



## Consumer Driven Care Training Kit

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# Consumer Driven Primer

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# Overview

## Terminology

Let's start by discussing language. As an emerging movement, the terminology for consumer driven health care is evolving. This means that there is not necessarily great consistency within the industry regarding the syntax for concepts, products and various structures.

Add to the mix the fact that some of the consumer driven models and plan designs can appear quite complex at first blush, and you have a recipe for confusion. Indeed, complexity and confusion are primary concerns expressed in a number of employer and consumer surveys regarding consumer driven health care.

The marketplace will help sort out the confusion over time, and the language will adapt and further evolve. But in the mean time, we are all "terminology challenged" as we wade through the primordial soup of consumer driven health care. A [glossary](#) is provided in this Primer to provide some assistance.

The dilemma starts with what to call the basic concept. For better or worse, the health care industry has labeled the general movement as "consumer driven health care." "Consumer-centric" health care is perhaps a better generic term used to refer to the overall application of consumerism concepts to health care. Why? If no other reason, because as discussed below, "consumer driven" also refers to one of the two main health plan structures associated with the movement.

"Consumer-Driven", "Consumer-Directed" and "Self-Directed" are all terms somewhat inter-changeably used to refer to the specific structure we will discuss in the Primer. Interestingly, the Health Insurance Association of America (HIAA) recently completed a market research study that found consumers are not enthralled with any of these terms, and would prefer that such health plans were called "Consumer Choice Health Plans."<sup>1</sup>

Just a couple of years ago, "defined contribution" health care was often the generic term used in the marketplace to refer to the entire movement, before "consumer driven" took hold. Now "defined contribution health plans" are more accurately and specifically used to refer to another model we will discuss in this Primer.

"Consumer-centric health care" is the generic term used in this Primer to refer to the overall health care consumerism movement, and "consumer driven health plans" and "defined contribution health plans" refer to two major separate models of consumer - centric health care. And of course, there are a variety of terms that apply to different types of structures within each model. But let's not get ahead of ourselves, so enough about language for now.

## Why a movement towards Consumer-Centric Health Care?

As we will subsequently discuss in the [Trends](#) section of this Primer, the birth of consumer-centric health care can be attributed to a number of factors:

- Consumer and Provider backlash against traditional managed care caused discontent with the prevailing system and began to create a demand for new solutions
- Double digit health care cost and health plan premium increases during the past five years fueled demand for new solutions, combined with a growing perception that traditional managed care was no longer capable of best addressing these rising costs.
- The explosion of Internet based health information, application and tools created the means for consumers to have easy access to a wealth of health care decision support and related information
- The enactment of new IRS regulatory provisions that improved the tax and other overall financial incentives involved with consumer driven health plans
- The lack of another significant competing alternative movement to traditional managed care

## What are the broad goals of Consumer-Centric Health Care?

On the surface, the goal of consumer-centric health care is to empower consumers to become involved and take more responsibility for their health care decision-making and for the purchasing of health care services.

But peel back one layer, and there seems to be two different camps regarding the “vision thing” for consumer-centric care. On one hand, a goal of many employers and health plans is to simply reduce costs by shifting costs to consumers and capping costs where possible.

On the other hand, there are those who cite “it’s the behavior, stupid!” The thought being that a system that positively influences consumer behavior to become more cost and health conscious, and influences providers and plans to become more consumer oriented will bring about cost savings as well as greater satisfaction all around.

You could also argue there are additional camps. The agenda of consumer-centric health care for some is the general objective of consumerism in any market sector meaning they want consumers in charge of their own care and decision making because they feel consumers are generally entitled to that shift in power. However we would hold that this viewpoint is generally based in the behavioral camp.

The consumer-centric agenda for some employers (a minority) has been characterized as a vehicle to get them out of the day-to-day business of providing employee health care benefits, or at least diminish their role. The motivations here however trace back to either of the main camps: such employers want to cap or eliminate their costs by diminishing their role, or they see this change as a means of making the consumer assume greater responsibility and thus influence consumer behavior.

While these two camps can potentially co-exist, i.e., shifting costs to consumers and capping costs can influence consumer behavior, there is also the danger that the objectives of one camp can trample the hopes and dreams of the other camp if a reasonable equilibrium is not reached.

If the course of the consumer-centric movement is primarily directed at simply shifting costs to consumers, then consumers will most likely not feel empowered to behave differently, they will just feel frustrated. It can be argued that by incrementally charging consumers more while still using the same structure, there is no basis for significant behavioral change. Unions will continue to fight the movement with tremendous passion. Consumers, whose sense of entitlement regarding health care benefits won't have changed, will seek political solutions regarding state mandates to limit how far cost shifting can go. One of the most popular tools in costs shifting- raising the required employee payroll deduction- provides no financial incentive for consumers to behave differently in how they use their health plan throughout the year.

However if the course of the consumer-centric movement focuses just on letting consumer "be in charge" without any form of cost shifting whatsoever, there is no guarantee of any immediate savings or controls, meaning we must place all trust in long term controls and savings that may or may not ever materialize.

A simple argument for some level of cost shifting is the need to correct for the prevalence of HMO style flat copayments, which do not keep pace with medical inflation, create a perception of entitlement, inhibit consumer awareness of health care costs, and provide no incentive for consumers to assume greater responsibilities in dealing with costs or with health care decisions. Due to the significant growth of HMOs during the 1980s through the mid 1990s, flat copayments caused total consumer out-of-pocket costs as a percentage of total health care expense to actually decrease significantly from the 1970s through the end of the last century.<sup>2</sup> Thus it can be argued that some costs need to be shifted just to correct for the flat copayment phenomena.

Lastly, it is difficult to argue how consumer behavioral changes can occur without making consumer empowerment and responsibility apply to the financial aspects of health care. In so empowering consumers, you must increase their involvement with costs to make them more responsible for the costs.

Thus the challenge for the consumer-centric health care movement going forward, in "Star Wars" terms, is to find a "balance in the force" between shifting costs and positively changing behavior.

A more detailed discussion of these and other concerns is provided in the [Issues](#) section of this Primer.

### **What is the purpose of this Primer?**

This Primer has been designed to give the reader a reasonable understanding as to:

- The trends that have shaped the emergence of the consumer-centric health care movement
- The basic models involved in consumer-centric health care, and the specific alternative structures that exist for each model
- The components typically included in consumer-centric health care structures, and how they interact
- Details regarding health care navigation tools and benefit plan design
- The major issues surrounding the consumer-centric health care movement
- The terminology used when discussing consumer-centric health care

<sup>1</sup> "Consumer Choice Health Plan Opinion Study 2003", commissioned by HIAA, Bill McInturff and Elizabeth Frontzak, Public Opinion Strategies. <http://membership.hiaa.org/pdfs/apps/consumerchoice.ppt>

<sup>2</sup> EBRI Brief #247, released July 2002, [www.ebri.com](http://www.ebri.com)



# Trends

## Factors Driving Consumer-Centric Health Care

Historically under traditional health care, many consumers were fairly insulated from decision-making regarding their care. The financial aspects were handled between plans and providers without much consumer involvement and physicians called the shots regarding the care the consumer would receive.

As managed care evolved, plans got more proactively involved with providers regarding the financing or delivery of care. Still many consumers weren't that involved in the cost of the care or in the clinical decision-making.

Consumer-centric care refers to the rising importance of health care consumers in clinical health care decision-making, and in health care financing. Factors driving consumer-centric care include:

- The ability of the Internet and mass media to disseminate comprehensive health care information to Consumers
- The aging of Baby Boomers who now require more medical attention, but are more willing to question their doctor than previous generations
- Growing recognition of positive benefits from consumers being more responsible and involved with their health care decisions
- Growing use of direct-to-consumer health care advertising from pharmaceutical companies, hospitals and other providers
- Response by employers and health plans to escalation of health care costs by increasing consumer cost sharing responsibilities.
- A sustained consumer and provider backlash to the classic managed care model, prompting employers and health plans to be more receptive to change

## e-Health

Before the explosion of e-health initiatives starting in the late 1990s, a vacuum existed in delivering the vast array of health information and resources a consumer would want and need in a consumer-centric world.

To some degree supply has created demand: the introduction of a wealth of health informational resources via the Internet stimulated significant consumer demand for even more information, as well as consumer demand to discuss this new found information with their providers and become more involved in treatment option decisions. Certainly e-health continues to be a cornerstone to the consumer-centric movement.

A recent e-Health Institute survey of e-health professionals regarding who the most influential e-health driver for the next five years would be, indicated the top role of the consumer:<sup>3</sup>

- Consumers: 29%
- Health Care Organizations 28%
- Government Agencies 24%
- Pharmaceutical Companies 6%
- e-Health vendors 6%
- Large Technology Companies 3%
- Academic Institutions 1%
- Others 2%

e-Health Institute has published data on overall consumer health care Internet usage which indicates that:<sup>3</sup>

- 63 million Americans currently go on-line for health purposes;
- This represents two thirds of all Internet users;
- The number of e-health consumers is growing at twice the rate as the overall on-line population;
- The Internet is second only to physicians as the preferred source for health information for these on-line consumers.

A recent Harris Interactive survey indicated that 80% of patients with chronic medical conditions search the Internet for health related topics, and average such health searches nine times a year.<sup>4</sup>

However, from the employer and health plan perspective the focus on the consumer-centric phenomenon is not on e-health, or demanding patients that want a consumer-centered system. Instead, most initiatives to date have addressed costs, with the focus on increasing consumer cost sharing through a variety of platforms.

### **Change in Health Plan Economic Behavior**

Escalating health care costs and health plan premiums have been the economic driver paving the way for emergence of consumer-centric health care. There have been many factors attributed to these annual double-digit increases. But a more fundamental shift in health plan economic behavior may be the root cause for emergence of a new economic model.

To understand this change in behavior, we first must examine the health plan premium pricing model that existed for the past forty years, referred to as the health plan “premium pricing cycle” or the “underwriting cycle.”

Under this historical model, plans are driven by cyclical market share and premium price competitive behavior. There are periods where premium increases are significant, then decline, and then rapidly increase again. Here's how the cycle works:

- During profitable periods: a) plans want to expand market share; b) they start to lower price to do so; c) other plans match lower prices to keep pace and not lose share; d) price wars similar to airline fare wars erupt and multi year contracts develop.
- Then a downswing develops: a) due to insulation of provider contract capitation and discounts and the time lag on fee for service claims, considerable time elapses before financial pressures are fully visible from the lowered premiums; b) due to multi-year contracts and price pressures nothing much can be done about the problem as it becomes apparent.
- A period of significant losses then occurs: finally enough of the market is losing money so that several major players break rank and begin increasing rates and everyone else follows suite.
- Finally there is a return to profits: the premium increases continue until profits are being generated, and the cycle begins anew.

However, with the new century, health plan economic behavior appears to have changed:

- Plans are now much less driven by long-term market share
- Plans are now more driven by short-term bottom line profitability
- Plans are more willing to rapidly exit unprofitable markets and product lines
- Plan consolidation has occurred due to closures of failing plans, market exits and acquisition of plans.
- Premium competition has diminished because of all the above.

### **Emergence of a new economic model: the Benefits Cycle**

The rapid increase in health plan cost sharing, combined with a profound recent change in health plan economic marketplace behavior may pave the way for new model: the "benefits cycle" involving periodic upward and downward shifts in the general level of health plan benefits provided to consumers.

