PBGH
Pacific Business Group on Health

Benefit Strategies to Promote Quality, Value and Access in High Deductible Health Plans

The 2005 Pacific Business Group on Health (PBGH) Board of Directors Strategic Planning Retreat focused on how benefit design can best improve the value of Members' health plan options and the health status of enrollees. With the advent of Health Savings Accounts launched through Medicare reform legislation and the evolution of consumer-directed health plans, the Board Retreat focused on benefit design strategies. In particular, high deductible health plans and high performance provider networks were considered with a view towards assessing features needed to assure enhanced quality of care, health outcomes and consumer engagement. The Retreat discussions on the "Promise" and "Perils" of these strategies generated broad recommendations of "Dos" and "Don'ts" for purchasers to consider in plan offerings and benefit design. This summary highlights issues concerning the implementation of high deductible health plans.

Background

Over the last several years, a significant portion of premium increases has been unfunded relative to what employers have typically budgeted. Whether public or private, large or small, many purchasers are more directly sharing cost increases with employees through changes in plan contributions, copayments or benefits. Thoughtful cost-sharing is more than cost shifting and demand management. It considers the potential allocation of costs between healthy and sicker employees, and the extent to which cost-sharing encourages employees to get the right care at the right time. When cost-sharing is utilization-based (e.g. increased copayments and coinsurance) higher-frequency users of services pay more.

Indeed, there is growing concern about adverse consequences of increased cost-shifting such as avoidance of necessary care and non-compliance in medication management. Likewise, when low-wage earners are faced with higher premium contributions or increased point-of-service cost-sharing, the dangers of waived coverage or underutilization of both preventative and necessary care are even more pronounced. Employers are interested in aligning incentives for healthy behavior changes, which also positively impact productivity in the workplace. Many are also concerned about implications of benefit changes on disadvantaged sectors of employees, whether because of health status or income level. These considerations parallel critical efforts to better align incentives for providers by supporting performance measurement, public reporting and performance-based payment.

Measuring the Value of Benefit Design

This exploration of benefit options was framed by a discussion of "Net Present Health Value," a concept the Board used to consider the elements they currently, or would in the future, incorporate to assess whether benefit designs meet their overall objectives. Virtually all participants closely measure the economic value to the employer of their designs in the form of direct costs of premium/health costs, and most consider direct costs to the employee (though less often looking out over three years). Areas where many participants did not have but WANTED tools to measure the impacts of their health benefits strategies include:

- Better clinical outcomes over three to five year horizon;
- Short and long-term impacts on productivity, presenteeism and disability;
- Degree of consumer engagement and lifestyle change to reduce health risk; and
- Whether consumers are choosing higher value providers and treatments.

Evidence for Quality-Based Benefit Design

To support "quality-based purchasing," PBGH and the California HealthCare Foundation commissioned PricewaterhouseCoopers (PwC)

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to review current literature and "gray research" on quality-based benefit design. In a forthcoming report, PwC documents available evidence on the use and impact of a range of benefit design tactics in the areas described **Table 1**. Major observations include:

- Most benefit design choices (e.g., plan options; provider/network design; co-payments) have very little formal "health services research" on use and impact;
- Instead of looking to traditional health services research, purchasers rely heavily on actuarial evidence and their critical judgment of how strategies and tactics have worked in similar settings; and
- Even where there has been research on particular interventions, measurement has often focused on short- rather than long-term results.

Despite the limitations on evidence for benefit design, experience in specific areas such as pharmacy services provides lessons directly applicable elsewhere. While prescription drugs may be viewed as a more discrete product for purchase in comparison to other health care services, the evidence does indicate that consumers (especially lower-income) will respond to increases in cost-sharing. A positive behavior change can be in shifting to higher value treatments (e.g., to less costly generics); the potential negative result can be in reducing appropriate care leading to adverse health effects and ultimately higher costs (e.g., if high deductible products do not have first dollar coverage for preventive care). At the same time, consumers are seeking more information and patient decision aids can improve the quality of their treatment decisions.

PBGH Members advocate a comprehensive approach to understanding and managing the impact of benefit design changes. A recurrent theme was the desire to consider the effects of design changes on different segments of population, particularly:

- From well to chronically and acutely ill;
- Those with different income levels; and
- Consumers with different education levels and levels of "engagement" in their health care decisions.

