



## **A NEW PARADIGM TO CONTROL HEALTH CARE COSTS: CONSUMER DRIVEN HEALTH CARE PLANS**

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### **ABSTRACT**

In the face of incessant double digit cost increases in the health care field, an emerging stage in the evolution of health care finance and delivery is the consumer driven health plan (CDHC). The CDHC is a high deductible insurance plan wrapped around a health reimbursement account that has all the tax advantages of a traditional employer-provided health care plan. Its proponents say that it is structured to provide incentives for the consumer to be more prudent in health care purchases and more accountable for health care decisions. Opponents of the CDHC concept contend that it is designed by employers to cut costs for employee health care coverage and place greater financial responsibility on employees. This paper discusses the current health care milieu, reasons for the increases in health care costs and our inability to control them, and the characteristics of as well as the advantages and disadvantages of the CDHC paradigm. The conclusion is that the CDHC is not the solution to soaring health costs, but it is an important step in the right direction.

### **A New Paradigm to Control Health Care Costs: Consumer Driven Health Care Plans**

#### **Introduction**

Inflation is running rampant in the healthcare field. One reason is that under the current system, patients or end users of medical care are insulated by low deductibles and low co-payments (co-pays) from the financial consequences of their decisions. They do not have a factual understanding of how much medical services cost because the percentage of the cost that they

pay out-of-pocket is so low (Benko, 2003). Consumers see a visit to a doctor as costing only \$15, when the true cost of the service may be \$80 (Schultz, 2002). Consumers are unaware of and have become inured to the real and persistently rising cost of health care, and they use it freely, thus creating unnecessary demand and driving up costs (Findlay, 2003 and Crompton, 2004).

Many authors believe that if we are to ever get a hold on health care costs and relieve pressure on employer budgets for health care costs, we must configure a paradigm that is consumer driven. The new model must strip away employee insulation from the real cost of health care that has existed in the past (Schultz, 2002). It must integrate the consumer in the health care purchasing decision in a manner that takes into account both the suitability and cost of care (Herzlinger, 2004).

The shift to consumer driven health care plans (CDHC) attempts to build a more rational health care model. While price is the equilibrating force that brings total demand in balance with total supply in a free market system, price cannot bring total demand into balance with total supply in an artificially controlled market system like the health care industry. The demand curve the consumer faces is based on the cost he/she bears—the deductible and co-pay. The market cannot function normally because patients do not “feel the sting” for the services and products they consume (Harrington, 2003). Rather, health care costs at point of purchase are borne by a third party, such as an insurance company, HMO, PPO, government entitlement program, or charitable organization (Duncan, 2004). Consumers do not understand and have little reason to concern themselves with actual cost (Geisel, 2003). Price cannot serve as an efficient and impersonal rationing mechanism because the services are essentially free to the consumer, whose demand is loosed of market forces (Jones, 2001).

Suppliers benefit from an artificially controlled health care market as much as consumers. They can spend enormous sums on research and development for expensive new drugs, the most sophisticated technology, and the most advanced treatments, knowing there is a good chance that the market will use them. Use of “create the demand” advertising directed toward consumers by drug companies and providers helps assure that a market is available (Word, 2003). The new products, drugs, and services provide incremental revenues and profitability to suppliers, which fuel even more expenditure (Jones, 2001).

The argument has been posited that the health care sector is fundamentally different from other sectors of the economy and that it defies normal economic conventions (Jones, 2001). However, a careful analysis of the facts reveals that it does not. The core premise of this contrarian argument is that health care is unique because it is a necessary service and not discretionary like most other goods and services. While this position may have merit with regard to some treatments or services (e.g., dialysis for a diabetic), it is not credible with regard to many others that are powered by either the user (the patient demands that the doctor prescribe the “miracle pill” advertised on TV) or the provider (medical costs tend to be higher in large cities where there is a concentration of providers) (Thaler, 2003). Clearly, as numerous studies have shown, not all medical care that is rendered is essential.

