Walden University

Walden University ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

1-1-2009

A case study of factors influencing health benefit offerings by small businesses

Richard J. Dahlkemper
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Health and Medical Administration Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

COLLEGE OF HEALTH SCIENCES

This is to certify that the doctoral dissertation by

Richard Dahlkemper

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Jim Goes, Committee Chairperson, Health Services Faculty
Dr. Daniel Girdano, Committee Member, Health Services Faculty
Dr. Chester Jones, Committee Member, Health Services Faculty
Dr. Gary Burkholder, School Representative, Health Services Faculty

Chief Academic Officer

Denise DeZolt, Ph.D.

Walden University
2009

ABSTRACT

A Case Study of Factors Influencing
Health Benefit Offerings by Small Businesses

by

Richard J. Dahlkemper

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Health Services

Walden University
February 2009

ABSTRACT

If the United States is turning to consumer-driven health plans to control costs and improve access, research is needed regarding the perception of such plans among small businesses. Nearly half of Americans are employed by small businesses where access to health insurance has declined most rapidly. Reviews of the literature revealed solid theoretical bases for high expectations regarding the diffusion of consumer-driven health plans among small businesses, but relatively little information was found regarding the attitudes of small businesses toward emerging health plan models. Qualitative case studies of 6 small employers in the Ogden, Utah, area were conducted to address this problem. Data were collected from documents, archival records, and participant interviews and analyzed using memoing, coding, and iterative pattern matching. Key findings were that leaders of these firms did not believe employees could or would find adequate information about the quality and cost of health care services and alternative providers that would allow them to make effective choices. As a result of this belief, all firms maintained managed care controls on available providers and access to expensive services. The results imply that despite policy assumptions about the attractiveness of consumer-driven plans for small business, such plans may in actuality not be offered by small businesses as an alternative or replacement for managed care. Rather, high deductibles may simply be layered on top of managed care controls without a corresponding expansion of choice for employees. Some employees of participating firms engaged in both passive and active resistance to the imposition of high deductibles. Policy and plan designers will benefit from enhanced understanding of ways to diffuse consumer-driven plans in small businesses that will reduce employee resistance.

A Case Study of Factors Influencing
Health Benefit Offerings by Small Businesses

by

Richard J. Dahlkemper

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Health Services

Walden University
February 2009

UMI Number: 3342483

INFORMATION TO USERS

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleed-through, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

UMI Microform 3342483
Copyright 2009 by ProQuest LLC
All rights reserved. This microform edition is protected against unauthorized copying under Title 17, United States Code.

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

TABLE OF CONTENTS

LIST OF TABLES v

CHAPTER 1: INTRODUCTION TO THE STUDY 1
Introduction 1
Background of the Problem 1
The Problem Statement 5
Purpose of the Study 5
Research Questions 6
Significance of the Study 7
Nature of Study 8
Operational Definitions 14
Assumptions 15
Limitations 17
Scope and Delimitations 18
Summary 20

CHAPTER 2 LITERATURE REVIEW 22
Introduction 22
Evolution of Health Care Financing in the United States 25
    Overview 25
    From Social Welfare to Corporate Model 27
    Federal Safety Nets 28
    Managed Care 29
    Moral Hazard 32
    Societal Wants and Politics 34
    Resurgent Expenditure Growth 34
    Impact on Access to Health Services 36
    Consumer-driven Health Care 39
Ethical Distribution of Health Services 41
    Introduction 41
    Impact of Consumer-driven Health Care on Ethical Issues 43
    Summary 46
Decision Theory 49
    Information Processing 49
    Availability 51
    Choices Versus Limits 52
    Likely Sources of Information 54
    Impact of Attitude 57
    What is the Definition of a Good Decision? 59
    Summary 60
Diffusion Theory 61

How Does Consumer-driven Health Care Fit with Social Change Theory? 65
Social Challenges for Consumer-driven Health Care 68
Summary 73
Methods of Investigation 75
Conclusions 79

CHAPTER 3: METHODOLOGY 83
Introduction 83
Choice of Paradigm 84
Research Design 88
Protocol and Data Gathering 88
Role of the Researcher 89
Selection of Participants 90
Ethical Protection of Participants 93
Analysis of Data 94
Writing the Report 99
Summary 101

CHAPTER 4: FINDINGS 102
Introduction 102
Organizations in the Sample 103
Data Collection 105
Records 105
Interviews 106
Coding 108
Synthesis: Cross Case Analysis 110
Expected Findings 110
Research Questions 118
Question 1 118
Question 2 120
Question 3 122
Themes 124
Cost and Premium Increases 124
Increasing Deductibles and Coinsurance 125
Managed Care 126
Health Savings Accounts 127
Benefits of High Deductible/Consumer-driven Plans 128
Concerns about High Deductible/Consumer driven Plans 128
Disease Management 129
Personal Responsibility 129
Future of Health Insurance Benefits 130
Case Summaries 132

Abco 132
Billco 135
Crane Corp 138
Darden Inc. 142
Franklin Foods 145
Gray Mortuary 148
Summary 151

CHAPTER 5: IMPLICATIONS 154
Introduction 154
Conclusions 155
    Research Question 1 155
    Research Question 2 157
    Research Question 3 158
Interpretation of Findings 160
    Managed Care 160
    Resistance to Change 162
    Predictors of Deductible Level 164
    Summary 167
Implications for Social Change 169
Recommendations 172
    Dissemination 172
    Policy 173
    Practitioners 174
    Further Study 175
Reflections on the Study 176
Summary and Conclusion 179

REFERENCES 182

APPENDIX A: INTERVIEW TEMPLATE 191
APPENDIX B: CONSENT FORM 193
APPENDIX C: INTERVIEW WITH ART ADAMS 196
APPENDIX D: INTERVIEW WITH BEN BLACK AND
BARBARA BARNEY 204
APPENDIX E INTERVIEW WITH CARLY CARR 213
APPENDIX F: INTERVIEW WITH DAN DARDEN 223
APPENDIX G: INTERVIEW WITH FRED FIELD 233
APPENDIX H: INTERVIEW WITH GARY GRAY 242
APPENDIX I: CURRICULUM VITAE 252

LIST OF TABLES

Table 1 Background Information on Participating Organizations

Table 2 Summary of Organizations Considered for Study

Table 3 Participant Responses to Questions Regarding Continuation of Health Insurance Benefits

Table 4 Factors Other Than Premiums Considered in Health Plan Design

Table 5 Abco Health Plan Summary

Table 6 Billco Health Plan Summary

Table 7 Crane Corp Health Plan Summary

Table 8 Crane Corp Health Plan Premiums

Table 9 Darden Inc. Premiums

Table 10 Darden Inc. Health Plan Summary

Table 11 Franklin Foods Health Plan Summary

Table 12 Franklin Foods Premiums

Table 13 Gray Mortuary Health Plan Summary

Table 14 Predictors of Deductible Level

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

Access to health care services is a major economic, social, and political issue in the United States. This chapter will describe how the proposed study will focus on one of the most important aspects of this issue: deterioration in the offering of health insurance benefits by small employers. Context for the specific problem to be studied will be provided through background information relating high and rapidly rising health care expenditures in the United States, the demise of the managed care model's effectiveness in controlling expenditures, the degree of interest in consumer-driven health plans as a replacement model among insurance carriers and large employers, and the impact that small employers have on access to health insurance coverage.

This chapter will delineate the problem statement for the study, based on the background provided, as well as the resulting research questions, and the research design that was implemented to achieve the purpose of the study. Technical terms will be defined and the limitations, scope, and delimitations of the study will also be described. The background information will summarize and make references to the extensive literature search documented in chapter 2. Similarly, the research design section will refer to the more extensive description provided in chapter 3.

Background of the Problem

More than 15% of Americans are without health insurance coverage and the number has been rising significantly in recent years (Nichols, 2004). Nearly half of

Americans procure their health insurance through plans subsidized by their employers and nearly half of the workers in the United States are employed by small businesses (Helfand, 2007). However, small businesses are less likely to offer health benefit plans than larger employers and the proportion of small employers offering health insurance has declined significantly in recent years (Gabel et al., 2005; Kaiser, 2007). The cost of health care in the United States is substantially higher than in other countries when measured either on a per capita basis or as a percentage of gross domestic product (Anderson, 2003). Total expenditures for health care and health insurance premiums have risen by more than 10% per year since 2000, resuming a general trend that had been evident from the mid 1960s until the mid 1990s (Gable et al.).

Managed care moderated health expenditure growth during the 1990s but failed in the long run, however, because Americans refused to accept the legitimacy or morality of restrictions placed on care by provider networks or insurance companies (Robinson, 2005). Health care expenditures subsequently reaccelerated to double digit annual percentages leaving political and business leaders to search for new cost containment strategies. One obvious alternative would be the approach taken by almost every other industrialized country: government control of supply through legislated funding priorities and rationing mechanisms. But Americans do not recognize the right of government to limit their access to care any more than that of insurance plans or employers (Robinson). If both managed care and a national system of rationing are politically infeasible, two general types of alternatives remain: continue to fund escalating health care expenditures through higher taxes and product prices or shift more of the cost to the consumers at the

point of service. A movement to implement the latter strategy is underway using the label consumer-driven health care.

The Bush administration demonstrated its support for the consumer-driven approach by including Health Savings Accounts in the Medicare Modernization Act of 2003. The sources cited in chapter 2 documented that deductibles and coinsurance levels have risen substantially in recent years and that more than 4 million Americans were enrolled in Health Savings or Health Reimbursement Accounts in 2006. Proponents of the consumer-driven approach argue that it is congruent with American social values for autonomy and personal responsibility; that it reduces moral hazard and brings essential price/demand equilibrium principles to bear in health care economics; and that Health Savings Accounts add value in the form of tax advantages, portability, and accessibility to funds. There are serious concerns, however, including the possibility that high deductible plans will have little impact on the majority of health care expenditures that are caused by a small percentage of consumers whose costs would exceed annual deductibles and out of pocket maximums; that patients lack access to and understanding of quality and cost data making it impossible for them to make effective choices among providers and services; and that consumer-driven plans discriminate unfairly against those with low incomes or chronic health problems.

The history of health insurance models (first indemnity plans and then managed care) showed that they were adopted when benefit managers felt confident in the value they would bring to the company and its employees and that they were first adopted by large business and then diffused to smaller employers (Gabel, Whitmore, Rice, & Le Sasso, 2004). As documented in chapter 2, significant numbers of large employers are

interested in consumer-driven models but most are skeptical of their ability to solve cost escalation problems. Small employers are much more cautious about consumer-driven plans and especially Health Savings or Reimbursement Accounts and most of the increase in the number of Americans without health insurance has been caused by elimination of health benefit offerings by small businesses (Gabel et al., 2005). It would appear that the current best chance to halt or reverse this trend could be the adoption of lower premium consumer-driven plans by small employers.

Review of relevant literature revealed that private sector initiatives, driven by health insurance companies and large employers, are focusing on consumer-driven plans characterized by greater freedom of choice but substantially higher out of pocket costs for the consumer at the point of service. The literature review in chapter 2 will demonstrate that large numbers of studies were found relating to the impact of employer-based health insurance benefits (including specifically consumer-driven health plans) on health care economics, access to health care, evolution of the American health care system, consumer decision making, ethical issues, diffusion of innovations, and social change in the United States. When the terms *small business* or *small employers* were included in the database searches, however, no articles were found. Some of the articles found included occasional references to small businesses and some statistical databases include aggregate data regarding health insurance offerings by small business, but very little information was found describing the perceptions, attitudes, and decision making models of small business owners or managers with regard to consumer-driven health plans.

The Problem Statement

For most Americans, access to health services is dependent on employer subsidized health insurance. Rapidly rising premiums have driven many employers to eliminate plans, fueling the increase in the number of uninsured persons. Other employers have shifted the cost control strategy to one that relies more on employee cost sharing. If the United States is turning to consumer-driven plans to control costs and thus improve access, research is needed regarding the perception of such plans and models that will be used in related decision making. The need is particularly strong among small firms where nearly half of Americans are employed and where access to health insurance has declined most rapidly (Gabel et al., 2005; Helfand, 2007; Kaiser, 2007). Therefore, the research question for this study is as follows: How do small businesses make decisions regarding the offering of health insurance plans to employees?

Purpose of the Study

The purpose of this study is to describe attitudes of small businesses toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. In depth understanding of the ways in which small business decision makers perceive and evaluate the purported advantages and challenges of consumer-driven health plans will be critical in predicting their adoption patterns and in designing and presenting benefit plans.

Research Questions

Research questions for this study center around theoretical issues that have been identified in several fields and applied to the design of health insurance plans by several researchers. Specifically, to what extent do small employers implicitly or explicitly believe the theories and findings on which the movement toward consumer-driven models is based? Employees will be more diligent in their decision making when they perceive greater personal risk (Isen 2001; Janis, 1977; Robinson, 2003) and will spend less when they have significant out of pocket costs at the point of service (Feldstein, 2003; Fuchs, 2005; Hadley & Holahan, 2003; Moran, 2005; Neuhauser, 2003; Nichols, 2004; Scheffler & Felton, 2006). People rebel against limitations on their choices and are more satisfied with decisions when they participate in selecting the alternatives (Christianson, 2002; Isen, 2001; Janis & Mann 1977; Nichols, 2004; Nolin & Killackey, 2004). How does this impact small employers' decisions regarding the broadening of provider networks, relaxation of managed care controls, and divergence from the tradition of offering only one health benefit plan (Regopoulos, Christianson, Claxton, G., & Trude, 2006)?

And, to what extent will the potential negatives impact the employers' consideration of consumer-driven health plans? Will concerns about adverse impact on older, less healthy, or lower income employees (Berenson, 2005; Carpenter, 2006; Fuchs & Emanuel, 2005; Regopoulos et al., 2006; Remler & Glied, 2006; Robinson, 2005; Robinson, 2006; Scheffler & Felton, 2006) factor into decisions about consumer-driven plan designs? Do small employers believe that employees will be unable to find or effectively process information regarding the relative cost and quality of alternative

providers and services (Boscarino & Adams, 2004; Christianson, 2002; Galotti, 2002; Hogarth, 1987; Kahneman & Tversky, 1982; Nolin & Killackey 2004; Tunis 2005)?

Significance of the Study

The purpose of this study is to describe attitudes of small businesses toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. This study is important for social change because access to health care is one of the most complex social problems in the United States. Uneven distribution of health insurance coverage and its impact on access to health care services is one of the leading social and political issues in the United States. Consumer-driven plans are touted as the replacement model for managed care. However, this approach is also at high risk of failure unless these benefit plans are designed based on a clear understanding of how consumers will make health care choices and the factors that small business owners will consider in making decisions about health benefit offerings.

The literature reviewed in chapter 2 clearly indicates movement among health insurance companies and large employers toward consumer-driven health plans that expand choice when compared with typical managed care plans but also significantly increase consumers’ personal responsibility for payment at the point of service. The federal government also expressed support for this approach with the expansion of Health Savings Accounts enacted in 2003. All of the factors listed in this summary were considered in the research design described in chapter 3. If it is likely that the United States will continue with a health care system that is primarily privatized and

employment based but where consumers have greater freedom of choice and bear greater financial responsibility at the point of service, it is important to understand the attitudes of small employers toward consumer-driven health plans. This study will advance social change by adding depth to the understanding of small employers that will be valuable to the newly formed commission for the study of health insurance reform in Utah, to firms designing health insurance plans for small businesses, and to the development of future quantitative studies regarding trends in health benefit offerings among small employers.

Nature of the Study

A multiple case study design was chosen for this research because the research questions call for a rich understanding of the attitudes of small employers toward the current phenomenon of consumer-driven health care and how these attitudes may impact health plan design. Several well established theories are at work here and have been used to develop the inquiry: moral hazard, price/demand equilibrium, decision theory, and the diffusion of innovations. Multiple data sources are available and cross case analysis will be used both to provide context for the phenomenon and to validate the findings. Qualitative research, specifically the case study approach, seems to be an appropriate tool to add to understand this critical element of the health care system.

Case study is an empirical method of investigating both a contemporary phenomenon and its context. It relies on prior development of theory to construct its inquiry and often uses its multiple data sources to find redundancies that narrow the focus from a large field of variables (Yin, 1994). As noted above, several well established theories have been used to develop the inquiry and multiple sources of data are also

available including company financial reports, health plan documents, and interviews with company owners and managers. The case study method is most appropriate here because the purpose of the research is to describe or explain in depth a small number of instances of a contemporary societal phenomenon where the researcher has little control and where the research questions ask how or why a certain phenomenon exists (Babbie, 2004). The relevant phenomenon for this study is the decline in the proportion of small employers offering health insurance and how that may be impacted by the rising interest among larger employers and insurance companies in high deductible consumer-driven plans. There is no opportunity for control over this phenomenon but there is the advantage of gathering data from multiple contemporary sources to understand how and why these trends have developed.

The population studied consists of small employers defined as those employing fewer than 200 regular workers who qualify for health insurance benefits. This population was chosen because firms employing fewer than 200 workers are less likely to offer health insurance than larger employers, the proportion of firms of this size offering health benefit plans has been declining in recent years (Kaiser, 2007), and firms of this size employ nearly half of the workers in the United States (Helfand, 2007). Small employers from the Ogden, Utah, area were selected for the case studies because of their availability to the researcher. Cases were selected to provide variety in terms of number of employees, types of businesses, rates of pay, and health benefit offerings. Six employers were chosen including two with fewer than 50 full-time employees, two with between 50 and ten0 full-time workers, and two with more than ten0 but fewer than 200 full-time employees. Firms were chosen to represent a variety of business types from both the

manufacturing and service sectors and a range of employees from lower paid service or semi-skilled workers to more highly compensated skilled, technical, or professional staff.

Additional participating employers, up to a maximum total of 10 as recommended by Yin (1994), were considered but it appeared that the saturation point had been reached as evidenced by the level of redundancy found in analysis of data gathered from the initial six, and no gaps were identified or modifications made to the research protocol after the fourth interview. In multiple case studies purposeful, rather than random, sampling should be used in order to select units with characteristics that will provide the optimal variety of data (Miles & Huberman, 1994). Creswell (1998) concurred with issue focus, multiple cases, and purposeful sampling with emphasis on maximum variation among units to provide an array of points of view. A single case study design can be appropriate when one case is considered to be a critical test of theory, an outlier, or revealing of new information; or for a longitudinal study. However, multiple case designs are of 10 considered to provide more compelling evidence. Yin (1994) put less emphasis on variation among units; rather he recommended that 6 to 10 cases should be carefully selected either because they are expected to have similar experiences or because they are expected to have contrasting results that will support the research proposition. Miles & Huberman (1994) also seemed to be looking for both variety and redundancy, suggesting that units be selected for variation but looking for replication of results.

To enhance the depth of this research, data were collected not only from multiple participants but also from multiple sources within each participating firm, including documents, archival records, and participant interviews. Documents requested for these case studies included summary health insurance plan descriptions, agent proposals, and

consultant memos. Archival records collected were health plan participation summaries and reports of premium experience and design changes. The researcher made contact with the general manager of each potential participating firm to obtain qualifying information about the company regarding its number and mix of employees, health benefits offerings, willingness to participate, and availability of data. In most cases the general manager was an owner of the business. If the business met the selection criteria described in the above paragraph, the participant was asked to sign the Consent Form (Exhibit B). Participants were assured that their names and the names of their companies would be kept confidential. Disguised names are used throughout this document. The participants were then asked to provide selected documents and records from the last 5 year period.

The general manager was asked to participate in an interview and was asked to include any other individuals who are key decision makers regarding health benefit offerings. Since these are small businesses, it is quite possible that the general manager may be the sole decision maker regarding the design of benefit plans but each general manager was also asked if there were others with substantial influence such as a financial officer, human resources officer, or benefits consultant. In each case except Crane Corp the general manager chose to participate personally. The Crane Corp manager designated the Vice President of Human Resources to be interviewed. Only Ben Black asked that another staff member be included in the interview, Billco's Vice President of Administration and Finance. Interviews were conducted at each firm's place of business except for Dan Darden who asked to be interviewed at another location following a meeting he had there. Some entities were approached but not selected. A financial

services company and a manufacturer had health benefits and were interested but each had about 230 employees which exceeded the study parameter of 200. Two restaurants were approached but one did not offer health insurance for employees and the other had only members of the owners' family enrolled in the plan. A major appliance retailer also had only three enrollees who were all members of the owner's family. One company, a financial institution, declined to participate.

Participant interviews were conducted using the interview template shown in Appendix A. While the protocol is well defined based on clear research questions and relevant theories, the interview questions are not identical to the research questions and are constructed in a way that encourages the participants to lead the investigator to data (Yin, 1994). Despite the emphasis on organization and structure, flexibility was emphasized to allow the interviewer to follow the lead of participants and draw out relevant information as the conversation proceeded (Miles & Huberman, 1994). The principal investigator personally conducted all interviews. Given the expertise of the researcher and his access to potential study participants, it did not seem advisable to train and employ others to be involved in gathering data for this study. The number of participants was manageable and direct contact with each participant gave the researcher maximum opportunity to observe both the verbal and nonverbal responses of the participants, follow the data, and modify the protocol as appropriate with each participant and from employer to employer.

