

# PERSPECTIVES

PROVIDING INSIGHT INTO TODAY'S EMPLOYEE BENEFITS ISSUES

## Consumer, Heal Thyself: Consumer-Directed Health Plans – The Cure for All That Ails Us?

**A** panacea or a puzzle? Consumer-Directed Health Plans (CDHP) have caught the attention, if not the serious consideration, of most of this country's health care payers as they continue to be buffeted by the relentless upward spiral of health care costs. With traditional managed care losing its effectiveness as a cost control mechanism and little or no help offered at the state and federal levels, employers and insurers are frantically searching for a new way out of their health care cost and quality dilemma.

Although there are almost as many definitions as there are opinions about them, CDHPs generally include three components: a health insurance plan with a high deductible; an accompanying tax-advantaged account to pay for expenses below the deductible amount; and decision-support tools to assist the consumer in assessing health care cost and quality and available treatment options.

To evaluate the CDHP trend objectively, it is helpful to examine a number of questions related to this emerging option, including:

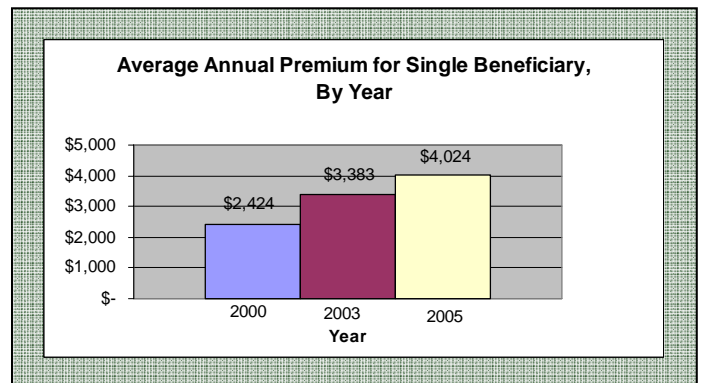
- The rise in health care consumerism – what is behind this movement?
- The prevalence of these plans – what are they, who is adopting them and why?

- Challenges – what roadblocks remain in the health care system that threaten their success?
- Successful employer implementation – what can an employer do to stack the odds in their favor when implementing a CDHP?

### The Rise of Health Care Consumerism *How Did We Get Here?*

Premiums for employer-based health insurance rose by 9.2 percent in 2005—the fifth consecutive year of increases over nine percent and considerably higher than cost of living increases over the same period. The numbers speak loud and clear that traditional cost containment measures such as discounts from providers, utilization controls, and increased deductibles and employee premium contributions have not only failed to rein in cost increases, but have done little to improve the efficiency and effectiveness of the health care system. In 2000, the average annual premium for a single beneficiary was \$2,424. In 2005, that number rose to \$4,024.

**Figure 1**



Source: Kaiser/Health Research and Educational Trust, Employee Health Benefits Surveys 2000-2005

### True Costs Are Hidden

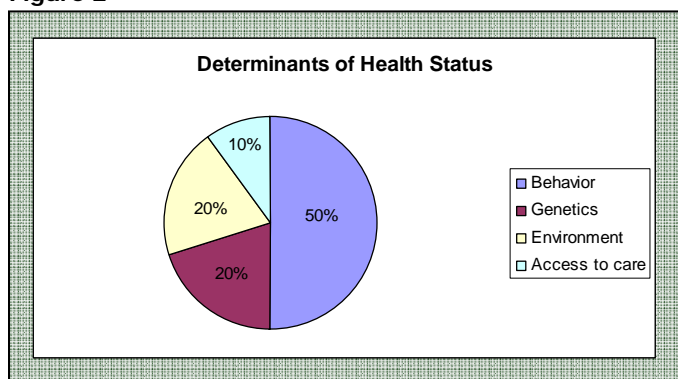
While health care costs continue to rise sharply, employees are well insulated from the true costs of care. Even though employees are contributing more in absolute dollars for their health care, their share of the costs has actually decreased significantly over the past 30 years. In 1970, employees' out-of-pocket share of total health care expenditures was 35 percent. In 2003 that share was down to an astounding 12 percent. Even as employees bemoan shrinking medical plan benefits, the reality is that they are paying a significantly smaller share of the total cost of care.

