

Can “Consumerism” Slow the Rate of Health Benefit Cost Increases?

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Issue Brief

- Employers are considering ways in which they can restructure health benefits. A few employers have turned to, and many others are considering, a trend that started in the 1980s to give employees more choice among different types of benefit arrangements, while at the same time exposing employees more directly to the cost of providing health benefits and health care services. This *Issue Brief* explores the spectrum of various health benefit options to understand the issues involved.
- Americans have been spending an ever-increasing amount of money on health care services. Health spending totaled \$73 billion in 1970, rising to \$1.3 trillion in 2000. Spending increases have been attributed to the aging of the population, the comprehensiveness of insurance, increased income of employees, differential productivity growth from medical care, avoidable administrative expense, provider-induced demand, and technological innovation.
- The terms “defined contribution” and “consumer-driven” have been used to describe a wide range of possible approaches to give employees more incentive to control the cost of either their health benefits or health care and to reduce the size and volatility of employer spending. All strategies to increase consumer involvement in health care spending decisions have a common theme: to shift decision-making responsibility regarding some aspect of health care or delivery from employers to employees. The approaches fall along a continuum of options. They include the traditional large-employer health plan choice model, the out-of-pocket choice model, tiered provider networks, various health spending accounts, and vouchers.
- While various types of consumer-driven health benefit approaches may result in more efficient spending on health care services, this does not necessarily mean that spending will either decline or slow down. It is well known that a small fraction of the population accounts for a large share of health spending. Among the adult population with employment-based health insurance, the top 1 percent of spenders accounted for 20 percent of all spending in 1998. Overall, the top 10 percent of spenders accounted for 58 percent of all health care spending, while the top 50 percent accounted for 95 percent of all spending. Unless consumer-driven health benefits include incentives and tools to affect the spending patterns of high users of health care services, the total cost of providing health care benefits is unlikely to be significantly affected.
- A movement to consumer-driven health benefits has implications for health benefit costs, utilization of health care services, quality of health care, the health status of the population, risk selection, and efforts to expand health insurance coverage. Ultimately, the success or failure of consumer-driven health benefits will be measured by its effect on the cost of providing health benefits and its effect on the number of people with and without health benefits.

Paul Fronstin of EBRI wrote this *Issue Brief* with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Key Issues for Plan Sponsors

Objectives in Moving to Consumer-Driven Health Care:

- Hold down health benefit cost increases.
- Provide greater flexibility to employees (health plan, provider).
- Increase employee satisfaction (i.e., a response to the managed care backlash).
- Raise employee awareness of the true costs of insurance and health care services.
- Respond to the threat of patients' bill of rights (i.e., litigation).

Issues to Consider:

- The administrative capability needed in switching to and running a consumer-driven health care plan.
- The communication/education strategy required.
- Understand the marketability issues with different employee sectors.
- Understand the impact on employer costs.
- Understand the impact on employee costs.
- Understand the impact on employee satisfaction.
- Offering Flexible Savings Account with a Personal Care Account (PCA).
- Full replacement with a consumer-driven health plan, or an additional choice to the existing plan? How to price the benefit, relative to other choices?
- How to handle new hires.
- How to handle terminations.
- How to handle family status changes.
- What services would the PCA pay for (exclusions—such as Lasik surgery, acupuncture, orthodontics—exclusions defeat the purpose of giving employee more control)?
- How to handle COBRA benefits, retiree health, long-term care.

Consumerism:

1. The promotion of the consumer's interests.
2. The theory that an increasing consumption of goods is economically desirable; also: a preoccupation with and an inclination toward the buying of consumer goods.

—Webster's Dictionary

Introduction

A number of health policy analysts have suggested that employers are rethinking their entire approach to managing employee health benefits (Fronstin, 2001a; Ogden and Strum, 2001; Salisbury, 1998; Salisbury, 1999; Scandlen, 2000).¹ One option being considered would have employers giving employees a fixed amount of money that employees could use to purchase health insurance either on their own or through some type of group purchasing arrangement. Researchers have surveyed both employers and workers to understand their interest in these arrangements, and have found that no clear consensus exists within either group.²

The terms *defined contribution* and *consumer driven* have been used to describe a range of potential health benefit options available to employers.³ These terms generally connote programs in which employees are intended to be treated more as *direct purchasers* of health coverage and health care services rather than the *indirect beneficiaries* of purchases made by the employer, so that they will be more careful purchasers and will be more satisfied with the choices they make on their own, rather than having someone else make those choices for them. A previous *EBRI Issue Brief* discussed how these health benefits could work and the major issues that are involved (Fronstin, 2001a). The options included not only employers giving employees a fixed amount of money that employees could use to purchase insurance, but also allowing employees to choose from an array of health benefits offered by the employer. Discussion regarding these issues continued at an EBRI-ERF policy forum in May 2001 (Blakely, 2001), and again at the May 2002 policy forum (Jaffe, forthcoming).

Employer interest in these health benefits continues to grow for a number of reasons. First, employers continually look for more cost-effective ways to provide health benefits for their work force, and are

concerned about future cost increases; these arrangements would allow them to set a monetary contribution for health benefits regardless of the size of cost increase of providing the benefit. Second, many employers sponsoring health plans are concerned that the public and political “backlash” against managed care will result in new restrictions or laws that will entangle them in litigation. Employers could distance themselves from health care coverage decisions by limiting their involvement to only the contribution amount for health benefits and not to the actual coverage or delivery of the health care services. Third, employers may be able to provide workers more choice, control, and flexibility through these arrangements.

Employers continue to consider ways in which they can restructure health benefits for the reasons mentioned above. A few employers have turned to, and many others are considering, a trend that started in the 1980s to give employees more choice among different types of benefit arrangements, while at the same time exposing them more directly to the cost of providing health benefits and health care services. The purpose of this *Issue Brief* is to explore the spectrum of various health benefit options—some of which are new and are being used, some of which are not being used, and some of which employers have already been using for numerous years—and to understand the issues involved with those options. The first section includes a discussion of why the cost of providing health benefits is increasing, and is followed by a section that presents the spectrum of health plan options. The concluding section discusses how increased consumer involvement may affect the cost of providing health benefits.

Health Benefit Costs

Americans have been spending an ever-increasing amount of money on health care services. Health spend-

ing totaled \$73 billion in 1970 (Figure 1), rising to \$1.3 trillion in 2000. Because the rate of increase in spending on health care services has increased faster than it has for other services, the United States is devoting a greater proportion of its resources to health care than it has historically. In 1970, spending on health care accounted for 7 percent of gross domestic product (GDP) (Levit et al., 2002), rising to 13.2 percent of GDP in 2000. This is largely unchanged since 1993, but is projected to reach 17 percent in 2011.

As spending on health care services has increased, so has the cost of providing health benefits to employees. Furthermore, annual increases in the cost of providing health benefits have been increasingly outpacing the consumer price index (CPI) and the medical

Figure 1
**DISTRIBUTION OF NATIONAL HEALTH EXPENDITURES,
BY SOURCE OF FUNDS, 1970-2000**

	1970	1980	1990	2000
(\$ billions)				
National Health Expenditures	\$ 73	\$246	\$ 696	\$1,299
(percentage)				
Private Funds	62%	57%	59%	55%
Consumer payments	56	51	53	49
out-of-pocket payments	34	24	20	15
private health insurance	21	28	34	34
Other private funds	7	6	6	6
Public Funds	38	43	41	45
Federal funds	24	29	28	32
Medicare	11	15	16	17
public assistance	4	6	6	9
State and local funds	14	14	13	14
public assistance	4	5	5	7

Source: EBRI estimates from Levit et al. (2002); and www.hcfa.gov/stats/nhe-oact/ (reviewed April 2002).

portion of the CPI since 1998 (Figure 2). Ultimately, the rising cost of providing health benefits will drive employer decisions regarding the provision of those benefits. However, employer decisions regarding health benefits may have little impact on national health spending, since employer

spending on health benefits accounts for only 27 percent of national health expenditures (Nichols, 2002).

