Breakthrough Thoughts

Prescription for Change

Health plans that put consumers in the driver's seat are the last chance to avoid a government-controlled monopoly.

by Gary Ahlquist, David Knott, and Philip Lathrop

The American health-care system has been so troubled for so many years that it is a cliché to say that it is broken beyond repair. Errors, including fatal errors, are far too common. Health-care professionals, when surveyed, say they feel dissatisfied and overburdened. Consumers feel angry and powerless. And the costs rise unrelentingly. Overall, U.S. health-care spending tripled between 1990 and 2005, from $655 billion to $1.9 trillion (projected). Annual health insurance premiums that might have cost a family of four (or their employers) $12,000 in 2000 would probably cost $17,000 today. If the current double-digit rate of increase continues, those premiums could cost $25,000 by 2010 — and as recent news headlines about General Motors' retiree obligations have demonstrated, such costs can be crippling to individuals and corporations alike.

It has long been recognized that these trends are unsustainable. Each of the major players associated with health care has taken its turn trying to rationalize demand and costs in the United States. Health-care providers (both institutions, such as hospitals, and individual professionals), employers, insurers, and government programs all took their swings with little lasting impact. Now comes the last group: consumers. During the next year or two, consumers will get a chance to reshape the system through a form of insurance called consumer-directed health plans (CDHPs), which have been written about at length but not implemented until recently. If this solution fails, it is hard to see any alternative but a government-sponsored "universal" initiative — perhaps not nationalizing assets, but almost certainly involving price controls, supply constraints, and utilization mandates.

But before we abandon private-sector initiatives entirely, it's worth doing what we can to give CDHPs a fighting chance. They have the potential not only to transform health-care markets, but also to become part of new thinking about larger issues such as retirement savings, wealth-building in general, and even large government programs such as Social Security and Medicare. For the first time, in

Illustration by Lars Leetaru

short, consumers could be given the lead role in shaping the health system of the future — which in turn would give providers and insurers of health care their first real incentive to transform. The next few years will be crucial in determining whether CDHPs can spark a new paradigm for health care, or whether we're simply taking another step toward what is, to many, an inevitable nationalized approach.

Health Care's Backstory

The U.S. health-care system didn't arrive at this juncture overnight. The problems — and various attempts at solutions — have been around for more than 50 years. Before 1950, providers themselves sought to bring equity to health care by providing services to the needy through free care, barter (a chicken for an office visit, for example), and solicitations of financial contributions. The federal government was involved primarily on the supply side by giving money to communities for hospitals, and through programs to expand the number of new doctors being trained. Employers, unions, and insurers started to expand their roles during World War II, when the Ford Motor Company, in trying to avoid a labor strike over health benefits, approached the war-saddled government for relief. The solution came in the form of a tax deduction for health benefits by employers, spawning the employer-based group benefit model that became prevalent in the 1950s and 1960s. Then, in the mid-1960s, the Medicare and Medicaid programs were launched. Medicare and Medicaid greatly increased the demand for services at the same time that medical advances were making their biggest strides. Second-generation antibiotics, advanced imaging, chemotherapy, and revolutionary new cardiac care technologies combined with increased overall demand to create the industry's first cost crisis — a dramatic rise in hospital costs toward the end of the decade.

Medicare and Medicaid responded with several unsuccessful mechanisms to control the growth in costs — first by capping costs and then by linking payments to diagnostic codes and severity of illness. The crisis crossed a threshold of public awareness when Lee Iacocca told Congress in 1988 that there was more money for health care than for steel in the cost of a new car. (This is still true, only more so.)

In the 1990s, about the only idea on the table to address the crisis came from the insurance sector. Health maintenance organizations (HMOs) and other variants of managed care, long a staple of the unionized work force in the Northwest and Upper Midwest, moved front and center as "the answer," promising to cut costs by encouraging prevention and eliminating unnecessary measures via "gatekeepers" and third-party review. There was just one problem: Many consumers and even more providers resented employer/insurer intrusion into their choices of doctors, treatments, specialists, and facilities.

