Customer for the Ethics Advisory Group
The customer for the July 21 EAG meeting was Scott Polansky, Director of Product Management in the HPHC Department of Marketing and Sales.

Background
At the end of the last EAG meeting (May 19, 2004) several participants noted that as HPHC has responded to the rapidly evolving insurance market the EAG has conducted a series of meetings focused on the values dimensions of new insurance products considered one at a time. The group suggested that at its next meeting the EAG should look at a range of HPHC’s actual and potential products in light of a “values framework” derived from the major values identified in the four EAG meetings that have explicitly addressed the ethical aspects of product development.” This was the agenda for July 21.

The first question an organizational ethics program must consider is what values does the program apply and where do they come from? The EAG makes a two-part answer to these questions. First, it uses HPHC’s explicit values statements – especially the mission, vision and value proposition – as its basic written scripture. These statements, however, are relatively broad, and it is not always clear what guidance they give for complex business decisions, especially when values conflict with each other. In considering how the basic HPHC values may be put into operation, the EAG supplements the mission/vision/values proposition with a second approach – a widely used framework for organizational ethics called “stakeholder theory.”

A publication from the American Medical Association Institute for Ethics gives the best summary of stakeholder theory I am aware of:

The core thesis of stakeholder theory is the normative claim that the interests of all the parties involved in any transaction ought to be considered in determining how to act ethically. In order to determine how an organization ought to act in a particular situation, it is necessary first to identify each of the parties (individual and collective) with whom the organization interacts and what each party has at stake. Second, one must ask how the organization ought to act in relation to each party, and then how the organization’s several obligations to these parties ought to be ranked, both in general and in the situation at hand. We refer to the first as the analytic step and the second as the normative step.

(Organizational Ethics in Health Care: Toward a Model for Ethical Decision Making by Provider Organizations, by David Ozar, Jessica Berg, Patricia Werhane and Linda Emanuel, published June, 2000, pp. 5-6)

* The four meetings that focused on product development are: “Ethical Issues in [Affordable Products] and Defined Contribution” (7/18/01); “Affordable Products – Enhancing Ethical Benefits/Minimizing Ethical Risks” (7/24/02); “Implementing HPHC’s ‘Affordable Products’ – Ethical Opportunities and Risks in ‘Consumer-Driven Health Care’” (3/27/03); and, “Health Insurance/Rapid Change: Developing a Framework of Values” (5/19/04).
The EAG has identified five key stakeholders for HPHC’s operations – members, purchasers, providers, HPHC itself and, given that the HPHC mission includes improving the health of society as well as the health of its members, the wider public. I have derived the working draft of a values framework for product development by a) listing (table I) the top four values for each stakeholder that emerged from the meetings focused on new products and then b) condensing the twenty values to five (table II). The framework presented in tables I & II should be regarded as a work in progress:

**Table I: The four most frequently mentioned values for each stakeholder group**

**Members:**

- Improved health & health-related quality of life
- Affordable, low-hassle health insurance
- Choice and control re insurance products and health services
- Information & tools for making decisions about insurance and services

**Purchasers:**

- Employees/beneficiaries receive the health services they need
- Health insurance is affordable
- Employees/beneficiaries are value-oriented and aware of costs and trade offs
- Employees/beneficiaries are satisfied with the insurance the purchaser provides

**Providers:**

- Insurance facilitates provision of needed services to patients
- Insurance is administratively simple and low-hassle
- Insurance supports the clinician-patient relationship
- Insurance provides fair compensation for services rendered

**HPHC:**

- Products foster health improvement for members and society
- Products enhance trust from all stakeholders
- Products are consistent with financial stability
- Products encourage members to be value-oriented/aware of costs and trade offs

**Wider Public:**

- People get the services they need
- Health insurance is affordable
- New products maintain (and expand) overall access to health insurance
- Citizenry is value-oriented and aware of costs and trade offs

**Table II: Condensed values framework for assessing insurance products**
• The product facilitates health improvement for members and society∗

• The product promotes affordability

• The product promotes a value-orientation and awareness of costs and trade offs

• The product supports financial stability for HPHC

• The product maintains/enhances stakeholder trust for HPHC

Questions for the Ethics Advisory Group

1. What is the EAG’s assessment of the following range of HPHC insurance products in light of the values framework (Tables I & II)?

