrative Impacts

- A small, clearly delineated, across-the-board co-payment may not be perceived as a significant administrative burden for providers and their staff. However, some co-payment systems could increase administrative burden. For example, tiered co-pays could be confusing to patients and providers[16].
- Co-pays could reduce the administrative costs of claims handling because fewer claims would be generated (due to lower utilization)[17].
- Many Oregon health safety net clinics currently require sliding scale co-payments from uninsured individuals. (Yakima Valley Farm Workers Medical Clinics).
- Health policy research has shown that a system of co-payments can be effectively instituted, that Medicaid patients usually pay the co-payment, and that a co-payment policy is not perceived as negatively affecting quality of health care by patients[18,19].

[14] DG Smith, "The Effects of Copayments and Generic Substitution on the Use and Costs of Prescription Drugs," *Inquiry* 30, no. 2 (1993).
[15] D Werner, *Where There Is No Doctor*, 1995 ed. (Palo Alto, CA: Hesperien Foundation).
[16] CE Hopkins, MI Roemer, DM Procter, Gartside, F Lubitz, J Gardner, GA Moser, M Moser, "Cost-Sharing and Prior Authorization Effects on Medicaid Services in California: Part I: The Beneficiaries' Reactions," *Medical Care* 13, no. 7 (July, 1975).
[17] Stuart and Zacker (1999).
[18] Nelson, Reeder, et al (1984).
[19] Hopkins, Roemer, et al (July, 1975).

Possible Cost-sharing Strategies

Small Co-Pays *(possible approaches)*

- **Equal co-payment for all services ($1–$2 per visit)**
- **Co-pays based on a sliding scale tied to income level (approximately $1–$4 per visit)**

Advantages of small co-pays:

~ discourage some over-utilization

~ administratively simple

Disadvantages of small co-pays:

~ minimal revenue generation

~ don't distinguish between appropriate and inappropriate utilization

Targeted/Tiered Co-Pays or Coinsurance *(examples only)*

- **By type of service:**
  - preventive/maternal/family planning visits ($0 co-pay)
  - outpatient provider visits (higher level co-pay: $2–$5)
  - emergency room visits ($25–$50 per visit)
  - hospital admissions ($100–$200 per admission)
- **By high use/high cost procedure:**
  - place a very large co-pay on certain elective surgical procedures (such as circumcision, restorative dental procedures, etc.)
  - place a co-pay or coinsurance (% of cost) for expensive diagnostic testing such as MRI's, CT's
  - place a co-pay or coinsurance on less cost-effective procedures or testing (such as prenatal ultrasounds not medically indicated but desired by patient)
- **By categories of care used to establish OHP list:**
  - would need to be collected after the diagnosis is made so as to differentiate (such as
  - those in treatable fatal versus treatable non-fatal categories)
  - place some coinsurance on the procedures in the 10th thru 17th categories, even higher amounts for those below the line

Advantages of targeted co-pays/coinsurance:

~ Targeted co-pays do a better job of encouraging effective utilization and discouraging ineffective utilization than across-the-board co-pays.[20]

~ Hospital benefits account for 40–50% of typical benefit package cost, so targeting specific expensive procedures could control expensive utilization[21].

[20] A Markus, S Rosenbaum, and D Roby, "Chip, Health Insurance Premiums and Cost-Sharing: Lessons from the Literature," (Washington, DC: George Washington University School of Public Health and Health Services Center for Health Services Research and Policy, 1998).

Disadvantages of targeted co-pays:

~ A given co-payment amount will have a greater impact on someone with a lower income than on someone with a higher income in terms of percentage of income spent (especially a problem with strategies using very high co-pay/coinsurance amounts).

~ Co-pays that attempt to target "good" versus "bad" utilization presume that *effectiveness* can be satisfactorily defined. This isn't as easy as it sounds.

~ To be done effectively, tiered co-pays need constant monitoring of the cost and effectiveness of various therapies, settings, and types of providers to assure the most appropriate ones are encouraged, and to make periodic adjustments to the cost-sharing mechanisms.

Premium Share Strategies

- **Current situation:**

– OHP began charging premium shares in December, 1995. Premium shares range from $6 to $23 per

– month depending on income level and family size.

– Premium shares contribute about 1% to total OHP budget.

– At least 12 other states collect premium shares for their low-income health insurance programs.

Advantages to premiums:

~ Premiums generate about $13 million per biennium (1997–1999).

~ Participants pay something toward their own health care.

~ Premiums offer a possible Medicaid buy-in strategy (allow people above current income eligibility levels to enroll contribute something toward cost of insurance).

~ Premiums offer a possible consumer choice mechanism (pay more for better coverage).

Disadvantages to premium sharing:

~ Premium sharing can reduce participation. Even modest premiums can have substantial enrollment impacts. A study of Hawaii, Minnesota and Washington found that the percent of eligibles who enrolled fell from 57% of eligibles to 35% to 18% as premiums went from 1% of income to 3% to 5% [22].

~ Premium sharing can create adverse selection if those who need services are more willing to pay the premium to remain enrolled[23].

~ Premium sharing can lead to more churning and more discontinuous coverage[24].

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[21] JT Phillips, JM Carstens, G Eckard, T Harrington, LM Lewis, B Miller, J Saari, D Shea, S Swanson, and D Wille, "Actuarial Issues Involved in Evaluating a Guaranteed Standard Benefit Package under Health Care Reform," (Washington, DC: American Academy of Actuaries, 1994).

[22] S Haber, J Mitchell, A McNeill, "Effects of Premiums on Eligibility for the Oregon Health Plan," (Waltham, MA: Health Economics Research, Inc., 2000).

[23] Haber, Mitchell, et al (2000).

[24] Haber, Mitchell, et al (2000).