As discussed, new market behaviors are altering the premium cycle, and now large health plans are sacrificing market share for profit and continuing to consolidate, which reduces price competition.

The benefits cycle theory holds that the employer and consumer marketplace will still work to drive health plan premium prices down, by increasing demand for lower cost benefit plans that contain greater employee cost sharing. Ultimately in this new consumer-centric age, a cycle would emerge where the general benefit levels and cost sharing requirements relax, and then constrict, based on economic competitive forces.

In essence, plans will compete more on benefits than on prices, because consumers (and employers through defined contributions) will dictate what they're willing to pay for, and plans will have to deliver benefit packages at these pricing levels. When plan costs rise rapidly, benefits may constrict. When plan profits rise rapidly, benefits may expand.

### **Direct-to-Consumer Advertising**

Certainly one of the most significant current manifestations of consumer-centric health care is the continual growth of direct-to-consumer health care advertising. Dominated by pharmaceuticals, such advertising is also prevalent with health care services typically not well covered by insurance, such as Lasik eye surgery, or for health plans purchased on an individual basis, such as Medicare plans.

Direct-to-consumer advertising includes advertisements targeted toward consumers through magazines, newspapers, television, radio, outdoor advertising, and web-based advertising.

A common denominator for much of direct-to-consumer advertising is thus based upon the relationship between the service and how close the consumer is to controlling the purchase decision and how responsible the consumer is financially for such decisions.

You might ask if prescriptions really fit such a definition, but consider the following:

- Medicare doesn't cover prescriptions, thus seniors without applicable retiree or Medicare HMO plans providing Rx coverage must purchase their own drugs, and most plans offering coverage are subject to various annual maximums or other limitations
- Many employer prescription plans also have various annual maximums or other limitations in their drug benefits
- Health Plan drug coverage is now typically "tiered", requiring use of generics or designated brand names, or providing better benefits when these drugs are used
- A greater number of high profile and formerly prescription only drugs have been re-classified as over the counter, where consumers can purchase them directly and there typically is no insurance coverage
- As further discussed below, physicians are now much more accepting of patients bringing up potential prescription options, and patients are increasingly willing to become more proactive and involved in prescription decision making

What is the size and scope of prescription drug direct-to-consumer advertising in the United States?

- Total direct-to-consumer advertising costs in were almost \$2.5 billion. <sup>5</sup>
- In 2002, direct-to-consumer advertising accounted for 14% of overall prescription drug promotional spending. <sup>6</sup>
- Direct-to-consumer advertising spending has grown an average of 28% per year since 1996. <sup>6</sup>
- The percent of consumers saying they had seen or heard an ad for a prescription medication grew from 63% in 1997 to 85% in 2002. <sup>6</sup>

Why are prescription drug direct-to-consumer advertising expenditures growing at this pace? Because the data support that such spending is effective in stimulating prescription interest and sales. According to a recent study published by the Kaiser Family Foundation: <sup>7</sup>

- “for every 10% increase in DTC advertising, drug sales within the classes studied increased on average by 1%.”
- “each additional dollar spent on DTC advertising in 2000 yielded \$4.20 in additional pharmaceutical sales in that year.”
- “30% of adults say they have talked to their doctor about a drug they saw advertised, and 44% of those who talked to their doctor received a prescription for the medication they asked about. This means that 13% of Americans have received a specific prescription in response to seeing a drug ad.”

The larger point here is not to focus just on prescription drug advertising, but to consider the future potential impact of direct-to-consumer advertising as the consumer’s role in health care decision making and purchasing grows.

A strong case can be made that direct-to-consumer advertising across the spectrum of health care services will grow significantly over time, with some of the following potential outcomes:

- Increased regulation of consumer health care advertising;
- Increased “class action” style litigation over the claims of such advertising;
- Adjustments by physicians and other providers in their patient relationships as they deal with increased patient demands in response to such advertising;
- Changes in mixes of demand for certain health care services based upon which types of services are the most conducive to stimulating sales through advertising.

<sup>3</sup> “Sustaining e-Health in Challenging Times” e-Health Insitute, April 2003; [www.ehealthinstitute.org](http://www.ehealthinstitute.org)

<sup>4</sup> “E-Health’s Influence Continues to Grow as Usage of Internet by Physicians and Patients Increases” Health Care news, Harris Interactive, April 17, 2003; [www.harrisinteractive.com](http://www.harrisinteractive.com)

<sup>5</sup> Competitive Media Reporting, Strategy Report, and IMS Health, National Prescription Audit Plus, as quoted by Kaiser Family Foundation. Publication Source: Health Care Industry Market Update, Pharmaceuticals, January 10, 2003, CMS. [www.cms.gov](http://www.cms.gov)

<sup>6</sup> The Impact of Direct-to-Consumer Advertising, Carol Lewis, FDA Consumer magazine, March-April 2003, U.S. Food and Drug Administration [http://www.fda.gov/fdac/features/2003/203\\_dtc.html](http://www.fda.gov/fdac/features/2003/203_dtc.html)

<sup>7</sup> Impact of Direct-to-Consumer Advertising on Prescription Drug Spending; June 2003; [www.kff.org](http://www.kff.org)



# Models

**We will discuss five consumer-centric health care models:**

- I. Empowered Decision Making
- II. Health Plan Cost Sharing
- III. Defined Contribution Health Plans
- IV. Customized Health Plans
- V. Consumer Driven Health Plans

Four of the five models discussed address health plans. The health plan models can apply to self-insured or fully insured plans. The following table helps outline the definition and role of each of these models:

Model	Definition	Relationship
Empowered Decision Making	Initiatives to enhance consumer role in health care services and treatment decision-making	Function can exist in any setting, including the four health plan models below.
Health Plan Cost Sharing	Initiatives to increase the level of out-of-pocket costs borne by consumers for health plan premium and or health plan benefits	Function can be incorporated into any health plan, including the other three health plan models below
Defined Contribution Health Plans	Employer funding of a fixed-dollar amount for health benefits, which employees may then use to purchase benefits from an employer arranged funding mechanism	Customized and Consumer Driven Health Plans can be included in Defined Contribution benefit offerings
Customized Health Plans	Health Plans that offer various options in benefit levels and or participating provider networks, that may be selected by the consumer prior to enrollment	May also be included as a feature in Consumer Driven Health Plans
Consumer Driven Health Plans	Combination of an employer funded spending or savings account with a high deductible insurance policy	See Above

## I. Empowered Decision Making

Of course, empowered decision-making is an objective in various forms of any consumer-centric health care model. But for purposes of this Primer, the other four models discuss consumer health plan structures. In this context, the “Empowered Decision Making” model addresses initiatives to empower consumer health care services and treatment decision-making as opposed to specific payment and coverage decisions.

Facilitating consumer empowerment in the health care decision-making process involves various combinations of the following:

- Increased access to health care information designed for consumers
- Increased access to decision support tools assisting consumers to act on such information
- Increased availability of health care services that may be directly obtained by consumers without a physician or other provider’s prior prescription or authorization for treatment
- Changes in provider behavior to increase patient involvement in treatment decisions

Health care information and decision support tools are provided in many formats:

- Web Sites and e-mail newsletters
- Call Centers including ask-a-nurse services
- CD-ROMs and downloadable files
- Videotapes/ DVDs
- Printed newsletters, newspapers, magazines and books
- Television or radio
- Live Presentations

The resources provided can thus take such forms as: news bulletins, advertisements, reference material, narrative articles, data tables, interactive reports, lectures and seminars, phone interaction, multimedia presentations and many other possibilities.

The primary questions to consider with any of the above formats center around who is the sponsor of the information or the tools? What is the sponsor’s objective in providing these resources? Is something being sold or promoted by the sponsor? How can the accuracy of the resources provided by the sponsor be determined?

Sponsoring organizations typically fall into the following categories:

- Government
- Non Profit Research and Advocacy Organizations
- Industry Associations
- Information companies providing resources on behalf of other sponsors
- Providers
- Health Plans
- Pharmaceutical Companies
- Vendors offering specific products

A recent Harris Interactive survey of consumers accessing health information on-line indicated they chose to visit the following types of sites (% of consumers visiting each type of site):<sup>4</sup>

- Health Pages provided by on-line services: 50.9%
- Pharmaceutical companies: 27.3%
- Academic or research institutions: 27.2%
- Medical Journals: 27.2%
- Patient support or advocacy groups for specific diseases: 21.3%
- Health plans: 20.7%
- Medical societies: 19.0%

Decision support tools provide the translation of consumer health information, typically based upon consumer interaction, into actionable data that can assist consumers in making or being involved in health care treatment decisions. The predominance of such tools are Internet based. The tools are discussed in more detail in an upcoming section on [Navigation](#).

Even before we add the context of health plan coverage to empowered decision making, which is addressed in the other subsequently discussed models, an essential ingredient of consumer health care information and decision support tools is the element of price transparency for health care services. In a less consumer-centric environment, the actual entire price of health care services is not all that visible or meaningful to consumers. Properly designed consumer health care information and decision support tools provide a view of the total actual pricing.

As discussed in the previous section on [Trends](#), one of the most significant developments involving empowered decision making to date has been direct-to-consumer advertising, primarily from the pharmaceutical industry. This approach has prompted a wide number of patients to proactively inquire about advertised drugs with their physician and pursue the possibility of a prescription.

The most significant manifestation of empowered decision making involving the increase of health care services directly obtained by consumers without a physician or other provider's prior prescription or authorization for treatment, is certainly the growing number of prescription drugs that have been re-classified as over the counter drugs. Pharmaceutical direct-to-consumer advertising of course has the clearest relationship to consumer decision-making with respect to over the counter medicines.

Another area with continual growth in regard to consumer directly obtaining services is in respect to wellness and preventive care. Such initiatives involve various combinations of services including:

- Primary care provider check ups
- Nutritional counseling and programs
- Exercise and fitness counseling and programs
- Smoking cessation programs
- Health education classes
- Health risk assessments

The reality remains however, that physician and other provider behavior have one of the largest impacts on empowered consumer health care decision-making. Providers resistive to increasing consumer involvement in the decision making process are certainly in a position to diminish potential empowerment.

Consumers on the other hand, can vote with their feet and choose to select providers that are more open to consumer involvement. Some consumers just as often simply work to pressure and "wear down" their providers over time.

Given that the Internet is a primary basis for consumer's access to health care information and decision support tools, provider use of the Internet for consumer interaction is a good gauge of how willing providers are to involve consumers in this regard.

Clearly health care organizations such as hospitals and pharmaceutical companies have invested major resources towards reaching and interacting with consumers over the Internet. But what about physicians?

A Harris Interactive survey indicated 25% of physicians conduct on-line communications with patients, and 51% of those physicians did so because their patients requested it <sup>4</sup>

For the 75% of physicians who aren't communicating on-line with their patients, the reasons they've offered as obstacles include: <sup>8</sup>

- Concerned about the potential volume: 64%
- Concerned about professional liability: 62%
- Not reimbursed for on-line activity: 41%

Numerous professional organizations have recently issued guidelines to assist physician in appropriate patient e-mail communications, which help address potential professional liability issues. Physician volume and reimbursement concerns are of course inter-related, i.e. you're less concerned about the volume of an activity if you're getting paid for it.

Recently, a number of health plans have initiated pilots or company wide policies to reimburse for e-visit communications that meet specified criteria. National vendors, such as Relay Health Inc., have rolled out e-visit tools for physicians to integrate into their practices that can also integrate health plan transactions for applicable reimbursement. To the degree that these tools and reimbursement becomes more prevalent, one could expect more widespread changes in physician behavior in this regard.

