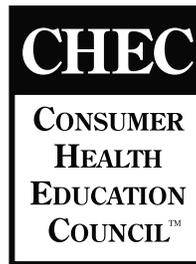


Consumer-Driven Health Benefits: A Continuing Evolution?

Edited by
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Established in 1978, the Employee Benefit Research Institute (EBRI™) is the only nonprofit, nonpartisan organization in the United States totally committed to original public policy research and education on economic security and employee benefits.

EBRI's overall mission is to encourage, to contribute to, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

EBRI does not lobby or endorse specific approaches. Rather, it provides balanced and unbiased analysis of alternatives based on the facts. Through its activities, EBRI advances knowledge and understanding among the public, the news media, and government policymakers of how employee benefits function and why they are critically important to our nation's economy.

Since its inception two decades ago, EBRI has grown to include a cross section of the public and private sectors with an interest in economic security programs. EBRI is funded by membership dues, grants, and contributions from foundations; businesses; labor unions; trade associations; health care providers and insurers; government organizations; and service firms, including actuarial firms, employee benefit consulting firms, law firms, accounting firms, and investment management firms. International members look to EBRI's work to gain understanding of the U.S. economic and employee benefit systems.

Today, EBRI is recognized as one of the nation's most authoritative, objective, and reliable resources on the rapidly changing employee benefits sector—health, savings, investment, retirement, work/family issues, demographics, and economic security.



Table of Contents

Foreword viii
 About the Authors x
 Executive Summary xvii
Jim Jaffe, EBRI

Overview

1. Can “Consumerism” Slow the Rate of Health Benefit Cost Increases?
Paul Fronstin, EBRI

Executive Summary 3
 Introduction 4
 Health Benefit Costs 5
 Consumer Involvement in Health Care Spending Decisions 12
 Consumerism, Incentives, and Health Spending 20
 Conclusion 22
 References 22

New Models for Providing Employment-Based Health Benefits

Overview of Spectrum

2. A Continuum of Defined-Contribution/Consumer-Driven Health Plans
James Murphy, American Academy of Actuaries

Introduction 27
 Characteristics of Consumer-Driven Health Plans 27
 The Shift in Employer/Employee Responsibility 27
 Active Plan Management 28
 The MSA Approach 28
 Using Intermediaries and Vouchers 29
 Conclusion 29

Insurer/Vendor Perspective

3. Consumer-Centric Healthcare Asset Management Model: The Evolution of HealthcareIRA™
Amit Gupta, MD, CareGain

Abstract 33
 Introduction 33
 Rising Health Care Costs, Patient Misconception, and Lack of Consumerism 33
 Impact of Managed Care on Providers ... 35
 CareGain’s Consumer-centric Health Care Asset Management Model 35
 The Core Model 36
 Employer Plan Design 36
 Employer Choice: When Are They in the Driver’s Seat? 37
 The Economic Benefit and Chronic Case Management 38
 HealthcareIRA™ Benefits and Health Care Asset Management 38
 Predictive and Prospective Medicine 39
 “Can you trust your HMO?” – *Time Magazine*, Feb. 2002 39
 Provider Reimbursement and Long-term Impact on the Industry 39
 Tax Treatment of HealthCareIRA 40
 Summary 41

4. The Definity Model of Consumer-Driven Health Care
Bill Reindl, Definity Health

Introduction 43
 Significant Results 43
 Cost Control and Satisfaction 44
 Personal Care Accounts 44
 Supporting Member Responsibility 44
 Results 45
 Cost Containment 46
 Conclusion 46

5. The Vivius Approach <i>Lee Newcomer, MD, Vivius</i>	
The Program	47
The Role of Consumers	47
6. Consumer-Driven Health Care: Incentives, Infrastructure and Information to Improve Value <i>Michael D. Parkinson, MD, Lumenos</i>	
Introduction	49
Aligning the Elements	49
Four Imperatives for Change	50
Consumer-Driven Models	51
Acquiring Three Competencies	53
Conclusion	57

Employer Perspective

7. Consumer-Directed Health: It's a Matter of Choice <i>Pattie Duca, Pharmacia Corp.</i>	
Introduction	59
The Benefits of Early Adoption	59
Conclusion	60
8. Optimizing Cost and Quality Through Consumer-Driven Health Benefits: Where Does the Evidence Point? <i>Arnie Milstein, Mercer Human Resource Consulting and Pacific Business Group on Health</i>	
Introduction	61
The Goals of Plan Sponsors	61
Selection of Providers	63
Selection of Treatment Options	63
Participation in Care Management	63
Motivating Selection of Efficient Options	64
Net Savings	65
Conclusion	65

Researcher Perspective

9. The Promise and the Peril of Consumer-Driven Health Plans <i>Jon R. Gabel, Health Research and Educational Trust</i>	
Introduction	67
Consumer-Driven Health Care as Seen by Consultants	67
Consumer-Driven Products of Large Insurers	68
Conclusion	69

<i>Discussion Following Panel on New Models for Providing Employment-Based Health Benefits</i>	70
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**The Role of Managed Care in a
Consumer-Driven World**

Employer Perspective

10. Consumer-Driven Health Plans: Watch, Wait, and See <i>Miles S. Snowden, MD, Delta Airlines</i>	
Introduction	79
Financial Issues	79
Administrative Concerns	81
Conclusion	82

Benefit Consultant Perspective

11. Preserving the Benefits of Managed Care in a Defined-Contribution Environment <i>Ken R. Jacobsen, The Segal Company</i>	
Introduction	83
How DCHC Works	83
Conclusion	85

Researcher Perspective

12. How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing
Jason S. Lee, Academy Health, and Laura Tollen, Kaiser Permanente Institute for Health Policy

Abstract 87
 Data and Methods 89
 Effect of Paring Down or Eliminating Benefits 91
 Effect of Increasing Enrollee Cost Sharing 93
 Summary of Findings 94
 Discussion and Policy Implications 95

Consumer Knowledge

Educator Perspective

13. New Models of Health Care Coverage Demand New Skills and Responsibilities
Ray Werntz, Consumer Health Education Council, Employee Benefit Research Institute

Introduction 101
 A Greater Role for Consumers 102
 Dimensions of Consumer-Driven Care .. 102
 Personalizing Health Care 103
 Five Skills for Quality, Affordable Care ... 104
 Conclusion 105

Benefit Consultant Perspective

14. The Emergence of Health Care Consumerism
Daniel B. Holmes, Fidelity Employer Services Company

Introduction 107
 State 1: Selecting/Purchasing Health Plans 107
 Stage 2: Education and Care Management 108
 Stage 3: Planning for Retiree Health ... 108
 Conclusion 109

Consumer Perspective

15. Work to Cut Costs—Not Benefits
John D. Abraham, American Federation of Teachers

Introduction 111
 The Merits of Pooled Risk 111
 Cost-Shift Issues 112
 Proposals to Cut Costs 113

16. Healthy Consumer-Driven Health Care: Shifting Costs to the Sick
Gail Shearer, Consumers Union

Introduction 115
 Variations in Health Care Costs 115
 The Myth of Choice 117
 Legislative Initiatives 118
 Conclusion 118

Insurer/Vendor Perspective

17. Consumer Knowledge: Do We Have Enough for the New Health Plans?
Lee Newcomer, MD, Vivius

Introduction 119
 Categories of Information 119
 Current Information Sources 120
 Data Problems 123
 Conclusion 123

The Role of Public Policy

18. Consumer-Driven Health Care and Public Policy
Charles K. Kerby, III, Mercer Human Resource Consulting

Introduction 127
 Impediments to Legislative Changes .. 127
 The Pitfalls of Regulations 128
 Effective Tax System Incentives 128
 Qualification Requirements 129
 Conclusion 129

List of Policy Forum Attendees 131



About EBRI-ERF Policy Forums

The Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) holds two policy forums per year. The goal of the policy forums is to bring together a cross section of EBRI sponsors, congressional and executive branch staff, benefit experts, and representatives from academia, interest groups, and labor to examine public policy issues. It is a roundtable discussion featuring verbal and written exchange among speakers and participants. The roundtable format is designed to encourage discussion.

Past EBRI-ERF policy forums include:

- 12/6/01 “The Ongoing Growth of Defined Contribution and Individual Account Plans: Issues and Implications.”
- 5/3/01 “Defined Contribution Health Benefits: The Next Evolution?”
- 5/3/00 “The Economic Costs of the Uninsured: Implications for Business and Government.”
- 12/1/99 “The Next 25 Years of ERISA: The Future of Private Retirement Plans.”
- 5/5/99 “Severing the Link Between Health Insurance and Employment: What Happens if Employers Stop Offering Health Benefits?”
- 12/2/98 “Beyond Ideology: Are Individual Social Security Accounts Feasible?”
- 5/6/98 “The Future of Medical Benefits”
- 12/03/97 “Do Employers/Employees Still Need Employee Benefits?”
- 04/30/97 “Retirement Prospects in a Defined Contribution World”
- 12/04/96 “Assessing Social Security Reform Alternatives”
- 04/30/96 “Comprehensive Tax Reform: Implications for Economic Security and Employee Benefits”
- 12/07/95 “The Changing World of Work and Employee Benefits”
- 05/11/95 “When Workers Call the Shots: Can They Achieve Retirement Security?”
- 10/26/94 “The Future of Employment-Based Health Benefits”
- 05/04/94 “Retirement in the 21st Century: Ready or Not?”
- 10/06/93 “The Changing Health Care Delivery System”
- 05/05/93 “Pension Funding and Taxation: Achieving Benefit Security”



Foreword

Health care cost inflation has always precipitated experimentation and angst. This time around it is no different, and in spite of a different name and focus, the central emphasis of the current reform initiatives resembles that of the “managed competition” reforms of the late 1980s and early 1990s: Competition and market forces can lead to a better system. During that earlier Bush/Clinton series of public and private initiatives, expanded worker choice of plans was viewed as at least a partial answer to the need for cost control. This time, expanded worker choice in actual medical purchasing—combined with “health savings accounts” that can be rolled over for future health care expenses if not spent—is seen as the new panacea. This approach, “consumer-driven health care,” is greatly facilitated by technological advances since the last bout of high rates of health care inflation. The Internet has provided an information access and delivery tool that allows any individual to visit the files of the National Cancer Institute, review the results of the most recent clinical trials, find information on drug interactions, etc., without ever leaving home.

The first stage of this movement began years ago with legislative authorization of medical savings accounts (MSAs), followed by discussions of “defined contribution health care” and “health care vouchers.” The Internet can do “anything” period of the recent past, combined with the bottom of the health underwriting cycle and the “revolt against managed care” to generate “noise” about a health insurance supermarket in which the individual could

design every aspect of the health package he or she wanted and then negotiate price and terms with health care providers, leading to higher satisfaction, lower health spending, and higher quality outcomes. Futurists predicted that like the 401(k) wave, this trend would soon sweep the nation and employers would no longer be needed as health insurance intermediaries. As with Internet stock prices, much of the air has come out of that particular balloon. In practice, “consumer-driven health care” may have several parts: a base preferred provider organization (PPO), augmented by an internal MSA to help pay co-pays and deductibles and bills for uncovered items on a pre-tax basis, without a use-it-or-lose-it requirement; a flexible spending account (FSA) to pay on a use-it-or-lose-it basis; and payment by the health plan of all spending that exceeds an out-of-pocket cap. The premise is that fewer consumers will reach the cap than did under a traditional plan because of more careful consumption.

The EBRI Education and Research Fund explored these issues during the “loud noise phase” in its 49th policy forum in May of 2001. Research on the issue has continued, and the 51st policy forum returned to these issues in May of 2002. By then, the focus on “consumer-driven health care” had replaced “defined contribution health care” in much of the discussion; several of the major health insurance companies had introduced consumer-driven products, making use of health spending accounts; several major employers had made consumer-driven plans available as an option to their work forces; and the Trea-

sury Department/Internal Revenue Service had moved to embrace the new concepts as “appropriate interpretations of the tax law.” The May 2002 policy forum, and this resulting book, continue our march toward understanding and building a base for future research to assess the implications of this new movement for health care cost control, quality, and satisfaction.

These issues are of primary importance both to EBRI and to its EBRI-ERF affiliate, the Consumer Health Education Council (CHEC). CHEC was a co-sponsor of the policy forum on which this book is based, and its president, Ray Werntz, was deeply involved in the policy forum as a presenter and participant. CHEC helps educate individuals on how to acquire, keep, and use health coverage effectively, and also serves as an information clearinghouse for employers, plan sponsors, policy experts, and others who influence access to coverage.

Paul Fronstin, Ray Werntz, and Rachel Christensen of EBRI worked on the substance of the policy forum, with able administrative

support from Alicia Willis and Adrienne Wells and editorial assistance from Steve Blakely, Jim Jaffe, Deborah Holmes, and Lynn Cox. I thank all who assisted with the forum and the production of this book.

I also wish to thank the Robert Wood Johnson Foundation and the Commonwealth Fund for grants that helped make possible the policy forum, the book, and the book’s distribution.

The views expressed in the book are solely those of the authors and participants. They should not be attributed to officers, trustees, members, or staff of EBRI or the EBRI Education and Research Fund. In publishing this book no effort is being made to influence any specific legislation or proposals.

The book is available online at www.ebri.org

Dallas L. Salisbury
EBRI and EBRI-ERF
October 2002



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Ms. Duca received her B.S. degree in business management with a double major in finance from Fairleigh Dickinson University. She is a past member of and has served on Conference Board committees, the Association of Private Pension and Welfare Plans, Employee Benefit Research Institute, the Society for Stock Plan Professionals, the Council on Employee Benefits, and the Washington Business Group on Health. Ms. Duca has been recognized for excellence in benefits communications, including the prestigious Business Insurance Communications Award for Excellence. She is a frequent speaker on Global Benefits issues.

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Dr. Gupta is also the former founder and President of Boston Medical Center's Community Outreach Health Information System (COHIS). Under his leadership, COHIS became one of the first e-Health organizations in 1994 to promote a model for technology-driven disease management, and was awarded the "Award for Innovations in Health" under the Healthy People 2010 initiative by then Secretary Donna Shalala of the U.S. Department of Health and Human Services. Dr. Gupta has previously spoken on the topic of consumer-centric health care technologies for disease management for the Massachusetts Department of Education, various medical associations and literacy organizations, and for the public television system. He received his medical and radiology specialty training from Boston University, Harvard University, and Washington University/Mallinckrodt health care systems.

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Prior to joining Fidelity, Mr. Holmes was Managing Director of Watson Wyatt, an international employee benefits and human resources consulting firm. In his 14 years with Wyatt, he served on the Company's Board of Directors, managed the firm's Boston office, led the National Health Care Practice, and consulted to large employers on health care, and related employee benefits issues. Mr. Holmes holds a Bachelor of Arts degree from Colorado College, as well as an M.B.A. from the University of Michigan and a Masters of Science degree in Information Technology from Ohio State University. He is a Certified Financial Planner (CFP), Chartered Life Underwriter (CLU) and Chartered Financial Consultant (ChFC).

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Mr. Jacobsen has more than 25 years experience in health care benefits design, purchasing, and plan management. He is the former President of the Georgia Business Forum on Health, a health care coalition, has run his own health care consulting firm, and

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Jacobsen has extensive experience in the structure, administration, management, and analysis of managed care group health plans, and is recently involved in the planning and development of Consumer Driven Health Plans. He often speaks at national forums and is quoted on and writes about health care economics and strategy issues in national business and trade publications. Mr. Jacobsen served as a member of a collaborative advisory panel on HEDIS sponsored by the Rand Corporation, Harvard University, and the National Committee on Quality Assurance (NCQA). He is a graduate of Merrimack College (Andover, MA) and has completed the Executive Program of the University of Michigan in Ann Arbor.

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A graduate of the University of Delaware, Mr. Kerby holds a law degree from the Washington and Lee University Law School, and a masters in law from the Georgetown University Law Center. He is a member of the National Health Lawyers Association and the Employee Benefits Committee of the Tax Section of the American

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Jason Lee is a Senior Research Manager at Academy Health, where he co-directs the Program in Research Synthesis, helps manage the RWJF-sponsored Changes in Health Care Financing and Organization (HCFO) Program, and is Principle Investigator for the National Library of Medicine-sponsored HSRProj database of ongoing health services research studies.

Prior to joining the Academy, Mr. Lee worked for Congress for nine years. Most recently, he served as health policy counsel for the House Commerce Committee, where he worked on HMO reform legislation, medical errors, Medicare and Medicaid, and various public health service issues. He was lead counsel on six bills that were signed into law. In 1999, he was named a top congressional aide by the *National Journal*, was profiled in *The Almanac of the Unelected*, and served on the board of the National Health Policy Forum. Before this, he worked on a range of health care issues for the Congressional Research Service of the Library of Congress and at the U.S. General Accounting Office.

Mr. Lee has written on a wide range of health care and social psychological topics. His work has been published in books and peer-reviewed journals; as congressional policy briefs, bill comparisons, and legislative analyses; and as research syntheses, briefs and reports. His doctorate is in sociology from the University of Michigan.

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His 30 book chapters and published articles have centered on health care program design. A member of NCQA's national committee to develop HEDIS and a Leapfrog Group co-founder, *Business Insurance* magazine selected him as "one of the 20 people who has made a difference in employee benefits management in the past 20 years." *The New England Journal of Medicine's* series on employer-sponsored health insurance described him as a "pioneer" in efforts to advance quality of care.

Mr. Milstein was educated at Harvard, Tufts (MD), and UC-Berkeley. He is an associate clinical professor at the University of California-San Francisco Medical Center and a Worldwide Partner at Mercer.

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Dr. Newcomer earned a Bachelor of Arts degree in biology from Nebraska Wesleyan University, an M.D. degree from the University of Nebraska College of Medicine, and an M.S. degree in health administration from the University of Wisconsin at Madison. He completed his internship and residency in internal medicine from the University of Nebraska Hospital, and fellowships in medical oncology and administrative medicine from the Yale University School of

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During her 16 years at Consumers Union, Ms. Shearer has been a leading voice on behalf of health care consumers. In 1990, she coordinated the successful campaign that culminated in simplification of the Medigap market with standard benefit packages. In 1993 and 1994, she testified extensively on developing health reform that serves consumers' interests. In 1996, she was a recognized expert on the controversial issue of medical savings accounts (MSAs), writing two reports that played a significant role in the debate. While MSAs were included in the final health insurance reform bill, Ms. Shearer's efforts ensured significant consumer protections also were part of the legislation. In 1998, her report, "*Hidden from View: The Growing Burden of Health Care Costs*," analyzed consumer health care expenditures with a focus on variation of risk

and the growing number of underinsured consumers. In 1999, she wrote *Blueprint for Fair Share Health Care: Incremental Steps Toward Universal Coverage* with the goal of guiding incremental reform in the right direction.

Prior to joining Consumers Union in 1985, Ms. Shearer served in various positions at the Federal Trade Commission. She was a program analyst in the Division of Policy and Evaluation, Bureau of Consumer Protection, from 1981 to 1985. From 1977 to 1981, she was chief policy analyst in the FTC's Office of Policy Planning. Ms. Shearer is a cum laude and Phi Beta Kappa graduate of Smith College. She received a master's degree in public policy from the John F. Kennedy School of Government at Harvard University.

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Dr. Snowden joined Delta Air Lines in 1999, following 14 years of work in Louisville, Kentucky, where he was medical director of an occupational health consulting practice, with special emphasis on the airline industry. He is board certified in the specialties of Internal Medicine and Occupational Medicine.

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Ray Werntz was named President of the Consumer Health Education Council (CHEC) in May 1999. CHEC's mission is to build a diverse coalition of private and public sector organizations committed to raising public awareness and knowledge of the importance of health insurance coverage to health care access, quality, and personal health.

Previously, Mr. Werntz was Vice President of Compensation and Benefits for Whitman Corporation in Rolling Meadows, Illinois, where he was a strong proponent of health and financial education for employees and their families. In addition to his over 30 years experience as a human resources executive, he has been active on many Boards and in other private- and public-sector organizations established to address health care delivery, quality, education, and access. A native of Chicago, he has a B.A. and M.A. in history and philosophy from De Paul University and a J.D. from John Marshall Law School.



Executive Summary

By Jim Jaffe, EBRI

A return to double-digit annual growth in health benefit costs is fueling interest in new structures for employment-based health benefits. The new plans are still works in progress and there's not even agreement yet on what these plans should be called: Some of them are called "consumer driven" because of the hope that individual consumer choices will help contain health care costs. Others call them "defined contribution" because they could create a situation where sponsors that establish and limit their contribution to the benefit could prompt workers to take responsibility for using this fixed amount for health coverage provided by the employer.

The basic goal is to control cost increases by delegating more direct responsibility to consumers (and beneficiaries) of health insurance. Advocates say such plans could reduce consumer resentment caused by the restrictions common to managed care plans. Critics say the plans—by whatever name they are called—will only shift health care costs away from the employer and onto the worker.

Today's employment-based health benefits system covers the vast majority of insured Americans under 65. Not only do most Americans depend on jobs for health insurance coverage, they also rely on employers to choose and/or design health plans, negotiate premiums and terms of coverage with insurers and providers, and even inter-vene on their behalf when there is a coverage dispute.

Historically, employers have played a crucial role in determining how the health insurance system operates in this country. For decades, employers have known that

using a limited number of carefully selected healthcare providers, and changing protocols for providing health care services, can cap costs—although using that knowledge has proven difficult. This insight fueled the growth of managed care plans, especially health maintenance organizations (HMOs) and later the less-restrictive plans that became popular in the 1990s. The decline of "traditional" indemnity health insurance over the last decade is a direct result of this employer response to sharp increases in health coverage costs.

Now that health care and health benefit costs are soaring again, employers are looking once more for new ways to provide health benefits that are affordable, palatable, and medically adequate for beneficiaries, and sustainable for both employers and their workers. Whatever the potential ancillary benefits of these plans may be, cutting costs is clearly the driving force and top priority.

"If it wasn't for costs increasing 15 to 30 percent a year, we probably wouldn't have moved as quickly as we have to discussing new ways to provide health benefits," said Paul Fronstin, director of EBRI's health research program.

Policymakers, leading thinkers on benefits, employers, and labor representatives examined some of the deeper implications of greater cost sharing generally, and consumer-driven models in particular, during the May 2, 2002, policy forum on "Consumer-Driven Health Benefits: A Continuing Evolution?" sponsored by the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF). Attended by about 100 invited

experts, the policy forum examined the research that has been done on consumer-driven health benefits, how health insurance coverage is changing in the United States in an effort to perfect managed care, and the implications for consumers, business, and government.

■ **New Models for Providing Employment-Based Health Benefits**

The theory is that giving consumers greater power over some diagnostic and treatment options will have two positive results—simultaneously providing them with broader choices than are currently available, while their aggregate decisions would cap costs more effectively than top-down conventional managed care plans have done. But some analysts warn that consumers lack the discipline and sophistication to successfully navigate an increasingly complex system and understand what care is truly necessary. They see the initiative as an opportunity for employers to lay off a growing portion of rising costs on employees. Whether employees are willing to take on greater responsibility, have the ability to be more successful and economic shoppers than health plans have been, and can thus create a more efficient system are all open questions. These questions are particularly relevant for the minority of plan participants who are ill enough to be responsible for the majority of the costs. This problem is particularly acute in low-income families, who will most feel the impact of increased cost sharing.

So far, there is no real consensus on what exactly constitutes “consumer-driven health care” and few specifics on precisely what the new plans involve. While the new concept has various names and definitions, all aim to contain health costs—or, at least, employers’ costs—while increasing consumer

choice. Jim Murphy, chairman of the American Academy of Actuaries Defined Contribution Health Plan Work Group, said it could take the form of traditional cost-sharing methods (such as higher deductibles, co-insurance, out-of-pocket limits) or it could include the newer form of spending or savings accounts that give the participants more involvement in cost sharing.

Murphy envisioned a menu of options ranging from structures where the employer designated selected plans, determined a single, level contribution level and allowed employers to pick the coverage they preferred and pay any difference to some type of savings account option where the employer merely decided the per-worker contribution and left all other decisions about coverage and carriers to employees.

The basic concept that drives the new plans is a shift of responsibility for health care decisions from employers to individuals. The common components include:

- Full or partial employee responsibility for the first several thousand dollars in expenses.
- An employer-funded account that eligible workers can use for a wide variety of medical expenses, including premiums and/or out-of-pocket expenses for health care services, that sometimes can be rolled over from one year to the next if unused.
- Catastrophic coverage covering costs above a certain level, usually higher than those now commonly in use.

Many questions about portability and taxes remain to be worked out. Changes in tax laws could make participation more or less attractive to employees (the IRS announced June 27 that balances in individual health care accounts could be carried over untaxed from one year to the next, a step seen by proponents as a major boost for consumer-driven plans). But, regardless of the financial structure, the one common feature is the transfer of responsibility from the employer to

the workers, a change that proponents say offers potential rewards to both groups.

Consumer-driven plans can provide consumers with adequate coverage at all ages, smoothing out the current pattern where healthy young workers often have more coverage than they need while their older, sicker colleagues have inadequate protection. Under today's system, the younger group subsidizes the older. The new plans might reduce such intergenerational cross-subsidies. An individual health account would allow workers to accumulate assets during the earlier period that could be spent later when more costly and comprehensive care is required.

Amit Gupta, a physician who founded CareGain, a New Jersey firm that is one of the earliest to offer such plans, predicted that "employees will respond to an opportunity to save for future health care expenses, which will lead to real cost savings for the employers today, which is where CareGain is turning the theory into practice."

Under CareGain's plan, some money initially reserved to pay employee health bills that remains unspent at the end of the year is then rolled over into health IRAs. Because this computation reflects spending for the entire group, the employee rebate depends on both individual and group behavior.

In other words, the worker doesn't receive savings for his long-term account unless the employer enjoys immediate savings.

These short-term employer savings are common to all such plans, whatever their specific dimensions, noted Bill Reindl, senior vice president of Definity Health, a Minneapolis-area plan that also offers such plans. Having consumer-driven health care cost more for the extra individual choice and control has never been part of the package, he indicated: "Everybody holds us up to the standard of helping to control long-term costs of health care," Reindl said.

Definity Health covers basic preventive care and leaves decisions beyond that to employees, who become aware of the economic consequences of their decisions and regularly check their employer-provided health account balances on a Web site. "Pricing transparency is critical to the success of this plan, and our members are actively looking at what things cost and what the alternatives are, and they're using that information to make economic decisions," he says. One result, he noted, is that their members have a higher-than-average usage of generic drugs.

Partly because of this sensitivity, Definity Health estimates that 60 percent to 70 percent of participants will have money remaining in their accounts at the end of the year that can be rolled over. Working with fewer than three dozen employers (including CVS, Staples and Budget Rent-A-Car), Definity Health is finding that employees selecting consumer-driven plans are slightly older and sicker than the general population offered the choice, making age-specific disease management plans for those with chronic problems essential.

But the needed tools sometimes aren't available yet. For instance, he said, a child just diagnosed with Type 1 diabetes has far different needs than a 54-year-old male who's had Type 2 diabetes for 30 years. But "because we haven't been able to leverage the data that's been available, we are still using 'one-size-fits-all' disease management programs," he explained.

This need to focus on sicker, more expensive patients is an obvious priority for all the new carriers and generally seen as a key component of containing costs generally. A worst case feared by many would have the new plans siphon off young and healthy participants, creating an adverse selection problem in more conventional plans.

Dr. Michael Parkinson, executive vice president and chief health and medical officer

at Lumenos, counsels self-insured employers who want to create such plans. Parkinson argued that new plans should not be portrayed solely as opportunities for employers to reduce their responsibility, but rather as a way to refocus it and concentrate on those who were using the most resources and needed the most help.

“Consumers can’t be asked to ferret out the third of care that experts believe is now inappropriate, and will need a lot of counsel if they’re going to make decisions that are both correct and cost-effective,” Parkinson said. “Critics worry that consumers may forego care they truly need just to save money. One way to avoid this is to make money decisions before medical problems appear—by selecting specialists, for instance.”

Perhaps the most complex plan discussed was Vivius, another Minneapolis-area plan. Executive Vice President Lee Newcomer said the plan allows consumers to create their own individual provider network and premium, with the result that “the payroll deduction that they will make goes up or down depending on who they choose to be in their network.”

Unlike the other plans, Vivius doesn’t use spending accounts. Instead, it allows employees to start with a level employer contribution and, in the course of making 18 decisions, build an individualized provider network and copay level.

Whether any of these products will win a lasting endorsement from employers—and their employees—remains to be seen. At first blush, some employers are enthusiastically embracing the plans while few have explicitly rejected them. The largest group is still watching from the sidelines.

The pharmaceutical firm Pharmacia is an early adopter, partly out of frustration with the existing conventional system. “We all know that health care—and retiree medical as the long appendage to that—is a train wreck

ready to happen,” said Pattie Duca, senior director of global benefits for Pharmacia. “So why not consumer health care? There really does need to be some fundamental change.”

The company faced two issues, one unique (a merger required it to deliver promised cost savings while creating a new, unified plan) and one not (the sickest employees regularly selected the more expensive and extensive plan offered, routinely costing the employer more than anticipated). The result was a menu of four plans, each with the same benefit package and each requiring employees to pay \$1,200, or 20 percent of the entire annual premium. But there were differences in provider selection, copays and the option of having a health care savings account and rolling over unspent money into subsequent years. Only 5 percent of eligible employees selected the new consumer-directed plan, which was not unexpected. But the firm was surprised that the composition of this group did not skew toward the young and healthy as had been anticipated.

Michael Thompson, a principal in the PricewaterhouseCoopers global human resource solutions group suggested that such modest take-up rates were unsurprising and that participation in the new programs will continue to be too small to alone impose the changes needed in the entire system. But he does believe that their components would be the pillars of a new, broader policy that resulted in both happier consumers and more affordable coverage.

“I think there’s a belief that people will be more satisfied with their health care and we will save money if they are involved in a shared decision-making process. So again, the objectives are increased transparency and shared responsibility to supply participants with the tools to act as better informed consumers,” he said.

But he stressed that the specifics of plan design would determine whether these

goals were achieved—and that the precise parameters to maximize the odds weren't yet clear. Change is a certainty, but progress isn't a given, Thompson said.

This emphasis on execution was seconded by Arnie Milstein of Mercer Human Resource Consulting, also medical director of the Pacific Business Group on Health, who pointed out that the consolidation of insurers was another goal for finding a new approach from the employer side.

Milstein, who began his quest for a new approach three years ago, recalled nearly two years of frustration in trying to come up with the elements of a better system. He concluded that consumer choices in three areas could curtail costs:

- Choice of provider (the key issue here is total treatment cost per incident, rather than the price per visit).
- Treatment options (generic versus brand-name drugs are one example).
- Care management for the sick (with a focus on the 5 percent of participants who run up 55 percent of health costs).

The importance of focus on those with expensive illnesses was echoed by researcher Jon Gabel, vice president of health systems studies at the Health Research and Education Trust, the research affiliate of the American Hospital Association. Gabel said that managed care taught employers some valuable lessons about what worked—that disease management made sense, while forcing those with few health needs to first approach gatekeepers merely caused resentment. He summarized his ongoing research in this area, and concluded that, despite the obvious self-interest of consultants in promoting consumer-driven health plans, something truly important is occurring in health plan design.

Nonetheless, Gabel added, most employers are reluctant to be pioneers, especially in something that appears to be cutting back on health benefits. As a result, he

expects the new options (at least initially) to augment rather than replace existing plans. Gabel agreed with the Wall Street view that consumer-driven choices offered by major insurance companies would soon overwhelm those from the newer firms in the field.

■ The Role of Managed Care in a Consumer-Driven World

One such wary employer is Delta Airlines. Miles Snowden, Delta's director of health services, said that most of Delta's 200,000 employees are in a single plan, and there was a fear that offering greater choice would dilute the airline's bargaining power in the market. That raised questions about whether such a plan would prove to be cheaper than the one already in place.

And rollover provisions raised some significant questions, since Delta expected workers to spend down their accounts before they quit a job. "We as a company have not been willing to accept the premise that if you are going to develop a consumer-driven health plan and you're going to provide them with a personal health or medical spending account or care account, that upon termination of their relationship with the company that account just disappears," Snowden said. "If an employee knows that they're going to lose the balance in their health spending personal care account, our sense was that we would lose much of what we had previously gained by altering that consumer's behavior."

Delta was also troubled by the idea of "first-dollar" coverage, which would lead to higher payments to the 40 percent of participants who had low health care bills. It was difficult to see how giving these workers greater benefits would drive down the airline's total health benefit bill.

Despite frustration about rising costs, some employers feel they've learned some valuable lessons from managed care and want

to utilize these lessons as new plans are developed. Ken Jacobsen, senior vice president of the Segal Company, a New York actuarial and consulting firm, argued that plan sponsors know a lot more about how to contract for health care than before because of managed care. Nevertheless, he said, health costs cannot be controlled unless consumers become sensitive to them.

“The consumers have been forever insulated from cost,” Jacobsen said. “If we don’t introduce consumerism at some point along the way, we’ll continue to spiral out of control. Anybody can walk in and put \$10 on the counter and buy \$1,000 or \$100,000 worth of health care under the system today...the HMO model is an all-you-can-eat frenzy.”

Jacobsen presented a glowing summary of how a consumer-driven health benefits system could work if consumers knew the real costs and made appropriate purchasing decisions. But he warned that both consumers and employees are cautious, and predicted there would be a transition period before necessary economic and medical information is fully shared with consumers—as was the case with managed care.

Kaiser Permanente, which provides care for more than 9 million Americans, thinks the consumer-driven health care movement raises some interesting and provocative issues for insurers. Christine Paige, a vice president of marketing for Kaiser, predicted her company would remain competitive in the next few years, but expressed concern about subsequent developments, particularly very low-cost, minimum-benefit plans that could be attractive to healthy young people and create serious adverse selection problems for big carriers like Kaiser.

