

# The Evolution of Health Care Plan Designs

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## Introduction

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In the previous chapter we set out the “raison d’être” of employer-sponsored health care. We also outlined some of the complexities of our health care system, as well as the significant health care inflation that continues to make it more difficult for employer sponsors to continue coverage for their employees. Finally, we described the basic indemnity (fee-for-service) plan and its design features, and briefly discussed the lack of traditional market features in the delivery of health care in the United States.

We spoke about an evolution of health care plan designs beyond the indemnity plan, and in this chapter we will be covering the types of plans that have evolved in the last 20 years in the United States. As the evolution unfolds, you will see an incremental insertion of market features into the basic indemnity plan. Each new plan takes on a new identity, but the core of the indemnity plan remains. We will explore the intended and actual impact of these changes on the employer’s ability to meet his goal of sponsoring quality and cost-effective health care while respecting the important feature of choice—the ability to choose one’s providers.

## Preferred Provider Organization (PPO)<sup>1</sup>— Discounts and Volume

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An inherent problem for employers offering the traditional fee-for-service indemnity plan is that the medical provider unilaterally determines which

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1. PPO network providers typically agree to prescribed cost controls and offer services to subscribers at less than usual charges. Cunningham R., III, & Cunningham, R. M. (1997), p. 261.

health care resources to prescribe. The only exception is in special instances where some form of utilization review is applied. From a market standpoint, this places the provider in the unique position of determining not only the services to be rendered, but also the revenue the service will generate. In the late 1980s, a new plan design evolved that offered a partial solution: the preferred provider organization (PPO). Let's take a look.

The TPAs and sponsoring employers decided to select some providers in a geographic area who would offer a discount for their services in exchange for an increase in number of patients; a simple volume discount concept. The TPA agreed to place the name of the provider on a preferred list.<sup>2</sup> The participants were given a financial incentive in the form of a lower coinsurance amount if they would select health care services from among those appearing on the list. For example, if the participant used the preferred provider, the coinsurance might be 90 percent paid by the employer and 10 percent by the employee, instead of the traditional 80/20 percent. Since choice remained an important value in most plans, the decision by the participant to use a network provider was voluntary. There was only a financial incentive to do so. If the participant chose a provider not on the list, the coinsurance remained at its original 80/20 percent level. It was called a preferred provider organization (PPO). Except for the incentive to see a physician in the network, the PPO retained all of the basic features of the indemnity plan.

Although this appeared to be an inventive introduction of market features, there were several flaws. First, participants are highly motivated by choice and often believe their doctor is the best. And second, was a 10 percent change in coinsurance sufficient incentive to move large numbers of participants to the providers on the preferred list? In many cases the providers were disappointed in the lack of increased volume.<sup>3</sup>

From the sponsor's perspective, while the provider did offer discounts for those participants in the PPO plan, there were no real disincentives to increase the volume of health care resources for each patient. So the risk was that more services, albeit discounted, would be provided and the plan sponsor would wind up paying less per procedure, but more in total.<sup>4</sup> Evidence of this began to appear.

There were virtually no limitations on the referral of a participant to a specialist whose treatments ordinarily cost more. While there were

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2. A substantially large percentage of persons in the United States is covered by PPOs. For an interesting history and review of health care programs in the United States, see *Fundamentals of employee benefits programs*. (2005). Part Three, Health Benefits, Chapter 20, Health Benefits: Overview. Washington, DC: Employee Benefits Research Institute (EBRI).

3. See EBRI (2005), p. 10.

4. Beam, J., & McFadden, J. (2001), pp. 189–220.

some specialists included in the preferred provider network, the participant was largely free to decide when and who to see, even though the condition might have been treated in a more cost-effective way by a family physician.

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## Point-of-Service (POS) Plan—Management of Referrals

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So, the idea was advanced. Why not create a PPO with added control over the utilization of health care resources, and put that control in the hands of a medical provider versus a TPA?<sup>5</sup>

Suppose you have a sore elbow and want to go to an orthopedic surgeon for treatment. Instead, you visit your family physician and she tells you it is not necessary to see a specialist at this time. She recommends regular icing of the elbow, gives you the name of an over-the-counter, anti-inflammatory drug, and tells you to see her again in three weeks. If the symptoms persist, she will refer you to an orthopedic specialist. The objective is to avoid unnecessary additional health care resources and to secure effective treatment of your elbow.

Controlling the utilization of health care resources was the objective of the new point-of-service (POS) plan. The design included unique features that modified the indemnity and the PPO plans by creating a new role for the family physician, or primary care physician (PCP), who became a gatekeeper. Certain financial incentives were offered to the PCP by the TPA to control medical resources by following protocols and controlling the referral to a specialist. This initially involved trying the most conservative approach in responding to a patient's symptoms, followed by an incremental transition to more complex therapies if the need was demonstrated. The PCP, hoping for additional patients under this plan, discounted his fees, but also was offered financial incentives to control the use of medical resources. The PCP was the only person who could refer the patient to a specialist. If the patient chose to bypass the PCP and go directly to a specialist, then either no coverage or less generous coinsurance would result. So, we now had an indemnity plan, but with a network and a gatekeeper.

Next we see a further introduction of market factors. Discounts, expectation of additional volume, financial incentives to the consumer and provider, and additional effort to manage care and costs all represent important elements in the POS design. While this new design achieved some success in curbing health care cost inflation, it was insufficient to significantly impact the spiraling costs generated by the use of health care

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5. Cunningham, R., III, & Cunningham, R. M. (1997), p. 260; EBRI (2005), p. 13.

resources.<sup>6</sup> Also, the administrative costs in establishing the gatekeeper's role offset some of the savings attributable to the reduced utilization of specialists. TPAs and employers began to embrace a plan design that had been legislatively acknowledged by Congress some years earlier. The original intent was to provide every employee covered by an employer-sponsored health care plan the opportunity to participate in an alternative design. It was called a health maintenance organization (HMO).

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## Health Maintenance Organization<sup>7</sup> (HMO)— More Managed Utilization and Care

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In the HMO, choice was no longer an option. Suppose you had a deep cough and wanted to see a doctor. You look at the list of doctors in your employer-sponsored plan, but would rather see a pulmonary specialist who is not on the list. You expect your decision will result in a less generous coinsurance payment, 80/20 percent, instead of the plan's normal 90/10, but are willing to pay the difference. When the pulmonary specialist's bill is submitted, however, the TPA pays nothing. That is how the HMO works. There is no out-of-network reimbursement.

The design concept behind the HMO is straightforward; if you go out of network to a physician not on the list, your treatment is not covered and the TPA will not reimburse your provider. The expectation was HMOs would lead to the creation of highly integrated, multispecialty networks. These units usually offered primary or ambulatory care, as well as a variety of specialists that would effectively control the utilization of health care resources by its participants.<sup>8</sup> The network would have access to a common set of medical records, adding efficiency to the treatment

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6. Beam, J., & McFadden, J. (2001), p. 294. In 2004, 90 percent of Americans with employer-sponsored health care participated in an HMO, PPO, or POS plan. EBRI (2005).

7. See the Federal Health Maintenance Organization Act of 1973, 42 USC §303, which required all plans covered by the Employee Retirement Income Security Act to offer, as an alternative to the prescribed employer-sponsored plan(s), the right of an employee participant to elect an HMO as an alternative. For purposes of this discussion, we focus on group HMOs that involved integrated physician groups from primary care to specialties that could offer a comprehensive set of health care services.

8. The PPO, POS, and HMO designs are commonly called "managed care plans." These plans control the delivery of services, they can involve gatekeeper functions, and they monitor physician decision making. The HMO was the ultimate design in this evolution and still today holds the prospect of providing excellent care at reasonable costs. Cunningham, R., III, & Cunningham, R. M. (1997), p. 259

process, and coordinate referrals to its colleague specialists on a more cost-effective basis. With significant disincentives imposed on those participants who chose providers outside the network, the expectation was there would be a large increase in patient volume for HMO providers. The bargain was modified and discounts and stronger management of health care utilization were afforded to the sponsor in exchange for a higher volume of patients who were given an ultimate incentive to come. They no longer had a choice to go anywhere else. The HMO is an indemnity plan with a network and no option or choice of providers.

TPAs often reimbursed HMO physician groups based on the number of participants they treated, referred to as a capitation basis, creating an opportunity to realize a profit if the capitated fees exceeded the providers' actual expenses. A financial risk existed, however, in the event treatment costs exceeded their per capita fees.<sup>9</sup> The old fee-for-service reimbursement plan was no longer applicable. With capitated fees there was a clear financial risk for inefficient providers. Because of the prospect of increased volume, however, they were more willing to offer deep discounts for their services.

