California HealthCare Foundation

Insurance Markets

Understanding Consumer-directed Health Care in California

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Trends & Analysis

Why Consumer-directed Health Care? Why Now?

The record low inflation in the health care sector from 1994 through 1999 now seems as distant as the dot-com boom from those same years. In 2001, average premiums among employment-based health plans rose by 11.0 percent, and in 2002, by 12.7 percent.[1] Although predictions of future trends have been notoriously unreliable in the past, there seems to be little reason to believe that the key drivers of recent inflation, such as prescription drug utilization, hospital outpatient care, and nurses' wages, will abate soon.[2,3]

The resurgence of health care expenditure inflation has left employers and employees in a quandary. Continued increases are bad both for employers, who pay the majority of costs, and for employees, who are finding benefits dwindling and premiums and cost-sharing requirements escalating. But the most recent successful strategy for dealing with these costs — tightly managed health maintenance organizations (HMOs) — is increasingly out of favor. This leaves no obvious mechanism available to deal with rapidly rising costs.

Enter consumer-directed health plans, which explicitly link consumers' health coverage choices to the financial consequences of those choices. If, for example, consumers choose a health plan that results in greater overall expenditures, they will have to pay more in premiums. Typically these plans also offer consumers a meaningful choice of features — such as insurance carriers, provider networks, or level of benefits — and provide information to assist consumers in making an intelligent choice. Often this includes Web-based tools to help patients make decisions about a particular course of medical treatment. Although these plans offer some appealing features for many consumers, most of the impetus for them has come from employers seeking new ways to contain the cost of care.

This report gives consumers, employers, and other stakeholders an overview of consumer-directed health plans in California. It examines how the products work, the industry players behind them, and the factors likely to influence their growth. In addition, it compares the state's early experience with consumer-directed plans to the rest of the country's — and finds that California, usually a bellwether for health-care trends, has been slow to accept these plans (see Table 1). The study is based on in-depth interviews with 27 industry experts, including insurers, employers, benefit consultants, policy-makers and academics (see Methodology).

Table 1. Consumer-Directed Health Care in California vs. the United States

AREA	CALIFORNIA	U.S.
Enrollment	• Most enrollment is in customized plans; Blue Cross alone has more than 800,000 enrollees. • HRA enrollment is small, probably less than 20,000. • Enrollment in start-up plans such as Definity and Luminos is small. • Most enrollment is distributed among traditional carriers such as Blue Cross, Blue Shield, and PacifiCare.	• Most enrollment is in customized plans. • HRA enrollment estimated at 400,000. • Definity has 175,000 enrollees. • Most enrollment is distributed among traditional carriers.
Employer Offerings	• No major employer in the state offers an HRA product as its only plan.	• Most employers offering HRAs also offer other options; a few large employers offer HRAs as total replacement (no other options).
General Observations	• Employers are reluctant to become early champions of consumer-directed health care. • No consensus exists about consumers' ability to use Web-based tools, consumer-directed plans' ability to control cost, or the plans' effect on access and quality. Great concern exists about potential for adverse selection.	

Developments in the California Market

Consumer-directed health plans are classified into three categories: health reimbursement arrangements, customized plans, and "design-your-own" products. A summary of how each product works, and which companies offer them, is provided below.[4]

Health Reimbursement Arrangements

The Product. Health reimbursement arrangements (HRAs) offer the strongest incentives for cost-consciousness on the part of the consumer. In these plans, an employer establishes an individual health reimbursement arrangement for a specified amount (for example, $1,000 annually) for each enrolled employee. As the employee incurs qualified medical expenses, he or she can submit these expenses for reimbursement until the $1,000 is exhausted. If not exhausted, the balance rolls over to the following year. HRA plans usually include a high deductible (perhaps $2,000 annually). Once the employer-provided allocation is exhausted, the employee is responsible for 100 percent of medical expenses, until the deductible is met; at that point, the plan covers most remaining expenses. Unlike medical savings accounts (MSAs), only employers can contribute to HRAs. HRAs are deliberately called "arrangements," not accounts: they do not earn interest, are not portable from employer to employer, and, as distinct from MSAs, they can be used only for medical expenses.[5]

