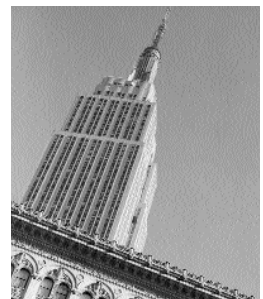
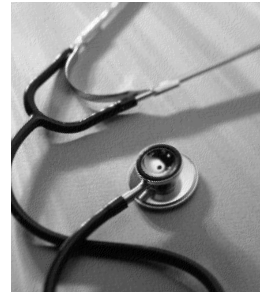
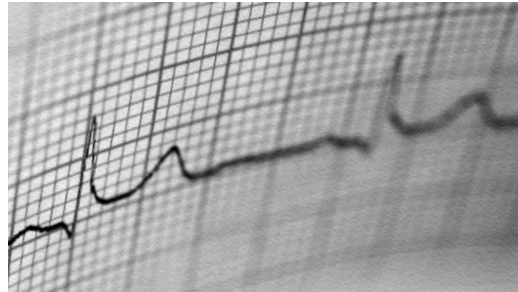


Meeting Consumers Where They Are: Patient Engagement in New York's Evolving Commercial Insurance Market



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Meeting Consumers
Where They Are:
Patient Engagement
in New York's
Evolving Commercial
Insurance Market

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Foreword

Periodic Affordable Care Act enrollment reports, received raptly by the media and reviewed carefully by health reform watchers, are one way to track progress made under the ACA. Here in New York and across the nation, those numbers show reform taking hold: the ranks of the uninsured are dropping to historic lows—an overarching goal of the legislation. But with enrollment growing steadily, the focus is shifting to other important goals: improving quality, the health of populations, the patient experience with care, and controlling costs.

In this special report, supported by the New York State Health Foundation, researchers from the Fund's Health Insurance Project examine a promising strategy for achieving those goals: enhancing patient engagement. This strategy, with us for a while, has been embraced by diverse segments of our health care system, all coalescing around ways to help consumers become active participants in improving or maintaining their health. *Meeting Consumers Where They Are: Patient Engagement in New York's Evolving Commercial Insurance Market* presents a broad picture of these efforts, coupled

with a review of pertinent literature evaluating such activities and an analysis of new data on health plan investments in quality improvement, and concludes with a discussion of opportunities for engaging patients and challenges to doing so.

This review comes at a pivotal time. Provider groups in the vanguard of delivery system reform are partnering with health plans to assume increasing responsibility for care management and other important tasks. At the same time, tens of thousands of new enrollees have joined New York's depleted individual market, rejuvenated by available subsidies and new product designs. Effective patient engagement, discussed here, will be critical if New York is to sustain reform over the longer term.

As always, we welcome your thoughts and comments, and hope you find this report a useful contribution.

JAMES R. TALLON, JR.
President
United Hospital Fund

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The New York State Health Foundation supported this work. Many individuals at the New York State Department of Financial Services, New York State Department of Health, and New York State of Health took time out of their busy schedules to share their knowledge and opinions. Many representatives of trade associations and health plans were also generous with their time and insights, including those of: Capital District Physicians Health Plan, Cigna,

EmblemHealth, Excellus BCBS, HealthNow BCBS, Independent Health Association, MVP Healthcare, North Shore-LIJ CareConnect, and Oscar Health Insurance. We're also grateful to a number of other individuals with whom we spoke, too numerous to mention, who improved our understanding of these issues. Finally, many thanks to the Fund's Andrea L. Lucas and Miles P. Finley for editorial support.

Part I: Introduction

Like a river that grows wider as it is joined by tributaries along its route, the concept of patient engagement has coursed through health policy for more than a decade; a recent analysis identified nearly 60,000 papers on patient engagement and related terms.¹ An early study traced its headwaters to the rise, in the early 2000s, of consumer-directed health plans pairing higher cost sharing for consumers with incentives to limit spending, and the Chronic Illness Care Model, which stressed training patients to manage their chronic conditions.² These two developments put “patients and consumers in a key role for influencing health care quality and costs.”³

Interest in patient engagement has grown as research has revealed a link between levels of patient activation (a way to measure engagement) and positive health outcomes and reduced costs,⁴ and as a patient-centered health system has become an urgent national goal.⁵ Proponents of patient engagement make up perhaps health care’s biggest club: its members include health system analysts, academics, policymakers, regulators, health plans, provider groups, information technology advocates, patient and consumer activists, and employer groups—along with the burgeoning number of vendors and entrepreneurs that serve them, or hope to.

This report examines patient engagement efforts in the commercial insurance market, and the access consumers have today to the providers, benefits, tools, and services that help them take an active role in improving or maintaining their health and realizing the full value of their health benefits—our working definition of patient engagement, distilled from literature on the subject. We organized our analysis according to four forces shaping benefits and services available to patients: the regulatory framework,

employers, health plans, and providers. For those accustomed to discussing patient engagement only within the confines of behavioral economics or behavior modification, this represents a broader focus. We also highlight current research on the potential quality and cost impact of effective engagement in a patient-centered health system, and conclude with observations on some opportunities to improve patient engagement.

Patient Engagement in Context

Patient engagement means different things to different players in the health care system. Analysts have sorted through voluminous references and competing visions to develop a consistent definition and framework for it.⁶ Our approach was informed by the Engagement Behavior Framework^{7,8} and the Patient Activation Measure.⁹ The Engagement Behavior Framework establishes 42 tasks or competencies, within 10 categories, characteristic of engaged patients. These categories include “find safe, decent care,” “pay for care,” “promote health,” “get preventive care,” and “seek health knowledge.” Tasks in the “pay for care” category, for example, include “compare coverage options, match to personal values, needs, and preferences, and select coverage”; “seek health knowledge” calls for patients to “assess personal risk for poor health and disease” and “know personal health targets (e.g., blood pressure) and what to do to meet them.”

The Patient Activation Measure is a respected tool for measuring patient engagement, using answers to 13 questions to place respondents in one of four stages. A patient in stage II, for example, demonstrates that “I understand the nature and causes of my health condition.”

Both are important to this report because, in explicitly stating what their respective developers believe patients need for engagement, they provided a grounding for our assessment of activities and benefits meant to support such engagement.

We fleshed out this patient-centered focus through interviews with health plan representatives, brokers, regulators, providers, business leaders, and consumer advocates. We also reviewed regulatory filings, accreditation standards for plans and providers, health plan and wellness vendor marketing materials and websites, relevant State and federal statutes and regulations, and the extensive literature related to engagement. Two major themes emerged during the course of our review.

Providers Assume More Responsibility in Partnerships with Health Plans

First, health plans are seeking to engage patients directly, and are simultaneously engaging providers to engage patients through new delivery system models and payment methodologies. These groups of providers are taking on responsibility for core functions such as care management, sometimes in partnership with health plans, which might embed a nurse care manager within an individual practice. Many individuals we spoke with believe providers are much better positioned to effectively engage patients, since consumers may regard insurance company initiatives with

suspicion. But others praised effective health plan care and disease management programs, and questioned the capacity of providers and systems to take on these responsibilities now.

Growth in the Individual Market Calls for Effective Engagement

Second, Affordable Care Act (ACA) provisions have completely reinvigorated New York's moribund individual health insurance market. Over 408,000 individuals have enrolled in commercial coverage through New York's Exchange, New York State of Health (NYSOH),¹⁰ and the number of individual purchasers in the Exchange and non-Exchange markets is projected to reach nearly 900,000 when the ACA is fully implemented.¹¹ The significant growth of the individual market calls for careful attention from policymakers, and is a focus of this report. Individuals are shopping for coverage much more than before, signaling a more direct relationship between the plan and consumer than exists in employer-sponsored coverage, and the shopping experience itself is an opportunity for engagement. Significant cost sharing allowed under the ACA, and premium subsidies that do not go as deep as many would like, however, make it imperative to restrain the need for annual premium increases. Patient engagement is a promising tool for achieving this goal, but must be provided without some of the built-in advantages of employer-sponsored coverage.