We are currently emerging from the "managed care as the answer" era. Employers backed away from these mandated programs as the economy grew rapidly and labor markets tightened. In addition, providers got smarter about how to gain and use oligopoly-like market strength to regain pricing power. Although HMOs and their kin briefly slowed the

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rate of health-care cost increases, we were soon back on the same growth curve for health-care costs, as technological advances combined with weakened utilization controls. This is where we stand today, and there are only two ideas on the table to rein in costs: National health insurance and consumer-directed health plans.

Turbocharged Incentives

Until the introduction of CDHPs, most people made few choices about health care beyond selecting their physician and their health plan — and even those choices were restricted by the paternalistic policies of the employers or membership groups through which most people obtained health-care coverage. CDHPs, by contrast, put individuals "in the driver's seat" by allowing them to design and select their own health plans in a more open market with a range of choices at every stage for treatment and prevention — with innate, turbocharged incentives for making economical, high-quality choices. Just as defined-contribution pension plans placed individuals at center stage in the 401(k) world, CDHPs establish individual choice as the core of systemic improvement.

In a typical CDHP, an employer places a sum of money each year (perhaps $2,000 for an individual or $4,000 for a family) into a health savings account (HSA) that can be used only to pay medical expenses. The employer will also typically provide a high-deductible major medical policy for expenses over, say, $5,000 in any given year. To encourage proper preventive care, many such plans also cover screenings such as mammograms on a first-dollar basis. What sets CDHPs apart from traditional coverage is the *rollover:* Under many plans since 2004, the employee may carry over any unused cash balance, to which the employer will then typically add the following year's contribution of $2,000/$4,000. This rollover feature is crucial to changing behavior. If unused funds disappear every year, consumers rationally view them as an evaporating asset they had better spend, thereby driving up costs. But if the unused funds accumulate, then consumers learn to spend the money judiciously, balancing the costs of preventive measures in the short run with long-term savings for possible crises. This also lowers the odds of incurring larger expenses in the long run.

The second key feature of these new CDHPs with health savings accounts that permit rollover and accumulation of unused balances is *portability.* Individuals can take their accumulated balances with them when they change employers, withdraw from the work force, or retire. This feature transforms health benefits from an annually evaporating asset into a lifelong savings scheme for almost any approved health-care expense. Under new regulations, HSA balances can even be part of an individual's estate at death.

The final feature that makes CDHPs with HSAs truly unique and powerful is that the HSAs are *triple tax advantaged* — tax-free when contributed; tax-free as they grow (they can be invested); and tax-free at withdrawal (whether one day after the money is deposited or 20 years later). These advantages will undoubtedly inspire financial-services providers to create new ways for individuals to maximize lifelong capital accumulation across categories (retirement, health care, life insurance, disability, higher education), as well as to mix and match these funds at different stages of life. People will accumulate significant balances while single and in their 20s, which can be spent later on the expenses of having children and middle age. They may be able to borrow from long-term funds to cover high-expense years, or to leverage their assets in other creative ways. The new HSAs should be viewed as products within a full range of consumer risk protection and wealth-building services, with several key interrelated components:

- *Transaction convenience and flexibility* have already seen significant activity and development. Debit cards are the current norm for health reimbursement accounts (HRAs) and HSAs, and card issuers are likely to push their services further into the back rooms of insurance to take on additional aspects of claims processing.
- *Protection of assets* will be driven by insurance providers. As consumer services expand beyond health-care coverage, this protection will come to encompass life insurance and perhaps disability insurance. The increasingly high deductibles of health-care plans will create a need for mechanisms and products that bridge the gap between the funds that consumers have available for spending and the higher threshold costs of a catastrophic illness or accident.
- *Borrowing products and services* make up the segment of the value chain that is likely to see the most innovation over the next year or two — making it easier for people to leverage their assets during low-expense years to pay for the added costs of years with high health-care or education expenses.

• *Accumulation products and services* address the need to invest and manage longer-term savings. These components will be more important in five years or so, when HSAs have been in place long enough to have generated a critical mass of rollover capital.

Private-Sector Innovation

In their short history, consumer-directed health plans have already driven structural change in the health insurance industry. The early results on costs, utilization, and satisfaction are decidedly upbeat. As the potential for a broader, more comprehensive framework becomes more evident, HSAs are garnering more serious interest from traditional financial-services firms. Virtually all of the major insurance players have now joined the CDHP fray, and the pure-play entrants continue to grow and innovate. In the biggest structural move so far, the UnitedHealth Group of insurance providers acquired the CDHP pioneer and specialty firm Definity in June 2005.

