



**An Employers' Guide to
Healthcare Consumerism**

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INTRODUCTION

In September, 2001, Wye River Group on Health Care (WRGH) published the Employers' Guide to Patient-Directed Healthcare Benefits, widely viewed as a landmark document in helping to shepherd in a new era of health benefits. This Guide defined a variety of models along a continuum of what was being referred to as defined contribution. Since that time, public policy and the marketplace have moved rapidly to enable the adoption of tools and policies to broaden these financing concepts to a model of medical consumerism.

We recognized even then the inherent pitfalls in viewing this movement as merely an alternative financing mechanism, and were anxious to ensure that the concepts did not fall into the managed care trap of the 1990s, where managing costs took precedence over managing care. Alongside many others, WRGH has worked to encourage honest evaluation of progress, and to facilitate public policy changes that optimize the advantages of prevention and consumer empowerment, while mitigating potential risks to the underprivileged and those with chronic disease.

Encouraged by our allies in the healthcare, business, and public policy communities, WRGH and its affiliate Foundation for American Health Care Leadership, once again worked with a broad array of interests to develop An Employers' Guide to Healthcare Consumerism.

This Guide is an effort to frame the promise of healthcare consumerism, which represents a true sea change in how all stakeholders view and participate in American healthcare, while being realistic about its challenges. Each chapter provides a perspective on different key elements for an effective transition and explores the roles and reactions of payers, providers, and consumers.

Chapter I takes a step back in time to examine the trends that have influenced health policy and healthcare delivery over the past 50 years. Next, the myths and realities about healthcare consumerism, as espoused by advocates and detractors, are considered. Finally, the chapter looks at the reaction of those stakeholders who will strongly influence its success or failure—the provider community.

Chapter II defines what we mean by healthcare or medical consumerism and describes the drivers of the movement and how they are influencing the marketplace and public policy. This chapter further highlights critical success factors for the future.

Chapter III provides a detailed description of the on-going evolution of the financing mechanisms, known as personal care accounts, developed to enable greater individual choice and control. The implications for current and emerging roles and interactions between employees and their employers are considered.

Chapter IV highlights the importance of seeing this movement as something beyond just developing new ways to finance healthcare services. It focuses on the supply side of the healthcare equation and the importance of improving the health of the entire population, by shifting the paradigm from illness care to prevention and chronic care management.

Chapter V makes the case for transparency. Cost and quality information must be readily available in a comprehensible form in order to help individuals evaluate care options in real time, before and after they are sick.

Chapter VI presents one framework for considering different generations of consumer-directed health plans and the key components of each. Ideas under consideration by employers and health plans to meet new challenges are described.

Chapter VII provides a detailed look at current regulatory enablers and barriers to constructive change. The chapter also provides an instructive analysis of what can and should be done to promote a consumer-driven marketplace with adequate consumer protections.

Chapter VIII looks at challenges and trends in healthcare consumerism in several European nations. It offers constructive insight into what learning is transferable to the US and why.

Chapter IX examines the social and behavioral changes that will be necessary to advance the consumer movement and avoid unnecessary pitfalls.

We are indebted to a number of individuals who drafted and edited various chapters of this book. Ron Bachman, President & CEO of HealthVisions, Inc and a former Senior partner with PricewaterhouseCoopers provided a great deal of the content in CH II, III, IV, VI and VII. Terry Humo, Terry Humo Benefit Compliance, formerly with Marsh, contributed significantly to CH II and III and was primary author of CH VII. He also was a critical resource in ensuring general legal and regulatory accuracy. Catharina Maulbecker, PhD, Vice President, Marketing & Sales, CAS, provided us with her insight into medical consumerism in European countries as primary author of CH VIII. CH V on transparency was drafted by Scott Werntz, Vice President of Product Development and Robert Sanchez, Product Development Director of Consumer Engagement Initiatives with Caremark.

We are most grateful to Helen Lippman, our professional editor, who undertook this project on a very tight timeline, and Sooki Moon who once again applied her talents as a graphic artist to make the Guide visually appealing. We also want to express our appreciation to Jessica Comola for providing the photograph appearing on the cover of this publication, as well as for her previous contribution of the cover photograph on the January, 2005 Communities Shaping a Vision for America's 21st Century Health and Healthcare, Phase II Progress publication.

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Chapter I

Consumerism in Healthcare: The Next “Best” Thing?

The goal of this Guide is to educate, inform, and create a “strawman” concept to spur development of supporting legislation, regulation, market products, and implementation of consumerism concepts that create a better system for cost, quality, and access to health and healthcare.

For the most part, we take a positive perspective on the current trends and the opportunities associated with Consumer-Driven Healthcare (CDHC). However, for balance, in this opening chapter we want to take a 20,000-foot look at both the myths and the realities of consumerism in healthcare. We also want to give readers the perspective of the provider community, recognizing its critical importance in achieving the overall objectives of CDHC.

In the first WRGH publication on this topic, *An Employers’ Guide to Patient-Directed Healthcare Benefits*, released in October 2001, we attempted to clarify the possibilities inherent in a “defined contribution” model. We described a continuum of financing models that could move employers from their current state to a more consumer-directed model, emphasizing greater individual choice and control.

This made sense at the time, since public policy debate was focused on concepts of “defined contribution” versus “defined benefit”. Many policy experts feared that this movement represented a way for employers to abandon their traditional role as interlocutors for the payment and management of medical services.

Consumerism’s staunchest proponents, on the other hand, saw it as the answer to all that ails our healthcare system. Our goal was not to advocate, but rather to clarify terms and describe both pros and cons. Even then, we were careful to point out that for CDHC to have lasting impact, it had to go far beyond financing.

Building on our previous work, this Guide moves further along the continuum. It encompasses both the financial and the delivery components of con-

sumerism in healthcare, using a uniform framework to define different “generations” of CDHC.

Why Consumerism?

In some ways, we can look at this direction in health benefits as part of a natural evolution—a “back to the future” of sorts. Most observers are aware that employers’ prominent role in healthcare did not occur through some master design, and realize, as we do, that the employer role is not likely to appreciably change anytime soon. Nearly 160 million people in this country have employer-sponsored health benefits, and surveys suggest that most of them are not looking for a major change. Organized labor and some traditional and historically paternalistic corporations are committed to continuing to provide health and retirement benefits, as is the federal government.

Simplistically speaking, you might consider the progression this way. Between 1945 and 1970, there was a mutuality of interests among insurers, physicians and hospitals. This pact served these stakeholders well by providing a vigorous flow of dollars that enabled scientific progress in medicine, as well as financial security among all three groups.

In 1964 the Great Society movement swept the country, and its promise added more demands and public expectations through Medicare and Medicaid.

In the 1970s tensions began to mount as consumers’ appetite for the latest medical marvels began to outstrip the system’s capacity to cover the costs of care. In response to financial concerns of employers, Congress passed the HMO Act in 1974.

Initially, managed care seemed to be the answer to spiraling healthcare costs. It was envisioned as a dramatic shift that placed the emphasis on preven-

tion and wellness and channeled patients to high quality/low cost providers. We now know that, in most cases, managed care became synonymous with managed cost—and little else. The main problem: Managed care largely overlooked the fact that our science-based model in healthcare is geared to the industry itself—not the consumer, or patient. Americans’ cultural abhorrence of “Big Brother” and “Mother, may I” proved to be a major sticking point as well.

In the 1980s and 1990s, employers responded to the growing financial pinch by applying common business practices to their relationships with the healthcare industry—practices like competitive bidding, vendor contracts and supply and demand negotiations. In one sense, consumerism might also fall under the rubric of a business practice, since it offers a way for employers to more accurately predict annual healthcare expenditures and limit their financial risk.

It’s cultural first, last and always! The reason we are looking to the consumer now is simple—we’ve tried everything else and repeatedly found that Americans react negatively to any entity that tries to substitute its priorities for those of the individual. In our culture, rugged self-determination generally wins over social responsibility and equity.

Consumerism may also be seen as the latest attempt to navigate the tensions between limited resources and unlimited expectations. In other words, it’s about money! Ultimately, the health reform debate gets down to this fundamental question: Who will control healthcare decisions, bureaucracies or individuals? Since we cannot finance all the services that might provide some benefit to some people, hard choices need to be made. And who better to make those tough choices than those whose lives are directly affected?

“Consumer cost-sharing may contribute to bottom up health system reform after the exhaustion of governmental and corporate initiatives.” [James Robinson]

“...actuarial models in healthcare “conflict with a sense of justice and social responsibility.” [Victor Fuchs]

The pluralistic nature of our country also means that there is increasing diversity in health-related attitudes and individual preferences, which vary within communities and even over the lifespan of a given person. This is another strong argument

for a healthcare system that’s capable of satisfying individual values rather than imposing a one-size-fits-all solution upon the U. S. population.

Economist James Robinson points out that whatever approach we choose has to recognize that unrealistic and rising expectations—largely driven by direct to consumer advertising—are going head to head with an increasingly elastic definition of health. More and more therapies that had been viewed as cosmetic, optional or discretionary are seen by many as essential to their health.

But the jury is still out on the question of whether CDHC—thought by some to be the next “best” thing—really is the right direction. Here are two opposing viewpoints from two nationally known health economists.

Can we adopt a model of consumerism from other industries? Consumerism is a powerful force that has transformed industries like financial services, telecommunications, travel and entertainment in ways that could hardly have been predicted a decade ago. It has largely supported the 21st century notion of more choice, higher quality and lower cost. There is a sense that it is the duty of the system to figure out the equation.

This conundrum requires a fundamental shift in how we view the value equation in healthcare. For example, the “higher quality, lower cost” theory has yet to be proven in healthcare, much to the chagrin of purchasers.

“Consumer cost-sharing may contribute to bottom up health system reform after the exhaustion of governmental and corporate initiatives.” [James Robinson]

“...actuarial models in healthcare “conflict with a sense of justice and social responsibility.” [Victor Fuchs]

The big question that remains is, Will consumerism in healthcare amount to little more than a cost shift or lead to a fundamental cultural shift?

In order to imagine the possibilities of a fully developed consumer model in healthcare, consider some of these examples of its evolution in other industries. The framework for stages or generations of CDHC used here is described more fully in chapter V:

1st generation consumerism: “*personalized service*”—house calls; pharmacy delivery of med-

ications; the milkman; full service gas stations; dry cleaning delivery.

2nd generation consumerism: “*customer convenience*”— stores open after 5 pm and on Sundays; the telephone company accepting payments at the grocery store; multiple locations for paying bills or customer service booths; travel agents who negotiate for individuals.

3rd generation consumerism: “*information access & technology*”—credit card use over the telephone; 24 hour access to account information over the telephone; fax machines; and, eventually, the Internet.

4th generation: “*hybrid-customer convenience + operational efficiency*”—online checking; catalogue ordering; online shopping; bartering on Ebay

Today’s consumerism has redefined our expectations and created demand for things that look and feel more like self-service. We pump our own gas. We book our own travel online, print out boarding passes from our computers at home, and check our own baggage at the kiosk. Many of us scan and bag our own groceries as well.

One can only imagine how far we will go in healthcare!

What are we trying to achieve? Are Americans looking for a utopian healthcare system? Can we agree on what is a better system? Here are a few attempts to define a vision.

A *pluralistic* system that *empowers* patients and demands *accountability* from individuals and the health system, while adequately *supporting* the needs of the *disadvantaged*. (from WRGH communities initiative)

“*Collaborative care*” with an *engaged patient* and a *partnering* physician sharing expertise, as contrasted with a more traditional model of a *passive* patient and a *dominant* physician seeking compliance with instructions. (Thomas Bodenheimer, MD, Clinical Professor, Department of Family and Community Medicine, University of California at San Francisco.)

Knowledge-based care; patient centered; system orientation (Institute of Medicine)

To reiterate a point made earlier, today we have a science-based model created to support the healthcare industry. What we need is a humanistic-scientific model that is designed to support consumers and patients as well.

Evidence suggests that, if channeled correctly, consumerism has the potential to radically change our dysfunctional healthcare system and move us toward a system characterized by value, accountability, operational transparency and partnerships.

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The Theory Versus the Reality

Let’s focus a bit more narrowly on the purported goals of CDHC, looking at each of the following in terms of theory vs. reality:

Put the patient-consumer at the center of healthcare and create a true healthcare marketplace. In essence, we are talking about giving patients the ability and incentive to think differently about health and healthcare, by providing greater system transparency of cost and quality information that they can use for comparison purposes.

In addition, we will promote and reward value-added innovation and increase system accountability. Here are some of the theories:

- **Enigma theory:** The normal market incentives present in practically every other service industry have not been present in healthcare. In what other industry is the consumer of goods not the purchaser? In what other industry does the supplier determine how much and what kind of product or service you need? Where is the incentive for consumers to shop wisely or question value or for providers to reduce costs or utilization? Only the toy industry is similar, since adults make purchases on behalf of kids!
- **Back to the future theory:** Consumers have been shielded from the true cost of healthcare for years. In 1960, over 55% of total healthcare spending was paid directly by consumers. That number has dropped to approximately 17% now, although that’s a smaller percentage of a vastly larger total. What’s more, the expenses that consumers pay directly tend to be the least essential ones,

like vision, dental, and over the counter medicines. Clearly, this situation is changing as some cost elements, such as prescription drug copays are rapidly increasing. In general, when consumers don't feel the true cost of care, they over consume. In some ways this is back to the future! Remember fee for service; 80/20 insurance; deductibles with caps?

■ **Scrutiny theory:** As patients become increasingly responsible for the cost of care, they'll be much more discriminating about what diagnostics and therapeutics they request and receive. and this will help address the problem of infinite demand.

■ **Self empowerment theory:** Providing those with employer-based coverage more choice and control will allow individuals to shape their own healthcare benefit options. In managed care, dictating or mandating these choices for employees created resentment; in contrast, giving them more control can be an impetus for positive health system change.

■ **Doctor-patient relationship theory:** Consumer-directed healthcare will help patients get the most out of the relationship they have with their physician, because this new model supports a decision-making partnership.

But what about the realities?

■ **Skin in the game reality:** These theories will only become reality if consumers are aware of the true cost of care, have a personal stake in it and have enough information and confidence to make healthcare decisions. Much of the information needed is just not there today, especially on the value dimension. There are obstacles to understanding quality or even the true price of health insurance or healthcare services. Furthermore, not all patients will be price sensitive and not all physicians will joyfully embrace being interrogated about cost and quality!

■ **Competency reality:** Even if the information were there, consumers vary enormously in their ability and willingness to navigate a complex healthcare system. Providers, payers, hospitals and health plans have an obligation to ensure that as information quality improves, it is made available in a relevant and usable form, especially for the disadvantaged. In addition, some say that consumer-directed plans are ask-

ing patients to ration their own care. The question is, When they are faced with financial risk, will they do a better job of making decisions about their own care than physicians did under managed care? That is not at all clear.

■ **Emotional vs rational reality:** Let's face it, it's only human to want, hope for and seek a greater quality, and quantity, of life. When confronted with medical marvels the desire to achieve health optimization through any means possible makes the decision process less rational and much more emotional. This is a particular risk when an individual is suddenly faced with making a major healthcare decision without the benefit of time to research the options or to reflect on the consequences of each.

Consumerism will help contain healthcare costs.

There is no consensus today on this point, although the most common opinion is that the impact will probably be minimal overall and occur through lowered demand. The theories go something like this:

- High deductible plans are less expensive.
- Self managed accounts yield decreased administrative costs for small employers.
- There will be decreased use of "discretionary" care, estimated to account for approximately one-third of all healthcare spending.
- There will be an increased use of generic medications.
- The resulting development of more efficient care networks to serve a price-sensitive public will lower costs.
- Longer-term, lifestyle behavior changes will result in decreased risk.

But the following facts need to be taken into account.

- Large deductibles but relatively low out of pocket maximums will not tend to reduce utilization for individuals who experience an expensive episode of care in a given year or for those with chronic diseases. For these patients, the annual deductible will be met and stop-loss insurance coverage will provide for nearly all of the remaining expenses.
- Since 5% of the population is responsible for

approximately 45% of costs, this population will require more aggressive and effective early intervention. Disease management programs will be necessary to succeed in controlling medical expenditures for these high-cost patients.

- If not properly designed, these models could cost employers more by overcompensating healthy workers—the approximately 77% of employees who spend less than \$500 per year on healthcare. Thus, employers that provide \$750 to each employee for a health savings account (HSA) or other type of account will lose money on most employees.
- Some research suggests that cost reductions come from less use of necessary as well as unnecessary care. After all, who can accurately determine what third of care is discretionary? Low and modest income families might feel financial pressure to cut their use of medical services under a consumer-directed model. Even advocates of CDHC admit that wealthier people will always get what they want because they have the means to pay for it. Some point out, however, that the wealthy are a relatively small proportion of the population so it does not really matter what they do.
- Some people question whether the lost revenue to government from not taxing employees on the value of healthcare benefits is appropriate, as the largest tax savings flow to higher income taxpayers while many individuals remain with no health insurance.
- A simulation based on consumer-directed plans provided by Definity, one of the first niche insurers created to offer CDH plans, showed that cost savings would accrue to both the healthy (63% of the population) and the sickest 5% of the population. But the rest would end up paying more than with traditional insurance.
- People in the middle group may not moderate their spending because the relative effectiveness of many healthcare products and services is not clear.

Consumerism creates an opportunity to get more people insured and to allow individuals to save for future needs. Advocates point to several ways this might occur.

- More small businesses will be able to provide some support for employees, as high

deductible or catastrophic policies can be priced lower than standard plans.

- New tax-free health savings accounts might reduce small employer administrative costs.
- The ability to accumulate funds in such accounts will help individuals plan for future healthcare needs—as a bridge to Medicare for early retirees, for example. Proponents believe this opportunity to save is the real point, rather than the tax advantage. Accumulated funds may also help those who change jobs by enabling them to afford to pay for COBRA policies.

But here, too, there is another side to the story.

- High deductible insurance products have never been very popular. Take-up rates have historically been low and may remain so.
- The plans could have an adverse impact on people with higher anticipated healthcare costs by fragmenting the risk pool. They complicate pooling of insurance risk between the consistently healthy and the chronically ill. Self-insurance, experience rating and managed care ended the subsidy of healthcare across employers.
- To some, applying the actuarial model to healthcare conflicts with their sense of justice and belief in collective responsibility. There is concern that there will not be sufficient financial subsidies for the poor.
- Detractors point out that many of the uninsured are in the 10-15% tax bracket and would not find the tax advantages offered by HSAs a compelling reason to buy health insurance.

The Goals of Medical Consumerism

- **Put the patient-consumer at the center of healthcare**
- **Create a true healthcare marketplace**
- **Help contain healthcare costs**
- **Create an opportunity to get more people insured**
- **Allow individuals to save for future needs**

How Are Providers Reacting?

Through the power of their pens, physicians alone are responsible for approximately 80% of healthcare expenditures. Along with hospitals and other providers, they have historically adopted technology and added services in order to pursue two

objectives: higher earnings and, better outcomes. Physicians see themselves, first and foremost and in some cases exclusively, as agents for patients. As such, they want to advocate for more resources to be devoted to healthcare and have little interest in working to balance the healthcare needs of individuals with other national economic priorities.

Physician groups generally support the concept of health savings accounts, but how it will all play out remains to be seen. Leading state medical societies and the American Medical Association (AMA) have promoted CDHC and health savings accounts (HSAs) as a more attractive option for helping to meet healthcare needs and as a means to strengthen the doctor-patient relationship. CDHC, in their view, encourages greater communication and shared decision-making. As one former AMA president was fond of saying, "Put the patient in the driver's seat, with the doctor riding shotgun."

On the positive side, physicians point to the opportunity to maintain long-term relationships with patients, even if jobs change or employers change plans. They also tend to like the emphasis on preventive and behavioral services that support doctor-prescribed treatments and make for healthier patients.

Physicians also cite a number of administrative advantages to the consumerism model, the main one being that it decreases "non value-added" bureaucratic oversight. Third party administrative hassle is perceived to be much less than that of managed care. For one thing, generally CDHC does not require referrals.

Doctors also emphasize the potential of CDHC to inject more plan competition. After all, if employees have a limited choice of plans, the plans have little incentive to be customer focused.

Many doctors appreciate the fact that CDHC may help address some purchaser concerns about cost.

Finally, they like the fact that in some cases, this approach allows physicians to set their own fees.

And, at least they say.

But here, too, as in most aspects of CDHC, concerns and unknowns remain!

Physicians are a little leery of the "impatient patient"— who demands better service and more convenience. It's unclear, too, how doctors who did not appreciate having their decisions questioned or second-guessed by managed care plans will respond to a similar interaction with their patients.

Indeed, patients are bound to ask more questions about cost and the necessity of various procedures if they are paying the freight! Some doctors say they're not sure it's good for patients to be worried about the cost of care. They say, too, that they try not to make decisions based on cost and, in fact, have tried to ignore insurance status in making healthcare recommendations and decisions in the past. When a patient with an HSA gets the bill for an office visit that seems too high for the time spent with the physician, the doctor or office manager needs to explain overhead and the value of nurses and other support professionals.

Today, with the proliferation of on-line health information, physicians are encountering patients with piles of unsorted information downloaded from the Internet, some of it useful and reliable, much of it not. In order to make CDHC work, physicians stress the need to make the information available, accurate, relevant and understandable.

Because patients will be making more choices, physicians will need to carefully document that they have fully explained all treatment options. If a patient selects a less costly treatment and results are less than optimal, it will be especially critical to have such documentation.

A much more fundamental concern expressed is that CDHC plans could drive the "last nail in the coffin" of primary care physicians. This approach makes basic, routine healthcare services a commodity. These are the types of services that people who have control over their healthcare dollars are likely to limit. After all, why pay \$70 to see an MD if you can see a nurse practitioner for \$30, or go to the pharmacy for a routine blood pressure or glucose check without an appointment for \$10?

