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How to Design Consumer-Driven Health Care Plans

Which Model is Best for You?

Benefit managers can use the information in this brief to develop health benefit programs and to form the basis of communication materials on new plans for employees.

Components of Consumerism

Keys to Model Success

According to experts, successful consumer-driven health models have five primary features. This paper discusses these characteristics and how they may be included in a number of different models.

- 1 **Personal savings accounts attached to an eligible health plan.** This is the main component of a consumerism model and drives the need for the other four criteria. This paper discusses the variety of health plans and personal savings accounts employers can develop and offer their beneficiaries.
- 2 **A wellness program that provides incentives for positive health behavior.** Health improvement/wellness programs, provide employees and dependents opportunities to improve health and engage in positive lifestyles that could prevent future diseases. Employer-sponsored or employer-supported health improvement programs also offer beneficiaries a chance to save money in personal savings accounts by reducing the need for health services.
- 3 **Disease management programs.** Disease management programs can help employees and dependents manage conditions such as diabetes, asthma and cardiovascular disease that cause detrimental health problems and increased costs.
- 4 **Decision support tools** that will provide consumers with information on:
 - Pricing of all services including providers, facilities and medications.
 - Evidence-base for all interventions and prescribed treatments.
 - Options for treatment and/or alternatives to treatment.

Consumerism, consumer-driven, consumer-directed and consumer-centric are all terms for the same model of health care: individuals taking a greater financial responsibility in exchange for more options in health care decisions and options.

- 5 **Rewards and incentives for successful participation in prevention, disease management or health improvement programs.** Rewards and incentives provide a reason (in addition to the opportunity to improve one's health) to practice healthy lifestyle behaviors and use health care services appropriately. The section on developing incentive and health improvement programs to support consumer-driven health care plans explains this concept in greater detail.

Structure of Consumer-Driven Plans

Employer-sponsored consumer-driven health plans consist of two main components:

- ✓ Health plan benefits
- ✓ Health-related personal savings accounts



Health-related personal savings accounts provide tax-free financing or reward incentives to employees that participate in consumer-driven plans (descriptions of these plans occur later in this brief.) Employers can augment these plans and personal savings accounts with other health benefits such as worksite or employer-sponsored health improvement programs, clinical preventive services and employee assistance programs.

Consumer-driven health plans provide greater opportunities for beneficiaries to manage their health care than managed care or traditional indemnity plans. With this additional flexibility comes higher deductibles and co-pays than other plan types. There are three main types of consumer-driven plans — high-deductible health plans, point-of-service plans and preferred provider plans.

High-Deductible Health Plans

A **high-deductible health plan, or HDHP**, is any health plan with an annual deductible higher than standard indemnity plans. Even though the deductibles are higher, they still have limits. HDHPs have a minimum and maximum limit on out-of-pocket medical expenses for both individuals or families. The deductible excludes premiums.

- ✓ For an individual the minimum deductible is \$1,000 and the maximum deductible is \$5,000.
- ✓ For families, the minimum deductible is \$2,000 and the maximum deductible is \$10,000 per year.

- ✓ For family plans that offer both a family and an individual deductible, the individual deductible must be at least \$2,000 to qualify as an HDHP. For example, a health plan with a \$7,000 family deductible but a \$1,500 individual deductible does not qualify as an HDHP.

Key Components of HDHPs

High-deductible health plans need two criteria to work effectively and provide the best health and financial outcomes.

- ✓ **Transparency** — In order to make informed decisions, employees need to know the true cost of health care services and medications they are spending their money on including the true cost of health services to make informed decisions. Many health care consumers erroneously believe that co-pays are the full charge for health care services and will be surprised to find otherwise under HDHPs. For example, with high-deductible plans, consumers may not have a co-pay for prescription drugs until they reach their deductible. Employees need to understand the costs associated with different pharmaceutical options such as formulary versus non-formulary, brand name versus generic and store versus mail order, in order to make informed decisions.
- ✓ **Preventive Services** — HDHPs stress preventive services. The U.S. Treasury Department allows HDHPs to provide preventive services with first dollar coverage (100% reimbursable) or with a reduced deductible that is lower than the deductible for other services.
- ✓ Therefore, employers may offer any of a host of preventive services that are permissible by IRS standards. Currently, the IRS places limited restrictions on what it considers preventive services.

USPSTF:

The U.S. Preventive Services Task Force (USPSTF) is a group of health experts that reviews clinical evidence to make recommendations about preventive services.

HEDIS:

The Health Plan Employer Data Information Set, or HEDIS, measures, examines and compares health plans according to a set of quality indicators. The National Committee on Quality Assurance (NCQA) develops the HEDIS measures.

The preventive services the IRS lists mirror those addressed by the U.S. Preventive Services Task Force's (USPSTF) clinical preventive service recommendations. This paper provides a list of preventive services that health plans may cover for children and adolescents that meet IRS regulations and follow the USPSTF recommendations and NCQA's HEDIS measures.

