



Consumer Driven HEALTHCARE

Value-based insurance design

VBID, much like CDH, attempts to align clinical and financial incentives

Value-based insurance designs (VBID) are getting attention as a new trend, but the trend has been around for almost a decade.

VBID involves lowering patients' out-of-pocket fees for high-value preventive services and pharmaceuticals to increase compliance, improve clinical outcomes, and potentially reduce costs over the long term.

In many ways, it's a complement to a CDHP. The concept reflects what's already happening in the CDH space—bringing clinical information to bear on benefit design.

At the heart of VBID is the alignment of clinical and financial incentives. VBID encourages the use of high-value care while discouraging the use of low-value or unproven services.

VBID, like CDH, allows for cost sharing, but in a more clinically sensitive way. Value-based benefit packages adjust out-of-pocket costs according to the (evidence-based) needs of specific patient populations. Simply put, the more beneficial the therapy for the particular individual, the lower that patient's share of the cost.

"VBID pairs nicely with [CDH goals], providing very specific incentives for individuals to take care of particular conditions."

—Jeff Munn

Quantifiable results are still pending, but early implementers of VBID are demonstrating that lowering or eliminating copays for certain medications can improve health outcomes and potentially save dollars.

Moreover, VBID appears to dovetail nicely into CDH. "The overall goal of [CDH] is for individuals to make smart purchasing decisions on healthcare. VBID pairs nicely with that, providing very specific incentives for individuals to take care of particular conditions," explains **Jeff Munn**, a principal with Hewitt Associates, a health management consulting practice in Washington, DC.

Among the employers trying this approach are Pitney Bowes, the University of Michigan, Marriott, and the city of Asheville, NC.

Complementing CDH

Ideally, higher deductibles discourage only the use of low-value care. But for this to happen, consumers must be able to distinguish between high-value and low-value interventions. If consumers can't make that distinction, they may fail to get needed care and have worse outcomes, explains one of the pioneers in this area, **A. Mark Fendrick, MD**, Departments of Internal Medicine and Health Management and Policy at the University of



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Michigan in Ann Arbor and head of the University of Michigan Center for Value-Based Insurance Design.

Right now, he says, consumers don't have adequate access to unbiased information about quality and cost of care. As a result, he argues, incentives are misaligned, and CDHPs risk discouraging necessary care. Incentives need to be better aligned for CDHPs to discourage use of unnecessary services without affecting use of vital ones, says Fendrick.

According to proponents, VBID does just this. The approach keeps cost controls in place but tells the consumer, "We are going to subsidize those elements of care which, based on your unique physiological characteristics, are essential for you," explains **Lonny Reisman**, CEO and founder of ActiveHealth Management in New

York City. That could mean a lower copay or first-dollar coverage, or simply reduced charges for the intervention.

Fendrick and his colleague Michael E. Chernenw, PhD, Department of Health Care Policy at Harvard Medical School, propose a "VBID waiver," allowing certain high-value services to be provided with little or no out-of-pocket contribution.¹

Fendrick tells **CDH** that ideally, he would like to see an HSA-deductible waiver that wouldn't apply only to preventive services but "maybe, much more importantly, services of extraordinarily high value." In fact, he'd like to change the terminology, moving away from "preventive" to "high value."

Munn doesn't think the HSA regulations, as written, stand in the way of VBID. "While more guidance would be helpful, we are not anticipating any on these issues anytime soon," he says. He points to two gray areas in HSA guidance that suggest HSAs are indeed compatible with VBID.

If something can be called preventive care, it can be offered predeductible, at no cost to the consumer. "This could include some drugs, but the rules there are pretty murky at this point," Munn says.

Current guidance appears to allow services to be discounted, regardless of whether they are considered preventive. Some medications, tests, or procedures that might not otherwise be preventive, then, could be discounted and still offered through a high-deductible health plan.

Munn stresses that any CDHP-related obstacles to VBID involve HSAs. "An employer could implement an HRA with no problems whatsoever. Even in the HSA world, though, I think there is more flexibility than people generally think."

VBID is a good match philosophically, as well, says **Andrew Webber**, president and CEO of the National Business Coalition on Health in Washington, DC.

Two principles are inherent in VBID—consumers must take a more active role in managing their own

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health, and plan designs should reward consumers when they do. "This is also fundamental to consumer driven healthcare," says Webber.

