Consumer-Directed Health Insurance Products: Local-Market Perspectives

Improved information support is desired by both consumers and employers.

by Lydia Regopoulos, Jon B. Christianson, Gary Claxton, and Sally Trude

ABSTRACT: During the past few years, health plans have focused product development on consumer-driven health plans. This paper examines how these products are faring in twelve Community Tracking Study (CTS) communities. Although there has been a proliferation in the number and variety of consumer-directed plan options available, employers have taken a cautious approach. Given the increased financial stake and decision-making responsibility consumers hold when enrolled in these plans, respondents expressed frustration that the availability of information support has lagged behind the demands placed on consumers. [Health Affairs 25, no. 3 (2006): 766–773; 10.1377/hlthaff.25.3.766]

At the time of the Round Four Community Tracking Study (CTS) site visits in 2003, consumer-directed health plans were in their early stages of development. These plans are intended to improve consumers’ health care decisions by combining financial incentives with cost and quality information. This paper focuses on how consumer-directed plan benefit designs are faring in twelve U.S. communities. One common design features a spending account tied to a health plan with a high deductible; consumers retain the savings from making economical health care decisions and use them to offset future out-of-pocket spending.1 A second features tiered provider networks, in which providers are grouped according to their performance on measures of cost and quality, with financial rewards for consumers who choose to receive care from groups that do better on these measures. Few health plans offered consumer-directed products in 2003, and employers questioned these plans’ effectiveness in lowering costs and improving quality.2

During the past two years, Congress established health savings accounts (HSAs), and most large insurers introduced benefit designs based on the spending-account model.3 Health plans and employer benefit consultants developed a variety of methodologies for comparing the performance of health care providers, and a sizable number of vendor organizations developed tools to support consumers’ decision making. Development of tiered-network products continued in some markets.4
Using interview data from the 2005 CTS site visits, we describe the range of consumer-directed products available in the study communities and discuss factors perceived to be driving their acceptance. We examine employers’ views of consumer-directed plans, including how these views vary across markets and types of employers, and how employers assess progress made in consumer information support. We conclude by discussing the broader implications of our findings.

**Study Data And Methods**

The CTS has been described in greater detail elsewhere. During Round Five of CTS site visits (January–June 2005), we conducted 1,008 protocol-driven interviews with provider organizations, health plans, purchasers, and the public sector. Our findings are based primarily on interviews with representatives of commercial health plans, large employers (with more than 500 local employees), third-party administrators, benefit consultants, and health insurance brokers.

In each community we completed multiple interviews at the three largest health plans, based on enrollment, typically including a regional Blue Cross and Blue Shield plan, a national plan, and a local plan. We interviewed representatives from fourteen regional Blues plans, two local health maintenance organization (HMO) Blues subsidiaries, twelve local plans, and twelve local divisions of four distinct national plans. Respondents usually included chief executive officers, marketing executives, and network contracting directors. We also interviewed several national respondents affiliated with consumer-driven health plans and representatives of approximately sixty public- and private-sector employers.

Our study elicited viewpoints from representatives of health plans and employers by asking neutral, open-ended questions about each type of consumer-directed plan. As a result, findings represent the range of issues identified by respondents. In particular, health plan executives were asked to describe their full line of products and any changes made since 2003. For new offerings, health plan representatives were asked about the strategic reasoning behind the launch. Large employers’ benefit managers were asked about any plans to offer a consumer-directed plan and their reasons for choosing whether or not to offer a product. Benefit consultants and brokers, representing large and small employers, respectively, were asked about their views on health reimbursement arrangements (HRAs), HSAs, and tiered-network products as well as the advice they give clients. All respondents were asked what decision support and consumer information they would like health plans to provide that is now unavailable. Respondents from health plans and employers offering consumer-directed plans described the information and decision support they provide.

**Study Findings**

- **Expanded range of consumer-driven products.** Over the past few years, health plans have focused new product development activities on consumer-directed plans, adding a range of products and features to their offerings. The vast majority of health plans in the CTS sites now offer HRA and HSA products, but high-deductible designs without savings accounts are common as well. HRAs and HSAs both combine a high-deductible health plan with a spending account that can be used to pay medical expenses and premiums. HRAs are solely funded by employers. Although unspent funds can be carried over from year to year, employees may not keep the balance if they leave their jobs. Employers and employees may contribute to HSAs, and employees keep the balance even if they leave their jobs or switch plans.

