Value-Based Purchasing

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From the Editors

Patient-Centered Care: "It's the Patient, Stupid!"

In its landmark 2001 report on *Crossing the Quality Chasm*, the Institute of Medicine (IOM) named "patient-centered care" as one of the six fundamental aims of the U.S. health care system.[1] The IOM defines patient-centered care as:

> *"Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care."*[2]

Studies show that orienting health care around the preferences and needs of patients has the potential to improve patients' satisfaction with their care as well as their clinical outcomes; patient-centeredness also been shown to reduce both under-use and over-use of medical services.[3] Yet, according to a recent Commonwealth Fund survey of patients in five countries (Australia, Canada, New Zealand, United Kingdom, and the U.S.), one-third of sick patients in the U.S. leave the doctor's office without getting answers to important questions.[4] And across all countries in the study, one-third to one-half of respondents said their doctors sometimes, rarely, or never tell them about treatment options or involve them in making decisions about their care.

Increasingly, patients are asking to be partners in their care. A patient-centered health system can help achieve that partnership through improved provider–patient communication and educational materials and self-management tools that enable patients to make informed decisions and better manage their conditions. Other attributes of a patient-centered care system include superb access to care (such as timely appointments and after-hours services), continuity of care between primary and specialist physicians, post-hospital follow-up and support, effective management of drug regimens and chronic conditions, and use of information technology, such as automated patient reminders and patient access to electronic medical records.[5] Giving patients access to reliable information about the cost and quality of physicians, hospitals, and other health care providers is also

an essential step toward creating a patient-centered care system. In this issue of *Value-Based Purchasing*, we focus on the growing role of employers in helping to activate and engage their employees in the selection, use, and payment of health care services. Employer leadership is critical to driving the health care system toward greater patient-centeredness, by helping to create both the information and incentives that will motivate consumers to assume greater responsibility for their care. Informed and engaged consumers can in turn motivate providers to achieve higher levels of quality and patient-centeredness.

The emerging era of "consumerism" in health care means more than just asking employees to pay a greater share of the bill. While increased sensitivity to cost is important, employers must go beyond a simple cost-shifting strategy to provide educational programs and tools that truly empower individuals to become more informed decision-makers in their care. As described in one of this issue's feature articles, the City of Knoxville has pioneered several innovative programs designed to engage public employees in prevention and healthy lifestyles. This program demonstrates that employers can become meaningful partners with their employees by helping them focus on behaviors that are fundamental to personal health, and which also confer cost savings for the organization as a whole.

In a review of evidence related to the effectiveness of consumer-directed health plans, University of Minnesota researcher Steve Parente notes the failure of many CDHP products to make the cost implications of health care spending readily transparent to consumers. Without providing timely access to cost information related to their health savings accounts, employers can't expect enrollees in CDHP products to become better shoppers. We would add that it is equally important to include quality information as well as cost, to enable employees to discern value in their health care decisions.

Health care providers are increasingly discovering that achieving excellence in service to patients and their families is a key not only to outstanding clinical outcomes, but to a successful business enterprise as well. Purchasers can reinforce this message by rewarding providers who deliver excellence in both clinical and service quality, through benefit programs that educate and provide incentives to employees to become responsible partners in the health care delivery process. After all, when you come right down to it, it really should be all about the patient.

Dale Shaller and Neil Goldfarb
Editors, Value-Based Purchasing

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City of Knoxville Uses Simple Innovations to Curb Medical Insurance Costs

Gary Eastes

Like most employers, the City of Knoxville's health insurance costs have risen much faster than its revenues, a trend that is likely to continue into the foreseeable future. Many of the 1500 employees and 140 retirees participating in the city's health insurance program are low income, and injudicious cost shifting could have detrimental consequences.

