1 What are Consumer-Driven Health Care Plans?

An Introduction to Consumer-Driven Health Care

The Evolution of the Health Care Marketplace

Every decade seems to have produced a transformation in how health care is administered in the United States.

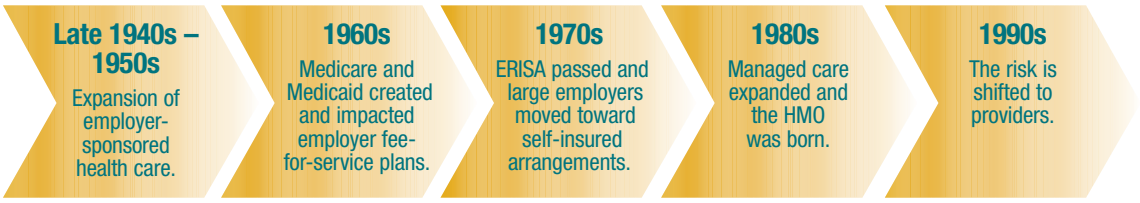


Fig. 1: Evolution of the U.S. Health Care System

And, true to form, the advent of this new millennium has brought about a new paradigm of health care planning.

Some traditional managed care plans were based on a supply-control model: control costs by limiting the supply of care. Others focused on control of costs. As timely as it may once have seemed, some of these models spawned a jumble of bureaucratic rules and medical protocols — primary-care gatekeepers, three-, four- and five-tier prescription drug formularies, outpatient utilization reviews, carve-outs and carve-ins of mental health and substance abuse coverage, arbitrary medical necessity mandates, etc. — to the chagrin of providers and the confusion of patients.

Old managed care may have run its course. As costs continue their upward spiral, employers have run out of room. Now some fear they are being forced to choose between two equally unpalatable options: reduce benefits (i.e., increase deductibles, coinsurance amounts and other plan out-of-pocket costs) or lower pay (i.e., increase the employee portion of the premium contribution).

However, a new option may provide an alternative: Consumer-driven health care may result in reduced health care costs and improved quality of health care by requiring consumers to take charge of their health care decisions.

➢ To control costs, focus on improving quality and changing demand rather than limiting supply.

Consumer-Driven Health Care 101

The new model of consumer-driven health care is about:

- ✔ Transforming the third-party reimbursement system into one that puts economic purchasing power — and decision-making — in the hands of the consumer.
- ✔ Supplying the information and decision support tools needed, along with financial incentives, rewards and other benefits that encourage personal involvement in altering health and health care purchasing behaviors.
- ✔ Letting consumers, rather than health plans, control health care decisions.

With consumer-driven plans, the employers' goal will be to optimize health care benefit dollars by purchasing plans that balance cost, quality and access.

What is Consumer-Driven Health Care?

The term consumer-driven (and similar terms, such as consumer-centric and patient-directed) evolved out of a concept of a defined contribution in contrast to a defined benefit. Defined contributions are best known in pension and retirement benefit funds. To employees, the expression carried with it negative connotations of limited employer support and selection in purchasing health care. For many, it was perceived as a take-back from the traditional employer-sponsored financing, and represented a decrease in affordability, quality and access to care and/or coverage.

Many large employers are offering consumer-driven plans, also known as high-deductible plans. These plans require employees and beneficiaries to be more involved, not less, in health care issues. Employee health and well-being affect not only absenteeism, but also bottom-line issues such as disability, workers compensation, "presenteeism" and productivity.