Part II. Market Forces

New York's Regulatory Framework

The regulatory framework in place in New York, even before the adoption of the ACA, supported patient engagement in a number of ways. Two state agencies, the Department of Financial Services and Department of Health, jointly regulate health plans in terms of network adequacy, rate increase applications, the inclusion of a broad set of benefits without the exclusions and caps allowed in other states, and oversight of a number of important consumer protections, such as the right to appeal adverse decisions by their health plans. The agencies also make available to consumers a number of quality and patient satisfaction measurements, based on rigorous reporting standards for plans.¹²⁻¹⁴ But while finding the right provider is also an important activity of engaged patients, and motivated and tech-savvy individuals can access a significant and growing amount of hospital quality data provided by the Department of Health, only limited information on individual providers is available from the site.¹⁵

The affordability of coverage and the process of selecting a health plan are fundamental to engagement, and the ACA and New York State of Health have made a night-and-day difference. For individual purchasers, ACA premium and cost-sharing subsidies have dramatically improved the affordability of coverage,* although national studies indicate that ACA tax credits for small businesses have had less of an impact.¹⁶ Working closely with its sister agencies, NYSOH has used its authority to certify and contract with Qualified Health Plans (QHPs) to standardize

products, and has launched online tools allowing consumers to access financial assistance, shop, and compare and enroll in health plans.¹⁷

Prior to the establishment of NYSOH, shoppers had to contact each health plan individually, construct their own “apples to oranges” comparisons at the kitchen table, and submit a paper application to the plan of their choice. Now, NYSOH filters allow consumers to narrow choices among QHP products based on cost-sharing, family size, health plan, product design, premiums, and quality. Improvements added for 2015 include refined benefit descriptions and two new tools: “View Plan Now” allows individuals to window shop and compare up to three plans at a time without creating a personal account, and “Plan Compare” provides a printable document with single-page highlights of all products offered in a county, including side-by-side comparison of a health plan’s standard and non-standard plan options.^{18,19} People needing personal help could contact over 11,000 in-person assistors, navigators, and brokers throughout the state in 2015 to aid with shopping for a plan over the phone, in person, or online, and with completing electronic or paper applications.

NYSOH’s provider search feature allows consumers with personal accounts to filter plans based on participating providers, and also includes links to individual health plans’ “doc-find” tools. These plan tools contain listings and some basic information about participating hospitals, and additional information about other providers, such as hours, geographic location, and hospital affiliation. Some sites offer more:

*A total of 370,604 individuals enrolled in Qualified Health Plans through April 15, 2014. Within that group, three-quarters (or 273,888) received financial assistance to reduce the cost of their insurance. [New York State of Health. June 25, 2014. NY State of Health details information on the nearly 1 million who enrolled through the marketplace during the first open enrollment period [press release]. <http://www.healthbenefitexchange.ny.gov/news/press-release-ny-state-health-details-information-nearly-1-million-who-enrolled-through>.] Qualified Health Plans offered through NYSOH in 2014 were on average 53 percent less expensive than coverage New Yorkers purchased directly in 2013. [New York State of Health. June 25, 2014. *2014 Open Enrollment Report*. <http://info.nystateofhealth.ny.gov/2014OpenEnrollmentReport>]

CDPHP's, for example, lists providers with icons that identify those offering enhanced primary care or Patient-Centered Medical Homes, and allows searchers to link to customer satisfaction measurements for each provider.²⁰

Going forward, NYSOH and State regulators will continue to grapple with the challenge of shaping engagement tools for individuals and small groups in the marketplace while preserving alignment with the off-Exchange market—and leaving health plans room to compete, innovate, and differentiate themselves from competitors. Although the ACA loosened many of the strictures on New York's individual market, it added many new ones—standardized benefits, benefit descriptions, and cost sharing; metal tiers; minimum loss ratios; geographic rating regions; specified variations in premiums by family size; and electronic rate and form filings. Although these ACA requirements improved benefits for consumers and allowed New York regulators and NYSOH to streamline and automate benefit options, they have left health plans operating in what one plan official called “a pretty tight box” in terms of their ability to bring innovative products and benefits to the market. The narrow federal actuarial value targets for platinum, gold, silver, and bronze metal tiers, for example, mean health plans must design products within a plus-or-minus-two-percent actuarial value band. Many health plans also cited New York's prior approval process as problematic, expressing reluctance to offer a new product with attractive engagement features or networks in the market, out of a concern that renewal rates approved by regulators may not allow the health plan to offset higher-than-expected claims experience.

Employer Groups

Employers exercise a strong influence on the market. Large self-insured employers, whose benefit plans are mostly exempt from State insurance regulation due to ERISA preemption, capture all the savings when medical costs for workers are reduced, since there is no insurer assuming risk for claims, with whom savings would be shared. But employers of all sizes in self-insured and fully insured plans can reap benefits from healthier workers, including reduced absenteeism, lower costs for life, workers' compensation, and disability insurance, and improved productivity. We briefly examine three important strategies employer groups use to better engage and motivate workers to improve their health and help reduce costs: High-Deductible Health Plans, Value-Based Insurance Design, and workplace wellness or health management programs.

High-Deductible Health Plans (HDHPs)

High-Deductible Health Plans (HDHPs), sometimes known as Consumer-Directed Health Plans, a type of coverage increasingly popular with employer groups, seek to engage consumers by exposing them to the cost of services. At a minimum, the policies have lower premiums but carry higher deductibles. Certain types of HDHPs are often offered in conjunction with tax-favored savings options such as Health Savings Accounts²¹ that offset the higher deductibles and provide an incentive for enrollees to spend health care dollars prudently. Some, but not all, HDHPs offer policyholders tools to help shop for coverage, such as cost and quality information.

While the primary goal of HDHPs is controlling costs, there may be additional benefits as well, much like those that occur in other strategies designed to promote engagement, such as averting overutilization that can involve possible harms. Researchers have found, for example, that HDHP policyholders were more likely to inquire about whether a service was covered, ask for a generic drug instead of a brand name, and talk to their doctors about other treatment options and costs, but cost reductions were concentrated among low- or medium-risk enrollees.^{22,23} Other analysts question the capacity of individuals to control health care costs—something government, large employers, and health plans have struggled to do.²⁴ A landmark study indicates that greater cost sharing reduces spending, but discourages both low- and high-value care.²⁵ One large and more recent analysis confirmed that HDHPs curbed enrollee spending compared to traditional coverage, but also reduced preventive care, even though these services are not subject to deductibles.²⁶

Although New York lags behind other states in HDHP market penetration,²⁷ sales have been increasing, and ACA provisions overriding New York limitations on offering individual HDHPs could also increase their market share.† Officials at most health plans consider HDHPs to be “part of the solution” to the challenge of engaging patients, but some thought they “worked better for employers than employees,” as an offset to annual premium increases. Interestingly, one health plan, which had recently completed a survey of members using its IT tools, found HDHP policyholders to be the most actively engaged, in terms of shopping for lower-cost and higher-quality providers, calling the health plan with inquiries about services,

tracking out-of-pocket costs, managing their savings accounts, and taking advantage of other available online services—but also found these members to be the most dissatisfied with their coverage.

