

Benefit Design and Beyond: Consumer Choice and the Role of Employers in Payment Reform

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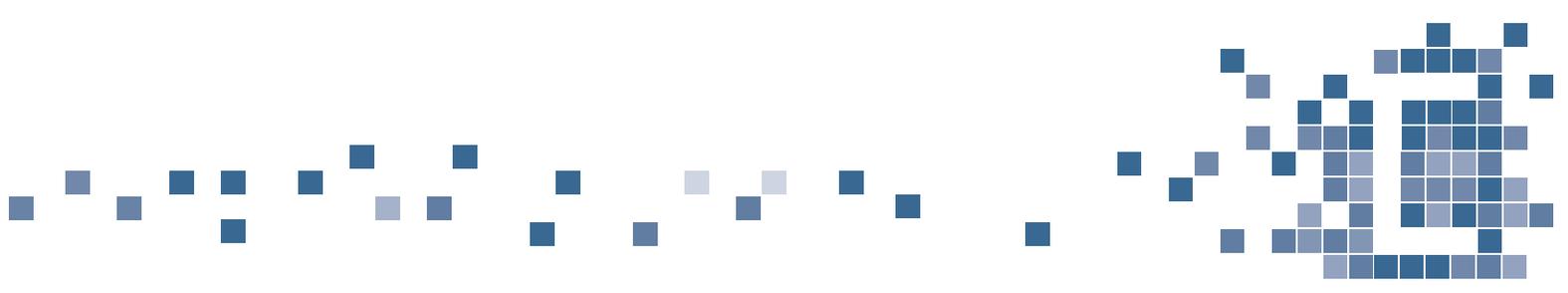
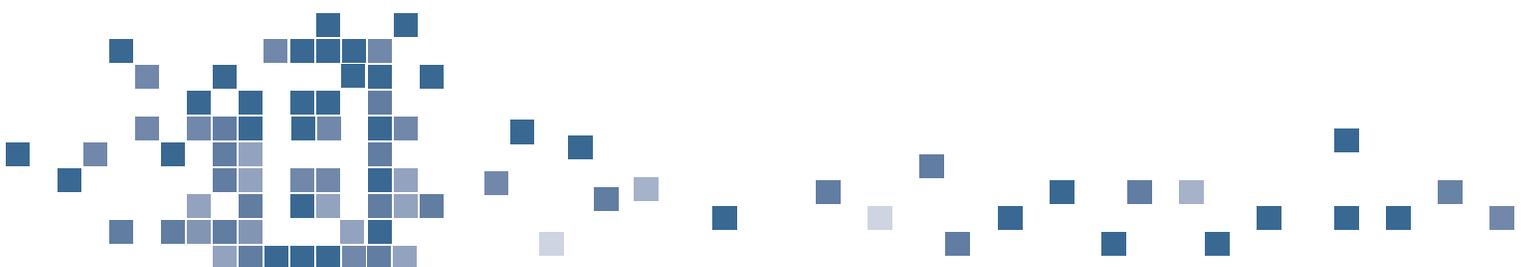


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Introduction

BENEFIT DESIGN WITHIN PAYMENT REFORM

An active discussion is now underway in Massachusetts about provider payment reform. This discussion has been fueled by the July 2009 recommendations of the Massachusetts Special Commission on the Health Care Payment System. The mandate of the Commission was to “investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.” The Commission recommended adopting a global payment system in the state and the developing provider Accountable Care Organizations (ACOs)¹ to pursue these objectives.

The Massachusetts Hospital Association (MHA) believes that the goals of improving affordability, efficiency and quality of care in the Commonwealth cannot be achieved without careful consideration of the health insurance product and benefit designs employers select, along with active consumer engagement.

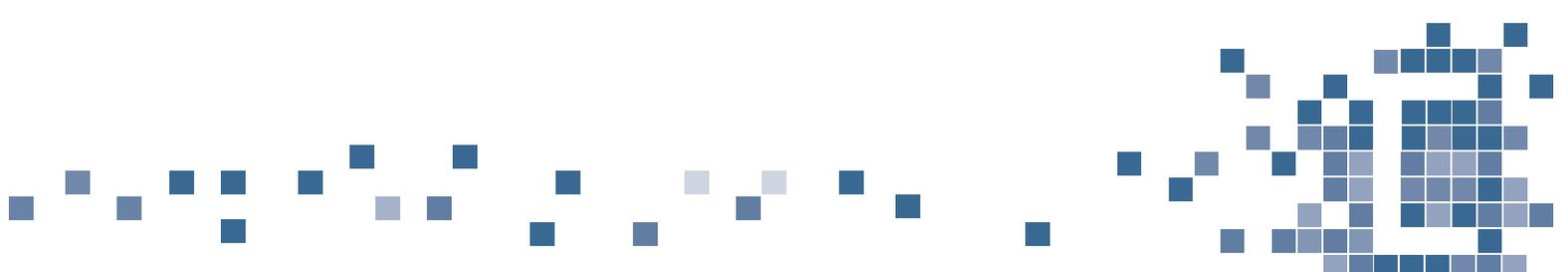
Massachusetts healthcare coverage benefits are rich by national standards, but policy makers must reconcile such benefit standards with their goals for payment reform. Current benefit design supports virtually unlimited choice of providers. In addition, the majority of Massachusetts employers offer plans with very low out-of-pocket costs and without disincentives for patients to use higher-cost providers and services.

The Special Commission report presents a conundrum: **there must be alignment between the goal of improving cost-effectiveness and consumer behavior in order for payment reform to succeed, yet the recommendations do not adequately address the changes to benefit design necessary to alter consumer behavior.**

A crucial issue is **enrollee choice**: while the Commission’s report acknowledges that “employers can maximize the benefit of payment reform by aligning the consumer incentives that are implicit in their benefit designs,” the report “does not require employers to modify their health plan designs.” **A system that gives consumers/patients unlimited choice to get whatever care they want, whenever and wherever they want it is incompatible with a model that puts the provider (ACO) at risk for all costs related to the care of the patient.** Under a successful global payment system, employers will have to offer plans in which employees select a primary care physician and get their healthcare within a smaller, interconnected community of quality providers. To make this effort successful, employers must also actively educate and inform their employees about the reasons and benefits behind such a new system.

Policymakers must understand that a substantial **consumer engagement and education effort** must accompany careful planning and design by ACOs and health plans in order for global payment to work. Individuals seeking healthcare services will need a clearer understanding of their own contributions to their care and its costs, beyond just co-payments and deductibles. They must also recognize that more care

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What the Special Commission Said

- **Health plan design and coverage policy.** “While payment reform would not necessarily require the redesign of health plan products, many stakeholders noted the importance of aligning patient and provider incentives under global payment. In addition, emerging evidence about the effectiveness of care for specific medical conditions suggests that a significant amount of care that is currently provided is ineffective and in fact may unnecessarily endanger patient health. Employers must be engaged to support the alignment of insurance benefit design and payment reform goals. “While global payment as envisioned by the Special Commission will not require employers to modify their health plan designs, employers can maximize the benefit of payment reform by aligning consumer incentives that are implicit in their benefit designs – for example, reducing cost-sharing for use of appropriate primary and preventive care, other care that is known to be effective, or patient use of coordinate care within the ACO.”
- **Consumer engagement.** “Many stakeholders emphasized the importance of engaging patients both in maintaining good health and in managing their own care, especially with respect to chronic conditions. The Special Commission recommends that existing efforts be coordinated and expanded to promote healthier lifestyles and support better self-management of chronic illness.”
- **Administrative simplification.** “Many stakeholders expressed concern about current administrative burdens resulting from complying with widely divergent performance measures and payment structures. The Special Commission recognizes that important private and government efforts toward administrative simplification in Massachusetts are currently underway. The Special Commission recommends that these efforts should continue to fruition, and views monitoring and ongoing efforts to reduce administrative costs as critical activities under payment reform.”

does not necessarily mean better care. There may be fewer choices for consumers under a global payment system, yet there will be the greater opportunity to work with a close group of physicians in a network to receive the best, most coordinated care, including preventive care. **This shift in approach is at the heart of a successful new payment system.**

Networks must be sufficient to assure reasonable access and choice, but even then, consumers will need to be educated up front – not simply notified – so that they understand the changes in their benefit design; if not, they may make choices inconsistent with that design or, worse yet, revolt because of their dissatisfaction with the changes. Payment reform efforts must therefore include consumer education efforts – by the state, health insurance companies, and other entities. **Providers must not be put in the position of trying to explain these issues for the first time to consumers at the time of service.**

Benefit design and benefit levels determine out-of-pocket expenses for patients, as well as overall affordability, which influences a patient’s ability and/or willingness to adhere to recommended treatment regimes. Patients’ adherence levels in turn influence the risk for acute episodes in chronically ill patients, as well as providers’ downstream risk for bad debt. **Employers – by offering plan designs that incorporate incentives for patients to participate in and take responsibility for their own care and that realign incentives for payers, providers, and patients – are crucial to the success of a global payment system.** ACOs must be able to be part of the decision-making process in designing insurance benefits to ensure that the level and types of risk providers are taking on are reasonably within their control.

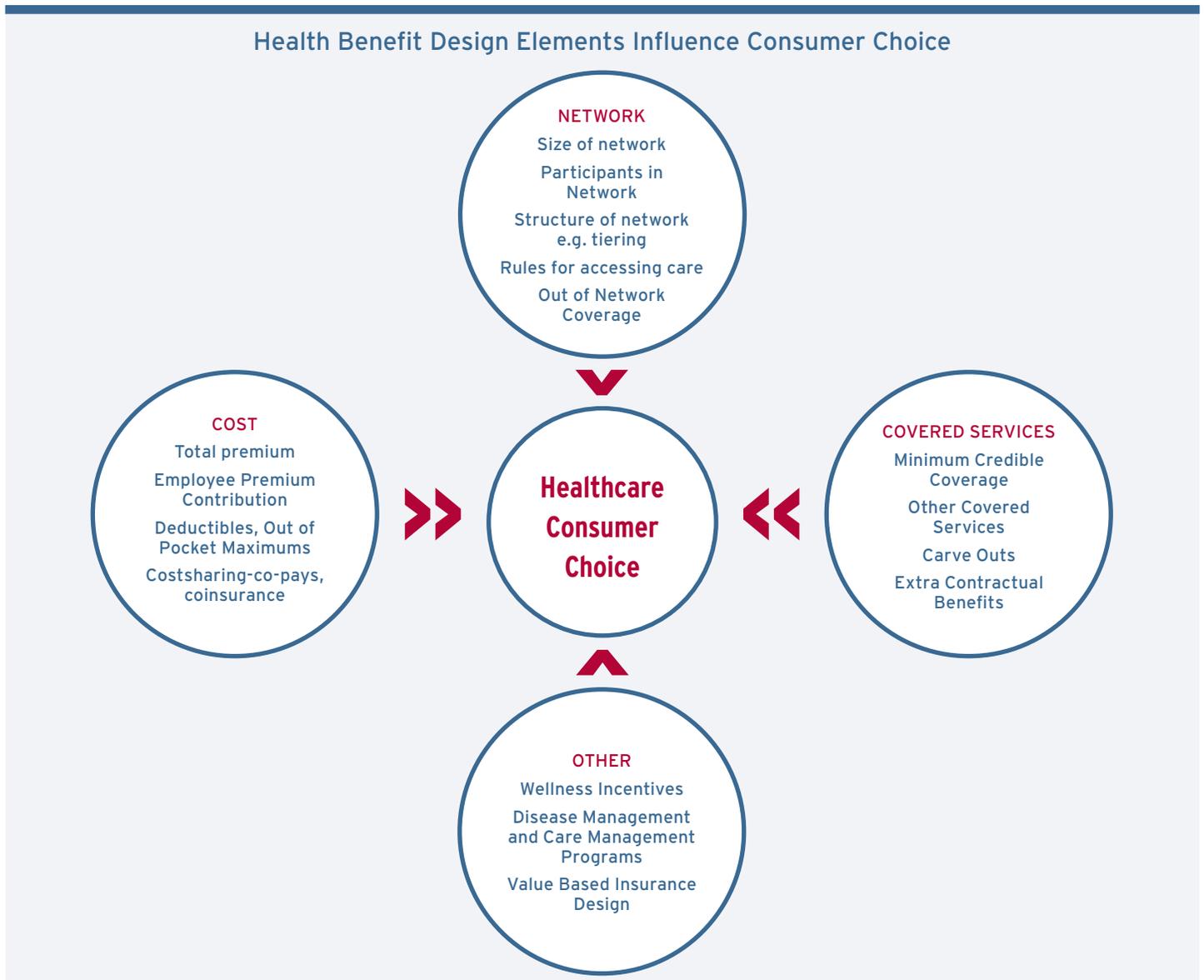
Employer sponsored private insurance coverage enrolls more than 80% of the under-65 population with health coverage in the state. And because employers are instrumental in defining the health insurance products and benefit designs that will be offered, they will play a critical role in aligning consumer incentives with the incentives set for ACOs. In this paper, we make specific recommendations to help guide employer decisions on health benefit design.