DEFINITION

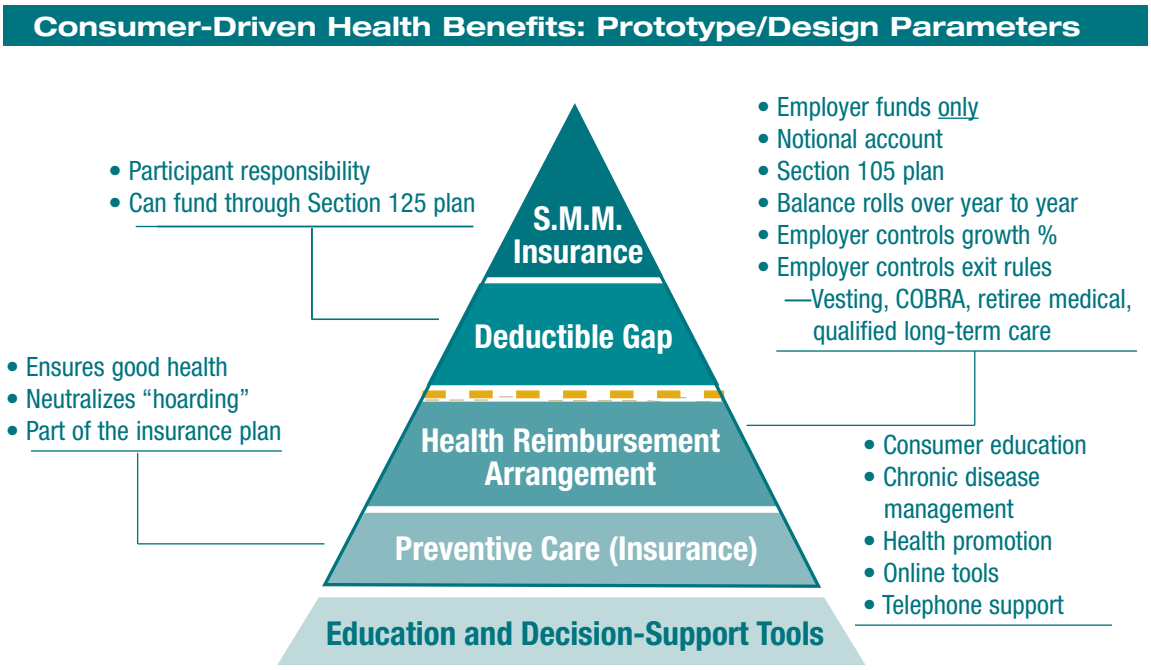
Defined Contribution

A defined amount of health care dollars—fixed by an employer that the employer contributes to a savings account for an individual employee.

Successful consumer-driven health plans must satisfy two overarching objectives:

Objective I: Must be suited for the healthiest AND the most ill.

Objective II: Must be appealing to those who want to make all health decisions AND those who want to make none.



Consumer-Driven Health Care Plans (CDHPs):

The Basic Structure

Under the basic consumer-driven model, members receive an annual allocation of Health Reimbursement Account (HRA) funds from their employer that they may use to pay for covered services. These allocations generally range from $1,000 to $2,000 per year. Unused funds can be rolled over into future years and added to the next annual HRA deposit. Once the HRA fund is exhausted, the member must meet a **deductible gap** before being able to receive insured coverage under the plan. First-dollar coverage, however, is usually available for preventive services such as physicals, mammograms and well-child care. HRA funds can be used to fill in plan deductibles or co-payments, for non-plan IRS-qualified medical expenses and even to purchase other health insurance coverage (e.g., long-term care).

DEFINITION

Deductible Gap
The financial gap between the end of the employer-funded program and the beginning of full coverage when the employee has sole responsibility for medical expenses.

With members responsible for spending their own HRAs and HSAs, physician gatekeepers and prescription drug formularies may no longer be needed. It is easy to see that consumer-driven plans incorporating HRAs and HSAs have the potential to change member behavior and overall health care expenses.

Consumer-Driven Health Care:

A New Focus on Personalized Wellness and Prevention

Proper implementation of an HRA and a consumer-driven plan may allow patients to deal with underlying health conditions not covered by traditional insurance. Services that a traditional managed care plan considers "not medically necessary" may be desired and valuable to a patient's long-term health and well-being. Two plausible examples include:

EXAMPLE 1:
A man with a family history of Huntington's Disease and his wife are considering starting a family. They wish to know his risk of developing the debilitating disease and the risk of passing on the disease to their future children. Traditional insurance may not cover the full cost of genetic testing and counseling, despite the obvious need of these services for the family. A consumer-driven plan would allow the couple to pay for these services in entirety. The knowledge gained from genetic testing and counseling will help this couple make appropriate life and health decisions for themselves and their future children.

EXAMPLE 2:
Parents notice that their four-year-old child is having extreme difficulty at home. The parents are concerned about the possibility of developmental problems and emotional troubles. While traditional insurance would cover the cost of a child psychiatric evaluation, the parents also wish to enroll the child in therapeutic nursery school, a service not typically covered by traditional insurance. With an HRA the parents could directly access this type of support service without stigma or coverage denial.