Value-Based Insurance Design (VBID)

Patient engagement requires consumers to both seek knowledge about any medical conditions and to access services needed to address those conditions. Value-Based Insurance Design (VBID) promotes patient engagement by removing economic barriers that might prevent consumers from learning about their health status, or by treating chronic conditions identified through preventive care.

Also known as Value-Based Benefit Design, VBID emerged in the early 2000s as a strategy to improve quality and temper costs by reducing cost-sharing requirements for high-value services, particularly drugs used to treat patients with chronic conditions,²⁸ with the goal of better adherence and avoided hospitalizations. Interest in VBID surged after early positive evidence emerged on the strategy’s effectiveness for employer groups;²⁹ many cases have been cited showing positive results for individual employers, particularly public ones (see “Value-Based Design in Oregon,” page 6). Yet only 27 percent of large employers responding to a 2013 national survey reported using VBID,³⁰ an adoption rate that one local business group found disappointing, attributing that result to mixed evidence of cost effectiveness and the need for solid clinical data to tailor programs, among other factors.³¹ One article cited the “intuitive appeal” of the strategy, but noted that “its impact on health care quality and costs remains to be conclusively established,”³² and another concluded “VBID may improve quality of care

† These provisions capped out-of-pocket costs at \$1,500 annually, below the HSA-eligible limit, but ACA cost-sharing levels for some metal tiers match HSA eligibility levels. [New York Insurance Law § 4321: NY Code - Section 4321: Standardization of individual enrollee direct payment contracts offered by health maintenance organizations. <http://codes.lp.findlaw.com/nycode/ISC/43/4321>]

Spotlight: Value-Based Design in Oregon

The Public Employees Benefit Board and the Oregon Educators Benefit Board (PEBB/OEBB), Oregon's largest purchasers of commercial coverage, design and administer benefits covering 283,000 enrollees.* In 2010, the OEBB and PEBB adopted a value-based design system with free preventive services, chronic care medications, weight management, tobacco cessation, and substance abuse treatment, and increased copayments for low-value, overused, and preference-sensitive procedures identified by an analysis of claims data.† Other innovations include administering biennial health risk surveys to identify members' health status, teaching members how to self-manage chronic conditions, promoting greater use of generic medications, advancing coordinated systems of care (such as Patient-Centered Medical Homes), and increasing the use of decision support tools to choose treatments based on value and outcomes.‡ Since implementing this model the OEBB and PEBB have reported significant improvements in health status. PEBB employees reported a 21 percent decrease in obesity, a 59 percent decrease in smoking, and a 55 percent decrease in tobacco use in 2012 compared with prevalence in 2007 before adoption of a value-based benefit design. OEBB employees reported a 21 percent decrease in obesity in 2011 compared with 2009.§

* Kapowich JM. November 2010. Oregon's test of value-based insurance design in coverage for state workers. *Health Affairs* 29(11): 2028-2032. <http://content.healthaffairs.org/content/29/11/2028.full>

† Oregon Health Authority. February 2013. *OHA health programs Public Employees' Benefit Board Oregon Educators Benefit Board 2013-2015 budget overview* [PowerPoint]. http://www.oregon.gov/oha/2013_2015BudgetMaterials/Public%20Employees%20Benefit%20Board%20Oregon%20Educators%20Benefit%20Board,%20Feb.%2014,%202013-2015.pdf

‡ Personal communication with OEBB/PEBB representative, October 10, 2014.

§ Oregon Health Leadership Council. Value-Based Benefits. <http://www.orhealthleadershipcouncil.org/value-based-benefits>

without greatly increasing or decreasing health expenditures."³³

Still, the free preventive services required under the ACA's Essential Health Benefits structure represent a strong affirmation of VBID, and the Department of Health and Human Services recently solicited ideas for VBID use in the Medicare Advantage program.³⁴ Recent research suggests that a focus on applying VBID disincentives to low-value but high-cost services, such as self-administered drugs, advanced imaging, and joint replacements, might help unlock the strategy's clinical and economic potential.³⁵

Workplace Wellness Programs

More than three-quarters of U.S. firms offered some type of workplace wellness or health management program in 2013,³⁶ and ACA provisions loosened federal anti-discrimination provisions in order to encourage such programs.^{37,38} Loosely defined, and available

from health plans, vendors in the overheated wellness industry,[‡] or a combination of both, wellness programs seek to identify employees at risk of chronic disease that could require costly interventions, such as hospitalization, and seek to engage them more actively in their own care.³⁹ In addition to tools to help employees learn about their health status and change health-related behavior, the programs usually provide incentives, such as cash, gift cards, merchandise, or enhanced employer contributions, or penalties, including higher cost sharing or lower employer contributions. Larger firms are more likely than small firms to offer wellness programs, and more likely to offer more comprehensive programs. For example, only 38 percent of firms with 3 to 24 workers reported diabetes management programs, compared to 88 percent of firms with 5,000 or more employees; smoking cessation programs (36 percent versus 91 percent) and behavioral coaching (30 percent versus 78 percent) show the same pattern.⁴⁰

‡ Reuters estimates workplace wellness programs to be a \$6-billion-a-year industry. [Begley S. January 6, 2014. *PepsiCo's workplace wellness program fails the bottom line: Study*. Reuters. <http://www.reuters.com/article/2014/01/06/us-wellness-workplace-idUSBREA0510R20140106>.] In response to demand, the NCQA now offers an accreditation program for wellness vendors. [<http://www.ncqa.org/Portals/0/Programs/Recognition/wellness-web.pdf>]

Although identifying healthy employees and helping them stay healthy is also an important focus,⁴¹ employer wellness programs that require at-risk workers to reach specific targets in areas such as smoking cessation or weight loss continue to garner support (see “On-the-Job Engagement”). So-called “outcomes-based” and “health-contingent” programs are subject to more stringent standards under complex federal rules than are “participatory” programs.^{42,43} Three employer programs were recently challenged in court by the federal Equal Employment Opportunity Commission (EEOC),⁴⁴⁻⁴⁶ but in the wake of strong pushback from business organizations the EEOC proposed preliminary regulations⁴⁷ that appear to resolve one issue in the litigation—that incentives and penalties within the ACA limits on premium differentials do not make a wellness program “involuntary” if the program is properly designed.⁴⁸ Supporters of outcomes-based programs believe they are more

effective and that employees respond better to “loss aversion”—losing a higher employer contribution, for example—than to incentives, but conclusive evidence is lacking and the approach does not enjoy strong public support.⁴⁹

Critics of these programs question the waste and potential harm of screening workers without risk, particularly the use of assessments involving blood and other lab tests;⁵⁰⁻⁵² they also cite the invasive nature of some questionnaires,⁵³ and the inflated cost savings often claimed by vendors. In a fascinating exchange, researchers traded comments on the value of the programs, and whether noncompliant employees paying penalties essentially funded the savings cited by supporters.⁵⁴⁻⁵⁶ Although a widely touted study of workplace wellness programs calculated a “return on investment” of \$3 for every \$1 spent on the program,⁵⁷ subsequent research presents a picture of modest improvements in measures

Spotlight: On-the-Job Engagement

Over 1 million U.S. workers were enrolled in Interactive Health’s NCQA-certified workplace wellness program in 2014, at over 2,200 organizations.* In New York, the 20-year-old company partners with third-party administrators, brokers, and health plans including CDPHP and Excellus. Marketing materials, backed by a study it commissioned, describe results such as a “20 percent lower medical spend compared to employers not using the program” and reduced workers’ comp and short-term disability expenses.†

Under its outcomes-based model, employees who agree to participate in the first year of the program receive an enhanced employer contribution to coverage of about \$50 per month, or \$600 annually, in exchange for completing a health risk assessment and undergoing extensive biometric testing focused on blood pressure, LDL, cholesterol, glucose, and triglycerides. Based on Interactive Health’s analysis of the tests, employees with critical health issues are contacted within 48 hours; all employees receive a personal risk score, along with health goals for the coming year. In order to be eligible for rewards the following year, employees must meet their individual health goals, such as maintaining their low-risk status or reducing their risk score by 60 percent, particularly by quitting tobacco use. A variety of tools help them do so, including a mobile fitness app, personal health record, decision aids, social sharing, online workshops and team challenges, and a weight log. About 30 percent of participants receive immediate and ongoing outreach and help from coaches with expertise in specific areas of health risk and behavior change. Overall, employees receive 30 “touches” a year online, over the phone, via mail, and through newsletters and other publications; the company, with permission, will fax members’ lab results to individual physicians.

