Chapter 29

Managing Health Care Costs

Introduction

Health care spending in the United States has grown rapidly, increasing from $73 billion in 1970, or 7 percent of gross domestic product (GDP), to $2.0 trillion, or 16.0 percent of GDP, in 2005.[1] Expenditures are projected to reach $4.1 trillion, or 19.6 percent of GDP, by 2016. Factors that have contributed to increased spending on health care services include the aging of the population, the comprehensiveness of insurance, increased income of employees, differential productivity growth from medical care, high administrative expense, provider-induced demand, and technological innovation (Newhouse, 1992, and Cutler, 1995).

In the United States, about two-thirds of the civilian population under age 65 received health insurance coverage through employment-based plans in 2005. Employers' contributions to employment-based health plans and Medicare on behalf of employees and their insured family members have risen dramatically, reaching nearly $439.6 billion in 2005, up from $12 billion (2 percent of compensation) in 1970 (Cowan and Hartman, 2005).

The use of cost management strategies in health care became more prevalent during the mid-1990s as a result of health care cost increases during the late 1980s and early 1990s. Employers have made sweeping changes in the operation of employment-based group health plans. While such measures are designed to contain individual employment-based group health plan spending, they also serve the broader goal of managing the increase in overall health care costs.

Changes in benefit design are the most often used means of managing health care costs because they are the easiest for employers to implement and manage. Design changes most commonly initiated by employers include imposing or increasing cost-sharing requirements such as deductibles, coinsurance, and the employee contribution to the premium; adopting utilization review (UR) techniques requiring that tests be performed prior to hospital admission and that approval be obtained before covering certain prescription drugs, i.e., drug utilization review (DUR); and requirements that plan participants and beneficiaries use lower-cost alternatives such as ambulatory surgical care, treatment in extended care facilities, home health and hospice care, case management, telemedicine, and wellness or health promo-

[1] Source: http://cms.hhs.gov

tion programs. Many employment-based group health plans also use demand management programs as an approach to provide health care benefits that are designed to help beneficiaries receive the appropriate level of care at the appropriate time (e.g., thru a 24/7 nurse advice line program).

Other plan design techniques used to manage health care costs include coordination of benefits (COB) and subrogation clauses. A COB provision regulates payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. A subrogation procedure allows the health insurance plan to recover from a third party when the action resulting in medical expense (e.g., auto accident) is the fault of another person.

In addition to these changes within the framework of existing employment-based group health plans, some employers have initiated more sweeping reorganizations of their health insurance benefits. Other employers have more fundamentally reorganized their plans within the framework of flexible benefit or cafeteria plans. Employers have adopted flexible benefit plans to induce employees to share more of, and take greater responsibility for controlling, their health care costs.

Most employment-based group health plans have shifted plan participants and beneficiaries into managed care plans: 93 percent of workers with employment-based health plans were enrolled in some form of managed care in 2006 (Claxton et al., 2006). As recently as 1994, traditional indemnity plans were the most commonly offered type of health plan among employers that offered health benefits. As fewer employers offered traditional indemnity plans, participation in these plans declined and participation in managed care plans increased. In 2006, only 3 percent of employees participating in a health plan were enrolled in an indemnity plan, compared with 73 percent in 1988. During the same time period, enrollment in managed care plans increased from 27 percent to 93 percent. In addition to the decline in participation, the structure of fee-for-service indemnity plans has changed as employers and insurers added managed care features to these plans. Enrollment in health maintenance organizations (HMOs) grew from 9.1 million in 1980 to 33.6 million in 1990, a 269 percent increase. However, starting in the 1990s, the growth rate in HMOs has slowed and enrollment in the most restrictive types of HMOs has even declined.

One reason for the decline in staff and group model HMO enrollment may be the lack of flexibility afforded the employee. Employers offer health benefits as a form of compensation in order to recruit and retain qualified employees. Locking employees into a plan that limits choice and perhaps reduces their satisfaction may be less costly but may undermine an employer's recruitment and retention goals. Under independent practice association (IPA) and mixed-model HMOs, employees can switch to a plan with greater flexibility, and in many cases, retain their family physician or specialist.

A second reason for the decline in staff and group model HMO enrollment may be that employers' disappointment with expected cost savings has caused them to experiment with other plan types. And yet another reason may be that staff and group model HMOs were not as aggressive as IPAs and network plans at increasing market share because they were more likely to be owned by less aggressive nonprofit organizations.

Health Plan Type

Health plan designs can be arranged in a variety of ways according to the extent of financial control the payer (e.g., trust or employer) has over such plans and the extent of control such plans have over patient choice. At opposite ends of the spectrum is the traditional fee-for-service indemnity plan, with no managed care elements, and the staff model HMO, with the most. Between these two extremes lie fee-for-service plans with managed care features (known as managed indemnity plans), preferred provider organizations (PPOs), and HMOs that permit greater choice of physicians. Finally, as health care delivery systems have evolved and employers have become more involved in the design of corporate benefit plans, point-of-service (POS) plans have developed that combine elements of the HMO and PPO in an attempt to balance freedom of choice for the employee and financial control for the employer.

