

Consumer Driven Health Care

A New Agenda for Cost Control in Massachusetts

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Executive Summary

Annual double-digit medical inflation has plagued our health care system for years, leading purchasers to seek new ways to constrain health care costs. Recent data suggest a modest slowing in health care cost growth partly explained by the economic downturn.¹ However, the reduction in utilization is greater than what economists would expect from the recession alone. Increased enrollment in consumer driven health care (CDHC) plans, among other factors, likely played a significant role. According to the U.S. Bureau of Labor Statistics, CDHC plans are “proving to be an important lower-cost option to help both employers and employees manage increasing health care costs.”² New research suggests that the growth of CDHC plans nationally in the employer market from the current level of 13 percent to 50 percent could reduce health care spending by at least \$57 billion annually.³

The current health insurance marketplace in Massachusetts resembles more of a pre-paid medical care system than traditional insurance, which provides financial protection from major health events. The result has been some of the highest premiums in the country. Significant government regulatory involvement in the insurance marketplace over the years, along with a culture of generous coverage, and the prevalence of HMOs, has left the Commonwealth far behind other states in embracing CDHC.

While unit costs and insurance premiums have continued to rise correspondingly; locally the debate has focused either on shielding patients from as much cost as possible at the point-of-service (i.e. co-pays or co-insurance), or on

supply-side strategies of restricting patient options. Paradoxically, the resulting system often allows high-cost low-quality care to remain lucrative, and yields more expensive insurance for everyone. In addition, dominant provider market power remains unaddressed, which the Attorney General has identified as the primary driver of increasing healthcare costs.⁴

A narrow discussion over the right balance of the point-of-service cost or first-dollar coverage (i.e. deductibles) for low-income patients fails to acknowledge the role that insurance design can play in empowering consumers to seek out low-cost, high-quality care at all income levels. Undeniably, the status quo in Massachusetts has led to the highest insurance premiums in the nation, lower wages for employees as a result, and a depressed incentive to hire new employees. It has also hurt lower middle class working families since they cannot afford the Commonwealth’s high-premium insurance plans. A robust literature review shows that CDHC plans have numerous potential benefits for patients, employers, and the government.

Employee Benefits:

- Lower premium contribution (on average 11-28% less), resulting in more take home salary to cover future medical bills.
- An asset building health savings account (HSA), that is tax advantaged, fully portable, owned by the employee for life, and can be used for expenses not covered by insurance like dental and eye care, certain forms of alternative medicine, and long-term care. A quarter of health savings participants have accumulated over \$3,000.

- Opportunity to engage in one's health. For example, they are 21 percent more likely to participate in a disease management program, report 20 percent fewer medical emergencies when compared to those on traditional plans, increase their participation in preventative services, and are more likely to see a medical provider that follows an evidence-based care protocol. For those with chronic conditions, they receive care at the same or higher levels than those on a traditional plan. CDHC plan enrollees are also more likely to engage with health tools such as online programs, 24-hour nurse lines, and use mail-order prescription drug services.

Employer Benefits:

- Lower premium contributions, ranging from 12 to 20 percent in the first year.
- Savings on average of \$1,500 per employee when compared to employers who did not offer a CDHC plan.
- Opportunity to engage individual employees across all ages, income levels, and health statuses.
- Realize the production benefit of healthier employees.

Government Benefits:

- In 2006, Indiana became one of the first states to offer CDHC plans with HSAs to state employees. Today, 90 percent of the Indiana State workforce is enrolled in a CDHC plan. A 2010 study found that the State saved on average 10.7 percent annually over the study period. Not only was the State projected to save \$23 million in 2010, but, in addition, state employees who enrolled in the plans saved a combined \$7-8 million in 2010.

- Indiana also expanded their Medicaid program with CDHC plans and HSAs, and saw an increase from beneficiaries seeking preventative services.⁵

• Florida is estimated to have saved \$118 million last year in a five county pilot in Medicaid that incorporates an HSA-like account. Beneficiaries surveyed have been extremely satisfied by the pilot, and early health outcomes are promising.

The health, cost and quality trends for those on well-designed CDHC plans are promising. New research has demonstrated that these plans appeal to all age, income and health groups. They have also shown that insurance design can play a key role in incentivizing a patient to become more engaged and help them lead a healthier lifestyle. This CDHC induced "health dividend" is important as 70 percent of current healthcare costs are related to treating diseases caused by lifestyle choices.

Consumer driven health care plans are sometimes inadequately described as "high-deductible health plans." The term high-deductible health plan has some negative connotations. When people hear high deductible, they often think of deductibles much higher than the federal minimums, which may not be considered very high. This term also ignores the equally important account feature of a CDHC plan: an HRA (health reimbursement account) or HSA. Moreover, not all CDHC plans are paired with a "high" deductible. Such characterizations have led to the perception that CDHC plans are simply a cost-shifting vehicle for employers and will result in employees paying a higher proportion of benefit costs out of their pockets. This paper

demonstrates that this perception is often not true in the marketplace, and highlights the fact that the lower premiums of CDHC plans translates into tax-advantaged health savings accounts that can be used for any number of health spending needs. Evidence from the private market, as well as public programs, has demonstrated savings of tens of millions of dollars a year. Critics of CDHC plans have stubbornly ignored changes that have been made over the years to address some early design issues with the products, and it is time for Massachusetts to incorporate consumer-driven features into our insurance marketplace to better engage patients in their health.

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Introduction

Massachusetts recently passed a bill aimed at constraining health care costs—Chapter 224, “An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation.” Its focus on capitated payment reform and Accountable Care Organizations (ACOs), or “supply-side” approaches, for controlling costs is one-sided. Massachusetts employers and others should couple the recent reforms with the relatively untapped “demand-side” approaches to cost containment such as CDHC to realize faster and more significant health care cost containment moving forward.

This paper provides a discussion of CDHC, what it is and how it can help constrain health care costs and increase patient engagement in Massachusetts. While supply-side approaches are also necessary for cost control, without engaged consumers, Massachusetts may find that it cannot accomplish its cost-containment goals as quickly or as successfully as desired. A review of the recent literature on CDHC was conducted along with interviews with various Massachusetts stakeholders, including brokers, employer groups, and insurers, to explore the reasons why penetration of these plans in Massachusetts lags behind other states and to discuss strategies for encouraging their growth in the future. Several opportunities, in both the public and private market, for increasing enrollment in CDHC are presented.

This report is one in a series by Pioneer Institute aimed at improving patient-centered approaches to constraining health care costs in Massachusetts.

I. Options for Controlling Costs

Strategies for controlling health care costs can be broadly categorized as either supply-side or demand-side approaches. Supply-side approaches usually involve limiting the supply of various providers and/or services while demand-side methods typically focus on the consumer and look to reduce demand for health care services through better education about health care costs and increased cost-sharing.

A single-payer health care system is the best example of a comprehensive supply-side approach. That is, government entities control the supply of providers and services thereby limiting access. This is particularly true for expensive services like technology and specialists. Closer to home, managed care – epitomized by Health Maintenance Organizations (HMOs) – is an example of a supply-side approach where patients are limited to certain network providers and insurers control access to care via prior authorization, primary gatekeepers, and other utilization tools. ACOs are managed care’s newest incarnation, focusing on limiting the supply by using primary care gatekeepers to coordinate and oversee the amount and type of care a patient receives and where they receive it. Other supply-side tools used by state governments are “Determination of Need” or “Certificate of Need” programs. Under these programs, a state agency determines how much of a particular service or technology is needed for a population within a specific geographic region and regulates the number of market entrants for various services through licensure. All of these approaches are included in some fashion in Chapter 224.