Targeting

Right now, says Fendrick, employers are experimenting with two approaches to VBID. The first simply targets certain high-value services for copayment reduction. (Pitney Bowes, for example, has reduced payments for all users of drugs commonly prescribed for diabetes, asthma, and hypertension.)

The second approach lowers cost sharing for specific, high-value services for patients with specific clinical indications. This requires more sophisticated targeting technology. For example, the city of Asheville, NC, and the University of Michigan both focus on diabetes. A more nuanced approach to targeting also has a positive effect on return on investment (ROI), says Fendrick.

Cost matters most?

Fendrick has been actively promoting the VBID concept for eight years (and working on it for nearly a decade). Why is it catching on now? Because, he says, he and his colleagues have begun focusing on controlling costs, as well as enhancing outcomes. VBID provides more health for every healthcare dollar spent than existing benefit plans, he explains.

But as he promoted VBID, he learned that employers, already overwhelmed by healthcare costs, didn't have any more dollars to spend, no matter how good the bargain in terms of improved health.

VBID has started to gain momentum, he says, because he and his colleagues recognized that controlling healthcare costs was a more pressing problem than healthcare quality. The marketplace wouldn't seriously consider, much less embrace, VBID, without first understanding the financial implications.

So that led him to change his VBID tagline from "clinically sensitive cost sharing" to "fiscally responsible, clinically sensitive cost sharing." And that has made a

difference, capturing the attention of employers and moving pilot projects forward.

The following are three ways VBID can be fiscally, as well as clinically, smart, Fendrick says:

1. Cost savings through improved health outcomes. Ideally, increased screenings and broader use of necessary, high-value medication will yield savings. The question is: Will it be enough to offset the increased expenditures? That's where targeting (such as that provided by ActiveHealth) comes in.

The better you target, the better your ROI, says Fendrick. So, for example, if you made statins free to all users, you would improve outcomes, but you would have a much longer time frame for ROI. If statins were free only for those who have had heart attacks, the ROI would be much faster.

Targeting provides a level of "clinical granularity" that identifies those who will benefit most from a specific therapy, says Fendrick. (And, Reisman points out, it also identifies those for whom a targeted therapy would be contraindicated. For example, diabetics with kidney failure should not be given Glucophage.)

2. Savings through increased productivity (e.g., less absenteeism and fewer disability claims). The link between improved health and enhanced productivity is "very interesting," Fendrick says. He believes that it's a valid hypothesis, but he is "underwhelmed by available data claiming high levels of cost savings."

3. Savings by shifting costs to lower-value interventions. Fund the subsidy of high-value services by increasing the cost sharing of those services with lesser value. This can be done by identifying a few interventions as low-value and increasing patient prices for those items or, as Fendrick prefers, spreading costs across the drugs, screenings, and interventions that are not of high value.

Working with ActiveHealth, Fendrick and his colleagues have been able to develop models that allow employers and health plans to see what the short-term subsidy would be, depending on which high-value

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interventions are being subsidized. Preliminary analyses suggest VBID ends up being value-neutral, with extra expenditures offset by savings, says Fendrick. VBID, he asserts, can be incorporated into any financial strategy to yield improved health outcomes for any level of dollars spent.

It's all a matter of how it's designed, Reisman says. "There are ways to make it revenue-neutral out of the gate."

There's plenty of data demonstrating that prescription compliance goes up as copayments go down, says Munn.

Education, evidence, and value

VBID, says Reisman, also dovetails into the educational component of CDH. Instead of simply pointing the consumer toward appropriate information, VBID "explicitly directs them" to appropriate treatments, identifying which interventions are essential, which are neutral, and which may be dangerous. Consumer choice is important, but it shouldn't replace evidence-based medicine. Reisman made this argument in a *Health Affairs* commentary about VBID earlier this year.

"No well-informed cardiologist today would view as discretionary the use of statins, aspirin, ACE inhibitors, and beta blockers after MI [myocardial infarction]; the evidence of benefit is hard and overwhelming. Yet use of conventional copayments in this situation assumes that the patient should decide, and nonadherence is accepted as a consequence of these financial barriers."²

Fendrick agrees, stressing that the value of a particular approach is defined on the individual level. He offers an obvious example: A colonoscopy for a 50-year-old with a family history of colon cancer is more valuable than one for a 26-year-old with no family history.

Charging the full fee to both is not clinically wise; across-the-board cost sharing leads to decreased utilization, not only of services you want to limit, but of necessary ones, says Fendrick.