Health Maintenance Organizations—HMOs' basic functions are to provide comprehensive health care services to subscribers, contract with or employ physicians and other health care professionals who will provide the covered medical services, and contract with hospitals to provide covered hospital care (a few HMOs own and operate hospitals). Conventional insurance plans simply reimburse health care providers, usually under a fee-for-service arrangement. However, commercial insurers, self-insured employment-based group health plans, and Blue Cross and Blue Shield plans are increasingly using PPO and other managed care arrangements to encourage employee use of certain designated health care providers.

Until the mid-1980s, the typical HMO model was a staff or group model. The recent expansion in HMOs has been dominated by network model and IPA HMOs. Currently, there are five different HMO models: staff model, group model, IPA, network model, and mixed model. Each of these models differs with respect to its rules for patients and the financial incentives it imposes on health care providers to limit services and costs:

- *Staff Models*—In a staff model HMO, the health plan owns its health care facility and employs health care providers on a salaried basis. Patient choice is limited. Enrollees are restricted to network providers and are required to see a primary care physician first, who then refers

them to specialists within the HMO when it is considered medically necessary and appropriate.

- *Group Models*—A group model HMO is similar to a staff model HMO, but the group model HMO contracts with a single physician group to provide services to the HMO participants. The physician group is managed independently and is usually paid on a capitated basis. Group model HMO providers of health care usually spend most of their time serving HMO patients, but they may spend some time in private practice.
- *Independent Practice Associations*—IPAs are groups of physicians in private practice who provide services to HMO participants, but they primarily provide services to patients not enrolled in an HMO. In recent years, IPA providers working with HMOs have increasingly been paid on a fee-for-service basis. During the mid to late 1990s, many IPA HMOs reimbursed primary care physicians (PCPs) on a capitated basis. The advantage of an IPA is that contracting with physicians practicing in their own offices allows the HMO to offer services in a broader geographic area, requires less capital investment than a staff or group model HMO of similar size, and generally offers employees more choice among providers.
- *Network Model*—In the network model, HMOs contract with two or more independent physician groups that often provide specialty services as well as general services. The HMO typically pays these groups on a capitated basis, but these groups also spend some time in private practice on a fee-for-service basis.
- *Mixed Model*—A mixed model HMO will initially adapt one type of model, such as a network model, and then expand either its capacity and/or its geographic region at a later date by adding another type of model, such as an IPA.

The financial incentives within a health plan can affect physicians' decision-making process, how that process ultimately affects patients, and the cost of providing health care. Within the network-based models mentioned above, reimbursement schemes have evolved from a salaried or capitated basis to one in which physicians share less of the risk associated with treating patients. In addition, some HMOs use withholding accounts[2] and bonus programs based on quality of care or productivity to reimburse providers.

[2] In a withholding account arrangement, a percentage of the payment is withheld until the end of the year. Premiums are set aside in a referral fund that is used to pay for the services of primary care physicians, specialists, hospitals, and outpatient testing. If the referral fund runs a surplus, physicians receive the amount that accumulated in the withholding account. If the referral fund runs a deficit, nothing is returned to the provider.

Preferred Provider Organizations—PPOs are currently the dominant type of health plan. A PPO is a panel of health care providers who individually contract with insurance companies and/or employers to offer health care benefits to their members. PPO network physicians generally do not assume financial risk for the provision of health care services. Typically, PPOs reimburse their physicians on a negotiated fee schedule or a discounted fee-for-service basis. PPO plans choose physicians to fit geographic and specialty areas, often in response to employer requests. Enrollees can receive health care services from PPO (or in-network) providers or non-PPO (or out-of-network) providers, but they face higher cost-sharing requirements when receiving care from a non-PPO provider. While the PPO structure differs greatly from the HMO structure, they both combine three broad cost management strategies: a limited provider panel, negotiated fee schedules, and medical management.

Exclusive Provider Organizations—An exclusive provider organization (EPO) is a plan that limits coverage of nonemergency care to contracted health care providers. It operates similarly to an HMO plan but is usually offered as an insured or self-insured product. Typically, the plan only allows patients to choose medical care from network providers. A patient who elects to seek care outside of the network will usually not be reimbursed for the cost of the treatment. An EPO uses a network of providers and has primary care physicians serving as care coordinators. Typically, an EPO offers physicians financial incentives to practice cost-effective medicine by using a prepaid per-capita rate or a discounted fee schedule, and by providing a bonus if they meet cost targets.

Point-of-Service Plans—POS plans are essentially HMOs that allow participants to choose a provider from outside the list of network providers. Enrollees are required to select a primary care physician. The enrollee's cost-sharing responsibilities vary with the choice of provider—the highest cost sharing is associated with the use of non-network providers. The single major difference between POS plans and HMOs is that POS participants can seek non-network treatment and receive benefits from non-network providers as long as they are willing to accept higher cost-sharing responsibilities. Typically, the costs associated with receiving care from the "in-network" or approved providers are less than those incurred when care is rendered by noncontracting providers. Or the costs are less if the care is received from approved providers in either the HMO or PPO rather than "out-of-network" or "out-of-plan" providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.

