

Value-Based Benefits Design Research

High-level Findings

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Value-Based Benefits Design Research – High Level Findings

During a period from late September to mid-October of 2010, a series of research forums were conducted to get feedback from those impacted by a value-based benefits design; the benefit design is intended for employers and individual purchasers in an Oregon health exchange. Insurers, agents/brokers, hospitals, providers, employers, consumers, and consumer advocates participated in the forums. **Attachment A (Methodology)** provides a description of the 20 forums that included meetings, small groups, in-person focus groups and online focus groups that were conducted to gather feedback. The key objectives were to 1) find out how these groups would be impacted by a value-based benefits design, 2) how they react to specific features of the design, and 3) overall how they respond to it given their own circumstances. The State of Oregon's value-based benefit design that was presented to the forums is shown in **Attachment B**.

Following are the high-level findings that cut across multiple groups. These are themes that represent the main ideas expressed over and over again. Following this sections are high-level findings for each of the groups.

A note about qualitative research:

Qualitative research represents an excellent forum for the free-flowing interchange of ideas with respondents. The results of focus group discussions can be seen as representative of ideas held by the persons in the communities from which the respondents are drawn. However, the results cannot be projected to an entire population. This is due to the small sample size, non-random recruiting techniques and the unpredictable effects of small group interaction.

Overall

- **Services that are “value-based” and services with low or no cost-sharing are appealing**

The first level of services (value-based, preventive, diagnostic and comfort care) is well received, primarily because they are at no cost or low out-of-pocket cost for the people. Part of the appeal is the belief that access to these services at low cost will prevent chronic conditions from becoming worse. People also appreciate that the first two diagnostic visits are covered in full and that preventive services will detect problems early when they can be easily treated.

- “If I could get help to stop smoking, that would prevent a lot of future issues.”

Despite the enthusiastic response overall, there are some reservations expressed. One is that there is a perceived inequity, because people with chronic disease – often resulting from poor lifestyle choices – actually get better coverage than people who have made different choices and are healthy. Another concern is the added cost as a result of the comprehensive coverage of value-based services, preventive, diagnostic and comfort care services. Some presume that

the comprehensive coverage will **add** cost to the monthly premium, not reduce the premium. Finally, people do not always understand how decisions are made about what services qualify as “value-based.” They have reservations about the placement of some services/conditions on the list and the absence of others.

- **An emphasis on wellness is desired**

The participants in these groups recognize that benefits such as office visits at low or no cost sharing, as well as some of the value-based services such as smoking cessation and immunizations, will prevent illnesses. Some people want to see an even greater emphasis on “wellness.” People (especially employers, brokers and consumers) expect to see services tied to nutrition, exercise, and healthy lifestyles. In addition, they want to see incentives offered for those who are maintaining a healthy lifestyle.

- “Also, does the tier system have any preventive care attributes? Not just screenings either. Healthy people do not go to the hospital/doctor as much. Is there a benefit [for covering the cost of membership to the] YMCA or similar? I know I had an insurance [plan] that encouraged that but don’t see that here.”

- **The levels and tiers are complicated**

In all the groups, there is the belief that all the levels and tiers are complicated and that consumers will struggle to understand and use their tiered benefits. Insurers, agents, hospitals and medical groups think it will take more of their time and additional administrative costs to explain the benefit design and unravel problems that they believe could happen when people do not have a good understanding of it. Insurers say that re-engineering their claims adjudication system to accommodate payments based on both diagnosis and procedure is complicated and that it could take up to a year to accomplish the changes.

- “I would guess that most patients would not know what they have and what is covered.”

Both insurers and agents believe that the level of complexity is one reason that few employers have adopted the value-based insurance products so far that are already available in the marketplace. Employers fear that their employees will be dissatisfied with something that is difficult to understand and that is perceived to have a greater out-of-pocket expense to them.

- “And small groups, unless it was a significant cost reduction, my gut tells me . . . your small groups, your under 20 groups, [would say something like] ‘Man, this is just too confusing.’”

- **Significant education and communication will be required to introduce this benefits design**

Since this benefits design is different in many ways than what most purchasers and consumers are familiar with, participants in all the groups say there is going to be a significant amount of education required.

- “It has to be in a language that [is understandable] – you have different sets of employees. Not all employees let’s say are created equal. Some will understand this whole concept. Some will be at the lower-end of the scale that this concept is going to be a little bit difficult . . . That’s probably the hardest thing to kind of overcome in a general marketplace.”

Employers say they will require significant education themselves to be comfortable enough with it to make a purchase, explain it to their employees, and provide ongoing support as the employees use their benefits and have questions about claims.

- **Lower premiums is a top criteria in selecting a benefit design**

Costs are the ultimate benchmark as these groups consider the value-based benefit design. First and foremost is the monthly premium. Although a few people say they would consider buying the benefit design if the premium were comparable to a traditional plan, many say it would need to be a significant discount such as 10 percent. Some mention discounts even higher such as 20 or 30 percent. Employers say that they would tend to offer this plan side-by-side with a traditional plan.

- “It has to be less expensive or they’re going to balk at that. Twenty percent or better.”

And some think that the premium for a plan design like this could be higher, not lower, due to the comprehensive coverage of chronic diseases and services that have low cost-sharing.

- “I’m not quite grasping where the cost savings (to the Plan) is realized. If the intent is for early treatment, there seems to be quite a loaded up front cost.”

- **The benefit design has some perceived inequities**

There is a perception that this benefit design could “penalize” healthy consumers both by giving them higher out-of-pocket costs, and also by charging them a premium that covers very comprehensive services for the chronically ill. The belief is that people who are basically healthy are more likely to need the services in Tiers 3 and 4 and therefore have higher cost-sharing. Part of the reasoning also stems from the perception that many of the chronic conditions are the result of poor choices in lifestyle – overeating, lack of exercise, smoking, etc. – and are things that healthy people should not have to subsidize.

Value-Based Benefits Design Research – Overall Findings

Also, some believe that low income people will fare poorly with this benefit design and be unable to afford the Tier 3 and 4 services when necessary. So for low income people, this benefit design would not merely discouraging those services, it would actually block access due to the higher cost.

- **The underlying philosophy has some supporters as well as detractors**

Some of the people believe that this benefit design will help chronic conditions from becoming worse, make it possible for people to get preventive care, and prompt consumers of health care to think more carefully before getting treatments that are not effective. But others think that there is no track record to determine whether a program like this can control costs. Some think there could be unintended consequences – for example, people that cannot access needed medical care because the disincentives and cost-sharing thresholds (deductibles and out-of-pocket maximums) make it cost-prohibitive.

Another opinion people express is that the benefit design is structured in a way that the consumer cannot find out beforehand what their out-of-pocket costs will be. Some of the service tiers are contingent on diagnosis, but diagnosis is not something that the patient knows before a treatment is offered and often it can be difficult to find out. Insurers say that by combining diagnosis and treatment criteria, it would not only be confusing for the member, but it would present the insurer with a complicated set of criteria to incorporate in their claims and reporting systems.

Some of the people that discussed this benefit design argue that if the benefit design were simplified it would not only make things easier for many of the groups impacted, but would actually save money; insurers, brokers, employers, hospitals and medical groups would not have to add the staff in order to handle added complexity.

- “And so to try to avoid [confusion and complexity] sometimes you have to make hard choices about maybe expanding the benefit a bit even if it’s not necessarily consistent with the intent, but for the ease of administration.”

- **People appreciate that the State asked for feedback on this benefit design**

The participants in these discussions express their appreciation for being asked by the State for input. One of the consumer advocates asked if the presentation is available online so more consideration could be given. A hospital participant in the online discussion is thankful for the opportunity to comment but gives a preference for a face-to-face group instead of an online forum. A medical group participant requests more lead time to schedule involvement, and also the possibility of inviting more than one participant from her medical group.

- “I’m glad people are looking into this and coming up with alternatives. Thanks.”

High-Level Findings Table of Contents

In the report that follows, there is a section of high-level findings for each type of group that gave feedback: Insurers, Agents, Hospitals, Medical Groups, Employers, Consumers, and Consumer Advocates. A small sample of verbatim comments is provided throughout the report.

Insurer Findings.....	Page 7
Agent/Broker Findings.....	Page 16
Hospital Findings.....	Page 21
Provider Findings.....	Page 28
Employer Findings.....	Page 36
Consumer Findings.....	Page 45
Consumer Advocate Findings.....	Page 52
Appendix A – Methodology	
Appendix B – Presentation Slides	

Insurers

Three small-group interviews were conducted with ODS, Providence, and PacificSource. (Kaiser declined an interview because they believe their delivery model does not lend itself to this benefit design, and Regence was not available for a group interview.) The sessions were 60 minutes in length. Each insurer's interview included four representatives from different areas of the company that could evaluate the impact of a value-based benefits design on the organization. The representatives included areas such as Executive leadership, Operations, Claims and Customer Service, Product Development, Marketing, Benefits/Provider configuration, Actuarial & Underwriting, and Information Technology. These themes represent the highlights of the insurer discussions.

- **Interest in value-based benefit designs in the market has been low so far**

Although ODS and Providence have developed their own value-based products and are just now rolling them out to the employer market, there have been no takers thus far. One comment is that the “jury is still out on value-based plans” due to their complexity. Another interviewee calls it a “tough sell.” A participant remarks that small groups will find it “too confusing.”

- “We have groups that will mention it as something they’d like to look at. We’ve had nobody that’s said, ‘We want to go with it.’ . . . The market’s telling us that they still don’t either get it or don’t appreciate it yet. “

- **Structure tiers by procedure or diagnosis, but together is difficult for insurers to administer**

Insurers say that it is easy to identify a benefit for claims adjudication based on procedure code **or** on diagnosis code. One participant says that paying a benefit on just the service provided is “straightforward and fairly simple to do.” But all insurers say that the two together – procedure and diagnosis – would not be easy to accommodate in their billing/claims payment system. The concern is that a procedure might be covered one way if it is one diagnosis, and the same procedure might be covered a different way if it is a different diagnosis. Another complication they report is that the diagnosis is not always on a claim.

Sometimes the lab and doctor will have different diagnosis codes. Or a situation with primary and secondary diagnosis codes could confound determination of how the benefit applies. Another concern is that health reform regulations could be at odds with a benefit design such as this. It is believed that some procedures (for example thyroid testing) are required under health reform – regardless of the condition. One interviewee envisions that a system like this could even necessitate looking at chart notes to determine how the benefit applies. The bottom line says one interviewee, is that it is simpler for a consumer to understand benefits based on procedures: “If I had this service then this is what I [have covered].”

- “These categories – there’s hundreds of codes behind them. So if you said, ‘Okay, diabetes is covered in full,’ . . . there could be 10,000 codes that have something to do

with diabetes, so does that mean all 10,000 codes are covered in this manner, and if so, then all 10,000 of those codes have to be identified and lumped together?”

- **Administrative impact is significant**

Throughout the insurer conversations, several areas of administrative impact are discussed. The impact is seen from two perspectives: 1) Handling claims adjudication, and 2) communicating with members and doctors about how the benefits will cover any particular situation.

- *Customer service:* One anticipated difficulty is providing customer service to members about how their benefits will cover a particular situation when the member may or may not know their condition/diagnosis. Customer service would need to determine if this is one of the first two office visits, the status of the deductible, etc. It will be necessary to ask more health information of the member and to make more assumptions about coding to give answers. Primary and secondary diagnoses could impact how a benefit is tiered, and the member may not have that information.
- *Automating information:* One comment is that while some of the information can possibly be automated, perhaps some cannot completely be automated. One of the most difficult areas, it is thought, is adjudicating lab tests/procedures that are diagnosis dependent, for example an EKG that might or might not be subject to the deductible depending on the diagnosis recorded by the lab. Another example of complex claims adjudication is a colonoscopy that involves not only surgery but anesthesiology, lab services, and other ancillary services that may or may not have the colonoscopy code. Polyp removal becomes even more complex, and is sometimes not associated with a colonoscopy procedure. One interviewee estimated there are an estimated 16,000 CPT codes, but another says it is more like 8,000. It would take a minimum of 12 months, estimates one interviewee, to adopt a claims adjudication system for the value-based benefit design.
 - “If it can be defined by a procedure code – that these procedure codes are paid at tier 2, and these procedure codes are paid at tier 3, and these procedure codes are paid tier 4 – we can do it, but somebody has to define those procedure codes. That’s the hardest thing that we have.”
- *Diagnostic tests:* It is also discussed that a balance is needed between the level of detail that can be automated and the amount of details that a member can reasonably be expected to track. One of the most difficult areas, it is thought, is tests/procedures that are diagnosis dependent. One problem is that the diagnosis is not always on a lab claim, or it is a general code. But if the diagnosis is known, it could determine how a procedure is covered. For example an EKG might or might not be subject to the deductible depending on the diagnosis provided by the lab.
 - “So that becomes both difficult to administer as well as difficult to explain to a member or a provider in terms of what is it that you’re paying for . . . is it treatment order, is it diagnosis mode?”

