



Promoting Consumerism Through Responsible Health Care Benefit Design

National Business Coalition on Health
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About the National Business Coalition on Health

The National Business Coalition on Health (NBCH) is a national, non-profit, membership organization of more than 70 employer-based health care coalitions, representing over 10,000 employers across the United States. NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. In developing, identifying, and disseminating best practices in value-based purchasing strategies, NBCH seeks to accelerate the nation's progress towards safe, efficient, high quality health care. For more information, call 202-775-9300 or visit www.nbch.org.

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Introduction

Corporate America, faced with intense competition in an increasingly global marketplace, often forgets that it has a critical role to play in influencing both health and health care. Employers need to be reminded that their success (or failure) in promoting better health and higher quality health care has a direct bearing on bottom line profitability and, in the context of non-profit and public employers, the ability to fulfill their organizational missions. While not immediately connected in the minds of most employers, the link between an employer's viability as a commercial or non-profit enterprise and good health and health care is incontrovertible. First, for most employers, the health and productivity of their workforce is a key competitive asset and market differentiator. Second, corporate America provides health insurance for approximately 160 million people, and thus it is imperative that the rapidly rising costs of health benefits be efficiently managed while still yielding important health status and productivity gains for workers. Viewed from this lens, there is no escaping the fact that employers have a vested interest in improving employee health and the health care that employees and their dependents receive.

Employers are deploying many strategies to achieve the twin goals of improved health and health care. NBCH member business and health coalitions are working with a national network of 10,000 employers to test and implement successful strategies. Enlightened employers are instituting worksite health and productivity programs to keep employees well and value-based purchasing programs that demand high quality and continuously improving health care for employees and dependents.

One strategic current that runs through all health- and productivity-enhancing programs, including value-based purchasing, is consumer activation, often called "consumerism." Simply stated, the goal of consumerism is to help employees make better choices regarding decisions fundamental to their own health status, including choosing a healthy lifestyle, accessing cost-effective preventive services, selecting evidence-based medical and pharmaceutical interventions, managing one's own conditions, complying with treatment regimens, and selecting high-performing health plans, hospitals and physicians.

At NBCH we believe that a critical component of any employer's consumerism strategy is health insurance benefit design, which is the theme and focus of this white paper. An employee's health benefit is their entry ticket to the health care delivery system, and it influences, in ways we are only now beginning to understand, how an individual selects and uses health care services and navigates the health care system. As such, the design of health benefits is an important determinant of consumer behavior. For example, as many economists have pointed out, the very presence of third-party payment insulates individuals from the cost consequences of their demand for services (this problem is known as "moral hazard"), leading to the provision of excessive and unnecessary services. While some economists have called moral hazard a major flaw in the health care system, it is important to remember that the presence of health benefits allows consumers to access needed services, which has a positive impact on health care status. The balance between these two extremes lies at the heart of the challenge: how do employers and their health plan partners build a benefit architecture with responsible individual cost-sharing features and attendant information and counseling support that steers individuals towards needed, cost-effective services and providers, while at the same time discouraging demand for unnecessary, marginal services and the selection of poor-performing providers? Or, more


simply stated, how can health benefit design increase the probability that individual consumers receive evidence-based care leading to improved health outcomes?

The answer is a concept and strategy NBCH calls value-based benefit design or VBBD. So how do we get there? NBCH believes that a good starting point should be a set of principles for responsible health benefit design that can serve as a guidepost for employer decisions moving forward. We are hoping that the 10 health benefit design “principles” laid out in this white paper can help fulfill this function. NBCH recognizes and encourages the current proliferation of different benefit design models as employers search impatiently for solutions during a time of rising costs. Our hope, nevertheless, is that public and private employers will take the time to apply a set of core principles to the benefit design models being considered before rushing to judgment.

NBCH also recognizes that benefit design should be influenced by many factors, including an employer’s financial resources and the demographics, health profile, and health care utilization patterns of the employed population and their dependents. High-deductible, catastrophic plans, to give just one example, can be a reasonable response for employers with limited resources; certainly such plans are better than offering no insurance at all. At the same time, we should guard against employer decisions that are motivated simply by a short-term interest in shifting costs to employees, or by the presumption, which is yet to be proven, that employees with greater financial “skin in the game” will make better decisions. Employers need to realize that creating economic barriers to front-end preventive and chronic care maintenance services may very well lead to higher employer costs and worse health outcomes for their workforce over the long term. During this time of experimentation, upfront investments in objective evaluations of these benefit models will be needed to measure the impact on worker health status and total costs over time.

These are difficult and challenging times for the employer community. But the opportunities for improving workforce health and productivity and the quality of America’s health care system have never been greater. NBCH is convinced that consumerism and responsible health care benefit design will be essential ingredients to the creative solutions that can and must be found. We hope that this white paper and the following principles will play a small part in clearing a path forward to value-based benefit design.

Sincerely,



Andrew Webber
President & CEO
National Business Coalition on Health

10 NBCH Principles for Responsible Health Care Benefit Design

NBCH believes that employers should consider adopting 10 basic principles related to their health benefit design. The primary goal of these principles is to provide “tried-and-true” recommendations for responsible, thoughtful, and thorough approaches to health care benefit design, regardless of whether the employer is working with a health plan, consultant, or independently. These principles encompass the entire benefit development process, from the initial “cost-benefit” analysis, including the company’s health care profile, to benefit design architecture, to change management and communication techniques, to strategies to evaluate the impact of benefit changes. Consumers need to be engaged, empowered, and activated to make informed health care decisions regarding choice of providers and treatments. Employers and business coalitions alike continue to play a vital role in bringing the right resources directly to consumers so that they are able to make the best choices for themselves. Each of the 10 NBCH Principles for Responsible Health Care Benefit Design are laid out below, along with guidance and/or considerations related to implementing them.