In this study, the documents and archival records described above were requested from each participating employer well in advance of scheduling interviews. Analysis of the documents and records revealed any significant changes in benefit plan designs,

administrative strategies, or costs of premiums. These findings were noted on the interview template for that case and used to modify or expand the interview as appropriate. Interviews with participants were audio recorded and transcribed verbatim. A copy of the transcript was shared with the participants and they were asked to review it for accuracy. The interviewer also made notes on an interview template during each conversation with the participants. Information provided by the interviews was coded using predetermined master themes following the pattern coding approach recommended by Miles & Huberman (1994) and Yin (1994). Pattern coding and initial master themes are described in chapter 3 but were modified as appropriate based on data gathered from each participant. An executive summary of findings from each case was prepared and distributed to the interviewees from that entity. They were asked to review the summary, indicate if it fairly represented their situation, and whether they would recommend any changes. The narrative reporting findings from the full study will emphasize cross case analysis. Conclusions will be organized around the following expected findings based on the literature search:

1. Participating small business owners and managers will be concerned about their ability to continue offering health insurance benefits because of rising costs.
2. They will be somewhat unfamiliar with the terminology and concepts of consumer-driven health care and unlikely to fully implement them.
3. They are likely to offer only one health insurance plan.
4. They are likely to reflect the attitudes of large employers and health insurance firms that lack confidence in consumer-driven plans as the sole solution to health care issues.

In keeping with the traditions of multiple case study research, additional themes emerged as data were gathered and are included in the summary of findings in chapter 4.

Operational Definitions

Small employer is defined as an entity with fewer than 200 full-time workers on its regular payroll. This population was chosen because firms employing less than 200 workers are less likely to offer health insurance than larger employers, the proportion of firms of this size offering health benefit plans has been declining in recent years (Kaiser, 2007), and firms of this size employ nearly half of the workers in the United States (Helfand, 2007).

Defined contribution health insurance plans are those where the employer establishes a standard amount available to employees for health care coverage and allows employees to make choices among various designs with any overages coming from the employee's pocket (Nolin, 2004).

Health Reimbursement Accounts are funded by the employer and made available for employees to use for health care costs. Unused funds can be carried forward for use in future years but if the account is used up, then excess costs will fall into the health insurance plan (Sinnett, 2004).

High Deductible Health Plans are defined in 2007 as those with a minimum deductible of $1,100 for Self and $2,200 for Self and Family coverage (U. S. Office of Personnel Management, 2007).

Health Savings Accounts are federal tax advantaged savings plans that are available to persons enrolled in High Deductible Health Plans (Sinnett, 2004).

Consumer-Driven Health Plans are defined in this document as High Deductible Health Plans in combination with Health Savings Accounts (Sinnett, 2004), defined contribution health plans (Nolin, 2004), or plans that have substantially increased deductibles and coinsurance during the last 3 years. This broad definition will be used to be inclusive of any health plans that have been introduced or substantially changed for the purpose of increasing enrollees' out of pocket expenditures at the point of service (Herzlinger, 2004). Regopoulos et al. (2006) also found that many small employers were implementing consumer-driven models without Health Savings Accounts because of concerns over the administrative burden.

General Manager is used in this document to designate the highest ranking manager of each participating firm. Various titles such as President, Chief Executive, Chief Operating Officer, or others may not be used consistently by companies so the generic general manager term will be applied when speaking of them as a group.

Assumptions

It is assumed that summary health plan descriptions contain accurate information regarding plan design elements such as deductibles, copayments, coinsurance, and maximum out of pocket limits.

It is further assumed that information in the summary plan descriptions is consistently reported from year to year and from firm to firm as required by the Employee Retirement Income Security Act (U.S. Department of Labor, 2007).

It is also assumed that health plan participation summaries, reports of total claims paid, and loss ratio reports are accurate and consistent as required by the state of Utah (Utah Code, 2007).

It is assumed that the general manager is the key decision maker regarding health benefit offerings. This was verified during the initial contact with the general manager and the general manager will also be asked if there are other influential parties who should be interviewed.

It is also assumed that the general manager is knowledgeable about health benefit offerings. Information provided by the general manager during interviews was verified by review of documents provided by the company. General managers were asked to make staff members or consultants available for interview if those individuals would be more familiar with the plans and decision making process. It should also be noted that the primary purpose of the study is to describe attitudes of decision makers and the factors they will consider. Thus, a pattern of attitudes will be valuable even if they are based on perceptions or biases that may not be based on perfect knowledge.

It is further assumed that participants were honest in their responses to interview questions. No misstatements of fact were found through analysis of documents. Dishonesty regarding attitudes will be more difficult to detect but seem unlikely given the willingness of individuals to participate in the study and their interest in effective health benefit plans.

Limitations

This is a qualitative study involving six small employers in the Ogden, Utah, area. The relatively small number of participants prevents the development of statistically valid measures that could be projected on to larger populations. While this approach limits the breadth of findings, the use of multiple sources of data as well as cross case analysis is designed to enhance the depth and richness of the findings. Large databases have been maintained by both government agencies and private entities showing the amount, types, and costs of employer health benefit offerings. Quantitative analyses have also been conducted in this area, most notably the Kaiser Family Foundation Health Research and Educational Trust Survey of Employer Sponsored Health Benefits and the Community Tracking Study. Several of the studies cited in the literature review drew their data from one of these surveys. However, the only results found specifically addressing the attitudes of small business toward consumer-driven health plans are described in chapter 2 from the studies conducted by Gabel et al. (2004, 2005) and Regopoulos et al. (2006).

Qualitative research, specifically case study, seems to be an appropriate tool to add to the understanding of this critical element of the health care system. Case study is an empirical method of investigating both a contemporary phenomenon and its context. It relies on prior development of theory to construct its inquiry and often uses its multiple data sources to find redundancies that narrow the focus from a large field of variables (Yin, 1994). The case study method is particularly effective here because the purpose of the research is to describe or explain in depth one or a small number of instances of a societal phenomenon (Babbie, 2004). The case study method is also most appropriate because this is a contemporary issue where the researcher has little control and where the

research questions ask how or why a certain phenomenon exists. Research questions dealing with who was impacted, or how many, or how much are, on the other hand, best answered with quantitative analysis of surveys and documents. Some how and why questions can also be answered using history or experimental approaches, but experimentations can only be used if the researcher can control events. Histories (such as biography, ethnography, or phenomenology) and case studies may have some overlap but case studies deal more with contemporary issues and have the advantages of observing relevant events and interviewing participants (Yin, 1994). The grounded theory method could be applied here, but the objective is not to create new theory, rather to understand how the attitudes and actions of small employers will reflect existing theory.

Scope and Delimitations

The boundaries of the study were established by the choice of participants. As explained in the *Nature of the Study* section, participants were selected from among Ogden, Utah, area small businesses. While participating employers are diverse in terms of size and type of business, homogeneity of cultural and economic environment are delimiting factors that could impact the attitudes of participating small business owners and managers.

The population of Utah is less diverse than the United States as a whole at 83.5% White non-Hispanic versus the national average of 66.9% (U. S. Census Bureau, 2005). However, Ogden is the most ethnically diverse city in Utah with White non-Hispanic persons accounting for only 57% of the population (2005). The state of the economy

could also have an impact on health benefits attitudes and decisions. Unemployment rates in Utah have been below the national average during recent years and stood at 2.8% in October 2007 as compared to the national average of 4.7%. Weber County, which includes the city of Ogden, has typically been among the highest unemployment rates in Utah but still below the national average. The rate for Weber County in October 2007 was 3.2% (Department of Workforce Services, 2007).

The researcher was sensitive to the impact that the state of the local economy and the status of each participating firm may have. Data gathered included changes in insurance premiums, numbers of employees, and enrollment rates. Analysis of these data informed the researcher about the level of health plan cost increases for each participant. Interview questions, including those in the template and follow up questions in each interview, were modified to probe for the impact that current economic conditions have on health plan decision factors for each employer.

The goal of qualitative study is to produce results that are conceptually representative (rather than statistically) of individuals in a certain context (Ulin, Robinson, & Tolley, 2005). While the delimitations make it difficult to broadly generalize findings beyond the Ogden area, diversity in the Ogden population and economy as well as the in depth nature of the multiple case study design, make the conclusions transferable to other contexts (Miles & Huberman, 1994), preserving the purpose of the study. Results will enhance the understanding of small employer attitudes toward health benefit offerings, especially consumer-driven designs, and will be valuable in developing future health benefit designs and broader scope studies. For example, the Utah Legislature recently established a commission charged with implementing a three

year study of health care financing reform within the state. Results of this proposed study will be valuable in structuring the commission’s efforts.

Summary

The number of Americans without health insurance exceeds 45 million and has been increasing significantly. One of the main causes has been a decline in the proportion of small businesses offering health insurance benefits to their employees. Health insurance premiums stabilized during the 1990s but reaccelerated after 2000 because of backlash against strict managed care controls on access. The consumer-driven health care model has received strong attention from large employers, insurance companies, and the federal government as the replacement for managed care. While the consumer-driven approach does address some of the fundamental flaws in the American health care financing system, there are also concerns about its implementation. There are also very few studies in the literature that focus on small business attitudes toward consumer-driven plans. This is a significant gap because small businesses employ nearly half of the American workforce and are also much less likely to offer health insurance benefits.

The purpose of the study is to enhance understanding of the attitudes of small employers toward health benefit offerings and the factors they consider in making decisions about health plans, especially consumer-driven models. The study will be significant because consumer-driven plans are viewed as the emerging model for health insurance benefits while elimination of health insurance offerings is most prevalent among small employers. The research consists of case studies of six small employers where data was gathered from financial records, archives, and interviews.

Both the theoretical underpinnings of the consumer-driven model and concerns about its implementation are described in the literature review. chapter 2 will review studies that have described American health care from the points of view of complex adaptive systems behavior, economic theory, social change, ethical principles, decision theory, and diffusion of innovations. Findings indicate that while there is substantial demand for universal coverage from a social justice perspective, strong American values for autonomy, private enterprise, distribution based primarily on contribution, and quick, open access to services present formidable barriers to the implementation of a nationialized health care system. The literature also consistently reported findings that the root cause of high expenditures for health care has been ever increasing demand unfettered by the normal impact of price considerations. All of the factors listed in this summary were considered in the research design described in chapter 3. If it is likely that the United States will continue with a health care system that is primarily privatized and employment based but where consumers have greater freedom of choice and bear greater financial responsibility at the point of service, it is important to understand the attitudes of small employers toward consumer-driven health plans. chapter 4 will summarize findings while chapter 5 will present implications and recommendations.

CHAPTER 2: LITERATURE REVIEW

Introduction

This review includes findings from recently published studies on topics related to the research questions for this dissertation. The purpose of this study is to describe attitudes toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. In depth understanding of the ways in which small business decision makers perceive and evaluate the purported advantages and challenges of consumer-driven health plans will be critical in predicting their adoption patterns and in designing and presenting benefit plans.

The works of multiple authors have coalesced around a series of theories and findings on which the movement toward consumer-driven models is based. The research questions for this study are designed to determine the extent to which small employers believe these theories and findings and how their beliefs impact their decisions. These theories and findings are summarized as follows: Employees will be more diligent in their decision making when they perceive greater personal risk (Isen 2001; Janis, 1977; Robinson, 2003) and will spend less when they have significant out of pocket costs at the point of service (Feldstein, 2003; Hadley & Holahan, 2003; Scheffler & Felton, 2006). People rebel against limitations on their choices and are more satisfied with decisions when they participate in selecting the alternatives (Christianson, 2002; Janis & Mann 1977; Nolin & Killackey, 2004). How does this impact small employers' decisions regarding the broadening of provider networks, relaxation of managed care controls, and

divergence from the tradition of offering only one health benefit plan (Regopoulos et al., 2006)?

And, to what extent will the potential negatives impact the employers' consideration of consumer-driven health plans? Will concerns about adverse impact on older, less healthy, or lower income employees (Berenson, 2005; Carpenter, 2006; Fuchs & Emanuel, 2005; Regopoulos et al., 2006; Remler & Glied 2006; Robinson, 2005; Robinson, 2006; Scheffler & Felton, 2006) factor into decisions about consumer-driven plan designs? Do small employers believe that employees will be unable to find or effectively process information regarding the relative cost and quality of alternative providers and services (Boscarino & Adams, 2004; Christianson, 2002; Galotti, 2002; Hogarth, 1987; Kahneman & Tversky, 1982; Nolin & Killackey 2004; Tunis 2005)? The articles studied are predominantly from scholarly, peer reviewed journals published within the past 5 years. A few older articles have been included because of their strong relevance to topics integral to this study as well as a few articles from non juried business and trade publications to assist in illustrating the treatment of related topics by that sector.

Literature database searches were conducted using Academic Source Premier, Business Source Premier, ABI Inform, EbscoHost, and Medline. Keywords used in the searches were consumer-driven health care, High Deductible Health Plans, health benefits, and health insurance in combination with decision making, change, innovation, economics, employers, small business, small employers, ethics, or access. The literature review below will demonstrate that large numbers of studies were found relating to the impact of employer-based health insurance benefits (including specifically consumer-driven health plans) on health care economics, access to health care, evolution of the

American health care system, consumer decision making, ethical issues, diffusion of innovations, and social change in the United States. When the terms small business or small employers were included in the database searches, no articles were found. Some of the articles included occasional references to small businesses and some statistical databases include aggregate data regarding health insurance offerings by small business, but very little information was found describing the perceptions, attitudes, and decision making models of small business owners or managers with regard to consumer-driven health plans.

This review is organized around several theoretical concepts that have converged to generate a high degree of interest in consumer-driven health care models. With regard to economic theory, several texts and articles have held that the primary driver of health care systems and policies in the United States has been the employer-based third party payment system that has neutralized normal forces of price/demand equilibrium. Many authors have discussed the likely impacts of consumer-driven plans on demand, price, and supply of health care services. On one hand, the high proportion of American health services that are financed by third party payment has created economic concerns while on the other hand the lack of coverage for about 15% of the population has generated ethical issues regarding just distribution. The second section of this chapter will review literature regarding relevant ethical theory. Proponents claim that consumer-driven models are based on the ethical principles of autonomy, personal responsibility, and distribution based primarily on contribution. Critics argue, however, that consumer-driven plans discriminate unfairly against older or less healthy persons as well as those with lower incomes. Two additional theoretical concepts are also strongly involved in assessing the

ways in which consumer-driven health care is likely to affect the American health care system. Since the basis of this concept is that the system will become more efficient when consumers are given financial incentives to make more effective health care choices, decision theory should ground the study of how consumers (both individuals and employers) are likely to gather and process information related to these choices. Diffusion theory is also important here because the potential shift to consumer-driven models would be an innovation having major implications for American society.

Evolution of Health Care Financing in the United States

Overview

The rapid expansion of the health care industry in the United States over the last few decades has been well documented and heavily publicized. Only a brief summary of key economic indicators will be presented here to set the stage for discussion of the application of economic principles to various control models. Total expenditures on health care in the United States were $26.7 billion in 1960, only about 5.1% of GDP. These expenditures approximately tripled during the 1970s, doubled in the 1980s, and almost doubled again during the 1990s (Sultz & Young, 2006). Residents of the United States invested more of their resources in health care than in any other area of the economy. Health care expenditures per person in the United States were $4,631 in the year 2000. This was more than 2.3 times the average per capita spending of $1,983 for industrialized countries of the Organization for Economic Cooperation and Development (OECD) during the same year (Anderson, 2003). Per capita spending in the United States exceeded the next highest country, Switzerland, by almost 44% and third place Germany

by almost 69%. In 2000 more than 13% of GDP in the United States was devoted to health care as compared with an average of only 8% for OECD member nations. Switzerland was at ten.7% and Germany at ten.6%. Spending for health care reached 1.7 trillion in the United States in 2003, more than 15% of the Gross domestic product (GDP), more than one dollar out of every seven. (Centers for Medicare and Medicaid Services, 2005).

The United States has a largely private delivery system but nearly half of all expenditures are publicly funded through Medicare, Medicaid, SCHIP, and other governmental programs. In addition more than one third of all expenditures are made by private insurance leaving less than 15% to be paid directly out of pocket by the consumers (Sultz & Young, 2006). Employer sponsored health insurance plans have been the dominant model for private coverage for 50 years insuring 159 million Americans under age 65 in 2005 and providing gap coverage for an additional 15 million Medicare beneficiaries (Gabel et al., 2005).

Two developments during the 1980s and 1990s have had the greatest impact on health care financing in the United States: prospective payment and managed care. Medicare adopted a prospective payment system for inpatient hospital services in 1983. This DRG system that paid hospitals a predetermined amount based on the patient's diagnosis and other factors was so successful in reducing the average length of stay and the consumption of inpatient services that Medicare moved on to implement other forms of prospective payment for physicians, nursing homes, home health agencies, and ambulatory surgery centers. Prospective payment mechanisms were also copied by Medicaid programs and private insurance plans. Managed care combines the

responsibility for financing care and for delivering it. Managed care contracts included discounts from standard provider fees as well as incentives and sanctions aimed at controlling the utilization of services. Because of managed care's success in slowing the rate of growth in health care expenditures, employers shifted to this model almost exclusively during the 1990s until more than 90% of privately insured Americans were in managed care plans (Sultz & Young, 2006). Prospective payment and managed care each enjoyed some success in slowing the rate of growth in health care, mostly among inpatient and specialty services, but they apparently did not deal with the underlying economic causes because since 2000 expenditures have again risen at double digit annual percentage rates each year except 2004 which was just under 10% (Gabel et al., 2005).

Even though U.S. citizens consume health care services at two or three times the average rate of people in other industrialized countries, there are serious concerns about access to care and quality of service. More than 15% of Americans are without coverage from either private insurance or government programs (Nichols, 2004). Additionally, America does not compare well with its peer nations on overall measures of health such as life expectancy and infant mortality or on specific quality indicators like deaths caused by medical errors (Beauvais, 2006; Nichols et al., 2004).

From Social Welfare to Corporate Model

Following World War II the demand for health coverage increased dramatically. It was spurred on by federal income tax policy which made the cost of health insurance premiums deductible for employers and nontaxable for employees; by union strategies to control benefit funds; by the rising cost of specialized medical and hospital care; and by

the expanding population of the baby boom. Commercial insurance companies capitalized on this demand, and during the 1950s moved ahead of Blue Cross in market share. One of the reasons for their success was experience rating which attracted younger, healthier groups by offering them lower premiums. Blue Cross was forced to switch away from their traditional community rating policy further fragmenting the health care system by increasingly leaving older persons, the poor, and the chronically ill without coverage. This move away from a community or social insurance model was accelerated by the Employee Retirement Income Security Act (ERISA) of 1974 which gave strong incentives to large employers to withdraw from broad risk pools by self insuring their health care benefits. This further isolated small groups and individuals making coverage for them more scarce and expensive (Moran, 2005).

Federal Safety Nets

Post war social priorities and health care provider goals had been mutually supportive: increased investment in facilities, technology, and research; shifting priorities from infectious diseases to chronic conditions; and refocusing psychiatry from mental illness to mental health. By the 1960s, however, society became more concerned with maldistribution of services. Surveys showed that medical insurance was the chief concern of three fourths of elderly Americans; the AMA continued to vigorously fight mandatory national health insurance; and states desperately petitioned the federal government for assistance with funding the health care needs of the poor. Unions supported Medicare because they needed to shift the cost of health care for their retirees from themselves to the general taxpayer base (Feldstein, 2003). The political result was mandatory

hospitalization insurance funded by payroll taxes through Medicare Part A; voluntary physician services coverage funded by premiums with federal subsidies through Medicare Part B; and comprehensive coverage for the "medically indigent" financed by the states with matching federal funds through Medicaid. Even though American politics were dominated by liberals at this time, these federal health programs were structured to accommodate doctors and hospitals because of fears that the programs would fail without their support. Provider controlled Blue Cross and Blue Shield were ordained as fiscal intermediaries and the payment system followed their model of full cost reimbursement. The result was a financial bonanza for physicians and hospitals while Medicare covered only about half of the health care costs of the elderly and Medicaid accepted only about a third of the poor (Starr, 1982).

Managed Care

During the 1970s a tripling of national health care expenditures, stagnation in the general economy, and increasing maldistribution of medical resources led to shifts in economic pressure and political climate. The Nixon administration and the business press consistently referred to a crisis in the health care system and skyrocketing health care costs. The public lost confidence in hospitals and doctors and came to view them as too expensive, not accommodating, and too impersonal. Powerful forces aligned against health care providers (Starr, 1982): Government needed to reign in Medicare and Medicaid costs; employers' global competitiveness had been hurt by health insurance costs; and insurance companies were reacting to the needs of employers and concerns

that cuts in Medicare and Medicaid payments would result in further cost shifting to private insurance plans.