Nonetheless, she added, Kaiser shared the perception that consumers must be more cost-conscious. “There is no getting away from the fact that some kind of meaningful cost sharing is in the future of all of us,” she said.

While there seems to be little doubt that both employers and workers will be asked to pay more for health insurance, there is lots of debate about who pays how much more.

The pressures for this change were documented by Jason Lee, senior research manager at the Academy of Health Services Research and Health Policy, a Washington, D.C., health policy center. He noted that a Harris poll of corporate human resource directors found that within the next two years, almost 80 percent of employers intend to increase the share of employee cost-sharing of the premium, and 70 percent plan to increase employee cost sharing. He noted that a study by Watson Wyatt found that 71 percent of surveyed large employers are considering decreasing benefits or increasing cost sharing in the next 12 months.

Lee discussed two models, each of which could reduce premium costs by more than 20 percent—one simply eliminates certain types of benefits, while the other increases participant copays. When those decisions will be made—and by whom—remain open questions.

■ Consumer Knowledge

Ray Werntz, president of the Consumer Health Education Council (CHEC), summarized the extent of consumer decision-making contemplated by the consumer-driven models by comparing the structural differences between these models and conventional managed care-type (HMO) plans. Besides having to make more of their own decisions regarding health care providers for the services they need, individuals may also have to make some medical necessity decisions formerly made by third parties, he predicted, which highlights the need for giving patients information that is accessible and relevant to their concerns. CHEC, which aims to inform and educate both consumers and sponsors of

health insurance, is currently conducting research to better identify what individuals expect of the U.S. health care system.

One group that is likely to face special challenges is the “near-elderly”—workers who retire prior to age 65 and find themselves ineligible for Medicare at a time when employers are reducing their health insurance commitment to retirees generally. Getting a group of people, many of whom lack adequate retirement savings, to put away money for health care that will be required during the last years of their life could prove to be a particularly challenging task, noted Daniel Holmes, an executive vice president of Fidelity Investments.

Holmes said that even those in Medicare are often ignorant of the health-related expenses that lie ahead in retirement. For instance, he said, Fidelity research has estimated that a couple currently age 65 faces present-value costs of about \$160,000 just to cover Medicare Part B, the co-pays and deductibles under Medicare, prescription drugs which are not covered by Medicare, and some miscellaneous expenses.

Despite the acknowledged flaws in the current system, reformers should be wary of changes that would undermine its strengths, argued John Abraham, senior associate director of the research department of the American Federation of Teachers, a union that represents many of America’s public school teachers. Existing conventional employer plans are very good at pooling risk to allow the healthy to subsidize the care of the ill, who otherwise might find necessary medical attention unaffordable, and large groups have relatively low administrative costs, he noted.

Abraham embraced the idea of concentrating on the 20 percent of the covered population that generates 80 percent of health care costs. And he called for a bipartisan effort to force government to address the issue.

“Regardless of your position on reform, lend your voice to the various reform coalitions and press your representatives to address the health care problem,” Abraham said.

A similar wariness about abandoning the strengths of the existing system came from Gail Shearer, director of health policy analysis for Consumers Union, publisher of *Consumer Reports* magazine, which maintains a Washington office that analyzes and lobbies on policy issues from a consumer perspective. “This type of new health care could actually undermine the employer-based system and throw more people into the individual market,” Shearer said, criticizing “the myth of consumer choice.”

Shearer voiced a special concern about medical savings accounts (MSAs), which she characterized as an extreme consumer-choice option that pushes people into the individual market. “There’s growing evidence that affordable coverage simply isn’t available to some patients with serious chronic problems. Insurance companies that adjust annual premiums based on claims, mirroring the pattern with auto insurance, push out the group that needs the most care,” said Shearer. Whatever the appeals of the individual market, it has yet to come up with a way of coping with the adverse selection problem.

Despite disagreements about what a more “efficient” health insurance system would look like, there’s a universal belief that patients who came to the system with more and better information could help bring about better and cheaper outcomes. But how to collect and communicate that information is not an easy or obvious task. Lee Newcomer of Vivius points out that patients tend to depend on friends, neighbors, and some medical professionals who seem to have expertise. He noted that managed care health plans are not trusted by patients as a reliable source of medical information, which is why they tend

to refer patients to third-party sources, including medical Web sites on the Internet.

■ The Role of Public Policy

Given the significant role of federal tax policy in shaping the nation's current health benefits system, policy forum participants inevitably focused on whether government policies—particularly in the tax area—could be used to push individuals into participating in a reformed system and making appropriate health insurance choices. Charles Kerby, III, of Mercer Human Resource Consulting, a multi-national human resources consulting firm, reviewed the issue of what employees could do with money in MSAs and rollover restrictions on flexible spending accounts (FSAs), and said that the recent IRS announcement on individual health care accounts may make the options more attractive to individuals. He suggested another possibility might be to impose structural requirements on employer health plans so as to push them toward using medical or administrative techniques that had been proven effective in dealing with price and quality issues.

But any such incentives should not be viewed as a quick fix, as there is no consensus within the health care industry on how to proceed, and lawmakers in Congress currently are struggling with more immediate problems than health insurance issues.

Nevertheless, according to EBRI's Fronstin, health policy professionals see the movement toward consumer-driven health care to be inevitable and unstoppable because of ever-growing cost pressures—even though there is still no clear definition of what it is or precisely how it will work.

“We do think it's going to happen. There are going to be winners and losers. The plans are going to be very flexible in their funding and in their structure, providers will need to be engaged in the plans and the decision-making. Employees will need to be engaged and they will need to be educated, and they will need to be provided with tools to navigate the system,” Fronstin said. He also predicted that rather than replacing managed care, consumer-driven care will build on it and alter the way managed care currently operates.

“I think we're at the point we were with managed care in the late 1980s, where it was just about to take off, except that we're moving faster than we did back in the '80s with managed care,” Fronstin said. “On one hand that's exciting. On another hand, my fear is that 10 years from now we'll all be back a little bit grayer talking about why consumer-driven health care didn't work, and what the next latest and greatest thing is that we think may solve the health care problem.”



Overview

Can “Consumerism” Slow the Rate of
Health Benefit Cost Increases?: Chapter 1

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

By Paul Fronstin
Employee Benefit Research Institute

(This paper was originally published as *EBRI Issue Brief* no. 247, “Can ‘Consumerism’ Slow the Rate of Health Benefit Cost Increases?” July 2002.)

■ Executive Summary

- 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.

■ 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, 2002).

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 deci-

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.cdca.org for more information.*

sions 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 report 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 spending totaled \$73 billion in 1970 (Figure 1.1), 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 portion of the CPI since 1998 (Figure 1.2). 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 employees, differential productivity growth from medical care, avoidable administrative expense, provider-induced demand, and technological innovation. Figure 1.3 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.

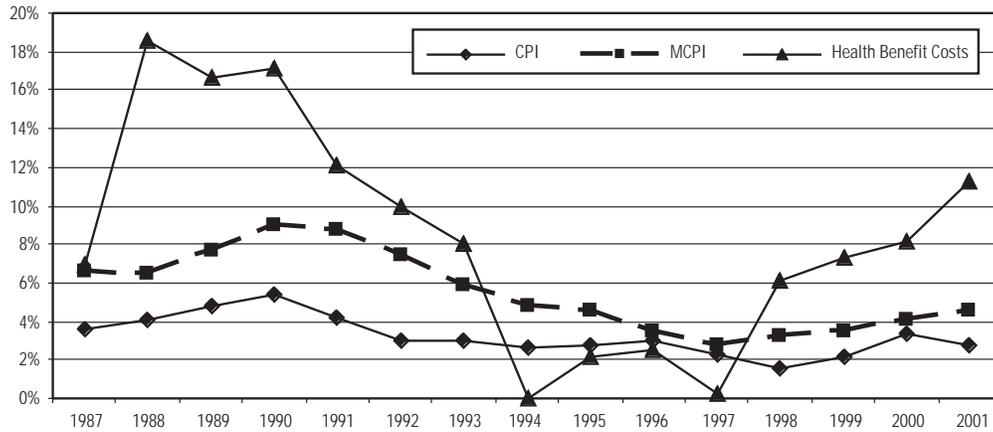
As is well known, a small share of the population accounts for a large share of spending on health care services. Among the adult population with employment-based health insurance, the top 1 percent of spenders accounted for 20 percent of all spending in 1998 (Figure 1.4). Overall, the top 10 percent

FIGURE 1.1
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).

FIGURE 1.2
HEALTH CARE COST INFLATION, 1987–2001



Source: Council of Economic Advisors (2002); and William M. Mercer (2001).

FIGURE 1.3
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).

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

FIGURE 1.4
DISTRIBUTION OF HEALTH CARE SPENDING

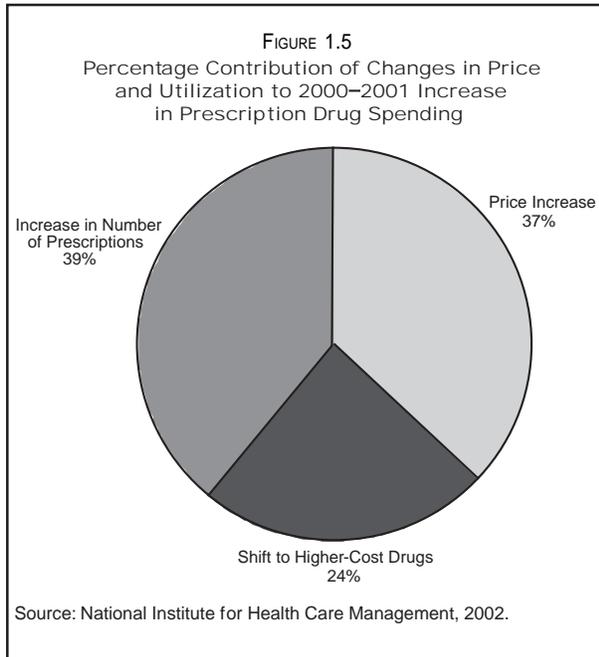
Percentage of U.S. Population Ages 18–64 With Employment- Based Insurance, Ranked by Expenditures	Distribution of Health Expenditures, by Magnitude of Expenditures
Top 1 percent	20%
Next 4 percent	23%
Next 5 percent	15%
Next 5 percent	10%
Next 7 percent	9%
Next 15 percent	11%
Next 13 percent	6%
Next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

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

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. Murphy and Topel (2000) found that improvements in life expectancy due to techno-



logical 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

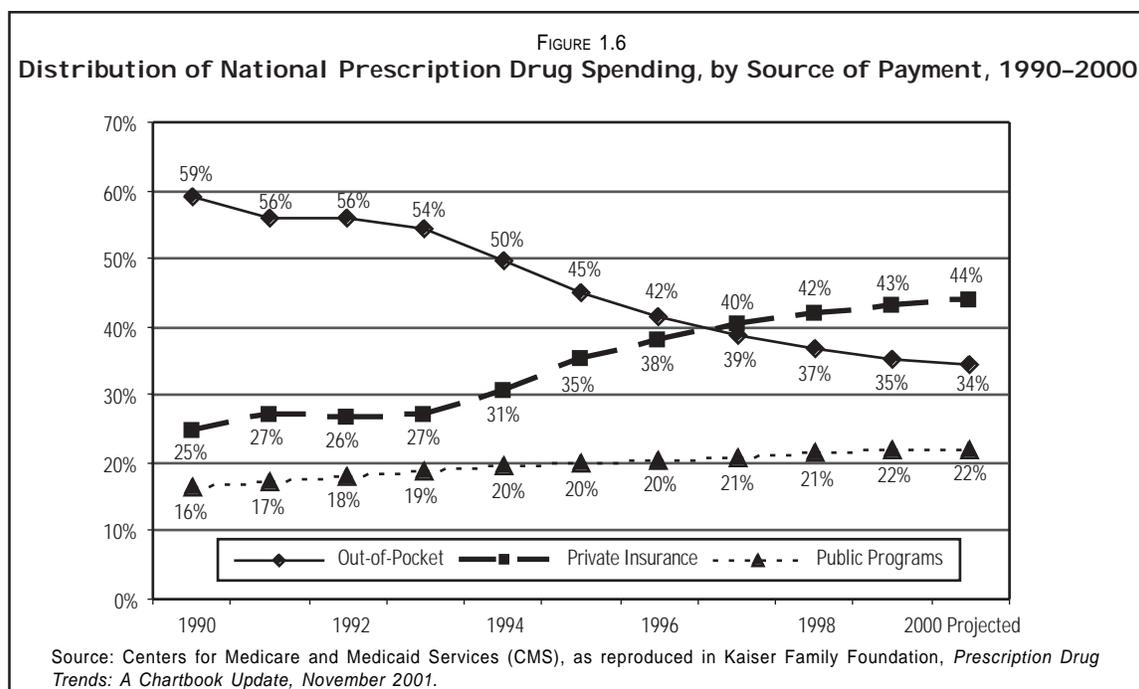
growth due to technological innovation in health care, until they are shown how health benefits improve the bottom line, most employers will view health benefits as a *cost of doing business* rather than an *investment in their business*, although there are always exceptions.

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 1.5).

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. Oppo-



nents 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 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.

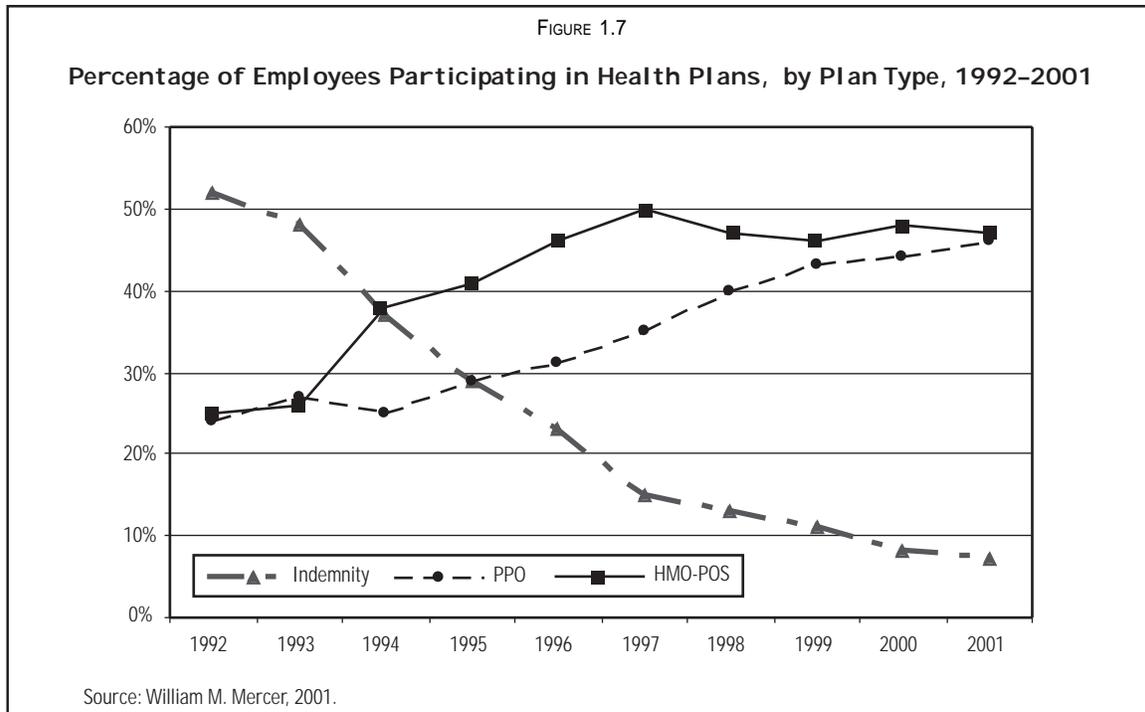
One study estimates that the 10 drugs most heavily advertised directly to consumers in 1998 accounted for about 22 percent of the total increase in spending on drugs between 1993 and 1998 (NIHCM, 1999). Overall, four categories of drugs—oral antihistamines, antidepressants, cholesterol-reducing drugs, 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 1.6, 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. Alternatively, 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 1.7, 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

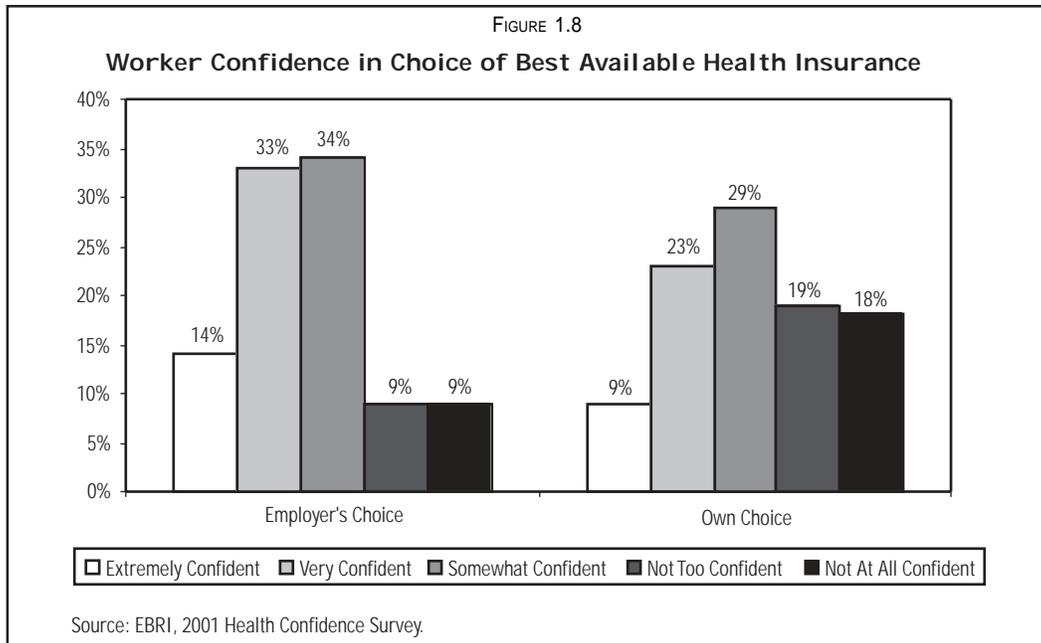
and negotiate for better reimbursement rates from insurers.

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 competition” 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

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



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

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

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 1.8). 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

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.

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 comprehensive 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.

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

Tiered Provider Networks

After a couple of years of experience with tiered co-payments 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 indi-

viduals 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 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

¹⁰ *Consolidated Omnibus Budget Reconciliation Act of 1985 (see footnote 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.*

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

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).

FIGURE 1.9
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.

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 1.9). 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 spend-

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

FIGURE 1.10
DISTRIBUTION OF HEALTH CARE SPENDING, BY TYPE OF SPENDING AND BY MAGNITUDE OF THE EXPENSES

	Total Expenditures	Office Inpatient Stays	Based Visits	Outpatient Visits	Prescription Drugs	Dental Visits	Emergency Room Visits	Home Vision Aids	Health Care	Other Medical Supplies & 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.

ing, 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 1.9 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 1.9, 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 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 1.9). Furthermore, 63 percent of the spending was spent on inpatient services, while only 5 percent was spent on prescription

¹⁵ The data presented in figures 1.9 and 1.10 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.

drugs (Figure 1.10). 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.

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New Models for Providing Employment-Based Health Benefits

**A Continuum of Defined Contribution/
Consumer-Driven Health Plans: Chapter 2
Insurer/Vendor Perspective: Chapters 3, 4, 5, 6
Employer Perspective: Chapters 7, 8
Researcher Perspective: Chapter 9
Discussion**

Will Consumer-Driven Health Plans Work? The Jury is Out

Interest in consumer-driven health insurance plans is driven by three broad trends: Economic, political, and technological.

As discussed at length elsewhere in this report, the recent return of double-digit health insurance premium increases has proven particularly painful to both sponsors and beneficiaries during a period of declining profits and stock prices. Consumer-driven plans are seen as a way of containing costs, at least for employers and possibly for beneficiaries.

There are two political motivations behind consumer-driven health:

- First, from an ideological perspective, such plans are consistent with a libertarian interest in taking power away from large institutions—including governments and employers—and giving it to individuals instead. These proposals are attractive to proponents of medical savings accounts and consistent with the idea of privatizing Social Security. The basic idea is that an informed consumer is better able to make choices that will maximize personal benefit and societal efficiency.
- Second, and simultaneously, the political system has been responding to those who find managed care too restrictive (the “managed care backlash”). Congressional consideration of patients’ bill of rights legislation, and numerous state laws that mandate particular types of benefits and appeal procedures, are political responses to complaints about managed care. Promoters say consumer-driven plans hold the promise of broadening patient choices and thus responding to many of these complaints.

Technology, particularly the Internet, is seen as a way of helping to actually achieve the goal of creating a more informed consumer. Consumer-driven health plans presuppose that consumers have timely access to a large amount of reliable information, allowing a quick evaluation of both cost and quality issues. The Internet seems like the perfect tool to meet these needs—at least, for those who have access to the technology and the education and skills to use it. Much of what is being promised in the name of consumer-driven health would not be credible in the absence of the Internet.

Insufficient evidence currently exists to answer the question of whether consumer-driven plans can or will fulfill any of these promises—it is simply too early to tell.

A Continuum of Defined-Contribution/ Consumer-Driven Health Plans

By James Murphy
American Academy of Actuaries

■ Introduction

The American Academy of Actuaries' Work Group on Defined Contribution Health Plans is writing our first article on defining the spectrum or continuum of consumer-driven health plans, which is the basis for the discussion to follow. We hope to address issues such as costs; employer/employee issues, such as issues of equity; some administrative issues; and other things that may arise.

■ Characteristics of Consumer-Driven Health Plans

Whether we use the term “defined-contribution” or “consumer-driven” health plans, these plans stem from a concept to help deal with the key issue of rising health care costs and share a number of characteristics. And while not every plan has all of these characteristics, in one way or another, they all share them:

- The cost driver is clearly common to all, as employers seek to set or at least control increases in health care costs.
- The consumer-driven element provides more participant choice, which can take the form of traditional cost-sharing methods, deductibles, co-insurance, out-of-pocket limits, etc. The structure may be one of the newer forms of spending or savings accounts, which give participants more involvement in cost sharing.

- Participant education is key; as we provide more choice and sharing of costs, the need to make good choices, and have a good basis for doing so, grows.
- As the names for some of these plans (i.e., e-health plans) imply, the use of the Internet is integral to administrative functions, such as tracking spending or savings accounts, and it plays a role in issues, such as participant education.

■ The Shift in Employer/ Employee Responsibility

Although there are several ways to think of these consumer-driven plans, we consider them a continuum of plans, reflected in the level of employer or sponsor involvement or management of the plan versus the level of employee responsibility in the plan. As you will see, we're really talking about two sides of the same coin.

Figure 2.1 shows how we define the continuum, as it compares plan management by the employer on one axis and participant responsibility on the other axis. The employer is seeking to move from a higher level of management to a lower level of management. As that occurs, the responsibility of the employee or participant increases. This gives rise to the continuum, as we see it, of consumer-driven plans. As employer management decreases, employee responsibility increases.

Within this continuum, some plans

currently are actual plan types in place in the marketplace or coming to the marketplace. Others are more theoretical in nature and may never be viable, at least in the near term.

■ Active Plan Management

Active plan management is very similar to what we have seen for a number of years now in the employer market with the defined-benefit (DB) plan or the cafeteria plan. The sponsor determines and offers a limited number of plans and benefit options, sets a maximum employer contribution, and the employee picks up the difference. In the pure sense of DB plans, employers seek to set the dollar amount they're going to pay. In the real world, it's more likely that they're going to try and control it by how they set the amount—but getting the exact amount to be what they want is more difficult.

Sponsors' plan contributions can be predetermined, a set amount; they can be based on the lowest cost plan they have available; and they can vary with tenure and position and family status or salary and in other ways, maybe to encourage the selection of certain plans. It all sounds very much like the way we've been doing things for a number of years. The difference here is the shift toward thinking about controlling costs and giving employees more choice in their plans. One alternative is perhaps to increase the distance, the arm's length the employer has from plan management, by perhaps just selecting a number of recommended plans. An employer may negotiate a discount or in some other way choose a set of plans and then let the employee make a selection from those plans.

■ The MSA Approach

The next example along the continuum, moving down the slope of less management by employers and more responsibility by employees, is the medical savings account

(MSA) or spending account approach, as shown in Figure 2.2. In this plan, participants have accounts that they can use to purchase health care. Typically the account is used for high-incidence, low-severity services; typically, insurance is a component that covers high-severity, low-incidence services.

The idea is that the account and the management of the account by the employee or participant will provide an incentive to be more efficient at selecting health care and reducing health care costs. Whether it will provide an incentive is yet to be established, and we hope to address that element in future issue briefs, assuming we can find some good data on which to base the answer—always a problem in this arena.

There are typically three types of MSA accounts and they vary in two ways: whether real dollars or what we might call notional dollars are used to fund the account, which affects tax issues. A MSA within the legal definition is an account that is clearly tax advantaged by law, provided it is done in a specific way. Beyond that specific definition, some other savings accounts are tax-advantaged under a recent new Internal Revenue Service ruling. For example, spending accounts using notional dollars may very well be tax advantaged if they are set up appropriately. The existence of these three alternatives probably means that we may see continued regulatory action regarding the differences among these accounts.

With these MSA-type accounts, a number of issues arise:

- Is it a notional account or a funded account?
- If it is funded, how are you going to fund it?
- What amount are you going to fund?
- In what are you going to invest?
- What are the tax implications?
- Will it be a portable account that can move to a new employer?

- What expenses are eligible for reimbursement from the account?

■ Using Intermediaries and Vouchers

The next point on the continuum, again moving the employer further from the management of the plan, is what we refer to as an intermediary approach, as shown in Figure 2.3. From the perspective of employees, this plan may look very much like one of the other plans, but from the employer's perspective, there will be a third-party intermediary to provide the benefits and the plans and to do much of the management.

The third party may be an insurance carrier, an employer coalition, multiple sponsors, the same intermediary, or some other variation. The intermediary may be one carrier offering multiple plans or a third party that essentially does what the employer would have done in designing plans.

Moving much further down the continuum we get to vouchers, as shown in Figure 2.4. Here the plan sponsor grants vouchers to employee participants, who may use them to purchase health plans. Typically, the choice will be from a set of plans that the employer has chosen or pre-defined as eligible; or perhaps the plans have said they will accept the vouchers. It may again be one plan with lots of options, or it may be a number of different plans. Of course, participants have to

make up the difference between the voucher and the cost of the plans they select. If they don't use up the voucher, it is forfeited.

The final point on our continuum essentially is no active management on the part of employers or sponsors, as shown in Figure 2.5. At this level, one might wonder if we're really talking about an employer health plan at all. To even think of it as a health plan, the employer must say that a designated part of salary is for health care benefits and employees are expected to use it that way. Over time, that distinction can be lost quickly. And, of course, any employer contribution will be treated as salary for employees, regardless.

■ Conclusion

The continuum of consumer-driven health care plans follows a pattern from a high level of employer management to less employer management, while the slope of responsibility increases for employees as employer responsibility decreases. As noted earlier, you can look at it as two sides of the same coin. Whether we are referring to defined contribution, which focuses on an employer trying to reduce costs and reduce responsibility and management, or a more consumer-driven concept, in which the employee wants or is being perceived to want more responsibility in his or her plan management, it's all pretty much the same thing.

Figure 2.1



Figure 2.2

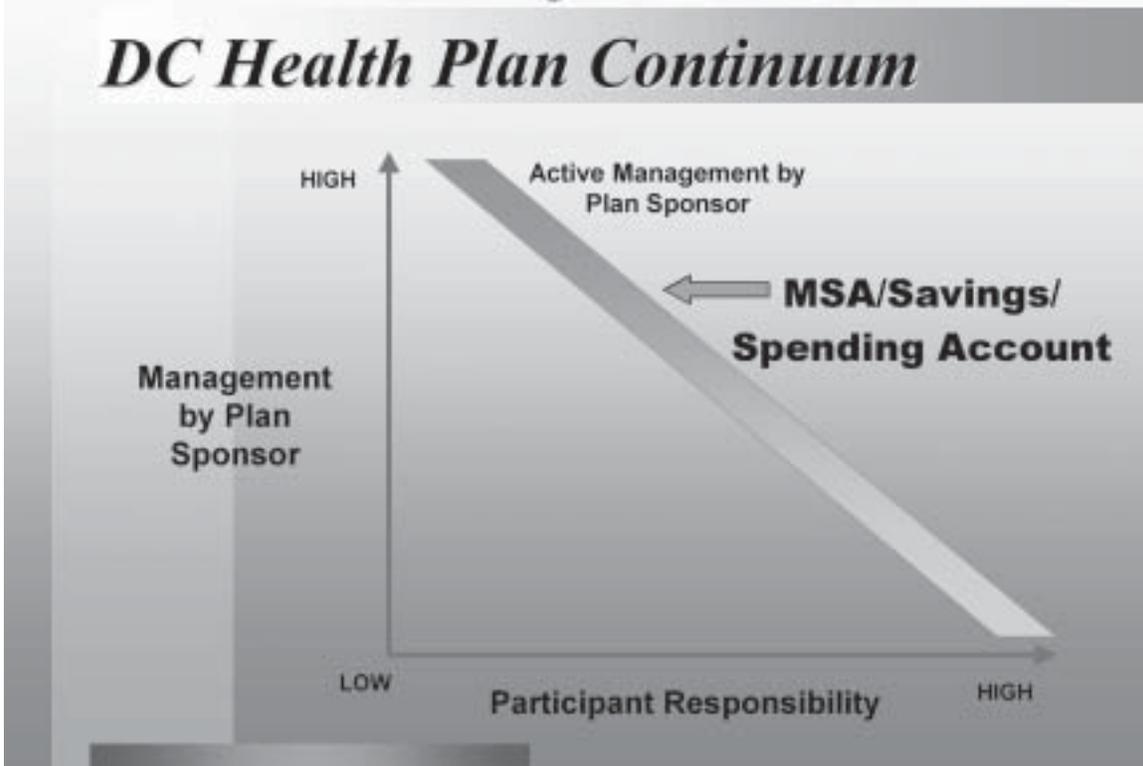


Figure 2.3

DC Health Plan Continuum

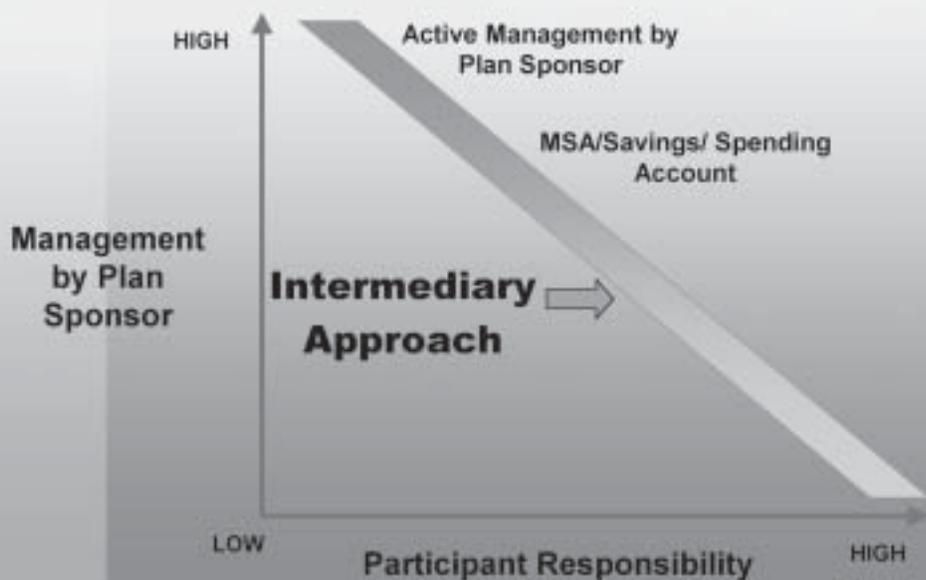


Figure 2.4

DC Health Plan Continuum

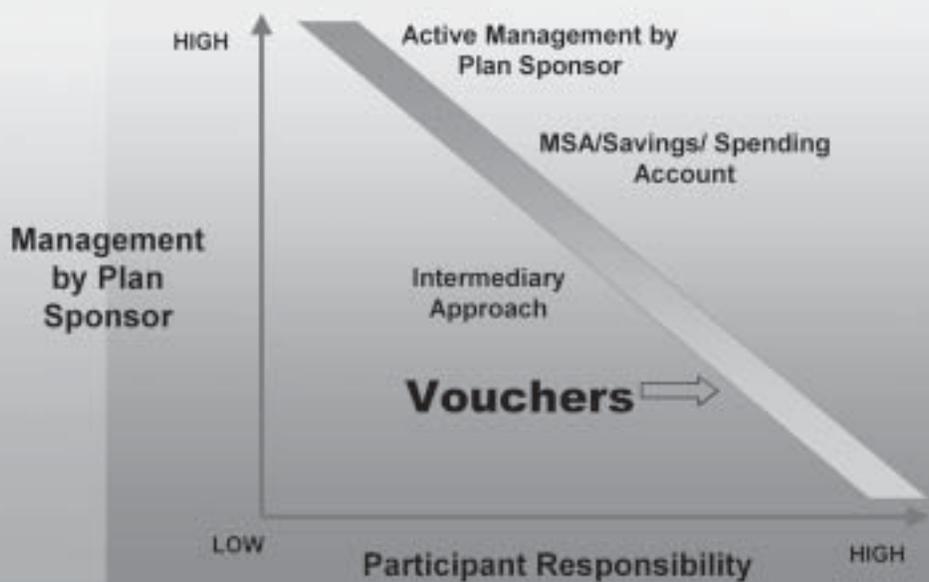
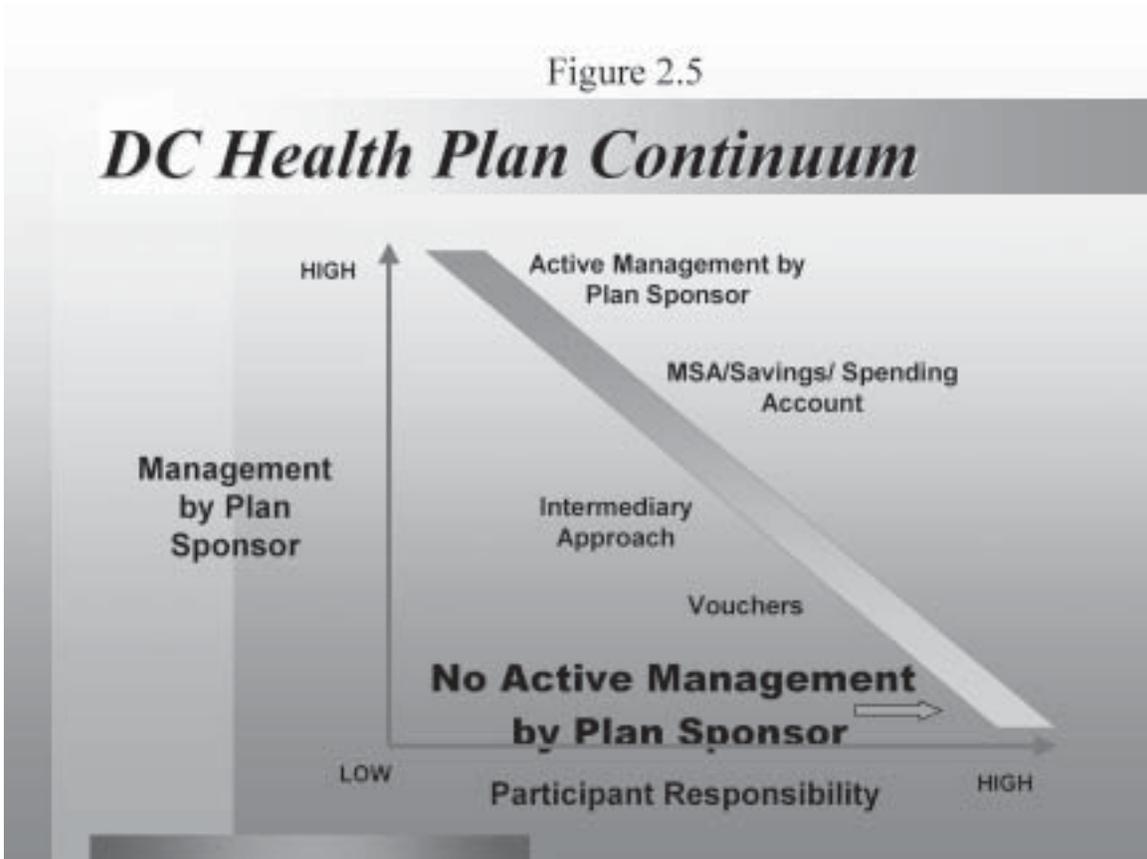


Figure 2.5



Consumer-Centric Health Care Asset Management Model: The Evolution of HealthCareIRA™

By Amit K. Gupta, MD
CareGain

Abstract

Employers are once again faced with double-digit increases in the cost of providing health care benefits to their employees. Driven by these rising premiums, and accelerated by greater administrative burden and legal liability, employers are finding themselves in the same position as in the 1980s, having to make decisions to move to new alternatives for health care financing, delivery, and administration. Changes in the current managed care model must, however, result in a solution that is permanent and viable in the long-term. What are the drivers for such change and what should the resulting new health care delivery system look like? To answer this question, we must first appreciate the reality of today's health care infrastructure, and ask, "In a patient-centric health care industry, why is the health care consumer excluded from any involvement in the core health care processes and decision-making regarding the most important assets they have, their health care benefits?"