1) Understand the company philosophy, employee culture, overall business strategy and goals, as well as the health risk and disease burden profile of employees and their dependents (e.g., demographics, disease prevalence, lifestyle factors, geography) to determine the appropriate direction of a new benefit design.

It is critical to think long-term, focusing on the impact of health benefit and design changes on total long-term health care costs and health status. Consider the following when implementing this principle:

- ◆ The short- and long-range implications on corporate profits, direct medical costs, productivity, health

The 10 NBCH Principles in Brief

1. Understand the company philosophy, employee culture, overall business strategy and goals, as well as the health risk and disease burden profile of employees and their dependents to determine the appropriate direction of a new benefit design.
2. Consider the company budget for annual health care spending. Provide, when possible, an actuarially equivalent benefit to the historical or traditional benefits offered to employees.
3. Consider using benefit copayment differentials, tiered benefits, and other benefit plan incentives to encourage the use of evidence-based preventive, medical, and pharmaceutical services, to encourage employee use of higher value treatments, and to discourage use of marginal services.
4. Consider tiering providers by performance and use copayment differentials to encourage employees to choose the better-performing providers.
5. Consider an approach to reward providers differentially based on their performance.
6. Promote health care quality data transparency within your company and local community, independently or through contracted health plans.
7. Promote health care price transparency within your company and local community, independently or through contracted health plans.
8. Build employee capacity to understand health care information and use that information to change their behavior and influence provider behavior.
9. Develop an effective change management strategy that focuses on helping employees to understand and accept benefit choices and changes.
10. Evaluate consistently the impact of benefit design changes in health status, workforce health and productivity, and total costs to employers and employees.

outcomes, prevention and treatment compliance, and employee retention

- ◆ Whether the company wants to provide more choice and oversight to employees, or if it wants to make care decisions on employees' behalf
- ◆ The health status of the employee and dependent population (including age, education, lifestyle factors, marital status, current health care costs, health status, and disease burden), which should form the basis of the design of any benefit and health promotion package

2) Consider the company budget for annual health care spending. Provide, when possible, an actuarially equivalent benefit to the historical or traditional benefits offered to employees, as the development of a more consumer-focused design package should not be perceived as a way to shift costs to consumers.

Key considerations in implementing this principle include the following:

- ◆ Can the employer afford the time and resources to make a benefit change? In order to develop a customized benefit plan with a carrier, a company typically needs to be big enough to self-insure (generally 1,000 employees, but perhaps as low as 500). Smaller employers will need to rely on other employers' claims experience to get a perspective on the quality of providers within the network.
- ◆ Maintaining a similar benefit will preserve all-important trust between employer and employees, which is critical to a company's success. Maintaining benefit levels creates a perception that change is taking place for the right reasons—i.e., to provide new, more, or perhaps better coverage options, not to simply shift costs

Tips on How to Create a Health Care Profile of Your Population

- ◆ Study cost data relative to each disease and injury burden affecting your organization.¹ Try to obtain the following information relative to your organization: specific inpatient and outpatient claims data, workers' compensation claims, and short and long-term disability claims provided by the organization's insurance provider.
- ◆ Review absences to determine their causes, length, and whether or not they were elective (this is usually provided by the payroll department).
- ◆ Monitor presenteeism (i.e., diminished productivity while on the job), which can be assessed through a survey to find out how employees felt while on the job. Allergies are often a major culprit of presenteeism.
- ◆ Consider the total employee population, as demographics and geography have an impact on productivity and health care outcomes. For example, are employees predominantly young or old, single or married? In what area of the country do they live? These factors and others should be part of an assessment tool that allows for predictive modeling of the impact of benefit design on health care status, costs, and how care is provided. Design a program that not only helps the high-risk, high-cost employees to determine their health care needs and to self-manage their conditions, but that also allows focuses on allowing healthy employees to stay healthy.

and administrative responsibilities to employees. This approach should more quickly result in desired behavior changes (i.e., adopting healthy lifestyle changes, enrolling in disease management programs, engaging in self-management of chronic conditions), which is where the proven cost savings ultimately are realized (not through cost-shifting, which has yet to be proven to save money).

3) Consider using benefit copayment differentials, tiered benefits, and other benefit plan incentives to encourage the use of evidence-based preventive, medical, and pharmaceutical services, to encourage employee use of higher value treatments, and to discourage use of marginal services.

Key action steps when implementing this benefit include the following:

- ◆ Identify beneficiaries who would benefit from health care education and decision-support, such as a health risk assessment, personal health record, and disease or care management programs.
- ◆ Consider providing appropriate clinical support programs for the beneficiary population. Current options that plans make available to employers—some at an additional cost—include the following: online enrollment in disease management programs, low-cost or free preventive services, links to health coaching/nursing advice services, evidence-based information about care guidelines and diagnosis/treatment options, information about community resources, e-mail based inquiry support, and online discussion groups.
- ◆ Recognize when benefit design may be creating obstacles to appropriate care related to culture/ethnicity, age, income, education, language, chronic disease, and/or differences in levels of individual expenditures for care.
- ◆ Continuously monitor benefit and/or formulary design for efficacy, compliance, value, and efficiency, with a focus on the impact of cost-sharing requirements on low-income employees.

4) Consider tiering providers by performance and use copayment differentials to encourage employees to choose the better-performing providers.

Key action steps in implementing this principle include the following:

- ◆ At a minimum, provide robust information on provider performance, including but not limited to information on mortality, complication, readmission, and infection rates, along with data on costs.