While the factors accounting for rising health benefit costs are the subject of debate, a number of studies provide some evidence of the relative magnitudes of selected cost determinants. Newhouse (1992) and Cutler (1995) discuss how a number of factors have contributed to increased spending on health care services. They include the aging of the population, the comprehensiveness of insurance, increased income of

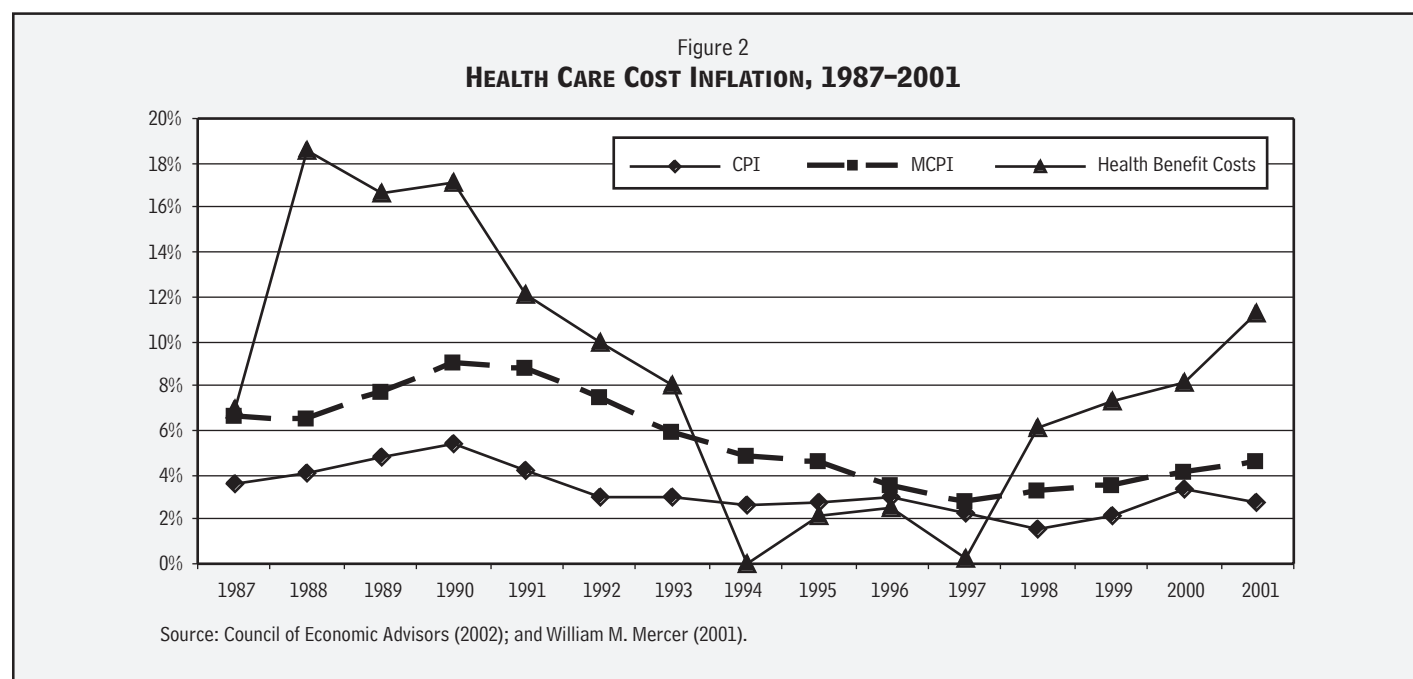


Figure 3
RESEARCH ON CAUSAL FACTORS ACCOUNTING FOR GROWTH IN REAL PER CAPITA HEALTH CARE SPENDING

	Newhouse (1992)	Cutler (1995)
Aging Population	2%	2%
Insurance	10	13
Income Growth	<23	5
Relative Medical Price Inflation	0	19
Avoidable Administrative Expense	n/a	13
Provider Induced Demand	0	0
Technological Change	>65	49

Source: Smith et al. (2000) as replicated in Technical Review Panel on the Medicare Trustees Report (2000).

Figure 4
DISTRIBUTION OF HEALTH CARE SPENDING

Percentage of U.S. Population Ages 18–64 With Employment-Based Insurance, Ranked by Expenditures	Distribution of Health Expenditures, by Magnitude of Expenditures
Top 1 percent	20%
Next 4 percent	23
Next 5 percent	15
Next 5 percent	10
Next 7 percent	9
Next 15 percent	11
Next 13 percent	6
Next 50 percent	5

Source: EBRI estimates from the 1998 Medical Expenditure Panel Survey.

employees, differential productivity growth from medical care, avoidable administrative expense, provider-induced demand, and technological innovation. Figure 3 contains a summary of these findings, which show that technological innovation in health care accounts for between 49 percent and 65 percent of increases in health spending, while the comprehensiveness of insurance accounts for between 10 percent and 13 percent.

As is well known, a small share of the population accounts for a large share of spending on health care services. Among the adult population with employment-based health insurance, the top 1 percent of spenders accounted for 20 percent of all spending in 1998 (Figure 4). Overall, the top 10 percent of spenders accounted for 58 percent of all health care spending, while the top 50 percent accounted for 95 percent of all spending. The cost of providing health care services is also influenced by numerous factors that are independent of utilization. Unless health benefit designs include incentives to affect the spending patterns of the small percentage of the population that uses a large amount of health care services, the total cost of providing health care benefits is unlikely to be significantly affected by new benefit designs. However, since a small percentage of the population has the most costly health problems, it may be unreasonable to expect patient choice to have a greater affect on health costs than reductions in utilization. Some of the major factors affecting the cost of providing health benefits are discussed below in more detail.

Technological Innovation

According to Newhouse (1992) and Cutler (1995), development and diffusion of technological advances in the production of health care services, including both new types of medical equipment (such as magnetic resonance

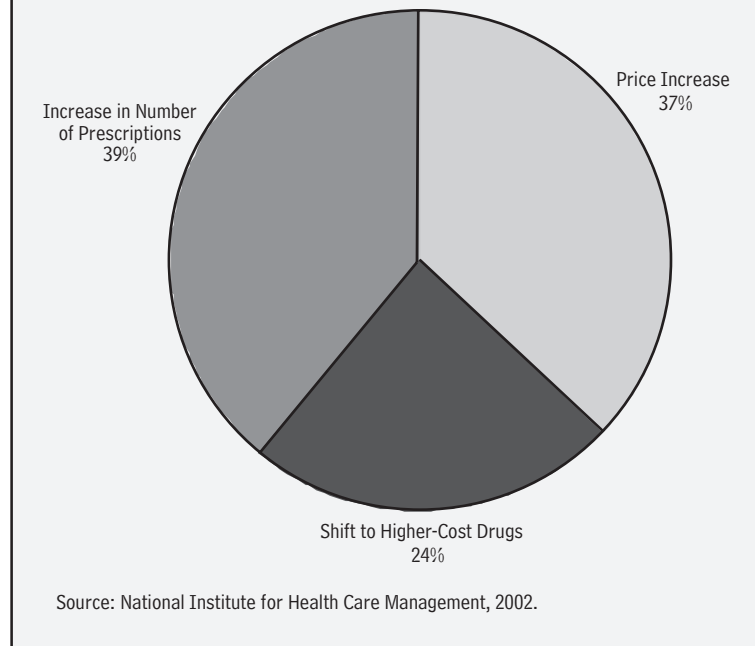
imaging) and new types of procedures (such as coronary artery bypass grafting) accounts for between 49 percent and 65 percent of the increases in health care spending. Other examples mentioned by Newhouse (1992) include renal dialysis, transplantation, artificial joints, endoscopies, monoclonal antibodies, and drugs (to be discussed in more detail in the next section).

