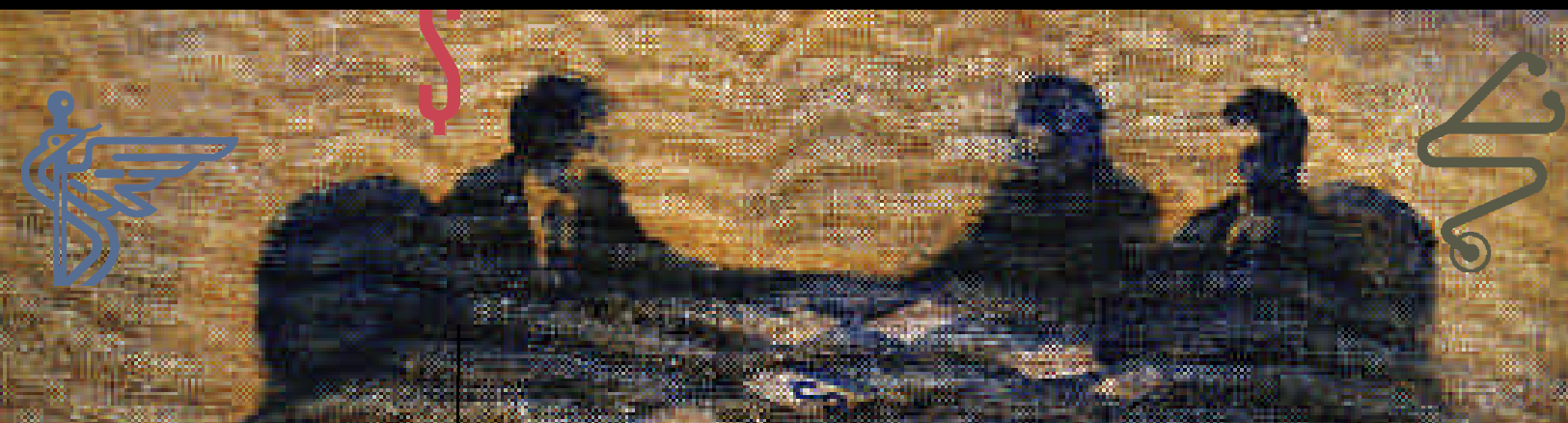


NATIONAL  
HEALTH CARE  
PURCHASING  
INSTITUTE



*Building Quality Improvement Into Defined  
Contribution Strategies*

Jack A. Meyer  
Ingrid A. Tillmann  
New Directions for Policy  
Washington, D.C.

*An Initiative of The Robert Wood Johnson Foundation. September 2001*

## About the National Health Care Purchasing Institute

**Mission:** The National Health Care Purchasing Institute was founded to improve health care quality by advancing the purchasing practices of major corporations and government agencies, particularly Fortune 500 companies, Medicare, and public employers.

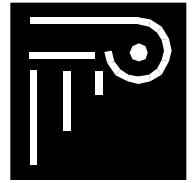
**Objectives and Offerings:** Our objectives are to help health care purchasers buy higher quality health care, save lives, and empower consumers to choose higher quality health plans and providers. We are also building the business case for effective, value-driven health care purchasing. Institute offerings include courses and workshops, technical assistance, convening of experts and working groups, research, and information on tools and best practices.

**Sponsor:** The Robert Wood Johnson Foundation ([www.rwjf.org](http://www.rwjf.org)) sponsors the Institute through a \$7.7 million grant to the Academy for Health Services Research and Health Policy ([www.academyhealth.org](http://www.academyhealth.org)).

**Institute Director:** Kevin B. (Kip) Piper, MA, CHE, a vice president of the Academy, directs the National Health Care Purchasing Institute. His background includes Wisconsin state health administrator, CEO of the Wisconsin Medicaid program, managed care company executive, and senior health financing examiner with the White House budget office. Board certified in health care management, Piper holds a Master's degree in public administration from the University of Wisconsin. E-mail: [piper@ahsrhp.org](mailto:piper@ahsrhp.org).

**Deputy Director:** Margaret Thomas Trinity, MM, an Academy senior manager, is the Institute's deputy director. Her background includes director, public programs for the American Association of Health Plans and senior manager with a leading health care consulting firm. A graduate of Yale University, Trinity received her Master's degree in management from the Kellogg School at Northwestern University. E-mail: [trinity@ahsrhp.org](mailto:trinity@ahsrhp.org).

**Institute Staff:** Other Institute staff include Katherine O. Browne, MBA, MHA, and Sarah R. Callahan, MHSA, senior associates; Donna-Renee Arrington, program coordinator; and Christopher Hayes and Nathan Marvelle, research assistants.



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## About the Authors

**Jack A. Meyer, Ph.D.**, is the founder and president of New Directions for Policy. Meyer has conducted policy analysis and directed research on health care issues for several major foundations as well as federal and state government and the business sector. He has led projects developing policy options for reforming the overall health care system and directed research on employers' innovations in health care purchasing. Many of these projects have highlighted new strategies for extending health insurance coverage to the uninsured. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty.

**Ingrid A. Tillmann, MS, MPH**, is an independent consultant in health policy research and analysis. She is also the former senior vice president of the Economic and Social Research Institute in Washington, D.C. Tillmann has engaged in numerous projects relating to the promotion of quality and accountability in health care, and she has followed the evolution of value-based purchasing, conducting evaluations, participating in strategic planning, and writing a guide on the subject for business coalitions and other purchasers of health care. Most recently, Tillmann's work has focused on informing and involving the business community in three prominent developments within today's health care environment: the expanding role of the consumer, the emergence of e-health products and services, and the explosion of biotechnology in medicine.

**New Directions for Policy (NDP)** is a Washington, D.C.-based organization that assists purchasers and providers of health care and government through policy research and analysis, strategic planning, and program evaluation. NDP's purposes are to promote more effective operation of the health care system, and to aid the development of sound public policy on health care and social welfare issues. NDP analyzes the forces driving health care spending, designs innovative strategies to improve financing and delivery systems, and evaluates reforms to extend health coverage to the uninsured.

# INTRODUCTION

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Several developments have prompted employers to take a look at the defined contribution approach to health care. Premiums are rising sharply and employers' concerns about open-ended financial exposure are mounting. The public backlash against managed care raises the specter of more regulation, legislation, and litigation, creating the potential for even more financial exposure, as well as administrative burden, for employers. Managed care continues to frustrate employees and their families who are tired of pre-authorization hurdles, referral requirements, and payment delays or denials. Physicians are tired of pushing papers when they want to be practicing medicine. Health plan screening and performance measurements are falling short of employers' expectations for improving health care quality. The growing trend of consumer activism, ably assisted by the Internet, is poised to influence virtually every dynamic in health care purchasing and consumption.

Against this backdrop, some employers are understandably re-evaluating their role in providing health benefits. In recent years, strong economic growth and tight labor markets have generated concerns about recruitment and retention of employees, and this may have constrained business leaders from shifting health costs to workers. A number of experts representing large employers believe that despite recent sharp premium increases, employers are

unlikely to move to defined-contribution approaches in the near future as they struggle to attract and retain highly valued employees. But employers are worried about the longer-term future, and are beginning to re-think their roles in funding and managing health care as part of a strategic plan that may take a number of years to unfold.<sup>1</sup> In anticipation of a changing environment in which defined contribution could represent a popular, even favored, approach to health care financing, abundant issues surface around the question of how it would work and its likely impact on quality of care.

Currently, there is more talk and speculation about these defined contributions than actions and real-world models. But that could change quickly if some major companies take the plunge and cap their financial exposure to rising health care costs. This report assesses how a strong movement among employers toward defined contributions would affect the quality of health care. It also explains the forces that are driving the growing interest in defined employer contributions and develops a continuum of alternative models, featuring the potential new roles for employers and employees under each and highlighting examples of emerging forms and structures. Lastly, the report assesses the features of each strategy that would be most likely to promote – or hinder – health care quality.

