Consumer-Driven Health Care:

The Future Is Now

by Ron Bachman

▶ **Given that managed care seems to have run its course, employers are forced to deal with escalating health care costs by reducing benefits and lowering pay—or are they?** *Why not bring the power of the responsible, informed consumer to health care? Consumer-driven health care offers a new, economically rational direction that can simultaneously address the needs of both employers and employees. This article reviews the factors leading to the need for consumer-driven health care and describes the characteristics and benefits of its current and next generations of development.* ◀

SETTING THE STAGE

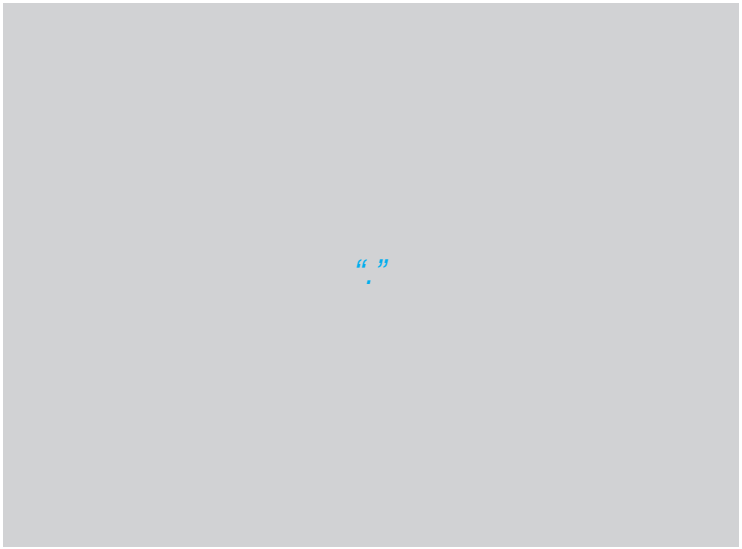
Every decade seems to have produced a transformation in how health care is administered in the United States. In the late 1940s and the 1950s, it was the expansion of employer-sponsored health care. In the 1960s, it was the creation of Medicare and Medicaid and their impact on employer fee-for-service plans. In the 1970s, it was the passage of ERISA and the movement of large employers toward self-insured arrangements. In the 1980s, it was the expansion of managed care and the birth of the HMO. And in the 1990s, it was the shift of risk to providers.

And, true to form, the advent of this new millennium has brought a new paradigm of health care planning.

The traditional managed care plan was based on a supply-control model: control costs by limiting the supply of care. As timely as it may once have seemed, this model nonetheless spawned a jumble of bureaucratic rules and medical protocols (primary care gatekeepers; three-, four- and five-tier prescription drug formularies; outpatient utilization reviews; carve-outs of mental health and substance abuse coverage; arbitrary medical necessity mandates, etc.) to the chagrin of providers and the confusion of patients. Essentially, managed care was grappling with one fundamental, structural problem: how to face unlimited demand in the absence of individual financial responsibility.

But managed care seems to have run its course. As health care costs continue their upward spiral, employers have run out of room. They can no longer move employees into tighter networks with more restrictions and lower negotiated fees. Now they are forced to choose between two equally unpalatable options: reducing benefits (i.e., increasing deductibles, coinsurance amounts and other plan out-of-pocket costs) and lowering pay (i.e., increasing the employee portion of the premium contribution).

But there is another way. Instead of controlling costs by limiting supply, why not focus on limiting demand? Demand for services is limited in every other part of our lives in the form of costs, trade-offs and economic choices. Why not



bring the power of the responsible, informed consumer to health care?

One powerful new tool for accomplishing this is the *health reimbursement account* or HRA. An HRA allows all patients—those with chronic conditions, those with acute care needs and those that are healthy—to participate in value purchasing and to share in the savings created by a rational model based on personal decision making. This concept is elaborated upon below.

