

The Promise of Consumer-Driven Health Care

*How Putting Consumers in Charge of their Health
Will Improve Wellness – and Reduce Excessive Costs*

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The case studies in this report (other than Mendocino, Logan Aluminum, Rutland Pharmacy and Southwestern Vermont Medical Center) are based on research by David Hogberg of Consumer Choices in Health Care, a leading nonprofit health policy research organization based in Maryland.

The Ethan Allen Institute, founded in 1993, is Vermont's independent, nonpartisan free-market public policy research and education organization.



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Understanding Consumer Driven Health Care

From the dawn of humanity people have gotten sick or suffered injuries. Their first response was bed rest and folk remedies. Then they sought assistance from the shaman and surgeon. Gradually there arose a respected, research-based profession called medicine, complete with certification, licensing, specialization, institutions, and discipline. This system was well established by the time of the First World War.

People who got sick or suffered injuries consulted medical professionals for advice and treatment. Some of the treatment was provided as charity. Most of it was paid for by the consumer – in cash if available, in services, hams and chickens if not.

Such treatment was episodic – it occurred only when someone's health broke down and caused a problem. There was little in the way of preventive care beyond the occasional physical exam and vaccination. Most people understood that reckless driving, heavy smoking, and excessive alcohol consumption led to health problems. They were not so clear about the importance of physical activity, diet, nutrition, vitamins, and mental health factors in maintaining wellness. They went on about their lives, and when a medical problem appeared, they went to the licensed medical professional for treatment. For this treatment they received a bill. There was no third party to step in and pay.

People have long understood that fire, flood and earthquake could destroy their most important investment, their home. They also understood that their unexpected death could leave their dependents in desperate economic straits. With the coming of the automobile age, they quickly understood that auto accidents could expose them not only to injury and the loss of their vehicle, but to large damage judgments if they were at fault for injuries and property damage to others.

But such unlikely or unexpected events could be insured against. By paying modest and regular premiums to an insurer, calculated to reflect the statistical risk of claims, that insurer would step in and settle losses and claims of calamities occurred, or pay a large death benefit to the survivors. Insurance coverage cost money, but it brought protection, security, certainty, and peace of mind.

So people became consumers in the insurance market, just as they were in the food, housing and vehicle markets. Typically aided by an independent agent, they shopped among many insurers for the most suitable coverage and the most dependable service at an acceptable price. But though unfortunate health outcomes could be insured against, a comparable commercial health insurance market did not develop in this country.

Government health insurance flowered in Great Britain and Germany in the late 19th Century. Despite a major push for compulsory government insurance in the 1910s, Americans rejected the idea as destructive of America's values and self-help traditions. Instead, Americans sought to insure themselves through non-commercial programs created by fraternal, religious, and charitable societies. Members of the group paid a small premium, entitling them to treatment through contracted physicians and hospitals.

The commercial insurance industry sensed that there might be a large market for health insurance. Aided by federal tax rulings authorizing employers to deduct the cost of premiums, commercial group health insurance made rapid advances in the 1920s. In the 1930s hospitals entered the competition, creating nonprofit Blue Cross plans for hospital services. Both types of vendors sought to sell policies wherever possible to employers, acting paternally on behalf of their employees as a group.

Ill-advised wage controls during World War II gave employers a major incentive to offer compensation in the form of tax-advantaged insurance benefits in place of government-capped and taxable salaries and wages. This practice made employment based coverage America's dominant form. Fraternal and mutual benefit plans diminished in importance and eventually all but disappeared.

By the 1980s, driven by labor union pressure, major private and public sector employers typically offered low- or even zero-deductible health insurance policies covering a wide range of benefits, with all but a small portion of the premiums paid by the employer. The employer selected the policy, agreed to the benefits, defined the deductibles and co-payments, and paid the premiums. The ultimate consumer, the patient, had very little to say about it.

Indeed, the consumer had little or no access to information about health care options, pricing and quality measures. Until recently hardly anyone had such access. For obvious reasons, physicians and hospitals were highly averse to publishing data on treatments gone wrong, mortality and infection rates. As noted physician Howard Dean MD once observed, "there is no such thing as an informed consumer of health care."

Until recently, a majority of working Americans might have health insurance, but unlike purchasers of life, property and auto insurance, they had little influence, few choices, and zero responsibility for what a fourth party – the employer - bought on their behalf.

From the first party consumer's standpoint, if anything went wrong, a third party hired by the fourth party paid a second party to fix it. There were no direct and visible cost consequences for the person receiving the treatment or service. The third party insurers paid the second party providers to deal with the first party's medical problems, and the fourth party employer selected the coverage and paid most of the premiums. The system did not put much emphasis on helping the first party maintain wellness. And of course, since the fourth party paid the bill, there was always an incentive for highly insured patients to overutilize services whenever they felt below par.

With the advent of Consumer Driven Health Care (CDHC), where much of the decision making and some of the payment responsibility is restored to the first party, all this is rapidly changing.

Consumer Driven Health Care is based on empowering health care consumers with information, control, incentives, and choice.

Health care consumers are rapidly becoming much better informed and effective purchasers of health care insurance and services. They are increasingly looking for health insurance that meets their own needs – not needs collectively determined for them by their employers or a government bureau.

Consumer driven health care rewards innovative insurers and providers for creating the higher quality, lower-cost services consumers want and deserve. In a consumer driven system, government provides useful consumer information, protection against fraud and incompetence, and financial assistance for the needy. It does not allocate resources, unduly restrict choices, force people into insurance pools, control prices, or micromanage care.

The key outcome of CDHC plans (CDHPs) is behavioral change. People behave differently when they have information, control, incentives, and choice – and when there is at least some first party responsibility for paying for benefits received.

Given reliable information about wellness, treatments, providers and outcomes;

Given trusted advice and counsel by knowledgeable professionals;

Given choices among providers, products, and services; and

Given incentives to better manage their health and financial decisions,

the great majority of American families can and will make intelligent choices, achieve better health outcomes, and rein in excessive costs caused by third party involvement, ill-informed choices, and provider inefficiency.