The Players. Benefit consultants identify three insurance carriers that offered California employers HRA products as of January 2003 — Blue Cross, Aetna, and CIGNA. In addition, two start-up companies, Definity and Lumenos, essentially acting as third-party administrators, offer such plans in the state. Yet, as Table 2 shows, the number of employees covered by an HRA plan is minuscule. Nationally, HRA enrollment is estimated at 300,000 to 400,000, and it appears that consumer uptake has been even slower in California than elsewhere.[6] Furthermore, benefit consultants and health plan executives were unable to identify any major California employer where the HRA was the sole plan offered.

Definity Health, based in Minnesota, now is available to four major employers that are members of the

Pacific Business Group on Health. Two to 15 percent of employees in these four companies selected Definity as their health plan, with enrollment varying according to the firm's contribution formula and benefit strategy. At least one large California employer offers a Lumenos plan.

Blue Cross had three contracts as of January 2003 for its Power Health Fund, a Web-based HRA product that allows consumers to track their health care spending, obtain information about providers, and get clinical information to assist in their decision making.

PacifiCare began offering an HRA product to 400 of its own employees in January 2003, and brought a product to market for both large employers in spring 2003 and for small employers in August 2003. Blue Shield will launch an HRA product in 2004.

Customized Packages

The Product. In customized plans, employers make a fixed contribution toward the employee's premium, and the employee then chooses among an array of products with different prices. For example, a plan may offer three provider networks — a very broad (and

Table 2. Health Reimbursement Arrangements (HRAs) in California, January 2003

HEALTH PLAN	Market Entry Date(s)	Product Design	Enrollment January 2003
Aetna*	Bid on RFPs† in 2002.	Has bid on RFPs† for large employers.	Info unavailable.
Blue Cross	Introduced product in January 2003 to employers with 500 or more workers. Plans to offer the product to small employers in the future.	"Power Health Fund" is a Web-based product with large deductibles sold to large employers.	Estimated 1,000 employees from three employers.
Blue Shield	Planned for 2004	Plans to bring an HRA product to market in 2004.	0
CIGNA	Bid on RFPs† in 2002.	Has bid on RFPs.†	NA
Definity	Bid on RFPs† in 2001.	HRA with Web-based tools; sells self-insured product. Has contracts with four major employers that are members of the Pacific Business Group on Health; obtained market shares of 2 to 15 percent.	Info unavailable.
HealthNet*	Info unavailable.	Info unavailable.	Info unavailable.
Kaiser	NA	Does not offer.	0
Lumenos	Bid on RFPs† in 2001.	HRA with Web-based tools; sells self-insured product. Has contract with one major employer from Pacific Business Group on Health.	Info unavailable.
PacifiCare	Introduced product in January 2003 to own employees; broader offering to small employers spring 2003 and large employers in August 2003.	For large firms, offers a full PPO with pharmacy benefits incorporated into its HRA. Plans to add an exclusive provider product later. Plans to offer small employers an HRA with a $2,000 deductible and a tiered network.	400
Sharp	NA	Does not offer.	NA

*Unable to arrange interview with carrier.
†Requests for Proposals

relatively expensive) panel, a very narrow one, with less costly and/or more cost-effective providers, and a middle tier. Such plans also may offer three benefit packages, with varying levels of covered services. Hence, the employees could have a choice of nine combinations, whose premium reflects the breadth of the network and richness of the benefit package; the lowest-cost product would feature a narrow network and thin benefits, and the highest-premium product would feature a broad network and comprehensive benefits.[7]

Customized packages exemplify a more modest change from traditional HMO and PPO coverage than do HRAs. In California, as in the nation, enrollment in customized packages greatly exceeds that of HRA plans. Because customized packages work best when only one carrier serves an employer, they are more commonly sold to small and midsize employers.