One of the distinguishing features of a network of providers is the way providers are selected. Some plans evaluate candidates against a set of predetermined selection criteria. Providers must be able to achieve the

network's goals for cost control and quality improvement by successfully managing health care delivery. In addition, most networks require providers to agree to accept UR procedures, refer patients only to other providers in the network, and accept the network's reimbursement procedures. Many networks also monitor their providers' practice patterns in order to identify unjustifiably high costs and then alter provider practice patterns through education and financial incentives.

Some employment-based plans use objective information provided by accrediting organizations on the quality of care to identify potential providers for their network. Employers contract with specific networks of health care facilities for high-cost procedures such as open-heart surgeries and transplants. These facilities, commonly known as Centers of Excellence, are selected according to a number of criteria, including experience, efficiency, effectiveness, and outcome measures such as mortality and morbidity rates. Providers have challenged the use of unadjusted outcome measures as criteria for selection because providers with sicker patients will appear to be of poorer quality. In response, health care organizations have developed systems to analyze medical records that attempt to adjust for the severity of case mix. The outcomes achieved by physicians and hospitals can potentially allow health plans and plan sponsors to objectively compare and assess the quality and cost effectiveness of care. Selectively contracting with providers using objective criteria such as these begins for the first time to directly reward providers for low-cost, high-quality health care. This may eventually lead to a reimbursement methodology that rewards population health improvement outcome as opposed to the current system in which rewards tend to be based merely on the amount of service provided.

Consumer-Driven Health Benefits

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). Terms such as *defined contribution, consumer-driven, and consumerism* have been used to describe a range of potential health benefit options available to employers. These terms generally refer to programs in which employees are intended to be treated more as *direct purchasers* of health coverage and health care services rather than as the *indirect beneficiaries* of purchases made by the employer. It is assumed that they will be more prudent purchasers and will be more satisfied if they make their own choices rather than having someone else choose for them.

Employers are interested in these health benefits for a number of reasons. First, they 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 for providing the benefit. Second, many employers sponsoring health plans are concerned that new restrictions or laws will entangle them in litigation. Employers could distance themselves from health care coverage decisions by limiting their involvement to only the contribution amount for health benefits and not 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.

Some 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. 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 employees can choose, as many companies now do. At the other extreme, employers could simply give employees an increase in cash wages and not offer any health plans, allowing the employees to determine how best to spend the money on health insurance and health care services. This section explores the spectrum of health benefit options—of which some are new and are being used, others are not being used, and still others have been used by employers for a number of years—and outlines the issues involved with these options.

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 among them.[3] An employer may offer an HMO, PPO, POS, and consumer-driven health plan (CDHP), allowing employees to choose how they prefer to have the benefits administered, the size of the network of providers, the ability to receive benefits for health care services outside the network, out-of-pocket payments, and the level of premium contribution. Essentially, the employer chooses what plans to offer the employee, who then chooses the plan that seems best.

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

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 in 1997 (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 of picking the best available benefits. According to findings from the 2002 Health Confidence Survey, 46 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 17 percent were not too or not at all confident. In contrast, 37 percent were not too or not at all confident that they could choose the best available health insurance for themselves (Employee Benefit Research Institute et al., 2002).

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 Claxton et al. (2006), among firms offering health benefits in 2006, 51 percent of covered workers had one plan type; 31 percent had two plan types to choose from; 18 percent had three or more plan types to choose from. Among employees in small firms (3–199 workers), 80 percent had one plan type; 19 percent had two plan types to choose from; just 2 percent had three or more plan types to choose from. In fact, some large employers and employer purchasing groups, such as the California Public Employees' Retirement System (CalPERS), have cut back on choice of health plans.[4] Employers are making most of the choices for employees by deciding which insurance plans to offer and which benefits to cover in these programs, from the universe of choices available to them. In essence, the employer provides the employee with only "residual choice" to decide in which plan to enroll. Employees might have a greater

[4] See www.calpers.com/index.jsp?bc=/about/press/archived/pr-2002/april/newhealthrate.xml for additional information on CalPERS.

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. To the degree that plans selectively contract with health care providers, employees and their families may have to change doctors when they change health plans. Employees sometimes forego job opportunities that could potentially increase their productivity, and rewards, in order to preserve existing health insurance benefits—a situation referred to as "job lock."

There is another way to examine the impact of lack of health insurance portability. The patient-provider relationship may be disrupted if a health care provider leaves a network, forcing employees to change doctors even if they did not change their job or their health plan. The patient-provider relationship may be less of an issue today than it was in the recent past[5] 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 may result in more workers with *some* health insurance coverage that provides less comprehensive benefit options, such as high-deductible plans; is more affordable; and leads more employers to offer benefits and more employees to take health benefits when they are offered.