These economic concerns and a Congress controlled by the Democratic Party combined to create some new momentum for a national health insurance plan. The Nixon administration was forced to find a more conservative approach that could be controlled by private enterprise; they landed on Health Maintenance Organizations (HMO). It is most interesting that this model had been around for decades with another name, prepaid group health plans, and had been shunned as liberal and socialistic. The corporatization of American health care was under way in earnest. The shift of public belief away from the idea that more medical care is better along with employer and government budget concerns increased emphasis on cost control and limiting overuse of services and away from increasing access, thus working against adoption of national health insurance. As costs rose dramatically politicians and businesses were forced to implement controls. These changes led to entrepreneurship, consolidation, competition, and centralization, as health care in the United States came to be viewed as a market commodity rather than as a social good (Lee, 2003). The federal government has contributed to this movement by following an economic theory of government rather than a public good theory. That is, politicians have redistributed wealth to those able to deliver political support. For example, Medicare was financed by a regressive tax on all wage earners and employers and redistributed this wealth to physicians, hospitals, and middle and upper income seniors and their families. In American society concentrated interests can succeed politically when costs are diffuse, meaning they can be spread in small increments over a larger population (Feldstein, 2003). Medicare was enacted because of strong support

from interest groups, general public sentiment favoring the concept, and the ability to spread the relatively small cost (at the time) over the entire tax base.

The federal move to prospective payment began in 1983 with diagnosis related groups (DRG) and HMOs evolved into a variety of managed care plans that dominated American private health insurance in the 1990s. Employers preferred a competitive model for controlling health care costs propelling the growth of managed care to over 92% of private insurance enrollees by the year 2000 (Lee, 2003). The economic philosophy of managed care was that consumers should not make decisions about health services based on ability to pay; clinical professionals should make those choices based on the cost and benefits of the services provided (Ginsburg, 2005). Therefore, managed care reduced consumers' out of pocket payments and implemented limits, approval requirements, professional utilization review staffs, and financial incentives for physicians to limit care. The changes were successful beyond expectations (Ginsburg); premium increases slowed, market share grew, and managed care plans were highly profitable through the middle 1990s. Hospitals found themselves with excess capacity, physicians were fragmented into small groups, and managed care plans were able to negotiate even better discounts (Neuhauser, 2003).

From an economic standpoint, it appeared that dramatic improvements had been made in the American health care system. However, the growth of health care expenditures was only slowed, not stopped, and even the slowing was only temporary. Efficiency in the provision of health care has steadily improved since the 1980s because of prospective payment systems initiated by Medicare, managed care controls, and increased competition for outpatient services. However, total costs to the society

continued to grow rapidly because of inefficient use of health care by Americans. Optimal economic efficiency occurs when the price received by the producer is equal to the perceived value received by the consumer. In health care this is very difficult to achieve because consumers usually lack the information or ability to determine the quality and value of the services received and, 85% of American consumers are isolated from the cost of services used through either government programs or tax free, employer subsidized health insurance benefits (Feldstein, 2003). Under the economic conditions prevailing in American society, those paying the bills (government agencies and employers) are likely to perceive that physicians are making too many services available. In societies where the health care system is government controlled like Great Britain or Canada, consumers are likely to perceive that too few services are available (Feldstein).

Moral Hazard

The underlying causes of health care expenditure growth did not change through all of the financing changes from World War II until today. An increasing majority of consumers became isolated from the cost of care by a third party payment system. Physicians have no financial incentives to limit care, are often unaware of the cost of services ordered, and the fee for service payment system actually gives them incentives to provide more care. People with third party coverage use more services, about twice as much as found in some studies (Fuchs, 2005; Hadley & Holahan, 2003; Moran, 2005).

The essence of the social science of economics is that human wants are infinite but resources are limited. In a competitive marketplace, supply and demand continually return to equilibrium because large numbers of buyers choose among large numbers of

sellers on the basis of product availability, perceived quality, and price. In the American health care system, however, disequilibrium has been the norm and almost always disequilibrium where demand exceeds supply. There have been a couple of exceptions but they have been short term and have been isolated to certain segments of the health care system or to specific geographic areas. During the 1980s there were temporary excesses of inpatient facilities and staff because of shorter average length of patient stay following implementation of the DRG prospective payment system by Medicare. In local areas where HMOs garnered substantial market shares there was excess supply of specialty physicians and inpatient hospital services at times. However, the persistent trend is for demand to exceed supply even though there are large numbers of consumers choosing among large numbers of providers in an apparently competitive market place. How can this be? Are the basic principles of economics invalid?

No, the principles are valid; it is the system that is flawed. In most cases the consumers are not paying for the services they want. While many causes are often discussed for American health system expansion (technologic advancement, specialized medicine, malpractice liability exposure, more knowledgeable consumers, and so on), they are all driven by the demand-pull inflation created by the third party payment engine. To the consumers, health care services have been priced at or near zero resulting in virtually limitless demand (Moran, 2005). This has become the prime example of moral hazard in operation. “If insurance pays for it, why not do it?” (Neuhauser, 2003, p. 172) The summary here is no different than findings in older studies because current researchers are finding the same root causes of rampant health system expansion that have been discussed by authors of texts on health care financing and economics for more

than thirty years: the combination of third party payment and fee for service medicine have disempowered normal economic forces.

Societal Wants and Politics

If this has been known for several decades, why have solutions not been implemented? Health care policy adjustments have been largely political and have focused on social issues related to access rather than on economic reform. The implementation of HMOs by the private sector, with support from government, attempted to establish price competition at the insurance plan level causing consumers to choose among competing plans on the basis of premium price, provider availability, and perceived quality (Neuhauser, 2003). This approach is certainly reflective of Menzel's (1983) assertion that for health care choices to be rational, they must be made in advance of need through the selection of a set of insurance benefits that fit the consumers' wants for availability, price, and quality. But strict HMOs succeeded in only a few local markets, were quickly superseded by less restrictive Preferred provider organizations (PPOs), and the entire managed care model lost its effectiveness by the late 1990s as politicians and employers acceded to consumer demands for broader choice of providers and fewer restrictions on care.

Resurgent Expenditure Growth

After a hiatus in the mid 1990s when total health care expenditures grew at about the same rate as GDP, rapid inflation resumed with the beginning of the new millennium. Employer health insurance premiums have risen at double digit rates in every year since

2000, except 2004 which came in just under 10% (Gabel et al., 2005). American consumers rebelled against the restrictive provider networks and tight utilization controls imposed by managed care plans. Physicians fueled the insurgence because of their longstanding dislike of utilization restrictions and the fee discounts demanded by managed care plans and the media publicized instances where apparently needy individuals were denied coverage for expensive services by their insurance carriers (Ginsburg, 2005). Hospitals had downsized since 1983 and pursued consolidation strategies that eliminated excess inpatient capacity. Severe shortages among various medical specialties arose as predictions that managed care gatekeeper and prior authorization systems would dramatically reduce specialty service utilization proved inaccurate. The American economy experienced a prolonged boom causing more profitable businesses to be less concerned about cost cutting and more concerned about finding and retaining workers. Employers asked for broader networks in their health benefit plans and reduced utilization restrictions. All of these factors combined to make it impossible for managed care plans to effectively negotiate discounts or control service usage as they had during the 1990s (Nichols, 2004). In addition, politicians felt pressure from their constituents and many states enacted legislation requiring independent appeals processes for consumers, mandating coverage levels for certain services, or requiring plans to accept any provider who was willing to accept their fee schedule (Ginsburg).

Two key factors here could be important to the design of future health financing models. First, early adopters of managed care (that is, consumers who joined HMOs in the 1970s and 1980s) consistently expressed high levels of satisfaction with their plans despite tight restrictions, apparently because they had freely chosen this model and felt

that it met their needs. Extreme dissatisfaction, backlash, and demise came later when the rest of the population was forced into these restrictive plans during the 1990s because employers dropped traditional indemnity plans (Ginsburg, 2005). Second, consumers maintained a strong relationship with their physicians (Ginsburg) while dropping their trust of health insurance companies below any other group except tobacco companies (Sultz & Young, 2006).

The critical economic strategy within the employer-based private health care system of having managed care plans bring price considerations into the market place at the plan design level was lost. The effort to have managed care plans and employers make rational economic decisions about health service priorities failed because American social traditions and individual consumers were not willing to let go of these highly emotional matters (Robinson, 2005). Now, however, they are faced with a situation where costs are escalating rapidly, more than 15% of Americans are uninsured for health care services, administrative costs are very high, and medical error rates are a major concern (Fuchs, 2005).

Impact on Access to Health Services

The high cost of premiums causes very few Americans to purchase health insurance coverage on their own. For reasons described above, the private health insurance system in the United States has become solidly employer-based. However, high and rapidly increasing benefit plan costs have also caused a breakdown of this system. Financial executives of private companies consistently listed rising health insurance premiums among their greatest concerns and 70% of small businesses rated health care

costs as the greatest threat to their entity (Sinnett, 2004). The portion of small businesses offering health insurance coverage for employees slipped from 57% in 2000 to 52% in 2004 and dropped below half to 47% in 2005 (Gabel et al., 2005). As a result, about one out of every six Americans was without health insurance coverage (Fuchs, 2005).

As one would expect, having health insurance coverage positively impacts access to medical services. Hadley and Holahan (2003) found that even though physicians and hospitals provided substantial amounts of charitable and uncompensated care, people without health insurance received only about half as much care as those with private insurance coverage. While it can certainly be argued that some of the care received by those with insurance coverage may have been inappropriate or of only marginal benefit because of moral hazard (Fuchs, 2005; Hadley & Holahan, 2003; Moran, 2005), it is difficult to justify a system where the uninsured receive only half as much service. Ginsburg's (2004) respondents indicated that all citizens should have comparable access to services, including expensive specialized care.

It also appears that providing direct access to service for people without health insurance did not substantially narrow the access gap. Cunningham and Hadley & Holahan (2004) studied differences in availability of health insurance coverage and the accessibility of community health centers in various parts of the country. They found that communities with higher numbers of insured residents had better access to care than those with access to a community health center. The authors ran simulations to model the impact of increased funding for health centers to the impact of spending the same amount of additional money to expand insurance coverage. The models indicated greater improvement from investing in health coverage expansion than in centers. They

concluded that lack of financial resources was the primary barrier to care rather than lack of access to physicians. This seems to reinforce Menzel's (1983) position that the poor should be given resources to purchase care rather than direct services, although he advocated cash distributions rather than vouchers or insurance coverage. A related concern is the quality of care to which the uninsured have access. Beauvais and Wells (2006) found that hospitals with lower net incomes (or higher losses), fund balances, and expense to patient ratios tended to invest less in quality enhancing infrastructure and processes and to have significantly worse outcomes using measures of several quality indicators.

With the weakening of managed care, the American health care system has found itself in recent years in a situation where restrictions on utilization and financial encouragement for providers to be efficient have been largely removed but no economic incentives have emerged to replace them (Ginsburg, 2005). There has been some movement toward plans with higher deductibles and coinsurance on the theory that consumers will make more effective health care decisions if they are spending a significant amount of their own money at the point of service (Nichols, 2004). There is some evidence, however, that this approach is aimed more at shifting costs from employers to employees and retirees and skepticism regarding its ability to reform health care financing as a whole (Moran, 2005). The next section will closely examine this consumer-driven health care model.

Consumer-driven Health Care

The phrase consumer-driven health care (Herzlinger, 2004) has come into common usage to describe a variety of health insurance plans designed to expose consumers, usually employees, more directly to the financial consequences of their health care decisions. Defined contribution is a term transferred from retirement benefit design where transition has been widely made in recent decades from the former defined benefit pension plans with generally satisfying results on the part of both employers and employees. The two terms are often synonymous although they can be separately defined. Consumer-driven health care usually refers to plans combining an employer funded health care spending account with the old concept of a major medical policy providing catastrophic coverage but with high deductibles. Defined contribution plans can be specifically defined as those where the employer establishes a standard amount available to employees for health care coverage and allows employees to make choices among various designs with any overages coming from the employee’s pocket (Nolin, 2004). In this study, consumer-driven health plans will be used as the umbrella term encompassing any plan designs that shift significant financial risk associated with health care decisions to the individuals making those decisions (Herzlinger, 2004; Regopoulos et al., 2006).

Sinnett (2004) described some of the options. “Health reimbursement accounts” are funded by the employer and made available for employees to use for health care costs. Unused funds can be carried forward for use in future years but if the account is used up, then excess costs will fall into the health insurance plan. “First dollar coverage plans” provide full coverage up to a certain dollar amount. Beyond that amount a substantial deductible must be met by the employee and, finally, costs above the

deductible are subject to significant coinsurance on the part of the employee. The goals are to encourage routine preventive care, award employees who use few services beyond that, and engage employees in decision making at all levels. “Cafeteria plans” provide employees with a fixed amount of credits to spend on benefits, including a variety of health care plans, and allow employees to add their own funds to purchase additional benefits. Health Savings Accounts were enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This Act enabled both employers and employees to invest pretax dollars into an account that can be used to meet health care expenses falling under a high deductible insurance plan. Withdrawals to meet health expenses are tax free, unused amounts can be carried forward for future use, and can be used tax free even after retirement (Robinson, 2005).

The theory behind these consumer-driven approaches is that if consumers realize they are spending money out of their own pockets they will make health care decisions that are more cost effective (Nichols, 2004). For example, high deductibles and coinsurance impact employees´ personal expenditures if more expensive providers are chosen to provide services available elsewhere at lower cost. This could develop a self regulating array of preferred providers reducing the burden on employers and insurance plans to manage such panels and do battle with employees over which providers should be included or excluded from the list of choices available to them (Robinson, 2003).

There is, in fact, a move underway in this direction as employers revise their health benefit programs to include higher levels of direct financial responsibility for employees at the point of service (Ginsburg, 2005). It seems that this consumer-driven model would directly address the key economic issue identified in the literature: rapid

growth of American health care expenditures has been driven for several decades by demand pull inflation because consumers have been shielded from price considerations by third party payment sources. Because this approach seems to address this economic principle that has been danced around by health policy makers for so long, and because its use is increasing, further serious consideration of the consumer-driven model is warranted. There are concerns and unanswered questions about consumer-driven health care and there are alternatives; but, none of the alternatives appear to be very attractive to American society: live with burgeoning health care expenditures that continue to constitute a larger and larger share of GDP; implement nationalized health care wherein political units ration services through budget caps; or return to a restrictive managed care model where insurance plans and employers ration care based on benefit plan designs.

Ethical Distribution of Health Services

Introduction

American health care expenditures are dramatically higher than those of other industrialized countries and have been rising rapidly. Major causes of this situation appear to have been employer and tax subsidized third party payment mechanisms that have eliminated natural price/demand controls and created moral hazard combined with a fee for service payment system that fuels producer driven utilization. To date, social traditions strongly valuing autonomy have made government rationing of service through limitation of supply a political impossibility. Private enforcement of restrictions on access to service through the managed care model enjoyed only temporary success but then was rejected as paternalistic, unjust, impersonal, and lacking in compassion for individuals in

desperate situations. American society has also traditionally implemented distribution based on contribution as its primary ethic with need as a secondary consideration. This has resulted in a health care system where better educated and higher income individuals are much more likely to be insured privately and significant needy populations are covered by government programs but more than 45 million citizens are not covered by either. One of the potential successors to the managed care model is consumer-driven health care.

Impact of Consumer-driven Health Care on Ethical Issues

In their most pure form, consumer-driven health plans combine high deductibles with tax-favored Health Savings Accounts (HSAs). In fact, deductibles must be very high, exceeding more than $1,000 per person and $2,000 per family per year before plans can qualify for use of an HSA. Enrollment in HSAs has been growing rapidly in recent years (Robinson, 2006) because both contributions and investment income are tax free if ultimately used for health care and because the accounts belong to employees who can accumulate funds from year to year if there is a surplus and can also take the account with them when they change jobs or retire (Burchfield & Battistella, 2003). There are also other plan design elements that shift more financial responsibility to employees including defined contribution plans where employers provide a fixed amount of financial support to employees who then choose among various insurance plans and pay any addition premium from their own pockets; higher deductibles and co-payments that do not reach the level required to qualify for an HSA; and coinsurance that requires consumers to pay a percentage of service costs after deductibles are met.

All of these models have two goals: one, to shift more of the responsibility for both health insurance premiums and first dollar costs from employers to employees and, two, to address moral hazard by giving consumers financial incentives to consider the price when deciding which health care services to use. Consumer-driven plans have expanded rapidly in recent years and one survey found that about two thirds of employers expected them to continue to become more prominent in moderating the inflationary impact of moral hazard on health care costs (Burchfield & Battistella, 2003).

Criticisms of consumer-driven health care seem to fall into two main categories. First, most health care expenditures are for catastrophic or chronic cases that far exceed deductibles (Fuchs & Emanuel, 2005; Robinson, 2005). Once the annual deductible is exceeded, or even is expected to be exceeded, services again become “free” in the mind of the consumer who might even have incentive to use more elective services in that year in the hope of staying under the deductible in succeeding years (Fuchs & Emanuel, 2005). This affect can be partially ameliorated by the use of coinsurance payments but will still apply to the many severe cases who exceed their annual out of pocket maximum (Robinson, 2005).

The second major criticism of consumer-driven health plans is that they favor younger, healthier, and higher income people who will be better able to pay high deductibles and coinsurance, fund savings accounts, and accumulate balances in them over the years. Lower income workers are much less able to meet higher out of pocket costs and may therefore be more likely to forego needed primary and preventive services or to go without health insurance at all (Fuchs & Emanuel, 2005). Proponents argue that lower income workers are already discriminated against by the current system and that

more employers are forced to drop health insurance coverage every year because of rapidly rising premiums. They suggest that consumer-driven plans will lower premiums in the short run and make the health care financing system more efficient in the long run thus allowing more employers and employees to afford health insurance. Various mechanisms have been used or suggested to moderate the negative impact on some segments of the population including sliding scale deductibles, mandating coverage, and waiving deductibles and co-payments for preventive services. It seems interesting that while one of the advantages of the consumer-driven approach is its congruence with American values for autonomy and contribution, modifications are deemed necessary to make it more paternalistic out of concern for the needy and doubts that consumers will make wise decisions regarding preventive services (Berenson, 2005).

Trends toward emphasizing outcome measurement in clinical medicine and personal responsibility for health have paralleled the beginnings of movement toward increased personal financial responsibility. Emphasis on analyzing evidence to predict likely outcomes from a particular treatment protocol, technology application, or prescription drug; estimating the costs of the procedures; and then comparing those outcomes and costs with those of alternative treatments clearly come from a consequentialist or utilitarian ethical construct (Wynia et al., 2004). The chances for consumer-driven health care to succeed in overcoming moral hazard to enhance decision making clearly hinge on the availability to consumers of accurate and understandable information regarding both clinical outcomes and cost. From a population wide perspective, it has been suggested that consequences be analyzed by policy makers using

measures that blend both quality and extension of life, such as "quality adjusted life years" (Wynia et al.,).

American society has demonstrated a strong predilection for autonomy, utilitarianism, individual responsibility, and distribution according to contribution. Consumer-driven health care seems consistent with each of these societal preferences. Individuals are given control over which services they purchase from which providers; have financial incentives to make cost effective choices; and have the opportunity to accumulate savings if they stay healthy, forego unnecessary or ineffective services, and make wise choices when they do need care (Burchfield & Battistella, 2003). Critics argue, however, that the U.S. health care distribution system already leans too far toward contribution and that the consumer-driven approach will drive financing even farther away from need considerations. Robinson (2006) expressed concerns that principles of consumer-driven health care while enhancing personal accountability will weaken societal feelings of responsibility for vulnerable citizens who are already underserved.

Reliance on the cultural values listed in the preceding paragraph has resulted in a health care system in the United States where 85% of the population has access to the most advanced medical care in the world but where the remaining 45 million residents are uninsured. This system has also facilitated a free riding effect wherein employers and individuals can choose not to sponsor or acquire health insurance coverage. While many of the uninsured are truly needy because of low income and lack of employer subsidized health plans, one study found that most of the uninsured with incomes more than 300% of the federal poverty level were young males with good earnings whose catastrophic care, if needed, was covered by the rest of society anyway (Menzel & Light, 2006). It appears

that consumer-driven health care, by itself, will not adequately overcome either lack of coverage for the needy or the free riding effect. Individual and employer mandates, such as those adopted in Massachusetts, along with expansion of public programs will probably be needed to address these issues (Menzel & Light).

Summary

It is interesting to note that several authors arrived at a conclusion that a combination of approaches would be the best way to reform the American health care system. They did not all arrive at the same combinations but there seem to be definite similarities in their findings. Cunningham and Hadley & Holahan (2004) concluded that while direct service through Community Health Centers should be maintained, expansion of access to insurance coverage through a voucher system would be the most effective way to improve health care for the currently uninsured. Fuchs and Emanuel (2005) favored a similar approach but went further in recommending that a federally funded voucher system guarantee universal basic coverage for all with individuals having choices among competing plans and the opportunity to purchase more extensive coverage from their own funds. Cunningham and Kirby (2004) made a strong case for the political and social effectiveness of expanding Medicaid to cover more children but also noted that consumer-driven style plans would also enhance access by making health insurance affordable for more small businesses and middle income households. Menzel and Light (2006) concluded that a three pronged approach is needed: mandated coverage to eliminate the free rider effect; tax financed subsidies for low income individuals; and heavy regulation of the insurance market to assure open access to objective information regarding prices, benefits, and effectiveness of alternative technologies and treatments.

Each of these models ignored, or at least failed to comprehensively address, the central issue of demand for service. Each would provide more buying power to more consumers without implementing controls on either demand or supply. Thus Americans are still left with four choices that each has undesirable characteristics: third party payment with rapidly escalating health care costs; return to tight managed care controls on supply; government rationing of supply through a nationalized financing and or delivery system; and substantially increased out of pocket expenditures at the point of service to curb demand.