"Rising costs have not resulted in improved health - our society continues to cope with alarming increases in obesity, diabetes and other chronic conditions," according to City of Knoxville Mayor, Bill Haslam. Decades of providing all medical services at little or no charge to the patient have resulted in consumer disengagement from responsibility for their health and the cost-effectiveness of their care. "The popular definition of 'good' insurance is that when an employee develops medical problems, no matter how many services the doctor bills for, it will cost him/her less than dinner on Friday night," explains Gary Eastes, the city's Risk/Benefits Manager.

To address the healthcare issue, the City of Knoxville introduced a comprehensive program that integrates health promotion and medical insurance. The program includes:

1. City-funded health screenings for employees, retirees and covered spouses.
2. 100% health insurance coverage for preventive medical services.
3. Health Reimbursement Arrangement (HRA) funding based on healthy behaviors, including spouse non-tobacco use.
4. Low- and high-deductible HRAs to afford low-wage employees the opportunity to earn additional HRA funding.
5. Prescription credits as incentives for self-care compliance for members with chronic conditions.
6. Contract with a private medical practice to provide screenings, monitor incentive compliance, and provide other interactive health promotion services.
7. Data gathering, analysis and sharing.

Health Screening

Annual health examinations for city police and fire employees were expanded to include complete blood work (including thyroid screens), EKGs (age-based stress and standard), PSAs and other pulmonary and cardiac tests. Other employees, retirees and covered spouses are offered similar health screenings with the sameblood work, standard EKGs and PSAs. Participants are given copies of all test results, counseled about concerns, and encouraged to provide their test results to their personal physicians.

Over 75% of employees opted to participate in the program. In the first 18 months, many previously undiagnosed conditions were identified, including: over 40 participants with diabetes; multiple cases of early stage prostate cancer; multiple employees with coronary blockages that were subsequently treated; at least one rare disease; and other health problems such as anemia, thyroid disease, blood and cardiac disorders, and widespread high cholesterol. The existence of these problems is not good news, but early identification is. In addition, through direct contracting the city saw improvement in price, quality control and member participation.

One revelation, backed by broader studies, is that the majority of adults who visit their physicians regularly are not receiving universally recommended health screenings. At least three employees identified with serious conditions had recently discussed their symptoms with a personal physician and had been advised "not to worry" or to "wait and see" if the symptoms continued.

100% Coverage of Preventive Services

According to Chris Kinney, the City of Knoxville's Senior Director for Finance and Accountability, "Providing 100% coverage for preventive services sent a message to employees and providers about its importance. It also ensured there is no monetary obstacle to any covered individual obtaining preventive services."

Despite the modest risk of duplicating services and costs (i.e., combining 100% coverage of preventive services with city-funded screenings), the city opted to err on the side of overuse rather than under-use.

Health Reimbursement Arrangements (HRAs)

The City of Knoxville's decision to provide spending accounts was based on the concept of employees earning the funds through healthy behaviors. HRAs were chosen because regulations permit roll-over of funds into future years (in contrast to FSAs). Although HRAs are usually associated with high deductible plans (i.e., employer funding less than the employee's deductible) city employees can choose a $300 deductible and qualify for HRA funding. In most cases they qualify for more than their individual deductible.

Participation in medical screening is a pre-requisite for HRA funding for employees. Funds can be earned by employees and spouses for not using tobacco and by employees who exercise regularly. Employees or spouses who use tobacco can earn the non-tobacco funding by attending tobacco cessation courses and "regular exercise" is defined on an individual basis.

The primary purpose of the spending accounts is encouraging healthy behavior. To encourage judicious use of funds, unused funds can be rolled over into future years, including retirement, as long as the individual remains in the city's health insurance program. Since funds can also be used for dental or vision care, there is anincentive for any employee to earn HRA money. The 100% coverage of preventive services ensures that employees are not motivated to save money by neglecting prevention.