According to Interactive Health officials, about 80 percent of employees agree to participate, and about 83 percent of participants reach their goals in a given year; some of those who make progress toward goals retain a portion of incentives, in “bracketed” employer incentive programs.‡ Although the cost of the program is about \$150 to \$200 per member per year, the program is promoted as “budget neutral” to employer groups using premium differentials, since “non-participants will offset the entire cost of the program.”

* Interactive Health. <http://interactivehealthinc.com/about-us/why-interactive-health/>

† Interactive Health and Zoe Consulting, Inc. *Study demonstrates Interactive Health Outcomes-Based Wellness Program lowers medical costs and increases productivity.* <http://interactivehealthinc.com/wp-content/uploads/2014/06/Claim-Study-Research-Summary-Interactive-Health.pdf>

‡ Personal communication with Interactive Health representatives, October 23, 2014.

such as weight loss, smoking cessation, and other health improvements, and very modest savings, based on incomplete data available from employer groups sponsoring the programs. A thorough federal study found a return on investment of only about 50 cents on the dollar, with the lion's share coming from traditional disease management programs.⁵⁸ And, although it seems as if hardly a day passes without news of an employer case study trumpeting a successful weight loss program, another recent study concluded that the higher the quality of research, the lower the return on investment found.⁵⁹ An updated federal study, released on the same day as the new EEOC rule, found no evidence that the “prevailing type of lifestyle management programs offered by employers” was effective or cost-effective enough to have a “meaningful impact” on health and costs, and recommended that future research should “investigate the potential of ‘personalized’ wellness programs, which match intervention modality, intensity, and objectives more closely to an individual’s beliefs, attitudes, and preferences, and of ‘public health’ type programs, which aim to create a culture of health in the workplace rather than targeting individuals.”⁶⁰

While the potential for improving bottom lines may be the factor that draws employer groups to wellness programs, mixed evidence on cost savings has not slowed the growth of these arrangements. Many employer groups have embraced a “culture of wellness,” seeing value in programs that increase the well-being of their employees without reducing the cost of coverage. Policymakers seeking to enhance patient engagement through investments or regulatory requirements are in a similar position, balancing the desire to reduce the cost of health care with the broader goal of improving population health.

Health Plans

Health plans are actively engaging enrollees in a variety of ways, in response to state regulatory and accreditation requirements, market competition, employer groups’ preferences, and plans’ own views of their missions and responsibilities to their communities.⁶¹ In order to provide an overview of these activities, we examined three areas: new requirements for reporting expenses related to “improving health care quality”; services and tools; and products, benefits, and networks. Taken together, these categories encompass many facets of patient engagement, such as care and disease management, education, behavioral change aids, and self-management tools.

Improving Health Care Quality Expenses

New ACA reporting requirements on minimum medical loss ratios^{62–64}—the proportion of total premiums health plans must pay out in medical payments to avoid providing a rebate to enrollees—are a useful jumping-off point for both a quantitative and qualitative analysis of activities and benefits associated with patient engagement. A new category of expenses reported to the National Association of Insurance Commissioners (NAIC), “improving health care quality expenses,” is treated as a benefit payment rather than an administrative expense. Within this category, health plans report in five subcategories: improve health outcomes; prevent hospital readmissions; improve patient safety and reduce medical errors; wellness and health promotion activities; and health information technology (HIT) expenses related to improving health care quality.

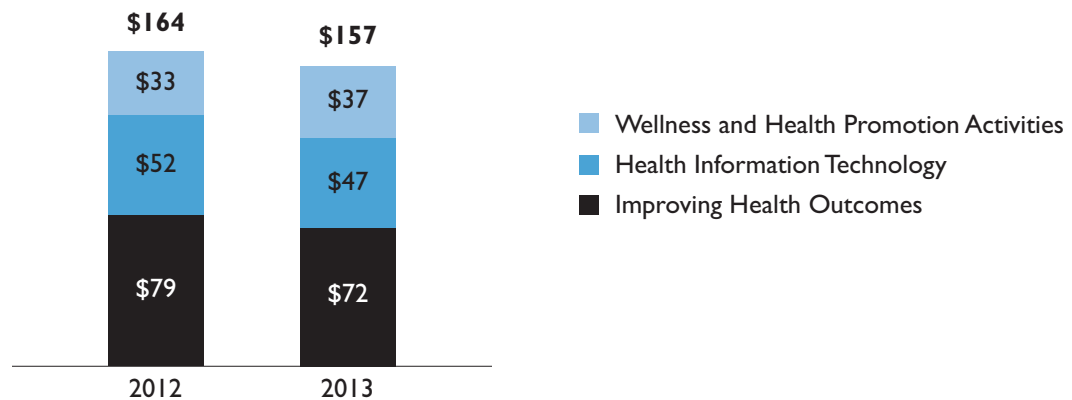
In 2013, major New York health plans reported over \$200 million in expenses in these subcategories in the individual, small, and large

group commercial markets. We selected three subcategories for further review, because they involve activities closely associated with patient engagement: improve health outcomes, wellness and health promotion, and HIT expenses related to improving quality. Together these account for almost 80 percent of total spending on improving health care quality.

Federal guidance defines “improve health outcomes” as patient-centered interventions rooted in the provision of effective care management, care coordination, and chronic disease management. Wellness and health promotion activity expenses include personal risk assessments, wellness/lifestyle coaching programs, public education campaigns performed with local health departments, and member rewards, incentives, and bonuses. And the HIT category includes investments to advance the ability of enrollees, providers, and insurers to communicate patient-centered information efficiently, rapidly, and accurately, to determine patient status and direct appropriate care.

We analyzed 2012 and 2013 NAIC reporting for major New York health plans in the commercial individual, small group, and large group markets.⁶⁵ As shown in the figure below, health plans reported a total of \$157 million in these expenses in 2013, a roughly five percent decrease from their 2012 total. But this overall decline is largely because of an enrollment-related decrease in spending by one Article 42 insurer, as spending increased in 2013 for Article 44 HMOs and Article 43 nonprofit insurers (see table, page 10) on both an aggregate basis and a covered-life basis. Spending to improve health outcomes accounted for the largest share of these expenses in 2013. Measured by type of licensee, Article 43 nonprofit insurers reported the highest spending (\$63 million), but Article 44 HMOs reported higher spending on a covered-life basis (\$50.49). Plan by plan, UnitedHealthcare licensees Oxford Health Plans, Oxford Health Insurance Company, and UnitedHealthcare Insurance Company reported the highest total spending (\$50.1 million), followed by EmblemHealth companies HIP and GHI (\$35.1 million) and

New York Health Plan Expenses for “Improving Health Care Quality,” 2012 and 2013 (Annual Expenses in \$ Millions)



Source: Author’s analysis of the 2012 and 2013 NAIC Supplemental Exhibits (rows 6.1, 6.4, and 6.5).

