

MARKET WATCH

Consumer-Driven Health Plans: Are They More Than Talk Now?

Consumer-driven plans are catching on and could be in the mainstream of health care in a few years.

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ABSTRACT: This paper reports marketplace developments for consumer-driven health plans in spring 2002. Findings are from interviews with executives from start-up and health insurance firms, benefit consultants, employee benefit managers, Wall Street analysts, consumer organizations, thought leaders, and policymakers. We detail available evidence about the performance of consumer-driven health plans concerning access to care, risk selection, cost containment, use of information, and legal issues. We find that these health plans are now a central pillar of health insurers' business strategy and that an estimated 1.5 million persons are enrolled in them.

OVER THE PAST YEAR medical journals, business magazines, and major newspapers have boldly pronounced that the era of heavy managed care is over and that a new era of consumer-driven health care financing is beginning. Conferences on consumer-driven health care are noteworthy by both their abundance and their high attendance. When informed of this alleged changing of the guard, many Americans ask, "What is consumer-driven health care, and how did we get to the current situation?"

Consumer-driven and *defined contribution* are two terms often used interchangeably, although they have different meanings. Defined contribution refers to an employer contribution strategy whereby employers set a fixed contribution for health insurance and place the employee at risk for costs beyond that point. Defined-contribution strategies limit

employers' costs in two ways. First, they cap the employer contribution for health benefits. Second, they reward employees financially for choosing lower-cost plans and thereby promote price competition among health plans.

The term *consumer-driven* or *consumer-directed* refers to health plan design. Such plans generally involve a greater role for employees in choosing providers and health plans and in designing their own benefit package while assuming greater financial risk. Web-based medical information tools are a key element of consumer-driven plans and are viewed as essential for creating more-knowledgeable consumers of health care. Conceptually, defined-contribution plans and consumer-driven health care are not mutually exclusive: While some consumer-driven plans make more sense in a defined-contribution environment, in most cases defined contribution is not a neces-

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sary condition for consumer-driven health care. In this paper we focus on consumer-driven plans.

At its heart, the consumer-driven health care movement seeks to combine incentives with information to enable consumers to make informed choices about non-life-threatening health care. Managed care succeeded in restraining costs because a third party (or, in some cases, an at-risk physician) was placed in the role of saying no to patients. Managed care's effectiveness in constraining costs was also the source of its unpopularity. By contrast, consumer-driven health care is an effort to put patients in a position to say no to themselves. This can happen only if consumers are aware of the true cost and have a personal stake in it, and if they have enough information and confidence to make treatment decisions.

For purposes of clarity, we classify consumer-driven plans into three loosely defined groups. The first group we term "health reimbursement arrangement" (HRA) plans because they establish an account from which consumers draw to make health care purchases. When the account is exhausted, enrollees must typically pay out of pocket until the annual deductible is met, after which the plan becomes a traditional major medical plan. A second class of consumer-driven plans allows employees to design their own networks and benefit packages. Employees' network and benefit selections determine the premium for their individual plan, and employees bear the financial risk for these choices above some fixed contribution from the employer. A third class of consumer-driven plans, termed "customized package" plans, allows employees, using Web-based tools, to choose from a predetermined selection of network offerings and benefit packages, such as a narrow, medium, or broad network and a rich, medium, or thin benefit package.

Customized packages and "design your own network and benefits" plans require a defined-contribution formula from employers. In contrast, HRA plans do not require fixed contributions by employers. When HRA plans are offered as full-replacement, self-insured

products, there is neither a choice of health plans nor a capping of the employer's liability.

Interest in HRA plans has increased in the wake of the Internal Revenue Service's (IRS's) recent guidance clarifying the tax treatment of such plans.¹ The ruling allows employers to fund individual health spending accounts with pretax dollars, which may be rolled over to the following year if they are not spent. The Bush administration has picked up on the ruling as a good first step toward encouraging more firms to offer consumer-driven health plans.² With the clarification of the taxation issues and with a supportive administration, employers may perceive less risk to implementing such plans.

Methods

Our discussion is based largely on semi-structured interviews with thirty-seven industry leaders and stakeholders conducted during the winter and spring of 2002. We identified many of the interviewees through a review of the trade literature and from attending industry conferences. We interviewed ten benefit consultants and insurance brokers, seven health plan executives, three employee benefit managers, four Wall Street analysts, three large purchasers of health care such as purchasing co-ops, two federal policymakers, four consumer and employee representatives, and four "thought leaders" from think tanks and universities. Different interview protocols were used for each of the eight groups. Questions were open-ended and aimed to allow interviewees to expound upon what strategies they were planning to follow in the market, and in what direction they believed the market would move. We also asked industry leaders about their views with regard to specific policy issues, such as potential for adverse selection. Interviews typically lasted thirty minutes to an hour and allowed for follow-up questions from the interviewers. The authors of this paper conducted all interviews. We took notes and then summarized responses to each question, as well as other points of discussion, when the interview was complete.