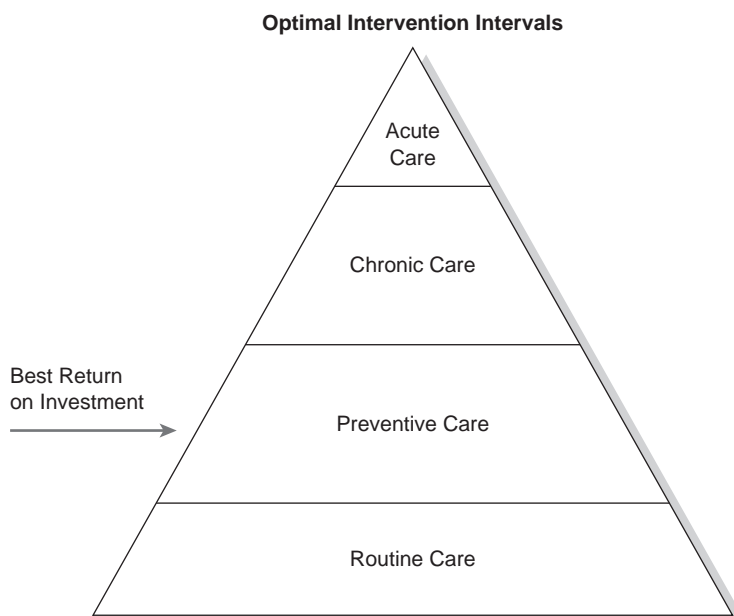
Many aspects of the health care delivery system were controlled or managed in an HMO. In fact, the HMO is the centerpiece of a category of plans, including the PPO and the PPS, referred to as managed care. Primary care and early preventive care were emphasized. There was an interest in avoiding catastrophic and costly health care events among their participants. Less costly outpatient treatment was encouraged and, indeed, facilitated. Treatment protocols were followed by the providers, referrals to specialists were controlled, and prereviews of health care treatments were increased. Practice patterns of physicians were closely monitored. So both care and cost were more intensively managed in an HMO. In order to encourage higher HMO enrollments, employer sponsors, who offered several choices of plans to their employees, provided for lower deductibles, coinsurance, and premiums. In many instances, the coinsurance for an HMO was 100 percent employer paid.

With such a strident interest in cost containment, there was concern that HMOs would create new health care risks; for example, a proliferation of cheap medicine in their networks. This did not happen.<sup>10</sup> HMOs increased the utilization of diagnostic procedures that were designed to

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9. In some cases, individual physicians within a multispecialty, integrated group were paid on a salary basis.

10. According to a recent report by a group that measures quality practices and outcomes and accredits managed care networks, particularly HMOs, the quality of care provided has significantly improved. *Measurement improves health care quality for 70 million Americans*. (2006). National Committee for Quality Insurance, <http://www.ncqa.org>. Additionally, a report by the *Journal of the American Medical Association* (1996, October 2) indicated there were no differences in quality of care between traditional fee-for-service and HMO plans.

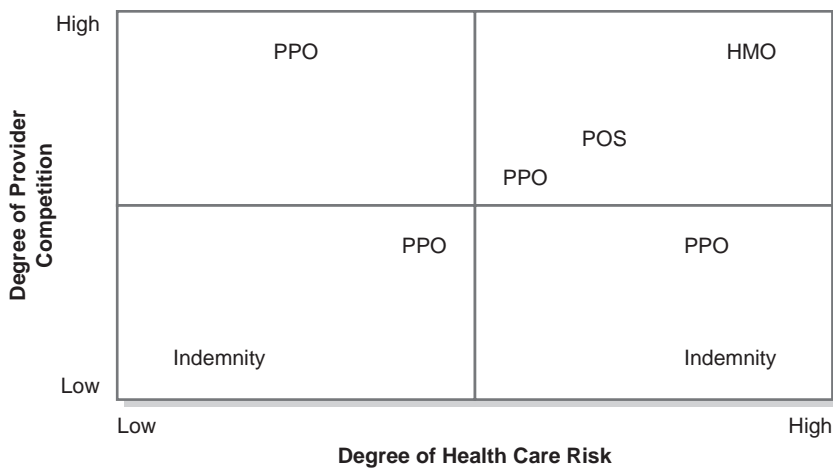


**Figure 7.1** The Hierarchy of Medical Care and the Importance of Preventive Care

identify early symptoms of acute illnesses. Clearly, with a capitated reimbursement scheme, there is a higher financial return on such practice patterns for both sponsor and provider. For the first time, the market incentives for both were congruent. Figure 7.1 makes this point.

During the 1990s when HMO plans were very popular, having achieved success in reducing health care cost inflation and creating the opportunity for more volume, providers agreed with HMOs to significantly reduce their reimbursement levels. Likewise, employers reduced their employee cost sharing design features to encourage additional enrollment. Even Medicare offered HMO alternatives to its participants. HMOs, however, had created an appetite among participants for full coverage with minimal cost sharing. Providers began to consolidate their practices, creating area markets with more leverage to negotiate higher reimbursements.<sup>11</sup> When a market has many providers and is fragmented, the resulting extensive market competition allows TPAs to reduce reimbursement levels. Thus, providers in managed care plans such as HMOs were so competitive they were willing to reduce reimbursement levels to get the business. When markets consolidated, TPAs and employer sponsors lost their bargaining leverage and reimbursement levels in most plans increased. This change

11. Grembowski, D., Cook, K., Patrick, D., & Roussel, A. (2002). Managed care and the U.S. health care system. *Social Science and Medicine*, 54, 1167–1180.



**Figure 7.2** Health Care Market and Appropriate Health Care Plan

caused employers either to lose interest and discontinue their HMO or to move to higher cost sharing with the participants.<sup>12</sup> They could no longer afford 100 percent coinsurance, low premiums, and no deductibles as an incentive for their employees to join the HMO. When the incentives began to dissipate, employees were less willing to give up their right to choose providers by participating in an HMO.

Figure 7.2 shows how the degree of competition in a given geographic area will control the suitability of certain types of health care plans. HMOs can exist only where there is strong competition and a high incidence (risk) of medically complex health care. Where there is little competition and low risk care, discounts and managed care efforts are unlikely to be attractive to providers. Consequently, the indemnity model is more suitable.

HMOs also created the need for significant administrative activity by TPAs, further raising the costs of such plans to employers. These factors, combined with some negative anecdotal publicity concerning the controlled utilization of health care resources by HMOs, caused them to lose their competitive advantage. Though a decline in HMO enrollment followed, they still exist today.<sup>13</sup> Employer sponsors began to gravitate back

12. Enrollment in HMOs declined in 60 percent of the United States from 2004 to 2005. Walker, T. (2006, August 1). Top 20 states by HMO enrollment. *Managed Healthcare Executive*, <http://www.managedhealthcareexecutive.com/>.

13. It is universally agreed that HMOs offered too much to participants; the financial incentives to enroll were too generous. Cost sharing between the sponsor and the participant were largely out of balance and the cost of offering the plans became unacceptable to plan sponsors. Generally speaking, however, HMOs were accepted by participants, and surveys showed high degrees of customer satisfaction.

to more simple forms of plan designs such as the PPO. Reducing the cost of administration seemed to be a more prudent course.

During this evolution, we see economic incentives being introduced in order to affect behaviors, reduce costs, and achieve quality health care for employees. Despite HMOs' success in achieving these results,<sup>14</sup> new approaches continued to evolve as employers searched for more cost-effective designs. Perhaps the problem was the TPA. Why not simply contract directly with the providers?

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## Direct Contracting and Capitation<sup>15</sup>

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Except to a certain extent in the case of HMOs, one of the troubling design elements of the previous cadre of health care plans is that providers are reimbursed for all services rendered. There is no financial or performance-based risk placed on them. Do the work and you will get paid. With managed care there is the network creation, fee negotiation, claims processing, and efforts to control care, all of which generate a lot of administrative expense.

To address these problems, a new concept was tested. Why not eliminate the traditional role of the TPA and allow the employer sponsor of the plan to contract directly with the providers?<sup>16</sup> This would have the effect of eliminating the excessive administrative costs of traditional plans. Moreover, if the providers would accept a per capita annual fee from the

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14. During the period 1985–1993, hospitals in areas with high concentrations of HMOs had a 3 percent lower inflation rate than hospitals in low penetration areas. Estimates of the cumulative impact of HMOs on hospital inflation alone during this period was \$56.2 billion. See Gaskin, D., & Hadley, J. (1997). *The impact of HMO penetration on the rate of hospital cost and inflation, 1985–93*. Washington, DC: Institute for Health Care Research and Policy, Georgetown University Medical Center.

15. Although we discuss this alternative design in the context of modern employer-sponsored plans, capitation and direct contract between employers and providers were included in the initial health plan designs offered by employers in the 1930s. See Cunningham (1999), p. 35.

