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CONSUMERISM IN HEALTH CARE: EARLY EVIDENCE IS POSITIVE

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Consumerism is working in the health sector, with a number of studies showing that companies and individuals who move to Health Savings Accounts and similar plans experience lower costs while maintaining access to needed health care.

Health Savings Accounts are the newest entrants in the field of consumer-directed health care. HSAs were created as part of the Medicare Modernization Act and became available January 1, 2004. They allow individuals, employers, or employees to invest tax-free dollars in health accounts to pay for routine health care. The accounts are accompanied by insurance policies to

cover larger medical bills.

America's Health Insurance Plans, which represents the country's major insurers and health plans, surveyed its members earlier this year and found that more than a million people were enrolled in HSAs as of March, 2005.¹ The study also found that 37 percent of those purchasing individual policies were previously uninsured.

While critics claim that HSAs will be attractive only to the young and healthy, studies have shown that 40 percent of HSA purchasers make less than \$50,000 a year, a majority of purchasers are families with children, and about half are over age 40,

showing they have broad appeal. Consumerism in health care also has led to new incentives for people to be more engaged in managing their health. Many companies are instituting new programs to provide better coordinated care for those with chronic conditions, such as diabetes, heart disease, and asthma. One study found that patients in consumer-directed health plans were 20% more likely to comply with treatment regimens for chronic conditions.²

HSAs are only one example of a constellation of offerings that give consumers more power and control over health care decisions. Other consumer-directed products, such as Health Reimbursement Arrangements (HRAs), also are helping companies to lower their health costs while providing incentives for employees to be more engaged in managing costs and care.

HRAs, which were enabled by a Treasury Department ruling in 2002, are sister accounts of HSAs but are available only through employers. Where deposits and insurance deductibles are prescribed by law for HSAs, HRAs give employers more flexibility to decide the size of the health fund contribution and the structure of health insurance plans. It is optional for employers to allow employees access to the funds after they leave or retire. Some companies that have replaced their traditional health insurance with HRAs have seen their health costs fall by more than 10 percent, even as the use of preventive services by workers increased by as much as 23 percent.³

The evidence so far:

Companies in the health field have produced a number of studies reporting on experience with consumer-directed health care (CDHC) products. In addition, others have conducted surveys and produced studies analyzing the advantages and challenges of CDHC. Here are some highlights of those studies:

eHealthInsurance, the largest on-line health insurance broker in the U.S. representing more than 140 major health insurance companies, conducted a survey of people who had purchased health insurance from among the 6,500 products it offered in the first six months of 2005.⁴ It reported that:

- o Premiums for HSA-eligible insurance *dropped* 15% between 2004 and the first half of 2005.
- o Nearly two-thirds of HSA purchasers paid \$100 a month or less for their plans.
- o HSA plans are comprehensive, with most covering 100% of the costs of hospitalization, lab tests, emergency room visits, prescription drugs, and doctors' visits after the deductible is met.
- o HSAs also continue to be attractive to those with modest incomes: More than 40% of HSA-eligible plan

purchasers earned \$50,000 or less annually.

- o Age distribution continues to follow a bell curve: 55% of HSA purchasers are under age 40, and 45% are over 40 or older, including nearly 19% who were age 50 or older.

An earlier eHealthInsurance Study found that young people who live in California have access to the least expensive insurance.⁵ The company looked at the lowest premium prices available in the country's 50 largest cities for 30-year-old singles buying a policy with a maximum deductible of \$1,000 and 20% coinsurance after that.

It found that seven of the least expensive cities were in California, with Long Beach the most affordable city at \$54 a month. The common denominator for the least expensive cities was competition and a less-regulated market: the top-ranked cities have at least 66 health plans available on eHealthInsurance.com.

Not surprisingly, the two largest cities with the most expensive insurance were Boston at \$268 a month and New York at \$334. (Both operate under state mandated guaranteed issue and community rating laws.⁶)

Since the 10 million young people aged 25-34 are the largest segment of the uninsured, representing 23% of the total uninsured population, this more affordable health insurance could be an option for many and would help broaden the insurance pool.

Assurant Health,⁷ the leading health insurer to individuals and small groups, analyzed its data to see who was purchasing Health Savings Accounts and found that:

- o 73% were families with children
- o 57% were over age 40
- o 29% had family incomes of less than \$50,000
- o *And most importantly*, 40% did not indicate having prior health insurance coverage.