Technological advances bring obvious costs. There is the cost of research, development, and marketing of new medical equipment and prescription drugs. There is the labor cost of training physicians to do new types of procedures. There is the monopoly premium built into initial patent and scarcity of the materials and expertise. All of these costs will increase the price of producing various health care services.

The availability of new technology alone does not drive health care spending; consumer demand for new services does as well. Weisbrod (1991) argues that research and development into new technology is affected by the demand for new technology, which will depend upon how the insurance system reimburses for new technology. In turn, the demand for technology will also affect the demand for health insurance, as consumers seek ways to pay for new technology. However, it is impossible to say whether technological innovation is *costly* without considering the *benefits* of that technology. Economists have tried to compare the cost of technological innovations with the benefits derived from them to obtain the net cost (or net benefit) in an economic framework.

Cutler and McClellan (2001) analyzed technological innovation to examine whether the costs or the benefits were greater. They conclude that spending on health care services as a whole is worth the increased cost of care. Other researchers have shown that advances in medical technology that have improved life expectancy have had a significant positive impact on the economy.

Figure 5
**PERCENTAGE CONTRIBUTION OF CHANGES IN PRICE
 AND UTILIZATION TO 2000–2001 INCREASE
 IN PRESCRIPTION DRUG SPENDING**



Murphy and Topel (2000) found that improvements in life expectancy due to technological innovations in medical care added roughly \$57 trillion to national wealth between 1970 and 1990, or \$2.8 trillion per year (in 1992 dollars). After factoring out the cost of providing those medical services, the net benefit to the economy was \$2.4 trillion per year. They conclude that the potential gains from future reductions in mortality are extremely large.

One problem with justifying cost increases on a cost-benefit basis is that the benefit of a technological advancement often does not take into account the effects on the economy. While some technological advances may reduce the cost of treating a person with a specific condition (for instance, if a prescription medication could be used as a substitute for a more costly invasive procedure), most often technological advances will increase the cost of diagnosis and treatment. Employers tend to focus only on the cost of providing health care services. Quantifying the magnitude of the benefit to a specific employer, as opposed to the benefit more generally to the economy, is a much more difficult task. Even though employers should be sharing the benefit of economywide growth due to technological innovation in health care, until they are shown how health benefits improve the bottom line, most employers will view health benefits as a *cost of doing business* rather than an *investment in their business*, although there are always exceptions.

Prescription Drugs

While prescription drugs are one component of technological innovation, they are discussed separately because the increase in drug spending occurs for different

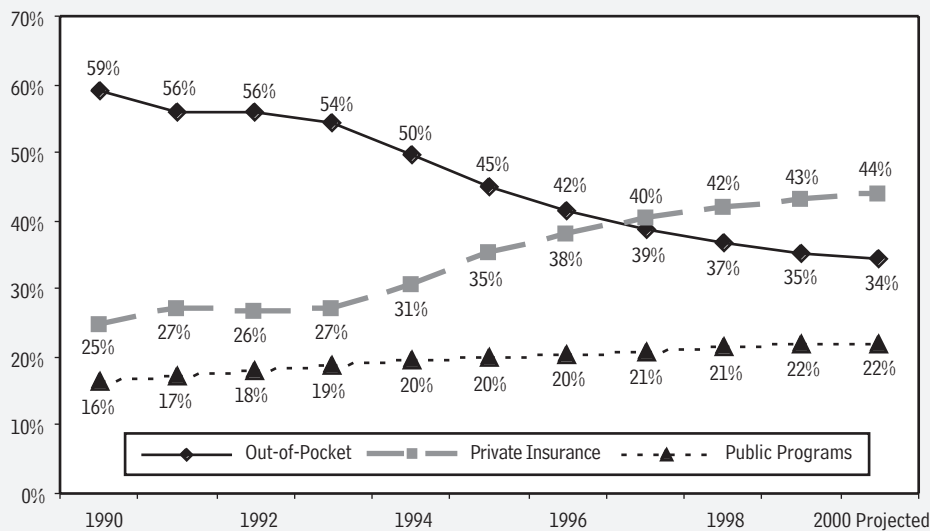
reasons. As mentioned above, spending on prescription drugs has recently increased on an annual basis between 15 percent and 20 percent, and is increasing more than twice as fast as spending on hospital services or physician services. Spending on prescription drugs has increased for three

reasons: 1) the price of existing drugs is increasing, 2) consumers are switching to relatively new drugs, which are priced higher than the drugs they are replacing, and 3) the number of prescriptions written for both new and older drugs has been increasing (NIHCM, 1999, 2001).

According to a report released by NIHCM (2002) on factors explaining the increase in prescription drug spending, increased utilization of drugs accounted for 39 percent of the total increase in drug spending between 2000–2001, higher drug prices accounted for 37 percent, and the shift toward higher-cost drugs accounted for 24 percent (Figure 5).

Some argue that the increase in utilization was driven, at least in part, by a dramatic increase in the advertising of drugs directly to consumers. Manufacturers argue that direct-to-consumer (DTC) advertising educates consumers about health conditions and available treatments, thereby encouraging them to obtain care for health problems using treatments they may have been unaware of. Opponents of DTC advertising argue that the ads induce consumer demand for newer, higher-priced drugs, which may be unnecessary or even inappropriate in some cases (Kaiser Family Foundation, 2001). Proponents counter that the ads do not lead to inappropriate use of prescription drugs because consumers still need to visit their physician to obtain a prescription for the drug; however, consumers still have

Figure 6
DISTRIBUTION OF NATIONAL PRESCRIPTION DRUG SPENDING, BY SOURCE OF PAYMENT, 1990-2000



Source: Centers for Medicare and Medicaid Services (CMS), as reproduced in Kaiser Family Foundation, *Prescription Drug Trends: A Chartbook Update* (November 2001).

to visit with a physician in order to determine that a drug is not appropriate. Physicians respond that it is easier to give patients the drugs they request, as long as they are not likely to do harm, than to try to persuade them that they do not need the medication regardless of what the ads tell them.

One study estimates that the 10 drugs most heavily advertised directly to consumers in 1998 accounted for about 22 percent of the total increase in spending on drugs between 1993 and 1998 (NIHCM, 1999). Overall, four categories of drugs—oral antihistamines, antidepressants, cholesterol-reducing drugs, and anti-ulcerant drugs—accounted for 31 percent of the total increase in drug spending during 1993–1998. Another study found that specific ads prompted consumers to talk to their physician about the advertised drug, and a small but significant minority received the drug as a result (KFF, 2001).