16. Several large companies like Purdue Farms, Inc., Caterpillar, Inc., and Cisco Systems, Inc. have eliminated the TPA and instituted direct contracting with their own networks of providers. Wessel, D., Wysocki, B., & Martinez, B. (2006, December 29). As healthy middlemen thrive, employers try to tame them. *The Wall Street Journal*, A1. Also see Terry, K. (2002, March 8). Cut out the insurance middleman? *Medical Economics*, <http://www.medicaleconomics.modernmedicine.com/>.



employer that would cover all the participants' health care services, the financial risk could be shifted from the employers to the providers. Naturally, the providers also would have the opportunity to achieve a good return should revenue from the capitated fees exceed the costs of the services rendered.

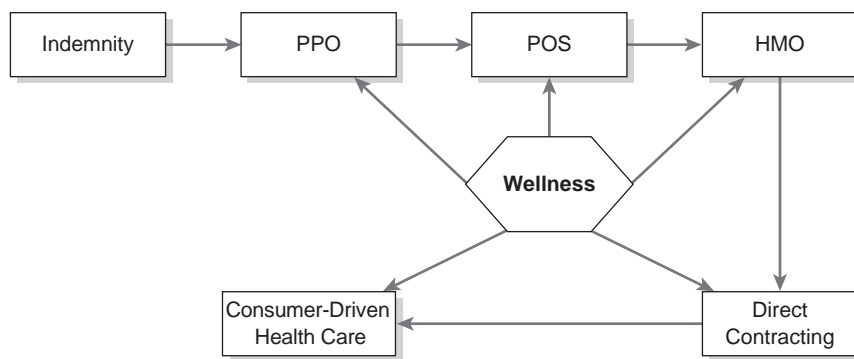
Except for some type of accounting audits, the administrative costs would be minimal. A simple and straightforward approach—participants receive treatment and there are no claim forms, reimbursement squabbles, or prereviews. Treatment becomes the sole business of the providers. Demographic information, actuarial and underwriting analyses, and periodic reviews of financial and clinical performances would have to be undertaken, but the comparative administrative costs would be less than the indemnity, PPO, HMO, and other TPA-administered health plans.

The provider has an incentive to improve efficiency and quality of medical services, since better and more efficient treatments will create a surplus of revenue. We see a more direct market relationship between the payer of the services and the provider. The employer can decide which providers to use based on some evidence of quality practice, accessibility, or other factors. Yet, the consumer of the services remains above the fray and is not directly involved in paying or contracting for the medical services.

Direct contracting did not draw a significant number of providers or employers. The providers were fearful of the financial risks, and the employers were reluctant to select and deal directly with providers. Hence, the design is hardly used in the employer-sponsored market.<sup>17</sup> Nevertheless, the concept and its components are worth noting as we continue to examine the evolution and search for new health care plan designs. Placing health care in a true market context was the continued goal. Before going further, let's review our health care evolution. Figure 7.3 takes us through the health care plan evolution from indemnity plan right up to the latest designs: consumer-driven health care and wellness programs.

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17. Capitation is often used by HMOs in the United States and in some European countries that sponsor single-payer, national health systems. In Europe it is used to create global budgets for health care delivery systems and hospitals. Additionally, in the 1980s Medicare began using a Prospective Payment System (PPS) to compensate hospitals. The payment is essentially a per capita fee for treating patients with a given illness, regardless of the actual utilization of health care resources. The PPS was found to have no adverse impact on the quality of care. Draper, D., & Kahn, K. L. (1990). Studying the effects of the DRG-based PPS on quality of care, design, sampling, and fieldwork. *Journal of the American Medical Association*, 264(15), 1956–1961.



**Figure 7.3** The Evolution of Health Care Plans

## Consumer-Driven Health Care

We have seen a variety of plans that have included the basic indemnity plan features. The evolution advanced the idea that, by introducing market factors, plans would be more cost-effective. But with each iteration, the employee participant—the consumer—remained largely a passive recipient of services. He had no particular market role. This was considered by many to undermine any effort to introduce effective market incentives that would lead to higher quality, more cost-effective health care in the United States. The saying went, “If the consumer had skin in the game, we would see different behaviors and more equilibrium.” Of course, the consumer did participate indirectly by paying premiums and point-of-service fees, but the employer sponsor and the TPA were the key financial and administrative participants in the plans. The consumer’s impact was not apparent.

The first effort to increase the role of the consumer was the flexible spending account (FSA).<sup>18</sup> Here the participant could deposit, on a pretax basis, a fixed amount of compensation that would go toward paying annual health care expenses. The amount was in the range of \$2,000 to \$3,000, and had to be spent within the calendar year or it was forfeited back to the employer. Using pretax money to pay for health care expenses represented some financial advantage to the participant. Provided the money was used on health care (not including premiums), the participant made the final decision on how and where the money would be spent. There was something for the employer as well. By facilitating the

18. For a comprehensive and helpful source of information on FSAs, see <http://www.fsafeds.com/>. The publication tracks the IRC and the IRS regulations on FSAs.

establishment of FSAs, the employer did not have to pay Social Security or Medicare taxes on income placed in the employee's account. Though still popular, since the plan was basically a tax incentive and included the "use it or lose it" feature, the FSA was not considered to have a major impact on health care costs or participant behaviors. After all, it was called a *spending*, not a *savings*, account, and it did just that.

In order to replicate truer market conditions, the participant had to have access to a larger account for health care spending, the choice on how and when to spend it, and the opportunity to carry it over if it was not consumed in a given year. It was argued that putting the consumer in charge would cure the problem of inefficiency and high inflation in our employer-sponsored system. The solution was for the IRS to allow the funding of a spending account with pretax income, to permit it to be carried over into subsequent years if not spent, and require that it be used solely for medical expenses. But who would fund this account?

There were several different approaches. First, Congress authorized certain smaller employers to pilot a medical savings account (MSA) plan that would allow for a large deductible in a traditional medical plan.<sup>19</sup> On a pre-tax basis, the consumer employee would defer compensation equaling the deductible into an account used to pay medical bills. He would then use his deductible amount in the MSA to pay expenses as they were incurred. After the deductible amount was exhausted, the traditional indemnity or PPO plan would kick in to reimburse providers. When paying for health care expenses still within the deductible period, the employee would pay only the reimbursement amount authorized by the TPA under the relevant health care plan. Unspent amounts in the deductible would carryover into the following year. Congress limited the use and availability of the MSA and decided to wait and see if the employee's health spending behaviors changed. More specifically, Congress wanted to determine if the new consumer in the MSA used more informed discretion in the utilization of health care resources, and if the cost of health care decreased without affecting quality.

While the MSA was being tested, some employers adopted a slightly different plan design, the health reimbursement account (HRA).<sup>20</sup> Here the employer funds the spending account for his employees. The account is treated like a large deductible that could be used by the participant for the reimbursement of providers. No employee participant dollars can be contributed to the account. The participant can carry over any unspent funds each year. The expectation was the employee would behave like an

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19. Formally called the Archer Medical Spending Account, it was authorized by the IRC. For a clear and excellent description of the MSA, see *Health savings accounts and other tax-favored health plans*. (2007). Internal Revenue Service, Publication No. 969.

20. *Health savings accounts and other tax-favored health plans*. (2007). Internal Revenue Service.

informed consumer and use health care resources more judiciously. The funding of the HRA by the employer does not constitute taxable income to the employee provided the monies are used for health care expenses.<sup>21</sup>

There are advantages and disadvantages to the employer who adopts an HRA. If the employer uses an insured instead of a self-insured plan, he can reduce his overall premiums because the plan design includes a large deductible and the TPA's projected risk of paying large health expenses is mitigated. In such instances, the employer is obligated only to fund the HRA as actual deductible expenses occur. The disadvantage to the employer using an HRA, however, is that it could have the effect of increasing expenses because he has assumed the liability to pay the deductible. Although the employee could carry over unspent funds to the following year, it was not his money.

For employers who sponsor a self-insured plan, the HRA seems like a less favorable step because they would not be taking advantage of lower premiums. And if an employer chooses to fund an HRA regardless of whether the employee incurs health care expenses, it would seem to be an even less attractive plan. Some employees have little or no medical expenses in a year, while others are just the opposite. Hence, if the employer sponsor funds the HRA for all his employees, he is significantly increasing his benefit expenses. What was really needed in the evolution of plan designs was a cost-effective design that triggered constructive and positive consumer behaviors among its participants. The most likely plan design to achieve this is one with high deductibles, where the employee spends his own money but has the opportunity to save his account for future health care needs.

That brings us to the latest iteration of the consumer-directed health care model, the high-deductible health care plan (HDHCP) with a health savings account (HSA).<sup>22</sup> This is simply a legislatively authorized plan that involves pretax funding of an account by the employee and, in some cases, the employer. For calendar year 2008, the amount of the account could not exceed an annual contribution of \$2,900 (single) or \$5,800 (family).<sup>23</sup> For participants over age 55, there is an allowable catch-up, with an additional contribution of \$900 in 2008 and indexed to a cap of \$1,000.

The HSA is a HDHCP typically linked with a PPO. The minimum deductible amount currently ranges from \$1,100 (single) to \$2,200

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21. *Health savings accounts and other tax-favored health plans.* (2007). Internal Revenue Service.

