Institute for Healthcare Improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

Financial Toxicity/Affordability of Health Care for Patients
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I. Research and Development Team:

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II. Intent:

The intent of this work is to deeply understand the needs and opportunities related to financial toxicity and affordability from a patient perspective. This works differs from other work that we have done around cost because we are going to look at it from the consumer's point of view.

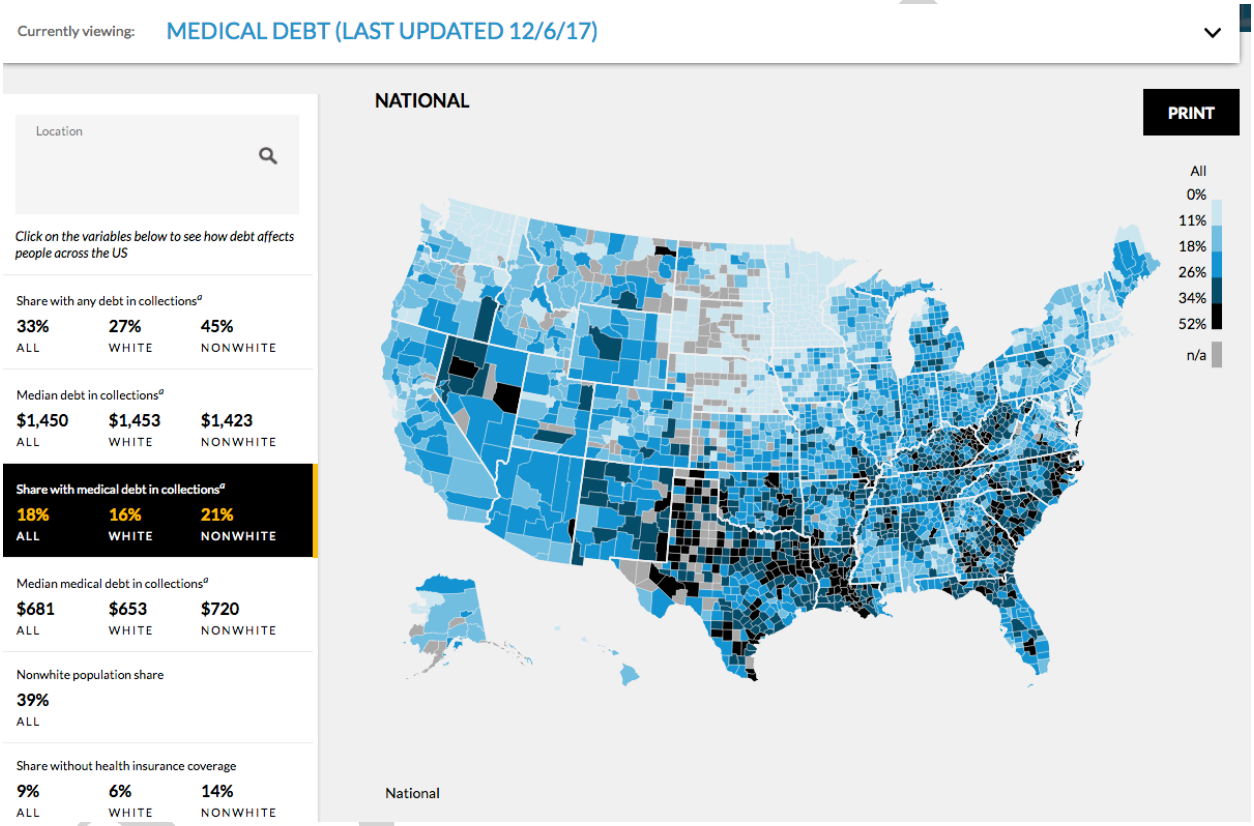
-What is the definition of financial toxicity (or affordability) as it relates to patients?
-How is it measured?
-What are the major drivers?
-What are the potential solutions (both those within and outside the direct influence of health care)?
-What stakeholders have the greatest opportunity and interest in addressing the issue?