The literature review has confirmed certain ethical principles that have been preferred (with modifiers) by American society. Autonomy includes not only the freedom to choose but the personal responsibility to make informed choices and to provide for one's own needs. Distribution according to contribution builds on the autonomy principle but has been modified by social safety net programs to assure that basic needs are universally met in areas such as food, housing, education, clean air and water, public transportation, and others. Combination of these preferences with a bias toward consequentialist or utilitarian decision models is manifest in an economic system that promotes private ownership and entrepreneurship while taxing income and property to protect natural rights such as those listed above and to provide for the common good through programs such as national defense.

Perhaps the authors cited earlier in this section were on the right track in recommending a combination of approaches. Vouchers enabling the poor to purchase basic health coverage would put health care on a par with other social needs. Mandated basic coverage could eliminate the free rider effect while encouraging more citizens to

appropriately use primary and preventive care. Defining basic coverage to include primary and preventive services plus catastrophic coverage for specialized and intensive services that requires substantial out of pocket payments at point of service could mitigate moral hazard by injecting standard price/demand dynamics. Strengthening federal approval standards for new technologies, including pharmaceuticals, to include added value or efficiency rather than just safety or effectiveness could greatly enhance the utility of research and development.

Proponents of consumer-driven health care contend that this approach is congruent with autonomy and personal responsibility and will address moral hazard and thus enhance accessibility by making health insurance more affordable. Opponents have cited two main ethical concerns: high out of pocket costs hit harder at low and moderate income households unjustly increasing the gap in accessibility by income level; and, the health care system is so complex both scientifically and administratively that consumers will be forced to make risky choices with inadequate information. However, as documented in this review, movement toward consumer-driven health plans in the form of higher deductibles and copayments, often in combination with a health savings plan, has already occurred and is accelerating. It seems prudent then that the public policy initiative should not be aimed at stopping consumer-driven health care but at incorporating its principles in ways that make use of its strengths while overcoming its potential ethical challenges. The combination of income based subsidies, mandated coverage, and more effective regulation described in the preceding paragraph would appear to accomplish this goal. Finally, many of the authors studied agreed that one of the keys to just distribution will be improved consumer decision making through easier

access to accurate information regarding both effectiveness and cost of health services and through stronger partnership with clinicians especially primary care physicians, nurses, and physician assistants.

Decision Theory

Information Processing

The inability of consumers to detect and recall the rapidly expanding amount of information available has been well documented by the findings of Kahneman & Tversky (1982), Hogarth (1987), and Galotti (2002). This limitation on capacity would seem to be a major impediment to successful decision making in a consumer-driven health care environment. Recent studies have supported this concern. Boscarino & Adams (2004) conducted an extensive study in New York State where information reporting the quality of providers is available from multiple sources including the state itself, insurance plans, public media, and the providers themselves. They conducted random telephone surveys of adults who demonstrated some knowledge of health services utilization in their household. In the initial round, ten01 surveys were completed during September, 2002. They were about 20 minutes in length and covered a range of health care topics including utilization of services, use of information in making health care choices, and experiences with the health care system. Six months later in March, 2003, 500 respondents were surveyed in a follow up using the same methods. The authors found that less than one fifth of the subjects indicated that they had used quality of care information when making their decisions.

Even with their strong need to find a new model for controlling health insurance premiums, employers recognize the information processing challenge. Many have expressed doubts that within consumer-driven plans employees will be able to sort through complex information and make good decisions (Christianson, 2002). Galotti (2002) found that accumulating large amounts of information was useless or even a negative unless there was an organized process for sorting and evaluating the data. Nolin & Killackey (2004) expressed even greater concerns that consumers would overestimate their own abilities to use health care information resulting in dangerous decisions. The likelihood of such events would be supported by a number of well researched decision theory biases including overconfidence, representativeness, and anchoring (Kahneman, Slovic, & Tversky, 1982 and Hogarth, 1987). It was interesting to note, however, that Boscarino & Adams (2004) found less than 25% of their subjects to be confident in health care decisions they had made. While this may seem to be in conflict with findings by Kahneman et al. that people tend to be unreasonably confident with their decisions, it may be further indication of just how complex health care decisions are.

Medical and scientific research have led to tremendous advances in knowledge and technology, but may have complicated decision making rather than enhancing it. Tunis (2005) noted a lack of user friendly information generated by the predominant model of clinical research. The system was designed around Federal Drug Administration requirements that new technologies must prove only that they are better than placebo and that possible side effects have been adequately documented. The system did not provide clinicians and consumers with information useful in choosing among technologies for effectiveness and cost efficiency.

An example may be useful in illustrating the complexity of information faced by consumers. Blue Shield of California stated its desire “to position itself as an entity that informs and supports consumers’ health care choices” (Robinson, 2003, p. 140). The company divided hospitals into choice and affiliate tiers, offered HMO and PPO products, and was planning to extend tiering to physicians, some of whom were capitated and some contracted on a fee for service basis. Benefits of their insurance plans then included a complex array of varying deductibles and copayments depending on whether the provider was choice or preferred, whether the insured chose the HMO or PPO product, and the size of the employer who sponsored the plan. Finally, getting to the information made available for consumer decision making, Blue Shield cited Leapfrog hospital quality improvement data, patient satisfaction surveys, outcome-based quality metrics, case mix severity cost indexing, and adjustments for the scope of capitated services or the hospital contractual arrangements for each physician group (2003, p. 140). Does Blue Shield really expect the average consumer to sort through this maze? In the face of supportive designs like this, it does not seem surprising that decision theorists, employers, and clinicians have all expressed doubts about consumers’ ability to effectively process information for health care decision making.

Availability

Individuals tended to assign higher frequency to occurrences if they were more publicized or more intensely experienced (Kahneman et al., 1982). For example, subjects tended to overestimate the frequency of car crashes because they were heavily publicized in the media and people who had been in a crash or eyewitnesses to a crash assigned even

higher frequencies. This bias appears to impact health care decision making as well. Boscarino & Adams (2004) found that subjects who had experienced adverse effects from perceived medical errors within 5 years of the survey were significantly more likely to use information about providers in making health care decisions. In addition, subjects who were better educated or who expressed major concerns about publicized health care issues were also more likely to use information when making decisions. While this could be helpful by encouraging more consumers to seek out and use information, it is also likely to cause them to focus on the most heavily publicized issues rather than on data that might be most relevant to their decisions (Galotti, 2002). Ginsburg (2004) noted strong resistance to the use of cost efficiency as a major criterion in health care decision making because of public perceptions that waste, greed, and abuse are rampant and should be attacked first as the primary solution to rising costs. This perception came from frequent media exposure for scandals, high prescription drug prices, and growing profit margins for health insurance companies and other health related businesses.

Choices versus Limits

It appears that the main reason for the short lived success of managed care plans in controlling health care costs and for the decline in the effectiveness of this approach in recent years has been backlash against strict controls and limitation of choices. Theorists argue that defined contribution plans and other consumer-driven approaches will increase individual's satisfaction by giving them more choices, even if they face increased financial consequences of their decisions (Christianson, 2002). Janis & Mann (1977) documented the increase in cognitive dissonance resulting from restrictions on choice.

Subjects felt less accountable for decisions as their freedom of choice was limited. As people perceived that their freedom to choose had been taken away they took steps to restore their ability to choose including passive resistance, ignoring restrictions, public action, or simply walking away from the decision. Such behaviors have been evident in the backlash against managed care. Consumers have hammered at their insurance plans, employers, and physicians until they received the services they wanted regardless of restrictions. Most physicians reported exaggerating symptoms to get approvals for tests or treatments on behalf of demanding patients (Sultz & Young, 2006). Employers have been overwhelmed by employee demands for greater choice and have sabotaged managed care plans' ability to control costs by broadening networks and eliminating gatekeeper requirements and prior approval requirements (Nichols, 2004).

The restrictive approach has also resulted in distrust of managed care plans. Americans have expressed their feelings that health plans focus only on cost reduction without regard for effectiveness (Ginsburg, 2004). Strong arguments can be made for a more participative approach. Janis & Mann (1977) found that participation in establishing the decision making process, parameters, and selecting alternatives improved compliance, reduced resistance, and enhanced satisfaction with the decision. More recent research, specifically in health care, has verified a correlation between the amount of patient participation in decision making and the level of satisfaction with the decision (Isen, 2001). Nolin & Killackey (2004) also cited findings that consumers were seeking stronger participation in health care decision making. There seems to be a strong theoretical basis for a move toward consumer-driven health care in terms of expanded choice, participation in decision making, and consumer satisfaction. Strong questions

remain, however, about consumers' capacity to sort information and their willingness to put forth the effort necessary to make good decisions. Among the most important concerns are where consumers will get their information and which information they will use.

Likely Sources of Information

Arguments continue that typical individuals do not have the capability to make effective choices in important health care matters such as treatment alternatives, health plans, and prevention of disease or injury. On the other hand, insurance plans containing high deductible and coinsurance provisions give consumers strong new incentives to make efforts to be better informed. In addition, relevant information has become more available through the internet. Data are available not only to describe diseases but to show the likely outcomes, risks, and costs of alternative treatments as well as the experience of physicians and hospitals in treating a particular condition (Winter, 2000).

The research of Boscarino & Adams (2004) gave indications of the type and sources of information preferred by health care consumers. Among all respondents, newspapers, television, and word of mouth were listed as the most common sources for information about both doctors and hospitals. However, the sources most likely to be used were reported as recommendations from family and friends and recommendations from health care professionals. The information sources perceived to have the lowest amount of credibility were insurance companies, the internet, and government agencies. Subjects listed the types of information they would use as the number of times a

physician had performed a particular procedure, how many times a physician had been sued, and whether a physician was board certified.

High exposure to television and newspapers plus strong reliance on recommendations from family and friends was not surprising, but should also be cause for concern in light of various tendencies documented in decision theory. Hogarth's (1987) research showed that people tended to start with a hypothesis and then select information to support it. Information was usually available from multiple sources and, because of humans' inability to process all of the available information; they tended to search for information that supported their predisposition. Preconceived notions about the relationship between two variables also had a stronger impact on decisions about relatedness than did objective evidence. In fact, objective evidence of correlation between the two variables was likely to be unnoticed or ignored unless it matched what the subjects expected to find (Kahneman et al., 1982). This research would also seem to indicate that individuals would have a tendency to scour the burgeoning information base available on the internet in search of information supporting their preconceived notions about the health care issue at hand. While the Boscarino & Adams (2004) study found low confidence in health care information on the internet, it would seem that further research is warranted on how consumers use the internet for health related information, especially since that information varies greatly in quality.

Other research has verified that physicians and nurses continue to enjoy a relatively high trust and confidence rating from the American public (Sultz & Young, 2006). This is impressive in the face of factors that would seem to erode that confidence such as shortened office visits, escalating malpractice suits and awards, and frequent

publicity regarding fraud and unnecessary procedures. In addition, through all of the shifts in financing and cost control methods, and even in socialized systems such as in Great Britain, physicians have remained in the very precarious position of being both provider and purchaser (through their orders and prescriptions) of services for patients (Kernick, 2000). Isen (2001) noted the importance of this positive, trusting relationship between physicians and patients and pointed out the potential for improved communication and more effective decisions as a result. Dowie (2002) also studied the importance of trust and decision making style within the physician patient relationship. He found that it was important for physicians to consider patient preference in each of three variables for relationships with clinicians: decision responsibility, information provision, and value clarification. Nolin & Killackey (2004) also found that consumers will need strong support from clinical experts in sorting and understanding available information if they are to be successful in making better health care decisions. Consumers will be faced with a huge amount of data, a very complex delivery system, and stressful decisions involving significant financial and quality of life risks. Nurses are well trained and positioned within the system to be a trusted and reliable source of decision support. The changing role of clinicians and their potential for prominence in a consumer-driven health care system will be discussed in the conclusions to this section.

The importance in a consumer-driven environment of managed care plans becoming a comprehensive and trusted source of current and accurate information useful in health care decision making was pointed out by several authors (Winter, 2000, Neuhauser, 2003, Nichols, 2004, Nolin, 2004, and Wisnicki, 2005). This would appear to be an uphill battle given consumers low regard for managed care plans (Boscarino, 2004

and Sultz & Young, 2006). It appears that much additional research is needed in this whole area of information resources for health conscious consumers. Very little research specific to health care decisions was found in important decision theory areas such as relatedness, anchoring, attribution, or decision making models used by health care consumers.

Impact of Attitude

Isen (2001) documented the impact of positive affect on decision making including greater flexibility and creativity applied to problem solving processes. Subjects with positive affect have consistently demonstrated enhanced thinking through consideration of a broader range of alternatives and more elaborative processes. In fact, their decision making was both more comprehensive and more efficient as long as the matter at hand was considered to be purposeful by the decision maker. Isen (2001) also found that people with a positive attitude were significantly less likely to attach themselves strongly to a preconceived position as a starting point for consideration of all information. Apparently, positive affect often modified the anchoring tendency described by Kahneman (1982) and others.

When specifically studying medically related decisions, Isen (2001) noted that people with positive affect were more efficient in their processes, less confused by complex data, better able to integrate the data, and more likely to go beyond the minimum requirements of the situation. She noted that positive physicians listened to their patients better and cited the importance of this trait in light of evidence that patients who felt they had more participation in medical decisions were more satisfied with the

outcomes. The author drew the conclusion that enhancing positive affect among clinicians could lead to greater opportunities for patient participation in decision making, more flexibility and creativity in medical decision making, and greater patient satisfaction. She related this possibility to the need for enhanced cost effectiveness in American health care noting that improved communication and trust could open the door to better economic decisions that would still be satisfying to the consumer.

These findings reinforce a substantial opportunity for positive impact on consumer decisions when combined with conclusions from the section above that physicians and other clinicians are trusted by American consumers and are a preferred source of health care information (Boscarino, 2004 and Sultz & Young, 2006). Isen's (2001) work also related to findings that people would not engage in a diligent effort at good decision making unless they perceived that serious consequences would result from their choice and believed that information or counsel was available that would lead to reasonable alternatives (Janis, 1977). Stated another way, "To be effective, incentives need to be combined with information, but information also needs to be combined with incentives (Robinson, 2003)." The implications are that positive affect on the part of physicians and other clinicians can reinforce the confidence level that already exists among most consumers thus making them more open to information and alternatives and leading to a more diligent effort at decision making. This effort in turn often leads to improved satisfaction with the decision.

What is the Definition of a Good Decision?

In the past, clashes between clinical considerations and economic factors have usually been decided in favor of pursuing the possibility of improved clinical outcomes, thus driving up the cost of health care (Kernick, 2000). Still, common wisdom among health care practitioners, administrators, and economists seems to be that if consumers and clinicians have accurate information available regarding the expected outcomes, risks, and costs of alternative courses of treatment, they will choose the most cost effective approach (Tunis, 2005). But what constitutes a good decision and will American consumers allow cost to be a significant factor in decision making? Ginsberg (2004) found substantial barriers to consumers embracing the cost effectiveness of individual treatments as a strategy but also some openness to the concept. A majority of the participants in her study were well aware of rapidly increasing health care costs and recognized that something must be done. Participants expressed strong trust in the motives and skills of physicians and support for physicians' ability to make individualized patient care decisions. Subjects stated that the primary reason for denying treatment should be that it did not meet the needs of an individual patient rather than it was not cost effective, and that issue should not even be discussed with the patient unless the patient's own money was being used for payment. Health plan guidelines should be allowed only if they are based on scientific evidence determined by an unbiased authority with no financial interest in the health plan. Ginsberg's (2004) conclusion was that while there were strong concerns about the role of cost effectiveness in treatment decisions, the time is right to begin discussing this factor with the public. It should be noted that these results of focus group discussions presumably conducted in California certainly cannot be

projected onto any larger population group. Nonetheless, this study does provide some evidence of cultural factors affecting health care decision making.

Health care economists might argue that the best decision is one that maximizes the ratio of resulting health improvements to resources expended. Decision theorists would counter that the success of a decision is measured by the decision maker's level of satisfaction and that satisfaction is determined by how well the outcomes met the decision maker's expectations (Kotler, 1986). Furthermore, theorists have consistently found that increased participation in goal setting and exploration of alternatives increased the likelihood of satisfaction (Janis, 1977, Kahneman et al., 1982, and Galotti, 2002). Dowie (2002) approached this question specifically in regard to health care decisions with concerns about assumptions that shared or informed decision making was the ultimate goal. He found that better decision making should be based on the patients' preferences for levels of information, clinician recommendations, and desired outcomes. It seems apparent that the movement to defined contribution health insurance plans will cause more consumers to add financial outcomes to their expectations for health care decisions as promulgated by the proponents of consumer-driven health care. Little research was found, however, to measure the extent to which economic factors will influence expectations and thus impact overall consumer satisfaction.

Summary

Concerns have been raised about consumer-driven health care in terms of humans' limited capacity for information processing; the biases and short cuts that result from this limitation; demonstrated low rates of information usage and confidence in

health care decisions; mistrust of managed care plans, government agencies, and the internet as sources of information; and resistance to considering cost as a criterion in health care decisions. There are, however, some indicators that consumer-driven health care is consistent with important aspects of decision theory. People rebel against limitations on their choices and are more satisfied with decisions when they participate in determining the goals and selecting the alternatives. People are also more likely to put diligent effort into decision making when they feel that their efforts will make a real difference and when they perceive a greater risk of loss. High public confidence in physicians and nurses is also a positive as it enhances the likelihood that consumers will seek out and listen to assistance from these knowledgeable sources when attempting to evaluate the vast array of information available. There is also some evidence that Americans recognize the need for more cost effective decision making in health care and are willing to participate in that decision making under certain conditions.

Diffusion Theory

Social change is a continuous process. In fact, in Sztompka's (1993) model static social structures did not really exist and social groups were seen not as defined structures but rather as networks of relationships in a state of constant flux as ideas, norms, and interactions changed. Traditions can emerge from a society because a few members adopt certain ideas and promote them or they can be imposed from positions of authority (Sztompka). Similarly, adoption of changes in a social group can be by individual choice, by collective consensus, or by authoritative edict (Rogers, 1983). Change resulted primarily from external forces, that is, crises that forced the society to change but internal

social movements were agents of change that promoted and dispersed it through society (Sztompka). Successful innovations diffused through society via a process that relied heavily on opinion leaders who were perceived by members to be knowledgeable, accessible, and in tune with the values of the group. Innovations were spread primarily through interpersonal communication and observation within the society rather than by governmental, scholarly, or mass media interventions (Rogers). Both Rogers (1983) and Sztompka (1993) found that innovations often produced unexpected and sometimes unwanted effects in a society.

Theories of social change and the diffusion of innovation have been supported by the evolution of the American health care system. Progress in health care has been defined by American society as the elimination or control of individual diseases or injuries leading to a highly specialized and fragmented approach to research, diagnosis, and treatment. Cultural traditions valuing entrepreneurship, private investment, and freedom of choice have stymied movements toward a nationalized or socialized health care system. Clinicians, especially physicians, have enjoyed unique power arising from the combination of their expertise and their close interaction with patients. They have institutionalized their authority through standardization of educational requirements and licensure laws. By their position as opinion leaders in society they have largely controlled the diffusion of innovations in health care. American political systems have followed an economic theory of government rather than a public good theory that has redistributed wealth to those able to deliver political support including physicians, hospital systems, pharmaceutical companies, insurance companies, and senior citizens (Starr, 1982).

Health system innovations, however, have had unintended consequences. Physicians' consolidation of power around specialized care and control of access to hospitals and insurance benefits as well as their opposition to a national health care system, ultimately led to the rise of corporate medicine. Development of each society is unique based on its own attempts to solve its problems and change results primarily from external forces, that is, crises that force the society to change. As cost increases became unbearable for employers, unions, and government programs they turned to managed care. Power dramatically shifted away from individual physicians and other providers toward private insurance plans, government payers, and consolidated corporate health care entities (Starr, 1982).

While the diffusion of the managed care innovation occurred rather rapidly, examination of the way it was introduced and diffused through American society reveals why its success was rather short lived. During the 1970s economic concerns and a Congress controlled by the Democratic Party combined to create some new momentum for a national health insurance plan. The Nixon administration was forced to find a more conservative approach that could be controlled by private enterprise; they chose HMOs. From this defensive, authoritarian start HMOs experienced only modest growth concentrated in a few communities such as Minneapolis-St. Paul where opinion leaders were active in recruiting early adopters to join the movement. These individuals freely chose to join HMOs because the emphasis on prevention, primary care, and cost control appealed to them. By the 1980s HMOs mutated into various managed care plans and found themselves positioned perfectly as national health care expenditures continued to expand at double digit annual percentage rates, physicians and hospital beds were in

excess supply, employers and politicians were overwhelmed by the cost increases (Brown, 2004). During the 1990s the rate of health care cost increases flattened and by the end of the decade more than 90% of privately insured Americans were in managed care plans (Lee, 2003). The change was an authoritarian one with most workers forced into managed care plans by their employers (Ginsburg, 2005). According to Rogers (1983) authoritative innovation decisions have been the most quickly adopted, but were also often resented and circumvented by members of the group. This appears to have been the case with managed care in America. During the 1970s and 1980s people who joined HMOs chose to do so because they perceived value in that choice. The roots of societal rejection of managed care controls lie in the fact that since about 1990 most people joined managed care plans involuntarily because that was the only choice available through their employer (Ginsburg, 2005). If managed care has been rejected by American society, where will it turn next to deal with burgeoning problems of cost and access? Will the innovations be diffused in an individual, collective, or authoritarian manner? Will they fit with the traditions and values of American society?