The new model of consumer-driven health care transforms the inflationary third-party reimbursement system into a system that puts significant economic purchasing power and decision making in the hands of the consumer. It's about supplying the information and decision-support tools employees need, along with financial incentives, rewards and other benefits that encourage personal involvement in altering health and health care purchasing behaviors.

Ultimately, it's about letting consumers, rather than government or HMOs, control more of their own health care decisions.

THE CORE OF THE PROBLEM: THIRD-PARTY REIMBURSEMENT

Distorted purchasing decisions and uncontrollable inflation will remain problems in health care so long as someone other than the patient is paying the bill. Clearly, using medical services is different from purchasing other consumer goods. But a time of change is upon us; unmanageable cost increases are forcing the issue. Under the current third-party reimbursement system, both the power of the marketplace and the personal decision making by consumers are marginalized; and attempts to modify patient behavior using relatively small out-of-pocket deductibles, copayments and/or coinsurance have had little effect on demand.

Health care costs have been rising faster than employers' ability to increase employee cost sharing. In 1970, about 30% of all health care spending came through out-of-pocket copays, insurance premiums or deductibles. Now, consumer out-of-pocket health care spending totals just 15% of overall health care spending. That means that government and employers have increased their relative share.

Employers are already absorbing higher health care costs, cutting into profits and, during a period of economic slowdown, potentially eroding wages. If the government must take over more health care spending, higher taxes will be required. Clearly, consumers will have to step up and contribute more in some form to get the care they want.

THE BABY BOOMER FACTOR

Another factor driving the emergence of this new model of health care is the demographic tidal wave represented by the baby boomer generation. As this new century unfolds, the boomers' insatiable consumption habits will increasingly focus on health care. Boomers are starting to hear diagnoses from their doctors about cancer, heart disease and diabetes. These demanding health care consumers will expect the best money can buy and will vigorously resist attempts to restrict themselves or their access to care.

During the 1990s, when they were a decade younger, boomers were quite happy with the bargain maternity care, free office visits and low-cost prescription drugs. They flocked to the convenience of HMOs and managed care arrangements that gave them lower out-of-pocket costs and the promise of preventive care. Many did not have the time or the inclination to focus on health care issues. They accepted the networks because they rarely had to use them.

Access limitations helped keep health care inflation low during the 1990s. Members were told, "You can't have those services," "It's not

medically necessary," or "You will have to wait two months for that type of appointment." Managed care organizations used primary care physicians as gatekeepers. To control drug spending, they designed formularies. But such maneuvers are not likely to pass muster with aging boomers.

Controlling supply is no longer the solution. Employers are well aware that demand is unmanageable under traditional managed care. To meet the growing needs of plan members, this nation must replace the supply-control model of health care with a demand-control model.

THE CASE FOR CONSUMERISM

Savings, of course, won't magically appear through the simple act of selecting a new plan. Consumerism is about much more than plan design. Rather, it is about transforming attitudes. Significant work will be needed to make the deep changes in behavior that will lead to secure savings.

Those who doubt the need for a transformation in health care planning should ponder the following questions:

- Is there waste in the health care system?
- Are emergency rooms sometimes used unnecessarily?
- Are prescription drugs used excessively or inefficiently?
- Are disproportionate amounts being spent on rehospitalizations and medical complications as a result of patients' noncompliance with treatment plans?
- Are wellness programs in areas like prenatal care being adequately used?
- Are patients with major conditions like diabetes, asthma and congestive heart failure being treated effectively?
- Are cost/quality measures being used to select health care providers?
- Are some employers essentially subsidizing unhealthy lifestyle choices?

Where there is waste, there is potential for savings. But how does a company achieve them? The consumer-driven approach is to induce behavior change in patients through cost transparency, financial involvement, compliance incentives and education.

HEALTH REIMBURSEMENT ACCOUNTS: FLEXIBILITY AND FREEDOM

One of the most powerful features of the consumer-driven model is the health reimbursement account (HRA). HRAs can be used in several ways. First, they can be used to pay for plan deductibles, coinsurance and copayments—in other words, for plan-covered expenses otherwise paid by the employee with after-tax dollars. These expenses would be processed through the normal plan payment system.