## **Purpose**

The purpose of this paper is to explore the rationale for and main issues affecting consumer driven health care. To achieve its purpose, the paper is divided into nine major sections. The first two sections are the Introduction and the Purpose. The third section discusses health care cost trends over the past three decades and reviews the reasons for persistent increases in health care costs. The fourth section explains what the CDHC paradigm is and how it is structured, why it represents a significant break with past health care financing and delivery practices, and why it offers the best hope among all available options to resist rapid health care cost escalation. The fifth section explains why the CDHC model works, and the sixth section discusses how providers view the plan. The seventh section examines potential cost savings available with a CDHC plan. The eighth section explores some of the problems and limitations inherent in the CDHC model, and the final section is the conclusion.

## **Rising Costs of Health Care**

The rapid, unchecked growth of health care costs is one of the more interesting and perplexing phenomena in the American economy over the past 50 years. Since nearly two-thirds of Americans (Word, 2003) receive health care coverage through their workplace, and more than three-fourths of all employers provide some form of medical insurance to their employees (Parmenter, 2003), the cost of health care is a major expense to, and a primary concern of, employers. Recent studies show that health care costs represent around 10.5 percent of employer payroll expenditures, or an estimated average cost of \$4,650 per employee (Parmenter, 2003). Americans are spending an increasing amount of money on health care services. Health spending amounted to \$73 billion in 1970, or roughly 7 percent of Gross Domestic Product (GDP), but it had risen to \$1.3 trillion in 2000, or 13.2 percent of GDP (Jaffe and Fronstin, 2002). It is expected to reach \$2.2 trillion by 2008 and to consume 16.2 percent of GDP (BCBS Health..., 2003). In contrast, health care spending in Canada and Germany, two of our major trading partners, amounts to 9 percent and 11 percent of their GDPs, respectively (Lieberman, 2003).

Health care spending is far outstripping the Consumer Price Index and the rate of wage growth (Thottam, et al., 2002). Health care inflation fell to very low levels in the mid-1990s, but then began rising in 1998. It rose to 9.4 percent in 2000, increased to 10.2 percent in 2001, and then jumped to about 15.6 percent in 2002 (Parmenter, 2003). It is not expected to abate in the near future (Hofmann, 2002), with a 15 percent surge anticipated in 2003. Out-of-control health spending is reaching crisis proportions (Parmenter, 2003 and Broder, 2004).

Several factors have contributed to the escalation of health care costs. These include aging of the population as baby boomers reach middle age, wave after wave of expensive new medical technology, and increasing use of specialists. Other cost driving factors are particularly sharp increases in prescription drug costs, increasing litigiousness of our society, and the imposition of new federal laws that require employers to provide a specific coverage or to extend coverage to protected groups (Parmenter, 2003; Thaler, 2003; and Crompton, 2004).

Managed care organizations (MCOs) were introduced in the early 1980s to help control health care costs. They managed to engineer lower costs by paying doctors to care for a group of

patients and limiting access to services (Lieberman, 2003). One of the primary characteristics of the MCO was preventive care, which was promoted through a reduction of the economic obstacles (high deductibles and co-pay) to see a doctor. The reasoning behind the preventive care push was that it is better to detect and treat diseases or conditions early to ward off more costly treatment or even hospitalization later. In some senses, MCOs performed their purpose too well. Consumers made an ever-increasing number of office visits and received more and more prescriptions as barriers to utilization were torn down. The share of national health care expenditures borne by patients dropped from 56 percent in 1960 to 15 percent in 2000 (Tuomala, 2003). The mindset of the consumer is clear: as long as someone else is paying the bill, who cares what the cost is? When the service is essentially free, demand is unconstrained. MCOs helped turn us into what one writer has called “a nation of profligate, sometimes even gluttonous, medical consumers” (Findlay, 2003).

In the early 1990s, MCOs began to increase deductibles and co-pays, reduce eligibility, cut back on coverages, and implement other techniques to discourage utilization. As a result, employee confidence in MCOs and satisfaction with their services began to erode, and MCO rules and conduct created a huge political backlash by doctors (Herzlinger, 2004). In the late 1990s and early 2000s, restrictions to control costs were loosened, and as might be expected, costs began rising sharply (Agovino, 2003). Now many observers believe that, while MCOs served a useful purpose, they have generated about all the cost savings they can (Albertson, 2004), and have run their course as principal vehicles to control costs (Parmenter, 2003).