America's Health Insurance Plans⁸

(AHIP), as mentioned earlier, found similar uptake among the uninsured in a survey of its members: 37% of those purchasing HSA plans were previously uninsured.

AHIP also found that the number of people purchasing HSAs doubled from September of 2004 to March of 2005, a fact that it attributed to lower premiums that are attracting employers, the uninsured, and older purchasers. Highlights:

- o 1,031,000 people had HSA-qualifying health plans as of March, up from 438,000 last September.
- o 27% of the policies in the small group market were sold to employers who didn't previously offer coverage.
- o Nearly half of the people covered by an HSA plan were over age 40.

The average premiums in the AHIP survey ranged from about \$100 a month for a

twenty-something single to \$460 for a family policy in the 55-64 age group.

Aetna has studied companies that had purchased Aetna HealthFund Accounts, its branded name for Health Reimbursement Arrangements.⁹

Aetna prepared a study in June, 2005, comparing HRA experience in 2003 to the first nine months of 2004 and found that employer savings basically were sustained in 2004. In 2003, medical costs in the HRA plans increased by about 4% and in 2004, they rose an average of 6%. This is higher than the first year, but still much less than the health cost increases experienced by companies offering traditional insurance.¹⁰

Other findings:

- o Costs fell by nearly 20% for some employers.
- o 50% of employees had some funds left at the end of the year to rollover into their account for the next year.
- o Lower use of inpatient, laboratory, and primary-care physician visits drove costs down.
- o CDHC plan participants are more likely to visit ambulatory care facilities and specialists than their colleagues in traditional plans.
- o Health measurements were stable for members with chronic conditions.
- o Companies with the highest employee uptake of CDHC plans had the greatest cost savings: Plan

sponsors with 70% or greater participation had a 13.4% decrease in medical costs. Plans with less than 5% participation, had a 9.9% increase in medical costs.

The company also found that those with chronic conditions, such as diabetics, continued to seek necessary care, and there were increases in the use of preventive services.

Aetna found that employers that made their CDHC offerings as attractive as traditional plans experienced the greatest participation and the most savings. Further, Aetna found that communication, education, and the engagement of leadership were crucial to the plans' successes.

McKinsey & Co. conducted the most extensive survey yet of consumer-directed health care plans, holding focus groups, one-on-one interviews, and an in-depth study of more than 2,500 Americans regarding their health insurance arrangements.¹¹ Most of the CDHC plans McKinsey studied were Health Reimbursement Arrangements but there were some HSAs in the study. It also eliminated adverse selection bias by studying consumer behavior under full-replacement health plans where employers offer only consumer-directed health plans to their employees.

McKinsey found that the early evidence about these plans is promising, but much more needs to be done before there will be broad acceptance in the marketplace.

It found that consumer-directed health plans increase consumer engagement in health care decision-making and health

management, and it found improved care for those with chronic diseases. But the biggest stumbling block right now is the lack of consumer-friendly decision support tools, especially information on prices. McKinsey found:

- o CDHC consumers were more value conscious: They were 50% more likely to ask about costs and three times more likely to have chosen a less extensive, less expensive treatment option. They also were much more likely to visit an urgent care center than a hospital emergency room.
- o Consumers were more attentive to wellness and prevention: They were 25% more likely to engage in healthy behaviors and 30% more likely to get an annual physical. Why? 51% of CDHC consumers agreed “If I catch an issue early, I will save money in the long run.”
- o Consumers are more attentive to cost control and to behavior changes that could result in better health outcomes and cost savings over the long term. CDHC consumers were more likely to perform independent research to identify treatment options, for example, even when insurance was paying, and they were 20% more likely to comply with treatment regimens for chronic conditions.

More work needs to be done before consumers will be generally happy with CDHC products. McKinsey found only 44% of CDHP consumers said they were more satisfied with CDHC plans than they

had been with their previous health plan. Many were dissatisfied with the information available to them to make health decisions, particularly the price differences among providers: 80% said they did not have sufficient information on the prices doctors charge.

This is the huge challenge of the CDHC movement. If consumers are to welcome new incentives to manage their health care and spending, they must have better information to support their decisions.

Some of our colleagues have argued that consumer-directed health care products should be held back until these decision support tools are in place. But these tools are much more likely to be developed quickly and to be more user-friendly when consumers are demanding the information. One major insurer that invested heavily in consumer-information support tools found that the system was seldom used because consumers had few incentives to become more informed and to shop for value.

In the Information Age, information about CDHC is absolutely key – both for employers and agents – in educating consumers about how HSAs and HRAs work, and obtaining user-friendly information about how best to use these accounts.