Value-Based Benefits Design Research – Insurer Findings

- *Pharmacy:* Medications under value-based services are difficult to adjudicate because the diagnosis is not on the prescription at the pharmacy.
 - The physician would know [the diagnosis] when they're writing the prescription, but they're not putting on the prescription that this is for [a particular] diagnosis. So when they go to the point-of-service pharmacy and get that filled, we would never know to not apply a co-payment, for instance, for a specific service because we wouldn't know what the diagnosis is.
 - *Physician billing:* One interviewee wonders how physicians can possibly collect co-pays at the beginning of a visit given that the diagnosis and treatments will not yet be determined. Also, this benefits design, it is believed, will make it likely that coding errors increase. With this benefit design, the physician that submits a benefit inquiry transaction for a patient to the insurer would also be required to submit more details about the treatment and diagnosis to find out how the procedure will be covered.
 - *Appeals:* Due to misunderstandings, coding errors, and misinformation or lack of information, insurers predict that the number of appeals will increase; it will be "labor intensive" for all involved including the insurers.
 - *Treatment cost navigator:* According to one interviewer, the treatment cost navigators provided by insurers are not often used even though insurers are required by law to provide them to members. Insurers say that the detail required by the value-based benefit design would require significant modification to their cost navigators. And it would require the member to enter significantly more information at the front end – perhaps information they do not have – to find out how the treatment would be covered.
 - *ICD9 conversion:* Current conversion from ICD9 to ICD10 would coincide and confound converting claims adjudication to a condition-based set of criteria. One insurer sees the ICD conversion as a "massive undertaking" that will span the next two years, with an effective date of 2012 or 2013.
- **The tiers are complex and perceived as arbitrary in some cases**

Insurers say that the tier structure could be simplified. Beginning with the first tier level with no deductible, a uniform cost sharing would simplify it instead of some services having no cost sharing and others having low cost sharing. Also the 4 deductible/cost-sharing tiers plus the 3 pharmacy tiers and the 3 diagnosis tiers could be simplified. One interviewee says that it feels like a "lottery" – depending on your diagnosis, you could get great coverage or poor coverage.

 - “. . .I don't think people are incented at that level of a detail – it's too complicated for them to grasp all of that. “

- **The benefit design may be complicated to explain to members**

When insurers visualize explaining the benefit design to members, whether it is on the phone or in an open enrollment meeting or online, they expect added challenges. Some think that a high-

Value-Based Benefits Design Research – Insurer Findings

level overview and examples will only go so far because 1) it would also be necessary to consult a detailed list and 2) people would not know the exact procedure or diagnosis. People, they say, are used to service-based cost sharing and a shift to diagnosis-based benefits would not be easy. Compared to the tiered services, the first level (value-based/no-deductible services) would be easier to communicate.

- “I have this thing wrong with me, then here’s what it costs me versus if I have this other thing wrong with me.”

Some insurers believe that it will be difficult, but necessary, to explain to members that some types of services have been proven to be less efficacious than others and therefore the member will be charged more. But other insurers feel trepidation about explaining to a member why a specific service/condition is in a particular tier.

- “. . . bladder infections – trying to explain to a consumer as to why a bladder infection would have a lower cost share than a compound fracture or broken arm – I don’t know how you explain that.”

Insurers point out that even the term, “life threatening” will require a definition that is understandable to members and also to insurers and providers so that procedures are coded correctly and without an increased administrative burden.

- “. . . the last thing that we want to do is stop every single claim, request chart notes, have an MD or an RN review it, and then tell us how to pay it. That would be complete cost prohibitive.”

One suggestion is that when customer service tells a member that a service is in a high tier, it is important to be able to explain to the member what the lower cost alternatives are.

- “You have additional [cost sharing] if they do this, but if you do this one, they don’t.”

The greatest concern is explaining the benefits is being able to understand the medical nuances, and getting enough information from the member to give reliable information about how benefits will cover each situation.

- “We’re almost going to have to hire nurses to be customer service reps because I don’t know that a standard customer service rep would know the clinical piece of it.”

Insurers comment that historically there is no benchmark from which to predict how well a benefit design like this can be explained. They go on to say that the OEBC benefit design that incorporates value-based elements is only now being introduced to their membership. The website that supports members is available but not yet being used extensively. As one interviewee points out, however, when tiers and variables are brought into benefit plans, history says that members struggle. For example, when a benefit design incorporates two

different out-of-pocket maximums, one for in-network and one for out-of-network, people struggle to understand.

- “[Currently we have the OEBC] shared decision model, but we try to get people to go out and look at the website, and I think they’re really struggling with it right now because they’re just going through open enrollment. . . . I think that somebody’s got to get creative on how to do this communication. And we haven’t been creative enough. We haven’t been able to figure out how to communicate it really well.”

One concern that insurers have (and consumers, too) is that members will not be able to anticipate or know ahead of time how to budget for their healthcare needs. Overall, they say the design is not “intuitive” so the member can understand what their costs are going to be. Until the member is actually diagnosed with a condition, the coverage and out-of-pocket costs are unknown. Insurers also anticipate that members could get caught between their providers’ billing practices and the benefit tiers.

- “Yeah, I think it’s going to be complicated to administer and to administer accurately 100percent of the time because you fall back to the provider’s billing practices, and it is going to be complicated for a layperson who doesn’t understand healthcare to know where their service is going to land. And this is just a small list, but there’s thousands of conditions.”

- **Customers might see the benefit design as a “take-away”**

Insurers say that the benefit design could be seen as a positive insurance plan, but if “it is not done well” there is potential for customers viewing it as a penalty.

- “. . . it looks like ‘you are trying to tell me what to do and give me worse benefits’ for your benefit. But what we’re really saying is, ‘the evidence is that this will be better for you...’”

Insurers caution that backlash could also occur in other ways. Greater numbers of grievances is one possibility. Another possibility is a greater adversarial relationship with between members and insurers. People might think their condition is in the wrong tier and feel their coverage is inadequate.

- “They’ll say, ‘You, the insurance company, are telling the doctor how to treat me.’ And they don’t like that . . . [But we would] say, ‘Well, we’re not saying you can’t get it, we’re just saying that you have to pay 70 percent co-insurance on it.’”

- **Members might not seek needed care**

Insurers say that deductibles are typically very high (the average being between \$1,500 and \$2,500 in the market) and cost-sharing for the member is already “pushed to the limit.”

Value-Based Benefits Design Research – Insurer Findings

Ultimately, with the value-based benefit design, people might not seek care when they truly need it.

- “I just worry about that from an incentive perspective, whether or not you end up with...especially as you look at the tier 4 treatments, are there things that people won't get treated that should get treated because they're worried about the cost-share?”

- **Premium price is paramount**

According to insurers, the primary appeal of the value-based benefit design is the first-dollar coverage for value-based/no deductible services. If the premium for that package were equivalent or lower than a comparable PPO plan, it would be strongly attractive to some employers. Insurers are curious if an actuarial analysis of this particular value-based benefits design has yet been done. A lower premium is needed to offset the difficulty of the tiered benefits of the design.

On the other hand, the plan could be appealing, one interviewee says, to employers that are struggling to offer any benefit package that offers their employees some coverage without very high deductibles.

- “But for those groups that do have the high deductibles today, this might be an attractive option for them because they could argue that most of their employees aren't getting a benefit at all because they're not meeting their deductible.”

Whether the price of the value-based benefit design is 10 or 20 percent less than a comparable plan, insurers say a lower premium is critical to attracting interested employers and individual purchasers.

- “I think employers would think it's too confusing unless there was a significant rate decrease for offering a product like this. . . . 20 percent”

Some insurers think there could be some adverse selection. People that have chronic conditions could “flock” to the plan. But others say that perhaps the adverse selection will be no different than other value-based products that are now being offered without any expectation for adverse selection.

- **Explore additional opportunities to control cost**

There are additional opportunities in this benefits plan that insurers say could control costs. First and foremost is a provider network. In-network providers are an effective means to negotiate lower costs. Another suggestion is to put differential co-pays or out-of-pocket maximums on each of the tiers. Furthermore, an observation is made that the out-of-pocket maximum is too low, it can inadvertently impact the incentive to avoid Tier 3 and 4 services.. If it is too low and is easily reached, there is no disincentive to avoid the higher tiers, especially if it is

a costly procedure. This dynamic between tiers and out-of-pocket maximum was noted by several interviewees.

- “If that was the first claim of the year, I know that I have 100 percent paid no matter what the rest of the year, so I don’t care if I have tier 4 services done or not. I don’t think it’s the right incentive for the member”

Some insurers question whether a Tier 4 is needed at all. They say that the incentive achieved by an even higher tier (for example 70 percent) has already been achieved at 40 or 50 percent – the belief is that the last tier adds to complexity and does not have the intended effect.

- “I’m guessing that actuarially speaking you’re not adding that much value when you get to 70 percent cost-sharing.”

- **Impact on the doctors is a consideration**

Insurers are wondering how doctors will know what co-pay to charge upfront when the procedure and diagnosis are not yet determined. They also say that the dynamics of the tiers could potentially pit the patients against their doctors.

- “They go into a doctor’s office and they don’t know what’s going on, and so, ‘Okay, well, I just went in because I had a stomachache and I didn’t know I had a bladder infection, so why are you charging me...’”

A word is being used by insurers, “up-coding,” to describe what could happen when doctors become aware of the financial pressures on their patients and decide to code a procedure or diagnosis so that the patient’s cost sharing is minimized.

- **If there is an incentive to get care in an outpatient setting, 5 percent is not a large enough**

Some insurers say that this kind of an incentive (plus 5 percent for outpatient versus minus 5 percent for inpatient hospital services) is easier than the value-based benefits approach for members to understand. And administratively, it is also more straightforward. However, they say that Medical Home adds another dimension – for example, if a service has been managed within a medical home, it should be eligible for lower co-insurance even if it is inpatient. And the definition of “medical home” itself would be important to determining what benefit is received.

- “. . . you could put that on benefit materials to say, ‘Services received at your medical home: \$15, \$20, \$30. Outside of the medical home [is higher]’”

Some people believe that if a doctor makes a referral, whether it is for care in an outpatient or inpatient setting, it should be a lower co-insurance. The emergency room services are also complicated to adjudicate with this rule. A “true emergency” it is assumed, would have the

lower co-insurance. Other qualifiers such as care needed on nights or weekends might impact the co-insurance rule.

- “It would be administratively difficult because . . . we’d have to look at those [emergency room] claims because . . . we’d then be trying to decide whether it was life [threatening] – well, was there was a true emergency or something they could have even gotten at the medical home?”

- **A step-wise approach to treatment and tier benefits is a good approach**

Some insurers believe that for certain costly treatments in Tier 3 or 4, it is important to try less costly alternatives to treatment first. If, after that, the problem is not resolved, the costlier treatment should be covered at a lower Tier with lower cost sharing for the patient. An example that is given several times is back surgery. Back surgery is an extreme, costly solution for back pain. However, participants are saying that if the other treatments for back pain have been tried and failed, and the severe back pain persists then the “right treatment” could be back surgery.

- “There’s some of these value-based benefit things where it’s more of, if you do step one, step two, step three and you still need surgery then it’s going to get covered at a rate similar to a typical plan because you’ve done step one, step two, step three. But if you don’t do those three and you jump straight to step four then you don’t get coverage. So these are more sort of black and white, one way or another.”

- **Other insurer topics**

Following are some of the other topics that emerged from the discussions with insurers.

- *Equity*: The equity of the value-based benefits design is troubling to some insurers. Since some people have very high deductibles, it seems inequitable that by chance a person has a condition or needs a Tier 3 or 4 treatment and must pay out of pocket for a large sum simply due to chance.
- *Dental, vision, and mental health coverage*: Insurers wonder why dental and vision services included in the tiers when typically those services are offered in separate benefits products. Insurers ask whether dental and vision overall will be incorporated together with medical benefits. Mental health is also a category of services that requires clarification on how health reform will approach them – part of a standard benefit plan, or not.
 - “You can’t pull out obsessive compulsive disorder under mental health and say you’re going cover it differently. [Health reform] kind of lumps everything together.”
- *Healthcare reform*: In general, insurers wonder how the provisions of healthcare reform will be incorporated in the value-based benefit design. As an example, the plus-or-

Value-Based Benefits Design Research – Insurer Findings

minus five percent co-insurance design option that was tested could be at odds with healthcare reform.

- *Terminology clarification:* Terms such as “life threatening” and “basic” lab and x-ray will require detailed definitions, both to help members understand their coverage and also to help the insurers when their claims adjudication systems are modified. The term “tier” itself can be confusing. One insurer has abandoned that term and uses the term, “value level,” instead.
- *Oregon Health Plan:* Insurers and others in this research project associate the value-based benefit design with the Oregon Health Plan. People sometimes assume this design is for the low income population. Some perceive the benefit design as “rationing,” and others are concerned about provider access.
 - “The second bullet [Tier 4] point sounds like the above-the-line and the below-the-line for OHP . . . It does. That’s exactly what I was thinking . . .”
- *Questions:* Other questions elicited by the benefit design are:
 - *Comfort care limits:* “Is there any limits on the comfort care then, or is it just pretty broad?”
 - *Network:* “And this is a non-PPO plan, right, because there’s no in and out of network differentials here? . . . You may have a different deductible . . . you’re still trying to manage the costs and you want to focus under the providers [not just] the services.”
 - *Referrals:* “I would hope that we weren’t going to be requiring referrals at this point. We’re not going back to HMO days are we?”
 - *Tier criteria:* “What’s the split between like a severe chronic disease and other chronic disease, between like the tier 1 and tier 2?”