MHA'S RECOMMENDATIONS

- ✓ Negotiate and adopt insurance benefits that manage care to improve outcomes and affordability.
- ✓ Involve providers in the benefit design process and build in the capability for modifications to benefits as the process moves from theory to practice.
- ✓ Greater standardization of health benefit design across payers and consumer groups.
- ✓ Provide some flexibility for ACOs to determine which services are covered under global payment and what services, if any, should be paid for using a bundled, fee-for-service or other model.

The Elements of Benefit Design

In the current healthcare delivery and payment system, there are certain elements of insurance coverage that determine consumers' financial and behavioral incentives, as well as when, how, and where they seek medical care and the clinical treatments and procedures providers choose. In this paper, 'health plan benefit design' is defined in its broadest sense to include *all* these elements, which are shown in the schematic below. Even though not all of what is shown below are traditionally included in the definition of 'benefit design,' we believe that these critical elements of an individual's insurance coverage affect the individual's decision-making, behavior, and interaction with the healthcare system. This broader view of health benefit design also helps underscore the crucial role of employers and consumers in the success of any payment reform effort.



Health benefit design traditionally has included features intended to balance premium affordability, choice of providers, comprehensiveness of covered benefits, and levels of patient cost-sharing in a package appealing to consumers while simultaneously containing the total cost of care. Once an employee or individual consumer enrolls in a health insurer's plan, the benefits within that plan influence the member's decision to seek care and can also influence a physician or other provider's recommended treatment. Health benefit design features can influence when and where a person will seek care, the choice of referral specialists and hospitals, treatment options, and patient compliance with recommended treatment and therapies.

Benefit design can also influence clinicians' recommendations for treatment. This may occur when a service is not covered under a particular benefits package; when there are differences in member cost sharing requirements for alternative treatments (as in tiered pharmacy benefit design with lower cost sharing for generic drugs); or if there are differences in provider reimbursement for the treatment options. Providers would rather provide services that are covered by insurance as there is a greater certainty of payment. And where consistent with good practice, they try to treat, prescribe and refer in ways convenient and cost-effective for the patient. Yet the plethora of different complicated benefit designs and rules can make it difficult for providers to do so. Reduction of variations and design complexity across a given patient population would mean less administrative complexity and lower costs for providers, and a greater likelihood that cost-effective, value-based benefit designs the ACO model promotes will succeed.

The Provider Delivery Network and Access to Providers

An essential element of health plan benefit design is the provider delivery network and how its members access care in the network. Network design takes on added importance because the Special Commission's proposals not only call for providers to form and offer care through ACOs, but also support patient choice, which would allow patients to seek care outside of the ACO unless it is a condition of the health plan benefit design.

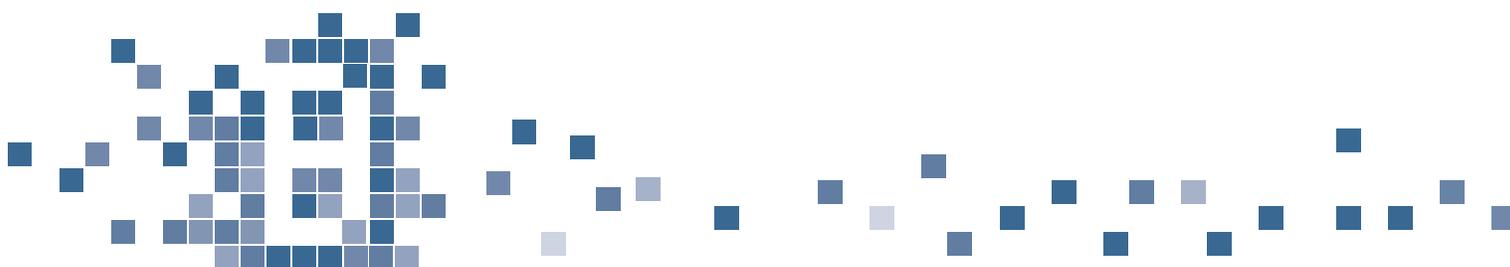
“Payments to ACOs will follow the enrollee's choice of a primary care physician. An enrollee will not be restricted (unless as a condition of his insurance contract) to providers in his primary care physician's ACO, although his insurance contract might require him to pay more if he obtains care from providers in another ACO.”

— *Special Commission on Payment Reform, July 2009.*

In general, more integrated provider networks² that have the capability to deliver the full range of covered services are expected to restrain growth in healthcare costs through better care coordination. This is because these types of networks, coupled with other benefit design features – such as requirements to select a primary care provider /medical home and differential consumer cost sharing – deliver a higher percentage of care within the network, and, as an extension, would encourage the member to seek more care within the network. This affords providers the opportunity to build stronger referral relationships in an integrated delivery network and to develop a more comprehensive understanding of patients' medical needs, thereby potentially improving the quality and efficiency of care.

From a health insurer perspective, a more integrated provider network protects the provider's patient base by directing a higher proportion of total medical payments to the contracted providers. The potential for greater in-network patient volume may be leveraged by the health insurer to negotiate more competitive reimbursement rates and to reward providers that demonstrate the ability to effectively manage the health needs of their population. This in turn, creates an incentive for the providers to develop new administrative and clinical processes to improve care and control costs. Larger provider networks, if well integrated and supported with effective protocols, data and communication tools such as an electronic health records, may also achieve strong referral relationships and build the capability to record and understand patients' total healthcare needs.

In contrast, broader, more open delivery networks offer more consumer choice, but may not provide as much opportunity for coordination of care. As a consequence, while consumers still may have the ability to receive all of their care within the network, providers' ability to coordinate care may be reduced. This will be an important success factor in the transition to ACOs and global payment.



Covered Services in Health Benefit Design

In benefit designs that are commonly offered to employer groups, public program enrollees, and through individually purchased policies, the scope of services covered typically includes hospital, physician, prescription drug and other medical services, excluding long-term care. The policies also usually include coverage of a range of physical, occupational, behavioral, and other therapies. Coverage of certain services may vary among policies: For example, not all insurance policies cover specific types of drugs, or in-vitro fertilization. Federal and state laws may impose mandates, or a requirement that a health plan offer coverage for specified conditions and services, patient populations or types of providers. Examples of mandated benefits include the federal requirement to cover a 48-hour hospital stay for normal newborn delivery and mental health parity. In Massachusetts, health plans also are required to allow the designation of obstetrician-gynecologists as primary care providers in managed care plans and to provide coverage for infertility treatment. It is important to note that self-funded plans are exempt from state mandates because these plans are governed by the federal ERISA law and are not regulated by state insurance laws. See sidebar on page 11 for more information on self funded plans.

Massachusetts has developed a Minimum Creditable Coverage (MCC) standard that sets a floor on healthcare services that must be covered, establishes limits on out of pocket cost sharing, and sets a minimum actuarial value³ for the policy to be acceptable as qualified coverage to meet the requirements for the “individual mandate” under the commonwealth’s health reform law. The MCC requirements set the minimum standards for all plans offered to state residents through the Health Connector, Massachusetts’ individual and small group health plan exchange. **Appendix A** includes a description of the MCC standards in the state.

In a global payment system, ACOs will be responsible for managing most or all covered services for a defined population. As a result, it will be very important to ACOs which services are covered, to ensure that benefit packages are structured in a way that enables ACOs to manage the quality and cost of care. ACOs will also want to have flexibility to provide for ‘non-traditional’ services if they think this will be most cost-effective, without undue administrative barriers. For example, value-based insurance design focuses on enhancing benefits to encourage consumers to be compliant with care plans, especially those with chronic disease. Language in provider contracts with payers that allows providers to order non-covered or non-traditional benefits to assist them in managing such high cost, high risk patients is vital if providers are going to be paid on a performance basis.

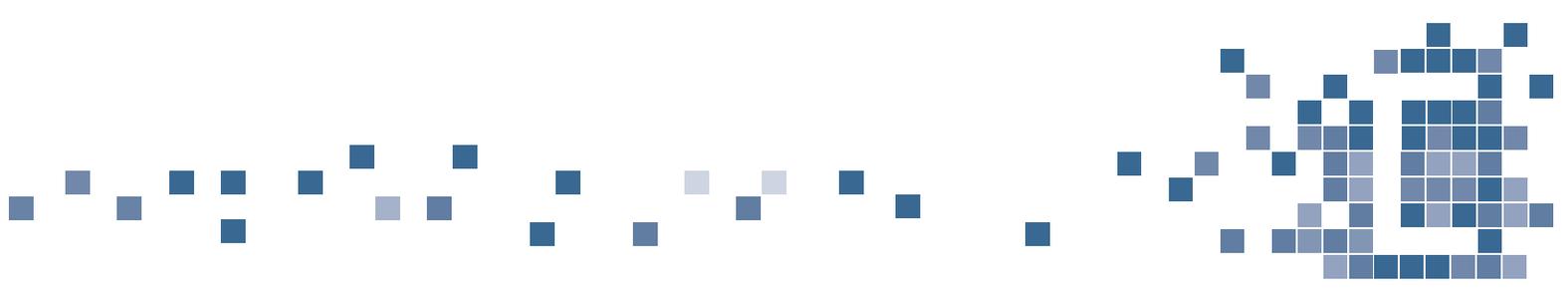
Consumer Cost Sharing in Health Benefit Design

Member cost sharing is defined here as contributions to premium and payments at the time services are obtained, including deductibles co-payments and co-insurance (point-of-service cost sharing). Limits on the total amount of out-of-pocket costs plan participants bear and lifetime maximum benefit limitations can be important determinants of cost-sharing, particularly for individuals with serious chronic illness or catastrophic medical costs.⁴

Contribution to Premium

In determining which benefit designs to offer and how to establish premium contribution requirements, employers balance their desire to provide benefits that will attract and retain the right employees with the need to contain employee benefits costs. Variation in premium contribution requirements can also influence which of a range of offered health benefit plans an employee chooses.

Research has shown consumer price sensitivity to differences in premium contribution requirements of as small as \$5 or \$10 per month⁵. It is not surprising that this price sensitivity is correlated with differences in expected healthcare costs. Those who are younger and consider themselves healthy are two to four times more sensitive than those who are older or recently diagnosed with disease. New enrollees are more sensitive than established enrollees. Consumers with established provider relationships and higher income show less price sensitivity⁶. This suggests that, in the context of multiple health plan choice, there is risk for adverse selection⁷, but at the same time, sufficient differences in employee premium contributions can be used successfully to influence employee choice of plans.



