

Consumer-Directed Health Plans: Pharmacy Benefits and “Better Practices”

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The Benfield Group

The Benfield Group, founded in 1989, is a health care market research, strategy and communications firm that is focused on improving health care value by: 1) helping health care companies market their value proposition to large employers; 2) conducting consumer, patient and physician research; and 3) providing employers with strategic communications support. The Benfield Group is headquartered in St. Louis and has offices in Chicago and Atlanta. Our team shares a passion for health care problem solving and a strong commitment to helping our customers understand, plan and succeed. For more information, visit www.benfield.com.



National Pharmaceutical Council

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Executive Summary

Understanding CDHPs

Consumer-directed health plans (CDHPs) are high-deductible plans offered in combination with an account that enrollees can access to offset the deductible expense. Premiums are generally lower than in traditional plans because enrollees must meet the higher deductibles before traditional medical and pharmacy coverage begins. Depending on how they are implemented, CDHPs have the potential to help contain health care costs and engage enrollees more fully in managing their health and health care decisions. And, due in large part to the excise tax that is set to go into effect in 2018 for expensive health plans (so-called “Cadillac Plans”), more employers are expected to begin offering CDHPs to their employees in coming years.¹ Employers that already offer CDHPs are expected to implement strategies that drive higher enrollment, or to only offer CDHPs to their employees.

Health savings accounts (HSAs) are the predominant type of CDHP and are growing at a much faster rate than health reimbursement accounts (HRAs). Some employers and benefits advisors consider HSAs to be more advantageous to employees, who can deposit part of their pre-tax income and have ownership of the account, which they can use for medical, long-term

care and/or retirement expenses. HRAs, in which employees are reimbursed for medical services not covered under a health plan, are preferred by employers that like the HRAs’ flexibility and ability to recoup money when employees leave the company.

Research Background

On behalf of the National Pharmaceutical Council, The Benfield Group conducted a multi-phase research project investigating pharmacy benefit designs attached to CDHPs. The research was intended to identify the current landscape and best practice approaches for CDHPs and pharmacy benefits, as well as understand the health and economic impact of best practice models and evidence about higher value approaches to CDHP pharmacy benefit design.

As part of this project, in the fall of 2013 Benfield conducted a survey of 96 large employers (1,000 to 4,999 employees) and jumbo employers (5,000+ employees), all of which offered at least one CDHP option to their employees. The survey asked in-depth questions about plan design and performance for each respondent’s two most popular CDHP offerings, and then explored overall benefit plan strategy and decision-making processes.

¹ Benfield Research. Employer Market Healthcare Reform and Private Exchange Report. The Benfield Group. 2013.

Additionally, Benfield conducted 25 interviews with multiple stakeholders [employers (13), employee benefits consultants (5), subject matter experts (4) and health plans (3)] to gain insights on issues ranging from market trends and benefit design strategies to gaps and opportunities.

Research Findings

This research revealed that a standard CDHP model has emerged that employee benefits consultants (EBCs) routinely recommend and employers typically follow. Although employers' strategies range in sophistication, most strategies include at least the following elements:

- Communicate in advance of roll-out to prepare employees and educate them about what to expect and how CDHPs are different than what they're used to;
- Make a contribution to employees' HSA or HRA accounts;
- Cover preventive care (at least their interpretation of what is required by law);
- Promote wellness and provide educational tools to help employees navigate health care choices; and
- Monitor outcomes and make adjustments.

Though employers generally follow this standard model, diversity exists in CDHPs. Plans vary according to deductible levels, account contributions, coverage of prescription drugs, the level of wellness, decision support and financial literacy programs offered, and the integration of program offerings with plan design (eg, incentives).

CDHP Pharmacy Benefits

Pharmacy benefits play second fiddle to medical benefits in CDHPs. As the greater driver of costs, medical benefits garner more attention and planning. Regardless of whether the employer is strategic or non-strategic in how it handles these benefits, the pharmacy approach is much the same.

Employers and EBCs determine coverage strategy (eg, covering drugs before/after deductible, number of tiers), but are likely to defer to the PBM in deciding which drug classes are covered and in determining which drugs go in which tier.

Under an HRA, employers may opt to cover pharmacy benefits through a traditional card plan, where medications are not subject to a deductible or they may require participants to use savings/reimbursement accounts until their deductible has been met. Of employers surveyed with an HRA, 56% have a traditional card plan, and 31% offer value-based designs that offer medications for common chronic conditions at a reduced or \$0 co-pay to recipients (also known as a value-based insurance approach).

For HSAs, US Department of Treasury guidelines indicate that pharmacy coverage must be included under the deductible in an HSA. However, prescription medications defined as “preventive” are allowed to be excluded from this rule and can be covered outside the deductible. The “preventive drug” guidelines are vague enough to allow varying interpretations about which drugs are considered primary prevention medications.

There are mixed signals about what effect the Treasury guidelines have on employers’ HSA pharmacy benefits decision-making. Survey responses indicate the guidelines constrict coverage, and that employers would cover more preventive medications if guidelines clearly allowed it. However, interviews show that employers are not that well-versed on the guidelines and that, along with EBCs, they largely defer to pharmacy benefit managers (PBMs) to interpret the vague guidance and determine the acceptable preventive drugs to cover.

The reliance on PBM interpretations can have both positive and negative outcomes. On the one hand, it has become standard practice for EBCs to recommend that their clients cover preventive drugs before the deductible, which benefits low-income employees with high health care needs. On the other hand, employers are being advised not to tinker with the pre-defined lists devised by the PBMs in order to avoid potential tax penalties associated with covering drugs that do not qualify as preventive. As a result, PBMs have

complete control over the drug coverage lists, and some experts interviewed for this research are concerned that this only adds to a lack of transparency around decisions about coverage.

Specialty/Biologic Medications

Strategies for providing specialty medication access while containing costs under CDHPs are not emerging. The attitude seems to be that people taking those drugs will hit their deductible and out-of-pocket maximum anyway, so a particular strategy is not needed.

Emerging Concerns

The experts interviewed for this research expressed some skepticism about the current state of CDHPs and the outcomes of the standard model relative to more sophisticated approaches. They questioned the quality of outcomes data (beyond cost and employee pushback), and whether employers and EBCs are using the right metrics to measure the impact of CDHPs. Part of the challenge is that most employers, advisors and plans lack the data, analytic capacity or will to more closely examine what is happening below the top-line plan measurements.

While many employers and advisors are not attuned to the health, productivity and longer range cost implications of their CDHP offerings, some employers have expressed moderate concerns that certain employees—particularly those with high health care needs and low incomes—are suffering under their current plan designs. Specifically, the employers interviewed pointed to research that shows reduced treatment adherence or avoided care after employers implemented CDHPs.² This indicates that some patients (lower income/high health care need) may be incurring the biggest brunt of high out-of-pocket costs associated with CDHPs, even if that result is not showing up in employers’ data. This prompts the question: Are these patients’ experiences being masked by the data or are their experiences being ignored?

The concern over employees with high health costs and low incomes is likely to intensify in coming years as more employers adopt CDHPs and drive them more aggressively into their benefit mix. Increasingly, these more vulnerable, cash-poor employees do not have a viable option to a CDHP. If they are not thoughtfully designed, CDHPs can put such employees in a very tough predicament relative to affording the care and treatments they need.

CDHP “Better Practices”

There are certainly some notable bright spots in the findings. Some employers are establishing “better practices” in overall CDHP plan design and in their approach to prescription benefits. Some of the innovations are designed to have broad impact, providing support and aligning incentives across the workforce to improve health and health care decision-making. Other innovations are targeted at mitigating the harmful impacts of blunt CDHP and prescription benefit plan design on high health care need/low-income employees.

Key differentiating “better practices” include:

- Use of integrated health and productivity data in plan design and performance measurement;
- Lower net deductibles (deductible minus company HSA or HRA account contributions);
- Varying contributions based on income (to protect low-income workers) or linking to incentives for wellness or consumer behaviors;
- Implementation of value-based approach to prescription drug coverage in HRA-based plans; and
- Implementation of broad list of preventive drugs, combined with a value-based approach in HSAs.

