



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

# A Typology of Benefit Designs

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

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## A Typology of Benefit Designs

The term “benefits” refers to the services and other medical care covered under any health insurance plan. “Benefit designs” are the rules that structure insurance plans and dictate how consumers can gain access to covered services. They determine which services will be covered by the health plan, from which providers a consumer can receive a service, and the cost-sharing amounts, such as deductibles, co-payments, or co-insurance, for which the consumer is responsible.

In the employer-sponsored insurance market, the employer and the employee jointly cover the cost of health insurance through a premium contribution. Typically, the employer’s share of the premium cost is higher than what the employee is required to contribute. Employers offer insurance coverage to employees as a nontaxable fringe benefit in place of additional taxable income. Therefore, because the employer makes the premium contribution in place of wages, it is essentially a blind cost to the employee. Experts argue that these “hidden” costs of care to consumers have led to moral hazard, the tendency of individuals to consume more services than they would otherwise because they do not fully pay for the services they receive. Thus, recent benefit designs have created financial incentives for consumers to be more cost sensitive and to steer them toward appropriate use of lower-cost, higher-quality care.

Almost all benefit designs leverage cost-sharing: to shift a portion of the financial responsibility for care onto consumers, consumers pay a portion of the cost of covered benefits out-of-pocket at the point of service. These out-of-pocket costs are shaped by co-payments, co-insurance, deductibles, and out-of-pocket maximums. The higher the out-of-pocket cost to the consumer, the lower the total premium and vice versa. Therefore, cost-sharing also can be used to control premium inflation. In theory, cost-sharing can influence consumer behavior, assuming consumers possess adequate information to distinguish between high- and low-value care. However, the RAND experiment demonstrates that people often seek less care if they pay more, regardless of the value of the service (Brook et al. 2006). To help consumers distinguish between high- and low-value care, low cost-sharing is generally tied to low-cost and high-value services and high cost-sharing is tied to high-cost and low-value services.

Benefit designs featuring cost differentials for particular services or providers may reduce inappropriate use of care (often referred to as *overuse*) or promote appropriate use of underused beneficial services, such as some preventive care. For instance, after meeting the deductible, a non-emergent visit to the emergency room may be subject to 30 percent co-insurance, but a visit to a primary care physician may be covered at 100 percent (0 percent co-insurance). Without these financial differentials to draw attention to distinctions among their choices, consumers may be unable to distinguish between effective and ineffective services. However, if a patient is willing to absorb the cost of services, benefit designs will not stop a provider from performing a procedure or prevent a patient from receiving a service (Kongstvedt 2015, 39).

Other benefit designs use a different financial mechanism to guard against unnecessary use—what we call “contingent coverage.” Under contingent coverage the consumer’s portion of the cost of services is dependent on obtaining authorization from a qualified entity, such as a payer or provider, before receiving care. Requiring consumers to receive approval for services or drugs that are high cost or that provide limited clinical benefits ensures protocols are in place to control service use. In addition, these guardrails can have significant financial implications for consumers; if the care is not authorized, the consumer may face severely reduced coverage or no coverage at all for service.

Both general cost-sharing and contingent coverage are intended to use financial incentives to affect how consumers seek health care services or select providers. We present a typology of benefit designs focused on these two aspects (table 1). The typology will highlight the array of options available for health plan sponsors who wish to motivate changes in consumers’ behavior, particularly supporting and aligning consumers’ incentives with the incentives providers experience through payment.

## Why Create a Typology of Benefit Designs?

Benefit design is evolving and expanding rapidly. As more options and structures arise, we must establish a common understanding for both those interested in implementing them (the payer or purchaser) and those directly affected by them (consumers).

A typology of benefit designs also can support efforts to align consumers' incentives with those of health care providers, payers, and purchasers. Understanding the array of benefit designs in the market can help employers and other health care purchasers, as well as consumers, understand the options available, the trade-offs among them, and where incentives most align across benefit designs. In addition, given the rapid rise of alternative forms of provider payment, such a typology can help purchasers and others determine how best to align benefit designs with payment approaches to make delivery system reforms more comprehensive and effective.

