The rise of consumer-driven health plans is fueling the dramatic shift in healthcare: the field’s focus is moving from patients to consumers. In patient-centric healthcare, the customer is a passive user with limited decision support who relies heavily on the physician and the health plan. In consumer-centric healthcare, the customer is more active and engaged in the decision-making process because he is both purchaser and user of the healthcare. Decision support comes from personal advisors, the Internet, medical staff, and patient decision aids. The physician remains a trusted source who serves as a provider and a consultant.

Consumer-driven health plans are the heart of healthcare consumerism. For the first time, consumers have the ability to take control of their own healthcare by selecting providers, services, and benefits that uniquely fit their needs and desires.

A survey conducted late in 2009 by Aon Consulting and the International Society of Certified Employee Benefit Specialists shows that 44 percent of employers offer their employees a consumer-driven health plan, up from 28 percent in 2006.
(Sharon 2009). Fifty-six percent of these employers link the consumer-driven health plan to an HSA that employees can contribute their own money to, retain ownership of, and transfer if they depart from that employer.

**A MOVING TARGET**

A critical mass of younger career professionals will have consumer-driven health plans for their entire careers. These consumers demand more choices, actively design their benefits programs, and are eager to establish HSAs and watch them build. Consumer-driven health plans are being adopted so quickly that the magnitude of the transformation is difficult to grasp.

A consumer-driven health plan coupled with a health savings account or a health reimbursement arrangement is the wave of the future. As of January 2009, more than 8 million people in the United States had such coverage, compared to roughly 6 million in 2008, 4.5 million in 2007, 3 million in 2006, and only 1 million in 2005 (AHIP 2009).

**Compelled to Spend Wisely**

The consumer-driven health plan concept originated in the mid 1960s. Multiple studies have determined that as individuals take responsibility for a greater portion of their medical costs, fewer medical services are actually purchased (Wharam et al. 2007; Gerfin and Schellhorn 2006). This may seem obvious, but health insurers and employers have taken decades to fully embrace this concept.

Consumers today absorb a rising share of healthcare costs, whether or not they have consumer-driven health plans. In general, employees are paying more than ever for their own healthcare, about a third of overall costs, while the rest is usually covered by employers or insurers (Halverson and Glowac 2008, 33).
In the coming years, the employee burden is likely to grow to as much as 50 percent of personal healthcare costs. Employees will engage in an unprecedented level of consumerism. They will seek to spend their healthcare dollars wisely and stretch them as far as possible. They will vigorously pursue cost and benefit information (as discussed in Chapter 1), be more demanding, and be more likely to switch to providers who offer a better deal. Providers have the edge in retaining current customers. The relationship between a doctor and a patient is the key asset a provider possesses in the quest to provide long-term, life-cycle services to that patient.

Helping with Effective Choices

Healthcare consumerism as embodied by the rise of consumer-driven health plans might seem similar to other consumer movements, but there are notable differences. The typical healthcare consumer is bewildered by her healthcare options and the onslaught of information on the Web. The variety of plans from sponsors, health program vendors, providers, and intermediaries is daunting. The medical and administrative aspects of healthcare are excessively complex. Taking charge of individual and family health is a personal, financial, and emotional issue that can be trying.

As consumers seek to make effective choices and keep pace with plan updates, they will want help. Particularly, consumers who aren’t sufficiently health literate will count on others to help steer them through the maze of consumer-driven health plans. Consumers who have been in the workforce for a decade or more may have little experience in shopping for healthcare. Younger professionals may prove to be more adept at healthcare shopping, as they are accustomed to mining information and making their own decisions.

Consumers are particularly vulnerable when something goes wrong. Their reflexive response in choosing providers under adverse
conditions is to rely on the two ubiquitous decision drivers—quality and price transparency (as discussed in Chapter 1).

