

*Source: International Society of Certified Employee Benefit Specialists

The Consumer- Driven Approach: *Can It Pick Up Where Managed Care Left Off?*

**by Steve Halterman,
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► **Managed care has failed and health care costs are once again out of control.** *Given the current political, social and economic environment, there are now two options: a single-payer health care system, or an aggressive and global employer health benefits redesign that strongly encourages consumer-driven behavior. This article discusses the failure of managed care and ways that employers can promote consumer-driven behavior now using available tools and plan provisions.* ◀

Health care costs are once again out of control. Not since the late 1980s have we seen such colossal cost increases. The problem now: We've used up our trump card. We've played the managed care hand one too many times. Health care providers have fought back and, with the exception of some residual discount arrangements, have won the battle.

Health maintenance organizations (HMOs) have created the perception that a doctor visit costs \$10 and prescription drugs cost \$5. Surely the employer is covering the difference, but what is the difference and why should the employee care? This has been the mentality of those covered through employer-sponsored health plans . . . until now.

Now that we've seen those \$10 copayments go to \$25 (or perhaps changed to coinsurance with a deductible) and prescription drug copayments climb up to \$20, \$30, even \$40+ for some drugs, employers and their employees are wondering what happened. Employees may even blame their employer, and perceive them as "cheap." "Whatever happened to that great insurance plan?" one might ask. The answer could be explained as a correlation to how we've created a giant hole in the Earth's ozone layer: "Overutilization, without a vested interest in the ultimate outcome."

To address this problem and perhaps even reverse this trend, health care economists and employee benefits professionals have developed a consumer-driven approach to health care delivery and coverage provisions, which so far has been implemented quite cautiously by only a small segment of employers. In fact, many human resource professionals are quite skeptical of the consumer-driven approach.

SYNOPSIS

This article will evaluate the application of a consumer-driven approach within our present health care system and employer-sponsored health care coverage platform. We will evaluate the defined contribution health reimbursement account (HRA) as well as other evolving consumer-driven health plan (CDHP) concepts currently being introduced. We will identify ways in which these concepts, if integrated with other existing provisions, such as flexible spend-

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ing accounts (FSAs) or medical savings accounts (MSAs) and perhaps new legislative initiatives, may actually change the way we seek and purchase health care services. These developments could lead to a global behavioral shift among health care consumers as well as providers, resulting in cost controls and stabilization far more effective and long term than those of the managed care approach. To help illustrate this, we will review the history of employer utilization of managed care and evaluate its role in controlling health care costs. We will then discuss the inherent flaws of managed care and identify why it has failed to produce a long-term solution to the rising costs of health care in the United States. The conclusion of this article will identify specific ways that employers can use tools and plan provisions available now to promote consumer-driven behavior within their workforce and perhaps help limit the impact of health care inflation.

CONSUMER-DRIVEN: DEFINED

What is meant by *consumer-driven*? Simply stated, it is the process of making an informed purchase with one’s own money that results in getting the best perceived value for the needed good or service. In applying this concept to our present health care delivery and insurance coverage system, we see that consumer-driven behavior is virtually nonexistent. For example, have you ever asked your doctor how much a procedure or a treatment plan would cost? Probably not. Perhaps you may have asked

about the recommended treatment and considered alternatives, but rarely is this due to cost considerations. When health care is covered by insurance, we want the best care possible. Cost is not a concern. Our health care is a very emotional subject and when something goes wrong, we want it fixed, no matter what. However, when a certain procedure or treatment plan is not covered, we tend to evaluate the situation more prudently. We may consider other, less costly options or even negotiate a more affordable fee for the service. Therefore, when the patient becomes a part of the cost equation, consumer-driven behavior is introduced.

In many ways the current system has discouraged patients/employees from being involved in the health care purchasing equation. The advent of the \$10 copayment in most health plans hastened the separation of employees from the equation by eliminating their need to file a claim for even the most basic care received.