Last, by examining the benefit designs in use and providing a framework for classifying them according to their relevant dimensions and characteristics, we hope to enable advancements in health care purchasing strategies that support higher quality and more affordable care.

## Challenges in Creating a Useable Typology of Benefit Designs

In developing a typology of benefit designs, our first step was to establish criteria for determining what we should and should not include. There is significant room for innovation and experimentation in aligning incentives for health care consumers with incentives for health care providers (such as those under alternative payment methods). Our typology includes mechanisms that affect consumers' care decisions through financial incentives. This limited our typology to benefit designs that feature cost differentials intended to encourage consumers to seek high-value care, as well as designs in which the consumer's portion of the cost of services depends on obtaining authorization from a qualified entity. We also limited the typology to designs that have already been implemented in the United States and are, therefore, not merely theoretical.

Some mechanisms, such as certain aspects of utilization management, wellness incentives, and transparency, are put in place to manage consumers' use of health care services but do not affect consumers' financial liability. Consumers' out-of-pocket costs do not change whether they choose to use these mechanisms. Other design considerations, namely carve-outs, offer services through an

outside vendor and may structure or administer benefits differently than service offered through the regular medical plan; however, a carve-out itself does not necessarily alter consumers' benefits. Mechanisms that attempt to change consumer behavior but do not leverage financial incentives can still have an effect, but they do not meet our criteria. As such, we list some examples below, along with more detailed explanations for why we exclude them from the typology.

## Utilization Management

Utilization management generally refers to activities by which the payer manages and reduces medical costs associated with the inappropriate use of services. These activities, among others, include precertification, preauthorization, case management, and demand management, which vary in how they involve the consumer or patient.

The utilization management techniques that directly affect consumers' benefits or create financial incentives to receive or avoid certain care are what we call contingent coverage, whereby the consumer's cost of care depends on the health plan's or provider's approval. For example, precertification, preauthorization, and continued stay review are protocols set by health plans that first determine whether the care is medically necessary, and then determine the patient's share of the cost. Generally, if patients do not receive prior approval but continue with the treatment, they must pay the full cost of care out-of-pocket. With these utilization management practices, patients' benefits and financial liability are largely affected by health plan or provider approval; therefore, these practices fit in our typology.

However, not all utilization management practices directly affect consumers' benefits or financial liability for care, and we have excluded those that don't from typology. For example, case management involves enrolling high-cost patients in programs that manage and coordinate their care between their health plans, their providers, and other non-health professionals to deliver higher-quality, more seamless care. Demand management services are intended to reduce consumers' need for health care services (Kongstvedt 2013, 183); these can include nurse advice lines, self-care or self-evaluations, and shared decision-making, among other strategies. Although excluded, these utilization management practices can increase the value of care delivered to patients. While on their own, case management and demand management services do not inherently change consumer benefits, these services can support benefit designs.

## Wellness Incentives

Similarly, wellness incentives rarely affect consumer cost-sharing for medical services. Instead, they encourage consumers to become more aware of their health and to adopt healthier behaviors, for example, through a weight loss or smoking cessation program. The incentive is usually a surcharge or contribution by the employer to an employee's health savings account (HSA). Employers also can impose financial "penalties," in the form of lower contributions to the HSA, if employees do not participate. Consumers can often use HSA funds to cover their share of any medical care costs, but the funds do not direct the consumer to choosing a higher-value provider or service.

## Transparency

While providing consumers with information on health care quality and costs is essential for certain health insurance benefit designs to function, we did not classify transparency as part of this typology. Transparency is not a benefit design in itself, but rather a supportive element forming the foundation of many benefit designs. Second, transparency does not generally affect consumers in terms of access to care or cost-sharing arrangements. In addition, most research suggests that price and quality information is much more likely to change consumers' care-seeking behavior when it is paired with incentives (financial or otherwise). However, without such information consumers would be unable to distinguish between services or providers, and be unable to understand how their benefits coverage may vary with their choices.