Lumenos, another firm offering CDHC-type coverage, found that within six months of switching to

What Do Physicians Like about Medical Consumerism

- More opportunity for long-term relationships
- Emphasis on prevention
- Less 3rd party hassle
- Potential for more plan competition
- Some opportunity to set fees

a consumer-directed health plan, there was a 6% reduction in physician visits. Although it is estimated that 20-25% of doctor visits are unnecessary and that 30-35% of all healthcare is ineffective or inefficient, at this point it is not always clear which services or what care is unneeded or inefficient. It is also likely that people with chronic disease will view choices differently than their healthier counterparts.

One physician leader also expressed concern about banks charging physicians transaction fees. He noted that a large national bank that instituted medical savings accounts is issuing a debit card to employees. This makes it easier and quicker for doctors to get paid and there is certainty that the money will be there. However the transaction fee adds to administrative costs when CDHC is supposed to reduce cost.

The transition to a new way of doing business and a new relationship with patients and third parties may not be easy for practices that have become accustomed to a steady flow of income from capitated contracts. Providers will need to institute very transparent pricing information, but they do not want to see a “free for all” around negotiating on price by patients who seek to save the money in their healthcare accounts.

There is also some concern about bad debt, depending on how the plans are executed on the financing side. Doctors do not want to play the role of collections agent, in the event that the HSA is depleted.

Finally, on the negative side, physicians are not at all sure that the money saved on the healthy low utilizers will offset costs of care for those with serious illnesses and chronic disease. It is important to ensure that there are no disincentives for preventive care in the design and that provisions are made to promote coordination of care for those who are chronically ill.

So far, there is little evidence that physicians’ experience with patients who have high deductible health insurance is different from their experience with those with more traditional insurance, but penetration of CDHC is quite limited. Regardless of the issue of health savings accounts, the rising cost of health insurance premiums in general could leave providers saddled with more uncompensated care as small employers—and more people overall—are priced out of the market.

Then there are some areas where physicians are

What are Physicians’ concerns?

- Impatient, demanding, overly “netted” patients
- Issues of informed decision-making
- “Commoditization” of routine healthcare services
- Potential for transaction fees
- Need for transparency
- The needs of the chronically ill

unsure of the impact. CDHC puts a lot more decision-making between the doctor and the patient. It is likely that patients will pay more attention to the quality of care and service they receive. So physicians will have more incentive to invest in their business and will need to do so if they are to compete effectively. Many predict a lot more patients will be willing to travel to providers in other cities for higher quality, lower cost procedures.

The reaction of the hospital industry: In general, hospital administrators are less sanguine than physicians about HSAs and high-deductible health insurance (HDHI) plans. Notwithstanding many opportunities for an expanded role for this trusted and credible community asset, few experts see them, in their current configuration, at the center of the universe for healthcare in the 21st century.

Some experts express the opinion that the hospital industry is not well prepared for the convergence of forces that will descend on it. Challenges are many. Some of those cited by well-known CDHC advocate Greg Scandlen in a recent edition of Health Care News include: lawsuits about tax-exemption status in exchange for care for indigent; the appearance of for-profits gauging self-pay patients; continuing patient safety concerns; the end of the specialty moratorium; a need to generate top line growth, not just reduce expenses; payment reductions; tiered benefits; and competition from off-shore facilities.

Scandlen points to a “restive” media portraying hospitals as the latest in a long line of healthcare villains that include greedy docs, evil insurance companies and profiteering pharmaceutical manufacturers. He sees the media theme as “*Hard working consumers are being overcharged by dangerous and poorly run facilities that have conspired to retain a monopoly position in the healthcare system.*”

He also believes that government is likely to intervene on behalf of hospitals only if communities or

beneficiaries across the state or country have begun to be affected to the extent that it might threaten access to care.

In the face of all this, having to deal with patients demanding price transparency, quality information and customer convenience seems like another annoyance.

Hospitals do have some specific concerns about consumerism. Industry leaders believe that some patients, in an attempt to save dollars in their health savings accounts, may delay seeking care until a problem costs more to treat. Another concern is that limited benefit plans often cap payments for hospital bills at \$5,000 or less, shifting risk to hospitals, which are required by law to at least stabilize emergency cases. They believe that more patient responsibility for healthcare bills, in whatever form, will add to the cycle of lower reimbursement that leaves hospitals at a financial disadvantage and will contribute to rising hospital bad debt, higher credit risk and cost of collections.

The American Hospital Association (AHA) says it hasn't done any official surveys, but a senior executive stated that the perspectives of its members on CDHC is all over the map. *"With our small and rural members it is not anywhere near their dopplers. In other places it depends on the level of market penetration, which is still pretty low everywhere. What the members are seeing are people whose traditional coverage has taken a whack — higher co-pays and deductibles — and they can't afford them."*

Many hospitals are preparing for a rise in high-deductible business by reviewing their financial aid and charity care policies and working to streamline revenue cycle management. Hospital officials will try to identify patients right away who may have trouble paying instead of having bills go to the collection process.

There appears to be a bit of schizophrenia on the subject. Interviews conducted by the Center for Studying Health System Change with more than 1,000 health system leaders in 12 communities revealed significant skepticism about the ability of market-based reforms to produce the type of changes that are urgently needed. But there was also deep concern about the potential for poorly conceived government intervention and agreement about "shared blame" for renewed healthcare inflation and receptivity to stronger market intervention.

There are even a few whispers of optimism. Hospital administrators and physicians like the fact that most plans build on the insurance company's existing provider network and negotiated rates, showing that there is a level playing field. In fact, a recent hospital survey of insurers revealed that 95% of HSA and HRA enrollment is in plans that build on existing networks. Finally, at least in theory, consumer-directed health plans have the potential to make patients more attentive to the details of care and costs, something most providers recognize as crucial to addressing healthcare challenges.

So far, the impact of high deductible plans on hospitals appears to be negligible. Some consultants say the fear of bad debt is overblown. As most of the costs of inpatient care will still be covered by insurance, hospital cash flow will be mostly unaffected.

What about other providers? Healthcare delivery is, after all, about more than physicians and hospitals. Consider the perspectives of three other provider groups:

Dentists see this whole consumer movement as nothing new. Dental insurance is a relatively newer benefit and much dental care has always been paid out of pocket.

Nurses are strong supporters of patient-centric healthcare in a broad sense, but most take no position on financing issues since they don't generally bill directly for services. However, advance practice nurses like nurse practitioners see significant opportunity to offer patients "better, more personal care for less money."

Pharmacists also can play a valuable role in educating and monitoring patients and in supporting self-care. But they certainly will want to be paid for their services!

Conclusion: Clearly, the jury is still out with regard to the impact of consumer-directed healthcare—and the truth of the matter is that there is no magic bullet. Even with the caveats outlined in this chapter, however, medical consumerism has the potential to fix at least some of our nation's biggest healthcare challenges—and to move us toward a more patient-centric, high quality and affordable healthcare system.

Chapter 2

A New Way for the New Millennium

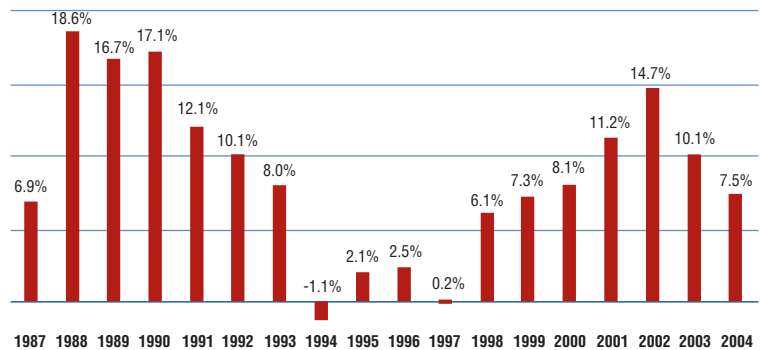
Every decade seems to have produced a transformation in how healthcare is administered in the United States. In the late 1940s and '50s it was the expansion of employer-sponsored healthcare. In the '60s it was the creation of Medicare and Medicaid and their impact on employer-based fee-for-service plans. In the '70s it was the passage of ERISA and the movement of large employers toward self-insured arrangements. In the '80s 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. True to form, the new millennium has seen another new paradigm —medical consumerism.

Essentially, managed care was grappling with one fundamental, structural problem with the U. S. healthcare system: how to control unlimited demand in the absence of individual consumer-level financial responsibility. The traditional managed care plan was based on a supply-control model designed to control costs by limiting the supply of care.

As costs continue their upward spiral, payers have run out of room: They can no longer move employees into tighter networks with more restrictions and lower negotiated fees. Instead, they're forced to choose between two equally unpalatable options: Reduce benefits (i.e., increase deductibles, coinsurance amounts, and other out-of-pocket medical costs) or lower pay (i.e., increase the employee-paid portion of the premium.)

Employers do have another choice, however: Begin moving toward consumerism in healthcare, which represents a shift from a supply control model to a demand control model. 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 healthcare? Such a change is unprecedented, complex and multi-dimensional—and gradual. It is not a revolution, but rather the start of an evolution.

Annual Change in Average Total Health Benefit Cost, 1987-2004



Note: Results for 1987-1998 are based on cost for active and retired employees combined. The change in cost from 1998-2004 is based on cost for active employees only.

Source: Mercer's National Survey of Employer-Sponsored Health Plans

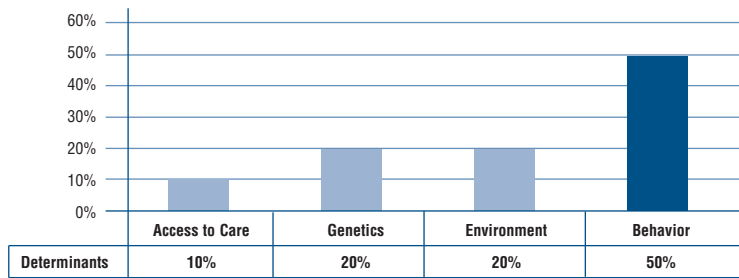
Medical consumerism represents an unprecedented, complex, and multi-dimensional shift from a supply control model to a demand control model of healthcare.

Defining medical consumerism: Consumerism can be defined as transforming employer-based health benefits into a model that puts economic purchasing power—and decision-making—in the hands of participants. Employers supply the information and decision support tools employees need to make informed choices, along with financial incentives, rewards, and other benefits that encourage beneficiaries to positively alter their health and healthcare purchasing behaviors.

Why is this important? According to the Centers for Disease Control and Prevention, 50% of Americans' health status can be attributed directly to their behavior, or lifestyle. Only 10% of overall health status is influenced by the healthcare

Today's Health Care Environment and Trends

Determinants of Health



Source: IFTF, Centers for Disease Control and Prevention

system, yet that's where most of the efforts are focused.

Initially, the term "consumer-driven" (and similar terms, such as "consumer-centric," "consumer-directed" and "patient-directed") were associated with a health benefit design in which an employer established an account with a defined amount of healthcare dollars for each employee, and coupled that contribution with catastrophic insurance. As consumerism has evolved, new generations of thought have resulted in the addition of other components. Stakeholders increasingly recognize that affecting personal behavior, quality of care and, ultimately, cost, will require a creative, multi-faceted and flexible approach.

Today's consumerism model is not limited to plan design changes. Instead, it encompasses the broad spectrum of tools, incentives and plan design that have the potential to positively impact health, healthcare purchasing and treatment decisions

Medical consumerism encompasses the broad spectrum of tools, incentives and plan design that have the potential to positively impact personal behavior, quality of care and healthcare costs.

Current Drivers of Consumerism

Under the current third-party reimbursement system, both the power of the marketplace and personal decision-making are marginalized—and

attempts to modify behavior by using relatively small out-of-pocket deductibles, co-payments and/or coinsurance have had little effect on demand. Many observers have concluded that cost control is impossible when patients are not aware of the true cost of healthcare services or able to judge the quality of care delivered to them. Distorted purchasing decisions and uncontrollable inflation will remain problems in healthcare as long as someone other than the patient is paying the bill.

Clearly, using medical services is different than purchasing other consumer goods. But experts estimate that up to 30% of care provided today is "discretionary" (i.e., either not medically necessary or available through less expensive, equally effective alternatives), and up to 25% is driven by unhealthy behaviors such as smoking, lack of exercise, and poor eating habits. Discretionary care and unhealthy behaviors alone are key drivers of the unmanageable cost hikes that are forcing employer-payers to embrace CDHC.

As a result of the increase in healthcare costs and the absence of quick solutions, the marketplace and policy experts have once again re-evaluated their approach. What emerged was the recognition that the individual user of health services could be encouraged to make better choices with the right incentives. More actively engaging consumers in decisions about their health and the care they receive is expected to increase both the quality of that care and the level of patient satisfaction. This fundamental shift would put the consumer at the top of the decision tree, but to get there will require a total revision of both the system and the consumer mentality.

The evolution began in 2000 - 2001, with the advent of the concept of Consumer Directed Healthcare. Several venture-capital backed entrepreneurial start-ups introduced health plan designs incorporating the consumer in innovative ways. Most of these included accounts that consumers controlled to pay for non-catastrophic care.

On June 26, 2002, the IRS issued guidelines that approved Health Reimbursement Arrangements (HRAs.) HRAs allow unused account balances to carry over from year to year, financially benefiting those willing to control discretionary healthcare expenditures. HRAs make it possible for health insurance plans to simultaneously provide protection and savings by allowing unused funds to be

rolled over. They may represent the most important change to affect healthcare benefits in 25 years.

The first CDHC products focused on plan design changes, such as implementing HRAs in conjunction with a high deductible plan. More recent programs have expanded beyond plan design by integrating and aligning incentives around population-based health programs for example, wellness and disease management. These newer designs more effectively address initial concerns that consumer-directed plans would be attractive only to the young and healthy and would penalize those with chronic conditions such as diabetes, asthma, or congestive heart failure.

The Expanding CDHC Marketplace

As consumer-centric healthcare evolved, several issues surfaced regarding the tax treatment and carryover provisions of spending accounts. The IRS' June 2002 ruling was undoubtedly responsible for major insurance companies such as Aetna, United, Humana and the Blues, joining start-ups—Definity Health, Destiny Health, Health Market and Lumenos—as the major sellers of CDHC plan designs. Although there were fewer than 500,000 people enrolled in CDHC plans at the beginning of 2003, enrollment as of January 1, 2005 was projected to top 3.2 million.

Growth prospects for CDHC through 2010 are projected at even higher levels.

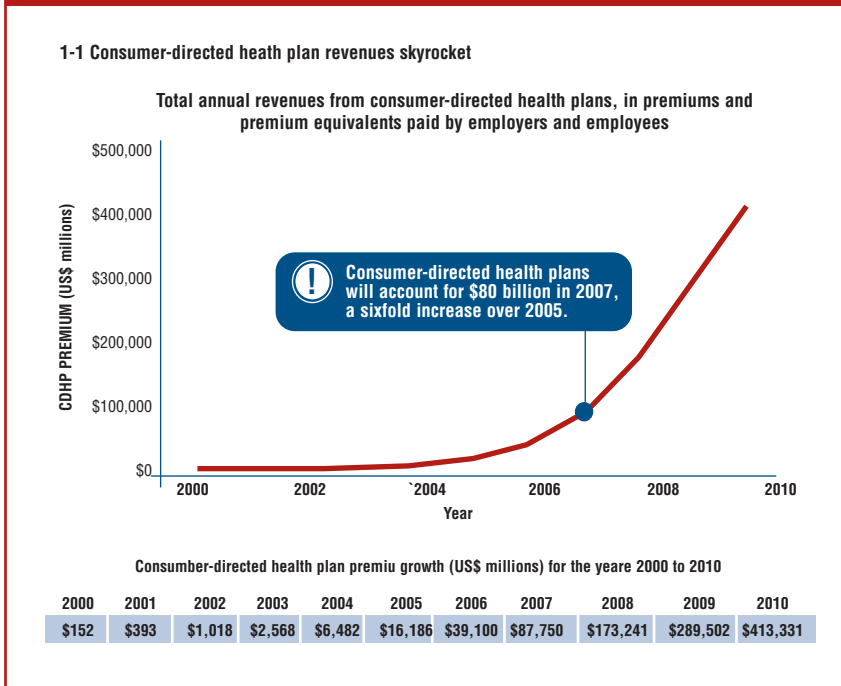
Effective January 1, 2004, as a part of the Medicare Prescription Drug Improvement and Modernization Act of 2003, the President signed into law an important development for CDHC. The legislation created new tax-advantaged, funded accounts—Health Savings Accounts—to pay for medical expenses.

Some liken HSAs to medical IRAs or 401(k)s. They can be funded by employers or employees, they are 100% vested (though in 401(k)s, employer contributions may not be fully vested the first few years) and they are portable. HSAs are the most tax-advantaged savings vehicle ever passed into law by Congress. They are triple tax-advantaged, providing tax-free income to employees, accumulating tax-free, and not being taxable when funds are withdrawn to cover eligible medical expenses.

With these new accounts, regulatory flexibility, additional proposed legislative initiatives and market-oriented IRS guidelines, CDHC and consumer

Under 3rd-party reimbursement the power of the marketplace and personal decision-making are marginalized. A fundamental shift to medical consumerism would put the consumer at the top of the decision tree, but to get there will require a major shift in both system and consumer mentality.

Figure 1 Forecast: US Consumer-Directed Health Plan Adoption, 2000 to 2010



centric concepts are entering a new era. It is now possible for payers, insurers and providers to join forces to create a healthcare system model that promotes better informed, more involved patients who demand higher quality care at reasonable cost; greater cost transparency; and individual behavioral changes that can simultaneously boost health and lower healthcare expenditures.

Critical Success Factors

The experience of early adopters of consumer-centric plans has formed the basis for improved versions of CDHC, creative new ideas and exciting product designs. Second generation products are now available to employers, with more improvements rapidly on their way. Greater awareness in the market and a growing number of believers are

building a reservoir of thoughtful and creative new solutions to old problems. National and regional payers have invested millions in new systems and product development. Second, third and even fourth generation products are being developed, and transformation of employer-based health coverage is well underway.

It is the creative development, efficient delivery, efficacy and successful interaction of these elements that will prove the success or failure of consumerism. It is not enough to deal only with high deductible plan designs associated with HRAs and HSAs. In the early stages of transformation, these designs may attract only 10-25% of the enrollee pool in an organization where they're offered. Even the most optimistic projections show that consumer-driven high deductible plan designs are unlikely to capture more than 40-50% of the healthcare market.

There are two basic requirements for a successful consumerism strategy. The consumer-centric program or options must:

- Encourage and attract enrollment from the sickest members, as well as the healthy.
- Work for those members who don't want to get involved in decision-making as well as for those who do.

By properly recognizing these core requirements for all plan options, concern about adverse selection is mitigated.

The 5 Key Building Blocks of Medical Consumerism:

- Personal Accounts (FSAs, HRAs, HSAs)
- Wellness/Prevention and Early Intervention Programs
- Disease Management and Case Management Programs
- Information and Decision Support Programs
- Incentive and Compliance Reward Programs

Note: The term "high deductible health plan" (lower case) is used in a generic fashion to mean a higher than normal front-end medical plan deductible (typically \$1000 or more). Separate carve-out programs for prescription drugs, or mental health may apply. The term "High Deductible Health Plan" (capital letters) or "HDHP," is a legal term as defined under the HSA legislation and means a plan meeting the design requirements of the 2003 Medicare Improvement Act.

Basic Consumerism for Any Plan							
	Untapped Potential for Consumerism				Most Consumer-Centric Plan Designs		
					Typical CDHP	Must Meet HSA Legal Definition	
Personal Accounts						HDHP	HDHP
Wellness/Prevention						PPO	PPO
Early Intervention	HMO	EPO	POS	PPO	PPO	Without Er Funded HSA	With Er Funded HSA
Disease Management					With HRA		
Case Management							
Information							
Decision Support							
Incentives & Rewards							

Chapter III

Financing Vehicles to Promote Demand Control: Personal Care Accounts

Individually owned accounts to help pay for medical products and services have been an integral part of the evolution of healthcare consumerism. Their key role has been to help promote individual responsibility. It's important to remember, however, that the accounts are a tool, not an end in themselves.

That realization can help employers and other plan sponsors craft a benefit policy consistent with their business philosophy and objectives, understand developing federal and state healthcare policies and design the best and most cost-effective group plans possible within our ever-changing healthcare environment.

Various types of individual medical accounts have developed in the new millennium as part of the consumerism movement. But neither the concept of defined contribution healthcare benefits nor individual accounts for healthcare purchasing are new. In fact, defined contribution health plans have been around for years under different names, but have attracted more attention as their ability to control costs and to influence and reinforce positive behavior has been recognized and better understood.

Defined contribution healthcare was made possible in the late 1970s through tax code provisions authorizing cafeteria plans and, specifically, medical flexible spending accounts (FSAs). Cafeteria plans provide for employer and employee contributions in defined amounts for individuals to use to buy various benefits based on their priorities.

The FSA, one of the choices of a cafeteria plan, allows an individual to set aside tax-free employer and employee contributions to pay for medical expenses not otherwise reimbursed or covered under another medical benefits plan.

A feature of the FSA that eventually led to the development of a more consumer-oriented funding design is the "use it or lose it" rule. Until recent-

ly, an individual had to use the FSA funds within a defined 12-month period or forfeit the money. The treasury department has recently added a 2-1/2 month grace period, during which expenses may be incurred and reimbursed from the FSA. The problem is that the "lose-it" feature has been an incentive for individuals to spend healthcare dollars remaining at year end, when the funds might be better saved for future medical care.

The Health Insurance Portability and Accountability Act of 1996 authorized a new individual savings vehicle, the medical savings account (MSA). The legislation authorizing MSAs did so as a pilot project and limited their offering to small employers. These limitations, as well as negative pressure from some legislators, essentially doomed these early MSAs. They were not attractive from an underwriting standpoint, and sponsors were reluctant to take on the administrative costs of setting up plans that potentially would be short-lived.