Carve-Out Programs

Individuals and family members cannot have additional health plan coverage if they have an HDHP. Employers may provide carve-out services not included in the HDHP. These services areas include:

- Vision
- Dental
- Long-term care
- Coverage for disease management
- Fixed-amount hospitalization

Other allowable services, not traditionally included in a health plan, are:

- Worker's compensation
- Accident insurance
- Disability (long term and short term)

Pharmacy plans present a different case than other carve-out programs. They provide employers with a number of options. Employers can include them in an HDHP and provide services under a deductible or they can offer them as a separate plan not under the deductible. In the future this will have eligibility implications for health savings accounts. Currently, individuals can qualify for a health savings account even if the pharmacy plan provides benefits before an individual meets his or her deductible. This will change after 2005 when pharmacy plans will need to be under the deductible for an individual to be eligible for a health savings account.

Other Consumer-Driven Health Plans

While high-deductible plans are the most visible plans in a consumerism model, in actuality any health plan that is offered in conjunction with a personal savings account (such as a health savings account, health reimbursement account or a financial savings account) can be defined as a consumer-driven health plan. This may include health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point of service (POS) plans or indemnity plans that are characterized by higher deductibles, but do not meet the IRS definition of a high-deductible plan.

Personal Savings Account Plans

All information on specific financial health plans comes from the US Internal Revenue Service Guidelines and can be found at <http://www.irs.gov/publications/p969/ar02.html>.

Qualified medical expense: any medical expense allowed by the Treasury Department to be paid through a health financial account such as a health savings account or a flexible spending account.

As explained in the previous section, employers can combine several different types of personal savings accounts with consumer-driven health care plans that may provide beneficiaries with tax-free subsidies for health care expenses. Each of these accounts provides different options and benefits and comes with a different set of restrictions.

Health Savings Accounts

A health savings account or HSA is a tax-exempt account that may earn a return through investments. An employer, individual, or trustee can set up an HSA to pay for or reimburse qualified individuals for certain medical expenses. Employers and employees can contribute to an individual HSA that can compliment a high-deductible health plan to offset costs such as deductibles, copays, medications and supplies. HSAs invest money either in stocks or bonds like a 401K or 403-B account. Individuals can only remove money from these accounts for qualified medical expenses or if they are older than 65. Removal for any other reason or premature removal will result in a 10% tax penalty.

HSAs are restricted accounts. To qualify for an HSA, an employee must meet the following requirements:

- Enroll in a high-deductible health plan
- Have no other unpermitted health coverage. Permitted coverage plans include dental, vision, long-term care, accident and disability plans. Pharmacy plans only apply if the plan does not provide benefits until an individual meets the health plan deductible.
- Be ineligible or not enrolled in Medicare
- Not qualify as a dependent of someone else for tax purposes

HSAs are individual accounts. Spouses or partners who may be eligible for an HSA must open their own accounts — HSAs cannot be joint accounts. Because of the claimed dependent rule, most children and adolescents (aside from those who may be employed or emancipated) will not be eligible for an individual HSA. Instead, parents may use their HSA funds to pay for health care services for their children.

HSAs have a number of benefits. These include:

- Tax deductions to the individual for any amount contributed by the individual or the employer
- Employee contributions may be excluded from gross income, lowering an individual's total taxable income

- Contributions are real dollars — they stay in the account from year to year until an individual uses them. Employees will not lose value in the account at the end of the year or after moving to a different employer
- Interest and other earnings from these accounts are tax free
- Any amount used for qualified medical expenses is tax free (taxes will only occur when money is withdrawn for non-qualified medical expenses at a 10% penalty)
- HSAs stay with the individual; they are not tied to a particular employer

HSAs can cover insurance premiums as qualified medical expenses only under certain circumstances. These circumstances include premiums for long-term care coverage, health care coverage during unemployment, health care continuation coverage and for non-Medicare supplemental health policies for those over 65.

Employers and employees can make contributions to an HSA, but only up to certain limits. Annual limits for individuals with self-only coverage are the amount of the HDHP deductible not exceeding \$2,600 (between \$1,000 and \$2,600). For family coverage, the annual limit is the deductible amount not exceeding \$5,150 (between \$2,000 and \$5,150). If an individual is over 55, that individual can contribute an additional \$500 per year. These values may change from year to year.

Health Reimbursement Accounts (HRAs)

A health reimbursement account or HRA is vastly different than an HSA. The main difference between the two is flexibility. HSAs are bound by a series of federal regulations. In contrast, employers are allowed to design HRAs and determine their benefits and limits as they see fit. Other differences include:

- HRAs are not real dollars until costs are incurred. They cannot transfer to different employers and values may not carry over from year to year like HSAs. Contribution amounts can only go toward incentives or health care services. They are not transferable or cashable like contributions to HSAs.
- HRAs are tax-free employer contributions to subsidize health care costs or to offer incentives for employees to engage in healthy lifestyles or prudent medication use.
- Only employers can offer HRAs. Unlike HSA accounts, self-employed individuals cannot issue or participate in HRAs.
- Employers have complete flexibility in the offerings and set up of HRAs. Where an HSA must adhere to a number of strict guidelines, employers decide levels of contribution, uses and incentives under an HRA. However, some highly compensated employees may need to adhere to certain guidelines.
- Employers have no limits set on contribution amounts.
- An individual can have an HRA with any type of health plan. Where employers can only offer HSAs with an HDHP, HRAs will work with managed care plans, fee-for-service plans, other indemnity health plans and even public assistance plans such as Medicaid.