This leads to a final point about provider behavior and consumer empowerment. Provider behavior to accommodate consumer empowerment in general could be expected to bear a strong relationship to reimbursement.

If enough patients vote with their feet to change from resistive providers, one could expect resistive providers to re-evaluate their position. If patients exercise greater control over health care purchasing decisions, providers will generally provide greater accommodations for their requests. And if patients gravitate towards consumer-centric models that affect provider reimbursement, provider generally will follow.

A corollary is that until reimbursement is sufficiently affected, a material number of providers will not take material steps to accommodate further consumer empowerment.

## **II. Health Plan Cost Sharing**

Currently, the primary strategy undertaken by employers and health plans under the label of consumer-centric health care has been to increase the consumer's share of ever rising health care costs, with the two-fold objectives that (1) simply transferring more of the costs to consumers will help reduce employer and health plan costs, and (2) burdening consumers with a greater share of the costs should engage them in a more proactive role in addressing the costs of their healthcare.

There are two categories of cost sharing under this model: Premium cost sharing and Benefit cost sharing. Premium cost sharing involves increasing the payroll deductions for employee contribution to the health plan premium costs, or getting the employee to opt-out of receiving health coverage. Benefit cost sharing includes the following mechanisms:

- Introducing or increasing tiered copayment structures for Rx, Hospitals and other services
- Introducing or increasing various deductible requirements
- Increasing copayment amounts or percentage coinsurance levels
- Changing flat copayments to percentage coinsurance
- Introducing or lowering certain annual benefit maximums and limitations, such as for Rx

While a major concept of employee cost sharing is to more proactively and directly involve the consumer in the purchasing of health care services, this does not have to necessarily mean that 100% of the purchases and cost sharing are “out-of-pocket” expenses. Mechanisms have been established under various defined contribution and consumer driven health plan models to provide for employer funding of certain levels of these expenses.

However, for purposes of this discussion, the Health Plan Cost Sharing Model involves cost sharing without provision of employer funding of some or all of these cost sharing requirements. The funded models involve Defined Contribution or Consumer Driven health plans. The structures discussed under the Health Plan Cost Sharing Model can of course be incorporated into Defined Contribution, Customized or Consumer Driven Health Plans.

Some mechanisms such as Opt-outs or benefit exclusions are really not so much as “cost sharing” as they are employer or plan “cost avoidance.” Still, if the consumer bears the entire burden for some types of health costs, in effect that is still part of overall consumer cost sharing.

Major costs sharing mechanisms may be classified as follows:

Premium Cost Sharing	Benefit Cost Sharing	
<ul style="list-style-type: none"> <li>• Opt-out</li> <li>• Employee Contribution:     Single and Dependent</li> <li>• Payroll Deduction</li> </ul>	<ul style="list-style-type: none"> <li>• Deductible</li> <li>• Coinsurance</li> <li>• Copayments</li> <li>• Annual Maximums</li> </ul>	<ul style="list-style-type: none"> <li>• Lifetime Maximums</li> <li>• Benefit Exclusions</li> <li>• Benefit Limitations</li> <li>• Tiered Benefit Plans</li> </ul>

Premium Cost Sharing mechanisms include:

- *Opt-out:* An opt-out refers to an employer offering the option for an employee to forgo receiving health coverage, typically in return for the employee pocketing a share of what would have been spent on their health plan premiums, or using those dollars to purchase other offered benefit options besides health coverage. Also, in a sense, employees that choose single coverage but have spouses and or dependents are opting out of providing dependent coverage.

Some employers design their contribution requirements and other benefit options in a manner to encourage employees to opt-out of dependent coverage, or health coverage altogether. Furthermore, some self-insured employers have written mandatory spousal exclusions into their benefit policies, so that if spouses have health benefit coverage through another plan, they will not receive dual coverage through the employee plan.

- *Employee Contribution*: refers to the share of the health plan premium that the employee must pay. Employee Contribution amounts may be set by the employer as a fixed dollar amount (such as \$50 per month), or as a percentage of the premium (such as 10% of the premium cost.) Employers undergoing cost sharing initiatives would typically seek to convert fixed contributions to percentage of premium contributions, and to increase the percentage contribution required. Employers offering more than one plan option would also typically seek to give employees additional incentives through their contribution rate, to select the lowest cost plan to the employer, or to set employee contribution rates so that employer costs are equal for all plans offered.
- *Single Contribution*: refers to the employee contribution when the employee has elected single coverage only. Often employers will set a different level of single contribution requirement compared to dependent contribution requirements, so that the corresponding percentage that the employer pays is much higher for single coverage compared to dependent coverage.
- *Dependent Contribution*: refers to the employee contribution when the employee has elected dependent coverage. Sometimes this contribution amount varies depending on the category of dependents covered (spouse, vs. children only, vs. spouse plus children, etc.). Employers undergoing cost sharing initiatives would typically seek to further the disparity between the employers contribution for single vs. dependent coverage, so that electing dependent coverage becomes relatively more expensive to the employee than single coverage.
- *Payroll Deductions*: Payroll Deductions refer to how employee contributions are actually paid by the employee.

Benefit Cost Sharing mechanisms include:

- *Deductibles*: Involve a fixed dollar amount per time period (usually annually) that consumers must pay out-of-pocket for eligible services before benefit coverage will start to apply. Deductibles can apply to an entire policy (such as \$500 before any benefits apply) or to a specific benefit (such \$100 before inpatient hospital benefits apply). Deductibles can also apply to such individual covered person, or to the entire family. Plans undergoing cost sharing initiatives would typically seek to increase existing deductible amounts, and to create new deductible requirements.

- **Coinsurance:** Involves consumers paying out-of-pocket for a set percentage of the covered benefit amount for eligible services. 20% coinsurance has typically been the standard coinsurance amount other than for tiered benefits, but plans undergoing cost sharing initiatives would typically seek to increase the coinsurance rate.
- **Copayments:** Involve fixed consumer out-of-pocket payments for eligible services, such as \$10 per physician office visit. Typically plans with copayments have a schedule of copayments with different dollar amounts applying to various services. Plans undergoing cost sharing initiatives would typically seek to increase the copayment amounts, or seek to change certain services from copayment to coinsurance requirements.

- **Annual Maximums:** Typically involve a fixed dollar annual limit for eligible benefits under a policy, and any services rendered after that limit is reached during that year become non-covered benefits. Maximums can also involve an annual limit on the number of services that can be rendered for a specific service.

Annual maximums can be for an entire policy (such as \$1,000,000 per covered individual per year) or for a specific benefit (such as \$1,000 for prescriptions per covered individual per year, or 20 mental health visits per year). Annual maximums can be applied to each covered individual or an entire family under a policy. Plans undergoing cost sharing initiatives would typically seek to impose annual maximums for an entire policy where one does not exist already and lower the maximum amounts for existing maximums.

- **Lifetime Maximums:** Function just like annual maximums, except that the time period is cumulative over the lifetime of the policy instead of annual. Plans can impose annual and lifetime maximums for the same policy or specific service.
- **Benefit Limitations:** Benefit limitations involve setting a limit to the services that can be provided for a specific benefit. The limitation could involve an annual or lifetime maximum, or could involve specific conditions that must apply for the benefit to be covered. Plans undergoing cost sharing initiatives would typically seek to impose additional benefit limitations for targeted services.
- **Benefit Exclusions:** Benefit exclusions involve specifying that a specific service is not a covered benefit. Plans undergoing cost sharing initiatives would typically seek to widen the scope of benefit exclusions for targeted services. Prescription drugs have been a particular focus of many plans in this regard.
- **Tiered Benefits Plans:** Tiered Plans involve setting different levels of benefits that can apply depending on the provider or type of service selected. PPO benefit plans and subsequently HMO Point of service plans were historically the most common examples of tiered benefits.

More recently, pharmaceutical benefits have been converted to tiered plans whereby the benefit level changes depending upon if generic, preferred brand name, or non preferred brand name drugs are used. Now, hospital and other services are sometimes being structured into tiered plans, based upon specified lists of upper tier vs. lower tier participating facilities.

Tiered benefits can involve various packaged combinations of the previously discussed benefit cost sharing mechanisms, with the lowest out-of-pocket cost package applying to the tier that the plan wishes to direct the consumer to. For example, a generic Rx tier might have \$5 copayments and no deductible or annual maximum, while the preferred brand Rx tier has a \$15 copayment with no deductible but costs counting towards a \$2,500 annual maximum, and the non preferred brand Rx tier has a 25% coinsurance after a \$100 deductible with costs also counting towards the \$2,500 annual maximum.

Plans undergoing cost sharing initiatives would typically seek to impose tier benefits for targeted services where they currently don't exist, and to increase out-of-pocket requirements for all tiers as well as the out-of-pocket differentials between tiers where tiers do exist.

The overall purpose of cost sharing mechanisms is to reduce or limit costs to the employer or to the health plan for providing benefits to consumers. An underlying assumption is that beyond immediate cost reductions created by cost sharing, longer-term savings can be achieved as a result of consumers becoming more involved in the purchasing of health care services.

The concept is that consumers might become more selective regarding the cost effectiveness of the providers they choose to receive services from. Consumer utilization might also be reduced. While reductions in utilization can of course achieve immediate savings, concerns have been stated that if the result is deferral of needed services, long-term costs could increase. Concerns have also been stated that to the degree consumers sacrifice quality for price, outcomes could suffer, driving up long-term costs.

Premium Cost Sharing mechanisms have the most immediate direct effect for employers in this regard, but provide no mechanism that would alter employee behavior while they use the plan. However, when employers offer multiple plans, setting different contribution amounts by plan will affect employee selection of specific plans, and certain plans may have longer term price stability and or benefit cost sharing features that would affect employee behavior regarding use of services.

Consumer spending cost sharing mechanisms might involve the consumer the most in direct purchasing decisions, and as most such arrangements are very new to the market, it remains to be seen what their ultimate long term effect will be.

### III. Defined Contribution Health Plans

Defined Contribution Health Plans involve employer funding of a fixed (as opposed to variable) dollar amount for health benefits, which employees may then use to purchase benefits from an employer arranged funding mechanism. The benefits could either be group benefits packaged and arranged by the employer, or purchased individually by employees. In a consumer-centric context, the defined contribution health plan offering should also provide the consumer some type and level of choices to make for health plan coverage within for that defined contribution allowance.

In contrast, a variable contribution involves employers committing to a specified level of benefit funding, regardless of the actual benefit price. Examples of variable contribution approaches (which can also be taken in various combinations) include:

- Setting all contributions as a percent of premium
- Setting family contribution at the single premium level, or at a percent of the single level (other premium tiers could be substituted for family or single)
- Setting all contributions in an open enrollment at the premium level (or at a percentage of the premium) of a designated plan, such as the least expensive or the mid-point plan.

Variable contributions are thus dependent upon the actual amount of the health plan premium (or the equivalent amount for self insured plans.) Health plan premiums are subject to change typically on an annual basis, and except for very occasional multi-year health plan policies that specify premium rates or rate ceilings for extended years, upcoming premium rates are completely unknown. Employers locked into variable contribution arrangements thus are committed to funding a benefit structure without knowing what the future costs will be.

In its simplest form, an employer’s defined contribution arrangement could involve one health plan being offered through an employer, where the employer makes a fixed contribution per month for health benefits for each employee.