Demand-side strategies for controlling health care costs focus on consumer

engagement. These approaches typically include more involvement by the patient to better understand their health and health care options. Financial incentives are provided for choosing cost-effective treatments and settings for their care. Examples of demand-side tools include tiered co-payments for pharmaceuticals or other health care services; cost-sharing, including co-payments, co-insurance, and deductibles; and wellness benefits that aim to reduce demand through healthier lifestyles. A catch-all term for these demand-side strategies is consumer driven health care. CDHC plans typically include a deductible paired with a financial savings vehicle such as a health savings account (HSA) or health reimbursement arrangement (HRA).

There is significant experience with supply- and demand-side strategies in the U.S. health care system and both have had some success at constraining health care costs. Based on data from the 1990s, HMOs were successful at bending the cost curve when they were first introduced, but this success was not sustained once they reached a stable level of market penetration. This may be because patients and providers were not fond of the restrictions HMOs placed on them regarding access to certain treatments and providers. Patients and providers alike fought to widen provider panels and eliminate some of the restrictive utilization controls, which were the very components that helped to contain health care costs. As the model became diluted, the market was left with a strategy that provided unlimited care with very little, if any, out-of-pocket costs for the patient.

ACOs are similar to HMOs in their approach to controlling costs, although there may be several distinguishing features such as

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better use of information technology; a more local approach that gives provider groups, as opposed to insurers, control; and a more diverse array of payment models. However, the cost-cutting strategy is the same: a supply-side approach where someone other than the consumer controls access to providers and technology, and consumers are largely detached from the cost of their decisions regarding the use of health care services.

Demand-side strategies are not new or untested. These approaches focus on the consumer and attempt to alter demand by introducing an element of cost-sharing at the time of service delivery. They are typically coupled with increased consumer engagement in their health and health care through greater exposure to education and information to appropriately use health care. In these plans, consumers take control of their health care decisions and are involved in active purchasing based on costs and quality. Employers have recently increased cost-sharing in several ways: by increasing the amount an employee pays at the time of service, by increasing the deductible an employee is required to meet before the insurance policy covers the services, or by varying cost-sharing amounts based on the quality, efficiency, or value of a particular provider or service. Cost-sharing has been shown to discourage the use of services such as costly pharmaceuticals, and outpatient services such as emergency room use and primary care and specialist visits.

The landmark RAND Health Insurance Experiment (HIE) concluded that the demand for insured health services did decrease significantly with increasing cost, and, moreover, that outcomes for all but the very frail and poor were not negatively affected

by the reduction in health care utilization observed, at least in the short-term.⁶ Despite the fact that the HIE was conducted thirty years ago, it remains the standard against which subsequent studies estimating price sensitivity of demand for health care services are compared. A number of studies have been conducted since the HIE to assess the impact of cost-sharing on utilization and outcomes. These studies have been consistent with the HIE for the most part, although many have focused their attention on vulnerable populations who are either lower income and insured through Medicaid or elderly or disabled and insured through Medicare.^{7,8,9} Studies assessing the impact of tiered pharmaceutical co-payments on pharmaceutical utilization in the employed population also have been well-documented in the literature.¹⁰

II. What is Consumer Driven Health Care (CDHC)?

Consumer driven health care plans are sometimes inadequately described as “high-deductible health plans.” This term was coined in federal statute and refers to a specific type of CDHC plan, that is, one with a deductible amount that meets statutory guidelines (in 2012, \$1,200 for individual and \$2,400 for family). These are the only plans permitted to be coupled with a health savings account. The term high-deductible health plan has some negative connotations. When people hear high deductible, they often think of deductibles much higher than the federal minimums, which may not be considered very high. This term also ignores the equally important account feature of a CDHC plan: an HRA or HSA. Moreover, not all CDHC plans are paired with a “high” deductible. Such characterizations have

led to the perception by some that CDHC plans are simply a cost-shifting vehicle for employers and will result in employees paying a higher proportion of benefit costs out of their pockets. Providing consumers with information on price and quality to encourage active consumer shopping and drive competition toward greater efficiency and effectiveness is another, arguably more important, feature of these plans. In addition, many of the plans promote greater consumer engagement by encouraging the use of health risk assessments, health coaches, disease management programs, and wellness programs.

Even before the Affordable Care Act (ACA) required plans to cover preventive care, most CDHC plans covered many preventive services without any cost-sharing outside of the deductible. In addition, many people with CDHC plans have access to an account (flexible spending account (FSA), HRA, or HSA) that they can use to pay for services before they reach the deductible amount. Enrollees sometimes will need or will choose to pay out-of-pocket for some services before their deductible is met and this is called the “deductible gap.” Once the deductible is met, insurance coverage steps in with its regular co-payment or co-insurance features until an out-of-pocket maximum is met.

In addition to the features noted above, America’s Health Insurance Plans (AHIP) reports that over 85 percent of insurance companies offer consumer-decision support tools for their members such as online member access to information regarding health savings accounts, health education, physician and other provider cost and quality, and personal health records.

Types of Accounts:

There are three primary tax-savings accounts that employers and/or individuals can establish to work with a CDHC plan. These are: flexible spending arrangements, health reimbursement arrangements, and health savings accounts. Each of these is described below.

Flexible Spending Arrangement (FSA): A flexible spending arrangement can be offered by an employer as an employee benefit and is not limited to employees enrolled in CDHC plans. At the beginning of the plan year an employee projects the amount of money that they will spend on approved health care services that will not otherwise be reimbursed by their health plan. Employers withdraw this money pre-tax from employee wages and the monies are placed in an FSA. Employees submit receipts for care or use an FSA debit card and are reimbursed from this account. One consideration regarding FSAs is that the participating employee’s entire annual contribution is available at the start of the plan year, commonly January 1, or after the first contribution to the FSA is received by the FSA vendor. Therefore, if the employee incurs an FSA-eligible expense during the first period, the entire amount of the annual contribution can be claimed against the FSA benefits. If the employee is terminated, quits, or is unable to return to work, he or she does not have to repay the money to their employer. These plans also require employees to “use-it-or-lose-it” and therefore employees must be somewhat knowledgeable about their medical expenses for the given tax year. In 2005, Congress enacted a provision to allow for an up to 2½-month grace period beyond the end of the standard 12-month plan year. It is an employer decision whether they want

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to include a grace period in their plan design. The ACA's new restrictions on FSAs may make them less attractive to employers and employees alike. First, beginning January 1, 2011, over-the-counter medicines no longer could be reimbursed by an FSA unless a physician had written a prescription for the medicine. And, for the first time, beginning in 2013, FSAs will be limited to a maximum deposit of \$2,500 per year (indexed annually for inflation).