Reisman adds that similarly, it doesn't make sense for a 50-year-old with no family history of colon cancer to be able to get a colonoscopy at no cost just because he's over age 50, whereas a 48-year-old man with symptoms of colon cancer has to pay hundreds of dollars.

But not all examples will be as obvious as the colonoscopy. Fendrick expects to see debate about just what constitutes a high-value intervention; as he points out, such efforts are already underway by disease management programs, pay-for-performance initiatives, and health plan accrediting organizations.

Even as definitions are being worked out, Fendrick believes employers and health plans can begin to incorporate the principles of VBID. "The clinically sensitive plan design, or value-based insurance design, can be incorporated into any financial strategy to yield improved health outcomes for any level of dollar spent."

However, whether employers will incorporate VBID remains to be seen.

Moving forward

Webber sees the advantages of VBID, but it may take more data to convince some employers.

"We find ourselves in the position where we know something intuitively—patients who are getting access to care before their condition becomes severe have lower total costs," he says. "Still, it's been difficult to demonstrate this for every employer, because they simply don't have access to the information they need to assess total healthcare spend. This is especially true for smaller employers." ■

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¹ Fendrick, A.M. and Chernew, M.E. "Value-Based Insurance Design: A 'Clinically Sensitive, Fiscally Responsible' Approach to Mitigate the Adverse Clinical Effects of High-Deductible Consumer-Directed Health Plans." *Journal of General Internal Medicine* 22, no. 6 (June 2007) (www.sph.umich.edu/vbidcenter/pdfs/jgimvbided.pdf).

² Brennan, T., Reisman, L. (2007). "Value-Based Insurance Design And The Next Generation Of Consumer-Driven Health Care." *Health Affairs* 26, no. 2 (2007): w204–w207.

Legal issues

Many HSA-prohibited transaction issues remain unclear

Does your company get a good deal on other services provided by its HSA bank? Does the bank offer a credit line to bridge the gap between the deductible and the HSA balance? If so, your company may be in risky territory.

ERISA rules and the Internal Revenue Code (IRC) prohibit certain related parties (e.g., fiduciaries and service providers) from engaging in specific types of transactions with benefit plans. In October 2006, the Department of Labor (DOL) issued Field Assistance Bulletin 2006-02 (FAB 2006-02) to clarify what constitutes a prohibited transaction. (The guidance is available at www.dol.gov/ebsa/regs/fab_2006-2.html.)

But confusion still exists, especially as new HSA-related products hit the market. **John Hickman**, partner and head of the Health Benefits Practice with Alston & Bird in Atlanta, addressed these issues at this spring's Consumer Health World meeting in Las Vegas, as part of a workshop titled "New Developments and Nuances in the Law: Is Your Design Still Legal."

Prohibited transaction basics

There are a few basics to keep in mind about prohibited transactions. First, IRC rules apply even if the plan doesn't fall under ERISA. So even if a company's HSA avoids ERISA regulation, problems arise when the transaction occurs between a plan and a fiduciary or other "disqualified person (DP)."

For HSA purposes, a fiduciary would include an HSA account holder, a trustee (or anyone with discretionary authority over management or control over plan assets), or one who renders investment advice for a fee.

A much broader net is cast by the "disqualified person" definition, which, in addition to fiduciaries, includes service providers and, in some cases, employers, Hickman explains.

Various transactions potentially cross the line and deserve scrutiny. Hickman offers a simple rule of thumb

to determine whether you are falling into a dangerous gray area: If a DP receives compensation with respect to a transaction involving the HSA, analysis is required.

Unfortunately, the line between what's allowed and what's not is often unclear, Hickman says. He uses credit lines to illustrate. It's clearly spelled out that an HSA cannot serve as collateral for a line of credit. There's little gray area there.

It's far less clear how personal lines of credit can be offered in conjunction with HSAs. The DOL guidance indicates such an arrangement is possible, but only if the HSA account holder receives no personal benefit from the arrangement.

Renewed scrutiny

Prior to FAB 2006-02, many HSA service providers had wrongly assumed that avoiding ERISA kept them out of prohibited transaction issues, Hickman explains. "FAB 2006-02 was DOL's affirmation that the prohibited transaction requirements applied, and that they applied with regard to many common situations (e.g., HSA overdraft protection and bundled service arrangements)."

So, over the last few months, stakeholders are re-examining what had been common practices. Many current practices may constitute prohibited transactions, says Hickman.