In the following one plan example, if the employer increases his defined contribution amount for a new plan year an additional \$20 for singles and \$40 for families, the employer’s additional monthly exposure is capped at that \$20/\$40, and the employee must make up the entire difference between the entire difference between the new premium rate and the set defined contribution.

Example of one-plan Defined Contribution offering for single and family:

Monthly	Plan Premium Rate (\$change)	Defined Contribution (\$change)	Employee Payroll Contribution (\$change)
Current Single	\$150	\$120	\$ 30
Renewal Single	\$200 (\$50)	\$140 (\$20)	\$ 60 (\$30)
Current Family	\$400	\$200	\$200
Renewal Family	\$525 (\$125)	\$240 (\$40)	\$285 (\$85)

However the one-plan defined contribution arrangement illustrated above would typically not meet our definition of a defined contribution health plan as a consumer-centric model, as no choice is being offered to the employee to select from using the defined contribution allowance. (An exception would be if the one plan offered was a Customized Health Plan, as subsequently discussed.)

The more typical consumer-centric application of a defined contribution health plan offering involves the availability of multiple health plans, with consumer choosing a plan using their defined contribution allowance and paying for the difference between the allowance and the total premium price themselves.

Example of a four-plan Defined Contribution offering for single employees :

Monthly	Plan Premium Rate	Defined Contribution	Employee Payroll Contribution
Plan A Single	\$120	\$120	\$ 0
Plan B Single	\$150	\$120	\$ 30
Plan C Single	\$170	\$120	\$ 50
Plan D Single	\$200	\$120	\$ 80

Just as we previously discussed in the Empowered Decision Making model, that health care service price transparency is an essential element of health care information and decision support tools, health plan premiums price transparency is an essential information and decision support element for defined contribution health plan arrangements.

In a less consumer-centric environment, the total health plan premium price is not visible, or at least not meaningful to employees. Often the employee is only made aware of the payroll deduction requirement, and many employers even intentionally keep the premium cost a secret, considering it proprietary information.

In order for the defined contribution health plan concept to be fully applied, employees should receive a statement indicating the full amount of the defined contribution allowance, and the full amount of the available health plan premium prices, so that employees can rationalize that they are involved in purchasing the full cost of the health plan using the allowance.

Defined Contribution health plans require some type of funding mechanism for the employer’s contribution to be applied to the purchase of health benefits. There are two main types of funding mechanisms: employer controlled or employee spending accounts.

Employer controlled funding means that the defined contribution allowance, the payment of health plan premium costs, are never actually recorded in individual employee accounts, with no additional potential pre-tax implications for the treatment of these contribution or expenses. The employer simply pays the premium payments, and enacts payroll deductions for any negative difference between the allowance and the premium costs.

Employee spending accounts involve employers recording their contribution allowance and health plan premium payments in dedicated employee “accounts.” As we will subsequently discuss, a properly qualified spending account can treat such transactions on a pre-tax basis, and even potentially roll over unspent balances to a new year. Employee spending accounts are more widely used in Consumer Driven health plans for the direct purchase of health care services, but for purposes of a Defined Contribution health plan arrangement, the account is used for the purpose of purchasing health plan premiums.

There are three main alternative structures under the defined contribution health plan model:

1. *Vouchers*: Vouchers are Defined Contribution health plan arrangements in which the employer takes no responsibility for arrangement of group benefits, and instead merely provides funding for employees to purchase benefits on the individual market. This approach is not widespread, and to date has been used primarily in the very small employer market.
2. *Single Carrier/ Multiple Options*: A single insurance carrier can offer multiple benefit options through an employer group policy, and the employer can set a defined contribution allowance for employees to spend in selecting one of the benefit options. This can be in the form of a single Customized Health Plan (as subsequently discussed) or in the form of a number of separate, distinct benefit packages offered by the carrier. Furthermore, one or more of the benefit options can involve a Consumer Driven Health Plan
3. *Multiple Carriers / Multiple Options*: In theory, a multiple carrier, multiple option arrangement could be offered, in a purchasing pool type offering. The ideal would be to combine the concept of something like the Federal Employee Health Benefit Plan including consumer driven health plan options with a defined contribution spending allowance funded through a spending account. This is the type of structure that could most closely resemble a 401(k) retirement plan, but the model has not yet truly emerged in the open market place.

In summation, a defined contribution health plan includes the following elements and consists of the following alternative funding mechanisms and structures:

Essential elements	Alternative Funding Mechanisms	Alternative Structures
<ul style="list-style-type: none"> <li>• Fixed dollar employer contribution for benefits</li> <li>• Employee choices in benefits</li> <li>• Price transparency in benefit total costs</li> </ul>	<ul style="list-style-type: none"> <li>• Employer controlled expenditure of funds</li> <li>• Employee spending accounts</li> </ul>	<ul style="list-style-type: none"> <li>• Vouchers</li> <li>• Single group carrier-multiple options</li> <li>• Multiple group carriers, multiple options</li> </ul>

The term “Defined Care” refers to the full application of Defined Contribution Health Plans, including spending-account funding mechanisms, with material consumer choice in benefit plan options including Consumer Driven health plans, and with the objective of altering behavior throughout the system. In a Defined Care system:

- The burden of responsibility shifts to the employee for being knowledgeable about plan features and selection.
- The employee needs extensive information to make informed choices and receive the best value possible
- Plan, provider and patient behavior all undergo change, as employees become empowered consumers. The anticipated behavior changes in theory hold the greatest potential promise for overall restructuring of health care, as opposed to specific benefit design or other features.

#### **IV. Customized Health Plans**

A Customized Health Plan offers a variable plan of benefits, and or participating provider networks, which a consumer may select from within the plan, during an open enrollment period, so that the plan premium price is determined by the variable options selected by the consumer.

For example, under such a plan the consumer might select:

- To cover or not cover certain services
- To change the annual maximums on certain benefits or the entire policy
- To change certain copayment amounts, deductible amounts or coinsurance levels
- To specify which provider network the consumer is tied to for certain benefits or benefit levels to apply.

Part of the structure of offering a customized health plan, as opposed to being a single carrier just offering a number of different set benefit plan options, is just in the packaging. Suppose a health plan offers a matrix of options in a Customized Health Plan that add up 40 different combinations of different benefits. The carrier could just offer 40 separate set benefit plans that accomplishes the same degree of choice, but by offering the selection to appear as one plan, the benefit choices the consumer makes within the plan creates the appearance of a single, customizable plan.

A Customized Health Plan can be offered as a Defined Contribution Health Plan arrangement, whereby the employer sets a defined contribution allowance and the employee must fund the difference if the cost of the customized options exceeds the allowance. Furthermore, a Customized Health Plan can also incorporate Consumer Driven Health Plan features if the options to select from include them.

## V. Consumer Driven Health Plans

Consumer Driven health plan arrangements (also called Consumer Directed or Self Directed) involve combination of an employer funded spending or savings account with a high deductible insurance policy where the deductible amount equals or exceeds the annual funding of the savings or spending accounts.

Payments for health care services are made directly from the spending or savings accounts until the account is exhausted and or the insurance deductible requirement is met. If the deductible exceeds the annual spending/savings account funding (as is usually the case) the employee is responsible for payment of this gap before insurance coverage applies. The insurance policies in Consumer Driven health plans vary greatly in nature in respect to benefit provisions, and if managed care features and other components are involved.

There are four types of employee spending or savings accounts that are designated for pre-tax treatment if properly qualified:

1. *Flexible Spending Accounts (FSAs)*: Employer FSAs, when qualified under the tax code regarding “cafeteria plans” for employees, pre-date the consumer driven health plan movement. They involve an employer pre-tax contribution that employees may spend on qualified medical expenses. However, there is a “use it or lose it” provision so that unspent funds can’t carry over from year to year.
2. *Medical Savings Accounts (MSAs)*: The following MSA definition and discussion is provided by Greg Scandlen, Director Center for Consumer Driven Health Care, Galen Institute: “MSAs require a high-deductible insurance plan, with no coverage below the deductible. They assume that an amount of money approximating the premium savings from the higher deductible will be deposited into the savings account for use by the account holder. The accounts are actually owned by the employee, not the employer. Unused funds stay in the accounts and may build interest over time. Account holders may withdraw money for non-medical purposes by paying taxes and a 15% penalty on the amount withdrawn. There are many problems with the way they were designed by Congress in 1996:
  - Only self-employed and employers with under 51 workers may use them.
  - There are enrollment caps and time limitations keeping most larger insurers from being willing to invest resources in developing and marketing products.
  - MSA contributions are limited to a percentage of the deductible, and only employers or employees, but not both in a single year, may contribute to the accounts.
  - Only a very narrow range of deductible is allowed, and there is a strict limit on total out-of-pocket exposure, which prevents the products from being fine-tuned to suit market demands.”<sup>9</sup>

3. *Health Reimbursement Arrangements (HRAs)*: HRAs refer to an employer funded health care spending account defined by the IRS in 2002 that allows for eligible funds unspent in a given plan year to be rolled over from year to year on a pre-tax basis (as opposed to the use it or lose it provisions of a FSA.) Numerous provisions apply according the IRS Revenue Ruling regarding requirements for eligibility under such arrangements. The Revenue Ruling addresses such situations as recognizing and allowing for spending accounts to occur in combination with a high deductible insurance policy such as the consumer-driven plans now in the marketplace, or for the spending accounts to pay for insurance premiums. Furthermore, the ruling allows for group retiree plans to use such arrangements.
4. *Health Savings Accounts (HSAs)*: HSAs refer the structure created under Title VII, section 1201 of The Medicare Prescription Drug, Improvement and Modernization Act of 2003, which includes the following provisions:
  - HSAs may be established January 2004 and thereafter
  - HSAs must be opened with a companion high-deductible health insurance policy.
  - A high-deductible policy is defined as at least \$1,000 for singles, \$2,000 for a family.
  - A taxpayer must be under 65 when opening an account.
  - The taxpayer may take an annual tax write-off equal to the deductible amount of the companion high deductible plan.
  - However, the tax write-off can't exceed \$2,250 for an individual plan, or \$4,500 for a family plan.
  - These maximum write offs are scheduled to increase in future years
  - For taxpayers 55 and older, the new law permits an additional \$500 contribution in 2004.
  - Contributions may be made for the previous year through April 15.
  - Eligible tax-free withdrawals from HSAs include expenditures for: Doctors, dentists and hospitals; Artificial limbs; Drugs; Eyeglasses and contacts; Chiropractic; Laboratory expenses; Nursing home costs; Physical therapy; Psychoanalysis; X-rays; Nursing home insurance premiums

MSAs have previously had limited appeal due to the many restrictive requirements placed upon them, With establishment of HSAs, MSAs should have even further diminished appeal, as HSAs are similar in basic structure without the same level of limits and restrictions.

The following table summarizes comparative provisions of the major types of accounts:

FSA	HSA	HRA
<ul style="list-style-type: none"> <li>• May be used by any employer and employees</li> <li>• May be funded by employer or employee</li> <li>• Balances may not rollover from year to year (use it or lose it)</li> </ul>	<ul style="list-style-type: none"> <li>• May be used by any taxpayer, must be opened before age 65</li> <li>• Require companion high deductible insurance policy</li> <li>• May be funded by employer or employee</li> <li>• Balances may rollover from year to year</li> </ul>	<ul style="list-style-type: none"> <li>• May be used by any employer</li> <li>• May only be funded by employer</li> <li>• Balances may rollover from year to year</li> </ul>

The other major coverage element to Consumer Driven Health Plans is the companion high deductible insurance policy that provides coverage once the deductible requirement is met. There are countless variations as to the specific benefit provisions of such policies. Typical provisions are further addressed in the section on [Plan Design](#).