## Carve-Outs

Some classify carve-outs as benefit designs in which health plan sponsors offer services for certain conditions or clinical areas (e.g., behavioral or mental health) through a separate payer or vendor with expertise in that area. However, by definition, a carve-out does not inherently change consumers' benefits for carved-out services; rather, the separate payer or vendor has the ability to alter the way those benefits are administered or structured. For example, if pharmaceuticals are carved out to pharmacy benefits managers, they may create a tiered formulary for covered drugs, a structure that the plan sponsor may not have offered if pharmaceuticals were covered under the medical insurance benefits. Despite the popularity of carve-outs, the ACA's focus on care coordination and better understanding of the relationship between physical and mental health have spurred a renewed interest in "carving in" services. Although both carve-outs and carve-ins could be more compatible with provider

contracts that hold them accountable for patients' total cost of care, neither approach inherently changes consumers' benefits for those services or requires financial incentives to drive decision-making. Therefore, we do not include carve-outs in our typology.

## **Ideas in Theory, but Not in Practice**

Innovative new ideas for benefit designs could affect consumers' health care choices and use, such as two theoretical nuances that build on reference pricing and value-based insurance design. Both are for patients with high-cost conditions who have met their deductibles and face limited cost-sharing for the remainder of the plan year. The first, called split benefit design, provides patients with a cash rebate if they choose less expensive treatments. Patients forfeit the rebate if they choose more expensive options.<sup>1</sup> The second, a variation of this idea by Chernew, Encinosa, and Hirth, not only provides a financial reward when patients select less expensive services, but also a penalty when patients choose more expensive services (Chernew et al. 2000). While these models are interesting, our research suggests that they have yet to be implemented. As a result, we considered it too premature to include them in the typology; however, we look forward to keeping an eye on the development of these designs.

## **A New Typology of Benefit Designs**

In this section, we present a new typology of benefit designs. As mentioned previously, the benefit designs we include are those that consumers view as relevant, specifically because the designs are intended to affect consumers' use of care by imposing financial liability. These include benefit designs featuring cost differentials intended to encourage consumers to seek high-value choices among services or providers. We also include those designs we call contingent coverage, in which the consumer's portion of the cost of services depends on obtaining authorization from a qualified authority, such as a payer or provider, before receiving care. Again, the typology focuses only on designs that have the potential to change consumer behavior, which also has implications for alignment with payment reforms and thus their success. Therefore, the typology is split into two categories: cost-sharing and contingent coverage.

# Cost-Sharing

Cost-sharing is the consumer's out-of-pocket portion of the cost of covered benefits owed at the point of service. These out-of-pocket costs can take the form of co-payments, co-insurance, and deductibles and are subject to out-of-pocket maximums. Co-payments are fixed dollar amounts that the patient must pay at the point of service. Co-insurance is calculated as a percentage of the total amount for a service that a patient must pay, and can have a more drastic effect on service use because the amount is relatively uncertain. Deductibles require patients to pay 100 percent of the cost of care they receive until they reach an established amount—the deductible. And an out-of-pocket maximum is the total amount the patient can pay out-of-pocket for care. Once that amount is reached, the health plan pays 100 percent of the costs incurred.

In cost-sharing benefit designs, the health plan establishes the consumers' share of the cost—through varying consumer co-payments, co-insurance, or deductibles—for particular services and providers before they seek care. By using these mechanisms, payers intend influence consumers to seek high-value services and care from high-value providers.