HRAs do not travel with an individual when they leave an employer. Because they are employer-created, they are tied to a particular employer.

HRAs have a number of benefits including:

- Employer contributions may be excluded from gross income, lowering an individual's total taxable income.
- Reimbursements may be tax free for qualified medical expenses paid through the HRA.
- Unused HRA amounts may be carried forward into future years. This, however, is subject to the discretion of the employer.
- HRAs can work in combination with other health benefits based on the employer.
- HRA funding comes solely from employer contributions and cannot come from salary deferrals. Such contributions cannot be counted as a portion of income.
- Employer contributions to HRAs are exempt from federal income taxes and employment taxes.

Flexible Spending Accounts

A flexible spending account or FSA is an account that allows employees to spend their pre-tax dollars on qualified medical expenses. An employee can fund an FSA through a salary reduction and through employer contributions. FSAs share characteristics with HSAs (they are funded by real dollars) and with HRAs (they offer employees flexibility).

FSAs have a number of benefits including:

- Employee contributions may be excluded from gross income, lowering total taxable income.
- All contributions are tax free (taxes will only occur when money is withdrawn for non-qualified medical expenses).
- FSAs have no regulatory limit on contributions — either for employers or employees. However, the FSA must determine a limit for either a maximum dollar amount or a maximum percentage of compensation that an individual can contribute. This means an employer will set the total limit in an individual's FSA or the total percentage of salary an employer can secure in an FSA.
- Employers can offer FSAs in conjunction with other benefits and are not restricted to just to those employees participating in HDHPs.
- Employers can work with the FSA to determine which services will get coverage and be considered “qualified.”

FSA's do have some limits. FSA's only allow for reimbursement of qualified medical expenses during a covered period. Also, FSA's are “use it or lose it” plans, meaning that an individual forfeits any unused funds at the end of the period, usually the end of the calendar year. FSA funds cannot be rolled over to the next period, nor can they be moved into another account.

<i>Comparison of all three health savings plan options</i>			
	HSA	HRA	FSA
Tax-exempt	Yes	Yes	Yes
Employer contribution	Yes	Yes	Yes
Employee contribution	Yes	Yes	Yes
Real dollars	Yes	No	Yes
Rollover funds	Yes	Depends on employer	No
Must have HDHP	Yes	No	No
Works with other plans	No	Yes	Yes
Minimum values	No	No	No
Maximum values	\$2,600 for individuals; \$5,150 for families	No	Set by employer — max dollar amount or % of compensation
Can provide incentives	No	Yes	No
Can cover carve out plans (i.e. dental)	No	Yes	Yes
Individual or joint account	Individual	Individual	Individual or joint
Reduces taxable income	Yes	Yes	Yes
Tax penalty for early withdrawal	Yes	Yes	Yes
Use for qualified medical expenses	Yes*	No	No
Ability to withdraw for non-health uses	Yes	No	Yes

* Includes some premiums

HSA, HRA or FSA — Which is the Best?

This question has no right answer. Each financial plan has clear advantages and disadvantages. The decision must come down to the needs of the individual or family. In the future, HSAs may shift to individual accounts and be offered less frequently by large employers. HSAs can also earn tax-free interest. HSAs allow for possible long-term savings for those who will not need to access them, but incur severe tax penalties for early or non-health care related withdrawals. HRAs allow for behavior and financial incentives, but are not portable. FSAs provide funding for services, but are “use it or lose it” programs. Sample scenarios later in the document provide suggestions for plan and account choices for different family situations.

Plan Considerations

As employers transition over to HDHPs from traditional indemnity or managed care plans, they may initially offer several plan options. This will allow employees to become familiar with the plans and to determine which plans will work best for them. This will also allow the most flexibility in offering and transitioning services such as pharmacy plans and disease management programs to accommodate an HDHP-only environment.

Employers need to take several factors into consideration when developing and implementing a CDHP.

- ✓ **How long will it take to completely transition over to an HDHP-only model?** This will require assessing the readiness and openness of employees to accept the new model. Also, contractual obligations through labor unions may preclude such radical changes to health plan delivery. Lastly, the costs of offering a cafeteria of plan options may become cumbersome. Employers will need to produce cost estimates to determine the feasibility of offering different plans.
- ✓ **Employers will need to classify different services under the health plan as preventive and customary.** These classifications will play an important role in how the employee and employer pay for services. All preventive services can receive first dollar coverage at the employer's discretion. Anything allowed by the U.S. Treasury Department and designated by an employer would be eligible if this option is in place. Customary services are those that would occur during a routine examination or procedure. These services should be covered through the health plan once the employee has met the deductible. Before that time, employees may use a health account to pay for these services should receive a standard set of coverage through the plan after an employee meets a deductible and through a health account before then.
- ✓ **How should an employer structure premiums and deductibles?** Employers initially may want to offer a number of HDHP selections, each with variations in deductible (as long as they have the minimum prescribed values) and monthly premiums to allow flexibility in coverage and choice. Younger healthier people will likely choose health plans with a higher deductible and lower premiums because they will incur fewer monthly out-of-pocket expenses. Individuals with chronic conditions may choose the reverse so they have lower guaranteed monthly payments. They can offset higher deductibles through personal savings accounts. The number and values of plan options will depend on the employee and dependent population.
- ✓ **What will the coverage percentage be once an individual meets a deductible?** This may be an 80/20 split, meaning the health plan will cover 80% of charges after the deductible is met. A health financial account may subsidize the remaining 20%, for which the individual is responsible.