### **What is Consumer Driven Health Care?**

There are three key components of a CDHC plan, the confluence of which serves to lower or at least stabilize health care costs for employers and induce employees to make cost-effective choices (Word, 2003).

- (1) A conventional medical plan that covers high-cost, hard-to-budget, or catastrophic events with a high deductible, typically \$1,000 for singles, \$1,500 for couples, and \$2,000 for families (White, 2002). This coverage is generally provided through a preferred provider organization (PPO) or point-of-service plan (POS) with in-network and out-of-network benefits. The in-network benefits are usually much richer than the out-of-network ones (White, 2002).
- (2) A health reimbursement account (HRA) that is paired with the high deductible medical plan. The HRA is infused annually with a specified, employer-provided sum (say \$2,000 for a family), which is used to cover allowable routine, discretionary, out-of-pocket health care expenses (Duncan, 2004). The amount contributed to the HRA by the employer, which is not taxable to the employee, is less than the amount of the medical plan deductible (Harrington, 2003). The employee is responsible for the difference. After the HRA is exhausted and the deductible is met, the insurance plan covers a specified percentage (say 80) of the cost of all allowable medical costs, and the worker covers the remainder until a stop-loss point is reached. Then the insurance plan pays 100 percent of the cost.

It is very important to note that HRAs do not have the use-it-or-lose-it provision that is characteristic of flexible spending accounts. Any amount not used in a given year can be rolled over to subsequent years. Thus, the worker has incentive to use the funds in the HRA prudently (Patricelli, 2003 and Duncan, 2004).

- (3) Educational resources that provide employees with a working knowledge of available options and the decision-making tools to help them navigate through the system (Duncan, 2003). This information may be disseminated through a website or through a hot line that members may call to discuss health care options with an RN (Benko, 2003).

Participants in a CDHC plan typically can access a password-protected site that will explain how they can acquire price and quality information that will help them to balance cost and value at the point of health care purchase (Caggiano, 2002). They can learn more about specific health care issues and the availability and cost of procedures relevant to their condition. Some have access to databases of local physicians and hospitals that rate providers according to quality and prices. Additional information may be provided about how to sustain good health and manage chronic illness. In short, consumers learn how they can self-direct their care purchases to get the best quality at the best price (Word, 2003).

Once consumers accept financial responsibility for purchasing decisions, buying patterns change—for health care as much as for any other product or service (Crompton, 2004). In other markets, consumers make choices with each transaction rather than once a year. For example, when buying groceries the consumer chooses the supermarket as well as the items purchased based on cost, needs, convenience, or even whim. The purchaser may choose one store one day and another on the next. In either case, the decision is based on cost/quality/convenience tradeoffs—a trendy deli versus Sav-A-Lot, a nearby convenience store versus a more distant but lower priced chain store, hamburger versus steak, or a national brand versus a store brand. However, under traditional or managed care health plans, consumers cannot compare prices at point of purchase because they do not know what the true costs are. There is little transparency in the price and quality trade-offs associated with competing alternatives (Tuomala, 2003, and Schultz, 2002). A single annual choice is not truly consumer driven—for groceries or for health care (Tuomala, 2003).

### **Arguments for the CDHC Approach**

CDHC plans are based on the well-established fact that health care utilization is price sensitive: usage declines as cost sharing increases (Higher Copays..., 2002). CDHC plans take advantage of this fact by offering a limited first dollar benefit account that employees can use for routine medical expenses (HRAs). If not used in the current plan year, funds in the HRA can be rolled over for use in future years (Findlay, 2003).

The ability to roll balances over encourages employees to view the money in this account as if it were their own. If employees view this account as “their” money, the desired change in consumer behavior (reduction in utilization) will have been achieved— just as it would have

been with a higher cost sharing plan. A culture of employee health care purchasing responsibility is created (White, 2002).