Note: In this analysis, we omit expenses to prevent hospital readmissions and to improve patient safety and reduce medical errors, and focus on three subcategories of “improving health care quality” expenses more directly associated with patient engagement: improve health outcomes, wellness and health promotion, and health information technology expenses related to improving quality.

Figures may not sum to total due to rounding.

Empire BlueCross BlueShield article 42 and article 44 HMO licensees (\$17.4 million). Independent Health’s HMO licensee reported the most spending per covered life, at \$181.26. While these expenses represented just a small fraction of health plans’ total revenues of about \$27 billion in these lines of business in 2013, they made up about 10 percent of all administrative expenses for the plans reporting the highest totals.

Services and Tools

The most obvious signs of health plans’ new focus on engaging enrollees are the retail customer service offices opened up by North Shore-LIJ Care Connect and EmblemHealth, for example, and the dedicated customer service units launched by many plans.^{66,67} Independent Health’s “Red Shirts” promise to “make health care easy,”⁶⁸ and HealthNow BCBS (the parent company of BlueCross BlueShield of Western

New York Health Plan Expenses for “Improving Health Care Quality,” 2012 and 2013

Health Plan	2013 Expense	2012 Expense	2013 Expense per Covered Life	2012 Expense per Covered Life
Art. 44 HMOs				
Aetna Health Inc.	\$3,074,557	\$2,428,834	\$50.83	\$39.63
CDPHP	4,439,425	4,700,130	41.05	39.77
Empire BCBS HMO	2,272,021	1,994,487	27.88	20.20
Independent Health Association	10,442,087	9,184,036	181.26	146.32
Managed Health, Inc.	36,433	N/a	50.53	N/a
MVP Health Plan, Inc.	3,762,085	1,937,054	36.18	127.90
Oxford Health Plans, Inc.	10,826,962	9,382,930	38.97	30.79
<i>Art. 44 Subtotal</i>	<i>34,853,570</i>	<i>29,627,471</i>	<i>50.49</i>	<i>44.83</i>
Art. 43 Nonprofit Insurers				
CDPHP Universal Benefits, Inc.	6,468,118	4,669,741	40.42	36.41
Excellus Health Plan, Inc.	11,660,474	6,256,305	11.79	6.03
Group Health Inc.	19,028,927	18,012,212	16.83	15.75
Health Insurance Plan of Greater NY	15,072,410	15,908,899	42.74	43.84
HealthNow NY, Inc.	4,090,653	2,299,548	12.21	6.55
Independent Health Benefits Corp.	6,686,817	5,499,422	63.98	50.53
<i>Art. 43 Subtotal</i>	<i>63,007,399</i>	<i>52,646,127</i>	<i>20.51</i>	<i>16.81</i>
Art. 42 Accident and Health Insurers				
Empire Healthchoice Assurance, Inc.	15,063,366	14,378,559	11.65	10.92
HIP Insurance Co. of NY	1,003,374	1,216,121	35.68	33.25
MVP Health Insurance Co.	3,385,394	5,048,944	37.44	38.95
Oxford Health Insurance Inc.	26,921,654	24,934,817	32.28	28.17
United Healthcare Insurance Co. Inc.	12,414,230	36,515,396	12.90	29.48
<i>Art. 42 Subtotal</i>	<i>58,788,018</i>	<i>82,093,837</i>	<i>18.33</i>	<i>22.76</i>
TOTAL	\$156,648,987	\$164,367,435	\$22.47	\$22.21

Source: Author’s analysis of the 2012 and 2013 NAIC Supplemental Exhibits (rows 6.1, 6.4, and 6.5).

Note: In this analysis, we omit expenses to prevent hospital readmissions and to improve patient safety and reduce medical errors, and focus on three subcategories of “improving health care quality” expenses more directly associated with patient engagement: improve health outcomes, wellness and health promotion, and health information technology expenses related to improving quality.

New York, and BlueShield of Northeastern New York) encourages members to contact its “health advocates” for help with making appointments with hard-to-see specialists, negotiating fees with providers, eldercare issues, arranging second opinions, and claims disputes.⁶⁹ North Shore-LIJ CareConnect’s “Connectors” offer similar services, such as scheduling appointments, resolving billing disputes, or notifying members of important health milestones.⁷⁰

Accreditation guidelines from entities such as the National Committee on Quality Assurance (NCQA) explicitly require plans to provide enrollees with a wide variety of services and tools promoting engagement. These include a health risk appraisal, creating the opportunity to learn about a risk or condition, and self-management tools in a minimum of seven key areas, such as healthy weight maintenance, tobacco use, managing stress, and depression.^{71,72} In addition to educational materials, plans must provide decision aids, typically pamphlets or videos, to help people understand specific options for treatment of a condition, help them weigh medical evidence, and choose an option that reflects their personal preferences.^{73,74} Plans must also identify members eligible for wellness and prevention programs, and offer incentives to encourage them to stay healthy and prevent illness. Complex case management is a required quality improvement activity, and disease management programs for members with chronic health conditions are also an important component of health plan accreditation.

The complete inventory of services and tools available to New York enrollees is extensive: online and video health information libraries;⁷⁵ special counseling programs;⁷⁶ mobile apps to help members monitor physical activities and store personal health records;^{77,78} health coaching;⁷⁹ and discounts with wellness vendors.⁸⁰ Oscar Health Insurance, a newly licensed insurer, is making its mark with a consumer-friendly approach and creative use of

technology (see “Technology Keeps Plan Members Plugged In,” page 12) to engage individual market consumers and make coverage easy to use.

Cost transparency tools, which can help consumers make informed decisions and save money, are also becoming more common, a positive trend for consumers. Recent studies on imaging use and elective pediatric appendectomies show that properly messaged cost and quality information can reduce both individual out-of-pocket costs and market prices charged by suppliers.^{81,82} These tools are not universally available to consumers, however, and differ in the amount of information provided. Some health plans base cost estimate tools on the actual rates paid to their network providers, so consumers can gauge the difference in what their out-of-pocket exposure might be. Other health plans rely on average costs charged by all providers in a region, resulting in a ballpark estimate. Most plans do not make available both cost and quality information for providers. UnitedHealthcare is an example of a plan that provides both quality and cost information to members in an easily understandable way.⁸³

Benefits, Products, and Networks

All plans in the individual and small group markets include a wellness benefit, based on the benchmark plan New York selected under Essential Health Benefits rules, reimbursing members up to \$200 for gym membership fees every six months, as long as proof is submitted showing consistent use of the facility. Health plans can substitute other wellness benefits.⁸⁴ Independent Health, for example, offers members a unique nutrition benefit, partially matching member purchases of fruit and vegetables from a local supermarket chain.⁸⁵ Many plans offer acupuncture, massage therapy, and naturopathy benefits, and nearly all offer discounts for a wide range of wellness services and classes.^{86,87} Value-Based Insurance Design features, beyond those required, have also been

incorporated into many plans. Drug costs for enrollees' chronic conditions are not subject to deductibles under plans offered by MVP Healthcare and CDPHP, for example, and several plans offer members free primary care visits in addition to free visits for required preventive services.^{88,89}

Similar diversity is found in products available with features to encourage engagement. Independent Health's "Empower" plans for group customers include cost-sharing that increases if enrollees do not maintain their health or make progress on modifiable risk factors, such as tobacco use, body mass index, or blood pressure.⁹⁰ CDPHP's "Healthy Directions" offers a "diminishing deductible" to enrollees who complete "four healthy steps"—taking an online health assessment, choosing a primary care physician, scheduling an annual preventive exam, and completing a biometric screening.⁹¹