- ✓ **How should an employer fund an HSA?** Because HSAs can be individual accounts, employers will need to determine if they will select the plan or if they will provide employees with tools in order to select his/her plan of choice using employer contributions.

Examples of Consumer-Driven Health Care Plans

Different consumer-driven plans and health accounts offer a variety of benefits to those who participate and change according to different combinations. Because of this variety, not all options and combinations work best for everyone. The following scenarios present family circumstances for which different plan and account combinations may work best. All scenarios are theoretical. All scenarios also assume that the employee wishes to enroll in a consumer-driven plan and that such plans are options available through the employer.

Example 1:

A couple consisting of two working parents in their late thirties. They have three grade school age children with no discernible chronic health issues. Two different companies employ the parents.

- ✓ **Option 1:** Each parent can open his or her own HSA if they have a family HDHP with an individual deduction of at least \$2,000. The HSA can contribute to the deductible for the family plan and any unused portion could be rolled over to future years as tax-free savings.
- ✓ **Option 2:** The family could choose a non-high-deductible health plan coupled with an HRA for incentives. The HRA could fund uncovered portions of vision and dental services for their children. The health plan may not have as high a deductible as an HDHP, especially if the family accesses in-network services and the HRA can offer incentives for positive health behaviors.

In either option, the family should focus on preventive services such as immunizations, lifestyle education screenings and counseling on safety measures such as protective helmet and seat-belt uses.

Example 2:

A single mother who works full time. She has two teenage children, one of whom has a chronic condition requiring regular medication.

- ✓ The mother can enroll in a non-high-deductible health plan such as a PPO or a POS plan to allow for wider physician selection for the chronic condition. If her children's physicians, including specialists, are in the plan she will have lower co-pays and deductibles for services. If they are not, she still has the flexibility to seek the medical care for her children that they will need and have it reimbursed at a higher percentage.
- ✓ She can also participate in an HRA for incentives in pharmacy and disease management programs. This will be especially helpful with her chronically ill child. Incentives may include reduced charges for pharmaceuticals, reduced costs for disease management programs or other financial incentives.
- ✓ If possible, she could augment her HRA with participation in an FSA to cover charges not covered by the health plan or HRA such as for medical supplies, non-worksites health improvement programs and over-the-counter medications.

Example 3:

A young couple in their twenties who work for the same employer. The woman is pregnant with her first child.

- ✓ The couple should enroll in an HDHP with an HSA for each parent. The health plan will cover both parents and the child when delivered.
- ✓ The parents should participate in all prenatal care. Employers should cover all prenatal services with first dollar coverage and these services should not be subject to the deductible.
- ✓ When the child is born, the parents should utilize all well baby care and immunizations. These should also fall under preventive services.
- ✓ The parents should focus on preventive services and health improvement programs that covered or are 100% reimbursable or coverable and which will allow for savings in the HSAs.

Example 4:

A retired couple in their late sixties both receive Medicare. They currently care for their grandchildren full time as legal guardians. The wife receives retiree benefits through her former employer.

- ✓ Because the couple receives Medicare, neither is eligible to open an HSA if they have not already done so.
- ✓ If they have an existing HSA, they can still withdraw money from the account for qualified medical expenses, premiums for their retiree insurance that is not Medicare and other expenses without a tax penalty.
- ✓ If the former employer offers it, the couple may choose to use an HRA to provide incentives for proper use of medications and disease management protocols for themselves and their grandchildren.
- ✓ They can focus first dollar coverage preventive services, including screenings and immunizations, for themselves and their grandchildren.
- ✓ Also if available, the couple might want to invest in an FSA to cover additional medical charges such as over-the-counter medications and medical supplies such as eyeglasses.

Example 5:

An 18-year-old man living on his own after high school. He has no major health issues and is no longer claimed as a dependent on his parents' income tax returns. He works full time for a large employer.

- ✓ He should enroll in an HDHP with an HSA. Because he is in relatively good health, this option will allow him to have lower monthly premiums and an opportunity to save money for later use through the HSA.
- ✓ He should focus on first dollar coverage preventive services such as annual physician visits and appropriate screening measures. This will allow him to continue to save money in the HSA and prevent future medical problems from arising through preventive screenings.
- ✓ He should participate in worksite health improvement programs that encourage healthy lifestyle behaviors and choices. These should be at no cost to the individual or a lost cost coverable through the HSA.
- ✓ He can also use an FSA to cover any over-the-counter medications or medical supplies not covered by an HSA.