**Tools for Health**

Consumer-driven health plan vendors populate the insurance market, and a few major players have emerged through consolidation. Employers welcome the consumer-centric approach to providing health benefits because they see it as an essential way to contain costs.

For consumer-driven health plans to be effective, consumers need tools and information to make better informed decisions. The consumer-driven health plan approach encourages consumers to adopt a wellness approach to healthcare, which minimizes future health issues and associated costs, and to build equity in their plan as a by-product of making wise healthcare decisions and purchases.

The consumer-driven health plan needs to provide decision support tools to help employees choose providers who specialize in diet and nutrition, exercise and fitness, health risk appraisals, and pain management. Such plans include preventive care services to encourage employees to seek early detection and early treatment of any illness or condition. The employee is encouraged to seek providers who offer discounted fees for service.

Employers who contemplate instituting consumer-driven health plans need to ensure their employees are protected. For example, the plan has to include catastrophic insurance for the runaway costs associated with critical injury and illness. The plan needs to include an employee-funded deductible in case the reimbursement amount is depleted. Usually reimbursement is initially funded by the employer. Any unused amount at year’s end can roll over tax-free to help offset future out-of-pocket costs.
HEALTH REIMBURSEMENT ARRANGEMENTS

Health reimbursement arrangements (HRAs), also known as health reimbursement accounts, are a common part of consumer-driven health plans and are usually coupled with a high-deductible health plan. Such plans currently have a minimum annual deductible of $1,150 for single coverage and $2,300 for family coverage (Rand Compare 2009). HRAs are employer-established, employer-funded benefit plans that include free preventive care for members, up to a maximum dollar amount, not charged against the deductible.

Consumers can roll over any unused funds at the year’s end for future use, COBRA benefits, long-term care, or Medicare premiums. Because consumers have to pay a high deductible, they will shop around for value at a reasonable price and, hopefully, make better-informed choices about care.

HEALTH SAVINGS ACCOUNTS

Health savings accounts (HSAs) have seen a dramatic rise. According to 2009 data from the U.S. Department of Treasury, 438,000 individuals were covered by HSA-type insurance plans in 2004, whereas the department projects a minimum of 14 million HSA policies by the end of 2010.

HSAs, like HRAs, are usually coupled with high-deductible health plans. HSAs are designed to help consumers pay and save for current or future qualified medical and retiree health expenses on a tax-free basis. HSAs are owned and controlled by the consumer and, like savings accounts, accrue a small amount of interest. An HSA can be funded by the employer, the employee, or a third party, and generally costs less than traditional healthcare coverage.

Increasingly, employers are contributing to their employees’ HSAs. In Aon Consulting’s 2009 study, of the 56 percent of
employers who contribute to employees’ HSAs, nearly half contribute $500 annually, with a small percentage actually matching employee contributions.

The employee decides how to invest the money to make the account grow. Without a health insurer dictating which providers can be seen or services can be received, the consumer is in complete control and can choose any provider. Ultimately, because she is paying, the consumer presumably chooses a provider who offers high quality at a competitive rate.

HSAs are by no means a cure-all. They have no appreciable impact on the value of healthcare delivery. However, when the majority of policyholders use their funds wisely, the results are positive. Aetna’s HSA subscribers tend to spend more on preventive care and experience notably lower rates of otherwise increasing healthcare costs. These subscribers also seek more information about healthcare choices, are more likely to use generic medications, and are less likely than other consumers to visit the emergency room (Porter and Teisberg 2006).

A Breed Apart?

Are consumers who establish HSAs a self-selecting bunch who are already healthy? Aetna and other insurers have seen differences in behavior among those with HSAs versus those without (Porter and Teisberg 2006). Perhaps having an HSA gives the consumer an enhanced sense of responsibility for making healthcare choices.

