Guiding Principles on Consumer Engagement in Benefit Design

Incorporating the holistic consumer perspective into health insurance benefit structures is a critical step toward a true value-driven health care system. True systemic transformation requires redesign that puts consumers at the center of every part of the care redesign process. The Health Care Transformation Task Force developed the following six principles to guide payers, purchasers, and providers in their efforts to better integrate consumer needs and preferences into care design. While these principles are written with a commercial audience in mind, they also contain elements that are applicable to public payer-centric organizations.

Payers, providers, and purchasers should utilize modernized ways of obtaining consumer input. They should also offer effective decision-making support tools that help facilitate greater partnership with consumers in navigating the health care ecosystem, including but not limited to obtaining information, coverage, engaging in care, reporting outcomes, and paying for services.

- People-centered, value-driven health care incorporates consumer insights and health care, quality of life, and well-being needs to drive greater engagement in decision-making. It prioritizes inclusivity, transparency, and the recognition of consumer diversity. Organizations should build upon existing evidence-based tools[1] that effectively engage consumers and identify communication/knowledge gaps in continuum of coverage, care delivery, and payment.
- Payers and purchasers should make available and encourage the use of tools and information that help consumers choose coverage that meets their current and future needs.
- Organizations should use simple data analysis techniques – such as rapid-response surveys, consumer journey mapping and consumer subgroup archetyping – to provide insight into consumer needs and behavior.
- Consumer governance structures, such as advisory councils or consumer participation in existing governance structures, should be used as appropriate to inform benefit and care delivery redesign. In some instances, existing structures such as unions and employer trusts as well as the distribution channel/brokers who represent them can serve this purpose; however, these entities must be vetted for impartiality and fairness to consumers.

Payers, providers, and purchasers should collaborate to create high-performance networks that enable people-centered care.[2] Value-driven networks should directly incorporate input from consumers in their design, including focusing on desirable outcomes and consumer experience.[3]

- The term "high-performance network" is defined as one that incorporates cost, utilization, and multi-stakeholder accountability while delivering on higher quality. Examples of effective quality metrics include patient-reported outcomes, 360-degree peer feedback for physicians, and established measure sets such as HEDIS.

[1]For example, modernization of CMS's Medicare Plan Finder tool to better assist consumers in selection between Medicare Advantage and Fee-for-Service.
[2]Special attention must be given to practical application of this principle to discourage any anti-competitive conduct.
[3]The term "value" includes both cost and quality.

- Data on cost and quality, provider use patterns, adequacy standards and preferred care delivery settings can help identify consumer preferences and network re-design. Network design should emphasize upfront transparency around cost structure and pricing to facilitate informed decision-making, and should help consumers easily identify relevant care programs that meet their needs.
- Health plans, providers, and purchasers should design high-performing networks in ways that reduce health disparities by ensuring members' access to culturally competent and high-quality providers.
- Networks should enable consumers to access the full range of necessary services – including specialists and subspecialists – without delay (i.e., by setting maximum wait times). Directories should be continuously updated.
- Financial guardrails like reduced cost-sharing and benefit level exceptions like waiver of tiering requirements should be created to protect medically complex patients who need expertise outside the immediate network.
- Coverage for medical services should be coordinated with behavioral health services to adequately address the complex interplay of medical and behavioral health conditions. Organizations should strongly advocate for more flexible privacy standards to facilitate improved coordination.

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- Payers, providers, and purchasers should work together to ensure that consumers receive the necessary information and education to proactively navigate the challenges of payment responsibility and fully understand their benefits. Individuals and providers should be able to see and easily compare service costs at the point they are making decisions about care (e.g., at the point of service). For example, embedding plan design into EHR records can help clinicians and patients jointly navigate payment as part of the care plan.

Value-based arrangements should include explicit accountability for member experience and outcomes.

- Payers, providers, and purchasers should collectively determine the balance of responsibility for member experience, which may vary by value arrangement and consumer type. At a minimum, payers should have accountability for member experience at the enrollment and payment stages, while providers should have accountability at the care delivery stage. Consumer shared decision-making should be incorporated into care delivery.
- Quality measurement should be well-coordinated at the payer-provider level, and consumer feedback should be formally incorporated into periodic measurement and continual improvement processes.
- Payers and providers should collaborate with consumers to design effective outcomes and experience measures, and with one another to promote consistency across the health care industry.

An ideal network and benefit structure centers primarily around the needs of the individual, balanced with the needs of the purchaser, payer, and provider. Elements of benefit design should be conceived through the consumer perspective.

- Ideal benefit designs should move away from plans that use high cost-sharing and coinsurance to disincentivize service use, toward designs that incentivize beneficiaries to seek appropriate preventive, diagnostic, acute and maintenance care from high quality providers at the right place and time. Penalties should never be used to incentivize consumers. For example, effective Value-Based Insurance Design positively incentivizes consumers' health care decisions.
- Consumers should be encouraged to establish and maintain a primary care provider relationship and should have the ability to opt in to high-performance networks.
- Consumer-centered benefit design should promote improved care coordination and reduced duplication of services.
- Payers should consider cross-industry partnerships with retail and tech organizations to harness top-line data on aggregate consumer preferences and purchasing patterns for person-centered design.

Organizations should operate systems that promote use of people-centered Health IT. Consumer interfaces should prioritize simplicity, clarity, and transparency. Consumers should have on-demand access to meaningful information that helps them understand their health and care, as well as directly supports informed decision-making.

- Consumer interfaces should help nudge consumers toward high-value products and evidence-based decisions. Designs should be periodically updated to reflect current consumer needs; e.g., consideration of elements such as color and screen placement, language/literacy appropriateness, and consumer archetypes.
- Consumers can also be prompted with messages that can encourage them to learn more about key factors such as their physician choices.
- Consumers should have two-way access to their own health data. They should be able to access and share their health records, and to supplement their health record with personal data such as health history, preferences, outcomes, and care goals.
- Clinical data sharing should incorporate intelligent design features that help effectively educate/engage consumers (e.g., context for lab results to avoid unnecessary visits/calls).

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. The Task Force is committed to rapid, measurable change, both for itself and the country. It aspires to have 75% of its member businesses operating under value-based payment arrangements by 2020.