There are other arguments for the CDHC approach. The cost structure in health care services not traditionally eligible for payment under employee benefit plans is very different from the health services that are typically covered. An example is vision care (Tuomala, 2003), which is not normally covered by health insurance plans. Rather, in most cases, vision care expenses are paid by employees out-of-pocket. The vision care market provides financial incentives for the consumer to purchase health care carefully, and it provides information on which cost and quality comparisons can be made. Prices are frequently advertised and/or plainly displayed, and services are frequently available at night or on weekends at no additional charge. Since the consumer pays the bill and feels the bite at the point of purchase, there is a combination of motive and means to drive consumer change (White, 2002). On the supply side, there are many providers competing vigorously for the consumer dollar. Therefore, despite being a necessary service, the market for vision care is dominated by the forces of supply and demand and is an antipode of the market for other health care services. Vision care has not shown the same signs of mushrooming cost increases as general health care, despite the fact that eye exams and prescriptions are delivered by trained professionals and are as indispensable to good health as countless other services (Tuomala, 2003). The question naturally arises, if we were to create a consumer market for other health care services, would we see the same results?

Further, costs in the vision care market react differently to new technology than in other health care services. The cost of laser vision corrective surgery has trended downward, yet the laser vision industry continues to generate enough revenue to fuel ongoing investment in increasingly more sophisticated treatments and costly new equipment and technology. The decrease in prices vastly expands the range of potential patients and creates new demand (White, 2002). That is the pattern we see in the markets for most other consumer goods (TVs, PCs, VCRs, digital cameras) as technology improves. However, in the health care services field, we have become conditioned to expect cost increases when new technology is rolled out (Hezlinger, 2004). Is it a coincidence that health service is the only market where third-party reimbursements rather than market forces determine the price of new services (Tuomala, 2003 and Crompton, 2004)?

Moreover, the structure of the current health care system tends to stymie and repress the desirable effects one normally expects from a free market system. While health care treatment and medical technology have vastly improved in the past three to four decades, quality and convenience in the health care field have tended to lag behind those in other sectors of the economy. The current system suppresses entrepreneurial incentives (Broder, 2004). Innovation is obstructed not only by the usual business considerations, but also by the prospect of whether an insurance company or HMO will include the new technology, treatment, or procedure in its benefit package. As a result, the universe of practicable health care business models is limited (Tuomala, 2003).

Many, perhaps most, Americans would consider our health care system to be adequate if it is viewed strictly from an access-to-care perspective. However, if other dimensions are considered, the perspective is less positive. For example, there are well-founded concerns about quality (Broder, 2004). The system is not completely void of preventable errors, as almost daily

headlines of horror stories of doctor or hospital malpractice suits attest (botched surgery, incorrectly prescribed drugs). An astounding eight million households in the United States have been affected by a medical error that caused serious health problems (Lieberman, 2003). This level of quality would not be acceptable in other sectors of the economy. Why should it be tolerated in health care (Tuomala, 2003)?

Few would regard the system as especially convenient for the patient. Every reader will be able to recall long waits in a doctor's office for a scheduled appointment. Non-emergency health services are generally available only from 9 a.m. to 5 p.m., Monday through Thursday or Friday, by appointment. In contrast, convenience stores and other retail establishments are open for business seven days a week, often on a 24-hour basis. The 24-7 convenience that consumers take for granted in the retail sector of the economy is not available in the health care field. Further, it may never be, as long as consumers are unable to assign an economic value to convenience or quality, and providers cannot compete on the basis of price and quality (Tuomala, 2003).