III. Background:

Health care in the United States is an example of a market failure. This particularly applies to inpatient care and medication. We see a steady stream of egregious behavior from pharmaceuticals, health systems, ambulances and air ambulances. None of this came about by accident. It is based on specific policy or lack of policy that has provided the opportunity to exploit patients. The cost of health care, both from an individual and societal perspective, is untenable. In the United States, some estimates suggest that approximately 20% of an individual's paycheck is spent on health insurance, over 60% of bankruptcies are due to medical expenses, and 18% of our GDP is spent on health care. While there is increasing agreement to address this issue from the public, policymakers, and some within the health care industry, identifying and implementing the most effective mechanisms to do so and the pace of improvements have been woefully inadequate. From the per capita cost component of the Triple Aim to the explicit goal of lowering costs as part of our strategic priority around impact,

probably the single most studied topic within the IHI research team has been health care cost. We have had at least 25 waves (90 day research cycles) that have focused on this topic.[1]
We have looked at it from many angles, but not from the consumer's point of view.

Perhaps a single measure of toxicity of health care cost is the number of people who are currently in collectors for health care bills. The following map[2] indicates the profound aspect of this problem.



IV. Description of Work to Date:
The main focus of this work to-date has been to understand the problems that consumers face in health care cost. Better understanding those problems, we identified a set of solutions. We then

[1] Waves 1, 4, 6, 8,9,10 (2), 13,14(2), 15, 16, 17, 19,23 (2), 24, 25, 29, 33,42(2), 44, 46, 47

[2] https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_collect

discussed which problems make the most sense for IHI to work on in the next wave of activity. We also began exploring potential measures for this work.

V. Results of the 90-Day Scan:

"Consumers live lives of quiet desperation because of health care cost" unknown author.
Health care cost toxicity from a consumer perspective is our focus. We have 25 R and D cycles that looked at cost from a meta level. There was no specific focus from the consumer point of view. We know that cost is high. The consumer feels insurance cost through lost wages that go to benefits, through higher direct premiums that they pay and through out of pocket issues. We are looking for situations that tend to make the cost high.

Billing issues for consumers
1. We have inaccurate bills: bills for too much or too little, sent to the wrong address, sent to collectors when already paid, multiple bills for the same service, etc. One consumer had a bill sent to the wrong address that became overdue. By the time the providers figured out the right address, the bill was overdue and sent to collectors. This ended up impacting credit score.
2. Uncoordinated bills: For anything significant, a patient gets multiple different bills that are received over a long period of time.
3. Lack of adequate outreach to help consumers with bills and payments
4. Surprise bills from out of network in which the provider attempts to bill the consumer for any amount that their insurance doesn't cover.
    a. Emergencies in which patients are taken out of network for everything: ED, hospital, physician
    b. Emergencies in which the hospital is in network and some or all of the doctors are out of network
    c. Emergency out of network transportation, either ambulance or air ambulance

Lack of transparency on pricing for health systems and providers

Drug cost issues
1. Large Pharmaceutical cost related with mainline meds, for example insulin
2. Large Pharmaceutical cost related with biologics like Humira
3. Smaller companies that have just been exploitative like Epipen
4. Pharmacy benefit manager and rebates
5. Lack of information on cost and quality of medication. How much better is one drug than another? How much more costly is one versus another?
6. Costly drugs, very limited improvement

Provider Issues for consumers

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1. More doctors opting out of a network since 2000
2. Hospitals opting out of medical networks. Some hospitals have enough market power to not join a network. This can give them higher pricing power
3. Hospital price inflation https://www.commonwealthfund.org/publications/journal-article/2019/feb/hospital-care-prices-rose-faster-cost-physician-services

Insurance issues for consumers

1. Narrow Networks of providers created by insurance products leading to increased possibility for surprise billings
2. High Deductible insurance products that leave the patient with greater responsibility
3. Playing word games with the insurance company. Sometimes the patient is told to request something in a certain way to get it paid for by insurance. If a women experiences hair loss from chemo, for instance, a wig is seldom covered, but if written as a request for a "hair prosthesis" or "cranial prosthesis," it might well be covered. Game playing and lots of women do not know this, so inequitable, cost of workarounds
4.There can be several categories of 'deductibles'. A consumer has a deductible for tests that is separate from the general deductible.
5. Increasing out of pocket responsibility for all insurance products, even ones that are not high deductible
6. The need for preapproval requires effort from providers and potentially impacts patients' care.