Health Reimbursement Arrangement (HRA): Similar to the FSA, an HRA also can be used in conjunction with a CDHC plan, or not. Most often these accounts are established with a health plan that includes a deductible of some sort, although sometimes these arrangements exist as “stand-alone” arrangements. These accounts are established and funded solely by the employer. Funds in these accounts can be used to pay for care before the deductible is met, for coinsurance, and for copayments, and can also pay for non-plan-covered expenses that are IRS-recognized “qualified medical expenses” under IRC section 213(d). What the HRA specifically can be used for is determined by the employer. Unlike the FSA, the HRA is very flexible and funds can be used to pay for premiums, COBRA premiums, retiree medical expenses, and some long-term care expenses. In contrast to an FSA, with an HRA employers can choose to carry funds over from one year to the next. Employers also do not need to pre-fund the accounts in a given year. Instead, they can choose to pay for expenses as their employees incur them. There is no limit on the amount an employer can contribute to an HRA for their employees. However, most employers set annual limits on HRA withdrawals. The ACA, therefore, requires that “stand-alone” HRAs (those not

integrated with a high deductible or other insured plan) apply for a waiver because the ACA precludes setting annual limitations of less than \$750,000 of essential benefit coverage.

Health Savings Account (HSA): The 2003 Medicare prescription drug improvement and modernization act (MMA) provided a generous tax incentive for individuals to enroll in certain CDHC plans through the establishment of HSAs. As mentioned earlier, an HSA must be paired with a sanctioned “High Deductible Health Plan” (HDHP). Congress initially limited the amount of funds that could be deposited annually into an HSA account to the annual deductible amount included with the plan. However, in 2006, Congress removed the requirement that annual deposits made into an HSA be capped at the level of a plan’s deductible and instead provided a fixed statutory limit for annual contributions. The limits for 2012 are shown in Table 1.

This type of account is the most tax-advantaged of the three accounts and can be funded by the employee, employer, or both. The funds can be rolled over from year-to-year tax-free, and no taxes are required when funds are withdrawn for eligible medical expenses. All deposits to an HSA become the property of the accountholder regardless of the source of the deposit. This is the only account that

Table 1: 2012 Limits for HSA and Consumer Driven Health Care Plans

HSA Statutory Contribution	Individual:	\$3,100
	Family:	\$6,250
CDHC Minimum Deductible	Individual:	\$1,200
	Family:	\$2,400
CDHC Out-of-Pocket Maximums	Individual:	\$6,050
	Family:	\$12,100

can be used by self-employed individuals as well as employers. Contributions made by individuals/employees outside of work are deductible on their personal income tax return while contributions made by employers and by employees are facilitated through payroll deduction. Pre-tax contributions are also excluded from Federal Insurance Contributions Act tax (FICA) and the Medicare Tax deduction, which amounts to an additional savings of 7.65 percent for both employee and employer. Employers may treat full-time and part-time employees differently as well as individual and family participants. For the individual, interest accrues tax-free and these accounts are completely portable. These accounts can be used for eligible medical services (either those covered by a health plan or not) as well as COBRA premiums, certain long-term care services and insurance, Medicare premiums (except Medigap), and they can be used to pay for medical expenses and insurance premiums when receiving unemployment. The ACA increased the penalty for withdrawal for nonmedical expenses from 10 to 20 percent in addition to applicable income taxes. However, people over 65 and the disabled pay no penalty for nonmedical withdrawals. HSAs are available from IRS-approved banks and credit unions and also are available from insurance companies.

Regulations enacted under the Tax Relief and Health Care Act of 2006 also allow employers to voluntarily make larger contributions for lower-income employees. In addition, a “catch-up” provision for individuals age 55 and older allows for an additional contribution to their HSA of up to \$1,000 per year (\$2,000 per family for couples where both spouses are 55+). The Bush administration also proposed allowing employers to contribute larger

amounts to the HSAs of employees who are chronically ill.¹¹

III. Results

CDHC plans have been evolving for the last decade or so. Early results suggested that there were a number of issues that needed to be addressed before CDHC plans could be more readily adopted. For example, critics worried that such plans were just a cost-shifting mechanism from employers to employees. Moreover, there was some evidence that these plans were causing risk selection in the marketplace, with healthier, wealthier people more likely to self-select into these plans, making traditional health plans much more expensive for the sickest members of society. Finally, there was the overwhelming sense from a number of policymakers that medical care was too difficult to understand and that consumers would not be able to discern necessary from discretionary care and, therefore, when faced with higher costs, would reduce all care indiscriminately. Critics of CDHC plans have stubbornly ignored the changes that have been made to these plans to address these very issues and the more recent promising results.

Cost Savings for Employers:

There is robust literature demonstrating that consumers are price-sensitive and will make different health care decisions when they are subjected to some out-of-pocket costs.^{12,13,14,15,16} CDHC works to constrain overall health care costs by both educating consumers about the cost of health care treatments and subjecting them to some of the cost, while also protecting them from catastrophic costs. Because first dollar coverage, which provides for coverage of insured events with no or little cost-

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sharing, shields users from the true price of high-cost but low-value treatments, too many consumers are not aware of the cost of their health care decisions. The evidence that more generous insurance encourages the consumption of medical services is overwhelming. Several recent studies offer specific data on the potential of CDHC for constraining overall health care costs.

New research suggests that the growth of CDHC plans could reduce health care spending by at least \$57 billion annually.¹⁷ A recent literature review of four studies that used historical claims data found a favorable effect on cost in the first year of a CDHC plan.¹⁸ Plan trends ranged from -4 percent to -15 percent. All the studies included a control population enrolled in a traditional plan that experienced trends of between +8 percent and +9 percent growth in costs. These figures suggest a potential total savings in the first year of between 12 and 20 percent. Savings after the first year were lower but in two studies were higher than traditional Preferred Provider Organization (PPO) plans by 3-5 percent.

Towers Watson research found that companies that have been successful at increasing enrollment in CDHC plans at a steady pace report lower health care cost trends. Companies that added 10 percent or more employees to such plans between 2009 and 2010 achieved zero percent cost growth, nearly 6 percentage points lower than companies with less than 6 percent growth in CDHC plans. Employers with successful growth in CDHC plans spent \$1,000 less per employee than employers with less successful enrollment and \$1,500 less per employee than employers who did not offer a CDHC plan.

More Engaged Consumers:

Increased messaging and education around necessary preventive treatments are consistent with CDHC proponents' view that individuals need to become better informed, proactive participants in their health and health care. There is significant evidence that CDHC plan members are more engaged in their health and health care decisions. A 2010 study by Cigna comparing its CDHC plan "Choice Fund" with its traditional plans showed that CDHC plan enrollees were in better control of their chronic health issues and were more engaged in their care. For example, CDHC plan enrollees were 21 percent more likely to participate in disease management programs than those with traditional coverage.¹⁹ In addition, according to a 2012 study of employer-sponsored health plans, about 10 percent of employers believe that people enrolled in a CDHC plan are better at reducing lifestyle risks than those enrolled in traditional plans.²⁰ A recent Aetna study of its members showed that CDHC plan enrollees were more engaged in their health care than traditional PPO plan members as evidenced by their greater use of online tools, preventive medical and dental care, 24-hour nurse line, and mail-order Rx.²¹ That same study found that CDHC plan households generated 20 percent fewer alerts indicating gaps in care than traditional PPO plan members. Finally, CDHC plan enrollees were more likely than traditional plan enrollees to report access to health risk assessments and health promotion programs and to use a smartphone or tablet application to access their medical claims history.²²