The theory behind consumer-driven approaches is that if consumers realize they are spending money out of their own pockets they will make health care decisions that are more cost effective. Additionally, it is thought that individuals will be more satisfied if they feel they have more control over their own health care choices and administrative burdens on employers will be reduced as employees take over more responsibility for managing health care choices (Christianson, 2002). For example, high deductibles and coinsurance impact employees´ personal expenditures if more expensive providers are chosen to provide services available elsewhere at lower cost. This could develop a self

regulating array of preferred providers reducing the burden on employers and insurance plans to manage such panels and do battle with employees over which providers should be included or excluded from the list of choices available to them (Robinson, 2003).

The time may be right for consumer-driven health care for several reasons. Premiums are rising rapidly again, motivating both employers and insurance companies to try new approaches. Consumers are better educated about products and services in general and seem interested to know more about health care and the internet has greatly enhanced information dissemination capabilities. In addition, consumers do not like to have their decisions constrained by external restrictions such as those imposed by managed care plans (Wisnicki, 2005). Among the keys to the success of this model are whether individuals feel truly empowered to make meaningful choices and whether they can be sufficiently well educated to make decisions that are both effective in meeting their health care needs and efficient in terms of cost (Nolin, 2004). Will trusted opinion leaders promote this approach and will there be sufficient numbers of early adopters to give this innovation the critical mass to diffuse through American society? What are the likely consequences, both intended and unintended, if this social change occurs?

How Does Consumer-driven Health Care Fit with Social Change Theory?

Perhaps the strongest indicator that consumer-driven health care may be the next change permeating the American health care system is the growing consensus that something must be done. Nichols, Ginsburg, Berenson, Christianson, & Hurley (2004) found broad agreement among various stakeholders that substantial change is needed to slow the increase in expenditures and resulting negative social impacts. Concerns over

rising health insurance premiums were consistently expressed by financial executives of private companies and about 70% of small to medium sized businesses listed health benefits costs as their number one challenge. Most of these firms indicated that shifting financial risk to employees was the best alternative available for controlling these costs (Sinnett, 2004). The mood of state legislatures has been demonstrated as they moved aggressively to curtail managed care restrictions. Federal politicians created Health Savings Accounts as part of the Medicare improvements of 2003 that are tax preferred when used with High Deductible Health Plans and President Bush listed expansion of those accounts as a priority for 2006 in his State of the Union address. Insurance plans are reeling from managed care backlash and are looking to get out of their position as deniers of care by moving to consumer-driven plans (Neuhauser, 2003). No research was found regarding provider opinions of consumer-driven health care, but physicians and other providers were leaders in the destruction of managed care controls and have consistently opposed a nationalized health system for more than a century.

There was also nothing found in the literature specifically describing individuals' attitudes toward consumer-driven health care or demonstrating their behaviors within such plans. There is ample research, however, documenting the connection between third party payment and increased use of services. "Health spending increases when someone other than the patient pays (Burchfield, 2003, p. 14)". Hadley & Holahan and Holahan (2003) found that people with insurance consumed about twice as much health care as people who were uninsured. Even in situations where government subsidized Community Health Centers were readily available, the insured consumed substantially more health care services than the uninsured (Cunningham, 2004). Proponents of consumer-driven

health care infer from these data that consumers who are directly responsible for paying a significant portion of the cost of services will reduce their consumption and will shop or negotiate for better prices. Perhaps even more incentive comes from the ability to accumulate tax deferred wealth by not using funds put away in Health Savings Accounts (Burchfield, 2003).

Managed care was rejected by American society in large part because its principles were contrary to traditions of open selection of providers by consumers, unencumbered clinical decisions by the physician, and fee for service medicine. Consumer-driven health care attempts to return to these traditions, but at a cost to consumers. While high deductibles and personal responsibility for routine, predictable items have not been traditional in health insurance, they are the norm for other types of insurance plans such as automobile or homeowners. Americans do not expect their auto insurance companies to pay for oil changes, new tires, or even worn out engines and when they have a collision, they expect to pay a significant deductible. Perhaps consumer-driven health care can be compatible with these expectations. Physicians, nurses, and other clinicians are well positioned to be opinion leaders and could push consumer-driven health care hard enough to engage early adopters. They meet all of the characteristics described by Rogers (1983) including that they are usually better educated, hold higher socioeconomic status, are more socially active, and have more external contacts. Opinion leaders are also viewed as knowledgeable on most subjects, accessible, and as representing social norms. Consumer surveys have rated physicians and nurses highly on these characteristics (Sultz & Young, 2006).

Social Challenges for Consumer-driven Health Care

The large majority of Americans who have either had employer sponsored private insurance or have qualified for government programs have become accustomed to comprehensive coverage at little out of pocket cost. Those who are better informed about health care economics and its impact on the economy in general are more likely to be open to consumer-driven models. Also, those without insurance or who perceive that they are in danger of losing coverage may be more amenable to this innovation. Change results primarily from external forces, that is, crises that force the society to change (Sztompka, 1993). Those who have no health insurance, fear losing it as costs escalate, or even fear losing their jobs if high health care costs send them to other countries, may feel that American society is forced to change its health care model. Whether they will embrace consumer-driven health care or push for more government control of health services remains to be seen.

Nichols et al. (2004) found a high level of doubt that consumer-driven health care could produce a substantial degree of improvement in the efficiency and effectiveness of the U. S. health care system. Even respondents from sectors that have strongly resisted nationalized health care in the past expressed concerns about another private sector model and its potential. Political and business leaders have now witnessed the failure of several highly touted models to achieve lasting control of costs or expansion of access. Perhaps the disappointments of indemnity insurance, capitated HMOs, and managed care restrictions on utilization have raised skepticism for private sector models to an insurmountable level. Nichols et al. (2004) reported that the vast majority of respondents

felt that the potential effectiveness of consumer-driven health plans would be stymied by lack of competition among providers.

A basic flaw in the concept of consumer-driven plans may be the inability of the approach to reduce expenditures among the 10% of Americans whose complex conditions result in more than 70% of total spending (Carpenter, 2006). A disproportionate share of health care expenditures is incurred by a small minority of consumers who would have exceeded even high deductibles and traditional out of pocket maximums (Robinson, 2005). Remler & Glied (2006) correctly pointed out that once out of pocket maximums are reached personal financial responsibility ends and incentives to shop for cost effective alternatives are lost. In fact, high deductible plans that do not also include significant coinsurance and high out of pocket maximums could be less effective than managed care plans that do include such provisions. In addition, consumers who have exceeded their deductible for the year, or who expect to exceed it for any particular year, might have financial incentives to seek additional services during that year (Fuchs & Emanuel, 2005).

The second major criticism of consumer-driven health plans is that they favor younger, healthier, and higher income people who will be better able to pay high deductibles and coinsurance, fund savings accounts, and accumulate balances in them over the years (Regopoulos et al., 2006). People who chose consumer-driven plans were younger and healthier than average leading to concerns that this adverse selection will drive higher premiums for traditional plans (Scheffler & Felton, 2006). Lower income workers are much less able to meet higher out of pocket costs and may therefore be more likely to forego needed primary and preventive services or to go without health insurance

at all (Fuchs & Emanuel, 2005). The RAND health insurance experiment also found that people who are without substantial financial resources or who suffered from chronic illnesses were disproportionately impacted by higher deductibles and coinsurance (Scheffler & Felton, 2006). Robinson (2005) expressed concerns that while increasing Americans' feeling of personal responsibility for their own health could be a positive result of consumer-driven health care, it may come at the expense of further deterioration of perceived responsibility for the health and welfare of more vulnerable members of society.

The third general area of concern revolves around whether the current health services market place structure will facilitate, or even allow, effective decision making by consumers (Scheffler & Felton, 2006). There is a huge knowledge gap between patients and providers, especially physicians, that is likely to cause consumers to rely heavily on provider recommendations and inhibit shopping (Saleh & Levin, 2005). Indeed, one of the keys to success for consumer-driven models is easy access to accurate information regarding the cost and quality outcomes of specific providers and procedures (Ginsburg, 2005). The whole concept of improving efficiency in the system by making individuals more accountable is jeopardized because consumers can not make cost effective choices if they do not have information on cost and quality and can not reasonably be held accountable for their choices if useful information is not available to them (Wynia et al., 2004). The RAND experiment found that while patients with higher out of pocket obligations used less care, they were no more likely to choose appropriate care than those with first dollar coverage (Fuchs & Emanuel, 2005).

Because of these concerns, much skepticism has been expressed regarding the overall impact of consumer-driven models. The 2003 round of the Community Tracking Study found a profound lack of confidence in market driven processes to improve the effectiveness and efficiency of the U. S. health care system (Nichols et al., 2004). Respondents predicted a cautious growth in consumer-driven health plans but expressed more faith in the likelihood that this approach would shift premium to consumers from employers than in the hope of causing consumers to make more economical choices overall. Later rounds of the study found continuing caution. Only 4% of the employers surveyed purchased consumer-driven plans during 2005 and typically less than 15% of their employees participated. Even employers who had adopted consumer-driven plans did not express confidence in them as the ultimate solution for health care costs and continued to place emphasis on other strategies (Regopoulos et al., 2006). Similar results were found in the Henry J. Kaiser Family Foundation survey. Only about 7% of employees worked for firms where benefits managers rated consumer-driven health plans as very effective in reducing expenditures, while about twice as many saw consumer-driven plans as very effective in shifting costs to employees. Managers representing about one in 10 employees stated that they were very likely to consider consumer-driven plans in the next two years while an additional 21% were somewhat likely to do so (Gabel et al., 2004). Few of the surveyed firms indicated confidence that any of the strategies would be highly effective in controlling costs although about 40% believed that each of the approaches would have some impact. Gabel et al. (2005) concluded that premium increases are not likely to slow down to a rate comparable to economic growth

and that the trend of decline in the portion of employers offering health insurance coverage is likely to continue.

Various studies found enthusiasm for disease management as a cost containment tool for employers and health plans. While high deductible plans transfer more of the first dollar risk from insurers to consumers, the concerns expressed above regarding high dollar expenditures by a relatively small proportion of the population have caused plans and employers to place more emphasis on strategies to contain these costs (Moran, 2005 and Regopoulos et al., 2006). Gabel et al. (2004) found that employers were most likely to choose disease management as a very effective tool for reducing health plan costs. In 2005 more than half of insured workers were enrolled in plans with active disease management protocols and that proportion was about two thirds among those employed by large entities with more than 200 workers (Gabel et al., 2005). It was interesting to note, however, that the authors tended to discuss disease management as an alternative strategy to consumer-driven plans rather than as a complementary one. It seems logical that not only would employers embrace disease management to address cost containment for employees who exceed their out of pocket maximums but employees in consumer-driven plans would also see this as a tool for both improving their quality of life and perhaps reducing their out of pocket expenditures.

Finally, the disparity in attitudes and adoption rates for consumer-driven plans between large employers and small ones seemed clear. High deductible plans supported by Health Reimbursement Accounts were offered twice as often by large firms as compared to small ones (Gabel et al., 2004). Large firms were also twice as likely to respond that they were very likely to introduce consumer-driven models in the near future

(Gabel et al., 2005). When small employers do offer consumer-driven models, they tend to follow certain patterns. Those who have offered consumer-driven plans have typically offered them as the only alternative for their employees and are more likely to increase deductibles and coinsurance without adopting Health Reimbursement or Health Savings Accounts because of concerns about administrative costs. Small employers with high salary employees reported more interest in Health Savings Accounts because of the tax benefits (Regopoulos et al., 2006).

Summary

Diffusion of consumer-driven health care should be consistent with key elements of social change theory. Political and business leaders should learn from societal rejection of managed care, the acceptance of expanding Medicaid through the Child Health Improvement Program (CHIP), and the successful diffusion of defined contribution retirement plans. It appears that managed care failed because it was forced on most consumers and because its restrictions were contrary to American social and economic traditions. CHIP was successful because the plight of near poor children was an appealing cause for large segments of society and because the relatively small cost of providing health care for these children could be diffused over a large number of taxpayers (Cunningham, 2004; Hoadley, 2004). Defined contribution retirement plans have been embraced by Americans because they have a greater feeling of control over their own accounts, because the plans were initially offered as an alternative to traditional defined benefit pension plans, and because both government and employers offered employees incentives to participate.

Plans with high deductibles and coinsurance should be offered by employers as an alternative to traditional managed care plans. Incentives for joining these plans would include lower premiums for the employee, freedom from restrictions on choice of providers and services, employer contributions to Health Savings Accounts, and the opportunity for employees to make tax advantaged additions to these accounts. Employers who do not offer any health benefits now may be able to offer this type of plan because their contributions would be defined allowing them to predict and control future expenditures. Following the CHIP model, it would seem possible to build public support for tax funded subsidies to support the enrollment of the working poor. Studies have shown that the cost of covering all of the uninsured would produce a relatively small percentage increase in total health care costs (Hadley & Holahan, 2003) and that providing health plan coverage is more effective than providing community health centers (Cunningham, 2004).

Insurance companies and employers should collaborate with opinion leaders to enlist their support in diffusing consumer-driven plans. Physicians, nurses, and other trusted clinicians should be included in the design and implementation of support systems that will help plan participants make more effective decisions. For example, disease management programs have already shown promising results in assisting consumers with chronic conditions such as diabetes or high blood pressure (Gabel et al., 2005). Diffusion theory (Rogers, 1983) suggests that as early adopters respond to incentives and opinion leaders by trying consumer-driven health plans, word of mouth will be the primary channel for spreading the innovation. Boscarino & Adams (2004) confirmed that health

care consumers are most likely to rely on information and recommendations from relatives, friends, and clinicians in making health care decisions.

Health system stakeholders at all levels should invest in information systems. If consumers are to make effective health care decisions, they need accurate and understandable information regarding the prevention and treatment of conditions as well as the capabilities, experience, outcomes, and cost of alternative providers. It seems appropriate for both federal and state government to enhance their abilities to monitor providers and disseminate useful information about them. As consumers bear greater financial risk, they will expect their insurance plans to have information readily available to support decision making (Neuhauser, 2003). Providers can enhance both their clinical and operational effectiveness by using their own Web sites to provide links to accurate information sources regarding disease management, prevention and treatment alternatives, and cost and outcome data. For example, patients could be much better prepared for physician visits if provided with online access to information, checklists, and possible questions related to their situation (Wisnicki, 2005). Finally, the research community can have a positive impact on the diffusion of health care innovations. Very little research was found studying the models individuals are likely to use in making health care choices within a consumer-driven environment or the factors businesses will consider when deciding whether to offer such benefit plans.

Methods of Investigation

Qualitative research, specifically case study, seems to be an appropriate tool to add to the understanding of this critical element of the health care system. Case study is

an empirical method of investigating both a contemporary phenomenon and its context. It relies on prior development of theory to construct its inquiry and often uses its multiple data sources to find redundancies that narrow the focus from a large field of variables (Yin, 1994). Multiple sources of data are available including company financial reports, health plan documents, and interviews with company owners and managers. Context is critical for this issue because while many small employers are concerned about employee health benefits for altruistic or human resource management reasons, they are rarely part of the mission statement or one of the key focuses of the business plan.

Case studies are particularly effective when the purpose of the research is to describe or explain in depth one or a small number of instances of a societal phenomenon (Babbie, 2004). The case study method is most appropriate for contemporary issues where the researcher has little control and where the research questions ask how or why a certain phenomenon exists. Research questions dealing with who was impacted, or how many, or how much are, on the other hand, best answered with quantitative analysis of surveys and documents. Some how and why questions can also be answered using history or experimental approaches, but experimentations can only be used if the researcher can control events. Histories (such as biography, ethnography, or phenomenology) and case studies may have some overlap but case studies deal more with contemporary issues and have the advantages of observing relevant events and interviewing participants (Yin, 1994). The grounded theory method could be applied here, but the objective is not to create new theory, rather to understand how the attitudes and actions of small employers will reflect existing theory. The relevant phenomena for this study are the decline in the proportion of small employers offering health insurance and the rising interest among

larger employers and insurance companies in high deductible consumer-driven plans. The researcher clearly has no control over the phenomena but does have the advantage of gathering data from multiple contemporary sources to understand how and why these trends have developed.

Case study methodology involves the study of a system of individuals, entities, or events defined by location and time. The researcher may study one system or several and gathers information from multiple sources. The focus may be on the case itself or on one or more issues using the cases for illustration (Creswell, 1998). The issue to be studied here is how high deductible consumer-driven health plans are viewed by small employers. There is, in fact, a move underway for employers to revise their health benefit programs to include higher levels of direct financial responsibility for employees at the point of service (Ginsburg, 2005). It seems that this consumer-driven model would directly address the key economic issue identified in the literature review: rapid growth of American health care expenditures has been driven for several decades by demand pull inflation because consumers have been shielded from price considerations by third party payment sources. Because this approach seems to address this economic principle that has been avoided by health policy makers for so long, and because its use is increasing, further serious consideration of the consumer-driven model is warranted.

Large databases have been maintained by both government agencies and private entities showing the amount, types, and costs of employer health benefit offerings. Quantitative analyses have also been conducted in this area, most notably the Kaiser Family Foundation Health Research and Educational Trust Survey of Employer Sponsored Health Benefits and the Community Tracking Study. Several of the studies

cited in the literature review drew their data from one of these surveys. However, the only results found specifically addressing the attitudes of small business toward consumer-driven health plans are described in the preceding paragraph from the studies conducted by Gabel et al. (2004 and 2005) and Regopoulos et al.(2006).

Neither Gable et al. nor Regopoulos et al. conducted primary research. Gable et al. used data from the 2005 Annual Health Benefits Survey conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. This survey provides a wealth of information regarding numbers of employers offering health benefit plans, types of plans offered, premium costs and benefit designs. It also categorizes data by employer size including findings from employers with less than 200 employees. It does not, however, go into any depth regarding employers' reasons for offering or not offering consumer-driven models; nor does it explore their specific thoughts or concerns about consumer-driven plans and whether they are an appropriate tool to expand the availability of health insurance coverage. Regopoulos et al.(2006) used information published by the Center for Studying Health System Change following its 2005 site visits as part of the Community Tracking Study. This Study provided significant information about the numbers of employers offering High Deductible Health Plans, the selections made by employees when alternative plans were offered, and the comparative premiums and other employer costs associated with consumer-driven plans versus managed care plans. No descriptions were provided, however, regarding employer attitudes toward consumer-driven plans or factors considered when making decisions about health plan offerings. Discussions with Center staff revealed that no other data regarding employer health benefit offerings had been gathered or published by the Center since 1997.

The proposed study will provide the type of thick description suggested by Geertz (1973) that is important to gain a deep understanding of the ways in which small employers will consider and make decisions about health benefit offerings. Geertz used an example of boys rapidly opening and closing one eyelid. He illustrated how this action could be a twitch, wink, sarcastic gesture, or have several other intentions. The purpose of a qualitative study would be to understand and provide a thick description of the phenomenon within the context of its culture, rather than to simply count how many boys were rapidly moving one eyelid. Similarly, another survey quantifying the proportion of small employers offering health insurance plans and the characteristics of those plans would add little knowledge to the field. Rather, the purpose of this study is to understand why small employers are offering, or not offering, consumer-driven health benefit plans. The proposed study will add depth of understanding to the questions that should be asked in future surveys regarding the design of health plans to be considered by small employers. The literature review gives an indication of what these considerations might be based on findings related to decision theory, ethics, social change, and economic theory. The proposed case studies will describe how the participants view consumer-driven plans and what factors they consider in making decisions about implementing such plans.

Conclusions

The American health care system has moved through a series of risk shifting phases. Prior to 1940 the financial risk of health care was born almost entirely by consumers who paid for care at the point of service. Philanthropic hospitals and

foundations attempted to meet the needs of persons unable to pay for care. Blue Cross and Blue Shield had their genesis in the 1930s, were followed by commercial health insurance companies, and by the 1960s when the Congress enacted Medicare and Medicaid the vast majority of financial risk for health care was shifted from the patients to third party insurance plans or government agencies. As the price of services approached zero in the perception of consumers demand became limitless and total expenditures for health care increased exponentially. By the 1980s both government budgets and employer resources were severely strained and both embarked on a new strategy of shifting financial risk to providers. Medicare initiated prospective payment systems and employers converted to managed care insurance plans that gave providers financial incentives to limit care and implemented financial penalties for failure to follow pre-approval policies or for seeking care outside of contracted networks. This approach enjoyed some temporary success as the growth in health care expenditures slowed to match the increase in total Gross domestic product during the 1990s.