A disadvantage of this approach is that healthy employees may be the only ones who choose the less comprehensive benefits, resulting in adverse

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

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 gained from choosing a less comprehensive benefit package and use them when they do need health care services, current tax law does not allow them 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, their savings may not materialize if only non-users of health care services sign up for less comprehensive coverage.

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

Tiered Provider Networks

To give employees more choice among types of health benefit arrangements and health care services, while at the same time exposing them more directly to the cost of those benefits and services, a few employers have turned to, and many others are considering, tiered networks for hospital and physician services. After a couple of years of experience with tiered co-payments and networks for prescription drug benefits, insurers and employers have begun to see the value in tiered networks for physician and hospital services as well. The impetus for tiered hospital networks came from the increased bargaining power that hospitals gained as the number of hospitals and hospital beds declined and the patient population grew. According to Robinson (2003), some hospitals are now willing and able to walk away from contracts with insurers unless reimbursement rates are increased and utilization review constraints are decreased. In fact, according to the American Hospital Association, the average number of managed care contracts per hospital declined between 1997 and 2001.

Under a tiered provider network benefit structure, employees pay different cost-sharing rates for different tiers of providers. For example, a provider may be in the lowest-priced tier if it is the lowest-cost provider, and may be in the highest-priced tier if it is the highest-cost provider. Tiers could also be assigned based on the size of the discount obtained from the provider. Quality measures may also be used to assign providers to various tiers. Tiered provider networks are essentially a variation of a long-standing practice of providing one level of benefits to employees who use in-network providers and another level of benefits for use of out-of-network providers.

Tiers make cost differences among providers more transparent to consumers and are a way to expose consumers to the actual cost of services, allowing them to decide whether a higher-cost provider merits the additional out-of-pocket expense (Yegian, 2003).

Insurers and employers can use tiers to distinguish among different types of hospitals or providers. Providers could be tiered according to the prices that they charge or the quality of care that they provide. One 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. A 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.

Rather than threaten to exclude a hospital entirely from its health benefits program, an employer can offer tiered provider networks as a "next-generation" way to leverage favorable cost experience from hospitals. Since employees have the option to use the more expensive hospitals and providers (albeit under less favorable payment conditions for the employee), this type of approach may cause less friction with employees and providers than entirely excluding providers from a plan. Under a tiered provider network benefits package, health care providers are typically separated into different tiers, with the tiers being based on some combination of cost and quality.

For instance, under one scenario, tier 1 providers, thought to have the lowest cost and highest quality, would have the lowest cost sharing for health care services, while tier 2 would have much higher cost sharing. Differences in cost sharing could be applied to either per-day or per-visit copayments, overall coinsurance, or even deductibles. For example, with hospital tiers, employees may face a $0 per day copayment for tier 1 hospitals and a $200 per day copayment for tier 2 hospitals. Alternatively, employees may face 10 percent coinsurance for tier 1 hospitals and 30 percent coinsurance for tier 2 hospitals, or they may face no deductible for tier 1 hospitals and a $1,000 deductible for tier 2 hospitals.

The tiered provider network concept is relatively new for hospital services, but employees may already be used to it, especially in preferred provider organizations (PPOs) and point-of-service (POS) health plans, which subject them to lower out-of-pocket expenses when they choose in-network doctors (or hospitals) over out-of-network doctors (or hospitals).[6] However, from the point of view of insurers and employers, tiered provider networks are fundamentally different from the combined in-network and

[6] Traditional HMOs also provide a form of tiered benefits. HMOs typically provide very comprehensive coverage when employees use in-network providers. In contrast, there are usually no benefits when employees use unapproved out-of-network providers.

out-of-network benefit structures. Under a tiered provider network, all providers can have a contract with the insurer or health plan. The terms of the contract may differ depending upon the cost of providing care and other factors. In contrast, under a PPO or POS plan with out-of-network benefits, out-of-network doctors do not have a contract with the insurer or employer. This means that payers are billed at and responsible for paying prevailing charges at different benefit levels.

Employers and insurers are particularly interested in tiered networks to control spending on hospital services. While for many years hospitals had a major surplus in the number of available beds, today there is much less excess capacity because of consolidation, fewer hospitals, fewer beds, and population growth. As noted above, hospital bargaining power over prices has increased, resulting in higher costs to insurers and employers, and, ultimately, higher premiums. Some hospitals have used their clout, especially those in small markets dominated by a single facility or in large markets dominated by hospital systems, by threatening to walk away from contracts with managed care plans (Robinson, 2003).

Tiered provider networks allow employers and insurers to include all or most hospitals and health systems in their plan, thereby allowing them to move away from limited provider networks that are characteristic of many traditional HMOs. In the 1990s, employers attempting to attract and retain workers in a tight labor market characterized by increasing wages moved away from relatively more restrictive to less restrictive managed care plans. Since tighter-managed HMOs had to compete against more flexible PPOs, many of the more tightly managed plans opened their networks to more providers. In many areas, distinctions between plans could no longer be made by comparing the selection of providers in each network, since providers were contracting with nearly every network. Tiered provider networks are one way to make distinctions between providers when all or most have network contracts.