- **Value-based insurance design (V-BID)** is built on the principle of lowering or removing financial barriers to essential, high-value clinical services based on the tenets of “clinical nuance.” These tenets recognize that (1) medical services differ in the amount of health they produce, and (2) the clinical benefit derived from a specific service depends on the consumers using it, as well as when and where they receive the service. Therefore, a specific service that is beneficial to a certain population may not be beneficial to all (e.g., a stent would be beneficial for a patient with a myocardial infarction but could be intrusive and unnecessary for others without a clear clinical indication). V-BID aligns consumers' out-of-pocket costs with a services based on its “relative value” for a consumer or population. Therefore, consumers' out-of-pocket costs are lowered for services considered beneficial to them, often based on long-established quality standards. In theory, V-BID also could raise consumers' out-of-pocket costs for non-beneficial services, though this is not common.
- **High deductible health plans (HDHPs)** require consumers to cover 100 percent of their health care costs up to a certain amount—the deductible—at which point other cost-sharing arrangements, such as co-pays and co-insurance, begin. According to IRS standards, a plan is considered a high deductible plan, and eligible for a tax advantaged HSA, if the out-of-pocket maximum limit is \$6,450 for individuals and \$12,900 for families and if the deductible is between \$1,300 and \$3,350 for individuals and between \$2,600 and \$6,650 for families.<sup>2</sup>

While consumers who choose high deductible plans pay more out-of-pocket for their care before meeting their deductible, they typically have a lower premium contribution. HDHPs are often paired with a tax-advantaged account that must meet IRS standards. A health reimbursement account reimburses the employee for medical expenses approved by the employer. A health savings account is an individual's tax-exempt account to be used for medical expenses as defined by the IRS, with contributions made by the consumer and his or her employer. HSAs are more commonly used with HDHPs, but only for plans that meet IRS requirements for the size of the deductible.

- **Tiered networks** are created by designating groups of network providers into levels, or tiers, ideally based on the value—cost and quality—of the care they provide. Providers that deliver high-value care are in the highest tier, while those that provide low-value care are in the lowest tier. Accordingly, tiered networks also are called high-performing networks. In general, to channel consumers to high-value providers, payers offer differential out-of-pocket costs per tier. Patients that seek care from higher-value, or preferred, providers have lower out-of-pocket costs. Differential cost-sharing by tier allows the consumer to make trade-offs between the choice of provider and the cost of care.
- **Narrow networks** are created by using cost and quality criteria to select health care providers from a broader network and then establishing strong incentives for consumers to seek care from that more limited set of providers. Consumers face high cost-sharing and the risk of balance billing—in some cases forgoing insurance coverage—if they receive care from a provider outside the narrow network (unless a payer makes an ad hoc agreement). Therefore, consumers are essentially limited to seeking care from a defined group of health care providers. Narrow networks are typically an elective product consumers can choose when enrolling in a health plan. Consumers generally choose to enroll in narrow networks to take advantage of lower premiums.
- **Reference pricing**, rather than fixing out-of-pocket costs, establishes a standard price for a drug, procedure, service, or bundle of services and requires that the plan member pay any allowable charges above this price. Therefore, the consumer's out-of-pocket costs are the difference, if any, between the actual price of the services received and the established reference price. Generally, the payer provides consumers with a list—often on a web site—that reflects providers' prices and whether they meet or exceed the reference price. This allows consumers to make a choice concerning their care, enabling them to weigh the trade-offs between their expected out-of-pocket costs and the provider from whom they wish to receive

health care services. Reference pricing can be applied to services that vary substantially in price and are commonly considered to have little variation in quality, for example, “commodity-like” services such as laboratory services, colonoscopies, MRIs, and imaging. Reference pricing also can be applied to complex, high-price items for which quality can vary substantially, such as hip or knee replacements or maternity care.

- **Centers of excellence (COEs)** are designated groups of providers that meet high standards for both the quality and the cost of care for a particular service or set of services. Health care payers designate COEs for procedures and other services for which quality and cost vary significantly. Common examples are non-emergent specialty services, such as total joint replacement, heart surgeries, spine surgeries, bariatric surgeries, cancer, and transplants. In return for COE designation, which they hope will attract more patients, the provider group may be willing to accept a lower negotiated price or an alternative payment arrangement, such as bundled payment. Therefore, COEs allow the purchaser or health plan to offer their members high-value care and by contract can establish precise performance expectations.
- **Benefit designs for alternative sites of care** are for locations where patients can receive care at a lower cost than from traditional venues, such as the hospital. Examples of alternative sites include worksite clinics, urgent care centers, retail clinics, and telehealth services. In addition to being less expensive for payers and purchasers, alternative sites offer patients lower out-of-pocket costs than traditional sites like the emergency department or other hospital-based clinics. Alternative sites also can be more convenient for the consumer than traditional sites of care.