### The Case for Employee Engagement

Beyond understanding the cost of health care, most consumers are not engaged in taking charge of their health. An obvious example is the growing prevalence of obesity in this country. According to the Centers for Disease Control and Prevention, an estimated 30 percent of U.S. adults aged 20 years and older - over 60 million people - are obese. Obesity is defined as having a body mass index (BMI) of 30 or higher. Sixty-five percent of U.S. adults aged 20 years and older are either overweight (a BMI of 25 or higher) or obese - a disturbing number when contemplating the myriad of health risks associated with obesity.

Employee behavior and lifestyle are significant factors in health status and, ultimately, the cost of health care - more so than genetics, the environment, or access to care. The Centers for Disease Control and Prevention estimate that 50 percent of an individual's health status is a direct result of behaviors.

Figure 2



Source: Centers for Disease Control and Prevention

Employers, who pay the majority of their employees' health care costs, have an enormous stake in engaging their employees in their own health care—from the lifestyle decisions they make to the

health care they seek out. Studies have shown behaviors can be modified when wellness programs offer a professional coaching component. Employees will seek appropriate, cost-effective care if they are motivated, engaged and accountable.

### What is Health Care Consumerism?

In the broadest sense, health care consumerism is about empowering health care consumers to be more successful in selecting cost effective, appropriate care. It is also about encouraging people to become more accountable, knowledgeable and engaged about their health care. More specifically, it is about assisting employees in:

- Becoming an active participant in their health care decision-making rather than a passive partner
- Spending their health care dollars wisely by seeking care from providers who are cost efficient and provide quality care
- Taking charge of their health by understanding their conditions and their treatment options and changing their behavior to eliminate unnecessary health risks

According to a 2005 employer survey conducted by Mercer Human Resource Consulting, consumerism and care management are the preferred health care cost containment strategies of the future—not cost shifting or the scaling back of benefits. In the survey, consumerism is defined as, “promoting informed and responsible spending by employees for health care.”

Figure 3

Employer cost-management strategies for the next five years		
	Strategy will be significant or very significant	
Strategy	All employers	Large (>500) employers
Consumerism	34%	55%
Care Management	32%	62%
Collective Purchasing	29%	25%
Data Transparency	28%	35%
High-performance networks	26%	33%
Benefit cutbacks/cost shifting to employees	21%	24%

Source: Mercer National Survey of Employer-Sponsored Health Plans 2005

## CDHPs – The Current Picture

### Healthy Growth

All the publicity surrounding CDHPs has had a definite effect on the market. Currently CDHPs represent a small but ever-increasing portion of the health care insurance market. According to an April 2006 Government Accountability Office report, in January 2005, three million people were enrolled in CDHPs. By January of 2006, that number had risen to between five and six million – a large percentage increase, but still a small fraction of the 177 million people covered by private health insurance in this country. The number of employers offering CDHPs to their employees increased from one percent in 2004 to four percent in 2005, according to the report.

A June 2006 nationwide survey conducted by Aon Consulting and the International Society of Certified Employee Benefits Specialists (ISCEBS), found CDHPs gaining a stronger presence in employer health care offerings. Of the 434 companies responding, ranging in size from less than 500 employees to greater than 10,000 employees, 28 percent are offering a CDHP, up from 22 percent the previous year.

When looking at the adoption of CDHPs by employer size, it appears that the larger the employer, the greater the likelihood they offer a CDHP option to their employees. In 2005, 22 percent of very large employers (10,000 or more employees) had adopted CDHPs, compared with five percent of large employers (550 to 10,000 employees) and two percent of small employers (10 to 499 employees).