Few employers have even one year of expe-

rience with a consumer-driven plan, and there are no evaluations of this experience by independent researchers. Hence, consumer-driven health plan staff, employee benefit managers, and consultants (who have advised employers and health plans) are the source of most of the data that we report in this paper. There is a clear self-interest among health plans and companies to report favorable developments in reviewing the performance of their plans. Nevertheless, their insights, supplemented by those of others we interviewed, are useful in providing the most up-to-date information on the emergence and growth of this product.

Plans In The Marketplace

■ **The start-ups.** Small start-up firms were the first to offer consumer-driven plans. The start-ups have generally been financed with venture capital. One group of start-ups markets HRA-type plans. Although a number of similarities exist among the HRA products offered by these nascent firms, individual products differ in some important respects. The first part of Exhibit 1 provides a basic description of the companies we interviewed that offer HRA plans. Note that all plans offer a high-deductible, major medical health insurance policy with a health spending account based on pretax dollars; when that account is exhausted, health expenditures must be covered out of pocket. To avoid creating incentives for employees to skip on preventive care, all companies use different methods of encouraging preventive care. Destiny Health differs from Definity Health and Lumenos in that under the Destiny model the HRA is used only for discretionary health care purchases, such as doctor visits and prescription drug purchases for acute illnesses, while the other plans use the HRA for all health care spending.

As seen in Exhibit 1, current enrollment overall in the three start-ups with HRA-type plans is relatively low: approximately 80,000 lives. Definity Health and Lumenos are not li-

censed insurance companies; they are third-party administrators (TPAs) that work only with self-insured companies that bear the full risk. Thus, they earn revenue from administrative fees for enrollment in their plans. Destiny Health, by contrast, is a licensed insurer but only in Illinois, so its market is limited to small-to-midsize Illinois-based firms. Definity Health and Lumenos offer products that both replace and supplement firms' existing insurance plans, depending on firms' preferences.

To date, most of their offerings have been combined with other traditional health plan offerings from employers with which they have generally experienced 5–15 percent enrollment penetration rates. Destiny Health has thus far offered its product

as a total replacement for the health plan previously offered by the employers.

As an essential component of consumer-driven health care, all plans include informational software and services to help enrollees to make decisions about their health care. For example, all companies have partnered with major providers of Web-based health information, such as Well-Med and Johns Hopkins, that are accessible through the plan's Web site. In an effort to encourage enrollees to become better consumers of health care, most plans provide varying degrees of information allowing people to learn about the cost of health care services and, ideally, comparison-shop for health care services based on price and quality.

The start-ups' second major product category is software to allow consumers to design their own networks and benefit packages.³ We spoke with representatives from two firms, Vivius and MyHealthBank, that market these products. These firms are software companies that license their products to health insurers interested in offering a consumer-driven product but wanting to avoid the time and expense of developing the necessary software in house. The products generally provide a Web-based interface from which enrollees

“Health insurers were slower than the start-up companies were to bring consumer-driven health plans to the market.”

EXHIBIT 1
Description Of Selected Consumer-Driven Health Care Products Offered By Start-Up Companies And Health Plans, 2002