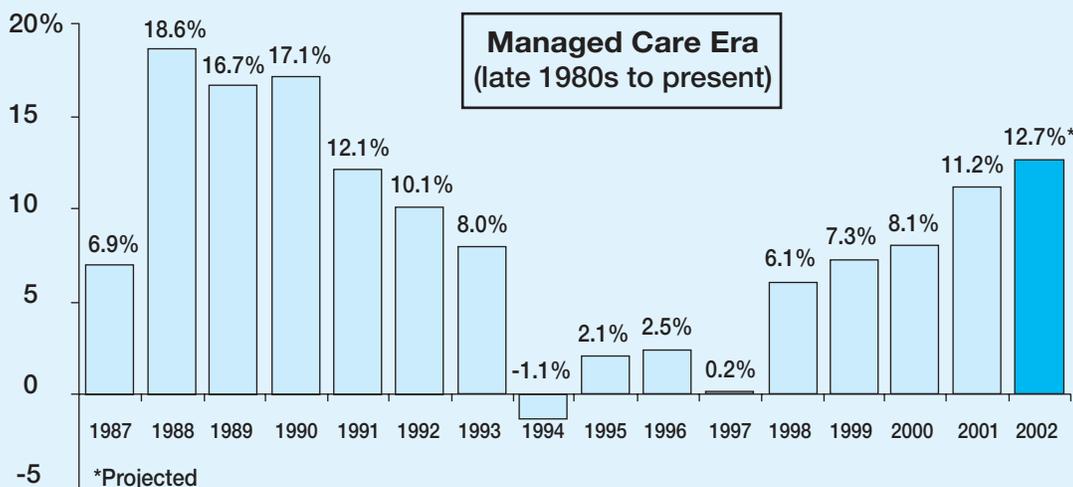
HISTORICAL PERSPECTIVE

The primary purpose of our health insurance system historically has been to provide coverage for catastrophic and significant health care costs, which gives the insured a sense of security. Traditionally, this was done by providing either first-dollar coverage or a split coinsurance arrangement, potentially with certain aspects covered under first-dollar arrangements (such as for hospitalizations). The former typically was provided through HMOs, by which benefits are paid at 100% after a nominal copayment. The latter was provided usually through an insurance carrier or employer-funded coinsurance arrangement of 80%/20% after an annual deductible of a few hundred dollars is paid. This arrangement actually involved the insured in the cost equation, but typically did not provide enough incentive for the insured to consider cost variables. Clearly, once a patient was comfortable with his or her physician’s care, he or she rarely questioned the physician about alternatives, as is happening today.

By providing this “entitlement-based” coverage, for which the insured is more or less removed from the cost equation, employers subject themselves to a liability that is known in

FIGURE 1

Annual Change in Employer Health Care Cost, 1987-2002



Source: Mercer/Foster Higgins Survey of Employer-Sponsored Health Plans, 2001.

the insurance industry as a “moral hazard,” or sometimes referred to as a “morale hazard” by economists and academicians. Nevertheless, the concept represents a carelessness or indifference that individuals may have because they are covered by insurance. The very nature of health insurance is a catalyst for this type of behavior. This is not necessarily a bad thing, if the purpose of providing coverage is to provide health care coverage to employees, whatever the cost. However, with the escalating costs of health care in the United States, this idealistic approach could put companies out of business, or at least force them to eliminate health care benefits.

Let’s take a step back now, to the late 1980s/early 1990s when employers were facing similar cost increases to those of today. Employers were looking for a “silver bullet” that would stop the pain and allow them to continue to offer competitive benefits to their employees. A combination of managed care and flexible benefits became that “silver bullet.” During this time there was also an attempt by the Clinton administration to reform the health care delivery system and move the country toward a single payer, socialized system. While never quan-

tified in terms of its impact, there was a sentinel connection to the significant drop in rate increases, as seen in Figure 1.

By the mid-1990s, HMOs, point-of-service plans (POSS) and preferred provider organizations (PPOs) were helping to mitigate employers’ pain. Figure 1 details employer health plan cost trend based on the *Mercer/Foster Higgins Survey of Employer-Sponsored Health Plans*. This clearly shows a significant reversal of the increasing cost trend from the late 1980s.

Further, if you refer to Figure 2, you’ll see the direct relation of these trends to employers’ adoption of managed care during the same time period.

COST CONTROL IN THE MANAGED CARE ERA

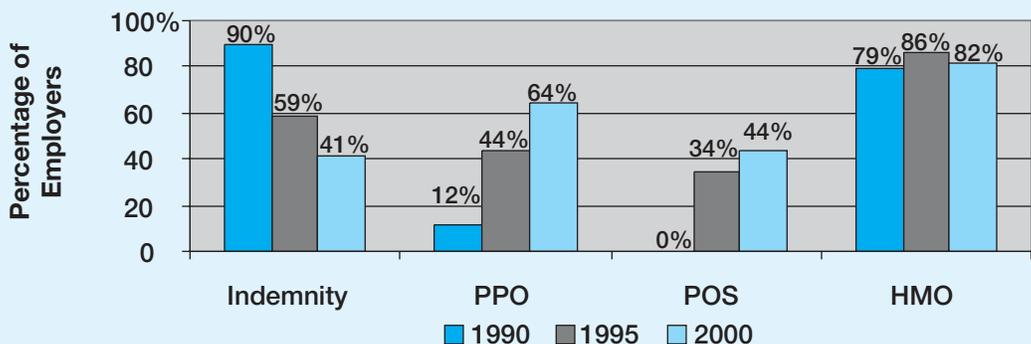
Cost Shifting

For several years, managed care shifted the burden of rising health care costs from employers to health care providers and insurers.

How did providers incur the cost? By accepting lower levels of compensation for services. Capitations, diagnostic-related groups (DRGs), case rates, per diems and deeply discounted fee-

FIGURE 2

Percentage of Employers by Plan Type Offered—1990, 1995 and 2000



Source: The Hewitt SpecSummary 1996 and 2001. Salaried Employee Benefits Provided by Major U.S. Employers in 1990 and 1995 and Salaried Employee Benefits Provided by Major U.S. Employers: 2000.

for-service arrangements between insurers and providers helped defer a large portion of costs to physicians and hospitals.

How did insurers incur the cost? Because of the abundance of HMOs and other insurers in the managed care market, pure competition helped to shift costs from employers to insurers. For several years, managed care organizations (MCOs) were ignoring their financial statements in order to build up membership. This allowed for maximum negotiating leverage from employers.