22. *Health savings accounts and other tax-favored health plans.* (2007). Internal Revenue Service. During the course of our discussion we will refer to this type of plan as an HSA or an HDHCP or "Consumer-Driven Health Care." They have identical meanings are used interchangeably in the practice.

23. *Health savings accounts and other tax-favored health plans.* (2007). Internal Revenue Service.

**Table 7.1** The Added Expense for a Funded HRA

<i>HRA Contribution of \$1,000</i>	<i>Annual Health Care Expenses of Company Before HRA</i>	<i>Annual Health Care Expenses of Company With HRA</i>
<b>Employee A (healthy)</b>	\$0	\$1,000
<b>Employee B (unhealthy)</b>	\$1,500	\$1,000
<b>Total Health Care Expenses</b>	\$1,500	\$2,000

NOTE: The assumption here is that the health care expenses are covered by the HRA account. There would, of course, be additional reimbursements by the health care plan after the deductible was exhausted. This table simply questions whether a company should prefund an HRA, as some do before any expenses are incurred. If so, total expenses will rise, because they are funding an account for a person who has no or very little health care plan utilization.

(family), up to a maximum of \$5,500 (single), \$11,000 (family).<sup>24</sup> The money in this account can be withdrawn on a tax-free basis provided it is spent on eligible health care expenses. Any earnings on the HSA are tax deferred, and if spent properly, they are tax-free.

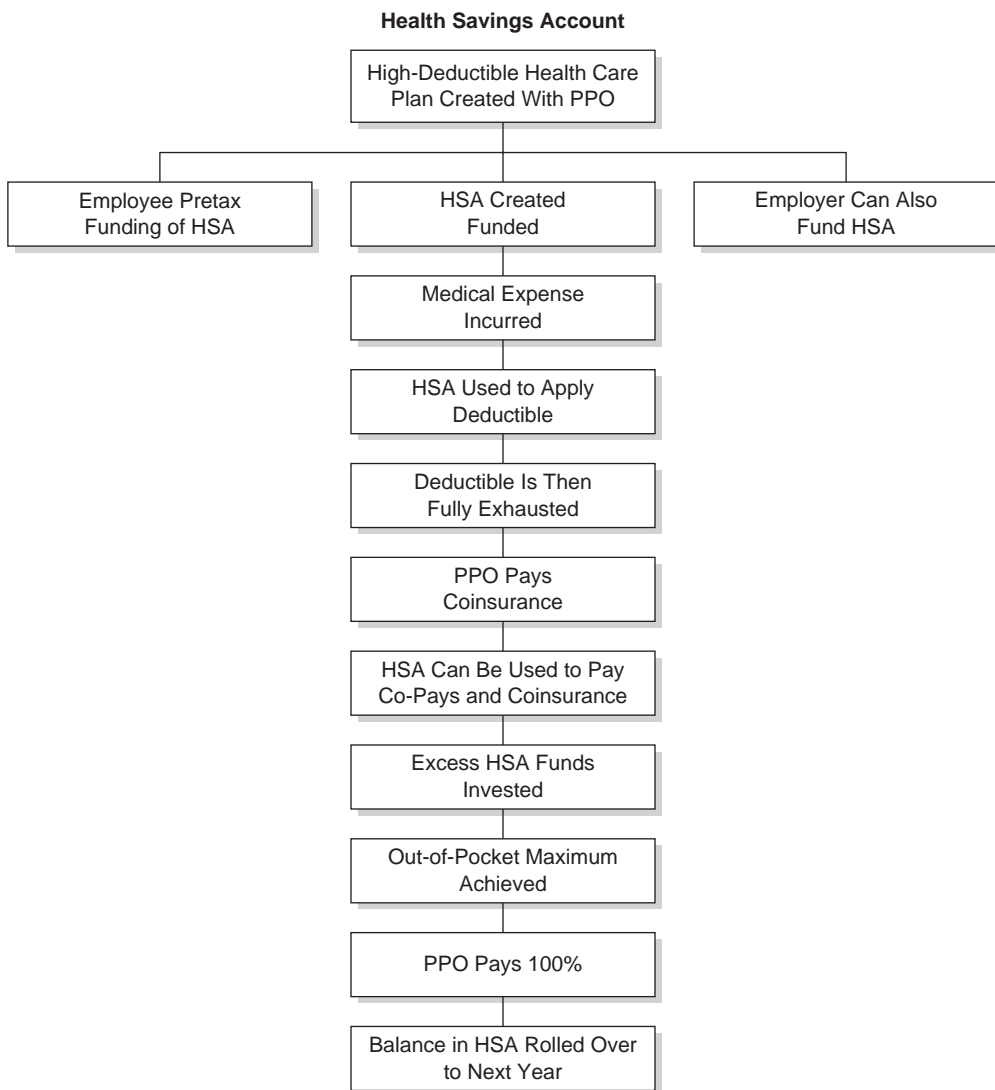
After the annual deductible is exhausted, the plan's PPO will begin to reimburse the employee's providers applying all the traditional plan features including coinsurance. For example, the employee pays the plan premium, office co-pays, and his share of the coinsurance, say 20 percent. The sponsor would pay 80 percent. Once the out-of-pocket maximum is met, the sponsor would pay a coinsurance of 100 percent.

The employee can carryover unspent funds up to retirement age, when the money can be used to pay for retiree health care premiums. There is no "use it or lose it" requirement. An HSA encourages saving, not spending, and it is portable.

The underlying design concept is to cause the employee to behave like a consumer, making decisions about when and where to utilize health care resources. He now has skin in the game. There is also a strong incentive to save the dollars in the HSA and build a large reserve for later.

Since there are tax advantages, the IRS restricts the type of health care expenses that can be paid using the account. For example, one cannot use the HSA to pay premiums for health insurance unless the person is unemployed. The funds can be used, however, to pay for retiree health care, Medicare premiums, and long-term care. In order to encourage preventive and diagnostic care, HDHCPs are permitted to exclude certain preventive care practices from the deductible expenses. These exceptions can

24. The maximum also includes other eligible out-of-pocket expenses. The out-of-pocket maximum for these plans is the same.



**Figure 7.4** The Basic Process and Flow of a Health Savings Account (HSA)

include annual physicals, certain blood work, colonoscopies, and mammograms, all of which are designed to detect a serious condition early and prevent the employee from encountering serious or catastrophic conditions later. Employer sponsors, however, are not permitted to unbundle certain elements of their health care plan, such as prescription care, in order to exclude drug expenses from the deductible.

Employers offering HSAs usually ascribe a lower premium as an incentive for employees to choose what is considered a more cost-effective plan. Most large employers offer their employees a choice of either an HMO, a lower deductible PPO, or an HSA. Typically, the HSA will have the lowest

premium. There are some other points to consider about HSAs and the whole consumer-driven health care program.

- First, from an economic standpoint, each \$1 spent out of the HSA goes to pay the provider. There are no administrative or TPA fees.
- The high deductible provides an immediate lowering of the employer sponsor's costs because they are shifted to the employee. Since the employer sponsoring an HSA can expect about a 20 to 25 percent reduction in health care claims costs, most employers offer lower monthly premiums to those who enroll. Also, no FICA taxes are paid on contributions to the HSA.
- The tax-free status of the contribution, as well as the opportunity to invest the funds without tax, represents a real value to the employee.
- It remains to be seen how many employees will enroll in these plans when they have a choice of more traditional plans to choose from, and to what extent participants under such plans will behave like real consumers.

Let's go back to our friend in Chapter 6 who had the herniated disk. With a large deductible and a funded HSA, a portion of the charges for the back treatment would be paid by the participant. Would he behave differently than our compliant character in the vignette? Let's review.

Perhaps with his own HSA, our friend might be inclined to ask whether there were some other, less expensive tests to assess the nature of his back problem. Perhaps a simple neurological exam would provide a less definitive, but probably more accurate, determination. He also might ask if there was a chance the pain and loss of sensation in his leg might resolve itself with some exercises or conditioning. Perhaps he would be told that some core body exercises, physical therapy, and weight loss could help stabilize the spine and mitigate his condition. Or maybe an over-the-counter, anti-inflammatory drug would reduce the swelling in his protruding disk and relieve the pressure on the nerve that runs down his leg contributing to his pain and numbness. He might also want to find out more from the spine surgeon. What are his prices, how many back surgeries has he completed, and with what results? What exactly should he expect in recovery? He would conduct the same research on the hospital and, instead of reviewing hotel-like conditions, find out its record on spine surgery, postsurgery infections, and costs. Finally, he probably would ask the spine surgeon if there are less invasive treatments that might be tried before surgery. If he did, he probably would find out that an injection of steroids could help. This would be cheaper and involve no time off from work, and certainly would be worth a try.

Obviously, in order for the HSA to be effective in terms of encouraging quality care, more judicious utilization of health care resources, and reduced costs, the consumer must take charge of his care. There are some concerns.