A Look at Benefit “Buy Down”

A recent Massachusetts Division of Health Care Finance and Policy report made the following observation about benefits “buy-down” in Massachusetts:

“An overall decrease in the level of benefits in Massachusetts is consistent with national trends, which indicate that employers and other payers have been ‘buying down’ benefits, by increasing cost sharing or raising deductibles over the past several years.

Nationally, annual employee contributions in actual dollars rose from 1996 to 2006 by approximately 130%, far outpacing premium or employer contribution increases. However, the trend towards benefit buy-down appears to be more significant on the national level than in Massachusetts. Nationally, deductibles for employer-sponsored plans overall tripled between 2000 and 2008, and deductibles for plans offered by firms with fewer than 200 employees more than quadrupled during this period. Cost sharing by employees is less prevalent in the Massachusetts market. The percent of private sector employees in Massachusetts who were enrolled in a health insurance plan with a deductible was 47.1% in 2008. Nationally, that figure was 70.7%. In addition, the average deductible in Massachusetts for individuals covered by plans with deductibles was \$627 in 2008 compared with \$869 nationally.

While reducing benefits lowers premiums, it also shifts costs to employees and leaves enrollees with less comprehensive health benefits, which can lead to a reduction in utilization of needed healthcare services, as well as financial insecurity and medical debt.”

Point-of-Service Cost Sharing Requirements

Point-of-service cost sharing requirements can influence whether an individual uses a contracted provider or an out-of-network provider, and can have a significant effect on the risk ACOs bear under a global payment arrangement, particularly if the ACO must cover the cost of all services regardless of whether they are obtained within the boundaries of the ACO.

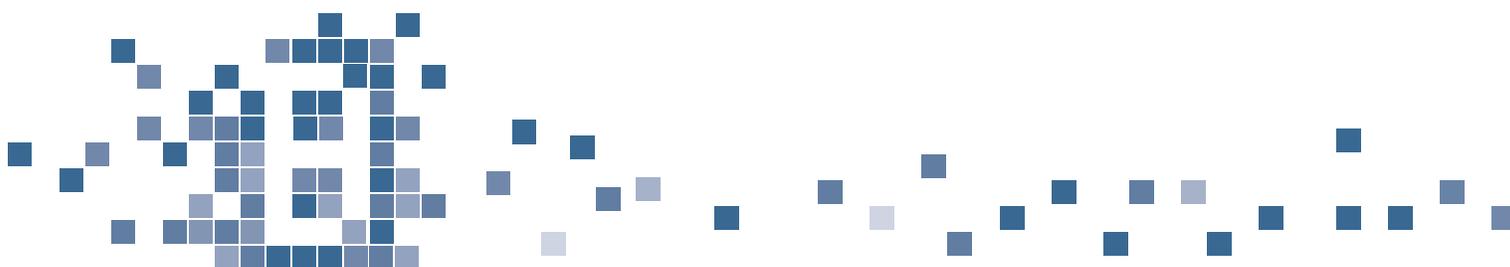
Point-of-service cost sharing is an element of benefit design used to influence the way consumers access care. Providers can ask patients about their cost sharing requirements when recommending referrals, and may change their referral recommendations based on the consumer’s payment obligation. Surveys of employer-sponsored health benefit plans have tracked the increasing use of consumer cost sharing as a strategy to slow the rate of premium increase – with resulting increases in consumer out-of-pocket costs. (See “Buy down” sidebar at left.) This reflects the widespread adoption of benefit designs that establish three or more tiers of pharmacy co-payments, higher deductibles, a shift from co-payments to co-insurance (where consumer payments increase proportionately as costs increase), separate deductibles for different service categories, such as medical and pharmacy or mental health, and combined deductibles and co-payments. At the same time, many plans now cover selected preventive and wellness services before the deductible is met.

Use of higher consumer deductibles and cost sharing in health plan benefit design has been shown to reduce utilization and expenditures. However, cost sharing may also be a hindrance to obtaining *necessary* services, and may be an area where ACOs need flexibility in determining the right course of treatment for their members. There is clear evidence that chronically ill patients, whose condition can be controlled when medications⁹ are taken as prescribed, are sensitive to higher out-of-pocket drug costs. Pharmacy benefit caps are also associated with higher rates of patients discontinuing medications. These findings are important because adherence to prescribed medication may reduce the need for other, higher-cost prescription drugs and the use of more expensive services, such as visits to the emergency department.

Additional research suggests that reduced cost sharing for selected preventive and screening services increases use of those services. As a result, there is growing acceptance that co-payments and other forms of cost sharing should be kept low for services that have demonstrated high value¹⁰. This evidence also suggests that health insurers and employers should be willing to consider more direct provider input into the application and amount of member cost sharing for services. As ACOs accept increased risk under a global payment methodology and begin to redesign processes and treatment protocols, they should be delegated some authority to modify cost sharing requirements. This will allow ACOs to achieve improvements in health status and possible reductions in the cost of care.

Additional Programs and Resources in Health Benefit Design

Reliance on member cost sharing as a tool for overall cost control is limited by the fact that a small percentage of the population accounts for the majority of health expenditures. Additional tools health insurers, employers, and provider health systems are



using disease management and wellness services to encourage members to maintain their health or to better manage existing conditions. While not strictly elements of health benefit design, participation in disease management and wellness programs can enhance the effectiveness of other components of health benefit design.

Disease Management and Chronic Conditions

Since most chronic diseases cannot be “cured,” the purpose of many disease management efforts is to improve, stabilize, or control a condition. Early disease management programs primarily focused on those with a specific health condition, such as diabetes, asthma, chronic obstructive pulmonary disease, or high-risk pregnancy. Newer models may target the entire population and preventable lifestyle conditions such as obesity, or adopt case management and care coordination for those with multiple conditions, in effect, customizing the disease management intervention¹¹. In the future, disease management programs could be expanded to patients that meet a high-risk threshold based not just on lifestyle but also on family history, or on dietary patterns based on culture and socio-demographic patterns. In the context of ACOs and global payment, the ability to offer effective disease management programs may be important for containing costs.

Prevention Programs

Proponents of health reform often focus on increased use of preventive services to reduce healthcare costs. Based on this assumption, an increasing number of health plan benefit designs reduce or eliminate consumer cost sharing for selected preventive services, such as well-baby care, immunizations, routine gynecological services, and screening procedures, such as mammography and colonoscopies. From the perspective of global payment, ACOs and benefit design, it is likely that ACOs will be interested in ensuring that those preventive services that have been shown to effectively reduce both short and long-term costs are included in the benefit design.

Consumer Education, Health Promotion and Resources

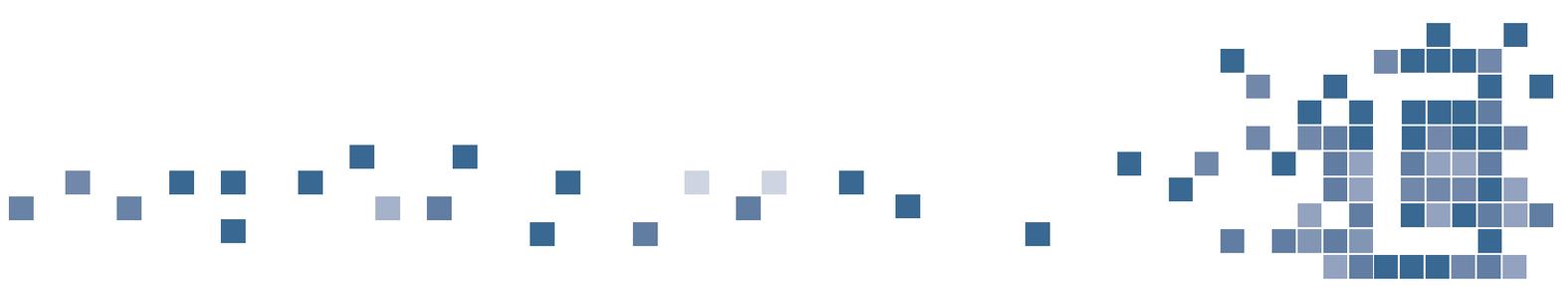
Consumer engagement in the context of health benefit design includes the tools, incentives, and disincentives to encourage the consumer to take actions to prevent disease, to seek knowledge of alternative medical treatments, and to inform themselves about the features of their health benefits coverage and healthcare providers. The goal is to help patients work with providers to receive the most appropriate services and technologies to improve their health outcomes. The expectation that consumers will actively engage in healthy behaviors and participate in their medical treatment decision-making is a significant change from the past. However, it is ironic that such an expectation is made more difficult by the rapid and multiple advances in medical care and technology. Additional information can add clarity or confusion to the decision making process. Increasingly, health insurance plans, employers, and other organizations are developing education and resource tools, many of which are internet based to provide consumer education to help consumers make decisions about how to manage their health¹².

An additional question is how these engagement tools can be used to direct consumers to healthcare within the ACO. Even as more information is provided, the incentive to act upon the information is influenced by other features of health benefit design, such as patient cost sharing. However, ACOs and primary care providers can assist consumers in sorting through information to make the most effective use of these tools.

Wellness Program Rewards and Incentives

More than half of employers that offer health insurance now offer at least one type of wellness benefit. These may include weight management, fitness center discounts, smoking cessation, nutrition counseling, and personal health coaches. Employers are also offering Health Risk Assessments that are increasingly tied to rewards and incentives. As with preventive care programs, primary care providers may be effective in encouraging patients to use wellness programs, and consequently may have some ability to control costs for at-risk members.

However, some researchers have concluded that while “there is some evidence that financial incentives can affect simple behavior changes, such as medical compliance...there is insufficient good evidence that they work in any sustained way to alter broader lifestyle behaviors.¹³”



Key principles, recommendations and issues to address in the design of benefits in a global payment system

Stakeholders and policymakers need to evaluate how current health benefit design processes and strategies should be modified to assure a more successful transition towards the Special Commission recommendations to adopt a global payment methodology across all payers using provider-based Accountable Care Organizations (ACOs).

The following four areas need to be addressed in a global payment system

- » Management of care to improve outcomes and affordability
- » Provider involvement in the benefit design process and flexibility to modify benefit design
- » Greater standardization of health benefit design across payers and consumer groups
- » Determining which services are covered – and excluded – under global payment

Along with these recommendations, there are current practices, policies and procedures followed by health insurance plans that could prove to be barriers to widespread adoption/ and success of a global payment system. Special attention should be focused on these to minimize their negative impact on achieving the goals and objectives of the Special Commission.