Types of Health Spending and Reimbursement Accounts

✔ *Flexible Spending Accounts (FSAs)*

The Flexible Spending Account (FSA) is the first tax-advantaged health care account available for most employees. Monies put into an FSA operate under an annual use-it-or-lose-it requirement. This feature requires that employees project the amount of money that they will spend that will not otherwise be reimbursed by their health plans.

The FSA accounts are attractive to employees who can benefit from the tax advantages and have significant medical expenses. The major disadvantage is that funds cannot be carried over from one plan year to the next.

✔ *Health Reimbursement Accounts (HRAs)*

One of the key features of a consumer-centric model is the flexibility offered by HRA funds. HRA funds can be used in several ways to promote employee health and stabilize health care costs.

First, HRAs can be used to pay for plan deductibles, coinsurance and co-payments. That is, HRAs can be used to pay for plan defined covered expenses otherwise paid by the employee with after-tax dollars. The processing and recognition of these expenses would go through the normal plan payment adjudication.

Second, HRAs can be used for non-plan covered expenses that are IRS recognized "qualified medical expenses" under IRC section 213(d). The processing of these payments can be provided by several entities, the insurance carrier, third party administrator (TPA), BCBS plans and specialty processors. In the current market, specialty FSA vendors are already familiar with 213(d) requirements. These vendors have been aggressive in marketing their expertise to handle HRAs. Traditionally, there has been a requirement for paper handling, review and certification of submitted expenses as meeting the 213(d) standards. Recently, the IRS approved the use of electronic processing of claims with certain safeguards to assure they are qualified medical expenses. This electronic process opens the door for cost-effective "debit/credit" card use to draw on HRA accounts.

Third, HRA funds can be used to pay for health insurance premiums. For example, HRAs can be used to pay for COBRA, Retiree Medical, Long Term Care and other medical insurance plans.

The IRS guidelines give the employer full power over structuring employees' use of HRA funds. Multiple uses can be phased in over a multi-year introduction. For example, an employer may initially restrict HRA funds to deductibles and other cost sharing features of the medical plan. In subsequent years, or for amounts in excess of some dollar level, an employer may allow extended use of HRAs for non-plan expenses. Introduction of a consumer-driven health care plan is best done with a pre-planned and announced multi-year strategy.

✔ *Health Savings Accounts (HSAs)*

Effective January 1, 2004 the president signed into law another important development for CDHPs — the legislative creation of new tax-advantaged, funded accounts to pay for medical expenses called Health Savings Accounts (HSAs). HSAs can be funded by employers or employees and they are portable. HSAs are the most tax-advantaged savings vehicle ever passed by Congress. HSAs are tax-free income to employees, they accumulate tax-free and they are not taxed when withdrawn for eligible medical expenses.

From MSAs to HSAs:
The Evolution of Health Accounts

1978: Flexible Spending Accounts ("Use It Or Lose It')

1997: Medical Savings Accounts

2002: Health Reimbursement Accounts

2005: Health Savings Accounts

With these new accounts, legislative initiatives and market-oriented IRS guidelines, CDHPs are entering a new era with the potential for greater member involvement, transparency, increased demand for medical information on cost and quality and behavioral changes. Hopefully, these factors will simultaneously increase member satisfaction and lower overall health care costs.

In order to access the tremendous tax advantages of an HSA, Congress imposed strict requirements on acceptable plan designs:

- An individual must be covered under a "high-deductible health plan," that is, a health plan that has a deductible of at least $1,000 for individual coverage ($2,000 for family coverage) and caps on the out-of-pocket amounts that the individual would have to pay ($5,100 for individual coverage/$10,200 for family coverage) (as of 2005).
- An individual and/or the employer can make contributions to the HSA up to the plan's deductible amount, but no more that $2,650 for an individual or $5,250 for a family (as of 2005). The underlying cost-sharing requirements will be adjusted for inflation in future years.
- For policyholders and covered spouses age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008 and $1,000 in all years after.
- Employers contributing to an HSA must make available comparable contributions on behalf of all employees with comparable coverage. If made for qualified medical expenses, distributions from an HSA are excluded from gross income. Distributions from an HSA that are not for qualified medical expenses are included in gross income and have a 10% penalty if the distribution is taken prior to age 65.

The Expected Evolution of Consumer-Driven Health Care

✔ *1st Generation Consumer-Driven Health Care Plans: A Focus on Plan Design*

The consumer-directed health care model may be attractive to employers and employees alike because it offers expanded choice and potential savings. The model was secured on June 26, 2002 when the IRS issued guidelines approving the right of HRA owners to carry over unused amounts from year to year. This ruling may have been the most important change to affect health care benefits in 25 years.