Internet-Based Resources on Provider Performance

Leapfrog Group Hospital Quality Ratings
(www.leapfroggroup.org)

Center for Medicare and Medicaid Services (CMS) Hospital Compare
(www.hospitalcompare.hhs.gov)

CMS Physician Voluntary Reporting Program
(<http://www.cms.hhs.gov/pvrp/>)

National Committee for Quality Assurance (NCQA) Health Plan Report Card (<http://hprc.ncqa.org/legal.asp>)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Hospital Accreditation Check (www.qualitycheck.org)

Consumer-Purchaser Disclosure Project
(<http://healthcaredisclosure.org/resources/>)

- ◆ When possible, encourage consumers (through education and/or benefit design incentives) to select high-performing doctors, hospitals, and other providers.
- ◆ Require contracted plans to make available data on the quality of health plans, hospitals, and, if possible, individual physicians or group practices. Lead employees to this data.
- ◆ Educate providers—or encourage contracted plans to educate them—about quality measures, reporting, and performance outcomes. Providers need to understand the quality improvement process and goals.

5) Consider an approach to reward providers differentially based on their performance.

Currently employers are limited in terms of their ability to provide incentives to high-performing providers (i.e., pay-for-performance). Typically payment incentives and rewards are contractual issues between plans and providers, and thus generally outside the domain of employer benefit design architecture. However, there are steps that employers can take to reward provider performance by working with a health plan's network management department to incorporate rewards for high-quality performance into the health plan reimbursement schedules for physicians/providers. Key action steps in implementing this principle include the following:

- ◆ Build provider performance expectations into plan contracts and benefit design. This includes locally developed measures which meet the needs of the employer and/or community as well as the adoption and public reporting of measures endorsed by the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
- ◆ Encourage contracted health plans to reward, through direct financial incentives and/or increased patient volume (e.g., consumer incentives to choose the best performers), high-performing providers who participate in national initiatives to measure the quality and effectiveness of the care they provide.

6) Promote health care quality data transparency within your company and local community, independently or through contracted health plans.

Employees must have the right resources to understand differences in the quality and value of treatments. Key action steps in implementing this principle include the following:

- ◆ Support and promote standardization of national and local quality, efficiency, and patient experience health care measures for comparing outcomes at all levels of the health care system, including but not limited to health plans, hospitals, medical groups, and individual physicians.
- ◆ Collaborate with federal purchasers (e.g., Medicare, Federal Employee Health Benefit Plan) by requiring contracted health plans to share administrative data that can be aggregated with publicly available data to produce robust provider-level quality reports.
- ◆ Require contracted health plans to demonstrate their use of standardized performance measures.

- ◆ Support national, state, and local anonymous and voluntary medical error reporting and disclosure programs.
- ◆ Develop contracts that promote the development of health benefit tools for consumers that provide information on quality, cost, and value. Health plans, carriers, and consultants can and should assist employers with the development and evaluation of health education tools and other support for beneficiaries. Patients need to understand their health care benefits (and ensure that their providers understand them as well) and how the health care system works before they can understand the intricacies of health care quality, cost, and value.
- ◆ Evaluate the accuracy of health care information and data that are being used for general consumer education and in incentive programs for consumers and/or providers. Ensure that commercially available quality measurement tools use nationally-recognized, proven measures and methodologies that comply with current scientific standards.^{2 3}

7) Promote health care price transparency within your company and local community, independently or through contracted health plans. Employees must have valid information that provides a fair reflection of the total cost of care for common treatments and procedures, including the employee's share of the cost.

Key action steps in implementing this principle include the following:

- ◆ Require plans to provide the cost of services for identified priority areas and conditions, including full charges or rack rate, discounted rate to providers in- and out-of-network, and cost to employees. This data should also provide a price benchmark for the uninsured or for people obtaining out-of-network care.

Improving Access to Employee Decision-Making Tools

Consider the following ways to work with health plans and providers to improve access to employee decision-making tools:

- ◆ Require a web-based, searchable practitioner directory that includes the following information on each provider: participation in specific networks and plan product options, disciplinary actions and malpractice history with verification and explanations to maximize effectiveness, publicly available evidence-based quality measures, mortality rates if applicable, and patient experience survey data.
- ◆ Require all plan-provided information to be sourced, updated at least annually, and verified.
- ◆ Request practitioner-specific performance information (e.g., HEDIS, CAHPS). While often difficult to obtain, this information should be a priority. If only medical group data are available, make sure that at least two practice sites are available for comparison purposes.
- ◆ Require hospital-specific performance results, such as performance on The Leapfrog Group's practice standards, H-CAHPS survey or other standardized patient experience results, NQF measures, AHRQ indicators, cost profiles, and/or complication or readmission rates.
- ◆ Require personalized prescription information, preferably web-based, such as a personalized member formulary that is searchable by brand name or generic equivalent. This tool should include information on a drug's primary use and its benefits and risks, alternative drugs, drug comparisons, cost management mechanisms (such as off-patent and over-the-counter options), a drug savings calculator for generic versus brand choices, and pill splitting options.⁴

- ◆ Provide on-line or a telephone-based tracking system for medical claims, including total charges, line item for each charge, amount paid by plan, amount paid by plan for each line item, and member liability.
- ◆ Provide a web- and/or telephone-based system to track an individual's progress toward reaching his or her deductibles, out-of-pocket maximums, and coverage limits.
- ◆ Provide web-based tools showing average cost per service, fee schedules, and clinical performance indicators for both physicians and hospitals.
- ◆ Support and promote adoption of national standards for health information technology infrastructure. Work with federal, state, and local efforts to develop a single health information exchange infrastructure that will eventually house all health records electronically.^{5 6}

A Call for Better Information for Consumers

Richard Wagoner, Chairman and CEO of the General Motors Corporation, in testimony before the U.S. Senate Special Committee on Aging on July 13, 2006, noted that employees and retirees need better information on effective treatments, better tools to identify effective and efficient health care providers (which will create greater provider accountability), and more effective community and employment-based education and outreach to prevent disease and better manage chronic illness.

8) Build employee capacity to understand health care information and use that information to change their behavior and influence provider behavior.