Good Care:

Another concern regarding CDHC is that utilization changes driven by CDHC designs

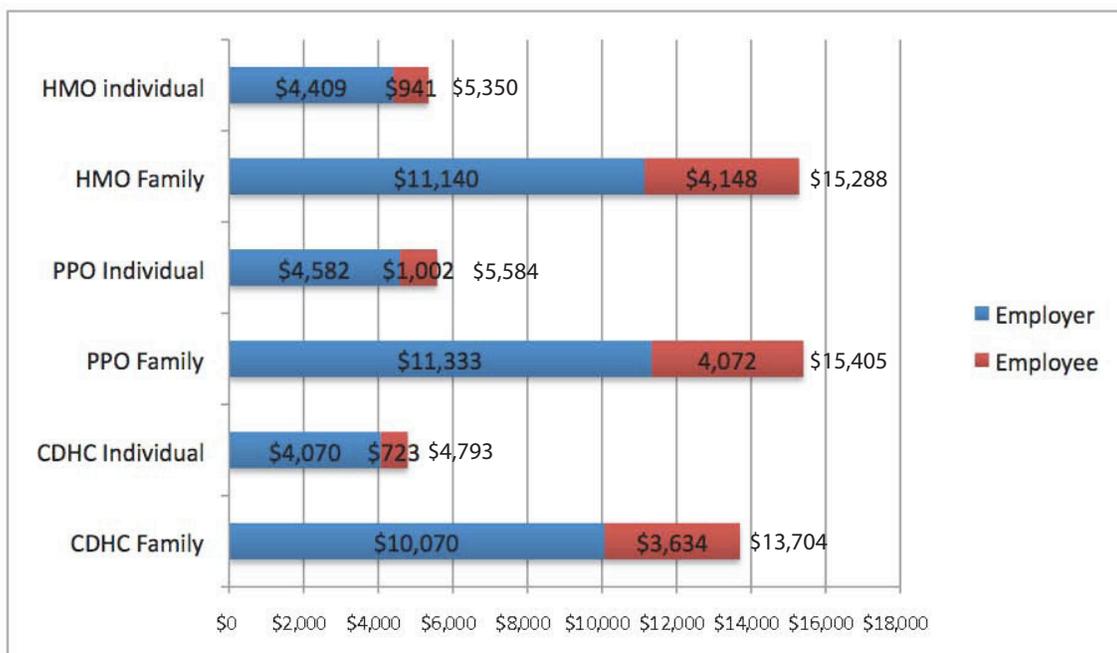
may have negative health consequences. In particular, people worry that participants will forgo preventive care, neglect management of chronic conditions, or not seek care early in the development of disease because of the deductible. While more research is needed to fully assess this issue, there is some evidence suggesting that this is not the case.

In the studies discussed above,²³ the observed cost savings did not result from avoidance of appropriate care, and necessary care was received in an equal or greater amount relative to traditional plans. In fact, all of the studies reported a significant increase in preventive services for CDHC plan participants. Several of the studies included in the review found that CDHC plan participants received recommended care for chronic conditions at the same or higher level than traditional plan participants and a few reported a higher incidence of physicians following evidence-based care protocols. An Aetna study of plan

enrollees also found that members enrolled in CDHC plans used screenings for cervical, prostate, and colorectal cancers, as well as mammograms and immunizations at a higher rate than traditional plan enrollees.²⁴ This study also found that compared with traditional plan members with diabetes, diabetics in CDHC plans had higher rates of diabetes-related tests and screenings.

To proponents of CDHC, these results are not all that surprising. Most CDHC plans provide commonly recognized preventive care outside the deductible with no cost to participants. About 84 percent of CDHC plans purchased in the group and individual markets provided first dollar coverage of preventive care. Virtually all plans in the large group (99%) and small group (96%) markets provided this coverage. Policies in the nongroup (individual) market were less likely to have this provision because premiums for individually purchased policies

Figure 1: Average Annual Firm and Worker Premium Contributions for Covered Workers for Single and Family Coverage by Plan Type, 2011²⁸



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Table 2: Distribution of HSA/HRA Account Balances, 2007-2011²⁹

	2007	2008	2009	2010	2011
\$3000+	16%	18%	20%	18%	22%
\$2000-\$2999	10%	8%	9%	11%	9%
\$1500 - \$1999	6%	7%	8%	5%	7%
\$500-\$1499	27%	25%	22%	21%	21%
< \$500	31%	32%	32%	35%	30%

are not tax-deductible except to the extent that they exceed 7.5 percent of taxpayers' gross income (beginning with their 2012 income tax returns this amount is increased to 10%). HSA accounts, on the other hand, are fully tax-deductible, thereby providing a financial incentive to pay for all care via an HSA account.²⁵

In addition, for those opposed to deductibles, it should be noted that a large share of workers in PPOs (81%) also face a general annual deductible that must be met before all or most services are reimbursed by the plan. It is true that deductibles in plans coupled with an HSA tend to be somewhat higher,²⁶ but that is because federal law requires that HSAs are available only to those enrolled in a high deductible health plan.

Cost Savings for Consumers:

CDHC plans can be of value to consumers because not only are the premiums less expensive for the employee (Figure 1), but also employers' costs are lower and they, on average, contribute \$886 for single and \$1,559 for family annually toward an HSA. These funds can accumulate interest tax-free in an account to be used for qualified health expenses. A recent review of HSA balances found that almost a quarter of the population had accumulated over \$3,000 in an HSA (Table 2). A fund administrator snapshot of HSAs in 2011 showed that, on

average, 65 percent of accounts had an annual contribution and 43 percent of accounts had a distribution every month in 2011; the average annual contribution was \$530 more than the average annual distribution; and 74 percent of accountholders contributed more than they spent during the year.²⁷

IV. Who is Enrolled in CDHC Plans?

CDHC plans are available in the group and nongroup (individual) marketplace alike. Among firms offering health benefits in 2011, 18 percent offered an HSA-qualified CDHC plan, an increase of eleven percentage points since 2007.³⁰