Consumer Driven Health Plans can include multiple spending accounts in the same plan. For example, many plans use an HRA for the employer to fund a portion of the high deductible, and an employee funded FSA to fund the balance of the high deductible.

Consumer Driven Health Plans also have often invested major resources in various components of the plan, including health navigation (consumer accessible health information, decision support tools, and plan transactions); claims payment tools (including debit cards); value added programs and managed care features. These items are discussed in the next two sections: [Components](#) and [Navigation](#).

<sup>8</sup> “E-Encounters” | Health Reports, California Health Care Foundation, November 2001; [www.chcf.org](http://www.chcf.org)

<sup>9</sup> “Consumer Driven Health Care: New Tools for a New Paradigm”, March 2003, by Greg Scandlen, as presented to the Defined Care 2003 Web Summit



# Components

**We will discuss the following health plan components:**

- Price Transparency
- Claims Payment
- Managed Care
- Value Added Programs
- Navigation
- Plan Design

These components are presented in the context of Defined Contribution, Customized, and Consumer Driven Health Plan models. [Navigation](#) and [Plan Design](#) and presented as separate sections because of the more extensive discussion required to address these components.

## **Price Transparency**

Price Transparency involves initiatives to proactively make the consumer aware of the entire price of applicable health plan services for Customized and Consumer Driven Health Plan arrangements, and the entire price of health plan premiums and other benefits for Defined Contribution Health Plan arrangements. The concept is that if consumers are more involved in health care decision-making, cost is typically a factor in such decisions, and if consumers are more responsible for payment of health care services, they need to know the price of the services they are purchasing.

In traditional HMOs and many other insurance plans, information regarding provider pricing is not easily accessible before services are rendered, and consumers are insulated from seeing a provider bill or claim form, and explanation of benefit documents, when they do exist for such plans, typically do not detail the provider pricing involved.

There are two major initiatives for provider price transparency: 1) making pricing information readily available before services are rendered, as a decision support tool; and 2) making pricing information related to the provider claim accessible to the consumer as a part of the claims payment process.

The complicating factor in providing information involves managed care provider arrangements. Managed care provider contractual discounts are often considered proprietary information between the plan and the provider, and publishing such pricing information to be available before services are rendered can be problematic for some plans and providers.

Historically, some plans have even only applied the discount rates to the plan portion of benefit payments, and applied the full retail rate to the consumer's percentage coinsurance (which has been the subject of litigation in a number of cases.)

The complexity of pricing for a number of types of providers is such that it can be quite difficult to publish pricing schedules in advance of the rendering of services due to the variables involved, and understanding the line items of such pricing in provider billings can be overwhelming for a layperson.

As a result, many price-publishing initiatives focus on representative, average prices for the most common types of services. Price information, as a decision support tool, is additionally discussed in the [Navigation](#) section. Price information related to claims payments is further discussed below.

## Claims Payment

There are three major issues relating to consumers and claims payment:

1. Submission of claims
2. Resolution of claims
3. Review of paid claims

Under traditional HMO and other insurance plans, providers have typically assumed responsibility for submitting insurance claims for payment on behalf of the consumer. However, Consumer Driven Health Plans contain complexities regarding if the claim should be directed to the spending account or the insurance plan depending upon the status of the employee deductible, and many spending accounts have requirements that are not as compatible for provider paper claims submissions. As a result, historically many FSA participants had to directly pay providers, and then file for reimbursement to the FSA administrator.

As a means of simplifying the submission and resolution of such claims for consumers and providers, many Consumer Driven Health Plans now offer debit cards, contracted through third party vendors, to facilitate the submission and resolution of claims electronically. Health care debit cards involve an ATM type card that can be used by providers to simultaneously bill and be reimbursed for services from applicable pre-funded spending or savings accounts. The debit cards typically are structured with major transaction intermediaries such as MasterCard, and only allow for eligible health care expenses to be involved in the transactions. Some plans have even integrated member eligibility information into the card, so it may also function as a plan ID card.

The IRS has issued a Revenue Ruling addressing and allowing for eligible debit and credit cards to be used in HRA, FSA and MSA transactions, which is available for review in the [Library](#).

Another consumer issue regarding submission and resolution of claims involves the status of the claims. If a provider has billed a plan on behalf of the consumer, and has not received payment, the provider typically sends an escalating series of statements, notices and eventually collection letters to the consumer. If the plan claims administrator has problems associated with resolving the claim, they may deny the claim, or request further information from the consumer or provider.

Many Consumer Driven Health Plans have created Health Navigation tools for consumers to easily check on claims status, and even interact with plan to ask questions or provide requested information. This is discussed further in the [Navigation](#) section of the Primer.

With traditional HMOs and other health plans, review of paid claims for accuracy and other purposes was a function the consumer was typically very insulated from. With consumers more involved in the cost and payment of services under consumer-centric models, consumers have a financial motivation to be more involved in the review of such claims as well.

As a result, many Consumer Driven Health Plans also provide Health Navigation tools for consumers to easily review paid claims for accuracy, with guides included to assist consumers on how to review a claim. This is also discussed further in the [Navigation](#) section of the Primer.

## **Managed Care**

While the perception sometimes exists that consumer-centric health plan models are an alternative to managed care, the truth is that managed care is very inter-woven into these models.

HMO and PPO benefit plans have significantly adopted consumer cost sharing features into their plan designs. Defined Contribution Health Plan arrangements typically offer traditional HMO and PPO plans as benefit options. HMO and PPO benefit plans are offered as Customized Health Plans. The majority of new product offerings for Defined Contribution Health Plans, Customized Health Plans, and Consumer Driven Health Plans are being introduced by existing HMO and PPO health plan organizations.

Consumer Driven Health Plans often incorporate managed care features on a more ala carte basis, with some plans including most or all managed care components, and other plans including only a few features. Major managed care components integrate with Consumer Driven Health Plans in the following ways:

- *Full Integration* – A number of Consumer Driven Health Plans have been structured from existing HMO or PPO benefit plans that simply incorporated a high deductible and added a companion spending account. In such situations, all managed care features of the plans remain intact.

- *Provider Contracting* – Most Consumer Driven Health Plans have arranged for a contracted participating provider network that provides services at a contracted discounted reimbursement rate for the insurance plan and the savings/spending account. In many situations, the provider contracts are arranged through a third party PPO network.
- *Medical Management* – Medical management including referral authorizations, prior authorizations for hospital and other selected services, and case management of high resource patients is problematic for many Consumer Driven Health Plans. Some plans actually incorporate no medical management features. Most plans do not apply medical management to services reimbursed under the savings/spending accounts. Hospital prior authorizations are the most common required medical management feature, sometimes handled through outsourced vendors.
- *Disease Management* – Disease management programs dedicate resources for populations with specific targeted conditions, often chronic in nature. The approaches vary in nature but typically include patient education, certain aspects of case management, and integrate pharmaceutical treatment solutions. Many Consumer Driven Health Plans include Disease Management programs, often handled through outsourced vendors.
- *Prescription Management* – Some Consumer Driven Health Plans simply carve out the prescription benefit, and let the employer select a prescription benefit option outside the plan. More Consumer Driven Health Plans do manage their own benefit. Some limit the prescription benefit to reimbursement from the funded spending accounts. Some spending accounts do not incorporate prescription management features.

However, many Consumer Driven Health Plans do include prescription management features in their spending accounts, and virtually all that have covered prescription benefits in the insurance plan incorporate prescription management features. Typically, the prescription management is outsourced to a Prescription Benefit Management (PBM) company. The most common prescription management features include some type of formulary, and generic substitution.

- *Provider Profiling* – Some Consumer Driven Health Plans provide comparative provider cost and or quality data for their plan members, via their Health Navigation Tools. Sometimes this information is made available through outsourced third party vendors.

## **Value Added Programs**

Value added programs involve discounts and services arranged by a plan on behalf of plan members that are not directly specified as part of the plan of benefits. Frequent value added offerings include various combinations of:

- Provider discount programs including services not covered by the plan
- Discounts and free trials on fitness, recreational, and nutrition services
- Discounts on exercise equipment
- Discounts and free trials in weight-loss and other self-help programs
- Discounts on books and educational items
- Frequent flyer miles and travel discounts



# Navigation

## Health Navigation

Consumer Driven, Defined Contribution and Customized Health Plan arrangements typically involve packaging of health care clinical and cost information, and transaction interfaces for consumers. This allows consumers to better navigate through benefit and provider selection, participate in treatment decisions, purchase health care services, and process health care and benefit transactions.

The formats provided for navigation were discussed in the prior [Models](#) section regarding Empowered Decision Making. While numerous formats are utilized, the vast majority of activity occurs through the Internet and call centers. Quite often these functions are facilitated through outsourced vendors.

There are no uniform standards regarding how health navigation resources are presented. The objective for Health Navigation is two-fold: 1) provide adequate, meaningful information and tools to support consumer decision making and interaction with plans and providers; and 2) present the information and tools so that they are easy to identify, access and use.

Health Navigation information and tools can be categorized into three main functions in this context:

- Health Care Decision Support
- Internet and Telephonic Care
- Health Care Transactions

## Health Care Decision Support

Health care decision support includes:

- *Provider selection* – provider selection tools include various combinations of participating provider status information; comparative cost and quality data; certification, licensure, qualifications and capabilities information; and contact, location and office information
- *Benefit evaluations* – benefit evaluation tools involve comparing different benefit options regarding cost and coverage, as well as researching detailed coverage information regarding a specific benefit option.

- *Clinical information* – clinical information tools provide consumers the resources necessary to learn more about specific diseases, conditions, and body functioning; assess conditions to provide more accurate descriptions to the consumer’s provider; and potentially “rule out” or “rule in” on an initial basis, specific conditions that may exist.
- *Treatment options* – clinical resources to identify, learn more about, and assess potential treatment options for applicable conditions; along with related cost information regarding the options, for purposes of discussing with the consumer’s physician or other provider.
- *Prescription Resources* – cost and clinical information regarding prescriptions, along with applicable benefit information regarding formulary status and related issues.

## **Internet and Telephonic Care**

Internet and Telephonic Care includes:

- *Personal Advisor* – some programs provide a “health coach” or “personal advisor” via phone or Internet that function somewhat like a concierge, triaging consumers to applicable information, resources, providers, and assisting with basic requests.
- *Self Help Resources* – resources that assist consumers with assessing and treating their own conditions when appropriate; such as basic first-aid, dealing with colds and flu, etc.
- *Support Groups* – resources to identify and assist in joining and participating in support groups for specific medical conditions.
- *Ask-a-Nurse services* – Internet or telephonic service to query nurses or other applicable health professionals regarding specific medical conditions and situations, and receive basic advice on treatment or provider referral.
- *e-Visits* – Internet enabled tools to facilitate a defined level of interaction between patient and physician regarding assessment and treatment of a specific condition

## **Health Care Transactions**

Health care transactions include:

- *Purchasing of health care services* – Internet based tools facilitating referral and payment of health care services from employee spending and savings accounts, or direct out-of-pocket consumer payments, including any interface with participating provider discount programs.
- *Benefit selection and changes* – Internet or telephonic tools to facilitate initial selection or change benefit options the consumer is enrolled in.