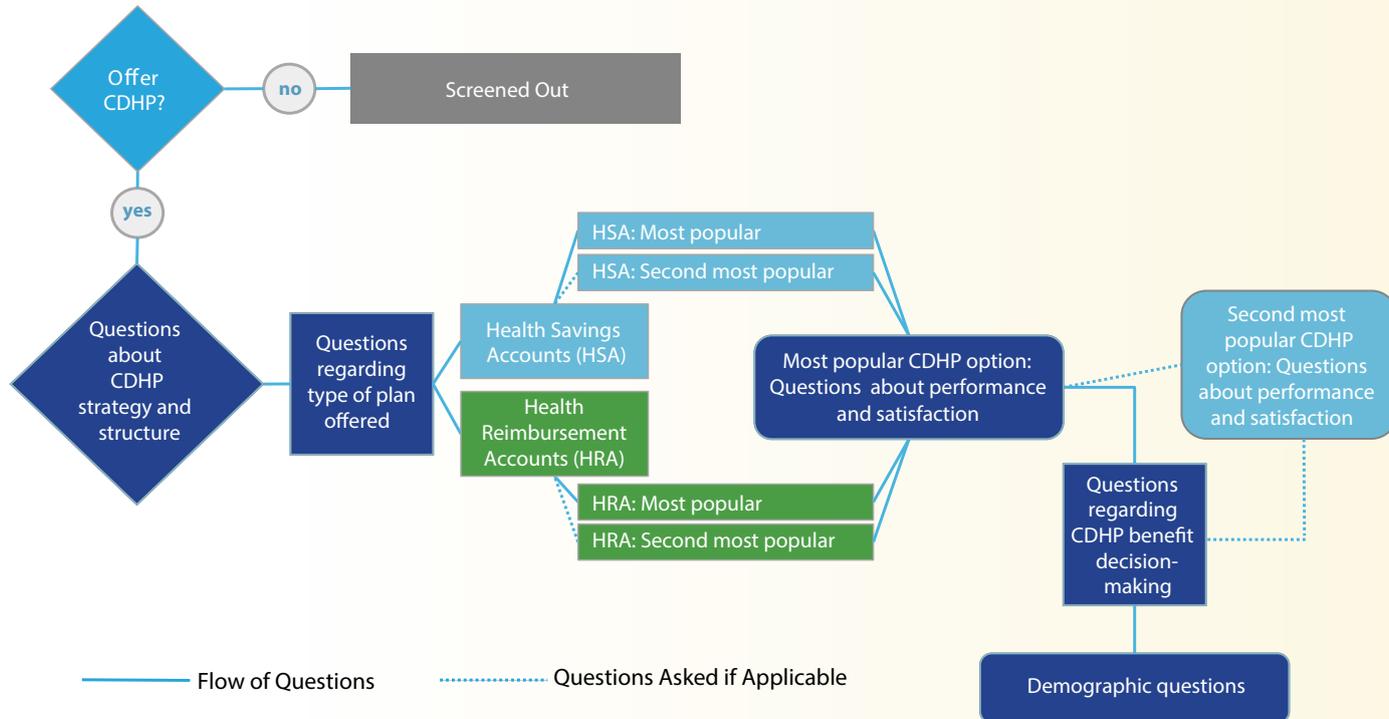
² Fronstin P, Sepúlveda MJ, Roebuck, C. Consumer-Directed Health Plans Reduce The Long-Term Use Of Outpatient Physician Visits And Prescription Drugs. *Health Affairs*, 32, no.6 (2013):1126-1134.

Conclusions

- The primary conclusion is that employers (and the EBCs and PBMs that advise them) have settled into a status quo that is likely to continue because even the most basic implementation of the standard model achieves cost-reduction goals without too much employee pushback.
- However, there are employers who have gone beyond the standard approach to implement thoughtful and strategic CDHP benefit programs that use data to anticipate potential problems and formulate solutions to make sure all of their employees receive appropriate care and have affordable access to the treatments they need to be healthy and productive.
- According to the literature and experts who were interviewed for this research, there is good reason to believe that employers with more sophisticated CDHP strategies are getting better outcomes in terms of employee health, satisfaction and overall health and productivity costs. The survey data is inconclusive in this area, perhaps because: a) most employers do not have data/data integration capabilities to measure health and productivity outcomes; and/or b) plans have not been in place long enough to impact outcomes in a significant way.

Survey and Demographics

Flow of Survey Questions

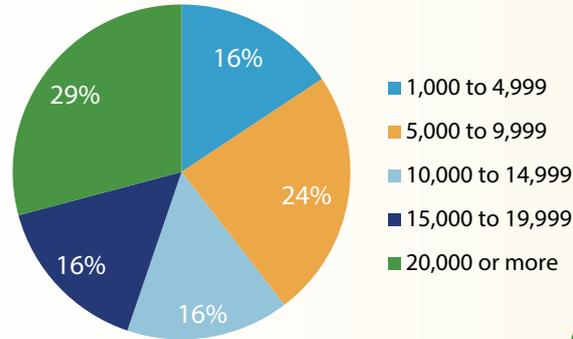


Issues Discussed in the Interviews

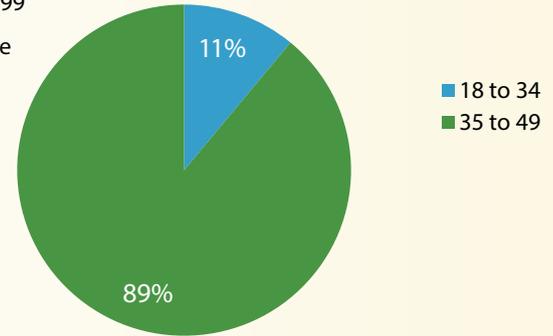
- CDHP landscape
- CDHP design strategies
- Pharmacy-specific benefit design strategies
- CDHP outcomes
- Measurement capabilities
- CDHP future trends
- CDHP best practices and policies to avoid
- Helpful CDHP resources
- Gaps and opportunities

Sample: By Size and Age of US Workforce

What is your total number of US employees?



What is the average age of your workforce?



n=96

Interview Participants

Employers

- American Express
- Delta Airlines
- Federal Signal
- Golden Living
- Goodwill Industries of Central Indiana
- IBM
- Land O'Lakes
- Mondelez International
- PSEG
- RaceTrac
- Silgan Containers
- USAA
- UTC Aerospace Systems

EBCs

- Aon-Hewitt
- Buck Consultants (2)
- Mercer
- Sibson Consulting

Health Plans

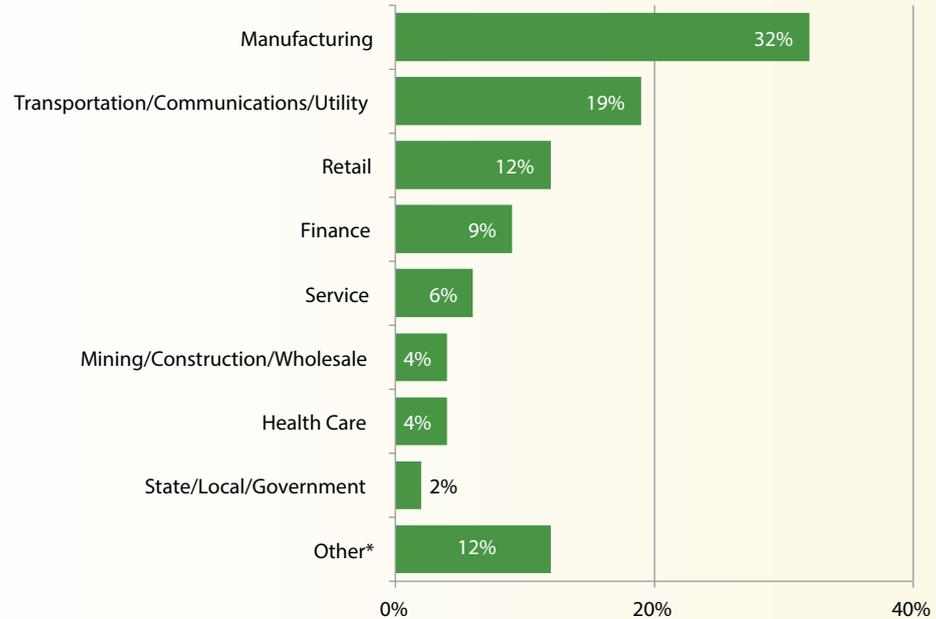
- Fallon Community Health
- Harvard Pilgrim
- United Healthcare

Experts

- EBRI
- Incenta
- University of Minnesota
- West Health

Sample: By Industry Type

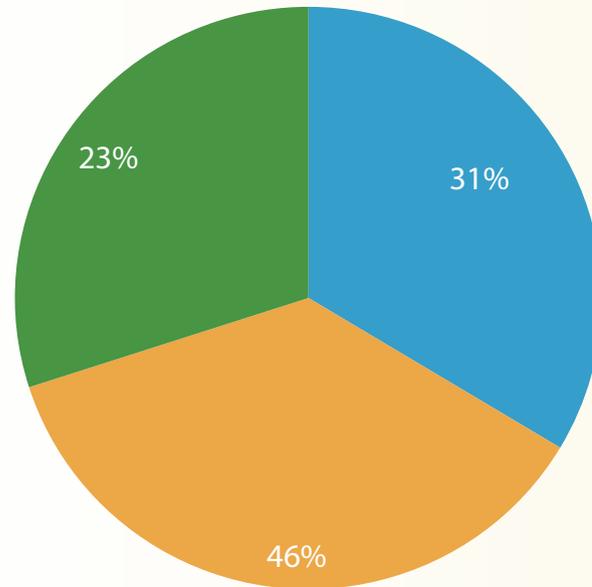
What is your company's industry?



