



American Consumers Hold The Key To Easing The Nation's Health Care Crisis

*Common sense reforms and
a broadened definition of
consumer-directed health care
will unleash their power*

Destiny  Health™

Introduction

In America, open competition and informed consumerism are the tried and true formula for lowering costs, raising quality and inspiring both innovation and increased convenience.

Examples abound:

- Amazon.com led the way in revolutionizing the way people shop.
- FedEx and UPS introduced a new, more dependable and convenient way to ship.
- Expedia.com and others took the hassle out of making travel arrangements.
- Low-cost brokers, including Charles Schwab, brought investing into the mainstream, while making the IRA rollover process painless with more options, accessible information and dependable service.
- Ditech.com and a host of others transformed the worlds of mortgage and retail banking, eliminating bankers' hours and facilitating competition.

In these and most other areas of commerce, regulatory reform and the emergence of the Internet have combined to create a dynamic, consumer-friendly marketplace in which much of the toil and mystery of comparison shopping has been eliminated.

But in the health care arena, where last year's average insurance-premium increase of "only" nine percent was considered cause for celebration, open competition and informed consumerism do not exist. Hobbled by outdated rules and archaic systems, it resembles the hogtied Financial Services industry of 20 years past. This is fact, not opinion. With Congressional experts predicting the U.S. will spend some \$2.1 trillion on health care this year—16% of the gross domestic product and growing—this critical segment of the nation's marketplace has been allowed to stand as the last bastion of Byzantine regulation and price secrecy.

The effects of this situation are everywhere to be seen. The funding crisis looming for Medicare and Medicaid is a \$28-trillion monster, six-times bigger and more dangerous than that of Social Security. Absent radical and rapid reform, America's Baby Boomers and Gen X'ers may live to experience Third World health care.

Change is needed, and more is required than a Band-Aid fix. The nature of the crisis is such that the nation cannot wait for the health care dinosaur to slowly evolve.

The answer—the all-American answer—is to unleash the time-tested and unmatched power of the knowledgeable and motivated consumer.

Critics fret that ordinary Americans are not up to the task, but the critics are wrong. In fact, consumerism already has proven effective in two popular medical procedures that are not covered in most insurance plans—Lasik and cosmetic surgery. With most individuals bearing the entire cost burden for these two procedures, a free and competitive marketplace has been prompted into existence, with the result that costs are tumbling, quality is readily evident and convenience abounds.

This paper examines two imperatives:

- The need for a more comprehensive definition of consumer-directed health care, currently a mere buzzword that will surely fail to live up to its great promise; and
- The need to clear-cut the existing forest of regulations and to address the lack of pricing and quality information that together stand as barriers to competition.

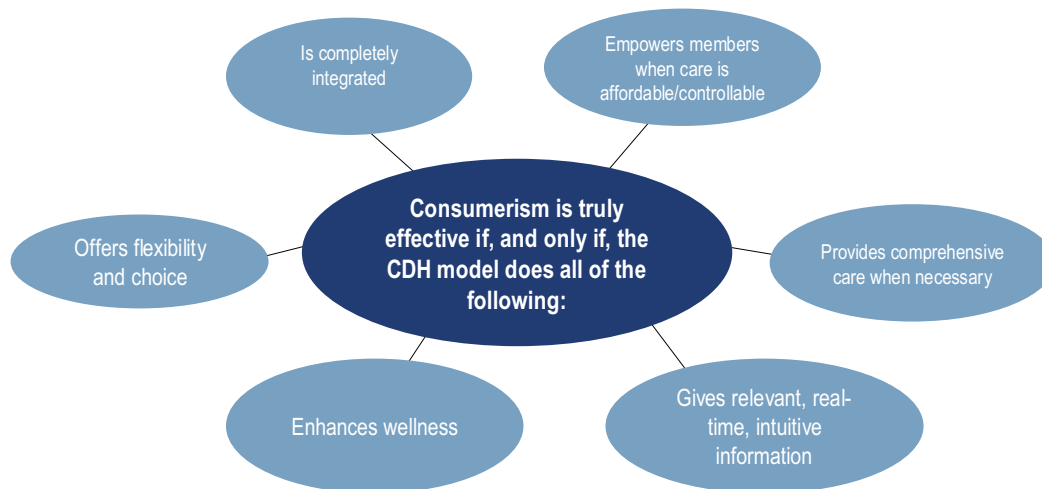
In industry after industry, marketplace after marketplace, knowledgeable consumers have motivated businesses to lower costs, improve quality and make the purchasing process more convenient. With the needed reforms in place, those good things also can be counted upon to occur within the American health care system. Even better, by putting consumers in the driver's seat, they will prompt many Americans to do what no amount of nagging has been able to accomplish—that is, to adopt healthier lifestyles and smarter spending habits.