CDHC plans give consumers a greater degree of control and say-so on how and where they receive health care (Herzlinger, 2004). There is no forced collectivization of heterogeneous consumers into the health care plan chosen by their employer (Kleinke, 2002). They can directly interact with health plan sites to search for and select their primary care physician (Wyatt, 2002), see specialists without referrals, review drug formularies, and visit any hospital or healthcare facility they wish. These are prerogatives not normally available to subscribers in more restrictive MCOs (Herzlinger, 2004). These facts, together with the fact that today's consumer is better educated and more health conscious, with access to more information than ever before, give consumer driven plans an intriguing launch pad (Word, 2003). Greater choice will have appeal to increasingly sophisticated clients who understand the new technology (although it may create problems for older workers who tend to be less tech-savvy) and who are becoming more active health care decision-makers because of the plethora of information available to them (Geisel, 2003).

### **Reactions by Providers**

Hospitals are more wary of CDHC plans than physicians are. Hospitals fear that they will be forced to absorb the cost of treating those patients who are unable to cover the cost of the deductible and/or co-pay once the HRA is exhausted. Inability to collect money from patients would add to their debt, and many hospitals are already facing debts that are straining their budgets (Benko, 2003). Hospitals also worry that they may get unfair consumer ratings on their care, and they are concerned, as are doctors, that patients may postpone or do without care to save money (Page, 2002).

Providers are divided about how effective CDHC plans will be and how these plans will benefit them. Physicians feel that consumer driven plans may strengthen the physician-patient relationship because of the freedom patients will have to choose and remain with their provider, even when they change jobs or their employer switches health plans. CDHC plans may also encourage greater communication and better dialogue between doctors and patients regarding the necessity of given procedures. The employee can ask better questions, be more specific about

symptoms, and acquire a better understanding of treatment options and procedures. Further, there will be a reduction of administrative hassles by the elimination of intermediation and embedded infrastructure costs that characterize managed care systems (Word, 2003).

Physicians also feel that CDHC plans may improve quality of care by injecting more competition into the system. Under managed care systems, the employer plan restricts choice by dictating which doctors and other providers are available to employees. With a limited choice of providers, there is no pressure on the plan to be responsive. Competition is effectively negated (Benko, 2003). On the other hand, choice of provider is an integral part of the competitively based CDHC model.

CDHC plans—with the proper financial incentives and effective communications of the right information to consumers to support rational decision-making—offer the hope of significantly modifying consumer behavior (Duncan, 2004). If patients are forced to be more discriminating consumers of health care, they might experience increased satisfaction, greater convenience, and higher quality. Consumer driven markets work in other sectors of the economy. Why can't they work in the health care field (Herzlinger, 2004)?

### **Cost Savings**

There is little consensus about the trend-dampening effects on health care cost increases by CDHC plans (Duncan, 2004). Many observers believe that the plans will reduce costs considerably. One study showed that an employee group that began using a CDHC plan experienced an 18 percent drop in physician office visits and an 11 percent decline in overall use of health care (Findlay, 2003). Other research reports show that medical claims costs dipped by as much as 75 percent when a CDHC plan was installed (Benko, 2003). Many studies report less dramatic results. One observer estimates that CDHC plans can reduce the rate of increase of health care costs by two to four percent per annum (Appleby, 2002), and another says that they will reduce health care cost increases by only one percent per year (White, 2002).

### **Problems**

The inherent design of the CDHC system brings with it potential flaws that could limit its effectiveness. Some observers believe that CDHC plans will not save money but may actually drive up costs in the long run by overcompensating healthy workers. Traditionally, employers have spent most of their health care dollars on just a few employees, very little on some, and none at all on others. Yet, under a CDHC model, employers are required to continue making payments into each employee's HRA, even if the money is never spent (White, 2002). If a large number of employees in a group had little or no health care expenditures, a CDHC plan could conceivably cost the employer more than a traditional or managed care plan (Benko, 2003).

Opponents also argue that there could be a perverse segmentation of the risk pool with a CDHC plan. While the CDHC model would be good for the cohort of healthy employees, it would penalize employees who have predictable, ongoing medical needs that require expensive treatment. Healthy employees would tend to gravitate to CDHC plans, under the assumption that they would need few medical services and might even be able to accumulate value in their HRA



(Gabel, et.al., 2004). On the other hand, those with chronic problems would prefer to enter an MCO or traditional plan to avoid the high deductible and co-pay associated with a CDHC plan. If a disproportionate number of greater risk employees choose MCOs or traditional insurance options, the premiums in those plans could skyrocket (Herzlinger, 2004).