   Harvard Pilgrim HMO. This product provides comprehensive coverage in which the member’s financial responsibility is generally limited to copayments at the time of care. Care is managed by the primary care physician. With limited exceptions (gynecological exams, behavioral health) specialty services require a PCP referral. More information about the HPHC HMO is available at:
   http://www.harvardpilgrim.org/pls/portal/docs/PAGE/SC/COVERAGE/HMO/CC1686_HMO.7_03.PDF

   Harvard Pilgrim PPO. This product offers members the highest level of choice with regard to their care. PPO members can receive care from any providers within the HPHC network without needing a referral from their primary care physician. PPO members can also elect to seek care from providers who are not part of the HPHC network. Members pay more for out-of-network visits than for in-network services, and out-of-network services are subject to a yearly deductible. More information about the HPHC PPO is available at:
   http://www.harvardpilgrim.org/pls/portal/docs/PAGE/SC/COVERAGE/PPO/CC1686_PPO.07_03.PDF

The following quote from an article on “Reinvention of Health Insurance in the Consumer Era” by University of California health economist James Robinson provides useful background for the next two products the EAG considered – the relatively newer Best Buy products and Primary Choice, which is under exploration.

The private health insurance industry in the United States has fundamentally changed its strategic focus, product design, and pricing policy as a result of the backlash against managed care. Rather than seek to influence the behavior of physicians through capitation and utilization review, the major health plans now seek to influence the behavior of patients through benefit designs that cover a broad range of services but with high copayments, tiered network designs that cover a broad range of physicians but with variable coinsurance, and medical management programs that provide incentives for patients to better manage their own health care. Premium prices are carefully adjusted to cover the expected costs of care for each type of product and each class of patient, with a commensurate willingness to abandon enrollment where insurance premiums cannot

∗ The reason “society” is included as well as the “members” who enroll in a product is that the EAG recognized that a product could promote good by serving its enrollees well but at the same time promote overall harm by fragmenting the risk pool and making insurance less available to others.
outrun medical costs. The contemporary product and pricing policies reflect a retreat by the insurance industry from previous efforts to transform the health care system and embody a delegation to individual consumers of responsibility for setting priorities and making financial tradeoffs. (JAMA, April 21, 2004, pages 1880-1886)

HPHC Best Buy HMO & PPO. Best Buy products seek to a) make insurance more affordable and at the same time b) encourage members to be value-oriented/aware of costs and tradeoffs by c) subjecting certain services to an annual deductible. More information about Best Buy HMO is available at: http://www.harvardpilgrim.org/pls/portal/docs/PAGE/SC/COVERAGE/BESTBUY/CC1686_BB HMO_MA.PDF More information about Best Buy PPO is available at: http://www.harvardpilgrim.org/pls/portal/docs/PAGE/SC/COVERAGE/BESTBUY/CC1686_PP O_BB_MA.6_03.PDF

Primary Choice. Harvard Pilgrim Health Care is developing a potential new product - Primary Choice – as part of the “reinvention” process Robinson describes. Primary Choice, which will be available to Massachusetts-based employers with 100 or more eligible employees, would create three tiers of primary care physicians (PCPs) based on risk-adjusted cost and performance measures. Premium would be lowest for Tier I, consisting of PCPs seen as providing the highest value or cost-effectiveness. Tier II adds a second group of PCPs to Tier I and incurs a higher premium. Tier III includes all PCPs in the HPHC network and has the highest premium level. Primary Choice members can receive care from any hospital or specialist in the HPHC network to which their PCP makes referrals. Primary Choice essentially overlays a tiering of primary care physicians onto existing HPHC HMO and POS (“point of service”) products.

2. How well does the values framework presented in Tables I & II work for identifying important values-related dimensions of different insurance products? How can the framework be made more useful?

EAG DISCUSSION/RECOMMENDATIONS
(I have organized these minutes into two sections. Section I summarizes the central points from the EAG discussion on July 21. The bulk of that discussion focused on Primary Choice – the one product that had not been considered at previous EAG meetings. Section II draws on all five of the EAG meetings that have focused on insurance products in order to provide the fullest possible basis for a “values profile” of a representative range of products.)

Section I – Summary of the central points from the 7/21 EAG discussion. Jim Sabin opened the meeting by introducing Mike Quirk, Ph.D. Mike has been the Director of Behavioral Health at Group Health Cooperative in Washington for 16 years, has recently taken on the role of facilitator of the newly restructured GHC Ethics Advisory Committee, and was interested in observing an EAG meeting. Emily Derr, a summer intern from Cornell working with Harvey Cotton in the legal department, was also introduced.