Understanding the Consumer's Options: FSAs, HRAs, and HSAs

Key to the rise of Consumer Driven Health Care are three tax mechanisms. Though different in their particulars, all three allow money to be channeled into tax-favored health spending accounts controlled by the individual consumer.¹

Flexible Spending Account (FSA)

FSAs originated in 1978 and are now held by some 20 million employees. The FSA is established by a company "section 125" or "cafeteria" benefit plan, which may include other benefits besides health spending. Employers contribute some amount into the plan; employees choose to reduce their monthly salaries by a designated amount each year, and have the employer put the difference into their FSA. The employer and employee contributions both reduce liability for income tax and payroll tax.

The employee can spend the FSA balance on any IRS-qualified medical expense², including preventive care, but not on insurance premiums. However if the FSA contributions are not fully spent by March 15 of the following year, the unspent balance in the account reverts to the employer. If an employee leaves or dies, the FSA balance also reverts to the employer.

Though available since 1978, the growth of FSAs has been generally limited to large companies with expert employee benefit staff to manage the complicated IRS requirements. The complexity, the "use it or lose it" rule, the ownership by the employer, and the lack of portability have been viewed as disadvantages.

Health Reimbursement Arrangement (HRA)

HRAs effectively originated in 2002 when the IRS issued a ruling clarifying their tax status. As of January 2005, employees benefited from some 2.6 million HRA accounts.

The HRA is established by a company plan. Only employers can contribute, the contributions are tax deductible, and all account balances are owned by the company. Employees can use their accounts to pay for all IRS-qualified health expenses, and also health insurance and long term care insurance premiums (if allowed by the company plan). Employee spending from an HRA is tax free.

The creating company has wide latitude to specify contributions, uses and terms of an HRA. The HRA is the employer's property. If the employee retires or leaves, HRA balances, with the

company plan's consent, can be applied to the former employee's COBRA premiums. Unlike an individually-owned HSA, the employer-owned HRA can not be taken to the employee's next job or retirement (unless the employer agrees to such a provision.)

Health Savings Account (HSA)

The predecessor to the HSA was the "Archer MSA" created in 1996 and closed in 2006. Because of that legislation's complex and restrictive rules, fewer than 100,000 persons created MSAs in their ten-year existence.

The HSA was authorized by the 2003 Medicare Modernization Act, and became available in January 2004. As of January 2006 over 3 million persons owned HSAs, and the number was rising rapidly.

The HSA must be coupled to a High Deductible Health Plan (minimum deductible of \$1,000 for an individual, \$2,000 for a family). Anyone with such a plan, whether company-purchased or individually purchased, can create an HSA. The HSA is typically held at a bank or credit union and accessed by check or debit card.

Employers, employees, the self employed, and even family members or unrelated persons can make contributions into a qualified person's HSA. The total contributions per year can not exceed the deductible on the qualified high deductible insurance plan (to a maximum of \$2,650 for an individual, \$5,250 for families).

The HSA carries a triple tax benefit. Contributions are tax deductible by whomever made, the buildup of value of account balances is not taxable, and disbursements for health expenses are not taxable. Withdrawals for other than qualified health expenses are treated as ordinary income, and also incur a ten percent penalty.

Unlike the HSA and FSA, the HSA belongs to the individual. An employer can not recover contributions, the account is portable, and in case of the owner's death the balance is inheritable.

HSA balances can be used for a wide range of IRS-qualified medical expenses, plus COBRA premiums and long term care insurance premiums. They may not be used to pay for the high deductible health plan premiums.

All of the models described here reflect the principles of Consumer Driven Health Care. Each account holder has the responsibility for making informed choices for spending his or her own health care money, among a range of providers competing for his or her business. A large fraction of consumers will now seek value when spending their own funds. This will include spending wisely on preventive care, so as to obviate more serious and costly health expenditures later on.

The main value of Consumer Driven Health Care is that it changes behavior. With CDHC, in a great many health situations people will spend their own money, instead of somebody else's money. Not all people will exhibit this behavioral change, especially at the beginning. Accident victims arriving at the emergency room will not make cost-effective choices. Older people will retain the third party payment viewpoint that they have known all their lives. People on Medicare will have only limited opportunity to gain any benefits, since such people may not create HSAs.

But as younger people see the advantages of consumer choice and control, and respond to the incentives of tax-favored health spending accounts to manage their health, America's health

care sector will see dramatic and positive changes. Providers, facing sharply increased consumer knowledge, will respond by improving safety, efficiency, service, and patient outcomes at competitive prices. These benefits will flow from restoring personal responsibility and increasing reliance on consumer driven market forces.

The Consumer Driven Health Care Record to Date

A wide array of research shows that CDHPs have strong appeal to those with lower incomes. A survey conducted by eHealthInsurance of insurance products purchased in the first half of 2005 found that 40 percent of HSA purchasers made less than \$50,000.³

A survey by America's Health Insurance Plans yielded a similar result, with 37 percent of HSA policyholders having incomes less than \$50,000.⁴

Destiny Health found that among those who had CDHPs for eighteen or more months, 70 percent had income under \$50,000.⁵

Research also shows that these plans are attractive to those without insurance. An analysis by Assurant Health found that 40 percent of HSA plan purchasers did not indicate having health insurance coverage prior to purchasing the HSA plan.⁶ Meanwhile, the America's Health Insurance Plans survey found 27 percent of HSA policies purchased in the small group market were purchased by employers who did not previously offer health insurance.⁷ The reason these plans are attractive to people who are not wealthy is not hard to discern. Since CDHC plans have lower monthly premiums, people with modest-to-low incomes are more easily able to afford them.