- *Enrollment and status changes* – Internet or telephonic tools to facilitate initial subscriber or dependent enrollment, and subsequent status changes.
- *Claims submission, status and resolution* – Internet tools regarding submission of claims for payment that weren't submitted directly by a provider; and Internet or telephonic tools regarding status inquiries about submitted claims, and facilitation of communication of requested information in order for pending claims to be resolved.
- *Medical and Disease Management status and interface* – Internet and telephonic tools regarding status inquiries about health care services that require medical management or disease management authorizations or other program requirements, and facilitation of communication of requested information in order for authorizations to be granted or programs to be enacted.
- *Document retrieval* - Internet and telephonic tools regarding consumer retrieval of plan or provider documents such as provider rosters, plan forms, benefit documents, and other related items.
- *Customer service interface* - - Internet and telephonic tools regarding consumer interaction with plan to handle inquiries, and address service issues.



# Plan Design

## Defined Contribution Health Plans

Defined Contribution Health Plan arrangements do not directly control the internal plan design of each benefit offered. Instead, they determine the benefit selection of what options are to be made available for selection using the defined contribution allowance (except for vouchers, where the individual employee would make that determination.)

Such benefit selection is not limited to choosing which health plan benefit packages will be offered. Related benefits, such as dental, vision, long-term care, and spending accounts all could be offered as choices alongside the health benefit packages.

Defined Contribution Health Plan arrangements that involve employer-controlled expenditures of the defined contribution allowance really have no additional plan design issues. Defined Contribution Health Plan arrangements involving employee spending accounts present additional plan design considerations, as either FSA, HRA or non tax advantaged accounts would be included such offerings.

The employer allowance is then funded into the selected spending account, from which premium payments are made for the benefit plans selected, and health care services can be directly paid from any residual balances.

## Customized Health Plans

The fundamental issue for Customized Health Plan design is determining which benefits are variable and thus subject to consumer selection. Each variable benefit must have an actuarially determined premium dollar value attached to it, as the total premium cost of the Customized Health Plan changes based upon the variable benefits selected.

Significant analysis needs to be dedicated toward the selection of what items are to be variable benefits, and the premium value attached to them, so that potential adverse selection is taken into consideration.

For example, if generic prescription coverage is provided for all employees, an actuary might assume everyone would average 7 prescriptions per year costing \$25 per Rx net of copayments, for an annual premium cost of \$175 (7 \* 25). But as a variable benefit, meaning the employee could choose if they wanted generic prescription coverage or no prescription coverage, the actuary might not want to assign an annual premium value of \$175 to the benefit.

Instead, the actuary might assume “adverse selection”, meaning that the employees opting out of prescription coverage would be the ones least likely to use the benefit, and the ones electing the coverage would be more likely to use the benefit. Thus for the population the actuary assumes would elect the benefit, the assumptions might increase to 9 prescriptions per year at \$30 per prescription net of copayments, yielding an annual premium cost of \$270 (9\* 30).

The same principles apply if the variable is not coverage vs. non-coverage of a benefit, but involves the copayment, coinsurance, deductible or other benefit provisions. Adverse selection might occur for employees choosing between a \$5 and \$20 copayment for the generic prescription benefit.

Certain services will be more subject to potential adverse selection than others, and thus might be less likely to be offered as a variable benefit than others.

Variable provider selection for PPO and HMO Customized plans can also involve premium-pricing differences based upon the selection. Different provider network combinations may involve different utilization rates of services rendered, different contracted payment rates for these services, and different levels of quality outcomes, yielding differences in total projected costs.

As previously discussed, part of the distinction of what makes a plan a “Customized Health Plan” is just packaging. The same net effect of options can be given if a carrier offers separate distinct benefit plans in an open enrollment period that equal the same matrix of combinations of variable benefits.

What makes a plan a “Customized Health Plan” is the ability for the employee to select each option one benefit at a time in the enrollment process, as opposed to selecting an entire slate of benefits over other benefit plans offered.

## **Consumer Driven Health Plans**

Consumer Driven Health Plan design focuses on the following factors:

- 1) the provisions and funding level of the employee savings/spending account (or accounts);
- 2) the amount of the insurance plan primary deductible requirement;
- 3) the gap (if any) between the funded level of the employee savings/spending accounts and the insurance deductible requirement;
- 4) the benefit provisions of the insurance plan;
- 5) the carve-out of any insurance benefit to be excluded from being subject to the primary deductible requirement;
- 6) the relationships between the employee savings/spending accounts, the gap, the primary insurance plan benefits and any carved-out benefits.

Few Consumer Driven Health Plans are using MSAs for their employer-funded account. Initially Consumer Driven Health Plans primarily used FSAs, but since the IRS designated HRAs in 2002, the majority of such plans are now using HRAs. Some plans also add an employee funded FSA to fund the employee gap and employee cost sharing requirements. HSAs may be incorporated into plans in 2004 and thereafter.

The actual IRS revenue rulings and notices relating to HRAs and HSAs are available for review in the [Library](#). Key provisions set forth by the IRS for HRAs include:

#### A. General Provisions

- Cafeteria plan IRS section 125 FSA rules don't apply to HRAs
- An HRA can be offered on a stand-alone basis or combined with other medical plans (as is the case with consumer driven plans that combine an HRA with a wrap-around policy)
- Employers may deduct HRA expenses as a business expense for tax purposes.
- HRAs can function as a retiree health plan, and an employer could elect to create an HRA just for the retiree population.

#### B. Funding Provisions

- HRAs must be funded solely by the employer and may not be linked or directly funded by an employee payroll deduction
- HRAs may allow employees to carry forward unused funds to subsequent years. Limits are not set on the amounts that may accumulate.
- There is no limit to what an employer funds under an HRA, and HRA funding may be made on a periodic basis defined by the employer (such as annual, quarterly, monthly, each pay period, etc.)
- If employers offer an insured health plan in addition to the HRA, the employer may still require employee payroll deductions for the insured health plan coverage, so long as the deductions aren't directly linked to HRA.

#### C. Coverage Provisions

- Those eligible to participate could include current as well as past or deceased employees, plus all spouses and dependents of any of the above.
- Those not eligible include those associated with an employer who has never held an employer/employee relationship with the said employer, including self-employed persons, independent contractors, and business partners.
- HRAs may cover domestic partners if the employer verifies that the domestic partner qualifies under IRS Code section 152 as a dependent of the employee, or if the value of the HRA coverage for a non-dependent domestic partner is taxed to the employee as compensation.
- HRAs may not be limited to specific classes of employees on a discriminatory basis (such as only for highly compensated employees)
- COBRA applies to HRAs. Those eligible for COBRA may elect to continue HRA coverage under COBRA.

#### D. Reimbursable Expenses

- HRAs may only reimburse for employee, spouse or dependent medical expenses, as defined in IRS Code section 213.
- HRA reimbursements for medical expenses are made on a pre-tax basis (they are excluded from the employee's gross income) and can cover payment for other medical insurance premiums, including COBRA.
- HRAs may pay for covered medical expenses incurred in a previous year, so long as the HRA was in existence at the time services were rendered.
- Long-term insurance premiums may be paid from an HRA, but direct long-term care expenses may not.
- HRAs may not reimburse for specified ineligible items such as cosmetic surgery, and health club dues, as well as non-medical expenses in general.
- The IRS recently ruled the applicable over the counter medications are eligible for HRA (and FSA) reimbursement.

There are two core features included in most consumer driven health plan benefit packages: a Spending Account and a High Deductible Insurance Plan. High Deductible Insurance Plans refer to policies containing an annual deductible requirement of \$1,000 or more. The deductibles requirements of course vary by plan, with the most common levels being \$1,000, \$1,500, \$2,000, \$2,500 or \$5,000.

The spending account is typically a qualified FSA or HRA, funded by the employer. The average annual employer contribution to such accounts last year was \$898 for a single person, according to a Mercer Human Resources study. The average annual deductible requirement according to Mercer was \$1,496 for a single person. What happens to the difference between the two? The amount (which averages \$598 and is referred to as the gap) is the responsibility of the employee.<sup>10</sup>

Of course the above averages reflect a range of different funding levels and deductible requirements. A typical actual spending account for a single employee is often \$1,000, and the deductible amount is often \$1,500, leaving a \$500 gap for the employee to pay. The Insurance Plan coverage starts paying claims only after the spending account is exhausted and the employee pays the entire gap. Of course there is a wide range of actual amounts funded for the spending accounts, and for the deductible requirement.

Timing is an issue for claims regarding when the gap must be paid as opposed to payments being disbursed from the employer funded spending account. Currently, many plans allow the spending account to be drawn down first, and the gap is only paid after the spending account is exhausted. This in effect, provides first dollar coverage for initial claims. A number of plans are shifting to, or considering requiring the gap be paid first before the spending account is touched, either for some or all of their benefit options.

Another feature incorporated by almost 75% of the plans surveyed by Mercer is a separate preventive care benefit. 50% of the plans provided a preventive benefit schedule through the insurance plan where the deductible and coinsurance does not apply, however a good portion of these plans provide an annual maximum preventive care benefit, such as \$500. Another 25% of plans according to Mercer fund a separate spending account, nearly always an FSA.<sup>10</sup>

The insurance plan schedule of benefits is subject to wide variance between the plans. Typically the plans are structured as PPOs with percentage coinsurance.

Some plans also function as Customized Health Plans and provide customizable insurance benefits and or customizable provider networks that must be selected during open enrollment periods. This means the employee can potentially select between different “gap” levels, coinsurance levels, and different provider networks, with the selections affecting the level of premium contribution/ payroll deduction required from the employee for the benefit level selected.

Employee out-of-pocket expenses thus are comprised of three components for Consumer Driven Health Plans:

- 1) employee premium contribution / payroll deduction if any
- 2) the gap amount, and
- 3) coinsurance and any other cost sharing requirements under the Insurance Plan

One last feature to discuss that is included in some plans is an additional and separate employee funded spending account (typically a FSA) to pay for employee gap and coinsurance requirements. Under such plans, the employee elects to have payroll deductions made to this account, which then based on funds available, can provide payments otherwise subject to gap or coinsurance requirements

An illustration of a Consumer Driven Health Plan incorporating various features discussed is as follows:

<b>Insurance Plan Preventive Care Benefit</b>		
<b>Insurance Plan Deductible</b>		<b>Insurance Plan General Coverage</b>
<b>Employer Funded HRA</b>	<b>Employee Funded FSA</b>	

<sup>10</sup> “How Employers Are Offering Consumer Directed Health (CDH) Plans, 2003” Mercer Human Resources, May 2003 as published in “Inside Consumer-Directed Care” May 16, 2003, Atlantic Information Services.



# Issues

**We will discuss the following issues involved with Consumer-Centric health care:**

- Vouchers
- Adverse Selection
- Deferral of Care
- Claims Transparency
- Ability to Pay Increased Cost Sharing
- Reduction of Managed Care
- Impact of Hospital Claims
- Complexity and Confusion
- Regulatory Environment
- Collective Bargaining
- Factors for Success

## **Vouchers**

Defined Contribution Health Plan vouchers have generated far more publicity than actual business. Several vendors have set up Internet based solutions for employers and employees to manage voucher accounts, but the only interest to date, which is very limited, has come from the small businesses typically under 10 employees in size.