Varying network designs offered by health plans are emblematic of an evolving delivery system, and the different paths health plans are taking to engage patients. In response to consumer demand, NYSOH's online product descriptions, submitted by health plans, begin with information on networks. Describing its "open" or "ungated" network design, Oscar Health Insurance's product description notes that members can "visit any of our doctors without ever needing a referral."⁹² Taking a different tack, EmblemHealth's capsule description informs shoppers that specialty referrals are required in its Select Care tailored network, which "features high-quality, community-based primary care and specialty providers who offer you a personal, caring experience."⁹³ Other plans hedge their bets, offering multiple plan designs. Health Republic, for example, offers an open network product and a Patient-Centered Medical Home-based network to enrollees.^{94,95} Upstate,

Spotlight: Technology Keeps Plan Members Plugged In

Visitors to Oscar Health Insurance's website are greeted with a simple message: "Hi, we're Oscar, a better kind of health insurance company."^{*} Oscar made its debut in the New York health insurance market in 2013 with a goal of improving the patient experience by using technology, and making health insurance more intuitive. Members can log in to their web profile via hioscar.com or a cell phone app to access personal health information. Central to the web portal is the member's timeline (like the one on Facebook), which keeps track of his or her health history, including information such as premium payments, doctor's appointments, and encounters with Teladoc, a free telemedicine service available at all times.[†] After a patient requests Teladoc service online, a doctor is alerted and receives the patient's health history to review before calling back. Members wait an average of 8-10 minutes before hearing from a physician, according to company officials. In-house physicians and nurses monitor Teladoc calls and may follow up with members to coordinate the care.[‡]

Other online features for members include a smart search tool to learn about specific medical conditions and recommended treatments, and a map showing local providers, with hospital affiliation, languages spoken, and average age of patients seen. A "Get Help" tool allows members to e-mail Oscar and receive a response the same day. Members can also see estimates of health care costs by highlighting the prices charged by the provider for common procedures and conditions under Oscar's negotiated rate, what Oscar will pay, and the member's share.

Oscar strives to become a member's entry point into the health care system, with better case management and cost reductions from avoiding preventable emergency room visits. Under its agreement with Healthix, the regional health data exchange, the company is notified each time a member visits the ER, to facilitate follow-up.[§] Oscar recently announced that it will equip all members with wearable devices to track physical activity, with daily incentives for members to achieve health-related goals.

* Oscar Health Insurance. <https://www.hioscar.com>

† Oscar Health Insurance. Teladoc. <https://d3ul0st9g52g6o.cloudfront.net/2015/NY/provider/Teladoc.pdf?1427396858>

‡ Personal communication with Oscar Health Insurance representatives, September 25, 2014.

§ Healthix. January 20, 2015. *Oscar describes how invaluable Healthix is for care management* [video]. <http://healthix.org/video-oscar-describes-how-it-uses-healthix-for-care-management/>

Independent Health's ChoicePlus line offers a three-tier structure, with the lowest cost sharing for preferred providers, and its complete network or an out-of-network benefit available at higher cost-sharing levels.⁹⁶ North Shore-LIJ CareConnect is an example of a new kind of insurer whose network is made up largely of hospitals and physicians affiliated with the health care system.⁹⁷ In a significant shift, and without State requirements, virtual networks are also taking hold. In addition to Oscar Health Insurance's Teladoc benefit, there is Health Republic's Stat Doctors benefit, which provides members with online or over-the-phone services, and EmblemHealth individual and group members can contact telehealth physicians and dietitians through online video, telephone, or mobile devices.⁹⁸⁻¹⁰⁰

Health plans, at times through outside vendors, are using proven patient engagement tools such as care management^{101,102} and, at the same time, entering into new relationships with providers and health systems to take on some of these responsibilities. This dual focus—on direct engagement and on deputizing providers to engage patients—has led to soul-searching at some health plans. As one official from a plan known for its embrace of advanced primary care models noted, “We’re thinking hard about whether that’s who we are as a company, or is it one type of product that we will offer.”

Providers

Health care providers have pioneered many strategies to engage their patients, leveraging their unique relationship with and knowledge of their patients, and the advantages of face-to-face encounters in clinical settings. “Motivational interviewing,” for example, was originally developed as a method of counseling problem drinkers, but has been adapted as a strategy to overcome ambivalence in patients with behavior-related chronic diseases.^{103,104} Shared decision making is another proven model, in which clinicians and patients share the best evidence

on treatment options and match them with patient preferences, often using decision aids to prepare and inform the discussion.¹⁰⁵⁻¹⁰⁷

Spurred by government and health plan initiatives to enable and incentivize patient-centered, integrated care models and reduce reliance on fee-for-service payment methodologies, providers are regrouping, retooling, and reorganizing to meet these challenges. New York is a leader among states in advancing Patient-Centered Medical Homes (PCMHs),¹⁰⁸ and Advanced Primary Care is a major component of the State's SHIP initiative.¹⁰⁹ Accountable Care Organizations¹¹⁰ have also taken hold in New York, playing an increasingly important role in the Medicare fee-for-service program and the commercial market.^{111,112}

Patient engagement is at the center of these new service delivery mechanisms, built in to accreditation and statutory standards such as those for ACOs, which in some ways function as overseers of engagement, much like a health plan. Reflecting their broader responsibilities for population health management, requirements for ACOs are less specific on daily interactions with patients but nevertheless establish an engagement framework. The federal Medicare Shared Savings Program, for example, requires ACO participants to “define processes to promote evidence-based medicine and patient engagement.”¹¹³ Underlying regulations require ACOs to establish processes that “promote patient engagement” through such means as evaluating the health needs of the population they serve and developing a plan to address those needs, partnering with community stakeholders, communicating clinical knowledge to patients in a way that is understandable, using shared decision making, and creating individualized care programs.¹¹⁴

NCQA guidelines for PCMHs start with redesign features that make it easier for patients to see providers at convenient times, and include

components to improve the patient experience through technology, such as patient portals for making appointments, accessing medical records, or communicating with providers electronically; enhanced customer service; and a team-based approach to coordinate care. As is the case with ACOs, in this context patient engagement means active participation by patients in helping practices and health care systems improve service delivery. Other requirements are more directly focused on individual patients. Like health plans, PCMHs must collect and update a comprehensive health assessment “in order to understand the health risks and information needs of patients and families,” establish a process and criteria for identifying patients who may benefit from care management, and collaborate with patients to develop individual care plans, with goals and self-management tools. NCQA requirements

also include provisions for group classes or other health education, and peer support.¹¹⁵ A unique collaboration among a health plan, specialty and primary care providers, and a hospital in Western New York (see “A Model Collaboration”) shows the range of transformation required and the promise of the approach.

These newer care models, embraced by New York, show great promise, but there is still some mixed evidence on their effectiveness.^{116–119} Many challenges remain, such as the need for universal payment mechanisms and metrics to support these entities consistently across multiple private and public payers. And just as considerable thought is being given to the best mix of services and incentives to engage patients, there is much work to be done to engage physicians in new models of care, beyond typical pay-for-performance incentives.¹²⁰

Spotlight: A Model Collaboration

Optimum Physician Alliance (OPA) was formed in 2012 as a joint venture of HealthNow BCBS (BlueCross BlueShield of Western New York) and the Kaleida Health System.* The 500-physician panel, split roughly 50-50 between primary care physicians and specialists, includes Kaleida Health System-employed and independent physicians, PCMHs, and patient-centered specialty practices. OPA’s board includes consumer members, a patient engagement committee, and a PhD patient engagement specialist. Early on, consumer focus group meetings with OPA physicians were used to identify shortcomings of participating practices and sources of frustration for patients, such as difficulty making appointments, waiting times, hours of operation, and the “people skills” of front office staff.