Agents/Brokers

Three interviews were conducted with insurance agents/brokers. One Portland agent services primarily small businesses under 99 employees, another Portland agent services primarily businesses with 100 to 500 employees, and the third interview was with an agent in Bend that services primarily individuals and groups under 99 employees. The interviews were 60 minutes in length.

- **Some employers would consider this design, but employer demand for a value-based benefit design is low so far**

One agent says that some employers with more than 100 employees are would look seriously at the State's value-based benefit design because they are struggling to offer something affordable to their employees. One estimate is that 30 percent of the market would look at a benefit design that is lower cost and includes basic care the way this benefit design does. It is asserted that some employers are not able to offer "full traditional products" but would see this as an alternative. It is anticipated that employers with large union-covered employees would not see this as an option. Another agent says it would not be difficult to sell this benefit design, especially if the premium is 10 percent lower than a comparable plan. The recommended approach is to present it as an option, with advantages and disadvantages.

- "Here's another option. I can do this and then within that plan, if people do things correctly, there's advantages, there's disadvantages.' I think people will be attracted to that, I really do."

On the other hand, brokers (and insurers) acknowledge that several health plans currently offer a value-based benefit design product, and few employers have adopted or incorporated value-based features thus far. They say that while there has been some interest, but no one seems ready to take the plunge. Not all employers and their employees, they say, are ready for the perceived "restrictions" placed by a plan like this. One agent says that employers see the value-based plans as complicated and pose added difficulty explaining it to employees. Because employers see health benefits as a hiring tool and key to employee satisfaction, they are cautious about significant changes.

- "Three or four health plans offer a value-based plan and the take-up is low. There are trade-offs and (employers) are not willing yet."

- **This is a good approach to save costs**

Agents are positive about the potential for the value-based benefit plan to save costs, especially with chronic conditions. They believe that treatment of these conditions with little or no cost sharing will prevent needless emergency room visits. It is also seen as a way to give people more involvement in their healthcare.

- “So we’ve eliminated that cost sharing, get people to do these things on a more regular basis to affect the bigger picture. I think there could be a lot of value there. It would be positive.”

- **Preventive benefits are important, including incentives to gain/maintain health**

Some see the State’s value-based benefits design as emphasizing prevention by treating and controlling chronic conditions and reducing more expensive costs. The deductibles and cost-sharing that is waived for preventive services is very important. But others want to see a more aggressive approach that provides monetary rewards to the member for being in good health and getting preventive services.

- “There’s also no reward for somebody that does things right, tries to be healthy.”

Upfront services for chronic disease and first two diagnostic visits are embraced philosophically as a way to promote health and provide basic coverage. Some say the two visits will adequately cover the healthy individual who may need a visit or two during the year. But not all agents are sure it will reduce costs.

- “I like that it doesn’t ding those moderate, healthy users of the plan. That it maintains very good benefits for those with certain chronic condition. I like that. I think that is all good.”

- **The perceived confusion and complexity for employees is a disadvantage**

Even though agents support the intent of the benefit design, the complexity of it and resulting confusion for employees is a disadvantage. Understanding the tiers and how the out-of-pocket costs will work will be difficult for people using this coverage. Although it has potential to promote “consumerism” it is also going to create confusion. It may force the consumer to “wait and see” what the price will be because it may be difficult to know ahead of time.

- “Is it under the value-based tier? Is it tier 1 - 2, 3 or 4? What am I going in for?’ I think that is going to be very complicated for an employee trying to understand what they need when they need it.”

It is the tiers that are perceived as counter-intuitive to the agents. One agent assumes the tiers are categorized according to chronic, acute or emergency services. Agents question the placement of certain services in tiers, for example: The placement of reproductive services under value-based services; placement of emergency dental care in a medical plan; putting attention deficit disorder in Tier 2; and placing a liver transplant for cancer in the same tier (4) as low back pain. Some are uncomfortable with categorizing treatments into tiers in the case of a serious illness such as cancer.

Value-Based Benefits Design Research – Agent/Broker Findings

- “To explain to someone why their particular cancer treatment is considered not effective and therefore a lower benefit level. That’s a little offensive I would say.”

- **Overall the tiers will be effective in impacting decisions about when to seek care**

Despite the confusion, some agents think the tiers will be a successful approach to influence member’s decisions about getting services for things that have less costly alternatives. Some say the State’s value-based benefit design is actually simpler and more straightforward than others and it “would not be difficult to communicate.”

- “I love this . . . That a patient will see an immediate incentive to consider the not so expensive scans. The CT, MRI, PET scans. We still don’t see this changing much in the market place in my view. Everyone still thinks they need an MRI.”

- **Significant education and communication with consumers will be needed**

Agents see a large education effort to help employees, and even to help employers, understand how to use this benefit. They recommend education that uses a lot of examples. Other recommendations are to provide: 1) A short explanation in “layman’s terms” that lays out the intent and approach; 2) a list of pro’s and con’s that speaks to the positive benefits; and a 3) good definition of the basic terms which consumers often do not know.

- “I think the biggest issue will be here’s tier one, tier two, tier three, tier four, and are very concise. There can’t be shades of grey . . . Some will understand this whole concept. Some will be at the lower-end of the scale that this concept is going to be a little bit difficult. They’re going to go, “Well, why?” That’s probably the hardest thing to kind of overcome in a general marketplace.”

- **It is all about cost**

Whether it is lower out-of-pocket costs or a reduction in premium, it is cost that will drive the employers’ decisions about a benefit design like this. Agents say that employers may or may not accept that the design will lead to a reduction in claims cost. Offering the benefit design at a lower premium is essential, but there could still be employer skepticism that ongoing savings can be achieved.

- “One thing would be the employer would have to see a pretty good premium reason to do this. The premium for the value-based plan should show a pretty significant decrease in the rate compared to a typical plan . . . I would love to see if this plan was 10 percent cheaper than this [comparable traditional] plan here.”

- **Agents/brokers have perceptions of “government involvement”**

One of the agents expressed concern about government involvement, a concern that was also expressed in other groups. This agent presumes that the government will get involved in areas such as underwriting that has traditionally been the business of insurance companies. There is concern that government involvement will mean new regulations that are perhaps not needed.

- “Here you have the state going in and being a provider. Insurance carriers with underwriting, this is their business . . . The regulations and because of those it costs money to go, ‘Hey, you changed things. Now we’ve got to redo this.’ You’ve got to change all of these pamphlets, redo this, and I think that can create cost.”

- **Incentives for outpatient versus inpatient care receive mixed feedback**

There are varying perceptions of the feature to lower co-insurance by 5 percent for outpatient care and raise co-insurance by 5 percent for inpatient care. Some think that there is already an incentive built into benefits designs by requiring higher co-pays for inpatient care. But others say there would not be resistance by consumers to an incentive such as this. One thought is that most services that can be delivered on an outpatient basis are already being done that way. A concern is expressed that “patient safety” could be jeopardized if people focus on the benefit incentive instead of their doctor’s advice, or they delay needed care in order to avoid an emergency room visit. Assuming that there are still procedures that can be done in either setting, the participants say that 5 percent is not a sufficient incentive – it has to be much more.

- “I think a five percent spread is not going to shift that trait of going, ‘I want healthcare now.’ [It should be] let’s say a 10 or a 15 [percent higher].”

- **Agents have additional questions, concerns, and recommendations, many of which reinforce those made by other groups**

Comments were made during the agent discussions that reflect some of the same themes from other groups, especially employers and consumers. These are some of the repeated themes:

- *Pre-authorizations:* One agent suggests that pre-authorizations would be a helpful step because it would alert the member that it is an advanced/less effective treatment that could bring higher out of pocket costs.
- *Rationing:* While the tiered approach may be the best way to encourage evidence-based treatment, it will be seen by the consumer as someone telling them “no” and a denial of coverage.
- *Provider/patient dynamic:* A concern (also voiced in other groups) is that treatment often hinges on a doctor’s best advice even though it is the patient who pays the price when the advice places the treatment in a high tier.

Value-Based Benefits Design Research – Agent/Broker Findings

- *Step-wise treatment:* Some want to know if the tiered design incorporates the stepped approach wherein people follow less costly treatment options first, and if they are not effective they advance to the treatment that is more costly.
- *Terminology and definitions:* One agent says that “diagnostic” is not a term that is normally used in describing coverage. There is confusion about whether the two upfront visits are only diagnostic or whether it applies to any office visit. He says the definition must be clear when the design is communicated.
- *Adverse selection:* Some agents question whether a value-based benefits design should be offered alongside a more traditional plan. They see it as all-or-nothing, and would offer the value-based benefits design as the sole option.
- *Out-of-pocket maximum:* Agents argue that the out-of-pocket maximum should be a level (\$3-5,000) that will not bankrupt people who have a catastrophic event. Members that have a family out-of-pocket maximum that is often three times the subscriber’s maximum, are especially vulnerable to hardship.

Hospitals

An online focus group was conducted with seven representatives of hospitals in Portland, Corvallis, Hillsboro, Eugene, Salem, and Bandon. The forum spanned a three-day period during which participants logged on for 10-15 minute segments to answer questions posed by the moderator and to comment on the answers of other participants. In addition, separate meetings were held in-person with 1) four Legacy representatives and 2) one representative of St. Charles Hospital. The meetings lasted 45-60 minutes. Across all the participants, the hospital areas included Patient Financial Services, Contracting and Business Development, Managed Care Contracting, Business Planning and Analysis, Financial Operations, and Community Development.

- **This benefit design is a more rational approach than traditional insurance plans**

Some hospital participants believe that this approach is on target because: 1) It is based on evidence, 2) it engages the patients in where to get care, 3) it keeps chronic conditions from getting worse, 4) it reduces high dollar expenditures, and 4) it encourages patients to be proactive.

- “We’re managing via claims management right now, but that’s after the exposure has occurred where here we’re talking about coming back to a chronic care condition, maybe identifying it before its chronic. And I know that’s the principle that underlines the whole essential benefit package.”

But others are not convinced that it brings the right approach. One argument is that the benefit design would use cost-share as a tool to influence patient behavior, but it would not influence the “decision maker” which is the doctor. Another view is similar – that it puts all the pressure on the shoulders of the patient, especially in Tiers 3 and 4 where the evidence may not be the strongest. Another participant says this approach does not address payment reform.

- “My biggest concern with this whole thing all along has been that it’s had very much an insurer view of how to deal with it. I mean the insurance companies have an approach of if something’s out of control you increase the cost share or you put in an authorization requirement or something. And it misses, it doesn’t get to the true decision maker in the doctor essentially, how do you get to that, and does this do that? And I don’t think it does.”

- **Preventive care coverage is good for patients**

Hospitals are in favor of good coverage of preventive services; they think this benefit design will remove cost barriers, encourage patients to better utilize their primary care physician, improve compliance with physician recommendations, and reduce inappropriate use of the emergency room. Ultimately, one participant says, there will be better health outcomes when people get health screenings such as mammograms. One participant suggests that IT tools would be

needed to track compliance and remind patients when screenings are due. Some would like to see financial incentives/disincentives for getting recommended preventive exams and screenings.

- “One question I have is whether there are going to be any ‘sticks’ to go along with the ‘carrot’ for those who don’t get their preventive services as recommended. For example, our employer gives us a discount on our health insurance premium for ‘knowing our numbers’ [cholesterol, blood pressure, etc.] and if, after two years, you don’t ‘know your numbers’ your premiums will increase.”

- **There could be an adverse financial impact on hospitals**

Many hospitals anticipate that the high co-insurance in Tiers 3 and 4 might mean that more people will not be able to pay their medical bills. Hospitals, they say, could have more bad debt as they write off the charges. The other financial impact will be the added cost to administer a more complex benefit design. Hospitals express frustration that they cannot control providers that prescribe inappropriate treatments.

- “I feel that many of our patients may be unable to handle the increased financial burden provided by the additional coinsurance. This would likely increase our organization’s bad debt write-offs and impact our patient satisfaction.”

Others do not see any impact, at least not by the first level of benefits for value-based/no-deductible services. Since many of the services are outpatient treatments, some participants say it would have no impact except perhaps to reduce inappropriate use of the emergency room.

- **The conversation between the doctor and patient could change – some think positively and others negatively**

There are those that think that conversations with patients will not be impacted by the value-based benefit design. Overall, most participants think that clinical care will be impacted less than the hospital’s administration. They say that physicians will continue to take care of patient’s medical needs without regard for how much the patient will pay out-of-pocket or how much the provider will be paid. Others think that the physician-patient conversation could improve as patients become more engaged, and patient compliance could improve. The conversation could shift, they believe, towards prevention, wellness, adherence to treatment plan, medications, and compliance.

- “As a facility based provider we would be performing the service based on order or referral. I foresee more conversation regarding the covered criteria and if there is an out-of-pocket expense to the patient.”

But others predict that conversations between physicians and patients could become adversarial, as physicians attempt to choose the best treatment for a particular patient and the patient struggles with the cost sharing implications.

- “So the struggle I’ve had with this all along is that basically what you’re doing is you’re putting the benefit plan between the patient and the doctor; because what’s going to happen is you’re going to have a doctor that says, ‘Yeah the evidence doesn’t necessarily say this is the best way of treating this, but in your case my professional opinion is this is what we need to do.’ And the patient says, ‘Well my health plan doesn’t think so, so I’m going to have to pay more.’ So it really is designed to manage physician behavior and yet the pressure and cost is on the patient. So you’re throwing a wrench between the patient and their doctor.”