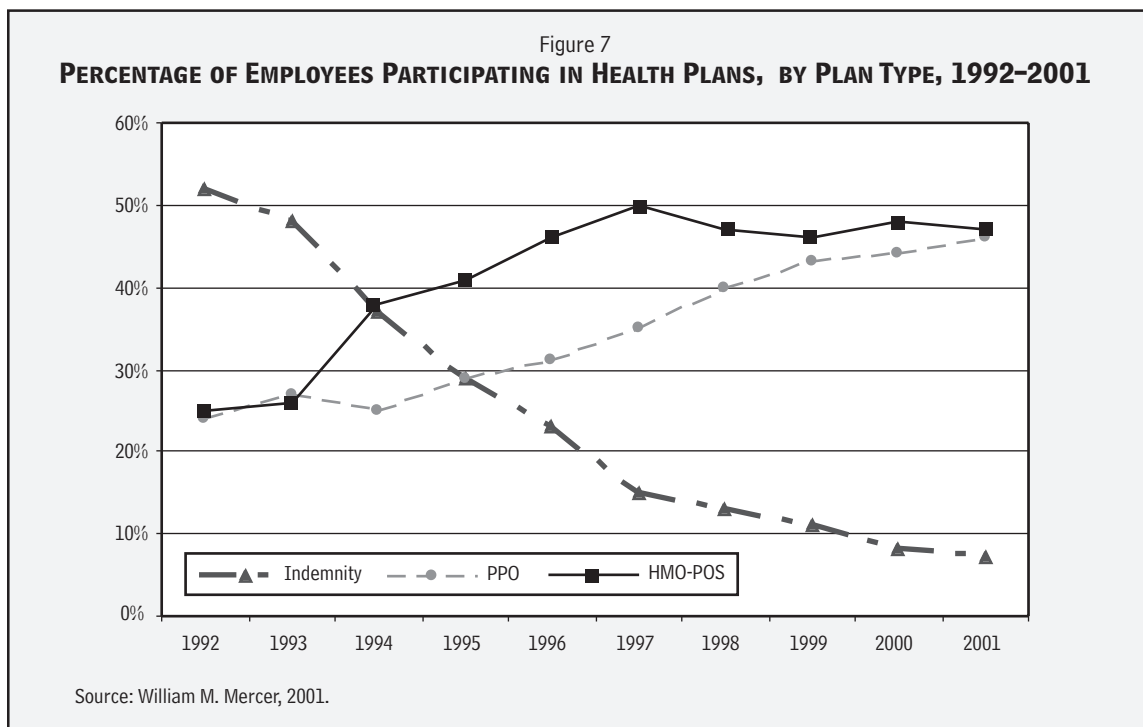
Employers have in large part paid the additional costs for prescription drugs. While many employers and insurers have moved toward three-tier co-pay systems, consumers are paying a smaller share of the cost of prescription drugs today than they did in 1990. According to the data in Figure 6, consumer out-of-pocket spending accounted for 59 percent of spending on prescription drugs in 1990. By 2000, consumer spending accounted for 34 percent. In contrast, private insurance accounted for 44 percent of spending on prescription drugs in 2000, up from 25 percent in 1990.

Comprehensiveness of Insurance

Insurance can become more comprehensive in two different ways. First, insurance becomes more comprehensive when more people move from being uninsured to having some form of health benefits. Second, insurance becomes more comprehensive as benefit packages cover a greater number of services or out-of-pocket spending declines, because of lower deductibles, higher coinsurance, or lower out-of-pocket maximums.

While in the late 1990s employees were increasingly likely to be offered health benefits by their employer (Fronstin, 2002), and the likelihood that employees and their families were covered by health benefits had been increasing, there is some evidence that employers may now be moving toward less comprehensive plans (Tollen and Crane, 2002), which would result in slower growth in employer health spending in the future.

The percentage of Americans covered by health insurance has increased recently, but today workers are being asked to shoulder more responsibility for paying for health care services that are provided. These factors will have direct and indirect effects on the cost of providing health benefits to employees. The insured population utilizes the health care system more than the uninsured population, so if more Americans were to gain health insurance coverage and increase their utilization of health care services, the cost of providing those services will likely increase due to increased demand. Alterna-



tively, since the uninsured do utilize the health care system, the per-person cost of providing health benefits may decline (or not grow as fast) if cost shifting from the uninsured to the insured population declines. The increasing cost of health care due to demand shifts assumes that additional resources will not be used to provide health care services. If the number of hospitals increases, if the number of doctors increases, or if the number of nurses increases, the per-person cost of providing health care services may be unchanged.

Increased Income

There are three ways in which income increases translate into higher utilization of health care services. First, as income increases, the number of persons with employment-based health benefits may also increase. Second, persons with health insurance may increase their utilization of health care services especially if out-of-pocket payments, such as co-payments to see a doctor, do not increase as fast as income. Third, as income increases, employees are likely to choose less restrictive forms of health insurance. As can be seen in Figure 7, this is already happening. Enrollment in (more restrictive) health maintenance organizations (HMOs) and point-of-service (POS) plans peaked in 1997 and has generally declined since. At the same time, enrollment in (less restrictive) preferred provider organization (PPO) plans has continued to increase.

After falling during the better part of the 1970s through the mid-1990s, real income has been increasing

since the mid-1990s, and is expected to continue to increase as the economy turns around. As income increases, spending on health care services should be expected to increase. According to Newhouse (1992), the income elasticity of demand for health care services in the United States is between 0.2–0.4. This means that for every dollar increase in income, spending on health care services will increase between 20 and 40 cents.

Consolidation of Hospitals and Insurers

Hospital merger activity has increased dramatically in recent years in many parts of the United States. The wave of mergers was a reaction to a competitive environment that has been placing greater emphasis on controlling costs and forcing high-cost providers out of the market (Goldberg, 1999). The growth of managed care placed considerable pressure on hospitals.

The evolution of the insurance market helps explain the hospital consolidation movement. As managed care became the dominant type of coverage, insurers became more active in trying to control costs. Recent evidence, however, suggests that hospitals have been able to leverage their consolidated positions and negotiate for better reimbursement rates from insurers.

Insurer merger activity has also increased dramatically in recent years in many parts of the United States. In 1997, there were 651 HMOs operating in the United States (InterStudy, 1997). By 2001, 541 HMOs were operating (InterStudy, 2001).⁴ Consolidation among insurers was a reaction to “fierce price competi-

tion” to increase market share that resulted in claims outpacing premium increases, and underwriting losses among three-quarters of insurers in 1996 (Levitt et al., 2001). The wave of mergers and acquisitions resulted in the largest HMOs getting larger. In 2001, the 25 largest HMOs accounted for 37 percent of HMO enrollment market share, up from 32 percent in 1997. Employer demands to manage costs and investor demands to increase profits placed considerable pressure on insurers to find new ways to increase revenue and reduce costs.

Consolidation among insurers has an effect similar to that of consolidation among hospitals. Consolidation has allowed insurers to leverage their positions and negotiate for better premium increases from employers. As a result, health plans have been able in large part to pass along higher reimbursement rates to employers in the form of higher premiums.

Goldberg (1999) discussed the impact that consolidation of hospitals will have on employment-based health benefits. Consolidation will increase the bargaining power of hospitals with insurers, but, simultaneously, the power of insurers is changing, and it is difficult to foresee what the relative power of the two sectors will be in the future. However, employers may have fewer insurers to choose from. So regardless of whether consolidation takes place at the hospital level or the insurer level, it is likely that either one will result in a higher cost of providing health benefits to employees.