■ Introduction

CareGain is a trusted health care asset management company, a leader in an evolving space being defined by the drivers for reform in health care. CareGain's objective is to

transform health care benefits into assets, where consumers have a vested interest in the management and accumulation of financial assets for future health care needs. This in turn will result in controlling health care utilization today and lowering costs for employers that provide health care benefits in both the short and long term. The drivers leading to the evolution of "health care asset management" marketplace are manifold and are discussed below.

■ Rising Health Care Costs, Patient Misconception, and Lack of Consumerism

Cost increases of 13 percent to 20 percent per annum are leading employers to cut benefits, limit their cost exposure through fixed-budget traditional defined contribution health plans, or shift greater financial exposure to their employees. This is further fueled by the recent downturn in the economy. Employee dissatisfaction and backlash are common, and employers face retention problems with key employees with such cost-shifting approaches.

The health maintenance organization (HMO) plan design is partially responsible for over-utilization of health care by individuals. Consumers have developed the common misconception that it costs only \$10 to visit a doctor, and the difference between a generic

drug and a prescription drug is only \$5. More importantly, such out-of-pocket costs are lower than the price of a movie ticket, leading many to exercise no control on their health care spending or utilization. Employees have demanded more open network plans, such as preferred provider organization (PPO) plans, as a result of a small employee share of the premium difference between HMO versus PPO plans, further contributing to rising employers' costs. However, this also demonstrates that consumers are willing to incur slightly higher charges for greater access and choice for health care services, provided that the bulk of the increased costs are borne by someone other than themselves.

Individual behavior is shaped by perceived self-interest. Consumers make decisions based on their desire for an economic or financial benefit. In all industries, except health care, such consumer decision-making is key to the economic cycle and underlying transactions. Consumers spend more time comparing features, test driving, buying, and financing an automobile, and place much more value toward such a depreciable asset, than they do learning about or selecting their health care benefits, a much more important asset. Consumers monitor each transaction on their credit card bills and hold themselves responsible for the payments for all purchases they knowingly and intelligently made, but in health care, they leave providers to deal with their transactions with little or no personal involvement in such matters. It is often said that most consumers know the price of everything, but the value of nothing. In health care, however, people know the value of everything, especially as it pertains to the delivery of a benefit by an employer, and the importance of that benefit to them, but the price of nothing. Lack of price transparency, shielding of costs incurred by plan sponsors, and lack of a consumer-centric infrastructure for the management of this valuable asset by

employees are the reasons why misuse of health care is adding significantly to the cost crisis.

It is the infrastructure that is flawed. The current health care infrastructure does not support consumer involvement or decision-making. Without such involvement and accountability, costs will continue to rise. The current infrastructure must evolve to a consumer-centric health care system, where small changes in the financial structure of employer-sponsored plans will have cascading effects in the remaining health care sectors, including health care financing, delivery, payment clearance, and pharmaceutical purchases. What is needed is self-management and financial accountability in a system that all individuals can call their own, where they have a vested interest. The pursuit of vested interests for them and their families will lead to cost containment, greater compliance, continuity of care and disease management, and ultimately to best practices.

Discontinuity in Health Care Financing and Care Management

Physicians have long been held accountable for the long-term management of health status and illness of their patients, from birth to death. However, the year-to-year financing of health care, changing provider networks, and changes in employment, have ended any possibilities of patients being under the care of the same physician over their lifetime. As a result, repeated tests, redundant medical records, lack of understanding of the natural history of an illness related to a patient, lack of access to timely medical information on patients, and complications—for example, medical errors and interactions, resulting from decisions made without the proper information—are all contributing factors to the medical trend and health care costs.

Much of the focus and effort in

health care has been directed toward disease management and preventative services, rather than just treatment of illnesses. Many of these prevention and maintenance programs have the ability to reduce acute exacerbations of chronic illnesses, or delay onset of diseases through early detection and treatment, thereby leading to reduced overall costs for health care per person over their lifetimes. These prevention and disease management programs are often disrupted due to the annual health care financing model or changes in employment that lead to replacement of health care providers. In addition, these programs are usually based on analysis of retrospective claims data. Under this system, it is difficult to identify onset-stage, at-risk individuals, until they have accessed health care and have had a claim. By then, it may be too late to affect positive outcome by use of prevention programs.

Administrative Simplification, Privacy, and Legal Liability

Administration in health care now represents 25 percent of the total \$1.3 trillion health care industry, accounting for approximately \$320 billion or 4 percent of GDP. The government introduced the Administrative Simplification Act in 1996, known as Health Insurance Portability and Accountability Act (HIPAA) in an attempt to standardize health care transactions, including claims, eligibility, and referrals for providers and health plans, as well as enrollment and premium payment transactions for employers. These regulations also introduced new privacy and security standards to protect confidentiality of individually identifiable health information. They also shift the ownership and the authority for access and authentication of medical records to the individual. To self-funded employers, these regulations pose greater legal liability, if

proper compliance guidelines and privacy standards are not maintained. More specifically, if the new infrastructure were to support early-stage identification of at-risk employees, who have not yet incurred a health care claim, such identification must not point to a specific individual and jeopardize his or her privacy. While the opportunity for a greater return on investment exists for plans, providers, and employers alike, from standardization of transactions and implementation of systems and practices for privacy and confidentiality, the upfront expense to achieve said compliance may be eventually transferred to employers by way of higher premiums in later years.

■ **Impact of Managed Care on Providers**

Providers have been significantly impacted under managed care, with the per-person cost of providing care sharply increased. Lack of standards in the industry led to high administrative costs, manual process for claims and eligibility, and high rejection and resubmission rates resulting in delayed provider reimbursement. The introduction of HIPAA regulations will also add further costs to their current cash-flow problems.

■ **CareGain's Consumer-centric Health Care Asset Management Model**

CareGain presents the first viable, long-term solution to the cost crisis, with further benefits to be achieved from regulatory compliance, and improved administration. CareGain is America's first Health Care Asset Management Company™ transforming health care benefits into assets and giving consumers a vested interest in the management and accumulation of financial assets for their future health care needs, including retirement health care needs. Much like a 401(k), CareGain's HealthcareIRA™ enables the delivery of a

universal, portable, and private account system, enabling the management of health care benefits and associated financial assets alike. The patent-pending HealthcareIRA is built on a new infrastructure, and is the first health care customer relationship management (H-CRM) system of its kind, incorporating health care delivery, employee benefits, and financial asset management into one integrated system.

■ The Core Model

CareGain's core model includes account structures that interconnect the employer's group management account, sponsored health care spending accounts, and employees' personal HealthcareIRA accounts in a manner that enables compliance to privacy regulations under HIPAA and portability of HealthcareIRA. The basis for the funding of employee Health care IRA accounts is the actualization of savings by employers resulting from economic incentive-based utilization by their employees.

■ Employer Plan Design

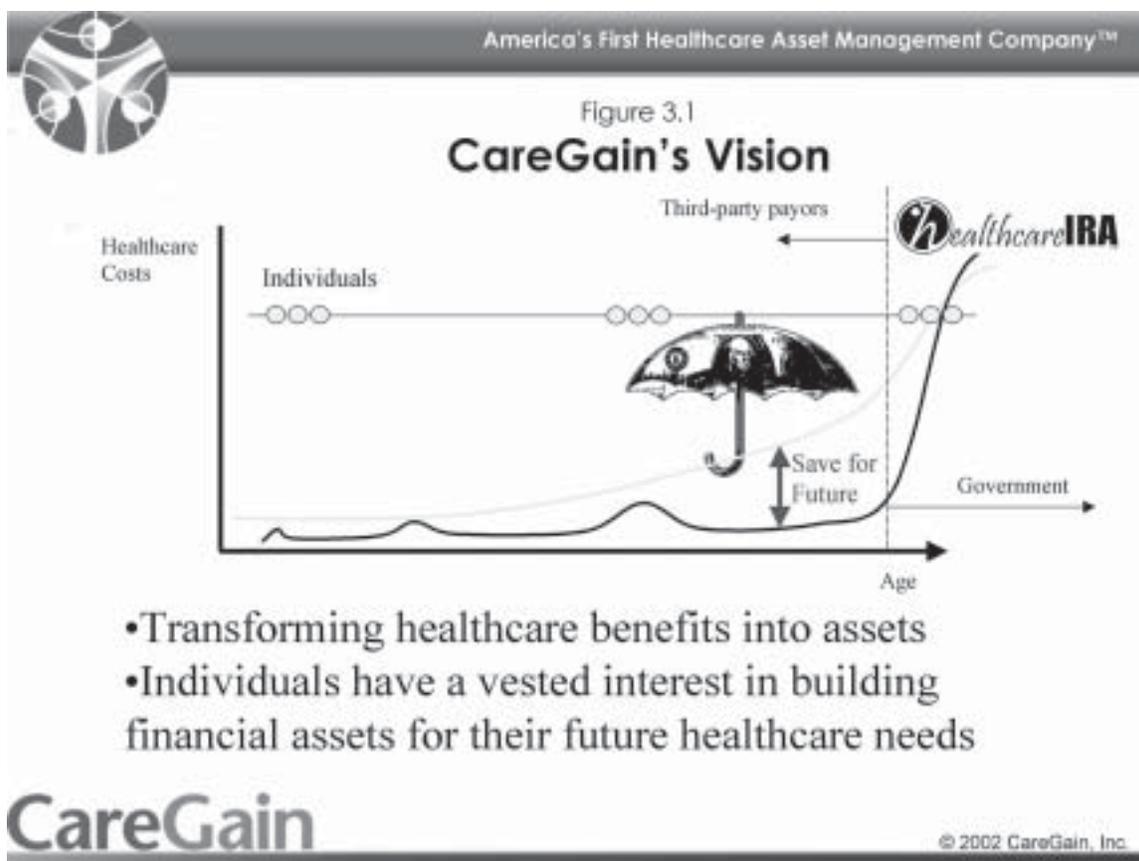
Under CareGain's model, the employer plan design is ultimately flexible and is based on the demographics of that employer's group. The plan design is also influenced by whether multiple plan options will be made available to the employees, as may be the case with large, self-funded employers, or whether the CareGain plan design will cover all employees under one group.

The goal of the plan design process is to achieve equality in financial exposure for employees, when compared to the other plan options, in a multiple plan option environment. This includes determination of whether an upfront deductible or a "bridge," employee out-of-pocket expense following the use of a spending account, will apply in the plan

design, what the amounts should be for these employee expenses, and what amount will be funded in the HealthTrustFund spending accounts. This eliminates any issues regarding adverse selection. In a single-plan option environment, and with fully insured employers, CareGain's model works in conjunction with the employer's existing insurer to minimize the impact on their employees. For these clients, CareGain has developed proprietary analysis software, which has projected, on average, 25 percent savings upfront, without having the employer shift greater cost-burden to the employees.

CareGain holds the viewpoint that employers will continue to use all methods currently available to control utilization and their costs of providing the health care benefit. These methods include the use of provider networks, formularies, care management programs, and prevention programs. Employees have developed the inherent perception that employer-sponsored health benefits restrict health care use, limit choice, lack decision-making ability and transparency of benefits, and operate in a health care system that is too complicated to comprehend.

CareGain provides a win-win solution to transition employees from being patients of the health care system to being consumers. The employer plan design includes the ability to use networks, formularies, and care management programs to control utilization, and adds the further financial incentive to control the use of funds in the employer-sponsored HealthTrustFund™ spending accounts set for the employees. Based on the usage of these spending accounts by the employees, the employer will distribute a dividend equal to a pre-fixed proportion (which is determined based on actualization of savings and applicable to all accounts equally) of the amounts left in these spending accounts at



the end of the year. CareGain also provides 100 percent prevention and maintenance program coverage, so that use of such programs is encouraged and does not count toward individual utilization, but only toward the overall group costs. This provides employees who have chronic conditions that have some preventative and maintenance aspect to them the same level of economic incentive as other employees. To encourage employees to take part in health risk assessments, comply to certain maintenance programs, or enroll in preventative services, such as smoking cessation and weight management programs, employers have the ability to structure incentives™ programs using CareGain's model that reward "good behavior" or a "positive health outcome," measured against certain baseline health risk indicators.

■ Employee Choice: When Are They in the Driver's Seat?

The employees receive dividends in their HealthcareIRA account at the end of the year, at which point, the funds become their personal assets (Figure 3.1). These assets can be used for immediate or future health care needs, such as for covering costs of services incurred out-of-network, costs of services not otherwise covered by the insurance plan in place by the employer, to cover COBRA premium payments in case of unemployment, fund dependents' HealthcareIRA accounts, or save for long-term, retirement health care expenses.

To transform benefits into assets, portability of HealthcareIRA is important. Employees accumulate these assets based on their utilization and the savings they achieve for their employer. It is the HealthcareIRA,

and personally owned assets accumulated within it, that become the vehicle for empowering employees to be in the driver's seat, to make better decisions, and become "shoppers" of health care services.

■ The Economic Benefit and Chronic Case Management

The primary decision that an individual must make under CareGain's model is whether they need health care today or need the funds to cover their future health care needs. Most people incur a significant amount of health care expense in the last two to three years of their lives, whether the lifespan of that individual is 60 years or 100 years. The private health care system covers most people at a level that is too high during the period of life when they need it the least, and the government provides the necessary coverage at a time when people need it the most. As shown by surveys of the individual health insurance market, and employees who become unemployed and are given the choice to enroll in COBRA, most of these individuals opt to enroll in high-deductible, catastrophic insurance. So, why is it that under the employer-sponsored plan only first-dollar coverage options are available in the form of HMO, POS, and PPO plans?

Employers may continue to provide first-dollar health benefit to attract and retain employees, but there is no reason for it to be an insured benefit. As statistics show, 75 percent of individuals use less than \$1,000 of health care annually, 94 percent of individuals use less than \$2,500 of health care annually, while 6 percent consume a significant amount of health care dollars.

CareGain's plan design financially restructures the plan to shift the benefit of the above utilization statistics in favor of the employer, whereas the premiums are paid to an insurer for an insurance policy to cover

chronic or catastrophic risk.

Employees benefit from the new plan design in that it provides them an equal level of benefit and financial exposure as before, and is equivalent financially when compared with other plan options that may be provided by the employer, while it further adds an economic benefit and the HealthcareIRA.

From an employer's perspective, in the fully insured scenario, the financial exposure to a chronic health care user or catastrophic risk is limited to the deductible chosen on the back-end policy. Importantly, CareGain's model is designed not to "select out" or disadvantage employees and their dependents with chronic health care needs. CareGain's unique account structure and plan design provides the same level of incentive to chronic health care users as others in the group to allow them to accumulate assets in their own HealthcareIRA accounts for their future health care needs. They are able to accumulate these funds by not having their utilization of preventative and maintenance programs for management of their condition count against their individual HealthTrustFund spending account. This increases compliance with such prevention and maintenance programs, and allows these employees to cover health care expenses outside of their employer's health benefit program using their HealthcareIRA, providing them the same level of choice, flexibility, and freedom as healthier employees.

■ HealthcareIRA™ Benefits and Health Care Asset Management

CareGain pioneered and defined the market for health care asset management, acting in the role of a "trusted" account manager for the HealthcareIRA™ accounts of individuals over their lifetime. In this regard, health care

information delivery, medical records, health benefit and financial asset management, payment clearance, and disease management efforts are centralized in the HealthcareIRA™. The benefits of such centralization include:

- 1) **Greater transparency.** Employees manage HealthcareIRA accounts the same way they manage their bank account, brokerage account, 401(k), or credit card accounts. They monitor their transactions and utilization on a real-time basis, become knowledgeable about the benefits provided by their employer, and are aware of the overall assets within their account.
- 2) **Greater knowledge.** Employees can personalize health information in their accounts relevant to their medical needs, search providers, look up cost and quality information on providers, compare costs and indications for the use of medications. Although individuals can use tools today to do all of the above, the HealthcareIRA provides the purpose for the use of these tools, which is that these individuals now have a vested interest in the appropriate use of their own “assets,” and therefore will be better informed to make better decisions.
- 3) **Lower redundancy of information and medical testing.** Due to changes in employment or insurer, many experience changes in their providers, which leads to disruption in continuity of care. New providers with new patients are faced with repeating medical records and ordering duplicate tests that may have been done in the past by previous providers. Lack of access and timely availability of information on patients continue to challenge the health care system, adding further cost. The HealthcareIRA will add the continuity of health care record keeping into the system, unaffected by employment or insurer changes, which will reduce redundancy.

■ Predictive and Prospective Medicine

The CareGain model turns a retrospective claims-analysis-based health care system into a prospective and predictive system. While maintaining individual privacy, CareGain enables aggregated health risk analysis, allowing employers to determine prevalence of certain conditions or risk factors in their group as a whole to determine appropriate benefit programs. These may be insurance benefits or prevention and maintenance programs. Such targeted approach will deliver higher compliance, greater retention of employees, and reduction of expenditures on non-useful benefits, while maintaining compliance to HIPAA privacy regulations.

■ “Can you trust your HMO?”- *Time magazine, Feb 2002*

Patients have developed the perception that HMOs are more interested in enforcing their rules for their own financial benefit than in the well-being of their members. Factors that contributed to the decline in “trust” include risk of denial of coverage due to preexisting conditions, fear of increased premiums for coverage, and now many public cases of indicated medical treatments being rejected by insurers. Similarly, employees fear that their self-funding employer may have access to their personal health information and may discharge them from employment due to cost reasons. It is for this reason that CareGain acts as the “trusted” third party to the employees, managing their health care assets in their HealthcareIRA™ while enabling an infrastructure and account structure that provides insurers and employers aggregated information on a need-only basis, without jeopardizing individual privacy.

■ Provider Reimbursement and Long-term Impact on the Industry

CareGain's model will have a significant impact on the 90 percent of outpatient claims by volume that are usually for routine health care services and are usually small dollar amounts. Many of the outpatient and preventative/maintenance health care services will be pre-adjudicated; therefore, claims for such services will be cleared and providers will be reimbursed within 48 hours. Many such transactions will also be processed using credit, debit, and check clearance networks and technologies, improving provider adoption, as 95 percent of providers carry such technology means in their offices and clinics today. CareGain's account structures and HealthcareIRA™ deliver the appropriate means by which such transactions can be cleared rapidly and efficiently, improving provider cash-flow.

To further improve administration, CareGain will issue smartcard-enabled HealthcareIRA™ payment cards. Employee benefits and basic medical information will be encoded within these smartcards for each HealthcareIRA™ member. When members seek medical care, they will be able to provide the physician point-of-care eligibility and general medical information. This will reduce waiting times and eliminate the need for expensive phone calls to insurers.

Another long-term benefit of CareGain's model is to allow providers to "broadcast" availability of certain health care services, which may be prevention or maintenance services. These services may not be covered by a member's insurer, or are services that are in demand. Consumers, with accumulated assets in their HealthcareIRA™ accounts, will be in a position to make decisions on whether they wish to purchase these services, and if so, at what price, through

direct negotiation with providers. This will further push the evolution of consumerism in health care, where consumers not only have an economic incentive to use health care appropriately under their employer-sponsored health benefit program to build assets, but then use these assets in HealthcareIRAs to pay for services. This will ultimately create a better balance in supply and demand for health care services. This consumerism will be the driver for long-term cost controls through self-service, price transparency, provider competitiveness, innovation, and improved quality of care.

■ Tax Treatment of HealthcareIRA™

CareGain is seeking HealthcareIRA tax treatment along the following guidelines:

1. Dividends made into the HealthcareIRA accounts of individuals from the employers would be tax-free to the individuals and tax-deductible for employers.
2. Funds in a HealthcareIRA not only should be available for access to the employees following their termination of employment with an employer but should also be completely portable. The portability may be subject to employer-dictated vesting rules.
3. Use of HealthcareIRAs should be restricted to pre-qualified health care services throughout a person's lifetime of ownership.
4. Any accretion in the value of the HealthcareIRA account for an individual should be tax free.
5. Contributions made from an employee's HealthcareIRA account to the HealthcareIRA accounts of that employee's dependents (defined as spouse, children, or parents who are legal dependents of that employee) should be tax free.
6. Charitable contributions from one's own

HealthcareIRA account to the accounts of the less fortunate or uninsured individuals should be tax-free.

7. Upon the death of an individual owning a HealthcareIRA, the assets should be distributed to his/her dependents or to other individuals as stated in his/her will—but only within a HealthcareIRA for such dependents of individuals.
8. Funds in a HealthcareIRA should be able to be used for purchase of long-term health care insurance supplemental policies and/or supplementation of Medicare/Medicaid coverage of individuals in the long-term.

The IRS ruled favorably upon the tax treatment of health care reimbursement accounts (HRAs) on June 26, 2002. This is important to the advancement of all consumer-driven models being introduced. This ruling is applicable to CareGain's HealthTrustFund spending accounts and HealthcareIRAs as well. The account structure within CareGain's model enables the accessibility and portability of funds, following termination of employment with any employer, which is a feature unique to CareGain. The IRS ruling on COBRA treatment further advantages CareGain's model, as the funds in HRAs are required to be made available to employees opting for COBRA even after end of their employment. CareGain's funding mechanism is financially beneficial to employers since funds are accessible by former employees only following the

receipt of dividends in their personal HealthcareIRA accounts. The amounts paid, and thus portable, are directly correlated to utilization by the former employee, which avoids any upfront payments to individuals in the beginning of the year and the problem of rolling over the balance as in other models, which produces little to no savings for the employer and continues to pose high out-of-pocket costs for employees.

■ Summary

CareGain delivers the first innovative approach from the managed care model to a more consumer-centric health care system. In CareGain's current experience with fully-insured clients, savings of, on average, 25 percent have been projected based on normal utilization patterns. CareGain will deliver the key set of data on the utilization savings achieved by fully insured employers based on the CareGain economic incentive model in 2003 for larger, self-insured employers. CareGain's consumer-centric model has addressed many of the problems associated with the managed care model and issues such as selection associated with early versions of the defined contribution model, resulting in high level of satisfaction by both employers and employees—a “win-win” situation. CareGain delivers a plan benefit and solution to employers of all sizes and insured status. CareGain acts as the “trusted” health care asset manager for HealthcareIRA accounts of individuals over their lifetime of ownership.

The Definity Model of Consumer-Driven Health Care

By Bill Reindl
Definity Health

■ Introduction

Over the last year and half, I have attended quite a few conferences in which consumer-driven health care has become a growing topic of conversation. At virtually every one of these conferences, some speakers say that consumer-driven health care is not the next silver bullet in health care. Personally, I am not sure that is a fair criterion to put at the feet of Definity Health, Lumenos, or even CareGain at this point.

What we do know is that it has taken us 55 or 60 years to get where we are today in employer-provided health care. Over the last 10 or 15 years, managed care has not delivered on its promise and currently is proving to be an unsustainable economic model, as stated by Tom Beauregard from Pugh Associates just last year at a policy forum sponsored by the Employee Benefit Research Institute.

For those unfamiliar with consumer-driven health care—and Definity Health in particular—my goal is to provide an overview of the model that Definity Health researched, pioneered, and brought to market. I also will share what I believe to be a growing and meaningful body of positive results.

■ Significant Results

Health care is the largest industry in the world; it is almost 14 percent of our economy—

and growing. Yet, it is virtually the only U.S. industry that incorporates little or no consumer dynamics. The average person still believes that health care costs \$10, the equivalent of their office co-pay.

Our goal is to incorporate and introduce plan design and financial incentives that create an environment where individual employees are positively and effectively encouraged to become more actively involved and educated in the purchase of their health care. By creating the appropriate plan designs and financial incentives, leveraging the latest technologies, seamlessly integrating best and market partners, providing pricing transparency, and fully integrating pharmacy benefits, we are well along in what we view truly as an evolution.

We are just getting started, but we have already achieved significant results. We have moved the bar by:

- Leveraging the tremendous amount of health care data that insurance companies have had—and been sitting on for years.
- Providing ever-expanding decision and support tools.
- Incorporating more advanced care management and predictive modeling.

What we will be doing five years from now will be significantly different than what we are achieving today. We are not looking for silver bullets; we are looking for implementing

solutions. And to date, we have very positive results, starting with the consumer, the demand side of the equation.

■ Cost Control and Satisfaction

No one has come to us and said, “We really like the idea of consumer-driven health care, the idea of let’s give people more choice and more control and more involvement, and let’s have it just cost a little bit more money.” Everybody holds us up to the standard, and we hold ourselves to the standard of helping to control long-term costs of health care.

The second value proposition that we bring to the market is to increase the satisfaction of employees, the members, in health care. We want to improve the health care experience for the average individual by offering truly distinct choices, as opposed to what many people have today—different versions of the “vanilla” plans A, B, and C. At a recent meeting, a chief financial officer said that health care is the only place he can spend \$27 million and aggravate his employees. The typical employer is continuing to pay more and more money and yet not receiving a return on that investment.

We seek to introduce consumer dynamics—to get individuals to understand that their health care does not cost \$10 and that there are alternatives. And, finally, we want to create a long-term vision, as opposed to the current scenario—in which people put down their \$10 and say, “I’ve paid my \$10; give me the works. Give me what is coming to me. Give me the best that you have.” Through design and financial incentives, we’re trying to incorporate a plan with the idea that people want to look at with a long-term horizon of their benefits. So far, our early results have shown that has been the case.

■ Personal Care Accounts

Plan features of Definity include the personal care account, the plan in which the employer allocates dollars that are funded fully and totally by the employer. It is used for traditional and nontraditional health care expenses, depending on the breadth of coverage the employer decides to make available.

If the plan also is used for traditional services, it is used toward meeting a high-dollar deductible plan, and unused balances are rolled over from one year to the next. From an average spread of claims, we expect the average risk to be between 60 percent and 70 percent of the population in any given year that they will roll over dollars.

Health care coverage is the next component. What we have learned from the research in management care is that for a relatively small amount of money, it makes sense to immunize our children, for women to get mammograms, for men to get PSA testing, and for both to get annual physicals. So, we take those elements out of the equation and provide those services on a variety of schedules with a 100 percent benefit. We’ve eliminated the hassle factor of managed care. There are no more gatekeepers, no rollovers, and employees are responding to that very positively.

But if you’re going to give people more access and more choice, more control of some of the dollars that employers are spending and ultimately more responsibility, you need to give them the necessary tools and information. We provide that pro-actively, either through their own personal Web pages, which half of our members actively utilize today, or through the 800 customer-service line.

■ Supporting Member Responsibility

The difference between the high-deductible plan and the personal care account is what we

call the member responsibility. The point is to engage the member throughout all of the financing of the personal care account up until, at least, they get through the deductible and into the health coverage.

Some of the tools we are providing are for an individual's member Web site; as mentioned, half of our members are currently using their Web site, half are not. We're providing easy access to a wide range of personal information, starting with "My Account." We already know more information about the personal needs and interests of our members than any of the traditional health care providers by simply analyzing the quick-stream data that we get from our members. Today, the most important questions are, "How much have I spent?" "What's my balance?" "What's my account?" In short, their questions are much like those they would ask about their 401(k) accounts.

Other than open enrollment, where enrollees still check to see if their doctor is in the network, the number one thing members are considering is price. Pricing transparency is critical to the success of this plan, and our members are actively looking at both costs and alternatives—and they're using that information to make economic decisions.

There is a range, which is a loose definition, in how the average individual incurs cost. The majority of people do incur a relatively low amount of claim dollars each and every year. For those individuals, we are very confident that through the appropriate financial incentives in the plan design, we can create the environment that encourages them to take a more active role. That has been our experience to date. But as we move along that continuum, for the active utilizers of health care—the chronic patients—no amount of plan design is going to give them incentives to make any changes in purchases.

For those people, we need to provide the next step, the next generation in care

management and disease management by leveraging the data on the individual to create personalized disease-management programs. We know for a fact that a child who was just diagnosed with Type 1 diabetes is far different and has different needs than a 54-year-old male who has had Type 2 diabetes for 30 years. But to date, we haven't been able to leverage the available data. We have created and are still using "one-size-fits-all" disease-management programs. As we continue to accumulate the data, we will be able to personalize those programs for the individual and throughout the entire process—regardless of where they are in that continuum. Ongoing education is key to this growing program.

■ Results

Employers are adopting these plans. As of July 1, 2002, Definity Health will have more than 30 employers enrolled from a diverse population. For example, the average income of enrollees at Budget Rent A Car is \$22,000. We certainly have some high-tech organizations, such as Medtronic and Ratheon. Textron is doing this on a full replacement basis, eliminating 156 health plans across the country for their non-bargaining U.S. employees. But the company also has significant manufacturing employees at each of those sites. CVS and Staples currently are rolling this plan out. We are appealing to a wide cross section of employers; most of them are fed up with the current cost situation and looking for alternatives.

Our plan is working from an enrollment perspective, especially when you consider that the average enrollment of HMOs when they first came out was in the area of 2 percent to 3 percent. On average, Definity's book of business over the last two years has achieved 10 percent. Overall, on the basis of new hires, 30 percent of those who have more individual information are signing up for our

plan. From a selection perspective, it's not just the young and healthy who have signed up for Definity. With the exception of the "bullet-proof males," we have enrolled a broad cross-section of the enrollment population.

The average age of eligible enrollees was 39, and the average age of our enrollees was 41. People say, "Well, that's great, if you're just getting the healthy segment of that population." The actuaries tell us that on a per thousand basis, we should receive about 19 large claims, those that exceed \$25,000 a year. To date, we have actually received about 21 large claims per thousand. These aren't otherwise healthy pregnant women with unexpected premature babies. Many of these individuals had these conditions prior to enrolling in Definity Health and really liked the idea of having more access, more choice, more control, and more information. They have told us that they are willing to spend a little bit more in order to be able to have those benefits.

■ Cost Containment

Directionally, we have achieved a reduction of about 10 percent in utilization as a result of the high-deductible plan with the Definity Health personal care account. To date, although it's still a little early to tell, we have achieved either that amount or a little bit of a higher reduction in utilization, but we are still waiting for more information to come in. From a hospital perspective, we are currently mirroring the well-managed plans, and we are very encouraged by that. But again, it's early information.

