PERSPECTIVE

Beyond Consumer-Driven Health Care: Purchasers' Expectations Of All Plans

Employers expect all of their health plans to contain better consumer information and decision-support tools.

by Peter V. Lee and Emma Hoo

ABSTRACT: Skyrocketing health care costs and quality deficits can only be addressed through a broad approach of quality-based benefit design. Consumer-directed health plans that are built around better consumer information tools and support hold the promise of consumer engagement, but purchasers expect these features in all types of health plans. Regardless of plan type, simply shifting costs to consumers is a threat to access and adherence to evidence-based medicine. Comparative and interactive consumer information tools, coupled with provider performance transparency and payment reform, are needed to advance accountability and support consumers in getting the right care at the right time. [*Health Affairs* 25 (2006): w544–w548 (published online 24 October 2006; 10.1377/hlthaff.25.w544)]

EVERYONE HAS probably heard the story of the drunken man who lost his keys in the alley but was looking for them around the corner under the lamppost, because "that's where the light is." The heated debate regarding consumer-driven health care (CDHC) brings this story to mind. The consumerist boosters are looking under a lamppost for incentives and tools to enable consumers to be "better shoppers." The critics cite potential adverse effects on the chronically ill and the unraveling of employer-sponsored insurance. Meanwhile, around the corner and still obscured by darkness are the value and quality shortfalls of the current system. The paper by Melinda Buntin and colleagues looks for the keys, but in too narrow a space.[1] Leading purchasers seek to address a wider range of problems, and CDHC is only one component of a broader quality-based benefit design strategy.

Buntin and colleagues offer three broad observations on the evidence about consumer-directed plans: (1) There is early evidence suggesting that such plans might help lower costs and lower cost increases; (2) the evidence about CDHC on quality remains mixed; and (3) there might be some modest favorable health selection among early adopters of consumer-directed plans that warrants monitoring. The relatively weak evidence related to CDHC actually mirrors the lack of good evidence more broadly in the area of health benefit design.[2] That said, each of these findings is important, but together they fail to illuminate purchasers' broader concerns. Purchasers want health plans to effectively engage consumers to make better decisions (versus simply shifting costs), promote provider accountability for quality and efficiency using

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standardized performance measures, align incentives to reward better performance, and induce reengineering of care delivery.

The evidence and the status quo, however, are all too clear: The current health care system has generally not given consumers the tools and incentives they need to make better choices; it has rewarded providers for volume, not for quality and efficiency. In addition, health care customers—employers, public purchasers, and consumers—have only recently revolted at the idea that much of health care in the twenty-first century is being provided on a nineteenth-century foundation, relying on individual physicians to "do the right thing" without the support of information technologies that have transformed other industries.

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The result is skyrocketing health care costs, while quality gaps abound. The Institute of Medicine has shed light on the problems of inconsistent quality, unjustified practice variation, and at times downright harmful delivery of medical services.[3] The high-cost, double-digit trends of years past, as well as quality and efficiency shortfalls, underscore a huge value disconnect for employers.

■ **Financial impact on plan sponsors.** A sizable and growing portion of premium increases is unfunded relative to what employers are typically budgeting. Whether public or private, large or small, many purchasers are sharing cost increases with employees more directly through changes in plan contributions, copayments, or benefits. This is true not only for consumer-directed plans, but for every form of health plan. The statistics should be of concern for all stakeholders. One national survey representing 500 large U.S. employers found that companies anticipated a 12 percent cost increase for providing health coverage in 2005 but could only afford a maximum 8 percent increase.[4] In another survey, the 2006 premium trend of 10 percent was estimated to be reduced by more than 3.6 percentage points (to 6.4 percent) as a result of shifting costs to employees and reducing benefits.[5] The reaction of many small employers has been to reduce or drop coverage altogether. The estimated number of Americans with employer-sponsored health benefits fell from 67 percent to 63 percent between 2001 and 2003.[6]

■ **Multiple approaches to the problem.** The fact that rising health care costs have particularly negative effects on the chronically ill, lead to reduced use of preventive services, or differentially affect lower-income Americans are not CDHC problems: They could arise in any type of health plan. Because of this, the Pacific Business Group on Health (PBGH) and many larger employers believe that CDHC is one of multiple parallel tracks that need to be taken to curb health care cost increases and improve quality. A quality-based benefit design strategy should include the following: (1) using collective and strategic purchasing leverage to address the overriding system problems that result in high costs and compromised quality, (2) engaging consumers to demand higher quality through use of better information linked to financial incentives, and (3) rewarding higher-value plans and providers with volume and differential payment.

Although not all employers are adopting this strategy, many see it as a way to foster breakthroughs that are necessary for real change to occur. Consumer tools linked to health savings accounts (HSAs) may indeed hold the promise of consumer engagement, but reducing rising health care costs, improving quality, and reengineering cannot be achieved without changing how performance is measured and how providers are paid. Quality-based benefit design can promote breakthroughs not only for an employer's own workers' care, but also for the entire health care system.

■ **Thoughtful cost sharing.** Purchasers

are not choosing consumer-directed plans versus a "traditional" health plan; they are choosing between thoughtful benefit design versus "dumb cost shifting" (or, worse yet, abandoning the provision of coverage altogether). 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 employees are encouraged to get the right care at the right time.

Regardless of the benefit structure, purchasers are rightly concerned about the implications of benefit changes on employees who are "at risk," whether because of health status or income level. Changes in cost sharing within traditional benefit designs have provided limited financial relief to employers at the margins. Some research has shown that if cost sharing is done right, there can be both financial savings and improvements in quality; done poorly, it can have substantial negative consequences.[7] Concerns about the potential adverse consequences of increased cost shifting, such as avoidance of necessary care and noncompliance in medication management, are real in "standard" preferred provider organizations (PPOs) and high-deductible plans, regardless of the "consumer driven" appellation.