Care management is a major focus, and OPA operates its own “hot spotter” program, based on a point system involving ER visits, inpatient admissions, multiple prescriptions, and other elements, and using this “multi-factorial intelligence” to help manage patients’ care. Case managers are assigned to patients with complex conditions, and disease managers focus on hemoglobin, A1c, and depression; OPA reports that it “can’t hire mental health social workers fast enough.” Participating physicians are alerted when patients visit ERs or after-hours clinics, and are asked to consider patients’ out-of-pocket costs in making treatment decisions; on the specialty side, OPA’s focus is on reducing costs by reducing treatment variations among specialists in the same field.†

OPA painstakingly tracks its own “return on equity” for the investments it makes, and carefully monitors its performance, offering evidence that it outperforms traditional delivery models. In the commercial market, the OPA option is offered to employer groups as part of the HealthNow “align” product line,‡ which features a tiered network providing lowest out-of-pocket costs for using the Kaleida Health System/OPA network, but also gives members access to the broader HealthNow network and an out-of-network benefit. As is the case with other tiered networks, OPA faces the challenge of making the case for a narrower network. And, like other organizations embracing patient-centered delivery models, OPA’s leadership is focused on finding a payment methodology to support its investments and sustain its work over the long term; one preferred option would be a three-part revenue stream incorporating fee-for-service payments, management fees, and performance-based compensation.

* Optimum Physician Alliance. <http://www.opawny.com/about.html>

† Personal communication with Optimum Physician Alliance representatives, September 22, 2014.

‡ BlueCross BlueShield of Western New York. align: Coordinated care with lower cost. <https://securews.bcbswny.com/web/content/WNYmember/get-coverage/individual-family-plans/align.html>

Part III. Discussion

We've described many ways in which policymakers, regulators, employers, health plans, and providers are seeking to engage patients through a variety of benefits, services, and tools. New York patients in the fully insured commercial market have access to a strong benefit package, networks deemed to have an adequate number of hospitals, primary care, and specialty providers after review by State agencies, strong consumer protections, and opportunities to assess their health risks and learn about their conditions and possible treatments, with options for care management and numerous self-management tools and incentives available. Yet evaluations of the system and health plan performance suggest there is still work to be done to engage patients.

In a recently released state health system scorecard,¹²¹ New York's health system earned a middling ranking overall, 19th among states, with good progress and performance on two measures, healthy lives and equity, but low marks in two other important measures, prevention and treatment, and avoidable hospital use and cost. State quality measurements through the Quality Assurance Reporting Requirements (QARR) tell a similar story. While about three-quarters of commercial enrollees reported collaborative decision making with their doctors, an important behavior of engaged patients,¹²² New York health plans reported that blood pressure levels for just 57 percent of their patients with hypertension were under control. Although this rate is consistent with the national average for health plans, there are wide variations among individual plans, and it means that 43 percent of patients with the disease have uncontrolled blood pressure, hardly a sign of a high-performing system, or one that is effectively engaging patients at risk of poor outcomes.

As New York enters an important phase in the evolution of its delivery system, following are some ideas worthy of discussion.

Coordination

During a transition period for New York's delivery system and the role that health plans and providers will play going forward, coordination emerged as a key concern for two reasons. First, the spate of initiatives currently underway in New York—the SHIP, the Medicaid Delivery System Reform Incentive Program (DSRIP), PCMH and ACO development, the State's Prevention Agenda, and the Population Health Improvement Program—represents an important opportunity for cross-fertilization, and to build a strong foundation for a transformed *and* aligned health care system.^{123,124}

For example,

- Will lessons learned from DSRIP Performing Provider Systems' use of the Patient Activation Measure on unengaged Medicaid beneficiaries and the uninsured, for example, be useful in the individual or small group market?^{125,126}
- How do goals for Medicaid Performing Provider Systems established throughout the state compare to the care management activities and priorities of health plans serving the commercial and Exchange markets?¹²⁷
- How can existing value-based benefit design features offered by health plans and employer groups be incorporated into the State's SHIP goals?¹²⁸
- Will the New York Medicaid Managed Care pilot program on incentives for smoking cessation and diabetes management help efforts in the commercial market?¹²⁹

Opportunities also exist to create linkages between initiatives, such as health plan incentives for patients to sign off on the transfer of their medical records to the State's SHIN-NY

health information system¹³⁰ or benefit designs or activities that support Prevention Agenda interventions.

Second, as the respective roles of health plans and providers evolve, coordination between them will become increasingly important. As one health plan official noted, “Right now, we need both payment reform and good care management from plans. The question going forward is, if providers and systems evolve as we hope, should insurance companies manage disease, or providers and systems with the proper incentives?” But in the current environment, some enrollees might have multiple opportunities for a risk assessment, to establish a personal health record, open a patient portal, or participate in a disease management or health coaching program through a provider, a health plan, or an outside vendor. An employee at a firm with a workplace wellness program, for example, might be asked or required to undergo biometric testing, right after a recent visit with his or her primary care physician.

Coordinating these activities would be more cost effective, and might produce better outcomes, especially if informed by patient preferences. One physician suggested that physicians prescribe wellness programs for patients, while another physician, citing low referral rates to care management programs, raised the idea of split incentives that reward both patients and providers for participating in the programs. Officials at NCQA noted that strong health plan support for providers taking on additional responsibility for engaging patients is a key ingredient in success. CDPHP, to cite one example, maintains a SMART Registry as part of its Health Coach Connection program, to alert participating providers to “care gaps” among members with any of six chronic illnesses. It also offers information on key utilization measures such as ER visits, and encourages providers to use its round-the-clock health coaching services

to “enhance...not replace” the physician-patient relationship.”^{131,132}

Clear Signals

For policymakers, revisiting a handful of important New York statutes and regulations related to engagement would be a worthwhile undertaking. For starters, New York’s lone statute on wellness programs¹³³ is mainly a safe harbor,¹³⁴ which references and restates federal rules for wellness programs exempt from anti-discrimination provisions in order to signal their acceptance in New York, and clarifies that premium differentials are not permitted in New York’s community-rated small group market. Although the statute explicitly applies only to “group accident and health insurance policy or group subscriber contracts,” individual contract filings under Department of Financial Services guidance are also required to meet the standards, despite the different federal wellness rules for group and individual coverage.¹³⁵ A listing of permitted wellness programs is inclusive, not exclusive, but permitted reductions in cost sharing, for example, are limited to “preventive services,” with no mention of reductions for *treating* a chronic disease, selecting a preferred provider in a tiered network, or receiving care from a center of excellence.

One recent report by a consumer group urged New York to consider supplementing consumer protections for wellness provided under the federal rules in order to better protect patients with disabilities, as well as the privacy of medical information, concerns that may grow because of recent EEOC rules.¹³⁶

Another related opportunity for clarity with regard to cost sharing stems from language appearing in various Insurance Law benefit standards requiring cost-sharing features to be “consistent with other benefits within the policy or contract form.”¹³⁷ This seems inconsistent with the goals of Value-Based Insurance Design,

under which all benefits are not equal. While Department of Financial Services guidance clearly exempts certain preventive services from cost sharing, guidance for other benefits is more open-ended in how it might be applied.

Engaging Individual Purchasers

Visitors to HealthNow's Buffalo New York headquarters pass an employee fitness center on the way in, a well-stocked bike rack in the reception area for employees to use during the day, posted invitations near the elevator to participate in walking and weight loss programs, and, upstairs, a company cafeteria with plenty of healthy food options. Obviously, many of these wellness-promoting features, found at many New York employers, are difficult to duplicate in the individual market context—there is no readily available physical space for diverse individual enrollees to congregate as employees do in a workplace—and other features, such as certain “outcomes-based” wellness programs, are not permitted in the individual market.¹³⁸ But given the significant growth in the individual market, considering how certain elements of group plans promoting engagement could be translated to that market is worthy of consideration. For example, health plans in the group market, such as Cigna,¹³⁹ are using digital technology including health risk assessments designed as games, mobile phone applications, and wearable devices and applications, known as “quantified self tools,” to supplement the typical collection of claims data from enrollees, in order to personalize the experience and better engage each group member. This group market strategy fits in well with the growing retail market for individuals.