Key action steps in implementing this principle include the following:

- ◆ Focus on personal employee accountability for health and lifestyle choices. Help shift the attitude that health benefits are an entitlement by helping employees to understand that health care requires personal accountability if it is to be used properly and effectively.
- ◆ In order to reach all employees in a format that they want, provide a variety of multimedia communications and messages, including use of print/newsletter, personalized messaging, 24-hour phone line, company intranet, and Internet. Train employees on how to access information through these different communication vehicles.
- ◆ Ensure consumers understand how to successfully navigate through the health care system. Make sure all health benefit-related resources are written in a clear and easy-to-understand manner.
- ◆ Request that contracted plans and vendors verify that they are using and presenting valid, accurate material by regularly and consistently checking the evidence base for the information presented and its usability and applicability to beneficiaries. Protocols should be in place for timely responses to member inquiries.

Tips for Communicating Health Care Information

Employees and dependents must be “health care literate”—that is, they need to understand the information made available to them. Improvements in health care literacy can lead to increased employee satisfaction with health benefits and better communication with health care providers, which in turn leads to safer, higher-quality care. However, according to a 2004 report⁷ from the Institute of Medicine, over half of all American adults—or approximately 90 million people—have difficulty understanding and using health information. This problem exists even in those who are highly educated, and among those who speak and read English well. Performance report cards, for example, are often quite complex and difficult for consumers to understand and use.

To help improve health care literacy, employers should consider developing information that is tailored specifically to their employee population, and then create financial and non-financial incentives for beneficiaries to use that information. Coalitions and employers can also use social marketing techniques in an effort to change the “entitlement” mindset and to examine and change risky behaviors and habits. Marketing and public relations consultants can often help with these tasks. In addition, a great deal of research has been conducted on how to present information to consumers. Employers should make use of this research. For more information, employers and coalition members should make use of the following resources on how to communicate information on health care effectively to consumers:

- ◆ NBCH’s Health Plan Evaluation Toolkit-eValue8 (www.evaluate8.org)
- ◆ Remaking American Medicine (www.RAMCampaign.org)
- ◆ Institute of Medicine, Roundtable on Health Literacy & “Health Literacy: A Prescription to End Confusion” (www.iom.edu)
- ◆ The Center for Information Therapy (www.informationtherapy.org)
- ◆ Agency for Healthcare Research and Quality, Talking Quality (www.talkingquality.gov)
- ◆ Health Literacy Institute (www.healthliteracyinstitute.net)
- ◆ National Institutes of Health (<http://www.nih.gov/icd/od/ocpl/resources/improvinghealthliteracy.htm>)
- ◆ Partnership for Clear Health Communication (<http://www.askme3.org/PFCHC/>)

9) Develop an effective change management strategy that focuses on helping employees to understand and accept benefit choices and changes.

Suggestions to help ease the transition include the following:

- ◆ Educate employees about health care costs and their impact on wages and the company’s bottom line. For example, provide information on the cost of employee health care benefits compared to other benefits and operational expenses (including payroll costs) and on short- and long-term trends in overall and per-beneficiary health care costs, particularly with respect to the employer and employee share of the premium.

- ♦ Educate employees about the important role of health care consumerism in maintaining the employer's ability to provide good benefits at a price that is affordable for both employees and employers.
- ♦ Provide sufficient lead time, tools, and support to help employees make the transition.
- ♦ Recognize that offering a rich, traditional benefit plan to employees at the same cost as a consumer-centric plan is likely to yield minimal enrollment in the latter.

10) Evaluate consistently the impact of benefit design changes in health status, workforce health and productivity, and total costs to employers and employees.

There is a wealth of information at a company's disposal to objectively evaluate the impact of health care benefit design, including the following:

- ♦ Health plan inpatient and outpatient claims data
- ♦ Health risk assessments (HRAs) and clinical screening
- ♦ Workers' compensation claims
- ♦ Short-term and long-term disability claims
- ♦ Data on absenteeism, including cause and length of time
- ♦ Data on presenteeism (While these data often are not available, some employers track presenteeism through employee surveys.)

Appendix

Consumer-Directed and Value-Based Benefit Design Models

The consumer-directed health benefit model and the value-based benefit design model represent divergent health care consumerism approaches. The latter approach relies on active management of the health of employees by both employer and employee, while the former approach puts the management of health squarely in the hands of the employee, with little intervention by the employer. But both models rely on the use of more and better information to engage employees in decisions about their own health care, which is the “heart” of consumerism. This appendix lays out the advantages and caveats of each model, and provides a list of resources that can assist employers and coalitions that are interested in learning more.

Consumer-Directed Health Benefit Design Model

This paper uses the term consumer-directed health benefit model to describe a health benefit design that relies on financial incentives to influence or directly change consumer and provider behaviors through increased patient cost-sharing. Many other terms have been used to describe this type of model as well, including cost-based health benefit model, consumer-driven health care, and consumer-centric health care.

History and Philosophy

“Consumer-driven health care” or CDHC refers to any of a variety of initiatives that are designed to get consumers to be more responsible for their own health care decisions. The popularity of CDHC has been driven by escalating health care costs, combined with the desire to empower consumers to be more knowledgeable about, and therefore more involved in, issues and decisions that relate to the quality, outcomes, and costs of their own health care. The hope is that knowledgeable, empowered consumers will choose benefits packages and plans that best suit their health care needs and financial situation. Sometimes called consumer-directed, consumer-driven, or consumer-centric health plans, this category of health insurance benefit design remains an ongoing, evolving process.⁸

The operational concept is broadly the same for all aspects of the CDHC model in that employers and/or consumers make deposits into a designated account that is then used to purchase incremental health care services. Qualified personal health accounts must be accompanied by a high-deductible health plan (HDHP). If consumers spend all the funds in the personal health account within a plan year, then the consumer has to compensate for the gap between the annual personal account contribution and the deductible. To promote conservation of spending account contributions, health savings accounts (HSAs) allow funds to be accumulated from one year to the next. The original personal health accounts, flexible spending accounts (FSAs), did not allow consumers to roll over unused funds from year to year. Health Reimbursement Accounts (HRAs), which are still being utilized but typically do not allow fund rollover, require unused funds to revert to employers when an employee resigns or retires. For that reason, they continue to be more popular with some employers, especially as an employee retention tool.