HSAs work best when there is competition among providers, an abundance of transparent information, and decision-making assistance. In the absence of sufficient information or choice of providers, an HSA is merely a device for shifting costs from employers to patients and restricting patients’ decisions about seeking care. Evidence suggests HSAs may prompt undesirable self-rationing, where patients forego needed care to save money (Porter and Teisberg 2006).
The Long-Term Impact of HRAs and HSAs

In consumer-driven health plans, HRAs and HSAs drive consumer involvement, transparency in quality and price, and free market forces to reduce the costs of healthcare. Ultimately, consumer-driven health plans will drive health insurers to lower premiums, customize plans, and cater to consumers to retain them as customers. Consumer-driven health plans are an excellent alternative to traditional health insurance plans. However, consumer involvement depends on factors such as consumers’ purchase criteria and availability of key information.

As consumers gain familiarity with HRAs and HSAs and these accounts grow significantly, issues of ownership, transferability of funds, and security will heighten. Consumers want easy access to their accounts, regardless of their employer or employment status. They might seek HSA credit for unused sick leave and vacation time, and the ability to use credit cards and debit cards when drawing from their account funds.

Implications for Your Hospital

Are you contemplating what services you can provide to the legions of consumers who will soon have consumer-driven health plans?

- Based on the demographics of your target population, do you have in place the kinds of programs customers are most likely to seek?
- How can you accentuate, price, and effectively promote your services?
- What is the potential for you to add new services to your current mix?
- Can you affiliate with organizations who offer what you do not?
- What other solutions can you devise?
DEDUCTIBLE AMOUNT MATTERS

Employees are recognizing that their employers are having a difficult time meeting rising healthcare costs. Astute employees also recognize that if they don’t need to spend on healthcare now, funds can be diverted to their future needs.

While deductibles in traditional health plans often exceed $1,000, the deductible in a consumer-driven health plan can range anywhere from $1,500 to $5,500 (AHIP 2009). Thus, the consumer has an immediate incentive to shop for healthcare services that offer needed benefits without costing too much. The higher the deductible, the more likely the consumer-driven health plan will be supplemented with an HSA or an HRA, which enable employers and employees to contribute funds to meet the cost of healthcare not covered by insurance.

Booz Allen Hamilton (2007) forecasts rapid growth in the enrollment of high-deductible health plans, predicting that by 2020, approximately 60 percent of those insured through their employers will be in some form of a high deductible and high cost-sharing plan, and 20 to 25 percent of the privately insured market will be enrolled in consumer-driven health plans with an HRA or HSA.

Short-Term Savings, Long-Term Drain?

Critics suggest that high-deductible consumer-driven health plans end up costing the consumer more in the long run, because some healthcare is put off (Halverson and Glowac 2008). Consider Tom, who initiates an HSA and has a high deductible consumer-driven health plan. Tom has not previously been concerned about medical expenses, but this year he has to be. He hurt his shoulder and needs surgery and follow-up care. Suddenly costs and providers matter to Tom: How much will the surgery and follow-up care cost? Where will he go for surgery and post-operative treatment?
Later in the year, Tom starts having back pain, but it is not as pressing as the shoulder injury. In light of his high deductible, he decides not to spend any more money for a while if he can manage. He adopts a de facto program of deferred maintenance. He will put off buying medications, undergoing a physical, and having other exams for as long as he can.

Normally Tom might see a specialist for the back pain, but if the visit costs him $180 instead of the $25 copayment of his previous insurance plan, he will avoid the expense. Deferred maintenance and reluctance to take action eventually put him in trouble when the pain gets worse. The cost of attaining proper treatment now is far more than the cost of paying a little bit along the way.

**Implications for Your Hospital**

If the trends continue, an explosion in the number of consumer-driven health plans is coming. Many consumers will seek to lower their premiums and build their HSAs.