Current Strategies

Many PBGH Members are already offering funded HRA account plans, with most early adopters matching these designs to existing PPO and POS products with relatively low deductibles and out-of-pocket liability. As more are considering HSA-eligible high deductible products, "full replacement" is an option that should be considered with great caution. Retreat participants believe:

- In many areas, there continue to be effective HMO or other offerings based on integrated delivery systems.
- There is a need for better consumer tools that integrate standardized measures and greater transparency in performance information.
- There are particular risks of negative impacts on lower-income or chronically ill employees.
- The regulatory environment remains uncertain and cumbersome relative to the potential overlapping coverage and exclusions under FSAs, HSAs and HRAs.

Ongoing discussion at the Board Retreat generated a summary list of the "promise" and "peril" of high deductible products, which in turn led to a set of purchaser "Dos" and "Don'ts" in implementing benefit design changes. The **"Promise"** of high deductible and consumer-directed products include:

- Potential savings for both the employer and many employees;
- Engages consumers with direct financial incentive to make better choices;
- Expands financial savings options, with varying degrees of portability, for retiree medical care; and
- Advances market push for better consumer tools and transparency of performance information.

The **"Peril"** of these products include:

- Risk of fostering patient non-compliance and avoidance of needed care;
- Absence of sufficiently robust consumer tools and transparency of performance information;
- Risk of negative impacts on lower-income or chronically ill employees;
- Could promote unnecessary care for those who have either saved substantial amounts in funded accounts or are in "use-or-lose" situation;
- Enrollee backlash in face of challenge of effectively communicating risks and implications are likely to lead to employees having "surprises" when they seek care; and
- May undercut and destabilize medical groups' efforts to support integrated care.

CONSIDERING HIGH DEDUCTIBLE OPTIONS:

PURCHASER DOs

- Define key goals and objectives of benefit design strategy with a multi-year view that includes measurement and evaluation of program impact
- Consider potential adverse risk selection and adjust contributions in a multi-plan environment that promote selection of a high value plan
- Identify and engage individuals with chronic conditions or who are "at-risk"
- Tailor benefit design strategies to segments in accordance with education, income levels, readiness to engage in self-care or risk reduction, or receptivity to information presented in various media
- Promote consumer awareness of health care costs and use of quality and value information to support plan and treatment choice
- Improve "appropriate" utilization through both low-touch (e.g., web-tools) and high-touch (e.g., nurselines and health coaches)
- Integrate elements (e.g., health coaching, health management participation incentives) to engage member in wellness, prevention and self-management, and to maintain engagement in the event the member exceeds the OOP max
- Consider providing 100%/first dollar coverage for preventive care
- Consider income-specific adjustments
- Consider how prescription drug benefits are covered, especially maintenance medications for chronic conditions
- Advocate use of standard measures to identify "higher value" providers
- Use targeted incentives to engage members in choosing high performance providers
- Invest in broad communications strategy and plan chooser decision support tools to assist members in understanding how the plan works and the trade-offs between near-term savings and portability of savings account vs. increased point-of-service costs

PURCHASER DON'Ts

- Adopt cost-shifting strategies with high likelihood of reducing compliance or access to preventive care
- Assume "one-size-fits-all" in benefit design
- Avoid addressing the inherent complexity in allowing for income-adjusted levels of cost-sharing (contribution strategies, copayments, deductibles, or OOP maximum) that can foster better access to coverage and care among lower-income individuals
- Apply wellness promotion strategies without defining an end goal (e.g., behavior change vs. completion of HRA only)
- Radically increase cost-sharing with no options for moderating potential out-of-pocket costs
- Focus only on cost-sharing without establishing comprehensive plan design expectations that include a full array of member support functions and a strategy to differentiate providers and treatment options
- Limit design strategy to near-term definition of funding and deductible levels to achieve cost target, but consider multi-year impact of accumulated savings and incentives/ disincentives for "gaming" use of services

Looking Ahead

A strategic approach to benefits architecture must address both the economic and behavioral rationale for cost-sharing. Thoughtful cost-sharing can be one element of an approach to engaging employees to be value-based consumers of health care by encouraging risk reduction, choice of high quality and efficient providers, and choice of treatments based on efficacy. Comparative information supplied in user-friendly interactive tools is essential to value-based decision making.