We expect to see more of these plays in the months ahead. Although enrollment in CDHPs remained small in absolute terms, 2004 was another year of triple-digit growth, and there's every reason to believe the country is on the early section of an S-curve of industry growth. The new HSA regulations that permit rollover and personal ownership have attracted the attention of such financial-services giants as Mellon — resulting in alliances with traditional carriers (several Blue Cross Blue Shield organizations) as well as CDHP pure-play companies (Lumenos and Definity). Other big names in financial services — Fidelity, Principal, and JPMorgan Chase — also have begun to place their CDHP/HSA bets.

Financial-services firms and policymakers are attracted to the field because they recognize that CDHPs can help fix a subset of problems that may never inspire a broad political consensus. Chief among these, of course, is upward-spiraling health-care costs. Employers have few options for addressing the alarming rate of cost increase. Higher deductibles and co-pays have, for many, run their course, and the only other private-sector option is mandating a return to highly restrictive, closed-panel HMOs. But consumers (and their representatives) have already made it clear that higher deductibles and co-pays, or a return to mandated strong-form managed care, are dead ends. They simply have not been accepted by employers or employees at large.

Consumers learn to spend their rolled-over health-care funds judiciously, balancing prevention with savings.

At the same time, the United States is about to experience a massive shift of assets as the World War II generation passes away and transfers unprecedented wealth to the next generation (the baby boomers). This will precede an equally massive surge of demand by aging baby boomers for higher-quality health-care products and services. Creating incentives and mechanisms for deploying the money effectively for future health-care needs will be the job of policymakers; serving those programs will be a major opportunity for the health-care and financial-services industries. We believe consumer-directed health plans and their associated savings mechanisms will be important elements of those future products and services.

Future innovations should focus on the opportunities presented by HSAs' triple tax advantage and the needs generated by the change in locus of decision making (from employers/insurers to consumers). Specific products and services might include:

• *Annuities that can be purchased within an HSA account.* These would allow borrowing to cover the years of higher-than-expected health-care expense.

• *Mechanisms to optimize the long-term triple tax advantage of HSA contributions and earnings.* These would include loans collateralized against life insurance equity or private retirement accounts. The goal would be to reach the retirement finish line with the most tax-efficient mix of assets.

• *New financial models and advisory services.* These would optimize "surplus" discretionary contributions across individuals' 401(k)s (and Roth and Keogh plans) and HSAs. Higher-income earners, in particular, will want investment products that blend retirement and health-care savings.

• *New high-deductible health plans.* These would incorporate strong-form managed care (i.e., closed-panel HMOs) with HSA

provisions and advantages. Insurance product innovation is likely to focus on ways to offer these.

• *Improvements in disease management and other techniques for optimizing the use of sophisticated medical technologies.* These improvements will become increasingly important, not just to employers and consumers trying to manage cost, but also to insurers seeking to control a coherent portion of the value chain.

• *Innovations in information gathering, sharing, and transparency.* Local and regional market makers will be needed to gather up-to-date pricing and quality data from providers. Consumers and their agents (primary care doctors and/or insurance intermediaries) will need this information to make informed decisions and trade-offs.

Transparency — clear and accurate information at the "point of sale" — will be critical for the broad and effective societal uptake of CDHPs. Incentives and choices mean nothing if consumers can't find out anything about the choices. Doctors, hospitals, clinics, and labs will be increasingly compelled to gather and publish clear and cogent information about their quality, cost-effectiveness, and service. Two efforts recently begun — the federally supported health information technology (HIT) initiative and a series of ongoing industry programs designed to create a readily shared electronic medical record (EMR) — will need to bear fruit over the next five to 10 years if CDHPs are to realize their full potential to transform the health-care scene. The current information gaps are unfortunate (but natural) results of health care's evolution over the past 50 years. The industry is poised to move from a "cottage industry" model to a high-tech, information-age business, but the technology has yet to be deployed to make this shift a reality.