Consumer Involvement in Health Care Spending Decisions

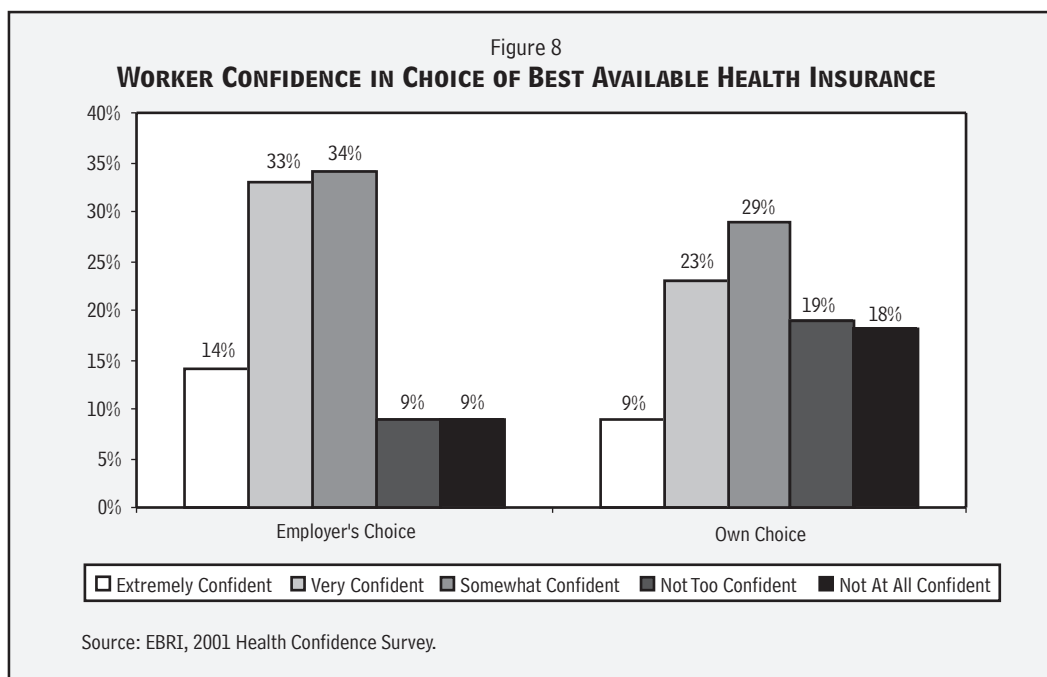
As mentioned above, the terms “defined contribution” and “consumer driven” have been used to describe a wide

range of possible approaches to give employees more incentive to control the cost of either their health benefits or health care and to reduce the size and volatility of employer spending. These approaches typically expose consumers to more of the costs of their health benefits and the cost of the health care services they use. All strategies to increase consumer involvement in health care spending decisions have a common theme: to shift decision-making responsibility regarding some aspect of health care or delivery from employers to employees. The approaches fall along a continuum of options that employers could use to shift decision-making responsibility. At one extreme, employers can provide an array of plan designs from which an employee can choose, as many companies now do. At the other extreme, an employer could simply give employees an increase in cash wages and not offer any health plans, which would allow the employee to determine how best to spend that money on health insurance and health care services. This section discusses a number of approaches that could be used to provide these benefits.

Traditional Large Employer Health Plan Choice Model

In the traditional large employer health plan model, employers usually offer several health benefit options and allow employees to choose from those options.⁵ An employer may offer an HMO, PPO, and POS plan, allowing employees to choose how they prefer to have the benefits administered, the size of the network of providers, the ability to receive benefits for health care services outside the network, out-of-pocket payments, and the level of premium contribution. Essentially, the employer is choosing what plans to offer the employee, who would then choose the plan that seems best.

Employers typically establish different employee contribution levels, depending on which options the employees choose, and whether they select employee-only coverage or family coverage. According to one survey of employers, 28 percent of establishments



surveyed paid a fixed-dollar amount for employee-only coverage for all health benefit options (Marquis and Long, 1999). In other words, the employee was required to pay the full price difference between more costly and less costly options. Another 34 percent of employers paid a fixed percentage of the cost for each option, so an employee who chose a more costly option would pay only part of the difference in total cost between that option and a less costly option. Nearly 40 percent of employers fully subsidized the cost difference by either paying the full cost of employee-only coverage for all options, or by setting a fixed-dollar contribution from the *employee* that did not vary across plan options.

There are a number of advantages and disadvantages to giving employees more financial responsibility for purchasing more or less costly coverage in the manner discussed above. An advantage of the traditional model is that employees generally think that their employer can do a better job picking the best available benefits. According to findings from the 2001 Health Confidence Survey, 47 percent of persons with employment-based health insurance were extremely or very confident that their employer had selected the best available health plan for its workers, while 18 percent were not too or not at all confident (Figure 8). In contrast, 37 percent were not too or not at all confident that they could choose the best available health insurance for themselves.

One disadvantage of this model is that employees actually have little choice in health benefit options and little likelihood of seeing their purchase decision have any impact on the price. According to Levitt et al.,

(2001), 60 percent of employees were offered a choice of health plan in 2001, and when they were, it was usually a choice between just two or three plans. Among employees in small firms, 28 percent were offered a choice of health plans. Furthermore, employees are unlikely to see an increase in available options under this model. In fact, some large employers and employer purchasing groups, such as the California Public Employees' Retirement System (CalPERS), are cutting back on choice of health plan.⁶ Employers are making most of the choices for employees by deciding which insurance plans to offer, and which benefits to cover in those programs, from the universe of choices available to them. In essence, the employer is providing the employee with only "residual choice" to decide in which plan to enroll. Employees might have a greater array of health insurance choices if health insurance coverage were not tied to employment, although choice would vary quite substantially with location.

Another disadvantage of the traditional model, and employment-based health benefits generally, is that health insurance is not portable from job to job.⁷ To the degree that plans selectively contract with health care providers, employees and their families may have to change doctors when they change health plans. Employees sometimes forego job opportunities that could potentially increase their productivity, and rewards, in order to preserve existing health insurance benefits—a situation referred to as "job lock."

There is another way to examine the impact of lack of health insurance portability. The patient-provider relationship may be disrupted if a health care provider

leaves a network, forcing employees to change doctors even if they did not change their job or their health plan. The patient-provider relationship may be less of an issue today than it had been in the recent past⁸ because health plans often offer out-of-network benefits. When given the choice of health plans, employees can often choose a PPO or POS plan that will pay for health care services provided by doctors not enrolled in the primary network. Employees usually have to meet a deductible before insurance will pay for any out-of-network services and may also be subject to higher coinsurance rates, after the deductible has been met, than when benefits are provided by in-network providers.

Out-of-Pocket Choice Model

Instead of choosing from among different types of health benefit options, employers can provide a standard set of benefits but offer options that vary based on out-of-pocket expenses. For the same benefits package, an employer could offer a combination of different deductible levels, different co-insurance rates for inpatient and outpatient services and for prescription drugs, and different maximum out-of-pocket limits. Employees would “buy” more comprehensive benefits (or reduced cost sharing) by paying a greater share of the monthly premium.

One advantage of this approach is that it allows employees to choose less comprehensive (and presumably, more affordable) benefit packages, without having to make decisions about what health care services are specifically included and excluded from coverage. This approach might result in more workers with *some* health insurance coverage, if less comprehensive benefit options (such as high-deductible plans) are more affordable, and more employers offer benefits, and more employees take health benefits when offered.

A disadvantage of this approach is that healthy employees may be the only ones who choose the less comprehensive benefits, resulting in adverse selection. Some employees may hesitate to choose less comprehen-

sive benefits if they are risk averse and do not want to incur potentially high out-of-pocket expenses. While employees could presumably take the savings from choosing a less comprehensive benefit package and use them when they do need health care services, current tax law does not allow employees to save on a pre-tax basis. If it did, this would provide an additional incentive for employees to choose *less* comprehensive plans, or plans with potentially higher out-of-pocket costs. Depending upon how employers price the various choices, savings to the employer may not materialize if persons who would not be consuming health care services were the only ones to sign up for less comprehensive coverage.

