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innovations in healthcare finance lessons from the 401(k) model

AT A GLANCE

- > Escalating health benefit expenses are leading employers to shift more of the costs to their employees.
- > Global financial services companies and startup entrepreneurs are competing to develop private-sector solutions to capitalize on the ailing and misaligned healthcare financing system.
- > Emerging innovations are targeting insured individuals who are facing increasing responsibility for first-dollar coverage.
- > Healthcare providers should view patients as individual "price-sensitive payers" as new tools enable them to shop around for services based on cost and quality.

The future of employer-based health insurance is uncertain, but the system that insures nearly 160 million Americans appears to have reached a tipping point because of unsustainable cost increases. Evidence is mounting that the employer-based model is running out of steam in its current form. Small employers are dropping coverage, 22 million of the total 47 million uninsured population are full-time workers, and the number of underinsured has risen to 25 million from 16 million in 2003.^a

Healthcare premiums have risen 91 percent between 2000 and 2007, while wages increased 24 percent.^b Held accountable for quarterly results in a global economy, large employers hope the newly elected president will fulfill campaign promises for healthcare reform. The situation is further exacerbated as companies are forced to cut costs while attempting to weather the current economic downturn. Just as record-high oil prices are driving rapid transformation in the automotive and airline industries, private healthcare purchasers are demanding equally transformative changes after absorbing years of double-digit health premium inflation. As U.S. employers run out of available capital to spend on healthcare benefits, private insurers are realizing that the current employer model of health insurance is nearly tapped out.

In the past few years, new types of health insurance products have allowed large employers to maintain health benefits while slowing the growth of their health expenditures—largely by cost shifting to employees in the form of higher premium contributions, deductibles, copayments, and co-insurance. One health insurance innovation—high-deductible health plans with a savings option (HDHP/SO), also marketed as consumer directed health plans (CDHPs)—has established a foothold

a. U.S. Census Bureau; Schoen, C., Davis, K., and Collins, S.R., "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May-June 2008, pp. 646-657. *Underinsured* is defined as those who were insured all year, but spent 10 percent or more of income on medical expenses, or 5 percent of total income for those with incomes under 200 percent of the federal poverty level.

b. Schoen, Davis, and Collins.

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in the market. However, enrollment is not growing as fast as expected. Although nearly all large employers continue to offer health benefits, the cost-shifting phenomenon is expected to accelerate as annual health premiums continue to rise at more than double the rate of core inflation. Collectively, employers have yet to settle on a single model for healthcare reform. However, the recent experimentation and fanfare in light of consumerism can be viewed through history's lens as employers take a page from their old playbook to get out from under escalating employee benefit expenses.

Defined Pension Plans Replaced by the 401(k)

Facing escalating long-term pension liabilities throughout the 1970s, large employers were quick to trade pension contribution expenses for the cost of 401(k) plan administration and associated expenses if they elected to match employee contributions. In 1978, Congress amended the Internal Revenue Code—later called section 401(k)—whereby employees would not be taxed on income they choose to receive as deferred compensation rather than direct compensation. The law went into effect on Jan. 1, 1980, and by 1983 nearly half of all major employers were either offering a 401(k) plan or had one in development. Between 1985 and 1994, the value of the 401(k) plans sponsored by the 1,500 large corporations surveyed annually by Greenwich Associates grew from \$137 billion to \$454.7 billion. The number

of employees able to participate in 401(k) plans rose to more than 48 million by 1991 from only 7 million in 1983. A key factor driving the rapid adoption of 401(k) plans was that the plans were significantly less expensive for employers to offer in comparison to a defined benefit pension for every retired worker.

As they did with pension expenses in the 1980s, employers have reached a tipping point with the financing of health benefits. Although large employers publicly state they are not ready to abandon their role as the backbone of health insurance coverage in the United States, the rapid adoption of a 401(k) model to provide and administer health benefits more affordably is conceivable. In fact, it can be argued that the trend has already begun under the moniker of consumerism. Currently, federal lawmakers have taken steps to create “401(k)-like” vehicles such as health savings accounts (HSAs) and health reimbursement accounts, but both can be offered *only* in conjunction with an HDHP. In the upcoming enrollment period, Watson Wyatt expects 54 percent of large employers will offer HDHPs, many of which are HSA eligible, up from 39 percent in 2007.

Since HSAs were established by the Medicare Act of 2003, more than 6 million Americans have enrolled in HSA-eligible plans.^c If legislation is eventually passed to authorize HSAs that do not require employers to offer a health plan component, many employers are likely to implement the model. In the absence of such legislation, some small employers that cannot afford to offer health benefits are simply dropping their plans. Regardless of which party wins the upcoming presidential election, future health reform will accelerate the cost-shifting phenomenon to workers/taxpayers—whether Republicans offer tax credits to offset the cost of health coverage or Democrats enact a universal healthcare system or a hybrid approach emerges.