Figure 4

Consumer-directed health plans, 2003–2005: Percent of employers offering program			
	2003	2004	2005
All employers	<1%	1%	2%
Small employers (10-49)	<1%	1%	2%
Large employers (500+)	1%	4%	5%
Jumbo employers (20,000+)	9%	12%	22%

Source: Mercer National Survey of Employer-Sponsored Health Plans 2005

Although very large employers lead the way when looking at future plans for CDHP adoption – 31 percent of the largest employers are expected to adopt CDHPs by 2007 – the smaller employers do plan to adopt CDHPs in greater numbers by 2007. Thirteen percent of small employers and 17 percent of large employers plan to adopt CDHPs by 2007.

Figure 5

Employers likely to offer CDHPs in 2006 or 2007			
	Currently offer	Likely to offer* in 2006	Likely to offer* in 2007
All employers	2%	11%	13%
Small employers (10-49)	2%	11%	13%
Large employers (500+)	5%	13%	17%
Jumbo employers (20,000+)	22%	29%	31%

\* Selected 5 on a 5-point scale, where 1 = not at all likely and 5 = very likely. Includes employers that currently offer; 2007 figure includes employers likely to offer in 2006

Source: Mercer National Survey of Employer-Sponsored Health Plans 2005

Surveys of health insurance carriers also point to the potential for strong growth of CDHPs in the fully-insured market in the near future. Milliman's 2005 Group Health Insurance Survey reports that 93 percent of the health insurance carriers surveyed expect to offer HSA-eligible or HRA-based plans within the next year.

### What is the Attraction of CDHPs?

Apparently, more employers are betting on the ability of CDHPs to improve the health care system over time, rather than relying on short-term cost reductions. According to the Aon Consulting/ISCEBS Survey, the top reason employers are adopting CDHPs is to introduce consumerism into the purchasing of health care to effect long-term change in the health care system. Forty-eight percent of respondents identified this as their main reason, while 38 percent identified controlling rising costs as the prime motivation. In the previous year, controlling health care costs was the number one reason (43 percent), while introducing consumerism was number two (38 percent).

### HSA vs. HRA

Most employers offer CDHPs in conjunction with a health care account. These accounts take two forms – a health savings account (HSA) which is owned by the employee and can be funded by both the employer and employee; or a health reimbursement arrangement (HRA) which is owned and funded only by the employer.

Both HSAs and HRAs are tax-advantaged. For HRAs, employer contributions do not have to be included in the employee's gross salary. For HSAs, the amount the employee contributes is tax-

deductible and interest earned in the account is not taxable. Unspent funds in both types of accounts can be rolled over from year to year. Most employers do not make HRA accounts portable; however, individuals participating in HSAs may retain their accounts if they leave their employers. Figure 6 identifies the key features of HSAs and HRAs.

**Figure 6**

<b>Comparison of HRA-Based and HSA-Eligible Plans and Account Features for 2008</b>		
	<b>HRA Based Plans</b>	<b>HSA-Eligible Plans</b>
<b>High-deductible plan features</b>		
<b>Deductible requirements</b>	No requirements, but most employers pair HRAs with high-deductible plans	Minimum of \$1,100 for single and \$2,200 for family coverage; to be adjusted for inflation in future years
<b>Maximum out-of-pocket limits(1)</b>	IRS does not specify a maximum out-of-pocket limit	Maximum of \$5,600 for single and \$11,200 for family coverage; to be adjusted for inflation in future years
<b>Account features</b>		
<b>Portability</b>	No requirements, but most employers do not make accounts portable	Accounts are fully portable, so individuals retain the accounts if they leave their employers
<b>Ownership</b>	Employer owned	Individual owned
<b>Who may contribute</b>	Employers only	Employers, individuals, and family members
<b>Annual contribution limits</b>	No requirements; employers typically determine contribution amounts	Contributions allowed up to \$2,900 for single or \$5,80 for family coverage; to be adjusted for inflation in future years
<b>Unspent funds</b>	May roll over from year to year; some employers limit the maximum amount that may accumulate	May roll over from year to year without limit