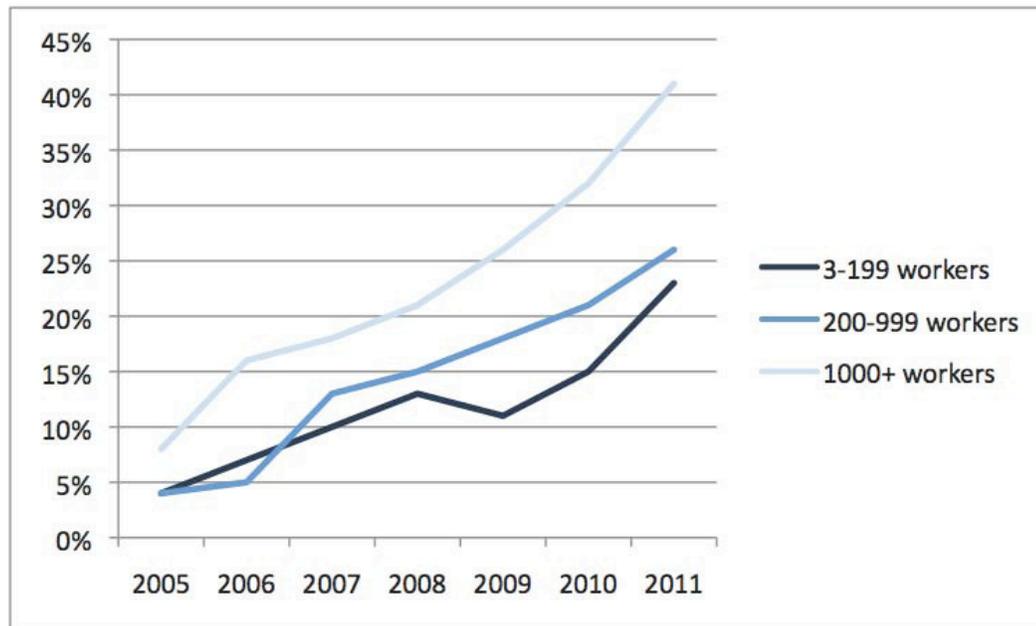
Twenty-six percent of enrollees in CDHC plans were enrolled in their plans for 3-4 years and 21 percent were enrolled for more than 5 years. This compares favorably to enrollment in traditional plans, where enrollees report 18 and 44 percent respectively, considering CDHC plans are fairly new to the market.³¹ According to an annual employer survey conducted by Kaiser and HRET, the percentage of firms that offer a CDHC plan varies by firm size and has seen a dramatic increase over time across firms of all sizes. Figure 2 shows the percentage of firms offering such a plan from 2005-2011.

America's Health Insurance Plans, which monitors enrollment in CDHC plans with HSAs (but not HRAs), found that 13.5 million people enrolled in CDHC plans with HSAs as of January 2012.³³ That means roughly

Table 3: Penetration of CDHC Plans with HSAs and HRAs, 2007-2012³⁴

	2007	2010	2012
CDHC Plan with HRA	20%	20%	23%
CDHC Plan with HSA	25%	38%	48%
Contribute funds to HSA	15%	30%	39%

Figure 2: Percentage of Firms Offering CDHC Plans by Firm Size, 2005-2011³²



7.8 percent of the under-65, commercially-insured population is enrolled in a CDHC plan with an HSA.

Towers Watson and the National Business Group on Health (NBGH) conduct an annual survey of employers with at least 1,000 employees regarding trends in health insurance. They found a significant increase in both HRA and HSA penetration among employers. According to their most recent survey, CDHC plans coupled with an HSA are the most popular. In 2012, of those employers offering a CDHC plan, 23 percent also have an HRA, while 48 percent use an HSA as shown in Table 3.

The attraction of these plans to employers can be explained in part by the savings they accrue when moving their employees over to a CDHC plan. However, even considering these significant savings, Towers Watson

reports that few employers have been willing to migrate their entire workforce to these plans. Typically an employer will offer a CDHC plan alongside a traditional plan. However, to encourage enrollment, employers often set the employee premium contribution for CDHC plans significantly lower than for other plan types. Fifty-six percent of employers set the employee contribution at least 20 percent lower than for the traditional plan. More than 25 percent of employers set the employee contribution at more than 50 percent less than for other plan types.

In addition, employers will offer employees some additional financial incentive by funding one of the accounts (HRA or HSA) to help with health care costs before the deductible is met. A 2011 Kaiser Family Foundation study found that 69 percent of employees with employer-sponsored CDHC

Table 4: HSA/CDHC Plan Enrollment, March 2005 to January 2012

	Mar 2005	Jan 2006	Jan 2008	Jan 2010	Jan 2011	Jan 2012
Individual	556,000	855,000	1,502,000	2,053,000	2,358,497	2,470,840
Small grp	147,000	510,000	1,816,000	2,970,000	2,779,208	3,019,347
Lrg grp	162,000	679,000	2,777,000	4,986,000	6,299,460	7,939,023
Other grp*	88,000	247,000	13,000	*	*	
Other**	77,000	878,000	10,000	**	**	72,865
Total	1,031,000	3,168,000	6,118,000	10,009,000	11,437,165	13,502,075

* Other grp contains enrollment data for companies that could not break down their group membership into large and small within reporting deadline.

** Other was for companies who could report number of lives but not by individual or group within reporting deadline.

plans with HSAs received contributions to the accounts from their employers.³⁵ The average contribution to HSAs was \$886 for single coverage and \$1,559 for family coverage. Only 16 percent of companies who offer a CDHC plan coupled with an HSA do not contribute to the HSA. The observed growth in these plans is likely to continue – a recent survey found that more than half of large employers offered a CDHC plan option in 2011 and another 13 percent planned on offering one for the first time in 2012.³⁶

AHIP’s most recent report on the penetration of CDHC plans with HSAs found significant growth across all markets (individual, small group and large group) from 2005 to 2011. The fastest growing market for HSA/CDHC products was large-group coverage, representing approximately 59 percent of all enrollment in 2012. Table 4 displays the enrollment trends.

When evaluating the characteristics of people enrolled in CDHC plans with an HSA, some surprising results are found. The distribution by gender has remained more or less equal over the last several years, although enrollees in CDHC plans were more likely to be female

(56 percent versus 44 percent male).³⁷ Young people have the highest percent enrollment in these plans, but people ages 50-59 now make up a significant portion of the enrollment in these plans in the individual market. Figure 3 shows the age distribution of plans.

Income distributions are more difficult to assess because insurers do not capture information on the income of their enrollees nor do employers have access to family income. One study conducted by AHIP estimated incomes of accountholders of HSAs using imputations of income from census tract data. Figure 4 provides the results of this study, which suggest that a large proportion of HSA accountholders have more moderate incomes.

A separate study conducted by UnitedHealth Care and Optum Bank found that HSA adoption rates were very similar across all income groups, with the highest adoption rate found among lower-income participants as shown in Figure 5.

Prior to the passage of the Medicare Modernization Act in 2003, several hundred thousand people had health plans that included a deductible. Since then, these plans

Figure 3: Age Distribution of CDHC Plans with HSAs in the Individual Market, January 2012³⁸

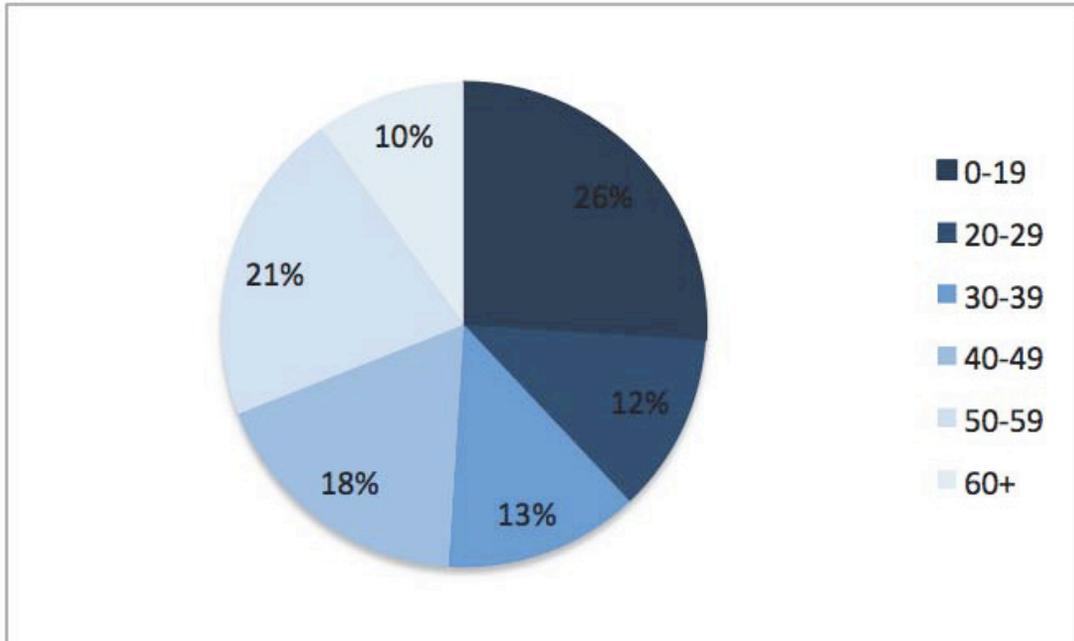


Figure 4: Distribution of HSA Accountholders' Census Tract Median Household Incomes, 2008³⁹