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1. Center for Studying Health System Change. Defined Contributions: The Search for a New Vision. Issue Brief No. 37. April 2001.

# EMPLOYERS NEED TO SET THE STAGE

An effective purchasing model should feature choices for employees, incentives for cost management and quality, meaningful competition among service providers, and good information. Defined contribution could be incorporated as a key element, but only the full complement of features stands to produce the desired result: high-quality, affordable health care. Moving parallel with exploratory efforts toward defined contribution, employers need to alter other aspects of their purchasing approaches that may not be optimal.

First, employers, as a group, have not done a very good job of providing choices. Only 45 percent of wage and salary workers have a choice of health plans.<sup>2</sup> Among workers in small firms, the picture is bleaker – only 9 percent of firms with three-to-199 workers that offered health coverage provided a choice of health plans, compared with 53 percent of such firms with 1,000 to 5,000 workers and 84 percent of firms with 5,000 or more workers.<sup>3</sup>

Second, only about one-of-four employers have set their contributions to health coverage in a way that is likely to control cost and promote quality. Marquis and Long found that only 28 percent of employers offering multiple plans made a fixed-dollar contribution toward single coverage.<sup>4</sup> A more recent survey confirms that this is also the

case among Fortune 500 companies; 24 percent of these firms used a flat-dollar contribution policy in which employer contributions are fixed at a single amount regardless of the plan.<sup>5</sup>

*Only about one-of-four employers have set their contributions to health coverage in a way that is likely to control cost and promote quality.*

Third, many employers have, in recent years, led the way in pushing health plans to have open networks of providers rather than selecting physicians and hospitals for their networks based on their adherence to quality standards. To address workers' concerns with managed care, they have also helped create a climate in which health maintenance organizations (HMOs) and point-of-service (POS) plans have moved away from the very controls that were originally put in place to manage utilization. The result: HMOs and POS plans have begun to look more like preferred provider organizations (PPOs), featuring price discounts over care management and gate-keeping, and PPOs have enjoyed a resurgence in growth.

2. Schone, Barbara S. and Philip Cooper. Assessing Health Insurance Plan Choice in the United States. AHCPR, November 1999.
3. Gabel, Jon R. Employer Health Benefits: 2000 Annual Survey. The Kaiser Family Foundation and Health Research and Educational Trust, 2000.
4. Marquis, M. Susan and Stephen H. Long. "Trends in Managed Care and Managed Competition, 1993-1997." Health Affairs 18(6):84, 1999.
5. Maxwell, James, et. al. Corporate Health Care Purchasing Among the Fortune 500. National Health Care Purchasing Institute. May 2001.

*The plans have most of the same doctors and hospitals in their networks, and few providers ever get dropped from health plans, no matter how far their practices deviate from best medical protocols.*

The bottom line is that even when employees are given a choice of health plans, it has little meaning. The plans have most of the same doctors and hospitals in their networks, and few providers ever get dropped from health plans, no matter how far their practices deviate from best medical protocols. In short, there is no real competition among the plans. In this environment, hospitals and physicians that are making an effort to improve quality or reduce medical errors have little hope of being rewarded with a growing volume of patients. Those who market to consumers based on convenience factors, but fail to adopt best medical practices, are certainly not punished and may even be rewarded. As employers think about how to use defined contributions to promote quality improvement, they need

to consider how to do so in a way that stops treating high-quality and lower-quality providers more or less alike.

The business community must act on information about quality of care and provider performance. If there are no consequences, there will be no behavioral changes.



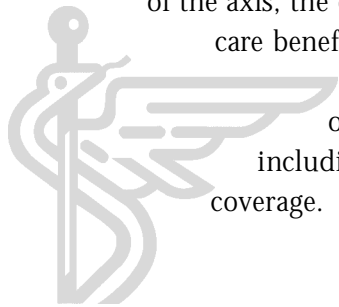
In addition, the business community has stood by rather passively as both the hospital and managed care industries have rapidly consolidated. Today, a splintered employer community is frequently facing some strong market power on the other side of the bargaining table. This also hampers employers' ability to enforce quality improvement targets or any penalties for poor performance.

Depending upon the type of defined contribution model selected, the business community should either tackle these issues directly or work to ensure that other groups get the job done. The more employers step back from their current roles of financing and managing health benefits, the more they should ensure that employees can get the help they need to work on these same goals.

## **A CONTINUUM OF MODELS**

Broadly speaking, the axis along which we arrange the defined contribution models represents varying degrees of employer control over health benefits. Under the most traditional application of defined contribution principles, employers retain their current roles in financing and managing health benefits, but cap their dollar contributions.

Next along the axis are arrangements characterized by shared control between employers and employees. These include flexible spending accounts, medical savings accounts, personal health funds, and other hybrids. A further point down the axis is one in which employers still choose the health plans, but totally outsource the management of health and other employee benefits to a firm that specializes in this work.



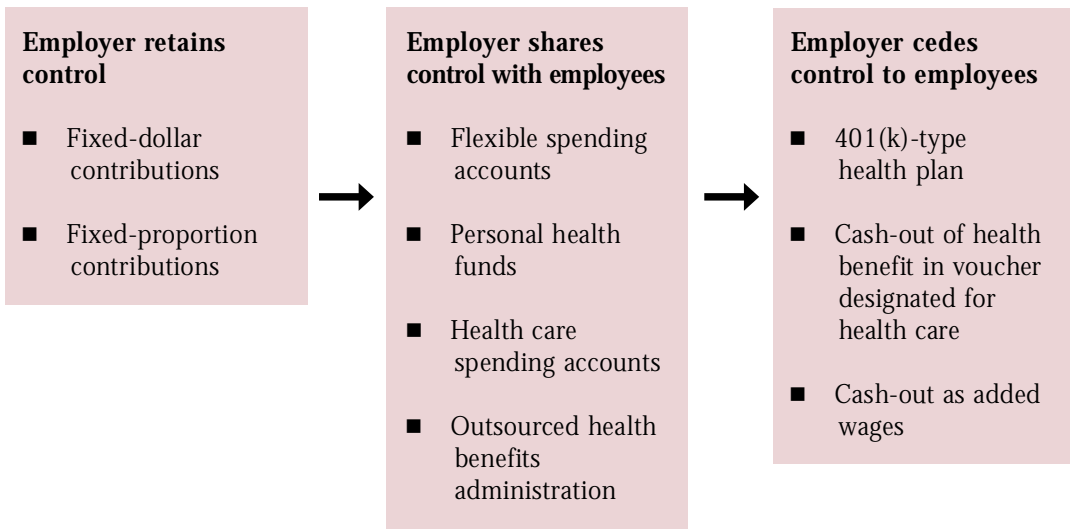
The next leap is to an environment in which employers cede control to workers. Firms would make a financial contribution to the worker, with the worker totally free to use it for health coverage that he or she chooses. Under this 401(k)-type arrangement, workers would “own” their chosen health plans and take the coverage with them when they leave the company, much like a vested pension. And at the extreme pole of the axis, the employer cashes out the health care benefit in the form of wages, leaving the employee fully in charge of what to do with those dollars, including going without any health coverage.

### Employer Retains Control

Under this model, the employer or employer purchasing group introduces a financial incentive to employees to select health plans or care systems with the best combination of price and quality by fixing its contribution at a designated dollar amount or a fixed proportion of average premiums. While the employer still decides what plans will be included in the offering, employees are now incentivized to consider whether plans whose costs exceed the employer contribution provide enough added value to justify higher out-of-pocket spending.