* "Other" includes: entertainment, higher education, IT, non-profit, services/retail, state university, technology.

Sample: By Workforce Type

How would you characterize your company's workforce? Please enter approximate percentages below to characterize your company's workforce.



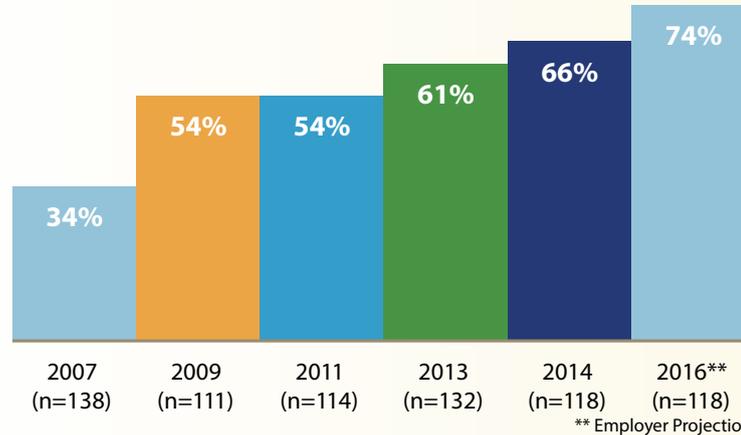
- Manual labor (production, manufacturing, construction, etc.)
- Knowledge and clerical (professional, executives, managers and administrative assistants, etc.)
- Service (transportation, food service, health care, hotel, delivery, repairs, etc.)

n=96

Employers' adoption of CDHPs is now growing rapidly.

Key Findings: CDHP Strategy*

Employers Offering CDHPs



Top 3 Reasons for CDHP Adoption:

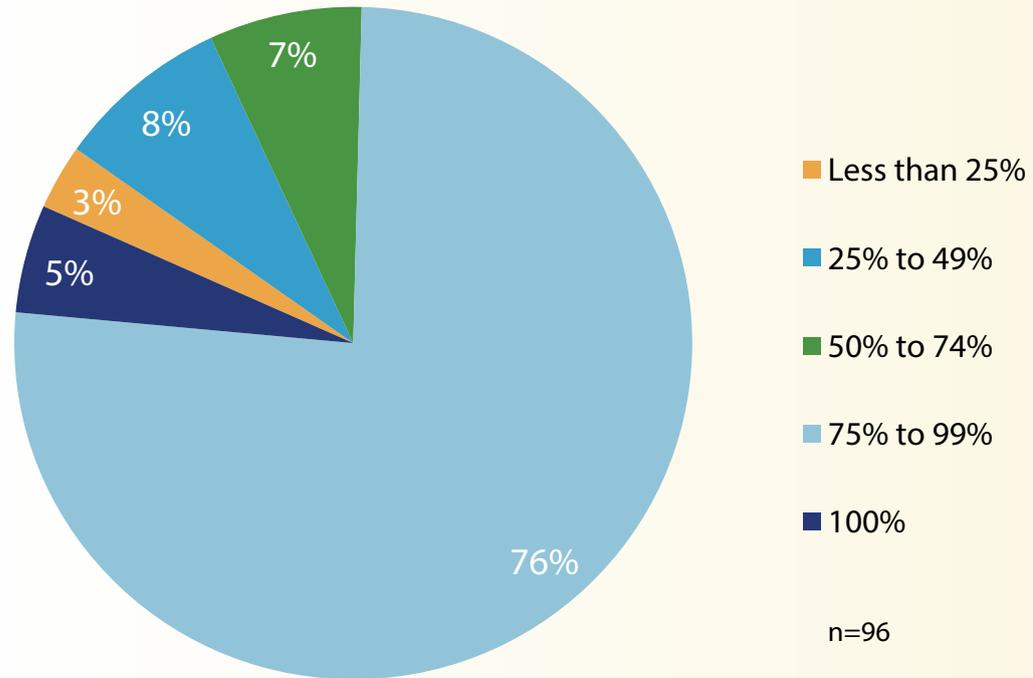
- #1: Sharing financial responsibility
- #2: Motivate employees to make behavioral changes
- #3: Combat increasing health care cost trends to avoid/delay excise tax in 2018

Source: 2014 Benfield Research, Employer & Coalition Market Overview and Trends. All rights reserved.

*For reporting purposes, only the most popular CDHPs, Health Savings Account and Health Reimbursement Account options are presented.

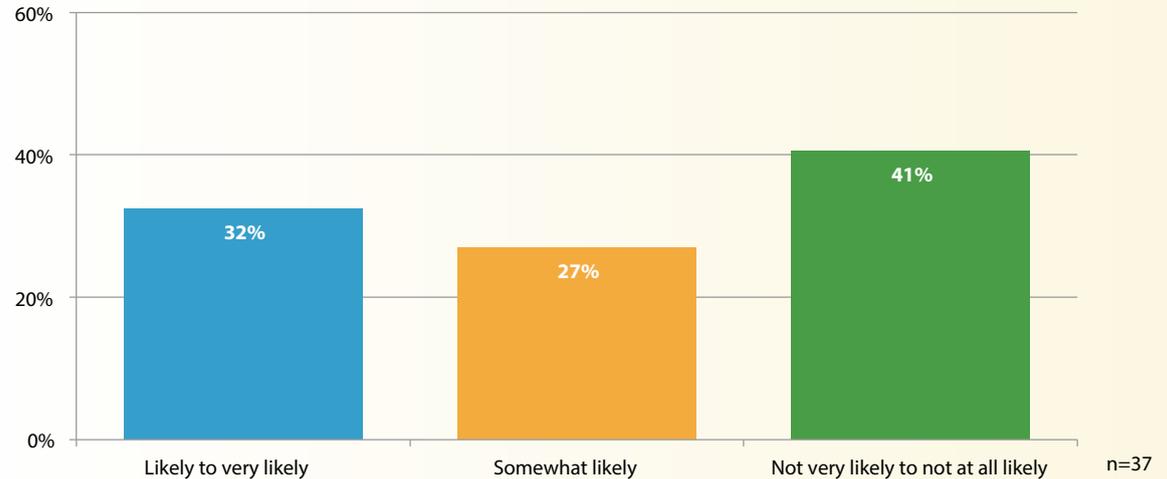
**8 in 10
employers
surveyed make
CDHPs available
to at least 75%
or more of their
workforce.**

What percentage of your workforce is eligible to enroll in a CDHP?