The research also strongly suggests that CDHPs are just as attractive to older people (who more likely to get sick) as they are to younger, healthier people. The same eHealthInsurance survey found that 45 percent of HSA purchasers were over forty and almost one-fifth were over 55.⁸

The America's Health Insurance Plans survey showed that nearly half of those who have HSA plans were over age 40.⁹

Assurant Health, a major insurer of individuals and small groups, found in an analysis of its data on health insurance purchases that 57 percent of those buying HSA plans were over 40.¹⁰ A recent survey by the Blue Cross/Blue Shield Association yielded similar results.¹¹

The Blue Cross/Blue Shield Association surveyed its customers who had HSAs, HRAs, and non-CDHC plans. Thirty-two percent of those with HSAs and 22 percent with HRAs were age 45-55, while 22 percent with a non-CDHC plan were in the same age range. Those over 55 still show a stronger preference for non-CDHC plans (24 percent); yet the fact that fifteen percent of those with HSAs and nine percent of those with HRAs were over 55 suggests that they have considerable appeal to older customers.

The BC/BS survey also showed no real difference among those in fair or poor health. Eleven percent of those with HSAs, twelve percent of those with HRAs, and twelve percent of those with non-CDHC plans reported having either fair or poor health.¹²

In January 2006 the Cigna Choice Fund reported the findings of its study of 42,200 first-time users of consumer driven health plans. The study found that these consumers generated an eight percent reduction in medical costs and made positive changes in health behavior, such as increasing their use of medications to treat chronic health conditions.

Ten Tools for Achieving Consumer Driven Health Care

American health care is moving rapidly toward consumer driven models built upon consumer-friendly information, choice, and two party relationships, backed by insurance coverage to protect against large and unpredictable medical events.

Every family has long used this consumer-driven model to select food, clothing, housing, cars, and vacations. It seeks to minimize third-party intervention, where an insurer, employer, provider, or the government decides what is medically necessary and what it will pay for. Its goal is to insofar as possible give patients control over information and resources, so they can ration their own purchases in light of their own values and priorities. Here are ten tools currently developing to bring consumer-driven health care into being.

1. **Health Savings Accounts.** Authorized for 2004, HSAs are individually owned (and thus portable) accounts funded with tax-deductible contributions from the individual, the employer, or both. The HSA is coupled with a high-deductible major medical insurance plan. The account owner uses the HSA to pay for health care expenses up to the deductible amount, where the insurance takes over. Unused funds stay in the accounts and build interest over time. (HSAs replace the MSAs authorized as a demonstration program in 1996).

2. **Flexible Spending Accounts.** FSA “cafeteria plans” can be established only by employers. Employees may assign part of their salaries into an account to pay for health care expenses. The accounts have a use-it-or-lose-it provision that requires unspent funds to be forfeited to the employer at the end of the year.

3. **Health Reimbursement Arrangements (HRAs).** First authorized in 2002, HRAs allow employers to fund employer-owned accounts from which employees can reimburse themselves for a wide range of health care expenses. HRAs may be used with any kind of insurance plan, and may be for any amount of money. Unlike FSAs, they may rollover and build-up over time.

4. **Indemnity Coverage.** Indemnity insurance, long common in property insurance, is a “two-party” contract in which an “insured” pays a premium for protection against future medical costs. The insured pays the health care provider, and is reimbursed by the insurer.

5. **Defined Contribution.** “Defined contribution” means that the employer provides a fixed payment dedicated to employee health insurance benefits. Employees use that contribution to select from a variety of benefit plans, often supplemented with their own funds.

6. **Opt-Out Provisions.** These provisions in health care plans allow workers to use their employer’s defined contribution to supplement a spouse’s coverage, or for both earners to pool their funds to purchase coverage for the whole family.

7. **Direct Pay.** A growing number of physicians, either independently or as part of networks, are offering offer their care for cash (credit card) payment, at substantial discounts made possible by their dramatically reduced costs of dealing with third party payors (especially Medicare and Medicaid)

8. **Independent Medical Centers.** Some health care providers- often offshore – are starting to offer fixed prices for defined services. This is especially suitable for “focused factories”, facilities that specialize in one or a few treatments or procedures such as cosmetic surgery, heart bypass surgery, and hernia repair, achieving high volume, high quality and high efficiency.

9. **Expanding Insurance Markets.** Insurance markets have traditionally been rigidly separated by regulatory jurisdictions. By requiring expensive mandates (community rating, guaranteed issue, mental health parity, pregnancy coverage, etc.), state regulatory regimes deny consumers the opportunity to find the kind of insurance coverage that best meets their needs and resources. National “association plans” (not yet authorized by Congress) will allow association members to buy appropriate coverage not available in their own state.

10. **Information Technology.** Few of these changes could happen without the remarkable power of the CD and the Internet, which now allow consumers to identify their resources and match them up with preferred coverage or services.

“Health care is about people. The best way for people to express their needs, values and desires is through a market-based system that gives them the power to spend resources in keeping with those values.” – Greg Scandlen, Director of the Center for Consumer Directed Health Care at the Galen Institute in Alexandria, VA.

This brief is based on a paper of the same title published by Greg Scandlen in 2003. It appeared in the Ethan Allen Institute report *Health Care in Vermont: A New Prescription* (2004).

Cigna VP Michael Showalter said “this early data suggests that the change in health care decisions making encouraged by a consumer driven plan doesn’t end once a consumer satisfied the deductible or reaches the out of pocket maximum. It also signals that health advocacy programs like health coaching, along with access to information tools and consumer advisors, are essential components of a consumer driven health plan.” He noted that the goal of these programs is to help members improve their health, which in turn controls costs.¹³

Definity Health released a study in Fall 2005 that found that persons in CDHPs took far more interest in their personal health care decisions. Some 70 percent of re-enrollees report being more actively involved in health and lifestyle decisions, compared to 60 percent of new enrollees. Consumers enrolled in a plan that incorporates personalized health messaging services and coaching to support decision making reported that “the plan helps me get the care I need” and “helps me save money on health care” at a rate significantly higher than those in a model without those services.