| Company/plan | Details | Current enrollment (July 2002) |
|----------------------------------|--|--------------------------------|
| Start-ups HRA plans | | |
| Definity Health | Pretax HRA for all health care spending, after which spending is out of pocket until deductible reached; preventive care does not come out of HRA; HRA rolls over and accrues over time; tie-in to quality information and decision-support tools | 40,000 |
| Lumenos | Pretax HRA for all health care spending, after which spending is out of pocket until deductible reached; employer earmarks a certain amount of the HRA for preventive care, which does not roll over; rest of HRA rolls over and accrues over time; tie-in to quality information and decision-support tools | 30,000 |
| Destiny Health | Pretax HRA for "discretionary" health care spending (lab work, doctor visits, prescription drugs), after which spending is out of pocket until deductible reached; unavoidable health care needs (hospitalizations) covered by insurance; separate program to encourage and reward preventive care; HRA rolls over and accrues over time; tie-in to quality information and decision-support tools | 12,000 |
| Benefit design plans | | |
| Vivius | Web-based software lets enrollee select desired copayments and doctors to be in the individual's "personal" provider network, then computes the required premium contribution; enrollee can then adjust choices and options and recalculate the premium; integrated access to quality information and decision-support tools; company wholesales product to HMOs | Just starting |
| MyHealthBank | Provides the technology to facilitate self-directed health care including comprehensive Web-based interaction of enrollee, provider, and payer; ability to administer HRAs and rollover; integrated access to quality information and decision-support tools; company wholesales to HMOs | 10,000 |
| Health plans | | |
| Aetna | HRA-type accounts with tiered networks are the major product; sold as a full-replacement product to small employers and an add-on product to larger employers | 400 |
| HealthPartners | Web-based tool allows employees to choose customized benefit plan, combined with defined contribution by employer; employee may choose from three network sizes and three benefit packages; uses actuarial pricing to minimize unfavorable selection | 300,000 |
| CIGNA | Will offer both HRA and customized package plans; will sell products as both add-on and full-replacement products; start date with active contracts, January 2003 | Not operational |
| Humana | Has array of HRA, customized package, and tiered networks; sells product as both full replacement and add-on; uses experience rating and actuarial pricing | 12,000 |
| Blue Cross and Blue Shield plans | Has array of HRA, customized packages, and tiered networks; sells products as both full replacement and add-on; project consumer-driven products will be 15-20 percent of enrollment within a few years; 95 percent of 900,000 total enrollees are in customized package products | 900,000 |
| Highmark Blue Cross | Web-based customized package with 43 different plan offerings sold largely to small employers; used with defined contributions from employers and underwritten as one plan; replacement product | 21,000 |

SOURCE: Authors' interviews with plan executives, 2002.

NOTES: HRA is health reimbursement arrangement. HMO is health maintenance organization.

can choose providers, manage their medical spending accounts, learn about health care issues, and get information on the quality of providers. Under the Vivius model, for example, when people initially enroll, they interactively build provider networks for themselves and their families in a process somewhat analogous to shopping online for a computer. Based on their selection of providers and copayment levels, their monthly health insurance premiums change. Doctors within the network can choose to be high- or low-cost providers, which in turn affects enrollees' willingness to select them.

As of July 2002 Vivius began enrolling people in Spokane, Washington, under a licensing agreement with HealthNet. MyHealthBank has been licensed by four Blue Cross plans in the Pacific Northwest; about 10,000 people are enrolled across forty-one employer groups that contract with these four Blue Cross plans.

■ **The health plans cometh.** Health insurers were slower than the start-up companies were to bring consumer-driven health plans to the market, but by spring 2002 insurers viewed such plans as an essential component of their business strategy. Carriers are largely offering HRA plans or plans featuring "customized package" models in which employees choose from specified network and benefit design alternatives (Exhibit 1).

One important component of health plans' consumer-driven products is tiered networks. With tiered networks, employees face different cost-sharing requirements among different preferred providers within a health plan's network at the point of service. Hypothetically, if an employee has a hernia repair performed in a teaching hospital, the employee pays a deductible of \$1,000. If the surgery is performed in a lower-cost community hospital, the employee pays \$500. Some carriers determine the tiers of network hospitals based on charges and discounts alone, while others aim to establish their tiers on measures of quality as well as cost. Tiered networks are compatible with HRA-type plans as well as customized package plans.

In consumer-driven plans sponsored by in-

surers, the vast majority of enrollment is in the "customized package" model, which has no HRA. Critics of the customized package model see it as differing little from old-style multiple plan offerings by an employer with fixed absolute employer contributions. Proponents note that the customized package offers employees and employers what they want. Employees, particularly in small firms, may choose from forty plans rather than having a choice of only one plan. Employers can cap their contributions for health benefits and place the financial risk for richer benefits or broader networks on employees.

Major insurers, such as Aetna, CIGNA, Humana, HealthPartners, and some Blue Cross and Blue Shield plans are offering or developing consumer-driven products. Aetna is investing resources in developing HRA plans combined with tiered networks. Although Aetna had just one employer contract operational in April 2002, the firm has signed contracts with many employers that were to begin in July 2002 and many more set to begin in January 2003. With large employers, the Aetna HealthFund is an additional plan offered to employees. With smaller employers (30–500 workers), the Aetna HealthFund is a full replacement for existing coverage. Aetna's full-replacement product may provide different preferred provider organization (PPO) or health maintenance organization (HMO) plans that one employer can offer simultaneously with the HRA.

Like other carriers, and similar to the advice offered by benefit consultants, Aetna envisions its Aetna HealthFund project as having looser medical management for low-cost employees. Thus, most employees will not be subject to preauthorization review and primary care gatekeepers. Like other insurers, Aetna foresees more-aggressive disease management programs for high-cost and chronically ill patients.