HSAs were created as part of the Medicare Modernization Act that was signed into law in December 2003 and first became available to consumers and employers in January 2004.

These consumer-friendly accounts have become the most popular type of personal spending account. Individuals and employers can contribute funds to HSAs for future medical expenses. Preventive care services are generally covered by HDHPs and typically do not count against an individual's deductible. Earnings on HSA funds accumulate tax-free, balances can be rolled over year-to-year, and withdrawals made for qualified medical expenses are tax-free. While the accounts are permitted in both the group and individual health insurance markets, one of the primary objectives of HSAs is to help level the playing field between individual and group coverage, which previously enjoyed preferential tax treatment.⁹

Regardless of the specific vehicles used, the CDHC model gives greater financial responsibility to the consumer while promoting consumer engagement and investment through personal spending accounts that the consumer oversees. Consumers are free to navigate and make choices in the health care delivery system or network. Advances in information technology, such as the Internet and electronic medical records, have helped promote health care consumerism by giving consumers the information and tools they need to make better decisions. The hope is that a more informed, financially involved consumer will begin to ask more questions, seek more information, and ultimately make better provider selection and treatment decisions based on his or her unique situation.

Proliferation of the Consumer-Directed Health Benefit Model

The consumer-directed health benefit model is rapidly increasing in popularity. In 2005, an estimated 75 percent of insurers offered at least one HSA-compatible HDHP.¹⁰ Most major insurers provide at least one HDHP-compatible spending account option to large employers, small employers, and individuals. According to a Kaiser Family Foundation survey, roughly 20% of employers offered such plans to workers in 2005, up from 5% in 2003. By the end of 2005, an estimated 5,000,000 consumers were enrolled in HSAs. HSAs are most popular in the non-group market; large groups (5,000 or more employees) account for only about 3 percent of total HSA enrollment.¹¹ Employers typically offer these products as a choice alongside more traditional options, as few employers have completely replaced their traditional offerings with CDHPs. The federal government now provides an HSA option, through Aetna, in 32 states and in Washington, DC. Thirty-three percent of small group HSA policies were sold to businesses that previously did not offer insurance, which suggests that HSAs have the potential to expand coverage to small business employees.¹²

For More Information on HSAs, FSAs, and HRAs

The American Benefits Council, a preeminent advocate of employer-sponsored benefit programs located in Washington, DC, maintains a substantial set of resources related to legislative and regulatory issues surrounding HSAs, FSAs, and HRAs. For more details, visit <http://www.americanbenefitscouncil.com/issues/health/consumer.cfm>.

Potential Advantages, Disadvantages of Consumer-Directed Health Benefits

Proponents of the consumer-directed health benefits model point to a number of potential advantages to these plans, as outlined below¹³:

- ◆ **More cost-conscious consumers:** CDHP enrollees who receive care appear to be more cost-conscious than their peers in more comprehensive health plans. Early evidence shows that people in CDHPs and HDHPs are significantly more likely to say that the terms of their health plan made them consider costs when deciding to see a doctor or fill a prescription. They also are more likely to report that they had checked the price of a service prior to receiving care, and whether the health plan would cover their costs. They are more likely to discuss treatment options and the cost of care with their doctors as well. That said, they are also more likely to go without care.¹⁴
- ◆ **Cost savings:** CDHPs may be less expensive for businesses to offer than standard plans with a lower deductible. While data are limited (due to the newness of this model), there is some evidence that spending accounts combined with HDHPs do reduce consumer spending. Studies comparing costs for CDHP enrollees with costs for PPO enrollees have found lower costs for CDHPs, particularly for prescription drugs.¹⁵ Much more work is needed, however, to determine if CDHPs save money over the long run. If these cost savings pan out, they could ultimately lead to lower premiums for employees and employers.
- ◆ **Less inappropriate care:** Greater consumer cost-sharing may encourage consumers to ask more questions about the appropriateness of care, thus leading to reductions in the provision of unnecessary services.
- ◆ **Tax free savings for employees:** HSA contributions and earnings are tax free as long as the funds are used for qualified medical expenses. (Taxes and penalties must be paid if the funds are used for non-medical expenses.)
- ◆ **Portability:** Employees own the account and can take it with them when they change jobs.
- ◆ **Retiree medical care option:** Investment provisions encourage consumers to save funds and treat them as tax-advantaged retirement accounts that can be used to pay for medical or non-medical expenses after the age of 65.
- ◆ **Reducing the number of uninsured:** The lower costs of CDHPs may encourage employers to offer insurance, as evidenced by the substantial percentage of new HSA policies written for small companies that previously did not offer insurance.
- ◆ **Network flexibility:** CDHPs place fewer restrictions on provider selection than do HMOs, PPOs, and point-of-service offerings.

Despite these potential advantages, many concerns remain about the consumer-directed health benefits model, as outlined below:

- ◆ **Long-term cost containment:** While HDHPs may reduce or contain short-term costs for healthy enrollees, there is concern that they will have little or no impact on the long-term costs of high-cost, chronically ill enrollees who account for the vast majority of all health care expenses. These individuals often quickly meet or

exceed their deductible, thus removing any incentive to control costs. The limited evidence to date related to the long-term impact on health care costs for HDHPs is mixed, and more work is needed in this area. In addition, the ability to realize long-term savings depends upon the widespread availability of standardized, comparative price and quality information, something that is not yet a reality. In addition, technological innovation is an important driver of increases in U.S. health care spending, and CDHPs have little impact on this factor. In fact, technological innovation is one important reason that the U.S. spends much more per person on health care than do other developed countries, and also spends a larger share of its gross domestic product.¹⁶