Even organizations closely identified with traditional HMOs now offer high-deductible products, and many have added, or are planning to add, spending-account products as well—a striking change because HMOs are known for traditional copayment models without deductibles. For example, Kaiser Permanente in Orange County has introduced several high-deductible products and plans to add an HSA in 2006. Although its core HMO product remains strong, Kaiser reports sizable...
enrollment in its new high-deductible products. In Seattle, Group Health Cooperative (GHC) introduced high-deductible plan options several years ago, and enrollment in those products rose from 35,000 in 2003 to about 100,000 in 2005, out of 590,000 covered lives. GHC is now introducing both HSA and HRA products.

Alternatives to HRAs and HSAs have emerged in some markets, combining a high deductible (followed by coinsurance and catastrophic coverage after an out-of-pocket limit has been reached) with some first-dollar coverage. For example, the FourFront product offered by Regence Blue Shield in Seattle provides coverage for four office visits and the first $500 in diagnostic and laboratory tests before the deductible applies. Excellus, a Blue plan in Syracuse, offers a similar product, as does Premera, a Blue plan in Seattle. Humana markets its CoverageFirst design in Miami, under which the health plan pays the enrollee’s first $500 in expenses, followed by a deductible paid by the enrollee. PacifiCare in Orange County has a product in which the health plan manages a savings account funded through the premium. In some communities, these products have garnered sizable enrollment. For instance, Regence, which introduced its FourFront product two years ago, reports an enrollment of approximately 100,000, out of more than one million members. The products positioned as HRA/HSA alternatives typically are offered as fully insured plans to mid-size and small employers that wish to avoid the perceived costs and administrative demands associated with spending accounts.

Belief in spending account approaches. Some health plans in the CTS sites appear to embrace the concept of consumer engagement and view it as the likely future direction of health care. This attitude is evidenced by statements made by the health plan managers interviewed as well as by plans’ level of investment in HSA, HRA, and other consumer-directed approaches. National plans and a few regional Blue plans most commonly shared this belief. For example, United Healthcare nationally has invested heavily in consumer-directed products by purchasing Golden Rule and Definity, in addition to its own bank, for administering HSAs.7 Local United Healthcare respondents noted the company’s commitment to HSA products and felt that the purchase of those entities and the resulting ability to offer an integrated product—combining the high-deductible plan and administration of the savings account on one platform—gave it a competitive advantage.

Defensive strategy. Other health plans are not as convinced that HSAs or HRAs will become lasting, popular products or have the potential to greatly affect the use of services. Typically, local plans and regional Blue plans offer these products largely for defensive purposes. They feel the need to match their competitors’ offerings in the quest for new employer accounts and the retention of existing ones, and they can’t risk not offering these products because of the “buzz” surrounding them. They attempt to maintain a menu of product options, which allows them to respond to diverse employers’ demands. Respondents representing an HMO noted that offering high-deductible products gave it a “foot in the door” with certain employers seeking lower-cost insurance options, whether or not the employer ultimately decided to offer the high-deductible product.

A few plans also reported implementing high-deductible products—with or without a spending account—to guard against adverse selection that might occur if their more comprehensive products were offered in conjunction with competitors’ high-deductible products. A respondent from a plan known for its HMO product reported that it often was the comprehensive plan in employers’ multiproduct offerings. Adding a high-deductible design improved the plan’s risk pool and, according to the respondent, contributed to the plan’s financial turnaround.

Employers’ cautious approach. Despite the range of new HSA products being marketed in the CTS sites, employers have taken a cautious approach in adding these products to their benefit plans. For example, while Arkansas Blue Cross Blue Shield received almost 300 requests for information on
HSA or HRA products, only twelve employers chose to offer them in 2005. In general, when these products were offered to employees, take-up rates were in the range of 2–35 percent but typically were under 15 percent. The 35 percent enrollment, an anomaly in the sites we visited, was achieved by a Syracuse-headquartered employer offering an HRA after an intensive employee educational effort.

Across markets, health insurance brokers and benefit consultants have found much business in educating purchasers about the mechanics of spending-account products, the details of relevant regulations, and the trade-offs between HRAs and HSAs. Benefit consultants and some employers reported that most employers have adopted “wait and see” attitudes. We found that the factors influencing employers’ decisions around these new products appeared to vary by type of employer, market characteristics, and product design.