First-generation CDHPs were focused on basic plan design structure and reducing discretionary expenditures (prescription drugs and physician office visits). But a CDHP can represent much more than a high-deductible supplemental major medical plan with a side savings account affecting only discretionary costs. When properly designed and implemented, CDHPs can also have a positive impact on the purchasing behaviors of most patients — including those requiring chronic and acute care and those with high-volume discretionary expenditures.

✔ *2nd Generation Consumer-Driven Health Care Plans: A Focus on Behavioral Change*

If the consumer-driven health care model is to lower medical plan costs for employers, it must help high cost health care users improve their health and reduce their use of health care services. Currently, 70% of all medical claims are made by only 10% of members. Further, the sickest 25% of the population uses 90% of the available medical resources.[1]

It is imperative that we improve the health of these individuals AND keep healthy individuals from moving up the health care utilization ladder.

Second generation CDHPs promote behavioral changes among members. The key is to develop a plan design to effectively change health and health care purchasing behaviors with individual and group incentives and rewards. Both HRAs and HSAs may be used to provide incentives and rewards to promote healthy lifestyles and disease management program participation. Second generation CDHP concepts address the early CDHP concerns that these plans are only for the young and healthy. Well-designed plans can benefit the sickest populations by improving their access to care and lowering the cost of their health care by encouraging compliance.

- For example, a diabetic who is compliant with accepted evidence-based medicine could have some or all of his/her CDHP cost sharing or deductible gap funded through reward payments made into the HRA.

To support the second-generation focus on behavior change, standard annual HRA allocations can be supplemented in many different and creative ways as long as the funding is through employer-only contributions. **HRA rewards, incentives and compliance dollars on either an individual or group basis are allowed. HSAs have different legal requirements that may limit their use in a second generation model.**

- **Employers benefit** from such awards because they do not experience a cash flow impact and they have the knowledge that any designed funds must go toward the employee's health care.
- **Employees benefit** because the additional HRA dollars are tax free. That is, 100% of the award they receive is available to be used for purchasing health care services.

✔ *3rd Generation Consumer-Driven Health Care Plans: A Focus on Health & Performance*

Third generation CDHPs focus on **health and performance**. The key is to measure the impact of health plan design and incentives on work performance and the corporate bottom line. Studies use work metrics to measure the impact of CDHC on turnover, absenteeism, productivity, disability and presenteeism.

DEFINITION

Health and Performance
A benefits strategy that is designed to balance the rising costs of health care while optimizing employee health and performance through targeted, strategic and value-added interventions.

Health risk appraisals can help an employer assess their population's health care needs. Employers can then tailor their health care plan designs to these needs, improving the health of the workforce, lowering costs and improving performance. For example, many employees struggle with stress.

Research suggests that stress has been directly attributed to:

- 21.5% of total health care costs
- 33% of all disability and workers' compensation costs
- 40% of the primary reasons that employees leave a company
- 50% of presenteeism
- 50% of the primary reasons that employees take unscheduled absence days including health care services that address stress in health care plans and incorporating stress management into existing worksite wellness programs can improve employee health and reduce overall health care costs.

The link between health care and other performance issues will continue to develop as third generation plans evolve.

✔ *4th Generation Consumer-Driven Health Care Plans: A Focus on Individualized and Personalized Health Care*

Fourth generation CDHPs focus on personalized health and health care needs. Some aspects of personalized health care are already developing. The future will include innovative decision support systems and wireless connections that link each person to a personalized health and health care cyber system that continuously searches the Internet for health information based on a personal health profile.

In this future, people will likely be connected with monitors that:

- Provide real time feedback on health status, lifestyle and health concerns;
- Calculate daily caloric expenditures and provide suggestions for a healthy dinner menu;
- Research and suggest health-related vacation packages; and
- Develop personalized exercise programs and purchase equipment through Internet searches or automatic cyber-auctions.

CDHPs and related health care programs are expanding into sophisticated predictive modeling programs that identify problem conditions and provide early warning notices to patients. Genomics testing will add to the personalized approaches as future scientific developments occur. With the use of the Internet and web portals, disease management programs with predictive modeling now have a channel to rapidly communicate with the patient. **Personalized health care resources will integrate individual health profiles with lifestyle and work activities.**

This **push technology** can identify potential problems and suggest courses of action before high cost medical complications occur. Cost-saving interventions and preventive approaches, such as those described above, may be more effective under a consumer-driven model than traditional insurance.

