VIEWPOINT

Aligning Patient and Physician Incentives

Amol S. Navathe, MD, PhD
Corporal Michael J. Crescenz Veterans Affairs Medical Center, Philadelphia, Pennsylvania; and Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia.

Ezekiel J. Emanuel, MD, PhD
Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia.

Kevin G. Volpp, MD, PhD
Corporal Michael J. Crescenz Veterans Affairs Medical Center, Philadelphia, Pennsylvania; and Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia.

Supplemental content

Corresponding Author: Amol S. Navathe, MD, PhD, Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, 423 Guardian Dr, 1108 Blockley Hall, Philadelphia, PA 19146 (amol@wharton.upenn.edu).

Since the passage of the Affordable Care Act, there has been an unprecedented pace of testing new payment models to increase health care value. These models have been directed across the continuum of health care professionals and organizations, including physicians, hospitals, and post-acute care facilities. Collectively, these models aim to combine financial incentives for efficient delivery of care, including elimination or substitution of low-value services, while incentivizing improvement on specific quality metrics, such as cancer screening and readmission rate. The use of these detailed payment models is rapidly increasing to cover a greater proportion of health care services.

Simultaneously, consumerism in health care has increased. This has included proliferation of high-deductible health plans (HDHP), urgent and preventive care provided in retail stores, and value-based insurance design (VBID). More than 71 million people are enrolled in HDHPs, and 86% of employers offer plans with either HDHP or VBID components.[1,2] Furthermore, VBID principles have been incorporated across Medicaid and state employee health plan programs as well as in national demonstration projects in Medicare Advantage and TRICARE. Proponents of consumer and insurance-based reforms have recently proposed the idea of "precision" VBID, in which the design of health insurance would be tailored to individual health needs.[3] The central premise of precision VBID is that the benefit design (ie, patient cost sharing) for health care services is adjusted based on an individual's health status and health needs. High-value services are adjusted to reflect little to no cost sharing, whereas low-value services involve higher cost sharing. This concept differs from traditional VBID in that the determination of value is made at the population, rather than the individual, level. There has also been progress in designing incentives to promote healthy behaviors related to prevention and chronic disease management.

Even though VBID aligns incentives for patients and health, it does not consider or include incentives that are focused on physicians that may also be important to high-value care. There are ongoing discrepancies between the incentives facing clinicians and patients, and these differences likely undermine the potential success of new payment models. How can health care organization–focused and physician-focused value-based incentives be better aligned with patient financial incentives to achieve improvements in population health?

Conflicting Incentives for Clinicians and Patients

Physician incentive design and health insurance benefit design have typically focused on different goals. Until recently, physician reimbursement incentivized behaviors that may have increased the quantity of services provided through fee-for-service, often paired with quality incentives to increase evidence-based care. Conversely, patient benefit designs, such as HDHPs, focused on reducing use of services. This different focus is illustrated across the clinical spectrum. For example, evidence-based care, such as cardiac rehabilitation after coronary artery bypass graft surgery (up to $100 copayment per session), physical therapy after hip or knee replacement surgery (up to $75 copayment per visit or 50% coinsurance), or medications after acute myocardial infarction or stroke ($10-$135 copayments per 90 days' supply) are frequently costly to patients (eTable in the Supplement).[4,5] This is in contrast to and would seem to run counter to physician and health care organization incentives based on processes of care, such as β-blocker use after acute myocardial infarction or readmission rate reduction.

Chronic disease scenarios are also illustrative. Primary care physicians frequently receive incentives to improve glycemic control or cholesterol levels and to complete eye and foot examinations for patients with diabetes. This may require physician-prescribed hemoglobin A_{1c} testing multiple times a year, lancets and glucose test strips, a home glucose monitor, and hypoglycemic medications. Patients with diabetes usually must pay for each of these items, frequently encountering large out-of-pocket costs.[6] Another example involves medications to manage congestive heart failure, including diuretics and β-blockers, for which patients have copayments, and physicians and health systems are financially penalized for readmission rates. Patient cost sharing is intended to deter unnecessary use, but in clinical contexts such as these, the predominant concern should be underuse not overuse. Substantial evidence suggests that when faced with cost sharing, patients reduce necessary care in addition to unnecessary care, making it more difficult for physicians to achieve goals and increasing frustration with policies.