The objective for the July 21 meeting was to review a range of products in the light of the values that the EAG had previously identified as especially relevant for developing and managing individual products. The desired outcome was a perspective on how different product design features interact with central HPHC values. The aim was not to rank products but to understand their particular strengths and limitations as seen through the lens of ethics.

I A – Reviewing Primary Choice through the lens of ethics. The EAG was especially interested in Primary Choice, which it had not previously considered, and the first two thirds of
the meeting was devoted largely to deliberations about it, with intermittent reference to other products.

David Cochran explained the essence of *Primary Choice* as follows. Primary care groups were divided into three tiers based on the risk-adjusted cost of total health care (primary care, specialty care, hospital care, etc) for members of the practice. The three tiers were then examined in terms of the currently available quality measures, including HEDIS results and the HPHC honor roll. Honor roll providers were distributed among the three tiers. HPHC envisions a 10% difference in cost between the tiers. *Primary Choice* members can receive care from any hospital or specialist in the HPHC network to which their PCP makes referrals. *Primary Choice* essentially overlays a tiering of primary care physicians onto existing HMO and POS (“point of service”) products. Benefits are identical for all three tiers.

Vin Capozzi and Scott Polansky told the EAG that the most extensive experience to date with a program like *Primary Choice* has been in Minnesota, where a tiered program called “Patient Choice,” which currently has 100,000 members, has been in existence since 1997, when it was founded by a coalition of large employers – the Buyers Health Care Action Group (BHCAG). While the cost of Patient Choice has increased each year, compared to other products in Minnesota it appears to have slowed the rate of increase by 2-3%. Enrollees have shown a preference for the least costly tier, and physicians have moved the cost of their practices from higher to lower tiers. In 1997 10% of the members enrolled in tier I. Six years later 50% were enrolled in tier I. (Further information is available at: http://www.patientchoicehealthcare.com)

The first observation the EAG made about *Primary Choice* is that even the well-informed participants in the July 21 discussion had to ask a number of questions before feeling confident that they understand the product. Given the Institute of Medicine findings about the widespread problem of limited health literacy, ensuring that purchasers and potential members understand *Primary Choice* well enough to make an informed decision about whether to enroll will be a challenge.

A participant in the discussion reported that employers were enthusiastic about *Primary Choice* based on their belief that the design of *Primary Choice* puts providers and patients “on the same page” with regard to cost management. Being in a less costly tier a) reduces costs to enrollees and b) brings more members to a practice, which “creates the potential for dialogue [about value] among these two stakeholders.” The employers hoped that this dynamic would contribute to slowing the cost trend in Massachusetts as had happened in Minnesota.

EAG members were told that HPHC intends to be explicit about the fact that the tiers are created on the basis of risk-adjusted cost of care. Enrollees will have access to HPHC’s measures of quality to assist them in making their choices. The EAG responded very positively to the degree of transparency associated with *Primary Choice*. The EAG saw tiering based on cost considerations as acceptable as long as HPHC makes the basis on which the tiers have been created clear to stakeholders.

Participants raised two opposing concerns about the potential impact of *Primary Choice* on quality. Given that quality measurement is still in an early stage of development, one participant feared that basing tiers on could trigger “a race to the bottom,” in which providers might reduce their costs at the expense of reducing quality of care as well. Another participant, however, worried that *Primary Choice* “does not go far enough.” *Primary Choice* rewards lower cost, but the ultimate aim is to reward the combination of high quality and low cost, not just lower cost.
**I B – Enhancing the ethical impact of products through services, supports and financial incentives.** The EAG emphasized that products are not magic bullets that will provide coverage, improve quality and slow the cost trend on their own. To exert their optimal impact over time, products must engage stakeholders in an ongoing dialogue about quality and cost.

Several HPHC employees cited their own experience during the recent reenrollment process to make the point that product design alone will not create this kind of engaged dialogue and activism. When HPHC changed its contribution policy from equal percentage (80% of whichever plan the employee chose) to equal dollar (80% of the HMO premium) the cost differential among alternative choices stood out more, which made the investment of time to make careful decisions seem worthwhile. The combination of meetings, opportunities for 1:1 coaching, and online information and tools helped employees reflect more deeply about their choices. One participant commented that “the key ethical issues aren’t in the products themselves but in the opportunity to make informed decisions about them.”