Managed care failed, however, because Americans refused to accept the legitimacy or morality of restrictions placed on care by provider networks or insurance companies (Robinson, 2005). Health care expenditures reaccelerated to double digit annual percentages leaving political and business leaders to search for new cost containment strategies. One obvious alternative would be the approach taken by almost every other industrialized country: government control of supply through legislated funding priorities and rationing mechanisms. But Americans do not recognize the right of government to limit their access to care any more than that of insurance plans or employers (Robinson). If both managed care and a national system of rationing are

politically infeasible, two general types of alternatives remain: continue to fund escalating health care expenditures through higher taxes and product prices or shift more of the cost to the consumers at the point of service. A movement to implement the latter strategy is underway using the label consumer-driven health care.

The Bush administration demonstrated its support for the consumer-driven approach by including Health Savings Accounts in the Medicare Modernization Act of 2003. The sources cited above documented that deductibles and coinsurance levels have risen substantially in recent years and that more than four million Americans were enrolled in Health Savings or Health Reimbursement Accounts in 2006. Proponents of the consumer-driven approach argue that it is congruent with American social values for autonomy and personal responsibility; that it reduces moral hazard and brings essential price/demand equilibrium principles to bear in health care economics; and that Health Savings Accounts add value in the form of tax advantages, portability, and accessibility to funds. There are serious concerns, however, including the possibility that high deductible plans will have little impact on the majority of health care expenditures that are caused by a small percentage of consumers whose costs would exceed annual deductibles and out of pocket maximums; that patients lack access to and understanding of quality and cost data making it impossible for them to make effective choices among providers and services; and that consumer-driven plans discriminate unfairly against those with low incomes or chronic health problems.

The history of health insurance models (first indemnity plans and then managed care) showed that they were adopted when benefit managers felt confident in the value they would bring to the company and its employees and that they were first adopted by

large business and then diffused to smaller employers (Gabel et al., 2004). As documented above, significant numbers of large employers are interested in consumer-driven models but most are skeptical of their ability to solve cost escalation problems. Small employers are much more cautious about consumer-driven plans and especially Health Savings or Reimbursement Accounts. Most of the increase in the number of Americans without health insurance has been caused by elimination of health benefit offerings by small businesses (Gabel et al., 2005). It would appear that the current best chance to halt or reverse this trend could be the adoption of lower premium consumer-driven plans by small employers.

Many facets of consumer-driven health care are worthy of further study. One important area appears to be the level of awareness, understanding, and interest of small businesses as well as their attitudes and concerns toward consumer-driven plans. chapter 3 will describe the research design selected to pursue this area of inquiry focusing on the problem statement described in chapter 1.

CHAPTER 3: METHODOLOGY

Introduction

This chapter will describe the design developed to study the social change issue that is central to this dissertation: small employer attitudes toward health benefit offerings, especially consumer-driven health plans. It will explain why the case study method was chosen and how it was applied including protocol development, the selection of participants for this study, data that were gathered, analysis of the data, and presentation of findings. The research question for this study is as follows: How do small businesses make decisions regarding the offering of health insurance plans to employees? From the literature review it is clear that for most Americans, access to health services is dependent on employer subsidized health insurance. Rapidly rising premiums have driven many employers to eliminate plans, fueling the increase in the number of uninsured persons. Other employers have shifted the cost control strategy to one that relies more on employee cost sharing. If the United States is turning to consumer-driven plans to control costs and thus improve access, research is needed regarding the perception of such plans and models that will be used in related decision making. The need is particularly strong among small firms where nearly half of all Americans are employed (Helfand, 2007) and where access to health insurance has declined most rapidly (Kaiser, 2007).

Several theoretical concepts have converged to generate a high degree of interest in consumer-driven health care models. With regard to economic theory, several texts and articles were cited in chapter 2 holding that the primary driver of health care systems and

policies in the United States has been the employer-based third-party payment system that has neutralized normal forces of price/demand equilibrium. It was noted that many authors have discussed the likely impacts of consumer-driven plans on demand, price, and supply of health care services. On one hand, the high proportion of American health services that are financed by third party payment has created economic concerns while on the other hand the lack of coverage for about 15% of the population has generated ethical issues regarding the theory of just distribution. Two additional theoretical concepts are also strongly involved in assessing the ways in which consumer-driven health care is likely to affect the American health care system. Since the basis of this concept is that the system will become more efficient when consumers are given financial incentives to make more effective health care choices, decision theory should ground the study of how consumers (both individuals and employers) are likely to gather and process information related to these choices. Diffusion theory is also important here because the potential shift to consumer-driven models would be an innovation having major implications for American society.

Choice of Paradigm

Case study methodology involves the study of a system of individuals, entities, or events defined by location and time. The researcher may study one system or several and gathers information from multiple sources. The focus may be on the case itself or on one or more issues using the cases for illustration (Creswell, 1998). The issue studied here is how high deductible consumer-driven health plans are viewed by small employers. There is, in fact, a move underway for employers to revise their health benefit programs to

include higher levels of direct financial responsibility for employees at the point of service (Ginsburg, 2005). It seems that this consumer-driven model would directly address the key economic issue identified in the literature review: rapid growth of American health care expenditures has been driven for several decades by demand pull inflation because consumers have been shielded from price considerations by third party payment sources. Because this approach seems to address this economic principle that has been avoided by health policy makers for so long, and because its use is increasing, further serious consideration of the consumer-driven model is warranted.

Large databases have been maintained by both government agencies and private entities showing the amount, types, and costs of employer health benefit offerings. Quantitative analyses have also been conducted in this area, most notably the Kaiser Family Foundation Health Research and Educational Trust Survey of Employer Sponsored Health Benefits and the Community Tracking Study. Several of the studies cited in the literature review drew their data from one of these surveys. However, the only results found specifically addressing the attitudes of small business toward consumer-driven health plans are described in the preceding paragraph from the studies conducted by Gabel et al. (2004, 2005) and Regopoulos et al.(2006).

Neither Gable et al. nor Regopoulos et al. conducted primary research. Gable et al. used data from the 2005 Annual Health Benefits Survey conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. This survey provides a wealth of information regarding numbers of employers offering health benefit plans, types of plans offered, premium costs and benefit designs. It also categorizes data by employer size including findings from employers with less than 200 employees. It does

not, however, go into any depth regarding employers' reasons for offering or not offering consumer-driven models; nor does it explore their specific thoughts or concerns about consumer-driven plans and whether they are an appropriate tool to expand the availability of health insurance coverage. Regopoulos et al.(2006) used information published by the Center for Studying Health System Change following its 2005 site visits as part of the Community Tracking Study. This Study provided significant information about the numbers of employers offering High Deductible Health Plans, the selections made by employees when alternative plans were offered, and the comparative premiums and other employer costs associated with consumer-driven plans versus managed care plans. No descriptions were provided, however, regarding employer attitudes toward consumer-driven plans or factors considered when making decisions about health plan offerings. Discussions with Center staff revealed that no other data regarding employer health benefit offerings had been gathered or published by the Center since 1997.

The goal of this study was to provide the type of thick description suggested by Geertz (1973) that is important to gain a deep understanding of the ways in which small employers will consider and make decisions about health benefit offerings. Geertz used an example of boys rapidly opening and closing one eyelid. He illustrated how this action could be a twitch, wink, sarcastic gesture, or have several other intentions. The purpose of a qualitative study would be to understand and provide a thick description of the phenomenon within the context of its culture, rather than to simply count how many boys were rapidly moving one eyelid. Similarly, another survey quantifying the proportion of small employers offering health insurance plans and the characteristics of those plans would add little knowledge to the field. Rather, the purpose of this study is to understand

why small employers are offering, or not offering, consumer-driven health benefit plans. The study adds depth of understanding to the questions that should be asked in future surveys regarding the design of health plans to be considered by small employers. The literature review in chapter 2 gives an indication of what these considerations might be based on findings related to decision theory, ethics, social change, and economic theory. The case studies describe how the participants view consumer-driven plans and what factors they consider in making decisions about implementing such plans.

Qualitative research, specifically case study, seems to be an appropriate tool to add to the understanding of this critical element of the health care system. Case study is an empirical method of investigating both a contemporary phenomenon and its context. It relies on prior development of theory to construct its inquiry and often uses its multiple data sources to find redundancies that narrow the focus from a large field of variables (Yin, 1994). Multiple sources of data are available including company financial reports, health plan documents, and interviews with company owners and managers. Context is critical for this issue because while many small employers are concerned about employee health benefits for altruistic or human resource management reasons, they are rarely part of the mission statement or one of the key focuses of the business plan.

Case studies are particularly effective when the purpose of the research is to describe or explain in depth one or a small number of instances of a societal phenomenon (Babbie, 2004). The case study method is most appropriate for contemporary issues where the researcher has little control and where the research questions ask how or why a certain phenomenon exists. Research questions dealing with who was impacted, or how many, or how much are, on the other hand, best answered with quantitative analysis of

surveys and documents. Some how and why questions can also be answered using history or experimental approaches, but experimentations can only be used if the researcher can control events. Histories (such as biography, ethnography, or phenomenology) and case studies may have some overlap but case studies deal more with contemporary issues and have the advantages of observing relevant events and interviewing participants (Yin, 1994). The grounded theory method could be applied here, but the objective is not to create new theory, rather to understand how the attitudes and actions of small employers will reflect existing theory. The relevant phenomena for this study are the decline in the proportion of small employers offering health insurance and the rising interest among larger employers and insurance companies in high deductible consumer-driven plans. The researcher clearly has no control over the phenomena but does have the advantage of gathering data from multiple contemporary sources to understand how and why these trends have developed.

Research Design

Protocol and Data Gathering

The case study researcher should make a conceptual choice between a loose or tight framework. Qualitative studies traditionally take a more open approach to avoid researcher bias and enhance the breadth of data collection. However, Miles & Huberman (1994) recommended that the approach should be tailored to the situation: loose when studying an unknown culture or with little theoretical background, tighter for studying a specific phenomenon within a familiar culture and related to existing theory. In this case, protocols will be more structured because the researcher is studying the specific

phenomenon of employer health insurance offerings within the familiar culture of small business organizations. Miles & Huberman also noted that they particularly favor a tighter framework in multiple case analyses for more consistent and focused data gathering.

One of the defining features of case studies is that evidence is gathered from multiple sources. In this case those sources include documents, archival records, and participant interviews. Documents requested for these case studies include summary health insurance plan descriptions, agent proposals, and consultant memos. Archival records collected were health plan participation summaries and reports of premium experience and design changes. Documents and records were received covering at least the last 3-year period. Participant interviews were conducted using the template shown in Appendix A. While the protocol, or framework, was well defined based on clear research questions and relevant theories, the interview questions were not identical to the research questions and were constructed in a way that encouraged the participants to lead the investigator to data (Yin, 1994). Despite the emphasis on organization and structure, flexibility was emphasized to allow the interviewer to follow the lead of participants and draw out relevant information as the conversation proceeds (Miles & Huberman, 1994).

Role of the Researcher

For these studies, all data were gathered and analyzed personally by the researcher. He identified participants, requested data, and conducted interviews. The researcher is thoroughly familiar with both health care economics and with the small business community in the Ogden, Utah, area. The author has 24 years of experience as a

health system executive including positions as Chief Financial Officer, Chief Operating Officer, and Chief Executive Officer of regional referral hospitals in Indiana and Utah. He also served on the Board of Directors of the Ogden area Chamber of Commerce for 10 years and as that organization's President for seven years. He continues to be active in community economic development and service organizations and was aware of many small business owners who are concerned about health benefit offerings and would be interested in participating in the study. In addition, the author has previously conducted research on health systems, social change in American health care, health care decision making, health care economics, and the ethics of health care distribution. These studies have added greatly to the depth and breadth of his knowledge in these areas.

Given the expertise of the researcher and his access to potential study participants, it did not seem advisable to train and employ others to be involved in gathering data for this study. Participants were asked to gather data from their own archives, but the researcher conducted the analyses. The number of participants was manageable and direct contact with each participant gave the researcher maximum opportunity to observe both the verbal and nonverbal responses of the participants, follow the data, and modify the protocol as appropriate with each participant and from employer to employer.

Selection of Participants

The comments of Yin (1994) regarding pilot studies are particularly relevant to the design of this research study. He recommended the selection of one site for a pilot study on the basis of its accessibility and because it is expected to include a broad array of data relevant to the study. A well selected and conducted pilot study can begin the

process of finding themes in the data but can also lead to refinement of the protocols and the methods to be used over the remainder of the study. Abco (a disguised name) was selected as the pilot on the basis of Yin's (1994) advice that the pilot participant be accessible and expected to present a broad array of data. Abco's owner had previously expressed strong interest in the study of health insurance among small employers. The company is toward the larger end of the range of small employers with 110 full-time workers, is involved in light manufacturing which is the largest sector of the Ogden area economy, has a broad range of pay from less than $ten per hour for clerical staff to more than $30 for some skilled machinists, and has lengthy experience with health benefits plans.

In multiple case studies, purposeful sampling should be used rather than random sampling in order to select units with characteristics that will provide the optimal variety of data (Miles & Huberman, 1994). Creswell (1998) concurred with issue focus, multiple cases, and purposeful sampling with emphasis on maximum variation among units to provide an array of points of view. A single case study design can be appropriate when one case is considered to be a critical test of theory, an outlier, or revealing of new information; or for a longitudinal study. However, multiple case designs are often considered to provide more compelling evidence. Yin (1994) put less emphasis on variation among units; rather he recommended that six to 10 cases should be carefully selected either because they are expected to have similar experiences or because they are expected to have contrasting results that will support the research proposition. Miles & Huberman (1994) also seemed to be looking for both variety and redundancy, suggesting that units be selected for variation but looking for replication of results.

In this multiple case study this investigator looked for variety among the participating firms in terms of number of employees, types of businesses, rates of pay, and health benefit offerings. Findings from the pilot study were incorporated into the multiple case analysis. Six employers were chosen (including the pilot firm) including two with fewer than 50 full-time employees, two with between 50 and 100 full-time workers, and two with 100 or more full-time employees. Firms were also chosen to represent a variety of business types from both the manufacturing and service sectors and a range of employees from lower paid service or semi-skilled workers to more highly compensated skilled, technical, or professional staff. Additional participating employers, up to a maximum total of 10 as recommended by Yin (1994), were considered but it appeared that the saturation point had been reached as evidenced by the level of redundancy found in analysis of data gathered from the initial six and no gaps were identified or modifications made to the research protocol after the fourth interview. The general manager of each firm was asked to participate. Since these are small businesses, it is quite possible that the general manager may be the sole decision maker regarding the design of benefit plans but each general manager was also asked if there were others with substantial influence such as a financial officer, human resources officer, or benefits consultant. In each case except Crane Corp the general manager chose to participate personally. The Crane Corp manager designated the Vice President of Human Resources to be interviewed. Only Ben Black asked that another staff member be included in the interview, Billco’s Vice President of Administration and Finance. Interviews were conducted at each firm’s place of business except for Dan Darden, who asked to be interviewed at another location following a meeting he had there. Some entities were

approached but not selected. A financial services company and a manufacturer had health benefits and were interested but each had about 230 employees which exceeded the study parameter of 200. Two restaurants were approached but one did not offer health insurance for employees and the other had only members of the owners' family enrolled in the plan. A major appliance retailer also had only 3 enrollees who were all members of the owner's family. One company, a financial institution, declined to participate.

Ethical Protection of Participants

Privacy of participants and confidentiality of all data gathered were protected through strict adherence to the policies and procedures of the Institutional Review Board (IRB) of Walden University. Signed informed consent forms (Appendix B) fully and clearly disclosing the nature and purpose of the research, the participant's involvement, and all other IRB requirements were obtained from each participant before any data were gathered from that participant. Only the researcher was involved in data gathering and the names of participating employers and individuals were disguised in all transcripts, narratives, and addenda. A simple alphabetic coding system was used to identify the participants and these codes were maintained by the researcher only in password protected electronic files. Interviews were audio recorded and transcribed verbatim. Participant names were coded in the transcript and only the transcriptionist, in addition to the researcher, had access to the original recordings and codes. The transcriptionist signed a confidentiality agreement before receiving any data. The transcriptionist and researcher will each maintain electronic files of the transcripts on password protected computer drives. The transcriptionist will destroy her copies after the research is

completed. The audio tapes and paper copies of interview notes, interview transcripts, reports, and archival materials gathered from participants will be maintained by the researcher in locked file drawers for approximately three years. After three years tapes will be erased and paper copies shredded.

No members of vulnerable or protected groups participated in this study. No personal health information was gathered from any participants and no participants were asked to divulge any illegal activities. The only discernible risk is the potential for exposure of participating private employers' financial reports, aggregate health benefit plan performance data, or attitudes and strategies toward employee health benefit plans. This risk will be minimized by using the security procedures described above.

Analysis of Data

As suggested by Cromwell (2003), activities involved in the analysis of case study data included reading through all data to get a general sense of the situation, making margin notes, coding material into related categories, and selecting a few major themes that will shape the description of the setting and the findings. Standard qualitative analytic methods were applied including coding field notes, making notes in margins of interview templates and transcribed interviews, identifying patterns within the case, connecting with patterns in prior or subsequent field work, and developing generalizations that are consistent with both findings and prior knowledge (Miles & Huberman, 1994). Yin (1994) emphasized that while tools can be useful in manipulating or reshuffling data, it is most important to have a general analytic strategy to guide the process. The general strategies followed here were relating findings to the theoretical

propositions stated in the research purpose and questions and developing the case description as planned in the protocol outline (Yin).

The coding process was based on a provisional list of codes developed from the research questions and the research protocol. Codes may be added during field work and sub-codes may be developed as some master categories fill with large amounts of data. Miles & Huberman (1994) stressed the importance of this preliminary structure based on the conceptual framework and modified as findings developed. As they recommended, data gathered from one trip to the field were always coded before making the next trip. Data were analyzed using the pattern coding (Miles & Huberman, p. 68) process of identifying themes by mapping codes and sub-codes into patterns as they developed and then using the pattern codes to organize future field work. Since this is a multiple case study, pattern matching (Yin, 1994, p. 116) was used as an effective tool for descriptive studies where expected patterns are laid out in advance and will then be matched with patterns found in data gathering. For explanation building, a special type of iterative pattern matching (Yin) was applied wherein findings from an initial case were compared to research propositions, propositions (expected patterns) were revised as appropriate, findings from a second case were then compared to the revised propositions, propositions were revised again if indicated, and so on to achieve cross case analysis. If propositions are revised, materials from prior cases will be reviewed and recoded as appropriate.

Memoing was used during and following interviews to enhance analysis of data. Miles & Huberman (1994) gave a detailed description of the memoing process. Again they were firm about always writing down notes immediately, as soon as thoughts come to mind. Thoughts appropriate for memoing typically represent connections within the

data, contrasts, new threads, or relationships to propositions. Notes were captioned or coded just like transcribed interviews and other documents. As field work progresses, codes should stabilize indicating that data collection is reaching the saturation point. This typically occurs by about two-thirds of the way through the field work (Miles & Huberman). In this study no changes to master codes were needed after the fourth interview.

In this study, documents and archival records were requested from each participating employer well in advance of scheduling interviews. Documents requested for these case studies include summary health insurance plan descriptions, agent proposals, and consultant memos. Archival records collected were health plan participation summaries and reports of premium experience and design changes. Documents and records were received covering at least the last three year period. It is during this period that managed care controls have generally been weakened (Ginsburg, 2005; Nichols, 2004) and consumer-driven models have emerged (Ginsburg, 2005; Herzlinger, 2004). Three to 5 years of data were sufficient to recognize any related changes made by the participating employers. Analysis of the documents and records revealed significant changes in benefit plan designs, administrative strategies, or costs of premiums. These findings were noted on the interview template for that case and used to modify or expand the interview as appropriate.

Interviews with participants were audio recorded and transcribed verbatim. A copy of the transcripts was shared with the participants and they were asked to review them for accuracy. The interviewer also made notes on an interview template during each conversation with the participants. Information provided by the interviews was coded

using predetermined master themes following the pattern coding approach recommended by Miles & Huberman (1994) and Yin (1994). Master themes will include the following:

1. Cost and premium increases (PREM).
2. Increasing deductibles and coinsurance (HDHP).
3. Health savings accounts (HSA).
4. Benefits of high deductible/consumer-driven plans (PRO).
5. Concerns about high deductible/consumer-driven plans (CON).
6. Disease management (DM).
7. Future of health insurance benefits (FUT).

Analysis of the first two interviews with Abco and Billco executives as well as the Summary Plan Descriptions of those entities showed continuing use of strong managed care components in their health benefit plan designs. While these data could be categorized under the benefits or concerns about consumer-driven health plans, it appeared that a strong managed care theme might develop and, therefore, an MC code was added. Also during the first two interviews, two respondents made some significant statements about personal responsibility for health and the use of health care services. These were also initially coded under benefits of High Deductible Health Plans but it was felt that these comments related more to the executive's philosophy of health and benefits in general rather than narrowly to only consumer-driven health care concepts so the PERS code was added. Abco and Billco data were recoded using these two new categories which were then included among the master themes for coding of future data. Additional modifications were made following analysis of the Crane and Darden data. Large amounts of information were accumulating under the benefits (PRO) and concerns

(CON) regarding consumer-driven health plans categories. Review of the research questions indicated that the use of subcategories in these two areas would make sorting and analysis of related data more effective. PRO-HAZ was added to categorize items related to more diligent decision making in the use of health care services and avoidance of moral hazard when consumers have greater financial risk at the point of service. Positive employee feelings about broader networks and relaxation of strict managed care controls were recoded as PRO-FLEX. A CON-AI category was added to code concerns about adverse impact on low income, older, or chronically ill employees and issues relating to the lack of data regarding cost and quality of individual procedures and providers were relabeled under a CON-LACK code. Once again, data from all prior participants were recoded and these codes were added to the master coding scheme for future participants.