Recommended “Covered Services” for Children and Adolescents

Regardless of plan offerings, employers need to cover a core group of benefits for children and adolescents. These core services range from preventive services to carve out programs to catastrophic coverage. These services do not need to fall under an HDHP. Employees and their dependents may access them through worksite health improvement programs, incentive programs or even school-based programs.

Other programs and services, also called ancillary services, are those services not necessarily critical to all health plans, but that will provide additional benefits to employees and dependents. Through health plans and personal savings accounts, employees may choose to access ancillary services to either augment or substitute general health care.

Organizations such as the U.S. Preventive Services Task Force (USPSTF), the American Academy of Pediatricians (AAP), the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP) provide recommendations and guidelines on health care services for children and adolescents.

This list groups services into core and ancillary services based on their importance to health promotion and ease into which they will fit into standard health packages.

Below are descriptions of recommended covered services and suggestions for offering these services to employees. A list of reference sources at the end of this section identifies the organizations making recommendations.

Core Services

Preventive Services

Preventive services are those services meant to prevent a disease or condition or prevent a condition from escalating. These services are eligible for 100% coverage in high-deductible health plans. The IRS allows for first dollar coverage of preventive services without a deductible or with a lower deductible than that of the health plan. The preventive services listed below are consistent with U.S. Preventive Services Task Force recommendations and other clinical guidelines and are allowable under IRS guidelines.

✓ Primary Care

- Office visits including well-baby visits, annual physicals and sports physicals
- Routine screenings and tests such as for tuberculosis, phelyketonuria, hearing and vision screenings, weight checks, etc.
- Immunizations that follow the Advisory Committee on Immunization Practices’ (ACIP) recommendations and schedules

- ✓ **Preventive Screening and Counseling**
 - Drug and alcohol misuse
 - Abuse — prevention and detection of physical, mental, emotional and sexual abuse
 - Injury prevention — household, recreational and motor vehicle accidents
 - Tobacco use

- ✓ **Prenatal Care**
 - Preconception counseling (alcohol and smoking cessation, etc.)
 - Routine prenatal care
 - Screening for alcohol and drug use for parents and dependents
 - New parent education and counseling
 - Routine tests and screenings (amniocentesis, sonograms, etc.)
 - Prenatal vitamins that include folic acid

- ✓ **Protective Devices**
 - Car seats (one approved adjustable seat per child)
 - Helmets for bicycles, skateboards, rollerblades, etc. (one approved helmet per child)
 - Medical supplies¹

- ✓ **Well-Baby Care**
 - Baby safety
 - Child safety
 - “Tough topics” (e.g., discussing sex education, drug use, etc.)

General Services

General services are those services covered through the high-deductible health plan, a managed care plan or any other basic indemnity health insurance plan. Health savings accounts may be used for co-pays and deductibles with a high-deductible plan. HRAs and FSAs can work with other non-high-deductible plans. These are generally services outside of preventive care that include illness, injury and emergency situations.

- ✓ Primary care including acute care visits for ill children and follow-up appointments
- ✓ Urgent care — care that requires immediate medical attention but is not considered life threatening (also called non-emergent). An example might be a broken leg (that has not ruptured blood vessels).
- ✓ Emergency care — life-threatening conditions that require immediate attention
- ✓ Laboratory services
- ✓ X-ray and other diagnostic imaging services

- ✓ Medical testing
- ✓ Medical procedures handled either in an acute care or ambulatory setting such as stitches
- ✓ Hospitalization

Specialty Care

Like general services, employers can cover specialty care through high-deductible health plans and employees may use health savings accounts to pay for deductibles and co-pays.

Mental Health

Mental health services are basic health care needs for children and adolescents and should be offered by all employers. Mental health services may reimburse at different rates than acute care services.

- ✓ Depression screening and counseling
- ✓ Screening and counseling for eating disorders such as anorexia, bulimia, compulsive overeating, etc.)
- ✓ ADD/ADHD screening/testing
- ✓ Screening and treatment for other mental health conditions such as anxiety, obsessive-compulsive disorder (OCD), etc.
- ✓ Treatment for victims of youth or family violence (emotional abuse, post traumatic stress disorder, etc.)
- ✓ Treatment for drug or alcohol abuse and dependence
- ✓ Inpatient, ambulatory and acute-partial hospitalization for psychiatric treatment

Ancillary Services

Disease Management

Under HDHPs, employers have the option to offer disease management benefits through a separate plan or plan provider, so long as this plan only provides disease management services to employees and dependents. An HSA can cover services under these conditions. Disease management programs have traditionally covered chronic diseases and conditions. When considering disease management programs for children, employers should remember that the chronic conditions that affect children are different from those that affect adults. Many are the result of congenital or environmental factors. Common disease management programs for children include:

- ✓ Asthma management
- ✓ Management of mental health disorders (depression, anxiety, bipolar disorder, attention deficit with hyperactivity disorder, eating disorders, etc.)
- ✓ Lead poisoning treatment and management

- ✓ Juvenile or Type I diabetes
- ✓ Obesity²
- ✓ Congenital disorders and disabilities such as cerebral palsy, muscular dystrophy, autism, etc.³
- ✓ Rheumatoid diseases such as juvenile arthritis