To ensure that low-income employees are not discouraged from obtaining basic care, an additional $100 in HRA funding is available for those with salaries of $25,000 or less, and $50 for salaries between $25,000 and $35,000. This encompasses over 60% of city employees. In keeping with the incentive nature of the program, employees must be involved in managing their health by participating in medical screenings in order to earn the additional HRA funds.

Chronic Disease Prescription Credits

This program may be the only one of its type in the country. By submitting monthly logs that demonstrate adherence to appropriate self-care practices, covered members with chronic diseases receive $40 quarterly in prescription credits ($80 quarterly if they have two or more chronic diseases.) Members who participate in the diabetes program also receive free testing

supplies, and those with asthma or congestive heart failure receive free peak flow meters. Use of prescription credits allows this incentive to apply to retirees and spouses as well as employees. To be eligible for this benefit, the member must participate in medical screening.

Contracted Private Medical Practice

A contract with a private medical practice (Family Care Specialists, P.C.) includes a dedicated registered nurse and medical assistant who provide services on-site as well as services provided through the practice's own facilities. The nurse and medical assistant monitor members' compliance with the incentive programs, eliminating the need to share personal health information with the City of Knoxville. The nurse and medical assistant are provided computer access to help participants research the growing internet consumer information on diseases, medical treatment and other health issues.

Data Collection, Analysis and Sharing

Medical screenings provided a new dimension of aggregate data for analysis. For instance, the City of Knoxville found that average cholesterol levels for fire department employees were significantly higher than those of other employee groups. Such information allows the city to target health promotion programs more accurately. In the near future, participants in the diabetes prescription credit program will be able to download their blood sugar readings into the health promotion nurse's computer for analysis of individual and group progress.

A member of HealthCare 21 Business Coalition, the City of Knoxville participates in a medical claims data-sharing cooperative that provides actionable information about medical treatment trends and anomalies that can be used to improve medical plan design and improve the quality and cost effectiveness of health care. The analytic capabilities are state of the art. Jerry Burgess, President and CEO of HealthCare 21 states, "Managing the dilemma of health care cost and quality is only possible when a company mines its data to inform the process."

Employee Acceptance

A year in advance of program launch, employees were educated about the necessity of making changes to curb the increases in medical insurance costs. While reaction was mixed, the vast majority appears to understand and accept the need for change and the necessity for more personal responsibility. Several employees have voiced appreciation for motivating them to do things they have needed to do for years.

To date, over 75% of employees have participated in the medical screenings. In the first month, almost one-third of employees turned in exercise logs to earn the exercise incentive, and there appears to be great potential for participation to increase. Seventy-eight covered members are currently enrolled in the chronic disease prescription credit program, including several who admit they had not performed the recommended self-care practices in the past. Over 100 members have indicated that they plan to participate in the tobacco cessation classes scheduled during the year.

Obstacles

Because of the program's many unique features, capabilities of the health insurer, pharmacy benefit manager and savings account administrator had to be taken into account in program design. Details remain to be worked out, but the selected providers

(BlueCross/BlueShield of Tennessee, Caremark and PayFlex) have been supportive and have viewed the program as an opportunity to prepare themselves for the future.

One surprising obstacle has been the reluctance of local providers to use preventive service codes on insurance claims. Because health insurance plan views on coverage of preventive care are inconsistent, providers have learned to use diagnostic codes when filing insurance claims - a difficult habit for them to break. The City of Knoxville mailed over 400 letters to local providers advising them of the 100% coverage for preventive services. The city also provided employees with wallet cards describing the preventive benefits.

The Future

By broadening the definition of "consumer driven", the City of Knoxville has created a model without the large deductibles usually associated with consumer driven designs (less invasive treatment). "Consumer behavior is not just choosing the right mechanic and getting cost effective repair; it is also regularly checking the oil to help avoid the need for repairs," Eastes remarks. "It is the most innovative program we are aware of," says Leigh Cattell-Roberts of Cowan Benefit Services, benefits broker/consultants for the city.