- **Medical home is an optimal way to deliver this benefit design**

A frequent comment by hospital participants is that “medical home” model is the best way for patients to get the care at the correct level and to take responsibility for their own health. This benefit design and the medical home model have the same goals: Link the patient to their primary care physician at every opportunity in order to get the best care, at the correct level. One idea suggested by a participant is to use the medical home approach for as many people as possible, but use the value-based benefit design for those people who are not enrolled in a medical home; this would assure that preventive services are used and that care is received at the right treatment level.

- “. . .[suppose that the VBBD] is the approach you take with people who choose not to enroll with a medical home. And if they do choose to follow that path and follow the rules within the medical home, which means you follow the care that’s being managed for you, with you hopefully, then the tiers are moderated or go away . . .”

- **Hospitals do not always agree with how treatments are assigned to tiers**

Similar to other group discussions, hospital participants do not always agree with how treatments and conditions in the examples are assigned to each tier. The term “rationing” is used in conjunction with this benefit design; they say that a particular set of criteria that favors some treatments over others may not apply in every situation. One argument is that while a particular procedure in Tier 3 or 4 might not be appropriate in many cases, it might be the most appropriate procedure for a particular patient.

- “The simple example is if a patient comes in with a broken arm, the doctor will examine and take care of it. Doing so will cost the patient more money yet the treatment was in fact necessary. The rationale for the tiering of services seems arbitrary and I believe will increase administrative expense for everyone.”

- **Hospitals want doctors and patients to have tools to make sure the best treatment at the correct level is being used**

More than any other group, the hospital participants suggest ideas that can help providers deliver the best treatment at the best level. The first one is the step-wise approach that has been discussed by other groups. The goal is to assure that only the most cost effective and evidence-supported treatments are used initially and if they are not effective, the more costly treatment is used next. Another suggestion is to gather and analyze practice patterns in order to incentivize physicians in addition to the tiering approach. One participant recommends that EMR systems now make it possible for doctors to have access to best practices, standards, and tiering information at their fingertips as well as the evidence behind the tiering. Hospitals say that it is unreasonable to expect most doctors to take the time to get familiar with every patient's health insurance, but electronic tools can give them a customized view of options for each patient and the research behind it.

- “If these exchanges become prevalent, there's a motivation for doctors to become more experienced or to use tools that might be provided. We all know that doctors can't keep current on everything.”

- **Make the benefit design simpler**

One recommendation is make the design simpler and to look at the Providence PEBB Choice Plan as an example. Some are concerned that patients will need significant coaching to know the list of 20 services, since it would be impossible to memorize it. Providers also cannot be expected to know all the insurance benefits in detail. Another comment is that this benefit design deviates from the OHPR Administrative Simplification work group; this benefit design could generate more administrative costs that could offset any savings in patient care.

- “Someone goes to the doctor and it is asthma. No deductible, no payment. The bill goes to the payer to process it. The patient does not know until after the fact. The provider (cannot be expected to) say, ‘You have asthma and you will be required to pay [a certain amount of the charges] . . .’ There are too many (insurance) plans for them to know that detail.”

- **Education and communication to patients is crucial**

Hospitals think that poor understanding of the tiers by patients and also providers could lead to mix-ups and confusion. They say that many people do not understand the “intricacies” of their benefit structure, and that education will be of supreme importance.

- “We deal in the reimbursement side of things – we're going to get inundated [by complaints that arise when] a physician may go ahead and provide whatever level of service and the patient's not going to understand that this is a tier 4 service.”

Value-Based Benefits Design Research – Hospital Findings

During the hospital online group, despite a full explanation of the benefit design, some participants did not understand the tiers as evidenced by one participant's comment that patients need to have their tier clearly identified on their insurance card – incorrectly thinking that members are assigned to tiers.

Regarding education, hospitals wonder whose responsibility it will be to educate the patient on the benefit design and cost tiers. It is believed that it will take more time to explain this design so that patients can have a better understanding of evidence-based medicine. Some say this will impact hospital and provider productivity and others say it will indirectly impact hospitals financially because those who are caught off-guard by being charged a high co-insurance might not pay their bill.

- “. . . I think a lot of it is just making sure that people truly understand and have more incentive besides just the cost side of things to move into something like this.”

- **Administrative impacts are significant**

Not all hospitals agree that the added administrative demands will be significant, but many say it will. The added demand stems mainly from the complexity of the tiers, although some participants believe they can adapt their administrative systems so that it “can be done” successfully. Verifying benefits and patient responsibility is an important function at the front end of hospital service, and that first step would be more difficult, according to some hospital participants. Some think it will require a “whole new coding paradigm.” And another impact could be lower patient satisfaction due to the difficulty of knowing ahead of time what their cost sharing will be.

- “Some meds and labs are covered at no/low co-pays, for certain medical conditions, yet the associated MD office visit may have a higher cost to the patient because it falls into a higher tier. Isn't this adding to billing complexity? Also, a potential patient and provider ‘dissatisfier’?”

Some hospitals say that the benefit design will require more resources for patient registration and for training in the hospital business office. Business office functions such as cash management, reimbursement, systems, billing and the customer care center will all be impacted. Making system updates will require more resources.

- “Collecting the accurate co-pay/coinsurance from the patient at the time of service would be nearly impossible for registration/front desk reps. I don't know if payers will be able to figure it out, it's a mess [as it is] now!”

- **Hospital strategy could focus more on outpatient services**

Many hospitals say their strategy would not be impacted by value-based benefit designs, but three of the participants say that in the future, this would mean incorporating a greater

Value-Based Benefits Design Research – Hospital Findings

emphasis on outpatient services. Hospitals say they support a preventative approach to medicine, and with this benefit design a greater focus would go to those efforts.

- “Certainly if offering these types of benefits improves patient outcomes (mostly in an outpatient and physician office setting) and overall utilization trends for inpatient services decreased across the population of patients, then how and what services are offered would need to be reviewed. It would make sense to devote healthcare resources to areas where they would be most effective and utilized.”

- **A 5 percent reduction in co-insurance for outpatient care might not have the intended effect**

Predictably, most hospitals object to an additional 5 percent for inpatient services, and some say that 5 percent less for outpatient services would not work as intended. The first problem they have with an incentive for outpatient care is that patients often do not understand the difference. Another problem is that even if they do understand, 5 percent is not a sufficient incentive to change decisions or behavior. For those indigent patients who fail to pay their co-insurance for hospital services, a 5 percent incentive is meaningless. One participant maintains that it is a predicament because some services are not effectively delivered outside a hospital, and it seems an unfair penalty to make the patient pay 5 percent more in co-insurance for something that can only be done in a hospital.

- “If the suggestion is to impose a higher coinsurance for, for example, MRIs or surgical procedures done in a hospital setting, vs. these same types of procedures done in a non-hospital based/free-standing setting... this type of design would be unacceptable to most integrated systems and/or hospitals.”

- **Hospitals have questions, concerns, and recommendations and many are similar to those made by other groups**

- *Low demand:* A hospital participant observes that while three or four insurance plans now offer a value-based style of benefit, few employers have selected them so far.
- *Provider incentives:* Give doctors incentives and better information regarding their practice patterns so that the financial impact is not only on the patient but on the doctor as well.
- *Negative impact on health status:* The tiers could create a disincentive on treatment so that needed care is delayed.
- *Beware unintended outcomes:* Provider dissatisfaction could lead to “disengagement from their contractual arrangements.”
- *Remove the highest tier:* The co-insurance rates of 40 or 50 percent at Tier 3 are significant enough to impact patient decisions, without including an even higher one, i.e. a Tier 4.

Value-Based Benefits Design Research – Hospital Findings

- *Consider new forms of reimbursement:* One participant explained that phone outreach by nurses has been shown as effective in managing compliance with Congestive Heart Failure treatment, but currently it is not possible to be reimbursed for those services.
- *Premium increases:* It is assumed that the expanded services with no deductible and low/no cost sharing will result in higher premiums and lower consumer satisfaction.
- *Authorizations and disputes:* Hospitals wonder how authorizations for services will be handled in conjunction with this benefit design, and whether there will be disputes that arise out of requests for exceptions. If payers and providers have a payment dispute, they wonder how it will be resolved and who decides.
- *Other benefit design options:* Hospital participants question why a simpler benefits design is not being considered. Some are aware of the Health Leadership Council design and they wonder why that simpler design was not adopted. Some of the insurance companies' value-based benefit designs are also thought to be simpler.
- *Comfort care importance:* There are several comments about the comfort care benefit. One is that more training for providers is needed in handling comfort care conversations with patients and families. Another comment is that beyond terminal illnesses, there are some serious illnesses, for example severe disorders of children, which warrant services to promote quality of life. Overall, it is applauded that palliative/comfort care is being covered more broadly. One participant thinks it is important to provide a definition so people know the scope of care that is envisioned.
- *Pharmaceutical benefits:* Since the 20 value-based services will have a significant impact on pharmacy benefits, altering the co-pays will shift the dynamics between the pharmacy providers and payers.

Medical Groups

An in-person focus group was held in Portland that drew participants from Portland, Tigard and Vancouver. Eleven (11) different medical groups were represented including primary care, multi-specialty care, and specialties such as anesthesiology, outpatient surgery, pediatric cardiology, newborns, and women’s specialty. The participants included physicians, practice managers, and billing managers.

An online focus group was also conducted with participants from Coos Bay, Hillsboro, Salem, Portland, Bend, Eugene and Seattle (a medical lab). Thirteen (13) different medical groups were represented including primary care, multi-specialty, and specialties such as plastic surgery, radiology, outpatient surgery, lab testing, cancer treatment, home infusion and specialty pharmacy. The participants included physicians, patient advocate, practice management, billing manager, director of managed care, and claims/payment. The group session spanned a three-day period during which participants logged on for 10-15 minute segments to answer questions posed by a moderator and to comment on the answers of other participants.

Note: During the recruit of medical groups (and hospitals) only one person per organization (with two exceptions) were allowed to participate. The goal was to gather information from as many perspectives as possible and also to prevent any single group from dominating the conversation. However, there were groups that wanted to send more than one representative to the session.

- **There will be added administrative impact on the medical groups**

The participants say that patients often expect the medical group’s receptionist and billing office to know the details of the patient’s insurance. The medical group personnel say they are already overwhelmed by the demands on their time, and believe that educating people on their coverage is the rightful role of the insurance company, not the doctor’s office. With a benefit design such as the value-based design, some providers say it would be very difficult to give their patients accurate information about what would be covered at what benefit tier. For example, a single visit could begin as a screening exam, but due to the symptoms and family history it can become something more intensive that requires lab tests and diagnosis of a condition. When it comes to pharmacy, medical groups wonder how an insurance company will know that a particular medication has been prescribed for a particular condition.

- “Also, what happens when patients have multiple issues, some of which are covered under this first- level benefit, and others that are not? It would be best to structure a benefit plan that takes that into consideration as many patients have multiple conditions and they will be looking to the physicians and office staff for answers as to what is covered and what will cost them out of pocket.”

Value-Based Benefits Design Research – Provider Findings

Medical groups also think that their front office staff will not know which co-pay to charge at the beginning of a visit nor how many visits the patient has already had, especially if the patient has received care at other provider offices. Some wonder if co-pays will need to happen retroactively.

- “So how are we supposed to know when a patient walks in the door with a sprained ankle whether it’s a Tier 3 or a Tier 4 co-pay, because we don’t know yet [whether it is] sprained or broken? If it’s broken it’s Tier 3 and if it’s a sprain it’s Tier 4. So how are we supposed to manage that at the front door?”

Participants that represent specialties say that certain unique aspects of treatment require a different approach. For example, cancer care (Tier 2) probably would require large out-of-pocket costs for the patient with this benefit design because diagnostic workups and cancer treatments are so expensive. Another example is pediatric cardiology – patients are referred by their primary pediatrician but the underlying problem could be anything from gas in the ribs to something more critical; the problem is that the diagnosis happens after the expensive diagnostic tests.

On the other hand, some medical groups do not think the conversation with their patients would change significantly if a patient were to have a value-based benefit plan. They say that it is unusual for patients and doctors to have any discussion about cost sharing or financial matters unless the provider is aware the patient is having financial difficulties. Instead, they say, providers focus their conversations on medical necessity, not their patient’s insurance coverage.

- **Medical groups do not always understand how medical services will align with the structure of benefit tiers**

There are those participants who see the value-based list and the tiers as a “sterile structure” and wonder how ongoing care will be handled that might not neatly fit the evidence-based categories. Some are concerned about childhood chronic illnesses such as ear infections that can sometimes be agony for the child and could result in possible hearing loss if not treated. The access issue is one of affordability balanced against the “child’s best interest.”

- “There are always categories of patients that kind of fall out of the guidelines or sometimes they’re left up to the judgment of the physician so it could put a lot of burden on . . . the clinic [to explain to the patient] why you [are prescribing a] treatment that may not be on that high value list in a particular circumstance. I know geriatrics is a common example . . .”

Others wonder who determines if a medication is effective. They say there are always exceptions when something that is not ordinarily effective is indeed effective for a particular patient. Some are concerned about the authority that a central body such as the Health

Services Commission would have; they are also worried about timely updates, since evidence and research is constantly changing.