Definity also found that the use of preventive services was higher among CDHP participants on a risk-adjusted basis, and that chronically ill patients reduced their emergency room visits.¹⁴

John Torinus is CEO of Serigraph Corporation in Wisconsin. In July 2005 he found that 18 months into his company’s Humana CDHP, medical costs were down one percent over 18 months, and were flat for the trailing twelve months. “We make wellness and prevention virtually free, and we encourage early and frequent doctor visits by making the co-pay only \$20. Our cost per employee for the fiscal year ending June 30, 2005 was \$7,437, about \$1,000 under the national average.”¹⁵

In March 2005 McKinsey & Co. surveyed 2,500 consumers, 1,000 of whom had been enrolled in a CDHP for at least one year. The researchers found that the CDHP enrollees were more likely to engage in health-conscious and money-saving behavior, such as researching treatment options and choosing a less extensive, less costly course of treatment. They continued to seek preventive care at a higher rate than did consumers in traditional plans and were more interested in company sponsored wellness programs. For CDHP members with more than \$5,000 in annual medical costs, the findings were even more pronounced.

Significantly, the McKinsey researchers found that chronically ill respondents in CDHPs were three times more likely than traditional-plan members to engage in health-conscious and money-saving behavior. They also adhered more strictly to treatment regimens for chronic conditions than their traditional-plan counterparts.¹⁶

In early 2005 the Segal Company surveyed 27 large employers with CDHPs covering 110,000 employees. Half of the respondents said that their CDHPs reduced overall medical spending trends, and only 8 percent said they had increased those trends. Medical costs and claims dropped at 46 percent of the companies, and rose at 21 percent. Hospital costs and claims dropped at 33 percent of the companies, and rose at 25 percent. Prescription drug costs dropped at 54 percent, and increased at 17 percent.¹⁷

EHealthInsurance, the largest on line insurance broker in the U.S., representing more than 140 major health insurance companies, surveyed customers who chose among the 6,500 products offered in the first half of 2005. It found that premiums for HSA-eligible insurance dropped 15 percent between 2004 and the first half of 2005. Nearly two thirds of the HSA purchasers paid \$100 a month or less for their plans. More than 40 percent of HSA-eligible plan purchasers earned less than \$50,000 a year, and 55 percent were under age 40.¹⁸

Aetna released a study in June 2005 of its experience offering HRAs. It found that medical costs increased by 4 percent and 6 percent over the first two years, well below the average of traditional plans. Half of all employees had HRA funds left over at the end of the year. Plan participants were more likely to visit ambulatory care facilities and specialists than their colleagues in traditional plans. Companies with 70 percent HRA participation showed a 13.4 percent decrease in medical costs; plans with less than 5 percent participation showed a 9.9 percent increase.¹⁹

Since CDHPs are relatively new, much more study needs to be done to obtain definitive answers to the policy questions they present. Initial findings, however, are almost uniformly positive. This is true for spending trends, patient behavioral change, patient outcomes, and patient satisfaction.

CHDPs have attracted a torrent of criticism and abuse from labor and socialist organizations and their supporters in Congress and state legislatures. These groups support universal tax-supported national health insurance. As a way station toward that goal, they favor having the government require all employers to fund generous health care benefits for their employees, delivered through government controlled alliances. These groups naturally see the rise of consumer-owned, Consumer Directed Health Plans as a large and irreversible step away from their goal of an all-embracing single-payer collective health care system.

These critics are right. The growth, success, and consumer approval of CDHC will make it much more difficult for collectivist health care proposals to win political support.

Case Studies in Consumer Driven Health Care

Mendocino School District

Perhaps the earliest example of a CDHP was that developed by two officials at the Mendocino County (CA) public schools in 1978.

Like all employers, the district was feeling the pinch of rising health insurance costs. So it hit upon a new plan. The district bought its employees a health insurance policy with a \$500 deductible. Then it deposited \$500 a year in each employee's health savings account at the local credit union. (Using the medical care price inflation index, \$500 in 1978 is equivalent to around \$2,250 in 2006.)

With the accounts, employees paid for health care costs below the policy deductible. The district administrators soon reported that the employees became much more careful shoppers, and much more thoughtful about their health choices. Of the district's 200 employees, 109 spent less than \$200 of their \$500 accounts, and only 38 spent all of their balances. Employees didn't skimp when they had a real problem, but they didn't rush to the emergency room when they had a minor problem, either.

The school district reported that it saved \$40,000 to \$50,000 in premium costs in the first three years, and the insurance company held the premiums steady even as other firms saw double digit increases.

Spokesperson Claudia Lynn of the county education office said "everybody saves, including the doctors, who are paid faster", because of the elimination of the health insurance company in relatively minor cases. She added that for the employees, the program is "an incentive to remain healthy."²⁰

T. Rowe Price

T. Rowe Price is a financial services company with 4,100 employees. It purchases its CDHP through Definity Health. The employee premium represents 20 percent of the total premium cost. The premium that the employee pays is as follows:

Type of Plan	Deductible	Employee Monthly Premium Cost	HRA	Out of Pocket Limit
Individual	.....\$1,500	.....\$51	.....\$1,000	.....\$500
Couple	.....\$2,250	.....\$107	.....\$1,500	.....\$750
Plus Child	.....\$2,250	.....\$97	.....\$1,500	.....\$750
Family	.....\$3,000	.....\$153	.....\$2,000	.....\$1,000

The plan is coupled with an HRA that covers a portion of the deductible; the other portion of the deductible the employee must pay for out of his own pocket. There is first-dollar coverage for preventive care.

Once the deductible is reached, the patient pays for 10 percent of any cost exceeding the deductible, with the insurance company picking up the remainder, as long as it is “in network” (a group of doctors, hospitals, and other providers approved by the insurance company.) The patient must pay for 30 percent of any cost exceeding the deductible for out of network providers.

Randall Singer, T. Rowe Price’s Vice President of Corporate Benefits, says that so far the experience for employees with the CDHP seems positive. “People usually call me when they have a problem with a plan,” he states. “So far, no calls.”

The CDHP costs up to 35 percent less than T. Rowe Price’s traditional plans. Singer reports that while prices for the other plans went up for next year by about 50 percent, the price for the CDHP stayed flat.