Inclusion of exercise incentives for spouses and preventive care for children may be considered in the future. Incentives for preventive practices for covered children would be complex to implement and administer, but these may also evolve.

Expansion will be considered for the prescription credit program currently limited to five chronic diseases. There is also a possibility for changes to incentive and deductible levels, but these will be based on experience and analysis.

The City of Knoxville budgeted to reinvest roughly half of the savings from its medical insurance plan re-design into the incentive programs. The city is confident that return on this investment over time will more than offset the cost.

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Consumer Directed Health Plans: Evolution and Early Outcomes

Stephen T. Parente, Ph.D.

The first Consumer Directed Health Plans (CDHP) were introduced by health e-commerce ventures in the late 1990s. These products were designed to engage consumers more directly in their health care purchases. The conceptual model made cost and quality information evident to the consumer, usually through the Internet, thus creating a more efficient health care market.

CDHPs have evolved since their inception, and the focus has shifted to designing a health benefit that couples a high deductible health plan (HDHP) with an account to pay for first dollar medical care expenses. Typically, there is a gap between the account contribution and deductible threshold, with unused portions of the account accruing without penalty into the subsequent benefit year. The most common models of these

plans today are Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs).

The HSA benefit design has become part of the political agenda since its inclusion in the Bush Administration's health reform package in 2004. The enduring policy dimension of CDHPs is evidenced by explicit mention of the HSA benefit design in the 2006 State of the Union address. Through a combination of tax breaks for premiums and the health savings account and tax subsidies for lower income individuals, HSAs are proposed as a solution to the high rate of health care inflation as well as potentially reducing the number of the nation's uninsured.

CDHP Impact Study

Since 2002, I have been investigating the impact of CDHPs with University of Minnesota researchers Roger Feldman and Jon Christianson. To complete this research, we have elicited the participation of four large employers with a total population of several hundred thousand covered lives. These partnerships have provided early evidence of the impact of CDHPs in large private and public employers. Specifically, we have found that: 1) income is the primary driver of CDHP selection, not age or health status, 2) CDHP plan designs without coinsurance are not showing cost-savings, and 3) favoring co-insurance as an expenditure control over deductibles decreases demand for the CDHP product. Though the results described below are the product of research focused on HRAs, some may be generalizable to the entire CDHP market.[1]

What Characteristics Influence Selection?

Earlier predictions suggested that consumer directed health plans would enroll proportionately more low-risk, low-cost consumers and experience favorable risk selection relative to traditional health plans such as HMOs or PPOs. Our findings suggest much less favorable risk selection into CDHPs than originally thought. Using data from four employers, we found that the most important characteristic influencing CDHP enrollment is wage income. There were small and occasionally significant differences in chronic illness attributes and age, but these were not the rule and are unlikely to lead to a major adverse selection problem in the traditional health plans.

Do HRA-Style CDHPs Reduce Per Employee Expenditure?

Economic theory predicts that CDHPs can save money if the benefit design includes a large deductible and significant cost sharing after the deductible has been met. However, with the exception of pharmaceutical expenditures, [2] we have not seen savings in the employers we studied. Preliminary analysis completed by one participating employer suggests smaller increases in total health care expenditures because of a significant copayment in the benefit design. We are in the process of verifying this result using the same methods as our published research. Newer CDHP benefit designs are closest to this firm's design, and we expect to see similar results compared with our earlier published analyses of designs with no coinsurance after the deductible is met.

The Coinsurance vs. Deductible Trade-off

Using data from several employers, we found that consumers are more price-sensitive to coinsurance than deductibles when they choose health plans. Specifically, the coinsurance rate is associated with twice the price sensitivity as

[1] We will be able to test this assertion soon with data from two employers offering HSAs as well as PPOs and HRAs.