Some say that the two-visit benefit (without deductible and low/no cost sharing) seems inadequate in certain circumstances. One situation is newborn care and newborn illnesses, when more frequent visits during the first year are to be expected. Case management is another example when more than two visits are typical. Primary care and specialty care in mental health are normally more than two visits. And finally, there are some evidence-based care guidelines that recommend more than two visits as part of the protocol.

- “So if you’re doing evidence-based care, some of the guidelines for treating these actually tell you to see them more than twice a year. ...if you were going by the evidence and the accepted guidelines, the times a year could adjust for them, I guess, per the disease.”

- **There will be a potential for patient dissatisfaction due to charges in high tiers**

The medical groups are anticipating some dissatisfaction among patients, and also among themselves if patients direct their “disenchantment” towards their providers. It is the benefit design restrictions that providers think will be most troublesome for patients because currently patients see access to care as a right. Medical groups suspect that authorizations and exceptions could be burdensome, and that patients will get angry when they are surprised to learn that a procedure will be a high tier with high cost-sharing.

- “I foresee that we will be spending more time explaining why the service that they need/want is not included in the first level of benefits. Some things that are clearly indicated and cost effective for a patient may not be included in the list of freebies. This will create some confusion and may cause these services to not be accepted. Some of the included services may not be clinically indicated and we will be explaining to patients why they don’t need it.”

- **An administrative impact on medical group is anticipated**

There are some medical groups that do not anticipate difficulty administering the benefit design as long as the program is “clearly defined.”

- “The difference on the provider side would be the ability to collect or charge for co-insurance, co-pay and deductible at the time of service. The provider would need to know what benefit plan is driving the patient care and collect and or bill patient responsibility accordingly. This can be done especially with electronic look up that most insurers currently support.”

However, most of the participants think that this benefit design would mean administration changes, sometimes significant, for their medical group. Many of the medical group participants

expect it would be necessary to add staff to handle a benefit design like this, particularly additional time for educating the patient. When patients are surprised by their tier and cost-sharing, some say they might balk at paying their bill. Medical groups have difficulty envisioning the kind of software at the State level or insurance company level that would be needed to code the benefits and track services, for example the two diagnostic visits.

- “We would attempt to educate the patient on their possible cost sharing amount at the time of the visit but really won’t be able to do any collection at the time of service due to the complexity of this design and they typical patient’s needs.”

Some participants like the design because it helps people afford preventive care or because the tiering could be a good strategy to change patient behavior. But they say those advantages could be outweighed by the cost added to providers and the cost overall to the system and members.

- “I do like the desire to create more access for customers. It is rather complex operationally and would increase provider operating costs, thus increasing cost of care. We’d have to staff up, probably incorporate new pre-visit procedures etc.”

- **An impact on reimbursement is expected**

Medical groups say this benefits design could effectively reduce their reimbursement level in two ways: 1) Less upfront fees collected and 2) more people unable to pay their deductibles and co-insurance bill. Some even say they could not participate in a benefit design like this and that it could “put us out of business.”

- “Patients look to physicians and office staff to understand and explain what is covered, or what is not. We’ll be dealing with very upset patients if they’re surprised by an out-of-pocket expense when they did not expect one. We will have difficulty collecting payment when that happens.”

- **The value-based/no-deductible services will encourage patients to get care**

Although participants think there would be significant administrative changes required by this benefit design, they do not foresee the same degree of influence on clinical practices. Some think that the benefit design would even have a positive impact. For example, medical groups are enthusiastic about the first level of care because they think that patients would be more likely to get the care they need, and that communication with the patient would be enhanced. By covering chronic conditions, it is believed that doctors and their patients would get good control over the illness to prevent it from worsening. Some also believe that it would improve compliance and perhaps diagnosis. One participant says that for the services that are no-deductible/no or low cost-sharing, it would reduce collection costs and make the patient’s upfront interaction with reception staff go more smoothly. Another participant states that to

make the upfront benefits easy to administer it must be very clear when a patient comes in for their service (lab work, for example) that there is no out-of-pocket cost to the patient.

- “Willingness among the population to seek out services will likely rise. And if so, a marked increase in our ability to communicate with patients about healthy lifestyle choices, care management options and the like. Currently, some patients are quite reluctant to seek care because of high co-pays and deductibles.”

Under this benefit design, comfort care is an area that can make a real difference for patients according to some medical groups. They say that with the cost barriers gone, patients (especially cancer patients), will be much more likely to get the care they need, when they need it. However, they also say that it is important to clearly define what is included in comfort care. One participant is worried that when families and patients decide to stop further treatment, then all medications would stop. Another participant wonders if primary care clinics are expected to provide this “specialized focus” of comfort care; if so, she says extensive training would be needed.

- “Again, individual patients need to maintain the option of potentially expensive treatments as a component of comfort care.”

Medical groups say that mental health is another area could be better for patients by being within the value-based benefits coverage. One participant says that primary care doctors often see patients with multiple medical and mental health issues under the existing mental health “carve-out” benefit coverage; with this new benefit design, it could be easier to manage if the doctor can use a mental health diagnosis and address those problems along with the patient’s other issues.

- **An emphasis on education and prevention would help prevent chronic conditions from happening**

Several participants say that treatment of chronic conditions such as obesity, mental illness, and substance abuse should be coupled with strong prevention services that would also be covered in full. One says that “patient activation occurs too far down the health continuum.” They would like to see a stronger education component in this benefit design. And one participant is even concerned that the richer the chronic disease benefit, the less inclined people will be to get involved in their personal health maintenance.

- “The US misses the mark in early and ongoing intervention and education throughout our population’s early growth and development. We are a nation that promotes low personal energy expenditure (lack of exercise), famously high fat and sugar consumption (fast food), and low personal accountability for the resultant health impact. Once in a sad state of health, we have a notion that we can walk in to any healthcare provider and get a quick fix for all that ails.”

Value-Based Benefits Design Research – Provider Findings

Another need for patient education, some say, is to understand the benefits themselves. Health benefits are a “muddy” area for many people, according to one participant. As benefit costs have become more expensive and cost sharing for the member is increasing, people are not always getting more familiar with their coverage. One participant envisions that it would be a shock to some patients when they go to a specialist for treatment and are confronted with Tier 4’s 70 percent co-insurance .

- “Until medical services are required, very few people understand their coverage and most expect it to pay more than it does. Benefit coverage has decreased and cost has increased.”

- **Physicians focus on medical care, not health insurance benefits and will need some new tools to make this work**

Medical groups say physicians cannot be expected to know the intricacies of this benefit design on top of all the other hundreds of designs that their patients may have. That puts the provider at a disadvantage to have conversations with patients about what things will cost.

- “And I think the physicians truly don’t have – at least in my practice – don’t have a high understanding of insurance and what’s covered and not covered and they truly don’t know offhand who’s covered by what.”

Some of the participants envision that their group’s physicians/providers will do what they always have done – deliver the “most cost effective” medicine they can in each situation without regard for insurance benefits. Others see medical groups having perhaps a greater focus on prevention.

- “I would think we would put more time into making sure all our patients have preventive care appointments. Currently it is very hard to know who has and has not that type of care.”

A prediction made by several participants is that those physicians/providers that do have a greater understanding of the benefit design would “up-code” their diagnoses so that their patients have a more favorable cost-sharing arrangement. Up-coding by doctors might happen, participants say, so that doctors can ease the financial burden on their patient or even to ease the burden on a clinic that does not have to collect a co-pay.

- “Unfortunately, there may be some ‘diagnosis shift’ from less reimbursed conditions (URI) to higher reimbursed conditions (Sinusitis). This shift will be asked for by patients, and providers will likely be willing to do this because of the decreased hassles and not needing to bill the co-pay to patients.”

Several suggestions are made to help providers navigate a benefit design like this and to help patients find out what their cost sharing will be:

Value-Based Benefits Design Research – Provider Findings

- A triage nurse,
- Case management services,
- An educational service that patients could call,
- An online tool for office staff to use to estimate a patient's out of pocket costs.

Participants say that for both patients and providers, tools are needed to explain the overall benefit design and to give determination of what will be covered and the cost sharing for the patient.

- **Medical home is top-of-mind for many medical groups as they evaluate this benefit design**

Medical home is one of the most frequent areas of discussion during the medical group sessions. Although some see a medical home model as more expensive in the short run, they believe there will be much better health outcomes in the long run. Some believe comprehensive case management that is part of a medical home model can achieve some of the same things that the value-based benefits design is attempting to do: 1) Better compliance, 2) get the right care at the right place in the medical system, 3) avoid duplication of services, and 4) ultimately reduced health care costs.

- “This relates to the improved primary care model where a patient chooses a Medical Home and is then welcomed and introduced to the care team at that Medical Home office. This involves a process called ‘on-boarding’ into a physician practice with an initial visit, orientation, patient activation agreement, full exam, treatment plan development, and scheduled next visits or referrals.”

- **Medical groups are skeptical of the benefit design with a 5 percent drop in co-insurance for outpatient care and 5 percent increase for inpatient care**

Although these participants represent medical groups that deliver mostly outpatient types of care, only one participant says the 5 percent incentive would change patient behavior as intended. The others say it could have many unintended consequences such as penalizing people with cancer for getting specialty treatments that are only available in a hospital due to safety for all concerned. Also, patients could be penalized because typically they have no control over the setting for treatment. Furthermore, they say, an incentive like this could sway a doctor to treat a patient in a primary care home to save money when the hospital was truly the best choice. And finally, the patient themselves could make a wrong decision if there was, for example, chest pain and the patient decided to avoid the ER to save on cost. An alternative approach suggested is to have a place for patients to call and find out whether the facility is the right decision given the circumstances. With this approach, when people do make the right choice, there would be no penalty or disincentive for those decisions.

Value-Based Benefits Design Research – Provider Findings

- “There has to be some way of triaging those people. They’re not going to be able to make the decision. Somebody has to kind of make it for them. Even if they know they’re going to save the money, I don’t know that they will necessarily make the correct decision.”

- **There are other problems with financing healthcare**

There are some medical groups that do not believe that the value-based benefits design will address the fundamental shortcomings of payment for medical care as it exists now. One participant says that an insurance-run healthcare system is a for-profit model that is not suited to paying for needs that are basic to our population. Another says that this benefit design simply covers the least expensive care and shifts the most costly care to the patient. It is thought by another participant that a change in the provider reimbursement model should be incorporated in this benefits design so that doctors are rewarded for effective use of resources. Finally, some are worried that people will delay or forego needed care under a value-based benefits design in order to save costs.

- “As economists will point out, healthcare lacks ‘moral hazard.’ It is viewed by most as an entitlement. Entitled to be made healthy at no cost. I’m not sure how to fix this. It is very personal and very dependent upon a certain willingness to be accountable for the care consumed. Does a no-cost front-end accomplish this if necessary care on the back end is not also fully paid for?”

- **In some cases, medical group strategy might change**

Some medical groups do not foresee any change in their organizational strategy if this benefit design were to become common. But other groups do envision ways that it might impact their strategy such as placing a greater emphasis on educating their patients on the value-based/no-deductible services. One participant says their medical group’s work could actually become easier, although in the long run it might mean that there would be fewer patients overall. And another participant says that by increasing their overhead for education and billing, it could shift their focus to higher margin services instead of higher value services as intended. However, one participant claims that if pay-for-performance were part of the design, it would not necessarily shift their focus to high margin services.

Employers

Feedback on the value-based benefit design was collected during several employer forums. The first session was a focus group in Portland of employers sized 100-500 employees that included eight representatives from a variety of industries including manufacturing, law firms, education, restaurants, healthcare, and car insurance/travel services firms. That session was followed by another Portland focus group of public employers that included eight representatives from state, county and city government as well as one school district. A focus group in Medford of employers sized 25-100 was held that included eight representatives of companies in industries including retail, manufacturing, healthcare, transportation, real estate development, a car dealership, and a retirement community. Additionally, an online focus group of employers ranging in size from 25 to 250 employees had nine representatives that were from these cities: Joseph, Independence, Portland, Klamath Falls, Eugene, Bend, and Salem. They represent industries including construction, real estate, agriculture, restaurants, manufacturing, non-profit services, and banking. Among all the employer groups, the participants are primarily HR or benefits directors/managers, but also their titles included a controller, office manager, employee benefit specialist, bookkeeper, deputy administrator, CFO, Safety Director, payroll specialist, and director of business and support services.

- **The value-based/no-deductible services will be good for employees**

Employers recognize that the upfront value-based/low-cost sharing services will mean healthier employees, and less out-of-pocket costs. The employers that have minimum wage workers say that the two visits per year without co-pay would be helpful to their employees. Several comments acknowledge that employees with chronic conditions such as mental health issues or diabetes will now be able to afford treatment of their condition. Also, several comment that the coverage provides an incentive to get preventive care and to treat conditions before they become severe.

- “I think the positive is that the initial visit is at no cost, therefore employees would be willing to go to the doctor earlier in their sicknesses before they got to the point of needing further care.”

One participant believes that this benefit design would result in lower utilization that would help to keep premiums low, and as a result, minimize the share of premium that employees must pay.

- “As an employer, having lower utilization of the health plan does help keep competitive rates available to the group plan. In our case, this helps keep the cost such that we can cover all of the premiums for our employee’s health insurance. Under our current plan structure, if utilization/rates increase, we may have to have our employees share some of the cost of the insurance premiums.”