Similarly, tiered provider networks could also allow employers and insurers to address their concerns about any-willing-provider (AWP) laws. In a number of states, providers cannot be prohibited from joining a network if they are willing to accept the terms of the network. Tiered provider networks would allow employers and insurers to make distinctions between providers in states that have AWP laws.

Tiered provider networks can also benefit consumers by giving them more choice of providers, especially when it comes to hospital care. Hospitals formerly not in a network may now be included in the offering, but at higher cost sharing. In fact, one goal of tiered provider networks is to allow consumers to see any provider that they choose, with their out-of-pocket costs determined by their choice of provider.

In some sense, tiers build upon the selective contracting foundation of managed care and HMOs. One of the distinguishing features of a network of providers is the way the network selects its providers. Some networks evaluate candidates against a set of predetermined selection criteria. In the early HMO and managed care models, providers that met the predetermined selection criteria were able to be part of the network. Today, with tiered provider networks, all providers can be part of the network, but within the network, the predetermined selection criteria can be used to determine the providers' tier and, therefore, the consumers' cost sharing.

The introduction of tiered provider networks is part of a larger movement to sensitize employees to the real cost of health care. Many employers expect that consumerism generally will result in a decrease in their own health benefit costs.[7] However, it is unrealistic to expect a decrease in health care costs to occur immediately. Twenty percent of the population accounts for 80 percent of the spending (Fronstin, 2002), and new benefit designs will need to focus on the highest-cost users to have an impact in the short run. It may be found that the tiered hospital network is better than other benefit package changes at controlling costs and utilization in the short run because it targets high-cost users more than it targets the general population. However, as mentioned above, modest out-of-pocket payment differences between tier 1 and tier 2 hospitals may have very little, if any, impact on consumer behavior. In the long run, data and information on prices and quality should be more readily available to the general population, and should begin to affect other aspects of health care utilization.

The extent to which tiering incentives will impact consumers' behavior is still unknown. It is clear that one of the goals of tiered provider networks is to provide financial incentives for consumers to use lower-cost and/or higher-quality health care providers. By exposing members to higher out-of-pocket expenses, they will have more of an incentive to become engaged in the process of provider and treatment selection. This may provide additional pressure on hospitals and physicians to disclose information about costs and performance. However, while there is little evidence that tiering has had an effect on consumer choice between in-network and out-of-network physician care and prescription drug choice, it is unknown how large the difference in out-of-pocket payments would need to be before a significant number of consumers factor price into their hospital choices (Robinson, 2003). In fact, the difference in out-of-pocket payments may need to be substantial to generate changes in consumer behavior because inpatient services tend to be

[7] Mercer Human Resource Consulting (2002) reports that about one-half of employers responding to a recent survey reported that lowering health benefit costs was an important objective for offering a consumer-driven health plan.

price inelastic, although employers may realize some savings even if only a few consumers change their behavior and choose tier 1 providers. Consumers may be constrained by factors other than price from using certain hospitals. They rely heavily on their physicians for treatment advice and may be unwilling to use a hospital in a different geographic region, where their physician does not have admitting privileges, to save a modest amount of money.

It is also unknown how tiering will impact the behavior of providers. Tiered provider networks may result in providers renegotiating contracts if they are sensitive to being in the highest-cost tier. Some providers may view being in the higher-cost tier as driving patients to lower-cost providers and may take steps to renegotiate contracts to become tier 1 providers. Other providers may view being in the higher-cost tier as an indication that they are a high-quality provider and may use that to differentiate themselves from tier 1 providers. Tiered networks for hospitals, if associated with quality information, may also result in increasing physician knowledge about hospital quality differences, which may affect physician affiliations and recommendations of hospitals, thereby improving quality.

Tiered networks may also increase the amount of uncompensated care, such as bad debt and charity care that is provided by hospitals. As consumers' out-of-pocket expenses increase, there may be an increase in bad debt in the form of uncompensated care. Providers, especially hospitals, may look at ways in which they can collect a patient's out-of-pocket payment at the time of service. Hospitals and physicians may respond by reducing the amount of charity care that they provide in order to offset the increase in bad debt.

There may also be less integration of health care for consumers in tiered networks. Presumably, consumers will "shop" based on cost and quality. In some cases, this will mean that consumers will move among providers to contain their costs. This may increase total spending if, for example, consumers do not bring their medical records and the results of prior tests to new providers and those providers request new tests. Health spending may increase and quality of care may decrease if patients have less attachment to providers, and providers either do not know or have a history of a patient's total care and either request new tests or simply need more time to educate themselves about their new patients.