It behooves employers, vendors, custodians, and anyone else affected by this guidance to carefully review their procedures—ideally with counsel, says Hickman. The DOL has indicated its interest in policing this area, and you don't want to be noncompliant.

There are DOL and IRS penalties for noncompliance. For instance, HSA account holders engaged in prohibited transactions may forfeit their HSA's tax-favored status. Employers and HSA service providers also face penalties, including potential excise taxes and lawsuits from participants whose HSAs have been adversely affected.

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Transaction issues

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Credit problems

One of the biggest potential pitfalls relates to credit lines linked to HSAs. Many financial institutions provide credit lines intended to help fill in the gap between the deductible and the amount in the HSA. “Conceptually, this approach makes a lot of sense, because it will provide adequate funds to secure medical care,” Hickman says.

On its face, it’s not a prohibited transaction. As the guidance points out, “a prohibited transaction would not result merely from an HSA account holder directing the payment of HSA funds to the credit line vendor to reimburse the vendor for HSA expenses paid with a credit card.”

Prohibited transaction issues arise if the HSA serves as security against a loan or if the credit extension is on terms more favorable than are granted commercially outside of the HSA context. This could bar most traditional overdraft protection arrangements, Hickman warns.

Good business may cross the line

Offering discounts and incentives may be good business, but they could be bad business practice under ERISA and the prohibited transaction rules, Hickman says. There’s no “relationship banking” exemption for HSAs, as there is for IRAs. (In other words, a bank can’t promise someone a lower rate on other services or a toaster for opening an HSA.)

Cash incentives are allowed, but they too should be approached carefully, notes Hickman. Although cash incentives deposited to the HSA are not prohibited, he considers them “problematic.” It all comes down to where the money goes, he says. An HSA vendor may offer a cash incentive to a prospective HSA holder without creating a prohibited transaction, so long as that incentive is deposited in the HSA. But then the IRS contribution limits must be carefully monitored.

The real issue with incentives is whether they are deposited to the HSA—which is permissible—or provided to the HSA account holder, which isn’t. But even that isn’t completely clear.

Another common business tactic is completely off limits: If a discount or reduced fee is charged for other services (e.g., FSA administration or COBRA services) because the HSA is also offered by the same vendor, it could be viewed as impermissible “compensation” to the employer and thus in violation of the prohibited transaction rules. Therefore, great care should be exercised in “packaging” services, Hickman says.

Deposit promptly—or else

Another area of concern relates to how quickly an employer deposits employee contributions in the HSA. Employers who fail to transmit participants’ HSA contributions promptly may violate the prohibited transaction provisions of IRC Section 4975(c)(1)(D)—the same timely transmittal rules that apply to 401(k) plans. Likewise, it would appear that failure of an HSA administrator to forward such contributions to the HSA custodian would also be a prohibited transaction. Unfortunately, “prompt” isn’t clearly defined.

Ashley Gillihan, a member of Alston & Bird’s employee benefits group, addressed this issue during the workshop. He pointed out that IRA rules could provide employers with a helpful road map regarding what constitutes “promptly.” However, he also noted that what remains unresolved is how long the employer can hold on to the money before crossing the line into a prohibited transaction.

More guidance?

Some of the murkier issues may become clearer as the DOL moves forward with enforcement. Hickman expects the agency to address prohibited transaction issues on a case-by-case basis.

But at this point, it’s not an area into which employers or vendors should venture without guidance, he says. “Given the fluid nature of the law and the high stakes [and] penalties, I believe counsel should always be engaged.” ■

Until consumers 'get' CDHPs, plans can't fulfill potential

CDHPs require new mind-set from employees, employers alike, says Towers Perrin report

CDHPs have tremendous potential, but that potential isn't being met, according to the 2007 *Towers Perrin Study on Account-Based Health Plans* (ABHP, Towers Perrin's designation for what is often known as CDHP). Neither employers nor employees are fully reaping the promised rewards.

But unlike some studies critical of CDHPs, this one doesn't fault the plan design or the CDH philosophy. Rather, it finds that employees often don't "get" CDHPs, and employers aren't always doing enough to help them understand and embrace this new approach to healthcare coverage. (Some of the general media coverage of this study has reduced it to a condemnation of CDHPs. But it's more accurate to characterize it as a warning: Rethink how you approach these plans, or they won't endure.)