As pressure for more individual responsibility in healthcare utilization and purchasing grew, the insurance industry began to experiment with a type of self-funded plan that looked a lot like an FSA but allowed some accumulation of funds, or rollover. In 2002, Treasury gave its blessing to the health reimbursement arrangement. HRAs are individual employer-funded accounts in which unused funds can accrue and be used for future medical needs. This rollover feature carried the gene for the evolution of healthcare consumerism, offering individuals a real incentive to take a more consumer-oriented approach to buying healthcare products and services.

The HRA still had two major drawbacks, however: a lack of assured portability and a lack of a mechanism by which employees could make contributions. Employers and other plan sponsors could, by design, allow individuals to take accumulated HRA funds to new employers or into retirement, but were not required to do so. While a few employers built in these provisions, the general lack of guar-

anteed portability still needs to be addressed. Without it, the opposite of the intended effect could occur: Any individual who plans to change jobs might have an incentive to spend an HRA balance rather than lose it. Also, the prohibition against individual contribution to the HRA undermines the critical feature of individual responsibility in purchasing healthcare. Employees with HRAs are still spending their employer's money rather than their own— which means there's less incentive to use the funds judiciously.

The health savings account (HSA), essentially a second-generation MSA, addresses both concerns. HSAs may be funded through employer or employee contributions, or both, but the funds belong to the individual and thus are fully portable. This is not to say that the HSA is the end of the evolutionary line in the development of individual accounts, however. Certain features of the HSA and the HRA have resulted in a hybrid of the various health savings vehicles, which suggests that there still may be a better design.

More detailed discussion of the various accounts is warranted to help employers understand how each type of account can further their business objectives, consistent with a consumerism approach to healthcare. Ultimately, the goal for both business and consumers should be a healthier society, which in turn results in a healthier, more productive workforce as well as long-term control of healthcare costs.

Let's look at specific features of the three most significant accounts— the FSA, HRA and HSA.

Ultimately, the goal for both business and consumers from these accounts should be a healthier society, which in turn results in a healthier, more productive workforce, as well as long-term control of healthcare costs.

Flexible Spending Accounts

Medical flexible spending accounts (FSAs) were enacted as part of Tax Code section 125, the cafeteria plan rules.

Medical FSAs are individual accounts that can be funded by employer and/or employee contributions. They are available only to employees, although employees' dependents may be beneficiaries. Employee contributions are made on a

salary-reduction, tax-favored basis.

Business partners, sole proprietors and 2% shareholders are not employees, therefore they cannot participate in FSAs.

Funds availability: FSA funds generally must be used within the 12-month plan year, although employers can now authorize an additional 2-1/2 month grace period through formal plan document amendment. Funds not used within the allotted time frame are lost.

Although employees typically contribute to an FSA each pay period, employers under the "at risk" rule must make the entire plan year election amount available at any time in the course of the year. Thus, an employee who has made only one month's contribution is entitled immediately to the entire annual contribution, whether made by employer or employee—provided the spending meets the fund criteria.

COBRA: FSA funds are portable only through COBRA continuation of coverage rules, and under limited circumstances.

Reimbursable medical expense: Reimbursable expenditures are limited to Tax Code section 213 medical expenses and, under Treasury guidance, include certain over-the-counter products or services to treat specific conditions or injuries. FSAs may not be used to pay health plan premiums.

Non-discrimination requirements: FSAs are subject to cafeteria plan non-discrimination rules prohibiting contributions that favor highly compensated participants.

Health Reimbursement Arrangements

Health reimbursement arrangements (HRAs) are funded exclusively by employers and used to reimburse employee medical expenses, including health insurance premiums. The contribution does not count as part of the employee's gross income. Excess funds at year-end may be rolled over for future medical expenses.

The program enables employers to define certain health benefit contributions and shift more responsibility for healthcare choices to employees.

The HRA is defined as an arrangement that:

- Is paid for solely by employer contributions, without any cafeteria plan style pre-tax, salary reduction or election;
- Reimburses the employee, spouse or dependent for medical expenses as defined under Section 213 of the tax code, including premiums; and,
- Provides reimbursements up to a maximum amount for a coverage period. Any unused portion at the end of the coverage period is carried forward, thereby increasing the maximum reimbursement amount for the subsequent coverage period.

Unlike FSAs, all funds do not have to be immediately available to the individual, a feature that protects employers.

- Funds must be used for medical expenses only, there is no opportunity to “cash out”;
- Unused funds may be carried over for medical expenses in subsequent years;
- Plans may provide for funds to carry over after retirement or termination;
- Premiums and other medical expenses may be reimbursed from the same HRA;
- HRAs and FSAs may be provided simultaneously;
- When an individual is covered under both an HRA and an FSA, plans may determine which pays first; and,
- HRAs are subject to COBRA and HIPAA.

The typical HRA scenario is for a plan sponsor to offer a high-deductible, major medical insured or self-funded health plan, along with an HRA to help employees pay the deductible and other out-of-pocket expenses not covered by the major medical plan. The employer may establish a structure that requires an individual to be covered under a major medical health plan in order to be eligible for the HRA, but that is not required.

In fact, HRAs are being promoted as a way for small employers that otherwise cannot afford to provide health benefits to offer the account alone. The theory is that by offering at least a minimal package, with a possible link to state-funded health programs such as Children’s Health Insurance Programs, employers will introduce employees to the healthcare system and help them to learn to budget for healthcare needs and to otherwise take responsibility for some of the costs. In addition, this consciousness-raising may lead to healthier behavior and lifestyle choices.

Who can receive reimbursement? The HRA is a healthcare plan under tax code provisions that allow reimbursements to be excluded from the employee’s income, as provided under sections 105 and 106 of the tax code. HRA reimbursements are available to employees, former employees, and their spouses and dependents—but are not an option for the self-employed. Retirees and terminated employees may continue to receive HRA reimbursements even if they do not elect COBRA coverage.

Reimbursable expenses defined: To avoid being counted as taxable income, HRA reimbursements must be used for medical expenses as defined under Tax Code section 213—which includes long-term care services. Such expenditures must be substantiated, a requirement similar to that of medical FSAs. Unlike FSAs, however, HRA funds may be used to reimburse premiums for a major medical plan.

There is a catch to this provision, though: If the plan requires the individual to be enrolled in a major medical plan in order to participate in the HRA, the employer cannot impose a premium contribution requirement on the employee that is larger than the insurance cost without the HRA. IRS guidelines require that HRAs can only be funded by the employer, and any extra salary deduction above the cost of the major medical premium would be seen as an employee contribution to the HRA—which is not permitted.

There are also timing limitations on HRA reimbursements: An HRA may not reimburse a medical expense incurred before the date that the account is in existence—or before the employee enrolls. Nor can an HRA reimburse any medical expense that is attributable to a deduction allowed in a previous year.

Cafeteria plan prohibition: Because HRA contributions cannot be made on a pre-tax, salary-reduction basis, these accounts cannot be part of, or linked to, a cafeteria plan.

In another limit related to cafeteria plans, the HRA amount contributed by the employer cannot be linked to any amount forfeited under an FSA. However, an individual can have both an FSA and an HRA.

Order of payment: Generally, FSA funds cannot be used for a medical expense that is otherwise payable or has been paid by another plan. If coverage is provided under both an HRA and an FSA for the same medical expenses, the HRA funds

must be exhausted before FSA reimbursements are allowed. If the expense is not covered by the HRA, even though HRA funds still exist, then the FSA may be used to reimburse the expense.

There is one caveat, however. Plan sponsors may steer clear of that general rule by setting the payment order through the plan document. If, before the FSA plan year begins, the sponsor specifies in the plan document that FSA funds must be exhausted before an HRA will pay an expense covered under both accounts, then reimbursement may be made first from the FSA. The same expense cannot be paid by both accounts, of course.

Non-discrimination rules: HRA funding cannot favor senior management. The tax code non-discrimination rules that prohibit offering more favorable benefits to highly compensated individuals apply to HRAs, since they are self-funded plans. Thus, employers are required to make a flat contribution to the HRA—\$1,000 per participant, say—regardless of the employee’s status.

COBRA: COBRA rules apply to HRAs. An individual may choose COBRA for just the major medical plan or just the HRA, or both—unless the plan is designed so that the HRA is available only to those covered under the major medical plan.

Other matters: The tax code rules under sections 419 and 419A regarding employer deductions and reserves for retiree medical coverage apply to HRAs. Also, the section 404 rules regarding when an employer gets to take a deduction, i.e. when the expense is paid, also apply to HRA reimbursements.

HIPAA’s nondiscrimination rules apply, too, including when HRAs are used to fund individual health insurance policies treated as a group health plan. In addition, HIPAA’s portability rules apply, requiring certificates of prior coverage to be issued.

ERISA’s requirements for welfare benefits plans apply, as well. This could create issues under plan asset and trust rules, for example, depending on how the HRA is structured—as a funded account or a notational credit. The normal ERISA health plan document and other disclosure rules also apply.

Health Savings Accounts

HSAs were created by the Medicare prescription reform act signed by President Bush on Dec. 8,

2003, as a means of instilling a sense of personal responsibility in healthcare purchasing—and helping Americans save for future qualified medical and retiree expenses on a tax-free basis. Offering of HSAs was authorized starting Jan. 1, 2004.

HSAs essentially are 2nd-generation medical savings accounts. While available only to “eligible individuals,” anyone can contribute to them on behalf of an individual. But HSAs are not stand-alone plans. They may be offered only in conjunction with a high deductible health plan (HDHP) and are funding vehicles for medical expenses until the minimum required deductible is met under the high-deductible plan. HSAs also are designed to be used as a tool with other consumer-directed health plan features that promote wellness.

To qualify as a high deductible plan, the annual deductible must be at least \$1,000 for individual coverage and at least \$2,000 for family coverage, adjusted for cost of living with a year 2003 base. However, there does not have to be a deductible for preventive care.

In HDHPs, the total deductible and other annual out-of-pocket expenses, other than for premiums, cannot exceed \$5,000 for an individual and \$10,000 for family coverage, with this exception: In network plans, the maximum allowable out-of-pocket expense may be exceeded due to higher costs for out-of-network services.

Individuals with an HSA and a high-deductible plan may also have coverage for:

- Workers’ compensation;
- Specified disease or illness coverage; and,
- Hospitalization per diem.

Any “eligible individual” may establish an HSA. The contributions belong to the account-holder and are completely portable. Every year, money not spent may remain in the account and gain interest tax-free, just like an IRA. Unused amounts remain available for later years, unlike amounts in FSAs, which are forfeited if not used by the end of the year.

An “eligible individual” is someone who:

- Is covered under a high-deductible health plan;
- Is not entitled to benefits under Medicare; and
- May not be claimed as a dependent on another person’s tax return.

Tax-advantaged contributions can be made to an HSA in three ways:

- The individual and family members can make tax-deductible contributions to the HSA even if the individual does not itemize deductions;
- The employer can make contributions that are not taxable to either the employer or the employee; and,
- Employers with cafeteria plans can allow employees to contribute untaxed wages through a salary-reduction plan.

Funds distributed from the HSA are not taxed if they are used to pay qualifying medical expenses. Thus, an HSA essentially is a second-generation MSA with far fewer limitations. Any employer – including partners, sole proprietors and S corporation 2% shareholders – may offer the accounts. Employers and employees may contribute, unused funds roll over for future years' medical expenses, and individuals own the accounts. Plan rollovers –when changing employers, for instance—are limited to one per year.

Preventive care: Although an HDHP generally cannot pay benefits until the high deductible is met, preventive care, and related treatment, such as removal of polyps found during a routine colonoscopy, is an exception. Such services may be covered by an HSA or through the HDHP before the deductible is met.

In addition, drugs or medications may be considered preventive when taken by a person who has risk factors for a disease that has not yet manifested or to prevent recurrence of a disease.

Trust requirement: HSAs must be funded through a trust and used exclusively for qualified medical expenses. There must also be a plan document that limits contributions to no more than \$4,500 per year for individuals up to age 55. The maximum contribution may be increased by \$1,000 in 2006 for those over 55. The contribution cap is subject to cost-of-living adjustments.

HSA assets cannot be commingled with other property, except in a common trust fund or common investment fund, and are the property of the individual—not the employer that establishes the funds. Thus, HSA funds are portable when an individual leaves an employer, regardless of the reason.

Tax treatment of HSAs: Contributions to and payments from an HSA are excluded from taxable

income if they are used exclusively for qualified medical expenses, within the following limits: The maximum excludable contribution under a high-deductible plan is

- \$2,250 for an individual or the amount of the plan deductible, whichever is less; and
- \$4,500, or the plan deductible, for a family. The dollar amounts date from 1997 and are subject to annual cost-of-living increases.

Both the HDHP and HSA may be provided through a cafeteria plan. However, special provisions apply regarding HSAs provided through a cafeteria plan:

- Accelerated contributions by the employer are not required;
- Individuals may make mid-year contribution and participation election changes at any time; and,
- Employers may incorporate negative elections.

Qualified medical expenses: Qualified medical expenses include diagnostic and curative services, mitigation and treatment of medical conditions or prevention of disease. They also include transportation primarily for and essential to medical care, and qualified long-term care services.

Prescription drugs may be covered, but over-the-counter drugs are not. Nor are health insurance premiums qualified medical expenses for HSA purposes, with the following exceptions:

- COBRA continuation coverage premiums;
- Premiums for long-term care insurance;
- Health plan premiums while an individual is receiving unemployment compensation;
- Any health insurance other than a Medicare supplemental policy if the person is age 65 or older or meets certain disability requirements under the Social Security Act.

IRS guidance on HSAs also provides that an individual may use HSA funds to pay for medical expenses of a spouse or dependents, even when the spouse or dependent is covered under a non-HDHP. If HSA distributions cover expenses that are also reimbursed through another health plan, the HSA distributions would be taxable. If a husband and wife have separate HSAs, either spouse may use his or her account for medical expenses of the other.

A distribution does not have to be made in the year the medical expense is incurred to be excludable from income, as long as the individual has records to show: that funds were used exclusively

for qualified medical expenses; the expenses have not been previously reimbursed from another source; and the expenses have not been taken as an itemized deduction in a prior year.

If an individual elects to pay qualified long-term care insurance premiums with HSA funds made by salary-reduction through a cafeteria plan, the excludable distribution is limited to the annually adjusted amount allowed under tax code section 213(d)(10). If the premium paid through the HSA distribution exceeds the allowable LTC premium, the excess not only counts as taxable income, it may be subject to a 10% tax penalty as well.

Similarly, taxes and 10% penalties are imposed when HSA funds are used for prohibited expenses, unless the payment is made after the account-holder becomes disabled or dies. In the event of the latter, the funds must go to a designated beneficiary's account or be subject to taxes.

There is no penalty if funds are transferred to another HSA within 60 days of payment from the original HSA or in the case of a similar transfer under a divorce or separation document.

Special rules apply for married couples when both have HSA coverage. If one has family coverage, then the couple is regarded as having family coverage.

COBRA: HSAs are not subject to COBRA, although HDHPs are.

Non-discrimination: HSAs are subject to tax code non-discrimination rules, which require employer contributions to be “comparable” for eligible individuals. Contributions are considered comparable if they are either the same amount or the same percentage of the deductible under the HDHP. There may be different contribution levels for full-time and part-time employees, however.

The overriding question left is whether there can be different contributions based on classifications of employees, such as by years of service or by employee “matching” contributions to HSAs. Comprehensive guidance from IRS allows some different contribution schedules, but only through cafeteria plans. Specific guidance is as follows:

- Employers may not make matching contributions that would result in some individuals receiving different contributions than other

individuals based on the individuals’ contribution rates. However, an employer may make matching contributions through a cafeteria plan based on each individual’s contribution to it.

- HSA distributions are not subject to nondiscrimination rules of section 105(h), which apply to self-funded plans generally.

Unless contributions to an HSA are made under a cafeteria plan, an employer may not base them on an individual’s participation in health assessments, disease management programs or wellness programs.

Account administration: Employers may charge reasonable administrative fees for HSAs. Under account administration guidance HSA funds may be placed in investments approved for IRAs (e.g., bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds) or in certain types of bullion or coins. However, they may not be invested in life insurance contracts or in collectibles. The HSA trust or custodial agreement may restrict investments to certain types of permissible funds.

Strategies For Use Of Accounts

The consumer-directed healthcare purchasing movement is just the first step in a new approach to getting control of rapidly increasing healthcare costs which emphasizes individual responsibility.

HRAs and HSAs, along with FSAs, should further this objective by enabling employers and other plan sponsors to define their liability at least somewhat, while putting more decision-making – and thus responsibility – in the hands of employees. There are certain design considerations and market issues that will affect the success of such consumer-directed purchasing efforts.

While immediate cost-savings should not be the sole purpose of medical accounts associated with consumer-directed health care, some immediate savings may be achieved. Long-term savings are more likely to result from healthy behavior and lifestyle choices that CDHC encourages through disease management, healthcare coaching and other wellness programs.

For HRAs and HSAs to bring immediate cost-sav-

ings, there must be high-deductible plans that offer sufficient premium discounts to provide meaningful savings to employers. For insured major medical plans, cost savings will depend on carriers' willingness to offer products with a deductible that is high enough to sufficiently lower premiums and thus provide savings to plan sponsors.

Then, there will be the issue of rising premiums for the high deductible plans to offset losses from the reduction in the market for lower-deductible coverage. In addition, there will have to be choices associated with major medical plans that require individuals make informed decisions and be cost-conscious in shopping for health coverage.

Employers that self-insure, on the other hand, have the flexibility to set their own deductible levels and are more likely to see advantages from HRAs.

A plan sponsor may terminate its dental and vision plans and instead allow related expenses to be reimbursed from the HRA, for example, thus reducing multiple plan administration costs. For smaller plan sponsors unable to otherwise provide dental and vision coverage, an HRA could be introduced with the explanation that the purpose is to reimburse dental and vision as well as major medical expenses. The plan sponsor is thus able to tell employees they are, in essence, receiving dental and vision coverage—but to do so at minimal, if any, extra cost to the employer.

Because of the potential relation of an HRA amount to a health plan funded at least in part through employee pre-tax salary reduction, a fixed level contribution to an HRA regardless of the choice of health plan option may be needed. There still could be tiered HRA contributions, depending on circumstances, such as one contribution level for single coverage and a second level for family coverage.

Order of payment: Generally, under regulations governing FSAs, a medical expense that's reimbursable under any part of the health plan—or any other health plan—may not be reimbursed from a medical FSA. Under normal IRS rules, if coverage is provided under both an HRA and a Section 125 FSA for the same medical expense, the HRA funds must be exhausted before reimbursements are permitted under the FSA. However, the 2002 IRS ruling allowed reversal of the ordering

The consumer-directed healthcare purchasing movement is just the first step in a new approach to getting control of rapidly increasing healthcare costs which emphasizes individual responsibility.

arrangements. Thus, a violation does not occur if the medical plan has contract language that is properly written. A plan with a combination of accounts can not provide double reimbursements, of course.

Requiring FSA payment first may force individuals to be more judicious in their use of medical care. If the ultimate goal is to enable employees to save toward post-retirement medical expenses, then requiring reimbursement to come from the FSA first may make more sense.

Cost-containment plan designs: Plan sponsors will have to exercise care in creating incentives for participants to minimize healthcare spending. Providing rewards, such as bonuses, will have to be unrelated to HRA or HSA balances.

Non-discrimination rules: The extent of ultimate employer liability will depend in part on whether the plan allows accumulated HRA funds to be available after termination or retirement, or both. Plan sponsors may first want to allow such carryover as a perk for senior management. However, the nondiscrimination rules must be considered. The plan may end up being discriminatory, either forcing plan sponsors to make the post-termination coverage available to everyone or exposing senior management to income tax liabilities.

Medical expenses limitation: The guidance specifically limits HRA reimbursements to tax code-defined medical expenses. A major medical plan may cover treatment that does not meet the tax code definition of medical expense, such as cosmetic surgery that is not related to post-injury or post-surgical reconstruction, in which case the reimbursement amount counts toward gross income. Such expenses should not be reimbursed through an HRA.

COBRA: It is not clear from the guidance how premiums would be determined. Apparently, the same rules—that COBRA premiums are 102% of the full annual employer contribution— would apply as for medical FSAs. An individual would not elect COBRA for an HRA unless there had been carryover of

prior years' amounts that would make the election worth the cost. For example, if an HRA balance had accumulated to \$4,500 for an arrangement with a \$1,000 annual contribution, the individual would pay \$1020 to have a right to reimbursement of \$5,520 ($\$4,500 + \$1020 = \$5,520$). Depending on what the plan sponsor ultimately wants to achieve, there could be a limit on the maximum build-up.

The Future?

The concept of a 3rd generation personal care account (PCA) focuses on the impact of employee health on broader corporate metrics of productivity, absenteeism, "presenteeism," turnover, accident rates, etc. PCAs will need to accommodate incentives and rewards for broader corporate initiatives. For example, they could be structured so that the funds are increased if an individual or group meets predetermined performance, safety, or sales standards. A mix of individual and group awards would add a new dimension to the total compensation package, making PCAs the new "frequent flier" program.

4th generation PCAs would focus on the individual characteristics and lifestyle needs of each member. As employees become familiar with HRAs and begin to accumulate sizeable sums, they will likely demand more ownership and security of the funds—with guaranteed portability, a feature that would have to be created with additional legislation. Vesting issues and "notional interest" will become increasingly important to employees to secure the value of their accounts. Eventually, too, demand will grow for more immediate use of the funds for non-plan-qualified medical expenses (QMEs) and for paying health premiums.

Employees may also want the right to bolster their HRA accounts by cashing in unused vacation or sick leave. Finally, PCAs will likely need to accommodate personal lifestyle expenses such as various alternative medical modalities. and, perhaps, the ability to use debit/credit cards to cover Internet purchases and cyber-office visits. The IRS will have pressure to expand the definition of QME to encompass cosmetic surgery and other personal care services.