Carve Outs (employers should cover through alternative plans)

Employers can provide some health benefits as carve outs and still have employees remain eligible for HDHPs and HSAs. Carveouts may include:

- ✓ Dental
 - Regular cleanings (every six months for children)
 - Orthodonture (includes false teeth, implants, bite plates, braces, etc.)
 - Extractions
 - Fillings
- ✓ Vision
 - Routine exams (one per year for children)
 - Glasses (frames and lenses)/contact lenses
- ✓ Long-Term Care
 - Extensive rehabilitation for severe injuries
 - Extended treatment for life-threatening diseases such as cancer
 - Long-term mental health and substance abuse treatment

Pharmacy

Because of the variability in the ways that employers can provide pharmacy benefits, each employer should evaluate what will work best with the types of health plans it offers. Regardless of health plan type, pharmacy plans, especially those with services for children and adolescents, should cover the following:

- ✓ Prescriptions (brand name and generic based on a formulary) including:
 - Oral and topical medications
 - Prescription vitamins
 - Comprehensive birth control methods including condoms, pills, shots and devices such as the IUD
 - Antibiotics
- ✓ Consumable medical equipment such as asthma nebulizers
- ✓ Diabetic supplies (insulin shots, blood glucose testing strips and monitors)
- ✓ Employers may want to tier pharmacy benefits to steer patients toward preventive medications and to encourage medication adherence.

Other Ancillary Services

Employers need to consider additional services not considered core to a health care plan to provide additional benefit. The IRS allows coverage of the following services through employee contribution portions of health plans concerning children and adolescents. Employees may cover these through an FSA, HRA or HSA. Employers may also consider providing first dollar coverage for some items such as children's vitamins, dental hygiene products and diabetes screening tests that promote prevention.

- ✓ Co-pays and deductibles

- ✓ Medicine and Supplements
 - Over the counter (OTC) medications (FDA approved)
 - Children's vitamins
 - Some herbal and alternative remedies (consult with the FDA on generally accepted and approved products and services)
 - Oral and topical treatments for worms, ringworm, pinkeye and other common childhood communicable diseases, infections and parasites
 - Topical treatment and cleaning supplies for head and body lice

- ✓ Medical and ancillary supplies
 - Emergency allergic reaction kits (epinephrine pens)
 - Contact solution and cleaners
 - Hearing-aid batteries
 - Other non-covered medical supplies

- ✓ Other Health-Related Services
 - Chiropractic services

Example of Preventive Services in a Health Plan

A large employer wishes to cover recommended childhood, adolescent and adult immunizations, but because of a largely decentralized workforce, it will not have the facilities or the critical mass to implement an on-site immunization clinic. To facilitate its plans and to encourage all beneficiaries in recommended groups to get immunizations, the employer includes all recommended immunizations (including the flu and pneumonia vaccines) as preventive services within the health plan. The employer covers all preventive services at 100%, meaning that beneficiaries will be reimbursed for any out-of-pocket costs.

Additional Resources

1. Internal Revenue Service. Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans. <http://www.irs.gov/publications/p969/ar02.html>. Viewed on January 24, 2005.
2. American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care (RE9535). <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/3/645>
3. Advisory Committee on Immunization Practices. 2005 Childhood & Adolescent Immunization Schedule. <http://www.cdc.gov/nip/recs/child-schedule.htm>. Viewed on February 28, 2005.
4. American Academy of Family Practitioners. Familydoctor.org. <http://familydoctor.org/children.xml>. Viewed on February 28, 2005.

Section 2 Footnotes:

- ¹ Includes crutches, wheelchairs, hearing aids, diabetes testing and treatment equipment and other medically necessary supplies and devices
- ² Although not universally considered a disease, obesity should be managed to prevent the onset of related diseases such as diabetes and heart disease
- ³ Disease management programs such as physical therapy programs, coordinated care programs, specialized treatment for learning disabilities, etc., can benefit children with special health care needs.

Addressing Disparities in Consumer-Driven Health Care

The success of consumer-driven health care rests on consumer education and involvement. When crafting a CDHP, special attention should be paid to vulnerable populations who face challenges in actively managing their health. Vulnerable populations may include the “hard-to-reach,” the chronically ill and racial and ethnic minorities.

Currently many consumers — especially those from vulnerable populations — are not as engaged or knowledgeable as they need to be in order to be effective health care consumers. A 2001 survey of American households found that in the past year only 38% of healthy working-age adults and 50% of adults with chronic diseases had sought health information from a source other than their doctor.¹ Alarming, it is estimated that each year in the US there are 32 million people who neither seek health information (from any source) nor see a doctor. These “hard-to-reach” people are characterized as low-income earners, males, ethnic or racial minorities and/or those with a low level of education.

This fact sheet will present information on vulnerable populations and provide strategies employers can use when crafting CDHPs to ensure that plans address the needs of all employees.

Racial and Ethnic Minorities in the CDHP System

What are racial and ethnic disparities and why do they occur?