Second, HRAs can be used to cover nonplan expenses that are recognized by IRS as "qualified medical expenses" under IRC Section 213(d). The processing of these payments could be provided by several entities—the insurance carrier, a third-party administrator, Blue Cross/Blue Shield or specialty flexible spending account vendors, many of whom are already familiar with 213(d) requirements and have been aggressively marketing their expertise in handling HRAs. Further, IRS has recently approved the use of electronic processing of claims (with certain safeguards to ensure they are qualified medical expenses), opening the door to the use of cost-effective debit-type cards to draw on HRAs.

The third way of using HRA funds is to pay for health insurance premiums such as COBRA, retiree medical, long-term care and other medical insurance plans.

IRS guidelines give the employer full power to structure how employees may use their HRA

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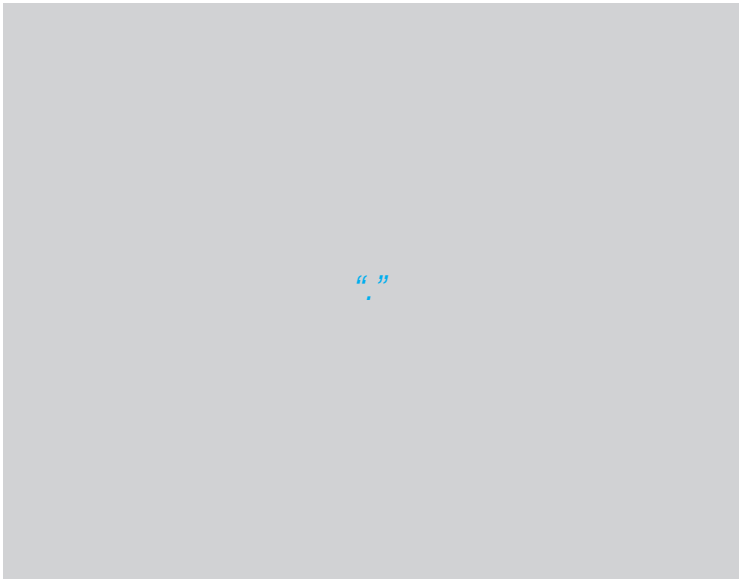


funds. Multiple uses can be phased in over multiple years. For example, an employer may initially restrict HRA funds to deductibles and other cost-sharing features of the medical plan. In subsequent years, or for amounts in excess of some dollar level, the employer may allow extended use of HRAs for nonplan expenses. Whichever way the plan is designed, a consumer-centered health plan is best introduced in stages and, in a clearly communicated way, over a multiyear period.

CONSUMER-DRIVEN HEALTH CARE: THE FIRST GENERATION

The term *consumer-driven* and similar terms such as *consumer-centric* and *patient-directed* evolved out of *defined contribution.* Strictly speaking, *defined contribution* denoted an employer fixing a defined amount of health care benefits it would contribute for an individual employee. To employees, the expression carried with it negative connotations of limited employer support and/or selection in purchasing health care. For many, it was perceived as a take-back from the traditional employer-sponsored financing and it represented a decrease in affordability, quality and access to care and/or coverage.

And although some small employers (those with fewer than 100 employees) have yet to, but soon may, move in the direction of defined contribution plans in their quest to streamline administration and minimize health care expense, many large employers are already moving beyond managed care to embrace consumer-centric plans. They know that they need to be more, not less, involved in health care issues for their employees. After all, employee health and well-being affect not only absenteeism, but also bottom-line issues such as disability, workers' compensation, *presenteeism* (being at work although not fully effective) and productivity. The employers' goal will always be to optimize health care benefits dollars by purchasing plans that balance cost, quality and access. And nowadays consumerism seems to offer the best solution.

The true viability of the consumer-directed health care model was ensured on June 26, 2002. That was the day IRS issued guidelines approving the right of HRA owners to carry over unused amounts from year to year. This ruling may have been the most important change in health care in 25 years. Now, health insurance can be offered with a combination of protection and savings.