How does the average health care consumer access reliable information about the propriety or efficacy of certain health care treatments? Can he get access to best practices? Can he position himself to ask the right questions about alternative medical treatments or the skill and performance levels of the providers? With the advent of the Internet, WebMD, and Google, one can find a lot of information about health care conditions, providers, and treatments. This should not necessarily serve as a means to second-guess the medical provider, but it can put the participant in the position to ask relevant questions that can lead to more informed decision making.<sup>25</sup>

Since there is a correlation between education, economic status, and health status, it is more likely that younger and healthier participants and those at higher income levels will enroll in an HSA, as opposed to others who have higher health care risks.<sup>26</sup> Will this type of plan really have a significant impact on the cost of health care, or will it simply distort the risk pool by causing healthy persons to move to the HSA, leaving the higher risk, lower income participants in other health plans? If this does occur, the premiums for the other plans could increase dramatically, leading to an eventual forced migration of employees into an HSA. Of course, this would reduce employee choice, but it probably also would reduce overall employer costs.

There are more issues. Will deductibles be spent on routine versus chronic, severe, or acute health care needs? This might happen because the employee would be more informed about routine care as opposed to more serious conditions. If this is the case, will the employer's savings be confined to reducing the utilization of less serious health care conditions that are not as costly? Will the consumer participant ignore treatment of health care conditions that could become chronic or acute?<sup>27</sup>

With early detection, a potentially deadly medical condition that can go unnoticed until it becomes severe or acute can be reversed or cured. As more health care plans exempt preventive care diagnostics and treatments from the deductible, these early detections will become even more prevalent, saving lives and, ultimately, reducing health care expenses. From an administrative expense standpoint, since the patient with an HSA is

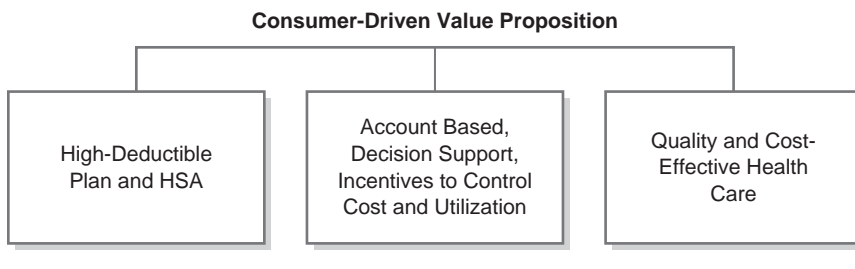
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25. See Condon, K. (2006, July). The financial case for integrating direct advice programs into consumer-directed health plans. *Employee Benefit News*, <http://www.benefitnews.com/>. The author discusses the daunting medical education challenge among prospective enrollees in a consumer-driven plan and urges employers to offer direct advice to their employees.

26. *Consumer-directed health care plans—Early enrollment experience with health savings account and eligible health plans*. (2006, August). General Accountability Office (GAO – 06-798).

27. Some argue that HSAs have a positive impact on the choice of treatments and early interventions among the chronically ill. *HSAs and the chronically ill*. (2006, July). Council for Affordable Health Insurance, No. 136, <http://www.cahi.org/>.





**Figure 7.5** The Basic Value Proposition and Workflow of the HSA

responsible for keeping track of his expenses, the role of the employer sponsor in substantiating health care claims becomes extinct. If there is an IRS audit, the employee patient must verify how his HSA account was used to pay for health care expenses, further reducing the time and expense related to plan administration.

Will lower premiums and the opportunity to build one's account be sufficient incentives to attract large numbers of employees into HSA plans? Thus far, the enrollment in HSAs by employees in the United States has been quite small, about 3 percent.<sup>28</sup> Will employers move to reduce the number of health care plan choices and try to nudge more employees into the HSA?

What we see with HSAs at a significantly higher level than we saw with other plan designs is a combination of tax and financial incentives, consumer engagement, and the need for quality information about products and services. Employer sponsors of HSAs, however, need to provide guidance and support as employees navigate their way through the Web and other sources to become more informed about their health care issues. Also, it remains to be seen what impact HSAs will really have on health care inflation and quality. Perhaps it is enough that the HSA allows the consumer to know what the health procedure costs.<sup>29</sup> That may just stir enough inquisitiveness by the employee patient to start down the road for more information, and that is a big first step.

As we have pointed out, a big issue with respect to HSAs is how will the accounts be spent, and will they change the behavior of patients to seek less costly but good quality care. There is a new player in the health care scene

28. National enrollment in HSAs is still relatively small. Many employers, however, are indicating a keen interest in introducing them. Some have experienced major increases in enrollment as employer contributions to the HSA increased. (Interview of Michael Stoll, Vice President of Benefits, The Kroger Co., April 2008.)

29. Jenkins, H. (2006, September 20). No, consumer theory isn't a cure-all for health care. *The Wall Street Journal*, A27. Also see Albeson, R., & Freudenheim, M. (2006, November 4). Rolling the health care dice. *The New York Times*, <http://www.nytimes.com/2006/11/04/business>.

that might be relevant to this question: the “Mini Clinic.”<sup>30</sup> It is gaining momentum and might be a good fit for an HSA participant. The Mini Clinic’s business plan is to reduce wait time and costs for an appointment with a medical provider and to create a retail approach to consumer health care. They can be found in shopping malls and pharmacies. Many are going into Wal-Mart. Visits cost about \$50–\$60, prescriptions can be filled next door, and Medicare and many insurance companies are now covering these expenses. Patients sign in, are given a beeper, and return when called. Most often they are staffed by nurse practitioners. More complex conditions are referred to a doctor. Clinics are striving for uniform standards to overcome the patients’ desire to see their familiar doctors. They just may be the answer to offering more cost-effective care, particularly as it relates to the low end of the acuity level. With HSAs we see another example of the relevance of the benefits model. The employer is introducing market features, particularly incentives, to positively influence the behavior of his employee participants. What are some other issues an employer must deal with in selecting a particular health care plan?

## Choice of Plans—What Should the Employer Sponsor Offer?

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### *GENERAL CONSIDERATIONS*

Many, if not most, employer sponsors of health care plans offer several types of plan designs to their employees. The underwriting and pricing of the various plans are designed to have an impact on their respective enrollments. Demographics of the workforce, health care expenses of the employee group, and the health care market where the employer does business will affect the types of plan choices offered. Also, deductibles, office co-pays, and coinsurance will vary within an assortment of plan offerings, and each will have different premiums the employee must pay. One can easily ascertain the employer’s overall evaluation of his plans by looking at plan premiums. By selecting different premiums for different plans, the employer attempts to lead the employees to select what he considers to be his most cost-effective plan.

As we have seen, the health care market where the employer operates may have an impact on the type of plan chosen. The degree of competition and complexity of health care risks will determine whether it is appropriate for a simple indemnity plan or a managed care approach. A consumer-driven plan is probably best augmented by a PPO or POS plan because the employee has incentives to search the market for good treatment opportunities.

There are some additional issues an employer sponsor must address. Should he consider taking steps to encourage healthier lifestyles among his

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30. McClinics. (2007, April 14). *The Economist*, 78–79.

employees? Should he offer health care to his retirees? Will his plan be insured or self-insured? How does he go about selecting a TPA?

### *EMPLOYER-SPONSORED WELLNESS PROGRAMS*

Wellness programs are designed to impact long-term health positively. They increase the opportunities for preventive health care by using health care assessments and changes in lifestyle. They create incentives to initiate and maintain good health habits and consistent treatment of chronic conditions. They often are included as part of a health care plan administered by a TPA or can be a supplemental plan initiated and managed by the sponsoring employer.

In general, there is a sequence of events that should occur as a wellness program is designed and implemented. First, the employer should assess what health conditions are leading to the highest utilization of health care resources and expenses among his workers. For example, let's say the employer and his TPA examine his health care claims and learn that cardiovascular and low back problems, as well as chronic diabetes and asthma conditions, are generating 80 percent of the claims costs.

Next, the employer will want to make some assessment among his workers, usually by a survey, to determine what potential lifestyles or behaviors might be driving these conditions. For example, he may find there are a number of workers who smoke or fail to take their blood pressure medicine on a regular basis; there may be others who are obese or physically unfit, who have extremely unhealthy diets or are not managing their diabetes or asthma conditions, or are simply failing to follow orthopedic guidelines on lifting or are not following through with physical therapy for their low back problems.

This step might be followed by some independent screenings by the TPA to further assess hypertensive conditions, body mass indices, tobacco use, the extent of diabetic and asthmatic conditions, and stenosis of the spine, as well as other diagnostic steps.