Within cost constraints necessary to keep individual premiums affordable—there is no employer contribution to offset premiums, just ACA subsidies where available—additional ideas to consider include:

Onboarding. New York State of Health officials stressed that many individual consumers lack a good grasp of fundamental insurance terms such as copayments, coinsurance, and deductibles—much less the difference between “embedded” and “aggregate” deductibles—findings echoed in surveys of the newly insured.¹⁴⁰ NYSOH offers a number of tools to help consumers understand coverage, but policymakers could also consider enhanced standards for the way health plans “onboard” or communicate with new or renewing members. The mailing of an information packet is the minimum action necessary under NCQA standards, but more effective first contacts (such as Interactive Voice Response telephone calls to new members, a strategy used by Independent Health), or personal interactions between patients and providers or health plan representatives, are an opportunity to improve health literacy, assist patients in understanding their benefits and obtaining their full value, and reinforce the availability of incentives for risk assessments, primary care visits, or other services.

Cost-sharing. Average deductibles for individuals in employer-sponsored plans in New York more than doubled between 2003 and 2013, from \$485 to \$1,112, with greater cost sharing in the small group market, in which deductibles grew from \$638 to \$1,261.^{141,142} The market penetration of High-Deductible Health Plans is growing overall in New York, and, according to the most recent enrollment report from NYSOH, over 40 percent of 370,000 individuals enrolled in QHPs in 2014 were covered under policies with deductibles of greater than \$1,200 and out-of-pocket maximums of \$5,200 or more annually.¹⁴³ This growth in cost sharing suggests an opportunity for two engagement tools. First, Value-Based Insurance Design that encourages utilization of high-value services, such as medication and treatment for chronic conditions, could improve population health by removing financial barriers to these services, and reduce out-of-pocket

expenses for individuals with chronic illnesses. Second, continued progress on making cost and quality transparency tools available could improve quality and relieve cost pressures on consumers. Rules for physician ranking or tiering programs, in which health plans make physician cost or quality information available to enrollees, are based on settlements negotiated by then-Attorney General Andrew Cuomo in 2007.¹⁴⁴ While publicly available reporting shows effective monitoring of these programs since their inception, only four insurers (UnitedHealthcare, Aetna, Cigna, and Anthem BCBS), all national companies, are participating.¹⁴⁵ In an era when outside vendors are increasingly making available cost, quality, and satisfaction ratings on providers it may be a good time to revisit both this approach and the ranking guidelines, with an eye toward expanding health plan participation and increasing low consumer utilization of these tools.^{146–148}

Small steps. Supporters of the Patient Activation Measure, behaviorists, and others¹⁴⁹ maintain that engaging patients begins with small steps and the setting of modest, reachable goals tailored to individuals; chances of success grow with the assistance of specially trained coaches, use of decision aids,¹⁵⁰ or motivational interviewing or other behavior change strategies,¹⁵¹ along with incentives that provide immediate and ongoing rewards for engaging in desired activities.^{152,153} While coaching and incentives are universally available in group products, some plans do not offer these services to individual purchasers. New York’s main wellness incentive, its gym membership benefit, is a known quantity, but delivers its incentive in six-month intervals, and only to those who log 50 gym visits in that period; that’s an approach that is inconsistent with current thinking on effective incentives, since the action required is not simple, and there is far too long a time between the behavior and the reward. Instead, small but steady incentives (along with reminders of missed opportunities) that reward enrollees for

signing up for and participating in a diabetes care management program, for example, or achieving daily or weekly physical or dietary goals, are more likely to have an impact. Expanding the use of these strategies is worthy of consideration and further study of their impact.

“Leaving the building.” Some of the most promising results we learned about from interviews and a review of the literature derived from what one health plan official described as “leaving the building.” These initiatives included outreach to community partners to promote an incentive program for mammography screening, and enlisting community volunteers to design and execute a colon cancer screening program.¹⁵⁴ Although group coverage more easily accommodates initiatives such as employee weight loss and walking programs, health plans are creatively working to put the power of groups to work in individual plans too, creating opportunities for virtual groups, such as CDPHP’s CaféWell, and encouraging the creation of peer support groups to improve diabetes management.^{155,156} Since there’s a proven value in the power of groups and peers to help patients engage in behavior changes,^{157,158} these activities by providers and health plans should be supported.

Communicating with Consumers on Engagement

As health plans, providers, employer groups, and policymakers pursue diverse engagement strategies, it will be important to communicate effectively with consumers. For example, employer surveys¹⁵⁹ show that products offering out-of-network benefits, such as Preferred Provider Organizations, are by far the most common, and public polling indicates that consumers are willing to pay more for a broader network than a less expensive narrow network, although that dynamic is changing due to the interest from Exchange customers in keeping

premiums low;¹⁶⁰ purchasers in New York's Exchange have ample opportunities to enroll in products that do not require referrals from primary care physicians for specialty care. At the same time, the commercial marketplace is moving toward narrow networks, and policymakers are emphasizing advanced primary care, and encouraging integrated delivery systems such as ACOs, which are responsible for managing patients' care.

While a consumer at the center of and directing his or her own primary and specialty care might be functioning at the highest level of engagement, the implications of that model for costs and overall population health management are worth a conversation. A conversation with

consumers on their perceptions of value and quality would also be useful, as they may not necessarily align with efforts by payers and policymakers. Research has shown, for example, that consumers are reluctant to consider cost as well as quality in the value equation, and often view higher costs as a proxy for higher quality.¹⁶¹ Since Value-Based Insurance Design remains at the center of quality and cost control efforts, informing consumers about overutilized services, providing solid evidence of benefits and clear explanations of the impact, and soliciting input on VBID strategies from consumers and providers, such as developing a menu of high- and low-value services,¹⁶² might lead to greater acceptance and more success.

Part IV. Conclusion

New York is pursuing a promising “boots on the ground” strategy emphasizing the role of providers and integrated delivery systems in engaging patients, and payment systems that hold those providers accountable for results. Yet many of the respondents to whom we spoke noted the “mixed evidence” on the best path to take in engaging patients across the whole spectrum of provider, system, health plan, and employer-based efforts. Many noted a “faith-based” element to their approach, or making decisions to move forward with a particular program or service because “it’s the right thing to do.” One reason behind this somewhat intuitive approach is that many activities result in improvements in quality and the reduction of risk factors but do not necessarily reduce costs in the short term.

If patient engagement has been the mantra for the last decade in health care, “meeting consumers where they are” appears to be the rallying cry going forward, embraced by health plans, providers, regulators, and researchers

alike. This approach means first identifying patients receptive to health improvement, through advanced primary care, the PAM, motivational interviewing, online risk assessments, or other means, and then tailoring interventions—care management, coaching, incentives, or integrated behavioral health services—to each individual, based on degree of engagement and motivation. But unlocking patients' motivation, either to achieve that openness to change or to undertake activities characteristic of engaged patients, remains a formidable and somewhat mystical task. One physician we interviewed, remarking on the limitation of incentives, noted that his own dramatic weight loss was triggered not as a youth, when he realized his weight was holding him back as an athlete, or in adolescence, where it affected his social life, but when he “felt like a hypocrite” while counseling obese patients. “Motivation is all around us,” he noted. “We need to educate and engage our patients for when that moment arrives.”

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