First-generation consumer-directed health plans (CDHPs) were focused on basic plan design structure and reducing discretionary expenditures (prescription drugs and physician office visits). But CDHPs can represent much more than a high-deductible supplemental major medical (or SMM) plan with a side savings account affecting only discretionary costs. CDHPs, properly designed and presented, can also have a positive impact on the purchasing behaviors of most patients—including those requiring chronic and acute care and those most responsible for high-volume discretionary expenditures.

Under the basic consumer-driven model, members receive an annual allocation of HRA funds from their employers that they can use to pay for covered services. These allocations generally range from $1,000 to $2,000 per year. Unused funds, as we have seen, can be rolled over into future years and added to the next annual HRA deposit. Once the HRA fund is exhausted, the member must meet a *deductible gap* before being able to receive insured coverage under the plan. First-dollar coverage, however, is usually available for preventive services such as physicals, mammograms and well-child care. HRA funds can be used to fill in plan

deductibles or for copayments, for nonplan IRS-qualified medical expenses and even to purchase other health insurance coverages (e.g., long-term care).

With members responsible for spending their own HRAs, physician gatekeepers and prescription drug formularies may no longer be needed. It is easy to see that these kinds of consumer-driven plans incorporating HRAs have the potential to dramatically change member behavior, along with overall health care expense.

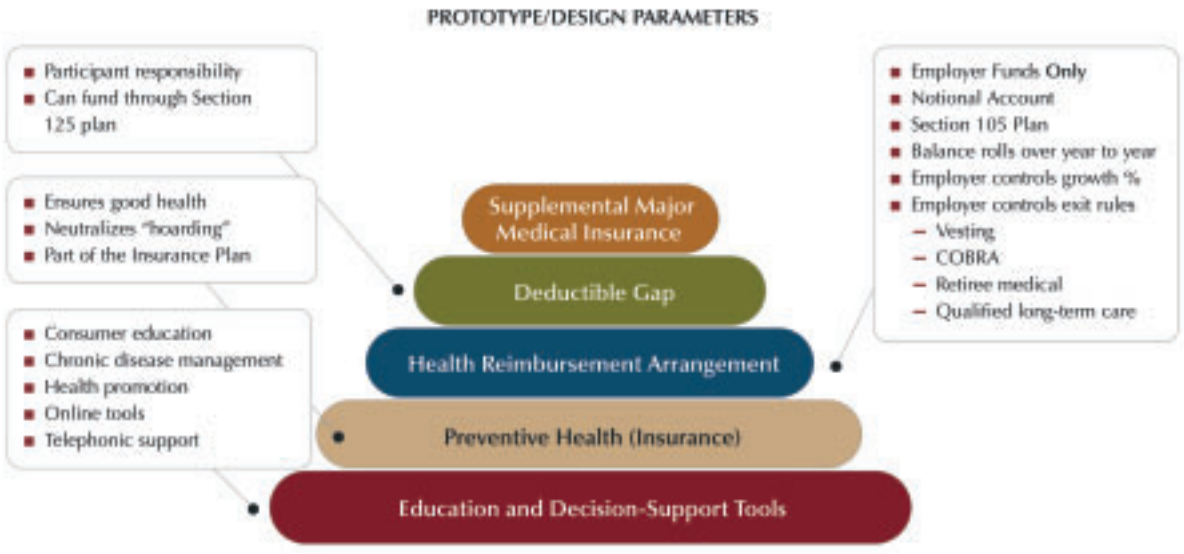
Coverage Beyond the Traditional

Properly designed, consumer-driven plans can also allow patients to deal with underlying health conditions or procedures not covered by traditional insurance. Some services that an HMO would normally consider not medically necessary may in fact be both desirable to a patient and valuable to his or her long-term well-being. For example, a patient with high cholesterol and a family history of heart disease might find it extremely useful to have a CT-heart scan. The scan would produce a calcification number that makes the patient's condition "real." Armed with this benchmark, the patient might be more willing to take healthy preventive steps. In this example, it is easy to see how the long-term value of such a scan—to both patient and insurer—could clearly exceed the short-term savings derived from limiting treatments to clinically defined medical necessity. The point is that, within the guidelines of the system, the patient is in control. And his or her decisions can be made under the same pretax financial reimbursement system allowed for other medical services.