Finally, tiered networks may have unanticipated effects on academic medical centers (AMCs). AMCs provide medical education and training and conduct research on new medical practices and technologies. AMCs also provide health care services to the poor and medically indigent. This care is financed through cross-subsidies from private- and public-paying patients, and is also subsidized by state and local governments. AMCs have in the past provided twice as much uncompensated care (as a percentage of revenue) as nonacademic medical centers (Reuter and Gaskin, 1998). As a

result, AMCs are usually the most expensive source of health care and are unable to compete on price. Tiered networks based on cost will likely place AMCs in the higher-cost tier. This will drive private-pay patients toward lower-cost nonacademic medical centers. In turn, AMCs will see an increase in bad debt and charity care (as a percentage of revenue) and may put pressure on policymakers to increase public sources of financing. Tiered networks that essentially steer private-pay patients away from AMCs may therefore have the effect of increasing taxes, increasing the use of tax revenue for hospital services (at the expense of other services), or causing fewer uninsured patients to receive care, which may cost society more money in the long run.

Account-Based Health Plans

There are a number of accounts that employees and employers can contribute to, using pre-tax dollars, to save money for future health care bills. The theory behind these accounts is that by giving employees more control over funds allocated for their health benefits they will spend the money more responsibly, especially once they become more educated about the actual cost of health services. Prior research has shown that individuals respond to increased out-of-pocket payments by reducing their utilization of health care services, although according to Tollen and Crane (2002), these studies are dated and do not accurately reflect current employee responses to increased cost sharing and less comprehensive benefits. However, a recent study did find that Medicare beneficiaries will forgo medically necessary drugs when out-of-pocket costs for these drugs increase (Adams et al., 2001). This concept is known as *moral hazard*—meaning individuals demand a greater quantity of health care services when health insurance pays for at least part of the cost of receiving care. Whether health spending accounts provide an incentive for employees to consume health care services differently, and reduce the prevalence of moral hazard, is a subject of debate and is discussed further below.

Health Savings Account—A health savings account (HSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Contributions to the account are deductible from taxable income, even for individuals who do not itemize their taxes, and tax-free distributions for qualified medical expenses are not counted in taxable income. Tax-free distributions are also allowed for certain premiums.

HSAs are owned by the individual with the high-deductible health plan and are completely portable. There is no use-it-or-lose-it rule associated with HSAs, as any money left in the account at the end of the year automatically rolls over and is available in the following year. A bank, insurance company,

or other non-bank trustee approved by the Internal Revenue Service (IRS) must trustee the HSA.

HSAs were first introduced by a select number of insurers in January 2004. Employers waited for Treasury Department and IRS guidance (discussed in more detail below) before offering a plan. Many employers began to offer HSAs in 2006, as it was too late for most employers to design and implement a new plan in time for the 2005 open enrollment season during the fall of 2004.

High-Deductible Health Plan—In order for an individual to qualify for tax-free contributions to an HSA, the individual must be covered by a health plan that has an annual deductible of not less than $1,100 for self-only coverage and $2,200 for family coverage in 2008. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,600 for self-only coverage and $11,200 for family coverage, with the deductible counting toward this limit. The minimum allowable deductible and maximum out-of-pocket limit will be indexed to inflation in the future. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services.

Contributions To an HSA—Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum annual contribution is $2,900 for self-only coverage and $5,800 for family coverage in 2008. Future contribution limits will be indexed to inflation.[8]

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.[9] Individuals enrolled in Medicare are not eligible to make HSA contributions, although they are able to withdraw money from the HSA for qualified medical expenses and certain premiums.[10] Individuals also may not make an HSA contribution if claimed as a dependent on another person's tax return.

[8] The maximum annual contribution is actually the sum of the limits that are determined separately for each month. The monthly contribution limit is $^1/_{12}$ of the lesser of the annual deductible or the maximum annual contribution. If an individual first becomes covered by a high-deductible health plan mid-year, the annual contribution is pro-rated, and the monthly contribution limit is based on the number of full months of eligibility. As an example, an individual who enrolled in a plan on July 1 with a $1,100 deductible would be eligible to contribute one-half ($^6/_{12}$) of the annual maximum contribution or $550 to the HSA.

[9] Permitted insurance also includes workers' compensation, tort liabilities, and liabilities related to ownership or the use of property (such as automobile insurance).

[10] Only Medicare enrollees ages 65 and older are allowed to pay insurance premiums from an

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2008, a $900 catch-up contribution was allowed. A $1,000 catch-up contribution will be phased-in by 2009.[11]

Distributions From an HSA—Distributions from an HSA can be made at any time as long as the expense was incurred after the HSA was established. An individual need not be covered by a high-deductible health plan to withdraw money from his or her HSA (although the individual must have been covered by a high-deductible health plan at the time the funds were placed in the HSA). Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax-free. This means that distributions used to pay Medicare Part A or B, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits are allowed on a tax-free basis.

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

Individuals are able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover takes place within 60 days. Rollover contributions from Archer MSAs are also permitted. Earnings on contributions are also not subject to income taxes.