From the perspective of pharmaceutical costs, the fastest growing component of health care costs today, we are having a dramatic impact. We have a 90 percent generic substitution—10 percent higher than

Merck Medico's overall book of business, our integrated partner. We also have a lower utilization per member, about 10 percent versus Merck's well-managed plan, with all the bells and whistles and formulary requirements. Definity Health uses "No Tiers"; you don't need to pay \$10 for this plan or \$5 for a generic if there is no brand available. It's purely the market forces at work that provide people with information choice and pricing to make those decisions.

We also have a 24-hour nurse line. We are getting twice the number of calls that the typical managed care plan receives, and 76 percent of those calls are for symptom-based types of information. For example, someone will call and say, "I'm a first-time parent, my child has a 100-degree temperature. Should I take him to the emergency room?" We are getting the kinds of questions that more engaged consumers should be asking.

From the perspective of "world class" service delivery, an independent consultant has stated that on a scale of one to 10, "world class" service from health care delivery would be 8.5. So far, Definity has consistently exceeded those levels, whereas the typical bar in the average health plan today is significantly lower than "world class" service. Some will have used our design against us, but we have results that show that this is working; 97 percent of our members have re-enrolled, and 100 percent of our clients have re-enrolled.

■ Conclusion

Through innovation, leadership, and new design, Definity seeks to create an environment where people have alternatives and where employers can truly measure differences. We have significant experience, we have some results to date, and we're going to continue to share more of that as we proceed.

The Vivius Approach

By Lee Newcomer
Vivius

■ The Program

Until recently, Vivius has been “a science project” rather than a product sold in the market; however, a few months ago we announced a partnership with Health Net, and we expected approval from the State of Washington insurance commissioner to market our product in that state. It was scheduled to be offered to employers in Spokane last June.

Vivius retains the social function of insurance—it has comprehensive coverage using co-payments. It is unique because the consumer picks his own individual provider network; the insurance premium or the payroll deduction varies depending on which providers the consumer chooses to be in his network.

Vivius asks physicians and other providers such as hospitals to provide us with their fee schedules. We don’t negotiate—this is simply an order-taking process. The providers understand that their fees will determine their “prices” to the consumer and that they will be competing against their peers for potential patients. Vivius then converts the fee schedule to a monthly insurance premium unique to that physician.

Vivius is not an insurer—we partner with an insurance company for this task. For example, if an orthopedist in Spokane, Wash., gave a fee schedule rate equal to 130 percent of Medicare, it could be converted into a \$4 monthly insurance premium. The insurer is also allowed to raise the rate for a

history of higher utilization than the community average, and the provider’s rate can be discounted as well.

■ The Role of Consumers

In our program, consumers begin by naming the physician they usually call if they need help locating a specialist. Each physician who is listed in Vivius also has recorded a list of physicians for referral recommendations in each specialty. Consumers use this list to help them decide which doctors they should buy for their network. Then, it is up to the consumer to affirm that choice. The consumer selects about 20 different providers, which become the consumer’s personal network. Payroll deduction varies with the choices of consumers. If consumers spend too much money, they can change their selections or adjust their co-payments.

Consumers first pick their co-payment levels for the network. This allows the system to set the pricing—a higher copayment means lower insurance premiums. Next, the consumer selects the doctor who will recommend a network based on the doctor’s assessment. I’d use my internist, Sam Carlson. I would see a screen showing the specialists, hospital, and outpatient surgery unit normally recommended by Sam. With that list, I also would see my premium amount, my employer’s contribution, and my calculated payroll deduction.

Consumer-Driven Health Benefits: A Continuing Evolution?

Now I can make changes. If this year's household budget is tight and I can't afford my \$55 payroll deduction, I could start by raising my co-payment levels. As a second approach, I could review the expensive providers on my list and change them. With each change I would see the new payroll deduction amount.

When I'm through, I have purchased coverage that looks like an HMO. When I visit my selected physicians, I make a co-payment and I'm covered. In some other models, consumers buy individual services with their dollars. Both models encourage the consumer to think carefully about the provider they choose for services, but they take different approaches.

6

Consumer-Driven Health Care: Incentives, Infrastructure and Information to Improve Value

By Michael Parkinson, MD
Lumenos

■ Introduction

Like many in attendance at the Employee Benefit Research Institute's policy forum, I have those initials—MD—after my name. I've tried tackling clinical, quality, and administrative challenges from the perspective of a primary care, family practice doctor, seeing many patients who wouldn't have needed to be in my office if they had access to information and support from their own resources, family, or community. I've studied and practiced epidemiology, wondering what was the attributable fraction of disease due to true causal factors that could be addressed through a more proactive, prevention-oriented approach. In the United States, we live to be 72 despite ranking 37th in the World Health Organization rating of countries that efficiently spend their health care dollars. Okinawa, my wife's country of birth, had, until recently, the world's longest and "healthiest-living" population. Living to be 100 is not unusual—hence the reason for the study just published in a best-selling book, *The Okinawa Program*. We should all be asking, "What is the amount of health care spending that actually produces to health?"

Over the years, through working with Peter McMenemen on evidence-based health programs in the U.S. Air Force, reading John

Iglehart's NEJM articles, and many collaborations with colleagues, it dawned on me that we just didn't have "it" right. We had a lot of pieces to put an effective health care system in place, but we lacked three key elements. We used to think that we could just tell doctors "what to do" and voila, quality care would result. At one point I had 13,000 physicians that I supposedly controlled in terms of writing a military plan to optimize a health care system with eight million people. But by and large, doctors didn't listen to me. They didn't listen to Dr. Lee Newcomer at United Health Care either. But ironically, 73 percent of family doctors say that they'll prescribe a drug that they don't think is indicated or optimal for patients when patients *ask* for that drug. Hence the genius of direct-to-consumer advertising. There's a principle here that we have to recognize, return to, harness, and energize. Doctors *do* listen to their patients, although we've typically focused on the converse.

■ Aligning the Elements

For change in any system, three "Is" have to be aligned: incentives, infrastructure, and information. I borrowed this construct from the benefits director at Ford Motor Co., who I recently heard at a meeting of the Robert

Woods Johnson Foundation National Health Care Purchasing Institute. For much of medicine, we've had the information about what works and what doesn't. I learned 25 years ago as a second-year medical student that antibiotics don't work for the vast majority of viral sore throats. Yet as recently as 1999, patients still received antibiotics 70 percent of the time when they saw a physician. The information about appropriate practice has been there for a quarter century, but the incentives and infrastructure to support that information were lacking—and actually, in some cases, contradictory to best clinical practice. By refocusing incentives, infrastructure, and information around the consumer's needs, we can provide the needed transformation to drive the delivery of best clinical practices in a cost-effective fashion.

Consumer-driven care is no longer a notion. We're doing it with leading companies across the country. These companies and the growing list of new clients offering Lumenos in 2003 to their employees attests to the fact that we're really beyond the "early adopter" phase of this consumer-driven transformation of the health care marketplace. While many of us from clinical and policy circles may think that these consumer-driven models are a "new, new thing," employers in the trenches have understood the inherent appeal of consumerism and markets; it's what they do.

These same employers, faced with dramatic cost increases, cannot swallow, say in Florida's case, a 40 percent average increase in the Tampa area. Inertia insures unsustainable cost increases. Our consumer-driven financing model essentially has employers depositing previously "unseen" health care dollars into an employee-controlled health savings account. We treat prevention a little bit differently, but we preserve the two key principles necessary to insure receipt of evidence-based preventive services:

- We provide financial incentives for pre-

vention and appropriate routine care by creating a "non-rollover" provision, approximately 15 percent of the health savings account, which cannot be rolled over from year to year.

- We promote evidence-based screening tests, immunizations, and counseling interventions through our Web tools and personal health coaches.

Rather than decreasing their roles in health care purchasing, employers need to shift their responsibility from what I call the battle of the \$22 discounted current procedural terminology (CPT) visit (which was really never worth their effort anyway), to the battle of high-cost hospitalizations and procedures in the traditional insurance part of the consumer-driven benefit model.

Employers will have unique clout, particularly in the early years of the consumer-driven movement, to focus on the use of growing, new, and in many cases, only marginally better expensive technologies and hospitalization practices. Employers should shift their focus, rather than drop their role in the purchasing of health care. I believe employers are the only regional purchasers with enough clout to engage such difficult issues and the number, types, and appropriateness of procedures and hospitalizations in their respective locales. That's the message we're giving to employers in meeting after meeting as we go around the country.

■ Four Imperatives for Change

The test of consumer-driven health care is the degree to which it delivers the four imperatives (I called them the "Four Horsemen" in a recent newsletter) of value-driven health care:

- Reducing the need for health care.
- Reducing the demand for health care.
- Decreasing inappropriate and inefficient care.
- Increasing appropriate and efficient care.

To reduce the need for health care, we have to ask if these models optimize or improve evidence-based disease prevention and health promotion. Behaviors account for more than 50 percent of all preventable mortality in the United States. And it is likely much higher when environmental concerns are added. The reason that Okinawa has more centenarians than the United States—despite spending double their health care costs—is lifestyle, not bed days per 1,000.

To reduce demand for health care, we have to ask how consumer-driven care promotes appropriate self, family and community care. We've essentially eliminated self and family care from the civilian health care system. In the military we teach self care and buddy care on the battlefield, and we extended that into families. How do we build that back into the civilian health care system? How do we use incentives, infrastructure, and information to maximize these underutilized elements of a cost-effective health system?

It's also important to decrease inappropriate and inefficient care. Others will cite the percentage of total health care spending that is inefficient or, even worse, "pure waste." There's a lot of work for both employees and employers to do to identify and ferret out care that is of little clinical value to the patient.

To increase appropriate and efficient care, we need to ask how consumer-driven care increases the likelihood that care which "works" actually gets delivered. Evidence-based guidelines by themselves don't solve the problem. Incentives, infrastructure, and information around the consumer will significantly improve all four horsemen.

■ Consumer-Driven Models

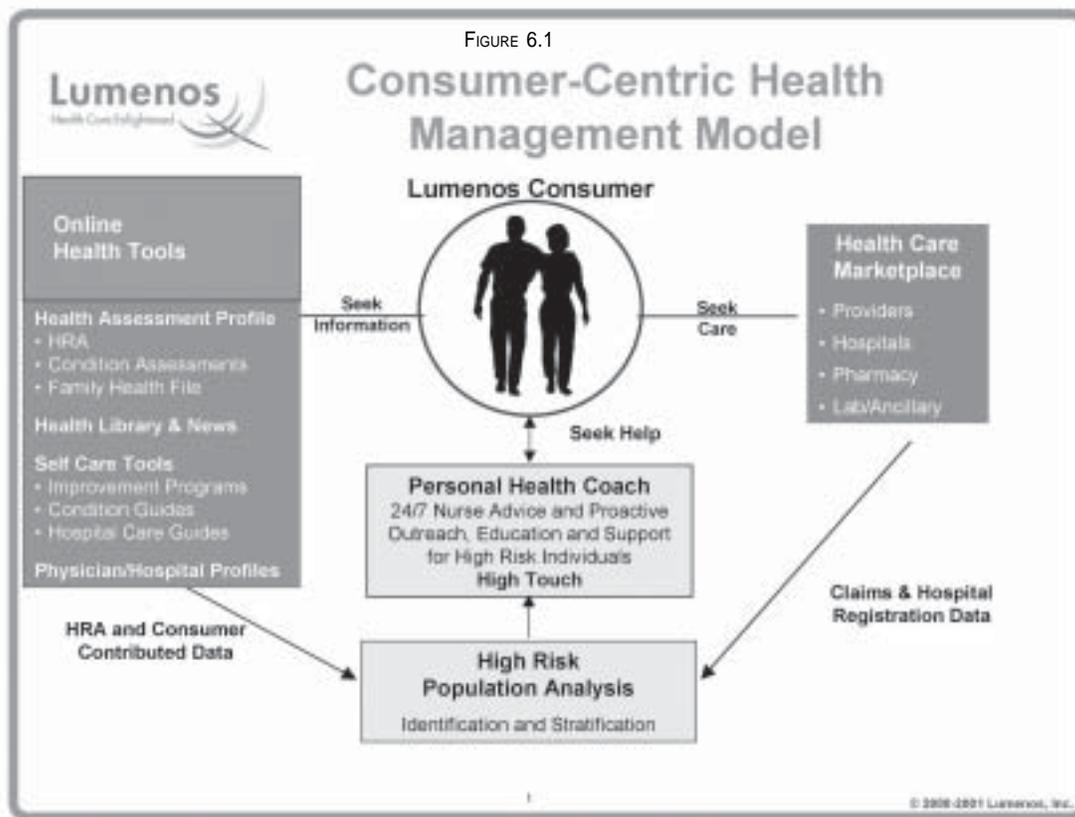
In the traditional health insurance benefit area, the threshold of high-dollar expenditures above the health savings account and out-of-pocket "bridge," the engaged con-

sumer continues to be supported within the hospital. They are supported in their attempt to break down the barriers between in-patient/out-patient, home care, recuperative, or rehabilitative care. The unique role of employers in this area of the benefit, examining the prevalence, distribution, and appropriateness of a \$50,000 procedure over time will place pressure on hospitals to improve quality and cost-efficiency.

Leap Frog represents an important first quality step in this direction. We need a "ambulatory Leap Frog" set of standards, something that might come out of Don Berwick's work at the Institute for Healthcare Improvement, the National Quality Forum, or the Center for Evaluative Clinical Sciences at Dartmouth. Which characteristics of quality outpatient care can we define and publicize to drive quality purchasing? Consumer-driven models will catalyze the movement of these standards into reality once individual consumers choose their doctors and medical groups based at least partially on practices that reduce errors and improve quality.

Consumer-driven models also must address the actuarial view of the health care world: the no or low utilizer, the medium utilizer, or high utilizer. How does consumer-driven care, combining a financial incentive with transparency of costs, Web-based tools/information, and a high-touch personal support system address the needs of these three groups?

At Lumenos, we acknowledge that for the near term at least, there's no way that a doctor in a seven-minute visit is going to be delivering the high-touch personal, intimate, consultative services that patients seek. We can use new technologies and Web-based platforms to provide information in an easy-to-use and understandable fashion, but the human element has essentially been "carved out" of our current managed care system. Parenthetically, it will be very interesting to



see how consumers react when their doctors receive \$48 for a visit. Will they embrace it as too much or too little? Will they compare it to a plumber’s house call, which averages two to three times as much, and be pleased? Or will they be more willing to pay for more time? I just don’t know, but it will be fun to monitor.

In terms of health care utilizers, I ask for a representative “sentinel condition” for each. How does Lumenos support a different and better outcome than the status quo? First, you have to have a strategy to deliver health care. This is not rocket science, but without one, you can spend a lot of time on products and services that don’t produce the desired outcome. This strategy requires the following:

- Assess enrollees and identify high-risk individuals. Three groups of consumers we particularly need to identify and assist are people with three or more risk factors, those with existing chronic diseases/ conditions, and anybody who thinks his or her health status is “poor.” By definition,

this last group is likely to include high utilizers, regardless of their actual health status or clinical history.

- Reduce the demand for health care through self and family care.
- Optimize evidence-based disease and condition management. How does Lumenos assist the 5 percent of patients who consume 60 percent of health care dollars?
- Identify and access health-producing but “non-medical” community resources. There is a growing body of evidence around shared decision-making, functional assessments, and community linkage and support that demonstrates that utilization and quality of life can be favorably enhanced by these health-producing but nontraditional activities. Cancer patients do much better if they can talk to similar cancer patients with their condition. I may not need as many doctor visits if I can find information and

support outside a formal clinical setting. We're just beginning to understand and leverage these resources. The technologies we have available today to create communities of interest and support should be maximized under consumer-driven models of care. Consumers want this support.

- Analyze outcomes for continuous quality improvement. This is a critical focus for this emerging model of care. Current performance measures may not be adequate to describe the key competencies and performance indicators that capture the engaged consumer of health care.

Figure 6.1 shows how we tactically try to create an engaged consumer of health care at Lumenos. When we re-engineered the military health system, we came to a startling conclusion: Health care wasn't really about doctors, hospitals, plans, premiums, and actuaries. It's about taking the assets of the health of an individual and a population with which you're entrusted and improving it over time—in a cost-effective fashion.

■ Acquiring Three Competencies

In our plan, we want to create consumers who over time can acquire three competencies that we should be able to measure. To a large degree, our ability to create engaged consumers who demonstrate these competencies is a measure of success for the consumer-driven care movement. The first competency is the ability to seek information from an easy-to-use integrated source of information. People are going to the Web for health information but are not having an easy time of it. The value proposition of a consumer-driven plan must be to make health information easy and intuitive to access—and clinically relevant.

So, we integrated and consumer-tested health care information and tools, calculators,

a health reimbursement account (HRA), in an engaging fashion, which we hope will empower individuals to understand their baseline health status, risks, and conditions. This is the cornerstone of self- and family care. Access to and promotion of our 24-7 nurse-advice line (which is connected to our Personal Health Coach program for chronic disease patients) completes the infrastructure for this first consumer competency.

Engaged consumers also have to seek care, our second competency, from a health care marketplace. We do not use the word “network,” although we access a major national network of discounts. I believe a network may be an artificial creation of the managed care era—financial agreements struck largely out of the consumer's view that steered patients toward certain providers or facilities largely based on price. If you think of a true market, you want to promote true transparency of cost and quality. Networks, as they are currently operated and constructed, may or may not prove themselves to be of value to an engaged consumer with access to price and outcome information. This is a long-term goal but one which is achievable, particularly if we begin to focus on outcome measures to which the consumer/patient can relate.

That's why at Lumenos, we believe that the definition, measurement, and dissemination of general and disease-specific competencies (e.g., “What should a ‘competent diabetic’ be able to know or do to optimize their health?”) needs to be undertaken. Those measures are not out there yet, and we'd like to explore them further with foundations and forward-looking organizations.

Finally, the competent consumer needs to know when and how to seek help. We've got to re-inject the intimate, trusted, and personal relationship back into health care. We must talk to patients. I cannot understand if the diabetic is competent,

FIGURE 6.2



IOM 15 Priority Conditions “Content Map”

- Cancer (HC)
- Diabetes (HWC)
- High Cholesterol (HC)
- Emphysema (HW)
- HIV/AIDS (H)
- Hypertension (HWC)
- Ischemic Heart Disease (HW)
- Stroke (HW)
- Arthritis (CW)
- Asthma (HWC)
- Gall bladder disease (W)
- Stomach ulcers (HWC)
- Back problems (HWC)
- Alzheimer’s disease and dementia (HW)
- Depression & anxiety disorders (HWC)

H – FutureHealth Model
 W- DoctorQuality.com Workbook
 C – WellMed Condition Center

2

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FIGURE 6.3



Seek Info: Asthma Care Guide



My Lumenos Page
Doctors Plus Directory
My Health
My Account
My Benefits

At a Glance

My Health Profile

Health Library

Get to A Point

Medical Care Guides

Hospital Procedures

Health Quizzes

Asthma (Children)

General Information
Seeing Your Doctor
Managing Your Condition

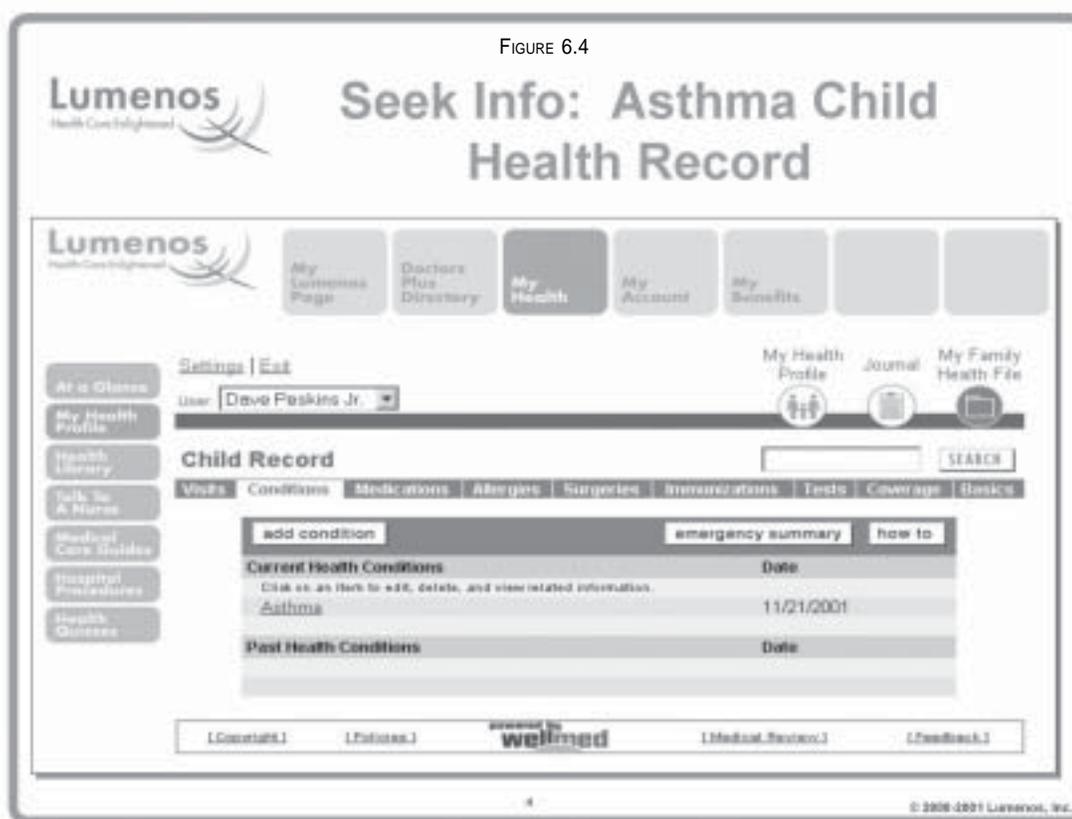
- [Essential Care](#)
- [Goals of Treatment](#)
- [Notes on Classifying Severity](#)
- [How to Use a Zone Chart](#)
- [Treatment Plan](#)
- [How to Grade Severity](#)
- [How to Use a Peak Flow Meter](#)

Everyday Care

- Make certain that your child is taking all the medicines that the physician has prescribed. Adolescents are well known for not taking medicines.
- Make certain that your child is measuring and recording peak flow measurements daily.
- Use the zone chart as often as recommended.
- If your child’s condition changes in a significant way, make sure that you get in touch with your doctor.

3

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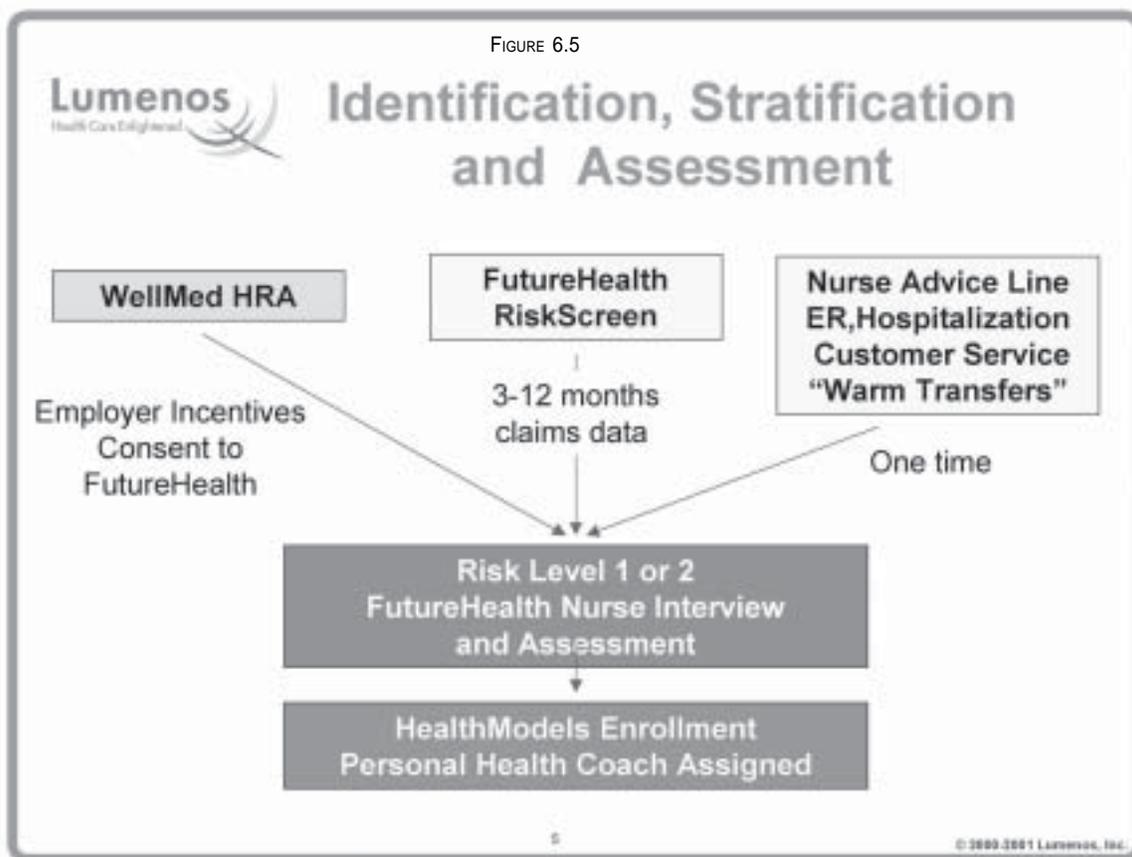


knowledgeable, engaged, and “healthy” from more sophisticated analysis of claims data. I cannot get it from touch support to address the needs of these patients. As shown in Figure 6.2, the IOM Quality Chasm report of 15 defined priority conditions, which comprise the vast majority of U.S. health care spending, are mapped to our content—both our high tech information sources and our high touch Personal Health Coach behavior change curricula (called “HealthModels”). In fact, through our partner, Future Health, we have 28 Health Models addressing the most common chronic conditions, which produce health threats and high health care costs.

Consider asthma, a very common chronic condition. Employers are getting a really raw deal in the non-coordinated and inefficient care asthma patients receive. A poorly managed asthmatic (and at least 50 percent of all asthmatics are not managed

using best practices) costs employers \$5,000 per year more than they need to pay, not to mention the indirect costs that can run two to three times greater. Figure 6.3 and Figure 6.4 demonstrate how our Web-based information and tools can be used to help the patients better understand their asthma care. These tools build their medical record and their understanding of asthma, use of a peak-flow meter, recording of daily results, triggers for asthma, etc.

At the same time, we realize that the majority of patients are not likely to use these tools without a coach. So, we incorporate the Personal Health Coach, trained on our Web site using a behavior change model specific for asthma. The Health Coach also assesses the quality of the physician-patient relationship and provides specific support for the patient before and after their visit. “Here’s your list of questions to discuss with the doctor. Would



you like us to call the doctor for you if you don't feel comfortable about talking to her?" About 15 percent of the time, the Health Coach will speak to the physician or her office when we see a serious issue of quality of care or the patient is unable or unwilling to discuss a care-management issue. But we start with the patient. The goal is to make the patient competent in the management of his or her condition in the context of a healthy, doctor-patient relationship. It's always been about the patient. But we seem to be re-discovering that the person who should care most about their asthmatic lungs or diabetic retinas is the patient with the condition or the patient's family members.

Having multiple, sensitive means to identify those high-risk individuals or those with existing chronic illnesses is a major design feature of our integrated care-manage-

ment strategy. Figure 6.5 depicts the five different ways we do this—through HRA, claims analysis using proactive identification algorithms, nurse advice lines, hospital/ER review, and internal customer service advocates "warm transfer" to a Health Coach. We're focusing on how to best to create incentives for the completion of HRAs, and we suspect that over time, as individuals more closely connect their health status with their health saving account spending, that an additional incentive for healthy behaviors will be energized.

We want to align our communications and incentives with those of the employers to maximize completion of the HRA and the transmission of the data to a Health Coach for review and possible enrollment in care management. Using 78 proprietary risk screens for claims and pharmacy data, we identify key

omissions in quality care practices which, over time, will lead to poor health outcomes and increased health care costs. Of course, we also identify individuals who do incur high-dollar claims through emergency room visits or hospitalizations.

At Lumenos, we also encourage warm transfers, via our IT investments and in-house customer service advocates, to identify individuals who may have an administrative question that really is a signal for a care-management need. We then assess these individuals by conducting an in-depth interview and comprehensive medical history. Patients are stratified into four levels of risk: those incurring high costs currently or at immediate risk of a poor outcome (level 1) and those who have major indications or poor monitoring or care management (level 2) are candidates for enrollment with a Personal Health Coach. The Personal Health Coach, one of 35 specialized nurses with experience in that disease or condition, works weekly with patients for an average of four to five months, using a tailored care management plan called a Health Model. If you take the time to actually talk to patients and create a system where this personal support and behavior change is encouraged, you find out amazing things. For example, you'll find out that patients may look clean or well managed on claims data mining, such as noting whether a beta blocker was prescribed post MI. However, in talking to the patient, you discover that not only was a beta blocker prescribed but also that three beta blockers were prescribed by three different doctors—and all three prescriptions are sitting on a kitchen table and yes, the patient is taking all three. Or you find out that a patient is demented and unable to comply with doctors' orders. Or a patient may not know the name of the principal care physician or if he does, he doesn't feel he can talk to him (the physician). So much for

compliance with evidence-based care.

Enter the Personal Health Coach. Building a healthy doctor-patient relationship takes time, and it's often not easy. We find that to achieve the requisite competencies from the consumer's perspective takes an average of four to five months of weekly contacts. Neither the doctor, nor more importantly the patient, can do it in a seven-minute visit. And we evaluate the patients' quality of life—how their diseases affect their ability to function. We perform baseline and post-graduation function assessments using SF12s. We automatically screen patients and coach them on underlying behaviors driving their illnesses and recommend the preventive services they need. Even depression screens are performed on all patients enrolled with a Health Coach because it's not surprising that chronically ill patients are frequently depressed. The integrated approach to care management using the Health Coach looks at the whole patient—not an organ-by-organ series of “DM modules” that need to be cobbled together by the plan or employer.

■ Conclusion

I believe that consumer-driven care will be the predominant health care trend for the next 20 years. There will be a lot of fits and starts along the way, but I am excited about the direction it's going. Many of the concerns that all of us began to address more than 20 years ago have not been solved in the era of managed care, although the seeds for success have been sown. Consumer-driven health care offers us the promise to maximize what we know and to improve health care through alignment of incentives, creation of supporting infrastructure, and more effective dissemination of information.

Finally, we should identify the processes and structures needed to better inform

Consumer-Driven Health Benefits: A Continuing Evolution?

consumers about the appropriateness, effectiveness, and cost of care. For example, who has the responsibility of assessing the relative value of new drugs, technologies, or procedures compared to existing practices? How does this information get into the marketplace in a way

that makes it usable and actionable by the consumer or employer-purchaser? The movement toward consumer-driven health care will offer all of us—policymakers, practitioners, purchasers, and consultants—a worthwhile opportunity to achieve our original goal: high quality—and high value—health care.

Consumer-Directed Health: It's a Matter of Choice

By Pattie Duca
Pharmacia Corporation

■ Introduction

The merger of Pharmacia & Upjohn and Monsanto in 2000 provided the opportunity to create a new and innovative employee benefits program. Our strategy is to provide equity and value to employees through benefit choices that meet their diverse needs. All our benefit programs—from choices in pension and savings plans to choices in health and group plans—are designed to appeal to the broad diversity of both the current work force we want to retain and those we want to attract as we grow.

Our new program choices are designed to have equal financial value but different delivery methods, which can address demographic and geographic choice drivers. We have about 18,000 active U.S. employees, with primary sites in Illinois, New Jersey, Michigan, and Missouri and several smaller sites in California, Georgia, and Ohio, along with a countrywide sales force.

For health care benefits, we developed choices among four actuarially equivalent plans and have priced them equally—no more high, medium, and low plans with corresponding price tags. This traditional way of pricing benefit programs is a futile approach that encourages selection and, in turn, will ultimately generate a plan that becomes cost prohibitive for most employees.

This course has no happy ending.

Either you cut benefits to manage the cost, or you put employees in a position of having to select a less costly, but less extensive plan. In our new model, it doesn't matter which plan an employee chooses; and we get to examine experience as a single exercise. That's on the expense management side; but what about on the employee value side? If the plans are equivalent in value and they all cost the same in terms of employee contributions, why would an employee choose one over another?

We offer four types of plans: an exclusive provider organization (EPO), similar to an HMO; two preferred provider organizations (PPOs); and one consumer-directed plan. Each plan appeals to a different segment or profile of employees, based on demographics, geography, and the local market place. For example, employees who like the predictability of out-of-pocket costs and ease of use prefer EPOs. Employees who gladly trade off some of the prior two characteristics for more flexibility prefer PPOs; and the consumer-directed health plan appeals to employees who want the most control over their care and its reimbursement.

■ The Benefits of Early Adoption

Nearly everyone recognizes that a fundamental change in the way employees and employ-

ers participate in the purchase and use of health care is required. TV commercials now market drugs directly to patients and encourage them to “ask their doctor”; local community hospitals send promotional brochures in the mail; doctors and dentists advertise in the newspapers; and center-of-excellence ads for pulmonary, cancer, and transplants are found in airline magazines. The problem, of course, is that employees get to spend a portion of their company’s profits on those services, and the most difficult part is having them understand and appreciate just how much that is. After all, a \$10 office visit or an occasional \$100 hospital stay is not much money for a company to kick in when employee health, satisfaction, and productivity is at stake.

A consumer-directed health plan puts employees back in the equation. In addition, it allows our employees to experience the evolution in the marketplace before it becomes mainstream. This gives them some advantage and ease of acceptance. And while we did not include it as a cost-control measure, the consumer model, theoretically will produce savings.