Future Outlook

The emerging consumer model, based on HSAs, has the potential to remove employers from their role as intermediaries for healthcare purchasing. Similar to

c. McQueen, M.P., “HSA Users Find Hassles Amid Savings,” *The Wall Street Journal*, May 1, 2008, p. D1.

the 401(k) model whereby employees can work for different employers while maintaining only one 401(k) account, the health savings model allows payers to achieve their goal of having a “member for life” (i.e., health benefits would travel with the individual, regardless of his or her employer). Nontraditional players from outside the health industry view this seismic shift in medical economics as an opportunity to play a role in the \$2.2 trillion U.S. healthcare market.

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Financial services firms and startup companies alike are rapidly introducing new products and services to carve out a niche in the emerging landscape. Banks and asset management companies are attempting to duplicate their success in the 401(k) industry in the expanding HSA market. One such financial services company has projected that the average American couple faces \$200,000 in healthcare bills after age 65 (despite Medicare coverage and not including dental expenses or long-term care). HSA administrators are also partnering with health insurers and online health content providers (e.g., WebMD, Revolution Health) to develop personalized health information and healthcare cost and retirement planning tools to help employees become better educated healthcare consumers. The most recent iteration of the tools allows employees to estimate their healthcare costs in retirement based on their individual conditions and cost data of local providers in their metropolitan area.

Online startup firms such as Plymouth, Minn.-based carol.com and Mountain View, Calif.-based vimo.com are launching health shopping portals that allow consumers to compare the costs of medical

procedures and research health insurance plans. National health insurers are getting into the act as well. Aetna and Cigna have launched web sites that let subscribers compare quality measures and costs for specific providers. For example, a recent check showed that contracted prices for a colonoscopy range from \$600 to \$3,700 in the Philadelphia metropolitan area. Cigna reports that about 20 percent of subscribers with HDHPs who needed a colonoscopy checked the web site.^d

Building upon the momentum of private-sector innovations, the federal government is experimenting with methods to promote greater price-sensitivity among Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) is now piloting a program in four western states where patients will

share in the program’s savings when they choose hospitals that have negotiated discounts with Medicare. For example, if a hospital agrees to accept \$3,000 less from Medicare for a heart bypass, a Medicare subscriber choosing that hospital for the procedure would get a \$1,500 rebate check.

Expected Impact on Providers

Implications for providers are vast, even if only a portion of health consumers become more price sensitive:

- > The basis of competition will shift from a focus on gaining scale and attaining “must-have status” in local managed care networks to developing targeted services that deliver demonstrable value (defined as quality care at a competitive price).
- > Competition will be based on easily understood (and defensible) pricing and quality metrics (e.g., in the past 12 months, *Consumer Reports* and Zagat Survey have started rating hospitals and physicians, respectively).
- > Enabled by medical and technological advances, the migration of care to the lowest-cost setting will

d. Burling, S., “The Cost of Hospital Care Is Difficult to Pin Down,” *Philadelphia Inquirer*, June 8, 2008, p. D01.

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accelerate from the high-cost 365x7x24 receiving hospital to freestanding ambulatory surgery centers to the home via telemedicine.

- > Competition will be enhanced from new entrants attempting to provide better, faster, cheaper care to attract more “first dollar” health spending (e.g., Wal-Mart Pharmacy & Retail Clinics, CVS Minute-Clinic, etc.).
- > Direct-to-consumer marketing will be an increasingly important lever to differentiate services (e.g., we may not be far from seeing “Columbus Day Sale on Health Screenings at Your Local Community Hospital” advertisements or health system patient loyalty programs similar to airline reward programs).

Takeaways for Providers

Vertically integrated health systems that provide coordinated hospital and physician services in all care settings (inpatient, outpatient, home, etc.) will have a distinct advantage in the emerging playing field. A few pioneering integrated systems are already beginning to experiment with bundled pricing for hospital/physician services and “money-back guarantees” with consumers in mind, not insurers. These initiatives

go beyond simply setting “defensible” prices; rather, leading health systems are beginning to develop strategic pricing strategies to be more competitive in markets with high HDHP penetration and ultimately growing volume. To implement such strategies, care delivery will increasingly need to be organized in a more consumer-centric fashion (e.g., bundled solutions for a patient’s heart disease, cancer, diabetes, etc.) rather than siloed hospital departments.

Nontraditional Business Models

As consumers become more informed about their healthcare options and take on greater responsibility for their healthcare costs, they will look for providers that offer both quality and competitive prices. Health systems will need to innovate and experiment with non-traditional business models to compete successfully for a larger portion of HSA/out-of-pocket spending. ●

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