[2] Parente S.T., Feldman, R., and Christianson J.B. "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization," Health Services Research Vol. 39, No. 4, Part II (August 2004), pp. 1189-1209.

deductibles. At first, this finding seemed counterintuitive. However, the rationale for this behavior could indicate that deductible expenses are much more predictable than coinsurance expenses. Some consumers may feel that a 10% or 20% coinsurance rate up to $9,000 maximum out-of-pocket expenses is too uncertain compared with 0% coinsurance and a $6,000 deductible for a family policy. The message to benefit managers who are considering, or currently using, CDHPs may be to design HRA and HSA products with 0% coinsurance and a higher deductible that is actuarially equivalent to existing non-zero co-insurance designs. Employee acceptance of CDHPs may improve if these changes are made.

What Opportunities Does Collaborative Research with Employers Provide?

Through our cooperative venture with employers, we are using both HR data and claims data to identify who is choosing these plans and what the cost and utilization impacts are. Much of the research on CDHPs today is survey-based. By using claims data, our results are based on actual expenditures. While claims data are limited in their usefulness for gauging health care quality, they are the most appropriate data to answer this question.

Currently, many plans do not release their claims data results for public scrutiny. The large insurers in this market are doing everything "in-house" without external peer review or oversight. Our work has proceeded with substantial transparency and peer review to meet the standard set 25 years ago with the first empirical results from the RAND health insurance experiment.

Next Questions to Address

Do Employees Who Choose an HSA Act Differently about 401K Retirement Investment?

HSAs are now sold by financial services companies as part of a health/wealth package. We are currently preparing to work with the employers offering an HSA to test the "ownership society" hypothesis that there is a relationship between health savings and retirement choices. There are two critical questions to examine in this line of research: 1) is HSA choice related to retirement investment decisions, and 2) if HSA choice is related to retirement investment decisions, do consumers make rational retirement portfolio changes? Specifically, we posit that HSA election, HSA contribution size, and retirement portfolio decisions will be conditional on prior personal states including income, previous contribution, previous health history and demographics such as age and number of dependents. Addressing these questions will help to understand the viability of ownership society policy and the health-wealth presentation of benefits to employees that is common among many large firms.

Will the Limited IT Infrastructure to Support HSAs Limit Their Acceptance and Use?

An emerging irony in the CDHP market is that a product originally designed to activate the consumer by providing price transparency is not consistently doing so. The easiest illustration of the problem is the failure of current HSA designs to link the health savings account electronically with the claims data system of the high deductible health plan. For example, the consumer might hold the HSA in a money market account that is drawn down only when the consumer submits a debit request. The consumer is responsible for alerting the CDHP about expenses related to an approved medical service. This drastically increases the

paperwork burden on the consumer and makes it more difficult for the consumers to manage their medical expenses over time. We are working with employers to examine the consumer feedback and the evolution of the IT infrastructure.

Summary

CDHPs offer a significant opportunity to change the consumer's conception of health care spending. However, their success is contingent on demonstrating a more cost-effective health insurance product than the status quo of PPOs and HMOs. Only serious and transparent accounting of the cost differences among the plan designs will address these questions.

About the Author

Stephen T. Parente, Ph.D. is the Deputy Director of the Medical Industry Leadership Institute (www.csom.umn.edu/mili) and an Assistant Professor in the Finance Department at the Carlson School of Management at University of Minnesota. Since 2002, he is has been the principal investigator of five empirical analyses of Consumer Driven Health Plans funded by the Health Care Financing Organization initiative of the Robert Wood Johnson Foundation and the US Department of Health and Human Services. Progress on CDHP research efforts of Dr. Parente and colleagues can be tracked at: www.ehealthplan.org

News Briefs

Electronic Health Records: As reported by *Business Week* (4/7/2006), Dell is about to become the largest U.S. employer offering an electronic health record to all of its employees. Unlike the EHR's used by many companies, including Dell up to now, the new system will be directly populated in part with treatment and test result information, rather than being entered manually by employees. The system also will communicate health information and advice to the employee, and invite participation in health and wellness programs, based on information entered into the record. More information is available at: http://www.businessweek.com/technology/content/apr2006/tc20060407_825324.htm?campaign_id=rss_daily