Health Flexible Spending Accounts (FSAs)

Health flexible spending accounts (FSAs) are a type of cafeteria plan benefit, authorized under Sec. 125 of the IRC as part of the Revenue Act of 1978. FSAs can be offered on a stand-alone basis or as part of a larger cafeteria plan, under which participants can choose among two or more benefits and cash. FSAs are perhaps the most well-known type of health spending account. Eighty-one percent of employers with 500 or more employees offered FSAs in 2006 (Mercer Human Resources Consulting, 2007). FSAs are a simple and inexpensive way of allowing employees to use pre-tax dollars to pay for health care services not covered by health insurance. Employers have often introduced or expanded these plans to soften the impact of a benefit reduction, such as an increase in the deductible or co-payments. FSAs do not

HSA. A Medicare enrollee under age 65 cannot use an HSA to pay insurance premiums.

[11] The catch-up contribution is not indexed to inflation after 2009.

need to be paired with a high-deductible health plan. Individuals are eligible for an FSA only if an employer offers it as an option.

Contributions To an FSA—FSAs typically are funded through employee pre-tax contributions. Employees must designate their contribution in the year prior to the plan year. Once made, changes are allowed only for certain circumstances, such as a change in family status, plan cost changes, and plan coverage changes. Contributions to FSAs are withheld in equal amounts from each paycheck throughout the plan year, 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. 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. This rule is a disincentive for a small employer to offer such an account. While there is no statutory limit on annual contributions to a health FSA, employers are allowed to set an upper limit, and usually do so to mitigate losses related to turnover.

Contributing to an FSA not only reduces salary for federal income tax purposes, but also reduces the wages on which Social Security and Medicare taxes are paid. As a result, employees with earnings below the Social Security wage base ($97,500 in 2007) will also pay less in Social Security taxes, after the deduction is made for FSA contributions. Employees at all income levels will also pay less in Medicare taxes. The employer's share of Social Security and Medicare taxes will also be reduced, and this reduction may in fact be large enough to offset the cost of administering the benefit.

Distributions From an FSA—Distributions from an FSA can be made at any time during the plan year or, if the employer has adopted one, a grace period of up to 2½ months following the plan year's end. Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d).

Employees forfeit any money left over in the FSA at the end of the plan year; this is known as the "use-it-or-lose-it" rule. Employers can keep the forfeited funds and use them for any purpose, except that the funds cannot be returned to employees who have forfeited them. Employers typically use the forfeited funds to offset losses or to offset the cost of administering the benefit. The forfeiture of unused funds may partially explain why only 19 percent of eligible employees participate in these plans (Mercer Human Resources Consulting, 2004).

Employees also tend to make conservative contributions when participating. In 2006, the average contribution was $1,261 (Mercer Human Resources Consulting, 2007). 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 in both their participation and contribution levels.

There is some evidence to suggest that much of an employee's FSA election amount is based on foreknowledge of expenditures. Cardon and Showalter (2001) examined 1996 data from an insurer and found that very few accounts had a substantial amount forfeited and also found that participants tend to use their accounts strategically, spending their election amount relatively early in the plan year.

Health Reimbursement Arrangements (HRAs)

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses. IRS Revenue Ruling 2002-41 and Notice 2002-45 (published in *Internal Revenue Bulletin* 2002-28, dated July 15, 2002) provide guidance clarifying the general tax treatment of HRAs; the benefits offered under an HRA; the interaction between HRAs and cafeteria plans, FSAs, and coverage under COBRA; and other matters under current law.[12] HRAs are typically combined with a high-deductible health plan, though this is not required. HRAs can also be offered on a stand-alone basis or with comprehensive insurance that does not use a high deductible. Employees are eligible for an HRA only when their employer offers such a health plan.

HRAs are typically part of a health benefits package that includes comprehensive health insurance after a deductible has been met. As an example, an employer may provide a comprehensive health insurance plan with a high deductible, for instance, $2,000. In order to help employees pay for expenses incurred before the deductible is reached, the employer would also provide a HRA with $1,000 that they would use 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—that is, the difference between the initial value of the HRA and the deductible level. After the employees' expenses reach the deductible, comprehensive health insurance would take effect. Employers can also set up an HRA to allow employees to purchase health insurance directly from an insurer. Generally, distributions are excluded from taxable income if they are used to pay for qualified medical expenses as

[12] See www.irs.gov/pub/irs-utl/revrul2002-41.pdf and www.irs.gov/pub/irs-drop/n-02-45.pdf (last reviewed July 2004).

defined under IRC Sec. 213(d), although employers can place restrictions on the use of an HRA.

Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. 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 often cover certain preventive services in full, not subjecting them to the deductible. 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 cost sharing 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.