Greater and greater numbers of patients believe in the power and value of alternative modalities. With an HRA, the decision to "go alternative" can be made by the patient rather than by a managed care reviewer. Advocates for proper mental health and substance abuse benefits will be happy to find, too, that patients can access care according to their own prerogatives. For example, with traditional insurance, a patient can get coverage for gastrointestinal problems and musculoskeletal pains. The underlying cause of this physical pain might be stress at home or work. With an HRA, the patient can directly access psychological support services without stigma or denial of coverage. Focusing on the underlying condition of stress rather than paying for symptomatic stomach problems and heart conditions can also be good health care economics.

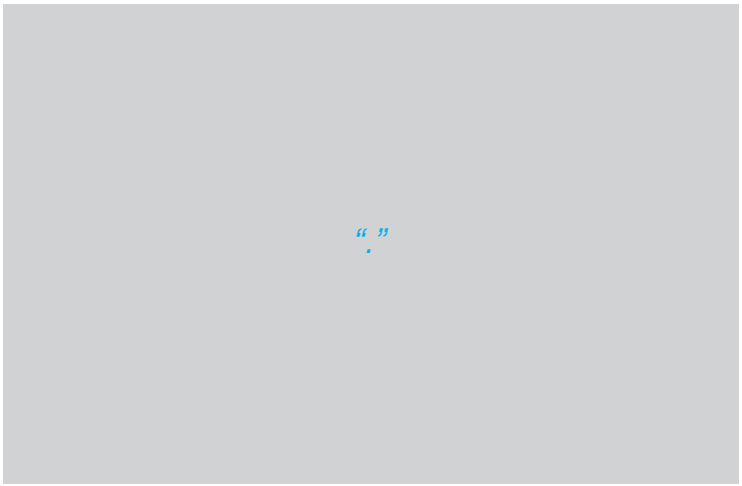
Thus, by carving out discretionary costs and placing more personal responsibility on the

FIGURE



patient/employee, now employers can focus more effectively on high-cost services. At each level of cost, consumer-driven designs can establish a degree of responsibility by creating incentives or disincentives for appropriate use of services.

Are patients ready to handle their own health care decisions in these new ways? Studies show they are. In most studies, they rate themselves more ready than insurers, employers or physicians give them credit for. The consumer-driven



movement is a market-based movement. The case for it is compelling—it is driven both by employers searching for ways to lower insurance costs and by employees desiring to have more health care options available to them.

The Value Proposition

Evidence of savings, though not yet statistically significant, is nonetheless directionally consistent. Experience and rational modeling indicate that a company can expect to save 5-8% annually over the next five years and enjoy a 2% reduction in trend each year over that period. Actual annual savings have in many cases topped 10%.

Example: A company has a stable population of 4,000 employees and annual total health care costs of $20 million. The CDHP provides for a $1,000 HRA with a $1,000 gap deductible. The in-network medical plan reimburses 90% with an out-of-pocket maximum of $1,000. Out-of-network reimbursement is 70%. There is 100% coinsurance for preventive care, including well-child, mammography and prostate-specific antigen (PSA) tests.

Low estimate of savings: 5% × 5 years + 2% × 5 years = 35% of current-year costs.

High estimate of savings: 8% × 5 years + 2% × 5 years = 50% of current-year costs.

In this example, the company can reasonably expect savings from $7 million (35% of $20 million) to $10 million (50% of $20 million) over the next five years. This quick estimate assumes an appropriately designed CDHP benefit structure, an accessible decision-support system, an incentive-based HRA that supports the needed behavior changes in an economically rational way and an effective employee communications effort.