However, enrollment in the CDHP has also remained flat, at about 8 percent of employees. Singer offers two explanations why more employees not made the CDHP choice, with costs rising for the other plans: “Our employees’ preferences may be somewhat inelastic. They seem willing to pay the increased cost to stay with the traditional plan.”

His other explanation offers lessons for employers contemplating a CDHP. “The plan is somewhat complicated,” Singer says, “and employees may shy away from it because of the time it takes to understand it.” The reason seems to be the rather complex payment structure. An employee enrolled in the CDHP first pays for no medical costs; the HRA does. Then he pays for all of the medical costs until the full deductible is met. After that, he may pay 10 percent or 30 percent of the cost, depending on whether he stays “in network.” The lesson appears to be that complexity can hinder employees’ willingness to switch to a CDHP.

For the time being, T. Rowe Price has no plans to change any of its health insurance offerings. Right now, the CDHP plan is only two years old, and the company will need more data on the CDHP before it decides what changes to make.

ConnectiCare

ConnectiCare is an insurance company with just over 500 employees. It offers employees a choice of four different health-care plans. One option is its CDHP with a high deductible policy

and an HSA. ConnectiCare pays for ninety percent of the monthly premium. Once the deductible is reached, the policy covers 100 percent of covered services, including hospitalization and outpatient care.

ConnectiCare first offered its CDHP in 2005. Sixty employees out of an eligible 480 signed up. Bill Walton, Director of Compensation and Benefits for ConnectiCare, says that the CDHP is the least expensive. “The company’s share of the premium along with the HSA contribution is less than the company’s premium share for the other plans,” he says.

Type of Plan	Deductible	Employee Monthly Premium Cost	Employer HRA Contribution (Annual)
Individual	\$1,500	\$22.53	\$780
Employee +1	\$3,000	\$49.12	\$1,560
Family	\$3,000	\$60.84	\$1,560

Nevertheless, employees seem very satisfied with the CDHP. “We’ve heard nothing negative about it,” says Walton. Indeed, Walton relays the story of one patient who knew that he faced hospitalization costs and switched to the CDHP in 2005. “His wife was pregnant. He did the math, and realized that he’d come out ahead of the game by switching to the CDHP from a more traditional plan.”

For 2007, ConnectiCare plans to scale back the number of plans it offers from four to three, with the hope of directing more employees into the CDHP.

Mercury Office Supply

Mercury Office Supply is a small business in St. Paul, Minnesota that employs thirteen people. It was the first company to sign up for the group HSA plan offered by Prime Health Care. The plan has high deductibles. Mercury Office Supply contributes half the cost of the deductible to an employee’s HSA, as shown below:

Type of Plan	Deductible	Employer HSA Contribution
Individual	\$2,400	\$1,200
Family	\$5,000	\$2,500

The new plan has saved Mercury a large amount in premium costs. Under the old plan, premium costs were set to rise to \$36,000 annually. Under the HSA plan, premiums cost Mercury only \$24,000. Mercury uses much of what it saves in premium costs to help fund employees’ HSAs.

Medtronic

Medtronic is a medical technology company with about 25,000 employees in the United States. It has offered a CDHP with an HRA for the past six years. Medtronic self-insures with Definity Health as the administrator. About one quarter of its employees have chosen this option.

Medtronic pays for about 87 percent of the premium costs. The company puts in the HRA \$1,000 for an individual, \$1,500 for a spouse (employee +1), and \$2,000 for a family. The employee also has a choice of deductibles, with a higher deductible resulting in a lower premium:

After the deductible is met, the plan pays for 90 percent of expense in-network and 80 percent out-of-network. It also covers 100 percent of preventive care expenditures.

Type of Plan	Low Deductible	Medium Deductible	High Deductible
Individual	\$1,750	\$2,750	\$3,750
Employee + 1	\$2,625	\$4,125	\$5,625
Family	\$3,500	\$5,500	\$7,500

Roger Chizek, director of U.S. benefits for Medtronic, states that premiums in the CDHP “are about 12-15 percent below those of the traditional plans, depending on the deductible.” The CDHP has also induced behavioral changes that yield cost savings, such as increased utilization of a nurse-help line instead of emergency room visits and a preference for generic drugs over name brands.

Employee satisfaction with the plan is high. “Employees enjoy the freedom to obtain health care where they want under this plan,” says Chizek. “They also seem to enjoy being able to obtain information on the total cost of health care.” He notes that there is a substantial amount of employee traffic on the portion of the Definity website that contains health care information.

The Medtronic experience also “blows the adverse selection theory out of the water,” states Chizek. The average age of employees in the CDHP is 41. “We’ve seen the same type of catastrophic illness among employees in this plan as in other plans,” he says.

Forbes, Inc.

Since 1991 Forbes, Inc., the New York business and financial magazine, has offered its employees a CDHP. At its inception, the plan offered employees a cash bonus equal to twice the difference between their health insurance claims and \$500. For zero claims, the bonus was \$1,000. Publisher Steve Forbes reported that “suddenly, every employee became cost conscious. On major medical and dental expenses, claims went down 30 percent. These savings financed the bonuses and our total health care costs went up zero percent in 1992. This was because we let a few hundred individuals make their own health care decisions.”

In its current version, Forbes offers a high-deductible plan with the option of an HSA or an HRA, to which the company contributes \$2,500. After the employee meets the deductible, the plan pays 80 percent of health care costs. Once the employee’s expenses reach \$2,000 above the deductible, the plan pays 100 percent of the cost. Forbes uses United Healthcare as its administrator and provides a network of health-care providers for employees to use.