Patient issues

1. Overutilization of unnecessary healthcare
2. Specific diseases like cancer tend to be costly. This may not be a patient specific issue but it is definitely a cost issue

State level modifiers

1. There are different policies within the states that protect against balance billing for some insurance types
2. There are also different policies within the states that protect consumers on credit issues. In Minnesota only 3% of consumers are in collectors versus 26% for Texas.

All of the above problems are leading to toxic financial issues for consumers with significant life impact such as: high debt load, debt collection and impact on credit rating, health care access issues related to cost and debt and finally medical bankruptcy that can lead to situational poverty. In addition to these major issues, there are time issues related to dealing with the complex billing practices.

In Table 1 we segment the various insurance types to see which problems impact them.

DRAFT

Impact by Insurance Type	Innacurate Biling	Uncordinated Billing	Out of Network Surprise Billing	Price Transperency	Drug Cost
Medicare	+	+	0	0	+
Medicaid	0	0	?	0	0
M A	+	+	+	+	+
HMO self insured	0	0	+	0	+
PPO self insured	+	+	+	+	+
HMO not self insured	0	0	+	0	+
PPO not self insured	+	+	+	+	+

"0= not much impact"
"+=this type of insurance is impacted by this"

From this table we see that there are variable impacts of the problems we described on the different insurance types.

The following text outlines a series of ideas and thoughts that could be explored to help consumers in the next wave of IHI research.

1. Improve the billing process including coordinated, timely and accurate bills from all billers.

2. Policy changes at the federal level around surprise billing. Because of Employee Retirement Income Security Act of 1974 (ERISA), self-insured businesses fall out of state jurisdiction and therefore legislation would be most effective if it occurs at the federal level. Someone could facilitate consumer organizations to work together to lobby congress for change. You can also work at the state level on surprise billings, but there is still the ERISA problem that the states can't change. Lastly, health systems themselves can work to decrease surprise billing by being sure that they have their physician partners join the same insurance networks. Memorialcare in California, for example, had success in getting doctors to be part of their insurance networks. Patients should be informed by health systems when care is out of network. Patients have a right to know about the costs of their treatments and options.

3. Work for greater transparency. IHI's Leadership Alliance did some work in this area. You could look at health systems that are leading good work in this area. Consider tools that help provide some consumer cost guidance. Here are a few examples.

https://www.youcanplanforthis.org
https://www.healthcostinstitute.org
https://www.guroo.com/

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https://www.healthcarebluebook.com/ui/consumerfront
CMS launched a new mobile application that Medicare beneficiaries can use to look up whether their health plans cover certain medical devices or services. CMS said the app is part of the agency's eMedicare Inititative that features "a cohesive, multi-year strategy of consumer data integration and web product development to modernize Medicare.gov and improve access to personal health care data." (Source: MobiHealthNews, 1/28)
Medical Debt policy issues from National Patient Advocate Foundation NPAF - Promotes price transparency so that providers and patients can clearly know what medical services and products cost, whether they are covered and patients' cost- sharing requirements;
Delineates patient, provider and payer responsibility – so that all parties know how best to access the right treatment protocols and obtain optimal reimbursement.

4. Because of the high cost of drugs, you could do an in-depth evaluation of the history of a drug like insulin. The goal would be to have greater insight on what is driving up its cost.

5. Certain diseases like cancer have major cost for an individual. Similar to a deep drug cost analysis, focusing deeply on a specific health care issues may provide insight into specific financial challenges