For example, consider the cost of LASIK surgery. A few years ago, virtually no employer plans covered it. Yet consumers have had and paid for many, many thousands of these procedures, and now it can be obtained for a couple of hundred dollars per eye. This suggests a market for consumerism in addition to the so-called “defined-contribution” piece, which, of course, can be used to manage a portion of the company’s cost. So consumer-directed health plans can save money without shifting costs to employees.

■ Conclusion

Our consumer plan was launched with Lumenos, a group of very experienced and visionary individuals with a major commitment to customer service and information/education to health care consumers. An early look at who chose the consumer plan last January shows a mirror image of employee population, from young to older, single and family, well and sick, from all geographies. This dispels the notion that only young, healthy people will opt for the plan and increase your costs. Only about 5 percent of the eligible population elected it, and this was not a surprise given the plan costs the same as the other options and was not promoted in any way.

On the other hand, it’s the only plan in which we have not experienced complaints and administrative issues. In addition, employees are finding the personal health coaches are a lot more like what a primary care physician (PCP) was supposed to be during the height of the gate-keeper phase—someone who managed the total care of a person while helping them navigate the health care system. In fact, the Web site is so good in terms of its “my-health” approach that we are considering offering it to all employees, whether or not they chose the Lumenos plan.

Anecdotally, we are hearing that employees like the plan, and we will do a formal survey soon. I am personally excited to be in a position of having a plan in place that anticipates the next wave of health care delivery. Maybe I can finally schedule a vacation while everyone else goes into the design and implementation cycle.

Optimizing Cost and Quality Through Consumer-Driven Health Benefits: Where Does the Evidence Point?

By Arnie Milstein, MD, MPH
Mercer Human Resource Consulting & Pacific Business Group on Health

■ Introduction

What approach to engaging consumers will do the most to:

- Moderate rates of increase in health benefit cost?
- Improve quality of care?
- And preserve employee satisfaction?

Milt Freudenheim's article in *The New York Times* in 2001 foreshadowed the importance of the question. It described a worst-case scenario for consumer-driven health benefits, in which blunt increases in consumer cost-sharing led to impoverished sick people and vilified benefits managers. Alternatively, a well-designed and well-executed program to enable a more quality-savvy and cost-conscious consumer might elicit significantly higher quality and employee satisfaction—at lower rate increases in insurance premiums.

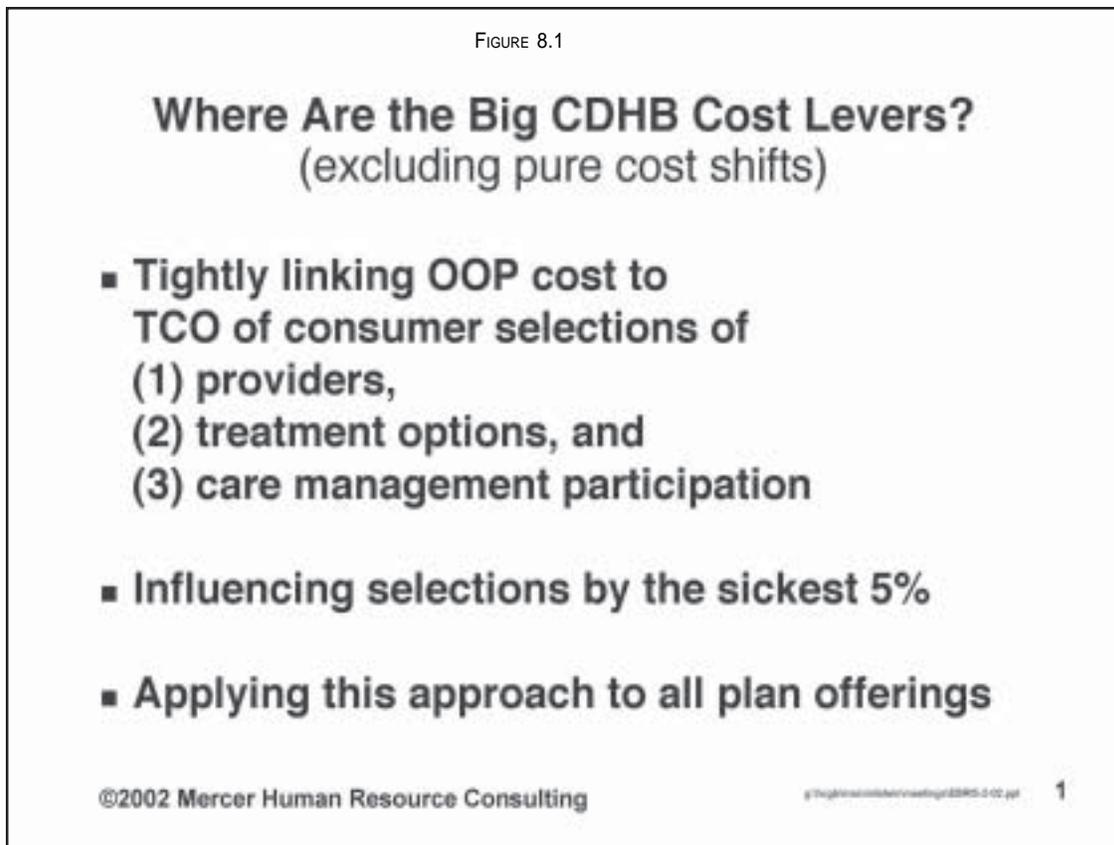
Managed care demonstrated that a health benefit innovation could produce widely varied results, depending upon pivotal features of design and execution. This article will summarize likely pivotal design features identified in the course of a 15-month assessment of approaches regarding consumer-driven health benefits by Mercer Human Resource Consulting.

The Mercer assessment incorporated

several other thoughtful published analyses by the Employee Benefit Research Institute (EBRI), the Center for Studying Health System Change (CSHSC), the National Health Care Purchasing Institute (NHCPI), and the Wye River Group. The effort mobilized internal and external resources, including experienced, strategic researchers of health benefits, such as Paul Ginsberg, Paul Fronstin, Alain Enthoven, Peter Lee, Randy Johnson, Bill Maloney, and George Wagoner. Entering new territory inevitably involves imprecise vocabulary, new applications of yesterday's knowledge, and frequent course correction. Our assessment converged on the interplay of variables associated with consumer-driven health benefits and the baseline state of today's managed care. As we approached a stable conclusion, the number of charts needed to convey our conclusions shrunk dramatically.

■ The Goals of Plan Sponsors

What goals do sponsors of large health benefit plans commonly pursue—irrespective of whether the plan is sponsored by an employer, a union, or a membership association? Provoked by four years of large cost increases, most sponsors seek to offset ambient health



insurance premium increases by more than 10 cumulative percentage points over the next several years. At a minimum, they also seek preservation of employee satisfaction and quality of care, and many seek substantial increases in quality.

Most sponsors don't know the combined indirect health-related costs from absenteeism, impaired productivity at work, and disability payments; but they realize that it would be senseless to make any change that would be likely to increase such costs. Finally, and most importantly, any risk to employee relations arising from a new approach needs to be manageable. For most sponsors, causing economic hardship to sicker enrollees or profoundly increasing the percentage of total health benefit costs paid by enrollees is unacceptable.

The Mercer analysis began with an examination of empirical evidence concerning:

- If tilted toward more efficient options that did not reduce quality, which categories of consumer choice would generate the greatest reduction in the upward trend of health benefit costs?
- What methods of motivating selection to more efficient options would work best?

To access empirical evidence, we turned to health service researchers, health economists, benefits managers, insurers, consultants within Mercer and other firms, and four published reports on consumer-driven health benefits. Briefly stated, the evidence pointed toward the core principle that consumer out-of-pocket costs at the point of care should be more tightly linked to the relative cost-effectiveness of high-quality options in three categories of well-informed consumer choice: selection of providers; treatment options, and participation in care management, as shown in Figure 8.1.

■ Selection of Providers

The first “high-leverage” category of consumer choice is selection of providers. Pioneering programs by Pitney Bowes and Union Carbide to shift enrollees to more economically efficient providers—identified via the application of first-generation software of provider profiling—reaped double-digit reductions in the following year’s insurance trend. This occurred without detectable reductions in quality or patient satisfaction. Prior successful programs shared the characteristic of measuring provider efficiency on a total stream-of-care basis.

For example, when United Health Care selected its organ transplant network, per-diem or per-admission costs per organ transplant were avoided when gauging provider efficiency. Instead, among hospitals with superior clinical outcomes, United selected those with the lowest average total cost for the entire transplant episode, including readmissions and other high-cost, pre-admission care and follow-up care in the three to 12 months after the transplant process was clinically initiated.

Similarly, optimization of savings from consumer-driven health care will require a stronger linkage between consumer out-of-pocket payments and the longitudinal cost-effectiveness of favorably quality-rated doctors and hospitals. This is very different from encouraging consumers to pick providers with the lowest fees. Rather, it implies that health plan sponsors use stronger incentives to move market share to providers who may in some instances charge higher fees. The technical term for this concept of longitudinal efficiency incorporating all costs related to an episode of care, ranging from an acute episode of illness to a year of maintenance care, is termed “allocative efficiency.” It is analogous to the concept of total cost of ownership of an automobile or electrical appliance over a period of time.

■ Selection of Treatment Options

A second high-leverage category of consumer choice is selection among treatment options. A simple example is the choice between generic and brand drugs, which differ greatly in longitudinal cost over a treatment episode and undetectably in their impact on quality. A more complex example is the choice between aggressive and non-aggressive initial diagnostic evaluation of acute onset musculo-skeletal back pain. For patients for whom more than one care option offers similar expected clinical outcomes and patient experience, linking out-of-pocket costs to the efficiency of each option offers a significant opportunity to reduce total health care costs.

To generate maximum savings without jeopardizing quality of care will require additional research on the cost-effectiveness of major treatment options and predictors of individual patient treatment responses. In the meantime, research at Dartmouth College has already identified “preference-sensitive” services that comprise a significant portion of health care costs. These services could be used as a starting point to create incentives for consumer selection of more efficient treatments in addition to generic drugs.

■ Participation in Care Management

A third high-leverage category of consumer choice is participation in care-management programs. The programs that have been able to achieve lower net longitudinal total health care costs when well implemented for typical commercial populations include: disease management of congestive heart failure, centers of excellence, self-care advice lines, and targeted risk-reduction programs, such

that this model could be cost-effectively expanded for highest-risk consumers to positively reward their selection of efficient options in all three high-leverage categories of choice. This would reduce, rather than increase, average out-of-pocket costs paid by the sickest enrollees, as well as reduce the overall cost of their care paid by their insurance plans. For lower-risk enrollees, perhaps defined as enrollees who have not reached annual maximum out-of-pocket payment limits, negative incentives to select more efficient options at the point of care are likely to maximize net savings to employers.

Modification of this strategy will likely be necessary for very low-wage employees if maximum out-of-pocket limits are not appropriate to their incomes. Although issues of perceived equity between lower- and higher-risk enrollees will require thoughtful management and communication, ultimately every health plan enrollee is a candidate for tomorrow's 5-percent high-risk pool and positive incentives for selection of efficient options.

A second pivotal feature of benefits design in these plans is the need to more tightly link consumer out-of-pocket costs to selection of efficient, high-quality options within all of a purchaser's plan options, or to adopt a single purchaser plan with this feature. Even within well-performing staff model HMOs, which have made the most progress in systematically achieving provider-driven selection of efficient, high-quality options, better tailored out-of-pocket consumer incentives would increase the selection of such options, such as use of formulary drugs.

Finally, when purchasers offer multiple plans, maximum savings will require adherence to the enduring principles of managed competition among plans. Although many purchasers believe that employee relations and HMO-bashing may limit their ability to more tightly gear the premium

contributions of employers to overall plan value, intensified managed competition among plans offers significant additional savings for most employers, when feasible.

■ Net Savings

What is the best-case purchaser upside? Depending on baseline circumstances, our analysis suggests that thoughtfully implementing these pivotal features of consumer-driven health benefits offers a 10 percent to 25 percentage point net premium trend reduction¹ and improved quality over two to five years, if executed well by a single purchaser. If a critical mass of large purchasers effectively applied these principles, to the point that robust consumer demand for greater efficiency and quality accelerated, gains in core process re-engineering by health care providers, savings, and quality would likely be far greater, as shown in Figure 8.2.

Care process re-engineering, which represents a large opportunity for efficiency gain, estimated to equal net health benefit cost reductions of greater than 30 percent, holds by far the largest opportunity for offsetting increases in costs while improving quality of care.

■ Conclusion

Very few large employers are considering the meat-axe approach to health benefits in terms of consumerism, about which some policy analysts and writers are expressing concern: aggressively raising deductibles and/or offering a defined cash contribution toward individual health insurance coverage and then

¹ Mercer Human Resource Consulting, *Improving the Value of Health Benefit Plans Through Consumer-Driven Health Care*. April 25, 2002.

“walking away.” Most large employers and unions won’t accept the resulting risks to relations between employees and members, respectively. Long-term trends in employee cost-sharing support the prediction that massive cost-shifting from employers to employees, and especially to the sick, is unlikely to occur among larger employers.

Fortunately, existing evidence and expert opinion suggest that well-planned and

executed versions of consumer-driven health benefits offer a viable solution for all health care stakeholders. Its essence lies in carefully tailoring consumer out-of-pocket costs paid by high- and low-risk enrollees within all plan offerings to the most longitudinally cost-effective, high-quality options in three high-leverage categories of consumer choice. That strategy will strengthen the “business case” to re-engineer among American providers.

The Promise and the Peril of Consumer-Driven Health Plans

By Jon Gabel, Vice President,
Health Research and Educational Trust

■ Introduction

In 1996, America experienced the lowest inflation—less than 1 percent—in health insurance premiums since we have begun tracking those statistics. In 1997, we started the retreat from managed care. During the late 1990s, the economy boomed, and the unemployment rate fell to 3.9 percent. Employers competed for scarce workers by offering richer benefit packages.

Consequently, consumers paid less for health care in 2000 than they did in 1996. Employers and health plans retreated from managed care, inflation returned, and premiums increased by double-digit amounts in 2001, with claims expenses growing almost as much. This is the status today and why this discussion is underway.

This presentation focuses on interviews with industry leaders conducted by co-authors Tom Rice from the University of California at Los Angeles and Tony LoSasso of Northwestern University.

The objective of the project funded by the Commonwealth Fund is to report developments in defined-contribution, or consumer-driven, health care. There are different phases to the study. First, we completed a literature review. Second, we interviewed key stakeholders, such as benefit consultants, health plans, employers, Wall Street analysts, and others. Third, we will conduct three case studies—one

with a health plan and two with employers. Finally, we will conduct a national survey of employers in the 2003 Kaiser Family Foundation Health Research and Educational Trust.

■ Consumer-Drive Health Care As Seen by Consultants

Two observations are apparent through the interviews with benefit consulting firms, including Watson Wyatt, Towers and Perrin, Milliman USA, Hewitt, Palmer and Kay, and Mercer. First, like my experience in the mid 1980s when I was interviewing pioneer preferred provider organizations (PPOs), those in this consumer-driven health care movement are eager to be interviewed. They volunteer, call me, and ask to be interviewed. They believe in what they are doing. Second, as one consultant said to me, consumer-driven health care is a benefits consultant's dream. He noted that when you change the plan design, you get lots of actuarial work, lots of communications—and lots of billable hours.

The following views emerged from these interviews with benefits consultants:

- The most successful model will be the medical savings account (MSA) or personal spending account (PSA) plans. In general, benefits consultants believe that the Vivius model is too complex.
- The cash-out approach that was discussed

two years ago—the premise of, “Here’s your money and now fend for yourself”—is a non-starter.

- The market is ready for consumer-driven plans. Six months ago, I would have said it’s a big to-do about nothing, but these interviews demonstrate that this is serious business. One snag is that the mindset of many employers is that they don’t want to be that pioneer who will be observed by everyone and take the heat from their own employees.
- There’s a general belief that we need to enlist the consumer in the crusade against high health care costs.
- Large employers will offer consumer-driven plans as add-ons, rather than replacements for existing plans.
- The key to success is changing the way consumers view and purchase health care.
- An essential question concerns whether consumers will use Web-based products in making medical decisions. That is paramount to truly being successful and changing the way health care is delivered.
- Many consultants and actuaries are concerned about employers spending on large personal accounts for formerly healthy nonusers of health care. And they question whether a PSA-type plan can save money without favorable selection in an environment with multiple options.
- Many, but not all, consultants believe that the large health plans will replace the plans offered by pioneers such as Definity and Lumenos. This is because they think the PSA product is easily replicated and that the large health plans have larger networks and can obtain deeper discounts. Additionally, health plans can sell fully insured products, as opposed to only self-insured products, which the start-up consumer-driven health plans offer.
- Employers will retain the aspect of disease management. As Arnold Millstein¹ notes,

plans will target the sickest 5 percent of patients for high-cost case management. Plans will waste energy keeping low users away from specialists, as was practiced before. What plans need to do is identify sick people and use medical management for sick persons.

- Early results indicate favorable selections for new consumer-driven plans. The start-ups do not share this viewpoint.

■ Consumer-Driven Products of Large Insurers

Insurers believe consumer-driven products will be a central part of their business strategy, but different insurers have different approaches. Aetna now has a Definity-type product available, but only one large employer is active in it and that employer has only 600 people enrolled out of 30,000 employees. Aetna managers say that they expected many new employers to be on board by mid-summer of 2002 and again in January of 2003.

Aetna will introduce a replacement product for small and mid-sized employers. For this first employer, Aetna management believes wealth, not health, determined who enrolled in the PSA-type plan. Persons accustomed to taking financial risk—people who were used to making more difficult financial decisions—were much more comfortable with Aetna’s product.

The model offered by Health Partners differs from the PSA type products. This resembles a matrix in which you have three vertical networks and three horizontal benefit plans. In all, nine different plans are sold to one employer. Health Partners sells this product as the only vendor in 90 percent of the cases. The employee bears the financial

¹ See Arnie Milstein, “Optimizing Cost and Quality Through Consumer-Driven Health Benefits: Where Does the Evidence Point?” p.61.

risk for choosing the more expensive plans.

Health Partners has nearly 300,000 people already enrolled and reports clear risk selection, but it tries to mitigate risk selection by pricing each product on an actuarial basis. Products are not priced on the basis of claims' experience where too often unfavorable selection drives up the premiums into a death cycle; instead Health Partners prices products according to the estimated covered expenses for each product. Health Partners can use actuarial pricing if it's the only carrier selling to an employer, but it's more difficult to practice actuarial pricing when competing with others. Health Partners reports dramatic increases in consumer satisfaction among employees that adopted this plan.

Lastly, Humana is very serious also about their consumer-driven products. It offers three basic products and uses a combination of actuarial pricing and more traditional experience rating. Humana also sells a health-partners type plan. The company plans to roll out a Definity-type plan, and it is selling many web tools. Humana now covers about 11,000 employees in its consumer-driven plans. Humana management believes the products are selling very well. Now that employees are taking financial risk, they migrate from the richest packages to medium-level packages.

In terms of Wall Street analysts, they believe we're moving toward consumer health plans but are unsure about which plans ultimately will be in the market. There's a perception that Definity and Lumenos are doing the best, but analysts are undecided how this move will affect the managed care industry.

■ Conclusion

Based on our research and interviews, the future of consumer-driven health plans would appear to be guided by these trends:

- Consumer-driven plans are a reality, and

there will be a substantial increase in enrollment in such plans.

- Although we will see replacement products later, these plans will enter the market largely as new options.
- Tiered networks, such as those promoted by Aetna, will be combined with personal savings accounts. In tiered networks, the network's preferred providers are segmented. For example, for certain kinds of less complex care, such as a hernia repair, if you go to the community hospital you would have a deductible of \$500. If you go to a teaching hospital, you would have a deductible of \$1,000. In this way, networks offer a way to channel patients to certain providers. The trick is in channeling patients to providers who are truly cost effect when you consider quality divided by price, not simply providers with the lowest charges or those where the biggest discounts can be obtained.
- Multiple-choice plans, like those offered by Health Partners, may become part of the mainstream.
- The key to risk selection is the contribution policy of employers. We know how to alleviate risk selection, but employers have not done so. Employers certainly didn't alter contribution formulas in managed care to reduce favorable or unfavorable selection. Let's hope that employers will use the actuaries and economists to set contribution policies that mitigate favorable selection.
- Disease management and high cost case management will play a key role.
- New products, and particularly the Definity and Lumenos-type products, will reduce the rate of growth in prescription drug expenses but have little impact in controlling hospital expenses.
- Humana thinks it has a very favorable trend on claims expenses for their new covered population in consumer-driven plans.

■ Discussion Following Panel on New Models for Providing Employment-Based Health Benefits.

Michael Parkinson, Lumenos: The message Jon Gabel brings is from the usual suspects, which I would say are Wall Street analysts, health care consultants, and, to a large degree, the existing big national health care players. Emulation or plagiarism is the ultimate form of flattery, and those of us out there would agree that we think it's great that Aetna's moving dramatically into the market. I don't think you can just slap on an HSA (health savings account) or a personal care account (PCA) or a Web-based tool and some degree of care management and predict a data modeling on a core philosophy around customer service and the culture of the customers in charge.

One of the major things that we say is that we're not a big national health plan. We invest \$2 million in customer-service applications; so, I get the same level of service from Lumenos as I get from USAA. When I call, I hear, "Hello Colonel Parkinson." The whole company is based around consumerism, as opposed to the back-door processes of claims adjudication, such as pre-certification and utilization management and utilization review. A lot of employers that we have talked to are saying, "Persuade me that Aetna, United, Cigna, Blues—whatever—have fundamentally changed the philosophy and culture around customer service." Customer service is the core of consumerism, and I think that it's going to be interesting to see as we go forward.

I can speak for this company: We aren't interested in being bought by any of the big guys because we believe it's not as simple as an HSA, Web tools, and a nurse on the phone. The test of the metal is going to be whether or not we can make it in and of ourselves in this

market place with 10,000-pound gorillas breathing down our back. I think this is very healthy for the market place to sort out, which is the essence of consumerism.

Bill Reindl, Definity Health: In the spirit of full disclosure, I spent 16 years with Aetna, and I left when they handed the keys over to US Healthcare. I thought I would never go back to health care because of the hassle factor concerning what we were trying to deliver or not deliver. I was a consultant for three years and was very content; I was not looking for a job. Finally, because I knew one of the eight founders of Definity and he bugged me long enough, I humored him and found out what was really going on. I was totally taken by a group of dedicated people who were absolutely committed to changing the health care equation. That being said, our business has never been so in demand or popular until Aetna and the others went out and said, we're going to go ahead and do this.

It's been more than year and half since I first joined Definity, when people said this will never happen. All the people I knew at Aetna said, "Oh, you're wasting your time." But we've had some success, and we've moved the bar. It's been interesting to watch all of the major players scramble to come to market and say they're going bring it, but if you listen to their presentations, it's much like a kid at Christmas—a kid who's growing older and at Christmas time says, "I'm not sure I believe in Santa Claus but, just in case, I'm going to go ahead and offer that."

From our perspective, we're going to give them a run for their money because none of this is based on old technology. In fact, we're convinced you couldn't do this on old legacy mainframe system. Some of them will be paying this on a flexible spending account system. When I was there, a flexible spending account was a challenge on the old legacy mainframe systems that don't speak to each

other. Because of price and transparency, many of those contracts are going to have to be re-negotiated.

We're not saying the major players can't move the bar, but along with Lumenos we're already two and three generations ahead looking down that road. So we welcome the challenge, and we welcome the opportunity. Bring it on.

Arnie Milstein, Mercer Human

Resource Consulting: One of the things I didn't hear come through in Jon Gabel's remarks from almost any of the sectors interviewed is that it doesn't sound like anybody is feeling very optimistic that the best way to engage consumers is around choice of plans. It's really choices within plans where most of the action was. Do you disagree with that? And if you don't, why is so much of the Washington policy debate around consumer-engagement choice of plans when the real opportunity for improvement is in consumer choices within plans?

Jon Gabel, Health Research and

Educational Trust: It depends a lot on which company you're talking to. If you're talking to a company like Health Partners, it obviously thinks, "Let us be your vendor. Let people choose from nine different plans, and let them bear the consequences."

I hear from other people that they believe a personal spending account is the best way to engage the consumer. The word transparency, we hear again and again. So, I'm not sure there's a real consensus. I think different companies have different philosophies, and I guess we're going to see that in the market place. I hope in our later phases of the study that we will actually be able to have real data. Right now, when I give you figures, I am depending upon Humana or Definity or another company in terms of their public presentations of the reality of their

experience. I hope we can have an opportunity to look at the real claims experience, and then we will know better.

The people I talk to are very good sales persons. And in talking to the think tanks, you get a very strong ideological push. People like Milt Freudenheim are really turned off by the strong ideological push. When I talk to the benefits consultants and I talk to marketing professionals, there is a spirit of pragmatism; they say, "This is a lousy deck of cards you have dealt me; you've taken away strong managed care from me. What else are my options?"

Lee Newcomer, Vivius: I just want to acknowledge the criticism about complexity because I think that's clearly what any reasonable person would say. Focus groups have shown that the average consumers get it in two minutes, and the burden of proof is on us to see that it shows in the marketplace. I welcome that challenge. Based on what we've seen in focus groups, I think it will work.

The other point, though, is this concept of tiered networks. People are really dramatically underestimating the provider backlash that's going to come out of that. I'm already hearing the rumblings of people being willing to actually drop the carrier if they don't have a say in what tier they're placed in, and most of the tiering that I've seen so far has been arbitrary on the planned side.

Jon Gabel, Health Research and

Educational Trust: In my interviews, nobody who was advocating tiered networks ever talked about the backlash against tiered networks. I went to a meeting of the Hospital Administrators at the American Hospital Association, and they were going through our concerns. Of course, first they started off by saying that government is too heavy-handed, right? That was their first concern. Their next concern was tiered networks. So, I'm hearing

from the hospital community, if nobody else. But I did not hear from benefits consultants that their customers don't want anything to do with tiered networks.

Lee Newcomer, Vivius: Actually my question was on tiered networks, and it's partially answered. Could you just spend a minute and tell people what tiered networks mean? I don't think everybody at this policy forum knows that.

Jon Gabel, Health Research and Educational Trust: Tiered networks are based on the idea that you may be a preferred provider but you're a community hospital and your neighbor is a teaching hospital, for example. For certain kinds of care, let's say simpler type of care like a hernia repair, if you go to the community hospital, you'll face a deductible of \$500. If you go to the teaching hospital, you'll find a deductible of \$1,000. Tiered networks are a way of trying to channel people to the more cost-effective providers. It sounds like PPOs all over again, right? As Arnie Milstein said, the key is to do it right. It isn't just the sense of the people who have the lowest charges or those with the biggest discounts. It's the people that we can show are truly most cost effective when you look at quality divided by price in examining the long-term situation with regard to health care outcomes.

Jon Gabel, Health Research and Educational Trust: Of the very significant administrative costs, the educational component is quite expensive. That's why it's a dream for benefits consultants. I talked with one employer yesterday who is a Definity client, and he indicated that once the plan began, it was no different from any other plan. And the person also indicated that clients are using the nurse hot-line more often than when they were with their traditional

carriers; so, they believe that holds down the number of questions very substantially.

Patti Duca, Pharmacia: I personally live in fear of the day that Aetna or United Health Care buys the companies that have started these programs, and that's because they're huge, hulking big behemoths of machines that are not agile and flexible. We do business with both those groups, and some of the Blues, and we ask them very early on about how to involve the consumer. They just couldn't get their brains wrapped around it. Their systems are not going to address the networks. And, the Aetna product is so complex that I can't imagine giving that to employees. The product or the program that we rolled out to employees is very simple. Beyond that, we did have it as a choice. We didn't promote it, and we didn't not promote it; it was in the mix with a bunch of other programs and priced the same.

So, there is not a true incentive based on the price tags alone. What we found, at least in the quarter that's ensued, is that we have a fair amount of employee complaints that have arisen out of their new programs *except* for the Lumenos program. We had hospitalizations and doctor visits and a whole bunch of things occur in January, and it's the only group in which we haven't been fielding complaints.

Sally Trude, Center for Studying Health System Change: This may not be a fair question, but 10 years from now, what do you think the product will be like for a small firm with perhaps 75 employees? What will they have offered to them?

Jon Gabel, Health Research and Educational Trust: Some of these offer wonderful products for small employers. For example, Highmark has about nine configurations or alternatives. Somebody can go

through and have about three choices or so. But when you do all the math, there's about 48 different choices. When you take this Highmark product—called Blue Choice—you have to agree that you're only going to contract with Highmark, nobody else. But it's all underwritten as one plan. So these small employers are going to have more choices, and, going back to my title, "The Promise and The Peril," here we see some of the promise that small employers could actually reduce the amount of medical underwriting if they go with this approach. We could actually increase the amount of choice that employees in small plans have and certainly increase plan satisfaction. The problem is that if history repeats itself, there will be this group of very healthy people, and some insurer is going to come in and cherry pick, as it has happened before.

In the late 1980s, I worked for the Health Insurance Association of America (HIAA). At that time, they used to talk about the Big Five commercial insurers—Cigna, Aetna, Travelers, Metropolitan, and Prudential. Their senior executives were not pleasant people to be around when they came to HIAA. The interesting thing is, how many of them are still in the business? So, if people do deliver customer service, it may take some time. But you compare the set of competitors to those of the late 1980s; it's a different group of characters.

Michael Parkinson, Lumenos: I want to just make one comment on Jon's question about administrative costs and also the glaring omission yet again of talking to physicians. One of the things that I say when I get in front of physician groups is that we cannot make the mistake that we systematically—if not intentionally—did. And that was to leave the physicians at the gate when these models started to get realigned. Physicians will ask me, "You mean to say

that you're going to have this health code get between me and my patient?" And I said, "Well, with a seven-minute visit and six or seven competencies that the typical patient needs to control, number one, they're going to get assistance. Number two, you've already got six or seven people between you and your patient, and none of them are there for clinical support. There are the two-thirds of their staff doing the administration, and there are the various people coming by to make sure their protocols are in compliance, which make up maybe 10 percent of their patient base for any given payor.

A lot of that gets put under scrutiny when you simplify benefit plan design, as Patti Duca's company has done and go from 60 to three, so you have a generic plan design in consumer-driven care with two or three different levels of HSA spending. As George Lundberg said, we spend so much in this country on various iterations of the benefit design. Let's get to a standardized benefit design. Let's separate the true insurance function from the financing function. Let's get evidence-base medicine and the high-dollar cost procedures. Let's build in the tools Arnie Milstein mentions, and you get a lot of administration out of the way and maybe the doctor gets more than 30 cents out of the current premium dollar, which is what they're currently getting.

I don't know if Medicare is going to cut reimbursement rates each year for the next five years from 5 percent to 7 percent to 8 percent. I'm not sure that's a good thing when malpractice (insurance) is going up 25 percent to 30 percent. But we're trying to make an attempt to say, what would make your doctor/patient relationship optimal in whatever time you have to spend with them? Everything else is non-value-added from our standpoint. In multiple conversations with Big Blues plans we have been very candid in saying, when you strip away your value

proposition to most employers, it's really two numbers, which you keep secret. It's a zip code and a CPT discount. I said, "Don't talk to me about how you qualify credentialing and providers because I did that." Basically a state license is no measure, nor, for example, is board certification.

And we're still struggling with "what is quality?" When you go into one of their backyards and you put on a Web site and you say, as I did in Kalamazoo, Michigan, when I talked to physicians, we're going to post your prices. All of a sudden, the Blues are looking over their shoulder saying, "What's our value proposition?"— which has always been to trade off networks quietly from employer to employer. The biggest challenge these plans have is posting prices. As much as we all talk about quality and the other things, that's the bitter pill that they're having a hard time swallowing.

Jill Yegian, California Health Care Foundation: I was interested in the intersection between some of these models and the cost drivers. Much of the effort around personal spending accounts and so forth really focuses on the demand side and focuses on reducing the point-in-time level of utilization. I'm interested in hearing about to what extent people think it would address where the system is going in terms of cost, along with some of the drivers that don't necessarily factor into this, such as the aging of the population, innovations on the pharmaceutical side, and medical devices and technologies that improve quality of care but improve costs tremendously. There is a bigger picture here, and I'm interested in hearing comment on how that plays into consumer-driven health care and how it doesn't.

Lee Newcomer, Vivius: By setting up true competition from hospital to hospital to hospital, which does not exist today, you do

create a marketplace mentality. At Vivius, we already saw it happen as we were enrolling hospitals in Kansas City. Providence sits out in the northeast quadrant of the city. It's fairly isolated, it seems to have a market block, and they gave us their prices and we put them in the system. Then, we showed them how they ranked on a percentile basis with the rest of the hospitals. They were in the 99 percentile, and their immediate response was to refigure their pricing. So, you've never seen that happen; they don't do that with Blue Cross. In fact, they gave us the Blue Cross rates. And Blue Cross made the consumer indifferent to whether they went to an expensive hospital or a less expensive hospital.

The same thing happens on the service issues. If suddenly you have two hospitals across the street from each other truly competing with one another, they're going to start thinking about how they can provide far better service levels than they do today. That might be something as simple as, "We'll actually go park your car for you," which the Mayo Clinic did for me the other day. Or it could be something important, such as, "We'll get you in with one hour of your emergency room visit."

Today, the incentives aren't in place for that, and the Vivius model starts to create that. You can also do that with information. At Definity/Lumenos, a lot of this information became transparent. There's isn't quite as much pricing variation in their models because it's generally a PPO network, but there is information about these doctors that was never available before.

Michael Thompson, PricewaterhouseCoopers: I think what's happening with these models is that they are trying to correct the failure of the managed-competition model. Its original design was supposed to be competing integrated health care delivery systems; yet the reality has been that IPA models with overlapping networks

dominated the market and we really haven't had true competition at the provider level. These models start to get at providing competition both on cost and quality, and that's part of the goal.