<b>Definition of qualified medical expenses</b>	As specified by IRS(2)	As specified by IRS(2) however, payment for health insurance premiums is restricted to long-term care coverage, certain continuation coverage, coverage while receiving unemployment benefits, and coverage after age 65 (except Medigap)(3)
<b>Tax treatment</b>	Withdrawals for qualified medical expenses are exempt from federal income taxes; employer contributions to account are excluded from gross income by employers and are not treated as taxable income to employees	Subject to income tax; additional 10 percent penalty assessed for nonmedical withdrawals before age 65
<b>Non-medical withdrawals</b>	Not allowed—all withdrawals must be for documented medical expenses	Subject to income tax; additional 10 percent penalty assessed for non-medical withdrawals before age 65
<p>(1) Premiums and services not covered by the insurance plan do not count toward the out-of-pocket maximum.</p> <p>(2) Qualified medical expenses include expenses intended to prevent or alleviate a mental or physical condition, including vision and dental services. Qualified medical expenses may also include certain insurance premium costs, long-term care insurance, and the costs of transportation to obtain medical care.</p> <p>(3) Medigap is private supplemental insurance available to Medicare enrollees. It helps to pay for some of Medicare's deductibles, copayments, and coinsurance amounts, as well as some benefits Medicare does not cover.</p>		

Source: 2006 GAO Report – Consumer-Directed Health Plans

Although, initially, many employers professed confusion over which type of health care account to offer with a CDHP, their preference seems to be solidifying. According to a nationwide Aon Consulting/ISCEBS Survey of 434 employers, the HSA is gaining favor over the HRA. Issues such as portability, ownership and contribution flexibility can all be cited as possible reasons for this shift. Figure 7 illustrates the change.

**Figure 7**

<b>Comparison: CDHP Offerings with HSAs vs. HRAs</b>			
<b>Employers offering</b>			
Year	HSA	HRA	Both
2005	15%	66%	15%
2006	48%	43%	10%

*Note: Percentages may not equal 100% due to rounding*  
 Source: Aon Consulting/ISCEBS Survey of CDHPs, June 2006

Several insurance industry surveys corroborate this move toward HSAs. According to a survey done by the health insurance trade association, America's Health Insurance Plans (AHIP), the number of enrollees and dependents covered by HSA-eligible plans has increased from about 438,000 in September 2004 to about one million in March 2005 and about three million in January 2006.

HRA participation continues to grow as well, although not at the same rate as HSAs. According to a survey conducted by Atlantic Information Systems, the number of enrollees and dependents in HRA-based plans grew from about 2.5 million in January 2005 to about 2.9 million in January 2006.

**Contribution Levels**

In an effort to encourage employee participation and engagement, most employers contribute to their employees' health plan accounts; although the amounts contributed vary widely. For HRA-based plans, the most common employer contribution for single coverage ranged from \$500 to \$700 and \$1,500 to \$2,000 for family coverage in 2004.

For HSA-eligible plans, the employee is not required to open an account, although estimates indicate that approximately 50 percent to 60 percent do so. According to survey data reported in the 2005 GAO report, two-thirds of employers contributed to their employees' HSA account, with an average contribution of about \$553 for a single and \$1,185 for a family.

**CDHP Challenges  
Not Quite There Yet?**

While CDHP offerings and participation are growing at a rapid pace, several challenges exist which may limit their future and ultimate effectiveness

- Lack of flexibility in federal and state provisions

- Lack of understandable consumer decision-support tools offering transparency of price and quality and treatment options
- Lack of competitive pricing of the plans by insurance carriers
- Lack of plan administration information for consumers and providers when care is sought
- Lack of interest from the chronically ill

**Threat of Federal and State Provisions**

Despite recent increases in HSA adoption, there are several federal and state provisions that may inhibit the future growth of HSA-eligible CDHPs. For example, IRS guidelines preclude coverage for most prescription drugs before the deductible is met. Many health care plans offer drug coverage outside of the deductible – thus, this restriction could hurt the wider adoption of CDHPs.