In discussing the four products that were presented for consideration at the meeting, participants focused on the degree to which the different products could: a) encourage enrollees to reflect on cost, quality and value and b) align stakeholder interest in these factors. For products with deductibles, if employees are given timely information about cost and quality they may become—over time—more discerning, value-oriented consumers of health care. The three-tier pharmacy benefit has engaged consumers in this kind of value-oriented decision making about drugs, but participants felt that there is a long way to go before a similar dynamic could emerge with regard to MRIs, laboratory tests, specialists’ charges and other services. One participant commented that where Primary Choice appears to align patients and providers with regard to the importance of cost management, deductibles act primarily on the patient. For the PPO and Point of Service products, the premium differential and the increased cost of out of network care make the connection between increased choice and increased cost clear to enrollees. The HMO product typically gives primary care physicians and integrated groups incentives to attend to costs and information but, as a participant at the July 21 meeting said, it can “divorce the patient from concern about the cost of care.”

**Section II – “Values profiles” for different products.** Given the goals of a) understanding how different product design features interact with central HPHC values and b) characterizing the strengths and limitations of different products with regard to these values, I have drawn on the four prior meetings devoted to product design in addition to the July 21 meeting. What follows is a bulleted summary of the values associated with four products—HMO, PPO, Best Buy (and HAS) and Primary Choice—that emerged at the five EAG sessions focused on products. The heading “potential strengths” lists values the EAG saw the product as enhancing, while “potential limitations” refers to values that the EAG felt the product might constrain. The numbers of bullets reflect the degree of EAG attention to an area and should not be interpreted quantitatively. Thus the fact that the “potential limitations” for Best Buy has the largest number of bullets reflects the fact that the EAG has discussed the new deductible products more than any others, while the fact that only one “potential limitation” is listed for the PPO product reflects the fact that PPOs have received little EAG attention.

a) **HMO:**

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Potential strengths:
- Few barriers to care (comprehensive benefits & modest copayments)
- Easy for members to understand and use the product
- Encourages PCPs and integrated practices to manage care
- Easy for providers to understand

Potential limitations:
- Limits consumer choices
- First dollar coverage may decrease member engagement with cost value & trade offs
- As of 2004, diminished marketplace interest in the HMO product

b) **PPO**:

Potential strengths:
- Increased choice for enrollees
- Premium and out of network differential connect increased choice with cost to enrollee
- Easy for members to understand

Potential limitations:
- Less encouragement for providers to manage care than under the HMO product

c) **Best Buy (& other products with deductibles, such as HSAs)**:

Potential strengths:
- Encourages enrollee engagement with cost, value and trade offs
- Contributes to cost containment efforts
- May allow employers to offer health insurance rather than no insurance at all
- Strong market interest in products with deductibles
- If good cost & quality information are available, consumers are more empowered

Potential limitations:
- Deductibles may create a barrier to needed care, especially for low-income enrollees
- Providers may not know at point of service who is financially responsible for payment
- May create risk of bad debt for providers
- “Blunt deductibles” (as under HSAs) may impede use of incentives to promote health
- May contribute to fragmentation of the risk pool
- Enrollees may not want to “shop” and “negotiate”
- Enrollees with lower health literacy will have difficulty “shopping for value”

d) **Primary Choice**:

Potential strengths:
- Can align enrollees and providers re cost, value and trade offs
- Contributes to cost containment efforts
- Offers same benefits as HMO (or PPO) but adds tiering by risk-adjusted cost
- Minnesota experience suggest it may facilitate continued cost containment over time

Potential weaknesses:
• Might focus too much provider attention on cost alone (v cost & quality)
• Can be difficult to understand

Summary
1. The discussion of Primary Choice highlighted the importance of finding ways to align stakeholders with regard to their interest in improving value in health care – by a) holding quality steady while reducing cost, b) ensuring that any increase in cost reflects an increase in quality and ideally c) finding ways to increase quality and decrease cost, as has happened in other areas of the market economy.
2. Although the focus of the meeting was on products, the EAG emphasized that products promote values in concert with the education that accompanies them and the tools that can be applied in using them. The experience HPHC employees reported from their own recent experience in making their own health insurance choices reinforced this perspective.
3. Given the importance of education and information for effective use of products, the issue of health literacy requires special attention, to address the difficulty those with low literacy are likely to experience in making informed insurance choices and effective use of their coverage.
4. The EAG was very appreciative for the opportunity to contribute to this basic business function from the perspective of ethics.

Jim Sabin