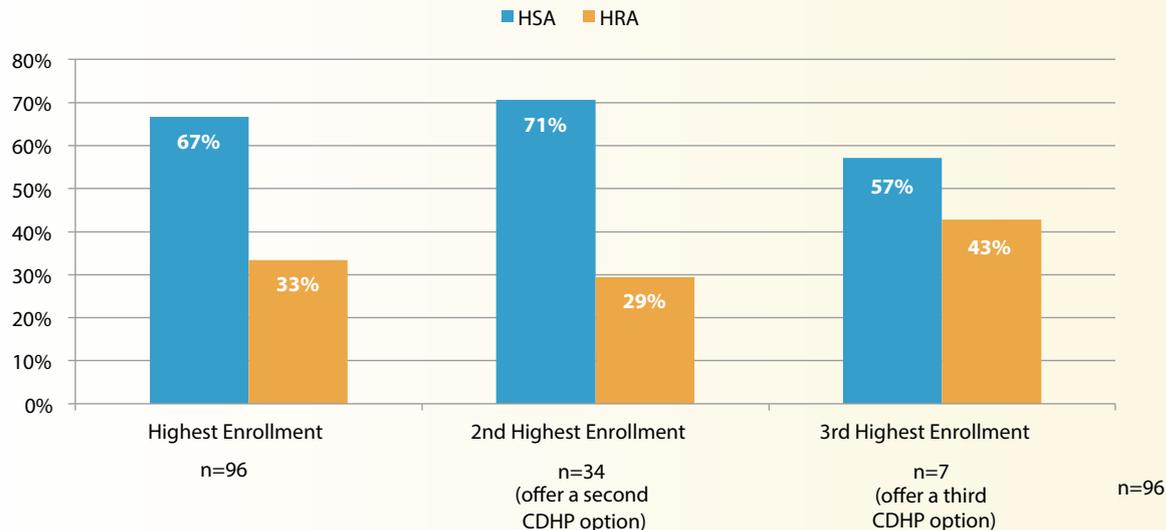
6 in 10 employers who don't currently offer a CDHP to all employees are at least somewhat likely to expand enrollment eligibility within 2 years.

If 100% of workforce is not eligible: How likely is it that employees who are not currently eligible to enroll in a CDHP will be offered a CDHP option in the next two years?



In the survey sample, HSAs are the dominant type of CDHP offering.

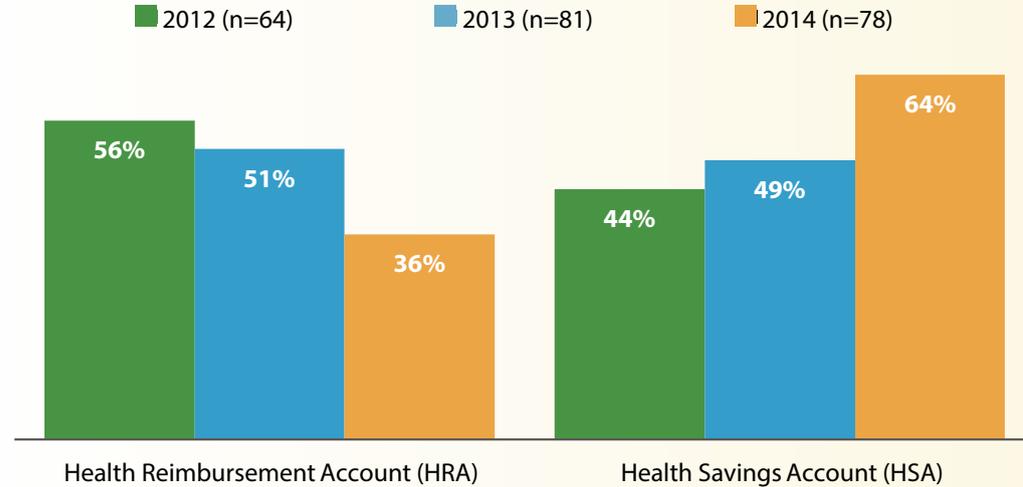
For each CDHP your company offers, indicate if the plan is attached to an HSA or an HRA.



HSAs have recently become the CDHP approach of choice.

Health Care Accounts Linked With CDHPs

(among employers offering CDHPs)



Source: 2014 Benfield Research, Employer & Coalition Market Overview and Trends. All rights reserved.

A standard approach to CDHPs has emerged.

General Consensus Among Interviewees:

It isn't hard to design a CDHP that meets employers' primary goals

- Lower costs/bend the curve
- Engaged employees
- Mitigate workforce disruption/employee dissatisfaction

Lots of information and templates exist

- EBCs have accumulated experience
- Process readily transferrable within consultant practices
- Plenty of benchmarks to ease anxiety for newcomers

Components of the Standard CDHP Design/Strategy

Design a CDHP

(almost always HSA-based) appropriate to the employer's specific population (culture, current approach, population health, income)

Cover preventive services

to discourage members from avoiding care (mandated)

Contribute

enough to employees' HSA or HRA to minimize disruption

Offer support

tools and services to help employees practice good health and be more informed health care consumers

Identify any worrisome trends

Track cost, engagement, disruption and satisfaction

Innovations Differentiating Some CDHP Strategies

Mechanism to reduce the net deductible for employees

- Incentive-based account contributions (typically tied to wellness/health management program participation) (30% of respondents with HSA, 40% with HRA)
- Salary band-based account contributions (11% of respondents)

Providing access to primary care and chronic disease management at a nominal out-of-pocket cost to employees

- Direct contract with community provider network
- Worksite clinic

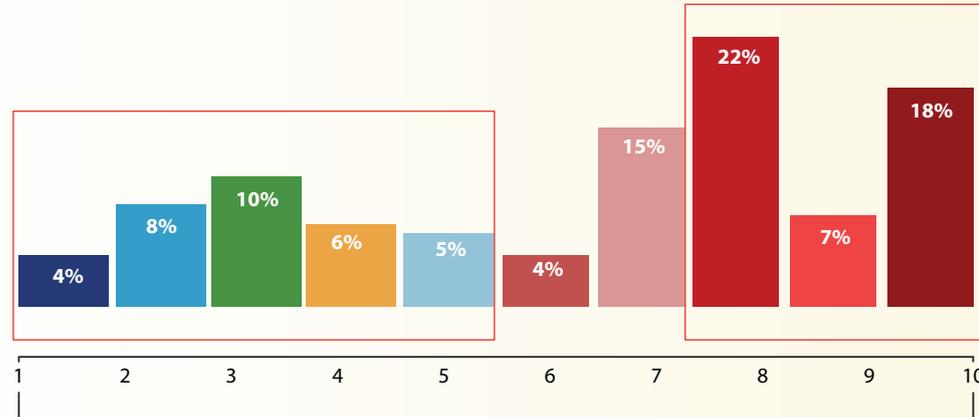
Front-loaded account contributions/access to account funds

Enable HRA roll-over (perhaps with limits)

1/3 of respondents self-report being non-strategic and reactive about pharmacy benefits.

Key Findings: CDHP Pharmacy Benefits Approach

Enter a number that best characterizes the approach your company has taken in making decisions about prescription benefits associated with your CDHP offerings.



n=96

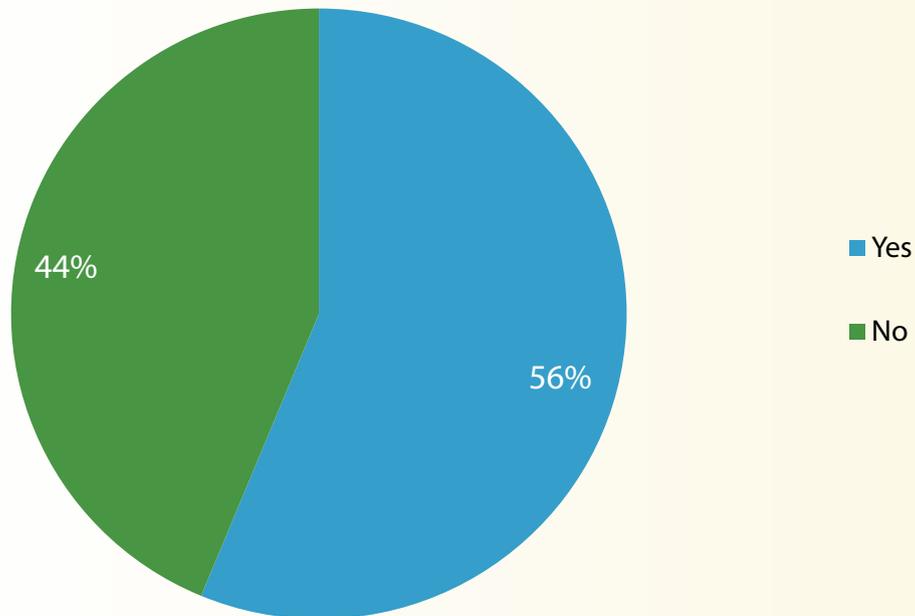
Decisions about prescription benefits were non-strategic and considered only after we had made core CDHP medical plan decisions (HRA vs. HSA, deductible levels, employer contributions, etc.).