The coming wave of innovations will most likely create new battles for portions of the value chain. Traditional health-care insurers and pure-play CDHP firms currently have natural advantages with both employers and individual customers, but these advantages are not necessarily unique or permanent, and other players may evolve or find natural advantages of their own. Whatever specific innovations and structural changes lie ahead, the nexus of health-care benefits and financial services will be one of the most fertile areas of the economy over the next decade.

The nexus of health care and financial services will be a fertile economic driver.

The Public's Benefits

As significant as their impact on the private sector could be, CDHPs could actually have their strongest effect on public-sector programs and policies — extending the trends of the past two decades toward greater personal ownership and responsibility.

CDHPs aren't just the best idea currently on the table for dealing with health-care costs; they are also the only private-sector solution in sight that could make a difference to this immense public problem. They are being actively encouraged by the Bush administration via tax law rulings and legislative relief; that is one reason (but not the only reason) that they are growing at rates that equal or eclipse the uptake of managed care in the 1990s. Private investment accounts for younger Social Security participants have been an active area of debate in the U.S. federal government since mid-2004. Whether or not any specific reforms become a reality, there is clearly an ongoing political movement to increase personal ownership of and responsibility for life's major decisions — and that movement will not go away anytime soon. CDHPs are an integral part of it. They suggest that a future is possible in which some of the pressures on public programs like Social Security and Medicare are alleviated, and the funding and structures of those public programs can thus be transformed. Early actuarial estimates, for example, suggest that many of today's 20- to 40-year-olds with CDHP plans will hit retirement age with substantial accumulated balances (in the low six figures, at least). These funds would be available for any qualifying medical expenses, including long-term care, pharmaceuticals, and even supplemental insurance — bills that other health funds, public or private, would otherwise have to pay. It is too early to assert that CDHPs are the key to fixing either Social Security or Medicare, but the potential for relief will inevitably be brought into the debate by policymakers soon.

CDHP-friendly attitudes are not limited to one end of the politi-

cal spectrum. Conservative and liberal policymakers alike have seen that CDHPs can improve their chances of reaching their very different goals. CDHP-style pharmacy benefit programs, in which patients have an annually renewed pool of money for prescription drugs, have already succeeded in encouraging more rational purchasing behavior. This is likely to be seen as an example for Medicare to follow. HSAs with portability and rollover balances will open up new design alternatives for Medicare as it enters the high-drain years of the baby boomers' old age.

Furthermore, the possibility of national pooling of catastrophic risk (enabled by the design of most CDHPs) will be seen as a way of reducing the problem of the uninsured and perhaps as a step toward a national financing system. High-risk health insurance pools already exist in many states, but a comprehensive nationwide system could take advantage of significant economies of scale — in terms of both administrative costs and actuarial leverage. Both major American political parties could conceptually support this approach, though they might not agree on how to implement it. The Democrats have already suggested a government-managed catastrophic risk pool, and this argument could presumably receive Republican backing if the private sector did the pooling. Either way, helping today's uninsured with this approach could be a major step forward in creating a more equitable health benefits system.

The question remains: What if CDHPs don't receive the support (private and public) that they seem to deserve? A system of "muddling through" would not last much longer, especially with employers facing obligations to millions of retirees who would be entitled to 20 years or more of company-funded health care. One way or another, the political pressure for a national or "universal" health-care system in the U.S. will become impossible to ignore. The U.S.'s strong history of private enterprise and individual choice would preclude a fully nationalized system; for example, nationalization of assets seems well beyond the political pale. But the solution would undoubtedly incorporate serious controls on prices, intrusive utilization management, and centralized constraints on the supply side (hospitals, technologies, and physicians).

Even if such a universal solution succeeded in reducing the rate of cost increases, it would have profound unintended consequences. Chief among these would be the emergence of a parallel, totally private health-care system for the well-off. This is already happening in countries with long histories of publicly funded and publicly provided health care, such as the U.K. and Canada. Whether to skirt waiting lists or avoid the denial of certain procedures, the affluent would seek private alternatives, while using the public system whenever it made economic sense (which is what happens in Britain today). In short, if the goal of any health-care system and policy is equity and social justice, we should be very wary of approaches that use terms like *universal* but end up creating a society of health-care haves and have-nots. CDHPs offer the prospect of a different future and deserve the political, financial, and innovative support that they need to succeed. ✚

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