The employer and his TPA should consider how best to address these ailments and whether expanding the use of diagnostic and treatment provisions in the employer-sponsored health care plans would be helpful.<sup>31</sup> Are the right incentives included to encourage early medical

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31. For example, screenings and diagnostic procedures typically include colonoscopies to detect colorectal cancer for participants over a certain age or with certain medical histories, diabetes screenings and aggressive management of this chronic and often acute disease, PSA blood tests and other related tests to provide for the early detection of prostate cancer in men, mammograms to detect breast cancer in women, cholesterol and hypertension screening and control programs, asthma and other pulmonary disease management programs, and pap tests to detect cervical cancer in women.

diagnoses and treatments? Are the physicians in the network able and willing to secure better compliance with their patients to follow the treatment regimens prescribed? They should closely identify the key risk factors leading to the health care problems. For example, smoking does lead to heart problems and stroke. What can be done to cause employees to cease smoking? Obesity does lead to diabetes, cardiovascular, and orthopedic problems. Can the employer do something to control the waistlines of his employees? Better diet can reduce fat and cholesterol and curb cardiovascular and a variety of other conditions. What can be done here?

Now the employer and his TPA should develop a series of incentives and programs that, ultimately, could change the behaviors leading to poor health. For example, the employer could offer cash contributions to an employee's FSA if he successfully completed a smoking cessation program and quit smoking.<sup>32</sup> Alternatively, the employer could introduce higher cost sharing in the health care plan for those who continue to smoke. Similar approaches could be taken with regard to compliance with treatment regimens, chronic disease management, and obesity. Some believe the carrot is a better incentive than the stick, but both can work.<sup>33</sup> And the U.S. Labor Department has issued guidelines on wellness incentives, including penalties, that do permit both approaches with some limitations.<sup>34</sup> Whatever the choice, the wellness initiative should include communications and informative materials that can be easily accessed by workers to support their changes in behavior. It is important that wellness initiatives reward results, not activities.

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32. The Cincinnati Employers' Health Care Alliance surveyed 300 employers and found that some have initiated surcharges and many others are giving the idea serious consideration (May 2006).

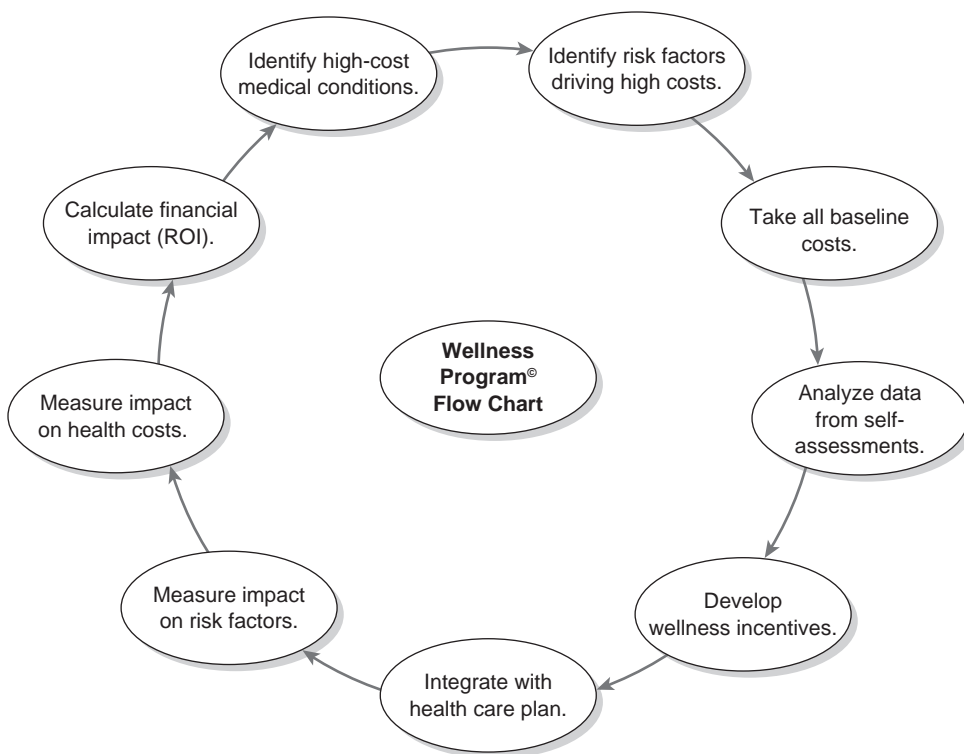
33. For example, an employee enrolled in a wellness program could be assessed to have excess body weight, calculated as body mass index (BMI). The employee would be advised of the health risks inherent in such a condition, and given targeted BMI reduction goals as well as a specific diet and exercise program to achieve results. As the BMI is monitored and shows measured progress, financial credits would be contributed by the employer to the employee's FSA. These contributions can be used by the employee to pay for out-of-pocket medical expenses incurred during the year. The administration of such plans can involve medical professionals who monitor compliance and progress. It is important that the employer makes sure there will be a financial return on his investment in wellness programs.

34. See the U.S. Department of Labor Guidelines on HIPAA and Wellness Programs at <http://www.dol.gov/ebsa/>. The specific conditions are that the reward cannot be more than 20 percent of the total cost of coverage, it must promote health or prevent disease, must be available to all in the plan, and alternatives must be available to those who cannot meet the standard. Some states specifically prohibit premium surcharges under their health insurance laws.

The employer should take baseline measures of his claims occurrences, costs, the extent of the targeted conditions, and the specific risk factors and behaviors that are driving up his expenses. For example, how many workers smoke, how many are overweight, and what is the extent of non-compliance with treatments. He should also determine reasonable goals for each of these measured items, as well as a hypothetical financial return (less the fully loaded accounting costs of the wellness program) should the goals be achieved. The employer should not ignore productivity losses and potential gains attributable to the targeted problems.

Once the program is underway, good controls and interim reviews should be undertaken to identify any barriers or problems that are interfering with its progress. When certain timetables are reached, measurements of the risk factors, targeted behaviors, related health care utilization and expenses, and changes in health care conditions should be taken and compared to the baselines to see what, if anything, has been achieved. The financial implications of these results should be calculated in the format of a return on investment or other appropriate metric.

There are several important considerations in designing a wellness program. First, participation must yield measurable results. The employer should avoid rewarding participants for mere activities. Simply joining



**Figure 7.6** The Basic Step-by-Step Process of Implementing a Wellness Program That Is Designed to Affect the Drivers of High Health Care Costs

a fitness center does not warrant a financial reward. Specific health or physiological-related goals for all wellness participants should be the key to reward.

Next, a wellness program should be an initiative among employers whose human resources strategy encourages long service. Though changes in risk factors may occur in a relatively short period, the overall improvement in health status and lowering of health care claims and costs may take years.

In general, a wellness program has the potential to improve the health and productivity of workers and to reduce the level of health care utilization and claims costs.<sup>35</sup> Most programs focus on changing risk factors and underlying lifestyles and behaviors. Employers should not ignore the idea of integrating a wellness approach into their health plans. A program that broadens health assessments, screenings, diagnostics, treatment, and compliance efforts can have a major impact on enhancing the overall health of the workforce and reducing health care costs.

### RETIREE HEALTH CARE

Another health care program employers may consider offering is retiree health care. There are two approaches: (1) a plan designed to provide full benefits during the period when the employee is eligible to retire under the employer's retirement plan, at age 55 or 60, but too young to qualify for Medicare, which typically occurs at age 65; and (2) a Medicare supplemental health care plan designed to reimburse expenses not paid by Medicare. In many companies employers offer both plans to their retirees.

As with other benefits, there is no legal obligation on the part of the employer to offer this. Moreover, unlike retirement benefits provided by a defined benefit plan, the employer sponsor is not obligated to prefund retiree health care and, with some exceptions,<sup>36</sup> can discontinue the

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35. See Loeppke, R., & Hymel, M. (May 2006). Good health is good business. *Journal of Occupational and Employment Medicine*, 48(5), 533–537. This study showed that absenteeism and low productivity generated more costs than health care claims.

36. ERISA provides no such obligation and the courts have basically held that when an employer's benefit summary plan description clearly states that the company reserves the right to modify and cancel its retiree health care plan for current retiree participants, the company may cancel the plan and further decline to offer it to future retirees. There is currently a conflict among U.S. circuit courts as to how and when an employer subject to a collective bargaining agreement may modify or cancel retiree health care. See *Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006). Also, the law seems to be well settled that coordinating Medicare and employer-sponsored retiree health care does not violate the Age Discrimination in Employment Act. Equal Employment Opportunity Commission, 29 CFR 1625 and 1627 (2004).

benefit to newly retired persons, and cancel existing retiree health care plans for those who retired when the benefit was offered. Current accounting rules, however, do require the employer to show his retiree health care liability on his financial statements.