Both insurers and providers operated under the illusion that the volume an insurer could send to a provider should directly relate to the level of discount the provider was willing to accept. The insurer that had the most lives would often be able to negotiate a “favored nations” agreement that basically guaranteed it would get the best discount.

Unfortunately, this illusion that “bigger is better,” coupled with declining Medicare and Medicaid reimbursements, drove many providers into financial hardship. Providers started to revolt in the late 1990s and insist that financial arrangements directly relate to the actual cost of care. Many physician groups are no longer willing to accept the financial risk that capitations represent based on their experiences with trying to manage their member populations. In many cases, physicians were not

only put at risk for managing the care of patients, but part of the capitation was withheld as a performance incentive based on various measures, such as inpatient days, pharmacy costs and referrals to specialists. If benchmarks were exceeded, physicians would not receive the full capitation rate promised. This perverse incentive to limit care caught the attention of many states and consumer groups and, for the most part, has been eliminated. In fact, most capitation and gatekeeper arrangements have also given way to deeply discounted fee schedules and “open choice” non-gatekeeper-type plans.

STEERAGE

Steerage is a fundamental concept behind managed care. By requiring the primary care physician (PCP) to be a gatekeeper in coordinating all aspects of medical care, it is (was) believed that more efficient utilization of health care will result. Patients would be directed to appropriate specialty providers by their PCP gatekeepers rather than self-referring where they felt they should go. This would theoretically keep patients at the right place at the right time. If the PCP could diagnose and treat the patient’s problem, thus averting a specialist visit, all the better. As the principal care director for patients, the PCP was even to be consulted about emergency room visits so that unneces-

sary utilization of one of the most expensive treatment sites could be avoided.

Further, by limiting patients to a select provider network, for which in many cases providers are grouped together into revenue risk-sharing pools, it was believed that further efficiencies could be gained. However, the management of these risk pools proved difficult. In the early 1990s, physician management groups sprang up across the country buying up physician practices. Their claim was that they could manage the financial aspects of the physician practices and negotiate better contracts with managed care organizations (MCOs) due to their market clout. However, here again the theory that “bigger is better” proved to be incorrect. By the late 1990s, most of the physician practice management groups had folded. Today, many MCOs employ a strategy of contracting directly with physicians in a discounted fee arrangement.

MANAGING CARE

In addition to controlling care through steerage, MCOs have several protocols that patients and providers must follow in order to ensure the most efficient treatment is given. This includes hospital preadmission certification, concurrent review and case management and authorizations to refer to specialists. Many of these strategies to manage care really represented tollgates to avoid unnecessary care. By late 1999 at least one major insurer admitted that something like 99% of these authorizations were approved and that they were reorganizing to shift focus away from tollgates to actually managing the care of patients.

Managed care has meant that certain unnecessary practices were identified and eliminated. Virtually nobody goes into the hospital until the day of a surgical procedure. Before managed care, patients were often admitted days in advance of a procedure for tests and monitoring. The number of days someone stayed in the hospital after a procedure often varied, with little clinical evidence to justify the difference. Indices as to how long it should generally take to recover became widely used as a way to measure the length of stay for a procedure or illness, eliminating much of the variance. Unfortunately, some of these new managed care

techniques backfired and opened the door for consumer revolt, and much of the backlash associated with managed care.

Most recently, disease state management and sophisticated data screening for potential “at risk” members has emerged, with the idea that rather than trying to micromanage all members of the MCO, efforts should be focused on the chronically ill and large-dollar patients. Supporters want to ensure care is overseen by care managers that will employ best practice techniques and actually attempt to manage the care these individuals receive, as opposed to putting up a series of tollgates. This practice should prove highly beneficial to helping control long-term costs for employers, in the authors’ opinion.

HAS MANAGED CARE RUN ITS COURSE?

Our society has had a love-hate relationship with managed care. While we as consumers of health care services have embraced managed care for its low cost, enhanced first-dollar coverage with low copayments and no filing of claim forms, we continually see the media bashing managed care for various cost-based claim denials, or other controversial activities. While we enjoy the low out-of-pocket costs for routine health care events, we also tend to have a fear of the unknown, should something serious happen to our families or ourselves. From this, our distrust of managed care prevails over our financial concerns. To many, when the option of a PPO or some other more flexible, less managed plan is offered, the up-front cost is paid without regret, as it is a small price for the peace of mind it may provide.

Even when cost factors lean toward the managed care option, individuals will pay a premium for flexibility and security. Because of this, managed care has had to loosen up its cost controls. As noted earlier, one major insurer made a bold move in November 1999 by removing precertification features from its managed care plans. The argument is that the feature saved less than 1% of plan cost while it produced far more than that in administrative costs, litigation cases and general bad press. Many other organizations followed with similar changes. We’ve seen the replacement of capita-

TABLE

Expected Cost Trends, 2003

HMO	15.1%
POS	15.1
PPO	15.8
Indemnity	18.1
RX	18.3

tions by discounted fee-for-service arrangements. Various state mandates have restricted the use of financial incentives in risk sharing among providers. Provider network strategy has shifted from controlling steerage with small groups of physicians and hospitals to growing vast provider networks, in which a significant portion of providers in any given metropolitan area participate.