The reason for such limited interest to date is vouchers require employees to directly purchase health care coverage in the individual market. Individual coverage involves the following inherent issues:

- *Underwriting*: individual coverage may be underwritten, meaning an employee with even somewhat minor health problems might get turned down for coverage.
- *Age Rating*: individual plan premiums are age-rated, so that an older employee must pay a much higher rate than a younger employee, making it difficult for an employer to develop a fair defined contribution policy to fund the vouchers
- *Instability*: the individual plan market, as compared to the group plan market, experiences much more market entrance and exit by carriers, greater fluctuation in premium pricing, more frequent changes in benefit provisions, and quite often generally reduced levels of benefits compared to group policies

## **Adverse Selection**

Adverse Selection refers to when a healthier segment of the population enrolls in greater proportion to one type of benefit option as compared to another. In a typical traditional health plan environment, consumers are not offered a wide range of choices in benefit options, thus often yielding a relatively balanced population enrolling in a given option. In Defined Contribution, Customized, or Consumer Driven Health Plans, the often-wider range of choices may cause skewing of the enrolled populations into specific benefit options that best match enrollees' specific health conditions.

There are two separate concerns regarding adverse selection for consumer-centric health plan models:

- 1) adverse selection for a carrier offering multiple options in a Defined Contribution Health Plan, or for a carrier offering a Customized Health plan, causing the pricing between the carrier's benefit options to be out of alignment. Subsequently, the carrier will have to enact major premium rate adjustments or change the benefit options offered.
- 2) adverse selection between different carriers offered in Defined Contribution or Consumer Driven Health Plan arrangements, causing the pricing between carriers to be out of alignment. Subsequently, the carriers will have to enact major premium rate adjustments or one or more carriers may have to withdraw from being offered.

## **Deferral of Care**

Increased consumer cost sharing, and consumer control of expenditures from savings or spending accounts may cause consumers to defer needed medical care for financial reasons. Such deferrals would not only produce a bad health outcome, but also drive long-term health care costs higher.

The trends are new enough that no definitive long-term study of this issue is possible without the additional passage of time. Shorter-term studies have been produced supporting both sides of this argument, and are largely inconclusive to date.

However, it is difficult to argue that the greater the financial barriers or incentives not to receive care, the greater the potential exists for deferral of care. Therefore, a challenge in plan design will be to identify at what point such thresholds tip towards deferral, and structure the plan designs below those tipping points.

## **Claims Transparency**

While "price transparency" refers to making consumers more aware and less insulated from the entire price of a health care service, "claims transparency" refers to the consumer being more aware and less insulated from the claims payment process.

With employee savings and spending accounts, Consumers have a direct financial interest in monitoring claims payments from their accounts for accuracy and other factors. As a result, the process in which claims payment information is reported is undergoing change to accommodate consumer involvement.

### **Ability to Pay Increased Cost Sharing**

The significant ongoing shift in consumer cost sharing raises the issue regarding the consumer's ability to pay dramatically increasing out-of-pocket expenses. This issue has a major impact on providers who have traditionally billed consumers for such services, and collected on patient out-of-pocket expenses after services are rendered. Providers now face major potential collection related problems in this regard. New financing alternatives may have to emerge for providers and patients to deal with this issue.

In addition to deferral of care, and provider – patient collection issues, the increasing health care cost sharing burden for consumers will most likely have long-term effect on the economy as a whole, as dollars previously spent on other consumer goods and services or savings are now shifted to health care payments.

### **Reduction of Managed Care**

Many Defined Contribution, Customized and Consumer Driven Health Plan arrangements involve HMO and PPO plans. However, a few arrangements are structured with a complete absence, and many more with a reduction of managed care features.

While some would argue this is a positive trend, there reduction of managed care features raises several issues:

- The much higher cost of health care services when retail prices are paid instead of pre-negotiated managed care contract rates
- The potential for over-utilization of services in the absence of medical management features, driving total costs higher
- The potential for lower quality outcomes in specific cases in the absence of case management following patients requiring significant monitoring and attention, and in the absence of profiling of providers with comparative quality data

## **Impact of Hospital Claims**

For Consumer Driven Health Plans, inpatient hospital claims almost always exceed the annual funding for employee spending / savings accounts (as well as the annual high deductible requirement for the insurance plan) for just one day of service. Thus a consumer requiring hospitalization will not derive as much perceived benefit of a Consumer Driven Health Plan structure, and may not feel as empowered as another consumer that was able to participate in making purchasing decisions for much smaller units of service from their employee accounts.

One potential plan design solution that has not been adopted to date would be to create two separate deductibles for the insurance plan, a hospital deductible and a general deductible for all other services. The employer funded HRA would meet most of the general deductible requirement, and an employee funded FSA would be dedicated to the hospital deductible and any remaining gap.

An example for illustrative purposes would be a \$1,100 general deductible and \$400 hospital deductible insurance plan, with a \$1,000 employer funded HRA and a \$500 employee funded FSA.

## **Complexity and Confusion**

A number of employer and employee surveys have indicated that consumers are fairly confused regarding the details of how Defined Contribution, Customized, and Consumer Driven Health Plans work. The structures involved may be so complex as to create inherent confusion. The problem is that if a consumer can't understand a "consumer driven" product, is it really consumer-driven, and does it have much chance for success?

Of course, managed care has also been labeled as complex and confusing, and only the passage of time and high enough managed care penetration levels brought awareness of managed care features more to the spotlight.

Nevertheless, consumer-centric health plan models in their infancy should proactively monitor consumer understanding of their plan structures, and be able and willing to adjust and adapt accordingly.

## **Regulatory Environment**

Currently, except for IRS revenue rulings, the regulatory environment governing consumer-centric health plan models is generated from existing state insurance, federal ERISA, and other related requirements. The lack of additional regulations specific to applicable features of these models creates a situation where few standards and the potential for abuse exist.

Growth in this sector will most likely spur more specific state or federal regulations, which of course may be designed to enhance consumer protection, or be plan or provider friendly, or may be backed by opponents to this movement who seek legislation to damper its growth.

Until additional time passes, and the regulatory environment for this sector becomes more clear, some uncertainty hangs over the sector's "head."

## **Collective Bargaining**

Organized labor to date has not taken kindly to increased cost sharing, and as a rule, is proactively opposing initiatives involving consumer-centric health plan models that are perceived as benefit takeaways. Health care benefit issues have been named in some union surveys as a higher priority than salaries.

The ability for consumer-centric health plan enrollment to materially increase over time is dependent to quite a degree on how the sector positions itself in respect to collective bargaining issues.

## **Factors for Success**

A primary problem for the consumer-centric health care movement is that some arrangements have been structured with the sole goal of reducing employer costs through increased cost-sharing, but have been packaged for promotional purposes as a new "consumer driven" plan. While employee costs sharing in various forms is an extremely important aspect, long-term success requires that other elements to be in place as well.

In order to achieve such long-term success, employers must provide three things:

1. *Funding*: A sufficient funding of defined contribution allowances, or savings/spending accounts when applicable so that the employee does not view the program as a significant benefit takeaway
2. *Selection*: A sufficient menu of choices must be made available so that the employee buys into the concept that the employee is really getting to make some decisions, and the choices must provide one or more benefit options that do not represent significant reductions in benefits.
3. *Information*: Sufficient information and decision support tools must be made available to assist employees with choosing and using their benefit options



# Glossary

Related terms to consumer driven health care and benefits

- [Actuarial](#)
- [Administrative Services Only](#)
- [Adverse Selection](#)
- [Agent](#)
- [Annual Maximum](#)
- [Benefits Cycle](#)
- [Benefit Limitations](#)
- [Broker](#)
- [Cafeteria Plan](#)
- [Claim](#)
- [COBRA](#)
- [Coinsurance](#)
- [Commission](#)
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- [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#)
- [Health Maintenance Organization](#)
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### **Actuarial**

Statistical calculations used to establish health plan premium rates, or projected medical expenses, determined by analyzing cost and utilization for a defined population under a given plan of benefits..

### **Administrative Services Only (ASO)**

An arrangement entered into by an Insurance organization to provide specified administrative services for a self-insured employer or another insurance organization. Services could include claims processing, eligibility maintenance, premium billing and collection, financial accounting, etc.

### **Adverse Selection**

A situation that occurs within an enrolled population, when the enrolled percentage of members having specific medical conditions or of members of specific demographic classes, is materially different than the corresponding percentages of the overall population eligible to enroll.

### **Agent**

Insurance organization representatives licensed by their state to present insurance plans to potential and existing policyholders, and perform certain services on behalf of insurance company to the policyholder. Agents typically receive commission payments from the insurance organizations.

### **Annual Maximum**

The total dollar limit of covered benefits that may be applied per member or subscriber per year.

### **Benefits Cycle**

The concept that in the consumer-centric environment, future marketplace competition between health plans will not cause major fluctuations in premium increases that have historically occurred over periods of time (see Premium Cycle) and instead will cause periods of increased or decreased cost sharing and benefit coverage based upon economic conditions.

### **Benefit Limitations**

Any provision, other than an exclusion, which restricts coverage in the Plan of Benefits, regardless of medical necessity

### **Broker**

Persons licensed by their state to represent insurance buyers and provide them quotations from multiple insurance organizations. Brokers typically receive commission payments from the insurance organizations.

### **Cafeteria Plan**

A more historical term referring to Group Arrangements under which employees may choose from a menu of benefit options, and if properly qualified according to IRS provisions, may offer tax-advantaged options. Typically the plans involve an employer funded Defined Contribution with employees funding the excess cost of benefit options selected. Cafeteria plans often include benefits outside the scope of health care.

### **Claim**

The submission to the Plan by the subscriber or provider of required information by the Plan in order to determine if and what amount of benefits should be applied for the services rendered.

### **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act federal law, with respect to health benefits, requires applicable employers offering health coverage to provide continued coverage to employees and dependents after termination of their employment for a specified period of time at the same premium rates as the employer's group premium rates for the same policy (plus a maximum 2% administrative surcharge).

### **Coinsurance**

The percentage of covered costs for a specific service the member is financially responsible for under applicable benefit plans.

### **Commission**

A payment by an insurance organization to an insurance agent, insurance broker or benefit consultant who has placed a group or individual policy with the insurance organization. Commissions are typically paid as an ongoing percentage of premium revenue generated from the policy, but sometimes may be paid on another basis.

### **Consumer-Centric Health Care**

Health care and or health insurance that is rendered in a more consumer-oriented fashion than traditional health care, with the focus on involving consumers more in clinical decision making, in the financing of the care, and in enhancing consumer knowledge about their health care.

### **Consumer-Driven Health Plan**

Health care funding arrangements that typically involve a Health Reimbursement Arrangement or other type of spending account funded at least in part by the employer to pay for member claims up to an annual dollar amount, combined with a health insurance policy providing coverage for services once the account is exhausted. Such plans often also provide various value added health care informational tools for members. The purpose of such plans is to involve the member more directly in the selection and purchasing of health care services.

### **Consumerism**

The trend towards consumer-centric health care, direct-to-consumer health care advertising, and increased consumer health care cost sharing.

### **Coordination of Benefits**

Procedures that apply when a member is covered under two separate plans at the same time in order to determine which plan has primary responsibility for payment, which plan has secondary responsibility for payment after the primary payment has applied, what payments remain the member's responsibility, and monitoring to ensure that total payments from all sources do not exceed the total allowable amount for covered services.