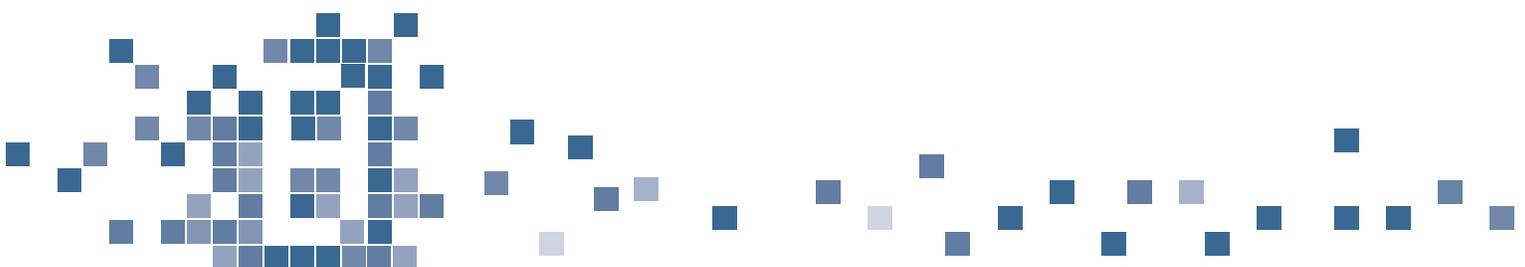
1. Management of care to improve outcomes and affordability (including managing access to the network and consumer assignment to ACOs)

Key to achieving a more affordable healthcare delivery system is the development and use of cost-effective care. Each provider included in an ACO must be attuned to the same value-based approach to care and coordinate effectively with others in the network to achieve the best possible outcomes for their patients. In MHA's recent publication, *Creating Accountable Care Organizations*, Harold Miller states, "Accountable Care Organizations cannot be expected to reduce the use of high-cost, unnecessary services if consumers feel they are entitled to those services under their insurance benefit plans. Although research has shown that more care and higher costs do not result in better patient outcomes, it's likely that most consumers still believe that they do. Moreover, it is likely that consumers will need greater sensitivity to differences in the costs/prices of care in order for Accountable Care Organizations to encourage use of the highest-value providers and services."

Increased consumer sensitivity to the actual costs of care is also key if ACOs are to succeed financially under the recommended new payment approach. As ACOs assume financial risk under global payment, we must determine whether such arrangements can succeed when ACO enrollees are in plans with greater patient choice and open networks, and are not balanced by other incentives, such as consumer cost-sharing, enhanced services, and consumer education tools that support changes in the healthcare delivery system. The ability of a globally paid ACO to manage the care of a group of patients, assess the adequacy of global payment levels, and control the cost of care depends not only on knowing which patients are in the panel but also the extent to *which* patients have flexibility to seek care outside of the ACO.

A member assignment process that allocates members to a specific provider network/ACO; the establishment of rules that determine under what circumstances a member can switch networks, and a determination on how provider reimbursement would work under those circumstances are critical to success, along with the establishment of appropriate consumer appeals processes.

Benefit designs that require members to identify the ACO as the "medical home" with responsibility for arranging referrals to



specialists and services both within and outside the ACO offer the strongest potential for ACO patient management, coordination of care, and the greatest incentives for provider efficiency under global payment. Insurance benefits should be designed to encourage patients to receive services provided or managed by their ACO whenever medically appropriate. This includes different levels of cost-sharing for services obtained inside and outside an ACO's provider network.

The level of financial risk ACOs take on also should reflect and adjust for the degree of patient choice and openness of the network that the benefit design allows.

Establishment of these processes must be accompanied by an active member engagement and education process to ensure that the member understands how the ACO participates in the health plan provider network.

2. Provider Involvement in the Benefit Design Process & Flexibility to Modify Benefit Design

Currently benefit designs are determined by the health insurance plan and the employer (or the employer's broker agent), with the employee choosing among the offerings or accepting whatever product the employer selects. Healthcare providers are generally not involved in developing benefit design options. **Appendix A** includes a discussion of the current decision making process in determining health plan design. **In a global payment environment, ACO representatives should be involved in recommending and approving preferred benefit designs that they consider most cost effective and that provide greater value.** Health plans should not be able to unilaterally reduce benefit levels, and participating ACOs should retain the right to review the impact of benefit "buy downs" on patient compliance.

Some of the principles of appropriate benefit design include the following:

- » Member cost sharing should be designed carefully to balance the affordability of premiums with maintaining access to needed care and ensuring financial protection against the costs of serious illness, particularly for people with lower incomes.
- » Patients should have appropriate positive incentives to engage in healthy behaviors, adhere to recommended care, and obtain the most cost-effective treatments
- » Benefits packages should be developed based on the principles of value-based insurance design, meaning that it is appropriate for consumers to have lower cost-sharing for more clinically beneficial services and higher cost sharing for services with little or no proven clinical benefit.

Additionally, under a global payment system, providers will have the responsibility of managing to a budget. There may be times when modifying the benefit design is the most cost-effective way of caring for a particular enrollee. Some examples include waiving deductibles or co-payments for particular services, providing alternative sites of care, and enhancing home-based services to keep patients out of the hospital. Currently, it is common for health insurance plans to allow modified benefits on a case-specific basis, and flexibility may also need to be given to ACOs to make similar modifications.

"Under global payments, employers will have to offer plans in which employees select a primary care physician and get their healthcare within a smaller, interconnected community of quality providers. To make this effort successful employers must also actively educate and inform their employees about the reasons and benefits behind such a new system. Without this support, executives would be stepping out of the process and saying to physicians, 'You be the doctor and the cop. You alone explain to patients why they can't go wherever they want whenever they want.' Doctors need to remain patient advocates. Employers, physicians and patients must work together; otherwise, we are setting ourselves up for failure and deluding ourselves about the true savings that reform can yield."

— From an August 12, 2009, op-ed in the *Boston Globe* by MHA President & CEO Lynn Nicholas and Ellen Zane, MHA Board Chair and President & CEO of Tufts Medical Center

This is not unprecedented; for instance, Medicare Advantage plans are required to offer at least the same benefits that traditional Medicare offers. But they have become popular because they frequently offer benefits not covered by traditional Medicare – such as health club memberships; preventive and wellness care; free or discounted non-prescription drugs, vision, hearing, and dental care. They may also pick up some costs Medicare beneficiaries normally have to pay out-of-pocket¹⁴. These additional benefits may help avert emergency department visits and hospital stays.

The Commonwealth Care Alliance (CCA) is a Massachusetts not-for-profit care delivery system that provides integrated health-care and related social support services for “dual eligibles” – elderly and disabled patients who are enrolled in Medicare and Medicaid. The CCA receives capitated payments from Medicare and Medicaid, provides comprehensive care and reduces costs by reducing hospital and nursing home admissions. Among the principles listed by the Alliance as crucial to improving care and managing costs is flexible benefit design¹⁵.

In a similar manner, ACOs should be given the latitude to offer expanded services within a global payment structure, in circumstances where it is determined that services not covered by an individual’s benefit design (i.e. extra-contractual benefits) would more effectively treat a particular condition. In this circumstance the ACO would need to have agreement with insurers about how payment for the additional services would be paid.

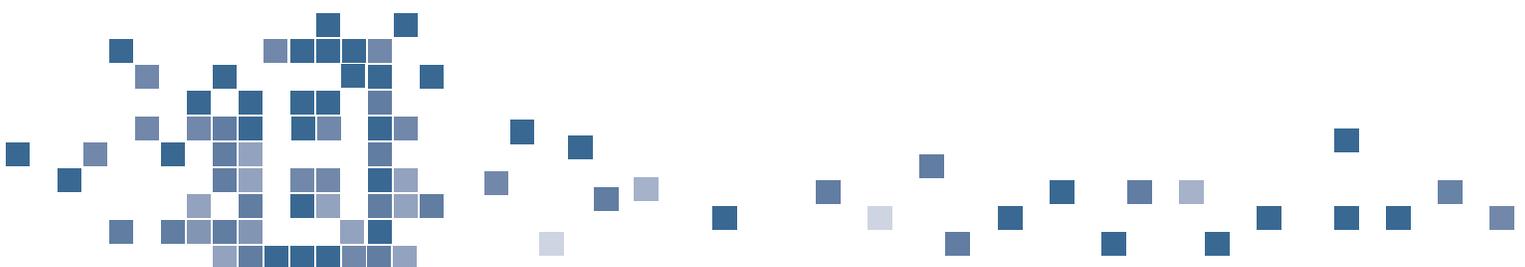
3. Greater standardization of health benefit design across payers and consumer groups

Currently, health plans offer employers a choice of a confusing and often customized array of benefits configurations with variations in provider delivery networks and systems of care, covered and excluded services, and the services targeted for member cost sharing. These configurations are often offered at the request of employers, particularly large self-insured employers. This plethora of options is ostensibly made available in an effort to balance premium affordability, comprehensiveness of benefits, and levels of patient cost-sharing in a package that will appeal to consumers while simultaneously containing the total cost of care. However, it adds a great deal of unnecessary complexity and administrative burden to the healthcare system, and is time-consuming and resource-wasting.

Appendix B includes a description of the basic types of insurance products. Underneath this seemingly simple structure is a bewildering range of customized health plan offerings, totaling in the thousands, often with specific billing and coding rules. This creates inefficiency and redundancy, and providers have to maintain costly, labor-intensive back-offices to deal with the resulting administrative quagmire. Such extensive customization can also result in added confusion and frustration for patients.

There are compelling reasons in a global payment system to standardize benefits – that is, to make them as consistent as possible across patients. These include:

- » Benefits standardization will allow health plans and ACOs to compete on factors other than risk selection. Risk selection occurs when a certain type of health plan attracts a disproportionate share of enrollees with relatively low (or high) expected medical costs. Health insurance plans can construct benefits packages that are differentially attractive to customers who are healthier (and hence more profitable) than others. Healthier enrollees are attracted to plans with lower primary care co-payments and larger primary care networks, while sicker enrollees are attracted to plans with lower specialty care co-payments and larger networks of specialists and to plans with higher quality ratings. Risk selection can lead health insurance plans to compete for lower-cost enrollees and to avoid higher-cost individuals and therefore compete on the basis of who they enroll rather than on the basis of true cost containment¹⁶. The price and profit advantages from such tactics can outweigh the gains achieved by cost-effective management of healthcare for the ill and injured and of administrative services. The Institute of Medicine recommends that one way to limit risk selection is to “...regulate the terms of health plan competition to limit the number of health plans, standardize benefit packages...”¹⁷. But with more widespread focus on the commonwealth’s goal for affordable, cost-effective care, substantial progress could be achieved through voluntary measures the state’s employer community adopts.
- » Where individuals have a choice of plans, they are likely to choose one that matches their preference for trade-offs between their health risk and the cost of the plan. Without standardization of benefits, especially in a global payment system, these trade-offs



may result in individuals choosing plans that include incentives for the individual that do not match the incentives for the ACO.

- » If the benefits available to patients in the panel of an ACO are standardized, the ACO can create care processes and systems of care that minimize unnecessary administrative cost. Standardization may also assist providers that are paid through a global payment system to better understand the range of coverage for all patients, and reduce variation in treatment recommendations for similar patients. Standardization of disease management programs, preventive services, and wellness programs would also enhance an ACO's ability to operate effectively.
- » Addressing risk selection through benefits standardization is also important in the context of maintaining coverage levels in the state. The cost of health coverage for an individual is linked to the risk level of the 'pool of covered individuals.' Premiums for those who find themselves in groups with unfavorable selection will be higher, even if their own risk of medical care expense is low. There is a financial incentive for lower-risk individuals to exit, perhaps opting to pay the state's penalty for not having insurance coverage. This makes the remaining pool even more expensive, perhaps so expensive that those most in need of the coverage cannot pay the premium and the plan fails.

Efforts to increase standardization will have to consider the important role of employers in offering health plans, as well as the high proportion of workers who are covered under self-insured employer-sponsored plans that are not subject to direct state regulation, but are subject to federal ERISA regulations. However, Massachusetts' health insurance mandate, with its Minimum Creditable Coverage regulation, does apply to the individual employees and dependents who benefit from the self-insured plans. Since state regulations cannot mandate requirements for benefit designs offered by self-insured employers, effective, voluntary approaches must be developed if the ACO/global payment initiative is to be successful.

4. Determining which services are covered under global payment and what services are excluded

While not directly related to determining benefits design, determining which services will be covered under a global payment is an important consideration for the ability of an ACO to effectively manage risk and to develop and test alternative processes in the delivery of care. In developing ACOs in conjunction with benefit design, it may be appropriate to exclude the costs of some conditions and/or services from the global payment.