Value-Based Benefits Design Research – Employer Findings

Several employers support the idea that people who would use this benefit design would consider the cost sharing impact before they get treatment and perhaps change their decision about treatment.

- “So it seems like what the thinking here is that typically people will want whatever the doctor will suggest that they do. It doesn’t matter what the cost is. ‘I’m sick; I’ll take it all; give it to me, give it to me.’ And here it’s being set up in such a way that it requires people to think a little bit about what treatments I’m going to take and not just necessarily take anything that the doctor will throw at me.”

Not all the employers believe that two visits with no deductible are sufficient, especially for families with young children.

- “You get two a year, but if you’ve got a 2-year-old you could use those two in the first two weeks . . . You’ve got a young family with three kids and they’re all under age 10 you’re going to be beyond that in the first couple of months you’ve got your plan.”

- **Perceived inequity is a concern regarding coverage of chronic conditions**

While most employers support the comprehensive coverage for chronic conditions to keep illnesses from getting worse, there is an impression that the benefit design means that healthy people “pay more.” They say there is an element of unfairness when those who lead a “cleaner, healthier life style” are getting a lower benefit value, while those that have chronic conditions due to lifestyle choices such as smoking and diet are getting a higher benefit.

- “I have an employee who is having these treatments right now, it is expensive. This employee put herself in the bind by not taking care of herself. There needs to be a careful balance so the people who are putting themselves in these situations don’t feel they are just going to be ‘bailed out’. The people doing the bailing out are going to be the ones who don’t need these services but are going to pay higher premiums.”

- **Prevention of illnesses is a high priority for employers**

Employers associate “value based” with wellness and offering wellness programs to keep employees healthy at a lower cost. Some are concerned that many of the value-based services are chronic conditions due to “lifestyle choice” and they want their benefits program to have an impact on that as well. Employers are focused above all else on controlling costs and many believe that a focus on prevention is a good way to control costs. They support the features of this benefit design such as the two upfront doctor visits without deductible/cost sharing, but they want an even greater emphasis on education and prevention. And some believe that incentives should be offered to people that do follow healthy practices.

- “The part that seems missing, at least at this preliminary start, is what’s being done to control the cost? And not just how often people use it, but what are the physicians

charging for the cost? How is it way more transparent? . . . There's not a lot of preventive from education and teaching so that people don't end up with diabetes. . . . but can't we start when they're young and prevent it instead of, 'Here, let's throw some medication at it.'"

- **Education is important to help employees understand**

While the challenges of educating people about a benefit design like this are significant, one participant maintains it will be worth it in the long run.

- "I'm thinking this should have been done 50 years ago and it would just be second nature to everybody now, so there's a huge learning curve."

Employers do not think it will be easy for employees to understand their out of pocket expenses with this benefit design. One participant asserts that even with less complicated benefit designs, employees are "overwhelmed" trying to understand them. Another participant adds that it would be simpler to let the doctors make decisions about treatment, "instead of the insurance company."

- ". . . I think trying to explain these tiers to the employees would be a nightmare. We have very good coverage right now and our employees have choices, but I can tell you that they do not want to have to look at tiers."

One participant thinks it is important for employees to understand not only the tiers but the foundation of value-based benefit designs – medical evidence and the intention to lower cost behind this benefit design.

- "I think it would be really important to be able to message to the users of the service the kind of the science behind it since it's such a new way of looking at insurance. People aren't used to having things parsed out that way."

Another concern is that people will not have the information they need when they need it. Often the point at which employees need to know their options and cost sharing is when they are at the physician's office. They fear the responsibility of explaining the benefits will be on the provider's office.

- "I think it'll put the burden on doctors to explain how the plan works as opposed to the administrators."

- **Some employers misunderstand the concept of tiers or think that their employees could have difficulty comprehending it**

There are comments during the discussion that suggest even some employers are not able to understand how the tiers work, despite the detailed explanation just given. One participant

assumes that the coverage was limited only to the 20 value-based services. Another assumes that only two exams are covered. Some employers are concerned that their employees will misunderstand; for example the employee might think that approval or authorization is needed for procedures such as an MRI, instead of knowing they should consult their benefits coverage and talk to their physician about whether it is needed or there are other options. Some employers had difficulty understanding how the tiers would work.

- “I have another question. If someone went with the Tier 1 and they’re 21 years old, when would they have the opportunity to change to another plan? When they got married and had kids and upgrade to Tier 3?”

- **Communication of the benefit design is the biggest challenge**

In thinking about communicating this benefit design, employers say they will need significant education themselves in order to do the communications. But one participant perceives that greater consumer involvement would be a “welcome change.” Another states that communication is not merely something that will happen at open enrollment, but throughout the year as employees use coverage and receive their bills. An added comment is that despite an emphasis on education about health benefits, people often do not retain information about their insurance benefits.

- “The tier plan will be very different to our group and will cause confusion for some. More area for questions. More time will be required to explain initially and more time during the work week will go to helping employees with questions. Not a problem but a concern.”

These are some of the employers’ suggestions for communication methods:

- Open enrollment meetings for both employee and spouse as well as Intranet material with lots of examples to explain why cost sharing will be higher for some diagnoses and procedures
- Lots of scenarios showing how the plan works
- Hand-outs and a verbal presentation, because take-home packets will not be sufficient
- A one-page spreadsheet or flyer listing the tiers
- Wallet cards
- Website with FAQs, articles, explanation of the design
- Internet tool to enter diagnosis or treatment and find out tier coverage
- Nurse hotline or advice nurse to call about benefit detail and options
- Newsletter
- Broker and insurance carrier presentations at staff meetings
- Individual sit-down with employees by administrators of the insurance

Value-Based Benefits Design Research – Employer Findings

Employers say that their staff will require substantial training in this benefit design in order to handle communications. They maintain that the first level of coverage (value-based/no or low cost sharing) is the simplest component to communicate, but they say the tiers are going to be challenging. They believe that providing a good explanation and answering employee questions to reduce the confusion, is going to be a big responsibility.

- “Administration of a tier plan will involve training for benefits manager to completely understand what procedures are covered under which tier level so they can provide answers on coverage questions. Employees will be confused at first and will delay setting appointments until they understand their out of pocket costs. I see my phone and email stacked with questions. If clearly written materials are provided to each employee to look up what tier each prescription or procedure falls under that may reduce the questions and confusion.”

A participant says communication must be a team effort that involves all the players involved so that it does not fall only upon the employer.

- “If this is where it’s going then I think that it’s just going to take a lot of communication, not just by employers offering these plans but by the government or by whoever is running the exchanges. I think it’s got to be a joint effort between insurance companies, medical providers, employers...to get people’s mindset almost flipped around really in some of the cases of how to utilize healthcare and healthcare insurance.”

- **There could be special considerations for employers that have unions, employees in other states, and employees that do not speak English well**

Some employers say they would face added challenges by offering a value-based benefit plan. Employers with segments of their employees in unions must negotiate any changes to the benefit design with the union; employers say that significant changes to union benefits are usually resisted. Employers with employees in multiple states find that educating their out-of-state employees/families is particularly difficult because they cannot hold in-person open enrollment meetings and they cannot offer direct HR assistance. There are some employers who assume that the benefit design will not be available in other states. One participant says a significant change in benefits such as this benefit design is something their company would approach very slowly. Employers with non-English speaking employees say it would be a challenge to communicate benefit designs to them, especially something as complex as the value-based benefit plan.

- “There’s a lot of complexity of the plan so from an administrative standpoint, explaining it and particularly, as she said, in my case we have multiple languages and union, non-union, multiple states and so forth.”

- **Greater administrative resources could be required to help employees understand the tiers and coverage**

In addition to the training needed that was explained earlier, employers think they will spend more time researching coverage levels on behalf of employees and finding out if something is on the value-based services list. In addition to that, they think they will spend more time on following up claims, addressing misunderstandings, and generally assisting employees to use this benefit design.

- “Since I handle all the questions that come in regarding health insurance, I see a potential for a lot of questions from our employees. While this plan makes sense to me since I deal with insurance on a daily basis, I think it would be confusing to the consumer to understand what their costs are going to be. I think there would also be some perception that some employees are ‘getting better coverage’ than others.”

- **Employers do not always agree with how treatments are assigned to tiers**

When employers look at the tiers’ examples, they disagree with the placement of certain conditions/treatments in the tiers and also on the value-based services list. One employer suggests putting all the things that people think of as emergencies in the same tier. Some employers (and employees) think that if a doctor recommends a treatment, it should be covered – at a low tier. The placement of liver surgery for cancer in Tier 4 is often questioned – not just in the employer groups but the other groups as well. Some employers are concerned that by placing expensive treatments in the highest tier, they will be out of reach financially for most employees. One participant wants to know who makes decisions about what “value” is since it will have an impact on the “entire overall health” of our state or nation.

- “ I’d much rather pay for x-rays and basic labs knowing that those costs are fairly low and I can afford to pay those, but when you start getting into CTs, MRIs, PET scans I need more help. Those are not inexpensive. They’re not ordered very often, but it doesn’t take more than two of those to break you.”

- **Some employers think the value-based benefit design should be offered together with a traditional plan**

Several employers say it makes most sense to offer this benefit design to employees as a dual choice with a traditional PPO plan or even an HMO plan. But also there is a concern that offering both could threaten the ability to offer the traditional plan; one participant says that if people were to start switching from the self-insured plan to this benefit design, the costs for the self-insured plan would go up. Another employer says this benefits plan is a “tough sell” and unlikely to be offered at all by his company.

- “I guess I’m sitting there thinking would I offer it with an HMO or a PPO? What does this plan offer? What makes this plan unique from any other plan? . . . There are so many plans out there that offer this same exact thing. There’s nothing that stands out differently. . .”

- **Employers wonder whether the benefit design will appeal to young and healthy people, or people with chronic and serious illnesses**

Some employers think the benefit design will appeal strongly to employees with chronic conditions and serious illnesses because under this benefit design their care is covered without any cost sharing. Other employers think it is the employees who rarely see a doctor who will gain the most because their once or twice-yearly visits to the doctor will be covered in full. One participant maintains that the new generation of healthcare consumer is better educated and better able to understand a benefit design like this – they take advantage of the Internet and do their own research before making healthcare decisions. But others disagree, saying that young and healthy people often disregard their health benefits.

- “I know we have a big over-50 group on our company and they use a lot of that stuff. My employees that are 30 and under, they couldn’t care less about any of this stuff.”

- **Employees could see it as a benefit reduction**

Some employers think their employees would object to this benefit design – it was called a “political nightmare” by one participant. They are concerned that employees will have greater out-of-pocket costs for routine services and will not view it as a true benefit. In fact one employer said that since employees of the company are mostly minimum wage, there are some who got their job solely to get the health benefits. Health benefits are also seen as a recruiting tool for professionals such as attorneys, and employers want to offer a benefit that is appealing to the prospective employee.

- “To me, my employees would think that this is just taking something more away and the firm is making more money on healthcare because it’s lowering the cost. Because we pay 100 percent for our employees and I think that they would just think that this is just one more thing that’s going away – that we’re now going to this lower cost to help corporations make more money.”

But not all employers agree. In the end, some employers argue, employees will see the new benefit design as adding to, not taking away, from their health insurance benefits.

- “With the different tiers and percentages offered, it would give employees a little more control in their decision making for health benefits while promoting a team/community atmosphere.”

- **Ultimately, it all comes down to cost**

Employers want to know if the premium for a value-based benefit design will be lower than a comparable traditional plan. Some say they would expect 20-30 percent less than a traditional plan, and some say perhaps as low as 10 percent or break even. One employer says the differential in premium would have to be as much as 50 percent lower. Escalating premiums are the biggest worry. In Portland and throughout the state employers say they are still paying 100 percent of their employees' premiums, and they say they are able to do so only by increasing the deductible from year to year.

- “Many of our employees are in the over 40 group who have more medical expenses and I see this plan benefiting them; however, it will also come at a cost at not only to the company but to the employees as we would have to pass some of the cost on to them.”

Employers say that a benefit design like this, if it were less expensive than a traditional plan, would appeal to those companies that currently cannot afford to offer any kind of coverage to their employees. Some employers that do offer coverage today are struggling to continue due to the increase in costs.

- “I think the plan sounds really good for companies that at this particular time offer no benefits to their employees. My mother-in-law runs a small business and she doesn't offer the health insurance. They have to kind of get everything on their own. I can see this would be a way for somebody to have something at least to get coverage.”

Some employers believe that the value-based/low cost sharing services might add cost, not decrease it. Since premium rates have risen steadily and steeply, employers are questioning whether this benefit design will keep cost increases low. Some of the participants approve of the intent behind the benefit design but they say it is just “theory” and it is unproven that it can lower cost.

- “I'm not quite grasping where the cost savings (to the Plan) is realized. If the intent is for early treatment, there seems to be quite a loaded up front cost.”

- **Employers question whether a benefit design with a 5 percent drop in co-insurance for outpatient care and 5 percent increase for inpatient care, will achieve its goals**

Some employers are not in favor of a disincentive for inpatient care. For one thing, they say, some admissions to the ER are necessary so there should be no “penalty” in those cases. Also they say there are procedures that can only be done in a hospital and again, a penalty is not fair and it could be an added stress for their employees during illness. For services needed at night or on weekends, it is not always possible to get outpatient care in a doctor's office – they say the night/weekend care should not be penalized. Another consideration is that people are making their treatment decisions often during medical emergency situations and an incentive such as plus or minus 5 percent is not top-of-mind. Some employers say that 5 percent is not

Value-Based Benefits Design Research – Employer Findings

enough of an incentive or disincentive, but rather 15 or 20 percent is more likely to change behavior.