Enhancing the Definition of Consumer-Directed Health Care

The internal combustion engine is a great invention, but it is not a car. Similarly, a Health Savings Account (HSA) combined with a High-Deductible Health Plan (HDHP) is a great concept, but it is not consumer-directed health care (CDH). Those two components are necessary, but alone are not sufficient.

On the contrary, that simple and broadly accepted two-part definition is a formula for failure, for it ignores the knowledge, simplicity, flexibility, motivating elements and access to information consumers require to make wise choices. Absent a broadening of the definition, members of such plans are unlikely to set enough money aside or adopt healthier habits. Disenchantment will inevitably result, and the model's wrong-headed critics will end up being proven right.

For truly effective consumerism to make its presence felt in the health care marketplace, the CDH model must meet the criteria displayed in the following chart:



To achieve the lofty objectives reflected in the above chart and to live up to its great and proven promise, the CDH definition requires not two, but six critical components:

1. Health Savings Account for lower cost or discretionary spending

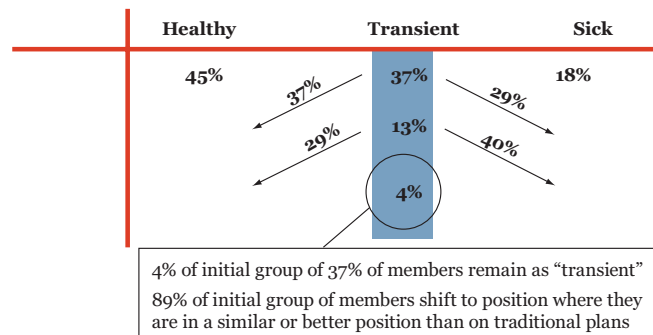
Tax favored HSAs, which currently in 2006 must be coupled with health insurance that has a deductible of at least \$1,050 for individuals and \$2,100 for families, represent an essential first step, because they put consumers' own dollars on the line. The savings instrument will become even more appealing if Congress acts on the proposal to make premiums for HSA-compatible insurance policies deductible from income taxes when purchased by individuals outside work.

Some say HSAs are only for the relatively rich, young and healthy, but that is also erroneous. The Website eHealthInsurance.com reports that half of HSA enrollees are over 40 years old, 20 percent earn less than \$35,000 and 40 percent earn less than \$50,000. Additionally, the Cato Institute's Michael F. Cannon has observed that even if the complaint were true, that wouldn't make HSAs bad, because by their existing definitions, the relatively healthy and wealthy account for 80 percent of the U.S. population.

Another important point is that sickness is rarely a permanent state of being. As the following chart shows, a clear majority of Americans are well almost all of the time and only ten percent fall into the category of being chronically ill. The Cato Institute's position is that the latter group would be helped by increasing the allowable HSA contribution to \$5,250 for individuals and \$10,500 for individuals. Another way of dealing with the issue is to allow people with chronic conditions to have those costs covered by their health plan (an option expanded upon below in component #5).

Is CDH Good for the Healthy and Sick?

Longitudinal study of transient behavior:
Those hindered are not the same each year



Transient members are the healthy and the sick of tomorrow

The White House has proposed leveling the playing field by giving individuals who purchase HSAs on their own the same tax advantages as those with employer-sponsored insurance by making premiums for HSA-compatible insurance policies deductible from income taxes. The administration also wants to allow Americans to cover all of their out-of-pocket expenses tax-free through their HSAs, not just the amount equal to their deductible as provided under current law. These are good ideas, but even as things stand, the value of an HSA to the vast majority of Americans cannot reasonably be denied.

2. High-deductible health plan to provide comprehensive care when necessary

On the surface, it would seem reasonable to assume that a high-deductible plan would translate to higher out-of-pocket costs, but again, appearances can be deceiving. The Kaiser Family Foundation has found that the average premium for an HSA-compatible health policy is \$1,324 less than traditional insurance—savings that often cover the entire deductible in the first year.

Another analysis showed that when all factors are considered, including the effects of a tax-favored HSA, both healthy and sick members of The Destiny Health Plan incur lower out-of-pocket costs than do individuals covered by an HMO¹.