This is also a very important consideration in facilitating transition to ACOs and global payment. As nascent ACOs transition to global payment, they will vary in their capabilities and experience with regard to specific specialties and disease types. They may wish to tailor benefit packages they will need to manage under a global payment contract to their current range of services. As ACOs gain experience in managing care delivery under global payment, they could transition to the full spectrum of care. It will be important to maintain maximum flexibility for providers and ACOs to operate under benefit designs in which they can succeed.

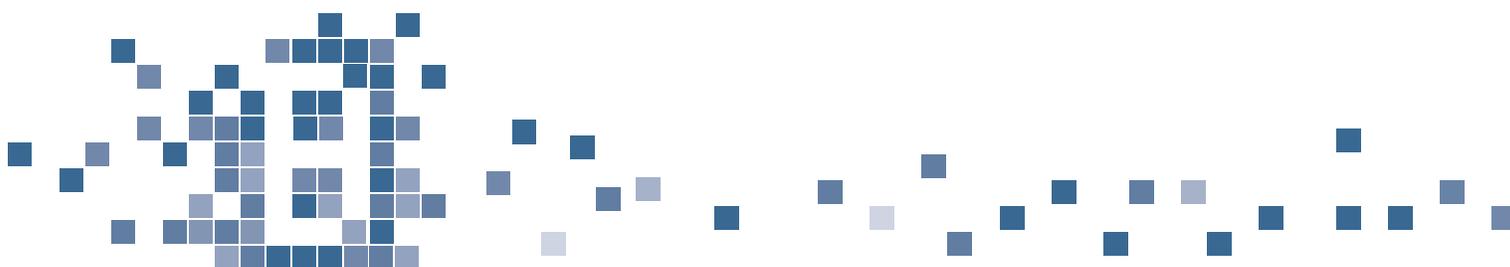
Self-Insured Plans

According to a recently published report¹⁸, self-insured plans cover nearly half the privately insured market population in Massachusetts and the self-insured market segment is the only employer segment that is growing.

Market Segment	Percent of Total Private Enrollment		
	2006	2007	2008
Individual	1.3%	1.2%	1.8%
Small group (1-50)	18.3%	17.7%	17.1%
Mid-size group (51-499)	19.9%	19.3%	19.3%
Large group (500+)	15.1%	14.7%	13.5%
Self-insured groups of all sizes	45.4%	47.1%	48.4%
Total	100.0%	100.0%	100.0%

Examples of health plan policies and procedures that could prove to be barriers to widespread adoption/and success of a global payment system

- “Benefits buy-down,” or cost shifting through increasing use of co-payments and deductibles could cause patients to delay accessing services, particularly preventive services, leading to greater costs in the long-run when patients access services at a more acute level.
- Tiered co-payments designed to provide incentives to use a particular physician or hospital could result in patients seeking services outside of the ACO network if the co-payment elsewhere is lower.
- Incentives to use freestanding services outside of the hospital (imaging, lab) could run counter to the integration of services within an ACO. Under global payment, the ACO should have incentives to choose the most cost effective, quality setting and could choose to send patients outside the ACO in cases where it is beneficial for the patient. However, if incentives are designed for patients and physicians to use free standing facilities, then quality may be affected and utilization may inadvertently increase, since freestanding providers might be on electronic medical record platforms that do not communicate with and/or are not accessible by the ACO’s providers.
- Prior authorization programs and other insurer administrative requirements (e.g. prior notification, radiology precertification etc) – add unnecessary administrative cost to the system and typically require providers to hire additional staff and/or make technological investments to comply with insurer programs/processes. These administrative burdens should be eliminated and/or delegated to the ACO’s medical officer under a global payment system. Retroactive reviews should be eliminated completely unless the procedure in question was outside the scope of benefits or experimental.
- Mandated use of specialty pharmacies has the potential for reduced quality, disaggregation of care, and patient dissatisfaction. Examples of this are policy changes by health plans that require medications to be pre-authorized, ordered from an outside specialty pharmacy and self administered. Some of these medications need to be administered in a timely fashion and can have significant side effects so it is important to have medical supervision while they are administered. Under global capitation arrangements, the ordering physician should have the flexibility to determine whether medications need to be provided in a more timely manner and administered in the clinic or hospital outpatient setting. Care providers should not be prohibited from doing what is best for the patient because of inflexible health plan policies.
- The pricing structure of tiered pharmacy benefits needs to be examined closely because patients who can’t afford their co-payments may become non-compliant and require costly readmission.
- Carve-outs of services like behavioral health and vision care can also lead to reduced quality and make coordination of care more difficult: Under carve-out arrangements, the management of care for certain diseases or conditions, service categories, or populations is contracted for separately. The expectation is that a unique set of managed care techniques can then be applied to a subset of particularly costly or complex patients. Under an ACO/ global payment model, such carve-outs can lead to fragmentation of patient care for interrelated disorders. The primary care physician/ACO’s input on what the most appropriate care management approach should be for these patients is reduced. The carve-out vendor’s clinical, administrative and reimbursement structure (as well as any provisions for consumer choice and accountability) may differ from that of the ACO, potentially leading to mismatched care approaches and incentives.
- Health plan advertising, marketing and messages to members that promote expectations that the member can go to any participating network provider (full freedom of choice) set up conflicts between patients and their providers and could doom an ACO under global payment. Lack of notification from health plans to providers when patients go to an out-of-network facility/provider would make it more difficult for ACOs to manage care and control costs.
- The rationale and validity of minimum length of stay requirements in acute care before eligibility for post acute care benefits should be reviewed as these can needlessly delay transfers to lower cost post acute care settings.



Conclusion

In the context of a delivery system based on global payments and ACOs, benefit design can support successful reform. It can also become a barrier if consumers and providers do not face incentives that consistently align their interests and needs to encourage more cost-effective care and to improve value. In other words, incentives have to be created so that those who receive care work with those who provide care to achieve the common objectives of high-quality care delivered in the most effective and efficient manner.

The time it takes to move from current benefit designs to those products properly aligned to support the new payment and delivery systems envisioned by the Special Commission – and to reverse current health insurance plan policies and procedures that could prove barriers to success of a global payment system – will be key factors in determining how long it takes to achieve the Special Commission’s goals. In fact, whether that transformation in benefits design occurs will be a key factor in determining whether the Commission’s vision and goals are achieved at all.

Clearly those who provide care must embrace change, but that is not enough to ensure success. Those who design benefits, those who pay for benefits, and those who use benefits must all share in the change. The incentives for insurers, employers and beneficiaries must all align with those of care givers to ensure that all are working together, pulling in the same direction, and sharing responsibility to support the efficient delivery of high quality care.

All those participants have to be willing to accept some restrictions and limitations in order to achieve improved value affordably delivered by our health care system because key incentives must be aligned and goals must be shared by all. That is the challenge and opportunity provided by redesigning benefits, as well as payments. For their part, the community of Massachusetts hospitals are ready to help lead this change.

Acknowledgements

The Massachusetts Hospital Association would like to thank its advisory group for collaborating on this paper.

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Nancy Turnbull

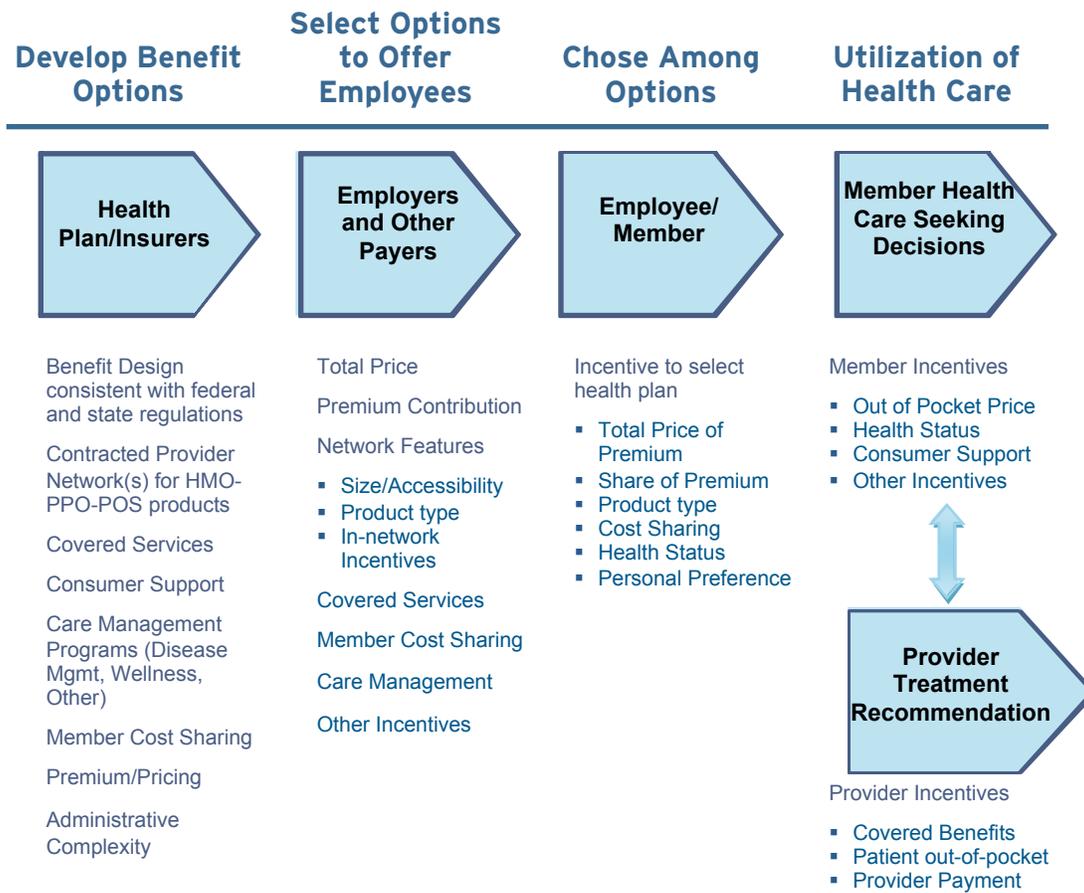
Hinckley, Allen & Tringale LLP

PricewaterhouseCoopers LLP

Appendix A: Health Plan Benefit Design and Decision-Making Process

The current health plan benefit design and decision-making process is guided by federal and state laws and regulations that define the legal and operational requirements for a health insurer. Because the majority of people with health insurance are covered under employer sponsored plans, the employer selection and design of health benefits determines the incentives faced by most consumers. The major government sponsored programs, Medicare, Medicaid and the Child Health Insurance Program, assume the role of payer for those who are eligible for these programs and must meet minimum benefit requirements established by federal legislation and regulation, the policies of the Centers for Medicare and Medicaid Services, and state Medicaid agencies. As part of the Massachusetts health reform, the Commonwealth established Minimum Creditable Coverage (MCC) requirements for all health benefit design available to Medicaid beneficiaries in MassHealth and for plans that are offered to state residents through the Health Connector exchange.

Decision Making in Health Plan Benefits



Role of Regulation

Both Federal and State regulations determine the range of benefit designs that may be available in Massachusetts. In addition, Massachusetts law requires that all individuals have health insurance coverage that meets minimum standards¹⁹.

Federal Laws

The primary federal law that affects health insurance benefits is the Employee Retirement Income Security Act of 1974 (ERISA) and its subsequent amendments. This statute established the minimum standards and federal tax treatment for health and pension plans in private industry. ERISA does not require that an employer offer a health benefit, but regulates the operation if the employer establishes a health benefits plan. Employers that establish a plan under ERISA are exempt from state health insurance laws and regulations. This exemption makes attempts at standardization and uniformity of certain state reforms very challenging.