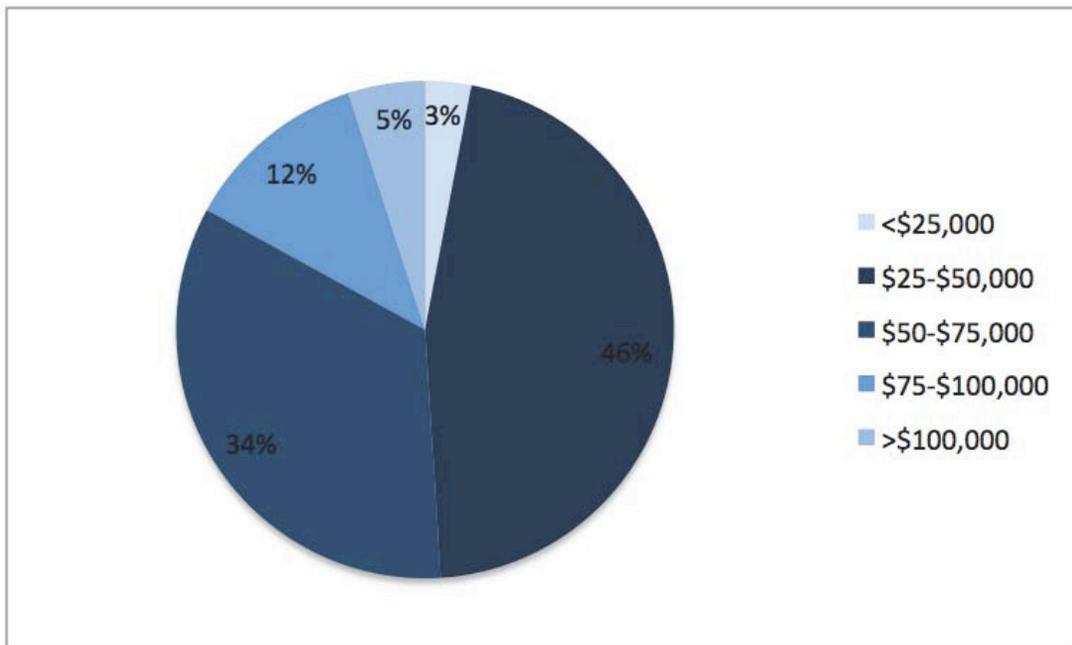
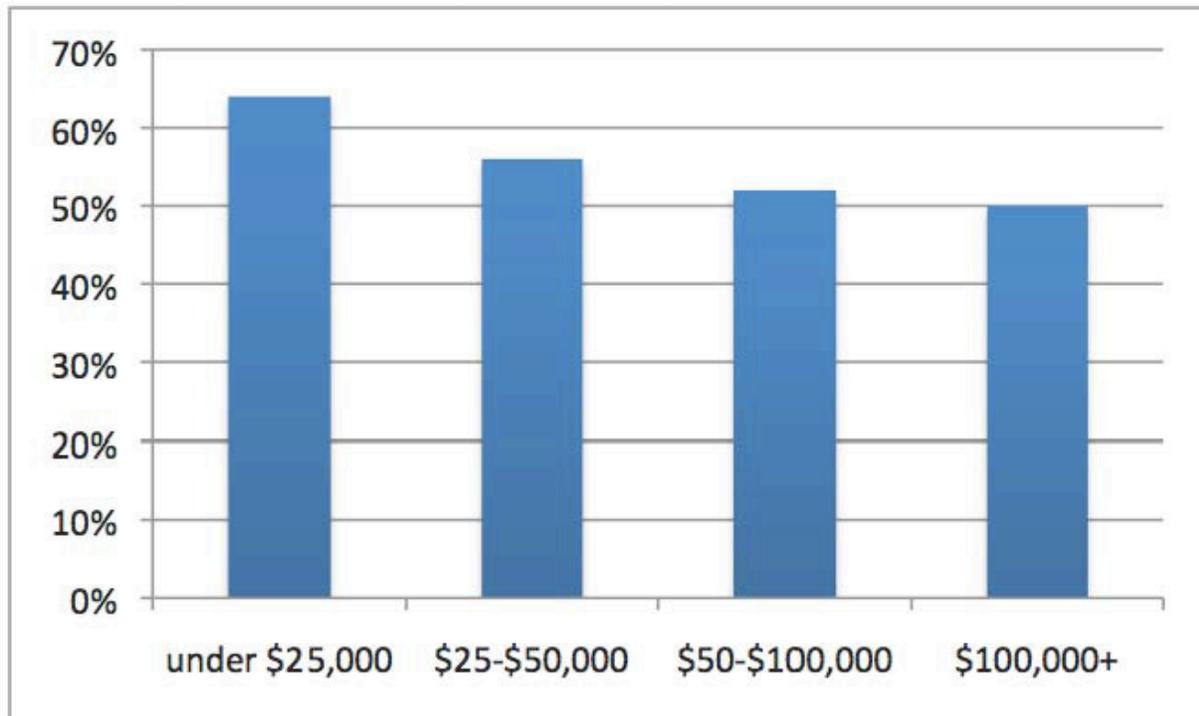


Figure 5: Health Savings Account Adoption Rates by Income, 2008⁴⁰



have expanded to cover almost 8 percent of all privately insured lives in 2012.⁴¹ Massachusetts, however, lags behind other states in adoption of plans with a deductible. In 2011, only 43.1 percent of private sector employers were enrolled in a plan with a deductible compared with 73.8 percent of employers nationally.⁴² Similarly, CDHC plans coupled with an HSA have experienced significant growth in the United States, but some states have seen more growth than others.

In 2012, the states with the highest penetration of CDHC plans with HSAs among the under-65 population with private insurance included: Vermont (19.9%), Minnesota (14.3%), Montana (12.1%), Utah (11.5%), Connecticut (10.6%), and Indiana (10.4%).⁴³ Massachusetts has one of the lowest penetrations of CDHC plans

with HSAs; in 2012, the percent enrolled in such plans was only 3.0 percent. Moreover, Massachusetts' penetration rate is not typical of its New England counterparts, all of which have seen greater adoption of these plans in the private market. For example, Connecticut and Vermont lead the New England states, as noted above, with Maine (9%) and New Hampshire (7.5%) close behind. Only Rhode Island's rate is similar to Massachusetts' at 3.7 percent. Massachusetts' penetration rate instead is similar to that of a number of southern states: Alabama (1.3%), Mississippi (1.6%), West Virginia (1.8%), and New Mexico (2.0%). Next, possible explanations for why the adoption rate of these plans in Massachusetts has been so low will be discussed.

