



version 8.0

# The Consumer Driven Care Primer

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The Tax Relief and Health Care Act of 2006 also provides for the following changes regarding HSAs effective January 2007:

- Allowing those who enroll mid-year in an HSA qualified High Deductible Health Plan midyear to make a full-year contribution to their HSA (previously only a prorated HSA contribution was allowed.)
- Allowing employees a one-time, tax-free transfer of qualified amounts in FSAs or HRAs until 2012 for the purpose of funding an HSA. FSA participants with a two and one half-month grace period will also be allowed to contribute to an HSA during that grace period, providing that no funds remain in the participant's FSA at the end of the plan year.
- Allowing HSA contributions up to the annual maximum regardless of the qualified health plan deductible (previously allowed contributions were the lesser of the qualified health plan deductible or the annual maximum).
- Allowing a one-time distribution from an Individual Retirement Account (IRA) to fund an HSA, subject to the HSA contribution limits.

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

FSA	HSA	HRA
<ul style="list-style-type: none"> <li>• May be used by any employer and employees</li> <li>• May be funded by employer or employee</li> <li>• Balances may not rollover from year to year (use it or lose it) other than for 2.5 month grace period</li> <li>• One time qualified transfer to HSA allowed until 2012</li> </ul>	<ul style="list-style-type: none"> <li>• May be used by any taxpayer, must be opened before age 65</li> <li>• Require companion high deductible insurance policy</li> <li>• May be funded by employer or employee</li> <li>• Balances may rollover from year to year</li> </ul>	<ul style="list-style-type: none"> <li>• May be used by any employer</li> <li>• May only be funded by employer</li> <li>• Balances may rollover from year to year</li> <li>• More flexibility in plan design than HSA</li> <li>• One time qualified transfer to HSA allowed until 2012</li> </ul>

The other major coverage element to Consumer Driven Health Plans is the companion high deductible insurance policy that provides coverage once the deductible requirement is met. There are countless variations as to the specific benefit provisions of such policies.

Consumer Driven Health Plans can include multiple spending accounts in the same plan. For example, many plans use an HRA for the employer to fund a portion of the high deductible, and an employee funded FSA to fund the balance of the high deductible. Consumer Driven Health Plans also have often invested major resources in various components of the plan, including health navigation (consumer accessible health information, decision support tools, and plan transactions); claims payment tools (including debit cards); value added programs and managed care features.

## VI. Value Based Insurance Design

Value Based Insurance Design has typically been deployed or discussed as an alternative to account-based Consumer Driven Health Plans. However, Value Based design can be incorporated into applicable Consumer Driven plan design as well.

Value Based Insurance Design involves designing benefit cost sharing requirements and coverage based on the ultimate evidence-based value of clinical services as opposed to strictly cost considerations. The objective is for the level of patient cost sharing to be a function of the value that the specific service provides to the specific patient.

Under Value Based Insurance Design, cost sharing requirements would be delineated by specific types of recommended medications, procedures, treatment plans or even specific providers for specific conditions, as opposed to more traditional tiering of benefits solely based upon costs, such as generic vs. brand name drugs, or network vs. out of network providers.

Value Based Insurance Design simply shifts out of pocket cost sharing from expense based tiering of benefits, to clinical outcome and service based tiering of benefits. The rationale is still to influence consumer behavior, in this case, to seek services that will more likely yield the desired clinical outcome. As such Value Based Insurance Design by definition is a component of an overall consumerism strategy.

<sup>8</sup> The Shared Search for Health Information on the Internet, June 11 2009 [www.pewresearch.org](http://www.pewresearch.org)

<sup>9</sup> Portland Business Journal, June 29, 2007, reported in IhealthBeat DataPoints [www.ihealthbeat.org](http://www.ihealthbeat.org)

### III. Methodologies

The following issues address the applicable methodologies used to disclose prices and related items:

- *Public or private disclosure*- some initiatives are designed for disclosure to the general public, while other initiatives are designed for disclosure to a restricted population, such as health plan members, applicable employees, etc.
- *Specific items vs. Episodes of Care* - some initiatives are designed to report pricing for specific items, such as by procedure code, prescription drug, etc.; while other initiatives are designed to report total pricing for a given episode of care, typically categorized by diagnosis or procedure.
- *Display of selected prices vs. all available prices* - some initiatives identify selected items for reporting, while other initiatives attempt to report all available items
- *Individual vs. average pricing* - some initiatives report pricing at the individual provider level, while other initiatives report pricing on an average basis for groups of providers
- *Retail, Contract or Out of Pocket Cost Reporting* - various initiatives report pricing on a retail basis, vs. contractual basis vs. out of pocket basis (net of health plan payments and reflecting patient cost sharing)
- *Range of pricing vs. Specific Pricing* - some initiatives report pricing within specified ranges, while others report specific amounts
- *Time frame* - some initiatives attempt to report current pricing, while other initiatives reflect data as of a specified prior date or time period
- *Markets* - some initiatives limit reported to selected markets, while other initiatives cover all applicable markets
- *Package pricing* - some provider initiatives involve packaging and reporting their prices based upon specified criteria or episodes of care
- *Non-provider transparency* - in addition to provider price transparency initiatives, there are additional related price transparency initiatives, such as employers reporting their full health plan premium costs to their employees.

### IV. Price Transparency Initiatives

Some of the objectives of price transparency initiatives include: 1) promoting competition based on comparative data; 2) making pricing information readily available before services are rendered, as a decision support tool for selecting levels of service, as well as specific providers; and 3) making pricing information related to the provider claim accessible to the consumer as a part of the claims payment process. Price transparency initiatives have been promoted through legal and regulatory channels, provider associations, individual providers, health plans, and third party organizations.

# G. Issues

**We will discuss the following issues involved with consumerism in health care:**

- I. Adverse Selection
- II. Chronic Conditions
- III. Ability to Pay Increased Cost Sharing
- IV. Deferral of Care
- V. Impact of Hospital Claims
- VI. Account Integration
- VII. Complexity and Confusion
- VIII. Employee Receptivity and Collective Bargaining
- IX. Managed Care Implications for Account Claims Payments
- X. Regulatory Environment and Taxation
- XI. Reporting Consumer Driven Enrollment
- XII. Providers
- XIII. Vouchers
- XIV. Factors for Success

## **I. Adverse Selection**

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

There are three separate concerns regarding adverse selection for consumerism health plan models:

- 1) Policy implications of adverse selection of enrollees being drawn to consumer driven health plans that cause such plans enjoy 'favorable experience', meaning lower levels of claims and utilization, due to the demographics of enrollees more likely to enroll in such plans (higher income, and relative better health). Such concerns generate from the assumptions that: a) lower income enrollees would be less motivated to enroll for tax advantaged treatment; b) higher income populations tend to be healthier; and c) sicker populations that require frequent care would be less motivated to enroll in plans involving a high deductible.

# H. Glossary

## Related terms to consumer driven health care and benefits

Account Administrator	p. 65	Health Opportunity Account	p. 68
Account Integration	65	Health Reimbursement Arrangement	68
Actuarial	65	Health Savings Account	69
Administrative Services Only	65	High Deductible Health Plans	69
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Agent	65	In Network	69
Annual Maximum	65	Insurance Organization	69
Benefits Cycle	65	Lifetime Maximum	69
Benefit Limitations	65	Managed Care	69
Broker	65	Medical Management	69
Cafeteria Plan	65	Medical Savings Account	69
Claim	65	Member	69
COBRA	66	Navigation	69
Coinsurance	66	Out-of-Network	70
Commission	66	Out-of-Pocket	70
Consumer Choice	66	Participating Provider	70
Consumer-Directed Health Plan	66	Pay for Performance	70
Consumerism	66	Pharmaceutical Benefit Management	70
Coordination of Benefits	66	Plan Design	70
Co-payment	66	Plan of Benefits	70
Cost Sharing	66	Policy	70
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Favorable Selection	68	Tiered Networks	71
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Health Insurance Portability and Accountability Act of 1996 (HIPAA)	68	Voucher	72
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