- ◆ **Curbing necessary care:** Some evidence suggests that individuals with CDHPs and HDHPs are significantly more likely to avoid, skip, or delay health care (including non-compliance with prescription medications) because of costs than are those with more comprehensive health insurance. This problem may be particularly pronounced among those with health problems or incomes under \$50,000.¹⁷
- ◆ **Unbalanced insurance risk pools:** There is concern that high-income, healthy people will be more likely to enroll in CDHPs, leaving traditional plans with sicker enrollees. This, in turn, could lead to higher premiums for those who can least afford it.¹⁸ That said, there is some research suggesting that very sick individuals with high out-of-pocket expenses would benefit significantly from the CDHP model.¹⁹
- ◆ **Potential coverage gap:** The maximum HSA contribution is often less than the deductible, creating the potential for the depletion of the personal account prior to satisfying the deductible.²⁰ In addition, some consumers may choose not to contribute the maximum amount to their HSA each year, which creates the potential for an even larger gap. Some plans, moreover, have increased or eliminated out-of-pocket maximums, thus creating the potential for consumers to be forced to pay even more out of their own resources.
- ◆ **Tedious administrative oversight:** State and federal regulations are limited and sometimes conflicting.
- ◆ **Promotion of unnecessary care:** Ironically, while CDHPs are designed to reduce unnecessary care, it is possible that some enrollees with “use-it-or-lose-it” accounts will spend money on unnecessary care in order to avoid losing funds at year’s end.
- ◆ **Insufficient information:** CDHPs will not work unless consumers have the information they need to make more informed decisions. But few plans today provide the kind of standardized, comparative cost and quality information about providers that people need. Available information gives consumers a rough view of some health care costs, but it lacks the detail, accuracy, and customization necessary for comparison shopping. Most of the tools focus more on general

“There’s a growing body of evidence that demonstrates that cost sharing leads to decreases in essential and non-essential care.”

—Mark Fendrick, Center for Value-Based Benefit Design, December 15, 2005

education than on helping consumers with decision-making.²¹ In addition, many consumers also do not trust the information provided by health plans, and thus may not be willing to use a health plan-provided tool.²²

Value-Based Benefit Design Model

A complementary approach to the traditional consumer-directed health care benefit model, the value-based benefit design model (also known as evidence-based benefit design or value-based steering) creates tiered copayments that offer lower levels of cost-sharing for individuals who select better performing, more efficient providers, and for those who choose evidence-based, cost-effective medical and pharmaceutical interventions, including better preventive screening and disease management. This model is becoming more attractive to employers as it holds the potential to be a long-term solution to cost containment while also improving the health outcomes and productivity of employees.

History and Philosophy

Initial efforts by purchasers and plans to incorporate quality into the provider selection process focused on passive information-sharing with consumers who received data on performance and outcomes. Purchasers and others producing this information assumed that consumers would embrace it and make choices and changes accordingly. However, for a variety of reasons, consumers never really used the information to the degree intended by purchasers. So employers and other purchasers are now pursuing more proactive strategies, such as value-based benefit design. While still a relatively new concept that is being experimented with by employers, there are some established “best-practices” related to applying quality measures and developing appropriate incentives and effective consumer communication.²⁴

Value-based benefit design recognizes that while consumers must share in the financial responsibility for their own care, they could benefit from both information and financial incentives to help them identify and select high-performance providers and evidence-based medical and pharmaceutical interventions. Copayments are used to steer consumers towards the highest performing providers and proven treatments. Like traditional HDHP/cost-sharing models, consumers still have the luxury of choosing providers and treatments, but the out-of-pocket expenses vary based on the selections made. This model also may include pay-for-performance programs providing financial incentives to providers if their patients follow care guidelines.

Tiered pharmacy benefits, which are considered the “low-hanging fruit” of value-based benefit design, were the first to be tiered by insurers and pharmacy benefit managers (PBM) in the 1990s. The level cost sharing in these programs depends on whether the consumer chooses generic drugs, preferred brand-name drugs, or nonpreferred drugs. However, the concept has begun to expand to other areas of health care delivery (e.g.,

Not Providing Good Information

According to an April 2006 study²³ by PricewaterhouseCoopers, only about one-quarter of executives believe they are doing a good job providing employees with health care quality data that is easy to access, understand, and use. Only 24 percent of top executives at 135 large U.S.-based multinational companies thought their information was good. The study also revealed that most companies are not asking employees whether they are satisfied with the information.

“Evidence-based benefit design is the pillar of value-based purchasing.”

— Andy Webber, President and CEO, NBCH

The Four Pillars of Value-Based Purchasing

- ◆ Standardized performance measurement
- ◆ Transparency and public reporting
- ◆ Payment reform
- ◆ Informed consumer choice

hospitals, medical groups). Some experts argue that the best strategy for encouraging the more efficient use of resources lies in varying the benefits depending on the provider, site of service, and type of service selected.²⁵ To date, however, pharmacy benefit tiering remains far more prevalent than hospital and medical group tiering, primarily because objective quality information relative to prescription drugs is more widely available.

Case Studies in Value-Based Benefit Design

What follows are brief case studies of organizations that have successfully implemented value-based benefit design models.

Oregon’s Medicaid Program

Since the mid-1990s, Oregon has been using an evidence-based benefit design in its Medicaid program, which provides coverage to about 15 percent of the state’s population. The process involves an independent, systematic review of the evidence that is used to make coverage recommendations related to prescription drugs.

The state has developed a process to determine the effectiveness of a drug or class of drugs. Once the most effective drugs are determined, the relative cost of these drugs is reviewed, including open proceedings with public testimony and third-party review of evidence.