Consumer selection of high-performing providers promotes quality and enhances the likelihood of favorable health outcomes, and in turn rewards those providers with volume. There are, however, gaps today in relative provider performance information, consumer tools, and providers' systematic use of evidence-based medicine. The collective action of PBGH members as thought leaders in this area is closing the gap for all purchasers by more progressively engaging consumers, and leveraging health plans and providers to demonstrate increased accountability.

Additional Information

Additional information may be found on the following Web site links:

PBGH Member Benefit Strategies: Promoting Quality, Value and Access. http://www.pbgh.org/programs/documents/PBGH_BenefitStrategyReport2005.pdf

Encouraging a Responsible Approach to Consumer-Driven Health Care. McDermott Will & Emery, 2004, http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/2e47ff0c-a12d-4516-bb00-a96a989f2ff0.cfm

"Consumer-Driven" Health Plans: Implications for Quality and Cost. RAND and California HealthCare Foundation, 2005. http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=111973&subtopic=CL499&subsection=reports

Table 1. Purchaser Strategies to Promote Quality, Value and Access	
Purchasers' choice of specific benefit design strategies and tactics is influenced by an array of factors: workforce composition, geographic concentration or dispersion, and prioritization of other health, welfare and compensation initiatives. Pacific Business Group on Health Members have both national and regional health care purchasing strategies, and recognize that California has unique market dynamics. In particular, California continues to have significant HMO enrollment, supported by well-organized and integrated medical groups. As a result, many purchasers have targeted approaches to benefit design strategy to optimize value. The examples below reflect a range of the benefit strategy options and purchasing criteria used by large employers that cut across a variety of plan types and options. The prevalence of such strategies and adoption of innovative approaches is described in "PBGH Member Benefit Strategies: Promoting Quality, Value and Access" (see www.PBGH.org).	
1. Health Plan Options, Eligibility and Contributions ▪ Explicit criteria (e.g. cost-effectiveness, quality, provider access and system capabilities, etc.) to select and offer "high value" plans ▪ Risk-adjusted plan payments to reward efficiency and recognize population health status provides fair compensation of plans that manage higher risk populations ▪ Contribution strategies that consider financial incentives and quality information to encourage employee selection of high-value plans determined by performance benchmarking ▪ Coverage rules and contribution strategy to assure access to coverage among active employees, dependents, early retirees and retirees ▪ Premium contributions adjusted by employee income	**4. Pharmacy Benefit Design** ▪ Design of formulary and prescription drug benefit to support selection of treatments based on efficacy and value ▪ Design to promote compliance with maintenance programs for chronic illness and continuously monitor for any unintended consequences of cost-sharing ▪ Encourage value-based purchasing by employees (e.g. use of generic drugs, mail order, and/or step therapy).
2. Provider Selection and Performance Differentiation ▪ Use of plan options that promote use of "high performing" providers through narrow networks, tiered networks, and/or centers of excellence ▪ Promote pay for performance to differentiate provider performance ▪ Promote the provision of consumer tools that differentiate provider performance ▪ Informing employees' choice of doctors and hospitals via standardized measurement and public reporting of provider performance	**5. Health Promotion, Health Risk Reduction and Chronic Care Management** ▪ Promoting wellness and health promotion programs, including use of Health Risk Assessments and member tools ▪ Care coordination, including use of RN support line, health advocate, or high risk case manager ▪ Incentives for "active" participation in chronic care management and risk reduction ▪ Credible measures of direct and indirect ROI (via direct research or contractual requirements of plan/ vendor) for targeted disease management and health promotion programs to build business case for sustained investment in such programs over the long-term
3. Inpatient and Outpatient Benefit Design ▪ Changes to enrollee share of costs in copayments, coinsurance, deductibles or out-of-pocket maximums with a clear understanding of the potential effect on preventive services, management of chronic conditions, and on low-income populations ▪ Benefit design incentives for optimal resource utilization, selection of optimal treatments based on efficacy and value, and understanding of health care costs, including but not limited to discretionary services ▪ Benefit design incentives for optimal provider selection	**6. Consumer Engagement: Tools and Incentives** ▪ Consumer engagement tools, resources and information to support employees' value-based decision-making (e.g., provider selection, prescription drug use, etc.); tools may consist of service support or be Internet-based ▪ Applying principles of preference-sensitive decision making relative to plans, providers, and treatments (e.g., shared decision-making, treatment option support, etc.) ▪ "Activation" of consumers through education of members about the cost of services and he total value of health benefits

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