Today it is not surprising to find that HMO rates for a traditional \$10 office visit copayment plan exceed the rates of a PPO plan offered side by side. It turns out that managed care plans of the 1980s and 1990s were able to contain costs—mainly because the plans really managed risk and cost shifting, and some might say, “prevented” care more than they “managed” care. Employers have recognized this, and in recent years have moved more toward a PPO platform, and away from the HMO, providing more flexibility to their workforce.

LEVERAGE SHIFTS BACK TO PROVIDERS

Today, providers are taking a hard look at how they contract with MCOs. It is not uncommon to read how large hospital chains and provider groups are leaving an HMO over a financial dispute. With the advent of managed care, as noted earlier, many hospitals were faced with a reduced number of patients coming to them for shorter stays. By agreeing to join as many provider panels as possible, hospitals hoped they would retain some level of patient steerage. However, this did not mean that hospitals were financially better off. In most cases, hospitals were forced to close beds and find ways to operate more efficiently. Many ended up as part of one of the large national hospital chains. Even not-for-profit hospitals were forced

to find ways to operate at higher efficiency levels and seek affiliation with various charity-oriented groups. Today many of these newly aligned groups are flexing their muscles and are willing to drop out of a network rather than agree to unacceptable financial terms.

Physicians are also walking away from what they consider to be poor financial deals. To a large degree, they feel the risk shift to them that capitation represents is no longer acceptable. In reality, there are very few examples of long-term successful capitation arrangements. Even some of the West Coast providers that were long the model of managed care have struggled under the pressures of these arrangements of late and are experiencing significant cost increases.

Over the past year, employers have experienced health care cost increases in the range of 15% or higher. While a portion of this can be attributed to provider cost increases, there are many other contributing factors to health care cost trend.

HEALTH CARE TREND: WHY SO HIGH?

Health care costs continue to increase at double-digit levels. A survey conducted by Aon Consulting in the fall of 2002 of eight managed care organizations indicates that managed care organizations expect a trend of 15.1% per year for HMO plans and 15.8% for PPO plans in 2003 (see the table). Prescription drugs continue to be a significant component of medical cost inflation and are expected to increase 18.3% in 2003 according to the Aon survey. The shift of leverage to providers contributes significantly to the nonprescription trend component.

Medical trend is made up of several components, including:

- *Price Inflation*—the increase of the cost of goods and services. Inflation has increased with a shift in leverage from managed care organizations to providers.
- *Deductible Leveraging*—the cost added to a health plan due to the subtraction of an unchanging deductible from a trended claim amount. Employers have been reluctant to change plan designs to reflect the increasing cost of health care.

- *Utilization*—the increase in the number of medical procedures performed in response to an aging population and new medical techniques.
- *Technological advances*—the change in cost due to new procedures replacing old procedures.
- *Cost shifting*—the shifting of costs from fixed or discount payers, such as Medicare, to reasonable and customary payers such as insurance companies or self-funded employers.

Employers now question whether they can afford the status quo in the future.

EMPLOYERS LOOK FOR NEW WAYS TO CONTROL COST

Since the beginning of the most recent trend escalation, employers have been fighting cost increases by revising their existing benefit plans to allow for greater cost sharing by employees. Unfortunately, there are limits to how much cost sharing can actually be shifted back to the employee. When those limits have been reached and cost continues to increase, something has got to give.

Now that we understand how we arrived at the current state, let's identify the major points of the issue:

- Managed care provided a short-term fix, but is no longer effective in controlling cost.
- Health care costs are increasing at five times the normal inflationary trend.
- Health care costs will continue to rise at increasing rates if the current system does not change.
- A major change in the delivery and financing of health care services in our country is unavoidable.

With this said, and considering the current political, social and economic environment, there are really only two options available to effect such change. They are:

1. On a global scale, employers aggressively redesign their health benefits to strongly encourage consumer-driven behavior, or
2. A single-payer health care system replaces our private, employment-based health care coverage platform.

There certainly may be arguments for some alternative, less dramatic options, but based on

the present situation, these two options have the most political exposure and support from those individuals and organizations that can potentially effect such global changes to our health care system. Thus, these are the most likely options.

This brings us to that ominous concept that so many of us try so desperately to avoid: "change." Our nature, especially when it comes to something so ingrained in society as health care delivery, is to resist change. Change leads to the unknown and what is not known scares us. How long did it take for us to figure out that bloodletting was a harmful practice? This barbaric practice of draining several pints of blood in an effort to cure an infection was a common medical procedure from before 500 B.C. until the late 19th century. To this end, we must assume when referring back to our two options, consumer-driven vs. single-payer health care,

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the option that allows for the least degree of change will usually prevail, thus escalating an evolution of our system rather than a revolution. Therefore, we believe if the consumer-driven approach is utilized by employers, we may eliminate the need for a single-payer health care option.

DEFINED CONTRIBUTION HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

IRS issued guidance last year that approved plan-year carryovers for defined contribution health reimbursement arrangements (HRAs). This landmark guidance has opened the door for the development of new consumer-driven health plans, which allow the consumer (employee) to manage a special account (funded by the employer) used to pay health care expenses. If the employee's health care expenses do not exceed the balance of the account at year-end, this balance may be carried forward to the next plan year, thus introducing a vested interest in the financial outcome of one's health care services.