CIGNA had no operational contracts with employers as of May 2002, but it plans to have many in the near future. CIGNA will offer an HRA-type product, termed Personal Health Solution. In addition, CIGNA is building a

Web-based customized package model. CIGNA is marketing these products to firms with 200 or more workers, as both add-on and replacement products. These new product offerings represent one phase of CIGNA's reconstruction of its entire medical management philosophy. CIGNA aims to reduce the use of preauthorization review and approvals for referrals to specialists and replace them with financial incentives and information for patients. CIGNA is now testing tiered networks.

HealthPartners, a Minnesota-based managed care organization, reports that nearly 300,000 of its nearly 800,000 members and most of its new accounts are enrolled in its "consumer choice" offerings.⁴ The company projects that in time more than 60 percent of its enrollment will be in the "customized package" model. HealthPartners offers a choice of three networks and three benefit plan options (making nine product offerings). For about 90 percent of the employers that have selected the "customized package" model, HealthPartners is the sole carrier available. Hence, the model offers more plan choices, but they are usually from one insurance carrier.

Humana terms its customized package product SmartSuite and had contracts with 600 employers and approximately 11,000 employees in the spring of 2002. SmartSuite offers six product designs based on two HMO products and one PPO product, and two levels of benefits. Humana is selling SmartSuite in fifteen metropolitan areas and sells the product as a total replacement product. Humana has a tiered PPO network in which employees face a 10 percent coinsurance rate when using services from the higher tier of preferred providers, but a 25 percent coinsurance rate when purchasing from the lower tier. Reporting strong demand for SmartSuite, Humana executives foresee that a "floodgate" of employers will begin offering the product to their workers in January 2003. Humana also plans to have its HRA product, SmartSelect, operational in January 2003.

Executives at the Blue Cross and Blue Shield Association estimate that fifteen to twenty Blues plans either offer or are develop-

ing consumer-driven health insurance products. Estimated national enrollment is 900,000 people, 95 percent of whom are enrolled in customized package products. Some Blues plans are operating tiered networks, whereas many more are experimenting and developing such networks.

Highmark Blue Cross of Pennsylvania was one of the first Blues plans to enter the consumer-driven market and the first plan to offer a Web-based customized package. This product has been sold to midsize and small businesses for more than a year. Individual employees can choose from a Web-based menu of forty-three different product designs that are determined by their model type (PPO, HMO, and point-of-service, or POS) and the richness of the benefit package. The employer makes a contribution for coverage, and employees can buy up or down according to their choice of products. When an employer purchases the customized package, the firm agrees not to contract with any other carrier. Approximately twenty-five employers with 21,000 employees have purchased the product. Highmark underwrites the entire pool of employers as one group.

Key Issues

■ **Use of information.** Nearly all observers agree that under consumer-driven health plans, consumers will have greater access to, and greater responsibilities to use, information on costs and quality of health care.⁵ Disagreements emerge, however, regarding whether adequate information will be available for making these choices and whether most consumers can use it effectively.

Most consumer-driven plans rely on some form of Internet-based tools. Those based on HRAs tend to provide information on a person's spending, costs of various treatments and providers, wellness, and, to some extent, provider quality ratings. Other plans, such as Vivius, go further and have the consumers choose plan benefits, cost-sharing requirements, and even their primary care and specialist physicians on the Web.

Many respondents expressed concern that

the most important type of information—the quality of available providers—is not yet adequate to meet consumer needs. Consumers, it was thought, are not nearly as interested in quality ratings of health plans as they are in plans' hospitals and doctors. Some benefit consultants noted that the consumer-driven plan that can deliver provider-specific information on cost and quality will break away from its competitors. The marketplace would be more likely to reward high quality if such information were available at the level of the individual physician and hospital—so long as many employees chose their providers based on such information.

Although some progress has been made in recent years in evaluating hospital quality, less progress has been made in evaluating that of physicians. Researchers have pointed to several challenges ahead: obtaining objective and useful information on physician-related health outcomes; adjusting for case-mix, which is still in its infancy; dealing with small sample sizes; translating information on the quality of large medical groups to the individual clinic and provider levels; and coming up with ways to present the information most effectively.⁶ Furthermore, the most reliable information is probably available only from medical charts; this information is very expensive to abstract and difficult to audit.

A particularly important issue concerns presenting quality information that is useful to the consumer. A woman with breast cancer, for example, needs to know about the quality of care provided by physicians for her particular problem—something that is difficult if not impossible to determine from the quality ratings now available. Several respondents observed, however, that to the extent that consumer-driven plans become popular, rapid progress is likely to follow in improving the quality and quantity of available information. This raises the question, however, of where the additional money needed to carry this out will

come from.