Significant amendments to ERISA includes the right of some employees to continue health insurance coverage for a limited period of time after the person has lost coverage (Consolidated Omnibus Budget Reconciliation Act 1985 – COBRA), and limitations on a plan ability to refuse coverage for pre-existing conditions (Health Insurance Portability and Accountability Act 1996 – HIPAA).

Federal law has also mandated some benefits for employer sponsored ERISA plans, such as a 48 hour stay for normal deliveries, requiring annual or lifetime limits for mental health benefits cannot be lower than those available for medical and surgical benefits under the plan and for a woman's reconstructive surgery after a mastectomy. A number of states have followed the federal lead by adding comparable requirements for health plans regulated under the state laws.

Massachusetts Health Laws and Regulation

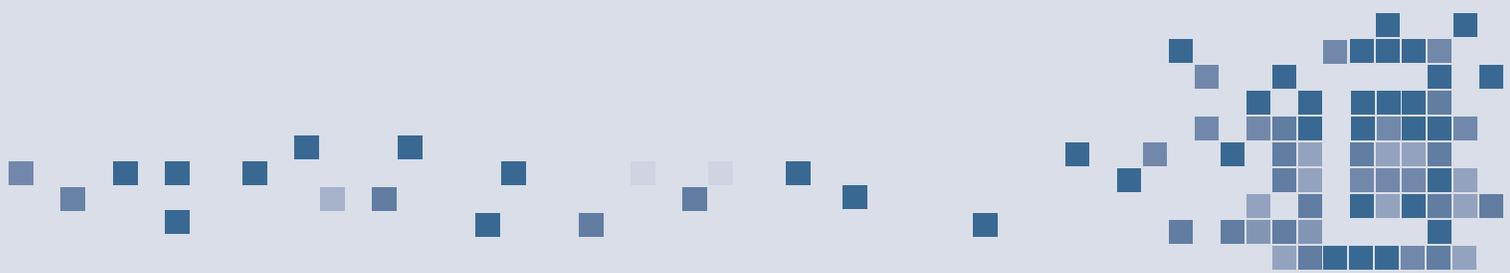
The Minimum Creditable Coverage (MCC) requirements establish a floor for services that must be covered and limits on out-of-pocket cost sharing. Effective January 1, 2009, any health plan benefit design that does not meet the MCC requirement is not acceptable under the Massachusetts individual mandate to obtain health insurance coverage and subjects the person to tax penalties. MCC requirements attempt to balance cost, cover core medical services, and encourage preventive care.

MCC coverage includes preventive and primary care, emergency services, inpatient and outpatient services, prescription drugs and mental health services. This requirement provides some boundaries on the specific benefit designs that may be offered, but is quite broad. Minimum creditable coverage standards, include:

- » Covers prescription drugs (may have deductible of up to \$250 per individual/\$500 per family)
- » Covers regular doctor visits and check-ups before any deductible
- » Caps the annual deductible at \$2,000 for an individual or \$4,000 for a family
- » If there is a deductible or co-insurance on core services, caps out-of-pocket spending for health services at \$5,000 for an individual or \$10,000 for a family each year
- » Does not cap total benefits for a sickness or for each year; and,
- » Does not cap spending for a day in the hospital.

The Minimum Creditable Coverage standards will be expanded in 2010 and must cover diagnostic imaging and screening, diagnostic laboratory, maternity and newborn care, radiation therapy and chemotherapy, and medical and surgical care. Preventive care must include routine adult physicals, well baby care, prenatal maternity care, medically necessary immunizations and routine gynecological exams.

The MCC requirements also set a minimum actuarial value, a measure of the proportion of the medical expense that will be covered by the health insurer²⁰. A bronze level package, allows lower premium and higher out of pocket cost sharing, and requires an actuarial value of approximately 56%. Plans are rated silver if the actuarial value is between 67% and 81% and the Gold benefit package has an estimated actuarial value of 93%²¹.



Role of Insurers, Employers, Other Payers, and the Consumer

Although there are many health plan offerings from many insurance companies in the market, consumers do not have an open-ended choice among all the options. In the current system, a series of decision-makers are involved in the design and selection of the health plan options that are offered to a given consumer. The decision makers include the health insurers, the employer or other payer, and the consumer; however, if an ACO-based global budgeting system is to succeed, providers will also need to play an active role in benefit design.

Insurance Plans: Working within the federal and state insurance regulatory framework, health insurers develop plan product types and a range of benefit designs that they believe will meet employer and consumer demands and that will effectively compete against other insurers' offerings in the market. Although an insurer may offer a range of health insurance products, the benefit design options that are available may vary by geography and local health market conditions, or by the type of purchaser and line of service - government, large employer, small employer or individual. Large employers and self-insured accounts are offered more options for products and greater flexibility in benefit design. Small groups and individuals typically select among a standard set of products that provide more limited variation in covered services and member cost sharing. Health benefit designed for government programs are usually standardized by product type, requirements for covered services and limits on member cost sharing. They may differ if the operation and management of the health plan achieves cost savings that can be retained and used to offer new covered services or to reduce the member cost sharing.

Employers and Other Payers: The role of the payer is to select among the health plan product and feature options that are offered by health insurers. Some employers choose to self-fund their employees' health benefits, but generally conform to current market standards in determining the benefit design that is offered, and may contract with health plans on an Administrative Services Only basis to take advantage of the health plan's expertise and provider network while retaining the risk of healthcare costs in lieu of paying premiums to the health insurer.

Employee/Consumer: Employee selection of a health plan is dependent first on whether they are eligible for health benefits, and, if so, on the option(s) offered by their employer. Those who do not have employer sponsored coverage, and those who are not eligible for public government programs, select among the plans available in the local individual insurance market. Similar to the employer decision, the individual considers affordability of the premium, the product type and benefit features, including covered services and cost sharing. Even those who are eligible for employer sponsored health coverage may determine that they cannot afford the coverage, and decline to enroll²². Consumer also have additional information when selecting a health plan – knowledge of their health status and that of their family members and their personal preference – to balance the trade-offs among choice of providers, the comprehensiveness of covered services, and willingness or ability to pay the premium and required cost sharing.

Appendix B: Comparison of Health Plan Products

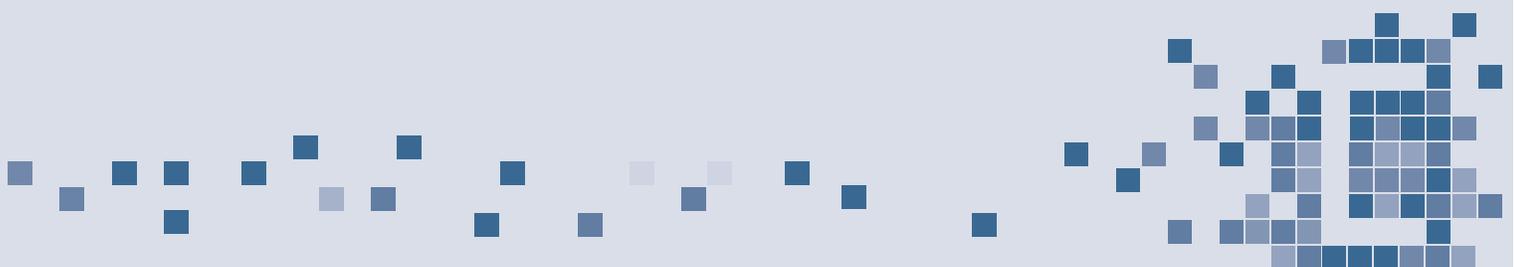
The primary health insurance products in the national market, and in Massachusetts, are managed care products. This section presents the general characteristics of **three types of managed care products, as well as of high deductible health plans (HDHP)**. In the past few years, HDHPs have grown nationally, particularly those that qualify for favorable federal tax treatment with Health Savings Accounts (HSAs); however, they still remain a small component of the Massachusetts health insurance market. A basic understanding of the types of managed care products is important because they represent a hierarchy of provider choice and consumer cost sharing, which are fundamental to determining health insurance benefit design. Each product offers flexibility in how treatment may be organized and can support ACO efforts to coordinate care. However, the ease of administration and monitoring of care will vary given current consumer incentives in the product design.

Health Maintenance Organization: A type of managed care organization where enrolled members are required to seek healthcare service from within a network of contracted physicians, hospitals, pharmacies and other providers who have a contract with the HMO. Members are required to select a primary care provider (PCP) or a medical home when accessing care. The PCP serves as a gatekeeper to arrange approved referrals to specialists and other necessary care. Services from a provider outside the contracted network are not covered by the HMO except in the case of an emergency or a pre-authorized referral. In exchange for the member's willingness to accept a more limited choice of providers and to adhere to the HMO guidelines, member cost sharing is limited. There are often no, or low, deductibles, and cost sharing is more likely to be based on an established amount of co-payment rather than co-insurance.

Preferred Provider Organization: A type of managed care organization where the health insurer has contracted with a network of physicians, hospitals, pharmacies and other providers for a negotiated rate and where these providers agree to adhere to the health plan's policies and procedures. The member is not required to select a primary care provider. When the member seeks services from a provider or is referred to a specialist within the contracted network, there is lower member cost sharing. There may also be richer benefits in terms of covered services. The member may seek care from providers outside the network, but insurance plan payments are lower and the member cost sharing can be substantially higher than when care is sought from in-network providers. A PPO product design is much more likely to use individual and family deductibles. In network care increasingly uses co-payment cost sharing, although some services may be subject to co-insurance against the negotiated fee schedule. Out of network services may use a separate deductible and are more likely to use co-insurance cost sharing.

Point of Service is a type of managed care organization that is an HMO-PPO hybrid and is sometimes called an open access HMO. Members of a POS choose the network of providers they will use each time they seek care. Members may be required to select a PCP to monitor their care, as in an HMO. Referrals to other providers in the smaller HMO core network have reduced cost sharing. Referrals to providers in the broader contracted network, or self-referrals outside the HMO core network have higher member cost sharing requirements. The following table presents a comparison of the major network and member cost sharing design features of the three types of managed care products. Examples of common or average features for each product type are based primarily on the Kaiser Family Foundation/Health Research & Education Trust annual national employer surveys.

High Deductible Health Plans (HDHP) are not considered a managed care product. They are a catastrophic coverage benefit design with high deductibles that may be supplemented by personal healthcare accounts, either health reimbursement arrangements (HRAs) or federally qualified health savings accounts (HSAs) Common HDHP designs includes "preventive safe harbors" to encourage receipt of primary care and preventive services that are not subject to the deductible. After the deductible is met, there are cost sharing requirements up to an out of pocket maximum where the health plan covers all subsequent services. Cost sharing may be covered by use of funds in the personal health accounts. These designs are intended to increase consumer consciousness of the cost of services by assuring that patients have 'skin in the game.'