Further, some contend that CDHC plans will not target high medical costs. Their reasoning is straightforward. A majority of health care benefit costs are incurred by a small minority of plan participants: about 80 percent of all claims payments go to about 20 percent of the participants (Parmenter, 2003). Thus, the critics note, there will be a few very large claims that will penetrate the CDHC plan well beyond the deductible, and the CDHC plan will be a factor only in the first few thousand dollars of costs for those claims. After that, the standard indemnity plan is left to take over. (The problem will be magnified even further if the HRAs are not indexed for inflation, since more people will tend to utilize the indemnity plan each year as health care costs go up.) Therefore, the CDHC model will not help to control health care costs unless some way is found to influence the spending behavior of the high users (Jaffe and Fronstin, 2002).

Finally, there is a risk that the CDHC plan could backfire because it undermines the good features of managed care plans. Managed care plans provide incentive for consumers to get annual physicals and to visit the doctor often, since the deductible per visit is low. The CDHC plan would discourage consumers from seeking appropriate and needed care because of the incentive to “pocket the money” and not seek early medical attention, possibly resulting in hospitalization and/or expensive long-term treatment later (Caggiano, 2002).

Companies offering CDHC plans are attempting to overcome this problem by educating consumers and designing their plans to help the consumer make smart, cost-effective decisions (Prince, 2003 and Herzlinger, 2004). Plans may contain provisions designed to encourage preventive care such as mammograms, colorectal cancer screenings, immunizations, and Pap smears (Benko, 2003). Some cover proven disease management programs at 100 percent rather than having the cost of such programs charged against the HRA (White, 2002). Others require that a certain amount of expenditures be directed toward preventive care services, or design wellness programs that reward members who practice healthy behaviors. Only time will tell how effective these efforts are (Is it Time..., 2002, and Findlay, 2003).

Finally, a question arises about what will happen to the excess capacity in the health care field if CDHC plans are widely used. If consumers are indeed over utilizing health care as is posited here, the clear implication is that some doctors, hospitals, nurses, HRI machines, etc., will be made redundant as the demand for health care services declines. If a transition to CDHC plans develops slowly, then the number of providers and the facilities might shrink accordingly, with no major disruption in the provision of services. However, if CDHC plans were adopted rapidly and on a large scale, there could be an interruption of the orderly flow of health care services with major dislocations of providers and a temporary diminution in the construction of health care facilities and the purchase of health care equipment. In any case, it seems likely that a large-scale adoption of CDHC plans would diminish the demand for health care services and have a dampening effect on inflation in health care prices.

## Conclusion

Rapidly rising costs and other problems in the health care system can be traced to the inherent nature of the third-party payment system. The current milieu of inexorably rising costs is the perfect distillation of an increasingly dysfunctional and fragile health care system. The system is flawed because both the patient and provider are disconnected from the basic economic transaction that occurs at the point of care. This shortcoming leads to very undesirable but highly predictable results. The patient, oftentimes facing a low deductible and co-pay (and hence insulated from the true cost of care), is not judicious in selecting providers and is induced to utilize increasing amounts of sometimes unnecessary care. Financial disincentives mitigate against utilization reduction and, in fact, condition the user to have an insatiable demand for health care services. Similarly, providers are shielded from the unfettered market forces of supply and demand and are induced to provide increasing amounts of high-priced care.

CDHC plans offer the hope of dampening health care cost trend acceleration where managed care has failed and a host of laws and government regulations have been ineffective. The concept is simple—people are more careful with “their” money than with other people's money—but the implications are profound. By unleashing supply and demand forces in a truly free market, CDHC plans may enable employers to control costs of employer-based health benefits and offer good employee benefits in spite of cost constraints. While not a “magic bullet” that will solve all of the nation’s health care problems, CDHC plans are a step in the right direction. The introduction of the CDHC paradigm is a bold and new idea that could affect the way most Americans select providers and pay for health care services in the future.

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