The second area of disagreement concerns consumers' competence in using quality and cost information. Research is ambiguous as to whether consumers can effectively use the information that is available to pick plans that are the best value.⁷ However, some recent research indicates that certain methods of presentation (for example, the use of stars to convey relative plan quality, or ordering plans by quality ranking) are more effective than others.⁸

Some respondents felt that most working-age persons are able to use Web-based tools to make good choices. Others, however, were less sanguine about consumers' Web ability. It is essential that families with members having a serious chronic condition—those

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5 percent of persons who account for 43 percent of medical claims expenses in group insurance—be able to use the Web tools.⁹ Such persons are disproportionately older and less educated and, hence, less likely to be Web-literate. Most respondents agreed, however, that over time computer literacy should become less of a problem as the working population absorbs a generation that grew up using computers. Nevertheless, some differences will remain across socioeconomic groups, particularly with regard to competency of understanding basic presentation techniques such as averages and charts.¹⁰

■ **Cost control.** There was no consensus among respondents about whether consumer-driven plans will lower health care costs, although consumer representatives do see them as a vehicle for shifting costs from employers to employees. Predictably, start-ups, health plans, and benefit consultants were more optimistic about consumer-driven plans' ability to control medical claims expenses. Most of those we spoke with, however, thought that in the aggregate, these plans would have relatively little impact initially because enrollments will tend to be small. In ad-

dition, to the extent that the plans draw healthier enrollees, most of the costs will still be under the traditional employment-based system. Unfortunately, there are few systematic data yet available providing evidence one way or the other.

The more interesting issue, perhaps, is whether consumer-driven plans would lower costs if they were to garner a large portion of the market. There was a good deal of disagreement on this point among those we interviewed. Those believing that costs would be lower projected that the driving force would be consumers' awareness of actual health care costs. As one respondent noted, "It doesn't cost \$10 to deliver a baby!" If consumers were to see exactly how their utilization would deplete their savings accounts, these respondents believe, utilization should decline. However, the ability merely to see health costs will translate into lower costs only if enrollees feel some degree of ownership over their spending accounts or, at a minimum, if consumers are trying to avoid the point at which they must pay out of pocket before the deductible is reached.

Others, however, were skeptical about cost savings even if these plans catch on. One reason is that large deductibles will not tend to reduce utilization for persons who experience expensive episodes of care, or those with chronic diseases, because the annual deductible will be met, and stop-loss insurance coverage will provide for nearly all of the remaining costs. More aggressive and effective early-intervention disease management programs will be necessary to succeed in controlling the costs of high-cost patients. Health plans reported that it is difficult to enroll patients who the plan predicts will develop a chronic condition or incur high costs in the near future. Some benefit consultants believe that employers and plans must provide financial incentives to enroll these predicted cases in disease management programs.

A second reason for skepticism was that even though high deductibles might reduce costs, this would, at the most, offset the cost increases generated by a movement away from heavy-handed managed care. Consumer-

driven plans, in theory, have less purchasing power than do heavily managed plans with narrow networks and therefore are less able to secure large discounts from providers. These plans also have less ability to affect provider treatment patterns. Nevertheless, even if these plans do not save money, proponents believe that they will at least result in consumers' making more-informed choices.

There is limited information about the record of consumer-driven plans to control costs among the pioneer employers and health plans. Definity Health reported that the use of generic drugs was dramatically higher under its plan compared with national averages and other health plans offered by their clients. Aon, one of the first employers to use Definity, said not only that the use of generic drugs has greatly increased but also that physician office visits are down, and the use of the nurse help line has doubled. Lumenos claimed that medical expenses incurred with the pioneer employers were below expectations.

Some health plans reported favorable cost trends. HealthPartners and Humana reported that under the defined-contribution formula for Web-based customized packages, employees tended to move down the continuum one notch. For example, people that previously selected the most comprehensive level of benefits shifted to the medium level, while people previously choosing the broadest networks moved to the middle level. Based on prior research, these changes are likely to reduce the use and cost of medical care services. Humana reported that trend rates in claims expenses incurred for its experimental employer (Humana employees) were ten percentage points less than those of people who did not choose the consumer-driven plan. On the other hand, Highmark Blue Cross found a similar trend in claims expenses for employers choosing its customized package product and employers choosing its traditional products.

■ **Access to care.** The emergence of consumer-driven health plans raises two issues concerning access to care. The first is how such plans are likely to affect the proportion of employees who obtain health insurance cover-

age from their employer. The second is whether the plans will have an adverse impact on people with higher anticipated health care costs, by fragmenting the risk pool. We discuss the latter in a subsequent section about risk selection.