How we would cover prescription drugs was integral throughout our CDHP benefit decision-making process. We used data to make our decisions about things such as HRA vs. HSA, deductibles and contribution levels.

A majority of respondents (56%) cover preventive drugs apart from the deductible.

HSA with highest enrollment

Does your company cover any preventive drugs (not required by law) apart from the deductible?

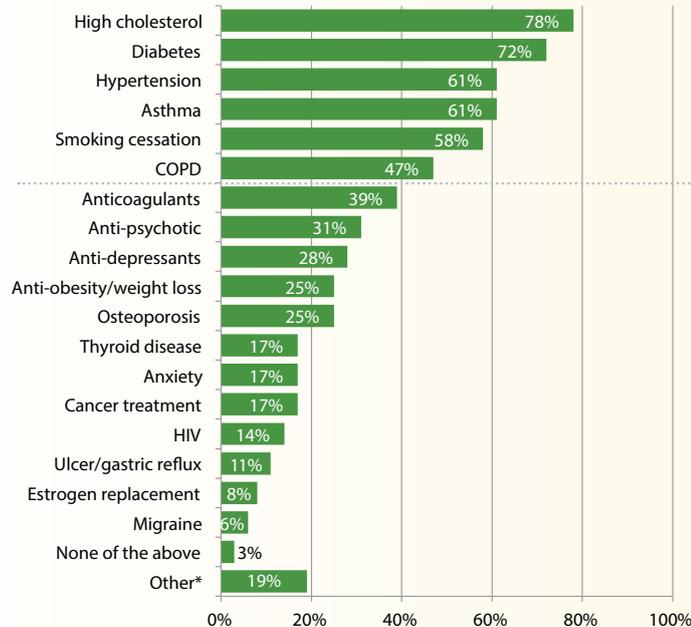


n=64

Preventive drug list coverage is concentrated among 6 therapeutic areas.

HSA with highest enrollment

Below is a list of drug types that may have preventive uses. Indicate the drugs your company includes on its "preventive drug list" for this CDHP option.



Roughly half of respondents are covering these drugs.

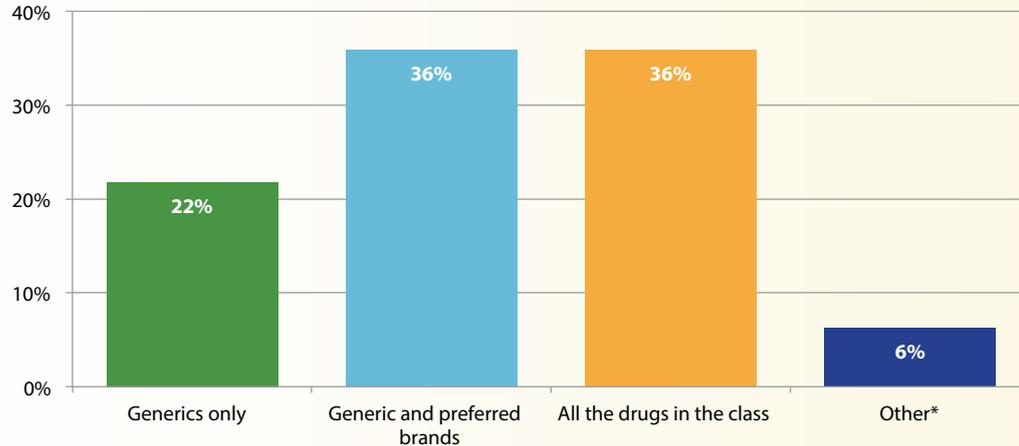
*"Other" includes: all preventive generics defined by PBM, aspirin, vitamin D, folic acid, contraceptives, chemotherapy, coronary artery disease, immunizing agents, respiratory disorders, stroke, pre-natal vitamins, pediatric vitamins, prescription vitamins.

n=36

Respondents' coverage of preventive medicines apart from the deductible varies. 36% cover all drugs in the class. Another 36% cover generics and preferred brands. 22% cover generics and preferred brands. 22% cover generics only.

HSA with highest enrollment

Please select the response that best describes your company's coverage of preventive medicines apart from the deductible:



* "Other" includes: None; only as required by law; we cover all the medications you stated previously but they are considered medications to treat a condition and not prevent a condition. Therefore, there is cost sharing after the deductible for those medications except for insulin for diabetes.

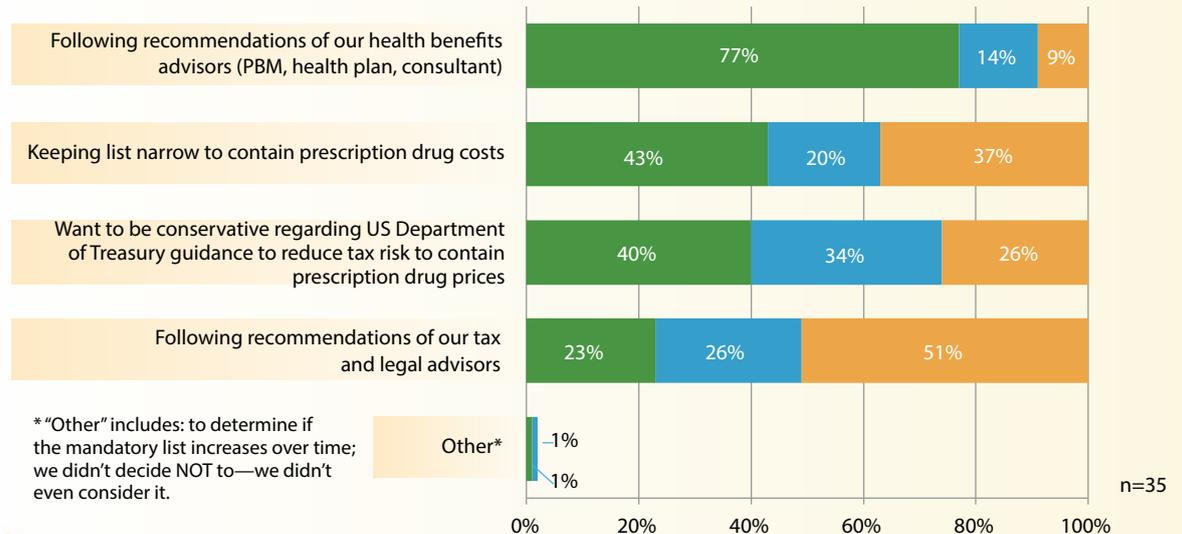
n=64

Vendor/advisor recommendations, cost concerns and tax risks influence which preventive drugs are covered.

HSA with highest enrollment

If you do not cover all the drugs on the previous chart: How important were the following factors in your company's decision to NOT cover certain preventive drugs apart from the deductible?

■ Moderately or extremely important ■ Somewhat important ■ Not very or not at all important

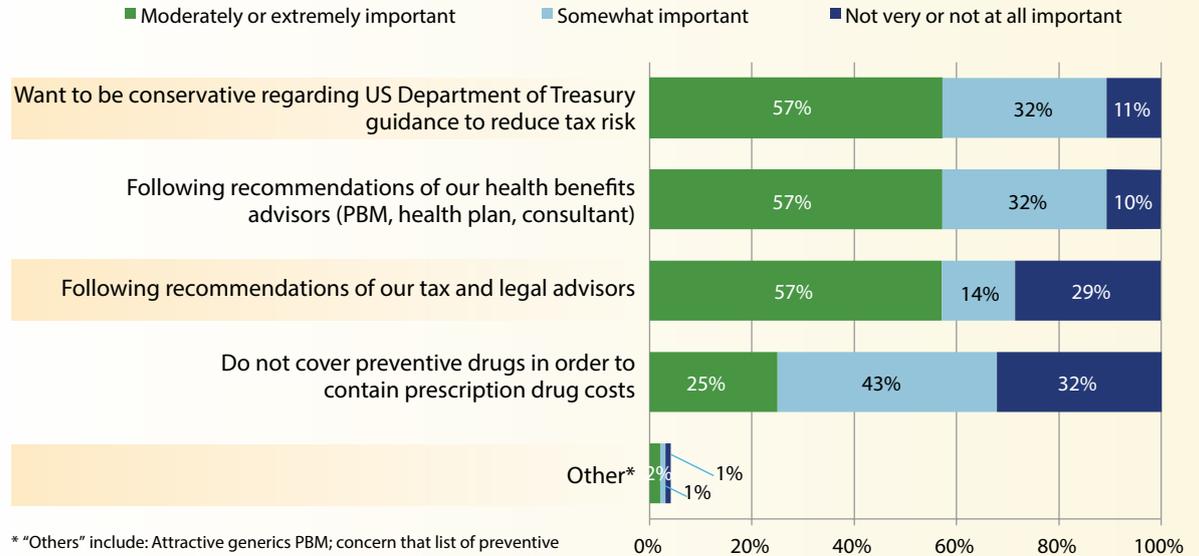


*"Other" includes: to determine if the mandatory list increases over time; we didn't decide NOT to—we didn't even consider it.