Chapter IV

The Supply Side: Supportive Services & Programs

As noted in Chapter I, medical consumerism is about much more than financing vehicles. The concept, in its maturity, takes a broad look at the importance of improving the health of the entire population, not just at developing new ways to finance healthcare services. If we are to optimize the advantages of medical consumerism and mitigate its potential drawbacks, there will need to be a significant shift in the focus of the delivery system from “sick” care to “health” care. The emphasis must be on the continuum of care, from prevention and primary, or wellness, care to tertiary care and disease management.

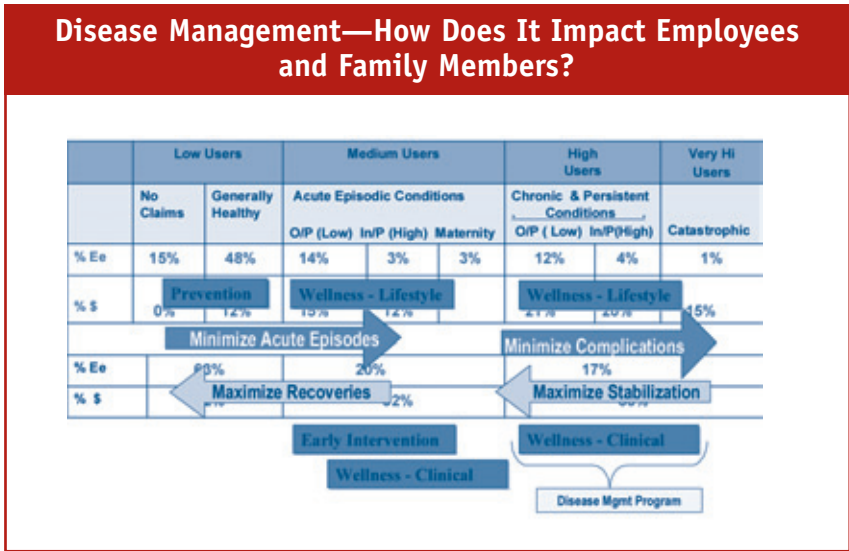
Preventive Care: The Promise of Wellness

Consumer directed healthcare plans typically minimize barriers to obtaining preventive care. The majority of CDHC designs include 100% coverage for preventive care so that plan participants can focus on maintaining good health and accumulating funds for future medical needs. Extensive preventive care coverage provides a greater potential for carryover of unused funds, since the cost of preventive services will not be deducted from HRA or HSA accounts.

Wellness care can be defined as a proactive, organized program providing lifestyle and medical/clinical assistance to help employees and their family members maintain good health. Wellness programs encourage voluntary behavior changes and support compliance with proven approaches to maintain health, reduce health risks and enhance productivity.

As shown below, most employees (83%) fall into the low and medium categories of healthcare spending. It is in an employer’s best interest to keep employees in the low-user category by providing preventive care and wellness-lifestyle support. It is also important to minimize the cost of

acute conditions with early intervention and of chronic conditions with wellness care and disease management. With consumerism, the power of employee self-interest and financial incentives are used to support lower costs and better health, both of which benefit the employer as well.



Employers can help keep employees in the low-user category by providing preventive care and wellness-lifestyle support, and can minimize the cost of chronic conditions with disease and care management.

One of the unfulfilled promises of HMOs is the delivery of member wellness and prevention. Under plans with first-dollar coverage, employee wellness programs were often inconsistent with the marketing hype, and underutilized even when available. Employers feared that they would incur the expense of wellness programs but that, because of high turnover, the benefits of such programs would accrue to other employers. Under CDHC HRA plans, the employer—not the HMO—decides what preventive care is covered and how much is reimbursed. And there is greater awareness of

employer payback through increased productivity and better job performance.

Knowledge alone does not change tough health behaviors among the masses of people with little motivation. A person may have timely, accurate and scientific based knowledge on what needs to be done

Knowledge alone does not change tough health behaviors. It is critical to address the gap between “knowing” and “doing”.

Wellness Preventive Care for HSAs

Preventive care includes, but is not limited to, the following:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.
- Obesity weight- loss programs.
- Screening services

However, preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition.

Safe Harbor Preventive Care Screening Services

Cancer Screening

Breast Cancer (e.g., Mammogram)
 Cervical Cancer (e.g., Pap Smear)
 Colorectal Cancer
 Prostate Cancer (e.g., PSA Test)
 Skin Cancer
 Oral Cancer
 Ovarian Cancer
 Testicular Cancer
 Thyroid Cancer

Heart and Vascular Diseases Screening

Abdominal Aortic Aneurysm
 Carotid Artery Stenosis
 Coronary Heart Disease
 Hemoglobinopathies
 Hypertension
 Lipid Disorders

Infectious Diseases Screening

Bacteriuria
 Chlamydial Infection
 Gonorrhea
 Hepatitis B Virus Infection
 Hepatitis C
 Human Immunodeficiency Virus (HIV)
 Syphilis
 Tuberculosis Infection

Mental Health Conditions and Substance Abuse Screening

Dementia
 Depression
 Drug Abuse
 Problem Drinking
 Suicide Risk
 Family Violence

to live healthier, but unless this knowledge is converted into tangible and sustainable behavior change, the promise of consumerism will never be fulfilled.

It is critical to address the gap between knowing and doing when designing a wellness program. A full complement of tools is needed to educate and empower consumers and, ultimately, to change their health habits and medical purchasing. Full service wellness programs offer some or all of the following:

- Health Risk Assessment
- Health screenings
- Effective communication programs
 - Health awareness
 - Program enrollment
 - Health education
- Web-based software programs
- Printed materials when appropriate
- Collection and analysis of data
 - Medical claims
 - Pharmacy claims
 - HRA data
 - HR data
- Benchmarking and reporting
- The Prochaska Transtheoretical Model for behavior change
- Health coaching
 - Coaches from multiple disciplines
 - Extensive training around the science of health behavior change
 - One-on-one patient-coach relationships
- Health concierge services
 - Extensive knowledge of employer’s full benefit plan
 - Ombudsman for all health and behavioral health benefits
 - Customized research for local community support services
- Incentives
 - Participation
 - Outcomes
- Worksite fitness centers

IRS defined preventive care: Because the law allows 100% coverage for preventive care, the IRS has authorized preventive care coverage at 100% for HSA eligible high-deductible health plans (HDHPs), without a need to meet the front-end deductible. Wellness and preventive services approved by the IRS as “safe harbor” benefits include those listed in the chart.

Additional preventive care guidelines and safe harbor definitions for HRAs were released in March 2004 by the IRS.

July 2004 IRS guidelines further clarified preventive care as follows:

Notice 2004-23 sets out a preventive care deductible safe harbor for HDHPs under section 223(c)(2)(C). Solely for this purpose, drugs or medications are considered preventive when taken by a person who has risk factors for a disease but is asymptomatic or to prevent the recurrence of a disease.

For example, the treatment of high cholesterol with cholesterol lowering medications (e.g., statins) to prevent heart disease or the treatment of recovered heart attack or stroke patients with angiotensin-converting enzyme (ACE) inhibitors to prevent a recurrence would constitute preventive care.

Drugs or medications used as part of preventive care services specified in Notice 2004-23, including obesity, weight-loss and smoking cessation programs also qualify. However, the preventive care safe harbor under section 223(c)(2)(C) does not include any service or benefit, including medications, intended to treat an existing illness, injury, or condition.

Broader approaches to preventive care: 2nd generation

Information by itself will not move everyone to better care or better health. Second generation preventive care programs provide incentives and awards. Because information alone is often ineffective, 2nd generation preventive care plans reward participation in wellness programs or health risk appraisals, for example. In addition, employees who demonstrate specific desirable health habits may receive points that convert to discounts, rebates, or improved coverage (e.g. non-smoking programs, health club membership, corporate sponsored runs, etc.).

An HRA with incentives offers individuals the potential to address underlying health conditions not covered by traditional insurance. For example, a patient with high cholesterol and a family history of heart disease might find it extremely valuable to have a CT scan to determine the degree of calcifications. Although this test is typically not covered by insurance, the information it reveals may help motivate the patient to comply with his medication regimen. Similarly, depending on the CDHC design, consumers who believe in the value of complementary and alternative medicine can potentially benefit from an HRA in which individual treatment choices can be covered based upon patient preference.

These approaches combine personal responsibility with patient financial involvement to incentivize program participation and foster compliance as well as better personal health management. The possibilities are many and depend on what type of behavior an employer aims to encourage. Incentives that reinforce a culture of health, well-being, self help and shared responsibility can have a significant effect on outcomes.

Second generation preventive care programs provide incentives and awards to enhance motivation to make changes that will lead to improved health.

Broader approaches to preventive care: 3rd generation

The concept of 3rd generation preventive care focuses on linking individual health to business performance metrics like productivity, attendance, and turnover. Thus, it emphasizes programs designed to maintain or improve the functionality and performance of a particular population. Measurements are being established to link personal safety, occupational hazards, accident prevention, prevention of worksite violence and stress, among others, to overall corporate productivity and costs.

Calculating the return-on-investment (ROI) for preventive care and wellness programs continues to be challenging due to the multitude of variables that influence health status and business performance. However, some employers are examining the correlation between employee participation in health promotion and wellness programs and direct medical costs and some business-unit operational metrics. The link between health and other performance issues will continue to develop as 3rd generation plans evolve.

3rd generation preventive care links individual health to business performance metrics like productivity, attendance, and turnover.

Organizational stress: Stress costs U.S. businesses over \$400 billion per year, according to the Bureau of Labor Statistics. Indeed, stress has been found to be responsible for an estimated 22% of healthcare spending, 40% of employee turnover,

and 50% of workers' compensation, non-occupational disability, absenteeism, and presenteeism.

Employers can design programs, however, to effectively address the effects of the demands and pressures on their employees. Stress management programs can help employees learn to use self-help tools, accept personal responsibility for solutions, master strategies to diminish the negative impact on their health and behavior, and do their part to establish a positive environment at home and at work.

For many companies, 3rd generation stress management programs can link healthcare, consumerism, and organizational quality, safety, and error reduction. Depression in the workplace, a major problem at many companies, needs to be addressed as well.

Broader approaches to preventive care: 4th generation

Personalized and individualized prevention and early intervention will be the hallmark of 4th generation medical consumerism. Personalized care will utilize genomics, predictive modeling, and push technology, and preventive care will include both lifestyle and clinical factors.

Preventive care is identified by the procedure (CPT) and diagnostic code submitted by a physician. Preventive services are scheduled based on recommendations by recognized experts, such as the US Preventive Services Task Force, the American Cancer Society, and the American College of Obstetrics and Gynecology.

The charts below summarize the recommended clinical screenings and immunizations for adults age 18 and over. Beyond limiting preventive benefits to specific dollar amounts, which is a common approach, employers can safeguard against abuse by specifying the type of services and the frequency with which they will be covered. The patient will have little incentive to make multiple requests for benefits, as payment will be denied for services that exceed the recommended limits.

By definition, a routine physical is a medical exam performed by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease. Therefore, if the patient is ill or seeking treatment of a medical condition, the doctor cannot bill for a routine visit.

Age 18 – 39: One exam every 24 months	
Recommended Clinical Screenings	Immunizations
Blood pressure Height & Weight Physical and mental status assessment including: - Clinical breast exam - Clinical testicular exam - Complete skin exam Serum Cholesterol/HDL Urinalysis screening Hemoglobin & Hematocrit Digital rectal exam Stool for occult Blood High Risk Testing/Screenings <ul style="list-style-type: none"> • Tuberculin Testing • HIV Screening • Barium Enema • Colorectal Screening (includes colonoscopies and sigmoidoscopies) 	Tetanus-diphtheria (Td) booster every 10 yrs. MMR for persons born after 1956 who lack evidence of immunity to measles Varicella vaccine with no history of chickenpox. <i>High Risk Immunizations:</i> <ul style="list-style-type: none"> • Hepatitis B - for adults at increased risk for hepatitis B • Pneumovax • Meningococcal • Hepatitis A

Age 40 – 64: One exam every 24 months

Recommended Clinical Screenings	Immunizations
<p>Height & Weight Physical and mental assessment including:</p> <ul style="list-style-type: none"> - Clinical breast exam - Clinical testicular exam - Complete skin exam <p>Serum Cholesterol/HDL Urinalysis screening Hemoglobin & Hematocrit Digital Rectal Exam Stool for Occult Blood Baseline EKG; once between ages 40-64 Sigmoidoscopy; baseline at age 50-55 then every 3 – 5 years.</p> <p><i>High Risk Testing/Screenings:</i></p> <ul style="list-style-type: none"> • Tuberculin Testing • HIV Screening • Barium Enema • Colorectal Screening (includes colonoscopies and sigmoidoscopies) 	<p>Varicella vaccine with no history of chickenpox.</p> <p>Tetanus-diphtheria (Td) booster every 10 years</p> <p><i>High Risk Immunizations:</i></p> <ul style="list-style-type: none"> • Hepatitis B - for adults at increased risk for hepatitis B • Pneumovax • Meningococcal • Hepatitis A

Age 65 & over: One exam every 12 months

Recommended Clinical Screenings	Immunizations
<p>Blood Pressure Height & Weight Physical and mental status assessment including:</p> <ul style="list-style-type: none"> - Clinical breast exam - Clinical testicular exam - Complete skin exam <p>Serum Cholesterol/HDL Urinalysis screening Hemoglobin & Hematocrit Digital Rectal Exam Stool for Occult Blood Sigmoidoscopy - every 3-5 years</p> <p><i>High Risk Testing/Screenings:</i></p> <ul style="list-style-type: none"> • Tuberculin Testing • HIV Screening • Barium Enema • Colorectal Screening (includes colonoscopies and sigmoidoscopies) 	<p>Tetanus-diphtheria (Td) booster every 10 yrs.</p> <p>MMR for persons born after 1956 who lack evidence of immunity to measles</p> <p>Varicella vaccine with no history of chickenpox.</p> <p>Influenza vaccine annually</p> <p><i>High Risk Immunizations:</i></p> <ul style="list-style-type: none"> • Hepatitis B - for adults at increased risk for hepatitis B • Pneumovax • Meningococcal • Hepatitis A

Cancer screenings as preventive care

PSA: – Covers prostate specific antigen (PSA) screening of males age 40 and older and men under age 40 who are at high risk for prostate cancer as a preventive service. Risk groups include African-Americans and those with a family history of prostate cancer.

Note: Diagnostic PSA testing is also covered, regardless of preventive benefits, for men of all ages with signs or symptoms of prostate cancer, and for follow-up of men with prostate cancer.

Mammogram: - Covers annual mammography screening for asymptomatic women age 40 and older and younger women who are judged to be at high risk by their primary care physician.

Note: Diagnostic mammography of women with signs or symptoms of breast disease is covered regardless of whether the woman has preventive benefits.

Annual routine ob/gyn exams, including a Pap smear for all women, is covered.

Disease Management: The Promise of Controlling Chronic Conditions

Disease management (DM) is a proactive, organized program providing lifestyle and medical/clinical assistance to employees and their family members with chronic conditions. DM programs encourage voluntary behavior changes and support compliance with proven medical practices designed to stabilize conditions, reduce health risks and enhance individual productivity.

Categorizing the covered population as non-users, low users, medium users, high users, and very high users helps to find the most effective programs and sources of savings. DM programs typically target patients with chronic diseases such as

DM programs encourage voluntary behavior changes and support compliance with proven medical practices designed to stabilize conditions, reduce health risks and enhance individual productivity.

diabetes, asthma, and congestive heart failure, as well as hypertension, depression, and back pain. Many employers also offer DM programs for employees suffering from co-morbid complications of two or more conditions.

Such programs typically include an active outreach component: Disease-specific educational materials and reminders about adherence to various treatment guidelines are sent to patients. Nurses who act as coaches on phone lines staffed 24/7 also play a major role as patient advocates and educators. Additional educational efforts are directed towards providers, typically covering treatment guidelines, research updates and updates on a particular patient's progress (or lack of progress) in adhering to a particular treatment regime.

The growth of disease management: As a rule, about 20% of the population generates about 68% of healthcare claims, while chronic conditions account for about 16% of claims and represent about 41% of total plan payments. Clearly, a focus on chronic illness is likely to have a payoff in terms of improving health and lowering costs.

There are currently 160 to 170 disease management companies in the United States, but many are expected to consolidate over the next few years. According to the Disease Management Association of America (DMAA), the disease management process:

- Supports the physician-patient relationship and plan of care.
- Emphasizes preventing medical complications by following evidence based practice guidelines and patient empowerment strategies.
- Evaluates clinical, humanistic and economic outcomes on an ongoing basis.

According to the Disease Management Purchasing Consortium, revenues for outsourced DM services grew from \$70 million in 1997 to about \$500 million in 2001. The Boston Consulting Group projects that this market could expand to \$10 billion by 2010. A PricewaterhouseCoopers study found that 44% of large employers offered a DM program in 2000, up from 14% in 1995.

Three separate areas can be identified, with specialty services and vendors for each. There seems to be a growing demand for comprehensive single vendor solutions.

- Basic DM services target broad populations of

patients with chronic conditions. But some specialized firms focus on specific clinical areas such as respiratory care, renal care, diabetes, or high risk pregnancy, including:

- Airlogix
- RMS Health Management
- Diabetix
- Padios Health Service
- Currahee Health Solutions

- DM companies specializing in multiple diseases, with an integrated approach, using case management of patients with co-morbidities:

- LifeMasters Supported Self Care
- American Healthways
- CorSolutions
- SHPS
- Health Dialogue- (offers patient support for making decisions about specific conditions like low back pain and prostate cancer.)

- High-risk patient management targets patients with complex conditions expected to be the most expensive within a population, rather than specific disease categories. Predictive modeling is used to help identify patients who need this service. Examples of companies taking this approach include:

- StatusOne
- FutureHealth
- Franklin Health

2nd generation disease management:

Specialized DM vendors have developed programs for a dozen or more conditions. These 2nd generation programs typically include incentives and a focus on self-care. Those with rewards for compliance with evidence-based treatment guidelines are proving to be effective.

Disease management program results are still preliminary, however, because of limited data and the difficulty of definitively linking program participation to outcomes among chronically ill patients. Some employers and health plans have demonstrated that specific DM programs improve patient care and reduce medical service utilization, but evidence varies widely across health conditions and the types of interventions. The most effective programs combine information and support with financial incentives.

Although reported ROI can range from 1-to-1 to

5-to-1, most vendors guarantee savings at least equal to the cost of the DM program.

Most DM programs are voluntary, so the decision to participate is entirely up to the patient—and getting people to do so has proven to be a major challenge. In some cases, data mining of prescription drug use and other health services can assist in determining the potential value of DM for an individual. HIPAA and privacy concerns can be effectively addressed while providing valuable information and self-help for DM candidates.

3rd generation disease management: Employee productivity, disability, unscheduled sick leave, workers' compensation and the like are the focus of 3rd generation programs, in addition to health and healthcare costs.

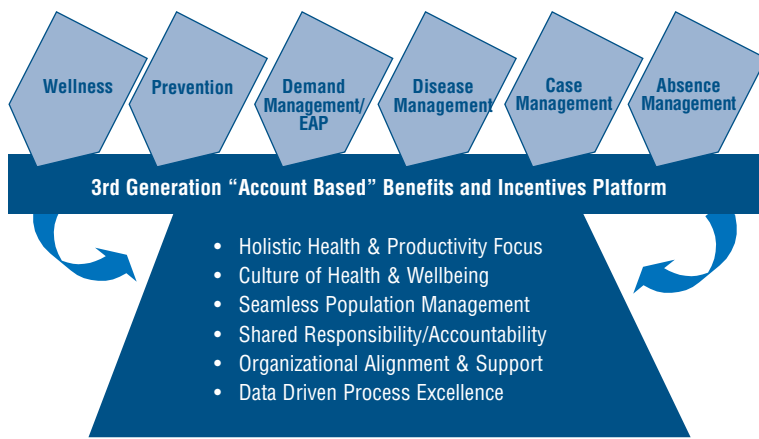
An important tool for discovering the key areas affecting the business entity is to have all employees participate in a Health Risk Assessment (HRA.) Aggregate information based on this type of population management tool can direct an employer's education, DM and worksite assistance efforts.

It is difficult to conceptually segment 3rd generation disease management programs from other efforts to positively affect human capital. Below is a spectrum of programs that promise to produce savings for the health benefit budget if they're properly integrated—and can go much further in producing an efficient, optimally functioning organization.

Another view of 3rd generation consumerism and disease management opportunities is to integrate population management, disease management, case management and quality management.

4th generation disease management: The concept of 4th generation disease management focuses on the individual. It looks at each beneficiary's lifestyle and clinical needs and the impact on his health and healthcare concerns. The 4th generation disease management programs will use Internet based information and services, offer more personalized support and be more integrated into the life of the patient via cyber connections. The future will include new tools that support personalized disease management programs to assure the delivery and impact of evidence based medicine. Imagine a world with a cyber-aide that continuously searches the Internet for the latest information and research on your disease state.

Optimizing Individual and Organizational Health & Performance



For example, consider a 4th generation DM program that focuses on the individual and personalized profiling, with self-help direction for stress management. Because of the historical stigma and benefit limitations on mental healthcare, emotional issues like stress and depression have not been adequately addressed. Yet we know that many physical symptoms and associated medical costs have a root cause of stress or depression which, if addressed directly and adequately, could mitigate both health costs and problems.

Information Therapy and Other Tools

Cyber-health aides: Some aspects of personalized healthcare are already developing. The future will include mind-boggling decision support systems and wireless connections that link each person to a personalized health and healthcare cyber-support system. Such systems can be built to profile activity and anticipate areas of interest.

In the future, we will likely be connected to services through monitors that will provide real time feedback on health status, lifestyle, and health concerns. Healthcare cyber-feedback may provide daily results of calorie expenditures and suggest a dietary menu for dinner, for instance. A personalized cyber-aide may seek out and suggest health-related vacation packages or personalized exercise equipment through Internet searches or automatic cyber-auctions.