With respect to the first issue, one must consider rates of both employer offer (the proportion of workers who are offered coverage from an employer) and employee take-up (the proportion of those offered coverage who enroll). Low offer rates are mainly a problem among small employers. Most respondents indicated that consumer-driven plans would either increase the number of small employers that offer health insurance or have little impact. Few believed that these plans would result in fewer employers' offering coverage. Employer offer rates are likely to rise if such plans can be priced more cheaply than current insurance, which might be the case if they have high deductibles. Offer rates also might rise if the plans can reduce the small employers' administrative costs associated with offering coverage. MyHealthBank, for example, reported that its product has realized savings of \$20–\$44 per member per year in administrative costs. Some respondents, however, believed that there would be little impact because few small businesses that do not offer coverage now would start doing so without major subsidies on their premiums.

Respondents tended to believe that the impact on take-up rates would be similar to that on offer rates, the logic being that if insurance were cheaper, more employees would purchase it. Some, however, were concerned that take-up rates could actually decline. This might occur if employees view these new products as providing little in the way of benefits, given that healthier employees might rarely reach their maximum deductible.

■ **Selection bias.** Some analysts and journalists are alarmed that consumer-driven health plans will further fragment employer risk pools, resulting in a de facto transfer of

resources from older and sicker employees to younger and healthier workers.¹¹ The concern is twofold. First, similar to the situation of a decade ago, when employers increasingly offered HMOs, many analysts fear that healthier people will enroll in the new consumer-driven plan rather than in the traditional plans offered. Accordingly, when employers offer customized package plans, sicker people will not enroll in the lower-cost, high-deductible plans. Consumer-driven plan executives con-

“We estimate from our interviews that about 1.5 million Americans are now enrolled in consumer-driven plans.”

tended that people with chronic conditions have the potential to gain the most from the increased flexibility afforded by their products. For example, Definity executives boasted of the two transplant cases experienced

this year. Nonetheless, the majority of benefit consultants, health plan executives, and employee benefit managers stressed that sick people are the last group of employees to change plans. Many consultants and plan administrators questioned whether an HRA plan could be profitable without enjoying favorable selection. As a result of the HRA, the lower 50 percent of users, who account for just 5 percent of medical claims expenses in a typical group plan, will each be due their spending account allowances (ranging from \$500 to \$1,000).¹² The HRA plan can only offset such increased spending by reducing claims expenses for families who exceed the HRA but do not reach their deductible, or families who exceed their deductible.

Second, even if an employer offers an HRA plan only (a replacement product), most analysts believe that resources will be redistributed from the sick to the healthy. Again, the basis of this belief is that young, healthy people who previously received no payments for medical claims expenses will now receive an annual payment for their HRA, and these payments will be offset by reductions in payments to sicker people, who use up their allotment.

There is limited information to clarify the true magnitude of favorable selection. In an

analysis of employees who selected Definity rather than a traditional HMO or PPO, Charter Communications reported no differences in the average age of people selecting Definity and the other plans. Aon described similar results from its analysis of persons who selected Definity over other plans offered. Aetna found from its first employer using the Aetna HealthFund product that earnings of the employees, not age, were the major predictor of who selected Aetna HealthFund. By contrast, Humana found that employees who selected the consumer-driven plan in its pilot were much lower users of medical care services in the year prior to enrollment and continued to be low users under the consumer-driven health plan. Most benefit consultants, who often represented competitors of the consumer-driven plan, expressed concern about unfavorable selection resulting from the new offering of an HRA-type plan.

Benefit consultants and health plan executives, however, believed that employers could control favorable selection through their contribution policy. They believed that the art of risk adjustment is sufficiently advanced that employers should use their contribution formula to compensate for favorable selection. Unfortunately, employers did not extensively practice this formula in the days of growing HMO enrollment, nor are they generally practicing it today. Moreover, consumer-driven health plan executives argued that their products are not substitutes for solid underwriting and other traditional insurance principles. Many admitted to screening out employers that they judged to be high risks.

HealthPartners and Humana reported predictable selection patterns with their customized package products. Healthier people are more likely to select high-deductible, low-benefit plans and narrower networks. HealthPartners rates each of its nine alternative plans not based on the individual plan's claims experience but according to its actuarial value.¹³ In so doing, HealthPartners aims to avoid an adverse-selection death spiral, which can occur when healthy workers exit more-comprehensive plans, leaving a concentration

of sicker workers in comprehensive plans and thereby driving up the price of comprehensive plans until they are removed from the market.

