Health Care Transparency and The Transition to Consumer Ownership

Sharing information on health care costs and services is a pivotal step in the transition from an employer-sponsored system to a defined contribution benefit structure in which consumers take ownership of their health care.

Kyle Rolfing

Whether on a price tag or in a purchasing contract, most people can easily locate and understand the cost of the consumer goods and services they are buying. However, if an employer asks its employees how much their health benefits cost, the employer will most likely get glazed looks and a variety of misinformed answers.

With the cost of health care and benefit programs continuing to rise, all human resources (HR) and benefit executives face similar questions:

- How can I affect the full cost of health benefits?
- How do I communicate the full value of benefits to employees?
- How can I help make employees more responsible health care consumers?

These questions may sound complex, but a growing number of organizations are providing innovative answers.

In this new age of health care consumerism, transparency in the system is tantamount to success. It is important that employers help make crystal clear to the consumer that convenience, service, cost, quality and value – all important factors in the buying decisions that we take for granted when purchasing any other good or service – are important in health care purchasing.

The advent of consumer-driven health plans served as a catalyst for transparency by getting people to care about the cost of health care at the point of purchase. However, for employers to control the total cost of health care, they need to take this a step further by introducing consumer-owned health to their employees.

Consumer-owned health ties the financial consequences of personal behavior to the total cost of health care premiums, thereby motivating individuals to take the actions necessary to improve their own health, lower their own costs and plan for their own health-

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related financial future. Most would agree the owner of an expensive sports car who gets many speeding tickets should pay more for auto insurance. Likewise, an individual who smokes, follows a poor diet and fails to get adequate exercise, most likely has increased health risks and accordingly should pay more for health insurance.

As individuals begin to “own” their health and become more accountable consumers, they will seek to control costs and increase the value of the care they receive. Those who do will be rewarded with lower premiums, rollover savings and improved health. Employers will be able to capitalize on the trend by implementing a defined contribution benefit structure that will not only lower their costs but will allow them to focus on their core business as opposed to an ancillary service that eats up precious resources.

The following discussion will review existing levels of health care transparency and consumerism and detail on how individual behavior should be tied to the overall cost of health plan premiums.

Creating a Demand for Transparency

With more employers offering consumer-driven benefits in the form of high-deductible health plans, including many linked to health reimbursement arrangements (HRAs) and health savings accounts (HSAs), consumers increasingly appreciate the need to control the cost of care to avoid paying more out-of-pocket. The concept of HRAs and HSAs is relatively simple: Any amount not spent in a given year will accumulate and eventually cover the cost of a deductible. Conversely, any amount spent ultimately increases an individual’s out-of-pocket cost under the deductible.

The symbiotic relationship between health accounts and high deductibles creates a mindset where the individual acts more like a true consumer – comparison shopping in the health care marketplace, only buying goods and services that truly provide value at a time and place that is convenient and appropriate. Consumerism requires attentive and informed stewardship, which in turn creates a demand for transparent cost and quality information that is easy to access, understand and trust.

To meet this need, many health plans are in the early stages of offering their members access to previously unreleased information historically hidden behind a veil of copays, deductibles, out-of-pocket maximums, coinsurance and paycheck deductions. Demand for transparent, personalized and accurate information from the health care industry will continue to increase as more employers pass costs and responsibility to their employees. Consumers will undoubtedly need to change from a traditional entitlement mentality to one focused on the personal ownership of health and its related costs.

With defined contribution on the horizon and the transition to increased consumer-ownership already underway, employers will need to adopt a strategy of transparent and readily accessible costs, quality and support, providing the resources necessary for employees and their families to navigate the complicated health care system.

Transparent Health Care Information

Transparency is a somewhat elusive goal in the health care industry. The complexities of the system create many hurdles not present in traditional consumer industries. Each procedure and office visit is highly customized for each individual, making it difficult to estimate costs and gauge quality. At the same time, traditional health plans and insurers
try to place large populations under one type of coverage. Nonetheless, transparency of health care information is largely focused on two major categories:

1) **Cost.** Health care cost information includes the actual price of a medical procedure, product or package of services. Comparative pricing information is still relatively limited and can be one-sided, with competing organizations not willing to share the full cost of services in an open market. Unfortunately, the health care system is still struggling to find a best-in-class approach to organizing and communicating cost information through a standardized and trusted source.