- “Or the kids are hurt. Then it’s just, ‘Get me to where I need to go.’ So all of this little in and out things, I think that it’ll be lost on [our] population. I think that might be too complicated.”

On the other hand, there are employers that see the 5 percent incentive as a way to increase the patient’s responsibility for making decisions about treatment settings and sharing the cost.

- “I think that the individual should bear some of the responsibility in cost if they are choosing to go to an emergency room when they could wait and see their doctor. I also think that they should bear more of the cost if they are having in-patient hospital care as the cost to the plan is more than when they see a primary care physician.”
- **Employers have other questions, concerns, and recommendations for the value-based benefit design – and many are similar to those made by other groups**
 - There is concern that this benefit design is not in compliance with the new federal regulations.
 - Employers have a perception that insurance companies are driven by profit,
 - Some are skeptical of “government involvement”, especially if it is to determine “value” of medical services.
 - It is recommended that this benefit design be offered with high out-of-pocket maximums so that when patients consider treatments in the high tiers they are cognizant of the cost sharing impact.
 - There is a fear that providers could “game” the system by coding treatments so that the cost sharing is lowered for the patient, while the employer loses the potential savings.
 - This benefit design does not address many of the most costly aspects of the healthcare system such as 1) the difficulty patients have in knowing ahead of time how much a procedure will cost, and 2) a convoluted billing system that has a patient receiving bills from different sources such as clinics, labs, anesthesiologists, etc., all for a single procedure.
 - A suggestion is made to allow professional associations to offer the value-based benefit design to their member employers.

Some find it difficult to evaluate a benefits design like this without knowing the impact of federal reform. Employers are hearing rumors about government-subsidized plans, fines for not signing up for coverage, and other potential scenarios that make it difficult to place this design in the broader context.

Consumers

Feedback on the value-based benefit design was collected during several consumer forums. The first session was a focus group in Portland of eight consumers – six work for companies with 100 to 500 employees and include a caregiver, customer service clerk, mechanic, phone tech support, mortgage loan officer, and stock order clerk. One consumer purchases health insurance individually, and the other is uninsured (both reported no occupation). That session was followed by a focus group in Bend of eight consumers – six work for companies with 2 to 98 employees and include a teacher’s assistant, operations supervisor, customer service representative, accounting firm owner, office manager, and bank branch manager. One consumer purchases health insurance individually and is the owner of a retail shop. The other is a landscaper and is uninsured. A Pendleton focus group of eight consumers included six employees of companies ranging from 2 to 44 employees and included a president of a manufacturing company, manager of manufacturing, owner/chemist of a water-testing company, auto technician, and funeral director. One consumer is the owner of auto repair shop and purchases coverage individually. The other is uninsured and a real estate broker. Additionally, an online focus group of 13 consumers was conducted that included five employees of companies with 100 to 500 employees; they gave their occupations as customer service rep, behavioral researcher, government policy analyst, teacher, and government clerk. Also five online participants said they purchase their insurance individually and reported their occupation as retiree, student, office manager, office assistant, and someone unemployed. Another three participants in the online consumer group were uninsured and included a home caregiver, real estate salesman, and an unemployed individual.

- **With this benefit design, consumers think more people could get coverage and at a lower cost**

Consumers are very enthusiastic about the benefit design’s low-cost care for chronic conditions and the ability to get the ongoing care needed. One consumer uses the example of diabetes test strips which can be expensive, but which make a big difference in treating the condition successfully. With this benefit design, some consumers believe that people will get care earlier for illnesses and prevent more serious conditions. And some think it could save money.

- “You learn when you really need to go to the doctor’s office. There are some more important services that we need taken care of my family but we just don’t have the money for it. If this insurance policy were to cover just the major things it would help a lot of families like mine.”

The consumers who are currently uninsured are very eager about this benefit design. Those that currently have rich benefits are less inclined to choose it for themselves, but see it as a good option for those with chronic conditions or difficulty affording coverage.

- “Because I feel I have really good healthcare benefits thru my employer I don’t believe I would be tempted to make any kind of switch. But I do think this new plan has a lot of potential to save money for the state and its subscribers.”

- **Under this design, people will think about medical evidence and give more thought to what level of care is needed first**

Several consumers comment that this benefit design will prompt the members to “think twice” about visiting the doctor for things that could wait or may not be necessary. The impact of the tiers on reducing out-of-pocket expenses could be significant. Comments are that the benefit design tiers “makes sense,” and one participant even says that the tiers are “brilliant.”

- “I think I would spend more time looking up stuff to see where I’m going to be in the tier. Right now I’ll go to the doctor if I think I have to, maybe for a chest cold or something like that. Maybe they’ll give me antibiotics, maybe they won’t. Where the other one I’ll be able to look and see what tier that’s going to be in, whether I’m going to have out-of-pocket.”

- **Consumers wonder if both out-of-pocket costs and premiums will be higher or lower**

Some consumers do not understand how overall costs would be lower given that the value-based services such as those for chronic illnesses could actually cost the insurance company more. Some of them question whether a benefit design like this will encourage people to be healthy. And others look at the difficulty of making decisions about what is “important” and “effective” which they doubt can be put into practice.

- “I’m not totally clear on the numbers. It’s not like the people with rare diseases are kind of subsidizing the people with the chronic diseases. Do you know what I’m saying?”

Some are confused about how it will impact their employer coverage. They wonder if the premiums will go up or down with this benefit design.

Consumers struggle to understand how they would balance the out-of-pocket cost in this benefit design against a possible savings in premium or perhaps even a higher premium.

- “Yeah, I think there are a lot of variables here that would be hard for a layman to know. You’d have to be an actuary or whatever. It sounds interesting. It also sounds, because of the significant savings with the fairly common illness of diabetes, it sounds like it would be more expensive.”

- **There is a perception that people who are healthy will pay more for their healthcare than those who have chronic conditions – often caused by unhealthy lifestyles**

Many participants wonder if the incentives are unfairly causing healthy people to pay more than those who are unhealthy, frequently by their own lifestyle choices. One participant predicts that a subsidy like this could “backfire in the long run” and another calls it “punishment for

being in good health.” But another consumer thinks that ultimately it could help get costs under control.

- “If I understand this if you are healthy you pay more and if you have a long-term illness (more expensive) you pay less? That doesn’t seem right.”

- **The levels and tiers are complicated**

Many comments address the complexity of the design and difficulty understanding it. One participant says it is so complicated that people will need a book called, “Benefit Packages for Dummies.” Another participant says she is thankful that her insurance agent has been indispensable in helping her understand her insurance – the agent comes to her home so that her questions and concerns can be addressed.

- “I believe our whole insurance system is way too complicated and even the [insurance] companies themselves cannot give you a straight answer when you ask in advance and the answer never matches the outcome. This Tier program is far too complicated to be able to figure out where you stand.”

People are worried that when a procedure is done, initially they might think it will be reimbursed as a low tier but then find out it is actually a high tier and high cost sharing. Some are confused about the difference between this benefit design and a traditional plan.

- “This plan would need to **clearly** outline which services are covered under each of the tiers. I’d hate to have a procedure done that I thought was covered under [Tier 1] only to find out I now have to pay \$3,000 out-of-pocket.”

The tiers themselves are not perceived as self-explanatory for these participants. One participant asked if the member picks just one tier. Another participant believes that lower tier medical problems would cost the member more out-of-pocket. People are uneasy that they would not understand the cost sharing and then find out they have prohibitive medical bills to pay.

- “You can look and hope that preventative care is going to prevent these things but there are things that hit you out of the ordinary and people go bankrupt for all the time.”

One participant is very comfortable with the tiers and finds the details easier to understand.

- “It is a lot simpler to understand this benefit plan than the one’s that insurance providers bury in their long booklets. Maybe I’m distracted by Tier 1 and two... Most of my problems fall into these categories. Free and low cost really attract my attention. It seems like that each tier is outlined well. A couple of free visit a year would really help get me in to see the doctor.”

Researcher's Note: In the course of explaining the value-based benefit design during the consumer focus groups, the participants began to lose interest during the explanation of tiers. Possibly the benefit design explanation was too lengthy, or possibly the tiers are a very challenging concept for consumers to understand. Either way, this benefit design perhaps exceeds the existing knowledge-base of consumers and/or the attention span regarding health benefits.

- **Consumers are uneasy about being hit with unexpected costs in high tiers**

Several participants say it is going to be difficult to make decisions about treatment if finding out which tier is contingent on having a diagnosis. Some wonder if the doctor's receptionist will explain which tier applies. One participant says that maybe the best option is to simply refuse treatment if a procedure or condition falls in Tier 4.

- “. . . how I can find out exactly what tier it is before I actually go to the doctor because I don't want to end up spending like \$3,000 that I don't want to spend if I didn't have to.”

- **Consumers do not always agree with how treatments are assigned to tiers**

In general, it is difficult for consumers to come to terms with the list of examples for each tier. In some cases, consumers say the list of conditions/procedures for a particular tier do not seem to “go together.”

- “The list seems odd to me. I would find it odd that ADD is plugged in with breast cancer. That seems to be odd to me . . . And head injuries and third-degree burns are all in level one but then where's a broken bone or other urgent care?”

A common example is “liver transplant for cancer.” Most people do not know that with a condition like cancer, a liver transplant is not successful in halting or slowing the disease.

- “Your statements make sense. [But] would a liver transplant really be in the same tier as acne or chronic sinus? That does not make sense.”

There is also confusion about diagnostic visits and prevention visits and how they would be covered.

- “[It says,] ‘Basic diagnostic test at two times a year.’ Okay, diagnostic meaning you actually have something you go in for because you said you needed x-rays and lab tests? So what about... Where does the preventative care fall into that?”

- **People want to know who is making the decisions**

It is not always easy for consumers to understand decisions about what is, and what is not, important. Knowing how, and who, makes the decision is crucial to consumers' acceptance of a tiered benefit design. People believe there will be exceptions and unique circumstances and they wonder how the decision would be made in those cases. One participant says that an evidence-based approach can only go so far, because there are areas of medicine that are not thoroughly tested.

- "I guess my question would be – you're looking for less important services – in certain particular situations that could be the more important option for somebody. For those people they are going to have to pay double because those things are actually written in there. That would be my concern."

- **Wellness and prevention is a high priority, and some think there should be financial incentives for maintaining good health**

Coverage for services that help people get healthy and stay healthy is highly prized by consumers. They recognize that the benefit design incorporates preventive services through low cost sharing for check-ups and basic labs. Most of them applaud the value-based services such as smoking cessation that address unhealthy choices. Even the services for chronic conditions, they say, can prevent a bad condition from becoming worse. However, the consumers want to see more education and financial incentives for people to follow behaviors that will maintain good health.

- "I also feel there should be more encouragement for people to live well, eat properly, stop smoking, exercise and [use] less drugs so freely handed out that have side effects that many aren't aware of or do not understand."

One participant recommends including services to promote exercise and good sleeping habits covered in value-based or Tier 1 benefits.

- **Tools for consumers to navigate the tiers and benefit design could be helpful**

Consumers make numerous suggestions to have tools that would help them understand the benefit design and use it properly when needed. Many of the suggestions are similar to those proposed by Employers.

- Website with symptoms and tiers
- Advice nurse to help determine the tier
- Video or CD
- Chart
- Handbook
- Outline

Value-Based Benefits Design Research – Consumer Findings

- 1-800 number & personal contact
- Booklet
- Insurance agent & personal contact

One innovative suggestion is a website that combines symptom look-up as the first step and tier look-up as the second step. Several people say they want a direct contact with a person on the phone with whom to discuss their own circumstances.

- “I’d want someone on the other end of the phone that I could run my own situation through.”

- **Consumers are uneasy about being able to anticipate their out-of-pocket costs**

One of the concerns for consumers about this design is that they would not be able to anticipate their out-of-pocket costs, either overall for the upcoming year or in any particular situation. That makes it difficult for them to decide if this benefit design is cost effective. One participant expresses concern that the cost of services in the higher tiers will “negate” the savings achieved for value-added and preventive services. Those participants that are buying coverage for a family are particularly cost conscious, and also are very uncertain how the cost would pencil out.

- “It is great on the lower tiers. It depends a lot on the cost of the insurance also. If I had one, with say, \$1,000 out-of-pocket, I would prefer that over the Tier 3 and 4 options, but it would probably cost much more.”

- **An incentive of plus-or-minus 5 percent for outpatient versus inpatient care is seen as effective by some and ineffective by others**

Some consumers think that a 5 percent incentive to get outpatient treatment could save money and prompt the consumer to reconsider getting inpatient services.

- “So what you’re saying is like surgical centers instead of a hospital? There’s nothing wrong with that. The hospitals are one of the biggest problems . . . That’s where you pick up a lot of infections and become worse.”

But others think that if a hospital-based treatment has been prescribed by a physician, the patient should not be penalized. They are concerned that outpatient services may not be an option during nights and weekends. Furthermore some people find it hard to believe that anyone would willingly be admitted to a hospital if it could be avoided. They also believe there could be other extenuating circumstances when inpatient care is the most responsible and humane setting.