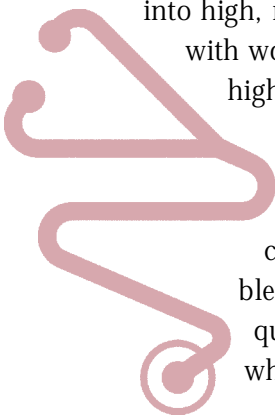
*Early assessment of plan switching in relation to performance indicators shows that workers are migrating toward higher-value plans.*

### DEFINED CONTRIBUTION MODELS: A CONTINUUM



In the fixed-dollar approach, the employer may designate one plan as the “benchmark,” based on a composite of cost and quality considerations, and tie its contribution to the premium for that plan. General Motors Corporation, for example, has been using such an approach for several years for its salaried workers. Early assessment of plan switching in relation to performance indicators shows that workers are migrating toward higher-value plans. Bruce Bradley, director of Managed Care Plans at General Motors, believes employers should stay involved in efforts to control health care costs and contribute to breakthroughs in quality. “Purchasers play a key role in better performance through expecting it, measuring it, and rewarding it,” says Bradley.

Similar findings have emerged from tracking enrollment shifts among workers in the 27 companies comprising the Buyers Health Care Action Group (BHCAG) in Minneapolis-St. Paul. BHCAG employers agreed to a common benefit package (to promote competition based on quality and cost management rather than benefit reductions) and to place health care delivery systems into high, medium, and low-premium tiers, with workers paying more to enroll in higher-cost systems. Employees are provided with information on patient satisfaction and various quality of care indicators for each care system, and can therefore blend cost considerations with quality information in choosing where to obtain their care.



The fixed-proportion approach to defined contribution is aptly illustrated by the Federal Employees Health Benefits Program (FEHBP), covering some 9 million workers and dependents. The FEHBP sets its contribution at 72 percent of the average premium of all plans offered, but not more than 75 percent of the premium of any plan. Employees can access results of the Consumer Assessment of Health Plans Survey (CAHPS) in selecting their plan, and refer to other pointers in handbooks, as well as the Office of Personnel Management (OPM) web site.

When quality considerations are a factor in establishing the level of defined contribution, plan screening, today, typically includes basic measures (e.g., National Committee for Quality Assurance (NCQA) accreditation, patient satisfaction, selected HEDIS measures). This “mild” form of defined contribution may promote quality by ensuring that basic standards at the health plan/care system level have been met. It stops short of direct assessment of physician and hospital performance in reducing medical errors and adopting best practices, and does not provide direct incentives to bring this about.

For example, only about 5 percent of hospitals are believed to be using Computer-assisted Physician Order Entry (CPOE), despite the fact that it has been shown to reduce prescribing errors by more than 50 percent. If the 95 percent of hospitals that are not installing and using this technology continue to remain in all of the health plans’ networks without any financial consequences, we are not likely to see either swift or widespread progress toward correction of this serious quality deficiency.

*Only about 5 percent of hospitals are believed to be using Computer-assisted Physician Order Entry (CPOE), despite the fact that it has been shown to reduce prescribing errors by more than 50 percent.*

The most common types of comparative assessment may tell us that one health plan allows fewer telephone rings than another and has a higher immunization rate for its members' children. This information does nothing, however, to inform patients about whether the plan pays any attention to volume/outcome relationships, tries to reduce unnecessary surgeries and emergency room visits, or properly manages chronic illness.

**ACTION STEPS FOR EMPLOYERS:  
EMPLOYER RETAINS CONTROL MODEL**

1. **The defined contribution should be set on the basis of both cost and quality assessments, not cost alone.** Many employers who use this defined contribution approach screen plans only on cost, and possibly some administrative features. Quality screening is not a given. There might be a tendency to view the defined contribution models at this end of the spectrum as most likely to have built-in mechanisms for safeguarding and promoting quality, but that cannot be assumed.

2. **If quality is used to help peg the defined contribution, employers should begin to include some of the “second generation” measures of quality.** These quality indicators go beyond plan-level measures that blend good providers and practices with poor ones across the plans. Instead, these more encounter-focused, provider-level measures could help reward superior performance and generate incentives for poor performers to make improvements. Additionally, these newer measures tend to be perceived as more personally relevant by consumers, and thus, are more likely to be used in their decision making.
3. **Employers need to be proactive in shaping the delivery system to promote quality.** If they want integrated delivery systems with non-overlapping networks of providers, for example, they need to structure their requests for proposals in a way that encourages this kind of restructuring.





#### 4. **Employers need to enhance their bargaining power.**

Purchasers are diffuse and frequently disorganized, while the other side of the market is cohesive and consolidated. There are two ways employers can address this challenge. First, they can form larger aggregations to confront the suppliers of medical services and the third-party payers with more strength in numbers. This could involve public/private partnerships with state and local governments, as have developed in Missouri, California, and Minnesota. It could also involve business coalitions reaching out to develop purchasing vehicles for smaller companies, as has occurred in Denver, Colo., Madison, Wisc., and New York City. Second, businesses can become more active in alerting the federal government (Federal Trade Commission, Justice Department) to the potential for anti-competitive outcomes in pending cases of health care industry mergers and acquisitions.

#### **Employer Shares Control with Employees**

Within the “shared control” segment of the continuum, one finds an abundance of emerging hybrid models. Each tests the waters of defined contribution, but continues to place the employer in certain strategic functions while offering consumers expanded choice and decision-making responsibilities.

#### **Employer-controlled insured benefit plus consumer-directed personal medical fund:**

Under this model, employers still select and manage health plans for insurable health events (high-cost, low-frequency). To assist workers and their families with more routine health expenses, employers make defined contributions into various types of personalized funds that provide employees with more self-directed options for financing their low-cost, high-frequency health services. First, employers may create various types of personalized medical funds (PMFs) for workers to pay their routine medical expenses. Workers can carry over unused funds from one year to the next without losing the tax preference that comes with employer group coverage. Second, employers can use flexible spending accounts in which employees may make tradeoffs among health benefits and other needs, such as child care.

A sizeable segment of employers has, for some time, been trying out more consumer-controlled benefits arrangements. Flexible spending accounts, cafeteria plans, and medical savings accounts are among these offerings, designed to give employees more choice about how benefits are spent according to their health needs and life stages. A new study from the National Health Care Purchasing Institute shows that these options are widespread among large employers. Some 54 percent of Fortune 500 companies offer flexible, cafeteria-style benefits for health care while 90 percent of these firms provide pre-tax spending accounts for health care.<sup>6</sup>

6. Maxwell et. al., 2001.

Benefits	Companies Offering Benefits
Flexible (cafeteria-style) benefits for health care	54%
Pre-tax spending account for health care	90%
Domestic partner health benefits	29%

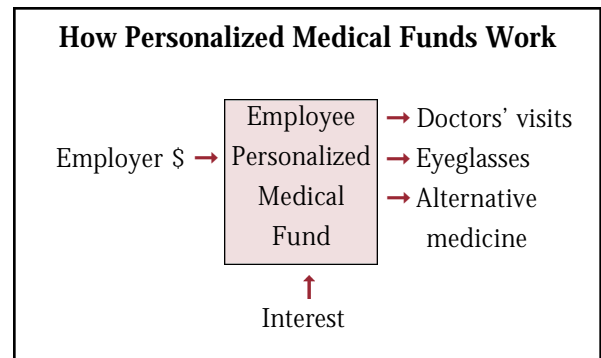
Most recently, the concept of the PMF has emerged as a vehicle for individually exercised decision making, joined with an employer cost-limiting mechanism that is a kind of defined contribution.

Although variations exist, PMFs work essentially as follows. A set amount of dollars – representing a defined contribution – are placed into the employee’s PMF each year by the employer or a combination of tax-preferenced employee dollars and matching employer contribution. The PMF builds interest, and any amount remaining at the end of the year is carried over and helps reduce the next year’s premium. When an employee leaves the plan, he or she receives the unused PMF balance. In essence, the PMF functions like a pre-funded deductible. Within a range, participants select an annual level for their fund, and the monthly share of this amount is added to the premium for insured benefits. The employer’s share of these insured benefits is typically funded with a fixed percentage contribution, hence the link to defined contributions.