CONSUMER-DRIVEN HEALTH CARE: THE NEXT GENERATIONS

As positive early returns on the CDHPs flow in, a reservoir of creative and increasingly sophisticated new ideas and solutions is accumulating.

The Second Generation: Focusing on Behavioral Change

According to the Centers for Disease Control, more than 90 million Americans live with chronic illnesses, and their medical care accounts for the lion's share of the nation's $1 trillion health care bill. If the CDHP model is to work, then it must focus on the 20% of participants who are responsible for 80% of the total claims.

The key is inspiring changes in behavior. Savvy plan designers can use direct, effective communications to focus these high-cost users on the advantages of being empowered consumers. CDHPs are already starting to incorporate sophisticated disease-management modeling programs that identify problem conditions well before the high-cost stages are reached. These programs allow employers to send automatic early warning notices to employees using Web portals, suggesting courses of action, an approach far better suited to the consumer-centric model than to the traditional insurance plan.

But disease-management and predictive modeling are not enough: Information alone

will not move everyone to better health practices. So second-generation CDHPs are also developing new "compliance" reimbursement approaches, allowing employers to supplement standard HRA allocations in creative new ways. For example, patients who comply with certain health care guidelines may receive rewards, discounts or other incentives (so long as the funding comes through employer-only contributions). Employers benefit from such awards because the awards do not affect their cash flow and because they know that any designated funds will go toward their employees' health care. Employees benefit because the additional HRA dollars are tax-free. In other words, 100% of the award they receive is available for purchasing health care services.

These approaches, which combine personal responsibility with financial involvement, encourage better care as they secure savings—a win-win situation.

Second-generation CDHP programs will address early concerns that these plans are for only the young and healthy. The fact is, when properly designed, consumer-driven health care can benefit the sickest population most of all, through improved access to care, higher quality and lower cost (from the sharing of "compliance savings" with employers, for example).

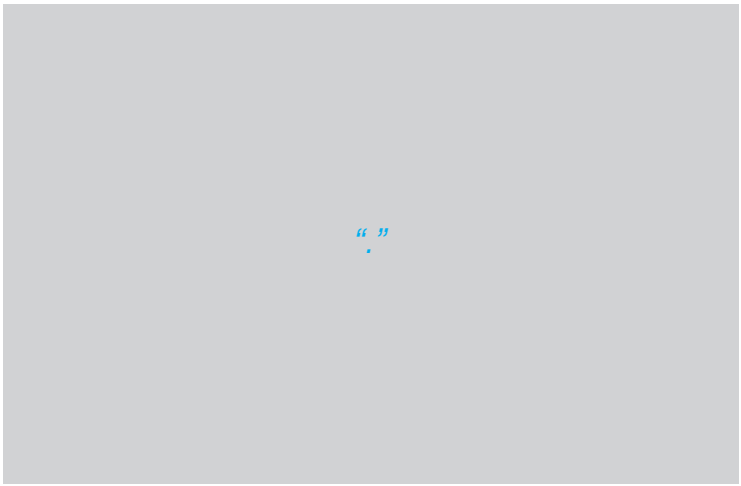
Other promising concepts that will emerge from this generation include tiered reimbursement structures based on cost/quality analyses (paying efficient health care providers a premium might well be more cost-effective in the long run); the coordination of flexible spending accounts and HRAs; the use of stored-value HRA cards to pay for selected claims (e.g., prescription drugs); and consumer-centric plans for dental, vision and other supplemental coverages.

The Third Generation: Health and Performance

Third-generation CDHPs will focus on measuring and optimizing the relationship between health care costs and employee performance. Metrics such as productivity, turnover, absenteeism, "presenteeism" and disability are used to gauge the efficiency of the workforce. These metrics are then plotted against health care costs, forming the basis for strategic interventions, where necessary, to realign these costs with the bottom line.

An important component of this strategy is the health risk appraisal. Profiling employees in areas such as stress can lead to an understanding of what health or workplace modifications are needed to lower costs and improve performance. For example, research has recently correlated the following employee expenses and actions with personal stress:

- Total health care costs (21.5%)
- Total disability and workers' compensation costs (33%)



- Primary reason for leaving a company (40%)
- Primary reason for taking unscheduled absence days (50%).