The Players. The leader in customized packages in California is Blue Cross, whose "FlexScape" product for small employers has about 800,000 enrollees (see Table 3). Employers can select among approximately six HMOs and six PPOs; plans vary as to the extent of consumer cost-sharing and the breadth of the provider network. In the future, Blue Cross hopes to offer its HRA product as an option in the FlexScape package.

PacifiCare offers its "Choice Series" to firms with ten or more workers, and enrollment is concentrated among small employers. There is a range of low and high benefit plans, and surprisingly, a PPO plan is currently the lowest-cost plan available. Kaiser, CIGNA, and Blue Shield do not offer a customized product.

Design Your Own

The Product. The most innovative (and, as yet, least common) type of consumer-directed plan is a "design-your-own" (DYO) product. Here, employees choose their own set of providers and benefit features—essentially designing their own provider network and specifying the services covered—with the employee's premium contribution dependent on the choices made. The idea is to offer almost unlimited choices in areas

Table 3. Customized Packages in California, January 2003

HEALTH PLAN	Market Entry Date(s)	Product Design	Enrollment January 2003
Aetna*	Info unavailable.	Info unavailable.	Info unavailable.
Blue Cross	1999	"Flexscape" package for small employers includes six HMOs and six PPOs. Expects to integrate this product with its HRA product.	800,000
Blue Shield	Info unavailable.	Does not offer customized packages; does offer dual account products (PPO and HMO to one employer).	0
CIGNA	NA	Does not offer.	NA
HealthNet*	Info unavailable.	Info unavailable.	Info unavailable.
Kaiser	NA	Does not offer.	NA
PacifiCare	August 2002	"Choice" product offered to small firms with more than ten employees. Firms have a menu of seven plans (four HMOs and three PPOs) and can choose four.	About 2,500 members from 100 employers.
Sharp	NA	Does not offer.	NA

*Unable to arrange interview with carrier.

people care about (hospitals and physicians, for example), coupled with incentives to select lower cost options.

The Players. Nationally, at least one company, Vivius, offers true DYO products. However, as of January 2003, no carrier or start-up firm selling such a plan, or any employer offering it, was identified in California.

Factors Facilitating or Impeding Growth of Consumer-directed Plans

The experts interviewed point to five factors likely to determine the future of consumer-directed health plans in California.

Macroeconomics and Health Care Cost Trends

In a tight labor market, employees would likely resist the new generation of health plans, as consumer and labor representatives generally have viewed them as a rollback of benefits.[8] However, the seasonally adjusted unemployment rate in California has mushroomed by 40 percent over the past two years, from a rate of 4.7 percent in February 2001 to 6.7 percent in June 2003. This shift has weakened the hand of employees, and perhaps emboldened employers to try something new. With the revival of double-digit health care cost inflation — and with a growing share of costs now being passed along to consumers — some observers suggest that employees are open to new approaches. Currently, consumer-directed plans seem to be the only new type of coverage being marketed.

Early Experiences

There have not been any peer-reviewed articles in scientific journals that have evaluated the success of consumer-directed plans. Many employers are waiting for such evidence and, until it is available, are reluctant to offer such a plan. Some respondents pointed to the danger faced by independent-minded employers, particularly those that currently do not offer coverage but would consider doing so if a less expensive product were available. If employers offer a plan, and then find that it does not perform as advertised, it will be difficult to drop — thus saddling these employers with a benefit that they previously found unaffordable.