Well-designed CDHPs/ABHPs can have a tremendous positive effect on employee attitudes and behaviors related to healthcare (leading to better outcomes and lower costs). But plan design alone isn't enough to drive the necessary changes. Accomplishing that requires a new way of thinking on the part of employees and a new way of communicating on the part of employers and health plans, says **Jay Savan**, principal of Towers Perrin, St. Louis.

For CDHPs to work, we need to rethink our most basic conceptions of health coverage, says Savan. Success is contingent on employees developing a new mind-set regarding healthcare costs. That means they need to sign up and:

- ▶ Take a long-term view of health and healthcare costs, as opposed to a traditional 12-month perspective
- ▶ Respond to and demand increased transparency regarding costs, provider performance, and alternative treatments
- ▶ Respond to rewards for effective personal health management

In large part, how clearly a plan is communicated—initially and as an ongoing practice—is the basis of its success. A plan's specific features are less important than how those features are explained—the design itself doesn't make a notable difference in how workers perceive the plan. It's not that the features are irrelevant, but plan design and support resources make a difference only when employees understand them and can use them properly.

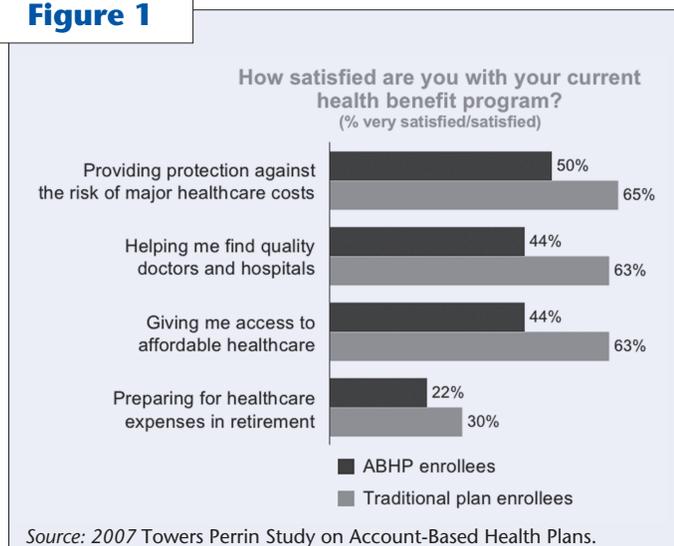
Once employees acquire that understanding, and once they're comfortable with the risk-sharing elements of CDHPs, then their satisfaction with the plan, and use of what the plan has to offer, is enhanced. But they aren't there yet. "This general lack of satisfaction, awareness, and understanding around ABHPs is a significant barrier to good long-term consumer behavior and positive change on the part of employees," the study says.

No satisfaction?

Employees enrolled in ABHPs are significantly less satisfied with many elements of their plans than are their counterparts in traditional plans (see **Figure 1** on this page). The report offers a few reasons why this is the case:

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Figure 1



CDHPs

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- Employee expectations of CDHPs appear to be shaped by comparisons with traditional plans
- Employees have negative emotional reactions to certain aspects of the program—particularly higher (perceived or real) financial risk
- Employees aren't always as impressed with the more positive aspects of these plans (e.g., employer contributions to the account)

But perhaps the biggest reason is that employees simply don't fully grasp CDHPs. "They clearly do not understand how the components work together or the overall value of the program," the study found. (Savan adds an

important observation: The plan-satisfaction data don't necessarily offer a ringing endorsement of traditional plans, either. Approval ratings from 30%–65% for various aspects of a system that's been in place for 70 years—or 25, if one counts only the managed care era—"isn't necessarily an overwhelming approval of the status quo," he says.)

It really shouldn't be a big surprise that employees don't really understand or appreciate CDHPs, says Savan. The concept runs counter to everything they've been told for decades. It's a shift from viewing healthcare episodically to viewing health and health financing as a durable proposition.

Cultivating a sense of well-being

The 2007 *Towers Perrin Study on Account-Based Health Plans* calls for creating a sense of well-being among employees. "Well-being" is a broad term, and for **Jay Savan**, principal of Towers Perrin, St. Louis, that's just fine. If employers want to "build a new culture around supporting employee well-being," they will need to take a broad, big-picture approach, he says.

The specifics will vary by employee population, but Savan offers some general insights into what such an approach may entail.