The account is then used to cover routine expenses encountered over the year: doctors’ visits, prescriptions for acute conditions, eyeglasses, procedures not routinely covered by traditional health plans (e.g., LASIK eye surgery), and even alternative medicine.

Choice of services and providers is fully within the employee’s discretion. Specialist referral and treatment decisions, reached between physician and patient, are unencumbered by managed care restrictions. The insured benefit covers catastrophic expenses. It can be accessed for routine care once the PMF has been exhausted, but only after a substantial out-of-pocket expenditure. An important feature of some of these plans is that they cover approved preventive services at 100 percent; these costs are not taken out of the personal account.



## COMPANIES OFFERING ONLINE INSURANCE PRODUCTS WITH A PERSONALIZED MEDICAL FUND AND WRAPAROUND COVERAGE

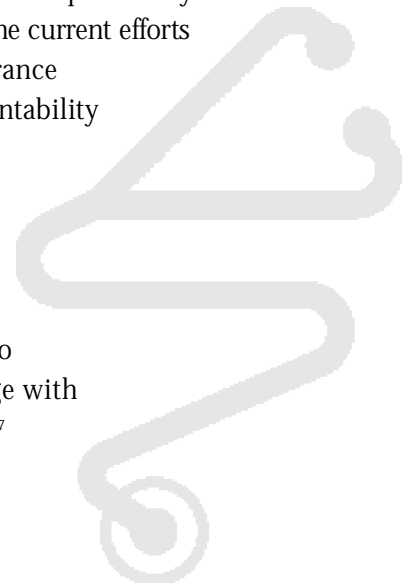
**Definity Health** has entered into a three-year contract with Johns Hopkins University. Hopkins will make available its extensive consumer health information library, developed with and fully reviewed by Hopkins scientists and physicians. The medical institution will also offer editorial services to create a wide range of customized information materials and tools to support Definity Health's members. ([www.definityhealth.com](http://www.definityhealth.com))

**Destiny Health** makes AMA-endorsed guidelines for preventive care available to its enrollees. Incentives are provided to encourage their appropriate use. For patients who develop specified conditions, but followed prescribed guidelines prior to their diagnosis, coinsurance is waived and out-of-pocket maximum payments are significantly reduced. ([www.destinyhealth.com](http://www.destinyhealth.com))

**Lumenos** offers several e-health programs – e.g., teen dermatology, an elective surgery program, an allergy arrest program – and is developing dozens of others to help patients be active and informed participants in their care. ([www.lumenos.com](http://www.lumenos.com))

Several new companies are offering online insurance products with a PMF plus wrap-around coverage. Definity Health, Destiny Health, and Lumenos are among these. Common to all are decision-support and educational tools that assist consumers in planning for health care needs, prudent spending of account dollars, and sound, care-related decision making.

There are some clear advantages of this approach, both for the control over cost that emerges from defined employer contributions and the potential to improve quality of care. First, this approach is closer to a true insurance model than the typical health plans in the market today. In other types of insurance (e.g., property and casualty), the insurers cover the big-ticket losses and the insured pay the front-end costs out of pocket up to some limit, usually in the form of a deductible. Second, this strategy may be more likely to realize the goal of portability of health coverage than the current efforts under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA features guaranteed issue by insurers at any price they choose, but does not really allow workers to take the same coverage with them from job to job.<sup>7</sup>



7. Scandlen, Gregory. Defined Contribution Health Insurance. National Center for Policy Analysis. Policy Backgrounder No. 154. October 26, 2000.

Even in advance of seasoned experience with this model, it seems likely that consumers using such a product will certainly be making more price-conscious choices and will enjoy greater freedom in decisions surrounding their health care encounters. They will not have gatekeepers telling them whether they may visit a specialist physician or obtain a second opinion. While the incentive against over-utilization is unmistakable here, and that should be noted as a positive, the possible hazard emerges on the flip side. Will under-utilization be the by-product if worried consumers log into their personal accounts to find a dwindling balance with a few months remaining in the year? Will this lead them to forgo needed care, or to opt for less expensive interventions strictly on the basis of cost, maybe to the detriment of quality? Will consumers feel less inclined to seek that second opinion when faced with a critical diagnostic or treatment decision? After all, a one-time consultation with a specialist can easily cost in excess of \$300, not including any tests. And what about those gray areas in deciding how to work-up a particular set of symptoms to arrive at the correct diagnosis and optimal treatment decisions? Does the consumer spend down his fund to have that MRI, or does he opt for the markedly cheaper x-ray instead, and essentially force his provider to render medical decisions with what may be less than an optimal clinical profile?

Is it even appropriate to place consumers in the position of deciding on the merits of specific medical interventions with the price tag waving so close to their faces? While no one would argue that total invisibility of cost is desirable, is this the middle ground we should be stepping onto? What tools will be available, and how effective will they be, to guide consumers in reaching optimal health care decisions and to help them in planning for their year-long, routine health spending? These are not functions that consumers are primed to assume independently, nor do they have the training to be making subtle, but highly consequential, clinical judgments that are often a challenge even for medical professionals with years of experience.

*Is it appropriate to place consumers in the position of deciding on the merits of specific medical interventions with the price tag waving so close to their faces?*



The University of Minnesota recently announced that it will begin offering Definity Health as a choice for its employees' health coverage. The University's Senior Vice President for Health Sciences, Dr. Frank Cerra, notes that approaches such as Definity offer maximum access and choice for consumers while providing the employer with flexibility in coverage and contribution level. He believes that there are consumers who have the knowledge base to function within this system and that it has the potential for cost containment. He expresses caution, however, about assuming the presence of an educated consumer. "Who is responsible for this education? How much of a doctor, nurse, or pharmacist do we expect the average consumer to become? And are we prepared to accept the inevitable, that if the consumer makes the wrong decision because of insufficient information, the consequences are totally on the back of that consumer?"

In sum, the PMF model appears to be a promising step into the realm of defined contributions and prudent consumer involvement in health care decision making. It also faces some serious challenges before it stands to realize its potential benefits without the downside risks.

Elsewhere along the spectrum, one finds models that still retain the employer-directed, wraparound insured benefit, but give employees yet another dimension of self-directed provider selection. Here, employees create a "virtual network" of providers. The employer makes a defined contribution for each employee who then uses the funds to finance the customized provider network and a wrap-around insurance policy. If the individual assembles a "low-budget"

panel of providers, the remaining dollars go into a health spending account that can be applied to cover deductibles, co-payments, and discretionary medical expenses.

Vivius is a prototype for this type of defined contribution model. It will enable consumers to select a primary care provider along with a panel of 16 specialists, a hospital, an emergency room, an outpatient surgery facility, a home health agency, and a pharmacy. Physicians determine their own pre-paid fees. In assembling their customized network, employees can compare the prices, credentials, and practice descriptions of individual providers. Employees choose their co-payment levels for physician and hospital services, and the Vivius web site calculates the annual cost of their coverage.

The employer's role under this shared-control model is limited to setting its contribution level and making the wraparound insurance selection, including deductibles, co-pays, and out-of-pocket maximums (for the wraparound component). Whether employers would continue in any capacity to exert leverage on the health care system, with the objective of promoting quality on behalf of their employees, is a highly speculative matter.

Under the Vivius model, employers could maintain an "adjunctive role," but the real driver of quality is the placement of both incentives and accountability at the level of patients and providers. (Personal communication with Lee Newcomer, M.D., MBA, medical director Vivius, April 2001.)