2) **Quality.** Quality information is typically derived from third-party and government organizations. While useful, it can be difficult to interpret and is often not comprehensive or consistent enough across physicians and hospitals to provide accurate side-by-side comparisons. The available information has grown significantly over the last several years and will continue to develop into a critical resource for all consumers accessing the health care system.

The following examples further illustrate the levels of physician, facility, prescription and health plan transparency that a relatively limited number of insurers and health and well-being organizations currently make available:

**Physicians and Facilities**

Physician and facility transparency initially came in the form of cost estimates that compared the price a health plan negotiated with a provider group (in-network discount) against the open market cost (reasonable and customary amount). This approach benefited health plans, in that the discounted charge was typically less than the open market cost. The complexities of the medical system, however, can make it hard for the average consumer to get an accurate cost estimate because each medical event may require unique, itemized procedures that can’t always be predicted. Nonetheless, even high level cost information helps to educate consumers about the nuances of health care finance, taking consumers beyond the assumption that copays and coinsurance cover the full cost of care.

For example, consumers with minor health problems could evaluate the cost of an emergency room visit in comparison to urgent care. With easily accessible information, consumers will often adjust their behavior and go to urgent care facilities rather than the emergency room. This not only saves both the consumer and their employer money, it also frees the emergency room to focus on urgent cases.

Quality information, which may include everything from mortality rates to number of procedures performed to consumer satisfaction, is available to varying degrees through health plans and third-party organizations. For example, independent and highly reputable organizations often provide comparative hospital quality information on an increasingly national basis. Other resources focus on specific data or geographic locations.

Developments here have been encouraging but provider groups need to be pushed even further. Employers that lead the charge to make providers more transparent will be rewarded for doing so. Employers that seek, and provide their employees with, access to a resource that centralizes multiple quality indicators alongside cost estimates will benefit from educated consumer decisions, helping build an atmosphere of empowerment, lower costs and greater satisfaction.
Pharmaceuticals

Many opportunities for cost transparency exist within the world of pharmacy benefits and prescription drugs. Educated consumers with information that imparts the actual cost of medications can find significant savings opportunities if their benefit design is not overly restrictive. For example, significant discounts can be achieved from:

1) switching from a brand-name drug to a generic;
2) pill splitting;
3) finding therapeutic alternatives; or
4) requesting larger supplies through mail order.

Information about the cost of prescriptions is becoming easier to find with many health plans now offering it through their member Web sites and telephone-based customer service. Some of the more innovative companies actually apply claim and purchasing history to support consumers with detailed information about their prescriptions, including contraindications, overuse, efficacy, doctor talking points and recommendations for lifestyle changes.

Employers that are able to provide their employees with personalized information about prescription utilization and the available alternatives will benefit from associated cost savings.

Health Plans

There have been exciting developments in health care cost and quality transparency in recent years; however, much more needs to be done. The exploration of other approaches is critical to engendering a health care market filled with informed consumers. As mentioned previously, consumer-owned health is one such innovation.

Traditional benefit plans, including consumer-driven designs, provide a limited understanding of the overall cost of health care. While consumer-driven benefit plans do a much better job of engaging consumers in purchasing decisions, they fall back into a traditional approach after the deductible. Copays, coinsurance and coverage limits are once again applied, hiding the true cost of care.

Employers face the reality of increases in health care premiums and new medical trends annually if not more often. Likewise, employees feel the affect through reduced benefits and increased paycheck deductions; however, they rarely have insight into the employer’s share of the cost.

By revealing the full cost of health benefits that employers and employees share, consumer-owned health helps drive individuals to change their behavior. With health care premiums serving as a proxy for how much an individual or group will spend on medical care, consumer-owned health takes us one step closer to a pure consumer dynamic in which the cost impact of personal behavior links directly with the total cost of health care. Employers that advance this concept with information resources, personalized well-being plans and independent advocacy will move quickly toward controlling costs while attracting and retaining talented employees who understand how their health-related behavior affects the total cost of health care.
Consumer Dynamics in the Health Care Marketplace

Those of us that have come to rely on cell phones have also come to understand the pricing structures of their service packages. To oversimplify, each service package typically gives you a set number of minutes to use each month. If you exceed the budgeted minutes, you pay a per-minute fee that can add up quickly. This design reflects a purist approach to consumerism, in that the full cost of the service is known and additional fees are transparent. For most cell phone users, this encourages careful consideration of the number of available minutes in relation to the importance of the call, which also helps cell phone companies manage cellular bandwidth and connection rates.