Educate

- Help employees think about their health and healthcare costs over a longer time horizon
- Encourage employees to think about health as an investment in future financial security
- Help build employee confidence in navigating the health-care system
- Describe the logic of tax-effective accumulation to help pay for future (including post-retirement) health costs

Encourage healthy behaviors

- Subsidize healthy cafeteria foods

- Stock healthy options in vending machines (ideally, instead of standard high-fat, high-sodium items)
- Replace donuts and rolls with fruit and whole-grain options at meetings
- Conduct health fairs, and include families in the event, to support healthy behavior (e.g., distributing bicycle helmets for kids, conducting car seat checks, etc.)
- Make mammography and biometric screenings available with follow-up guidance
- Offer programs to help participants overcome unhealthy behaviors (e.g., through smoking cessation, weight management, etc.) and help them understand the financial and physical implications of unhealthy behaviors

Provide meaningful benefits

- Offer coverage to protect against financial distress. (The definition of "financial distress" is fluid, but using the IRS' tax deduction floor of 6.5% of adjusted gross income as a basis, an employee earning \$40,000 per year would be fully protected beyond an out-of-pocket expense of about \$2,600, says Savan.)
- Provide benefits to help employees prepare financially for the future (through long-term care insurance programs, meaningful 401(k) contribution/match, etc.).

“We’ve spent the past quarter century telling people that all they had to be concerned about relative to their healthcare consumption, from a financial perspective, was a flat-dollar copay,” says Savan. “We’ve trained them to think episodically about health, which is the most nonepisodic thing we’ll ever experience. Think about it—your health is the one thing that lasts your entire life, never takes a break, never goes on vacation—it’s completely durable and nonepisodic.”

This cognitive dissonance presents a significant barrier to CDHP acceptance.

“It’s what clients bring up first,” Savan says, adding that a mea culpa is in order. Healthcare has been approached episodically for years. Now, we’re asking consumers to think “panoramicly.” It’s all part of creating the “new mind-set” that the study talks about.

Gradually, it’s happening: Savan points out that the study finds that those in CDHPs tend to view their healthcare costs—both premiums and point-of-care expenditures—in aggregate, whereas those in traditional plans tend to view them episodically and focus primarily on point-of-care expenses (i.e., what does it cost me when I go to the doctor?).

Inflated expectations

The dissatisfaction is across the board, and in some surprising places. For example, employees aren’t satisfied with how the plans help them find quality providers and

prepare for retirement—two areas in which CDHPs are supposed to excel (see **Figure 1** on p. 103). Such findings, says Savan, point to both misunderstanding and heightened expectations.

Participants want detailed information and useful tools to help identify quality, cost-effective providers, he says. But although the technology has improved, it’s not where it needs to be to help consumers truly differentiate among providers.

This shouldn’t be seen as a strike against CDHPs. But it is. “What’s challenging is that this same paucity of information exists, regardless of whether one is in a CDHP or a traditional plan. So the conclusion I draw is that the CDHP participants have a higher expectation that simply isn’t being met—yet,” says Savan.

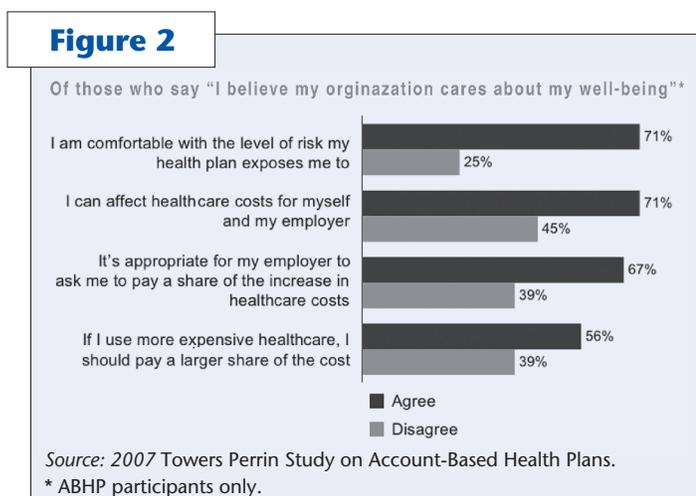
Conditions not yet in place?

So what needs to change? The report outlines conditions that need to be in place for CDHPs to fulfill their potential. Employees need to:

- Trust the employer and believe the company cares about their well-being
- Feel that the company promotes shared responsibility and rewards performance consistently
- Perceive that members of senior leadership communicate clearly and that their actions support their words
- Understand the promise of ABHPs and approach them with a new mind-set
- Be comfortable with the level of financial risk that they bear under the plan and how to manage it
- Feel confident that they have the ability to manage their health, their choices, their risks, and their expenses, and see a reward for doing so

To accomplish this, the study says, employers need to communicate information about ABHPs in ways that give employees a full understanding of the value of the program—its risks, as well as its advantages. They need to build employee confidence in both the concept and their ability to manage their health, their choices, their risks,

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CDHPs

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and their finances. And, as virtually every other study has pointed out, employers must provide ongoing support beyond the enrollment period.