- As consumers’ HSA balances rise, how will your service mix shift to meet the new opportunities?
- Do your top medical professionals and key executive staff understand the need to capitalize on these opportunities?
- How are providers outside of your region reacting to the growth of consumer-driven health plans?
- Could you employ, affiliate with, or form partnerships with massage therapists, naturopaths, chiropractors, and acupuncturists whose patients often spend money from HSAs?
- What are the innovators in your region offering, and what do they charge for such services?
- Have you surveyed your customer base to determine what additional services they would like?
- Who can design such a survey, administer it, and interpret the data?
PATIENT DECISION AIDS

Patient decision aids are tools specifically designed to help individuals make decisions about their healthcare options. Aids can be paper or electronic and should review the pros and cons of each available treatment method for a condition, using evidence-based information. The aids help patients quickly get information, gain clarity, and identify the personal value of certain health choices. Healthwise’s self-care guides (www.healthwise.org) are good examples of patient decision aids. Decision aids help all consumers, especially those with consumer-driven health plans who make major decisions about surgery and other procedures.

Patient decision aids are not designed to point patients in one direction or to diminish the role of person-to-person consultation with care providers. They make patients better informed and more aware of the impact of their decisions. Some 500 patient decision aids are available or are in some stage of development (IPDAS 2009).

Consumers have difficulty determining whether a particular decision aid is a reliable source of health information. The International Patient Decision Aids Standards (IPDAS) Collaboration (www.ipdas.ohri.ca) seeks to establish internationally approved guidelines for determining the quality of patient decision aids.

As patient decision aids proliferate, increase in quality, and become more user friendly, consumer-driven health plan holders and other consumers will have another tool with which to make healthcare choices.

OPTING FOR WELLNESS

Recent history has shown that using wellness programs reduces consumers’ health plan premiums. In Deloitte’s 2008 Survey of Healthcare Consumers, 83 percent of respondents showed interest
in participating in a wellness program offered by their insurance company, employer, or other health plan if it reduced their premiums or lowered their copayment burden.

The more involved a consumer is in healthcare decision making, the more likely he is to have favorable health outcomes and lower costs. Of the Deloitte survey respondents, 61 percent wanted tools that offer individualized tips for improving their health. Many also wanted the ability to monitor, assess, and manage their health and would pay extra for such tools. A surprising 53 percent would employ the services of a health or lifestyle coach if it were part of their health plan.

Consider Teri, who is in excellent condition and has been in control of her own health for years. She has an HSA with a significant balance. How does that alter the service mix you consider offering? A consumer like Teri might seek chiropractic care, massage therapy, or her own health coach. She might patronize a retail clinic. She would be enthusiastic to have a health club membership as part of her plan.

**Wellness Center Opportunities**

With the growing recognition that a patient’s health and well-being extend beyond office visits, medical procedures, prescriptions, and basic nutrition, many hospitals consider offering health and wellness components to their staff, customers, and the community at large.

Health and fitness centers are possible revenue sources that represent a form of wellness, supplementing many of the benefits that traditional medical facilities provide. With some 15,000 health and fitness centers across the United States, hospitals have many opportunities for affiliation. There are nearly 1,000 hospitals throughout the United States and Canada already associated with fitness centers (Medical Fitness Association 2010).
EXEMPLARY CENTERS

Hospital wellness centers often encompass a variety of services and features that go beyond mere fitness centers. Services such as massage, acupuncture, counseling, rehabilitation, stress reduction programs, pastoral care, and meditation sessions can be part of the mix. Examining ideal wellness centers can yield ideas for your organization’s own endeavors.

Piedmont Hospital Health and Fitness Club

The Piedmont Hospital Health and Fitness Club in Atlanta, Georgia, is notable for its range of amenities and for the personal attention it pays its members. The 25,000-square-foot facility offers strength-training equipment; cardiovascular exercise equipment; lap and therapy pools; an impressive variety of classes, including targeted classes for people with COPD, cancer, and other conditions and diseases; and deluxe locker rooms.