Type of employer. National surveys have shown that very large employers have been supportive of HSAs and HRAs. Many of the national employers we interviewed offered these products at the time or planned to do so in 2006, but always as an option alongside more traditional product types. Although, as we noted previously, some analysts expect that HSAs and HRAs could experience favorable risk selection, employers in the study sites did not view this as a problem, because of relatively limited enrollment and because employers can set employee contribution levels to discourage favorable selection.

Many benefit managers expressed the opinion that HSAs will be the most appealing to high-salary, white-collar workers, who will value them primarily as an additional tax-free savings vehicle. Further, for some employers, HRAs and particularly HSAs have the potential to offset cutbacks in retiree health benefits, particularly for those who are not yet eligible for Medicare. Benefit consultants noted that as employers search for alternatives to traditional retiree benefits, account-based products are appealing. Employers favor them because an accounting regulation effective since 1995, FAS 106, mandates that companies record as a balance-sheet liability the estimated cost of anticipated future payouts in retiree coverage. However, employers and consultants expressed concern about the amount of time required to build up the accounts, noting that only younger workers have the potential to accumulate sufficient funds to cover a sizable portion of their health care needs in retirement.

Unionized employers seldom offered HSAs or HRAs to their employees. Unions typically opposed these products, viewing them as simply tools to shift more health care costs to union members. One respondent also observed that union negotiations often become protracted to the point that even if an agreement were reached to offer an HSA or HRA, there would be insufficient time between the end of negotiations and the start of the new benefit period to permit adequate education regarding plan design features.

Public employers also were less likely to be enthusiastic about HSAs or HRAs. Unionization among public-sector employees is one factor. Also, the high level of out-of-pocket costs associated with these products is not aligned with public employers’ traditional benefit structures, because generous benefits are usually considered key to recruiting and retaining public-sector employees. In the twelve CTS sites, two state employers offering HSA products in 2005 experienced low enrollment. Arkansas began offering an HSA product at the start of 2005 as one of nine options. At the time of the site visit, only fifty-five state employees had enrolled. This probably reflected a premium structure that set the HSA product’s premium at about the same level as that of the HMO. Similarly, South Carolina added an HSA product in October 2004, but only 1.8 percent of employees enrolled. Disappointing initial enrollment led other public employers, including the State of Ohio and Marion County in Indiana to drop their high deductible or HSA plans. Florida plans to offer a spending-account product soon but expects initial enrollment to be low.

Small employers face a different set of problems when considering implementing these
approaches. According to broker respondents, some small employers made HSAs available to their employees as the only health insurance option but made no contribution toward the spending account. Small employers with high-salary employees reportedly offered HSAs because of their tax benefits. However, other small employers avoided offering HSAs out of concern for administrative costs. In addition, smaller employers with expectations of high claims were less apt to implement an HSA, believing that employees with more immediate health concerns likely would not be able to accrue enough money to defray costs.

Variation by market and product design. Market-specific characteristics affected the spread of new product types in CTS sites. One of the most important is the historical dominance of a certain product type or level of benefit in a market. Insurance markets in Orange County and Miami continue to be dominated by HMOs despite the trend away from such products elsewhere. In these markets, where consumers are accustomed to first-dollar coverage, and copayment models, the transition to higher-deductible health plan approaches is challenging. Although all of the plans in the Orange County market have introduced or are now developing a variety of products based on HSAs, HMO products have seen little or no erosion of enrollment to date. In Orange County, unlike many other markets, HMOs continue to hold a strong price advantage, a clear factor in their continuing popularity. Enrollment in HSAs and HRAs has been limited in Miami as well. We interviewed two Miami employers with plans to offer HSA benefit options in the near future, but both expected enrollment to be low. One of those employers, a large private company with a statewide workforce, will introduce a prescription drug benefit in 2006 that includes a $100 spending account with a $300 deductible along with education and decision-support tools to help employees adjust to the plan design. The company believes that this strategy will allow it to attract more employees into HRA and HSA options to be offered in 2007.

In contrast, the movement to plan designs with higher cost sharing has occurred much more rapidly in other markets. For example, sales of HSAs in small groups in Greenville (South Carolina) have been strong—in the range of 15–25 percent of new sales for some plans—reportedly because typical preferred provider organization (PPO) plan designs in Greenville are lean, with deductibles of $500–$1000 and 20–30 percent coinsurance. Thus, the transition to HSA-compatible high-deductible plans is not seen as a major change.