The state uses the Evidence-based Practice Center (EPC) at Oregon Health Sciences University (OHSU) to review the evidence. By purchasing the most effective drugs at the lowest possible price, the state is promoting the highest possible value. The key to developing an evidence-based drug policy is working with the best available evidence and information, being sure to consider the impact of drugs on an individual’s overall health and well-being (rather than looking more narrowly at drug costs alone).^{26 27}

Pitney Bowes Tiered RX Model

In 2001, Pitney Bowes’ leadership recognized the potential negative impact of increased employee cost-sharing for prescription drugs. The company conducted a predictive modeling analysis and found that 50 percent of its enrolled population had chronic diseases. The analysis also showed that plan costs and illness burden among employees had increased due to a lack of compliance with prescribed pharmaceuticals. In response, Pitney Bowes revised its drug benefit to increase coverage of drugs for certain costly chronic illnesses. This strategy seems to be working; utilization of targeted drugs increased, while overall medical costs fell.²⁸

Hospital Tiering at The Boeing Company

Boeing is giving its employees financial incentives to select Leapfrog Group-compliant hospitals, along with extensive education about the importance of hospital quality. The goal is to improve employee health care outcomes and worksite productivity, as well as ensure that Leapfrog-compliant hospitals are rewarded for their efforts to improve quality through increased market share. Under this program, Boeing employees and dependents

who participate in the company's traditional plan and who choose to go to a "Leapfrog Group-approved" hospital receive coverage for 100 percent of hospital expenses and are not required to pay any out-of-pocket expense beyond the plan deductible. Beneficiaries who select a non-Leapfrog Group-compliant hospital must pay five percent of their hospital bill.²⁹

Potential Advantages and Disadvantages of Value-Based Benefit Design

If value-based benefit design works as theorized, it offers a wide array of potential benefits:

- ◆ Improved health outcomes and long-term cost savings, as consumers choose better-performing providers and make evidence-based treatment decisions
- ◆ Increased consumer engagement
- ◆ Better utilization of health care resources
- ◆ Improved provider performance with respect to quality and costs, as providers fear losing market share if they underperform
- ◆ Better information, as providers have an incentive to make information available

But the jury is still out on whether value-based benefit design works as intended. There are reasons to believe that it might not, as outlined below:

- ◆ **Impact on consumer behavior is not yet known:** Research and evidence is limited on the impact of value-based benefit design. While higher cost sharing should encourage patients to select efficient, high-quality providers (which should pressure other hospitals and physicians to improve quality and control costs), it is not clear what degree of cost-sharing is required to change consumer behavior. Since the majority of health care costs result from a small minority of patients, the net impact of value-based benefit design will depend on how these higher cost patients respond to incentives. Tiered networks could even increase costs if consumers equate high cost with high quality and therefore select nonpreferred, high-cost tiers.
- ◆ **Limited access to needed information:** As noted, quality and efficiency measurement metrics are limited and inconsistent, and public reporting of existing measures is mostly voluntary.
- ◆ **Implementation challenges:** Deciding what services to cover and when to cover them can be difficult.³⁰ In addition, it is important that high-quality providers with higher costs not be wrongly placed in nonpreferred tiers, thus making them unaffordable for the poor. Tiered benefit designs should also be structured so as not to penalize poorer-performing hospitals and medical groups that are actively involved in quality improvement programs, or hospitals that are high cost solely because of their provision of charity care or teaching functions.

Deployment of VBBD

- ◆ Identify best practices.
- ◆ Measure ROI for the employer.
- ◆ Create a generic benefit design model – based on low hanging fruit.
- ◆ Link evidence-based benefit design to health and productivity programs.
- ◆ Create a distribution network of best practices in the coalition/ employer community (NBCH can help with this task).

- ◆ **Potential backlash from providers:** Providers with market power may refuse to accept placement in a nonpreferred tier, thus limiting flexibility in developing tiers.
- ◆ **Ensuring enough high-quality providers:** This model requires a sufficient supply of high-performing, participating providers for consumers to be able to make real choices. In markets lacking provider competition (e.g., rural areas), purchasers may be forced to accept lower quality and/or less efficient providers in their top tiers to ensure continued access to services.

“More purchasers are going to look closely at value-based steerage, but it’s not going to work everywhere.”
—Meredith Rosenthal,
Assistant Professor of
Health Economics,
Harvard School of
Public Policy

Benefit Design Resources

The following tools and resources are available to assist employers and coalitions with the design and implementation of consumer-directed and/or value-based benefits programs.

Consumer-Directed Health Benefit Resources

- ◆ Department of Treasury (<http://www.treas.gov/offices/public-affairs/hsa/faq1.shtml>)
- ◆ The HSA Insider (<http://www.hsainsider.com/>)
- ◆ Health Decisions: For up-to-date information on companies that currently offer HSA-eligible health insurance plans, including a state-by-state locator, please visit www.healthdecisions.org/HSA.
- ◆ National Association of Health Underwriters (<http://www.nahu.org/consumer/HSAGuide.htm>)
- ◆ Association of Health Insurance Advisors (http://www.ahia.net/consumers/guide_hsa.html)
- ◆ National Association of Alternative Benefit Consultants (<http://www.naabc.com/cbcd1.htm>)
- ◆ National Association of Insurance Commissioners (http://www.naic.org/state_contacts/sid_websites.htm)

Value-Based Benefit Design Resources

Agency for Healthcare Research and Quality Evidence-Based Medicine Resources

- ◆ AHRQ-EBM Resources: The National Guideline Clearinghouse (www.guideline.gov)
- ◆ Evidence-Based Practice Centers (www.ahcpr.gov/clinic/epcix.htm)
- ◆ U.S. Preventive Services Task Force (www.ahrq.gov/clinics/uspstfix.htm)

Oregon’s Evidence-Based Reports

Oregon’s Health Resources Commission oversees the development of the state’s evidence-based drug benefit process and produces recommendations/reports to the state Medicaid program. The state uses the material to choose the highest value drug(s) from each class for the state’s Medicaid formulary. Reports and summaries covering approximately 16 drug classes are available at www.OregonRX.org.