Having said that, you have some more fundamental issues of, is this going to do it? I would argue, "No!" I would argue that this is the demand side, but there's also a supply side, and there needs to be a concerted industry effort to take costs out of this system. Some of what Michael Parkinson addressed is in

that spirit of thinking, of looking at what is a value-added service and what is not. That's part of the industry collaborative effort to understand what is essential. How do we reduce variation on evidence-based care? Leapfrog Group is part of that. There's a lot of other things that need to happen in the system that are more supply-based, but from a demand-base, it's a step in the right direction because the managed-competition model has failed largely because the premises on which it was based didn't come true.



The Role of Managed Care in a Consumer-Driven World

Employer Perspective: Chapter 10

Benefit Consultant Perspective: Chapter 11

Researcher Perspective: Chapter 12

Consumer-Driven Health Plans: Wait, Watch, and See

By Miles S. Snowden, MD, MPH, CEBS
Delta Air Lines, Inc.

■ Introduction

After some careful consideration and a good deal of time spent with some of the very thoughtful people who have been designing new consumer-driven health care plans (CDHPs), Delta chose not to implement such a plan option for 2002. We continue, however, to consider what new health plans we can offer our employees in the next several years that will introduce medical consumerism into the health care utilization patterns of Delta employees. CDHPs remain an important option in our consideration for the future. For the purposes of this article, I have distilled our reasons for not implementing a CDHP this year into two categories—financial issues and administrative issues.

■ Financial Issues

Given that Delta is committed to remaining mostly self-insured, we were unconvinced we would not have greater expense with a CDHP than our national point-of-service (POS) plan. Our evaluation process suggested that we were going to need to pay substantially higher administrative service organization (ASO) fees to the CDHP vendor than we did in our POS plan, at least in the early years. Today, we leverage our size, keeping 85 percent of our almost 200,000 U.S. health plan members in a single national POS health plan. We leverage

that purchasing power to negotiate very competitive ASO fees. Adding additional plan options appears to risk dilution of that purchasing power.

The second financial issue arose from our concern about maintaining a competitive provider network fee schedule. Despite the present focus on prescription drugs and an aging work force as primary medical cost drivers, we still find that the provider fee schedule is a key driver of what we're paying for health care. At the point of our decision on CDHPs for 2002, we did not feel confident that we could enjoy the kind of competitive network fee schedule with a CDHP that we were presently enjoying with our broad national POS. Many of the CDHPs, at the time of our evaluation, were using leased provider networks. We were somewhat restricted by the fact that we have employees in all 50 states and thus lack the ability to carve out a region of the country and utilize a strong regional network. Instead, we needed a uniform, competitive, national network. We felt there were issues with regard to whether we could get a provider fee schedule in these CDHP leased networks that was as broad and financially competitive as our national POS.

We also had to consider that in offering a CDHP option, you can presume immediate forfeiture of the unused medical spend-

ing account balance upon termination. The concept of immediate forfeiture upon termination ignores two important points. First, requiring medical spending account balance forfeiture upon termination potentially creates an increase in medical spending just prior to separating from the employer. If employees know that they're going to lose the balance in their spending accounts, our sense was that we would lose much upon the employees' termination of what we had previously gained by altering that consumer's behavior.

Second, any employee with a substantial balance in their spending account upon termination need only pay COBRA premiums as long as necessary to exhaust the balance in the spending account following termination. We came to believe that to maintain appropriate medical consumerism, we were going to have to accept the burden of finding something to do with the spending account balances of terminated employees. At the very least we felt that, for the retiring employee, the unused spending account balance should be available to fund retiree medical benefits. As we are an employer who continues today to fund retiree medical benefits, rolling the CDHP spending account balance to fund retiree medical simply adds more to our already substantial obligation regarding accrued post-employment benefits.

Finally, it is somewhat frightening to conceive of transitioning to a health plan that requires the first dollar out-of-pocket expense to come from the employer. It has been a long time since any substantial U.S. employer has done that. And although it might eventually be proven the financially effective approach when used in the context of a CDHP, it is as yet certainly an unproved strategy. With a CDHP implementation comes the concern that our lowest utilizing health plan subscriber will now become an expense to the plan, rather

than a savings.

To illustrate this point, we asked our largest health plan vendor to provide us with some national data on large U.S.-based self-insured employers' medical expenses per employee. Forty percent of these employees had expenses of less than \$1,000 per year for their entire family's medical care. Therefore, putting our employees in a CDHP with a \$1,000 per year medical spending would likely result in 40 percent of our employees actually costing us more. This results from crediting a low utilizing employee's medical spending account with \$1,000, rather than actually paying the less than \$1,000 in medical expense that same employee would account for through the year. The national data suggested that about 20 percent of employees have family medical expenses between \$1,000 and \$1,500 in a given year. These employees would move into the out-of-pocket, also described as the "deductible" or "gap," portion of this plan design. Therefore, their behavior would potentially be affected by a medical consumerism perspective. Those employees whose annual medical expense for their family was greater than \$1,500 would comprise the remaining 40 percent. These employees would have exhausted their medical spending account if you presume no previous rollover, would have met their full out-of-pocket gap expense, and would be consuming health care in the traditional indemnity insurance layer of the CDHP design.

Therefore, these national data suggest that we are trying to leverage the consumerism of 20 percent of our employees to affect the expense of 100 percent. We have 40 percent for whom we are guaranteeing we will spend more money in funding their medical spending account than what they presently cost us, and we have 40 percent who are consuming care in a traditional indemnity plan fashion. In addition,

this later 40 percent generally is the source of the vast majority of the total expense on health care due to the chronic or acute, catastrophic nature of their medical conditions. If you try to lower the employer's portion of the health care expense by reducing the annual funding of the spending account to \$500, you actually make the risk leveraging even higher. With this approach, the consumerism band narrows to only 16 percent with whom you are trying to offset the health care expense of the remaining 80 percent, when based on national large employer experience.

■ Administrative Concerns

The second broad area that led us to making a decision not to implement a CDHP at this time brings up for us what was a substantial consideration—but one that is little mentioned. All employers and employee groups are not alike. Health plan designs that are right for one group may not be right for another work group. Demographically, educationally, geographically, and in many other characteristics, employee groups are not all the same. They may go to the same providers, receive the same medical care, even have the same provider fee schedules, but they may well also be very different people with different needs. This was a critical recognition for Delta in our consideration of the administrative concerns with CDHPs.

Delta has chosen to provide a health care benefit that is extremely employee-centric. It is very high touch and highly focused on customer service. At the point of our decision-making, many of the CDHP options we were reviewing still aggregated various plan administrative services from external sources. Outsourced claims service centers, customer service centers, technology,

and provider networks were common. We were concerned that by leasing or outsourcing these important functions, some problems with quality and service level were likely, with limited ability of the CDHP to affect improvement.

We also were concerned about the Internet-based aspects of these plans in the sense that we have not yet provided Internet access to every employee. Even with our initiative to do so for every active Delta employee, we still have only reached 70 percent of our employees to date with company-provided Internet access. Many of these plans are designed to provide health plan members only with Internet-based access to important and mandatory benefit information. This produced some concerns about equality regarding employees who might not have Internet access.

We also had concerns about U.S. Department of Labor compliance regarding Web-based delivery of benefit information. Some of those concerns have subsequently been addressed recently with a new final rule. In addition, we had concerns with the Internet literacy of some employees. By literacy, I am referring not to the common definition but rather to health plan literacy in terms of interpreting some relatively complex CDHP Web site content.

Finally, we were uncomfortable with the lack of IRS interpretation of applicable regulation regarding rollover of unspent medical account balances, coordination of flexible spending accounts with medical spending accounts, management of COBRA enrollees who have a medical spending account balance at separation, and the administration of Qualified Domestic Relations Order where divorce occurred while a spending account balance remained. (Some of these issues have been resolved since that time.)

■ Conclusion

These are some of the financial and administrative concerns that led us to not implement a CDHP in 2001. That decision should not be construed as permanent withdrawal from further consideration but rather a pause in

the evaluation of a continuum of new health plan options that leverage medical consumerism to create efficient medical utilization. It is a challenging and dynamic time for employer-funded health care and an environment that demands thoughtful innovation.

Preserving the Benefits of Managed Care in a Defined Contribution Health Plan Environment

By Kenneth R. Jacobsen
The Segal Company

■ Introduction

In their purest form, Defined Contribution Health Plans hand employees a fixed cash amount or voucher and set them free to shop for health services and insurance products in an e-Health environment. Engaged consumers, free to choose among service providers, become educated about cost and treatment options and apply that knowledge to their spending decisions. This model moves us away from the restrictive environment of managed care and creates the demand side market dynamic economists have long held is a must if we are to stabilize the nation's health care spending.

Pure Defined Contribution Health may one day replace the current system, but in reality the market operates incrementally. So a middle ground has been formulated to transition us there: Consumer-Driven Health Care (CDHC). Still a Defined Contribution archetype, CDHC stops well short of shifting the full responsibility to employees. It relies on three principles: provide employees with a personal spending account (PSA); educate consumers to become prudent buyers of health care; and as the Plan Sponsor, maintain practical, legal and financial oversight of the plan.

■ How DCHC Works

The participant is provided an annual spending account, say \$2,000. After that is depleted, the next \$2,000 (this is just one example) is borne by the individual. Once \$4,000 has been spent, conventional insurance picks up any remaining expenses, thereby capping the annual out-of-pocket cost an employee would bear. A favorable aspect of these plans is a rollover feature which allows unspent PSA dollars to accumulate. So if the employee spends less than the \$2,000 in the above example, the difference is added to subsequent years' accounts.

The consumer now manages a health care checkbook, changing the economic incentives at the point of purchase. In theory, the consumer will become more judicious about whether to buy the high-priced brand drug when a generic might be as efficacious. Or think twice before entering the system through the emergency room for nonemergency care. Or better yet, take a keener interest in preventive and self-care programs that encourage personal health management and result in fewer dollars spent on treatment for chronic and acute care.

The unanswered question though is if we create free agency, who fights the system on behalf of the individual consumer? Love

them or hate them, the managed care companies actively discipline the market on our behalf. They negotiate discounts, rule out unnecessary procedures, coordinate services along the clinical continuum, and employ vast databases to reign in outliers and influence practice patterns using evidence-based protocols. This creates an argument for staying with managed care and resolving its nagging problems rather than suddenly leaping into the promising yet unknown realm of Consumer Driven Health Care.

Nyet, say the DC health purists, who believe we should no longer abide a managed care system that is fundamentally flawed and in need of significant transformation. Far better to replace than tinker, and drive competition through a transparent marketplace that openly posts prices and outcomes. This allows consumers to comparison shop for cost and quality, and forces the providers to compete for business. As intriguing and meritorious as this model is, pure consumerism is long-term play. We can't prepare Americans for this level of responsibility overnight. And we cannot just walk away from our discounts, case managers and review panels, or the managed care industry that pulls together.

Rather than square off over the contrasting ideologies of emerging consumer models versus traditional managed care, it would be prudent to simply bridge the gap. For the foreseeable future, while CDHC morphs, employers choosing a Consumer Driven option should blend both worlds. Set up the PSA account and provide the unrestricted access people are clamoring for, i.e., no more gatekeepers, mandatory precertification, second opinions or drug formularies. Arm them with user-friendly market and clinical data so they can make prudent spending and utilization decisions on their own. But at the same time preserve the benefits of managed care.

Behind the CDHC platform, continue to provide strong local provider networks so people can access discounted medicine without having to muster negotiating clout on their own. For the risk borne by the plan after a high deductible, maintain co-pay differentials, e.g., 100 percent in-network versus 70 percent out-of-pocket, keeping employees mindful of conventional arrangements right from the start. This protects the plan sponsor from having to pay retail prices for the liability over \$4,000 in the cited example, and it reminds the employee that exploiting negotiated arrangements is still a sensible play. During pre- and open enrollment, educate employees that unwanted hassles could occur if they see one doctor under the PSA deductible and then have to switch to an in-network doctor mid-stream in order to receive full plan reimbursement under the insured arrangement. This sends a clear message that it is still beneficial to align yourself with the plan's doctors while enjoying the other features of Consumer Driven Health Care.

For acute situations, the same preadmission questions will exist regardless of the plan arrangement: Is the surgery or treatment necessary, should it occur in a hospital, for how long, at what price, etc.? Critical situations require advocacy on the patient's behalf. Case Managers and Discharge Planners will remain vital in stewarding the patient to the highest quality, most cost-effective treatment alternatives available. The average consumer is not prepared to tackle these imposing problems on his or her own. A CDHC plan must avail these advocacy features to its members or employers will experience a new brand of backlash when a sick or injured employee feels abandoned in troubled times.

From a total cost management standpoint, long-term success is linked to potential behavior changes regarding

personal health management. The majority of health care costs are related to a dozen or so chronic conditions such as asthma, diabetes, lower back pain and hypertension. Disease Management programs, designed to help patients take charge of their chronic illnesses and concurrently stem associated health costs, have been around for years. As CDHC plans engage consumers, Disease Management arrangements must remain accessible. The hope is that new economic incentives and access to robust information will make these programs more attractive and hook people in.

■ Conclusion

The goals of Consumer-Driven Health Care are noble: increased choice and control for members, and more predictable costs and less administration for employers. Managed care is showing signs of fatigue. But let's not throw the baby out with the bath water. Fifteen years of grueling legwork to organize the health market and create financial controls and care management programs should not be abandoned. Until we successfully migrate to a better model, whether it is CDHC in its current form or otherwise, we should steadfastly retain the benefits of supply-side disciplines *and* infuse demand-side dynamics into the health care marketplace.

How Low Can You Go? The Impact Of Reduced Benefits and Increased Cost Sharing

The same level of cost savings achieved by cutting benefits or raising cost sharing could be achieved by switching to group-model HMO plans.

By Jason S. Lee, Academy Health, and Laura Tollen, Kaiser Permanente Institute for Health Policy

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ABSTRACT

Amid escalating health care costs and a managed care backlash, employers are considering traditional cost control methods from the pre-managed care era. We use an actuarial model to estimate the premium-reducing effects of two such methods: increasing employee cost sharing and reducing benefits. Starting from a baseline plan with rich benefits and low cost sharing, estimated premium savings as a result of eliminating five specific benefits were about 22 percent. The same level of savings was also achieved by increasing cost sharing from a \$15 copayment with no deductible to 20 percent coinsurance and a \$250 deductible. Further increases in cost sharing produced estimated savings of up to 50 percent. We discuss possible market- and individual-level effects of the proliferation of plans with high cost sharing and low benefits.

After nearly a decade of relief from annual double-digit growth in health care costs, the nation is again experiencing explosive price

increases. Managed care is no longer perceived as the silver bullet it was in the early 1990s. The consumer backlash and some observers' doubts about managed care's ability to provide long-term cost savings, coupled with an economic recession, are fueling a new round of innovations by plans and purchasers. Such innovations include preferential use of cost-effective technologies and care, strategies to decrease medical errors and geographic variation in costs, chronic care management, multitier formularies, defined-contribution strategies, increased use of consumer information, and e-health technologies.

However, as employers confront today's immediate economic pressures, such as an 11 percent health insurance premium increase in 2001 and predicted increases of 12.7 percent by the end of 2002, they are also turning to the older, more traditional strategies of moderate premium increases, increased cost sharing, and reduced benefits.¹ For example, with respect to retiree health

1. Data from J. Gabel et al., "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs* (Sep/Oct 2001): 180-186; and William M. Mercer Inc., "Health Benefit Cost Up 11.2 Percent in 2001—Highest Jump in 10 Years," *Press Release*, 10 December 2001, www.mercerhr.com/press_release/details.jhtml?idContent=1011125 (14 May 2002).

benefits, the *New York Times* recently reported that “many large companies are increasing their forecasts of future health care liabilities because their current costs are rising more rapidly than they expected...Since accounting rules require companies to reflect their future health care liabilities as a reduction in current earnings...companies are trying to limit the damage to profits by demanding larger copayments, raising deductibles, and limiting coverage for retirees.”² In addition, several recent opinion surveys indicate that a majority of surveyed large employers plan to reduce benefits or increase cost sharing for their employees in the next year.³ There is growing concern in the health policy community about the effect that movement toward coverage with lower benefits and higher cost sharing could have on insurance markets in general and on the poor and chronically ill in particular.⁴

In this paper we estimate the impact of three “traditional” strategies used by employers to reduce their exposure to increasing health care costs: (1) paring down benefits by offering less generous coverage for specific services; (2) excluding benefits from coverage altogether; and (3) shifting financial liability

to employees by increasing their cost-sharing responsibilities. We also compare the cost-saving potential of these strategies with the savings that may be achieved by switching to a group-model health maintenance organization (HMO), although we acknowledge that the availability of such products is limited.

The purpose of this paper is to provide data to inform public and private decisionmakers as they consider various means of controlling health care costs through benefit design. We use an actuarial model and several assumptions to quantify the premium-reduction effects of the three strategies noted above. This analysis will allow employers, consumers, policymakers, and other stakeholders to evaluate the savings available from traditional cost containment tools they have implemented or are considering. The analysis also should be useful to purchasers that hope to use these tools in combination with newer ones, such as defined-contribution and other strategies employed by “consumer-directed” health plans.⁵ Finally, this information will be of interest to state Medicaid officials as they contemplate using new federal flexibility to expand coverage by reducing benefits for certain categories of current recipients.⁶

2. M. Freudenheim, “Companies Trim Health Benefits for Many Retirees as Costs Surge,” *New York Times*, 11 May 2002.

3. Watson Wyatt Worldwide, *Health Care Costs 2002—Watson Wyatt Worldwide Survey Results*, October 2001, www.watsonwyatt.com/research/resrender.asp?id=ONL002&page=1 (14 May 2002); and Harris Interactive, “As Corporate Concerns about Health Care Costs Continue to Rise, Many Employers Plan to Shift More Costs to Their Employees,” *Health Care News* (9 October 2001).

4. For example, see S. Trude et al., “Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes,” *Health Affairs* (Jan/Feb 2002): 66–75.

5. For example, see P. Fronstin, *Defined Contribution Health Benefits*, EBRI Issue Brief no. 231 (Washington: Employee Benefit Research Institute, March 2001); and J.B. Christianson, S.T. Parente, and R. Taylor, “Defined-Contribution Health Insurance Products: Development and Prospects,” *Health Affairs* (Jan/Feb 2002): 49–64.

6. Utah recently received federal approval to expand Medicaid coverage to all adults with incomes under 150 percent of the federal poverty level by reducing benefits and adding cost sharing for certain current recipients. Newly covered adults will pay \$50 per year for a benefit plan that covers primary and preventive care but does not include inpatient hospital care.

■ Data And Methods

To estimate the premium-reducing effects of paring down and eliminating benefits, we compare the premium estimate for a “baseline” plan (with generous benefits and low enrollee cost sharing) with premium estimates for plans with pared-down and eliminated benefits. Then we estimate the premium-reducing effects of different cost-sharing variants. These estimates allow us to compare the relative impact of reducing benefits versus increasing cost sharing.

Our analysis focuses on the small-group market, where affordability and accessibility have long been major problems. In 2000 more than half (61.5 percent, or 14 million) of uninsured workers in the country were employed by small firms (having one to 99 employees).⁷ In addition, health insurance premiums have been rising more rapidly for small employers than for larger ones.⁸

Source Of Premium Estimates

We estimated premiums using the Hay Group’s Mental Health Benefit Value Comparison (MHBVC) model, Version 2.0. The Hay Group, an actuarial firm, developed this and earlier Benefit Value Comparison (BVC) models for the Congressional Research Service (CRS) and the National Institute of Mental Health (NIMH).⁹ The current version of the

model is called the “Mental Health” BVC because it was last updated under an NIMH contract; however, it is a comprehensive pricing model that includes both mental and physical health services.

The MHBVC draws from four sources of medical claims data: (1) a study of insurance company experience performed by the Society of Actuaries for the CRS in the late 1980s; (2) a mid-1990s study by the Society of Actuaries on the characteristics and distribution of large claims; (3) a series of Hay Group studies performed for the NIMH in the late 1990s on the distribution and characteristics of mental health claims; and (4) annual Hay Group Benefits Reports (HBR), which are used to calibrate and update the model.¹⁰ The latest version is calibrated to the 2000 HBR.

Unadjusted, the MHBVC Version 2.0 reflects health care utilization and costs in indemnity plans in 2000. We used the 2001 HBR to update the model one year. Because our comparisons are among preferred provider organization (PPO) (rather than indemnity) plan designs, another modification of the model was necessary. To reflect the fact that PPOs negotiate discounts with preferred providers, we applied a management factor of 0.85 (a 15 percent discount) for in-network utilization.¹¹ We assumed no discount for out-of-network utilization. Drawing upon the experience of the Hay Group, we assumed

7. P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey*, EBRI Issue Brief no. 240 (Washington: EBRI, December 2001).

8. Gabel et al., “Job-Based Health Insurance in 2001.”

9. *The Congressional Research Service has used BVC models to inform congressional debate on the Federal Employee Health Benefits Program, tax credits for the uninsured, President Clinton’s Health Security Act, mental health parity, and other issues. The CRS has also used BVC models to provide premium estimates to the Congressional Budget Office.*

10. *The HBR is an annual survey of benefit programs and costs of more than 1,000 employers. It is representative of most sectors of the economy.*

11. *Recognizing that in some markets some carriers may obtain even deeper discounts, we chose 15 percent as a conservative estimate of average expected discounts across the country, based on the experience of the Hay Group.*

FIGURE 12.1
DIFFERENCE BETWEEN FULL-BENEFIT AND PARED-DOWN MODEL PLANS

Benefit	Full-Benefit Plan	Pared-Down Plan
Pharmacy	In-network: \$10 Out of network: \$25 (no distinction between generic and brand-name drugs)	In network: \$15 generic/\$25 brand-name Out of network: \$25 generic/\$35 brand-name
Durable Medical Equipment	\$0 in-network 30% out of network	Not Covered
Mental Health/Substance Abuse Care	\$15 outpatient, 20 visits \$0 inpatient, no limit on visits	Limit inpatient to 30 days
Preventive, Hearing, and Vision	\$15 or free No limits or restrictions	No hearing, vision, or Care immunization benefits Other preventive care limited in quantity
All care exceeding \$100,000 in insurer costs per year	Covered	Not covered

Source: Authors' analysis of model plans.
Note: This table lists only those benefit categories in which the plans differ.

that 70 percent of utilization would take place inside the network.

The MHBVC model is also adjusted to account for the fact that cost-sharing factors—coinsurance, deductibles, and out-of-pocket spending limits—influence demand for medical services. The relationship between cost sharing and demand for care is complex, but the direction of the relationship is known. Insured persons' demand for medical services decreases as their share of the total cost increases. In other words, increased cost sharing reduces demand.¹² Available evidence suggests that the extent to which cost sharing reduces demand is not constant across benefits. We used the Hay Group's default values of 30 percent reduced demand for hospital services, 100 percent for prescription drugs, and 70 percent for other medical services.¹³ The Hay Group based these values on its review of relevant literature, including the RAND Health Insurance Experiment.

When using the MHBVC to model premiums for the largest employers, the Hay Group adds 8 percent to total claims costs to account for administration and profit. To reflect the fact that the small-group market has higher administrative costs than the large-group market has, we increased this

12. J.P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

13. Consider, for example, an enrollee who faces the prospect of \$100 in prescription drug costs. Under Hay's demand reduction assumption, a \$10 copay reduces the demand for prescription drugs by 100 percent of the copay, or \$10, thus lowering the estimate for prescription drug costs to \$90. The enrollee's cost-sharing obligation would be applied to \$90, and the insurer would pay the \$80 balance. We note that in today's markets, direct-to-consumer advertising for prescription drugs may have a countervailing influence on cost sharing's demand reduction. As a result, the demand reduction factor of 100 percent for prescription drugs may be slightly high, but without empirical data to revise it, we relied on the Hay Group's default value.

number to 30 percent of health care claims.¹⁴

A final model adjustment concerns the pharmacy benefit. As noted above, model updates are calibrated against an annual survey of employer benefits to keep pace with health care inflation. The same inflation factor is applied to all benefits. Yet pharmacy costs have increased more rapidly than other health care costs in recent years. A recent study found that the average annual per capita health care cost increase between 1999 and 2001 was 7.3 percent for all types of care, but 16.0 percent for pharmacy alone.¹⁵ Without an appropriate adjustment, the model would underestimate the portion of premium attributable to pharmacy costs. Therefore, we fixed pharmacy costs in the model at 10.8 percent of premium. We chose this figure based on a 2000 national study showing that pharmacy costs accounted for 10.8 percent of all spending on personal health care services by all U.S. payers.¹⁶ It is also consistent with anecdotal evidence obtained from two major carriers we contacted. When we increased pharmacy to account for 10.8 percent of premium, we decreased all other benefits accordingly, so the total premium, which had been calibrated using the 2001 HBR, remained the same.

The Baseline Plan

To estimate what happens to premiums when benefits are pared down or eliminated, we created a generous baseline plan covering all major benefits. Because this plan also has low levels of enrollee cost sharing, it serves as the baseline for the cost-sharing analysis as well. We also refer to the baseline plan as the “full-benefit plan with level 1 cost sharing.” The term “full-benefit” denotes that all major traditional benefits (preventive, primary, inpatient, home health, pharmacy, durable medical equip-

ment, mental health, lab and x-ray, and so on) are covered at some level, in contrast to the plan we model that pares down selected services. “Level 1 cost sharing” denotes the relatively low level of copayment associated with the baseline plan, which we later contrast with higher levels of cost sharing (levels 2–9). We derived the baseline plan from an actual point-of-service (POS) plan that was sold in California’s small-group market by a major health plan in 2001.¹⁷

Although the baseline plan has a cost-sharing structure normally associated with HMOs (\$15 office visit copayment and no in-network deductible), it is based on a broad provider network, more similar to a large PPO (as offered by a Blue Cross Blue Shield plan, for example) than to a group-model HMO (such as Kaiser Permanente).

■ Effect of Paring Down or Eliminating Benefits

We ran the full-benefit plan with level 1 cost sharing through the adjusted MHBVC and estimated a monthly premium of \$274 for single coverage and \$742 for family coverage. To estimate and compare the premium effects of paring down versus

14. There is no generally agreed-upon estimate of administrative costs as a percentage of claims in small-group markets. We chose 30 percent based on the Hay Group’s experience, recognizing that the experience of carriers varies.

15. B. Strunk, P. Ginsburg, and J. Gabel, “Tracking Health Care Costs: Hospital Care Surpasses Drugs as Key Cost Driver,” *www.healthaffairs.org* (26 September 2001): W39–W50.

16. K. Levit et al., “Inflation Spurs Health Spending in 2000,” *Health Affairs* (Jan/Feb 2002): 172–181.

17. For a full description of the benefits and cost-sharing provisions of the baseline plan, contact Jason Lee at jlee@ahsrhp.org or Laura Tollen at laura.a.tollen@kp.org.

FIGURE 12.2

EFFECT ON PREMIUM OF PARING DOWN VERSUS EXCLUDING BENEFITS, SINGLE COVERAGE

Benefit	Percent Reduction from Full-Benefit Plan ^a	
	Pared Down	Excluded
Pharmacy	6.7%	10.8% ^b
Prevention	— ^c	5.5
Hearing and Vision	3.5	0.2
DME	0.7	0.7
Substance Abuse/ Mental Health	0.1	1.4
No payment for expenses above \$100,000/year	2.9	2.9
Total Premium Reduction	13.9%	21.5%

Source: Hay Group's Mental Health Benefit Value Comparison model, Version 2.0.
 Note: The percentage reductions are approximately the same for family coverage (not shown).

- ^a Full-benefit, pared down, and excluded plan designs all assume level 1 cost sharing (\$15 copay, no deductible) and an out-of-pocket maximum. The monthly single premium is \$274.
- ^b Pharmacy was fixed at 10.8 percent of total premium in the model, based on 2000 national health spending data.
- ^c Combined with hearing and vision care.

FIGURE 12.3

COST-SHARING LEVELS AND PERCENTAGE PREMIUM REDUCTION FROM LEVEL 1

Cost-Sharing Level	Copay or Coinsurance (In/Out of Network)	Deductible: Single, In-Network ¹	Out-of-Pocket Maximum: Single, In-Network ^b	Percent Premium Reduction From Level 1 ^c
1	\$15/30%	None	\$1,500	— ^d
2	20% / 40%	\$ 250	1,500	22.1%
3	20% / 40%	500	1,500	27.6
4	20% / 40%	1,000	3,000	34.6
5	30% / 50%	500	1,500	37.7
6	30% / 50%	1,000	3,000	43.2
7	50% / 70%	500	None	44.3
8	50% / 70%	1,000	None	48.4
9	50% / 70%	2,000	None	53.6

Source: Hay Group's Mental Health Benefit Value Comparison model, Version 2.0.
 Note: Copay/coinsurance refers to the amount the enrollee pays.

- ^a Out-of-network deductibles (not shown) are always two times in-network deductibles, except for level 1, which has no in-network deductible. For level 1, the out-of-network deductible is \$500. Family deductibles (not shown) are always three times single deductibles.
- ^b Out of network out-of-pocket maximums (not shown) are always two times in-network out-of-pocket maximums. Family out-of-pocket maximums (not shown) are always three times single out-of-pocket maximums.
- ^c Reductions are based on premiums for single coverage, averaged across full-benefit and pared-down plans.
- ^d Not applicable.

excluding benefits, we selected four benefit categories: pharmacy; durable medical equipment (DME); mental health and substance abuse care; and preventive, hearing, and vision care. We also modeled the premium effect of capping the annual dollar amount paid by the plan at \$100,000, essentially paring down coverage of catastrophic claims.

Figure 12.1 describes the differences between the full-benefit and pared-down plans for each benefit we examined. We selected these benefits for two reasons. First, we hoped to configure pared-down plans in ways that might actually be found in the small-group market, either now or in the near future. For example, we thought it likely that an employer seeking to provide

a moderate-price plan might reduce or eliminate coverage for DME or mental health care. Second, we wanted to “push the envelope” by creating plans that are not likely to be found in today’s markets, either because federal or state law prohibits them or because employers and employees would not buy them (for example, a plan that limits the insurer’s liability to \$100,000 per year, essentially leaving enrollees to their own devices, or to the safety net, for catastrophic events).

Figure 12.2 shows the relative premium-reducing effects of paring down and excluding the four benefits described above, as well as all expenses over \$100,000 in plan costs, holding cost sharing constant at level 1. The largest premium savings are attributable to paring down or excluding pharmacy benefits. Considered as a group, paring down all of these benefits produces a 13.9 percent reduction from the full-benefit premium, and excluding them results in a 21.5 percent reduction.¹⁸ In absolute terms, excluding benefits produced about 7.6 percentage points more in premium savings than paring them down.¹⁹

■ Effect of Increasing Enrollee Cost Sharing

Our analysis takes into account three cost-sharing variables: coinsurance (the enrollee’s financial obligation expressed as a percentage of costs), annual deductible, and maximum annual out-of-pocket expenses. We start with the baseline plan and gradually increase enrollees’ cost-sharing responsibilities.

Figure 12.3 lists the cost-sharing levels we modeled, from the least cost sharing to the greatest. Coinsurance varies according to whether services are received in or out of the network. Deductibles and maximum out-of-pocket limits vary by whether care was received in or out of the network, and also by

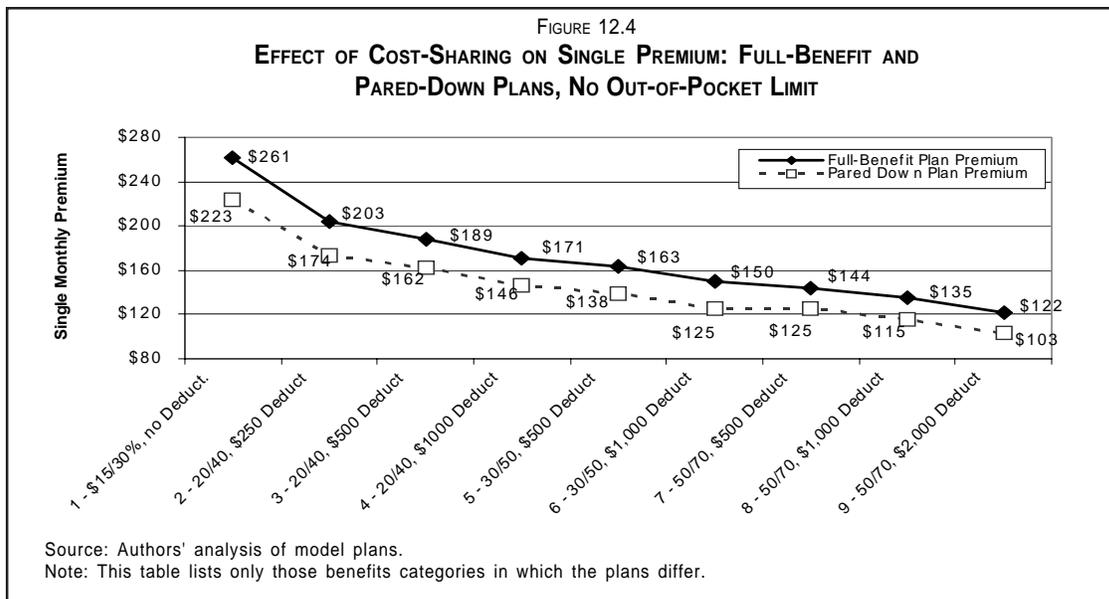
individual versus family coverage. We also consider whether a plan has a maximum out-of-pocket limit. If a plan does not, there is no limit on an enrollee’s financial risk. Because this reduces the insurer’s risk exposure, a plan without a maximum out-of-pocket limit is less expensive than an identical plan with such a limit. Level 1 cost sharing imposes the least amount of risk on the enrollee, while levels 2 through 6 create increasing risk exposure as coinsurance, deductibles, and out-of-pocket maximums rise. Cost-sharing levels 7 through 9 reflect the greatest financial risk to the enrollee. These levels are structured with 50 percent enrollee cost sharing in the network and 70 percent out of the network.²⁰

Figure 12.4 graphs the effects of cost sharing on premium estimates for the full-benefit and pared-down plans (with no out-of-pocket maximum), single coverage. Enrollee cost sharing increases from left to right, and, as expected, premium estimates decline from level 1 to level 9. (The relationship for family coverage was similar.) Monthly premium estimates for the full-benefit and pared-down

18. Although pharmacy benefits account for 10.8 percent of premium under the full-benefit plan, eliminating these benefits could lead to a premium reduction of less than 10.8 percent if increased use of other services offsets the effect of eliminating pharmacy coverage. However, without clear evidence to quantify such an offset, we were unable to model this effect. As a result, our estimates of total savings attributable to paring down and eliminating coverage of specific benefits may be somewhat overstated.