While the health care system faces more significant – in fact, life-threatening – variables than the cell phone industry, there are always opportunities to learn from other markets. The primary lesson we can take from cell phone and similar industries is that transparency and relatively simple fee structures make for a better consumer experience and more responsible use of that service. In addition to price transparency, other industries have started to explore fee discounts for specific behaviors. For example, the auto insurance analogy mentioned earlier points to an equitable distribution of cost where persons who behave responsibly save money and those that do not pay more. This is a practice health care needs to emulate.

Applying elements of these philosophies to corporate health care strategies will help employers control costs in the short and long term. If implemented appropriately, employers can move toward defined contribution benefit structures, which will place greater responsibility in the hands of employees and thus simplify the budgeting process. Unlike most cell phone and auto insurance companies, employers will need to provide an independent and highly personalized support system for employees to manage their increased financial stake as the market evolves into an era of consumer-owned health.

Examples of Applied Transparency

Using health plan premiums as a proxy for the total cost of individual health care, a health services company can integrate transparency across these interconnected services:

1) **Finance.** In this model, individuals are engaged in planning their current and future health care costs. Not only do employees need to understand the total cost of health care (health plan premiums) and how to pay for it; more important, they need to understand that their behaviors are linked to the total costs of their health plan. The mechanism to help them understand the link is financial incentives. Creating a responsible level of accountability, whether through rewarding positive behaviors or punishing negative ones, will require the individual’s understanding of the behavior/cost link. Financial rewards are useful tools to engage individuals and help them appreciate the link.

2) **Health and Well-Being Programs.** Information gathered from available and appropriate sources such as claim data, health surveys, biometric screenings, personal profiles and buying preferences should be used to design personalized wellness plans. Such plans enable people to adopt and maintain behaviors that improve their health, earn financial incentives – which can be used to pay down premiums – and ultimately lower their health care costs.
3) **Independent Advocacy.** With increased responsibility and insight into the cost of health plan premiums, individuals will require a resource that they can turn to for information and guidance on how to access and navigate the health care system. Individuals will require assistance with all aspects of their health care - from which health plans would serve them to which wellness program may be most appropriate. The consumer-owned health model creates a more trustworthy resource because an independent organization - not an insurance company - provides support and advice, thereby removing any perception of conflict of interest.

Employers that adopt such an integrated strategy will deliver a more personalized and supportive benefit. Facilitating a consumer-owned health experience will help employers move toward defined contribution benefits while improving employee accountability, satisfaction - and most important, health.

**Implementing and Communicating a Consumer-Owned Health Program**

To communicate and implement a consumer-owned health program, HR staff can do it themselves or contact a vendor that integrates the three primary service elements:
1) finance (behavioral incentives and premiums);
2) health and well-being programs; and
3) independent advocacy.

Either way, these services should be delivered separately from health plans to ensure an independent approach to advocacy and information. This allows employers to find best-in-class claims administration and network contracts while providing independent and highly personalized information and support through a consumer-owned health strategy.

**High-Level Checklist: Introducing a Consumer-Owned Health Program**

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<th><strong>Develop a Business Case for Consumer-owned Health</strong></th>
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<td>• Review and communicate the cost of health care with executive management, detailing how employers can’t sustain continuing medical cost increases. Show the effects of these higher costs on company budgets.</td>
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<td>• Provide information on how employees and their families can help control the total cost of individual health care through incentive-supported behavior change and decision support. Employers can influence both cost and satisfaction through empowering their employees to make informed decisions.</td>
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**Identify Resources**

• HR and benefit executives need to determine if their staff can implement, integrate and administer the services internally. If this is not possible, contracting with a vendor to fulfill all or a portion of the program is affordable when evaluated against existing services from disparate vendors.

**Set a Timeline for Implementation**

• The program can be implemented at any time. However, if the program includes the communication of premiums, incentive programs and health plan enrollment support, the implementation works best when combined with benefit plan effective dates.

**Develop an Incentive Strategy**

• Determine the amount and types of behaviors to be included in an incentive program. This should include evaluation of existing health plan premiums, employees’ needs, budget options and potential return-on-investment.
Conclusion

Linking transparent health care premiums and behavior-based incentives will help achieve consumer-owned health. Combined with personalized health programs and advocacy, employees will become aware of the total cost of health care. Employers will then be able to transition from an employer-sponsored system to a defined contribution benefit structure in which consumers take more ownership. The effect of these intertwined attributes will simplify benefit administration, create more predictable health care budgeting, and personalize each individual’s health care.