Such self-directed models rely on the initiative of consumers to ask the right questions pertaining to quality when selecting providers. Past evidence about consumers' desire to see past convenience features and practice style is mixed. Will consumers place the same value on clinical performance records that they do on bedside manner? Next, to the extent that consumers want clinical quality information about the providers they are selecting, will these models be equipped to furnish it?

Physicians who opt to enroll with Vivius free themselves of considerable overhead and third-party interference in medical decision making. They will, however, assume a sizeable new function: they will need to generate their own performance data and make their case directly to consumers. This will mean being competitive on both price and quality features that are compelling to consumers. It is expected to be some time before the measures coming out of this exercise will be clinical in nature; in the interim, they will center more on credentials, practice style, ease of communication, satisfaction ratings of other patients, and so forth.

Self-reported performance data carries the potential for serious biases; this concern will need to be addressed if the reliability and credibility of information that is to form the basis of consumer decision making is to be ensured.

This model relies heavily on physician-patient dialogue to guide treatment decisions and care management, a clear benefit over intrusive managed care policies. The model might be further enhanced by the incorporation of a mechanism for assisting patients to come to this dialogue better informed about their conditions and treatment options, and better prepared to demand the accountability the model claims to foster. While it is true that individuals can do this on their own, the credibility of the thousands of health information sources employees may encounter while surfing the net is a concern. Moreover, the sheer number of sources (e.g., an estimated 7 million for the generic diagnosis "cancer") makes locating the most personally relevant and reliable information quite daunting, if not infeasible.

In fairness, a number of these mostly e-commerce firms are fledgling enterprises of less than one year's worth of operation. At least in design, some very promising concepts have been developed, with a clear potential to benefit the health care consumer in making appropriate choices and with advantages that an employer-controlled process of plan selection does not typically offer. But successfully ushering in this innovation means anticipating various problems, such as some vendors going out of business and leaving consumers stranded, and putting in place a mechanism for preventing problems, first and foremost, and for resolving those that do occur effectively.

Over time, both the customers using, and the companies offering, these self-directed insurance alternatives will advance along the learning curve. That experience will undoubtedly be instructive for how to shape these innovative designs in a way that promotes quality improvement at this early stage of their evolution.

**Outsourcing health benefits management:**

The other major development in health care coverage and benefits management in this mid-range of defined contribution approaches is the outsourcing of the health benefits function. For a fixed price, the employer can hand over the full spectrum of functions that relate to providing employees with health care coverage.

Sageo is an example of a new online enterprise that can manage health benefits for its client companies. Participating employers still determine which plans they want offered to their employees, but then turn over to a contractor the responsibility for assisting employees with health plan choice, enrollment, and ongoing customer services.

Sageo offers employees several sets of online tools. One helps employees choose the health plan that is best suited to their individual needs. Another provides a scorecard to help people compare the field of health plans on measures of cost, quality, and patient satisfaction. A third assists with anticipating and planning for health care expenses that may be encountered over the course of the year. A fourth component involves a customer care center to assist individuals by telephone. Sageo emphasizes helping individuals see how life events may affect their coverage needs, and

enables them to adjust their plan choice and benefit design accordingly. Through an affiliation with the Mayo Clinic, enrollees can access health information.

An early in-house study shows that Sageo customers are spending an average of 30-40 minutes to select a health plan, in contrast to 15 minutes that is the norm elsewhere. Sageo reads this as an encouraging sign of consumers taking the time to consider more information, more carefully, before making a decision.

Another online service, Health Insurance Select, reduces the need for hands-on benefit management. This service helps employees select the most appropriate delivery systems and related health plans through its “BenefitsManager toolkit,” which includes:

- **SmartSelector:** to help in the decision of what type of health coverage is most suitable (HMO, PPO, indemnity, etc.);
- **HealthInsuranceSelector:** to guide the choice of a specific plan and policy, giving information about alternative medicine services covered, cost, and participating providers, while factoring in the enrollees’ specific medical conditions and health risk factors;
- **PhysicianSelector/HospitalSelector:** to help consumers choose providers according to specific preferences; and
- **MyBenefits:** a support service.

**Health Insurance Select’s “DiseaseManager”** helps employer groups identify relevant chronic disease states that account for direct medical costs, and indirect medical costs (e.g., paid time off) and related workplace inefficiencies. Working with local providers and health care organizations that have developed “best practice” protocols, this service helps employers to develop disease management programs to decrease medical costs, improve quality of life, and improve health outcomes. ([www.healthinsuranceselect.com](http://www.healthinsuranceselect.com))

It is beyond the scope of this report to compare and contrast all the benefits of outsourcing services available to employers today. The models highlighted here are not all defined contribution models, per se; some are mixtures of defined employer contributions and “catastrophic-level” insurance. These models are certainly providing a testing ground for some of the key principles inherent in the defined contribution approach. They appear to be creating consumer-focused products within which individuals can begin to receive assistance as they navigate unfamiliar waters. The degree to which health care quality will be affected under these increasingly popular alternatives to in-house benefits management will hinge, to a great extent, on the degree to which these firms can actually help consumers make smart, efficient, and health-promoting decisions.

#### **ACTION STEPS FOR EMPLOYERS: EMPLOYERS SHARE CONTROL WITH EMPLOYEES MODEL**

There are several ways that employers can help facilitate the development of these shared control models to improve quality.

1. Employers have a clear stake in ensuring that health care quality is a priority among the companies that are emerging to meet the demand for more consumer-directed models of health care coverage. Much like the working relationships that were cultivated at the beginning of the value-based purchasing era between employers and health care providers and plans, **employers need to open a dialogue with these new intermediaries and identify opportunities for collaboration.** For example, a new industry group – the Consumer-Driven Health Care Association – was announced this year. Eight leading companies have joined to develop awareness of these new approaches to health benefits: Definity Health, Destiny Health, Health Allies, Health Market, Lumenos, My Health Bank, Sageo, and Vivius. This association might provide a ready vehicle for employers to approach these companies about quality concerns, expectations, and how they might work together to raise the quality bar.
2. **Employers can continue to work through national associations, business coalitions, consumer groups, and other organizations pursuing quality improvement to develop new standards relating to quality at several levels:**

- the quality of services provided by the new intermediaries (e.g., ready access to a customer service representative to handle complaints and provide swift resolution of problems, the user-friendliness of decision-support tools);
- the quality-promoting mechanisms built into their products (e.g., affiliation with a respected medical institution to design and deliver educational programs to employees, access to guides for self-care, health risk assessment, treatment options); and
- quality standards built into the care delivery furnished by participating providers (e.g., formal incentives to physicians to adhere to evidence-based practice guidelines for selected conditions, policies that enable patients to be directed to high-volume hospitals for selected surgical procedures, mechanisms for generating valid and reliable clinical performance data).



These standards could then become part of uniform Requests for Proposals (RFPs). As the field of these companies widens, employers can be out in front promoting competition on features of quality that matter most to them and their employees.

3. **Employers can not only establish quality standards, but also take a lead role in setting quality improvement targets.**

These, too, can be incorporated into RFPs. The companies that provide the products and

services that are making a consumer-driven market possible have to start from scratch in many respects where quality is concerned. The health care delivery system is taking on all types of new configurations (e.g., virtual networks). Many old measures no longer apply (traditional HEDIS measures, for example). Other new measures are still under development or need to be adapted to online consumers. No ready systems are in place to monitor performance and gather data. Employers can have a major impact on how rapidly these new challenges are taken up by establishing milestones, targets, and specific incentives for quality initiatives to be undertaken by these new companies.