Predictive Modeling: Consumerism and related healthcare programs are expanding into sophisticated predictive modeling programs that identify problem conditions and produce early warning notices to patients. Genomics testing will add to the personalized approaches as future scientific developments occur. With the use of the Internet and web portals, vendors with disease management programs and predictive modeling now have a channel to rapidly communicate with the patient.

Push technology: Push technology refers to a process of timely delivery of needed information and self-help advice to consumers—before they request it. The idea is to identify potential problems and suggest an appropriate course of action well before they become serious and costly –conditions

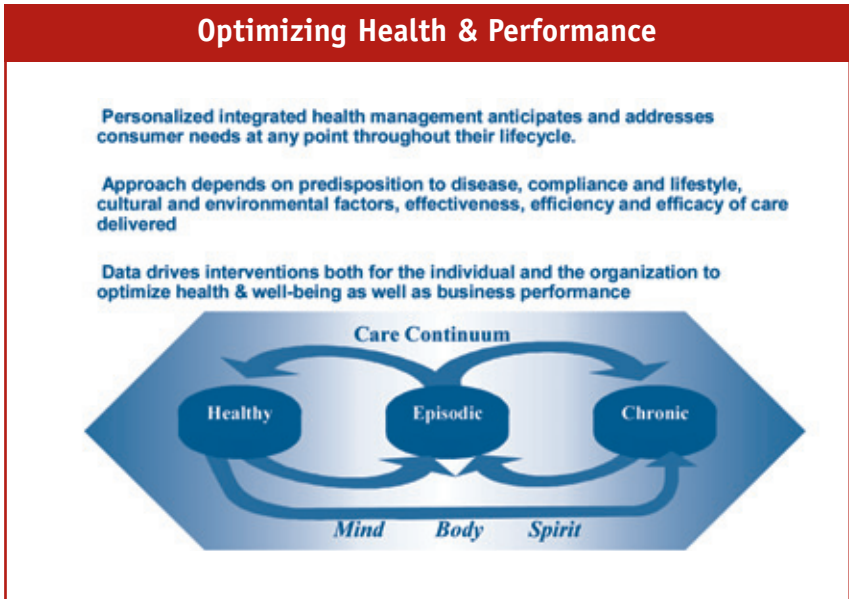
Disciplined Approach to Deliver Short Term and Long Term ROI



Imagine a world with wireless connections for continuous streaming of vital signs, creating real time test results that make it possible to monitor treatment progress.

In 4th generation DM programs, information will be linked on an interactive basis to actual care. Patient lifestyle and cultural differences will be accommodated. Consumers will receive holistic care, as the integration of mind, body, and spirit develops. And, prescription drugs and other therapeutic treatments will be customized, based on the genomics and physical characteristics of the patient.

Electronic Medical Records: EMR, which many healthcare systems and providers are already using, will be the foundation for accurate, consistent, and integrated preventive care and medical treatments. The next decade will likely see the federal government establish standards that make it possible for hospitals and health systems across the country to have instant access to patients' medical history through a national network of electronic medical records.



Chapter V

Information & Decision Support – The Promise of Transparency

As healthcare benefits develop into models designed to meet individual needs, decision aids will need to be coordinated with plan design to ensure that the benefits provided are effective. Likewise, as accountability shifts to the consumer, decision-support tools must be developed with input from the people who will use them. No two people are alike, nor are they at precisely the same level of health literacy. So tools will need to be customized—a “one size fits all” delivery mode will not work in tomorrow’s consumer healthcare marketplace.

Americans are accustomed to being in control of what and how they purchase products and services. They seek to make informed choices, balancing quality against price, within their budgetary constraints, taking into account the value of any reward or incentive. While consumers generally expect to have this purchasing power, many people find healthcare decision-making—and personal accountability—to be an intimidating prospect. The reason, of course, is that the stakes are so high.

The idea of making informed and cost-effective healthcare decisions is a new concept for most consumers, who recognize that doing so is considerably more complex than, say, buying a plasma television. However, some non-medical purchasing decisions are quite complex, yet most people are able to manage them. For instance, a first-time home buyer has a lot to learn before making such a significant purchase. Yet the idea of owning a home motivates us to master the details, so we can make a decision that best fits our needs.

With new consumer-based technologies that allow a comparison of product prices, quality and the reputations of the companies selling the products, consumers are better able to evaluate options. Given the right motivation, and appropriate information coupled with the right incentives, most consumers can learn to make wise healthcare decisions as well.

To successfully transition from restrictive plan designs to consumer directed strategies that promote optimal outcomes, plan sponsors need to provide consumers with more support and guidance than ever before. Decision-support tools must be developed with input from the people who will use them. A “one size fits all” delivery mode will not work in tomorrow’s consumer healthcare marketplace.

In order to successfully transition from restrictive plan designs to consumer directed strategies in a way that encourages choices that promote optimal outcomes, plan sponsors need to provide consumers with more support and guidance than ever before. As the rules of the road change, so must the vehicles.

The key to a consumer roadmap is a robust set of decision-support tools. In the managed care setting, consumer choice has mostly been governed by plan provisions, coupled with cost-share drivers to preferred providers or services. Thus, consumers have had relatively few decisions to make. Because the limited choices found within a typical managed care plan are strongly influenced by plan design, consumer tools have focused primarily on policies and procedures, out-of-pocket cost comparisons, condition-specific educational materials, and retail pharmacy and provider locators.

With CDHC models, consumer out-of-pocket expenses are driven more by broad cost-share strategies and less by plan design. This requires consumers to shoulder more of the decision-making process and the financial responsibility associated with those choices.

However, decision-support tools are not limited to CDHC plans. In an era of consumerism, traditional plan providers have also learned that such tools are instrumental in promoting optimal choices,

regardless of plan structure. Empowered consumers learn how to leverage any health plan to their greatest advantage, by learning the rules and seeking the path that best meets their needs with the least out-of-pocket investment. In a properly constructed plan, the best path for the consumer will also achieve optimal results for the plan sponsor. In a consumerism model, plan participants go from being victims of benefit design to active decision-makers, albeit within the boundaries established by the plan sponsor.

Let's look at how decision support and information has changed and will need to evolve further in order to be successful in CDHC.

1st Generation Decision Support : Account-Based Plans

The 1st generation of CDHC models focused on account-based benefits that placed more accountability on the consumer. Most decision-support tools in this setting were designed to help consumers make more cost-effective choices. The primary goal was to reduce out-of-pocket expenses and plan costs through proactive and retrospective cost awareness of medical services and prescriptions. These tools helped consumers to:

- Compare costs of common services and treatments
- Compare costs of prescription alternatives
- Check tax-advantaged account balances
- Check plan benefit balances, i.e., deductible and maximum out-of-pocket costs

Depending on the timing of healthcare utilization, cost-awareness tools are available through various channels, including call centers and online access. Retrospective cost-awareness tools are available via call centers, online, print communications, and text messaging. Most CDHC plan providers have made significant investments in these areas – often more than in the plan design technology

Plans must provide not only facts that encourage informed decisions, but the means to conveniently access information at the time of decision-making. A multi-pronged approach is necessary, with information provided through a variety of channels.

itself. In fact, decision-support tools are a vital component in successfully transitioning a population from managed care to a true consumer model.

To create an empowered consumer, plans must provide not only facts that encourage informed decisions, but the means to conveniently access information at the time of decision-making. Since individuals differ in the ways they learn and assimilate information, a multi-pronged approach is necessary. Information should be provided through a variety of channels – and in a manner that is understandable to the consumer.

Online decision support tools: The Internet is the most cost-effective and convenient channel for providing information. True to the spirit of consumerism, Web tools have also evolved to educate consumers about how to get the most out of their benefits – highlighting choices that encourage cost-conscious behavior and align with plan goals. With these tools, consumers can:

- Find in-network providers
- Access plan design summaries
- Look up formulary information
- Order prescriptions online
- Obtain information about general health and prescription drugs

Many plans have begun highlighting not only member out-of-pocket costs, but plan costs as well. This tactic reveals the monetary value of the health benefit to plan participants and increases awareness of the high costs of healthcare services through cost transparency. In an age in which consumers are becoming increasingly accustomed to Internet tools to find the highest quality products for the lowest price, it's a natural evolution to carry this over to the healthcare arena.

Call center support: But a Web site alone does not create a consumer strategy. Prompted initially by CDHC niche players, mainstream health plans have begun to supplement Web tools with consultants at call centers. The staff at these call centers are often referred to as “advocates” or “coaches.” Their primary objective is to help consumers gain a better understanding of the nuances of plan design and learn to balance cost and quality— issues that previously were hidden within complex plan policies and procedures.

Typically staffed by nurses, health educators or benefit counselors, these call centers provide

information pertaining to:

- Provider choice – understanding fee schedules of different providers within the network;
- Procedural alternatives – evaluating cost and efficacy of various healthcare diagnostics and treatments (e.g., understanding the difference between a CT scan and an MRI);
- Symptom evaluation – determining when to go to the emergency room and when to wait for a scheduled office visit;
- Plan design – understanding the rules and how to follow them;
- General health and wellness coaching; and
- Claims processing and appeals

Call centers are an effective means of providing consumers one-on-one access to information that can help them calculate the cost/quality equation central to making the best healthcare choices.

Direct mail communications: Plan sponsors have a fiduciary obligation to communicate with members regarding benefits. And, although many plan members have access to and are comfortable with the Internet, there are still many people who are not Web-savvy, do not own a computer or do not trust online communications. Others prefer to receive information by mail than to speak to a stranger on the phone. This means that some direct mail communications are still necessary. They may be used to:

- Explain service costs and plan costs associated with personal healthcare decisions;
- Recommend generic or formulary alternatives to widely used prescription therapies;
- Provide education about wellness and health maintenance targeted to individuals with specific chronic conditions

2nd Generation Decision Support—and Beyond

As plan design strategies continue to demand more consumer accountability, participants will need more sophisticated decision-support tools – particularly when it comes to balancing quality healthcare with financial management. That's where incentives and disease management programs come in.

Over time, consumers' sensitivity to both short-term and long-term costs will increase, including

the awareness that tactics which may offer participants short-term savings could ultimately result in higher costs to both the plan sponsor and to the individual. For example, if a patient doesn't take his blood pressure medication to avoid paying the Rx copay, the result could be a catastrophic medical event – clearly not a desirable outcome from any perspective. Therefore, while plan sponsors adopt account-based plan designs, many will also be adopting disease management and compliance programs as a way to help consumers control chronic conditions, improve their quality of life, increase their productivity and rein in healthcare costs.

Disease or care management programs are geared to consumers who have been recently diagnosed with a chronic condition as well as those who have been living with a condition but are using excess healthcare resources due to poor self-management. The objective is to provide individualized guidance to patients who need this additional support. Condition management programs educate patients about their condition, help them manage it through lifestyle changes and help them comply to a treatment regimen and follow their physician's advice.

Plan sponsors are increasingly interested in medication compliance programs to decrease the likelihood of adverse events. The goal is to prevent the onset or recurrence of medical crises severe enough to require a visit to the emergency room.

Consumers' sensitivity to both short-term and long-term costs will increase, including the awareness that tactics which may offer participants short-term savings could ultimately result in higher costs.

The 2nd generation decision-support tools will include a blend of strategies to encourage consumer empowerment while promoting healthy outcomes. Successful plans will focus first on clinical results influenced by consumer choices, and then on the financial impact associated with those choices. To strike this balance, plan sponsors can develop strategies in four basic categories:

- 1 preventive care: Encouraging consumers to be proactive in reducing health risks, e.g., get routine physical exams, regular exercise, adhering to drug therapy;

- 2 condition or disease management: Encouraging consumers with chronic conditions to adhere to their treatment regimen, e.g., taking antihypertensives as prescribed or measuring glucose levels routinely and undergoing HgbA1c diabetes testing;
- 3 risk mitigation: Supporting individuals with increased risk of adverse events in making the necessary behavior changes, e.g., helping smokers with a family history of lung cancer to quit;
- 4 treatment management: Ensuring that consumers understand appropriate care options, e.g., an emergency room visit versus office visit; a CT scan versus an X-ray, etc.

about lifestyle and management strategies for a specific condition;

- Event-triggered communications informing participants that gaps in their care have been identified, along with recommendations on steps to be taken;
- Status reporting to treating physicians to help coordinate care; and
- Electronic monitors that send a patient's metric results, i.e., weight, blood pressure, glucose levels, etc., to a secure Internet site for real-time monitoring.

Condition management and prevention programs are increasingly used not only to help beneficiaries stay healthier, but also to control and manage total healthcare costs over the long haul. As plan sponsors adopt consumer-directed strategies, they will begin to integrate such programs as part of a comprehensive healthcare benefit offering, recognizing that the investment is likely to pay off in the long run.

Successful plans will focus first on clinical results influenced by consumer choices, and then on the financial impact associated with those choices.

These programs use “push and pull” strategies to incentivize consumers to follow a self-care regimen and follow their physician’s recommendations. Some mechanisms used to engage plan participants include rewards and financial incentives for completing a health risk assessment or participating in condition management or wellness programs. Examples of incentives currently used include:

- Lower monthly healthcare premiums
- Reduced co-pay or out-of-pocket costs
- Additional deposits in their Healthcare Reimbursement Accounts
- Airline miles
- Time off work
- Cash or gift certificates
- Vouchers for generic drugs or mail order prescriptions

Individuals who could benefit from greater compliance and participation in a condition management program can receive information and education in a variety of ways, depending on preference. They may choose:

- Telephone counseling provided by nurse educators;
- Written correspondence via direct mail, phone or text messaging, reminding them to refill maintenance medications or to take important clinical tests;
- Brochures that provide detailed information

Health and performance: While condition management programs focus on individuals who are already living with a chronic condition, more plan sponsors are adopting wellness programs as another tool to control rising costs. The goal is to keep employees well and to cut costs for the consumers and the sponsors, by promoting healthy lifestyles and behavioral change. Some of the primary issues that wellness programs address are:

- Disease prevention
- Stress management
- Fatigue
- Absenteeism
- Employee productivity

Wellness programs are less intrusive and generally do not require as many resources as condition management programs. There are many tools that can be deployed that provide important information or convenient access to preventive services that encourage consumers to take the necessary steps to stay healthy. These tools can be interactive and fun and may have a financial incentive built in. Some of the more popular tools include:

- Discounts for gym membership
- Onsite wellness centers
- Onsite clinics
- Onsite immunizations
- General education via newsletters and company intranets

- Online tools, e.g., calorie burn and smoking cost calculators, headache assessment
- Online quizzes, e.g., Vitamin ABCs, Fitness, and Emergency IQ
- Employee volunteers who serve as wellness ambassadors

Before investing in any wellness program, a plan sponsor should assess the employee population's medical and pharmacy claims data to identify the most prevalent cost drivers—and ensure that programs are developed that address specific needs.

Combining a wellness program and condition management with a health plan design that offers financial incentives for making cost-effective decisions adds up to an effective arsenal of tools that give sponsors their best shot at managing health-care costs, promoting a healthy workforce and boosting productivity.

Before investing in any wellness program, a plan sponsor should assess the employee population's medical and pharmacy claims data to identify the most prevalent cost drivers.

Chapter VI

Plan Design – One Framework for Consumerism

The overall goal of a consumer-directed strategy is to provide medical plan designs that will assist consumers in making more informed and cost-effective decisions about healthcare. The intent is to favorably affect both clinical outcomes and the cost of care. With plan design as the basic foundation, CDHC holds the promise of positive results, achieved through the following:

- Breaking down barriers to good health by offering first-dollar coverage for preventive care, including drugs taken to prevent illness or recurrence of a disease in high-risk individuals.
- Supporting a healthy lifestyle and early interventions at minimal cost to the members. Support can be in the form of information, decision support tools, change management assistance, and incentives for adhering to healthy habits.
- Increasing the transparency of healthcare costs to plan participants, who have frequently been unaware of the true costs of medical products and services because of managed care's relatively low copays. This can be achieved by switching from a design with low copays to a PPO plan, which typically relies on front-end deductibles and coinsurance, and a personal care account.
- Reducing costs for "discretionary care." CDHC designs promote wise consumption of healthcare dollars via personal accounts and incentive programs. Reductions in cost are evident in preliminary data from office visits, lab and X-rays.
- Giving plan participants more control over and shared responsibility for managing their own health and healthcare costs. When members have such decision-making power as well as the means to track their personal account balances, it is believed that they will learn to make better choices.
- Supporting the clinical and financial needs of those with chronic health problems. Offering incentives in return for compliance can increase the financial coverage available through a basic CDHC model by supplementing the funds put into an individual's account. Taking advantage of such incentives and doing what it takes to win awards will give beneficiaries with serious conditions the possibility of getting full or nearly full coverage through shared savings.
- Supplying plan participants with the information they need to become well-informed healthcare consumers. Those who are armed with value-driven data make better decisions.

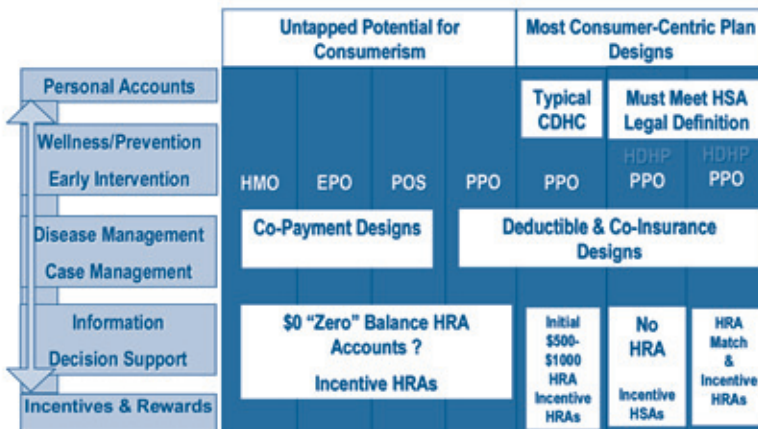
Roadmap to Change

There are significant issues for employers to address in order to establish a design foundation for CDHC implementation. The most basic change is the move from HMO, exclusive provider organizations (EPO), and point-of-service (POS) plan designs to a preferred provider organization (PPO) model with deductibles and coinsurance. High deductible health plans used with individual accounts require both a front-end deductible and a maximum out-of-pocket— legal requirements that are inconsistent with a copayment design.

It may be possible, however, to use personal care accounts with any plan design, as shown in the following chart. The flexibility of HRAs allows them to be used with any plan design, as can FSAs, although the latter are limited by the use-it-or-lose-it requirement. FSAs and HRAs cannot be used to cover the health plan's deductible.

One possible visual framework for the future of

Basic Plan Design Cost-sharing Differences



healthcare benefits is the combination of different “generations” of consumerism and the five building blocks:

- Personal accounts (FSAs, HRAs, HSAs)
- Wellness/prevention and early intervention programs
- Disease management and case management programs
- Information and decision support programs
- Incentive and compliance reward programs

A medical consumerism model ideally should have aspects of each of these components built into its core.

The first generation is primarily focused on plan design and financing changes. The later generations integrate the other critical elements for overall success.

Regardless of the initial design selected, a medical plan for a consumerism model ideally should have aspects of each of these components built into its core in order to achieve the desired effects of consumer involvement, changed behavior, financial security and member satisfaction.

1st Generation Plan Designs

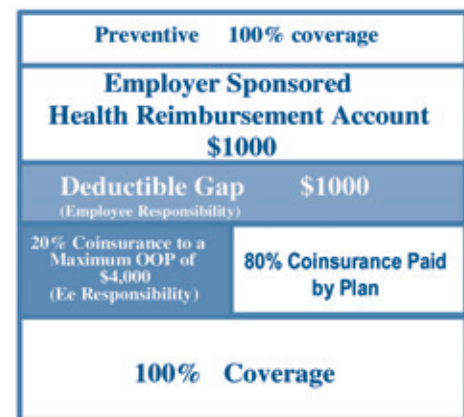
While consumerism can be built into any plan design, the most adaptable are PPO plans. In particular, 1st generation consumer plans focus on

the basic high deductible structures. The major focus of 1st generation CDHC is on reducing discretionary expenditures.

CDHC with HRAs: Under the basic 1st generation CDHC 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 \$500 to \$1,000 per year for a single employee and double that amount for families. Unused funds can be rolled over and added to the next annual HRA deposit. If the HRA fund is exhausted, the member must meet a coverage gap before being able to use the high-deductible plan. Network discounts apply to all services regardless of the source of payment.

First-dollar coverage 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. If allowed by the employer, HRAs can be used for IRS-qualified medical expenses not covered by insurance, and to purchase additional health insurance—most notably, long-term care. The following is a traditional CDHC plan design for a single employee.

CDHC PPO with HRA Sample Design



HSA eligible high deductible health plans: After the January 2004 effective date of the legislation, large employers began considering 1st generation High Deductible Health Plans. In order to realize the tremendous tax advantages of an HSA, however, they had to meet the strict plan requirements imposed by Congress.

To qualify for an HSA, an individual must be covered under an HDHP with a deductible of at least

\$1,000 for individual coverage and \$2,000 for family coverage and out-of-pocket caps of \$5,000 and \$10,000, respectively. The individual and/or the employer can make 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 figures cited were for 2004; the deductible and out-of-pocket amounts are inflation-adjusted each subsequent year.

Below is a sample 1st generation HSA-eligible HDHP design. The \$1,250 deductible, higher than required, forms the basis for the tax advantaged contributions by either the employee or the employer. For employees, the basic design shown below - without an employer HSA contribution - is a very low cost plan that provides the security of catastrophic coverage. Employees can take the premium savings and establish their own HSAs. Employers can also contribute to HSAs on behalf of their employees, but the total of employee and employer deposits must comply with the legislated HSA cap.

Policyholders and covered spouses age 55 or older have a higher annual contribution limit, which increases incrementally: In 2004 the additional amount was \$500; in 2005 it increased to \$600, and in 2006, it's \$700, and so on—until it reaches \$1,000. However, employers contributing to HSAs must make comparable contributions on behalf of all employees with comparable coverage. And as long

as the funds are used to pay for qualified medical expenses, distributions from HSAs are not taxable.