Not saving

At this point, employees don't see these accounts as savings vehicles and thus are not exploiting the long-term potential of HRAs and HSAs. (See "CDHP participants aren't saving, new study warns" in the July **CDH**.)

So how do you encourage saving? Savan sees it as a twofold process:

1. Participants need to be educated about the significant savings opportunity that HSAs provide
2. Plan sponsors need to offer plans that allow for a meaningful accumulation

The first issue is the easiest to tackle, says Savan. "If you needed new car tires, and they were going to cost you \$400, would you take the money out of your 401(k) to pay for them?" he often asks people. Generally, he gets an answer along the lines of, "No, that would be dumb, because my 401(k) has special attributes that make it appealing to save that money; besides, it's for my retirement."

So, asks Savan, "Why is it not dumb to take money out of an HSA, for example, whose tax efficiency and accumulative power far surpasses a 401(k)'s, to pay for a \$100 physician visit or \$50 prescription?"

The second issue mostly involves plan design and—as has been brought up in other studies—whether (and by how much) employers "seed" accounts. It's also about encouraging employees to save and accumulate rather than spend and deplete.

Figures 3 & 4

Figure 3

How satisfied are you with the following features of your health plan?
(ABHP respondents only)

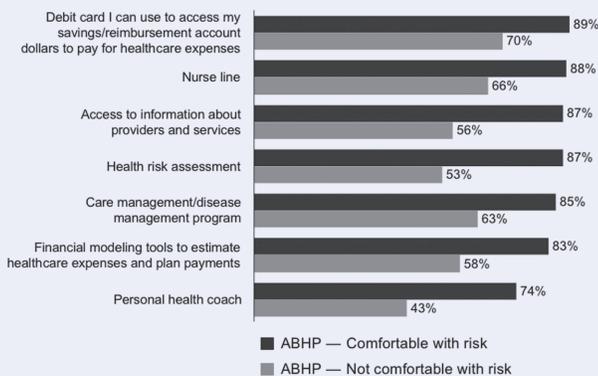


Figure 4

To what extent do you agree or disagree with these statements about your company?
(ABHP respondents % agree/strongly agree)



Source: 2007 Towers Perrin Study on Account-Based Health Plans.

Communicating design

Although much of the report focuses on communication, those issues are often inextricably related to plan design. Savan offers an example about how HRAs are positioned in plans.

Many HRA-based plans position a participant's FSA as the "second wallet," such that the HRA will pay any eligible expenses before the FSA. Although there are reasons to do this, it prevents a participant from using an FSA instead of an HRA to pay those expenses, allowing the HRA to accumulate for future (including retirement) use. "This is just an example, but it's the kind of example that demonstrates how plan design/operation can have a big impact vis-à-vis making it possible for people to actually try and realize the potential of these programs," says Savan.

Comfort and understanding

When employers are successful and employees have an understanding how their ABHP works and feel comfortable with the level of financial risk associated with it, they make better use of the plan and are better consumers. Health benefits and positive attitudes about the employer

are closely intertwined. Likewise, positive attitudes about the employer, comfort with ABHPs, and good consumer behaviors are highly correlated. (See **Figure 2** on p. 105.)

Companies that have cultivated trust—and whose employees believe the company cares about their well-being—end up with better consumers. Moreover, when employees are comfortable with the perceived risks, they are more satisfied with the tools available. (See **Figure 3** on p. 106.)

Increased comfort corresponds with increased plan satisfaction:

- ▶ Eighty-eight percent of ABHP members who are comfortable with their level of financial risk feel their experience in the health plan so far has been good, versus 29% of those who are uncomfortable
- ▶ Eighty-six percent of ABHP members who are comfortable with their risk level understand how their health plan works, versus 41% of those who are uncomfortable

Conversely, discomfort with perceived risk poses a barrier to the sort of behavior change that CDHPs demand. And this discomfort with risk is strongly related to negative attitudes about the company. (See **Figure 4** on p. 106.)

