

Consumer-Driven Health Care: The Role of Innovations in Benefit Design

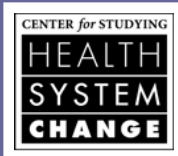
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Potential of Consumer-Driven Health Care (CDHC)

- Consumers use services more judiciously
 - Incentives to economize
 - Information on medical effectiveness
- Consumers make better choices among providers
 - Incentives to choose more efficient providers
 - Information on provider quality and costs
 - Choices yield lower prices or better quality
- Providers respond to shifts in market share
 - Increase efficiency and quality



Limitations to Potential of CDHC

- Limits to amount of risk that consumers can handle
 - Ability varies by income
- Large portion of spending for patients beyond reach of financial incentives
 - Exceeding deductibles
 - Exceeding out of pocket maximums
- Weak incentives to use more efficient providers
- Weak incentives to positive health behaviors and self management
- Other limits not addressed by this presentation



Potential to Achieve More with Refined Benefit Designs

- Incentives to encourage healthy behaviors and self management
- Vary financial incentives by service type or patient condition
- Vary financial incentives by income
- Explicit incentives to use more efficient providers
- Common characteristic: Melding of consumerism with management by health plans



Study of Innovative Benefit Designs

- Implemented, drawing board, future directions
- Interviews with
 - Thought leaders
 - Benefits consultants
 - Insurers
 - Large employers known for being innovative
- Innovations hard to find
 - Leaders in some directions often not in others



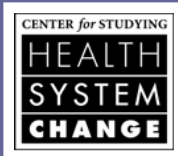
Incentives for Healthy Behaviors and Patient Self-management

- Wellness and prevention activities
- Undergo identification of risk factors (health risk appraisals)
- Disease management and lifestyle management
 - Common chronic conditions, smoking cessation, obesity reduction
 - Personal health coach programs



Types of Incentives

- Participation as prerequisite for insurance eligibility (rare)
- Straight cash bonuses
- Reductions in premiums
- Reductions in deductibles, copays, and OOP maximum
 - Example: King County, WA
- Spending account (HRA, HSA) contributions



Limitations of Approach

- Absence of consensus among experts on:
 - Extent of health benefits and cost savings achievable from self-management incentives
 - Which programs are most effective, within broad array of programs encouraging healthy behaviors and patient self-management

- Success depends on strong communication



Approach: Vary Financial Incentives by Service of Patient Type

- Term “evidence-based benefit design”
- Incentives designed to avoid discouraging the use of valued services
- Incentives to decrease the use of more expensive treatment options



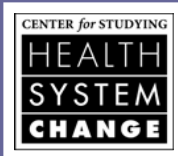
Avoid Discouraging Use of Valued Services

- Cost-sharing reductions applicable to specified chronic conditions
 - Pitney Bowes drug coinsurance
 - Potential to integrate cost sharing with disease management programs
- Vary cost sharing by patient subgroups
- Expansion of HSA preventive care safe harbor
 - Push led by large, self-insured employers to provide first-dollar coverage for drugs for certain chronic conditions



Incentives to Decrease Use of Overused or Expensive Services

- Administrative controls more common than incentive approaches
- Examples include
 - Imaging
 - Surgery for low back pain
 - Bariatric surgery
- Reference pricing for implants



Limitations of Approach

- Limited knowledge base to guide
 - Perhaps only 15% of condition-treatment dyads have solid cost-effectiveness information
- Difficult to incorporate into benefit design
 - Insurers and employers resist retooling information systems and rewriting contracts
 - Communication to enrollees is also a serious challenge
- Incentives to comply with evidence-based care limited to a few prevalent chronic conditions



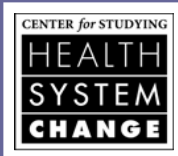
Vary Benefit Structure by Income

- Permits stronger incentives for some
- Information technology enabling greater refinement
 - On-line determination of cost sharing
- But employers only have information on earnings—not family income



Incentives to Encourage Use of Efficient Physicians

- High performance networks
 - Focused on major physician specialties
 - Broad assessment of physician efficiency
 - Per episode analysis of all claims (physician, facility, drug)
 - Large differences often in facility or drug
 - Typical benefit design: Lower cost sharing for using HPN physician (e.g., 10% vs. 20% coinsurance)
 - Impact on costly episodes
- Centers of excellence
 - Use in bariatric surgery, fertility services



Limitations to Approach

- Limited knowledge base about physician cost-effectiveness
 - Competing episode groupers sometimes yield different preferred lists
 - Limited sample size on physician episodes available to insurers
 - Rudimentary quality measures



HSA Compatibility with Innovative Benefits Design (1)

- Incentives to encourage healthy behaviors and patient self-management generally permitted
 - Cannot reduce deductible below minimum
 - Some limitations on employer contributions to HSA for healthy behaviors
 - Sum of employer and employee contributions does not exceed HDHP deductible
- Minimum deductible a barrier for reducing cost sharing for chronic disease care
 - Exception if preventive drug safe harbor



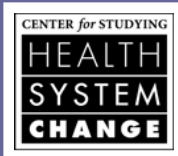
HSA Compatibility with Innovative Benefits Design (2)

- Minimum deductible limits varying deductible by income
- Minimum deductible dilutes incentive to use high performance network physicians



Increase Flexibility in HSA Benefit Structure

- Maintain requirement for substantial cost sharing but allow more flexibility in benefit design
- Precedent in Medicare Part D
 - PDPs vary benefit structure and assure CMS that actuarial value is at least as high as legislated structure
 - Give plans similar option to remain HSA-eligible
 - Actuarial value no higher than legislated structure
- Potential to allow a higher actuarial value for lower-income people



Conclusion

- Innovative benefit structures can enhance the potential for CDHC to achieve its goals
- At early stages and progress is slow
- Lack of knowledge base and limits on complexity are key barriers
- HSA benefit structure quite rigid
 - Could be made flexible without sacrificing intent