19. In the premium estimates for these lower-benefit plans, we held the administrative add-on constant at 30 percent of total claims. However, some administrative costs are fixed and will not be reduced in a linear manner as health care claims are reduced. As a result, administration as a percentage of claims may not be the same at all benefit levels. However, we do not expect that adjusting for this dynamic would materially change the results of this analysis.

20. For these plans, we assumed there would be no out-of-network use.



plans at level 1 cost sharing are \$261 and \$223, respectively.²¹

The final column of Figure 12.3 shows the percentage premium reduction achieved by moving from level 1 to each successive cost-sharing level, averaged across the full-benefit and pared-down plans. For both plan types, the largest premium decline (approximately 22 percentage points) occurs between levels 1 and 2. Note the similarity between this estimate and the reduction estimated by eliminating benefits—about 21.5 percent (see Figure 12.2). At the extreme, the effect of supplanting level 1 with level 9 cost sharing is to reduce premium estimates for both full-benefit and pared-down plans by 54 percent. Note that the premium difference between the full-benefit and pared-down plans at each level of cost sharing is generally less than the premium difference observed within the plans when moving from one cost-sharing level to the next.

21. Here the premium estimate for the full-benefit plan differs from the \$274 presented earlier because the latter estimate assumes an out-of-pocket spending limit, while this estimate does not.

Whether a plan limits an enrollee's financial liability by capping out-of-pocket spending is an important feature in plan design. Figure 12.3 presents out-of-pocket maximums for cost-sharing levels 1–6. We also estimated premiums at each of these cost-sharing levels with no out-of-pocket maximums. This enabled us to make a series of comparisons holding constant type of coverage (single or family), benefit level (full or pared down), coinsurance, and deductible, allowing these “matched pairs” of plans to vary only by whether or not they had an out-of-pocket maximum. The overall premium-reducing effect of having no out-of-pocket maximum (calculated across 24 combinations of plan types, coverage types, and cost-sharing variants) ranged from 5 percent to 32 percent, depending on coinsurance and deductible levels. The effect was the greatest at the higher cost-sharing levels.

■ Summary of Findings

As employers seek protection from rising health care costs by reducing benefits or increasing enrollee cost sharing or both, what

level of savings can they reasonably expect? Our analysis shows the following. (1) Estimated premium savings from eliminating specific benefit categories (preventive/hearing/vision care, durable medical equipment, mental health/substance abuse care, pharmacy, and all care exceeding \$100,000 in plan costs) were greater than savings from paring down those benefits (21.5 percent versus 13.9 percent, respectively). (2) Starting from a baseline plan with full benefits and low enrollee cost sharing, a similar level of premium savings can be achieved by either eliminating major categories of coverage or modestly increasing enrollee cost sharing. Specifically, eliminating coverage for the five benefit categories together reduces premium by about 21.5 percent. Increasing cost sharing from a plan with \$15 copays and no deductible to one with 20 percent coinsurance and a \$250 deductible reduces premium by about 22 percent. (3) Further increases in cost sharing produce estimated savings that eclipse those available from eliminating benefits. Specifically, premium savings of nearly 44 percent could be achieved, without changing benefits offered, by replacing the level 1 cost-sharing structure (\$15 copays and no deductible) with 30 percent coinsurance and a \$1,000 deductible. Moreover, savings of more than 50 percent could be achieved by increasing cost sharing from level 1 to a plan with 50 percent coinsurance and a \$2,000 deductible (in effect, a “catastrophic” plan). (4) Elimination of maximum out-of-pocket spending limits can reduce premiums by 5–32 percent, depending on the level of coinsurance and deductible.

We have shown that significant premium cost savings may be achieved by reducing benefits or increasing enrollee cost sharing. As a general proposition, there is nothing new in asserting the cost-saving properties of these strategies, but we have added quantitative estimates to the discus-

sion at a time when employers are reevaluating their role as sponsors of health insurance and seeking ways to limit their financial liability. However, we caution readers against focusing solely on the results of the empirical analysis. These results should be considered in light of possible effects, positive and negative, of reducing benefits or shifting greater costs onto enrollees.

■ Discussion and Policy Implications

Although our analysis has focused on the small-group market, this discussion raises issues that are equally relevant in midsize- and large-group markets, where employees may be offered high cost sharing or low benefit plans or both.

Consumerism

A desired effect of offering plans with increased enrollee financial responsibility is that they will help to make enrollees smarter consumers of health care services. This is one of the primary marketing messages of many of the new “consumer-directed” e-health plans, such as Definity, Lumenos, and Vivius. Such plans are betting that once first-dollar coverage and low cost sharing are removed from the equation, informed enrollees will have an incentive to limit their own demand for health care. In the process, medical care cost inflation will be constrained, and employees will be more satisfied with their health benefits.²²

Consumer-based cost containment strategies are founded on the assumption that patients will make wiser health care choices

22. Christianson et al., “Defined-Contribution Health Insurance Products.”

when cost and quality information is more widely available. However, the technologies that are needed to support a consumer-driven market—standardized quality measurement, risk adjustment, and effective communication of health plan performance—are not yet advanced enough to enable such support.²³ Therefore, a potential downside to consumerism is that patients who are ill informed but empowered with choice may purchase less or lower-quality care and may pay more for it. In a recent commentary describing the new consumerism paradigm in health care, James Robinson noted that “consumers vary enormously in their financial, cognitive, and cultural preparedness to navigate the complex health care system. The new paradigm fits most comfortably the educated, assertive, and prosperous and least comfortably the impoverished, meek, and poorly educated.”²⁴

Consumerism will likely work better for the “impoverished, meek, and poorly educated” to the extent that the technologies upon which it depends are further developed. Additional safeguards may also be considered, such as lower coinsurance for preventive care, tax credits, and subsidies for low-income employees, who have less discretionary income to pay for higher medical costs.

Risk Segmentation

A second effect of the increased prevalence of plans with high cost sharing or low benefits (or both) is that it may give rise to risk segmentation at both the employer and market levels. Although we did not simulate premium changes over time when employees choose between more and less comprehensive plans, it is likely that employees who expect to use large amounts of care would choose more comprehensive plans, while those who expect to use less care would choose less comprehensive plans. (Here, “more comprehensive” refers to plans with low cost sharing

and full benefits; “less comprehensive” refers to plans with high cost sharing and reduced benefits.) Over time, this dynamic would produce ever larger differences between comprehensive and noncomprehensive plan premiums.

Risk segmentation is especially troublesome when different plan types are insured by different carriers, rather than by the same carrier. In the former case, no single carrier can minimize risk-based premium differences between plan types by cross-subsidizing the premium of the comprehensive plan with that of the less comprehensive plan. Risk segmentation also can occur at the market level, as employers make coverage choices on behalf of whole groups. We would expect that employers who know their employees to be healthy would choose low-premium, less comprehensive plans, thereby driving up premiums for employers choosing a more comprehensive plan. As noted earlier, we expect that premium differences between more and less comprehensive plans would increase as the entire market segments over time. The resulting premium spiral could lead to a market in which comprehensive coverage becomes largely unaffordable.

Cost Shifting

A third effect is that less comprehensive plans would shift health care costs from employers to employees. Some will view this strategy as an employer effort to limit financial liability at the expense of workers and their families. Others will argue that em-

23. S. Silow-Carroll and L. Duchon, E-Health Options for Business: Evaluating the Choices, *Pub. no. 508* (New York: Commonwealth Fund, March 2002).

24. J.C. Robinson, “The End of Managed Care,” *Journal of the American Medical Association* 285, no. 20 (2001): 2622–2628.

employees already pay for employer premium contributions through forgone wages.²⁵ From the latter perspective, cost shifting may be seen as a wage-conserving strategy. Either way, less comprehensive employment-based health plans may carry affordable premium price tags, but covered workers who use large amounts of care may come to believe that they have traded premium savings for higher total out-of-pocket costs.

Possible Health Impact

Another possible effect of employers' moving to less comprehensive plans is the potential health impact of reduced demand for medical services associated with higher cost sharing. While the RAND Health Insurance Experiment provided important insight into this issue, the findings are now nearly 30 years old. They do not reflect intervening demographic shifts or health trends (such as the aging of the baby boomers and the increase in the prevalence and cost of chronic illness), nor do they reflect major changes that have taken place in health care markets in the past 30 years (for example, the advent of managed care, direct-to-consumer drug advertising, increased use of the Internet, and explosive growth in medical technology).

Given these changes, we cannot use the RAND findings to predict with certainty the effects of increased cost sharing on health outcomes today. However, many studies (on preventive, pharmacy, emergency, diabetes, and other types of care) support the RAND finding that increased cost sharing reduces utilization.²⁶ The time is ripe for new research into the magnitude of this reduction and, ultimately, its impact on health outcomes.

Rather than (or perhaps, in addition to) increasing cost sharing or reducing benefits, employers may consider a third cost-control option: selection of a group-model HMO. This model has traditionally achieved

savings by developing a narrow physician network with a homogeneous culture and practice style (among other cost-control tools), unlike the PPO networks of unaffiliated providers assumed in this study.

Analysis of an online insurance broker site, eHealthInsurance.com, allows premium comparisons among different types of carriers (traditional PPOs, group-model HMOs, and others). One example comes from the highly competitive Northern California market: For similar plan designs, group-model HMO premiums are 20–25 percent less than premiums for a PPO-style carrier. It is striking that the potential savings available from switching to a group-model HMO are similar to those demonstrated in this analysis when we eliminated benefits (21.5 percent) or increased cost sharing (22 percent).²⁷ It must be noted, however, that the availability of group-model HMOs is limited to a few geographic areas.

Our analysis quantifies the impact of

25. M.V. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance* (Ann Arbor: University of Michigan Press, 1997).

26. G. Solanki, H.H. Schauffler, and L.S. Miller, "The Direct and Indirect Effects of Cost Sharing on the Use of Preventive Services," *Health Services Research* 34, no. 6 (2000): 1331–1350; B. Motheral and K. Fairman, "Effect of a Three-Tier Prescription Copay on Pharmaceutical and Other Medical Utilization," *Medical Care* 39, no. 12 (2001): 1293–1304; R. Johnson et al., "The Effect of Increased Prescription Drug Cost Sharing on Medical Care Utilization and Expenses of Elderly Health Maintenance Organization Members," *Medical Care* 35, no. 11 (1997): 1119–1131; J.V. Selby, B.H. Fireman, and B.E. Swain, "Effect of Copayment on Use of the Emergency Department in a Health Maintenance Organizations," *New England Journal of Medicine* 334, no. 10 (1996): 635–641; A.J. Karter et al., "Self-Monitoring of Blood Glucose—Language and Financial Barriers in a Managed Care Population with Diabetes," *Diabetes Care* 23, no. 4 (2001): 477–483; and M. Wong et al., "Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study," *American Journal of Public Health* 91, no. 11 (2001): 1889–1894.

increased cost sharing and of paring down and eliminating specific benefits. We found that increasing cost sharing can have a relatively large impact on premiums; paring down and eliminating specific benefits had a more limited impact. While not new to actuaries, this knowledge may become more significant to decisionmakers because of the confluence of two factors: the recent return to double-digit health care inflation, and the sustained backlash against managed care. Even without federal legislation, managed care's cost-control techniques have been weakened.²⁸ Already seeing a trend, many analysts predict that more employers will turn to employee cost sharing or reduced benefits as the next most promising means to control health care costs.

However, shifting sizable financial risk to consumers on a broad scale could lead to another backlash, possibly larger than the one preceding it. What would happen next is pure speculation. Depending on the political and social environment, we could see a return to some aspects of managed care. Alternatively, health care could become (more) stratified if the wealthy can buy out of managed care constraints, while middle-class consumers resolve to view its cost-controlling devices as

the best way to limit their financial risk.

The authors gratefully acknowledge the contributions of Edwin Hustead and Sevim Kuyumcu of the Hay Group. Thanks are also due to John Bertko, Bob Crane, Anne Gauthier, Jamie Robinson, and our anonymous reviewers for their helpful comments on this paper. Finally, the authors thank Alain Enthoven for noting the need for such an analysis and providing guidance on the benefits to be examined. The views expressed in this paper are those of the authors and do not necessarily reflect the views of the Academy for Health Services Research and Health Policy, Kaiser Foundation Health Plan, Inc., or the Permanente Medical Groups.

27. This finding—that similar savings are available from either moving to a group-model HMO or increasing enrollee cost sharing—is consistent with the findings of the RAND experiment. See W.G. Manning et al., "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services," *New England Journal of Medicine* 310, no. 23 (1984): 1505–1510.)

28. Robinson, "The End of Managed Care"; and D.A. Draper et al., "The Changing Face of Managed Care," *Health Affairs* (Jan/Feb 2002): 11–23.



Consumer Knowledge

Educator Perspective: Chapter 13

Benefit Consultant Perspective: Chapter 14

Consumer Perspective: Chapters 15, 16

Insurer/Vendor Perspective: Chapter 17

New Models of Health Care Coverage Demand New Skills and Responsibilities

By Ray Werntz
Consumer Health Education Council,
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■ Introduction

Based on my experience in the benefits business of nearly 40 years, what strikes me about the current discussion of new models of health care coverage is how much things change and how much they stay the same. In the early 1980s, Bob Penscover, a creative benefits professional at Quaker Oats, developed a high-deductible, consumer-oriented model of health care coverage that operated like a profit-sharing plan. It was aimed at slowing demand for what we then called “inappropriate” care. In the late 1980s, we concocted demand-management programs. Lee Newcomer and I recently discussed a product that United Health Care marketed about 10 years ago called “Sole Source,” a consumer-friendly alternative to traditional managed care.

In short, the notion of influencing consumer demand and behavior regarding health care and other benefits has been around for a long time. My proudest accomplishment at Whitman Corporation was our health benefit plan and the educational and mentoring tools we wrapped around it. It was a system designed to enable consumers. Unlike some of the new, more exotic models, such as those offered by Definity, Vivius, or Lumenos, it was a hybrid plan, with some elements of managed care, a “soft” definition

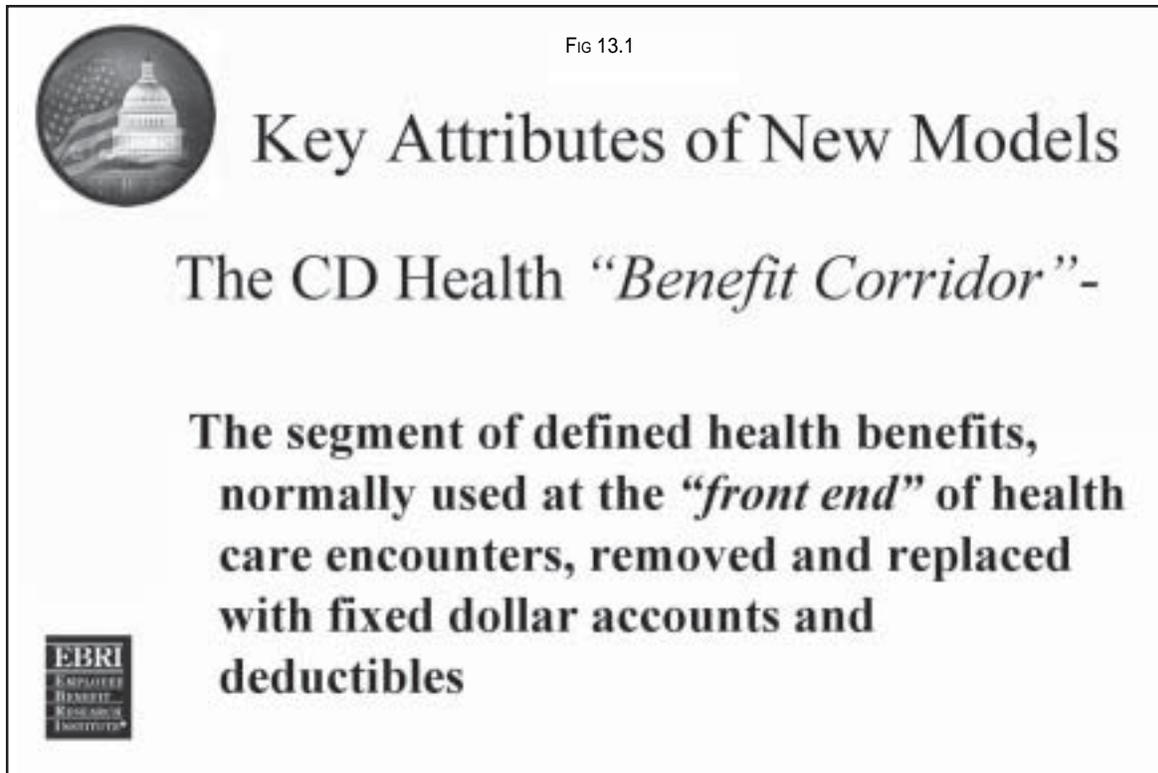
of medical necessity, lots of education, and a unique form of nurse mentoring. It was consumer centered and consumer driven—and it worked.

With the Consumer Health Education Council (CHEC) of the Employee Benefit Research Institute, my primary role is to develop knowledge and evidence that will lead to better consumer-education tools. Such tools will be necessary to help consumers acquire appropriate health benefits and use them to cope successfully with what will likely be a major shift in decision-making responsibility from benefit sponsors and their service providers to individual consumers. I believe this will occur regardless of the actual benefit structures that emerge in the future.

This article addresses four topics:

- How consumer-driven models will define the future of consumer education.
- What constitutes care quality from the perspective of consumers.
- What consumers expect from care givers.
- The skills that consumers will need to exercise their new responsibilities and achieve good health outcomes.

In some cases, I will refer to the work we are doing at CHEC to build a knowledgebase to support the education agenda required by the new models of health care coverage.



■ A Greater Role for Consumers

The most important aspect of consumer-driven health models is the elimination of what I call the “benefit corridor,” as shown in Figure 13.1. It is the front end of a typical HMO health plan, which defines health benefits and replaces it with fixed dollar accounts and deductibles. This requires consumers to manage, choose, and pay for health services necessary for diagnosis and initial treatment of an illness or injury, a role historically played by HMO plans or a plan sponsor. The consumer has a greater role in determining appropriate diagnostic and treatment services. While in this corridor, consumers decide what is and is not medically necessary for payment purposes.

The new models impose significant new responsibilities on consumers:

- Increased consumer decision-making with regard to services in the corridor.

- More freedom in choosing providers.
- Less care coordination—and if there is coordination, it is external to the care process, rather than imbedded in it, as is the case with many HMOs.

■ Dimensions of Consumer-Driven Care

The Wye River Group in its employers’ guide to consumer-driven health care, lists four noteworthy dimensions of consumer-driven health care:

- It expands the breadth of coverage and care choices, which appear to be a high priority for consumers, according to recent surveys.
- It gives consumers a greater stake in spending decisions, which makes them the arbiters of medical necessity.
- It provides funding flexibility in that

consumers must decide how much financial risk they will accept for health care and how much insurance they will require based on their own level of risk tolerance.

- It allows for continuity. When employees leave their companies, or when their companies change plans, a change in plans may break the continuity of care between individuals and their caregivers. Continuity is more assured in coverage models that are less structured, less dependent on sponsors, and more dependent on arrangements that consumers make for themselves.

According to the President's Advisory Commission on Consumer Protection and Quality in its report published in early 1998, four basic elements characterize good care:

- Quality care is evidence based.
- Quality is more likely if the care system itself is flexible, adaptable to change, and willing to change. Care system personnel must be trained and collaborative.
- Quality-care systems have adopted or intend to adopt state-of-the-art information technology.
- Quality-care systems are compassionate and humanistic.

The educational challenge, therefore, is to help individuals in a less-structured environment obtain high-quality care and achieve and maintain the highest possible level of health and functionality.

■ Personalizing Health Care

When we use any of the new terms, whether it is consumer-driven, consumer-centered or consumer-directed, what we are saying is that instead of having those that control the delivery or financing of care make care decisions, we prefer that consumers learn to “pull” on the care system so that they have choices and the skills and information to make those choices. This pull must cause the care system

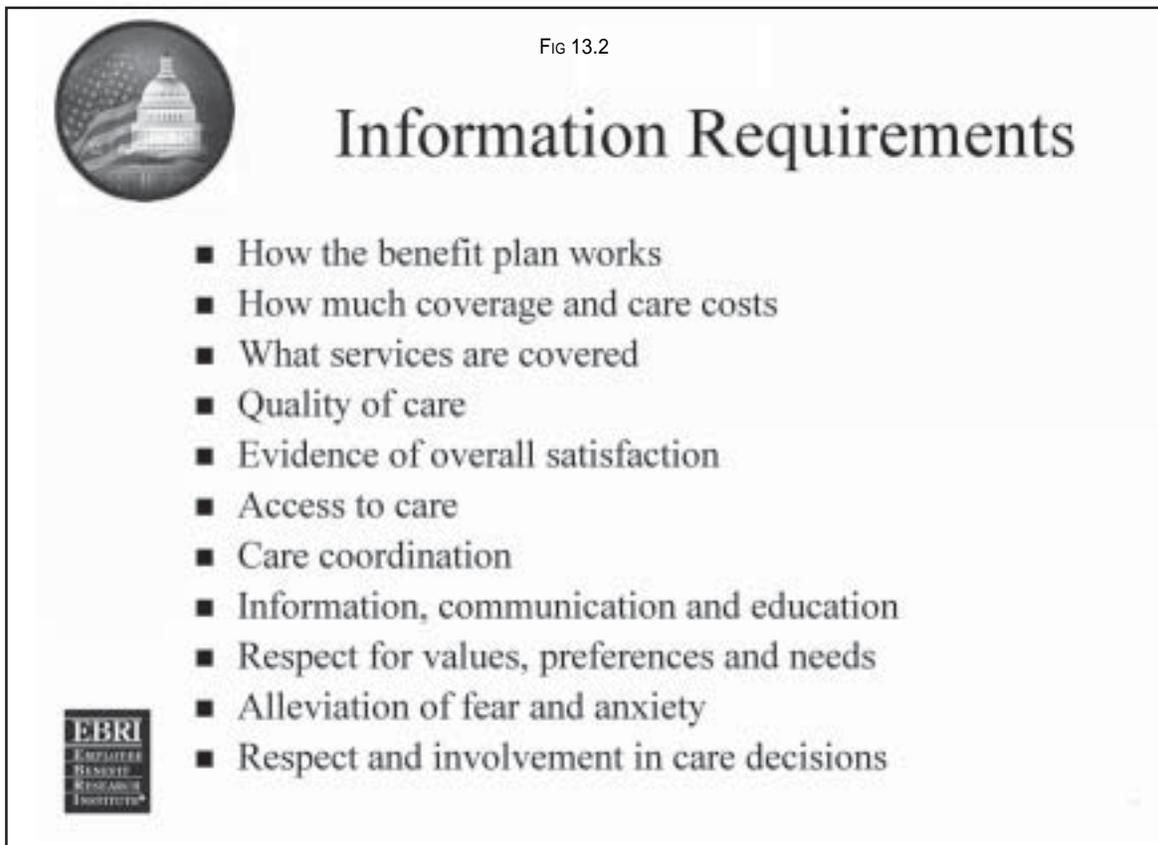
to personalize care and meet the very narrow and specific needs of individual patients. With that as background, we need to establish what new educational tools we need so that consumers are equipped to assume more control over their care.

We start by looking at the evidence that documents the types of information consumers expect. Next, we must understand the importance of personal health values to health affecting behavior. (The notion of values and their importance to health care financial decisions was introduced in EBRI's January 2002 *Issue Brief*.) Third, a “skill set” that defines what consumers need to know in the world of health benefits needs to be framed.

Figure 13.2 lists the literature reflecting what consumers want in terms of information and care. Consumers want to know how their benefit plans work and how much coverage and care costs. They also want information about the quality of available care. A recent study completed by the Voluntary Hospital Association documented the desire of frequent users of the care system for evidence of clinical quality. Consumers also want to know how well care is coordinated. They want good information and care givers who communicate well. They want respect for their values, their preferences, and their needs. They want alleviation from fear and anxiety, and they want to be involved in care decisions. Effective educational tools must reflect what is important to those who will be expected to adopt new skills and behave much differently than they did in the past.

Values drive personal decisions affecting health and care. Despite some apparent variability, for the most part personal values as an expression of personality are consistent. Most important, knowledge about a patient's values aids the clinician in diagnosing and treating health problems.

As a follow-up to the *Issue Brief* pub-



lished last January, we plan to publish the results of 11 focus groups conducted last year in the United States and Great Britain on the subject of health values. These focus groups, called “Living Dialogues,” were conducted by the Valeo Initiative (www.vvaleo.org). Valeo exists to create an “epidemic of health” (a notion developed by Jonas Salk) by engaging citizens in a process called “appreciative inquiry” to create the pull on the health system mentioned earlier. The goal is better alignment of roles and responsibilities essential to better health and care.

When I participated in an abbreviated version of a Living Dialogue focus group some time ago, I was paired with a war veteran who had suffered a spinal cord injury in combat. To learn about his values with regard to health and health care, I asked him when he felt most healthy. His response was a little surprising. He said he felt healthiest about

two years earlier when the federal government made certain additional services available to him and others like him in his community, largely due to his efforts on behalf of the Paralyzed Veterans’ Organization. For him, being healthy did not mean his physical condition before his injury; it had more to do with his ability to help other people in spite of his condition and perhaps even as a consequence of his condition.

■ Five Skills for Quality, Affordable Care

The new health care models on the horizon will require new skills for many consumers. The five skills that will determine the affordability and quality of health care that consumers will seek in the future are the ability to:

- Estimate what care will cost over time and

how much of that cost they wish to insure, as well as how much to pay out of accounts comprised of their personal funds or money contributed by a plan sponsor such as an employer. Regardless of the form of coverage they choose in the future, consumers will be risking more of their own money, and they will be required to make more decisions about which services will be purchased.

- Assume more responsibility for selection of doctors and hospitals. That requires consumers to have better information about providers to allow them to choose services and individual professionals pertinent to their health needs and preferences.
- Communicate better with providers and to receive and give information about their health problem, their preferences, and their values. This is a very high priority because consumers will play a larger role in the management of their care.
- Assume and coordinate responsibility for their health care. Paying attention to the interaction of multiple services and providers will be important to quality care.
- Make decisions about medical necessity, which may be the most difficult of the five skills. Consumers, not managed care administrators, will make the tradeoffs when they consider the worth of a particular test or treatment. They, not managed care, will be denying themselves procedures that might have improved their care.

■ Conclusion

As we think through all the implications of new coverage models, we cannot ignore the goal of our efforts. Health benefits or coverage are not merely dollars paid by sponsors and covered individuals; coverage sets out the rules of engagement for individuals and their caregivers.

Until about 20 years ago, sponsors and their service providers had little to say about what transpired between doctors and patients. They paid for most of what occurred based on the attending physician's decisions. Managed care's main contribution was greater involvement in care before it was provided. Although many came to resent the control attributes of managed care, structures were put into place that pre-selected providers and adopted protocols for coordinating care.

In the future, many of these structures will disappear and consumers will be expected to pay more for their care. This is change of a magnitude envisioned by system reformers in the past. If people did not get sick or suffer injuries, a health care system would not exist. The system is there to alleviate human suffering and realize human potential. Let us not forget that concept as we seek to engage consumers more actively in decisions affecting their health.

The Emergence of Health Care Consumerism

By Daniel B. Holmes
Fidelity Employer Services Company

■ Introduction

When we purchase health insurance, we are health care consumers. When we receive medical treatment, they call us patients.

More than 20 years ago, consumerism regarding the financing of retirement didn't exist. Financial consumerism began in the late 1970s with the individual retirement account (IRA) and, in the early 1980s, with the 401(k). The growth of IRAs, and 401(k) and 403(b) retirement plans led to new planning tools, financial consumer education, and planning services. Financial consumerism matured through the 1990s and brought us to a point where I think most of us are very engaged in our retirement benefits.

Employers shifted the responsibility for retirement saving to their employees. In doing so, they shifted risk. And to support that shift of responsibility, they introduced computerized planning tools, educational seminars, and other services that help employees manage their retirement programs. The same thing is happening today in health care and will continue to expand as employers shift more responsibility for health care to their employees.

This article will discuss the three stages in health care consumerism:

- Selecting and purchasing health plans.
- The education, care management, and the consumer (patient) purchasing of actual health care services, where we are today.

- Planning for post-employment retirement health care needs.

■ Stage 1: Selecting/ Purchasing Health Plans

After years of helping employees choose health plans, we understand the information employees need to make the right choice for themselves and their families. Twenty-plus years ago, asking employees to make choices in health plans was very new. The health plans' underwriting departments were afraid of adverse selection, and employers were afraid their employees would make poor choices. Today, it is common to offer choices.

To decide on which plan is best, people want to know what services are covered and what will not be reimbursed by the plan. Those with specific health care conditions want to know how those benefit structures will affect their health care treatment. What doctors or hospitals are available in the network? How much does the plan cost? Health plan education programs and support tools are built to support those decision processes. Planning tools show benefit comparisons, network providers and hospitals, and price comparisons.

In addition, we now provide medical expense calculators so employees can estimate how much to put in their flexible spending accounts (FSAs). Employers are supplying

quality metrics, which help employees select a plan and network. Today most plan choices are HMOs and preferred provider organizations (PPOs). The new consumer-driven plan is a different type of plan with a creative benefits structure. While it is a challenge to introduce these new plans and new concepts, we know how to do it.

■ Stage 2: Education and Care Management

When we become patients within the system and are expected to make health-purchasing decisions, it's a new ball game for consumers. I don't believe we know very much about the patient decision-making process.

It is hoped that most of us are trying to pursue a healthy lifestyle, and there is plenty of information available to help us. Employers promote and support wellness programs with preventive care schedules and routine testing benefits. But consider the patient decision-making process. Healthy living is a trade-off—immediate gratification (a chocolate sundae) vs. long-term weight control or smoking cigarettes vs. long-term health. We lose some weight, get in better shape, have physicals, and feel better in the short run.

But other lifestyle behavioral changes, such as lowering blood pressure, lowering cholesterol, and stopping smoking, seem to require a lot of pain over the short term. And in the middle of the pain, you see a television ad that says, you can just take a pill and forget the pain. I don't think we understand the decision-making process in this area, but we do know that a lot of wellness benefits are not being utilized today. As we move beyond wellness to actively utilizing our health services, we need to address true consumer purchasing of services.

Employers are introducing consumer-driven plans, tiered networks, and multi-level

Rx programs. Those will allow consumers to make true decisions. And while information and tools are available today, much of what a consumer needs is missing, such as the cost of health services and quality information. You can get price and quality on DVDs, cars, and personal computers, but you can't get it on health care.

In regard to health care today, patients are not consumers. We are patients who use advisors—and the advisor is the physician. Health care today is an advisory business. To move to true consumerism, we have to start emphasizing the trade-offs—the price, the quality, and the benefits—so that people can make true consumer decisions. This is beginning in the benefits industry as new companies and ventures begin to address the needs of the patient consumer.

■ Stage 3: Planning for Retiree Health

Employers have been withdrawing from post-employment health care benefits. Statistics from the Employee Benefit Research Institute (EBRI) show that most employers don't offer medical benefits after retirement. The bigger employers that offer it are on their way out, and future retirees will assume the financial burden. What are we doing about it? Well, there is almost nothing being done about it, and as employers and advisers to employers, we need to do something.

Employees are aware that pre-65 retirement means that they need a health plan, but often they are not sure if their employer gives them one. Maybe they know they have COBRA for 18 months, but they are unsure of the costs of plans in the individual market. So, people thinking of retiring before age 65 need to start planning and becoming educated and aware of what the costs will be.

EBRI's surveys also show that people are very unaware of their post-65 Medicare benefits. Most employees can't name the age that Medicare begins or that there is a Part A and a Part B. Most don't know that they will have to pay for Part B. Our work has identified an estimated present-value cost for a couple age 65 of \$160,000 to cover Medicare Part B, the co-pays and deductibles under Medicare, along with prescription drugs that are not covered by Medicare and some miscellaneous expenses.

That amount of money is going to be needed for their health care in retirement. That means that planning and saving for this expense is extremely important. Additional funds may be needed to cover the cost of long-term care. Helping employees prepare for health care in retirement is our next great consumer challenge.

■ Conclusion

Before employers begin implementing any of these consumer programs, they should have a health care strategy. The first decision for employers to make concerns their involvement. What are the responsibilities and obligations of an employer? Some employers believe their work force turns over rapidly, and they're not interested in promoting health care tools and consumerism.

Some employers promoting consumerism will decide to put the responsibility in the hands of their health plans, as demonstrated by consumer-driven plans providing a lot of this service, along with HMOs. Alternatively, some employers are going to manage this consumerism themselves, extract it from the plans, and take a pro-active employer-based approach.