2nd Generation Plan Design and Beyond

As large employers adopt CDHC options and create full replacement plans, there will be a greater demand for customized designs. Most large employers consider their companies and their workforce to be unique. As CDHC develops acceptance from a wide spectrum of employees, employers will begin to fine tune the design options to fit their corporate metrics. Type of industry, geography, demographics, and work environment are among the factors employers will use to determine how to refine CDHC coverage.

2nd+ generation CDHC designs are likely to be more flexible in determining what is charged against the personal care account and what is covered by the medical plan. For example, non-elective hospitalization could rapidly deplete an HRA account, which would remove the ability of an HRA with a balance to roll over to serve as an incentive driving behavioral change. While 1st generation CDHC designs fail to take this into account, designs that offer coverage for hospitalization or other costly medical events without

HSA Eligible HDHP

Plan coverage for all eligible Medical expenses, including Prescription Drugs, Mental Health and Substance Abuse Claims

1. 100% Preventive Care - Defined by Treasury HSA regulations
2. \$1250 Front-end Deductible
3. 20% In-Network Patient Coinsurance to a Maximum Out-of-Pocket of \$2,000
4. 40% Out-of-Network Patient Coinsurance; No Maximum Out-of-Pocket
5. Plan Maximum is \$1,000,000
6. Decision Support – Information tools, Nurse Coach Line, etc.

100% Preventive

\$1250 Deductible

20% Coins to a Maximum OOP \$2000

PPO 80% Coverage

100% Coverage

Decision Support Tools

Dental Coverage

Vision Coverage

PRICEWATERHOUSECOOPERS

reducing the funds in a personal care account may develop. Such an approach would ensure that PCAs that support prudent day-to-day use of benefits are not depleted by uncontrollable hospitalization, accidents or serious—and unexpected—illness.

Under CDHC models, prescription drugs costs generally come out of the HRA account, even if the drug is taken for preventive care or health maintenance. Coverage for preventive care and maintenance drugs will likely become more complex and targeted as experience on behavioral change develops.

Future generation CDHC plan designs may be more tailored to the individual as well. For example, in order to preserve the personal funds of a diabetic, the CDHP could be set up to deliver first-dollar coverage for insulin and other required medications. Complex CDHC plan designs based upon personal health status may be a wave of the future that will change the way individual behavior is affected.

However, 2nd+generation HSA-eligible HDHP options will require new enabling legislation. Since the 2003 Medicare Modernization Act defines a 1st generation HDHP, it is unlikely that we will see significant changes on the political front that will alter the definition of HDHPs for quite some time. Large employers tried to create design flexibility through recent IRS regulations. But regulators cannot create law, they can only interpret it, and many alternative HDHP designs that employers were interested in were not acceptable based on the July 2003 IRS guidance.

Efficiencies may be gained by differentiating between the payment of risk insurance for the rare but expensive events and the cost for routine medical care.

The most important—and unsuccessful—interpretations sought by large employers were coverage under the HDHP deductible for prescription drugs and the use of HRA and FSA accounts for first dollar coverage without violation of the requirements for funding HSAs. Employers have also been concerned about the inability to dedicate their HSA contributions exclusively to healthcare. Under final regulations, employer-funded HSAs can be cashed out by employees, with a 10% penalty, plus recognition as taxable income.

There may be legislative initiatives in 2006 that address these and other design alternatives that support flexibility in employer funding of HSAs. However, chances of passing enabling legislation are unlikely.

It is envisioned that 3rd generation plans will continue to build on enabling cultural change, placing an emphasis on health and performance, worksite health promotion and wellness, stress management and performance. And 4th generation plans are expected to be personalized based on lifestyle and individual health, along with genomics, push technology, information therapy and the like.

In the meantime, it is important that 2nd generation CDHC plans have a greater degree of consumer engagement. Besides having a larger out-of-pocket “bridge,” HRAs and HSAs need to be established so that consumers can decide whether to seek reimbursement from the HRA or a distribution from the HSA. Such plan designs are starting to take root and are likely to move into the mainstream.

A real insurance model: Consumer directed plans with HSA funding follow other insurance models, such as car insurance or life insurance, where “good” behavior is rewarded by lower premiums or higher savings. It remains to be seen whether an entirely market-based approach to consumer-directed spending is applicable for healthcare.

Some efficiencies may well be gained, however, by differentiating between the two healthcare components: the payment of risk insurance for the rare but expensive events and the “health maintenance” cost for routine medical care and from incentivizing consumer behavior accordingly.

We all understand that a third party will not pay for our windshield wipers to be replaced or for our oil changes and tune-ups. For CDHC plans to flourish, Americans need to be equally certain that it is unrealistic to look to a third party to pay for routine check-ups or our allergy medication as well.

Chapter VII

Regulatory Issues – Enablers or Impediment?

To know where you should be going and why, it helps to know where you've been and what has brought you to the present place. This concept holds true for new directions and progress in restructuring the American healthcare system in general, and in developing health savings vehicles in particular.

As a critical element in understanding the current situation, it is necessary to examine the relationship between national healthcare policy and national tax policy. They go hand in hand, sometimes smoothly and sometimes with one pulling on and straining the other.

To achieve the most effective and efficient healthcare system, tax policy should be used as a tool to encourage implementation of health policy, not the other way around. An obvious example is the tax deduction employers get for providing group health coverage and the exclusion from individual income tax for the value or cost of coverage.

Thus, healthcare coverage and health promotion should be the goals of tax policy. The more people who can be covered as a result of effective tax policy and health policy, the greater the risk-sharing, which ultimately helps keep costs down.

Tax Policy Implementation

Various savings accounts for medical care have developed as tax policy tools through the Tax Code. (For a detailed discussion of the main accounts, see Chapter III). Following is a discussion of the tax policies as reflected in the key types of savings accounts for healthcare.

Flexible spending accounts: Health flexible spending accounts (FSAs) allow for employer and employee contributions to a personal account for medical expenses not paid for through another health plan. Expenses reimbursable through an FSA include deductibles and co-pays as well as

treatment that is excluded from group health plan coverage.

The FSA concept originally was intended, in part, to provide an element of choice within a cafeteria plan financing structure. Individuals were given a defined amount of employer funds, combined with their own contribution, and the opportunity to select from a menu of benefits those that best met the needs of the employee or the employee's family. From a consumerism standpoint, the FSA did allow choice and instilled some modicum of individual responsibility in budgeting certain, albeit limited, healthcare dollars. Tax policy was used to encourage coverage, as reflected in allowing both employer and employee to make tax-free contributions to the FSA.

However, one feature caused the FSA to live up to its name as a spending account. Under cafeteria plan rules, there can be no deferral of compensation from one plan year to another. Thus, the "use-it-or-lose-it" rule results in forfeiture of FSA balances at the end of the year—or the end of a grace period that employers now may include if they so choose. The result of this rule has been to prohibit long-term medical savings and to encourage end-of-year spending on medical products or services that may not be necessary.

In this case, tax policy seems to have driven health policy in an inefficient and costly direction. This feature helped redirect efforts toward a more efficient type of savings account that addressed a couple of the defining FSA issues.

Medical savings accounts: MSAs eliminated the end-of-year spending problem inherent in FSAs by allowing the rollover of unused balances from year to year. Funds can build up, thus enabling individuals to save healthcare dollars.

A limiting feature of the MSA, however, is that the employer or the employee – but not both – can

contribute in the same year. Plus, the MSA must be offered with a high-deductible health plan. That means the MSA is likely underfunded in terms of meeting the HDHP premium and/or deductible.

Neither the employer nor employee may want, or be able to afford, to fund the MSA to the degree necessary for the individual to buy adequate insurance coverage. In addition, the MSA was designed for—and is limited to—small employers whose employees tend to be lower paid. Thus, MSAs have had limited success. Again, tax policy drove health policy, rather than vice versa, and limited the MSA's availability and effectiveness.

The healthcare market still saw the need for a medical savings vehicle that allowed for account funds rollover and would overcome the affordability flaw of the MSA. However, a full-blown savings vehicle that could be funded tax-free by both employers and employees and allow the rollover of unused funds could only be done by federal statute—not an easily or rapidly attained goal.

In time, however, the market took the initiative, driven by two concepts: the need to contain rapidly escalating healthcare costs and the related need to address the public attitude of entitlement to all the medical care one desires, with the expectation that a third party should pay for that unlimited care.

To get such a savings vehicle, the Treasury Department and IRS were persuaded to interpret the Tax Code in such a way that self-funded accounts with a roll-over provision were allowed, and that large as well as small employers could offer.

Health reimbursement arrangements: HRAs, which came next, addressed some problems inherent in the MSA, but still faced major tax policy barriers that impede health policy. These include limited financing sources and the related problem of limited ability to force a change in the entitlement attitude. However, the market did address the latter in the form of wellness programs.

Treasury and IRS rules for HRAs allow only employer contributions. Account funds, like those of FSAs and MSAs, can be used for medical expenses only, including health plan premiums. Funds remaining at year-end may be carried forward and—at the employer's option—move beyond the employment relationship. Here, to a greater

degree, healthcare policy is achieved despite tax policy.

While HRAs developed with the idea that individuals would also have high deductible health plans and thus reduce employer coverage costs, many employers have been willing to contribute in order to foster the concept of individual responsibility. The hope is that individuals will become more cognizant of the costs of medical products and services, in part by being forced to make choices with HRA dollars that can be used to pay premiums as well as deductibles, co-pays and other medical expenses—or saved for future medical needs.

Employers may condition HRA eligibility on individual participation in any of a number of wellness programs. Included are health risk assessments and programs that address specific behavioral or medical conditions. Examples include participation in smoking cessation programs, adherence to treatment regimens, and the use of healthcare coaches to help individuals manage chronic disease.

In another development, some smaller employers—or those otherwise financially unable to provide traditional group health coverage—have offered HRAs alone. This is not an option with MSAs, which must be provided in conjunction with HDHPs.

Stand-alone HRAs offer at least minimal coverage for those who might otherwise have no coverage at all. By doing so, they help introduce these employees, often low-wage workers, to the realities of the healthcare system, and to engage them in medical decision-making. HRA funds may be used to help pay for coverage under state (public) or private healthcare programs and can start the process of behavioral change, by helping individuals learn to accept responsibility for their health and the healthcare choices they make.

However, tax policy still impedes healthcare policy. The Tax Code prohibition against employee tax-free contributions to HRAs has left many employers dissatisfied. Many believe that employees who have no personal contribution at stake are not as judicious as they might be if the money came out of their pocket. Financially strapped employers that looked to HDHPs as a way to save on premiums still had to contribute to the HRAs to help make coverage affordable.

Flaws notwithstanding, this type of account does plant the seeds of individual responsibility. In addition, the HRA was a major step forward in fostering congressional and administrative awareness of the need for a more practical health savings account.

Health savings accounts: Ultimately, tax policy was changed to address a critical flaw in the HRA and to promote a key healthcare policy feature. The result: the HSA.

Employers and employees may contribute concurrently to HSAs on a tax-free basis, addressing limited funding issues, allowing rollovers of unused accounts, and encouraging better healthcare decision-making by consumers in part through the employee contribution. Consumerism got a real boost through some convergence of tax and healthcare policy.

HSAs do allow employee contributions and thus encourage individual responsibility. They do allow employers to contribute at the same time – thus aiding access. And they do allow rollovers and thus further promote individual responsibility. On the other hand, HSAs do not require employer contributions— and thus encourage HSA offering by providing options for employers who object to employees’ use of healthcare funds for non-medical purposes.

The Promise of Tomorrow

Despite the progress made, tax policy still presents impediments to health policy, as reflected in the following issues:

- HSAs are not required to be structured as health plans and their funds may be used for non-medical expenses.
- HSAs are available only in conjunction with high deductible health plans, a provision that limits access to those who can afford group or individual health coverage.
- The non-discrimination rules in the Tax Code have—through regulatory complexity— limited implementation or increased administrative costs of wellness programs.
- HSA funds generally may not be used to pay for healthcare premiums or coverage (self-funded plans). Thus, tax policy limits access by excluding individuals who cannot afford both the premium and the high deductible.

These limitations beg the question: What kind of account, or what combination of accounts, is needed to achieve optimal healthcare policy?

First, there has to be a clearly defined optimal healthcare policy. Then, there must be a fiscal commitment to achieve it. With such a commitment, tax policy would have to follow (rather than lead) to help us achieve that optimal vision. That, in turn, would require tax policy to be consistent with healthcare policy.

The current funding of healthcare has created artificial segmentation of healthcare coverage, both in the private and public sectors.

In the private sector, coverage from birth to adulthood is typically provided by the parents’ employer(s). That is the first financing segment. Once an individual enters the working world, his or her coverage is provided by a different employer— the second financing segment. The third segment comes post active employment, when the individual is covered through employer-sponsored retiree coverage, individual coverage, or Medicare. The fourth segment may involve long-term care or assisted living, and the fifth and final segment often involves hospice care. These segments are not necessarily distinct and may overlap—or even be skipped, but do serve to illustrate the segmentation principle.

On the public side, a child may be covered through a state Children’s Health Insurance Program, then as an adult through Medicaid, and finally as a senior through Medicare.

Yet, health and healthcare are continuums. Health needs and risks vary, but typically arise primarily in later years. The artificial segmentation of financing does not provide a means of building assets for those most medically costly later years. To the contrary, risk funding may be cut off with each segment. Thus, when an individual reaches the most costly segments under the financing segmentation structure, funding to pay for care is essentially starting anew.

Retirement (non-healthcare) savings are structured to enable a somewhat better spread of the funding over many more years. Yet, the problem remains that Americans, in general, do a poor job of saving. There is one asset, though, that can more easily be prefunded even in a period of low income and a culture of poor saving—and that

asset is personal health. Doing everything possible to protect that asset – through health promotion and a healthy lifestyle, – is the least expensive way to build assets for retirement. A person who is healthy during much of his adult life minimizes medical problems and delays the onset of chronic conditions. That same individual remains productive longer, holding high healthcare costs at bay until late in life. Thus, there is considerable return on an investment in personal health.

What is needed to accommodate such a continuum of healthcare, promote healthy lifestyles and help build assets for the later years? In the context of savings vehicles for healthcare, the answer lies in an individual account from cradle to grave.

In the broader context, programs could be established that allow for one contribution distributed actuarially, to address varying needs: lower cost coverage in the earlier, low-risk years, with excess contributions/balances designated for accounts to be used to buy coverage or pay directly for medical services in later years. There may be years, such as while raising families, where fewer dollars can be set aside for health accounts. But those years may be offset in later years when dependents are gone and earnings are greater. Catch-up contributions with greater amounts in excess of the premium – which would be actuarially determined – could be set aside for the most costly years as the end of life nears.

The continuum of coverage could include, in addition to the savings vehicles, contributions designated for group or individual coverage, long-term care premiums, Medicare, assisted living, and end-of-life care.

The current funding of healthcare has created artificial segmentation of healthcare coverage, both in the private and public sectors. Yet, health and healthcare are continuums.

The account for tomorrow: While the heading of this chapter refers to regulatory issues and the promise of tomorrow, that promise must be based in law. Allowing for the optimal healthcare savings account requires more than regulatory authority: Congress and the President must address the issues.

In this regard, healthcare policy must come before tax policy, so that the latter serves as a tool to help implement the former, rather than the other way around.

Because healthcare policy must be developed in the context of the real working world, it must include factors such as the continuum of health and healthcare needs, employment status, pay rate, fluctuations in income, and, healthcare affordability. What kind of account, or what combination of accounts, is needed to achieve our aim?

First, let's consider the objectives:

- Access
- Individual responsibility
- Health promotion
- A personal financial stake in health and healthcare purchasing
- Healthcare quality
- Cost control

Then, let's look at the shape needed for a health financing vehicle to support those objectives. A review of the history of savings accounts for health suggests that the savings vehicle of tomorrow should have most or all of the following features:

- A lifetime of care (cradle to grave);
- Coverage for medical expenses only;
- A stand-alone option;
- Individual accounts;
- Tax-free contributions from anyone, to include pre-tax salary-reduction;
- Establishment by any employer or individual;
- High-contribution limits that encourage long-term savings and promote catch-up in higher-income years;
- Premiums or coverage payable from the account for health care, long-term care, wellness, nursing homes and assisted living arrangements, hospice and other end-of-life arrangements;
- Rollover of funds;
- Full portability;
- Promotion of wellness programs in the broad context, to include risk assessments, disease management and other healthcare coaching, behavioral modification, and exercise and nutrition education and promotion;
- Design flexibility; and,
- More flexibility under non-discrimination rules.

Administrative issues: There are administrative cost savings and efficiencies from a single savings vehicle under a defined and set national policy. Any healthcare funding account necessarily implicates costs from implementation and compliance.

Establishing a set national healthcare policy that is implemented through coordinated tax policy can help minimize administrative costs. Having a set direction can mean fewer changes in course, thus less revamping of administration systems. Consistency in the regulatory environment similarly can mean reduced costs in education, training and implementation of new requirements.

Healthcare policy must come before tax policy, so that the latter serves as a tool to help implement the former, rather than the other way around.

Chapter VIII

A European Perspective on Healthcare & the Impact of Consumer Choice

The term “consumer driven,” as defined in the United States by Professor Regina Herzlinger of Harvard Business School, can be applied to healthcare when patients have unrestricted choice of providers and are exposed to the true costs of their own medical care.

In many European healthcare systems, consumers have long been accustomed to a relatively unrestricted choice of health insurance provider, coverage levels and co-payment ratios, in a model characteristic of consumer-driven care. European consumers in many systems have transparency regarding medical costs incurred, but do not bear the full financial risk.

In January 2004, the U.S. enacted a new law promoting CDHC in its financing and healthcare delivery systems. A relatively new concept here, the consumer-driven healthcare system is based on private HSAs, a model that’s not used in Europe. Instead, all European healthcare systems are built around the principles of solidarity and universal coverage, but in many cases do carry limited risk assumption by consumers, coupled with relatively unrestricted choice of providers and care levels.

We believe that the tools and processes developed to support consumer-driven care across Europe should be applicable to the needs of the newly empowered owners of HSAs in the United States.

Perspective on Healthcare Financing

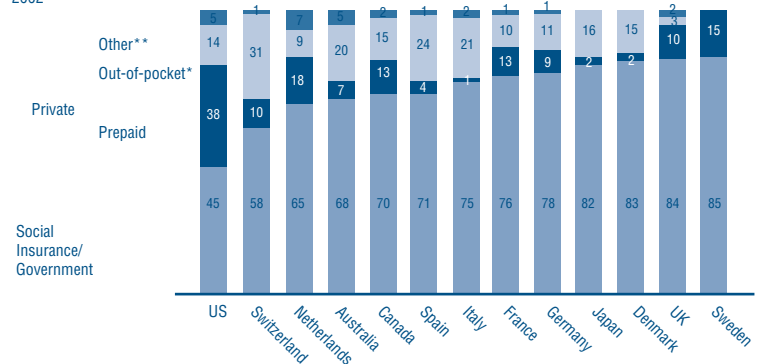
At 45% of total healthcare costs, the U.S. government’s portion of the country’s total healthcare tab is less than that of 12 other developed countries, with a per capita GDP of more than \$20,000 (See the chart below.) In all 12, the government contributes more than 50% of total healthcare costs.

What’s the major difference between the United States and these countries in terms of healthcare spending? In this country, a much larger portion (36%) of total healthcare funding comes from the private sector, via private insurance paid for primarily by employers who voluntarily provide medical benefits to their employees. No other Organisation for Economic Co-operation and Development (OECD) country has as high a level of prepaid private insurance, which shields the consumer from direct exposure to the financing of healthcare.

Rising healthcare costs in the early 1990s stimulated the development of a number of managed care initiatives. These almost eliminated increases in healthcare costs between 1994 and 1997.

The US has the highest share of private insurance levels for healthcare

Share of health expenditure in basket of nations with GDP/pc > \$ 20 000, percent 2002



	US	Switzerland	Netherlands	Australia	Canada	Spain	Italy	France	Germany	Japan	Denmark	UK	Sweden
Health spending %GDP	14.6	11.2	8.8	9.5	9.6	7.6	8.5	9.7	10.9	7.9	8.8	7.7	9.2
Life expectancy at birth	77	81	79	81	80	80	80	79	82	77	79	81	
% population > 60 yrs	16.3	22.6	18.7	16.9	17.4	21.8	24.7	20.5	24.4	25	20.7	20.6	23.2

* Includes uninsured in the US, ** other private funds
Source: WHO, OECD Health Data

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However, since 1998, healthcare costs have risen at double digit annual rates, reaching 16% in 2004 of the nation's gross domestic product (GDP). That's far higher than the percentage of GDP that healthcare expenditures comprise in these 12 developed nations. Yet U.S. employers have seen their share of healthcare costs rise at a compounded annual growth rate of 6.7%, faster than all other employee benefit components. (McKinsey Quarterly, January 2004). It is worth noting that medical outcomes, at least in terms of life expectancy, are comparable, if not better, in some other nations with similar demographics.

Not surprisingly, American employers are increasingly unable to offer comprehensive, fully funded healthcare benefits or to absorb the cost increases. As a result, many are forced to design and shop for new health benefits and to increase co-payment levels and deductibles. Large employers have seen unions and employee groups protest the reduction in health benefits, and some small and medium-sized employers may end up opting out of offering health benefits, labor market permitting.

In a recent *Wall Street Journal* poll, 61% of the respondents rated reliable health benefits as more important than higher salaries. U.S. employers are the major payers of health insurance and thus have a big stake in improving the efficiency of the healthcare system or changing the funding structure so that more costs are shared with employees or the government. The consumer-driven healthcare movement and the Health Savings Account legislation that took effect in January 2004 addresses both needs.