Incentives to prevent overuse of low-value care are also generally not aligned across patients and clinicians; both have incentives that dissuade health service use in general but are not clearly tied to value. Many health services are high value in certain situations but not in others (eg, coronary stents in patients with unstable angina vs stable angina). Creating closer alignment by providing incentives (eg, higher reimbursement) to physicians and adjusting cost sharing to patients that link to the value of the service could be more effective in decreasing low-value service use. Furthermore, sharing savings generated by reductions in potentially unnecessary use could be shared with patients.

Merits of Aligned Incentives

A clear means of improving the status quo would be to proactively align the incentives provided to clinicians around quality and the incentives encountered by patients through the design of their health insurance benefits. A recent study aimed at increasing statin use for

treatment of hyperlipidemia indicated that although physician incentives can improve initiation and intensification of therapy and patient incentives can improve treatment adherence, shared incentives for both patients and physicians was the only approach that improved both measures and achieved significant improvements in low-density lipoprotein levels.[7] Patients, physicians, and health systems would benefit from the alignment between incentives for physicians and patients. For patients, changes to plan design would reduce financial barriers to disease management and preventive care.

These changes could include decreasing or eliminating cost sharing for evidence-based medications (eg, antiplatelet therapies, β-blockers, statins, and angiotensin-converting enzyme inhibitors administered immediately after myocardial infarction), necessary laboratory or screening tests (eg, hemoglobin A_{1c} levels for patients with diabetes or urinalysis for patients with chronic kidney disease), and high-value preventive care, building on the no-cost coverage of preventive services required by the Affordable Care Act. These changes could be paired with financial and nonfinancial incentive programs that have been shown to increase health behaviors, such as smoking cessation, weight loss, and exercise. To avoid increasing health care costs and health plan premiums, cost sharing on low-value services could be increased to deter use of services such as elective cesarean deliveries and knee arthroscopy for patients with osteoarthritis.

For physicians, creating alignment between quality metrics and patient behaviors would likely be a welcome change that may lead to better patient health and higher incentive compensation. In response to physicians' concerns that they cannot control whether patients follow through on recommendations, reducing barriers to evidence-based care and promoting the same goals for physicians and patients may increase the likelihood that patients adhere to physician recommendations, as was observed in a study with shared patient and physician incentives.[7]

Health plans stand to gain as well. Adherence to treatment plans and avoidance of low-value care could potentially generate substantial savings. Furthermore, strategic use of patient incentive programs could increase patient engagement and activation. Creating a patient-physician dyad with explicitly shared incentives could lead to practice innovations and care redesign that is met with enthusiasm and a new sense of possibilities from patients and physicians alike.

Prioritizing Incentive Alignment

Evidence from consumer responses to cost sharing and incentive programs as well as from the structure of common physician pay-for-performance programs can help prioritize efforts. Given the burden of chronic disease and the health consequences and costs of complications, incentive alignment should initially focus on areas with commonly used metrics, such as Healthcare Effectiveness Data and Information Set measures, to complement other frequent care episodes, such as prenatal, delivery, and postnatal care. This focus will prioritize reducing costs for common chronic disease medications and tests that are frequently used in meeting quality metrics as well as high-value preventive services.

There are limitations to incentive alignment. For example, Medicare's oncology care model includes quality metrics for physician practices oriented to avoiding emergency department visits, hospital stays, and intensive care unit use within 30 days of the end of life. Although advanced care planning and palliative care may be patient-centered, large monetary incentives around these metrics may be viewed by some as ethically problematic. Further areas of complication include incentives to limit care that may exist in global budget models, such as accountable care organizations, or episodic models, such as bundled payments.

Conclusions

As payers pursue mechanisms to increase the value of health care, including alternative payment models, there is a lack of alignment between consumer benefit design and physician quality bonuses. Seemingly simple changes to insurance design, incorporating elements of VBID, and creating symmetric incentives for patients and physicians could generate synergies that help patients, physicians, and health insurers achieve greater improvements in population health.

ARTICLE INFORMATION

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