In markets where benefit coverage historically has been relatively comprehensive, insurers have introduced “transition products” that contain some first-dollar coverage but also deductibles that encourage cost-conscious behavior. These products can cost 10–15 percent less than the most common plan designs. FourFront and CoverageFirst are examples of transition products.

Other employer strategies. Despite the tremendous attention being garnered by HSAs and HRAs, they are only one part of employers’ health care strategies. At the time of Round Four of the CTS site visits (2002–2003), employers were focused on increasing employee cost sharing in the form of higher copayments and coinsurance, deductibles, and premium sharing. The strategies of larger employees are more nuanced now. Employers offering HSAs and HRAs see them as a way to increase employee cost sharing and also laud their potential to provide employees with the incentive and the means to be wiser consumers. However, they continue to place great emphasis on health coaching, disease management, and case management programs for workers with health risks. Some are coupling these efforts with predictive modeling to identify employees at risk of high costs in the future. Others are providing incentives for employees to complete health risk assessments, whose results feed into predictive modeling efforts and recruitment of employees into health promotion programs.

Tiered networks. During Round Four of site visits, tiered health plan arrangements were just beginning to emerge: Nine plans were offering these products in six communi-
ties. Although these products were new and enrollment was small, some health plans and providers saw tiered networks as a viable way to encourage enrollees to use lower-cost, higher-quality providers. We found continued interest in tiered networks but little expansion of offerings in our most recent site visits. Tiered networks were being marketed or planned for the next year in seven sites, and enrollments remained low. A noteworthy difference between site visit rounds was that respondents’ comments have now shifted from theoretical questions surrounding whether plans would base tiers on cost, quality, or both, to more technical discussions of feasibility. For example, respondents now are concerned with providers’ willingness to participate and the degree of cost differential between tiers.

Respondents offered several explanations for why tiered networks had not become major benefit options in their communities. Provider resistance, especially in communities with one or two dominant hospital organizations, continued to be cited as a roadblock. Some of these systems simply refused to be offered in a tiered product, essentially halting the product’s development and marketing. Other providers, while not holding dominant market positions, were at capacity and did not feel a need to compete for new business as part of a tiered network. Lack of real employer support was another common theme. When tiered-network products were available, some employers offered them alongside their self-insured PPO. In this case, consumers wanting access to a provider in a high-cost tier simply avoided the tiered product, choosing the PPO option.

The construction of tiers also has met with difficulty. For example, health plans might not have sufficient data about the performance of low-volume providers or individual physicians to assign them to tiers. Also, provider performance might not be consistent across the areas measured. Where there is much variation across individual providers within organizations, purchasers and benefit consultants recognized that tiers built on ranking these organizations could be misleading to consumers choosing individual providers.

Finally, some consultants pointed out that the savings from identifying groups of “high-performing” providers and building preferred options around them might not be as large as anticipated. Employers had hoped for differentials of 15–20 percent as a reward to consumers who selected these providers, but actual differentials, according to some respondents, have been in the area of 5 percent—insufficient to influence consumers’ choices, they felt, and probably not worth the costs of constructing the product.

The future prospects for tiered networks appear highly uneven across the CTS communities. In Indianapolis, for example, the Central Indiana Employers Forum is leading an employer effort with health plans to develop tiered-network products. However, in many other CTS communities, there is little or no employer demand for tiered networks, with employers focused on increasing employee cost sharing as a more dependable method for achieving immediate savings.

Consumer information support. Given consumers’ increased financial stake and decision-making responsibility when they enroll in consumer-directed plans, respondents often cited the need for strong consumer information support and expressed frustration that, in their opinion, the availability of adequate support has lagged behind the demands these products place on consumers.

We found that most health plans in CTS communities have invested in consumer information tools during the past two to three years, through either internal development or contracts with vendors. Although the driver has been the need to support their consumer-directed products, an important spillover effect has been that carriers typically make these tools available in their other products as well. Despite these efforts, it appears that the implementation of new health plan benefit designs is more advanced than the availability of reliable cost and quality information to support them.

Virtually all health plans have an online presence, although the tools vary widely in so-
phistication. At a minimum, health plans provide information online about common health-related questions, often through contracts with vendors. Some provide detailed information on specific conditions, advice on what to ask one's physician, and treatment alternatives. A second, relatively common, level of information support is assistance in choosing among plan options. Employees enter information about their past health care costs and expected health care use for the upcoming year, and they receive information about the likely cost of different options. Some tools automatically import employees’ claims from the previous year and incorporate the results of a health risk assessment. Similar tools assist with managing HSAs.