We believe that consumer-driven healthcare will be influenced more by technological and healthcare system innovations than by the private insurance reform in conjunction with the health savings accounts." (*Global "Consumer Driven" Healthcare Moving beyond the first generation private accounts; Feb 2005 W.R. Boyles, C. C. Maulbecker Armstrong; www.hsamarkets.com*) This is why we would like to focus more on technology and system innovations than on the financing in taking a closer look at international healthcare systems.

Consumer driven healthcare will be driven more by technological and healthcare system innovations than by the private insurance reform in conjunction with the health savings accounts.

Supportive Policies, Tools and Processes in Europe

All EU systems are converging around common denominators, such as more "power to patient" organizations, cost-control measures and the use of informatics to enhance cost-effectiveness. What's more, European Union regulatory bodies are having an increasing impact on national healthcare systems. In 1998, two landmark court rulings in favor of the free movement of goods and services within the EU markets were applied to healthcare: In the Kohl and Decker judgments (c-120/95 and C158/), two EU citizens won the right to be reimbursed by their national social security system for treatments—in this case, for spectacles and orthodonture. So-called "medical tourism," driven by consumers seeking to access the best possible care in both inpatient and outpatient settings, has become common in Europe ever since. (*Dr. C. Maulbecker; Economics and Finance – Consumer pressure, medical tourism and healthcare costs; Economist Healthcare Europe – 4Q1998*)

Financial responsibility drives change: Generally, in all healthcare systems with high consumer engagement—through co-payments, for example—there is a high demand for participation as stakeholders and for changes to enhance efficiencies. A 2004 EU survey showed that 1/3 of consumers are willing to spend their own money for healthcare, and are asking for better access to health-related information (*Impatient for Change, European Attitudes to Healthcare Reform, published 2005 by the Stockholm Network ISB 1-95476-630-0, <http://www.healthpowerhouse.com>*) Higher consumer engagement driven by greater financial responsibility through Health Savings Accounts is expected to have a similar effect in this country.

Among European countries, Switzerland has the highest co-payment levels, at 31%. Switzerland has also been the most aggressive EU country in working to change its healthcare system. A comprehensive health reform movement beginning in 1994, with a second wave in 1998, introduced Physician Practice Organizations, DRG-based hospital compensations and mail order pharmacy systems. (*Opportunities for PPMCs in Switzerland, Managed Care, July 1998*).

While this may seem very similar to the U.S. managed care models, there is an important difference: Consumers select and pay for their health insurance.

Every Swiss citizen purchases his or her own coverage, and a selection of private health plans compete for members. The government subsidizes low income families, not by providing coverage for them but by giving them the funds to purchase health insurance themselves. All health insurers must offer a standardized mandatory basic package. Plans can only differentiate by the premiums they set for this standard coverage and through ancillary private insurance modules offering additional healthcare services.

Independent brokers and online portals provide transparency: There are companies, including insurance brokers and online portals, that advise Swiss consumers on the most cost efficient health plan based on individual needs. A website, www.comparis.ch, calculates which of four possible co-payment levels is best for a Swiss citizen, based on age, gender and locale. Consumers can switch insurers annually without penalty.

Since consumers have the freedom to go to any provider they choose, there is no need to change doctors when changing health insurer. This provision supports continuity of care—and many Swiss families have had the same doctors for decades.

Prevention, wellness, health programs and information: One way insurers compete with each other for Swiss consumers is to have a range of prevention and wellness offerings, such as nutrition counseling, spa weekends, fitness classes, or alternative medicine treatments. Privately insured Swiss patients have a “Gesundheitskonto” (a health spending account) that can be used to cover the cost of fitness programs, including yoga and swimming classes, for example. Money spent by the consumer for such services is subsidized at 50% by the health insurer. Facts about nutrition, complementary medicine and preventive care appear in monthly magazines sent to all customers and are available on the insurer’s Web site and telephone information centers. To facilitate cost efficient decision making, the health plans offer free second opinion programs and 24-hour telephone help lines.

Partially financed coverage in Germany: Germany, similar to the United States, has a large part of its population (70 million) covered by health insurance that’s partially paid by employers, but based in the nation’s statutory sickness funds. Those whose earnings fall below a specified

level are required to be covered by the public sickness funds. While in Germany, unlike in Switzerland, employers often pay 50% of the premium for membership in a public sickness fund, the consumer still has many such funds to choose from. Premium levels in these public health funds are dependent upon income level.

Once they’re covered by a sickness fund or private insurance, consumers have a free choice of physicians, and few service limitations.

Increased co payment: Germany has increased the level of self payment from 13% in 1992 to 16% in 2002. This has coincided with ongoing reform that is gradually adding user charges to the public health insurance system, and creating a much larger movement of insured between the different sickness funds and private health insurances. German consumers increasingly pay part of the cost for medical care received, as the following examples illustrate:

- Consumers pay 10% of the prescription drug price, within a preset range of minimums and maximums. Generic drug use has increased in response to the additional out-of-pocket expense, which is similar to what happened when Medical Savings Accounts with high deductibles were introduced in South Africa. (*S. Matisonn, NCPA Policy Report # 254*);
- A one-time co-payment “entrance fee” of 10 Euros per quarter, which steers patients to a GP first, with free referrals thereafter, saved the German sickness fund 4 billion Euros in 2004—enough to make them profitable again. This highlights the power of low co-payments, while still retaining choice. The German patient who wishes to forgo seeing a GP first can pay another 10 Euros to go directly to a specialist without a referral.

Nationwide information, prevention and wellness: Last year the German Federal Ministry deducted 2.5 Euros for every life covered by the sickness funds in order to pay for a nationwide health information prevention program. In addition, targeted disease management programs with more than 1 million enrollees are funded with a lifetime approach, rather than the common fee-for-service model.

Another key to the German healthcare program is the position of patient advocate. Created in 2004 within the German Federal Ministry of Health, the

advocate received 400,000 e-mails that year alone. Patient advocates function together with the IQWiG (www.iqwig.de), a new institute for quality and cost efficiency in the German health-care system, and serve as information sources for patients and providers. Patient organizations as well as providers can request research into health risk assessments and cost-benefit analyses of therapeutic guidelines, drugs and medical devices.

Investment in technology: This year European citizens from 25 countries will receive the health insurance card shown here, which offers direct access to pan-European medical care and reimbursement.



This electronic insurance card is the first step that EU health ministers have taken towards an integrated e-health platform:

“It is well recognised that medical errors and accidents cost thousands of lives as well as millions of euro every year. It is also acknowledged that e-health tools such as electronic [prescriptions] and real-time decision support - when coupled with integrated, interoperable electronic health records - can reduce significantly the number of such accidents and errors,” attendees at a recent European conference concluded. “Yet patient safety will not be the only benefit of an integrated e-health infrastructure. Efficient e-health tools developed for the use of health professionals will facilitate more flexible and collaborative work within and between health institutions as well as between traditional health-care spheres, such as primary and secondary care and home care.”

Some European countries, such as the UK, France and Germany, have already begun introducing centralized Electronic Medical Records. In 2006, 80 million Germans will begin to be linked with their providers, pharmacies and health insurers.

A larger role in the evaluation of new drugs and technologies: The benchmark in Europe for health risk assessments combined with cost effectiveness considerations is the NICE (National Institute of

Clinical Excellence) in the UK. New technologies are evaluated at a cost per Quality Adjusted Life Year (QALY) level based on a comprehensive cost benefit analysis. NICE manages the entry of new technologies into the market as well as the exit of old technologies.

Patient representation at all levels: In more centrally organized healthcare systems, such as the UK or Denmark, the government has been driving health system reform. Patient bodies are part of the decision making in most EU systems. At the European level, the International Alliance of Patient Organization (www.IAPO.org) works with the legislature to insure patient representation. Patient representatives are, for example, involved in the evaluation of new drugs or medical devices at the EMEA (European Agency for the Evaluation of Medicinal Products) unlike its U.S. counterpart, the FDA.

Patients as stakeholders are integral to the evaluation of new technologies and in the setting of reimbursement levels in Germany. German patient organizations are represented in all decisions on whether a new procedure is to be admitted for reimbursement. In addition, Germany employs a highly regulated framework to determine which new technologies to adopt and at which reimbursement levels. The process is based on health technology assessments and requires the approval of all stakeholders: the health insurance industry, provider representatives, patient organizations and the German health ministry.

The other major difference between the United States and Europe is that in Europe, access to new technologies is also evaluated for its cost effectiveness; conversely, the United States does not determine whether to approve innovations based on cost criteria. In Europe, once a product or procedure is approved, there is no limit in its usage for all health consumers.

Conclusion: Given the boundaries of solidarity and equality, European healthcare systems are gradually introducing risk assumption, more choice supported by technology, and health information to their healthcare systems. Patient organizations are engaged in healthcare policy decisions and are empowered to safeguard the interest of consumers.

The government or large payer groups bargain with providers on behalf of the consumers. More

Given the boundaries of solidarity and equality, European healthcare systems are gradually introducing risk assumption, more choice supported by technology, and health information to their healthcare systems.

recently the European Union, national government bodies, as well as insurers are using technology to enhance access to health information and improve data management through centralized data sharing and the introduction of electronic medical records.

It is in those three areas—risk sharing, patient representation, and health information provision and management through technology—that U.S. healthcare policymakers and employers would be wise to compare and learn from international consumer driven approaches as they develop their strategies here.

U.S. healthcare policymakers can learn from international experience in risk sharing, patient representation, and health information management through technology.

Chapter IX

Who Needs to Change & How Do We Make It Happen?

Now that we've looked at consumerism in healthcare from a variety of angles, we want to conclude this report with our thoughts on what needs to happen—and who needs to do what—in order to reap the benefit and mitigate the liabilities inherent in CDHC. To reiterate a point made in the first chapter, experience suggests that having either the public sector, in the form of government, or the private sector, in the form of employers and health plans, arbitrate the tension between limited resources and unlimited expectations is incompatible with American culture.

The best healthcare system in the world could be one that provides empowered consumers with the right balance of physical health, psychosocial health, lifestyle, and genetic profile. But who pays for what? How do we address the disconnects?

There is a fundamental conflict between our concerns about cost and our demands for choice and freedom. People do not want to make trade-offs in healthcare. Although Americans generally accept them in the market sector, healthcare is widely viewed in a societal model. Furthermore, polls tell us most people don't really believe trade-offs are necessary; rather, the public believes that greed and waste in the system are responsible for the rising cost of care. Therefore, any actions designed to motivate the public to be more cost-efficient in the use of healthcare resources must address this perception.

We are experiencing an upward cycle of scientific and technological abilities which will have a major impact on cost. Just as with electronics, health-related technologies make specific products and services cheaper, but also drive market penetration and the development of better and more expensive technologies to replace them.

Scientific and technological advances will also have a major impact on values and ethics. It will become clear that the system is unlikely to find a way to pay for every available and potentially ben-

Having either the public sector or the private sector arbitrate the tension between limited resources and unlimited expectations seems to be incompatible with American culture.

eficial treatment. The struggle will be to define which treatments and therapeutics should be covered by insurance and which should be seen as lifestyle enhancements that people should pay for out of pocket, if desired.

As noted in the first chapter, the definition of health is increasingly elastic. In essence, a consumer-driven healthcare system will allow each of us, given adequate resources, to choose what we want to have—and for how much.

How can we ensure that this “brave new world” of consumer-focused healthcare is designed in a way that will optimize health? Clearly, to move from where we are today to a more desirable future state will require a lot more than finance mechanisms such as HSAs, HRAs and MSAs. Savings accounts are merely a tool that helps create an environment in which a discussion of cost and value, benefits and tradeoffs can occur. This is not a warm and fuzzy conversation, and realistic or not, people want to think of their healthcare as warm and fuzzy. It will take a fundamental shift in attitudes and behavior on the part of the American public, and significant business model changes of all healthcare organizations. Change is hard.

We should remember that at the end of the day, medical care principally revolves around the doctor-patient relationship, and ultimately that relationship determines both the cost and quality of care. The role of all other players in the healthcare system is to support that relationship.

As a result, the primary focus of efforts to change must be physicians and consumer-patients. And

what is needed from these key players' requires a difficult shift in thinking, a fundamental cultural shift from where we've been.

A consumer-driven healthcare system will allow each of us, given adequate resources, to choose what we want to have—and for how much.

What Do Physicians Need To Do?

What Do Physicians Need to Do?

- **Create customer-focused practices**
- **Practice evidence-based medicine**
- **Engage in shared decision-making**

In some ways, it's really quite simple: Physicians need to redesign their practice to be more customer-focused. This is a huge departure from most contemporary business models, including adoption of practices such as evidence-based medicine (EBM) and shared decision-making. After all, it is not a pretty picture when a 21st century consumer encounters a 19th century physician!

Many providers have not yet realized how dramatic the impact of putting consumers in the driver's seat is likely to be on their business. The focus of care for most physicians has always been the patient. But the pursuit of that focus has been from a provider-centered model. In contrast, a patient-centered model is one in which the physician leads the way to a greater or lesser extent but is attuned to the patient's perspectives, which are incorporated into the care process.

In designing their practice to be more patient-focused, doctors will have to learn how to compete on the basis of value in a more transparent marketplace. Such a marketplace will demand

Many providers have not yet realized how dramatic the impact of putting consumers in the driver's seat is likely to be on their business. Doctors will have to learn how to compete on the basis of value in a more transparent marketplace.

greater attention to clinical quality, service, productivity and responsiveness. In the new world of patient-centered care, people will not be willing to wait the average of 38 minutes to see the doctor as they are required to do today. They will demand much more convenience, continuity of care and comprehensiveness of services. They will expect their physicians to collaborate with other health and social service professionals to ensure that their needs are met. Consumers will drive changes in the provider community, and some providers are understandably anxious about this!

We hear a lot about EBM today, but how do we define this? Paul Keckley of Vanderbilt University offers a useful description of three dimensions:

- **Science**—What works best given what we know today as a result of population-based peer-reviewed research;
- **Clinician training and experience**—academic training, CME and credentialing; practice setting, locality; and
- **Patient preferences, understanding and values.**

Currently, this isn't happening. Providers are well-rewarded for redundancy and waste and often penalized for cost-efficient care. We need a healthcare system that is accountable for results and based on values, not procedures.

Jack Wennberg and his colleagues at Dartmouth were pioneers in demonstrating the huge and unwarranted variations in practices that result in three unacceptable patterns:

- **Underuse of effective care and services shown to work and that patients want.** Physicians provide preventive, acute and chronic care called for in the medical literature just 55% of the time. (McGlynn, 2003)
- **Misuse of preference-sensitive care, where more than one approach is reasonable and patient values should be considered.** Patients who are informed about treatment options tend to choose more conservative, lower cost care.
- **Overuse of supply sensitive care and services driven by providers.** High cost areas of the country, where there is a greater supply of physicians, hospital beds, etc., spend up to twice as much on healthcare than low-cost

areas. But people don't get more preventive care, nor do they have better outcomes or live longer. And they aren't more satisfied with their care. Instead, they get more visits and tests, longer hospital stays and more procedures—especially futile care at the end of life! (Fisher 2003)

There is more evidence than ever that the practice of medicine is anything but pure science today. In a Harris Poll conducted in March 2005, only 29% of U. S. adults reported that they or a family member had received a second medical opinion from a doctor in the past five years. (Of the 71% who did not get a second opinion, 46% said it wasn't necessary and 39% said they trusted their doctor.) Among those who did get a second opinion, 50% said they did it because they wanted as much information as possible. What's more, in 46% of these cases, the diagnosis was different from the original, and in two thirds of these cases, treatment was different as a result! That certainly suggests work needs to be done to improve the quality of clinical science as well as the quality of clinical decision-making!

The late John Eisenberg, former head of the Agency for Healthcare Research and Quality (AHRQ) put it this way: "... *there is sufficient evidence to suggest that most clinicians' practices do not reflect the principles of evidence-based medicine but rather are based upon tradition, their most recent experience, what they learned years ago in medical school, or what they have heard from their friends....*".

When the rules of clinical practice are not clear, variation results from subjective opinion, practice preferences and hospital capacity.

Why is there all this variation and what can be done? The fact is, physicians simply can't keep up with the rapid changes in science. Surveys conclude that the average physician spends approximately two hours a week reading scientific journals, and many doctors are overwhelmed by the volume of material confronting them. There are 10,000 randomized controlled trials published annually in primary care alone!

Most physicians also have little incentive to make a concerted effort to practice evidence-based medicine because they are not confident that health plans will pay for it. In fact, health insurers may not be in agreement with best practices. In addition,

Considerable work needs to be done to improve the quality of clinical science as well as the quality of clinical decision-making. When the rules of clinical practice are not clear, variation results from subjective opinion, practice preferences and hospital capacity.

most physician groups fear the widespread application of EBM because it challenges their professional turf.

It is clear that at least some consumer advocates also fume about what the docs call "cookbook medicine." However, as we have already pointed out, it is apparent that not all physicians know how to cook. So perhaps a good cookbook is necessary, if not sufficient, to improve healthcare quality.

As an example of a consumer advocacy group that echoes physician concerns, the Citizen's Council on Health Care, a non-profit group in Minnesota that promotes individual patient and practitioner control of health care decisions, describes EBM as "technocrats taking over the practice of medicine." They express concern about rigid standards of care imposed on patients, restrictions on professional freedom and judgment, rationing of healthcare services and the politicization of medicine. (http://www.cchconline.org/pdfreport/EBM_Report_-_Ex_Summary.pdf)

Its members cite numerous problems with available evidence. Some are certainly issues that need to be considered but others reflect the advocacy group's own biases. We should be cautious about the wholesale undermining of change, as clearly there are known and unknown risks. It is important to not let the desire for perfection keep us from moving forward.

There is a good deal of enthusiasm in some quarters for pay for performance, or P4P strategies, as a means of gaining provider cooperation with standardization and practice guidelines. P4P was given an important professional endorsement in 2001 in an IOM report, *Crossing the Quality Chasm*, which stated that private and public purchasers must modify their payment mechanisms to "recognize quality, reward quality, and support quality improvement." In a consumer-driven society, the idea of paying for performance resonates with patients, and currently there are at least 100

different pilots and programs sponsored by insurers, government agencies, employer groups and Congress.

However, despite all of this irrational, unexplained and unwarranted practice variation, there is not overwhelming enthusiasm even in the medical community for rewarding physicians for practicing EBM, even when standards are clear. Last year, the AMA board chair and current President-elect denounced P4P as a “scam designed by multimillionaire CEOs of health insurance companies” to cut reimbursement by taking advantage of gullible physicians. (AMNews, Wm Plested, Mar 1, 2004)

What do consumers think of this approach? Harris Interactive released a survey in June 2005 that found the public to be only moderately supportive of having health plans pay more to doctors for higher quality (38% of those surveyed said yes, 17% said no, and 32% were indifferent)—with one caveat: If P4P lowered their health insurance costs, 67% would be in favor. The more educated the respondent, the more he or she was likely to favor P4P. Consumers are somewhat supportive of measures that are associated with prevention and promoting patient compliance, but less so of measures of quality based on a particular disease or technology metrics.

The promise of shared decision-making: The third leg of the successful consumer-driven healthcare model is shared decision-making. This requires a fundamental change in attitude and behavior by many physicians. Unfortunately, the news is rather grim when it comes to the scientific research on just how frequently and how deeply the average doctor gets into shared decision making with the average patient.

Only 9% of all the healthcare decisions reflected even a limited degree of shared decision-making, perhaps because many prerequisites for shared decision-making don't often exist today.

One study (Braddock, et al., JAMA 1999) of over 3,000 medical decisions involved in 1,000 visits looked at six key elements of informed consent or shared decision-making:

- Decision itself was raised and discussed;
- Some discussion of alternatives;

- Discussion took place about pros and cons;
- Discussion of any uncertainties
- Attempt made to assess the patient's understanding of the decision or its implications
- Some exploration of patient preferences.

Only 9% of all the decisions reflected even a fairly limited degree of shared decision-making. And not one out of 3,000 included all six elements. The one element that is probably the most important, both in terms of developing and strengthening the doctor-patient relationship and leading to a higher likelihood of patient compliance, is a discussion and an exploration of the patient's understanding. That element was the least frequently noted of the six elements, appearing only 2% of the time.

Perhaps part of the reason for these results relates to the fact that there are a number of prerequisites for shared decision-making that don't often seem to exist today:

- Trust, something that is hard to achieve without a long-term doctor-patient relationship;
- Good communication skills, which, in general, are not taught to physicians;
- Adequate time, certainly more than the average 5 minute, 48 second office visit;
- Incentives, which are not provided in terms of compensation; and
- Commitment and conviction from both parties, as to the value and the need.

Many opine that one needs to experience it to appreciate the value of shared decision-making.

So it is perhaps not surprising that it rarely happens. Today's healthcare organizations and healthcare settings all too often produce non-compliant patients and demoralized clinicians, neither of which is conducive to the kind of shared decision-making we think would be ideal.

Interestingly, physicians have no better track record when it comes to taking the initiative to counsel patients about lifestyle changes than patients do in adopting them. The rationale they give for not doing so relates to a number of factors. They don't know how, they don't have time, they aren't paid for it, are among the reasons cited for not communicating well. But in reality, the number one reason is skepticism. They don't think it will make any difference—they don't believe patients will change!

What Do Consumer/Patients Need To Do?

What Do Consumer-Patients Need To Do?

- **Take responsibility for practicing healthy lifestyles**
- **Shop for the best care**
- **Comply with treatment recommendations**

With regard to the other side of that key equation in healthcare, what is it that consumer- patients need to do differently?

According to economist Jamie Robinson, there are some significant challenges when it comes to the central role of consumers. He points out that *“The natural role for the consumer in a market economy is to make informed, price-sensitive choices based on personal preferences and subject to individual budgetary constraints. This paradigm is poorly matched to the special features of health care.”*

However, as with the physician role, we will suggest three “simple” steps that would go a long way toward enhancing the effectiveness of the consumer role in healthcare decision making. First, consumers need to take personal responsibility for practicing healthy lifestyles. Second, they need to shop effectively for the best care. Third, they need to be compliant with their providers recommendations for therapy and treatment.