Variations in Employee Benefits and Premiums: A recent study supported by the Commonwealth Fund, and published in the May/June 2006 issue of *Health Affairs*, explored differences in health plan generosity and value across different plan types and geographic regions. The researchers looked at a standardized utilization pattern for an adult population, and examined the "actuarial value" of each plan – the amount of total annual bill paid by the health plan (versus the employee's contribution) – and the "adjusted premium" – the premium adjusted to account for quality of benefits. The authors found significant variation by state, with states with more rural areas getting the least value for their money. However, even larger variations were noted across plan types, with HMO's having a higher actuarial value than point of service plans, PPO's, and indemnity plans (listed in descending order of value). The authors conclude that "Many employers are considering adopting high-deductible health plans to dampen consumers' demand for health care services…but managed care plans with more modest levels of cost-sharing, such as HMOs, yield better value…" More information is available at www.cmwf.org/publications/publications_show.htm?doc_id=371983

Update on eValue8: The National Business Coalition on Health has launched the Community Coalitions Health Institute (CCHI), a not-for-profit consortium of employer coalitions, to support the further development and evaluation of tools to promote value-based

purchasing of health benefits. CCHI's first endeavor is focused on eValue8, NBCH's standardized request for information (RFI) on health plan structure and performance. The eValue8 database now contains information on nearly 300 health plans. CCHI's eValue8 Research and Reporting Project seeks to explore how best to use this resource to support value-based purchasing initiatives. More information is available at www.nbch.org/resources/news050106.cfm

Ambulatory Care Quality Measurement: AQA, the Ambulatory Care Quality Alliance, has announced a pilot project at six sites, implementing a standardized set of ambulatory care quality measures, and evaluating methods for measuring and reporting physician-level performance data. AQA is a national coalition of over 125 organizations seeking to develop and implement standardized measures at the physician level. Sites participating in the pilot include the California Cooperative Healthcare Reporting Initiative, Indiana Health Information Exchange, Massachusetts Health Quality Partners, Minnesota Community Measurement, the Phoenix Regional Healthcare Value Measurement Initiative, and the Wisconsin Collaborative for Healthcare Quality. More information is available at www.ambulatoryqualityalliance.org.

Literature Review

Joshua J. Gagne, PharmD

"Advancing quality in a consumer-directed world: 'may you live in interesting times'" (*Am J Manag Care*. 2005;11(5):287-8), by Lewis G. Sandy, and Dawn Bazarko

"Managed consumerism in health care" (*Health Aff*. 2005;24(6):1478-89), by James C. Robinson

"Consumer directed health care: ethical limits to choice and responsibility" (*J Med Philos*. 2005;30(2):207-26), by Linda M. Axtell-Thompson

"Do consumer-directed health benefits favor the young and healthy?" (*Health Aff*. 2004;23(1):186-93), by Dwight McNeill

The health insurance marketplace is an ever-evolving organism and, as Sandy and Bazarko insist, employers are driving the current revolution of consumer-focused and consumer-directed health care (CDHC). The idea of CDHC has emerged to promote patient choice and market competition while reducing the roles of employers and insurers in the health care decision making process. By engaging patients in their own health decisions, they are given greater awareness, control, and hence, responsibility for their health care spending. This concept is premised on the notion that health care cost and quality information should and will become increasingly transparent, allowing empowered patients to make more informed decisions, which will lead to a decreased use of unnecessary services. Sandy and Bazarko assert that if we focus on health outcomes, move toward increased transparency and improved accountability for use of health care resources, publicly report

provider performance, and accumulate knowledge and experience during this time of experimentation, we will move closer to an ideal health care system.