Another disadvantage may be that some employees will be underinsured if they were to choose a plan with high out-of-pocket expenses. Employees who could not otherwise afford a high deductible may choose such a plan because the premiums are affordable. Enrollees in high-deductible plans may also choose to forgo necessary health care.

Tiered Provider Networks

After a couple of years of experience with tiered copayments for prescription drug benefits, insurers and employers are considering, and in some cases experimenting with, tiered provider networks. Under a tiered provider network benefit structure, employees pay different copayment rates for different tiers of providers. For example, a provider may be in the lowest priced tier if it provides the largest discount, and may be in the highest priced tier if it does not provide any discount. Tiered provider networks are essentially a variation on a long-standing practice of providing one level of benefits to employees who use in-network providers and another level of benefits for utilization of out-of-network providers.

Insurers and employers can use provider tiers to distinguish between different types of hospitals or different types of providers. Providers could be tiered according to the prices that they charge or the quality of

care that they provide. The advantage of such an approach is to make employees more aware of the cost and quality implications of their decision to use providers in the various tiers. The disadvantage of this approach is that employees may choose the lowest cost tier even when they may get better quality health care services in a more costly tier.

Health Spending Accounts

There are a number of accounts that employees and employers can contribute to, using pre-tax dollars, to save money for future health care bills. The theory behind these accounts is that by giving employees more control over funds allocated for their health benefits they will spend the money more responsibly, especially once they become more educated about the actual cost of health services. Prior research has shown that individuals respond to increased out-of-pocket payments by reducing their utilization of health care services, although according to Tollen and Crane (2002), these studies are dated and do not accurately reflect employee responses today to increased cost sharing and less comprehensive benefits.⁹ Whether health spending accounts provide an incentive for employees to consume health care services differently is a subject of debate and is discussed further below.

Flexible Spending Accounts (FSAs)—FSAs, offered by 68 percent of employers with 500 or more employees (William M. Mercer, 2001), are perhaps the most well-known type of health spending account. FSAs are a simple and inexpensive way of allowing employees to pay for health care services not covered by health insurance. They often have been introduced, or expanded, to soften the impact of a benefit reduction, such as an increase in the deductible or co-payments. They are funded through employee pre-tax contributions. Employees must designate their contribution in the year prior to the plan year and lose any unused contributions that remain at the end of the year, which may partially explain why only

19 percent of eligible employees participate in such a plan (William M. Mercer, 2001).

Contributions are withheld in equal amounts from the employee's paycheck, but employers must make the full amount available to the employee at the beginning of the plan year. For example, an employee who chooses to contribute \$1,200 to an account will have \$100 deducted from his or her paycheck each month, but will have access to the full \$1,200 at the beginning of the plan year. This may be a disincentive for a small employer to offer such an account. If an employee is reimbursed more than he or she has contributed to the account, and then leaves the job, the employer will lose money on the arrangement. While there is no statutory limit on annual contributions to a medical FSA, employers are allowed to set an upper limit.

One disadvantage of an FSA being used to accumulate money to pay for uncovered health care services is the use-it-or-lose-it rule. Because unused funds are forfeited at the end of the plan year, employees may be reluctant to participate in the plan or may be conservative in their contributions. Mercer (2001) reports that among workers contributing to a FSA, the average contribution was \$1,023. While some would argue that the use-it-or-lose-it rule provides an incentive for employees to spend the balance of their account on health care services to avoid losing the funds at the end of the year, this may not be the case, as it appears that employees are conservative both in their participation and contribution levels.

Personal Care Accounts (PCAs)—Another type of health spending account is at the center of the "defined contribution" and "consumer-driven" benefit movement. Known as a personal care account (PCA), a health reimbursement account (HRA), and other names, it is typically part of a health benefits package that includes comprehensive health insurance. As an example, an employer may provide a comprehensive health insurance plan that has a high deductible, say \$2,000. In order to help employees pay for expenses incurred before the

deductible is reached, the employer would also provide a PCA with, say, \$1,000. The employee would use the money in the account to pay for the first \$1,000 of health care services. While the actual deductible is \$2,000, in this example, because the employer provides \$1,000 to an account, employees are subject only to the \$1,000 deductible gap. After the employee's expenses reach the deductible, comprehensive catastrophic health insurance, either purchased by the employer along with the PCA or offered on a self-insured basis, would take effect. The Internal Revenue Service (IRS) recently released Revenue Ruling 2002-41 and Notice 2002-45 (published in Internal Revenue Bulletin 2002-28, dated July 15, 2002) to provide guidance clarifying the general tax treatment of PCAs, the benefits offered under a PCA, the interaction between PCAs and cafeteria plans, FSAs, COBRA coverage, and other matters.

Generally, employers have a tremendous amount of flexibility in designing health plans that incorporate a PCA. For example, the amount of money that is placed in the account, the level of the deductible, and the comprehensiveness of the health insurance are all subject to variation. Employers can offer comprehensive health insurance that covers 100 percent of health care costs after the deductible has been met or they may offer coverage with 80 percent coinsurance (or some other portion of costs) after the deductible is met. If employers choose to pay less than 100 percent of health care expenses after the deductible has been met, they then have the option of designing the plan with or without a maximum out-of-pocket limit.

Employers can also vary employee cost sharing based on in-network visits and out-of-network visits. Employers may choose to pay 100 percent of health care consumed after the deductible has been met for employees who use network providers, but pay only 70 percent or 80 percent if employees use an out-of-network provider.

PCAs can be thought of as providing "first-dollar" coverage until funds in the account are exhausted. Leftover funds at the end of each year can be

carried over to the following year, allowing employees to accumulate funds over time, and, in principle, creating the key incentive for individuals to make health care purchases responsibly. Employers can place restrictions on the amount that can be carried over. One feature of PCAs is that when unused funds are carried over each year, employees may be able to accumulate enough funds in their accounts to satisfy their deductible in future years. In addition, as employees build account balances, they may be more likely to switch to higher deductible health plans in the future. However, employees may also choose to forgo necessary health care in order to accumulate funds in the account. Ultimately, the amount of money in the account will be a function of how long persons have had an account, usage of health care, and the size of the annual contribution. Funds in the PCA can accumulate tax-free as long they remain employer-provided funds paid out only for qualified medical expenses.

Employers also have used a design option based on paying for certain health care expenses in full before an employee would be asked to pay for services from the funds accumulated in his or her account. Some employers, for instance, will cover preventive services in full. Preventive services may include well baby care, immunizations, an annual routine office visit, an annual dental visit, an annual vision care visit, and routine screenings for cholesterol, mammograms, pap smears, and colorectal cancer. This addresses one of the most contentious issues regarding high-deductible health plans: that low-income families will be tempted to economize by avoiding preventive health care services and early treatment, only to be faced with more serious and costly health care problems later.

Perhaps the biggest difference between the health plan many employees are enrolled in today and a health plan with a PCA is that under the latter, employees would face a much larger deductible, and would be responsible for paying the full cost of health care services until they reach their deductible. Instead of paying \$10 or \$20 to visit a doctor, employees may pay \$100 or \$150.

Instead of paying \$5 or \$10 for a prescription drug, employees may pay \$30, \$125, for example, or even \$300, depending on the price of the drug. One goal of these plans is that the knowledge that employees will gain on the actual cost of providing health care will turn them into more cost-conscious and efficient users of care. Health benefits with a PCA can also incorporate features of managed care. Incentives are often provided for employees to use network providers, and employers and insurers typically negotiate a discounted fee schedule with doctors, hospitals, and retail pharmaceutical providers. Hence, employees would not be negotiating prices with health care providers.