In addition, limits on contributions to an HSA are capped at \$2,900 for an individual and \$5,800 for a family in 2008. With deductibles on some plans significantly higher, the gap created between contribution limits and the deductible could dissuade some employees from joining.

IRS guidance also may limit the ability of employers to steer employees suffering from chronic illnesses into CDHPs. IRS guidelines penalize employers that provide different contribution levels for comparable classes of employees. If an employer is prohibited from providing CDHP incentives to their chronically ill population (those who are most certainly consuming a significant portion of their health care dollars), their CDHP may have a nominal impact on their overall health care costs.

Finally, several states (Alabama, California Illinois, Missouri, New Jersey, New York, Pennsylvania and Wisconsin) maintain tax or insurance requirements that are incompatible with federal HSA statutory provisions. These incompatible state provisions range from the prohibition of CDHPs to be coupled with HSAs to the reduction of tax advantages by the disallowing of state personal tax deductions on HSA contributions.

**Decision Support Tools Remain Elusive**

In virtually every segment of the American economy, consumers have access to an abundance of information about anything they are considering purchasing. From automobiles to appliances to cell phone plans, consumers can obtain easy-to-find and easy-to-understand cost and quality information. If employers are going to expect their employees to act in the same consumer-savvy manner when it comes to health care, they are going to have to assist them

in obtaining the necessary decision support tools that enlighten them on the price and quality of health care and treatment options.

Currently, there is almost universal consensus that such support tools are in very limited supply, leaving health consumers to fend for themselves. For example, a survey of major insurance companies offering CDHPs conducted in 2005 by the actuarial firm Reden & Anders, found a significant lack of cost and quality information. Specifically, the results showed that:

- More than 55 percent of insurers offer customers no information on the quality of services provided by hospitals or doctors in their networks
- Less than 60 percent of major insurance companies give consumers any information on the expected cost of their medical care
- Forty-four percent of 28 major insurers surveyed say they publish no information on patients' probable medical costs. More than half of those that do provide this information give only averages without specifics for particular locations
- Only 50 percent of the surveyed insurers tell patients the cost of procedures or treatments in exact dollars, offering instead ranges or averages
- Ninety percent of insurance carriers did not adjust their cost information to reflect severity of illness and 67 percent did not severity adjust their quality information

Several reasons are cited for the lack of provider quality and price transparency information. One of the biggest challenges is how to present the information in a way that a consumer can understand and interpret. Health care quality and cost information does not always lend itself to simple presentation and facile comparisons. A multitude of opinions exist on what constitutes suitable quality measures, further complicating the issue.

Many providers are unwilling to compete on price, offering the argument that meaningful comparisons cannot be made since quality cannot be consistently and reliably measured. Providers will also point out that there may be potential anti-trust and contract confidentiality issues that would preclude more price transparency.

Lastly, even if the necessary support tools were available, without universal Internet access, many consumers would not have the means to acquire the information in a quick and easy fashion. Presently, it is estimated that over 30 percent of the US population

lacks access to the Internet, making the accessibility of information a difficulty for some.

### ***Enough of a Pricing Incentive?***

There are concerns that the current pricing of CDHPs may not jumpstart participation growth. The difference in premium costs for a CDHP and a typical low-deductible PPO plan may not be enough to attract employees to the CDHP. For example, according to a 2005 Aon Consulting/ISCEBS Survey, the nationwide average for a monthly premium for single coverage, HSA-eligible plans with deductibles between \$2,000 and \$2,999 was \$166, compared to \$213 for non-HSA plans with deductibles under \$500. With such a limited premium differential, it is questionable whether the typical employee would opt for the high deductible HSA-eligible plan.

### ***Administrative Confusion***

The current system of tracking HSA fund balances is confusing to patients and providers. Without knowing an up-to-the-minute fund balance, providers and patients may be unaware of fund balances, which could lead to slow payment to providers. Until recently, carrier and claims administration systems have been behind the curve in developing efficient and user-friendly CDHP processes and systems. Several companies are now experimenting with real-time debit cards for HSA accounts that may simplify the process. Until then, employers may be reluctant to take on potential customer service problems.