Employees pay income-adjusted premiums. Below is the proposed premium structure for 2006:

Income	Single	Family
Less than \$25,000	\$13	\$35
\$25,000-\$49,999	\$26	\$70
\$50,000-\$74,999	\$39	\$104
\$75,000 and up	\$52	\$140

The next table shows the income-adjusted deductibles for single and family policies in 2006:

Income	Single Deductible	Family Deductible
Less than \$30,000	\$2,500	\$2,500
\$30-\$60,000	\$2,500	\$2,700
\$60-\$100,000	\$2,600	\$3,200
\$100-\$175,000	\$2,800	\$3,600
Over \$175,000	\$3,000	\$4,400

Employees are generally satisfied with the plan, and there have been some changes in behavior. “The number of generic drugs we use is low,” says Jennifer Tyrrell, Director of Benefits for Forbes, “but employees do utilize our mail order program.” In the coming year, Forbes will be increasing the employee contribution beyond the deductible to \$2,500.

American Financial Group

American Financial Group is primarily a property and casualty insurance company with 5,000 employees located throughout the United States. From 2000 to 2004 American Financial Group saw its health insurance costs double. In 2004 it undertook a major overhaul of its health insurance plan that focused on issues such as cost management, consumer control, and accountability.

For 2005, American Financial Groups offered a traditional low deductible plan and two high deductible plans, one with an HRA and the other with an HSA. The company deposited \$600 into the HRA (it did not put any funds in the HSA). The following table shows the structure of the deductibles and maximum out of pocket costs for the plans:

Employee	Traditional Low Deductible Plan	HRA Plan Deductible	HSA Plan Deductible	Maximum Out of Pocket Traditional-HRA-HSA
Individual	\$250	\$1,000	\$ 2,200	\$1,250 – \$3,100 – \$ 4,000
Couple	\$500	\$1,200	\$ 3,600	\$2,250 – \$5,250 – \$ 8,000
Family	\$750	\$2,000	\$10,000	\$3,250 – \$8,000 – \$10,000

Although the out-of-pocket costs are considerably higher for the HRA and HSA plans, the costs are offset by lower premiums.

Employees can use any provider they wish, but in-network providers offer discounts. In 2005 47 percent of employees chose the HRA plan, 7 percent chose the HSA plan, and 46 percent chose the low deductible plan. Payroll deductions for health care were lower for a majority of employees in 2005 when compared to 2004.

American Financial Group shows the importance of seeking employee input and educating employees about the new plans. In early 2004, the company conducted focus groups with 10 percent of its employees. Employees brought up many concerns, including risks, trade-offs with the new plans, and adequate information on the cost of health care procedures. The “employee + 1” (couple) policy was largely the result of the request of many of the focus groups.

After meeting with focus groups, the company designed its new health care plans, and then informed their employees by mailing out newsletters, guidebooks, and DVDs explaining the new plans. From late October to early November of 2004, the company held employee meetings to answer questions. Currently, employees have access to a “plan comparison calculator” that enables them to choose the best plan based on anticipated health care costs and family size. They also have access to tools at United Health Care’s website (which administers the plans) that enable them to estimate treatment costs and provides them with quality measures.

The American Financial Group’s experience suggests that employers can ease the transition to CDHPs by education and involving employees in the decision-making process. This needs to be followed up with effort to educate employees about the new plans in order to complete a smooth transition.

Textron

Textron is a Fortune 500 company headquartered in Providence, Rhode Island. It is a multi-industry company with about 44,000 employees worldwide. In 2003 Textron replaced its traditional insurance with a CDHP. Thirty thousand employees are in the plan, which includes both HSAs and HRAs. Below is the deductible and the amount Textron contributes to the HRA and HSA for each tier of the insurance plan:

Type of Plan	Deductible	HRA Contribution	HSA Contribution
Employee	\$2,200	\$1,200	\$500
Employee + 1	\$3,300	\$1,500	\$1,000
Family	\$4,400	\$2,000	\$1,000

The monthly premiums for employees are \$60.67 for the employee plan, \$112.67 for the employee + 1 plan, and \$156.00 for the family plan. Once the deductible is met, insurance picks up 90 percent of the cost in-network and 70 percent out of network. The plan also covers 100 percent of preventative care, although it does not count toward the deductible.

George Metzger, Vice President of Human Resources and Benefits at Textron, says that the employees are very satisfied with the plan. “In fact, the company would have a very difficult time taking it away, it’s so popular,” he says. He notes that employees like the fact that the plan gives them a greater sense of control over their health care.

Costs have dropped. Emergency room visits are down, while use of generic drugs and mail order services is up. There has also been a significant increase in quality, including a two-fold increase in preventive care. “Diabetics on the plan are doing more to deal with hypertension, having annual vision exams and regular visits to the podiatrist,” states Metzger.

Metzger also says that Textron “has made a big investment in educating employees about the plan. We routinely poll employees about providers and services so that our employees have good information about price and quality.” Metzger says that as the company makes improvements in the HSA option, Textron employees will gravitate toward that portion of the plan and away from the HRA. “The HSA is a better savings vehicle for post-retirement health care,” says Metzger.

Whole Foods Market, Inc.

Whole Foods Market, Inc. is an Austin TX-based grocery store chain with 180 locations in the United States and the United Kingdom that employ about 32,000. Whole Foods has been in the forefront of CDHC since 2002. In that year, Whole Foods realized that it would have to pump \$7 million into its health insurance plans just to make them solvent. Seeing a future of health insurance bleeding red ink, CEO John Mackey embraced the CDHC approach by adopting a high-deductible policy coupled with an HRA.

Whole Foods pays 100 percent of the premium for its full time employees, about 87 percent of its workforce. The employee is responsible for a \$1,000 deductible in medical costs and \$500 deductible for prescription drugs. Once the deductibles are reached, the employee is responsible

for co-pays up to \$2,000. Thus, employees pay an out-of-pocket maximum of \$3,500; after that, Whole Foods pays 100 percent of the cost of health care.

To help pay for the deductibles and co-pays, Whole Foods puts funds in its employees' HRAs (called Personal Wellness Accounts) depending on the length of service of the employee. New employees receive up to \$300 in their HRAs; long-term employees with about five years of service receive \$1,800. Money can be saved in the HRA and rolled over to be used in the next calendar year.

Employees seem to be doing just that. In the first year Whole Foods had its CDHP, only one in ten employees used all of the funds in his or her HRA. Indeed, employees saved over \$14 million in the HRAs to be used in the following years. The savings to Whole Foods have been similarly striking: over 25 percent total savings on health care costs in the first year of the plan.