V. Reasons for Low Penetration Rates in Massachusetts

Informal discussions were conducted with brokers, employers, and insurers to better understand why Massachusetts lags behind other states in adopting plans with a deductible, in particular, CDHC plans with HSAs. There were a number of specific explanations proposed, and each is discussed below. Because of the cross-sectional and multifactorial nature of this examination, assessing causation is not possible. In other words, it is impossible to discern which of these factors lead to lower penetration rates. It is also likely that some of these conditions exist partly because of Massachusetts' low penetration of CDHC plans.

Culture of Employers: Since most privately insured people receive their health insurance via their employer, an important factor to consider is employer behavior. Most stakeholders mentioned that it was the “culture” of employers to offer insurance and to offer rich benefits in Massachusetts. High employer offer rates in Massachusetts have likely led to more first dollar coverage because of the open-ended subsidy to employment-based group insurance, with both employer and employee contributions being exempt from federal, state, and local income and payroll taxes. In addition, Massachusetts is viewed as a state with significant union penetration and union leaders typically argue for benefits that include less cost-sharing.

There has been a perception that insurance that included a deductible was not as “good” as first dollar coverage. One example of this can be found in the State's implementation of its 2006 health care reform bill. The State's Connector uses metallic tiers to describe the plans offered through its distribution channel.

The plans with first dollar coverage are called “Gold” plans, while the plans with a deductible are called “Silver” and “Bronze.” This language further cements in consumers' minds that plans without a deductible are somehow better plans. Little attention is paid to the fact that employees are paying for this benefit through reduced wages, and/or lower salary increases. Employers we spoke with believe that employees expect first dollar coverage in the insurance they receive through employment. Some worry about confronting employees about deductibles and believe that they are better able to attract good employees if they offer richer benefits. However, employers may not understand what their employees want. In 2010, 44 percent of employees in small businesses chose HSA/CDHC plans when offered a choice among those and other types of coverage.⁴⁴ This result varied somewhat depending on group size, with 49 percent for firms with 10 or fewer employees; 45 percent for firms with 11 to 25 workers; and 40 percent for firms with 26 to 50 workers. It is true that Massachusetts has a large proportion of small businesses, and small businesses have been slower to adopt CDHC plans than larger businesses.

Penetration of HMOs: Another possible explanation for Massachusetts' low penetration rates is its early and enthusiastic adoption of managed care, in particular, HMOs. Massachusetts has had consistently higher penetration of HMOs compared to the rest of the nation, with over 50 percent in 2000 compared to 30 percent nationwide.⁴⁵ Because of this widespread adoption of HMOs, Massachusetts has an entire generation of workers who have grown accustomed to first dollar coverage when it comes to health care. It is much more difficult to move people from first dollar coverage

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plans to plans with high deductibles, which may explain Massachusetts' slower and more gradual approach to CDHC plans.

Nonprofit Insurers and Providers in the Marketplace: Some respondents believe that the market penetration of nonprofit insurers in Massachusetts has affected the number of CDHC plans established and offered to employers. The market leaders in the development of CDHC, such as Aetna and United Healthcare, have very little penetration in the Massachusetts marketplace. This may explain why a state like Minnesota, similar demographically to Massachusetts, has had a much higher penetration of CDHC plans.

Insurance Regulation and Politics: Massachusetts has had significant regulation in its health insurance markets since the mid-1990s. The nongroup (individual) market was heavily regulated with laws requiring guaranteed issue and renewal, adjusted community rating and rating bands, and preexisting illness exclusions. Carriers also were restricted to offering only two plans, one of which was a "standard" offering, until the 2006 reform. This greatly limited the number and types of plans offered in this market and did not foster experimentation with CDHC plans.

Similarly, the small group market has been heavily regulated since the mid-1990s with guaranteed issue and renewal, adjusted community rating and rating bands, and preexisting illness exclusions. Buchmueller and Liu found that states that established regulations such as guaranteed issue and renewal, rating bands, and preexisting illness exclusions in their small group market had a greater movement toward managed care than states without these reforms.⁴⁶ They posit that because HMO coverage is likely

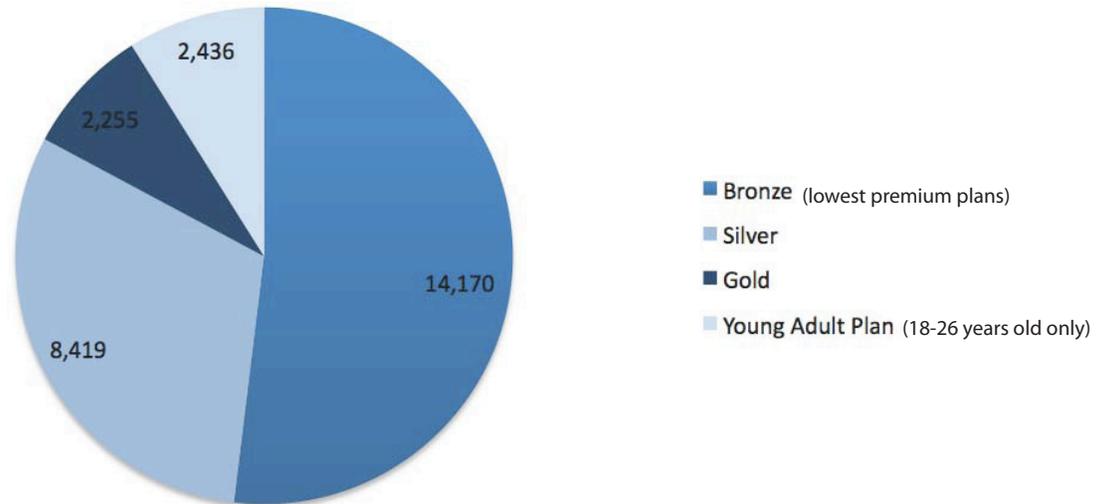
to be relatively more attractive to lower risk consumers, this movement represents a possible self-selection mechanism, with relatively healthy firms favoring HMOs in a regulated market that no longer provides rating preferences.

Cost of Plans: Stakeholders mentioned that the cost of CDHC plans in other states is more attractive than in Massachusetts. The 2012 average premium for CDHC plans for individuals and families in the United States is \$361/\$896 per month.⁴⁷ The average for these plans in Massachusetts is indeed much higher at \$453/\$1,127 per month. However, premiums in neighboring states with higher penetration of CDHC plans like NH, CT, and ME are similarly high. It is interesting to note that some states with the highest penetration of CDHC plans have much lower premiums, for example, Minnesota \$264/\$494, Vermont \$390/\$874, and Utah \$302/\$743. What is an arguably more important factor is the relative premium price difference between CDHC plans and other traditional plan types. We could find no evidence suggesting that the price differential between the two types of plans was less in Massachusetts than elsewhere. National figures for premium differences are shown in Figure 1.