In addition to implementing strategy, most employers also have to create a return on investment or "business case" in regard to health care benefits. If you do implement consumer-driven health plans, be sure you know how you will measure your ROI.

Work to Cut Costs—Not Benefits

By John D. Abraham
American Federation of Teachers

■ Introduction

According to a recent report in *The Wall Street Journal*, a couple was paying about \$400 a month for an individual health insurance policy in the mid 1990s when the wife was diagnosed with breast cancer. Over the next four years, premiums rose by 350 percent. By August of 2000, the couple's new rate would be \$1,800 a month. When they drove to the insurer's main office, they were told that their premiums were soaring because the wife had what underwriter's classified as a "dread disease," even though the cancer was in remission.

This is an example of re-underwriting, which occurs when companies that sell health insurance readjust individual premiums each year depending upon past utilization. If a participant developed a chronic disease in the past year or filed claims that seem to predict more claims to come, their premiums are increased at the annual renewal.

This type of modeling follows the auto insurance model, but significant differences exist between auto insurance and health insurance. First, speeding is controllable, while the use of health care is largely uncontrollable. Second, if you get enough tickets and lose your license, you can still ride Metro or walk. But if you get real sick, you either go into debt or die. In other words, there are no alternatives to health insurance, and the stakes are much higher.

■ The Merits of Pooled Risk

This example may be an extreme form of "Consumer-Driven Health Care," but it is one that should give pause to all plan sponsors. The reason is clear: This concept even in some milder forms would eventually lead to the elimination of pooled risk—the heart of the employer-sponsored, group-purchasing concept. Pooled risk is an important concept for several reasons.

- In the typical group health plan, 20 percent of the participants incur 80 percent of the total costs. Half of the remaining 80 percent of participants never incur an expense, and it is this pool, plus the other half with moderate expense, that funds the high-risk 20 percent. If this group is destroyed, each person or family unit stands alone. Without pooled risk, employees and dependents with chronic, acute, or life-threatening conditions will eventually bear the full cost of their maladies through re-underwriting based on individual health conditions.
- Most illnesses are beyond the control of individuals. People don't try to get sick to take advantage of the benefits. Diseases like cancer, heart disease, and diabetes are at least in part linked to our genetic code and will occur whether we take care of ourselves or not. It doesn't mean that we should stop wearing seat belts, stop exercising, and encourage smoking. We should

support these public health services and more. But until we discover a cure for heart disease, stroke, cancer, and other chronic conditions, humans will be faced with the emotional and financial responsibility for them. As these risks exist for all of us, I believe it is better to pool individuals into groups to manage the costs.

- The administrative burden placed on individual and small group plans in the range of 40 percent of premium lead many to conclude that employer-sponsored group plans add value to their employees. As employees continually rate employer-provided health insurance as a key attraction and retention benefit, employers should work with their employees to maintain good benefits while controlling their costs.

■ Cost-Shift Issues

Any type of arrangement that somehow limits or caps an employer's obligation to provide health care and shifts that cost to workers has to confront several issues:

- Although the incentives against over-utilization are quite explicit, workers will go into debt to pay for tests and procedures their doctors recommend, especially if they are for a spouse or child.
- The possibility of under-utilization also exists, as consumers worry about their ability to afford the cost of care. This is particularly difficult for those with low incomes, chronic conditions, or those with symptoms that are difficult to diagnose.
- Quality information is unavailable to judge the value of one plan versus another. Can a consumer realistically make an educated decision about the merits of any plan when virtually every doctor and hospital are in every network?
- The consolidation of the insurance market gives these providers a huge information

and pricing advantage over individual purchasers. They already know who is worth insuring and who is not. They control the market and dictate the price. Consumers have no bargaining power here.

Many plan sponsors are discouraged about our nation's failure to reach a political consensus on health care reform and now want to retrench and deal with the cost problem on their own. But does anyone really believe that shifting all of the medical risk to workers will solve the long-term cost problem? We all know that the ad men that gave us the hula-hoop and pet rocks surely are capable of developing the right phrases and slogans to convince employees that they are getting something very important, at least in the short run. But what they really get in the end is more risk. And shifting the risk will hurt real people both emotionally and financially.

Health care is not an ordinary good in a perfectly competitive market. The purchase of health care is not like the purchase of a car. You can't kick the tires, take the health plan out for a trial run, or read consumer reports to get an unbiased comparison of quality. People make choices based on convenience, physician network participation, and cost because that is all the information they get. As most doctors participate in most plans, no incentive exists to choose one plan over another. But a mistake can lead to a catastrophic expense or lower quality. This is why employees press for open networks—to protect the access to needed services for their loved ones.

Here's one example of the danger of this approach. A small school district in rural Louisiana was facing a large and unexpected jump in its health care premiums. The superintendent called up his local insurance broker and asked him to change the plan design to meet the budgeted figure. The broker complied by increasing the up-front deductible to \$1,000, and the plan was put into place.

Several months later, one of the district's bus drivers experienced heart attack symptoms—tightness in his chest, sweating, and a sore left arm; but he refused to seek medical attention because he could not afford the \$1,000 deductible. He died later that day.

What is driving the shift in thinking that employees should assume all future costs hikes—all health care risk? First is the sharp rise in premiums and concerns about open-ended financial exposure from new technology, drugs, and procedures. Second is the provider-orchestrated backlash against managed care, which has led to looser controls, more utilization, higher prices, and more risk exposure for plan sponsors. Third, there has been loosening of labor markets that may open up a window toward more cost shifting to employees. Finally, I imagine there are some consultants who dream of a day when all but a handful of employees are independent contractors and have to pay their own FICA, pension, health, and other benefits. A recent report that showed employees now pay more for their pensions than employers surely bolsters this way of thinking.

Do we really believe that employers will implement some kind of capped or limited program and stand by when a key employee experiences a catastrophic health expense? Our experience with cafeteria plans leads me to conclude that employers will not let their employees suffer the consequences of poor decisions but will intervene to protect their workers. Therefore, this strategy will ultimately fail.

■ Proposals to Cut Costs

Rather than spend time shifting risk to employees through an unproved and unsupported concept, let's use the existing collective bargaining structure and defined-benefit concept to share the health care risk. Let's work together and learn together how to solve

the cost problem to provide our families with this important benefit. We renegotiate our contracts every two or three years and rebalance costs with benefits and coverage.

Here are a few ideas that may help us find the path to more affordable health care for our families:

- Press our national and state political leaders for change. The Republicans want to protect the tax cut, and the Democrats want to stay away from the Clinton plan. But with costs threatening the foundation of the employer-based system, both labor and management need relief. Regardless of your position on reform, lend your voice to the various reform coalitions and press your congressmen for relief. The American Federal of Teachers (AFT) supports an expansion of Medicare to include prescription drugs and employer buy-in for both active senior workers and early retirees.
- AFT also has been advocating for state and regional pools for education and other employees, and the Minnesota Legislature passed the creation of such a plan despite a budget deficit. Oklahoma and Texas passed statewide health care bills for teachers as well.
- Develop new and better standardized, data-collection systems that determine which services and costs are rising, which are falling, and which remain unchanged. It would be useful to learn that the number of MRIs increased from 100 to 1,000, the associated cost, and some assessment as to their medical value, or if the number of ICU days had increased and why. Armed with this information, we could improve quality and save costs at the same time.
- Focus attention on the 20 percent of employees and dependents who account for 80 percent of the costs.
- Work together to develop disease-manage-

Consumer-Driven Health Benefits: A Continuing Evolution?

ment programs that encourage employee and provide participation through education and protocol support.

- Encourage the modernization of the practice of medicine by supporting the use of clinical information systems to improve quality and safety of patient care and increase the efficiency of health care personnel. For example, the devel-

opment of a standardized computer-based patient medical record could eliminate the need for memory-based medicine and duplicate tests.

- Work out the HIPAA safeguards to protect patient privacy, but make sure medical personnel have all the information they need to make timely decisions about patient care.

Healthy Consumer-Driven Health Care: Shifting Costs to the Sick

By Gail Shearer
Consumers Union

■ Introduction

So-called consumer-driven health care shifts costs to high-risk consumers, i.e., older, sicker patients. Although this may sound like a good idea, it creates several unintended consequences: It could lead to skimpy coverage, loss of coverage, and/or higher cost coverage for millions of consumers. This article addresses many aspects of this policy, including the variation in health care costs, the nature of the individual health insurance marketplace, and the potential of so-called consumer-driven health care to undermine the employer-based system, throwing more people into the individual market. It also addresses the myth of consumer choice and the winners and losers under defined-contribution health care systems.

■ Variations in Health Care Costs

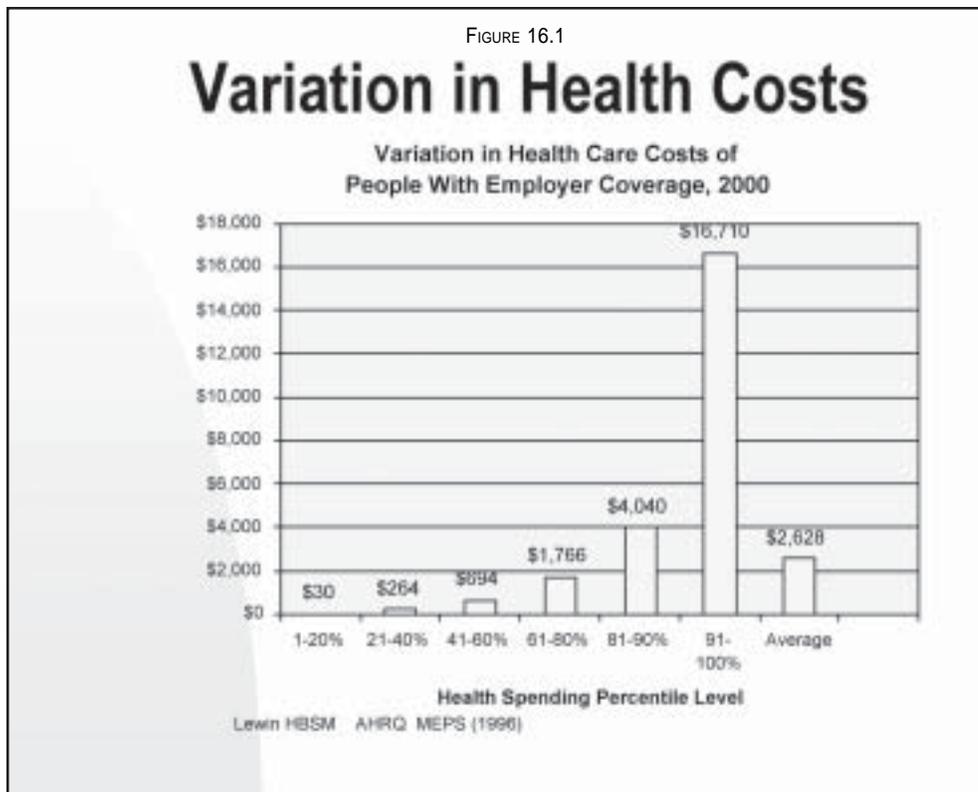
Figure 16.1 shows data from the national Medical Expenditure Panel Survey, which is administered by the Agency for Health Care Research and Quality. The data were adjusted with a microsimulation model to the year 2000, by the Lewin Group.¹ These data are for the year 2000.² The chart depicts the variation in health care expenditures among

people with employer-based coverage. It provides evidence that in any one year, most people are very healthy; those in the first 20th percentile of health care expenditures have average costs of about \$30, and even those in the 41st to 60th percentile have average annual expenditures of just \$694. But what is truly alarming is the level of expenditures for those in the top decile of spending: Their costs exceed \$16,700. The average expenditures (shown on the right) of slightly more than \$2,600 doesn't mean very much when the variation in spending is so large.

The focus of this article is the worst-case scenario, which is where the focus should be if there is a dramatic rush to defined-contribution health care. The worst case scenario occurs when employers stop offering health coverage and instead give employees cash or a voucher to purchase insurance in the individual market. Employers stop selecting coverage; instead, employees are on their own to navigate the individual health insurance marketplace. Employers cease playing the role of pooling people of different risk levels.

¹ *Consumers Union*, The Health Care Divide: Unfair Financial Burdens, August 10, 2002, Table 10.

² *The Lewin Group* used its microsimulation model to adjust the MEPS 1996 survey data to the year 2000.



Regulation of the individual health insurance marketplace varies tremendously by state. The variation of health risk among the population is what creates the need for extensive regulation of this market. What we see in the individual marketplace are high premiums, denial of coverage, and a dramatic rise in the number of currently insured individuals who become uninsurable. We see exclusions of individuals, body parts, and body systems. We see re-underwriting so that a person can pay an affordable premium but if that person gets sick, he or she could face a much higher premium the next year. One *Wall Street Journal* article tells the story of a person facing a premium of \$58,000 a year.³ A Kaiser Family Foundation study of the individual marketplace shows that individuals really are at risk in that market.⁴ The study shows that many applicants would face a rider that limits coverage under such a policy. For example, someone with hay fever might very well be

offered a policy that excludes coverage for the entire respiratory system. A breast cancer survivor would probably face an exclusion for any cancer. Because of these limits of coverage to people with pre-existing conditions, an expanded individual market should not be part of the nation's solution to the challenge of reducing the number of uninsured and underinsured people.

Many people suggest that high-risk state pools are one solution for the problem of denial of coverage in the individual health insurance market. It is very important to look

³ Chad Terhune, "Insurer's Tactic: If You Get Sick, The Premium Rises," *The Wall Street Journal*, April 9, 2002.

⁴ Kaiser Family Foundation, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* June 2001.

carefully at the details of how high-risk pools work and their coverage. The premiums tend to be very high, basically 125 percent to 200 percent of the standard rate. In addition, benefits tend to be limited. Many high-risk pools have long waiting lists. One issue that is seldom discussed is how high-risk pools are subsidized in most states by taxes on small businesses, which cannot escape such taxation by becoming self-insured the way large businesses do. In addition, high-risk pools are modeled on the individual marketplace, which is fundamentally flawed. Consequently, high-risk pools tend to have limited benefits and low lifetime benefit limits.

It is important to think about the winners and losers under defined-contribution health care. Winners are the relatively healthy, i.e., those who find high deductibles relatively attractive. Some people might even decide to “go bare” and forego coverage. They might end up being out of the risk pool altogether. The healthy will tend to find relatively low premiums and will have more choice in this system. However, the healthy are not our real concern. We are especially concerned about those in the top 10 percent of the risk spectrum, who spend on average almost \$17,000 on health care expenses each year. Unfortunately, these people are losers under this system. Losers include those who prefer low deductibles but might only be offered a high deductible plan, those who would face higher premiums, those who would have limited coverage with riders and exclusions, and those who would be uninsurable.

■ The Myth of Choice

Unfortunately, a myth that there can be choice in this marketplace has evolved. Many believe, for example, that Medicare beneficiaries can have the choice of participating in a voluntary private market for prescription drugs. The reality is, though, that adverse

selection goes hand in hand with choice in this market where individual risk varies so substantially. Proposals pretend that there can be choice, despite this adverse selection concern and the variation in risk. Two years ago, even the health insurance industry told Congress that a private, voluntary structure allowing choice of prescription drug plans is not workable. Yet supporters of free market health care systems (often with high deductibles) continue to pretend that you can have choice.

Studies show that if medical savings accounts (MSAs) are offered side by side with traditional coverage, the market is very unstable.⁵ Adverse selection leads more of the healthy to elect a MSA along with a high-deductible plan. Low-deductible plans and high-deductible MSA plans cannot exist side-by-side in the marketplace. Over time, the healthy select the high-deductible plan, while the less healthy select the low-deductible plan, and the premiums for the respective plans reflect the risk level of their enrollees. The higher premium low-deductible plans eventually are crowded out of the marketplace. Therefore, there is no true choice. The healthy and the sick have very different options.

Supporters of consumer-driven health care sometimes suggest that the marketplace will work better if consumers have more extensive information about their health care choices. There is one area of agreement with other participants in this dialogue: There isn't enough information. Consumers need information on what their employers spend for health care. It would be useful if there were a disclosure on W-2 forms of precisely how much employers are paying for health insurance

⁵ See, for example, Daniel Zabiniski, Thomas M. Selden, John F. Moeller, Jessica S. Banthin, “Medical Savings Accounts: Micro-simulation Results from a Model with Adverse Selection,” *Journal of Health Economics*, Vol. 18, no. 2 (April 1999).

premiums. In addition, consumers should have information about underwriting practices, including numbers and situations for denials of coverage and exclusions of coverage. If developments undermine the employer-based system, then there is greater need for information about underwriting and re-underwriting practices. It is important that consumers have a source of risk-adjusted, high-quality information about their providers, but this is challenging to provide. It is particularly difficult to adequately adjust for risk in quality data.

■ Legislative Initiatives

Several proposals before Congress have public policy implications of this topic. Recently, the Senate debated proposals for subsidizing health insurance through tax credits in the context of the Trade Adjustment Act. A key issue was whether displaced workers should be able to use a health insurance tax credit for COBRA coverage alone, or whether they should be able to use a credit in the individual marketplace. Consumers Union is concerned about any proposal that would encourage the healthy to shift out of

the employer-based market into the individual market. This issue arises whether tax credits for the individual are considered in the economic stimulus bill, the trade bill, or a freestanding tax credit bill.

Other important legislation involves medical savings accounts. Consumers Union is wary of any proposals to expand MSAs for reasons outlined above. In addition, it is important to look at the impact that such proposals have on people, based on income and health status.

■ Conclusion

It is vitally important to remember the variation in health risk when thinking about changes to the health care system and not to undermine the employer role of spreading risk broadly. Any proposal that undermines that function is likely to lead to rapid growth in the uninsured. Consumers Union is concerned that the trend away from employer coverage and toward individual coverage will benefit the healthy at the expense of the sick. The sick are likely to face higher out-of-pocket costs, higher premiums, and reduced access to affordable coverage.

Consumer Knowledge: Do We Have Enough for the New Health Plans?

By Lee Newcomer
Vivius

■ Introduction

Consumer-directed plans are defined as employer-sponsored plans that shift responsibility for choices of benefits and providers to employees. They are not limited to plans offered by new providers. Traditional carriers, such as Humana, United Healthcare, CIGNA, and Blue Cross, offer iterations of their signature products that also allow choices for consumers. These choices prompt the question, “Is there enough information available to support those decisions?”

■ Categories of Information

Before answering that question, categories of information should be established. The first category profiles providers. Imagine 100 diabetic patients thinking about selecting their providers. They need data on which physicians offer great service, such as those who guarantee same-day appointments; which endocrinologists have the least complications; and, of course, cost also is an important factor.

As we think about these data, we need to dispel the notion that all consumers are the same. None of us has exactly the same set of values when we make decisions about our medical care. If you examine any other market in which consumers are offered identical

choices, you notice that they make different decisions because they have different values. For example, one patient may be willing to wait two weeks for an appointment to see a physician with high technical quality, while other patients are willing to sacrifice technical quality for the convenience of a same-day appointment. These differences in values mean that consumers will process and rank the same data uniquely.

Difference in values also applies to other categories of information. For example, the same diabetic patients need information about their disease. These “disease content” questions range across all of the issues in diabetes:

- How can I learn about what it will do to me?
- How can I learn about my diet?
- How can I learn about what my complications might be?

Decision-support tools are the third category of required information. Computer-aided tools or video aids help patients make decisions about complex issues. Suppose I’m a diabetic with heart disease and accelerating angina. Should I be treated with coronary artery bypass surgery or medicines? They both have their trade-offs, and decision-support tools help me apply my values to the decision. Decision support isn’t limited to medical care



Figure 17.1

Patients Evaluate Providers

NRC Patient Satisfaction

- **Did he listen to you?**
- **Did he explain the tests or treatments in terms you understand?**
- **Would you recommend him to a friend?**
- **Skill in finding and recognizing problems?**

issues; it is also available for coverage decisions. The same diabetic receives support for decisions on questions such as, Should I take a high deductible, or should I take a medium deductible and a better pharmacy benefit? These decisions can be as critical as deciding about a bypass surgery.

■ **Current Information Sources**

Now that we know about the types of information patients are seeking, we need to understand where they get that information today. Consumers use multiple sources. Surveys show that the next-door neighbor is the most frequent source of provider referral. Their accuracy may not be superb, but they are the trusted source for most consumers. Physicians, nurses and other providers rank second as a source.

Nurses are frequently called because they are more accessible and they are frank

about their observations of hospitals and doctors. Consumers respect their medical credentials. I'm always astounded at my nurse neighbor who provides consultations on providers for the entire neighborhood—her credibility surpasses mine at block parties. I even ask her for help in evaluating doctors.

The Internet is the third most common source of information. Health care is the most common search on the Internet, through the media and hospital referral centers. It is important to note that health plans aren't trusted for this information. I've noticed that the savvy health plans know this, and they allow branding by the information sources on their Web sites. Consumers want the information to come from someone other than a health plan because they believe health plans will distort the information to save money. I don't have that cynical view of health plans, but unfortunately perception is reality. Health plans that persist as the source of medical

information will fail.

In terms of provider profiling, satisfaction surveys are perhaps the easiest way for consumers to evaluate a physician. National Research Corporation's recent pilot in Portland, Ore., and Cincinnati, Ohio, are good examples. NRC asked all health plans to pool their claims data so that NRC could identify at least 100 patients for each profiled doctor. Each of these patients was surveyed and asked several questions about his or her recent visit. Figure 17.1 lists four sample questions asked of patients for each provider. These data are aggregated for each physician and available on a public Web site. Any Portland consumer can review the opinions about a physician.

My physician colleagues chafe at the last question, "What is your doctor's skill in finding and recognizing problems?" They ask, "How could a patient evaluate me for technical skill?" My answer is that two studies from the 1980s filmed several patient-physician visits. Physicians and consumers were asked to view the tapes and provide their assessment of the physician's skill. There was complete correlation between the doctors and the consumers. Simply put, consumers can assess physician skills accurately, making the survey a valuable source of information.

DoctorQuality, a new company from Philadelphia, takes this idea one step further. It begins by asking physicians to confirm that they adhere to specific guidelines of care for specific conditions. If they agree, they are enrolled with DoctorQuality. After patients see their doctors for one of those conditions, DoctorQuality sends surveys to the patients asking if the doctors actually did everything the guideline recommended. Patients identify all of the procedures the doctors performed and those that were omitted. Data are aggregated and available for consumers to view.

The DoctorQuality site tells consumers if doctors really do what they say they will do. I think we all know that reality; most physi-

cians omit significant numbers of procedures with each visit. Imagine that you are a diabetic patient. You can scan several endocrinologists' data to see which ones are the most thorough with blood chemistries, eye exams, foot exams, etc.

Profiling information about technical performance also is available for Medicare data sets. Five sites that do an excellent job of making this information consumer friendly are www.Healthgrade.com; www.Selectqualitycare.com; www.Doctorquality.com; www.Subimo.com; and www.BestDoctors.com. Most of the information is about hospital performance—the data are not granular enough for physician performance, but these companies are on several insurance companies' Web sites. These sites aren't intuitive. When I asked my 15 year-old daughter to rank five hospitals for competence in heart valve surgery using the [Selectqualitycare.com](http://www.Selectqualitycare.com) site, it took her only two minutes. She knows nothing about medicine, but she knows a lot about buying on the Internet; however, my 78-year-old father couldn't get through the process—even though he sends e-mails and he's had a heart valve replacement.

Figure 17.2 depicts a sample data set from [Selectqualitycare.com](http://www.Selectqualitycare.com). These are data you would find doing an analysis of hysterectomies in the Minneapolis region. I asked the site to rank five hospitals based on mortality, patient volume, favorable outcomes, time in the hospital, and cost. The site allowed me to weight these criteria, and I gave no weight to time in the hospital. Within a few seconds, the system finished the ranking. I would argue that there are consumer reports available at least on some procedures and some diseases on various hospitals based on sites like these.

These data raise one other point—quality usually pays. Figure 17.3 displays the same data using bar graphs for cost and showing the quality ranking as a number in the bar. In this figure, St. Cloud Hospital is



Figure 17.2

Hysterectomy Outcomes

Key Measures in Order of Importance	Abbott-Northwestern Hospital	Fairview Southdale Hospital	Rochester Methodist Hospital	St. Cloud Hospital	United Hospitals
Money	4	3	2	1	5
Mortality rate	-	-	-	-	-
Patient volume	2	4	1	5	3
Unfavorable outcomes	1	2	2	5	2
Time	4	2	1	5	3
Weights average rank:	2.00	2.50	1.50	3.00	2.75
Overall rank:	2 nd	3 rd	1 st	5 th	4 th

Source: selectqualitycare.com



Figure 17.3

Quality Pays (Usually)

Hospital	Average Cost	Rank
St. Cloud Hospital	\$7,381	5
Rochester Methodist Hospital	\$7,678	1
Fairview Southdale Hospital	\$10,762	3
Abbott-Northwestern Hospital	\$11,612	2
United Hospitals	\$15,645	4

the least expensive facility, but it also had the worst statistics for volume, mortality, and complications. This graph supports the conventional wisdom that you get what you pay for—or that quality costs money for medicine. But it also discloses that Rochester Methodist, the hospital for the Mayo Clinic, costs only \$300 more per procedure but has the highest patient volumes and the best outcomes. For a mere \$300 extra, I can get superb care and I'm still in the lowest price bracket. Abbott Northwestern has the second-best quality rating behind the Mayo facility, but it costs \$4,000 more per procedure than Rochester Methodist. Quality can be very inexpensive—that needs to be the new conventional wisdom.

Consumers need a reason to use this information. In a conventional HMO or a standard PPO, the consumer's cost is the same whether they use Rochester Methodist or Abbott Northwestern; they make the same co-payment for each facility. In fact, the Abbott facility is more convenient for Minneapolis residents. The employer and insurer, however, pay more than 50 percent more for the same service. In a consumer-directed model with some responsibility for cost sharing, this information would be very useful for planning.

■ Data Problems

To return to the original question of whether there is enough knowledge and information for consumers to participate in consumer-directed plans, my answer is yes and no. We have oceans of data, but they are not organized into useful information. Diabetic patients with a complicated heart disease cannot simply ask a site to direct them to the best doctor to treat diabetes for patients who have complicating heart disease. If I type the word “diabetes” into the Google search engine, I am directed to visit 1.8 million Web sites.

Perfection is the enemy of progress. We

shouldn't prevent these early innovative businesses to stop offering data until they are perfect. If I'd been asked to discuss this topic two years ago, I wouldn't have any examples. For this article, I had to limit them to a manageable number.

I have some additional thoughts about information for consumers. Too many approaches are not using the physician as an asset. DoctorQuality is an excellent example of leveraging the information with the provider. They pro-actively engage physicians with their guideline review process and give them information about compliance that they can use in their practices. DoctorQuality allows physicians to use their patients to improve their practice by measuring the omissions. I think that's a far more intelligent approach to the area of performance measurement than trying to shove it down somebody's throat. It is not a surprise that the American Medical Association is condemning the five Web sites that measure technical competence.

■ Conclusion

You can't force every consumer to use these information sources. When my father was facing a heart valve replacement, he asked me to get the relevant information for him; however, my mother obtains her care from wherever her primary care sends her. She doesn't care about the data. Neither approach is wrong.

We shouldn't create systems that force people through data they won't use, but we do need to build systems that allow consumers the flexibility to use information if they desire. As to whether union members want this freedom or responsibility, I recently entertained a school superintendent who is a union member who was fuming about the fact that her health plan wouldn't let her make choices on some upcoming health care issues. She did not want someone else making the decisions for her. We need to let her have that choice.



The Role of Public Policy

Consumer-Driven Health Care and
Public Policy: Chapter 18

Consumer-Driven Health Care and Public Policy

By Charles K. Kerby, III
Mercer Human Resource Consulting

■ Introduction

My 24 years of experience working on legislative and regulatory issues in Washington, D.C., have taught me that changing policy is not easy. In terms of health care, a number of impediments arise out of the current context for health policy change—such as the amount of funds involved; the variety of view-points among lawmakers, constituents, and advocacy groups; and the fragmented constituencies for change.

■ Impediments to Legislative Changes

Health benefits are one of the largest single federal tax expenditures today—about \$110 billion per year. If we are to implement policy changes that will create more revenue losses, we have to find a way to pay for them. For example, if we want to expand medical savings accounts (MSAs), we need to find a way to pay for the resulting loss in federal revenue.

Unfortunately, the budgetary system in the country hasn't yet reached the point where we can essentially deficit-spend in ways that allow us to do some research and development in the current year so that we might achieve a return on investment for three, five, or seven years down the road.

Another major impediment to legisla-

tive change is that lawmakers don't hold common views of what works in the health care arena. In the U.S. House of Representatives, for example, extraordinarily diverse views are reflected in the positions of two very senior members. Rep. John Dingle (D-MI), has introduced his father's national health insurance bill for many, many years. The contrasting proposal of Rep. William Thomas (R-CA) would essentially try to take employers out of the health care marketplace and provide us all with individual tax credits to purchase insurance.

The health industry, a major player obviously, would like everyone to have health insurance—as long as the industry doesn't have to lose any revenue in the process.

Employers currently are providing health benefits coverage to around 165 million people, according to Paul Fronstin's article in the December *Issue Brief* published by the Employee Benefit Research Institute. Medicare now provides health coverage to about 40 million people, and Medicaid provides coverage to another 30 million, while the 2001 Census Bureau's Current Population Survey (CPS) indicates that 38.4 million people are uninsured.

In short, the constituencies for change are highly fragmented, we lack consistency of views, there is no consistent approach, and many groups advocate different things.

■ The Pitfalls of Regulations

We also want to be careful about what we seek. Do we really want policy change? Do we really want additional laws in Washington? Laws have some good characteristics, particularly those that provide uniform rules under which market systems can operate. But legislation coming out of Washington may also create static environments. It can lock in current plan designs, current technology, and current research and development.

The best example of this is the Medicare program. Here we are, 37 years after the law was enacted, and we are looking at a health plan design that is based on the 1965 status quo. Once you enact legislation, you create a more static environment, and it becomes much more difficult to change.

In addition, when you create regulations, you create a bureaucracy to handle them. Congress passes the law, but somebody in the executive branch has to write regulations and enforce them. And you activate constituencies that prior to a law being passed might have been quiet or relatively silent. Constituencies can become empowered—even enriched—by particular legislative efforts.

I was fortunate enough to work with Arnie Millstein as he went through his 18-month quest to try to identify some of the leading-edge factors that could make consumer-driven health plans work best. As part of that process, we tried to identify a set of policy changes that might help activate more efficient consumer selection of efficient providers, effective treatment options, and care management, and we identified four core legislative changes, which are discussed below.

■ Effective Tax System Incentives

One necessary and effective core legislative change would be to make more effective use of the tax system. If we start using the tax

system as a way to push plans and providers in certain directions, we can enhance the incentives, the information, and the infrastructure identified by Michael Parkinson.

The first change we suggest is to look at the tax system and start to link tax-favorable treatment to contributions that satisfy specific criteria that might make consumers choose more wisely. But how do we give consumers the ability and how do we ask the health plan system and the providers in this country to move in a direction where we can provide information and the necessary tools to consumers to make more economic health care choices? How can we devise a system that allows employers and other plan sponsors to provide additional incentives to those sickest 5 percent to 10 percent of the population?

We have seen over and over again that the people at the high end of the utilization scale present all of us with an opportunity to:

- Identify their health status early.
- Get them into disease and care-management programs early.
- Help them take a very activist role.

We should use the tax system in a way that encourages us to spend more money on this population, and we should not be constrained by discrimination rules that say you must spend the same amount of money on everyone.

Can we devise a system that would allow us to take some of these individual health account ideas that have been discussed and confirm the favorable tax treatment for those accounts? There is some uncertainty right now. But if we think this idea is meritorious, then we ought to clarify the tax treatment of these accounts. If carry-overs are permissible, we ought to say that they are permissible.

In addition, we think portability is a key factor. If you have an account-based system in which value will be created over time, those accounts ought to be portable. You

ought to be able to take them with you—whether you are working for yourself or are unemployed—to carry you through periods where you might need additional protection, such as like periods when you may need to pay COBRA premiums. There are some real gaps in coverage now if you exit the work place prior to being eligible for Medicare.

■ Qualification Requirements

A second core change is to put pressure on health plans to include some necessary features that will drive the entire system in the direction that we would like to see it go. Prior to the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), only a very short list of qualification requirements applied to retirement plans—perhaps six or seven different requirements. With the enactment of ERISA and subsequent legislation, that list has now mushroomed to something like 32 different requirements, all of which are highly detailed and highly complex.

While some might say that if we attempt to regulate health plans in the same manner, employers will drop out of the system and health plans will go bankrupt. The point of the analogy is that we still have plenty of retirement plans in the country. We have devised a retirement system that builds in some additional protections, and we have more coming. But it does represent a way in which to push a system in a particular direction.

Another idea is to establish minimum qualification requirements for health plans that require them to adopt some of the high-

yield features discussed previously.

Another critical element currently missing is public performance reporting standards. We have a lot of financial information in this country for publicly held companies, and the major for-profit health plans that have shareholders are required to report their financials in accordance with generally accepted accounting principles. We do not have similar standards for providers either on the physician side or on the hospital side that would require similar reporting of quality measures, including customer satisfaction and affordability.

A lot of information has been developed through provider performance profiling software. One idea to consider would be to have the Medicare program take some of the enormous data provided and start reporting fairly detailed efficiency and quality ratings for providers. Would that be a successful mechanism for jump-starting the kind of performance reporting that I'm talking about?

■ Conclusion

Along with the core changes described above, another important legislative change would be to bring Medicare and the other big governmental programs, especially Medicaid, into this discussion. If we can provide incentives for those systems similar to the incentives we would like to see developed for the employer-based system, we think they can provide a huge impetus toward the critical mass that we might need to accomplish the paradigm shift under discussion.



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