Because of the variety of data sources available and the personal involvement of the researcher in gathering and analyzing all of the data, software programs were not used to aid in the search for patterns in the transcribed interviews. This approach increases the importance of discipline in following the protocols described for gathering and analyzing data. Analyzing documents and records before interviewing informed the researcher about health benefit trends and changes made or considered by the participant. Starting the interview with open-ended questions (Appendix A, Questions 2-6) allowed the participants to voice feelings, concerns, and priorities in their own words without bias from the interviewer, especially regarding familiarity with and attitudes toward High Deductible Health Plans or consumer-driven models. Promptly summarizing each interview and using iterative pattern matching to analyze each interview transcript

facilitated appropriate modification of the interview template for future interviews, but maintaining discipline in gathering reports and documents and in starting each interview with open-ended questions promoted a fresh, unbiased experience for each participant.

Writing the Report

The report in chapter 4 describes not only the findings from the study but also important background elements of the case review. It gives a detailed description of the context for each case and of the participants as well as the process for gathering and coding data and for identifying issues and patterns. The report also explains the purpose for selecting each case and the participants from that site as well as the reasons for selecting the types of data to be collected. As part of the context, the report also describes the relevant background and experience of the researcher, any relationships he has with the participants, and the steps taken to gain access to the sites and participants (Creswell, 2003). As a multiple case study, this report includes some combination of single case analysis and cross case analysis. A multiple case report could be done in several different formats. Creswell (1998) suggested a detailed description of each case including themes found, followed by cross case analysis, then conclusions. This report more closely follows Yin's (1994) recommendation that the report emphasize cross case analysis and avoid overly detailed analysis of each case in order to keep the readers' attention and maintain focus on the most significant findings. The researcher also applied Miles & Huberman's (1994) suggested facilitation of final report writing through sequential analysis by summarizing individual cases immediately following the field work and creating a running draft of the cross case narrative.

The narrative of findings from this research emphasizes cross case analysis as recommended by several of the authors cited above. Exhibits include the interview template, consent form, and verbatim transcripts of each interview. Tables were constructed to summarize data from each case and to support the cross case analysis by illustrating consistencies or contrasts across participants related to the master themes. One format in particular, which Miles & Huberman (1994, p. 216) labeled as the "case-ordered predictor-outcome matrix" appeared to have potential for displaying findings from a study of small employers' health benefit offerings. With the likelihood to adopt higher deductible levels as the outcome, predictors were rated as found at the various sites such as number of employees, range of pay, or reasons for offering a health plan, for example. Conclusions were organized around the following expected findings based on the literature search:

1. Participating small business owners and managers will be concerned about their ability to continue offering health insurance benefits because of rising costs.
2. They will be somewhat unfamiliar with the terminology and concepts of consumer-driven health care and unlikely to fully implement them.
3. They are likely to offer only one health insurance plan.
4. They are likely to reflect the attitudes of large employers and health insurance firms who lack confidence in consumer-driven plans as the sole solution to health care issues.

In keeping with the traditions of multiple case study research, additional themes emerged as data were gathered and were included in the summary of findings as appropriate.

Summary

This chapter reviewed qualitative research traditions and explained why case study is the most appropriate model for this study. Multiple case studies will provide the thick description needed to understand the attitudes of small employers in the Ogden Utah area toward consumer-driven health plans. Participants were selected for variety in business type, numbers of employees, and rates of pay. Data were gathered from multiple sources within each participating employer including financial reports, administrative archives, and interviews. Data gathering protocols and data analysis were driven by propositions derived from the theoretical bases established in the literature review. Memoing, pattern coding, and iterative pattern matching techniques were used to analyze data gathered from multiple sources and multiple participants. As is standard with multiple case studies, propositions and master themes were expected to evolve as data gathering and analysis proceeded. The report of findings will provide a description of each case for context, but will emphasize cross case analysis organized around the research propositions.

CHAPTER 4: FINDINGS

Introduction

The purpose of this study is to describe attitudes of small businesses toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. Research questions for the study center around theoretical issues that have been identified in several fields and applied to the design of health insurance plans by several researchers. Specifically, to what extent do small employers implicitly or explicitly believe the theories and findings on which the movement toward consumer-driven models is based? Employees will be more diligent in their decision making when they perceive greater personal risk and will spend less when they have significant out of pocket costs at the point of service. People rebel against limitations on their choices and are more satisfied with decisions when they participate in selecting the alternatives. How does this impact small employers' decisions regarding the broadening of provider networks, relaxation of managed care controls, and divergence from the tradition of offering only one health benefit plan?

An additional question asked about the extent to which the potential negatives impact the employers' consideration of consumer-driven health plans. Will concerns about adverse impact on older, less healthy, or lower income employees factor into decisions about consumer-driven plan designs? Do small employers believe that employees will be unable to find or effectively process information regarding the relative cost and quality of alternative providers and services?

The purpose of this chapter is to report the findings of the research that was conducted. The study participants and the manner in which they were selected will be

described. Methods for gathering, coding, and analyzing data will also be explained. A brief summary of the data gathered from each participating entity will be presented, but the focus of the findings will be on cross case analysis (Yin, 1994). Integration and analysis of data from the several cases will be organized in three ways: first, in comparison with the expected findings that were gleaned from the literature search and listed in chapter 3; second, around the research questions formulated in chapter 1; and, finally, with reference to the master themes established before and during coding of the data as described above in this chapter. This analysis will include summaries of findings as they relate to expected findings, research questions, and master themes but will reserve expression of conclusions and implications for chapter 5.

Organizations in the Sample

Participants were selected by closely following the criteria set out in chapter 3. Table 1 shows that firms were chosen for variety in terms of number of employees, to represent business types from both the manufacturing and service sectors, and a range of employees from lower paid service or semi-skilled workers to more highly compensated skilled, technical, or professional staff.

Table 1

Background Information on Participating Organizations

Company	Type of Organization	Total Employees	Employees in Health Plan	Range of Pay Position Types
Abco	Manufacturing	110	110	Clerical/janitorial $10/hour Skilled machinists $55,000/year Supervision/mgt $60.000 to > $100,000
Billco	Collection service	90	80	Clerical <$10/hour Phone collectors and support staff $25,000-50,000/yr Collections specialists and management >$100,000/year
Crane Corp	Social service agency (not for profit)	54 Full-time 30 Part time	34	Clerical <$10/hour Social workers and job coaches $30,000-50,000/yr Management >$50,000/yr
Darden	Laundry	100	80	Production workers $8-12/hr Drivers, sales, supervisors > $50,000/year
Franklin Foods	Retail groceries and household goods	32-35 Full-time 50 Part time	19	Cashiers, stockers $9-13/hour Department managers $32,000-50,000/year
Gray Mortuary	Funeral services	18 Full-time	8	Clerical and support $11-13/hr Professional funeral directors >$50,000/year

Potential participants were approached by telephone, given a brief overview of the study, and asked if they would be interested in participating. They were then asked if they had a health insurance plan, how many individuals they employed, and how many were participating in the plan. Some entities were approached but not selected. A financial services company and a manufacturer had health benefits and were interested but each had about 230 employees which exceeded the study parameter of 200. Two restaurants were approached but one did not offer health insurance for employees and the other had

only members of the owners' family enrolled in the plan. A major appliance retailer also had only 3 enrollees who were all members of the owner's family. One company, a financial institution, declined to participate. Table 2 summarizes this information.

Table 2

Summary of Organizations Considered for Study

Organizations identified	25
Organizations approached	12
Organizations willing to participate but found to have more than study parameter of 200 employees	2
Organizations willing to participate but found to have only family members participating in health plan	2
Organizations found to have no health insurance plan	1
Organizations that declined to participate	1
Organizations participating	6

Each participant was provided with a copy of the consent form (Appendix B) and given the opportunity to ask questions regarding the scope of the study, requirements for their participation, or any other questions regarding the form. Each participant signed a copy of the form. At the time consent was received, participants were asked to provide access to the health plan records described in the Procedures section of the form.

Data Collection

Records

Each participating organization was asked to provide documents showing trends within their health insurance benefits during the last 3 to 5 years. Each company was able to provide records showing premium levels, the employee and employer portions of those

premiums, employee participation, coverage levels, deductibles, coinsurance levels, and copayment amounts over a period of at least 3 years. Except for Abco, the participants were not able to provide data on claims paid or loss ratios because Utah insurance regulations do not require carriers to report that information individually for groups with less than 200 employees. Participants were queried as necessary to fill gaps in the requested data or to reconcile discrepancies. Response from all of the participants was excellent.

Documents were analyzed and summarized for each entity prior to scheduling the interview with their representative(s). These analyses are presented in both narrative and tabular form in the summary of each case that is presented later in this chapter. In all instances document summaries were used in preparation for the interview, notes were made as appropriate on the interview guide, and a copy of the summary was carried into the interview for reference as necessary.

Interviews

Interviews were schedule at a time and place chosen by the participants. All were conducted in the office of the participant with the exception of Dan Darden. Darden was interviewed in a private meeting room at the Ogden Golf and Country Club at his request because he had other meetings at that facility on the day of the interview. In all cases except for Crane Corp, which is a not for profit corporation, the owner of the organization was also its general manager and chose to participate personally. The names (disguised) and positions of participants are listed in Table 1 above. Interviews ranged in length from 35 minutes to more than an hour, averaging about 45 minutes. Each

interview was audio recorded and transcribed. Only minor corrections were made where spoken words had been misunderstood and there were no substantive changes or additions to the content of the original transcriptions. Participants were sent copies of the transcript for review and comment. No changes to the transcripts were requested by the participants. Copies of the transcripts are included herein as Appendixes C through H.

The same predetermined interview template (Appendix A) was used as a guide in conducting each interview. The interviewer made appropriate notes on each template from the information gathered during the review of documents provided in advance by each company. Interviews began with open-ended questions designed to give opportunity for participants to express their most important feelings about health insurance benefits without prompting. These were followed by more specific questions regarding factors considered in health insurance plan decision making as well as the purported advantages and disadvantages of consumer-driven models as found in the literature review presented in chapter 2.

While the protocol was well defined based on clear research questions and relevant theories, the interview questions were not identical to the research questions and were constructed in a way that encouraged the participants to lead the investigator to data (Yin, 1994). For example, the first research question asks to what extent small employers implicitly or explicitly believe the theories and findings on which the movement toward consumer-driven models is based. Information relative to these beliefs was gathered by asking participants how they and their employees feel about their current health plan (Questions 2 and 3); what elements of consumer-driven designs they consider to be attractive or cause for concern (Question 10); and how likely they will be to consider

consumer-driven plans and which factors will be most important in their decisions (Questions 11 and 12). Despite the emphasis on organization and structure, flexibility was maintained allowing the interviewer to follow the lead of participants and draw out relevant information as the conversation proceeded (Miles & Huberman, 1994).

The researcher kept notes during each interview and drafted a brief summary as an addition to the document analysis as soon as possible following each interview. After the transcript was proofread and corrected a copy of each transcript was coded using predetermined themes, modified where appropriate, as described in the following section.

Coding

Information provided by the interviews was coded using predetermined master themes following the pattern coding approach recommended by Miles & Huberman (1994) and Yin (1994). Initial master themes included the following:

1. Cost and premium increases (PREM).
2. Increasing deductibles and coinsurance (HDHP).
3. Health savings accounts (HSA).
4. Benefits of high deductible/consumer-driven plans (PRO).
5. Concerns about high deductible/consumer-driven plans (CON).
6. Disease management (DM).
7. Future of health insurance benefits (FUT).

Master themes were modified during the data gathering process using iterative pattern matching methodology (Yin, 1994). Analysis of the first two interviews with Abco and Billco executives as well as the Summary Plan Descriptions of those entities showed

continuing use of strong managed care components in their health benefit plan designs. While these data could be categorized under the benefits or concerns about consumer-driven health plans, it appeared that a strong managed care theme might develop and, therefore, an MC code was added. Also during the first two interviews, 2 respondents made some significant statements about personal responsibility for health and the use of health care services. These were also initially coded under benefits of High Deductible Health Plans but it was felt that these comments related more to the executive's philosophy of health and benefits in general rather than narrowly to only consumer-driven health care concepts so the PERS code was added. Abco and Billco data were recoded using these two new categories which were then included among the master themes for coding of future data. Additional modifications were made following analysis of the Crane and Darden data. Large amounts of information were accumulating under the benefits (PRO) and concerns (CON) regarding consumer-driven health plans categories. Review of the research questions indicated that the use of subcategories in these two areas would make sorting and analysis of related data more effective. PRO-HAZ was added to categorize items related to more diligent decision making in the use of health care services and avoidance of moral hazard when consumers have greater financial risk at the point of service. Positive employee feelings about broader networks and relaxation of strict managed care controls were recoded as PRO-FLEX. A CON-AI category was added to code concerns about adverse impact on low income, older, or chronically ill employees and issues relating to the lack of data regarding cost and quality of individual procedures and providers were relabeled under a CON-LACK code. Once

again, data from all prior participants were recoded and these codes were added to the master coding scheme for future participants.

Synthesis: Cross Case Analysis

Following the recommendations of Yin (1994), primary emphasis in summarizing the findings will be placed on cross case integration and analysis. Detailed summaries of findings from each case can be found below in the Case Summaries section. Integration and analysis of data from the several cases will be organized in three ways: first, in comparison with the expected findings that were gleaned from the literature search and listed in chapter 3; second, around the research questions formulated in chapter 1; and, finally, with reference to the master themes established before and during coding of the data as described above in this chapter. For consistency and ease of understanding, all disguised names have been devised using alphabetic notation. So, for example, names related to the first participating organization all start with A (Abco, Art Adams); all references to the second case start with B (Billco, Ben Black, Barbara Barney); and so on throughout the cases.

Expected Findings

1. Participating small business owners and managers will be concerned about their ability to continue offering health insurance benefits because of rising costs.

This appeared to be a safe prediction given the level of publicity over high and rapidly rising health insurance costs in both the popular media and business media. In fact, each of the participants did mention high cost as the number one factor in their decisions regarding health insurance benefits. All except Art Adams mentioned their concerns about premium increases and reducing benefits even before being asked about

factors that impact their decision making. In anticipation of this overriding concern, the interview template was designed to draw out any other factors that the participants gave consideration to in their health plan decision making. At the same time, none of the participants indicated that they were likely to discontinue their health insurance benefits in the foreseeable future. Fred Field, however, did mention several times that he would have to discontinue if his other tactics failed to moderate premium increases to a reasonable level. Participants commonly cited competition for workers as the main reason for continuing the benefit even in the face of high premiums. Actions the participants would take in lieu of discontinuing their plan are displayed in Table 3.

Table 3

Participant Responses to Questions Regarding Continuation of Health Insurance Benefits

Participating entity	Likely to discontinue?	Reason for continuing	Likely tactics if premiums jump
Abco	No	Union contract Competition for skilled machinists	Increase deductibles Disease management
Billco	No	Competition Owners' family needs it	Increase deductibles Increase employee share of premium Change carriers (last resort)
Crane	No	Supplements low pay of social workers Helps recruit and retain staff Needed by single parents	Higher deductible combined with health savings account Raise employee coinsurance
Darden	No	Right thing to do Employees value it	Increase employee share of premium (already at very high deductible)
Franklin	No	Employees, including family of owner, need it	Increase employee share of premiums Increase deductibles and copays Shop for a new carrier Discontinue benefit
Gray	No	Wants employees to have coverage Owner's family needs it	Increase deductibles Consider health savings account

2. They will be somewhat unfamiliar with the terminology and concepts of consumer-driven health care and unlikely to fully implement them.

Among the interviewees, only Barbara Barney recognized the phrase consumer-driven health care. All of the participants, however, demonstrated understanding of health savings accounts and, except for Gary Gray, recognized that a high deductible health plan was necessary in order to implement a qualified, tax advantaged health savings account. Each already has some elements of a consumer-driven design in place in the forms of significant deductibles and/or coinsurance, but none has implemented a health savings account.

Abco and Billco indicated that they would be unlikely to significantly increase deductibles, coinsurance, or implement a health savings account, but for different reasons. Abco's union leaders are adamantly against a health savings account because, in the opinion of Art Adams, it would dilute their control over the benefits trust fund. Naturally, they have also resisted efforts to increase deductibles or coinsurance but recognize that incremental increases may be necessary to keep the costs of the plan within the amount of funds allocated under the contract. Both Ben and Barbara of Billco repeatedly stated their opinions that a high deductible, health savings account plan would not work for their employees. They see the lack of a deductible on services provided by preferred providers as a major satisfaction feature for their current plan. Billco's workforce is predominantly very young, with an average age estimated at 26, and it is the owners' opinion that they tend to live paycheck to paycheck and, because of their youth and good health, have neither the skills to make good health care choices nor an interest in acquiring those skills.

Crane was the only participating entity to indicate that it is actively considering implementation of a health savings account. Carly Carr recognized that their current plan is somewhat rich, with relatively low deductibles and coinsurance and was concerned about the rising premiums which are now in excess of $1,000 per month for family coverage. She has asked their broker for proposals showing how much they could reduce the premium by going to a high deductible plan in order to determine whether the savings will be sufficient to adequately fund a health savings account for each employee. Gary Gray was least familiar with health savings accounts but he did receive some comparative pricing for qualifying High Deductible Health Plans from his broker in 2006. Gray did double its deductible that year from $250 to $500. During the interview he indicated that he would look at health savings accounts again as an option for 2009. Darden and Franklin already had high deductible plans in place. Darden was unlikely to implement a health savings account because of lack of employee interest. Franklin has not seriously considered it because premium increases have been very low in recent years, but he indicated that he would consider a health savings account if things change in the future. Both Billco and Darden cited lack of participation in their tax advantaged defined contribution retirement plans as evidence for lack of interest in a participatory health savings account.

3. They are likely to offer only one health insurance plan.

None of the participating firms offered alternative health insurance carriers to employees, but some did offer more than one plan from the same carrier. Crane offered a swing out option through the same carrier which meant that employees have the choice of a plan with greater access to out of network services but with higher deductibles and

coinsurance. Darden had the same option available but employees were required to pay the full difference in premium and none chose to do so. Gray offered three plans from the same carrier. The plans had identical designs but an increasingly broad array of in network providers with corresponding increases in premiums. Ben Black (Billco) indicated a preference for offering alternatives through either an alternate carrier or a high deductible health plan but stated that it was not practical for an employer of his size.

4. They are likely to reflect the attitudes of large employers and health insurance firms who lack confidence in consumer-driven plans as the sole solution to health care issues.

While each of the participants expressed support for the concept of greater consumer financial responsibility for health care at the point of service, none of them indicated confidence that this approach alone would manage the cost of their own health benefits or that it would solve the problem of rapidly increasing national health care expenditures.

Art Adams may have stated it most directly:

> If we went to higher deductibles, it would certainly help the plan out considerably and it would also give them a better deal when they have a catastrophic illness. That really, as far as our plan is, is the way I see it. Most of these people make pretty good income and routine office visits and things aren't going to kill them. What they need is coverage for the catastrophic things. It is hard to get that message across…. Unless we are in dire straits, it is a tough one to crack.

The participants demonstrated these beliefs through the design of their existing health benefit plans, the types of changes they are considering, and their opinions about the future of the health care system in the United States. Each of the participating entities has incorporated some elements of consumer-driven design into their health benefit plan,

as described above, but each also retains strong elements of managed care controls. All have a network of preferred providers under contract through their insurance plan with substantial financial penalties for using out of network providers. Standard plans at Crane Corp (Select Med) and Darden (Peak) provide no coverage at all for out of network services except for emergencies. All of the plans require prior authorization for hospitalization and for selected expensive outpatient surgeries, diagnostic procedures, and therapies. Abco's plan includes a gatekeeper requirement whereby beneficiaries must have a referral from their primary care physician in order to have coverage for specialist services. Abco has also already contracted with an administrator for implementation and direction of a disease management program.

When asked about changes under consideration for their health plans, all of the participants, except Darden which already had a very high deductible, had multiple strategies in mind as shown in Table 3. Only Crane and Gray focused entirely on consumer-driven tactics such as increasing deductibles and coinsurance and implementing a health savings plan. The others all listed increasing the employees' share of premium costs as a primary strategy and Abco also discussed enhancement of its disease management program. None mentioned a tightening of managed care controls, but neither did they indicate that they were likely to broaden networks or eliminate prior approval requirements.

Each of the participants responded that consumer-driven designs will assist small businesses in continuing to offer health benefit plans for employees. Fred Field indicated that the move to a $1,000 per person deductible three years ago had been instrumental in his ability to continue offering health insurance benefits. Gary Gray stated that increasing

the deductible at the beginning of 2006 was a factor in reducing premium increases during the succeeding three years. Art Adams noted that some of Abco's competitors did not offer employee health insurance as start up businesses but are now forced to do so in order to compete for skilled workers. They are offering high deductible plans to keep the premiums affordable and Art felt that small businesses in other industries and other parts of the country will likely be forced to follow the same strategy. Dan Darden has already demonstrated his belief in this concept by implementing a high deductible health plan and Carly Carr backed up her positive answer to this question with her unprompted comments regarding the value of health savings accounts. It was telling, however, that when asked to comment on the future of health insurance in the United States, none of the participants indicated that the system will move or should move to a pure consumer-driven model. Comments in this regard are summarized below in the Future of Health Insurance Benefits section.