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■ **Quality-based benefit design.** A strategic approach to quality-based benefit design needs to address the economic and behavioral rationales for both cost sharing and provider payment. Thoughtful cost sharing should be one element of an approach to engaging employees to be value-based consumers of health care by encouraging healthy lifestyles, choice of high-quality and efficient providers, and choice of treatments based on efficacy. For consumers to be value-based decisionmakers, however, they need access to accurate comparative information via user-friendly, interactive tools. Consumers' selection of high-performing providers promotes quality and increases the likelihood of favorable health outcomes; in turn, it rewards high-performing providers with volume. There are gaps in today's provider performance information and consumer tools. But the good news is that efforts are under way to rapidly expand the array of physician and hospital performance measures nationwide. At the same time, every health plan is responding to purchasers' call to develop tools for consumers.

Purchasers and consumers alike must become more discriminating buyers of health care. Both can foster providers' efforts to drive improvement. The frequent focus on CDHC leads to a narrow assessment of account-based plans as the path to either salvation or Hell. Large employers expect all of their health plans to be "consumer driven" and to measure the performance of the providers they contract with. They also expect that the information will be used to create usable tools for their workers and to change how providers are paid.

The lamplight shining around the corner reveals employers' efforts to pursue quality-based benefit design. The six elements of that design are as follows.[8]

Health plan selection, eligibility, and contributions. The selection of which plans offer higher value and then the determination of eligibility criteria and premium contributions for employees are key components of purchasers' benefit design. Employers should create incentives for enrollees to join "high-value" plans. High value should be measured by plans' performance across risk-adjusted costs, member satisfaction, clinical outcomes, reporting, and how effectively the plan engages both consumers and providers. Although the majority of employers still opt to make the value-blind contribution of the same percentage of the cost for all plans offered, more and more are making the quality-based contribution that has enrollees pay 100

percent of the cost difference above the identified highest-value plan.

Additional contribution strategies being used to promote value include making contribution adjustments based on employees' salary levels, number of dependents, employment status (active, early retiree, retired beneficiary), and the extent to which employees adopt healthy lifestyles. Contribution strategies must be linked to tools that help employees make the right choices given their circumstances. The PBGH-developed Health Plan Chooser is one example of a tool that helps consumers choose the right plan based on cost, quality, and provider availability.

Provider network differentiation and selection. The greatest opportunity for premium reduction lies in use of high-performing, efficient providers. Given documented variance in provider costs and quality, there is growing interest among employers in adopting the strategy of high-performance or narrow provider networks. The use of interactive consumer tools to inform provider-selection decisions is also increasing, and carriers are launching cost calculators to help consumers estimate and compare the cost of selected services among different providers.

Inpatient and outpatient benefit design. Employers are seeking to influence consumers' provider selection and service use through new inpatient and outpatient benefit designs. Although there is concern about potential unintended consequences on access and avoidance of necessary care, and rightly so, employers are seeking to develop cost sharing that fosters patients' getting the right care at the right time. Examples of strategies being tested include tiered hospital copayments, coinsurance for outpatient diagnostics, and tiered primary care/specialist physician office copayments.

Pharmacy benefit design. The use of copayment structures by prescription drug tiers has slowed drug cost trends by promoting the use of generics and mail order. However, research has clearly shown that some cost sharing, particularly among the chronically ill, can actually deter care access and therapeutic compliance and can increase the medical costs associated with managing the acute exacerbation of a chronic condition.[9] Quality-based benefit designs can incorporate incentives linked to drug efficacy, information sharing about treatment alternatives, and reduced out-of-pocket costs for chronic illness medications. In light of cost and care issues related to pharmacy benefit design, employers are also requiring disclosure of formulary practices (drug selection, substitution, and so on) and rebate incentives.

Health promotion and health risk management. With 15 percent of employees accounting for 75 percent of health care dollars, health risk reduction and chronic care management have become central to achieving breakthroughs in health care quality improvement and cost trend reduction.[10] Increasingly, employers are investing in wellness promotion, lifestyle modification, and disease management programs that have the potential of improving both financial performance and employees' quality of life. Employers are also holding health plans accountable for reporting information on health management programs and measuring their impact.

Tools and incentives for consumer engagement. Consumer engagement must be at the core of any quality-based benefit design strategy. Employers not only hold plans and providers accountable for performance in this way but are also making direct investments to support their members. Through tools and incentives, consumers can become more actively engaged in recognizing and selecting higher-value providers and treatments. Employers expect health plans of all types to provider consumers with accessible and useable information.

■ **Evidence of progress.** The fact that quality-based benefit design is gaining ground can be seen on a variety of fronts. The National Committee for Quality Assurance (NCQA) has adopted new accreditation modules in the areas of consumer engagement, physician, and hospital quality (which includes an assessment of the degree to which all plans are reforming their payment strategies to promote quality).[11] Through common requests for information such as eValue8, purchasers are build-

ing into their health plans negotiating and selection processes expectations for consumer tools, payment reform, better management of employees with chronic illness, and health promotion.[12] Finally, the largest purchaser of care—the federal government—is echoing these expectations in the recent presidential Executive Order and in the statement of health and human services secretary Michael Leavitt, in its contracting of health plans that serve federal employees, and in its efforts to reform Medicare.[13]

WE WOULD ALL DO WELL to look beyond the lamplight shining on the strengths and foibles of CDHC to more broadly identify the range of benefit design elements that will foster health care reengineering and help consumers get the right care at the right time. There is no "silver-bullet" solution to health care's rising costs and quality deficits. And although poorly designed benefits can certainly make existing quality and access problems worse, quality-based benefit design contains critical elements that must be part of any set of solutions.

NOTES

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