Harris Interactive conducted a telephone survey of 2,000 adults to gauge “Consumer Attitudes toward Health Care.”¹² One of the most striking findings in this survey was consumer ignorance about health care prices. “While consumers can guess the price of a new Honda Accord within \$300,” Harris found, “those surveyed were off by

\$8,100 in their price estimations for a four-day hospital stay.” In addition, 63% of those who had received medical care in the last two years didn’t know the cost of the treatment until the bill arrived. Ten percent said they never knew the cost.

Clearly, new programs that give consumers information about the true cost of the health care they are consuming are a positive step.

American Financial Group (AFG), a Cincinnati-based property and casualty company with 5,000 employees, conducted an in-depth survey of its employees to determine the best way to introduce CDHC plans.¹³ Senior executives at AFG were actively involved in explaining the new health plans and how they could make the company stronger and give them more control. Once employees understood the challenges facing the company with health costs, they better understood that they could be part of the solution with the new plan offerings. The results:

- o 54% of employees chose either the HSA or HRA plans in the first year.
- o Greater choice was the most popular feature of the new health plans.
- o Giving the new health plans the AFG brand, rather than the UnitedHealth product it was, created a sense of ownership and investment.¹⁴

Interestingly, the term “consumer” carried negative connotations. The employees don’t see themselves as consumers and said the term suggested to them a lack of control. They liked knowing they had “choice” and “control.”

The company does not have financial data on its program yet since it was just launched this January.

Public opinion pollster Frank Luntz of Luntz, Maslansky Strategic Research stresses that communications matter greatly. Luntz conducted a focus group in June to learn how average people outside the health care industry respond to information about Health Savings Accounts. Key points:

- o The fact that HSAs provide choices and allow individuals great flexibility in investment options, contribution times, and disbursements is a big selling point for consumers.
- o The idea of personal responsibility resonates. People want to be treated like adults, and nowhere does that impulse burn more brightly than in managing one’s health. HSAs are an innovative program that empowers consumers to take control of their health care decisions.
- o People are very attracted to the fact that HSAs have no “use it or lose it” penalty. Luntz asked participants for the single most important attributes in considering an HSA. The top selections were:
 - √ HSAs are 100% portable so your account moves with you.
 - √ Savings are owned by the HSA holder and roll-over from year to year.
- o HSAs’ tax-free earnings and tax-free deposits – as well as tax-free expenditures – drew huge accolades.

Luntz recommends that HSAs be described as follows:

“Wherever you go, your Health Savings Account goes with you. You own the account. It’s yours – bottom line. So whether you change jobs or houses or communities...your account moves with you. We all know the nightmare of changing *anything*. With HSAs, change is not a problem. Your account is 100% portable. It goes where you go...providing savings for your healthcare when and where you need it.”

Other challenges

Some employers also have been reluctant to take the step from HRAs to HSAs because HSA legislation would limit their ability to provide a prescription drug benefit alongside the HSA. Employers don’t want to discourage employees from taking needed medications and fear they would if they have to pay out of pocket.

However, the U.S. Treasury Department has ruled that certain drugs could be covered under the insurance contract as part of Congress’ “preventive care” authorization. Medications for chronic conditions such as hypertension, high cholesterol, diabetes, asthma, and osteoporosis can be covered by insurance for HSA holders without violating the provisions of the insurance deductible.

Moving forward

Early evidence reported here shows that actual experience with consumer-

directed health care products should calm the fears of critics that they would be attractive only to the healthy and wealthy. They clearly have broad appeal and offer a new option for the uninsured.

But the marketplace still has a lot of work to do to make consumer-directed health attractive to millions more people. Forrester Research forecasts that there will be more than 6 million HSA holders in 2008 and that they will accumulate almost \$5 billion in assets by then.¹⁵ Employers, employees, physicians, hospitals, consumers, financial institutions, health plans, and many others involved in the health sector are still experimenting with the best ways to structure and market their CDHC offerings. Better information tools, more consumer-friendly delivery options, more competition, and, most importantly, information on prices are essential for the market to work in the health sector, as anywhere else.

CDHC needs to catch on quickly enough for companies investing in new plans, technologies, and services to survive, but not so quickly that people are in the plans before the market is ready. The Goldilocks pace would be ideal – not too fast, not too slow, but just fast enough for the market to be able to respond to the demands of millions of new and newly empowered consumers seeking more affordable health insurance and better value in their health care.

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ENDNOTES

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