Comparison of Common Features of Health Plan Benefit design by Type of Product

				Common Member Cost Sharing		
Product	Provider Network Gatekeeper/ Medical Home	Covered Services/Benefits	Premium	Deductible	In-Network	Out-of-Network
Health Maintenance Organization (HMO) Less Provider Choice/ Lowest Cost Sharing	Most limited provider network. Members select primary care physician (PCP). Referral to specialty care arranged through PCP.	Comprehensive benefits with high actuarial value. Services are paid for (covered) when using in-network providers. Out of network coverage for emergency or with prior authorization only.	Average annual premium somewhat higher than POS (\$4878 annual for single – KFF/HRET)	Limited use of deductibles (16% nationally); Some recent design apply deductibles to selected services (e.g. hospital inpatient, pharmacy)	Co-payments applied to office visit, Rx, ED and hosp. inpt.	NA/No coverage outside network except for emergency
Point of Service (POS) HMO-PPO Hybrid Medium Provider Choice/Low Cost Sharing within HMO Core	Combines features of HMO and PPO. HMO core network of providers with access to a larger number of contracted in-network providers. Point of Service refers to consumer ability to seek care with core providers or larger network of providers each time services are used. Members select primary care physician (PCP). Referral to specialty care arranged through PCP.	Comprehensive benefits. Higher actuarial value when using HMO core in-network providers. Out of network coverage for emergency or with prior authorization only.	Average premium slightly less than HMO. (\$4835 annual for single – KFF/HRET)	Common Feature: Single annual deductible before health plan provides coverage	Co-payments applied to office visit, Rx, ED and hosp inpt.	Higher Cost Sharing. May use separate deductible and coinsurance
Preferred Provider Organization (PPO) Broadest Provider Choice/ Highest Cost Sharing	Usually largest provider network of contracted providers. Members do not need to select PCP. May self refer to specialist	Comprehensive benefits with lower actuarial value. Services are paid for (covered) when using in-network providers. Out of network coverage for emergency or with prior authorization only.	Highest average premium (\$4922 annual for single – KFF/HRET)	Common Feature: Single annual deductible before health plan provides coverage. But there great variety – individual deductible before family deductible; separate deductibles by service type	Coinsurance applied to office visit, Rx, ED and hosp. inpt; some use of copayment	Higher Cost Sharing. May use separate deductible and coinsurance. Applied to lower insurer reimbursement with member responsible for balance billing

Notes: Summary of product design and plan features based upon Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits, 2009 Summary of Findings. Direct comparisons to Massachusetts plan offerings are not available.

Appendix C: Overview of Health Plan Benefit Design in Massachusetts

This section presents an overview of the current landscape of health plan benefit design for the major commercial health insurers in the state.

Tables of Massachusetts Employer Sponsored Coverage

As of March 2009, nearly 5.5 million people (excluding those with Medicare) were insured in Massachusetts²³. The breakdown by type of insurance and the change since June 2006 are shown in Table 1.

Table 1: Massachusetts Health Plan Enrollment				
	Jun-2006	Mar-2009	Change	March 09 Distribution
Private Group	4,333,000	4,429,000	96,000	80.8%
Individual	40,000	86,000	46,000	1.6%
MassHealth (Medicaid)	705,000	804,000	99,000	14.7%
Commonwealth Care	0	165,000	165,000	3.0%
Total	5,078,000	5,484,000	406,000	100.0%

Source: Massachusetts Division Health Care Finance and Policy. Health Care in Massachusetts: Key Indicators. August 2009.

Table 2: Massachusetts Statewide Health Plan Enrollment by Plan Type Major Commercial Health Insurers 2007-2008		
	Enrollment	% Distribution
Commercial HMO	1,985,357	46.3%
Fully Insured Commercial PPO	596,186	13.9%
Self Insured PPO	1,305,355	30.4%
Fully Insured POS	64,922	1.5%
Self Insured POS	185,496	4.3%
Medicaid HMO	10,996	0.3%
Medicare HMO	134,631	3.1%
Medicare PPO	4,763	0.1%
Subtotal		
Commercial HMO	1,985,357	46.3%
Commercial PPO/POS	2,151,959	50.2%
Medicaid	10,996	0.3%
Medicare	139,394	3.3%
Total	4,287,706	100.0%
Commercial Coverage		
Self Insured PPO/POS		69.3%
PPO/POS Self Insured Commercial		36.0%

Source: HealthLeaders-Interstudy. Boston Market Overview. February 2009. Data for Dec 31, 2007 and Jan 1, 2008. Includes BCBS Mass, Harvard Pilgrim HP, Tufts HP and Fallon Community HP. Fallon Community HP is the only plan that participates in Medicaid managed care.

Recent information on the types of health plan benefit design indicates that slightly more people are enrolled in commercial Preferred Provider Organization (PPO) and Point of Service (POS) plans, products that offer access to broad provider networks, than in Health Maintenance Organizations (HMOs). Within the Massachusetts commercial enrollment, 52% of the reported health plan members are in PPO or POS plans; of that, 69% are in self-insured employer based coverage. Even with a sizable enrollment in HMOs, over one third of the commercial market is in self-insured plans. These self-insured plans are more likely to be the large employers in the state.

Health Plan Products

Even before the Commonwealth of Massachusetts embarked on the health reform initiative, the state had one of the highest proportions of population with health insurance coverage. Since the health reform legislation was enacted in June 2006, more than 400,000 additional residents have obtained health coverage. More than a third of the recently insured have coverage through private group plans or the individual market²⁴.

In Massachusetts, nearly three quarters of employers offer health insurance to their employees, a percentage that rises to more than 90% for businesses with 50 or more employees²⁵. Although information is not available for Massachusetts, nationally, 86% of firms offer only one health plan. Among large firms (those with more than 200 employees), 45% offer a more than one health plan. Because a majority of workers eligible for health benefits are employed in large firms, slightly more than half of workers are in companies that offer more than one health plan. However, that leaves approximately 47% of workers who do not have a choice^{26,27}.

Recent information on the types of health plan benefit design for the major health insurers²⁸ in the state indicates that approximately 48% of the commercial insurance enrollment is in a Health Maintenance Organization (HMO) and 52% is in commercial Point of Service (POS) or Preferred Provider Organization (PPO) plans, which offer access to broad provider networks.

The Provider Delivery Network and Access to Providers

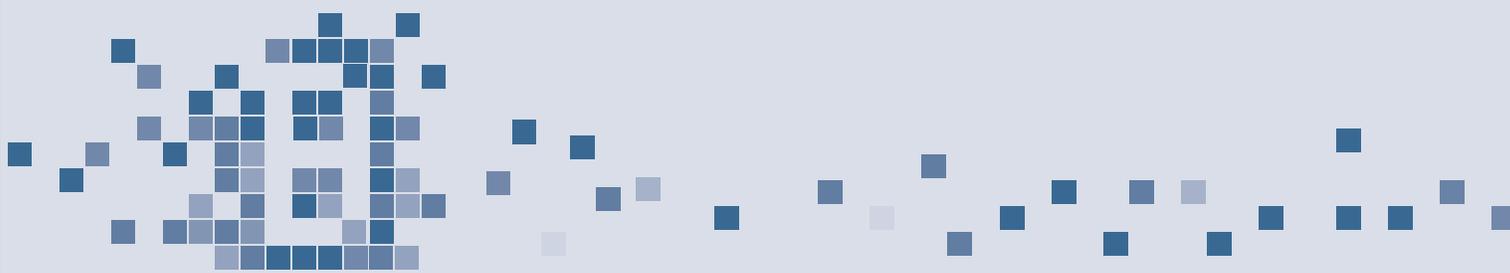
The major commercial health insurers in Massachusetts have contracted with as many as 20,000 physicians and over 80 hospitals to offer health insurance products to Massachusetts residents. These numbers are somewhat larger than hospital and practicing physician counts for providers in the state because the networks may include providers in neighboring states, such as New Hampshire and Rhode Island. Information is less readily available for the size of the provider networks contracted under the different products offered by each health plan, so it is difficult to assess the difference in provider choice for members who enroll in the various managed care products.

In recent years, Blue Cross Blue Shield of Massachusetts (BCBSM), Harvard Pilgrim HealthCare, Tufts Health Plan, and Fallon Community Health Plan have introduced products that tier physicians and hospitals within the contracted network and offer lower member cost sharing as an incentive for members to use the highest ranked providers. These tools can also be applied to ACO contracts within a health insurer network.

To date, provider financial incentives have been primarily through pilot programs and pay for performance type incentives. Recently BCBSM announced it had signed a five-year “Alternative Quality Contract” with a chain of six community hospitals and 1,100 physicians, which will pay providers under a risk-adjusted global payment and affect approximately 60,000 members in its HMO plan²⁹. This will be supplemented by performance-based incentives that are linked to national benchmarks of quality, efficiency and member satisfaction.

Consumer Cost Sharing in Health Benefit Design

While there is readily available information on covered benefits and cost sharing for the HMO, PPO and POS benefit plans offered by the major Massachusetts health plans, there is limited information on the distribution of specific benefits packages purchased by large employer groups, self-insured employers, small groups and individuals. It is therefore difficult to determine the strength of



current consumer financial incentives to remain in-network for their range of healthcare needs. More importantly, future benefit designs will need to provide appropriate incentives for patients to remain in-network and within an ACO to facilitate the proposed payment reforms.

The most recent Massachusetts Division of Health Care Finance and Policy (DHCFP) biennial survey of private employer-sponsored health benefits reported median cost sharing requirements in 2007 of:

Physician office visit	\$15
Emergency room	\$50
Inpatient hospitalization	\$250
Outpatient mental health	\$20
Three tier prescription drugs	\$10/\$25/\$45

The Massachusetts median copayment levels appear to be lower than copayment schedules reported in national surveys³⁰. Based on a limited review of the PPO benefit plan summaries on the websites for Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Plan, Tufts Health Plan and Fallon Community Health plan, it appears that:

- » PPO benefit packages impose a 20% coinsurance for use of out-of-network providers. This is in addition to first meeting a deductible, if a deductible is used in the plan design.
- » For plans that apply coinsurance to both in- and out-of-network utilization, a 20% differential exists.
- » Some PPO plans apply the same plan-year deductible and plan-year out-of-pocket maximum to in-network and out-of-network services combined³¹, (e.g., BCBSM PPO Saver plans)
- » High Deductible Health Plans (HDHPs) that qualify the plan participant for Health Savings Account contributions require “aggregate” family deductibles as opposed to the “embedded” deductibles that are more common among other plans.³²

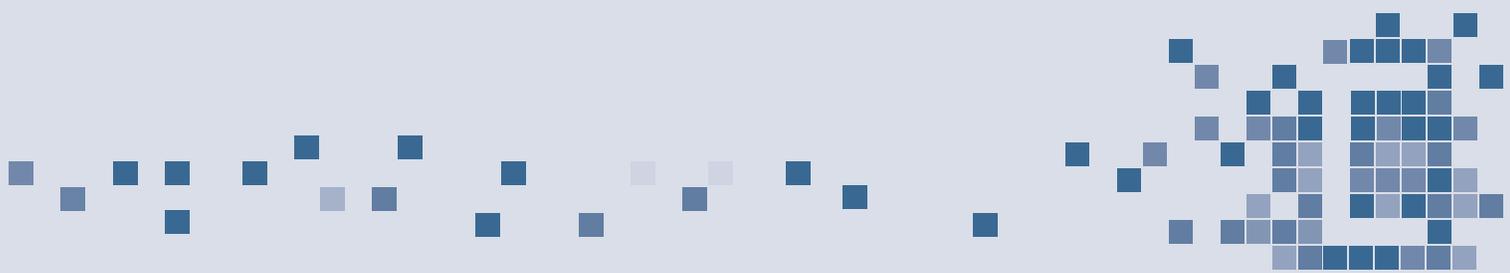
A 20% coinsurance differential is a common rule-of-thumb cost sharing design feature to encourage consumers to use in-network providers for high cost services such as hospital medical and surgical care, but may be less effective in encouraging patients to remain in-network for physician visits³³. This difference in coinsurance for out-of-network payment may also be a weaker incentive to remain in-network for planned or discretionary services, when members can anticipate and plan for the expenditure. New health benefit plan designs, such as those that require lower cost sharing for providers in higher ranked tiers, may begin to strengthen the consumer financial incentives.