Humana executives indicated that they price their health plans through a combination of actuarial and experience rating. Both Humana and HealthPartners executives noted that their deviation from standard experience rating is possible when they are the sole carrier available to an employer's workers but that such pricing is not possible when they are competing with other carriers.

■ **Legal and legislative issues.** At the time of our interviews, all consumer-driven health plans hoped for supportive IRS guidance regarding the tax treatment of the health spending accounts, which they received in the form of the previously mentioned IRS ruling. However, the firms ultimately saw the greatest potential impact on health insurance and how people think about health benefits coming from allowing portability of health insurance between employers. Some firms drew the analogy to 401(k) plans in retirement benefits, which can follow employees to new employers or at least be rolled over in some form. Portability, the firms argued, would allow people to set aside health benefits for a "rainy day" and would eliminate the "use it or lose it" mentality that still remains even when benefits can be rolled over annually, because employees might be planning to leave their current employer.

Despite positive comments from the Bush administration, in the current legislative environment such changes do not appear to be a high priority.¹⁴ Congress is concerned with prescription drugs, a patients' bill of rights, and the use of tax credits or expansion of public programs to cover the working uninsured. However, in our interviews, executives and legislative staff alike felt that if consumer-driven plans begin to gain a stronger foothold in the market, policymakers might quickly shift attention to the issues facing the industry.

■ **Popularity.** We estimate from our interviews that about 1.5 million Americans are now enrolled in consumer-driven plans. Interviewees' estimates of the future market share of consumer-driven plans ranged from "niche

player” to “will comprise 50 percent of the market.” Analysts who are dubious about the appeal of consumer-driven plans focused their comments on HRA-type plans, emphasizing the long history of employees’ avoiding high-deductible plans. Other interviewees thought that HRA-type plans would appeal to three types of employees: (1) those who enjoy making decisions; (2) high earners who enjoy and have experience managing financial risk; and (3) light users of the health care system who don’t see themselves at risk of acute illnesses. All but the third group constitute a small percentage of the workforce. Evidence to date from Definity Health indicates that when its plan is first offered, about 10 percent of workers choose it, with the figure higher among new hires at 30 percent.

Benefit consultants and health plans, in contrast, concurred that consumer-driven products will become mainstream in a world in which a wider range of insurance products is offered. One health plan executive noted that the product cycle is in its earliest phase, so it will take two to three years to learn the nature of successful plans. In our interviews with major health plans, it became clear that plan executives view it as imperative that companies bring consumer-driven plans to the marketplace and that these products will constitute the mainstream rather than competitive fringe of carriers’ insurance portfolios. Within a few years consumer-driven plans could constitute 15–20 percent of group business. Some plans foresaw that the majority of their book of business would be consumer-driven plans by 2005. “Customized package” plans and tiered networks will play a major role in this future.

Discussion

One year ago, discussion of defined-contribution and consumer-driven health care usually began with the possibility that employers would exit from the health benefit business and hand their employees a voucher to purchase health insurance in the individual market. This is a nonstarter today. We talked to no benefit consultant, health plan, or employer seriously considering this possibility.

Consumer-driven health care is a noteworthy subject today, nonetheless. If imitation is the ultimate flattery, the upstart plans such as Definity Health and Lumenos feel both pressured and reassured by the actions of mainstream health insurers. There may be no consensus about the products and vendors that will succeed, but every health insurer we talked to regarded consumer-driven products as a central pillar for its business strategy. We estimate that today about 1.5 million Americans are in consumer-driven plans—less than 1 percent of the employer coverage market.¹⁵ Customized package plans constitute about 90 percent of this enrollment. Many health plans and benefit consultants, however, see consumer-driven plans accounting for 20 percent of the market by 2005 and as much as 50 percent by 2007.

The major limitation of this study is that our information is largely from persons with a clear self-interest to report favorable developments about consumer-driven plans. Since there is limited experience and no independent evaluations of these plans to date, we depend heavily upon start-up and health plan executives, employee benefit managers, and benefit consultants for information and insights.

At their best, consumer-driven plans will provide a mechanism to inject incentive-based reasoning on the part of consumers into non-life-threatening medical care decisions. Employees do not bear most of the costs associated with higher use of care or use of more costly delivery systems. Consumer-driven products thus would reestablish the link between service use and an employee financial liability. If, as a result, employees respond to these incentives and use the Web tools not just to make decisions regarding their plan but to select providers based on quality, make informed treatment decisions, and manage chronic conditions, quality of care should improve. Customized package plans can expand the number of plan choices available to workers at small firms.