High-Deductible Health Plan—There is no statutory requirement that an employee have a high-deductible health plan in order to also have an HRA. However, it is standard practice among employers that an employee must also choose a high-deductible health plan in order to have an HRA. Overall, just 6 percent of large employers offered a plan with an HRA in 2006 (Mercer Human Resources Consulting, 2007), but offer rates were much higher among the largest employers, with 21 percent of those with 20,000 or more employees offering a plan in 2006, up from 7 percent in 2002. Since so few employers offer an HRA, there is not a wealth of data on deductibles and employer contributions. One study examined 128 plans to get a sense of the magnitude of deductibles and contributions and found that the median deductible for employee-only coverage was $1,250 with a $500 employer contribution to the HRA (Mercer Human Resource Consulting, 2007). This study found a median deductible of $3,000 for family coverage with a $1,500 employer contribution to the HRA. The study also found 32 percent of eligible employees enrolled in a CDHP with HRA among large employers.

Contributions To an HRA—HRAs are typically set up as notional arrangements and exist only on paper. Employees behave as if money were actually funding an account, but employers do not incur expenses associated with the arrangement until an employee incurs a claim. By contrast, were employers to set up the HRA on a funded basis, they would incur the full expense at the time of the contribution, even if an employee had not incurred any expenses.

Rollovers—HRAs 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 (at the employer's discretion), 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 HRAs 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, use of health care, and the size of the annual contribution. Funds in the HRA can accumulate tax-free as long they remain employer-provided funds paid out only for qualified medical expenses.

Distributions From an HRA—Distributions from an HRA for qualified medical expenses are made on a tax-favored basis. Employers can also let employees use an HRA to purchase health insurance directly from an insurer. Since unused funds are allowed to roll over, employees are able to accumulate funds over time. Employers can allow former employees to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. Employers are not required to make unused balances available to workers when they leave.

Medical Savings Accounts (MSAs)

A medical savings account (MSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. MSAs were first authorized as a demonstration project under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Employees are eligible to set up an MSA if employed at a firm with 50 or fewer employees. The self-employed are also eligible. Both must be covered by a high-deductible health plan.

High-Deductible Health Plan—In order for an individual to qualify for tax-free contributions to an MSA, the individual must be covered by a health plan that has an annual deductible of between $1,900 and $2,850 for self-only coverage and between $3,750 and $5,650 for family coverage. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $3,750 for self-only

coverage and $6,900 for family coverage. The allowable deductible range and maximum out-of-pocket limit are indexed to inflation.

Contributions To an MSA—Both employees and employers are allowed to contribute to an MSA, but both may not make contributions in the same year. Contributions are excluded from taxable income if made by the employer, and deductible from adjusted gross income if made by the individual. The maximum contribution for self-only coverage is 65 percent of the deductible in 2007. The maximum contribution for family coverage is 75 percent of the family deductible. Contributions cannot exceed annual earned income or net self-employment income.

Distributions From an MSA—Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d). Distributions for premiums for COBRA, long-term care insurance, and health insurance while receiving unemployment compensation are also tax-free.

Distributions for nonqualified medical expenses are subject to regular income tax as well as a 15 percent penalty, which is waived if the owner of the MSA is age 65 or older, becomes disabled, or dies.

Connector/Exchange Model

Under a connector or exchange model, employers would provide employees with a voucher or fixed contribution 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.

Employees would be able to choose from any health insurance offered in the individual market.[13] An employee who chooses an insurance policy that costs more than the voucher value would have to pay the difference. If the employee chooses a plan that costs less than the value of the voucher, the difference could be "refunded" to him or her using after-tax dollars.

There are a number of advantages to a voucher model. It could 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, for instance, by allowing insurers to offer products that exclude prescription drug, hearing, vision, or substance abuse benefits,

[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).

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 of the voucher model 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 is that marketing costs would be higher, driving up the cost of providing insurance to a level comparable with 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 might increase choice of *product*s, a voucher model might 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 could 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 Vermont, for example, one insurer offers HMO coverage in the individual market but two offer traditional indemnity coverage.[14] While employees may not have a large choice of insurers or health plan options in the individual market today, were employers to move toward a voucher model, more insurers might consider offering coverage in the individual market.

The success of a voucher model in providing health insurance coverage to Americans would ultimately depend on a number of factors, including whether the voucher is 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

[14] *Consumer Tips: Shopping for Individual or Small Group Health Insurance in Vermont, January 2007*, published by the Division of Health Care Administration. www.bishca.state.vt.us/HcaDiv/consumerpubs_healthcare/shopping_indiv-smallgroup_jan07.pdf (last reviewed June 2007).

needing health care services may 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.

Massachusetts is currently making available a connector model for small business and other states are considering them, most notably California.

Conclusion

There is strong interest among employers (and unions) in redesigning health benefit programs in response to rising costs. Some employers (sometimes in conjunction with a union) have turned to, and many others are considering, a concept called *consumer-driven health benefits*, a term used to describe a wide range of possible approaches to give consumers more control over some aspect of either their health benefits or health care. 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 the consumer-driven health benefits approach will be measured by its effect on the cost of providing health benefits and on the number of people with and without health benefits.

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