Over half of employers who *don't* cover preventive drugs apart from their HSA deductible identify tax risk as an important factor.

HSA with highest enrollment

If you do not cover drugs apart from the deductible: How important were the following factors in your company's decision to not cover preventive drugs apart from the deductible?

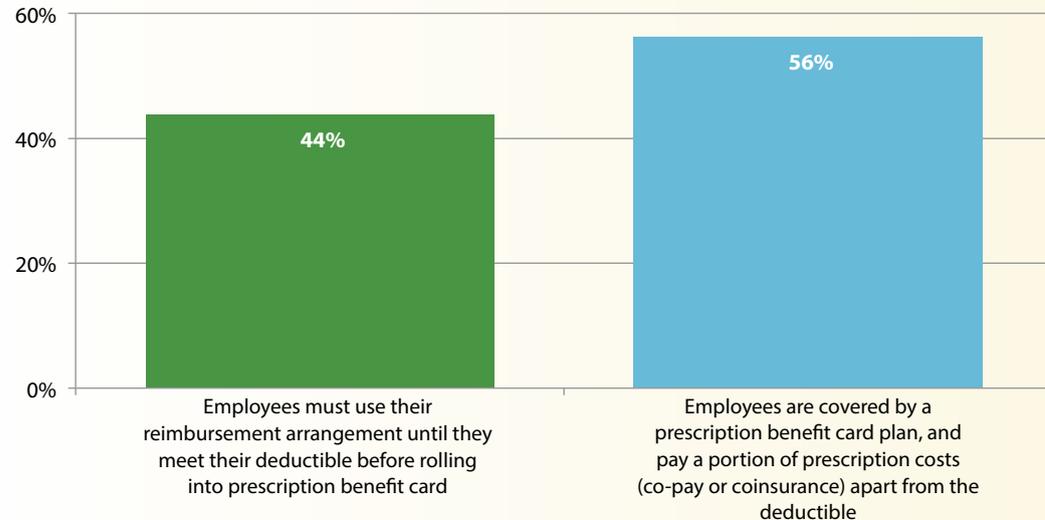


* "Others" include: Attractive generics PBM; concern that list of preventive drugs will change in the future; no distinction is made for preventive drugs; promote consumerism.

56% of HRA-based CDHPs cover prescription drug costs with a card plan before meeting the deductible.

HRA with highest enrollment

How does your company cover prescription drugs for employees enrolled in this HRA-based CDHP?

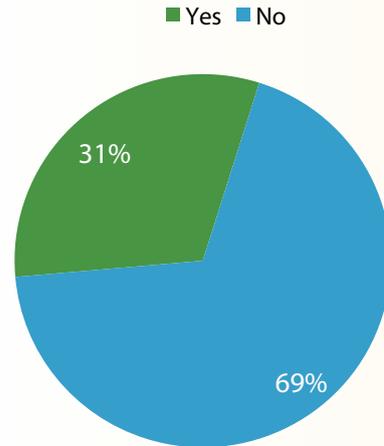


n=32

31% use Value-Based Insurance Design within their HRA-based prescription drug benefits.

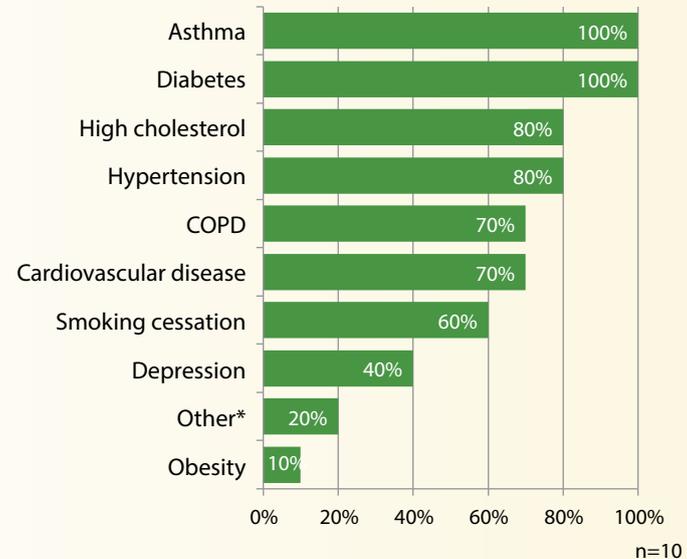
HRA with highest enrollment

Does your company use what is commonly referred to as a Value-Based Design approach to prescription drug benefits?



n=32

If yes: Indicate the conditions where your company currently uses a Value-Based Design approach.



n=10

* "Other" includes: Gastroesophageal reflux disease and pre-natal vitamins.

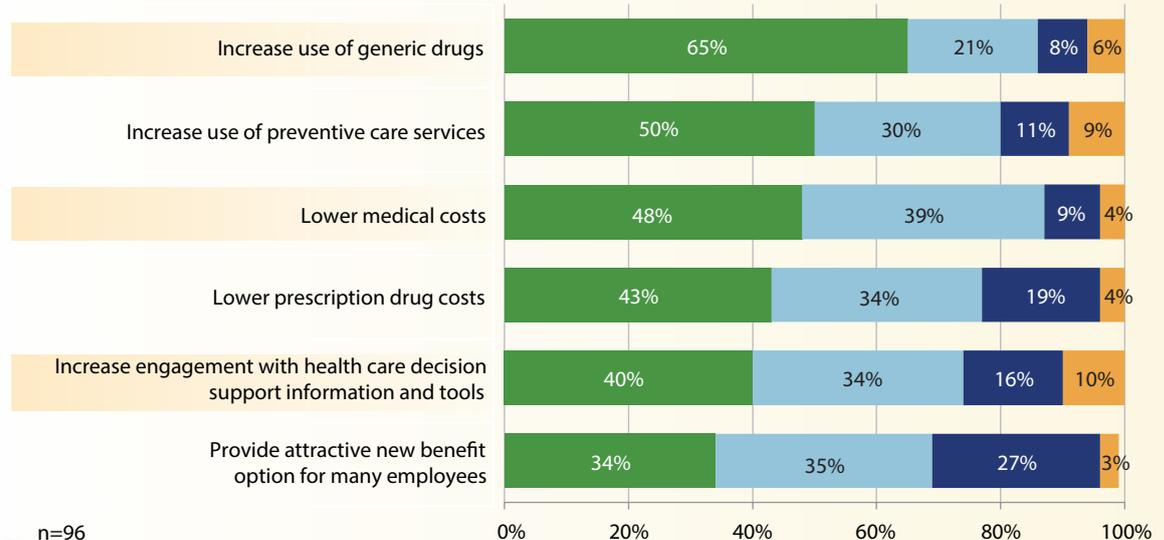
Respondents believe their top CDHPs are largely yielding beneficial outcomes.

Employer Perspectives on the Performance of Their CDHPs

CDHP with highest enrollment

Indicate the degree to which your company is experiencing each beneficial outcome.