PCAs can be set up as funded accounts or as notional accounts. As funded accounts, employers would incur the full expense of the account at the beginning of each year. With notional accounts, the accounts only exist on paper. Employees would behave as if money was actually funding an account, as employers paid claims from the accounts on a pay-as-you-go basis up to their cost-sharing limits.

If employers use notional accounts, they could retain ownership of the account. This means that despite the fact that an employee could use the funds in the account to pay for health care services and could carry over unused funds in the account each year, once the employee was no longer employed with his or her employer, because of a voluntary termination, layoff, retirement, or other reason, the employee would not have access to the funds accumulated. This raises an issue of induced demand for health care services as employees accumulate funds in the account. An employee anticipating a job separation, say retirement, may have an incentive to spend the funds in the account first, even if the additional utilization of health care services was unnecessary. Whether this should be of concern to employers is an empirical question. Suppose some employees are able to accumulate relatively large account balances that induce demand; but that, on average, employees spend the money in their accounts efficiently over their lifetimes. In this case, employers

would realize savings to their health programs and the effect of induced demand would likely be negligible. Employers could allow employees to have access to the funds accumulated in the accounts upon job separation, which would reduce the impact of induced demand but increase employer spending on health benefits. Funds left over in the account at job separation could be used to pay for COBRA¹⁰ coverage, retiree health benefits, long-term care insurance, or long-term care expenses, depending on how the employer structures the plan, although distributions from the account for nonmedical expenses are subject to income taxes, including distributions from the PCA for qualified medical expenses in that tax year. Employers might prefer not to make funds available for COBRA because they might not want to give employees an incentive to take COBRA coverage. Past research has shown that the claims experience of COBRA beneficiaries is 50 percent higher than it is for active workers (Huth, 1997 and 2000). Employers might also prefer not to make funds available for retiree health benefits. Employers have already made changes to retiree health benefits as a result of Financial Accounting Statement No. 106 (FAS 106), and are unlikely to exacerbate FAS 106 liabilities (Fronstin, 2001b).

One disadvantage of PCAs is that accumulation of accounts over time will effectively reduce some employees' cost-sharing responsibilities to zero. This could work to induce demand, especially in notional accounts when an employee is nearing job termination, if account balances are not portable. The ability to access real dollars upon termination will temper the induced demand effect. The question is whether employees will become more cost conscious and efficient users of health care, thereby offsetting any induced demand arising from large account accumulations.

Medical Savings Accounts (MSAs)—While employers have always been able to use an MSA, it was not until the enactment of HIPAA that federal law first allowed certain individuals to make pre-tax contributions to the accounts.¹¹ Eligible individuals include employees of

firms with 50 or fewer employees and the self-employed, as long as the individual is covered by a high-deductible health plan.¹² MSAs are similar to FSAs and PCAs but there are some notable differences. Unlike an FSA, but like a PCA, an MSA allows employees to roll over unused balances each year. Funds in the MSA can accumulate earnings, which are not taxed unless and until funds are withdrawn for nonmedical purposes. Distributions from the account for qualified medical expenses are not taxed. Unlike FSAs and possibly PCAs, MSA funds can be used on a pre-tax basis to pay COBRA premiums, long-term care insurance premiums, and premiums paid while unemployed. Persons with an MSA also have the option of taking a distribution from an MSA to pay for goods and services not related to health care, although the distribution would be considered taxable income and also subject to a 15 percent tax penalty.

Persons with MSAs *may* have an incentive to use health care services unnecessarily as they accumulate funds in their account. Because of the tax preference for distributions from the account for health care services, and the penalty that is imposed when persons use the funds in the account for goods and services unrelated to health care, persons with an MSA will either have an incentive to use the funds for health care services or save the funds until they need health care services. Eventually, as a person builds up a relatively large account balance, he or she *may* have an incentive to spend the funds in the account on unnecessary health care services. There is one situation that may result in efficient use of funds in the account. If a person becomes disabled or reaches Medicare eligibility age, distributions from the account are subject only to ordinary income tax and are not subject to the penalty tax.

Voucher Model

Under a voucher model, employers would provide employees with a voucher to purchase health insurance coverage directly from an insurer. Vouchers would allow employees to continue to benefit from the tax-exempt

status of employer spending on health care. It does not appear that any employers are offering a voucher model today.

Employees would be able to choose from any health insurance offered in the individual market.¹³ If the employee chose an insurance policy that cost more than the voucher value, he or she would have to pay the difference. If the employee chose a plan that cost less than the value of the voucher, the difference could be “refunded” using after-tax dollars.

There are a number of advantages to a voucher model. It may potentially allow employees to choose from a wider selection of health insurance policies, and choose a policy that meets their needs. Policies could vary by their network of providers, the benefits covered, and cost-sharing arrangements. The degree of variation would be a function of how strongly states regulate the benefits package. If a state allows insurers to sell products with different benefit packages, say by allowing insurers to offer products that exclude prescription drug, hearing, vision, or substance abuse benefits, then employees would be able to choose from among those plans. However, in states with a relatively large number of benefit mandates, employees’ choice among plans that cover different benefits would be limited. It is likely that they would have greater flexibility in choosing a combination of deductibles, co-insurance, and maximum out-of-pocket payments. The voucher model could also reduce job lock if many employers adopted it.

One obvious disadvantage is that, currently, individual health insurance is far more expensive and difficult to obtain than group health insurance obtained through employment (this is discussed further below). Another potential disadvantage of the voucher model is that marketing costs would be higher, driving up the cost of providing insurance comparable to that offered in the group market. Employers might then have a difficult time convincing employees that the voucher is of more value than traditional health benefits. They might also feel obligated to adjust the value of the voucher by age and sex to reflect differential rates on the individual

market, raising issues of equity in benefits. Another disadvantage is that while it may increase choice of *products* it may not necessarily increase choice of *insurer*. While persons in large states and large metropolitan areas might be able to choose from 20 or more insurers, persons in small states might have very few options. For example, in some New England states, individual purchasers of health insurance have a handful of choices. In the state of Maine, five insurers offer HMO coverage in the individual market but only one offers traditional indemnity coverage.¹⁴ While employees may not have a large choice of insurers or health plan options in the individual market today, were employers to move toward a voucher model, more insurers might consider offering coverage in the individual market.

The success of a voucher model in providing health insurance coverage to Americans would ultimately depend on a number of factors, including how large the voucher is, whether it would be large enough for employees to purchase a plan that they value, and whether they would be able to pay the difference between the voucher amount and the cost of the health insurance. If employers provide vouchers that are large enough for employees to purchase health insurance that they value, employees likely would be generally satisfied with the program. If over time the value of the voucher erodes relative to the cost of purchasing health insurance, some employees would drop health insurance coverage. Ultimately, if employees face experience-rated premiums and employers offer community-rated vouchers, employees at high risk of needing health care services might not be able to afford to purchase health insurance coverage. In other words, if premiums vary by certain characteristics, such as age and health status, but vouchers do not vary by these same characteristics, then the premiums could greatly exceed the value of the vouchers for some employees. If voucher programs are seen as the cause of increases in the uninsured, policymakers might intervene with solutions that are less appealing to employers than simply offering comprehensive health benefits.