### **Copayment**

A plan benefit cost-sharing feature involving a set flat amount per service to be paid by the member

### **Cost Sharing**

Specific arrangements whereby plan members pay for designated portions of their covered care, through plan benefit features such as copayments, coinsurance and deductibles; and or through payroll deductions funding a portion of the plan premium costs.

### **Covered Benefit**

Medical services specified in a Plan of Benefits and covered under the terms of the health plan contract between the subscriber and the health plan.

### **Customized Plans**

A defined contribution arrangement whereby an employer sets a fixed premium contribution, and a group package of multiple Plans of Benefits is offered by a single ASO, TPA or Insurance Organization. Subscribers may select their desired plan(s) during an enrollment period which will dictate the level of employee premium contribution required.

### **Debit Card**

A health care debit card involves issuance of card to participants in a qualified health care spending or savings account (such as HRAs, MSAs or FSAs) that can be presented to providers to transfer funds from the applicable account to the provider for payment of health care services rendered to the participant. In order for such accounts to properly qualify for tax advantaged treatment, the administration of the debit card payments must meet various IRS provisions.

### **Deductible**

A cost sharing mechanism whereby covered benefits are first applied to a specified dollar amount, which is the plan member's financial responsibility, and plan benefits are then paid after the Deductible requirement is fully met. Deductibles typically involve annual requirements (meaning that each plan year the requirement must first be met before benefits are paid) although sometimes they may involve other time periods or be applied per incidence.

### **Defined Care**

An umbrella term encompassing the various models of health funding arrangements and resultant system behavior involved consumer driven health plans, defined contribution arrangements and consumer-centric health care.

### **Defined Contribution**

A health plan funding arrangement whereby an employee is given a specified dollar amount each period from an employer or union to purchase health plan coverage or health care services from various available options

### **Design Your Own plan**

Subscribers choose their own set of providers and plan design features administered by a single ASO, TPA or Insurance Organization, which dictates the level of employee premium contribution required.

### **Direct-to-Consumer Advertising**

Advertising for health care services such as prescription drugs in mass media including print, radio, and television, targeted directly to consumers by the provider or vendors such as pharmaceutical manufacturers.

### **Disease Management**

Disease management involves aspects of case and outcomes management, but the approach focuses on specific diseases, looking at what creates the costs, what treatment plan works, educating patients and providers, and coordinating care at all levels: hospital, pharmacy, physician, etc.

### **Eligibility**

A process used by the Plan and providers to determine if a person is a covered member by the Plan at the time provider services are to be rendered. If so, the person is determined to be an eligible Member. If not, they are determined to be ineligible.

### **Employer Funded**

Employee Benefits that are paid for by the employer, in the form of Insurance Premium payments, saving or spending account funding, or other applicable items.

### **Exclusions**

Specific conditions or instances for which the health plan does not pay for and provide a covered benefit.

### **Favorable Selection**

Enrollment of members with relatively better health status than others in a defined population, while lower health status members enroll elsewhere due to conditions causing Adverse Selection.

### **Flexible Spending Account (FSA)**

A plan which provides employees a choice between taxable cash and non-taxable benefits for un-reimbursed health care expenses or dependent care expenses that can not roll over from year to year , and has qualified under Section 125 of the IRS code.

### **Formulary**

A listing of drugs chosen by an health plan, PBM, hospital or provider organization that indicates the specific drug(s) of choice applicable prescriptions. Drug benefit coverage levels are often tied to formulary use.

### **Group**

A employer, Union, trade association or other entity that has the capacity to enter into a Policy with a Insurance Organization, or to fund and create a self-insured Policy, or to fund savings or spending accounts, in order to provide Benefit Coverage on behalf of its individual employees, or retirees or other applicable members.

### **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Health Insurance Portability and Accountability Act of 1996. (HIPAA) A Federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

### **Health Maintenance Organization (HMO)**

Health Maintenance Organizations (HMOs) function much like an insurance company. They offer policies, collect premiums and bear financial risk. So how are HMOs different than regular insurance companies? Insurance companies are a third party to patients and providers. HMOs are also the provider. HMOs usually sub-contract out to provider organizations but also share financial risk with providers. HMOs require care to be delivered only by HMO providers, except in emergencies or under special benefit plans. HMOs, as the full name implies, emphasize preventive medicine.

### **Health Reimbursement Arrangement (HRA)**

Qualified employer funded health care spending accounts for covered employees or retirees designated by an Internal Revenue Service Revenue Ruling that allow for rollover from year to year of unspent funds on a tax-free basis. Such accounts may be included as a feature of a Consumer-Driven health plan.

### **Health Savings Account (HSA)**

Qualified tax favored savings account eligible to any taxpayer opening the account before age 65, in which tax free medical expenditures can be disbursed, as established by the The Medicare Prescription Drug, Improvement and Modernization Act of 2003

### **High-End Deductible**

An insurance policy with a relatively high deductible requirement, such as an annual deductible of \$1,000 or more for health plan coverage.

### **Insurance Organization**

An insurance organization could be an insurance company or HMO; and could be a health, dental or other specialty plan. An insurance organization offers a plan of benefits (policy) to members, and charges a specific dollar amount (premiums) for the plan. Plans can be offered on an individual basis, as group policies for employment-based coverage and under contract with the government. Insurance organizations bear the financial risk of paying providers.

### **Lifetime Maximum**

A dollar or service limit imposed under a plan of benefits for a specific benefit or for the entire policy that total cumulative payments or covered services by the plan cannot exceed, over the entire time the policy is in force.

### **Managed Care**

A type of health care delivery that emphasizes active coordination and arrangement of health services. Managed care usually involves three key components: oversight of the medical care given; contractual relationships with and organization of the providers giving care; and the covered benefits tied to managed care regulations.

### **Medical Management**

A system involving the oversight of medical care delivered by providers to plan members, administered by health plans, or contracting provider organizations, or by administrative organizations performing these services on behalf of health plans or providers. There are various components that can potentially be included in a medical management program.

### **Medical Savings Account (MSA)**

A private fund similar to an IRA (Individual Retirement Account) set up to save for future qualified medical expenses from the fund. MSAs were enabled under the federal Health Insurance and Portability and Accountability Act of 1996.

### **Member**

Each subscriber and dependent covered under a Plan of Benefits is called a member. Other terms used include enrollees and covered lives. A subscriber with a covered spouse and three children would equal five members.

### **Navigation**

In context of consumer-centric health care, navigation refers to providing consumers the tools to access applicable health care and benefit information, designed in a format with the objective that a layperson should be able to understand where and how to access the information. Navigational tools are often Internet enabled, but could also involve print, video and telephonic information.

### **Out-of-Pocket Expenses**

The dollar amounts the subscriber is still responsible to pay after the Plan has made payment for provider services rendered. Out-of-pocket expenses result from cost sharing requirements including deductibles, coinsurance, and copayments, as well as non-covered benefits, and costs in excess of plan maximums.

### **Participating Provider**

A provider that has contracted with an health plan, provider organization, ASO or TPA to provide services for specified managed care benefit plans.

### **Pharmaceutical Benefit Management (PBM)**

A Pharmaceutical Benefit Management (PBM) company or arrangement involves management of the drug benefit program, including eligibility, claims payment, formulary management, drug utilization review and other applicable functions on behalf of health plans and employers. Typically, a PBM company is a third party administrator, and does not bear the financial risk for the drug benefit. However, in some cases PBMs have borne or underwritten such risk.

### **Plan Design**

The specifications for a given plan of benefits, including the applicable cost sharing requirements that apply, as well as the list of covered benefits, exclusions and limitations.

## **Plan of Benefits**

The specified covered benefits, exclusions, limitations, maximums, copayments, coinsurance, deductibles, and other terms and conditions that apply to a specific policy.

## **Policy**

The document that issues and sets the terms of coverage for a Plan of Benefits between a Plan and a Group, a Plan and an individual, or a Plan and Subscribers covered through a group contract.

## **Preferred Provider Organization (PPO)**

The term Preferred Provider Organization (PPO) generally refers to managed care arrangements whereby plan members receive a higher level of benefits when they receive care from participating providers, and a lower level of benefits when they receive care from non-participating providers. The term PPO specifically can also apply to several different components within the above general definition. A PPO can refer to the Plan Design (a plan of benefits that has a dual option: a higher preferred level when PPO providers are used, and a lower standard level when non-participating providers are used); a PPO can refer to a provider organization that contracts with Insurance Organizations, employers, or TPAs to serve as the participating providers under dual option benefit plans; a PPO can refer to a TPA or other administrative organization that contracts with providers, and brokers these contracts with PPO Insurance Organizations or Employers.

## **Premium Rate**

Payment by a group or individual to an insurance organization in consideration for coverage under a policy offering a plan of benefits. Premiums are typically paid on a monthly basis.

## **Premium Cycle**

A health plan marketplace economic trend observed from the 1960's through the current era in which there are periods where health plan premium increases are generally significant, then diminish over time, and then rapidly increase again.

## **Self Directed Health Plan**

See Consumer Driven Health Plan

## **Self Insurance**

Employers and other organizations (such as unions) that directly operate their own insurance plan just for their employees or members. Instead of paying premiums, they set aside financial reserves to pay claims from providers. They might enter an contract with an ASO or TPA to process these claims and manage the self-insurance plan of benefits.

## **Section 125 Plan**

Plans that qualify under section 125 of the IRS code to offer Flexible Spending Accounts.

## **Subscriber**

Each person who has the health plan policy in his/her name, whether the policy is arranged just for the individual or for the whole family, is called the subscriber or the insured.

## **Third Party Administrator (TPA)**

An organization providing specified administrative services for a self-insured employer or an insurance organization. Services could include claims processing, eligibility maintenance, premium billing and collection, financial accounting, etc. Many times the scope of services provided by Third Party Administrators (TPAs) will not include all potential administrative services, but only certain components.

### **Tiered Benefits**

A plan design which specifies separate levels of benefits depending upon specified criteria, such as which providers render services, or the type of prescriptions orders. A standard PPO plan with a preferred benefit when participating providers are used, and a lower benefit when non participating providers are used could be referred to as a two tiered benefit plan. Some plan designs now include three tiered benefits for specified services such as prescriptions or hospital care.

### **Tiered Networks**

A tiered benefit plan design that specified the benefit level according to selection of providers with designated listings (networks) of providers. For example, a three tiered hospital benefit called the high, medium and low benefit tiers could be tied to selection of hospitals from the high, medium or low tiered networks.

### **Underwriting**

The procedures taken by an insurance organization to determine if coverage will be granted to an applicant for a specific plan of benefits.

### **Utilization**

Utilization in health care means “how often specific services are being used.”

### **Utilization Management**

The component of Medical Management that coordinates the utilization of services, with the objective of ensuring optimal versus over utilization of services (and hopefully also is designed to avoid under utilization as well.) Tools of utilization management include utilization review involving authorization requirements for specified services and retrospective review involving selected cases as well as profiling of provider statistics.

### **Voucher**

In a Defined Contribution setting, a voucher refers to employer funding whereby the employee must individually purchase coverage or services not arranged through a group policy

### **Web Enabled Tools**

In a health care context, Internet based information and applications designed for consumers, providers, employers or other constituencies that facilitate navigation and delivery of health care information, health plan information, decision support, and transactions between plans, members, employers and providers.

### **Wrap-Around Policy**

A high end deductible plan of benefits offered by an Insurance Organization that is offered in conjunction with an applicable savings or spending account such as a HRA, MSA or FSA.