Other features likely to emerge from third-generation CDHPs include:

- Group and individual HRA performance-based bonuses
- Multiple uses of HRA credits (not unlike a frequent flier program)
- "Virtual" office visits (medical services delivered via Internet) with stored-value HRA card processing
- Consumer-centric grading of health care providers
- Lower administrative claims-handling expense.

The Fourth Generation: The New World of Personalized Health Care

Fourth-generation CDHPs will focus on personalization. Mind-boggling decision support systems and wireless connections will be available

Health Savings Accounts—An IRS Work in Progress

Effective January 1, 2004 the president signed into law another important development for CDHP—the legislative creation of new tax-advantaged, funded accounts to pay for medical expenses called health savings accounts (HSAs). HSAs can be funded by employers or employees and they are portable. HSAs are the most tax-advantaged savings vehicle ever passed by Congress. HSAs are tax-free income to employees; they accumulate tax-free and they are not taxed when withdrawn for eligible medical expenses. IRS has issued some preliminary guidelines but has delayed until the summer of 2004 regulations that are needed to fully clarify significant technical issues.

With these new accounts, legislative initiatives and market-oriented IRS guidelines, CDHP and consumerism are entering a new era with the potential for greater member involvement, transparency, increased demand for medical information on cost and quality and behavioral changes that may increase plan satisfaction while lowering costs.

In order to access the tremendous tax advantages of an HSA, Congress imposed strict requirements on acceptable plan designs. An individual must be covered under a "high-deductible health plan," that is, a 2004 health plan that has a deductible of at least $1,000 for individual coverage ($2,000 for family coverage) and caps on the out-of-pocket amounts that the individual would have to pay ($5,000 for individual coverage/$10,000 for family coverage). An individual and/or the employer can make 2004 contributions to the HSA up to the plan's deductible amount, but no more than $2,600 for an individual or $5,150 for a family. The underlying cost-sharing requirements will be inflation-adjusted in future years.

Contributions to an HSA are deductible in determining adjusted gross income. Employer contributions to an HSA (including salary reduction contributions in cafeteria plans) are excludable from gross income and wages for employment tax purposes to the extent the contribution would be deductible if made by the employee.

For policyholders and covered spouses age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $500 in 2004, $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008 and $1,000 in all years after. Employers contributing to an HSA must make available comparable contributions on behalf of all employees with comparable coverage. If made for qualified medical expenses, distributions from an HSA are excludable from gross income. Distributions from an HSA that are not for qualified medical expenses are includable in gross income.

Some potential uses and interactions of HRAs, FSAs and HSAs are unresolved. The use of separate plans (e.g., covering prescription drugs with a copayment and other medical expenses covered under a high-deductible design) is unresolved. IRS rulings on these and other questions of plan design and structure may determine the ultimate viability of HSAs for many large employers.

to link each person with a personalized health care electronic support system. Imagine a world with a cyber-aide that continuously searches the Internet for personalized health care support.

In this future scenario, we will likely be connected with computers and monitors that will provide real-time feedback on health status, lifestyle and health concerns.

CONCLUSION

Employers' requirements and market competition will force new designs and variations over the next three to five years. New decision-support tools will be developed, new medical services will be marketed and creative Internet solutions will be offered, even as some problems and discontinuities occur in the transition from old to new. Issues of portability, security of accumulating HRAs, unnecessary restrictions on flexible spending accounts and medical savings accounts should be addressed. And Medicare reform should be a top political priority.

The problems of health care are huge and intimidating. Of course there is no silver bullet, no magic solution. But consumer-driven health care offers a new, economically rational direction that can simultaneously address the needs of both employers and employees. Yet it needs to be supported in turn by a more rational regulatory and tax structure. If we are to have a viable private market-based health care system in the United States, this movement needs policy support from both the legislative and the executive branches of government. ◀