Gaining and preserving employee trust

To further cultivate a new mind-set, employers need to look beyond the CDHP, to the company itself. It's about more than changing behavior; it's about changing thinking.

Although behavior may change in CDHPs, says Savan, true engagement appears to be reserved for those plans and plan sponsors that take specific steps to:

- ▶ Reach out to participants and ask for their input on program development and rollout. "In other words, demonstrate respect for participant attitudes and input."
- ▶ Educate and inform participants; address their questions in an open and transparent fashion. "Listen and respond empathetically, taking participant input and feedback seriously and using it to inform the program's design, implementation, and ongoing management."
- ▶ Actively ask for help in addressing the challenge—at design and implementation and as an ongoing process.

"One of my ongoing recommendations to clients is that they engage a group of employees to serve as an advisory body to the people making decisions about the plan's design, rollout, and management," Savan says.

This panel should have teeth but also boundaries, with a group charter outlining its role. It should conduct regular, ongoing meetings both to educate the members and to solicit their input. "By doing this, we gain the trust of the individuals directly involved, as well as the broader work force," says Savan.

In many ways, it comes down to one of the basics of CDHP implementation: Engage. Don't impose.

"We believe it's essential for employers to establish trust before implementing a CDHP, so that the employee doesn't feel [his or her] employer is trying to simply cost-shift at the expense of [his or her] health," says **Andrew Webber**, president and CEO of the National Business Coalition on Health in Washington, DC.

It's simply about being a considerate employer; it's good business, he contends. "At a time when labor is becoming increasingly competitive, this is extremely important for the employer, who benefits from a loyal work force. Employers can do this by introducing CDHPs alongside of comprehensive cost and quality resources for their employees." If employees are going to have to cover more of the costs of managing their own healthcare, he says, "they have to feel confident that they have the tools they need to understand how to do it."

Comfort with risk

Engaging consumers, engendering a sense of well-being—ultimately, it all comes down to increasing the individual's comfort with perceived risk. But the irony, says Savan, is that generally ABHPs/CDHPs do not increase a participant's risk when compared to a traditional plan. "Rather, they change the character of that risk from predictable, or fixed, to contingent, or variable." He offers a simple explanation:

If you're enrolled in a traditional HMO with a \$10 copay and you pay \$300 per month for that coverage, you

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run the risk that your premiums—\$3,600 per year—will exceed your claims and that you'll essentially have overinsured yourself. So, in your HMO, you have a fixed risk of \$3,600 plus negligible copays (which represent your variable risk—variable based on the number of office visits you experience) that might bring your total risk to, say, \$3,650.

Now, decrease the premiums to \$100 per month and change your cost sharing to a \$2,450 deductible, after which the plan covers all your claims at 100%. There's no increased risk. It simply changes from \$3,600 fixed + \$50 variable to \$1,200 fixed + \$2,450 variable, but it's still the same total risk. (Granted, there is some uncertainty related to the potential cash flow challenge.) "Some people—a lot of people—are uncomfortable with this, and they misinterpret this dynamic as an increase in risk," Savan says.

He also points out that it's possible—in fact, customary—to increase risk without a CDHP/ABHP. Employers and insurers have been doing this for years. Helping employees understand and manage risk goes a long way to instilling the comfort and confidence needed for CDHP success.

Humanizing the process

It's about what the study calls building "a new culture around supporting employee well-being." (For more about this, see "Cultivating a sense of well-being" on p. 104.)

Webber agrees, and stresses that a healthy worksite is part of the larger picture. "One of the first goals of the employer should be to keep their employee out of the healthcare system," he explains. And a healthy work force begins at the top—it starts in the "C-suite." Webber echoes the findings of the study on this point: The key to changing corporate culture and morale is for employees to recognize that their employer is invested personally in their wellness.

Ultimately, says Savan, these programs are not just about plan design and tax savings. They are intended to create positive behavior that manifests itself in lower operating costs, enhanced individual and business performance, "and attainment of human potential through the effective management of our most precious economic and worldly asset—our physical health."

And on this point, he rejects the characterization of individuals as simply employees, consumers, or patients.

"They are mommies and daddies, uncles and cousins, nieces and grandpas, and their lives are driven by issues that transcend their employment relationship or their health plan," he says. "They deserve to be respected, involved, and informed about something as critically important to their families' financial security as the mechanism through which their health and care will be financed, and doing so will result in a more engaged and satisfied participant. Our survey data clearly shows this, and it's incumbent on plan sponsors to respond accordingly." ■

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