Why would the employer sponsor even bother to offer either type of retiree health care? Once again, the reason is in order to remain competitive in its labor market and to enhance recruitment and retention. Also such a plan generally encourages loyalty and longer service among the workforce. By offering retiree health care, the employer actually facilitates retirement at age 55, or at whatever age the pension plan allows. Without retiree health care, many employees would remain employed until they qualify for Medicare.<sup>37</sup> Employers believe that early retirement opens career opportunities for younger employees who otherwise might be compelled to wait longer for promotions. If the wait is too long, they may leave the firm. Also, early retirement offers the employer the opportunity to replace higher paid workers with lower paid ones, thereby enhancing productivity. So it serves a number of purposes. But there is often a heavy financial burden associated with sponsoring retiree health care. This has caused many to discontinue offering the benefit.

Those employers who do continue to offer retiree health care have changed their plan designs to deal with the higher health care costs associated with an older workforce and increasing life expectancies. When they leave the firm and participate in a separate retiree health care plan, the costs of this plan are based on a higher utilization of health care resources. They are no longer subsidized by premiums paid by the younger workforce who uses less health care resources. The resultant higher costs<sup>38</sup> are passed on to the retirees in the form of new plan designs that require cost sharing in the form of higher out-of-pocket payments and premiums.<sup>39</sup> This is especially true for prescription care plans that may be part of the retiree health care package.

Increasing numbers of employers are shifting many of the costs to the retirees or discontinuing their plans altogether.<sup>40</sup> The message being sent

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37. When the retiree becomes eligible for Medicare, his dependent can continue in the employer-sponsored retiree health care plan until he becomes eligible for Medicare.

38. From an economics standpoint, there are no higher costs. The employer incurs the same amount of costs with the retirees in an active plan as he would when they are in a retiree plan. It is simply a different allocation.

39. See Chaikind, H. (2006, March 28). *Health insurance coverage for retirees*. Congressional Research Service, The Library of Congress.

40. Chaikind, H. (2006). It should be noted there are a number of legislative initiatives in the United States that would extend Medicare coverage, for example, to those retiring between the ages of 55 and 65, or would prohibit employers from changing their previously offered retiree health care for those who have retired.



is if you want to retire before you are eligible for Medicare, you either will have to find a position that offers health care or buy your own. In the latter case, the cost to the retiree can become excessive. In the former, if the employer terminates retiree health care, the retired employee will have to procure and pay for some type of plan to supplement the reimbursement gaps of Medicare.<sup>41</sup> Now that the newly adopted Medicare Part D includes reimbursements for some government prescription care, the need for employer-sponsored supplemental insurance may be less compelling.

### *FACTORS AFFECTING THE COST OF THE EMPLOYER-SPONSORED PLAN*

Whether a plan is insured or self-insured, the prevailing concern of employer sponsors is health care inflation.<sup>42</sup> The employer must closely examine the basic cost elements of health care: administrative fees for the TPA, past health care claims, and added risk premiums and pooling charges for insured plans that predict the number of claims for the coming year. Then he can take a number of steps to control his expenses, including:

- Negotiate an acceptable administrative fee and performance contract with his TPA
- Get more aggressive discounts for services from his health care providers
- Impact the utilization of health care resources by including various types of behavioral controls in the plan design
- Shift more costs to participate by changing the coinsurance, deductibles, and out-of-pocket maximums
- Direct the focus of employees to the most cost-efficient plan by charging lower premiums or deductibles

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(See HR 2072 and HR 1322.) See also Mincer, J. (2006, July 5). Health care costs to hit workers, retirees harder. *The Wall Street Journal*, D3. According to Mincer, the vast majority of employers surveyed by two large benefits consulting firms are planning to curtail medical plans for current and future retirees. In fact, according to the report by Mincer, 14 percent of the surveyed companies plan to eliminate retiree health care for future retirees and 6 percent plan to eliminate it for retirees over 65 years of age.

41. This is commonly called Medigap insurance and can be purchased individually by the retiree.

42. For a discussion of the magnitude and purported causes of this inflation, see Herrick, D. (2006) and Bodenheimer, T. (2005).



The most difficult aspect of cost containment relates to utilization. How can an employer and his TPA control inpatient and outpatient hospital services, physician treatments, outpatient services at special facilities, and the use of prescription drugs? The utilization review processes included in some plans are somewhat effective, but also require intense administrative services and are considered to be inefficient. Wellness programs have some efficacy but generate long-term returns and are not consistent with the current trend away from long-term employment.

For now, most employers are simply finding ways to shift the cost of health care to their participants using the standard out-of-pocket features of typical plans. Others are considering dropping health care as a benefit.<sup>43</sup> A few, however, are searching for health care plans that involve networks of both efficient and effective providers, and are studying “pay for performance” contracts where the appropriateness of care is better ensured.<sup>44</sup> As we look at the incentives among our varied participants in the health care landscape, an effort to join these diverse interests is imperative. Employers and their TPAs should insist on receiving value, providers should compete on the basis of their cost and demonstrated quality outcomes, and the participants should be engaged as real consumers. We will discuss this in more detail in Chapter 8.

## Insured Plans

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For small and medium sized employers who do not have the financial resources to risk paying for large health care claims, an insured plan is the appropriate solution. Insurance, of course, is simply a device to spread the chance of financial loss among a larger number of people. When a smaller company buys health insurance, it is sharing the risk and reducing the chance of a catastrophic health care event among a number of similarly situated employers. The larger number of employers in a group, the more predictable the number of future losses.

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43. See Porter, M., & Teisberg, E. (2006). *Redefining health care: Creating value-based competition on results* (p. 506). Boston: Harvard Business School Press. They argue that employers are “feeding the health care cost beast” by not insisting on more results-based deliverables from third parties and providers.

44. “Bridges for Excellence” is an employer-initiated coalition that is demonstrating the connection between health care quality and reduced health care costs. It is encouraging providers to use and publish quality measures in the practice regimens and to offer pay for performance programs. Lau, G. (2005, December 5). Pay for performance gains in popularity. *Investors Business Daily*, A14.

The prediction of loss will control the premium charged by the insurance company. These are called community or manual ratings. As the employer's number of employees increases, the more the employer's own health care claims experience for the previous year will control his premium for the next year. The underlying concept relates to the "Law of Large Numbers": the higher the numbers, the higher the probability of a predicted outcome.<sup>45</sup>

The premium charged by the insurance company includes this prediction, as well as a retention fee that is the insurance company's profit margin. It comprises administrative costs, risk charges, taxes, and commissions. The underlying risks included in the premium charge are based on experience ratings. Larger companies can usually insist that their own experience, and not that of the community, as well as negotiated retention rates be used to determine the renewal premium rates. They are taking some chances here since their numbers are smaller. However, if they have had a relatively healthy workforce and low claims cost, they can significantly reduce their health care premium expense by causing the insurance company to base their premiums on the employer's actual experience rating.<sup>46</sup>

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## Third-Party Administrator (TPA) Selection

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While we will discuss benefit care metrics in more detail in Chapter 10, the issue of vendor selection should involve a quantitative and qualitative evaluation. What are the employer's performance expectations of TPAs and their medical provider networks? In most cases, the selection process begins with the employer issuing a request for proposal (RFP) to a variety of TPAs. The RFP solicits information such as the identity and access to providers in the TPA's network, provider discounts, claims processing performance of the TPA, general customer service rankings, reporting content, and other TPA responsibilities, such as communication programs, enrollment assistance, and claims analysis. It also may include certain performance guarantees with respect to claims processing, cost containment, or general customer service guarantees. The National Council on Quality Assurance rates the performance of TPAs and its

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45. See Coates, R. (1956). *The law, the world of mathematics* (R. Newman, Ed.), (p. 305). New York: Simon & Shuster.

46. For certain medium sized employers, the premium and renewals will be based on a "blended" rate that comprises, for example, 60 percent based on actual experience and 40 percent based on the manual or community rating.

**Table 7.2** Old and New Criteria Applied by Employer Sponsors as They Select New Health Care Plans

<i>Old Measures</i>	<i>New Measures</i>
Quality providers	Measure clinical outcomes of providers
Access to hospitals and physicians	Health plan can create value
Preserving choice of providers	Transparency in cost and pricing
Cost-effective plan	Pay providers for performance
	TPA performance contracts
	Consumer is engaged in health care

reports are available to employers.<sup>47</sup> Moreover, the employer will examine the various plan designs offered by the TPA and their respective total premium costs.

For self-insured plans, details concerning TPA networks, plan choices, administrative costs, and choice of services are solicited; for insured plans, cost factors relating to the risk elements of the total premium would be studied. A very important element in the relationship between the TPA and the sponsoring employer is the development of cumulative participant data. Can the TPA provide detailed utilization data that will enable both parties to find opportunities to reduce health care expense? The bottom line for the employer sponsor is the formula:  $(Utilization \times Price) = Total\ Cost$ . Reduce the price and the utilization and costs will go down. How does the prospective TPA compare to others when considering this formula?