Although this guidance is a major achievement for the health insurance marketplace, it is only the first of many changes needed to help integrate consumer-driven behavior into the utilization of health care.

There are several aspects of the HRA model that still need to be approved and applied to the plans in order to truly promote and encourage employee ownership of the account. Currently, there is no specific guidance as to how the HRA may be used outside of Section 213 medical expenses, such as:

- Can the employee move unused balances to the 401(k)?
- Can the employee use funds to pay for nontraditional health care benefits?
- How are domestic partners affected? Can they participate?

In addition to these additional uses with the present employer, what about portability issues? Can an employee permanently vest over time so he or she may take the balance upon termination? This opens up more questions, such as:

- Can the balance be used to pay for COBRA premiums?

- Can the balance be rolled over into the new employer's 401(k) or the employee's individual retirement account (IRA)?
- Can the balance be rolled over into the new employer's HRA?

Portability issues are key to encouraging consumer-driven behavior. While rolling a balance over year to year with the current employer provides some incentives, it does not allow for true ownership. Employees change employers often. If the balance does not continue upon termination, employees will simply find a way to use the balance while covered under the current employer's plan. We will show further in the article that "use it or lose it" discourages consumer-driven behavior.

THE CONSUMER-DRIVEN HEALTH PLAN (CDHP)

While the HRA is the primary model being used by employers, insurance carriers have designed several other variations of consumer-driven programs, such as the tiered plan, in which physicians and hospitals are assigned various copayment levels, based on their discount arrangements and ability to control cost. Employees are then given the choice either at enrollment or at the point of service, to select their providers based on the provider's copayment level. This model does involve the employee in the cost equation, which is a step in the right direction. However, the vested interest or personal ownership component is missing.

Getting back to the HRA, we have found this to be the most promising model for the development of consumer-driven health plans. Now the question is: How to design the plan? Let's discuss some of the plan design issues.

Consider a plan whose structure is an HRA coupled with a high-deductible PPO plan.

For the HRA, set the annual employer account contribution at \$500 to \$1,000 for individual coverage. Dependent levels should be tiered and should increase significantly. For example, a common HRA structure may be:

- \$1,000 employee
- \$1,750 employee plus one dependent
- \$2,500 employee plus family.

Unique to HRAs, there is no individual limit within the family structure. The \$2,500 can be used entirely for one family member. This also

applies to the corresponding deductible and out-of-pocket maximums within the underlying PPO plan.

For the PPO component, the plan should begin with a deductible that is 200% of the annual HRA contribution, thus requiring the employee to fund 100% of expenses in the amount equal to the HRA balance (known as the “bridge”). For the design above, the deductibles would be set as follows:

- \$2,000 employee
- \$3,500 employee plus one dependent
- \$5,000 employee plus family.

The rest of the plan design is quite flexible, but typically resembles a fairly rich 100%/80% or 90%/70% PPO plan, with an out-of-pocket maximum of a few thousand in expenses.

Prescription drugs may be carved out of the HRA account or included in the HRA, but if carved out, should be provided at a coinsurance level, not set copayments. This allows the employee to understand the true cost of the drug, which can help encourage less costly alternatives to high-priced blockbuster drugs.

One of the few legacies of the HMO—providing first-dollar preventive care coverage to identify major issues earlier rather than later—continues with the CDHP. Preventive care may be included in the HRA, but it probably makes more sense to carve out and encourage preventive care utilization among the workforce. This can be used in concert with health risk appraisals and disease management programs to promote health and wellness.

Another important component to the CDHP is a personal “toolkit,” whereby participants are given access to Web tools such as:

- Provider quality and cost information
- Prescription drug cost information
- Personal health management information
- Access to claim and account balance information.

Further, such tools as a 24-hour nurse line, wellness programs and health risk appraisals are usually coupled with the CDHP. The idea is to promote self-management of health care. Essentially, this is the newest form of managed care, for which care is managed by each individual, not an HMO or a PCP.

The final, and arguably the most important, component to the CDHP is communication and

education. A change in behavior does not come through brochures and enrollment forms. Employers will have to make significant investments in educating their employees and communicating the program. Employee meetings are essential!

Figure 3 illustrates the various components of a typical CDHP.

WAYS TO IMPROVE THE CDHP

The CDHP is still new, but there are existing platforms and tax regulations that should be revised to allow for integration with CDHPs. What is the missing component?—Employee contributions. Why not allow for the employee to make pretax contributions into the account? Two existing platforms are the Archer Medical Savings Accounts (MSAs) which were introduced to small employers (with under 50 employees) on a limited trial basis through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and, of course, the flexible spending account (FSA) through IRC Section 125.

THE MSA

The Archer MSA is perhaps the original consumer-driven health plan. It is an account with year-to-year rollovers, designed to be coupled with a high-deductible health plan. The difference between the MSA and the HRA? The MSA allows employee contributions. Unfortunately, because of its limited application of the trial MSAs to just a few small employers, there has been very little interest by large employers, which are typically those that effect global change.