Racial and ethnic disparities in health care are a longstanding and widespread problem. The term “racial and ethnic health disparities” refers to the inequalities in health status and health care that members of racial and ethnic minority groups experience relative to the non-Hispanic, white majority population. For example, racial and ethnic minorities seek treatment later in the course of disease, have worse health outcomes from treatment, have higher rates of morbidity and mortality and are more likely to rate their health as fair or poor than are white individuals.² Racial and ethnic minorities — even those with comparable health insurance — also have more limited access to preventive, diagnostic and treatment services than do white Americans.³

Minority populations suffer from higher rates of many chronic diseases such as cardiovascular disease, asthma, Type 2 diabetes and hypertension. Minorities also experience more complications as a result of chronic disease than do whites. For example, African-Americans and Native Americans with diabetes have more than three times as many lower limb amputations as white diabetics.⁴

The causes of racial and ethnic disparities in health and health care are complicated and multifaceted. Disparities in health stem from behavioral, environmental, socioeconomic, educational, social and genetic influences. Disparities in health care result from linguistic barriers, racism and other biases, differing beliefs in health and health care, geographical barriers and other factors.

How Will Consumer-Driven Health Care Affect Racial and Ethnic Disparities in Health?

Because CDHPs are so new, we do not know how a consumer-driven system will affect racial and ethnic disparities in health care. Proponents of CDHPs argue that as consumers gain control and choice they will be able to influence quality of care through their purchasing power. Consumers will also be able to “shop” for physicians and medical services and will thus be able to go to providers who best meet their needs.

Opponents of CDHPs argue that a consumer-driven system will put racial and ethnic minorities at a disadvantage. These opponents argue that because health care needs are so often unexpected and require timely intervention, consumers will not “shop around” for services, but rather will rely on convenient services. Because consumers possess little medical knowledge they will not be able to adequately judge the quality of services and will thus rely on cost and superficial measures to judge value.⁵ Low-income populations, the less educated, non-native English speakers and racial and ethnic minorities are feared to be at a particular disadvantage in a CDHP system.

Areas of Concern

- ✓ Because racial and ethnic minorities are less likely than whites to seek health information, there is concern that racial and ethnic minorities may be at a disadvantage in a CDHP system that requires active consumer participation and relatively high levels of medical knowledge.
- ✓ Because racial and ethnic minorities — on average — have lower wages and lower total incomes than do their white counterparts, there is concern that they will be less able to pay for services in excess of the employer contribution that do not meet criteria for catastrophic coverage. Data from the 2000 US Census show that the median income of an African-American household is only \$30,000, 62% of the median income for a white household.⁶ The median income for a Hispanic household is \$33,000 per year or 69% of the White median household income.⁷ Women (of all races) earn less than their male counterparts; even with the same educational background and same position women earn only 77% as much as men.⁸ Female-headed households may thus face additional challenges in affording health care.
- ✓ There is also concern that due to socioeconomic inequalities, racial and ethnic minorities and women will have to spend a greater proportion of their incomes on health care, especially sensitive to price fluctuations and vulnerable to catastrophic events. For example, many low-income people — even with private insurance — are unable to cover the out-of-pocket costs of medical care and pharmaceuticals. Research shows that even small increases in patient out-of-pocket costs put prescription medications out of reach for many Americans. Racial disparities in access to pharmaceuticals are particularly stark: While only one in 10 white Americans reports foregoing a needed prescription medication due to cost, one in five African-Americans report cost to be a prohibitive factor.⁹ And in 2001, more than 30% of African-Americans and 25% of Latinos with chronic diseases reported that they were not able to purchase all of their prescription medications due to cost.¹⁰

Only time will tell how CDHPs will influence the health status and health care of racial and ethnic minorities. However, direct culturally competent consumer education and support services and an emphasis on reducing racial and ethnic health disparities will help improve the chance that CDHPs will benefit all employees.

Actionable Strategies for Employers

CDHPs offer the opportunity to improve the health and satisfaction of all employees. To ensure that the CDHPs your company offers meet the needs of all employees — including those who are from minority backgrounds — consider the following strategies:

- ✓ Provide culturally competent education materials to employees. Depending on your population this may include providing material in a language other than English, providing material written at a lower reading level than usual, or featuring information on diseases and conditions that cluster in a specific racial or ethnic group.
- ✓ Develop outreach strategies to target the populations least likely to self-initiate preventive care. Low-income populations, racial and ethnic minorities, males and those with low levels of education are less likely than other groups to initiate preventive care.
- ✓ Provide information on CDHPs in multiple media such as online tools or e-mails, printed guides/booklets and verbal information sessions. This will ensure that all employees have access to this important information.
- ✓ If online tools are a mainstay of the CDHPs your company offers, consider having confidential computer kiosks in the worksite for employees to use. Because not all employees have computers in their homes, online tools may not be helpful for all employees. Worksite kiosks can bridge this barrier.

Addressing Disparities Footnotes:

¹ Tu HT, Hargraves JL (2003). Seeking health care information most consumers still on the sidelines. The Center for Studying Health System Change. Publication No. 61.

² Weinstock B. (2003) Why companies are making health disparities their business: The business case and practical strategies. Analysis Paper. Health Disparities Initiative. The National Business Group on Health.