- “It sounds good. What happens if the doctor says, ‘Hey you need to go to the hospital for this?’ Would the doctor send you to the hospital without automatically cancelling out the increasing payment for going to the hospital or would it just still be there?”

Finally, there are some consumers that say 5 percent is not enough of an incentive in situations when it is an emergency or the doctor is recommending hospital care.

- “I’m not going to say, ‘I’m going to save myself \$5 by going to the doctor versus the hospital.’ I’m not going to get brain surgery in the doctor’s office.”
- **Consumers have other questions, concerns, and recommendations for the value-based benefit design – and many are similar to those made by other groups**
 - *Access:* Access to doctors is a concern – that not all doctors would be “on the plan” or that patient loads will be higher due to more chronic disease treatment and that it will be difficult to make an appointment. In Pendleton, consumers discuss the shortage of physicians in “rural America” and a concern that with the boomers aging there will be an even greater shortage.
 - *Delay in treatment:* If the cost sharing for treatment is unpredictable, some people will delay getting the care they need.
 - *Chronic benefit most:* Chronic people will gain the most from this benefit design.
 - *Healthy benefit most:* Healthy people will find this benefit design most appealing.
 - *Productivity:* An unintended outcome of the tiers is that working people, who delay care and are in pain or need of medications, will lower productivity. Teachers and parents are particularly vulnerable.
 - *Medications:* People are confused about how reimbursement for medications is determined--as part of the value-based services (no cost sharing), Tiers 1 to 4 (medical tier cost sharing), or as part of the pharmacy tiers.
 - *Dental and vision:* Consumers do not understand whether just selected dental and vision procedures are covered by the benefit design (diabetes eye exam, emergency dental care, etc.), or broader dental and vision procedures are part of the benefit design.
 - *Inflation of medical costs:* People are resigned to ever increasing premiums and cost sharing, regardless of this benefit design.
 - *Government’s role:* Some people are wary of “government involvement” and are not familiar with the Oregon Health Authority.
 - *Insurance company:* While some people think it is more logical for an insurance company to administer this benefit design than a government agency, there are those that are highly suspicious of the motivations of the insurance industry.
 - *The doctor’s role:* Certain participants say it is best for insurance companies to defer to doctors’ judgment and “let the doctor do his/her job.”
 - *Families/children:* There is concern that with children accidents and illnesses are to be expected – sprains, broken bones, ear infections, etc. – and that this benefit design will not provide adequate coverage.
 - *Phone services:* One participant recommends that since many services can be done over the phone, it would be more cost effective to cover those services in the benefit design.

Consumer Advocates

A group discussion was conducted at a regular meeting of “Health Allies,” in the Portland area. The Health Allies are an affiliation of organizations that advocate on behalf of healthcare consumers. A total of 19 individuals attended that were interested in giving feedback; they represent organizations such as the Oregon Health Action Campaign, Oregon State Public Interest Research Group (OSPIRG), Healthcare for All, Archimedes Movement, Metropolitan Alliance for the Common Good, and others.

- **The use of evidence in setting benefit coverage levels promising**

There are advocates that welcome the focus on evidence in determining what services are “value-based” and which tier other services fall into. One participant thinks the benefit design’s approach could influence consumers to consider prevention and long-term outcomes, just as long as the assignment of treatments to tiers includes criteria that weigh the impact of early intervention on future health.

- “I think evidence-based is the best thing about this, and the tiers I like because I think if it’s essential benefit it ought to be in tier 1. . . . [but it is important that things that are in tier 1 meet a criteria of] ‘if I intervene now and do this, later on – in other words it’s not going to be a great big thing right now but if I intervene now I prevent long term problems.’”

- **A preventive/holistic approach is valuable together with incentives for healthy behavior**

Several of the participants want to see a benefits design that is focused less on disease treatment and more on a holistic approach to educate consumers so that illnesses can be prevented and unhealthy lifestyles can be changed. One concern is that there is a disincentive for using some medical services, but no incentive to get advice that directs consumer to other options. Conversely, as one participant states, there should be incentives to seek advice early. One suggestion is to use a “negative premium” or a credit of some kind when people follow preventive guidelines. Also, education is seen as an effective way to approach prevention, and should be strongly emphasized in this benefit design.

- “. . . on the surface I totally agree with the incentives. My concern is that it’s very narrowly focused on how health plans operate today, which is all about the medical stuff. And . . . what we’ve also been talking about is encouraging people to use preventive services, to use other supportive things around the medical piece. ”

- **Consumers could be confused about their cost sharing**

There are several comments that consumers might not be able to find out, before treatment, what the cost-sharing will be for something such as an ear infection. They think people will not

understand whether their cost sharing is determined by the diagnosis, or by the treatment choices they have.

- “I guess it strikes me at this point that these kind of plans will be very complex and it will be very difficult for people to figure out what they’re getting. So there’s either going to have to be a lot of assistance or you’re going to have people choosing kind of blindly, it seems to me.”

- **Consumers would need direct assistance and advice**

Advocates ask that this benefit design be accompanied with an Advice Line that assists consumers in understanding how their condition/treatment will be covered and how it will impact their cost sharing. One participant says it is not reasonable to assume people will be able to navigate the tiers and get the kind of information needed to prepare for their treatment decisions.

- “But to me the difference between having a kid who’s got like a runny nose and green snot is really different than what do I do with a kid who’s screaming and can’t sleep at night. And they both might be an ear infection and using this approach I have a disincentive to get my child checked. But I would like to have also an incentive [for talking to] somebody who could help me [answer the question], ‘Should I take them in, should I not take them in?’”

Other concerns are that without assistance from a reliable source of advice, people will find themselves trying to self-diagnose their symptoms. Another concern is that people will not get the care they need because they assume their co-pay will be too high.

- **Advocates perceive a need to address exceptions and give physicians discretion, for example the ability to use a step-wise approach**

Consumer advocates express unease with a benefit design that treats all consumers the same in terms of treatment and cost sharing. They are concerned that some of the nuances will be lost that can make a big difference to an individual’s particular situation. They say that physicians need flexibility to decide what will work best for the patient. One example given is an anti-depressant medication that may not be effective for *most* people, but for *certain people* it might work when no other treatments or medications have so far been successful. Another example is a hysterectomy that might be a procedure of convenience for some women, but for other women it could also be a necessary treatment for cancer.

- “. . . but ideally you’d have to allow physicians to say, ‘This is a case where we’ve pursued the low cost option and it doesn’t work for this person but another option does.’ There will be times for example when that prescription drug that’s brand name is the only antidepressant for example that’s going to work for that person. If it’s the only thing that’s going to work, let’s do that but let’s make sure we’ve tried everything else first.

Several advocates suggest that a step-wise approach be used that requires that less-expensive treatments be prescribed first to establish if they are effective, and only if they are not effective are the more-expensive treatments prescribed even if they are more questionable treatments based on evidence. With this approach, the consumer is getting treatment at a favorable cost-sharing level because the most cost-effective treatments have been prescribed first.

An advocate suggests that physicians should be audited for their practice styles and treatment prescriptions; if their treatments are outside the guidelines, that they could be routinely sanctioned or disincentives used.

- “. . . you need to give the physicians enough flexibility to do some of the things that are an exception to what’s the [benefit] package or level one and still call it ‘Level one.’ And then you could audit and see if he’s been using that over time on particular kinds of things. And then if he is, you don’t let them do that anymore or you do something like that. You need to not micromanage using this piece and I don’t know how you’d do that.”

- **Subpopulations of our society have different needs for medical coverage and prevention**

An advocate makes the case that an across-the-board approach to evidence-based medicine will miss important differences for certain segments of the population. The example of lower back pain is given as a condition that has different consequences for a white-collar, middle class consumer versus a farm worker or domestic worker that must bend and lift repetitiously throughout the day, every day. The impact of treatments across all segments of the population is not necessarily the same; for example when back pain is treated, the impact on farm laborers or domestics would be different when considering productivity, wage earning, and suffering.

- “It feels like it’s an attempt to try to improve an existing system rather than be transformative with its approach. And it also continues with what I consider health disparities. . . . it had lower back pain as being something that’s not being paid for, so tier 4. And yet, if you’re in a community working in agriculture, working in the hotel industry, working in the building trades, [then] lower back pain can be indicative of something really major that’s coming down.”

- **Advocates want to know who is making the decisions and the criteria being used**

A comment several advocates make is that it is going to be difficult to set up criteria that can correctly guide decisions about coverage level and cost-sharing. People want to know who determines what is effective and they want to know whether good evidence really exists for all the types of medical care. A concern expressed by one advocate is that when allopathic doctors look at evidence, their focus will not include treatments that are more holistic and preventative.

- “So who determines what’s effective and what do you do about things that are neither proven effective or certain procedures that are either proven not effective, there’s just no data on it.”

Some advocates say that the benefit design overall has inequities because it covers some things comprehensively while others require significant consumer cost-sharing, simply because the patient has by chance contracted a particular illness.

- “You’re [thinking], ‘I wish I had diabetes instead of this low back pain.’ [Laughter]. That’s what it feels like.”
- **An essential benefit package should be part of the benefit design**

Several participants say a benefit design such as this one should be built upon a set of “essential benefits” that are assured to the population regardless of the insurance company or the benefit plan. One advocate recommends that the essential benefit package identified by the Oregon Health Fund Board should be assured and affordable for all Oregonians regardless of whether it is offered by the Exchange or whether it is a particular benefit design. The trouble with this benefit design, some say, is that by incorporating tiers of very high cost-sharing, the consumer is de facto lacking access to those benefits.

 - “And I think that perhaps the cart before the horse is the essential benefits package – we should have a determination on that and then figure out how do we pay for and how do we structure this. If you were to come to me and say, ‘. . . you’re covered, you’re insured, but you have a \$3,000 deductible and some things you’d have to pay 50 percent for,’ I am more concerned with what am I covered for . . .when the typical person hears they’re ‘covered’ they equate that with somehow that’s going to get paid for. And I just think that we have to just say kind of as a society, these are the essential things that people are going to get covered for.”

- **Dental, vision and mental health benefits at a low cost are wanted**

People are unsure whether dental, vision, and mental health services are included in the benefit design or whether it is limited to certain treatments and diagnoses. Since some specific dental, vision and mental health services do appear on the lists, some assume that more comprehensive coverage will be available. Also, some are unsure whether it is only the primary care physician who must provide the dental, vision and mental health services that are included. There are advocates that believe comprehensive services for dental, vision and mental health are “essential” and should be covered with little cost sharing.

- “It should speak to mental health, dental and vision for the entire population, because those are part of what I would hope would be part of the essential benefits package.”

- **Out-of-pocket cost and premium are the ultimate benchmarks**

Advocates say that high deductibles and high cost sharing of 50 percent or 70 percent co-insurance in the higher tiers could prevent the benefit design from offering truly affordable coverage. As an example, one participant compares a deductible of \$3,000 to one of \$10,000 regarding the impact it would have on the individual that has sinus surgery. The end result is that the combination of deductible, co-insurance, out-of-pocket maximums, and tiers in this benefit design will determine whether it offers affordable “benefits” to middle income and lower income individuals.

- “But if you’ve got a really high deductible plan, people who are poor are not going to be able to pay for those things. So you may not actually get as much. This will work well for middle-class people maybe, but not necessarily lower income people in terms of getting them to get early care as opposed to later care.”

Similarly, they say, the monthly insurance premium will also determine how affordable and how effective this benefit design will be in insuring people.

- “It’s very hard for me to generalize because it seems to me like a huge amount of this is going to depend on that premium question, well the premium question and the deductible question.”

- **Some advocates want to see other disparities in healthcare addressed**

Some consumer advocates are frustrated that a benefit design being put forward for the Oregon statewide health exchange does little to address some of the significant gaps and inequalities in the healthcare system. They give examples including 1) affordable coverage to low income people, 2) adequate coverage for people with children, 3) incentives for physicians to first try low cost or preventive treatments before more-expensive procedures, 4) rewards for people who live healthy lifestyles, 5) education for the overall population about healthy living, 6) coverage for those who by chance have medical conditions that are not easily treated, and 7) other examples given throughout the discussion.

- **Advocates have other questions, concerns, and recommendations for the value-based benefit design – and many are similar to those made by other groups**

- *Physician phone calls/emails:* One advocate says that sometimes a phone call or E-mail to/from a physician is the most cost-effective way to treat a condition, for example diabetes education. Often insurance plans do not cover anything but an in-person visit.
- *Comfort care:* Another says that the consultations that physicians and palliative care specialists have with patients and their families are a critical component of comfort care so that the right medications and treatments are chosen for the particular situation. But insurance plans often do not cover these consultations.

Value-Based Benefits Design Research – Attachments

- *Help people understand:* A comment is made that communications about a benefit design like this must be tailored to the specific needs of each sub-population. Examples or materials that communicate well to African Americans, for example, may not be as meaningful in other communities. Communications that work in Burns or other rural areas, might not resonate in metropolitan communities. The realities of care and even the prevalent illnesses, are not consistent across the whole State, which has implications for communication.
- *Federal health reform:* People are wondering how this benefit design will link up with federal reform. If federal reform includes a basic benefit package, the advocates are asking how the Oregon benefit design will conform to it.