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