Mackey notes that to avoid the adverse selection problem, Whole Foods eliminated its other health insurance plans. Mackey urges companies "not to put [the CDHP] as one option in a cafeteria plan, but to make it the only option. For a true insurance plan to work, you have to create a full universe of young, old, healthy, and sick."

Since CDHPs are often very different from the health plans employees are accustomed to, Mackey emphasizes the importance of educating the workforce:

"...since [the plan] was so radically different, there was a lot of unrest initially with our team member base. I went on this huge tour around the company where I visited almost all of our stores and did Q&A with team members [employees]. It was exhausting, but I learned quite a bit about our business. I also found it was upsetting to team members. That was when we made the decision to give the same deductible for families and couples as we did for the individual, which made a huge psychological difference for the team member base."

In the future, Mackey expects that Whole Foods employees will vote on offering an HSA plan for its employees, so that employees can keep the money if they leave the company.²¹

Logan Aluminum

Logan Aluminum is a 1,000 employee manufacturer of aluminum sheet products in Russellville, Kentucky. It has historically offered its employees a health plan that had no employee contribution to premiums, and no out of pocket costs except for a \$15 co-pay for in-network doctor visits. Since the mid-1990s the company has had an employee wellness program managed by an onsite wellness director.

Logan employees are encouraged to take advantage of health care screenings, including an annual physical exam, onsite at no charge, followed up by a health risk appraisal by an outside provider. High-risk employees are encouraged to join an intervention program. Ninety percent of the 250 so identified have done so. (The company does not have access to any individual's health history or risks.)

In 2001, after much employee education, Logan adopted a consumer driven health plan managed by Aetna HealthFund. Employees still make no premium contribution, but do face exposure through deductibles. The company contributes \$200 to an employee's HRA if the employee completes the health risk appraisal. Additional contributions bring the company's average HRA contribution to \$418 (in 2003).

The company experienced an 18.7 percent reduction in total medical costs in 2003, an improvement of \$925,000 to the company's bottom line. This performance compared to 13 percent increases facing companies under other health plans in the area. Emergency room visits dropped 2.1 percent, and office visits dropped 6.1 percent; but hospital days of care increased 4.4 percent and inpatient surgeries increased 4.2 percent. The company concludes that employees are getting good care for serious health events.²²

Rutland Pharmacy

Rutland Pharmacy, founded in 1982, operates retail pharmacies in Rutland and Springfield, VT and West Lebanon, NH. Prior to April 2004, the company offered its then 25 employees the Blue Cross/Blue Shield of Vermont Freedom Plan, with deductibles of \$1,000 (single), \$1,500 (couple), and \$2,000 (family). The employees paid one third of the premiums, and the company paid two thirds. The premiums under these plans were increasing at a rate on the order of 13 percent each year.

The Pharmacy then switched over to a consumer driven BCBSVT plan through an association plan managed by Business Resource Services of Vermont.

The new plan features higher deductibles (\$2,250 and \$4,500), making it compatible with employee-owned Health Savings Accounts. Employees continue to pay one third of the now substantially lower premiums. The company annually deposits \$1,500 (single), \$3,000 (couple), and \$3,500 (family) in its employees' HSAs. The single employee would thus have a maximum \$750 out of pocket the first year. By the end of the second year the employee could have as much as \$3,000 plus interest in his or her HSA, well above the annual deductible of \$2,250.

The company saw its monthly premium payments fall from \$14,000 to \$7,000 in the first year of the new plan. Even after making the generous contributions to employee HSAs, the company had saved \$20,000 in health insurance costs by the end of that year. Since the first year the company has seen premium increases of about half of what it experienced under the earlier Freedom Plan, and from a lower base.

Jason Smith, operations manager for the Pharmacy, says "The HSA-qualified plan has been a great addition to our benefit package. As an employer we view the plan as a way to control the double-digit increases we had been seeing in health insurance costs. We have not had to increase the employee contribution for what will soon be three years. We could not have done this with the PPO plans being offered."

"We also view the HSA plan as a way to retain employees. We would rather give the premium cost savings to the employee than to the insurance company. This plan works for 95 percent of our sixty employees, and we work with the other 5 percent."

"As an employee it gives me the freedom to see the doctor I want, when I want. It also gives me a new incentive to stay healthy, and to seek out lower cost medical solutions. Our company would never think of going back to the old way."

Southwestern Vermont Medical Center

Southwestern Vermont Medical Center is a community-oriented hospital in a health system with a nursing home, home health agency and medical practice division in Bennington, Vermont. It has for years offered generous health benefits to its employees, now numbering about 1000, some 700 of whom (totaling 1500 with dependents) are expected to take part in the new program.

Conscious as an employer of rapidly rising health insurance costs, SWVMC president Harvey Yorke and his staff developed a new CDHP scheduled to take effect in January 2007. SWVMC is negotiating for the terms of coverage with prospective carriers, so the deductibles and premium costs are thus not yet known.

Under the new plan, employees will have an HRA option in the employers' Flexible Spending Account plan. Employees can contribute to the FSA plan through salary reduction, and employers can make a contribution to the HRA within the FSA plan.

The plan provides 100 percent coverage for specified preventive care appropriate to the employee's age and sex. When diagnostic testing is required, the plan will pay 90 percent of the in-hospital charges, 75 percent of the in-network charges (outside the hospital), and 60 percent of out of network charges.

The employer will pay 60 percent of the premium cost for an individual employee, but the individual can earn an additional 20 percent premium contribution by complying with a three-tier fitness program called WellPro. (SWVMC would like to increase this percentage, but it is limited by federal HIPAA requirements.)

WellPro is an employer-designed incentive program to drive employee behavior toward healthier lifestyles. Tier I is an affirmation by the employee that he or she uses seat belts, has regular dental care, and has age and sex-appropriate health screening. Tier II is not smoking. Tier III is weight management.