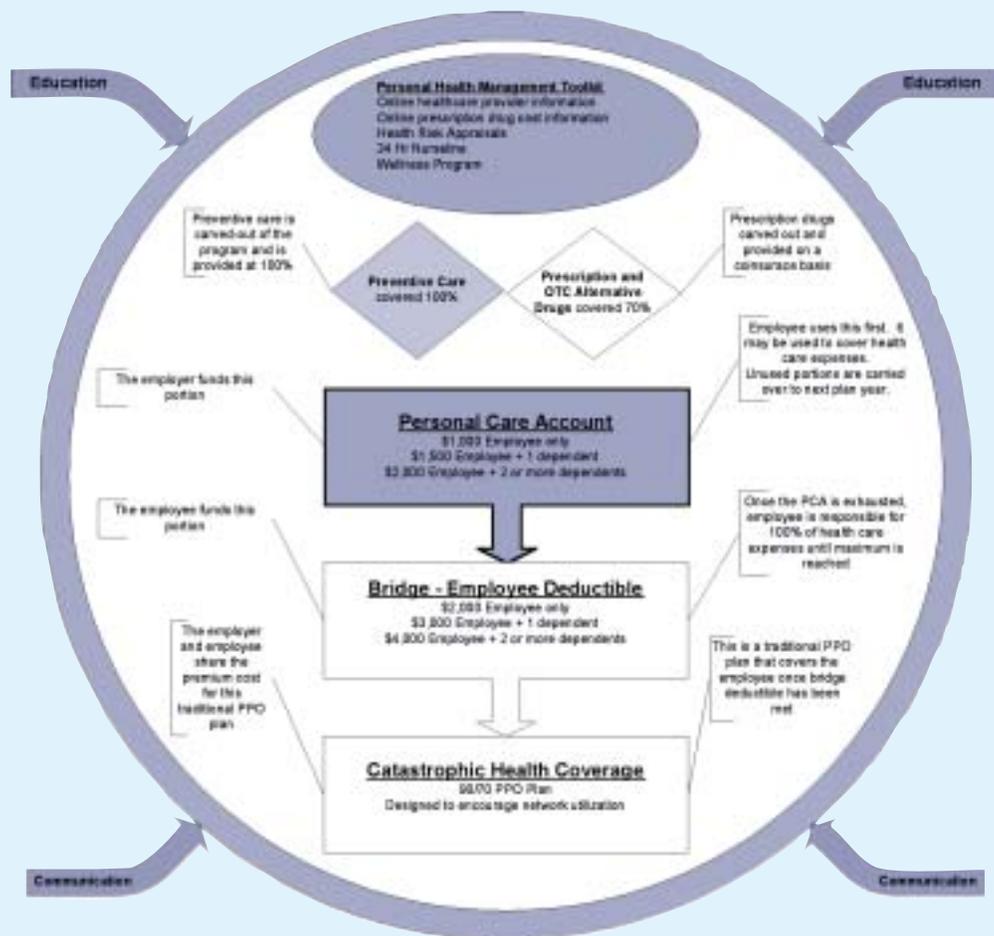
Let us focus then on a benefit provision that most employers are very familiar with: the FSA.

FLEXIBLE SPENDING ACCOUNTS (FSAs)—THE NON-CONSUMER-DRIVEN TAX-SAVING PLATFORM

The flexible spending account, introduced by the Internal Revenue Code Section 125 in 1986, provided the means for employees to considerably reduce their income tax liability through salary reduction. Employees could do this by setting aside pretax dollars that they could draw upon to pay for certain health care expenses. Although the FSA provides the oppor-

FIGURE 3

Components of a Typical CDHP



tunity for significant tax savings, there are several problems inherent to its design that result in modest participation levels. According to the 2001 *Mercer/Foster Higgins Survey of Employer-Sponsored Health Plans*, the average participation in FSAs in 2001 was 19% of eligible employees. This means the other 81% of eligible employees are paying more income taxes than they should, assuming those expenses were less than 7.5% of adjusted gross income, in which case, could be a qualified deduction through income tax filing.

Let's examine the problems with FSAs and why they do not support consumer-driven behavior.

To begin with, FSAs can be quite confusing. Many small and mid-sized employers would like to include FSAs in their benefits program, but they just don't have the resources to communicate the intricacies of how they work.

In addition to being confusing, actually filing claims for reimbursement can become a nightmare. For those who have a coinsurance-based health plan that is not directly linked to the FSA, the employee must first file a claim with the health plan. Then, once the employee finally receives an explanation of benefits (EOB), he or she must file another claim with the FSA administrator. This creates a situation known as the "shoebox effect," which means that one

may collect receipts in a shoebox over time and often forget to actually submit the claims for reimbursement, certainly not the intention of employers offering the benefit.

Now the most critical problem with the FSA is the fact that an employee must elect a specific amount of salary reduction at the beginning of the year, based on expected health care expenses, and use every dollar allotted by the end of the calendar year. Any remaining amounts are forfeited. What's wrong with this picture? Because of the "use it or lose it" rule, an employee may only be reimbursed for expenses incurred during the plan year. This rule causes both underutilization of the FSA and overutilization of health care.

Employees are often reluctant to defer funds into the FSA, fearing they will lose those funds at the end of the year. For many employees, health care expenses are budgetable. Absent any unforeseen illness or injury, many employees can budget for such expenses as copays, deductibles, vision expenses, etc. For unforeseen expenses, though, budgeting is not possible, and employees are understandably reluctant to put aside funds for expenses that may or may not occur.