Problems with Selection Bias

Some fear that, given a choice, healthier employees (who are less likely to exceed the employer's contribution to an HRA) would join such plans, leaving older, sicker, and more expensive individuals in the companies' traditional plans. This could fragment the risk pool, creating a potential "death spiral" in which plans with a less healthy population are forced to absorb higher costs, raise premiums, and ultimately drive off still more of their healthiest enrollees. If this happens, employers have two possible responses, but both are problematic. One is to make consumer-directed plans replacement products (and thus, the only choice available) rather than offering them side-by-side with traditional plans. Thus far, however, very few employers have chosen that option, and few respondents thought that consumer-directed plans would supplant the current array of plans any time soon. Second, employers could risk-adjust premiums to account for any selection bias.[9] Thus far, however, only 1 percent of employees nationally are enrolled in risk-adjusted plans, in spite of the fact that those tools are available to employers that wish to use them.[10]

Negative Publicity and Liability

Some respondents thought that consumer-directed plans, HRAs in particular, would be vulnerable to negative publicity in cases in which someone did not seek prompt medical attention when the money in his

fund ran out, and, as a result, became seriously ill or died. Such an eventuality raises a parallel issue: whether employers could face liability in such a case.

Regulatory Responses

Consumer-directed health plans are new, and the response of regulatory bodies in California is, as yet, unclear. Currently, health plans that are not subject to federal ERISA requirements are regulated by either the state Department of Managed Health Care (HMOs) or the Department of Insurance (PPOs and fee-for-service plans). Presumably, the particular characteristics of a consumer-directed plan would determine which regulatory body had jurisdiction. One respondent noted that plans regulated as HMOs by the Department of Managed Health Care would be subject to stringent rules regarding benefit levels under the state's Knox-Keene Act. Thus, most plans would probably seek regulatory authority from the Department of Insurance, whose plans are not subject to Knox-Keene. But, if seen as an attempt to skirt consumer protections, this could lead to calls for further regulation of the plans. And new regulations, in turn, could raise health care costs to employers, particularly if the regulations include expensive mandated benefits.

Conclusion

California has long been a health care innovator — the birthplace of prepaid group health plans, preferred provider organizations, point of service plans, and Medicaid HMOs. In the case of consumer-directed health care, however, this study suggests that the state is unlikely to take the lead. In general, California mirrors the experience of other states, but has lagged the rest of the country in adopting the most radical form of these plans. Enrollment in HRAs is miniscule, probably less than 20,000 individuals in the state. Customized plans have greater enrollment, but design-your-own plans are not available at all. HRA and design-your-own plans are likely to grow only incrementally, as employers and consumers assess their risks and benefits. Furthermore, consumer-directed plans are likely to find the path to growth complicated by the clout of HMOs in California. HMO plans constitute 54 percent of employer-based enrollment in California — about twice the national average — and that has helped keep the average cost of single coverage 7 percent less than such coverage nationally.[11] Hence, consumer-directed plans in California must compete against lower cost competitors than do plans elsewhere.

Some have called customized plans and tiered networks Act II of "managed competition," giving consumers financial incentives to choose cost-effective plans. However, these plans, and consumer-directed plans in general, are unlikely to have significant market impact unless they are seen as more than cost-containment schemes. Ultimately, such plans may also direct consumers to higher-quality providers — and put more powerful decision-making tools in consumers' hands — but those capabilities are only beginning to emerge in the marketplace. If more fully realized consumer-directed plans were to gain significant market share, they could influence patterns of care, to the benefit of consumers as well as payers.

To be sure, consumer-directed health plans have benefited from the soft labor market and slumping economy in California. On the other hand, few employers relish becoming pioneers in such sensitive areas as employee health benefits. Plans and employers fear becoming the first media horror story — the patient who died because he or she procrastinated

visiting the doctor, deterred by a high deductible, when a visit would have identified an early stage of cancer or other life-threatening illness.

HMOs and insurance carriers, nonetheless, view consumer-directed plans seriously — whether as a threat or an opportunity. Even health plans not currently offering such programs have explored the subject — although large, traditional carriers have dominated the market so far. For their part, employers remain cautious and seek reassurance from data-driven evaluations of consumer-directed plans in general and of HRAs in particular. If such evaluations demonstrate that HRAs control costs, do not lead to biased selection, and do not impair employee satisfaction or quality of care, we are likely to see many employers purchase consumer-directed products. Ultimately, the success of all consumer-directed plans will depend on their ability to control increases in medical care expenses, without antagonizing the consumers they purport to benefit.