Working with an exercise physiologist, each new member completes a comprehensive personal fitness profile and receives a unique exercise prescription. In a mission mindful of its affiliation with the hospital, the club focuses on optimal health maintenance, fitness and nutrition, disease prevention, and injury rehabilitation. Members include those who live and work nearby and Piedmont employees, and the club is open to all ages and fitness levels.

Galter LifeCenter

Galter LifeCenter (http://galterlifecenter.org) bills itself as Chicago’s premier medical fitness center. The center is a member of the Medical Fitness Association and is affiliated with Swedish Covenant Hospital. The facility offers educational events about healthy living, dozens of fitness classes, and a range of integrative
therapy such as massage and acupuncture. The center also offers health screenings including lipid profiles, blood pressure readings, metabolic panels, and more. The two pools house aquatic classes for adults, children, and families. Among other added values for members, the center runs member appreciation events and offers a newsletter and online wellness community.

The Center for Healthy Living

The Center for Healthy Living at Oklahoma University Medical Center in Oklahoma City conveniently centralizes many health services. The center comprises medical offices, an ambulatory surgery center, the Oklahoma Center for Athletes, and a 65,000-square-foot fitness facility called the Health Club. The club is remarkable because of its medical focus. It is staffed by medical professionals and includes a unique feature—fitness and nursing supervision stations.

Methodist H.E.A.L.T.H. Club

Methodist Hospital, based in Henderson, Kentucky, hosts the Hospital Employees Accomplishing Long Term Health (H.E.A.L.T.H.) Club. The club is a great example of starting a wellness movement within the hospital itself. The club is free to hospital employees, physicians, retirees, volunteers, hospital board members, and members’ spouses.

Implications for Your Hospital

Today’s adults fully understand that exercise, lifestyle choices, and an integrated approach to health and wellness are the best remedies against illness, disease, and infirmity. Here are some issues to
explore if you’re considering adding a health club, health and fitness center, or wellness center:

- How many of your customers would patronize the center?
- What is the potential revenue? Factor in various levels of membership fees and a la carte services.
- Can you integrate the center with other hospital-based programs to increase patronage, loyalty, and revenue?
- Which facilities in your area might be suitable partners?
- Which facilities within your existing structures might be suitable for conversion?
- How will such a center contribute to your overall brand, mission, community outreach, and ability to compete locally and regionally?
- Can you afford to ignore this opportunity?
- What existing models can you learn from?
- Who should lead this initiative?

A BOLD INITIATIVE

What if you initiated a consumer-driven health plan for your own employees? Consider Alegent Health, whose commendable transparency was discussed in Chapter 1. Alegent, a nonprofit healthcare system, launched such a plan for its own employees. In 2005, Alegent’s executives were discussing how to treat its workforce as consumers, and an idea emerged. Alegent would shift payment responsibilities from insurers to consumers—its own employees—through a consumer-driven health plan. Such a move would give employees a strong sense of control over their healthcare choices. With this move, Alegent became a pioneer among providers (Halverson and Glowac 2008).
**Implications for Your Hospital**

Developing your own consumer-driven health plan is a bold strategy. In addition to generating cost savings for your hospital staff, it helps you understand your customers’ motivations and makes you better able to serve them.

- Have you examined other providers’ consumer-driven health plans?
- What has been your experience thus far in treating patients who have consumer-driven health plans? Can your patient records or other data show you which patients have such plans?
- What mix of services and benefits do health plan customers opt for?
- How feasible is offering a consumer-driven health plan to your staff?
- How many people would be involved in the plan?
- From what benefits may employees choose?

**HOT TIPS AND INSIGHTS**

- Consumer-driven health plans are at the heart of healthcare consumerism, and soon your typical patient will have one.
- Establish the service mix you can provide to consumers who have consumer-driven health plans.
- Determine how to capitalize on the opportunities that come from consumers with high HSA balances.
- Help consumers navigate healthcare options and information by becoming the clear provider of choice.
- To what degree can you support consumers’ quests for wellness? Wellness is what all consumers ultimately want.