■ Quite a bit to very much
 ■ Moderately
 ■ Very little or not at all
 ■ Don't know

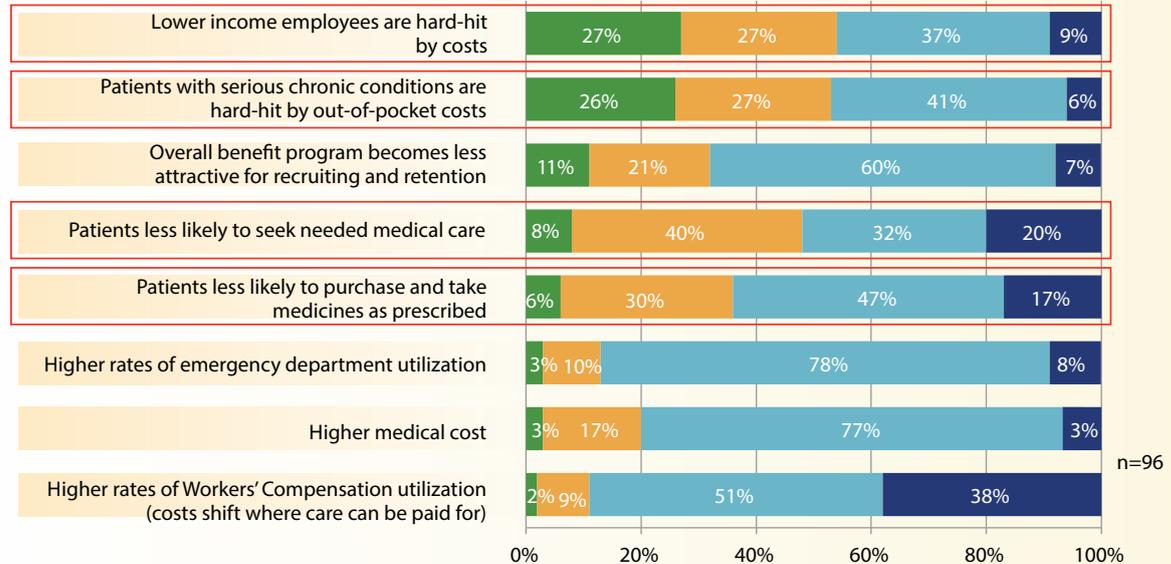


Relatively few respondents report experiencing the most negative outcomes from their most popular CDHPs, but some have concerns about vulnerable employees.

CDHP with highest enrollment

Indicate the degree to which your company is experiencing each undesirable outcome.

■ Moderately to very much
 ■ Moderately
 ■ Very little or not at all
 ■ Don't know



CDHP “Better Practices”

- Our assessment of better practices comes from considering the project’s survey and interview findings. (Employers, consultants, health plans, subject matter experts and PBMs participated in the interviews.)
- In this instance, “better practices” are those that:
 - ▶ address concerns about the potential negative impacts of “standard practices” on lower income and/or chronically ill employees; or
 - ▶ are likely to positively impact employee/family health, productivity and/or satisfaction.
- Best practice practitioners often have a broader perspective on the outcomes desired from their benefit strategy (total population health/access to needed health care services, productivity, satisfaction and cost). While best practices also may reduce costs in the short- or long-term, cost savings was not the primary consideration.
- The importance scale range is
 - ▶ Low Importance
 - ▶ Moderate Importance
 - ▶ High Importance
- The gap scale range is:
 - ▶ Small Gap
 - ▶ Moderate Gap
 - ▶ Large Gap
- The table on **page 30** displays the practices, arranged by importance/gap.
- The table on **pages 31-38** identifies better practices in CDHP design and implementation.

Attention should be focused in areas of moderate–high importance and a moderate–large gap in practice.

Summary of Better Practices' Importance and Gaps in Practice

	Small Gap in Practice	Moderate Gap in Practice	Large Gap in Practice
High Importance		<ul style="list-style-type: none"> • CDHP Strategy Formulation • Cover a Broad List of Preventive Drugs in HSA Plans • Deductible Levels • HRA Enrollees Covered by a Prescription Benefit Card Plan 	<ul style="list-style-type: none"> • Engage in Determining HSA Preventive Drug List • Front-Loaded Account Contributions • Salary-based Account Contributions • Use of Data • Implement Value-Based Pharmacy Benefits
Moderate Importance	<ul style="list-style-type: none"> • HRA Roll-Over 	<ul style="list-style-type: none"> • Affordable Access to Primary Care • Automatic HSA Contributions • Decision Support • Incentive-Based Account Contributions • Robust Cost and Quality Transparency Tools • Robust Wellness Program 	
Low Importance			

Summary of CDHP Better Practices: Beginning Steps

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
CDHP Strategy Formulation	Take a thoughtful, deliberate, long-term approach to the many considerations that impact CDHP strategy and structure decisions, including: HSA vs HRA, multi-plan vs. full replacement, relative pricing/cost to employees of different plan options.	<ul style="list-style-type: none"> • High Importance 	CDHP strategy needs to fit the company's broader financial objectives and human capital strategy. A thoughtful strategy will consider potential impacts of a CDHP on employees and families at all levels, and will balance the need for short-term cost savings with the need to mitigate potential short- and long-term impacts.	<ul style="list-style-type: none"> • Moderate Gap • Current "standard approach" is OK, but not well-suited to address potential negative consequences of CDHPs. Gap may narrow as employers drive adoption or full replacement and have more sick and low-income employees confronting issues of affordable access to needed treatment. 	<ul style="list-style-type: none"> • A smart strategy will balance short-term cost savings goals with medium and longer term objectives for all employees to have affordable access to needed treatments, resulting in a healthy, productive and satisfied workforce.
Use of Data	Formulate and evaluate strategy using integrated health and productivity data.	<ul style="list-style-type: none"> • High Importance 	Employers can maximize benefits and minimize unintended risks and costs when strategy is developed with an integrated view of employee health, productivity and satisfaction (ie, using medical, pharmacy, workers' compensation, disability, absence, wellness, productivity and/or employee satisfaction data).	<ul style="list-style-type: none"> • Large Gap • According to other Benfield research, 82% of employers in 2013 included medical data in an integrated database used for planning, measurement and management. 80% included pharmacy; 33% wellness. Only a small percentage integrated productivity-related data (20% Long-Term Disability and Short-Term Disability, 15% absenteeism, 4% presenteeism). 	<ul style="list-style-type: none"> • Better data enables employers to avoid unintended impacts on health and productivity, or drive employees to use other benefits (eg, workers' compensation).

Summary of CDHP Better Practices: Beginning Steps

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Deductible Levels (Focus on Net Deductible)	<ul style="list-style-type: none"> Don't focus on the deductible, per se, but on the net deductible. The net deductible equals the deductible minus the employer's contribution to an employee/family HRA or HSA account, including incentive-based and salary-adjusted contributions. 	<ul style="list-style-type: none"> High Importance 	By focusing on net deductible levels, employers can set deductibles to get employee "skin in the game," but then leverage company contributions (particularly contributions contingent on things like wellness program participation or use of decision support tools) to incent employees to improve their health and make smarter health care choices.	<ul style="list-style-type: none"> Moderate Gap Most (86%) of employers make account contributions to partially offset deductible levels. Smaller percentages make incentive-based contributions (29% HSA, 40% HRA), with additional employers expected to do so in the future (26% HSA, 28% HRA). Few employers make salary-based contributions (11% HSA, 0% HRA). No additional survey respondents expect to make these contributions in the future. 	<ul style="list-style-type: none"> When deductibles and account contributions hit the right balance, the net deductible sends a clear signal to employees that they have skin in the game, but also aligns incentives to promote health and informed decision-making. Further, the net deductible is flexible to make sure some employees (especially lower income and chronically diseased) are not put at risk.

Summary of CDHP Better Practices: Options to Achieve Appropriate Net Deductible

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Account Contributions (HSA and HRA)	<p>Incentive-based contributions: Employee/family can “earn” additional contributions by doing things like completing a biometric health risk appraisal, talking with a health coach, or achieving biometric targets.</p>	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> Account contributions provide incentive mechanism for employers to influence employee behavior toward goals of better health and smarter health care decisions. May not be a good cultural fit for some companies (eg, highly paid). Some companies may have a relatively low deductible, reducing the need and impact of incentives. 	<ul style="list-style-type: none"> Moderate Gap HSA: 29% currently, with 26% of others intending to do so by 2016. HRA: 40% currently, with 28% of others intending to do so by 2016. 	<ul style="list-style-type: none"> Well-designed incentives can promote better health and adherence to treatment. Additional funding into accounts via incentives reduces the net deductible.
	<p>Salary-based contributions: Employer puts more money into the HRA or HSA account for lower wage employees.</p>	<ul style="list-style-type: none"> High Importance 	<ul style="list-style-type: none"> Additional contributions for those with less money and most hard-hit by high deductibles reduces negative health, productivity and satisfaction consequences of CDHPs. 	<ul style="list-style-type: none"> Large Gap 11% of employers offering HSA-based plans. 0% of employers offering HRA-based plans. 	<ul style="list-style-type: none"> Additional funding into accounts for low-income workers reduces their net deductible and potential barrier to receive needed treatment.