4. Finally, **employers may choose to continue in some highly visible advocacy functions on behalf of their employees**, both to carry out their responsibility toward the well-being of their workers, and cultivate a positive mindset among workers toward the new forms of health coverage. This transition will not be without growing pains. Employers could sponsor periodic in-house workshops on timely subjects, such as how to spend one's medical account wisely. For example, a workshop might feature the mounting evidence that one of the most common forms of overuse of the health care system involves getting prescriptions for antibiotics for colds or related viral respiratory diseases.<sup>8</sup> Patients frequently plead with their doctors for these prescriptions, which, at best, can be

8. Nyquist A., R. Gonzales, J.F Steiner, and M.A. Sande. "Antibiotic Prescribing for Children with Colds, Upper Respiratory Tract Infections, and Bronchitis." *Journal of the American Medical Association* 279:875-877, 1998; Gonzales, R., J.F Steiner, and M.A. Sande. "Antibiotic Prescribing for Adults with Colds, Upper Respiratory Infections, and Bronchitis by Ambulatory Care Physicians." *Journal of the American Medical Association* 278: 901-904, 1997.

useless, and at worst, will lead to more and more “bugs” that are resistant to antibiotics. Employers could help educate workers about the folly of spending their account balances on these counter-productive measures.

### Employer Cedes Control to Employees

This model represents the purest form of defined contribution: an employer would make funds available to employees, who would use that money to purchase individual coverage in the non-group or individual market. Even within this model, further variants exist: the first is one in which the funds would go to the employee in the form of a voucher, available only for the purchase of health care coverage, or direct payments (fixed contribution toward premium) sent to the employee’s individually selected plan. As such, the money could remain tax-advantaged while the employer is completely severed from both plan selection and benefits management. In yet another variation, the employer would totally cash out the benefit and replace it with an addition to wages of equivalent after-tax value. Here again, the employee is in full control of health coverage decisions, including the decision of whether to use the money for health care at all.

The employee can use vouchers or 401(k)-type defined contributions either in the individual market or in health plans offered through various non-employer groups. The ability to customize benefits according to personal needs and resources is an attractive feature of this model. Also, as noted earlier, the worker can maintain enrollment

in a chosen plan even through a job change or a spell of unemployment. Like a defined contribution pension plan that is vested, health coverage under this approach belongs to the worker, and does not lapse when the worker changes employers. This should improve quality of care by enabling employees and their families to stick with their preferred physicians through job changes.

The ability to customize benefits according to personal needs and resources is an attractive feature of this model.

One significant challenge facing this approach is that coverage is, on average, more costly in the individual and small-group markets than in larger groups. Loading charges, for example, have been estimated at 40 percent for firms with less than 10 workers, compared to only 8 percent for groups with 1,000 or more workers.<sup>9</sup> Also, there is considerable risk selection in these markets so that vouchers set to an average cost may under-fund some people and over-fund others as they seek to buy their own coverage.

Since this model is still in its design phase, any discussion of the eventual impact on quality is necessarily quite abstract. The net direction of the effect on quality hinges on a whole composite of variables: the availability of reliable, consumer-focused information; the accessibility of that information through appropriate decision-support tools; and the readiness and willingness of consumers to use these tools effectively.

9. Fuchs, Beth and Mark Merlis. Private Health Insurance Options for Reform. United States Government Printing Office, Committee Print 101-35, 1990.

These models require that consumers receive sufficient education to carry out their responsibilities, first, by choosing to be insured, and second, by exercising diligence in selecting and customizing a health plan that will be a good match for their needs and resources. And that is just the beginning. Over time, the burden is on consumers to vote “with their feet” by demanding quality and accountability in their health care encounters and by being willing to switch providers/plans if their experiences are consistently unsatisfactory.

#### **ACTION STEPS FOR EMPLOYERS: EMPLOYER CEDES CONTROL TO EMPLOYEES MODEL**

1. **Employers could support changes in federal tax laws that would facilitate worker-owned, portable employee health benefits.** The newer, bolder forms of defined contribution, such as the 401(k) models or vouchers, will require changes in tax laws if these arrangements are to receive favorable tax treatment. The lack of a supportive tax climate could hinder this movement.
2. **Employers could work for national reforms in quality improvement.** If employers are going to step away from selecting health plans and managing health benefits, they can shift their focus from trying to negotiate with local health plans to improve quality to working on national or statewide initiatives that raise the bar for all. This could involve working with the Quality Forum, Foundation for Accountability (FACCT), NCQA, and other organizations. Employers can also work on quality initiatives

in tandem with federal, state, and local government, as well as university systems, which in most markets are usually the biggest purchasers.

3. **Employers could contribute to the design of an “aggregator model” to take the place of the responsibilities now being fulfilled by companies and coalitions.**<sup>10</sup> This aggregator might take the form of large regional exchanges. Individuals could purchase health coverage through this aggregator, and this coverage would not be tied to the workplace. The exchange could reduce problems of risk selection. It could also work on quality improvement initiatives.
4. **Employers could provide specific ideas or models of regulatory oversight and monitoring.** If the goal is to treat health care more like pensions, there will be a need for fiduciary standards as well as quality standards. The goal should be to protect consumers from shoddy practices without stifling innovation under a heavy regulatory blanket. When consumers select a plan from a “family” of health plans, they should have the same assurances as when they select a pension fund from the family of Janus or Fidelity funds. The future of the 401(k) models might be built more on an SEC model than an ERISA/HIPAA model of government regulation.



10. Scandlen, 2000.

# RE-THINKING FINANCING AND QUALITY

There is every indication that employers are grappling with how to reduce their financial and legal exposure in providing health care coverage. They are interested in reducing the administrative burden of health benefits management and are exploring alternatives to traditional managed care to offer their employees more autonomy. Interest in defined contributions is one by-product of this “re-thinking.”

In the process of making informed opinions about the likely impact of defined contributions on the quality of health care, we would be remiss not to consider that employer-driven quality initiatives are taking some dramatic turns of their own. Leaders in the business and medical communities are taking stock of the quality movement’s progress. Their conclusion: we are still not getting it right.

“American health care remains very far below obtainable levels of basic safety and overall customer value.” –(www.leapfroggroup.org)

Clearly, a decade’s worth of quality initiatives have not overwhelmingly spelled quality improvements. Two recent Institute of Medicine reports indicate how much work remains to attain system-wide health care quality.<sup>11</sup> Employers’ considerable efforts to promote accountability and drive improvements through RFP specifications, performance measurement and reporting, etc., have raised consciousness among the stakeholders. Yet, only a small proportion of companies are really working on quality of care, and there are few tangible outputs (i.e.,

fundamental improvements where the most serious quality problems lie).

“Sometimes a half-hearted effort is worse than none, because its presence precludes efforts the development of superior approaches.”<sup>12</sup>

Many employers and their employees are missing opportunities to use the very tools developed to ensure essential elements of quality in health plans. For example, while about one-half of Fortune 500 companies require NCQA accreditation, only a third of employers disseminate some quality information about carriers to employees. James Maxwell and colleagues report that “...only a small number (of employers) have been able to devote time and resources to health carrier quality management.”<sup>13</sup> Even when quality indicators are available to employees, the relative weight given to them as decision-drivers is barely discernable.

Some leading employers believe that real change will not occur until the true controllers of cost and quality – physicians and consumers – take ownership of the upcoming generation of managed care, the old one having matured into “market gridlock.”<sup>14</sup> The next wave of change looks to be a tsunami that will leave managed care shaken up and the other players – employers, consumers, and providers – scrambling to define their roles. Evidence that such a transformation is taking place is surfacing rapidly – and employers are taking a strong leadership role. Three examples are highlighted.

11. To Err is Human Institute of Medicine: Washington, D.C., 2000; Crossing the Quality Chasm: A New Health System for the 21st Century Institute of Medicine: Washington, D.C., 2001.
12. Reinhardt, Uwe. “Employer-Based Health Insurance: A Balance Sheet.” *Health Affairs*, 18(6): 124-132, 1999.
13. Maxwell et. al., 2000.
14. Galvin, Robert. “An Employer’s View of the U.S. Health Care Market.” *Health Affairs*, 18(6): 166-170, 1999.