Is this realistic today? Obviously, there are a number of challenges that even the most well-intentioned patient might have with these demands. Let’s look at each more carefully.

Take responsibility for practicing healthy lifestyles: One of the principle tenets of CDHC is personal responsibility. But we know there is strong resistance to this notion from some advocacy groups who see it as blaming the patient or trying to make the patient accountable for factors that are beyond her control.

Yet, it is realistic to say that when it comes to day-to-day decisions about exercise, diet, smoking cessation, and other health behaviors it’s the doc-

Physicians have no better track record when it comes to taking the initiative to counsel patients about lifestyle changes than patients do in adopting them.

tor who advises but the patient who decides. And lest we think this is a trivial matter, consider this statistic: According to the CDC, 50% of healthcare costs are directly related to individual behavior.

If we look at the need for behavioral change in the context of future healthcare needs, there are some sobering facts. We are all getting older—as individuals and as a population. And many of us are getting fatter. As a result, we are facing an impending tsunami of chronic care needs which will be extremely costly. Obesity, as a key underpinning of chronic disease, explains almost as much of the healthcare cost increases as tobacco, and leads to a huge increase in risk of death from many causes. So this is a big deal from a financial point of view, and as such, has received a good deal of attention from the national media.

Why are we getting fatter? It’s a simple matter of energy balance, or rather lack of it. We are facing a “perfect storm” for obesity. We are eating more and we’re eating out more. In 1970, a third of the food budget was consumed outside the home. By the late 90’s, it rose to almost half, and now the number is well over 50%. Everything is being super-sized—we are a super-size society! As a country, we are producing 4,000 calories per person, per day. No wonder 35% of the population are obese or severely obese—numbers that have almost doubled in the last 25 years.

When we highlight the need for consumers to take more personal responsibility for their health habits, however, we’re not just talking about energy balance and obesity. We are talking about taking responsibility as a society and as individuals for wellness and health promotion. At the heart of this is a need for comprehensive, effective behavioral change programs, which will be increasingly

When it comes to day-to-day decisions about lifestyle habits, it’s the doctor who advises but the patient who decides.

important to the future of healthcare, given chronic disease trends and demographics.

Whether we are looking at lifestyle behaviors and primary prevention or self-management of chronic disease, we should recognize the importance of scientific behavioral change models and tailor programs to meet individual stages. Otherwise, we won't motivate people to change and the impact is likely to be minimal. To make this whole CDHC movement work, we need to really understand how consumers view their role in health care decision-making and how they feel about making choices and possibly changing their lifestyles.

A few months ago, WRGH commissioned a Harris Interactive survey to explore some of the attitudes of the public around these issues. We found that although most Americans are aware that a healthy lifestyle can improve and/or prevent many medical problems, they are generally unwilling to require people who are overweight or who do not exercise regularly to pay more for their coverage and care. This suggests that payers should rely on a system of incentives that emphasize rewards for healthy behaviors rather than punishment for unhealthy habits. One possible exception to this rule is smoking, as the public appears more willing to require smokers to pay more for their health insurance and medical care.

When it comes to perceptions about the quality of healthcare, the public holds mixed views. Americans appreciate that there are great differences in the quality of care provided by different hospitals and physicians for serious medical problems. However, they are not willing to pay more for access to higher-quality hospitals or physicians. This may well be related to the fact that most Americans feel satisfied with their current physicians and would not change them if cost or other limitations were not an issue. With this in mind, insurers will need to use well-designed incentives to drive consumers to higher-quality providers.

There is considerable data that shows few Americans are preparing financially for their future healthcare needs. Given rising health care costs, it is significant that a large majority of adults say they would be willing to work an extra two or three years in order to ensure that they have enough money to pay for their healthcare in retirement. However, older adults – including those in their pre-retirement years – are less likely

than younger adults to be willing to do so.

Shop for the “best” care: Effective healthcare is all about decisions: decisions about healthy or unhealthy behavior; whether and when and where to seek care; about drugs, tests, and surgeries. To make good decisions, consumers must have access to personalized care management tools or decision aids for guided self-care management. By decision aids' we mean self-administered information tools that prepare patients to make informed decisions about medical tests or treatments. Their role is to provide a higher level of awareness about expected outcomes, and they are designed to work within the framework of a clinician-patient relationship and help encourage patient participation.

Tools come in variety of forms, including videos and DVDs, Internet-based guides, online interactive tools, decision boards, books, and CD-ROMs. All share the ability to help the patient gain a better understanding of options, risks and treatment alternatives. But this information has to be easily available, clearly presented, relevant and timely. In other words it must be “pushed” to the patient at the time of need. Information Therapy (IX), such as that promoted by HealthWise, is the timely prescription and availability of evidence-based health information to meet individuals' specific needs and support sound decision-making.

We know that many people do want information and want to be involved. A RAND study released in March 2005 showed that more than 60% of Americans had searched for information to help them make sound treatment decisions in the last 12 months. One-third of the 4,300 people polled said the information they found affected their treatment choice or the choice of healthcare facility. Of those who had not needed to do so, 94% said they would search for information if they or a family member needed medical care. And 52% said they alone wanted to make the final decisions, whereas 38% wanted to make it with their physicians.

However, the results of another survey were a little less encouraging when it comes to progress on consumer engagement. It showed that despite their interest in being involved, most people do not think they are in a position to affect the cost or quality of the care they receive.

Nonetheless, providing information and realigning incentives to support quality care does lead to higher consumer satisfaction, better healthcare

outcomes and greater affordability. So there is both a need and a demand for clinical decision-support tools to improve patient satisfaction and quality.

As part of the study, RAND also looked at existing literature of how treatment decision tools affect behavior and found that patients using aids are more likely to make more conservative choices,—and more detailed information has an even greater impact. Theoretically, at least, this should result in some cost savings without any perception by patients that they are being denied care.

Some providers are taking significant steps to support patients' use of online information. According to the Center for Information Therapy, Group Health Cooperative, Puget Sound, is on the cutting edge of guiding patients through online medical information and is using IT to transform patients' experience with healthcare.

For the majority of people who don't have access to a fully integrated HMO or don't want to, AARP launched its Health Guide to help patients through the health information maze. It provides easy to understand, scientifically valid health information presented in the way that patients deal with health care problems. AARP sees its Health Guide as a launching pad for providing more services, such as maintaining electronic medical records.

How are consumers using information that's available? What do we know about the way consumers are currently using cost and quality information on providers? CDHC is helping to bring cost transparency to health care sooner than many experts would ever have predicted. Access to cost estimates for drugs, tests, and surgical procedures is increasingly a reality. Cost transparency for hospital comparisons is rapidly improving, even though it is still evolving and not ideal. Transparency for most physician rates, however, is still some years away.

Transparency of quality information is on a similar trajectory. Partly as a result of pay for quality efforts by both private payers and CMS, many hospitals now report quality metrics that are published and available for use in decision support tools.

Efforts are being made to address this problem. In April 1, 2005, for example, CMS began posting quality performance data for the nation's hospitals on its new "Hospital Compare" Web site.

In October 2002, a Harris poll found that although healthcare quality ratings were available to an increasing number of U.S. consumers, the information led very few to alter their use of healthcare. But at the time, ratings advocates said that the information available wasn't presented well, complicating consumers' efforts to make good use of the reports.

Cooperation among representatives from different sectors is important. One model might be the Consumer-Purchaser Disclosure Project, a non-profit partnership of consumer and labor organizations, public and private purchasers and employer groups. Its goal is to make it possible by January 2007 for Americans to be able to "select hospitals, physicians, physician groups/delivery systems and treatments based on public reporting of nationally standardized measures for clinical quality, consumer experience, equity and efficiency."

Still, folks argue about whether consumers are capable of using such information. And consumers are a bit schizophrenic about it, too. We learned from our December 2004 Harris survey that an effective approach to getting Americans more involved in healthcare decision-making will need to ensure that the healthcare system is easy for them to understand and navigate. This is important in helping consumers become more comfortable using information sources other than those they have traditionally relied on. Nearly two out of three Americans feel that they would become more involved in decision-making if the healthcare system were easier to navigate. Reflecting a traditional reliance on physicians for making decisions about treatments or selecting specialists or hospitals on their behalf, over a third of consumers say they would still follow their doctor's advice even if it conflicted with reliable information from another knowledgeable source.

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Be compliant with therapy: The third fundamental requirement from consumers is to comply with recommended interventions, be they preventive or therapeutic. Yet, the statistics on compliance with physician recommendations, whether related to diagnostic testing, prescriptions or lifestyle changes are not encouraging. Patients fail to comply with directives for a whole host of reasons, many related to lack of understanding or trust, that is, a poor doctor-patient relationship.

It's quite clear from decades of research that without really good behavioral health communication programs in place, as a group, patients really don't adhere very well, particularly when it comes to complex or long-term regimens. It's particularly difficult when treatment is multifaceted and there are no symptoms.

Low health literacy affects 40 million Americans and is estimated to contribute 30-54 billion dollars in additional healthcare charges. The IOM says half of healthcare providers believe patients do not adhere to treatment because of language barriers, cognitive impairment, lack of knowledge or cultural issues. Other types of non-compliance relate to the regimen itself, which may be difficult, complicated, or disruptive of lifestyles. A third type of non-compliance is intentional. The patient makes a conscious decision to alter or stop treatment.

Without really good behavioral health communication programs in place, patients really don't adhere very well, particularly when treatment is complex and there are no symptoms.

Some experts have pointed out that the problem is compounded by the fact that doctors consistently underestimate the degree of non-compliance among their patients and overestimate their ability to identify it as an issue.

In summary, it is unrealistic to think patients in a consumer-centric healthcare model currently have enough information to make good decisions. But it is coming! Robust, reliable, trustworthy information isn't yet there on price and certainly not on quality. Patient coaches or patient navigators, especially for the disadvantaged and chronically ill, are going to be a critical component in ensuring that these strategies are truly useful.

What is the Role of Employers and Health Plans?

What Can Employers and Plans Do?

- **Serve as information brokers**
- **Base prevention and disease management programs on behavioral change model**
- **Reward provider for quality**

Most of this guide is focused on how the role of employers and health plans is changing. So we will not belabor many of the points already made.

As we pointed out in an earlier chapter, the debate over health reform gets down to the fundamental question over who will control healthcare decisions - bureaucracies or individuals. Those waiting for the "big bang" might reconsider. Whatever change occurs will preserve the current pillars that support our system. The change will be an evolution, not a revolution, and it will be painful. In fact, most leaders we've talked to recognize that change is imminent and that all stakeholders in healthcare will need to carefully redefine and articulate their value proposition.

Understandably, a principle interest of employer purchasers is cost control, although many of the strategies that can help address costs are supportive of employees and also can enhance productivity. They can also help the consumer get the most out of the relationship they have with their physician.

Communicate the need for and advantages of the new model and serve as "information brokers": Today, employers have the opportunity to avoid the mistakes of the managed care movement by taking a longer-term strategic view of their role in supporting their employees' health. Some employers may seize the consumerism movement as a quick fix to rein in escalating costs by shifting them onto their employees and just give lip-service to CDHC. But smart employers will not fall into that trap. Instead, they will recognize the opportunity to reposition themselves as trusted, honest brokers of information and as active catalyst for healthy lifestyles. In order to be successful, they will embrace all the facts of CDHC, move slowly, focus on communication, and truly empower and support their employees.

For some employers, this means setting aside the paternalism and control that marked the old way of doing business, in favor of supporting the underlying cultural changes necessary to empower each employee with the right incentives to take ownership of his or her health. It means actively supporting employees with credible information on doctors and hospitals. It means educating them about prevention and self-care for the most prevalent diseases. It means being thoughtful in benefit design, ensuring that no one is disenfranchised. It means ensuring that those with chronic illness are effectively linked to disease management and primary case management programs. And it means ensuring strong incentives are built into plans for prevention and wellness. In short, it is a whole new world, as described in detail in earlier chapters.

But the difficulty in putting CDHC theory into practice should not be underestimated. There is no question that there will be some unintended consequences that must be monitored and addressed. Critical details that will require sustained attention if the benefits are to outweigh the risks are often glossed. No single design, such as high deductible health insurance, is suited to everyone. Non value-added infrastructure will be subjected to the most intense scrutiny possible—that of the consumer and marketplace. Many of the issues are undoubtedly familiar to the reader and have been discussed earlier in the guide.

Benefit design is key to ensuring that needed care is not avoided. Accounts need to initially be funded with sufficient resources and incentives for consumers to seek appropriate preventive and chronic care. Information and a personal support safety net are critical components of successful design.

Plans need to facilitate movement by providing access to existing networks and on-line information tools.

Design and provide comprehensive programs in prevention and disease management based on behavioral change model: The importance of better management of those individuals with multiple chronic conditions is discussed in detail in chapter IV. Here, we will just reiterate some key points.

During the 1970s we began to think about health promotion and disease prevention as an alternative to only curing and repairing. Somewhat later

The difficulty in putting CDHC theory into practice should not be underestimated. Critical details are often glossed over by advocates and unintended consequences must be expected and addressed.

we began to recognize that tertiary prevention, or so-called disease management, was where we could really save money and improve care. Given that 5% of the population accounts for approximately 45% of costs, identifying and targeting this group with aggressive case management and care coordination is absolutely critical to cost-containment strategies.

Studies have shown that when someone else pays for disease management, participation rates are excellent. Under consumer directed plans, employers should ensure that there are no financial or logistical barriers to disease management for that segment of their population who can most benefit. Employers should also consider additional incentives, such as providing additional contributions to the employee's HSA or HRA in exchange for participation. Disease and case management is on the cusp of widespread acceptance among consumers and employers, but integrating it across the spectrum of consumer products such as HSAs or HRAs is still evolving.

A combination of traditional disease management, focused on diseases like heart failure or diabetes, which pay off in the short-term, coupled with tobacco cessation, which provides a big longer-term pay off, make sense. Some programs focus on members' total health profile and identify and work with those likely to develop multiple expensive conditions down the line.

Change reimbursement mechanisms to reward quality: Purchasers and payers need to incentivize total system redesign. They need to pay for outcomes, results, integrated care, and IT.

The P4P momentum is driven by a number of factors, including CDHC. In a consumer-based society, the idea of paying for performance theoretically resonates with patients. But as pointed out earlier, they are less than excited about it, both because they are reflecting some of their doctors' complaints and because they aren't convinced of the kind of tangible benefits they want for themselves.

In addition to the skepticism of physicians and the rallying of patients behind them, there are other reasons to wonder how effective P4P will be if payers don't develop a common agenda.

Despite the hopes and interests of some purchasers, the current generation of P4P is not designed to reap cost savings, particularly since most of the quality measures it targets are measures of underuse.

Although it was estimated a couple of years ago that by 2006, 80% of plans would use P4P strategies, the reality is much lower. If only a few of the many payers that a provider contracts with are paying for performance, or if each focuses on a different measurement set, the effects are diluted. Some private-sector employers have begun aligning efforts through healthcare quality improvement coalitions such as the Leapfrog Group and Bridges to Excellence, which offer standardized programs of performance measurement, reporting, and reward.

Given the overall focus of employers on cost control, it is significant that a recent Commonwealth Fund Health Care Opinion Leaders Survey found significant consensus on the most promising ways to do so from all sectors: academia/research; business, insurance, healthcare industry, labor/consumer advocacy organizations, and government. And their views support the recommendations outlined above.

All respondents agreed that to get value for the money we are spending, we need to change the way we pay for care, streamline administration, and foster collaboration.

The strategies rated as the most effective ways to control costs are:

- Rewarding more efficient and high quality care;
- Improving disease management services for patients with high-cost conditions;
- Enhancing primary case management and applying evidence-based guidelines to determining when a test or procedure should be done; and
- Increasing collaboration among private insurers, Medicare, and Medicaid to adopt common payment methods and rates and streamline administrative costs.

What are the specific implications of CDHC for

health plans themselves? Health plans see HSAs as both an opportunity and a potential threat. At this stage, most health plans are partnering with banks to offer accounts, in some cases because they fear that banks will cannibalize their business.

These plans pose a major challenge to payer information systems because of a complex array of service-specific elements: co-pays, three-tier drug pricing, provider network choices, etc. Core claims and membership systems have to be modified. Auto-adjudication rates are down because many of these claims require manual intervention. Some payers have outsourced IT functions because it is too costly to build these applications themselves.

What is the Role of Government?

What Can Government Do?

- Use its leverage as purchaser
- Recognize its leadership role
- Improve technology assessment
- Support clinical effectiveness research
- Support IT standards development
- Tests CDHC models in public programs
- Create more flexible accounts

The politics of healthcare represents the last big opportunity for broad social change. For many, this translates into a politically polarized vision—those who want to see government run and fund healthcare versus those who believe in a marriage of markets and public sector. This is a terribly unfriendly environment in which to bring about system wide change!

Healthcare pollsters repeatedly confirm the gap between what people say they want and what elected officials recognize and act on. This gap and political polarization with regard to healthcare has only gotten worse. However, with healthcare consumerism, there is reasonable alignment of political interests. The basic model of robust information plus incentives is a political consensus point, which has been advocated by such political polar opposites as Ralph Nader and Newt Gingrich. Gingrich promotes “information-rich decision support and health management tools,”

a concept that is not much different than Ralph Nader's call for information about physician fees, drug-prescribing habits, and so forth. Nader once said, *"That this country tolerates the very worst along with the very best quality of medical care, the poorly trained doctor along with the well-trained, those who overcharge along with those who charge reasonable fees, can best be explained by the total lack of information consumers have about doctors."*

So what are some constructive steps that government can take? As the payer of roughly 60% of the healthcare bill facing the impending swelling of the Medicare budget to care for an aging population, the government certainly has the incentive to use its most powerful tool—its leverage as purchaser. Government as a purchaser, similar to private-sector purchasers, should consider supporting models of reform that allow the reimbursement system to align with the quality agenda.

There are a number of examples in which the current Bush administration is looking to do just that. Integrated services, information, social support, logistics, complex case management and measurement, and standards are cornerstones to constructive change. Today CMS is advancing many of these ideas through pilots and demonstration projects, such as P4P demos and Voluntary Chronic Care Improvement pilots

The leadership role of CMS is central to furthering this goal as private payers historically have emulated many of CMS's significant payment reforms—for example, the prospective payment system. They could also support P4P by contributing patient data (stripped of identifiers) to an all-payer data set from which more reliable performance evaluation could be conducted because of the larger denominators.

Government should create improved technology assessment in order to speed the time it takes to get real innovation into practice. Currently it takes between 12 and 15 years for known improvements to become mainstream practice.

Government should drive improvements in medical effectiveness through clinical outcomes research and improved assessment and evaluation of the appropriate uses of new technology to mitigate variations in physician practices.

Government and business should help create and

The politics of healthcare represents the last big opportunity for broad social change.

disseminate information by supporting the development of standards for information on quality measurement, enabling consumers to make informed decisions and ensuring technology compatibility and data confidentiality.

Government should test CDHC models in public programs, such as Medicaid and Medicare. More pilots and demos are needed, like the self-determination Cash & Counseling Medicaid, which showed that even elderly, disabled patients and those with developmental disabilities can make choices which meet their needs.

Government also has formal and informal powers through administrative law, regulation, executive orders, legislation and the bully pulpit to have significant influence over the direction of healthcare.

On the savings account front, the fundamental need is for more flexibility, as discussed in Chapter VII.

With FSAs, unused funds should be allowed to rollover until retirement, both within the FSA and into other tax-deferred accounts such as HSAs, IRAs, and 401(K)s. They would also be more attractive if workers could make contributions more than once a year. Workers whose employers don't provide health savings accounts should be permitted to purchase through a third-party administrator.

Some say, too, that employees should be able to withdraw HRA funds as cash—after paying taxes on them— and that these funds they should be portable. If employees don't perceive that they will benefit from prudent consumption of health-care services, they have less incentive to make wise choices. Restrictions on who can contribute and the ability to tie contributions to salary reduction or deferred compensation serve no useful purpose.

The design of HSAs codified in tax law in unnecessarily restrictive ways. For example, employers cannot establish low deductibles for drug coverage or wellness programs. Nor can they create

accounts designed specifically for those with chronic disease. MSAs in South Africa have that flexibility, with varying deductibles. A plan might have no deductible for hospital care on the theory that patients have no discretion about when and whether it's needed, but have a \$1000 or higher deductible for outpatient care. Similarly, the deductible on drugs for a patient with chronic disease could be eliminated because skimping on medications could lead to higher costs later.

HSAs currently have a maximum out-of-pocket expenditure limit of \$5,000 for an individual and \$10,000 for a family. A person with a preexisting chronic condition might not be able to get an HSA because his yearly out-of-pocket costs exceed the maximum. People should be allowed to deposit pre-tax funds into HSAs even if they want to self-insure for higher amounts—or cannot obtain insurance at all.

Many also advocate for more flexibility in models of employer-sponsored insurance—allowing employees to purchase personal and portable insurance that is individually owned, for example. Different households should be accommodated. Employees who turn down employer-sponsored insurance because they are covered under a spouse should get higher wages instead. And part-time employees should be able to choose between higher wages or health insurance.

Others have focused their recommendations on ways to make these plans more equitable. Here are some suggestions from different sources:

- Limit the maximum out of pocket exposure to a small percentage of income, for example, 5%
- Adjust individuals' HSA contributions based on medical condition, self-management behavior and income
- Develop (and authorize regulations for) new CDHC/HSA plan features that exempt evidence-based disease management therapies and preventive services from high-deductible HSA requirements
- Permit employers to lower deductibles for lower-wage workers
- Exempt primary care and preventive services from the deductible
- Permit greater flexibility in plan design
- Set an income ceiling on eligibility for HSAs
- Guarantee choice of a comprehensive health plan to workers covered under employer plans

Making all the changes proposed here may seem like a daunting—or even impossible—process. But health system change, like all societal changes, is a process of evolution rather than revolution—and every one of us can take steps that bring us closer to an equitable consumer-directed healthcare system now.

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