Consumerism, Incentives, and Health Spending

While various types of consumer-driven health benefit approaches may result in more efficient spending on health care services, this does not necessarily mean that spending will either decline or slow down. It is well known that a small fraction of the population accounts for a large share of health spending. As mentioned above, among the adult population with employment-based health insurance, the top 1 percent of spenders accounted for 20 percent of all spending in 1998 (Figure 9). The next 4 percent of spenders accounted for an additional 23 percent of all spending, and the following 5 percent accounted for another 15 percent. Overall, the top 10 percent of spenders accounted for 58 percent of all health care spending, while the top 50 percent accounted for 95 percent of all spending. In other words, half of the population accounts for only 5 percent of health care spending in any given year.

The health spending categories in Figure 9 were chosen to try to identify the different populations that would reach their deductible, that would reach the deductible gap, and that would not exhaust their PCA.¹⁵ Assume that an employer offers a PCA approach with a \$1,000 contribution to the PCA and a \$3,000 deductible. According to the data in Figure 9, 63 percent of employees would exhaust their PCA balance in the first year. The population spending between \$1,000 and \$2,999 are the most likely to be affected by the savings incentives of PCAs. Those consumers expecting to spend less than \$1,000 may not change their use of health care services as long as they are rolling over funds each year. Those expecting to spend \$3,000 or more may not change their use of health care services because they are chronic care

Figure 9
DISTRIBUTION OF HEALTH CARE SPENDING AND SOURCE OF PAYMENT

Percentage of U.S. Population Ages 18–64 With Employment-Based Insurance, Ranked by Expenditures	Range of Expense Level	Distribution of Health Expenditures, by Magnitude of Expenditures	Percentage Paid for by Private Insurance	Percentage Paid Out of Pocket	Percentage Paid by Other
Top 1 percent	\$18,150 or higher	20%	81%	9%	10%
Next 4 percent	\$7,140–\$18,149	23	76	14	10
Next 5 percent	\$4,389–\$7,139	15	76	18	7
Next 5 percent	\$3,000–\$4,388	10	67	25	8
Next 7 percent	\$2,000–\$2,999	9	65	30	5
Next 15 percent	\$1,000–\$1,999	11	65	31	4
Next 13 percent	\$595–\$999	6	60	38	2
Next 50 percent	Less Than \$594	5	57	39	3

Source: EBRI estimates from the 1998 Medical Expenditure Panel Survey.

users. In fact, if these employees were previously enrolled in an HMO they might prefer to spend some of their own money if they think they are receiving higher quality health care in a PCA arrangement. That leaves about 20 percent of the population spending between \$1,000 and \$2,999. Even if PCA arrangements result in more efficient (and less costly) utilization among this population, overall spending reductions would not be very large because of the narrow focus of incentives. Unless consumer-driven health benefits include incentives to affect the spending patterns of high users of health care services, the total cost of providing health care benefits is unlikely to be significantly affected.

PCAs will also be challenged because of how the distribution of health care services is spent. Among the 1 percent of the population of persons who account for 20 percent of health care spending (minimum annual spending of \$18,150), insurance accounted for 81 percent of spending, while 9 percent was paid for out-of-pocket, and 10 percent was paid for by other sources (Figure 9). Furthermore, 63 percent of the spending was spent on inpatient services, while only 5 percent was spent on prescription drugs (Figure 10). In contrast, among persons with spending of between \$1,000 and \$2,999 per year, 65 percent was paid for by insurance while 30 percent was paid for out of pocket. In addition, 3 percent was spent on inpatient services while 23–25 percent was spent on prescription drugs. Since PCA incentives are more likely to affect discretionary services (such as office-based visits, outpatient visits, prescription drugs, and dental visits) and are less likely to affect nondiscretionary services (such as inpatient stays), and a relatively large portion of health care is for

nondiscretionary services, it is unlikely that PCAs would have a strong effect on reducing a large percentage of utilization of health care services. Until consumer-driven health benefits provide incentives and tools for the highest users of health care services, these plans are unlikely to have a major impact on total health care spending.

Conclusion

There is strong interest among employers in redesigning health benefit programs in response to rising costs. A few employers have turned to, and many others are considering, what is being called consumer-driven health benefits, a concept used to describe a wide range of different possible approaches to give consumers more control over some aspect of either their health benefits or health care. The major issues related to consumer-driven health benefits are discussed in this report. A movement to consumer-driven health benefits has implications for health benefit costs, utilization of health care services, quality of health care, the health status of the population, risk selection, and efforts to expand health insurance coverage. Ultimately, the success or failure of consumer-driven health benefits will be measured by its effect on the cost of providing health benefits and its effect on the number of people with and without health benefits.

Figure 10
DISTRIBUTION OF HEALTH CARE SPENDING, BY TYPE OF SPENDING AND BY MAGNITUDE OF THE EXPENSES

	Total Expenditures	Inpatient Stays	Office-Based Visits	Outpatient Visits	Prescription Drugs	Dental Visits	Emergency Room Visits	Vision Aids	Home Health Care	Other Medical Supplies and Equipment
Total	100%	25%	26%	15%	15%	12%	3%	2%	1%	1%
Top 1 percent	100	63	13	15	5	1	1	0	3	1
Next 4 percent	100	36	25	21	9	5	3	1	1	1
Next 5 percent	100	21	28	20	14	11	5	1	0	0
Next 5 percent	100	8	28	20	20	17	5	1	0	1
Next 7 percent	100	3	33	11	23	21	5	3	0	0
Next 15 percent	100	1	33	7	25	23	5	5	0	0
Next 13 percent	100	0	35	4	26	23	4	8	0	0
Next 50 percent	100	0	37	2	22	26	3	10	0	0

Source: EBRI estimates from the 1998 Medical Expenditure Panel Survey.

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¹ Employer and employee are defined loosely in this report. Employer refers to any entity that sponsors a health plan for workers. Employee refers to active employees and their dependents, and can also include retirees.

² The early surveys were reviewed in Fronstin (2001a).

³ Some providers of these benefits have formed the Consumer Driven Health Care Association. See www.cdhca.org for more information.

⁴ Enrollment in HMOs increased from 72 million in 1997 to 80.5 million in 1999. It then fell to 78 million in 2001.

⁵ The framework for the traditional large employer health plan choice model started in the 1980s with cafeteria plans.

⁶ See www.calpers.org/whatsnew/press/2002/0417a.htm (last reviewed May 6, 2002) for additional information on CalPERS.

⁷ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes it easier for persons with health insurance who are changing jobs to avoid pre-existing condition exclusion periods, but did not change the laws regarding portability of a health plan from job to job. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which was in large part unaffected by HIPAA, allows employees to continue their health benefits upon job termination.

⁸ Disruptions to the patient-provider relationship were not an issue at all until the managed care revolution in the 1990s.

⁹ See Tollen and Crane (2002) for a review of prior research and a discussion of issues related to the comprehensiveness of health benefits today.

¹⁰ Consolidated Omnibus Budget Reconciliation Act of 1985 (see endnote 7).

¹¹ The Balanced Budget Act of 1997 allows health plans offering coverage in the Medicare+Choice program to offer an MSA product. To date, insurers have not entered this market.

¹² Noneligible individuals are allowed to have an MSA, but contributions to the account must be made on an after-tax basis.

¹³ A voucher model could also apply to some type of non-employment-based group model. For more information about this arrangement and defined contribution health benefits, see Fronstin (2001a).

¹⁴ www.state.me.us/pfr/ins/indhlth.htm (last reviewed April 2002).

¹⁵ The data presented in figures 9 and 10 should be used strictly for illustrative purposes. They are not adjusted for inflation to make them comparable with 2002 health spending data. They also do not take into account the fact that many families will be in higher spending categories. However, while this would push more families above a \$3,000 deductible level, families are often subject to a higher deductible although they may also have a lower deductible for each person in the family.

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