### **“Safety Leaps” – targeting some of the most serious and preventable quality gaps**

In the Leapfrog Group, a new age of purchasing principles is being articulated by about 80 major purchasers representing business and government leaders who are becoming more involved as champions of health care quality and value. More than 20 million Americans receive health benefits from members of this group, accounting for over \$40 billion of health care spending annually. Their initiatives aimed at health care safety have the potential to save up to 58,300 lives and prevent up to 522,000 medication errors annually.<sup>15</sup> Leapfrog believes that this kind of “quality leap” is attainable through voluntary commitment to purchasing principles by a critical mass of America’s largest employers and will provide a jump-start for other purchasers to join. They assert that consumer understanding of, and support for, this process is essential, and that the more compelling the measures of quality, the more committed individuals will be to using them.

### **Measuring hospital quality**

Ford Motor Co., GM, Daimler Chrysler, the UAW, Detroit Edison, and other major purchasers in Southeast Michigan have developed tools to comparatively assess risk-adjusted mortality rates for chronic obstructive pulmonary disease, stroke, and a series of cardiac care procedures. Hospitals receive ratings of one, two, or three stars indicating whether they fall short of, meet, or exceed their expected performance, given their care mix. Other important measures include the percent of patients with heart failure who received ace inhibitors and those who had vaginal births after C-sections.<sup>16</sup>

### **Health and productivity management gets employers out of the “medical cost box”**

While disenchanted employers see health benefits as an unmanageable expense, “the new believers view them as a way to make workers more productive – as an investment that can produce a measurable return on their ‘human capital’ and provide a new source of competitive advantage.”<sup>17</sup> The strictly medical model for measuring the cost savings and value derived from providing health benefits consistently comes up short. Only when a workplace model is applied can total cost savings and employee performance gains be recognized. The total cost of illness is many times greater than the direct medical expenses incurred. Employers adopting the health and productivity model vigorously urge the business community not to retreat from health management. And while employers’ methods for managing employee health may need updating, a commitment to employee health is not going to be realized by handing employees a check and an 800 number.

15. Birkmeyer, J.D, C.M. Birkmeyer, D.E. Wennburg, and M.P. Young. “Leapfrog Safety Standards: Potential Benefits of Universal Adoption.” The Leapfrog Group: Washington, D.C., 2000.

16. Southeast Michigan Hospital Profiles: A Consumer Guide. January 2000.

17. Sullivan, Sean. “The Case for Employment-Based Health Benefits – It is a Productivity Issue.” Drug Benefits Trends March 2001, pp. 48-49.

The emergent generation of quality initiatives is by no means restricted to the employer sector. Providers, philanthropies, private and public entities – individually and cooperatively – are working to advance the state-of-the-art. Abundant opportunities are available for employers to lend their support, perspective, and experience to further

these efforts. Overwhelmingly, these initiatives are moving in the direction of provider-level quality measurement and promotion, and consumer-focused efforts that assist in sound decision making at the level of personal encounters with the health care system. Some examples highlight this activity.

**The Foundation for Accountability (FACCT)** is piloting a new consumer-focused tool, CompareYour Care. With this guide, patients with conditions such as asthma and diabetes can compare their provider's care with benchmarks, developed from the aggregated responses of patients' self-reporting. These condition-specific guides can help patients see where their provider is excelling in care, or falling short of optimal management. Patients are, thus, empowered with relevant information that they can then bring to their health care setting to promote the quality of the encounter. ([www.facct.com](http://www.facct.com))

**Consumers' Medical Resource (CMR)** is a new medical decision support service that employees at companies such as Honeywell, Hartford Insurance, and AIG can access. With diagnostic and treatment options accelerating dramatically, this tool gives individuals a fully customized guide through clinical information they need to help them make the best personal decisions, thus driving a whole new dialogue between patient and physician. Early results of patient experience with this product show that consumers are, in fact, willing to vote "with their feet" when given high-quality, personally relevant information. Based on information patients have acquired through CMR, one-in-five patients changed providers due to quality problems detected, one-in-six eliminated unnecessary side effects of treatment, and one-in-25 discontinued unnecessary treatment. ([www.consumersmedical.com](http://www.consumersmedical.com))

**Pursuing Perfection: Raising the Bar for Health Care Performance**, a Robert Wood Johnson Foundation initiative, is aimed at helping hospital and physician organizations improve patient outcomes by pursuing perfection in all of their major care processes. It is intended to: promote the delivery of all indicated services accurately and at the right time; avoid services that are not helpful; avoid safety hazards and errors; and respect the patient's unique needs and preferences. Major grants, technical assistance, a learning network, and a communications campaign comprise the initiative, which begins in Fall 2001. ([www.rwjf.org](http://www.rwjf.org))

# USHERING IN AN EFFECTIVE, CONSUMER-DRIVEN MARKET

A vote for defined contribution is, at least in part, a vote for consumer choice. Whether that is the motivation or the by-product, the net effect is the same: consumers will be making more decisions. While consumer empowerment has an appealing ring to it, there is considerable responsibility on the shoulders of those who lay claim to making it happen. Consumers first need education; they need reliable information and tools for using it, and they need safeguards against fraudulent and sub-standard practices that stand to seriously jeopardize their experiences within the health insurance and health care delivery systems. What should policy-makers, employers, and other stakeholders build into a defined contribution model to help individuals make responsible decisions?

**Redefining the employer's role:** Some employers view defined contribution as an opportunity to escape the administrative burden, liability, and political haggling that come with health benefits management. They might consider, however, that in relinquishing one set of responsibilities they acquire another; the employer role shifts more than it diminishes, from decision-maker about plan selection to a provider of employee education on the new insurance model and decision support for plan selection. While many consumers have acquired a comfort level with going online to seek health information, they will need considerable guidance to assume the far weightier responsibility of managing their own health care dollars.

**Developing new specifications:** In a defined contribution environment, instead of screening health plans, employers could be faced with developing a new set of specifications for screening outsourcing firms and online decision support products. They could be confronting the growing and largely unanswered concerns about the quality and credibility of health information that workers will be receiving online and using to make decisions. A major thrust of this report is to urge employers to develop some type of quality-related criteria with which to judge various vendors before simply outsourcing the health benefits management function to them. Employers have a huge stake in this role: if workers and their dependents suffer adverse health events as a result of inadequate attention to quality under new defined contribution arrangements, employers will ultimately pick up the tab in the form of lost work time, productivity effects, and turnover.

**Establishing safeguards:** A considerable amount of hype is circulating along with objective, substantiated information about the trendy new consumer-driven models; these models have not yet been tested in the health care marketplace. Employers should be aware of the current gap between what is being claimed and what has been proven; there is still a very long way to go. The further employers move down the axis of defined contribution, the further "out there" the consumer is placed. Until consumers are prepared for this and until the new infrastructure of a consumer-driven market is fine-tuned, there are hazards and vulnerabilities at every turn.

Employers surely do not want the business school case studies and newspaper articles to feature bungled transitions and personal catastrophes, as consumers were turned loose in an unregulated, unproven field of essentially direct-to-consumer marketing outfits. Furthermore, if employers do not take the lead in establishing adequate safeguards, it is not difficult to envision the emergence of a government entity empowered to impose restrictions and regulations that would complicate, possibly even impede, the evolutionary path of consumer-driven models.

**Consolidating and coordinating effort:** The business community need not tackle these new challenges one employer at a time. In fact, the past decade of employer involvement in quality initiatives gives every indication that the voice and purchasing clout employers need to drive change will most likely take the form of well-organized, nationwide efforts, fueled by a critical mass of businesses. Furthermore, employers should seek opportunities to collaborate with the provider community and the emerging sector of enterprises that are developing consumer-driven insurance products and services. In tandem with these efforts, employers must remain vocal within the policy community and participate in efforts to inform the debate over the future direction of health care financing and quality.