A third level of information support receiving much attention enables consumers to compare providers on cost and quality. Most major plans in these communities offer comparative hospital quality data on measures such as length-of-stay, complication rates, volume of procedures, and readmission rates. These data are typically purchased from a contracting vendor that has assembled information from Medicare hospital claims, although a small number of plans (such as PacifiCare) construct their own comparisons. Some plans attempt to indicate “value” by including dollar-sign rankings as well as quality indicators.

Comparative information on physicians is provided much less often by health plans. The prices of physician services are considered to be proprietary information by both health plans and physicians. However, cost comparison tools displaying generic versus brand-name drug prices are common. Many plans also offer cost estimators that include the average unit cost of a procedure by facility or region.

Shortcomings remain. Although information to support consumer decision making has become much more accessible, respondents identified several areas for improvement. Some noted that hospital comparisons involve a limited set of measures and that the underlying methodologies are not always clear or consistent. Thus, consumers might find conflicting performance rankings across different sources of information. Comparative data on physician performance that are accessible to consumers remain very sparse. This is especially true for specialists, whose decisions often have important cost implications for consumers and employers. Health benefit managers and consultants also are pushing health plans to reveal provider-specific costs rather than average costs. They also would like health plan tools that calculate the cost of “episodes of care,” because they believe that unit-cost information by itself can be misleading. In other words, a provider might be more expensive per service but ultimately have a lower cost for the entire course of a patient’s treatment, or vice versa.

**Policy Implications**

At the community level, a dynamic situation now exists with respect to plans’ development of new consumer-directed products as well as the creation of decision-support tools for consumers, with product development leading the way. When HRAs were introduced, their developers initially welcomed some policies such as rulings that allowed spending-account rollover but feared that stronger government involvement could stifle product innovation. In some of the CTS markets, new products developed by insurers have proved to be more popular than HSAs, whose parameters are set by legislation. A good example of this is the FourFront product being sold in Seattle. Although some respondents expected almost all employers to move to high-deductible plans eventually, others felt that legislated product features could limit these products’ attraction for employers. Enrollment in all consumer-directed products at CTS sites was relatively small at the time of our visits, so it is not clear who these products ultimately will attract or what type of regulatory oversight, if any, might be appropriate.

Because of employees’ limited take-up of consumer-directed products thus far, concrete evidence regarding the products’ performance is limited. It is still too early to evaluate either the successes or the problems with these products in the CTS sites. Also, the private sector is
still actively experimenting with solutions to rising health care costs and quality-of-care concerns: Employers are combining consumer-directed plan options with a more vigorous approach to disease management and growing use of health risk assessment, and health plans are expanding their pay-for-performance efforts. New regulations to promote or control consumer-directed products could unintentionally stifle experimentation. At the same time, this experimentation makes it difficult for policymakers looking to the private sector for models of consumer-directed approaches that could be incorporated in public programs.

In addition, consumer information and decision support continue to evolve. One common concern of employers is that employees might not be able to make informed choices with the current level of information support. Their concern relates primarily to the quality and quantity of comparative data on provider performance. Collaborative public/private-sector efforts under way at the national level have focused on defining standard clinical measures of performance, and this is critical for both the support of consumer decision making and the construction of tiered networks. However, less attention has been given to the disclosure of price information by providers and health plans. Our work suggests that progress in this area would increase purchasers’ enthusiasm for consumer-directed plans.

This research was conducted as part of the Center for Studying Health System Change’s Community Tracking site visits, which are funded by the Robert Wood Johnson Foundation.

NOTES
5. See P. Kemper et al., “The Design of the Community Tracking Study: A Longitudinal Study of Health System Change and Its Effects on People,” *Inquiry* 33, no. 2 (1996): 195–206. Study communities include Boston, Massachusetts; Miami, Florida; Orange County, California; northern New Jersey; Cleveland, Ohio; Indianapolis, Indiana; Phoenix, Arizona; Seattle, Washington; Lansing, Michigan; Syracuse, New York; Greenville, South Carolina; and Little Rock, Arkansas.
6. Definitions of these terms are available online at http://content.healthaffairs.org/cgi/content/full/25/3/766/DC1.
11. Mays et al., “Tiered-Provider Networks.”