3. Knowledge tools that provide relevant, real-time information

Years ago, a major U.S. computer manufacturer missed the product-development boat when company planners assumed the average Joe did not need and could not master a personal computer. Apple and Microsoft proved them wrong. Yet the same mistake is being made today by critics who argue that Americans are not up to the challenge of managing their own health care dollars.

CDH can and does work, but it is unlikely that the HSA/HDHP-combination alone will produce the desired results. Knowledge is required. Lacking health care education and answers to their questions, many Americans may be tempted to save too little or to cut costs by skipping necessary preventive care. For CDH to deliver on its promise the existing two-part definition needs to be expanded to require information tools tailored to meet members' differing preferences and needs—web, paper and telephonic.

¹ A case study conducted in 2006 by Destiny Health's parent company, Discovery Holdings, showed that healthy members of The Destiny Health Plan™ come out \$900 ahead of individuals covered by an HMO, and that sick members incur out-of-pocket costs that are \$120 lower than their HMO counterparts.

It can be argued that Americans would be better served if HSAs were allowed only when combined with plans, such as those offered by Destiny Health, that offer easy access to a wide variety of information.

As things stand, top plans, but *only* top plans in the insurance industry, offer tools including a 24-hour Nurse Hotline, hospital quality and rate information, prescription drug pricing and EMMI surgery education. These resources are not just “nice;” for the American health care consumer, they are necessary and need to be required.

4. Wellness-incentive and health-management programs that promote healthy behaviors and lifestyles

According to the Department of Health and Human Services, more than 75 percent of employers’ health care costs and productivity losses are related to employee lifestyle choices. This includes spending on chronic conditions, such as diabetes, obesity and cardiovascular disease—many of which can be avoided or delayed through early screening and healthy lifestyle choices (i.e., eating a nutritious diet, engaging in regular physical activity and limiting alcohol use).

The Destiny Health Vitality Program™ encourages members to make healthy lifestyle changes by providing health club memberships, discounts on travel and an array of other rewards for lowering their cholesterol, losing weight, quitting smoking, following preventive-care guidelines and engaging in beneficial activities. Motivating people to do the right thing raises on-the-job productivity and morale while minimizing future health care expenses and absences.

This, too, is fact, not theory. The Wellness Council of America reports that a \$1 investment in wellness programs saves \$3 in health care costs—savings that accrue to the individual as well as the employer. As reported in the *Wall Street Journal*, studies of the Vitality Program show that members “age 50 to 54, who are actively chasing wellness points, saw their health spending decrease even as they aged.”

5. Flexibility and choice to adjust to specific employer and consumer needs

A common concern about high-deductible plans is that they do not provide adequate coverage for members with illnesses, such as diabetes and asthma, that require daily medication. And the critics are right. Members of inflexible plans exhaust their HSA annually, leaving them with no way to build equity and stripping them of the incentive to control more discretionary services.

The Destiny Health Plan and those of other leading providers address this issue by offering optional, HSA-compatible riders that provide first-dollar coverage for preventive care services, including childhood immunizations, pap smears, and colorectal screenings, plus benefits for the medications associated with the most common chronic illnesses and conditions.

This kind of flexibility is essential if CDH is to work for sick as well as healthy Americans and for the young as well as the old. An important and positive reform would be to require it in the federal HSA enabling legislation.

6. Complete integration to reinforce the five other elements and maximize consumer convenience

Consumer-directed health care will never achieve its cost-cutting potential if Americans find it unwieldy, and that is exactly what is likely to happen if the CDH definition is not broadened to include the six-elements outlined in this paper.

Under the existing legislation, HSAs can be opened through virtually any financial institution or brokerage. And again, at first glance this seems like a good idea. But it is an arrangement that forces people to file separate claim forms with the insurance company and the HSA institution, and then to keep careful watch to ensure they receive appropriate network discounts and reimbursements. Additionally, it is an approach

that often exposes unknowing consumers to an array of fees for the set-up and maintenance of their HSA.

Freedom of choice is important, and should be retained in the legislation, but Americans need to know that no-hassle options are available through leading CDH providers.

For example, by integrating an HSA with the health plan and Vitality incentive program, Destiny Health members need only present a card to the provider, who submits the bill. The company then pays from the policy or the HSA and awards incentive points when appropriate. Time-consuming paperwork is eliminated.

Reform Regulations to Promote Competition and Enhance Access to Data

Twenty-some years ago, the retail banking industry was anything but customer-friendly. The hours were inconvenient and the lines to the tellers were long. Checks and deposits were slow to clear. Loan approvals took weeks or even longer.