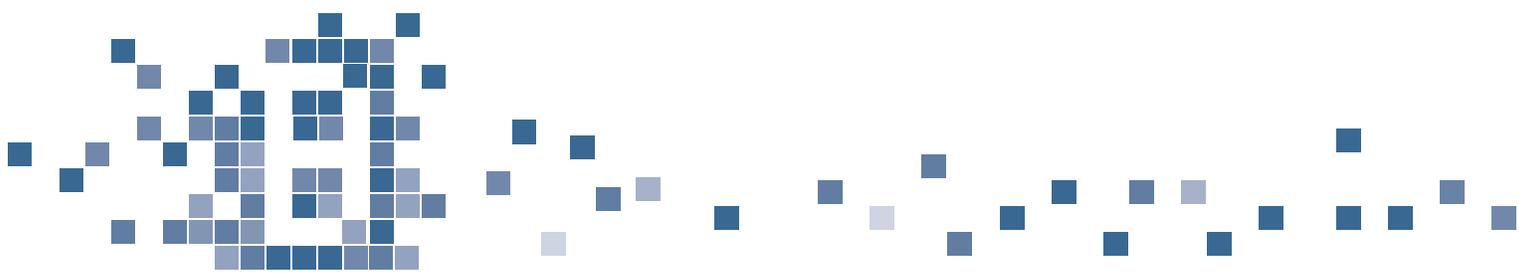
Additional Programs and Resources in Health Benefit Design

The major commercial health insurers in Massachusetts have implemented numerous programs designed to support appropriate care for members with chronic and high risk conditions, wellness programs and consumer education efforts to assist members to stay healthy.

Blue Cross Blue Shield of Massachusetts reports that more than 360,000 members have had contact with its disease management and care management programs, which are directed at people with more than 25 identified conditions, including more common program in asthma, diabetes, chronic obstructive pulmonary disease (COPD), as well as back pain, kidney conditions, and rheumatoid arthritis. Harvard Pilgrim, Tufts, and Fallon list similar ranges of care management support.

All plans also offer wellness programs such as smoking cessation and weight management, and have established online resource directories for information on preventive care and alternative treatments for conditions such as back pain and prostate cancer.

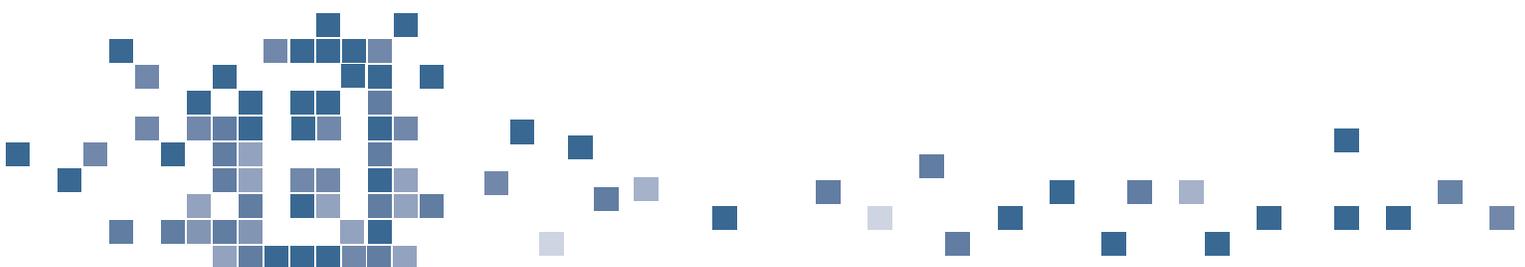




NOTES

- 1 From the Special Commission's report: "ACOs will be composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need". Please refer to the MHA White Paper "Creating Accountable Care Organizations in Massachusetts" available on the MHA website www.mhalink.org for further information.
- 2 An integrated provider network can be defined as a group of hospitals, physicians and ancillary providers which have joined together to create a system which provides comprehensive health care services through a coordinated, patient-centered continuum.
- 3 Actuarial value is a summary measure of a health insurance plan's benefit generosity. It is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. One purpose of an actuarial value is to distill all the benefit and enrollee cost-sharing provisions of a health insurance plan into a single number for easier comparisons among plans. (Source: Setting and Valuing Health Insurance Benefits; Chris L. Peterson; Congressional research Service.
- 4 Massachusetts MCC requirement do not allow caps on the amount of total amount paid for a particular illness in a given year or a fixed amount per day or stay in hospital with the member responsible for all remaining charges.
- 5 Buchmueller, Thomas. Consumer Demand for Health Insurance. NBER Reporter, research Summary. Summer 2006. <http://www.nber.org/cgi-bin/printit?uri=/reporter/summer06/buchmueller.html>
- 6 Srombom, BA, et al. Switching Costs, Price Sensitivity and Health Plan Choice. *Journal of Health Economics*. 21(1), January 2002.
- 7 People who buy insurance often have a better idea of the risks they face than do the sellers of insurance. People who know that they face large risks are more likely to buy insurance than people who face small risks. Adverse selection can occur when more the people with higher risk buy an insurance product. It describes a situation where an individual's demand for insurance (either the propensity to buy insurance, or the quantity purchased, or both) is positively correlated with the individual's risk of loss (e.g. higher risks buy more insurance), and the insurer is unable to allow for this correlation in the price of insurance
- 8 February 2010 DHCFP: Massachusetts Health Care Cost Trends Part II: Private Health Insurance Premium Trends 2006-2008 http://www.mass.gov/search?q=benefit+buy+down+trends&pageID=eohhs2searchlanding&sid=Eeohhs2&output=xml_no_dtd&client=mgov&proxystylesheet=mgov&numgm=0&ie=UTF-8&sort=date%3AD%3A%3Ad1&entqr=3&entsp=a&oe=UTF-8&ud=1&site=EOHHSx
- 9 Geoffrey F., D Goldman et al. Pharmacy Benefit Caps and the Chronically Ill. *Health Affairs*, v. 26, no. 5, Sept/Oct. 2007, p. 1333-1343. and RAND Research Brief.
- 10 Op cit.
- 11 May, G et al. Convergence and Dissonance: Evolution and Private Sector Approaches to Disease Management and Care Coordination. *Health Affairs* 26(6):1683-1891. Nov/Dec 2007.
- 12 Hibbard, J., Stockard, J., et al.. Development of the patient activation measure: Conceptualizing and measure activation in patients and consumers. *HSR: Health Services Research*. 39:4, Part I 2004..

- 13 <http://healthcarecostmonitor.thehastingscenter.org/adamoliver/do-wellness-incentives-work/#ixzz0h33wSbsx>;
- 14 http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=1
- 15 <http://www.commonwealthcare.org/about-us/index.html>
- 16 Employment and Health Benefits: A Connection at Risk. Marilyn J. Field and Harold T. Shapiro, Editors; Committee on Employment-Based Health Benefits, Institute of Medicine
- 17 Employment and Health Benefits: A Connection at Risk. Marilyn J. Field and Harold T. Shapiro, Editors; Committee on Employment-Based Health Benefits, Institute of Medicine
- 18 February 2010 DHCFFP: Massachusetts Health Care Cost Trends Part II: Private Health Insurance Premium Trends 2006-2008
http://www.mass.gov/search?q=benefit+buy+down+trends&pageID=eohhs2searchlanding&sid=Eeohhs2&output=xml_no_dtd&client=mgov&pr_oxystylesheet=mgov&numgm=0&ie=UTF-8&sort=date%3AD%3A%3Ad1&entqr=3&entsp=a&oe=UTF-8&ud=1&site=EOHHSx
- 19 Massachusetts Health Connector. Health Care Reform: Key Decisions. What is “Minimum Creditable Coverage (MCC)?
https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=MCC%20Benefits.htm&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/Health%20Care%20Reform/What%20Insurance%20Covers/MCC%20Background/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken
- 20 Actuarial value is a summary measurement of likely payments by a health plan for services that are covered under its benefits and coverage provisions. It measures the proportion of medical expenses paid by the health plan for a standard population and is expressed in the range of 0 to 1 or as a percentage, with 0.00 for a health plan that pays nothing and 1.00 indicating that the health plan will pay all expenses.
- 21 Congressional Research Service. Setting and Valuing Health Insurance Benefits. R40491, April 6, 2009.
- 22 In 2009, 81% of employees who were offered coverage through the employer elected coverage, but the proportion decreases in firms with a higher proportion of low wage earners. Kaiser/HRET op cit. Page 53.
- 23 Medicare covers about 15% of all insured residents
- 24 Health Care in Massachusetts: Key Indicators. Massachusetts Division of Health Care Finance and Policy. August 2009.
- 25 Massachusetts Division of Health Care Finance and Policy. Massachusetts Employer Survey, 2007
- 26 Kaiser Family Foundation and HRET. Employer Health Benefits, 2009 Annual Survey. Page 64 and Exhibits 4.1 and 4.2.
- 27 Some employees may have a choice if health plans because a household member is eligible for employer sponsored health benefits.



28 The major commercial health plans are Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Plan, Tufts Health Plan and Fallon Community Health Plan.

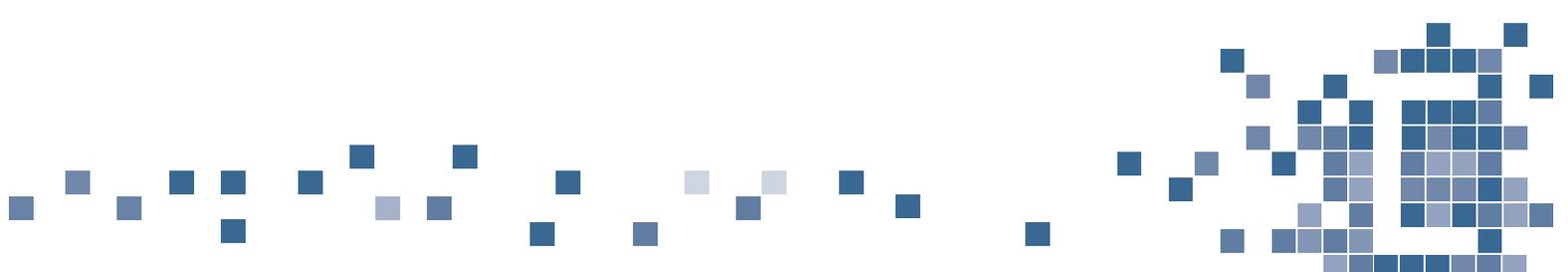
29 Blue Cross Blue Shield, Caritas Christi in pact. Boston Globe, November 28, 2009.

30 For example, the annual Kaiser Family Foundation/HRET survey reported that, across all plan types, including HMOs, PPOs, POS, and High Deductible Health Plans (HDHP), only 41% had a physician office copayment of \$15 or lower in 2007. This decreased to 33% by 2009. For the PPO plan type, 37% used a physician office visit copayment of \$15 or less in 2007, while more than half had a copayment of \$20 or \$25. By 2009, less than 30% of PPO enrollees had a physician office copayment of \$15 or less. More than a third paid \$20 a visit and another 20% paid \$25 per visit.

31 BCBSM Preferred Blue PPO Saver Middle Deductible, Summary of Benefits Effective July 1, 2009. for Renewals or New Plans Prior to 10/1/09. http://www.bluecrossma.com/common/en_US/pdfs/New_SOB/50-0018MH7-1_Preferred_Blue_PPO_Saver_Mid_Ded.pdf

32 Aggregate family deductibles require that the family deductible level be reached before any individual in the family is “in benefits,” whereas an embedded deductible may enable a family member to obtain benefits once they have reached the “individual” deductible embedded within the family deductible. HDHP plans are also different in that they require prescription drug claims to be subject to the same deductible as medical claims.

33 Aetna recommendation for high steerage is 30% coinsurance and \$30 copay levels. See Carrara, L. Tiered Provider Network Impact on Value Base Benefit Design. Prepared for The Healthcare Imperative: Lowering Costs, Improving Outcomes. Roundtable on Evidence Based Medicine. Institute of Medicine. July 2009.





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