For employees that do defer funds to an FSA, there is a tendency for overutilization of health care expenses toward the end of the year. Suppose you are approaching the end of the year with a surplus balance in your FSA but, instead of facing a forfeiture, you now have the opportunity to carry over all or a portion of your surplus. That changes everything. Without the steep forfeiture provision, employees could now feel more comfortable making contributions to their FSAs. Instead of being simply a "spending" account, the plan now has a "savings" component. Once the funds are carried over, they may be used or carried over into future years. Even more, what if the plan was portable and could be taken to future employers? Then, this could actually be used as a fund for postretirement health care expenses. Furthermore, perhaps a provision would allow a portion of this to be rolled over into an IRA or 401(k). With all of these incentives to save for the future, employees will take considerable care when using FSA funds. This is a format that effectively promotes consumer-driven behavior.

The tax advantages of employer-sponsored health plans and the structure of health FSAs also encourage employers to design plans with more generous benefit levels. Benefits paid from a health plan are a deductible expense to the employer. Benefits received by employees are not taxable. Employee contributions to health plans are paid on a pretax basis if paid through a Section 125 plan. Health care expenses incurred by the employee and not paid by the plan are not deductible for tax purposes unless they are paid through a health care FSA or to the extent they exceed 7.5% of an employee's adjusted gross income.

Thus, the tax code itself creates an incentive for employers to adopt plans that increase moral hazard. Moral hazard would not be a problem if health care expenses incurred by employees were the same whether or not they were covered by a health plan. Under such conditions, a plan paying for 100% of all covered expenses would be an efficient approach. However, other than one small, rural town in central Texas, we're not aware that anyone actually lives in Utopia, and moral hazard is a problem. When a visit to your physician costs \$10 and a prescription drug costs \$10, you are more likely to see your physician than if you had to pay \$100 for the visit and \$80 for the prescription. To think of this like an economist, under a typical health plan, the marginal cost of health care is low to any one individual while the marginal cost to the group is high. Since individuals and not the plan sponsor are making decisions about when and where to access health care, overutilization occurs. Consumer-driven health care should encourage employees to spend their health care dollar more wisely.

When employees are able to pick and choose their benefits, this arrangement is often referred to as a cafeteria plan. An employee goes through the line and selects the benefits he wishes. Today's health plans resemble an all-you-can-eat buffet. Once you pay the price of admission (enroll in the plan), you can chow down (consume the entire health care you wish for a small marginal cost).

There is currently a legislative proposal (HR 3105) to allow a \$2,000 annual carryover within the FSA. While the carryover creates a taxable event, this is still much more favorable than los-

ing the funds entirely. This proposal also includes a provision to allow portability of such balances to other employers, should the employer have the administrative capabilities. This is very encouraging for the promotion of consumer-driven behavior, yet this legislation is very far from becoming law.

While we don't have a rollover provision yet, CDHP administrators are integrating FSAs with the HRA. There are, however, several design issues to consider and communicate to employees, such as: Which account is used first? What expenses should be allowed? What limits to use? How to direct FSA funds for specific claims? We look forward to further guidance from IRS so these issues can be more easily understood.

WHAT CAN EMPLOYERS DO NOW?

Although consumerism is the buzzword in employer-sponsored health care these days, very few employers have actually implemented "consumer-driven" health plans (CDHP).

Why? Because the present models available to employers are too new. They have not been tested and there is very limited evidence that indicates real cost savings. Human resource (HR) professionals have voiced concerns over the potential fallout of implementing a CDHP because they know they'll be responsible to help employees through the initial education and learning that must take place. The prospect of employees showing up in HR after exhausting their HRA balance, and are now faced with a \$1,000 deductible that they cannot afford, is a very real concern.

When it comes to health care coverage, many employers tend to be conservative. The tried and true methods are far more reliable than the "unknown" plans. To many employers, the potential advantages to implementing the new CDHPs are far outweighed by the disadvantages, such as the significant investment in employee communications and unknown performance results.

However, as the media attention grows and the financial side of the house begins to see this as a potential solution to the cost spiral, HR must be ready to move forward and embrace this type of program. Understanding how these programs work, how vendors compare and what sort of

first step to take in this direction is something that HR should explore soon, rather than find the decision and process being driven by finance.

So, those employers who are willing to take a leap of faith, and cut to the chase, can at least get started by doing some or all of the following.

IMPLEMENT A CDHP

1. Replace all or part of the existing program with a CDHP.

For those employers that are progressive, but just aren't ready to dive into the deep end, here's an intermediate step to wet your feet.

2. Implement a CDHP at a site as a test option.

USE YOUR EXISTING PLATFORM

If a firm cannot implement a CDHP even as an option or by using a test site, the following are ways to introduce consumer-driven behavior to the workforce while using a traditional plan platform.