### ***Getting to the Twenty Percent***

It is well understood and accepted that approximately 20 percent of an employer's employees will be responsible for 80 percent of their health plan expenditures. It becomes obvious that in order to significantly impact costs, this 20 percent must become engaged health care consumers. Unfortunately, several studies indicate that this population is not inclined to leave their traditional plans for CDHPs.

According to a Kaiser Family Foundation report, these individuals cited fear of high out-of-pocket costs as the reason for not embracing CDHPs. It will be incumbent on employers to effectively communicate the advantages of CDHPs to attract this population. Further, employers should be especially focused on the ability of the mechanisms of any CDHP they are considering to successfully identify and manage the majority of its chronically ill population.

## Successful Implementation

### *What Does It Take?*

In spite of external challenges, employers can go a long way in controlling their own destinies when implementing a CDHP. An employer should target three major areas to increase their chances for success

- An effective employee communication plan
- Sufficient cost and quality information for employees
- Pre- and post-implementation surveys to assess employee understanding

### *Communication is Key*

Any implementation of a CDHP must include clear, consistent communication. Employee reaction to the adoption of a CDHP will likely be met with both skepticism (i.e., “they are just looking to pass costs on to me”) and trepidation (i.e., “how will I negotiate this new world of health care consumerism?”). In order to counteract these initial reactions and heighten the chances for success, employers must communicate why they are making the changes. On this point, it is important to communicate that the reason for the change has less to do with shifting costs and more to do with encouraging them to take control of their health and ownership of effective consumer decisions.

To achieve buy-in and enthusiasm, communication regarding health care consumerism must resemble a marketing campaign more than a typical human resources information campaign.

Sufficient lead time should be incorporated into communication efforts to ensure maximum traction. A variety of communication methods should be employed and key messages should be repeated to achieve sufficient exposure and understanding. Behavioral changes take time and require a consistent and concerted educational effort.

### *Identifying Tools*

Leading up to the CDHP implementation, it is imperative to identify what decision-support tools are available. Health care cost and quality information may be available from an insurance carrier, benefits administrator, health care coalition or other public data sources. A thorough educational campaign regarding the use of these tools is certainly advisable. Effective communication regarding the benefits of participating in a CDHP and guidance in identifying data sources must take place on an ongoing basis—not just during open enrollment.

## *Measure to Manage*

Conducting a survey of employees prior to introducing consumerism efforts and a CDHP makes eminent sense. Through research an employer can

- Refine strategies for communicating consumerism and CDHPs
- Determine how much employees understand about the reasons for rising health care costs and what they can do to impact them
- Find out how much they know about resources available to them to make wise health care choices
- Determine how employees presently navigate the health care system with the information available to them
- Understand what information employees want to assist them in making wise health care choices
- Investigate how motivated employees are to modify their behavior and become active health care consumers

Having the right information prior to implementing a CDHP plan will give the employer valuable assistance in designing the plan and effectively communicating it. Re-surveying employees after implementation will provide an assessment of where gaps in understanding remain, how effective the communication effort was and how plan design and communications can be modified for the future.

## *In Summary*

As employers have run the gamut of quick fix solutions to our growing health care crisis, CDHPs offer an intriguing option for long-term improvement. So much so, that many health care payers across the nation either have or are seriously considering their implementation. Meaningfully engaging employees to take ownership of their health and the selection of care is certainly a highly desirable goal. However, some might argue that the correct pieces are not yet in place to usher in a new era of health care consumerism successfully.

Employers considering CDHPs must carefully consider the risks and challenges associated with this new paradigm. They will significantly increase their chances for success by focusing on: which health care account is the most appropriate; what consumer-decision support tools are available; how to effectively communicate and evaluate the plan; and increasing participation on the part of the chronically ill.