DEFINITION

Push Technology
Sending valued, but unrequested, information to members based upon personal profiles, propensities or related general interests.

Summary

Consumer-driven health care offers many opportunities to improve the health of employees and to lower overall health care costs for employers. Most importantly, the consumer-driven health care model offers encouragement for employees, their families and other dependents to take a more active role in managing their health and health care service use.

The Business Case for Employers and Employees

The Business Case for Employers

Rising Costs: Why employers need to address consumer-driven health care

Health care costs have been rising faster than the ability of most employers to increase employee cost-sharing given pricing pressures to pass on costs to their customers. In 1970, about one-third of all health care spending came out-of-pocket through copays, insurance premiums or deductibles. Currently, consumer out-of-pocket health care spending accounts for just 15% of overall health care spending. Government and employers have increased their relative share of health care expenses to keep up with the rising cost of health care.

For employers, higher health care costs can cut into profits and erode wages. Traditional managed care relies on controlling cost through restricting supply and obtaining provider discounts. But as costs continue to rise and the ability of employers to shift costs to employees diminishes, creative new approaches are needed. Proponents of consumer-driven approaches seek to empower consumers to make better, more informed choices on their plans, providers and treatments — choices intended to both improve outcomes and limit demand through risk shifts, cost transparency and increased patient education.

Creative new approaches are needed as costs continue to rise and the ability of employers to shift costs to employees diminishes.

Consumerism: Moving from "supply control" to "demand control"

Unlike other household expenses, most families do not directly shoulder the financial responsibility for the health care services they use. Not surprisingly, under the current third-party reimbursement system, attempts to modify patient behavior using relatively small out-of-pocket deductibles, co-payments and/or coinsurance have had little effect on demand. So as costs continue to increase, employers are now being forced to rethink how they deliver health care services.

However, savings won't magically appear through the simple act of selecting a new plan. Consumerism is about much more than plan design; rather, it is about transforming attitudes. Significant work will be needed to make the deep changes in behavior that will lead to secure savings.

An Example: How Consumer-Driven Plans can save money

One creative idea is to use Health Reimbursement Accounts (HRAs) and/or Health Savings Accounts (HSAs). When well designed, these accounts allow all patients — those with persistent and chronic conditions, those with acute care needs and those who are healthy — to participate in consumer-valued purchasing and to share in the savings created by a rational model based on personal decision making.

Evidence of savings, though not yet statistically significant, is nonetheless directionally consistent. Experience and rational modeling indicate that a company could save 5 to 8% annually over the next five years and enjoy a 2% reduction in trend each year over that period. Actual annual savings have in many cases topped 10%.

SAVING 35% TO 50% ON HEALTH CARE COSTS:

A company has a stable population of 4,000 employees and annual total health care costs of $20 million. The CDHP provides for a $1,000 HRA with a $1,000 gap deductible. The in-network medical plan is 90%, with an out-of-pocket maximum of $1,000. Out-of-network reimbursement is 70%. There is 100% coverage of reimbursement for preventive care, including well-child, mammography and PSA tests. (This design closely aligns with the prior PPO plan's maximum out-of-pocket costs.)

Low estimate of savings:

5% x 5 years + 2% x 5 years = 35% of current-year costs.

High estimate of savings:

8% x 5 years + 2% x 5 years = 50% of current-year costs.

With full replacement, and if average CDHP experience can be generated, the company could see savings of $7 million (35% of $20 million) to $10 million (50% of $20 million) over the next five years. This "back of the envelope" estimate assumes an appropriately designed CDHP benefit structure, an accessible decision-support system, an incentive-based HRA that supports the needed behavior changes in an economically rational way and an effective employee communications effort.

The Business Case for Employees

It is easy to see how younger, healthier employees would be drawn to these new types of accounts. But let's take a look at another factor driving the emergence of this new model of health care: the demographic tidal wave represented by the baby boomer generation.

As this new century unfolds, the boomers' consumption habits will increasingly focus on the health care sector. Boomers are starting to hear diagnoses from their doctors relating to cancer, heart disease and diabetes and will expect the best care money can buy. They may also vigorously resist attempts to restrict their access to care.