VI. Moving Forward

It is important for Massachusetts to consider strategies to increase the prevalence of CDHC plans for several reasons. First, they offer the State a largely untapped strategy for constraining health care costs. Because of the low penetration rate of these plans in Massachusetts, significant savings could be realized should Massachusetts employers gravitate toward these plans. Next, with the recent passage of Chapter 224, "An Act improving the quality of health care

Figure 6: Connector Commonwealth Choice Individual Enrollment by Benefit Level, June 2012⁴⁸



and reducing costs through increased transparency, efficiency and innovation,” engaging consumers on the costs of care and appropriate utilization of health care services has never been more critical. Without this increased engagement, consumers may once again backlash against capitation and managed care, which are key features in Chapter 224. Finally, these plans offer consumers a savings vehicle that, if established at an early age, could help Massachusetts residents finance their long-term care needs later in life.

Although Massachusetts lags behind other states, enrollment in plans with deductibles has increased in the nongroup (individual) market since the passage of the 2006 health reform law. Figure 6 provides evidence that when Massachusetts residents are provided with choice and financial incentives, they favor lower cost options such as bronze and Young Adult Plans.

There are a number of steps that Massachusetts policymakers can take to encourage the acceptance and adoption of CDHC plans. By acknowledging that CDHC plans have a role to play in constraining health care costs and engaging consumers, and after reviewing the more recent empirical results, policymakers should be encouraged. Moreover, policymakers need to play a significant role in increasing transparency so that consumers have access to the best information to make their health care purchasing decisions. Finally, by embracing CDHC plans in the programs it oversees, the State could move a larger number of people into these plans and save millions of dollars. In addition to policymakers, employers no longer have reason to approach the adoption of these plans with trepidation. Instead, they should work to encourage their employees to engage in healthy behaviors, to become educated consumers of health care services, and to accumulate savings that can be used

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for health or other needs in their retirement years.

To accomplish these goals, first, Massachusetts policymakers need to revisit the current characteristics of CDHC plans and the empirical data on the outcomes of these plans. As with any area of research, it takes many years and numerous studies before evidence is sufficient to make conclusions. There is now a robust literature available, much of it cited in this paper, providing substantial confirmation that these plans can reduce costs without having deleterious effects on health for the vast majority of the population.

Second, Massachusetts should act quickly to increase the transparency of cost information. The State recently established an all-payer claims database that should help facilitate the transparency of both costs and quality information. Chapter 224 establishes a new agency, the Center for Health Information and Analysis (CHIA), which will assume responsibility for the consumer website from the Health Care Quality and Cost Council, which was eliminated by the law. The law adds many new required features such as reporting of actual prices of services at individual provider organizations to the consumer website. The website is also charged with producing a host of patient information and decision-making tools for selecting providers, insurance plans, and treatment options. Transparency and education are key features of CDHC and the State can and should take a leadership role in ensuring that people have access to data on the cost of health care services in a format that is understandable and useable. This will improve people's use of CDHC plans and encourage more employers to offer these plans to their employees. While

it would be valuable to provide data on the quality of providers, Massachusetts should not wait until quality data are available to begin this effort. Third, the Group Insurance Commission (GIC) should be required to offer CDHC plans with HSAs as an option for State employees. Although the GIC has incorporated some cost-sharing strategies such as small deductibles and tiered co-payments for many services, CDHC plans could offer the State additional savings as well as a new savings vehicle for employees. In 2006, Indiana became one of the first states to offer plans with HSAs to state employees. Today, 90 percent of the Indiana State workforce is enrolled in a CDHC plan. A 2010 case study analyzed the effectiveness of CDHC plans at decreasing the cost of state employee coverage in Indiana.⁴⁹ They found that the HSA plans saved the State an average of 10.7 percent annually over the study period. Not only was the State projected to save \$23 million in 2010, but, in addition, State employees who enrolled in the plans saved a combined \$7-8 million in 2010. The study found no evidence that participants avoided care and no adverse events were reported from deferred care. The study concluded that the savings appeared to come from better use of health care resources and more engaged consumers. The GIC could also provide access to additional tools that engage consumers in their health care decision-making. The GIC now reaches many towns and municipalities, as well as State employees and retirees, and should lead the way in the adoption of these plans.

Following Florida's lead, the Massachusetts Medicaid program could implement moderate consumer engagement with the plans it oversees. Although a wholesale move toward CDHC plans with HSAs may not be

possible at this time, consideration of features such as tiered co-payments, savings cards, or other incentives to encourage appropriate utilization of preventive care, compliance with disease management programs, and keeping scheduled appointments could begin to engage patients and move the program in the right direction.

In addition, the Connector should adopt a more open attitude toward CDHC plans and change its naming strategy for the plans it offers to reduce the negative connotations associated with plans that include a deductible. Bronze plans should not be considered “worse” or “less comprehensive” health care plans. Information about the benefits of opening and contributing to an HSA should be made available to individuals, and the Connector could facilitate the establishment of such accounts. Finally, the Connector should consider revising its small employer program altogether by either moving it in its entirety to the private sector or establishing a true choice program, as was envisioned by both Chapter 56 and the ACA.

On another front, employers should embrace these plans in their latest incarnation, perhaps by offering them side-by-side traditional plans at first. Working with their brokers and other benefit managers, employers need to educate and engage their workforce regarding health care decision-making. They should consider adding wellness benefits and tools to help consumers make better decisions about their health and health care. No reform, whether supply- or demand-focused, can succeed without the active participation of patients.

CDHC plans are not perfect. There are still a number of federal rules that make it difficult for these plans to achieve all of their goals. Federal policymakers could help by allowing

deductible amounts, when coupled with an equivalent HSA amount, to be included in the calculation of the actuarial value of the plan under the ACA. They should also allow spending on over-the-counter (OTC) medications in lieu of prescription drugs to be reimbursed tax-free from an HSA, whether or not the OTC drug is covered by the plan. Additional flexibility in how the deductible is applied would be welcome and would help to ensure appropriate use of necessary care. Currently, the deductible must be applied to all services covered by the plan (except sanctioned preventive care). More flexibility in this area would allow employers to adopt first dollar coverage for certain services that they want to encourage, similar to value-based insurance designs (VBID). This flexibility would likely provide an incentive for people to choose these types of plans as well.

As Massachusetts moves to implement the ACA as well as Chapter 224, CDHC should not be ignored. Towers Watson research⁵⁰ has shown that 60 percent of companies will reach the status of “rich” plan by 2018 as defined by the ACA: plans in excess of \$10,200 for single coverage and \$27,500 for family coverage. In Massachusetts, these figures are even higher as a recent publication illustrates.⁵¹ These plans will be subject to an excise tax. A survey conducted by Towers Watson found that employers will be motivated by the 2018 excise tax to implement a plan with a deductible and a health savings account. In addition, with the impending FSA cap, more employers will look to HSAs as a savings vehicle for their employees. Therefore, Massachusetts may begin to see increasing enrollment in CDHC plans even with little action.

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This paper provides a number of reasons for Massachusetts policymakers, state agency administrators, and employers to take another look at CDHC. It's time for Massachusetts to incorporate consumer-driven features into the health insurance marketplace and realize better health outcomes and reduced health insurance premiums, while engaging patients in their health and health care decisions.

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About Pioneer:

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to change the intellectual climate in the Commonwealth by supporting scholarship that challenges the “conventional wisdom” on Massachusetts public policy issues.

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