1. *Eliminate copayments.* Copayments have been one of the most detrimental factors in insulating employees from the true costs of care. Before there were HMOs, employees typically paid a share of medical costs in the form of coinsurance, which was a percentage of the actual cost of care. Although many plans have reverted back to this type of methodology, most employees enroll in and seek their care through a copayment-based plan. By using coinsurance, the employee is always involved financially. Once employees are reintroduced to the actual cost of health care services, perhaps a more responsible attitude can be embraced.
2. *Promote choice in the selection of prescription drugs.* Prescription drugs are one of the most rapidly increasing components to health coverage. Employers must find ways to control these costs even more than other aspects of their plans. However, higher copayments are probably not the answer for the future. Just as with office visits, a copayment insulates the employee from the true cost of care. Employers have taken measurable steps to shift costs back to the employee by implementing generic

incentives and even formulary-based incentives. Unfortunately, with the copayment-based platform, there is not enough incentive to change behavior. In many cases, employees will simply pay the higher copayment for a name or non-preferred drug, rather than explore alternative drugs or therapies. By utilizing a coinsurance-based platform, for which employees see (and pay a portion of) the actual cost of the drugs, there is much greater understanding of the actual cost. Therefore, there is an incentive to seek less costly alternative drugs or therapies. Eliminating the formulary will also reduce the employer's liability due to mandated drug replacements.

3. *Design plan options in a way that limits adverse selection and overutilization.* Before the recent cost explosion brought about "consumerism" as the health care buzzword, "choice" was perhaps the most prevalent employee benefit buzzword. With choice, employers took great measures to offer a variety of health care options. Unfortunately, the planning behind these designs lacked creativity and resulted in poor financial results. The approach of coupling a broad-based PPO plan with a national or local HMO(s) is a very typical plan offering today. But if the experience is not pooled, or worse yet, if the HMOs are insured, there is a high probability your plan is paying more than it should. This should be thoroughly analyzed prior to any redesign.
4. *Show employees the true cost of the plans.* Recent studies have shown that employees overestimate how much they pay and underestimate the employer portion. This dynamic must be addressed through communications programs that are straightforward and in plain English. If we want to bolster the concept of consumer-driven behavior, employees need to see the facts.
5. *Promote a shared ownership of the program.* Communications are going to play a large role in changing the dynamic of "un"involved consumer. The messages of the future must engage and help employees understand the situation and

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how they can help change it. Part of managed care's failure came about because a small percentage of employees felt the employer chose a plan that limited their access to what they felt they needed. They became consumers by necessity, not choice.

The new message must be about the opportunity to have choice in how the employees spend "their" money and that they will be protected in the event of a catastrophic event.

6. *Help your employees become informed consumers.* The new "consumers" will need information. They must be able to know the cost of buying something. If one is shopping for a new car, she or he can look in the paper want ads, buy a magazine, or search the Internet and so on. If one needs an annual physical, she or he needs a way to find the cost and a knowledge of what she or he should expect the physician to do during the exam. Provide the tools and resources to help your employees become informed health care consumers.
7. *Eliminate the "entitlement" concept.* Most small employers have long struggled with offering health benefits. Now many mid-sized companies are evaluating whether they can afford to continue offering health care. Without a shift away from the nonengaged employee/consumers, many firms, regardless of size, will have to ask the question in the future, "Can we afford

this benefit?" This is the time to change the entitlement mentality of employees and help them understand how they have an impact.

8. *Communicate the program.* For many reasons, communications will make or break the offering of the consumer-driven plans. The need for education materials, price information and decision support information, to name a few, must be accessible. And, it is not a one-time process. The information sources must be dynamic and up to date with current information.
9. *Be a proactive plan sponsor.* Unfortunately, we are at the end of a very comfortable period in employee benefits. As no one is offering BMWs to attract employees, the future will require plan sponsors to be educated and proactive with new options. Health care plans are no longer a benefit issue; they are a business issue. Failure to recognize this will cause some to likely seek other opportunities.

CONCLUSION

There is a real opportunity for HR to play an important role in protecting the company's bottom line. Not too long ago it was attracting and retaining important talent. The future will require this, as well as cost control, to be crucial roles for HR.

It is estimated that there were around 100,000 individuals enrolled in CDHPs in 2002. Projections indicate that perhaps over one million will be enrolled in 2003. While this may seem like a large number, it is important to un-

derstand that most of these current plans are provided to employees as an option and that fewer than 15% of employees actually select the CDHP when it is offered alongside a traditional plan. Thus, any utilization data collected from these lives will not be a true representation of a given employer's cost savings associated with the CDHP. To this end, we must understand that there will not be solid evidence of specific savings associated with CDHPs. It is important for benefits and HR professionals, as well as business leaders, to understand the potential effects of not promoting consumer-driven behavior. Perhaps this awareness will encourage employers to act quickly, rather than wait around for conclusive utilization data. The data will come in time, but with the current situation, time is one thing we don't have.

After examining the notion of incorporating a CDHP into a traditional health insurance platform, we see that although promotion of consumer-driven behavior is becoming more prevalent now than it was just last year, the CDHP still has many barriers to overcome. Barriers include both employers' reluctance to change, as well as limited legislative initiatives to help employers implement such programs. Without the proper tools, plan participants will be limited in their efforts to become true health care consumers. We have also seen that in order for an employer to reap the potential rewards from the CDHP, the employer must take significant initiatives for implementation and ongoing communications. CDHPs are our only real alternative to single payer health care. If employers start the process now, perhaps they will effect change before it is too late. ◀