The idea of CDHC does not come without caveats. Axtell-Thompson declares that "while CDHC is gaining attention in the popular press, business publications, and academic journals, it is not without controversy about its relative merits and demerits." In addition, Robinson recognizes that belief in CDHC rests on an optimistic view of consumers' ability to make cost- and quality-conscious choices at the time of seeking care. CDHC could even further disadvantage certain populations, thereby widening existing disparities in health care access and outcomes. In addition, McNeill argues that CDHC favors young, healthy patients and disadvantages the moderately sick. He also states that although the primary objective of CDHC is to reduce unnecessary health services utilization, less use is not always better use. Consumers interested in minimizing out-of-pocket costs by delaying or avoiding preventive treatment could make decisions that lead to potentially deleterious health outcomes in the long run. Regardless of its potential implications, CDHC is here and is garnering a lot of interest.

"Early experience with employee choice of consumer-directed health plans and satisfaction with enrollment" (*Health Serv Res* 2004;39(4 Pt 2):1141-58), by Jinnet Briggs Fowles, Elizabeth A. Kind, Barbara L. Braun, and John Bertko

In a survey study, researchers in Minnesota sought to determine who is more likely to sign up for CDHC plans, and why they choose them. They found that those selecting CDHC plans were less likely to be black, less likely to have a chronic health problem, and more likely to have had no recent medical visits. The investigators also found that those who were attracted to the CDHC plans were more likely to believe that lowest premiums were the most important plan attribute, and they were more likely to think that there were big differences in the premiums of available plans.

"Awakening consumer stewardship of health benefits: prevalence and differentiation of new health plan models." (*Health Serv Res*. 2004;39(4 Pt 2):1055-70), by Meredith Rosenthal and Arnold Milstein

"A report card on the freshman class of consumer-directed health plans." (*Health Aff*. 2005;24(6):1592-1600), Meredith Rosenthal, Charleen Hsuan, and Arnold Milstein

While the popularity of CDHC is growing, these types of models still constitute a small fraction of all employer-sponsored insurance coverage, according to a 2004 study by researchers at the Harvard School of Public Health. The investigators examined the prevalence of three types of CDHC plans: health reimbursement accounts (HRAs), premium-tiered plans, and point-of-care tiered benefit plans. In addition, they examined the extent to which these plans supported consumer choice and consumers' involvement in managing their own health. The authors found that decision support in these plans is still limited. They recommend that careful attention be paid to how well beneficiaries are informed about the consequences of their selections, such as the potential repercussions of passing up preventive care.

In the second report, the investigators acknowledge three fundamental but correctable weaknesses of CDHC plans. The first weakness is that most plans do not make available enough comparative cost and quality information to help patients discern higher-value health care options. Secondly, financial incentives for consumers are weak and do not

necessarily encourage consumers to choose higher-value options. The third weakness the authors mention is that none of the plans they examined made cost-sharing adjustments to preserve freedom of choice for low-income consumers. The authors offer suggestions on how to correct these weaknesses and conclude that in order for CDHC plans to thrive and to improve the quality and affordability of U.S. health care, major refinements are required.

Program Schedule

This e-journal, *Value Based Purchasing*, is a product of The College for Advanced Management of Health Benefits, a unique training program designed to help employee benefit managers meet the growing challenges of providing high quality health benefits and managing rising benefit costs. The College offers a practical, intensive program that focuses on benefits purchasing techniques and skills that emphasize improving the value, quality-cost ratio, and effectiveness of health care services purchased on behalf of employees. The program is a collaboration between the HealthCare21 Business Coalition in Tennessee, the National Business Coalition on Health, and the Department of Health Policy of Thomas Jefferson University.

The College holds three four-day training programs each year. The remaining program for 2006 is scheduled for September 18-21 in Charlotte, North Carolina. The program schedule for 2007 will be announced shortly.

For more information, or registration materials, please contact Jeannine Kinney, Program Coordinator, at jeannine.kinney@jefferson.edu, or 215-955-1709.

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