During the 1990s, when they were a decade younger, boomers were content with free office visits and low-cost prescription drugs. They flocked to the convenience of HMOs and managed care arrangements that gave them lower out-of-pocket costs and the promise of preventive care. Many did not have the time or the inclination to focus on health care issues. They were accepting of networks because they rarely used them.

Access limitations helped keep health care inflation low during the 1990s. Members were told, "You can't have those services," "It's not medically necessary" or "You will have to wait two months for that type of appointment." Managed care organizations used primary care physicians as gatekeepers. To control drug spending, they designed formularies.

But such maneuvers are not likely to pass muster with aging boomers.

As we now know, controlling supply is no longer acceptable to most workers and their families. To meet the growing needs of plan members, consumerism replaces the supply-control model of health care with a demand-control model.

How Changing Health Care Service Use Can Financially Benefit Employees

With consumer-driven HRAs and/or HSAs, employees will have more control over the purchase of their own health and health care services. Both HRA and HSA accounts are tax advantaged. While each type of account functions under different rules for deposit, accumulation and withdrawal, both HRAs and HSAs offer a new and exciting level of control for plan members:

- Without a change in health care plans, employees are likely to see increased plan benefit reductions through increased deductibles, higher co-payments and more plan limitations on services.
- Without a change in health care plans, employees are likely to see smaller paychecks as any annual salary increases are absorbed by increased employee contributions.

Consumer-driven health plans offer a mechanism to change employees' health care purchasing behaviors that can result in savings to be shared between the employer and the employee. Both parties can benefit financially by more effective use of health care services at lower costs.

HRAs are unfunded, non-portable accounts and are not taxable income to employees and are not taxed upon use. HRAs must be used only for health care. **HSAs** can be withdrawn for non-health care purposes with a 10% penalty if withdrawal is prior to age 65. **In both types of accounts**, the employee is in control of the expenditures and realizes the savings of year-to-year carry over and accumulation of the account balances. Again, different rules apply to the ultimate use of HRA versus HSA accounts. Generally, these account dollars can be used for retirement health care, long-term care and other uses based upon broad-based employer defined rules and IRS allowed medical expenses.

Employees are able to plan for future expenditures. Employees can save and accumulate accounts over a period of time to cover cost sharing requirements when a hospitalization or other expensive service is needed. The health plan becomes a valuable accumulating asset.

HRAs are unfunded, non-portable accounts and are not taxable income to employees and are not taxed upon use. HRAs must be used only for health care. HSAs can be withdrawn for non-health care purposes with a 10% penalty if withdrawal is prior to age 65. In both types of accounts, the employee is in control of the expenditures and realizes the savings of year-to-year carry over and accumulation of the account balances. Again, different rules apply to the ultimate use of HRA versus HSA accounts. Generally, these account dollars can be used for retirement health care, long-term care and other uses based upon broad-based employer defined rules and IRS allowed medical expenses.

How An Employee's "Right to Know" Can Improve the Quality of Care

Transparency or the "right to know" provider cost and quality is also a foundation of consumer-driven health care. Most consumer-driven carriers and vendors offer web-based tools that provide general cost information on physicians and hospitals. Companies such as HealthShare, Subimo and Health Grades offer hospital cost and quality indicators. Specific cost relationships and alternative substitutions for prescription drugs are available in most consumer-driven plans.

New plan designs are developing tiered reimbursement structures that reflect provider cost and quality. A promising approach for consumer-centric designs is a system that reimburses physicians who provide recognized "value." Instead of forcing patients to use network specialists who have accepted lower reimbursements, patients can now be persuaded to use physicians or hospitals with proven track records of quality care and patient satisfaction. For example, research indicates high-volume surgeons tend to have better outcomes. Developing data may prove a good ROI approach is to follow value purchasing and pay those surgeons more rather than less. Tiering by quality and value reporting rather than cost is another promising dimension for consumer-centric designs.

Consumer-Driven Health Plans: Opportunity for Long Term Savings

Both HRA and HSA accounts offer opportunities for employees to accumulate increased savings over multiple years that can be used for retiree health costs which will be important with the sharp decline in medical retiree benefits. Since HSAs can be withdrawn for non-health care purposes without penalty after age 65, HSAs can actually supplement IRA and pension plans.