In an effort to acquire more sophisticated administration in certain benefit areas, some employers have engaged specialists such as pharmacy management companies that assume a TPA role only for the prescription drug program. This is called a carve out, and specialized TPAs are currently

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47. As we will see in Chapter 10, Employee Benefits and Metrics, the Health Plan Employer Data and Information Set (HEDIS) is a group of performance measures designed to ensure that purchasers and consumers have sufficient information to compare managed care networks. HEDIS is sponsored by the National Committee for Quality Assurance, <http://www.ncqa.org/>, that also accredits managed care networks.

managing dental, vision, COBRA,<sup>48</sup> and retiree health care. Carve outs enable the employer to utilize highly specialized companies who are more aware of provider networks, have better information systems, and can be held more accountable for performance-based results.

Another initiative designed to improve the cost-effectiveness of the health care benefit is the employer alliance. Here groups of similarly situated employers join together to collaborate on health care issues, survey employers' health care practices, look at new designs and approaches to health care, and, in some cases, use their aggregate size to improve their leverage in buying health insurance products from TPAs.<sup>49</sup> Some TPAs are now offering new insured plan products for small employers that are more responsive to their cost limitations. These products have limited benefits, high deductibles, and lower lifetime or annual maximums.

## Conclusion

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The U.S. health program comprises employer-sponsored and government-sponsored health care, Medicare, and Medicaid. When combined, they have produced some impressive results.<sup>50</sup> Life expectancy of Americans and infant mortality have shown dramatic improvements. There are, however, too many people in the United States who are not covered by an employer-sponsored plan and do not meet the income tests of Medicaid or the coverage requirements of Medicare. As we look at the growing numbers of uninsured in the United States, we must ask ourselves, should the employer-sponsored health care plan continue to be a centerpiece of our health care system?<sup>51</sup> Should we consider some form of national health care to resolve this problem?

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48. The Consolidated Budget and Reconciliation Act (COBRA) is a law allowing employees who experience certain life events, such as loss of job, to continue their employer-based health care plan for up to 36 months. It is discussed in Chapter 12.

49. See, for example, the Employers' Health Care Alliance of Cincinnati at <http://www.cintiehca.com/> and the National Business Coalition on Health at <http://www.nbch.com/>, a national affiliation of regional employer groups.

50. Health improvements from 1970 to 1999 have added \$1.5 trillion in reduced work days missed. Bhattacharya, J., & Lakdawalla, D. (2005). *The labor market value of health improvements* (pp. 1–21). Rand Forum for Health Economics and Policy.

51. According to the Dartmouth study, the United States does not really have a "system." Wennberg, J. & Cooper, M. (1999).

It is far more complicated than simply repotting our current components into a comprehensive, single, national program. There are some fundamental and prerequisite issues to address. If a significant barrier to increasing access and coverage among the uninsured is cost, should we first look at ways to make our current health care system more affordable and cost-effective? Are there viable quality incentives that will cause our providers to get it right the first time? Will the introduction of more market factors enhance access and higher quality? Is it possible to create a high performance health care system in the United States without moving to a national health care system? How does our health care match up to those in other developed countries where other systems are used? What metrics should we use to make the comparisons? What can we learn from them? We will see this in Chapter 13, Global Benefits.

Now that we understand the basic designs and approaches to health care plans, we move to Chapter 8 to look more intensely at the question of improved access to quality health care and health care reform.

## Chapter Exercises

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1. Check the American Health Value Web site at <http://www.americanhealthvalue.com>, as well as some articles on consumer-driven health care, and be prepared to explain the essential design differences among an HRA, HSA, and FSA. Then describe how and under what circumstances an employer might provide all three plans for his employees.
2. How does the consumer-driven HDHCP approach fill a missing market element to traditional health care plans? What is needed to make HSAs achieve their intended purpose? How would you ensure this is included in your own company's strategy to introduce an HDHCP with an HSA?
3. What are the long-term prospects, if any, for consumer-driven plans in reforming health care in the United States? What would you think of a Universal Health Savings Account funded by the employer and employee that would allow the employee to buy a policy anywhere in the health insurance market that would be totally portable?
4. Look at Figure 7.2 and determine in which quadrant you would put an HSA.
5. You are single and a new employee looking at the health care offerings of your employer. The employer offers two health care

plans, an HMO and an HDHCP with an HSA to which it contributes \$75 per month. The deductible for the plan is \$1,500 per year. The premium for the HDHCP is 50 percent less than the premium for the HMO. The deductible for the HMO is \$250 (single); the HMO has virtually identical office co-pays, and coinsurance of 90/10 percent, the same as the HDHCP. Your total out-of-pocket health care expenses for the last year were \$600. Identify the factors, not necessarily precise numbers, you would use in calculating the usefulness of choosing the HSA over the other plans. Don't forget to consider, among other items, the pretax value of your HSA.

6. Your company currently offers a traditional indemnity-type retiree health care plan, as well as a supplemental Medicare policy for its retirees. The health care provider market in your community is somewhat competitive. Inflation for your retiree plans have exceeded national averages and your CEO, while sympathetic to her former employees, has demanded that something be done to control the costs. Identify and briefly explain a range of possible solutions that are responsive to your CEO's demand, and recommend a specific and optimal solution that will resolve the CEO's concerns and meet legal requirements.
7. Your CFO asks you what benefits you receive as a company by offering health care to your employees. Identify the factors you would include in your list to the CFO. How would you calculate the financial contribution the plan can make to the firm?
8. Assume you are uninsured and wish to buy a health policy on your own. Check the following Web sites, get a quote, and identify what factors appear to determine the pricing of such plans. See <http://www.insure.com/> and <http://www.ehealthinsurance.com/>.
9. Assume you are purchasing health insurance for a medium sized employer (300 employees) and want to send out a request for proposal to several TPAs. What information would you request in your RFP?
10. Suppose you are the CEO of a major hospital with a full array of medical services, including a level-three trauma center. A new quality and clinical outcomes-based health care data system indicates that your hospital significantly lags behind your competitors in heart, pulmonary, and orthopedic patient care. On the Internet or in the library, check some outcomes-based measures that are typically utilized by organizations measuring clinical outcomes and then develop an outline of a plan, including the steps you would take and the groups you would involve that

- could be used to improve your reported results. Include in your plan, among other items, how you would focus on business process changes (workflow) to help drive quality outcomes.
11. The Alliance Health Care Network, a large TPA in your area, has announced it will reward its medical providers with reimbursement bonuses provided they adopt and comply with certain evidence-based medicine or clinical protocol measures recommended by the Health Plan Employer Data and Information Set (HEDIS). Research and become generally familiar with such measures and then advise, as a prospective employer-customer of Alliance, your evaluation of this new approach. Will it create value for your health care program? Explain.
  12. You are the HR director of a firm that produces consumer products. You are responsible for all aspects of human resources services, including benefits. Your firm employs 8,000 workers who are located in three manufacturing plants in various locations in the United States. Your health care plan is self-insured and comprises several choices for the employees—a high deductible HSA, two PPOs with different deductibles, coinsurance, out-of-pocket maximums, and premiums. You have received a notice from your TPA, who administers all three plans, that for an extra fee you can include a patient advocate in one or all of your plans. You want to discuss this with your CEO, but first must check into what a patient advocate does, learn how its services are priced in your community, and make an evaluation as to whether such a service would add value to your overall HR and business plans. Do some research on this subject and develop some discussion points you will use in your upcoming meeting with the CEO.
  13. Your company just began operating in a rural area where medical provider competition is negligible. Your new workforce is basically young and healthy. You have been asked by your CEO to offer a health care plan that ensures quality and provides choice, but maximizes cost efficiency. Identify and briefly describe the design elements of an optimal health care plan based on these criteria.
  14. You have read in the newspapers that the answer to the health care crisis in the United States is to establish the following guiding principles and apply them to our system: “value purchasing, pay for performance, consumerism, and transparency.” Do some research and determine what these principles really mean, how they would apply to health care plan design, and how they would help resolve the problem of inefficient and inappropriate care in the United States.

15. Review the following Consumer-Directed Health Care Plan (Table 7.3) and comment on its potential efficacy in causing employee engagement, enhancing overall health status, and reducing claims costs for the employer sponsor. The PPO is the accompanying health care plan to the HSA. Is the employer sponsor of this plan too generous in giving both a unilateral \$250 contribution, as well as a 100 percent match up to \$1,000? What is the advantage to the company here?

**Table 7.3** Consumer-Directed Health Care Plan

	<i>HSA</i>	<i>PPO</i>
Deductible	\$1,100 (single) \$2,200 (family)	
Employee contributions (HSA)	\$2,900 (single) \$5,800 (family)	
Employer contributions	\$250 for all accounts and match of 100 percent up to \$1,000 (HRA)	
Out-of-pocket maximum		\$2,500 (single) \$5,000 (family)
Lifetime maximum		Unlimited
Coinsurance after deductible		80/20 percent in network, 60/40 percent out of network
Premium compared to standard PPO with \$350 deductible		HDHCP premium is 20 percent of premium for standard PPO
Preventive features		Variety of diagnostic procedures; annual physicals are 100 percent paid by plan, no deductible