SWVMC human resources director Kevin Ghidotti says that the Center believes that the new plan will not only restrain the Center's employee health care costs, but will also give strong encouragement to the Center's employees to take better care of their health, "In full operation, we believe we can have better health outcomes at lower costs both to the Center and to our employees," Ghidotti said.

Vermont Consumer Driven Health Care Initiatives

In 1992 the general assembly passed what became Act 160, the flagship of Gov. Howard Dean's health care reform effort. The bill created the Vermont Health Care Authority, commissioned year-long studies of single payer and regulated multiplayer reform options, imposed community rating and guaranteed issue on non-group policies, authorized a state purchasing pool, and established a safety net for persons whose insurers departed the state. During Senate debate, Sen. John McClaughry offered an amendment to add a study of a market-oriented plan built upon tax credits to defray premium costs, high deductible policies, and "tax-deductible medical expense accounts."

The Senate rejected the amendment (7-21). In the first four years after enactment of Act 160, the safety net program saddled Blue Cross with \$4 million in losses, within six months the Dean Administration gave up on the state purchasing pool, the two commissioned studies were summarily rejected, and the Vermont Health Care Authority was abolished. By 2004 the number of carriers active in Vermont dropped from seventeen to three.

In October 1993 the Ethan Allen Institute presented an early CDHC initiative called the Vermont Medisave Plan. It featured the high deductible policy, tax-deductible Medical Savings Accounts, smart cards to record an individual's medical history and debit the MSA for health care

expenditures, and state-funded MSAs for acute care Medicaid beneficiaries. An expanded version a year later added insurance premium discounts for healthy lifestyles and meaningful medical malpractice reform.

In 1994 the Associated Industries of Vermont (AIV) proposed a thorough and well-organized CDHC reform in a paper captioned “First Do No Harm”, endorsed by nine other trade associations. When the new legislature convened in 1995, Sen. Tom Bahre and nine Republican co-sponsors offered the “Vermont Medisave” bill (S.14), to enact the central feature of the EAI and AIV proposals. Despite having a Republican majority, the Senate gave little consideration to the bill. Instead, both chambers ended up approving Gov. Howard Dean’s proposals to create a vastly expanded Medicaid program.

In 2001 Rep. Frank Mazur and 73 cosponsors introduced the “Health Care Access and Affordability Act” (H.212). The CDHC-oriented plan included authority for insurers to offer basic health policy packages without costly mandates, and required them to offer at least one high-deductible health plan. It also ended strict community rating, allowed healthy lifestyle discounts, and authorized creation of a high risk pool for uninsurables. Despite the large number of cosponsors and Republican control of the House, the bill was never voted upon.

In 2004 the Republican-majority House passed a bill (H.759) offering tax credits to small businesses offering CDHPs, and authorizing insurers to give healthy lifestyle premium discounts. The bill also contained government control provisions quite contrary to the principles of consumer driven health care. The Democratic-majority Senate declined to act on the bill.

In 2005, the House Democratic majority offered “Green Mountain Health”, a sweeping single payer plan. The Senate’s Democratic majority shrank this down to a much smaller government-run plan for the uninsured, financed by a combination of income and payroll taxes. Gov. Jim Douglas vetoed the resulting bill, and his veto was sustained in January 2006.

In December 2005 Gov. Douglas unveiled his 2006 health care initiative. A central feature was a proposal to allow the uninsured with incomes between 150 and 300 percent of the capitalized Federal Poverty Level to buy a high deductible (individual \$2,500, family \$5,000) HSA-eligible major medical plan, with preventive care coverage not subject to a deductible. The state would make a premium assistance payment of up to \$1,000. The proposal was introduced as H.713, but the Democratic legislature did not consider it.

Conclusion

Thanks to Congressional authorization of HSAs effective in 2004, Consumer Driven Health Care is expanding rapidly throughout the country. CDHPs are proving to be popular not only with the “healthy and wealthy”, as their critics claim, but with people with a wide range of ages and incomes. At the same time, the government-controlled, taxpayer-financed single payer systems of neighboring Canada have increasingly fallen into disarray and disfavor.

The time seems ripe for Vermont legislators of 2007 to give center stage to reforms that, unlike government-centered schemes like Green Mountain Health and its successor Catamount Health, not only empower health care consumers with information, control, incentives, and choice, but also hold out the promise of restraining health care costs while promoting better health outcomes.

Endnotes

1. For a good summary, see America's Health Insurance Plans, "Health Care Spending Accounts: What You Need to Know about HSAs, HRAs, FSAs and MSAs" (July 2005.) See also IRS Publication 969, "Health Savings Accounts and Other Tax Favored Plans". The brief descriptions in this report omit many options and restrictions contained in the statutes and regulations. Persons or companies wishing to set up any of these plans should consult a qualified tax and benefits professional.
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Helpful CDHC Web Sites:

- Ethan Allen Institute: www.ethanallen.org
- America's Health Insurance Plans: www.ahip.com
- CDHC Solutions: www.bcsolutionsmag.com
- Consumer Choices in Health Care: www.cchc.org
- Council for Affordable Health Insurance: www.cahi.org
- Center for Health Transformation: www.healthtransformation.net
- Galen Institute: www.galen.org
- Heritage Foundation: www.heritage.org
- HSA Insider: www.hsainsider.com
- National Center for Policy Analysis: www.ncpa.org



Ethan Allen Institute

The Ethan Allen Institute, founded in 1993, is Vermont's independent, nonpartisan, free-market public policy research and education organization – a “think tank” for issues facing Vermonters.

The Mission of the Institute is to influence public policy in Vermont by helping its people to better understand and put into practice the fundamentals of a free society: individual liberty, private property, competitive free enterprise, limited and frugal government, strong local communities, personal responsibility, and expanded opportunity for human endeavor.

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- The fiscal practices and condition of state government – taxation, spending, and borrowing.
- State and local regulatory practices, and their effect on the economy and the rights of the people.
- The improvement of education for all Vermont children, and particularly the expansion of competition and choice for all.
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