³ *ibid*

⁴ *ibid*

⁵ Shearer G (2004). Impact of consumer-driven health care on consumers. Testimony of the Consumers Union before the Joint Economic Committee. February 25, 2004.

⁶ US Census Bureau (2003). PEOPLE: Income and employment. http://factfinder.census.gov/jsp/saff/SAFFInfo.jsp?_pageId=tp6_income_employment. Accessed March 7, 2005.

⁷ *ibid*

⁸ US Census Bureau (2002). PEOPLE: Gender http://factfinder.census.gov/jsp/saff/SAFFInfo.jsp?_pageId=tp3_gender. Accessed March 7, 2005.

⁹ Reed M, Hargraves JL (2003). Prescription drug access disparities among working age Americans. The Center for Studying Health System Change. Publication No. 73.

¹⁰ *ibid*

Case Study

Aetna's Consumer-Driven Health Plan: HealthFund®

Aetna is one of the nation's largest providers of health insurance. Aetna provides medical coverage for approximately 13.3 million members, dental coverage for 11.2 million members and pharmacy services for 8.1 million members. Aetna's nationwide network includes more than 618,000 health care service providers including 3,783 hospitals throughout the US and more than 362,000 primary and specialty care physicians.² Aetna first launched its Consumer-Driven Health Care Plan (CDHP), called HealthFund, in 2001. In 2003 Aetna expanded its CDHP program to include integrated pharmacy benefits and long-term care benefits. Aetna was also the first insurer to include a Health Savings Account (HSA) into its CDHP program and remains one of the few health plans to offer consumer-directed benefits to employers of all sizes. Aetna currently offers a line of CDHP HealthFund products including the:

- HealthFund Health Savings Account (HSA)®
- HealthFund Retiree Reimbursement Account (RRA)®
- HealthFund Flexible Spending Account (FSA)®
- HealthFund First Dollar Plan®

These funds are usually combined with traditional health plan options to offer greater protection and maximum choice.

“Health care consumerism

is about putting more of the decision in the hands of the consumers and providing them with useful tools and information that allow them to make decisions...consumers can and will responsibly manage their own discretionary health care spending, while continuing to seek the care that they need.”

“Aetna HealthFund...gives employers additional flexibility in customized product design and gives consumers greater choice and control in directing the health benefits provided by their employers.”

Aetna Press Center, 2002

To ensure that members have adequate information and resources to make informed decisions, Aetna offers a host of support tools to its 197,000 HealthFund members. These tools include health care pricing and quality information, online claims and plan fund tracking, health education and health risk assessments. Online interactive decision-making tools include:

- ✓ **InteliHealth®:** Aetna's consumer health information website that provides detailed information about diseases and health conditions, health management programs, healthy lifestyles and health education resources.

- ✓ Healthwise Knowledgebase®: An innovative decision-support tool that features an online formulary and Price-a-Drug database that provides members with cost information on pharmacy supplies and provides side-by-side comparison of brand-name and generic alternatives.
- ✓ DocFind®: Aetna's online physician, hospital and health care specialist database that allows members to search for providers by type, location, specialty and other characteristics. Aetna also provides information on physician and hospital quality measures and average health care service costs.

To document CDHP program success, Aetna conducted a survey of 14,000 of its HealthFund members from 19 different employers and compared their medical claims and level of satisfaction to a similar group of individuals in traditional and HMO plans. Survey results from 2003 showed that the consumer-driven aspects of the plan encouraged the active engagement of members in health care decision making, increased the rate of preventive service use and lowered the rate of increase in overall health care costs. Specifically, Aetna found that HealthFund members:

- ✓ Increased their rate of preventive care office visits by 30.1% compared to a 14% increase in the comparison population.
- ✓ Decreased their pharmacy costs by 6.5% by lowering their overall use of pharmacologics by 11% and by substituting generic drugs for brand-name drugs.
- ✓ Held their overall medical costs relatively stable (at 3.7%) while medical costs for the comparison group rose significantly.*
- ✓ Reduced their ER visits by 3% and their inpatient admissions by 5%.*

HealthFund members also became more active and engaged in health care decision-making:

- ✓ Members' use of InteliHealth increased 48%.
- ✓ Members' use of Healthwise Knowledgebase increased 100%.

And HealthFund members are satisfied with their CDHP:

- ✓ 90% of members reported that they are likely to renew their plan.
- ✓ More than 50% of members had money left over at the end of the year.

For more information on Aetna's Consumer-driven Health Plan products visit the website at www.aetna.com.

The information presented in this fact sheet is based on Aetna press releases, accessed 10-12-04:

http://www.aetna.com/presscenter/kit/aetna_healthfund/healthfund_others.html

http://www.aetna.com/presscenter/kit/aetna_healthfund/healthfund_factsheet.html

http://www.aetna.com/news/2002/pr_20020711.htm

¹Towers Perrin (2003). Health Care Cost Survey, Report of Key Findings, 2003.

²Current members as of 6/22/04

* *Results from the updated 12-month study that included 13,500 of the original 14,000 participants. All other results are from the nine-month study.*