## Contingent Coverage

This category consists of benefit designs wherein the consumer’s portion of the cost of services depends on obtaining authorization from a qualified authority, such as a health plan or a provider, before receiving care. Health plan or provider authorization is generally based on medical necessity and can prevent the use of services or drugs that either provide limited clinical benefits or can have dangerous side effects. The denial or approval of care determines the level of coverage for that service, which affects patients’ ability to pay for the care they want.

- **Preauthorization**<sup>3</sup> requires patients to receive approval from their designated primary care physician (PCP) before receiving care from specialist providers. Accordingly, this PCP also is

called a gatekeeper in the HMO context. The intention is to ensure that any specialty care the patient would like to receive is necessary. For example, preauthorization might be required for patients presenting with low back pain wanting to see an orthopedist.

- **Step therapy** is intended to control the costs and risks posed by particular treatments, by requiring patients to start with the most cost-effective treatment and move to more costly or risky treatments if their payers determine it necessary. For example, under step therapy, a health plan may require a patient with low back pain to receive physical therapy before allowing a more intensive procedure, such as lumbar epidural steroid injections. Step therapy can be used for many services but is most commonly used for prescription drug treatments.
- **Precertification**<sup>4</sup> requires consumers to receive permission from their health plan before receiving a particular service, to determine whether the care is medically necessary. If the care is denied by the health plan, consumers must pay for the full cost of care out-of-pocket if they follow through with it.
- **Continued stay review** is a protocol health plans establish for inpatient admissions to a hospital or another facility that requires regular review of a patient's stay. Health plans can determine whether they will cover the costs associated with the stay based on an individual patient's need. Another variation on this theme is caps on the quantity of a service, such as allowing a limited number of physical therapy visits for any one diagnosis. Caps are put in place to contain health care spending as well as to direct consumers to seek alternative care if the current services are not resolving the patient's need.

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## A Typology of Benefit Designs

### Cost-Sharing

- Value-based insurance design
- High deductible health plan (w/ or w/out tax-advantaged account)
- Tiered networks
- Narrow networks
- Reference pricing
- Centers of excellence
- Alternative sites of care

### Contingent Coverage

- Preauthorization
  - Step therapy
  - Precertification
  - Continued stay review
- 

## Glossary

**ambulatory surgery center.** Health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting.<sup>5</sup>

**benefit design.** In a health insurance plan, the benefit design is a set of rules that describe which health care services will be covered by the plan, the providers from which a member of the plan can receive a covered service, the cost-sharing amounts a member of the plan will be responsible to pay when receiving a service, and any other requirements or restrictions on how or when the plan member can receive covered health care services.<sup>6</sup>

**carve-out.** A set of services paid for in a way different than other services. For example, a single global payment might be paid to a provider for all services, except for a list of specific services or conditions that would still be paid on a traditional fee-for-service basis or through individual bundled payments. A carve-out may apply to the delivery of services as well as to payment. For example, many purchasers and payers have “carved out” behavioral health services and require that patients receive them from different providers than those delivering physical health services; the behavioral health providers are paid separately and in different ways than the physical health providers.<sup>7</sup>

**case management.** The identification and management of high-cost patients by physicians or other health care professionals, as well as care coordination over the long term, spanning any health care services the patient needs (Kongstvedt 2013, 183).