A major shift to defined contribution (in the form of employers “cashing out” the health care benefit) seems unlikely in the foreseeable future. Dwaine Hartline, process leader for benefits at Hershey Foods, believes that it is possible, however, to foster greater consumer awareness and responsibility within the present group health benefit structure.

Pertaining to health care quality, Hartline takes exception to the notion that “consumers ‘on their own’ would be able to achieve what employer-purchasers have, so far, been unable to do. Only with the collective efforts of consumers, employers, the federal government, and organizations like NCQA, along with considerable advancement in performance measurement at the hospital and physician levels, will real inroads to quality improvement be realized.”

(Telephone interview with Hartline, June 2001.)

**Phasing-in, not jumping into, defined contribution:** One of the surest paths to jeopardizing quality would be in a transition that is too abrupt and fails to establish a proper safety net. Even the more vocal advocates of defined contribution admit that employee education and consumer decision support capabilities are not generally far enough along in their evolution to just “turn consumers loose” with their health care dollars and expect them to fully exercise their new-found autonomy wisely and safely.

While CEOs and CFOs may be tasking their human resources managers with looking into defined contribution, it is exploratory in most cases; no one really wants to go first.

It is encouraging that all the recent, heightened interest in defined contribution principles does not necessarily foreshadow imminent, massive migration of employers to defined contribution practices (particularly those at the far end of the spectrum). While CEOs and CFOs may be tasking their human resources managers with looking into defined contribution, it is exploratory in most cases; no one really wants to go first. Furthermore, employer interests aside, there are substantial regulatory and tax law issues that would need resolution before a full-scale transformation of employer-sponsored health care coverage could take place.

One cautious approach might take the form of an employer introducing the idea through a “mild” dose of defined contribution (e.g., instituting only the fixed-contribution aspect, but continuing to administer health benefits, screen plans, etc.). There would be a strategic plan for phasing in other elements of a more consumer-driven process over a timeframe, such as three years, with specific milestones identified along the way. This would enable the employer to prepare employees for a more hands-on role. This might entail both technical education and attitudinal preparation.

Another option for phasing-in defined contribution would be to continue offering the traditional array of health coverage choices for some period of time, but adding an option under which employees are more in charge.

Employers would allow, but not require employees to essentially pilot test the more consumer-driven approach. The benefit here is to gain significant ground along the learning curve while not pushing reluctant or unprepared workers “over the cliff.”

**Staying involved:** Inevitably, the changing health care environment will demand that all players take on some new roles, sometimes reaping the benefits, other times towing the line. But at the end of the day, for employers, maintaining competitive advantage will always require a healthy, productive workforce. Is a defined contribution approach to health care financing compatible with a health and productivity management model? That would seem to depend on why the employer chooses this financing approach and on what the employer does in lieu of its traditional health benefits management role.

At the end of the day, for employers, maintaining competitive advantage will always require a healthy productive workforce. Is a defined contribution approach to health care financing compatible with a health and productivity management model?

The good news is that for every employer looking into defined contribution primarily to carve out a downsized role for itself, there are others who are pursuing employer-driven quality improvement with a new energy – a stance that need not be incompatible with defined contribution.

If employers are considering defined contribution strictly as a means to limit financial exposure, serious opportunities for optimizing employee health, satisfaction, retention, and productivity are being overlooked. If, on the other hand, employers' motivation includes developing a plan to incentivize employees to be cost-conscious in their health care choices and to be actively involved in plan selection, educated, and pro-active in every sphere of their health care-seeking behavior, then the door remains open for a win-win situation. The good news is that for every employer looking into defined contribution primarily to carve out a downsized role for itself, there are others who are pursuing employer-driven quality improvement with a new energy – a stance that need not be incompatible with defined contribution.

Gregg Lehman, president and CEO of the National Business Coalition on Health, remarks that “employers’ roles will inevitably take some new directions in an environment where the consumer is the new buyer of health care. Yet, that segment of employers that has been a vocal, active driver of quality improvement and market-based health care reform is neither moving rapidly toward defined contribution strategies nor viewing national-level initiatives as a substitute for local, employer-driven change, fueled by many years worth of data collected by business coalitions and individual companies.”

All evidence points to the need to engage employees in responsible, cost-conscious, health-related decision making, but that will only happen if employers stay committed to finding ways to do what they can do best: using their market leverage to help finance affordable health coverage for 158 million Americans. Then, if employees can be empowered to do what they can do best, the two parties will complement rather than exclude one another.



# CONCLUSION

Defined employer contributions to health care are taking many different forms. This report has presented a continuum of models ranging from those in which employers retain their current roles in financing and managing health care, but cap their contributions, to forms in which employers cede control over health benefits to workers. In between are various hybrid models in which firms and workers share control through a mix of insurance and personalized health funds.

Defined contributions have several advantages. They have the potential to control costs by giving the consumer a direct financial stake in the price of health care. They may help achieve the goal of making health coverage portable by giving workers a benefit that they do not have to leave at the company door when they change jobs. They might reduce consumer and provider frustration with managed care by forging more direct links between patients and their providers. And they could foster quality improvements if workers have timely, accessible, and reliable information and choose to use it.



This report has raised a number of cautionary notes about the impact of defined contributions on the quality of health care. It outlines some new roles for employers in promoting quality improvements even as they consider moving along the continuum toward relinquishing progressively more control over health care to their workers. First, personalized funds that can be carried over from year to year create incentives for consumers to delay or forgo care. This may plunge patients into trading an extra medical test or service that may improve their health tomorrow for an extra tax-sheltered dollar in their pockets today. Are consumers ready to make these judgments? Will they shortchange their health?

Another concern is that consumers are now flooded with thousands of emerging web sites, sources of health information, and vendors vying to build them a personalized health care network or health plan. How will they exercise quality control over quality information? How will they assess the medical qualifications of providers and the financial soundness of new organizations?

Consumers are now flooded with thousands of emerging web sites, sources of health information, and vendors vying to build them a personalized health care network or health plan. How will they exercise quality control over quality information?

The business community can help guide the process by which oversight and monitoring functions designed to promote quality are appropriately secured within new entities that may emerge in a true defined contribution environment.

Employers have important roles to play in each of these areas. They should set defined contributions on the basis of both cost and quality, taking care to incorporate encounter-focused, provider-level measures that reward superior provider performance. They can develop new standards and targets to assess and improve the quality of services provided by the new intermediaries, as well as the quality standards (e.g., evidence-based medicine) built into care delivered by participating providers. Employers can become more active in national efforts to promote quality.

Finally, the business community can help guide the process by which oversight and monitoring functions designed to promote quality are appropriately secured within new entities (e.g., insurance exchanges or “aggregators”) that may emerge in a true defined contribution environment. This would include oversight and monitoring functions designed to promote quality.

We are currently witnessing a high level of interest in defined contributions that is sparking considerable interest in the business and policy communities. It is also fueling innovation among enterprises developing consumer-focused products and services. We are not, however, seeing large-scale movement by employers to defined contribution strategies. From the perspective of health care quality assurance and improvement, the optimal scenario would feature a transition that is gradual and in proportion to the readiness of consumers, medical decision-support technology, and insurance products that are suited to the emerging market trends.



## **Acknowledgments**

The authors wish to thank the many individuals who contributed valuable insights and information over the course of our research. We would also like to recognize the Employers' Managed Health Care Association for their efforts to advance dialogue on the subject of defined contribution. And finally, the authors extend thanks to Kip Piper and Margaret Trinity of the National Health Care Purchasing Institute for posing the insightful and compelling questions that formed the basis for our research and analysis, and for their helpful suggestions throughout the project.



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