NBCH Coalition Member Value-Based Benefit Design Resources

- ◆ “Benefit Strategies to Promote Quality, Value and Access in High Deductible Health Plans, Pacific Business Group on Health, 2005.
- ◆ “Pacific Business Group on Health Member Benefit Strategies: Promoting Quality, Value and Access,” February 2005.
- ◆ “Getting What You Pay For: Early Reports from Value-Based Steerage Pioneers,” A White Paper from The Alliance (Employers Health Care Cooperative), April 2006.

Other Value-Based Benefit Design Resources

- ◆ National Business Coalition on Health eValue8 (www.evalue8.org/eValue8/about/overview.cfm)
- ◆ College for Advanced Management of Health Benefits (<http://www.nbch.org/events/collegenotice.cfm>)
- ◆ The Health Management Research Center, University of Michigan (<http://www.umich.edu/~hmrc/>)
- ◆ Integrated Benefits Institute (www.IBIWEB.org)
- ◆ Institute for Health & Productivity Management (www.ihpm.org)
- ◆ Pitney Bowes Power of 2 Initiative (<http://healthproject.stanford.edu/koop/pitneybowes1/description.html>)
- ◆ Center for Value Based Insurance Design (www.sph.umich.edu/vbidcenter)
- ◆ The Leapfrog Group (www.leapfroggroup.org)

- ◆ Center for the Evaluative Clinical Sciences at Dartmouth (www.dartmouth.edu/~cecs/)
- ◆ Oxford Centre for Evidence Based Medicine (www.cebm.net/)
- ◆ State of Oregon (www.oregon.gov/DAS/OHPPR/ORRX/HRC/about_us.shtml)
- ◆ National Committee on Evidence-Based Benefit Design (www.businessgrouphealth.org/healthcarecosts/evidenced_benefits.cfm)
- ◆ The Asheville Project (www.ncpharmacists.org/displaycommon.cfm?an=1&subarticlenbr=41)
- ◆ Prometheus Payment Reform (www.prometheuspayout.org)
- ◆ Bridges to Excellence (www.bridgestoexcellence.org/bte/)
- ◆ Institute of Medicine (www.iom.edu/CMS/3718.aspx)
- ◆ Consumer-Purchaser Disclosure Project (<http://healthcaresdisclosure.org/>)

Employee Health and Productivity Improvement Resources

- ◆ The Health Management Research Center, University of Michigan (<http://www.umich.edu/~hmrc/>)
- ◆ Integrated Benefits Institute (www.IBIWEB.org)
- ◆ Institute for Health & Productivity Management (www.ihpm.org)
- ◆ NCQA Quality Dividend Calculator (www.ncqa.org)

Endnotes

- ¹ Mahoney J, Hom D. "Total Value, Total Return: Seven Rules for Optimizing Employee Health Benefit for Healthier and More Productive Workforce", Pitney Bowes
- ² National Business Coalition on Health (NBCH) 2006 eValue8 RFI
- ³ Centers for Medicare and Medicaid Services, Public/Private Purchaser Value Charter, May 2006
- ⁴ NBCH 2006 eValue8 RFI
- ⁵ NBCH 2006 eValue8 RFI
- ⁶ Centers for Medicare and Medicaid Services, Public/Private Purchaser Value Charter, May 2006
- ⁷ "Health Literacy: A Prescription to End Confusion," Institute of Medicine Committee on Health Literacy, April 2004.
- ⁸ National Business Coalition on Health 2005 Federal & State Legislative Outlook
- ⁹ America's Health Insurance Plans (AHIP), 2006 Member Survey
- ¹⁰ "Consumer-Directed Health Plans: Implications for Health Care Quality and Cost," California HealthCare Foundation, Rand, June 2005.
- ¹¹ Kaiser Family Foundation and Health Research and Educational Trust, 2005 Health Benefits Survey
- ¹² AHIP, 2006
- ¹³ Improved consumer tools and greater transparency of provider-level performance are not listed among the advantages since these are required components of the model, which presumably lead to some of the advantages listed.
- ¹⁴ The Commonwealth Fund, December 2005
- ¹⁵ California HealthCare Foundation/Rand, June 2005 (See also Keeler, EB. "Effects of Cost Sharing on Use of Medical Services and Health," *Journal of Medical Practice Management* Summer 1992(8):317-21.)
- ¹⁶ California HealthCare Foundation/Rand, June 2005
- ¹⁷ The Commonwealth Fund, December 2005.
- ¹⁸ California HealthCare Foundation/Rand, June 2005
- ¹⁹ McNeill, D. "Do Consumer-Directed Health Benefits Favor the Young and Healthy?" *Health Affairs* January/February 2004;23(1):186-93.
- ²⁰ California HealthCare Foundation/Rand, June 2005.
- ²¹ The California HealthCare Foundation, "Online Health Care Cost Tools: Do They Meet Consumer Needs?" May 2006
- ²² The Commonwealth Fund, December 2005.
- ²³ "Few Execs Praise Health Care Data," Associated Press, Theresa Agovino, April 10, 2006.
- ²⁴ "Getting What You Pay For: Early Reports from Value-Based Steerage Pioneers" The Alliance, April 2006.
- ²⁵ California HealthCare Foundation/Rand, June 2005
- ²⁶ "Evidence-Based Medicine: Implications for Health Benefit Architecture," National Business Coalition on Health, National Health Leadership Council Meeting Proceedings, Berkley, California, August 4-6, 2004.
- ²⁷ Nicholson S, Pauly M, et al. "How to Present the Business Case for Health Care Quality to Employers." National Business Coalition on Health Annual Meeting, November 2005.
- ²⁸ "The Role of Health Plans: Employer Expectations in an Evolving Market," National Business Coalition on Health, National Health Leadership Council Meeting Proceedings, Saint Petersburg Beach, Florida, January 18-20, 2006.
- ²⁹ "Getting What You Pay For: Early Reports from Value-Based Steerage Pioneers" The Alliance, April 2006.
- ³⁰ California HealthCare Foundation/Rand, June 2005