Then came the S&L crisis, a costly event that had the positive effect of prompting sweeping and long-needed federal and state regulatory reform. Combined with dramatic advancements in technology, these reforms catapulted the banking industry into the modern world. Costs tumbled as competition and convenience soared.

Today, internet banking and ATM cards allow people to conduct their business anywhere and at any time. Thanks to the automation of the decision-making process, loan approvals are virtually instant, and multiple services—mutual funds, annuities, credit and debit cards—are available and integrated through relational databases to make possible a unified view of the client.

In contrast, the nation's health care system—less like a “system” than a conglomeration of mutually exclusive parts—remains organized like the financial industry of decades past. There are no common data standards. The sharing of records is cumbersome. And this, combined with the lack of common treatment and billing codes, opens the door to error.

Meanwhile, the nation's 50-state legislatures regulate their insurance providers in 50 different ways and do not allow their respective residents to reach across state lines to purchase policies.

To make things worse, many states dictate the types of treatments that must be covered by insurance companies operating within their borders, with costly and anti-competitive results.

For example, in 1994, when the State of Kentucky adopted a complex bundle of rules and mandates, 45 insurers left the state, premiums for the very few that remained jumped 35 to 165 percent and the uninsured population jumped from 12 percent to 15 percent, a 25-percent increase. Even so, the largest remaining insurer and the purchasing alliance set up by the state lost \$60 million and \$30 million respectively. Recognizing and stepping back from this mistake, the State reopened the doors to competition and many insurers returned.

To address these and other issues, the President and some members of Congress have introduced a number of proposals that need to become law:

- **Allow the purchase of health insurance across state lines.** This good idea would open up competition, especially in states such as Massachusetts and Minnesota where regulatory mandates and restrictions are such that only one or two insurers operate. It would free families who do not want to pay for coverage of, say, massage therapy or chiropractic care to purchase bargain-rate policies that exclude those types of treatment.
- **Give individuals that purchase HSAs on their own the same tax advantages as those with employer-sponsored insurance.** The current system penalizes those who purchase HSA-compatible insurance

policies outside of work, so providing the tax advantages would level the leveling the playing field for those who do not have access to employer health care plans.

- **Enabling portable HSA insurance policies.** This proposal would give employers the right to offer workers a portable HSA-compatible insurance policy that employees would be able to take with them when they changed jobs. Premiums on these policies would be tax-free and would not increase according to their health status when they moved to the new job. The proposal also would extend portability to Health Reimbursement Arrangements (HRAs), which currently may revert to the employer when the employee changes jobs.
- **Expand the use of health information technology to lower costs, reduce medical errors and improve quality of care.** With action on this initiative, electronic health records—the information needed to treat patients effectively—would be a click away, no matter where the patient is receiving care.
- **Allow employers to make a higher contribution to the HSAs of chronically ill employees.** This reform, combined with the availability of riders to cover medications these individual require, would go a long way towards making consumer-directed care as popular with the sick as it is with the healthy.
- **Eliminate all taxes on out-of-pocket spending through HSAs.** As outlined earlier in this paper, the liberalized rule would allow patients to cover all their out-of-pocket expenses tax-free through their HSA, not just the amount equal to their deductible as provided under current law.
- **Make available information about the price and quality of care.** Today, it is difficult, if not impossible, to comparison shop in the health care market, nor is it possible to know if a given hospital or doctor has a good or bad record. Americans should be afforded the privilege of knowing what a big insurance company pays for a treatment versus the inevitably much higher charge levied against the individual. They should have the right to know and compare the success rate of operations in hospital “A” versus hospital “B.” The goal is “transparency.” The power of consumerism in America’s health care arena will never be brought to bear until price and quality data are freely available.

Conclusion

The medical care available in America is arguably without peer, but in virtually every area, the overall health care system is badly in need of reform. As it is, the archaic system itself contributes to rising costs and the number of Americans—40-plus million—who currently live without insurance protection.

Reforming the regulatory environment and broadening the definition of consumer-directed health care to reflect the realities of human nature comprise big steps in the right direction, but the overarching goal must be to unshackle the great American consumer.

Given a level playing field and the information required to make sound decisions, the American consumer has been proven to wield huge power. In the health care industry, it will be the power to force down costs and inspire the creation of new, more open and convenient systems.

Consumerism thrives in America as nowhere else. It is time to unleash its power in easing a health care crisis that threatens the nation’s future.