The ultimate disposition of HRAs depends upon the initial rules set by the employer for long-term accumulations. HRAs typically end on termination of employment, except termination due to retirement. The IRS allows employers to continue HRA accounts after employment, but there is no individual HRA in the law, so employers have to date simply eliminated account balances of terminated employees. Employers have the right to set the rules and could offer vesting or other ownership rights that allow continued access to HRAs after employment.

HSAs are another story. If an employer contributes to an HSA, they are 100% vested upon allocation. HSAs accumulate tax-free. Banks and other trustees handle individual HSAs. HSAs can be transferred tax-free to a spouse upon death. Otherwise, HSAs are taxable to the estate or beneficiary. Transfers of HSAs are allowed upon divorce. The transfer is non-taxable and becomes the spouse's HSA.

Extent of the Problem

Those who doubt the need for a transformation in health care planning should ponder the following questions:

- Is there waste in the health care system?
- Are emergency rooms sometimes used unnecessarily?
- Are prescription drugs used excessively or inappropriately?
- Are disproportionate amounts being spent on re-hospitalizations and medical complications as a result of patients' non-compliance with treatment plans?
- Are wellness programs in areas like prenatal care being adequately used?
- Are patients with major conditions like diabetes, asthma and congestive heart failure being treated effectively?
- Are cost/quality measures being used to select health care providers?
- Are some employers essentially subsidizing unhealthy lifestyle choices?

Where there is waste, there is a potential for savings. But how does a company achieve it? The consumer-driven approach aims to induce behavior change in patients through cost transparency, financial involvement, compliance incentives and education.

The Business Case for Children and Adolescents

Children and adolescents present a unique situation for consumer-driven health plans. Because they are minors and dependents, they do not fit the standard beneficiary models for this type of health plan. Their dependent status precludes them from separate participation in an HSA and because their parents or guardians have responsibility for ensuring that they receive adequate and timely health care, children and adolescents will not be the direct recipients of health care service use education.

However, consumer plans can still benefit these populations for a host of reasons:

- Consumer plans place a major emphasis on early prevention and intervention. Most CDHPs offer preventive services with first dollar 100% coverage. With reduced cost-sharing parents can benefit from seeking routine and recommended services such as well-baby visits and immunizations.
- With more preventive services, early intervention and a greater emphasis on wellness, parents can provide more extensive care for their children. (This ideally will lead to higher productivity, lower absenteeism and less presenteeism from parents with sick children.)
- Consumer plans typically provide extensive information on pediatric care and child illnesses. Nurse lines offer immediate 24/7 contact for a sick child and information about their care.
- Consumer plans can help control costs for children and adolescents. Information and program assistance for childhood conditions like asthma, diabetes and other chronic or persistent diseases can assist with stabilizing and moderating an illness's impact. Lifestyle, diet and exercise standards are a part of most disease management programs available to children.
- Consumer plans allow parents greater control in service choices. Using accumulated HRA and/or HSA accounts, parents can seek medical treatment from centers of excellence that may not have previously been available through more stringent or limited access HMO or POS managed care plans.
- Finally, consumer plans with HRAs can provide incentives for greater compliance. This means discounts or financial rewards for adherence to medications, reducing requests for medications not medically indicated (such as antibiotics for viral infections) and completing therapy. Incentive programs can also provide rewards for participation in, and completion of, disease management programs.

However, employers still need to keep several considerations in mind when developing consumer-driven plans for children and adolescents.

- Dependents are not the direct decision makers. Parents and guardians need to receive as much information and education as possible to most effectively participate in a consumer-driven plan and to ensure their children receive the services and care they need.
- Some consumer plans, such as pure high-deductible health plans, may not be ideal for certain populations, including those with chronic illnesses or low incomes. Offering a variety of consumer plans, including PPO and POS plans that have lower premiums, co-pays and deductibles for in-network providers, may offer these groups some alternatives.
- Some parents may engage in rationing of health services — either skimping on services for themselves in favor of providing services for their children or avoiding treatment altogether. First dollar coverage on preventive services may help to reduce this behavior since most health services for children are preventive in nature, aside from the occasional illness and injury. Allergy treatments may be considered preventive services as well. Personal care accounts such as HSAs and FSAs may offset out-of-pocket costs, while HRAs can bring about positive behavior through rewards and incentives. Employers need to work with employees to educate them on maximizing their benefits package by emphasizing preventive services and worksite or school-based health improvement programs.