**co-insurance.** Co-insurance is a form of cost-sharing; the co-insurance amount is calculated as a percentage of the total allowed amount for a service. The patient is required to pay the provider a co-insurance amount to receive a service; the insurance plan or another payer furnishes the remainder of the payment. The patient is expected to pay an additional co-insurance amount each time an additional service is rendered.<sup>8</sup>

**co-payment.** A co-payment is a form of cost-sharing. It is a fixed dollar amount that a patient is required to pay to a provider to receive a particular service; the insurance plan or other payer furnishes the remainder. The patient is expected to pay an additional co-payment each time an additional service is rendered.<sup>9</sup>

**cost-sharing.** Cost-sharing is the amount that a patient pays out-of-pocket to a health care provider in return for a service, with no reimbursement from a third-party payer. The four principal approaches to cost-sharing are co-payments, co-insurance, deductibles, and balance billing.<sup>10</sup>

**deductible.** A deductible is a form of cost-sharing. Under a health plan with a deductible, the patient is required to pay 100 percent of the cost of all services until the patient's total spending reaches the deductible. At this point, other cost-sharing rules such as co-payments and co-insurance apply. Some services, such as preventive care, may be exempt from the deductible requirement; for those services, the patient may be expected to pay other forms of cost-sharing, or the patient may have no cost-sharing at all.<sup>11</sup>

**demand management.** Demand management serves to lower consumers' need for health care services. Demand management includes nurse advice lines, self-care or self-evaluations, and shared decision-making (Kongstvedt 2013, 182–183).

**health reimbursement account (HRA).** A health reimbursement account reimburses the employee for medical expenses approved by the employer.

**health savings account (HSA).** A health savings account is an individual's tax-exempt account to be used for medical expenses only, with contributions made by consumers or their employers.

**out-of-pocket maximum.** In a health insurance plan, if the cumulative amount of a patient's cost-sharing payments (i.e., co-payments, co-insurance, and deductibles) during a specified period (usually a year)

reaches the out-of-pocket maximum or out-of-pocket limit, the health plan pays 100 percent of the patient's health care costs for the remainder of the period.<sup>12</sup>

**premium.** A premium is the amount that must be paid for your health insurance or plan. Consumers and purchasers usually pay a premium monthly, quarterly, or yearly.<sup>13</sup>

**retail clinics.** Operating out of pharmacies, grocery stores, and big box stores, retail health clinics provide care for simple acute conditions, typically delivered by a nurse practitioner.<sup>14</sup>

**telehealth.** The use of technology to deliver health care, health information or health education at a distance. Telehealth is a way of increasing contact between a patient and the medical system.<sup>15</sup>

**transparency.** The availability of provider-specific information on the price and quality of health care services to consumers and other relevant parties, as well as the availability of patient-specific health information to consumers and their health care providers.<sup>16</sup>

**worksite clinic.** Worksite clinics offer health services at the workplace, but each clinic varies based on employer and workforce.<sup>17</sup>

# Notes

1. Michael Chernew and Aaron Schwartz, “Innovations in Health Insurance Design,” *Incidental Economist* (blog), February 25, 2015, <http://theincidentaleconomist.com/wordpress/innovations-in-health-insurance-design/>.
2. “IRS Provides Guidance on 2015 High Deductible Health Plans Out-of-Pocket Maximum Limits,” press release, April 25, 2014, Blue Cross Blue Shield of Michigan, accessed April 28, 2016, <http://www.bcbsm.com/health-care-reform/reform-alerts/irs-provides-guidance-on-2015-high-deductible-health-plans.html>.
3. The terms “preauthorization” and “precertification” are used variously. Some use the term “prior authorization” to describe either or both of these methods. To distinguish between the two, we adapt both terms and definitions in this typology from Kongstvedt P, *Essentials of Managed Health Care*.
4. The terms “precertification” and “preauthorization” are used variously. Some use the term “prior authorization” to describe either or both of these methods. To distinguish between the two, we adapt both terms and definitions in this typology from Kongstvedt (2013).
5. “ASCs: A Positive Trend in Health Care.” Ambulatory Surgery Center Association, accessed April 28, 2016, <http://www.ascassociation.org/advancingsurgicalcare/aboutasc/industryoverview/apositivetrendinhealthcare>.
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