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Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Account Contributions (HSA and HRA)	Front-Loaded Contributions: Employers put in place a mechanism to make HSA or HRA account contributions available early in the year (vs. equal installments over the year).	<ul style="list-style-type: none"> High Importance 	<ul style="list-style-type: none"> Similar to salary-based contributions, this tactic makes sure employees with cash flow challenges and/or those with high health care needs/costs early in the year can afford the treatment they need. Employers with high turnover should consider the cost and administrative burden associated with employees who receive advanced HSA contributions and leave before they'd have otherwise been eligible to receive such funds. 	<ul style="list-style-type: none"> Large Gap No survey data on this practice. It did not come up a lot in interviews, but when it did, the practice was noted as uncommon. 	<ul style="list-style-type: none"> Helps improve treatment adherence for low-income and/or high-cost employees and families, including those needing specialty medications.
	HRA Roll-Over: Employer enables HRA funds to roll over (sometimes to a limit).	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> Promotes responsible use of HRA funds in early years. Employees benefit in later years if they've built up their accounts. 	<ul style="list-style-type: none"> Small Gap Based on interviews, this practice is common. 	<ul style="list-style-type: none"> In early years, may deter treatment adherence, but in later years, may promote adherence when funds are built up.
	Automatic HSA Contributions: Employees need to opt out of making a contribution.	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> Like 401ks, this drives employee contribution to accounts by making it a default. 	<ul style="list-style-type: none"> Moderate Gap Based on interviews, this practice is not common, but becoming more so. 	<ul style="list-style-type: none"> Employee contribution effectively reduces the net deductible and increases employee engagement/skin in the game.

Summary of CDHP Better Practices: Pharmacy Design

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Prescription Drug Benefits	HRA-Based CDHPs				
	<p>Employees Covered by a Card: Employees don't need to spend their deductible before having access to a prescription drug card plan.</p>	<ul style="list-style-type: none"> High Importance 	<ul style="list-style-type: none"> Recognizes the important role prescription drugs/drug coverage plays in managing health, productivity and employee satisfaction. This tactic may promote non-formulary medication in some cases. 	<ul style="list-style-type: none"> Moderate Gap 56% of HRA plans provide prescription drug coverage via a traditional card plan before the deductible is met. 	<ul style="list-style-type: none"> Improves affordable access, a particularly important benefit to patients on multiple and/or expensive therapies.
	<p>Implement Value-Based Pharmacy Benefits: Employer reduces employee out-of-pocket costs for high-value therapies to treat some chronic/high-cost conditions to improve adherence.</p>	<ul style="list-style-type: none"> Moderate to High Importance 	<ul style="list-style-type: none"> Reduce financial barriers to treatment adherence for certain chronic conditions. 	<ul style="list-style-type: none"> Moderate to Large Gap 31% currently offer, with 14% intending to begin by 2016. 	<ul style="list-style-type: none"> May improve adherence to therapies for drugs under value-based coverage.

Summary of CDHP Better Practices: Pharmacy Design

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Prescription Drug Benefits	HSA-Based CDHPs				
	<p>Cover a broad list of preventive drugs: Employer covers preventive drugs before the deductible, and covers a relatively broad list of drugs.</p>	<ul style="list-style-type: none"> Moderate to High Importance 	<ul style="list-style-type: none"> This recognizes the important role that prescription drugs/drug coverage plays in managing health, productivity and employee satisfaction. 	<ul style="list-style-type: none"> Moderate Gap It has become relatively common (>50%) for employers to cover drugs for hypertension, diabetes, high cholesterol, asthma and smoking cessation. 	<ul style="list-style-type: none"> Improves affordable access, a particularly important benefit to patients on multiple and/or expensive therapies.
	<p>Engage in Determining Preventive Drug List: Employer engages in decisions that affect the classes of drugs covered and whether coverage is for generics only, or includes availability of newer brand drugs. The decision may be at the level of evaluating competing PBMs vs. list-level choices.</p>	<ul style="list-style-type: none"> Moderate to High Importance 	<ul style="list-style-type: none"> Without engagement, decision may be driven simply by price, or by comparisons that don't take into consideration the availability of brands vs. generics-only options. Employers should understand what's on the preventive list and to make choices based on their understanding of their population data and needs. 	<ul style="list-style-type: none"> Large Gap Interviewees indicated about 5% of employers get involved in the preventive drug list. Most employers (and consultants) defer to the PBM. The impression from interviews with EBCs is that PBM comparisons are typically simplistic and price-driven. 	<ul style="list-style-type: none"> When employer involvement assures important preventive drugs are available (including brands with notable benefits), employees and families will have fewer barriers to access the treatments they need.

Summary of CDHP Better Practices: Consumerism Support

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Other Consumerism Support	Robust Wellness Program: Employees have access to information and programs to help them practice a healthy lifestyle.	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> Supporting better health is part of the employer strategy to drive greater health and health care responsibility and accountability often central to a CDHP strategy. 	<ul style="list-style-type: none"> Moderate Gap It is common to offer wellness programs, but the intensity and quality varies. It is difficult to engage employees in the program. 	<ul style="list-style-type: none"> Programs can help people improve their health and may help promote treatment and treatment adherence.
	Robust Cost and Quality Transparency Tools: The employer assures employees and families are equipped with information and/or resources needed to make sound health care decisions based on both cost and quality data.	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> Consistent with the CDHP strategy to engage employees and their families by having a financial stake and information needed to make good choices. 	<ul style="list-style-type: none"> Moderate Gap It's common to have tools in place (through third-party vendors or plans), but tools are limited by data on cost and quality, which is better in some markets than others, and generally trending toward becoming better. 	<ul style="list-style-type: none"> Resources can help patients identify better value care. Choices made on reliable quality data may lead to better treatment recommendations.

Summary of CDHP Better Practices: Consumerism Support

Element	Better Practice	Better Practice Importance	Rationale	Optimal-Actual Gap	Patient Health and Pharmacy Considerations
Other Consumerism Support	Decision Support: Employer provides employees and families with access to resources, including websites and health coaches, to help them make decisions about providers and treatments.	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> This is consistent with the CDHP strategy to engage employees and their families by having a financial stake and information needed to make good choices. 	<ul style="list-style-type: none"> Moderate Gap It is common to offer decision support, but support is limited by data on cost and quality. 	<ul style="list-style-type: none"> Resources can help patients determine an appropriate course of action (eg, whether to have surgery), and can help to identify better value care.
	Health Reimbursement Account—Providing Affordable Access to Primary Care for Chronic Conditions: Employers design benefits to reduce barriers to and/or increase use of primary care.	<ul style="list-style-type: none"> Moderate Importance 	<ul style="list-style-type: none"> Response to recognition that employees with chronic conditions were not receiving care they needed because it was too costly. 	<ul style="list-style-type: none"> Moderate Gap A tactic that is only necessary in some instances (a lot of low-income employees) and in some situations (able to collaborate with providers in a market area). However, it exemplifies an innovative mindset to identify and solve potential problems inherent in CDHPs. 	<ul style="list-style-type: none"> Modest impact on patient care and treatment adherence.

Conclusions

1. **More and more people**—including those with chronic, high cost conditions—are **enrolling in CDHPs** (not always by choice).
2. **A standard CDHP approach has emerged.** It's helping most employers achieve key goals related to cost and employee satisfaction...
3. However, **many employers are** at least moderately concerned that sicker and lower income **employees may be harmed...**
4. But, **most employers** (and their vendors or advisors) **lack the data needed** to see the impact on subsets of employees...
5. As such, while the hypothesis that a **strategic approach provides better outcomes** can still be inferred, our research is not conclusive.
6. Some **employers are leading the way with strategic and innovative approaches** that address concerns about employees with costly chronic conditions and a high need for medical care and prescription drugs.
7. For patients, the **good news is that the standard approach that has emerged includes coverage of preventive drugs...**
8. However, due in large part to perceived tax risks, **employers are being advised to just choose among PBM lists** and to not mess with them...
9. And some may argue that **PBMs need more**, not less, **employer/advisor input and oversight** when it comes to what gets included and excluded from drug lists.



1717 Pennsylvania Avenue, NW
Suite 800
Washington, DC 20006
info@npcnow.org | 202-827-2100
www.npcnow.org