At its worst, however, consumer-driven health care can destabilize risk pools and lead

to a redistribution of health care services and income from the sick to the healthy. A system that controls costs through price rather than nonprice rationing will almost certainly be to the advantage of higher-income groups and to the disadvantage of low-income groups, who are more likely to delay care if they lack the resources to pay for it.¹⁶

As is often the case, the devil may be in the details—the details as to how employers and health plans structure consumer-driven plans. Large employers may mitigate unfavorable selection by risk-rating each plan offered to their workforce and setting employer contributions according to the expected spending levels of people who enroll in each plan. If history is our guide, we should not be optimistic that employers will do this on a large scale. If health plans price their products based on actuarial value rather than claims experience, more-comprehensive plans need not suffer unfavorable selection and fall into a selection-induced death spiral. On the other hand, if employers wish to drive workers into low-benefit, narrow-network plans, pricing plans according to the claims experience of workers is in the self-interest of the employer. People may be capable of behaving like rational consumers when they are purchasing prescription drugs or selecting health plans, but such rationality may elude them when they are informed that they have cancer.

If there is one message that resonates loudly from our interviews, it is this: “Political partisans, hold your fire! More research and experience are needed!” Independent research is desperately required to address the many issues we have identified. Researchers need to measure the extent of risk selection through studies that examine employees’ health status before they enroll in consumer-driven plans and their competitors. Researchers should analyze the redistribution of out-of-pocket costs and services in HRA plans among the sick and healthy. We need to learn the extent to which employees are using Web tools and determine whether they are becoming better consumers and whether physicians are more or less likely to deliver care according to clinical guidelines.

After controlling for risk selection, researchers need to analyze both the consumer-driven plans’ ability to control claims expenses and plans’ impact on health status and employee satisfaction. This is an ambitious research agenda, but surely one with a high rate of return, if the consultants and health plans are right about the future of the health benefits marketplace.

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NOTES

1. U.S. Department of the Treasury, Internal Revenue Service Notice 2002-45; Rev. Rul. 2002-41.
2. House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations, "Expanding Access to Quality Health Care: Solutions for Uninsured Americans," 107th Cong., 1st sess. (9 July 2002).
3. For a more extensive description of plans, see J. Robinson, "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design," 20 March 2002, www.healthaffairs.org/WebExclusives/Robinson_Web_Excl_032002.htm (24 September 2002).
4. The Buyers Health Care Action Group (BHCAG), one of the nation's most sophisticated purchasing coalitions, differentiates the Minnesota market from others in the nation and probably makes HealthPartners' "customized package" product more easily accepted.
5. The source of information for this section is largely from interviews with industry leaders, supplemented by a review of the trade and academic literature.
6. See, for example, P. Cunningham, D. Denk, and M. Sinclair, "Do Consumers Know How Their Health Plan Works?" *Health Affairs* (Mar/Apr 2001): 159-166; M.A. Rodwin, "Consumer Voice and Representation in Managed Healthcare," *Journal of Health Law* 34, no. 2 (2001): 233-276; and J.H. Hibbard, S. Sofaer, and J.J. Jewett, "Condition-Specific Performance Information: Assessing Salience, Comprehension, and Approaches for Communicating Quality," *Health Care Financing Review* 18, no. 1 (1996): 95-109.
7. Cunningham et al., "Do Consumers Know How Their Health Plan Works?"
8. J.H. Hibbard et al., "Strategies for Reporting Health Plan Performance Information to Consumers: Evidence from Controlled Studies," *Health Services Research* 37, no. 2 (2002): 291-313.
9. P. Fronstin, *Can Consumerism Slow the Rate of Health Benefit Cost Increases?* Issue Brief no. 247 (Washington: Employee Benefit Research Institute, 2002).
10. J.H. Hibbard et al., "Is the Informed-Choice Policy Approach Appropriate for Medicare Beneficiaries?" *Health Affairs* (May/June 2001): 199-203.
11. J.B. Quinn, "Paying Up for Quality Care," *Newsweek*, 13 May 2002, 49; and M. Freudenheim, "After Managed Care, Insurers Look to the Web for Plan B," *New York Times*, 25 October 2000.
12. M. Berk and A. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs* (Mar/Apr 2001): 13-15. This estimate is based on enrollment figures provided by interviewees.
13. Actuarial value is the estimated percentage of medical expenses paid by the health plan for a standard population.
14. See Subcommittee on Employer-Employee Relationships, "Expanding Access to Quality Health Care."
15. This estimate is based on interviews with start-ups and health plans.
16. The exception would be if all employers instituted income-based deductibles and contributions. Less than 1 percent do so today.