Methodology

The study is based on semi-structured telephone interviews, lasting an average of about 30 minutes, with 27 industry leaders and stakeholders in the state. The interviews were conducted from November 2002 through January 2003. Interviewees were selected by reviewing the trade and academic literature, as well as from attending industry conferences. The 27 interviews included 11 individuals either from or representing health plans in California, four representing employers, four state government officials, three benefit consultants, and five thought leaders from universities. For each group, a different interview form was employed, and questions were open-ended to allow respondents to provide greater depth.

ENDNOTES

1. B. Strunk, P. Ginsburg, and J. Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2001," *Health Affairs,* Web Exclusive. September 25, 2002: W299–W310.

2. In the early 1990s, researchers at both the Congressional Budget Office and the Health Care Financing Administration predicted that U.S. health expenditures would consume 18 percent of national income by the year 2000. However, these estimates were far off the mark. In actuality, the percentage of gross domestic product (GDP) spent on health care was fairly constant over the decade, ending at a level of about 13.2 percent in 2000. See Congressional Budget Office, "Projects of National Health Expenditures" (Washington, DC: Congressional Budget Office, October 1992); S. Sonnefeld, D. Waldo, J. Lemieux, and D. McKusick, "Projections of National Health Expenditures Through the Year 2000," *Health Care Financing Review* 13 (Fall 1991): 1–27; and K. Levit, K. Smith, C. Cowan, H. Lazenby, and A. Martin, "Inflation Spurs Health Spending in 2000," *Health Affairs.* January 2002: 182–181.

3. B. Strunk, P. Ginsburg, and J. Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2001," *Health Affairs,* Web Exclusive (September 25, 2002): W299–W310.

4. A discussion of tiered hospital networks is not included here. For an overview of tiered hospital networks, see J. Robinson, "Hospital Tiers In Health Insurance: Balancing Consumer Choice With Financial Incentives." For information on tiered networks in California, see J. Yegian, "Tiered Hospital Networks," *Health Affairs* Web Exclusives, March 19, 2003 (www.healthaffairs.org/WebExclusives/CHCF_Web_Excl_031903.htm).

5. For more information on MSAs, see *MSAs Are Not FSAs Are Not HRAs* at http://cahionline.org/cahi_contents/resources/msafsahra.pdf.

6. B. Kobliner, "A New Health Plan Works, at Least for the Healthy," *The New York Times,* March 2, 2003.

7. For more information about customized plans, see J. Robinson, "Renewed Emphasis On Consumer Cost Sharing In Health Insurance Benefit Design," *Health Affairs* Web Exclusive, March 20, 2002. (http://healthaffairs.org/WebExclusives/Robinson_Web_Excl_032002.htm).

8. Source: http://www.calmis.ca.gov/FILE/LFHIST/CAL$SHLF.TXT

9. When plans or employers risk adjust premiums, they adjust the price of premiums to take account of the health status of the different populations in the different plans. Thus, premiums for a plan with many young and healthy workers would be *increased,* and premiums for a plan with older and sicker workers would be *reduced.* The aim of risk adjustment is to create a level playing field where plans are not rewarded for enrolling healthy workers and penalized for enrolling sick workers.

10. P. Keenan, et al., "The Prevalence of Formal Risk Adjustment in Health Plan Purchasing," *Inquiry.* 39(3), Fall 2001: 245–259.

11. Kaiser Family Foundation and Health Research and Educational Trust, *California Health Benefits Survey, 2002* (Menlo Park, CA: Kaiser Family Foundation, and Chicago: Health Research and Educational Trust, February 2003); and J. Gabel, L. Levitt, E. Holve, et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs.* September 2002: 143–151.

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Future editions will identify trends in California's insurance markets, analyze regulatory and policy issues, and provide industry updates. Analyses will be posted as they become available at the California HealthCare Foundation's Web site at www.chcf.org.

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