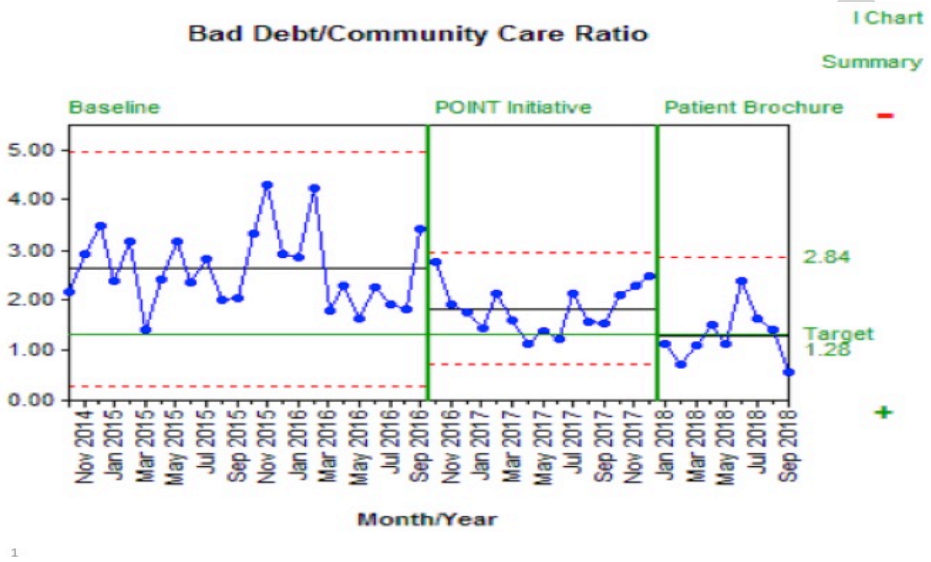
6. "Are there high leverage changes that patients themselves can do?" That wasn't the initial orientation, but definitely worth bringing up as we consider the future direction of this work. Some examples of consumer strategies to decrease cost and out of network billing include finding the nearest prompt care to avoid ED, knowing which ED uses your insurance along with checking ahead of time if the ED doctors are also part of the network. Also, online price comparison tools that consumers can use. See some under number three, transparency. Consider low cost text-based primary services like 98point6. Patients should consider that some services are over utilized.

7. In the problems list, we mentioned insurance workarounds: "Sometimes the patient is told to request something in a certain way to get it paid for by insurance. For women experiencing hair loss from chemo, for instance, a wig is seldom covered but if written as a request for a "hair prosthesis" or "cranial prosthesis," it might well be covered. What can be done to make insurance straightforward for the patient?

8.The creation of a financial risk identification tool that health systems could use to identify patients at risk from health care cost. This would be a predictive model to understand who is going to get in financial trouble from health care cost. There is some overlap with type of tool and just using a screening tool for social determinants of health risk. This work also is relevant in the area of contextual medical errors where a physician prescribes or recommends something that is very difficult for the patient to access because of financial constraints.

DRAFT

9. You could combine some of the ideas above along with others to build a bundle of change ideas to dramatically decrease health care cost toxicity, or to say it in a positive light, make health care more affordable from a consumer perspective. Bellin health system in Green Bay Wisconsin has built a bundle of interventions that decreased the number of patients that they send to collectors, to help hospitals decrease the number of people that they are getting in debt. At the IHI national forum, Bellin presented the following data which measures the ratio of bad debt /community care. What you see is a steady improvement as the team tried out various interventions.



10. Lastly, we need a to create a set of measures for this project. Can we create any real time measures from the patient perspective and the health system perspective? Measurements that we will explore include, but are not limited to: bad debt/community care, % of consumers in collectors for medical care, bankruptcy related to health, amount of health care debt that families have, % of out of pocket cost compared to income, % of out of pocket cost compared to premiums cost . We may also like to do something real time such as understanding the weekly number of GoFundMe's related to health care cost. There are also tools that will be helpful for our work such as the Household Health Spending Calculator: https:// www.healthsystemtracker.org/

VI. Conclusions

1. This wave of research was primarily exploratory in nature to help us better understand the issues that consumers face and the opportunities to work on possible solutions. In the next wave of activity, we would like to build a set of interventions for health systems that they could use to protect consumers from health care cost toxicity, i.e. make health care affordable. We know, based on our early work, that those interventions exist. This work should also have a positive impact on revenue cycle for health systems and bad debt for health systems. The goal would be to invite health systems to test these ideas and share other ideas that they have. The test bed for this work could be leadership alliance if they have the interest or we can seek other sites. We recognize that fundamentally, health care is just too expensive and that those costs must be controlled. We also recognize that all consumers need some level of insurance protection from health care cost and so insurance is needed for everyone. However, until those basic changes come about, we need to do as much as we can now for consumers.

2. Building on some early exploration and consideration, we do plan to produce a solid measurement set in the next wave of activity.

3. We noticed in this wave of activity that there are big fundamental differences going on between states in the US. As mentioned earlier in the paper, Texas has 26% of the adult population in collection for medical debt and Minnesota has only 3%. There have to be fundamental policy differences between those two states to cause that magnitude of difference. If we decide to study policy in the next wave, looking into these differences could be fruitful.

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