In summary, as expected all of the participants quickly stated that their chief concern regarding health insurance benefits was the high and rising cost of premiums. However, none indicated that they were likely to discontinue health benefits in the near future and each listed strategies they will use to cope with rising costs as shown in Table 1. The expectations that participants would be unfamiliar with consumer-driven health plan terminology and unlikely to fully implement consumer-driven designs were met. All but one of the organizations had implemented elements of consumer-driven design in the forms of higher deductibles and coinsurance, but none are likely to incorporate health savings accounts in the near future. An unstated, but implied, expected finding was that

all of the firms have retained and expected to continue managed care elements in their health plans.

The expected finding that the participating small employers would offer only one health insurance plan was partially met in that each organization offered only one insurance carrier, but three of the six did offer optional plans from the same carrier. Expectations that participating small businesses would be likely to reflect the attitudes of large employers and health insurance firms who lack confidence in consumer-driven plans as the sole solution to health care issues were met. There was an additional finding, however, that was not anticipated but flows logically from the combination of the expected findings with the elements of social change theory described in chapter 2. Several of the participants reported strong evidence of passive or active resistance to increasing deductibles and coinsurance. The implications of these findings will be discussed in chapter 5.

Research Questions

Question 1. To what extent do small employers implicitly or explicitly believe the theories and findings on which the movement toward consumer-driven models is based? Employees will be more diligent in their decision making when they perceive greater personal risk and will spend less when they have significant out of pocket costs at the point of service. People rebel against limitations on their choices and are more satisfied with decisions when they participate in selecting the alternatives.

Each of the participants indicated that employees would be likely to consume fewer and less expensive health care services when they have higher out of pocket cost at

the point of service, but to widely varying degrees. Dan Darden and Carly Carr both demonstrated explicit support for the concept but each also expressed significant drawbacks. Darden had already implemented a high deductible health plan based on his belief in this economic theory, but strongly suspected that many of his employees are circumventing the system by seeking care in hospital emergency rooms without disclosing that they have health insurance. Carr was actively pursuing a high deductible plan with a health savings account to counteract what she perceived as overuse of health care services caused by an entitlement culture among Crane's employees. However, she also feared that a significant number of employees might drop their insurance coverage if a high deductible plan were implemented. Fred Field had also already implemented a high deductible and stated that he would not hesitate to go higher if that was necessary to maintain a reasonable premium level. He did mention that more employees might drop the plan if deductibles were raised again, but was more concerned about being able to continue the plan at all. Gary Gray had also demonstrated his belief in the relationship between deductibles and utilization by doubling deductibles in 2006, although they were still only at about half the level defined by federal standards for High Deductible Health Plans. Art Adams probably expressed the closest alignment with this theory when he stated that both his company and the employees would be better off if they recognized that they could have more comprehensive insurance and better protection against catastrophes if they opted to pay more directly for minor items. However, he faced opposition from union leaders to more fully implementing that approach. Ben Black and Barbara Barney were at the opposite end of the spectrum. They gave implicit credit to the approach when they mentioned that premiums would go down significantly with a high

deductible plan and that employees do not care what they are spending because they are not paying for it. They were explicitly adamant, however, in their rejection of the practicality of implementing the theory because of their belief that the large majority of their employees would not make good health care choices, even with greater out of pocket liability for those choices.

Each of the participants saw broadening the network of preferred providers and reducing managed care restrictions as an important factor in choosing a health plan, but none of them saw a strong connection between consumer-driven design and an increase in employee choice. All of the participants reported that their insurance plans have broadened provider networks and reduced restrictions. Billco even changed insurance plans in 2004 for that purpose. Each participant also gave their opinion that employees were well satisfied with the providers and services available through their coverage. This is certainly reflective of the findings from many sources cited in chapter 2 indicating the trend toward relaxation of managed care controls and expansion of provider networks in response to consumer backlash during the late 1990s. It was interesting to note that the entity with the most restrictive plan (Crane Corp) also placed the most emphasis on employee participation in the plan design and selection process. Employee committees were used extensively to review choices in order to enhance understanding of the connection between restrictions and premium levels, thus improving employee acceptance of the decisions made.

Question 2. How does this impact small employers' decisions regarding the

broadening of provider networks, relaxation of managed care controls, and divergence from the tradition of offering only one health benefit plan?

All of the participants indicated that their provider networks have broadened over the past few years, but only Billco indicated that they had deliberately taken steps to make that happen. Only Crane Corp expressed an interest in further expanding their contracted provider network, but has not done so because of the increase in premiums involved (with concurrence from employee committees as described in the preceding paragraph). All of the participants also showed that strict managed care restrictions have been relaxed with some, especially Art Adams and Dan Darden, expressing strong distaste for bureaucratic approval processes. Darden stated that he had specifically asked his insurance carrier to relax restrictions. Only Carly Carr expressed some optimism that consumer-driven plans (including health savings accounts) could improve expenditure control while relaxing managed care restrictions. Overall, while participants saw broadening of provider choice and relaxation of restrictions as important, they felt that these issues have been resolved by insurance plans in recent years and did not see them as a major concern for their employees at the time of the interviews.

Several of the participants demonstrated, either by offering alternative insurance plans in the past or by stating a desire to do so in the future, that they would like to enhance choices for their employees. However, none were currently offering a viable alternative plan. Ben Black indicated that Billco had looked at a proposal for a high deductible plan and that he would personally love to have it, but felt strongly that less than 10 of his employees would select such an alternative, making it unfeasible. Crane and Darden both offer employees the option of enhancing their plan to include coverage

for out of network services (at higher premiums and with higher deductibles and coinsurance) but none of Darden's employees have chosen that option and only about 10% to 20% of Crane's have done so. Gray offered three options with increasingly broadened networks and correspondingly higher premiums. None of the participants thought it was feasible to offer a consumer-driven plan side by side with their managed care plan.

Question 3. To what extent will the potential negatives impact the employers' consideration of consumer-driven health plans? Will concerns about adverse impact on older, less healthy, or lower income employees factor into decisions about consumer-driven plan designs? Do small employers believe that employees will be unable to find or effectively process information regarding the relative cost and quality of alternative providers and services?

The strongest indicator that these concerns would have an impact on decisions about plan design would be if they were mentioned by participants either spontaneously or in answer to the open-ended question regarding any concerns about consumer-driven health care. None of the respondents mentioned adverse impact on older or less healthy employees. Most, however, did quickly express concerns about lower income employees. Billco executives indicated that their predominantly young workers live paycheck to paycheck and would be unlikely to plan ahead to provide for higher out of pocket health care costs even if an employer matching plan were instituted to help them fund a health savings account. Darden, who had already established a high deductible health plan, nonetheless had the same expectations for low participation in a health savings account,

especially among lower paid workers. Crane indicated that they were seriously considering a high deductible plan but would only implement it if they could substantially fund a health savings account from savings on reduced premiums. Their specific reason for this was the relatively low pay in the social work field. Even when specifically asked about the potential for disproportionate impact on older or chronically ill workers, only Art Adams indicated that he had considered this in his decision making. Abco had already implemented revisions to their pharmaceutical benefits and contracted for a disease management program to address issues most pertinent to older and chronically ill beneficiaries. Each of the other respondents simply indicated that, now that it had been mentioned by the interviewer, they could see the potential for disproportionate impact.

Billco executives did express, without prompting, strong doubts regarding their employees' ability to make good decisions about health care services. None of the other respondents made spontaneous comments in this regard. Some had comments in response to the direct question on this topic, but only Billco indicated that this concern would have a negative impact on implementation of consumer-driven concepts. Art Adams felt that the work his committee had done in selecting preferred providers had taken care of most of the effort and that it was the personal responsibility of each employee to make good choices within the network of providers offered. Fred Field showed a similar opinion when he stated that provider prices had been negotiated by the carrier and that information on experience and outcomes was available to patients who ask. Carly Carr cited personal experience in attempting to get information about the cost of specific procedures, but did not indicate that this would be a deterrant to implementing a

consumer-driven design. She felt that the positive impact from increasing employees' personal financial responsibility at the point of service would help overcome this drawback. Dan Darden felt that employees were able to effectively use the health care system and in fact that many were smart enough to figure out how to circumvent the deductibles to their own financial advantage.

Themes

Conducting cross case analysis from three different angles (expected findings, research questions, and master themes) has the advantage of enhanced thoroughness but also the potential disadvantage of excessive repetition. Since the interview template was designed to gather data related to the research questions and expected findings, and since coding was done using master themes that were designed to group data around the research questions and expected findings, one would expect to find a great deal of redundancy in analysis of the master themes based on the coding. Therefore this section will make many references to the above sections in order to minimize repetition but will also expound on additional themes that emerged during data gathering and analysis.

Cost and premium increases. There were no surprises here. All of the participants mentioned premium levels and increases first and frequently as the major factor in their health benefit plan decision making. When asked what other factors have an impact, each indicated at least one other consideration. Some added to the list when prompted by specific questions from the interviewer, as shown in Table 4.

Table 4

Factors Other Than Premiums Considered in Health Plan Design

Participating Entity	Unprompted	Prompted
Abco	Better catastrophic coverage Competition for skilled workers	Management of chronic conditions
Billco	Breadth of provider network Low and predictable out of pocket costs for employees Young workforce has low knowledge level and lack of interest in health care decisions	none
Crane Corp	Costs to low income employees Acceptance by most employees	Overuse because of rich benefits
Darden	Catastrophic and preventive coverage for all employees Easy to use Option to go out of network High deductible	none
Franklin	Provider network	none
Gray	Geographic coverage (availability of network providers) Quality of network providers	Maternity coverage

Increasing deductibles and coinsurance. Among the cases studied, only Darden has a high deductible health plan that would qualify for tax preferred treatment of a health savings account under the standards established by the federal government. Franklin came very close to that level when it increased its deductible from $500 per person to $1,000 per person in 2005. Abco increased its deductible from $200 per covered person to $300 in 2004 and increased coinsurance to 35% for out of network services at that same time while maintaining in network coinsurance at 15%. Crane Corp's deductibles were comparable to Abco's at $250 per person and $750 per family (double that for out of network services) but its coinsurance was quite low at 10% in

network and 20% out of network. Carly Carr expressed significant concern over the richness of this plan causing employee overuse of services and the resulting impact on premiums. Because of this she is seriously studying High Deductible Health Plans and health savings accounts. Gray had 20% in network coinsurance plus a $500 deductible on single contracts with a requirement on family contracts that at least two covered persons must spend $500 each before the deductible is met. Billco was farthest from a consumer-driven design of any of the participants. They had no deductible and 10% coinsurance for in network services although they did have significant deductibles and higher coinsurance for out of network services.

In summary, each of the participating entities did have significant out of pocket cost at the point of service as part of their plan design ranging from a high of $2,000 per person deductible plus coinsurance at Darden to a low of no deductible but still 10% coinsurance at Billco. Abco, Franklin, and Gray had raised their deductibles or coinsurance during the past five years while both Billco and Crane indicated that they would be likely to increase deductibles if future premium increases are too high. Each of the entities continued to rely heavily on a managed care plan design as even Darden with its very high deductible had even higher out of pocket costs for use of non-preferred providers.

Managed care. Managed care was not one of the predetermined master themes but it became quickly apparent that this code should be added. All of the participants had strong managed care features in their plans including preferred providers with higher coinsurance and deductibles for use of services outside the contracted network. Crane

Corp had a pure HMO with no coverage for services outside the network, except for emergencies. They did offer a point of service option but few employees have chosen it because of higher premiums, deductibles, and coinsurance. Abco had a primary care gatekeeper requirement. Both Abco and Crane mentioned that they do commonly have complaints from employees about the managed care restrictions. Each of the participating entities appears to rely heavily on their insurance carrier to screen out ineffective or excessively expensive providers and to negotiate standard, discounted prices with those in the preferred network.

Health savings accounts. None of the participating companies have implemented a health savings account and none appear likely to do so in the near future, although one is actively studying the feasibility. All of the participants were familiar with the term and could describe health savings accounts, but each had their own reasons for not implementing. Union leaders opposed the concept at Abco because, in Art Adam's opinion, they did not want to cede any control over health and welfare benefit funds to individual employees. Billco's owners believed strongly that their very young employees, who make up about 90% of the staff, were simply not interested in or capable of taking more responsibility for managing their own health care choices and finances. Dan Darden already had high deductibles that would qualify a health savings account for preferential income tax treatment but cited lack of participation in his company's defined contribution retirement plan (despite his offer to match employee investments) as evidence that there would be very little interest in developing a health savings account. Fred Field had been satisfied with the low premium increases experienced in recent years and felt no need to

investigate health savings accounts at this time. The interview rekindled Gary Gray's interest in health savings accounts to the point where he indicated that he will reconsider that approach for 2009. Carly Carr was the only participant to indicate the serious possibility of implementing a health savings account in the near future. She is concerned about overuse of health benefits because of an entitlement culture among her employees and would like to implement higher deductibles and coinsurance to counteract the effects of moral hazard. She felt that if Crane Corp could save enough on premiums to fully fund a savings account for the first year, then it might be feasible to implement.

Benefits of high deductible/consumer-driven plans. This theme was very directly focused on the first group of research questions and thus has been extensively addressed above in the Question 1 section. To briefly summarize the findings from that section: Each of the participants indicated a belief that employees would be likely to consume fewer and less expensive health care services when they have higher out of pocket cost at the point of service, but to widely varying degrees. Also: Each of the participants saw broadening the network of preferred providers and reducing managed care restrictions as an important factor in choosing a health plan, but none of them saw a strong connection between consumer-driven design and an increase in employee choice.

Concerns about high deductible/consumer-driven plans. As with the benefits of consumer-driven plans, this theme was a direct focus of research questions and has been thoroughly discussed in the Question 3 section above. None of the respondents mentioned adverse impact on older or less healthy employees. Most, however, did

quickly express concerns about lower income employees. Only one of the respondents expressed, without prompting, strong doubts regarding their employees' ability to make good decisions about health care services. When questioned directly in this regard, the common response was that participants were relying on their insurance carriers to contract with provider networks that would provide quality services at the best prices available.

Disease management. None of the individuals interviewed was familiar with the term disease management. Art Adams was certainly very well versed in the concept, however, because he and the other trustees of his employees' health and welfare fund had made the decision to contract with a vendor to implement an aggressive disease management program about six months prior to the interview. Art cited this program, without being prompted by a question about disease management, as an investment that the trustees expect will more than pay for itself by helping to counteract the adverse impact of aging and chronically ill employees on not only costs to the health plan on but both quality of life and personal expenditures of the beneficiaries as well. Ben Black and Dan Darden each speculated, quite logically, that their insurance agents had not suggested a disease management program to them because of the young age of their workforce. Carly Carr seemed a bit taken aback that she was not familiar with the term and made a note to follow up with her agent.

Personal responsibility. This theme was added to the master list after it appeared to be a strong basis for the philosophy of each of the first two participants. Art Adams

very clearly stated that people should be responsible for their own welfare. Those with low incomes are adversely impacted in many ways, not just by higher health care deductibles and coinsurance. In his opinion, they need to invest in themselves by developing the knowledge and skills that will position them for jobs that carry better compensation including health insurance benefits. Ben Black on the other hand, agreed with the economic theory of combating moral hazard by making consumers responsible for more cost at the point of service, but stated that it would be unrealistic to expect his young workers to plan ahead for major health care needs (even the ones with higher pay). Dan Darden provided an interesting bridge between Adams and Black. He demonstrated belief in personal responsibility by implementing a high deductible health plan but had also observed the tendency of his lower paid employees to circumvent the requirements. His conclusion was that the government (state or federal) needs to require both employers and individuals to participate in catastrophic coverage in order to minimize this free riding effect. Fred Field commented on personal responsibility in response to the question regarding disease management programs when he stressed the importance of individual learning about and implementing healthier life styles. Carly Carr also repeatedly touched on this theme expressing concerns about some employees' lack of responsible use of health benefits. Her hope was to inspire greater personal responsibility by instituting a high deductible health plan and health savings account.

Future of health insurance benefits. Participants' philosophies on personal responsibility had the major impact on their expectations for the future of health insurance benefits. Their projections regarding the plans of their own companies were

discussed in several places above, especially the first part of the Expected Findings including Table 1 and the last part of that same section regarding lack of confidence in consumer-driven plans as the sole solution to health care issues. Their expectations for the United States health insurance system in general have also been touched in various places but will be summarized here.

None of the participants indicated that the system will move or should move to a pure consumer-driven model. Art Adams was very strong in his opinions that competition among companies for workers will force them to offer health benefit plans and those individuals who invest in their own education and skill development will qualify for jobs that include good health insurance as part of the compensation. He shunned government involvement with health care, citing poor personal experience with both the British and Canadian systems. He saw increased personal financial responsibility as part of the solution to rising health care costs but also would like to see enhanced disease management programs, increased competition among provider networks, improved administrative efficiency through reduced government regulation and improved electronic records management, and malpractice tort reform. The owners of Billco clearly did not have confidence in consumer-driven health care as the solution to rising costs. They simply do not see younger workers as having the knowledge, interest, or skills to effectively participate in their own health care decisions. Billco, Crane, and Gray executives did not offer any strong feelings about the future of the health care system. Carly Carr felt the need for more government subsidies, but had no specific suggestions. Gary Gray was most concerned about the system's tendency to exclude people with low incomes or with serious health issues, but he also had no specific suggestions for reform.

Dan Darden, like Art Adams, had strong opinions but with a different focus. He clearly believed in the consumer-driven model as evidenced by his adoption several years ago of a high deductible plan. His main concern was over the free riding effect created by employers who do not offer health benefit plans and by individuals who do not acquire health insurance. He was well aware of the statistics showing the decreasing proportion of employers offering health benefits and the increasing numbers of uninsured persons and also clearly understood the negative impact this has on the cost of health care to him and to other employers who do offer insurance. He stated a belief that government should require employers to offer health insurance and individuals to acquire it, along the lines of the Massachusetts program. He sees full participation by all employers and all individuals as the key to getting health insurance costs under control. Fred Field, however, expressed opposition to this approach. He felt that such a mandate by the state would drive many small employers out of business. It is noteworthy that Franklin Foods' insurance agent expressed the same opinion at length and in stronger terms during a telephone conversation where the researcher was asking him to provide data regarding Franklin's health insurance plan. Field suggested that the federal government should investigate both insurance carriers and health care providers and implement a cap on charges and premiums.

Case Summaries

Abco

Abco manufactures metal products at a plant in the Ogden-Clearfield, Utah MSA. The company employs 1ten workers, predominately skilled machinists who are members of the American Sheet Metal Workers union. The current owner and President of the

corporation, Art Adams, whose grandfather started the business 80 years ago, is the third generation to manage this family business. Aeronautics and space exploration manufacturers are among the largest industries in Utah and are major customers of Abco. The national recession during 2000-2002 hit these industries particularly hard because of the September 11, 2001 terrorist attacks and impact was extended by the shuttle Columbia disaster in 2003. However, these industries rebounded strongly, the national economy expanded for three years, and the Utah economy was among the fastest growing of the 50 states. As a result, Abco has been booming in recent years and during 2007 was in production seven days per week, 24 hours per day.

Union membership is unusual in Utah, representing only 4.9% of the employed workers in the state (Bureau of Labor Statistics, 2007). Abco contributes a negotiated amount per employee hour worked to a union health and welfare fund which also includes several other participating firms. The fund is managed by six trustees, three from management and three from union leadership. Art Adams is one of the trustees. The trustees have established a PPO model health plan with significant deductibles ($300 per person per year) and coinsurance (15% within the preferred network, 35% outside of the network). The plan is self funded with reinsurance for individual cases exceeding total payouts of $160,000. Union members are automatically included in the plan which is fully paid by Abco. Nonunion employees (managerial, clerical, and janitorial staff) are offered membership in the plan and receive the same benefits as union members. Retirees enrolled in Medicare can buy into the plan as supplemental coverage at a cost equal to 55% of the COBRA premium.

Since funding available for the plan is fixed by the union contract, variables become the administration of the plan and the benefits design. Trustees monitor the plan on a quarterly basis and can enrich or restrict the benefits as necessary based on revenue and expenditure trends. Eligibility and claims administration services are provided by Jensen Administrative Services of Salt Lake City, a third party administrator contracted by the plan. Actuarial services and consultation regarding plan design have been procured through a contract with The Segal Company of Phoenix, Arizona. Contract fees are also paid to Altius Health Plans for administration of the preferred provider network including contract negotiations with providers. The fund also has contracts for a Family Assistance Program, prescription drug program, and disease management. While multiple contracts add to administrative expense, the trustees have seen each of these as investments that enhance the overall effectiveness and value of the plan.

The health plan currently in place combines elements of managed care restrictions with elements of consumer-driven plans. As shown in Table 5 members incur strong financial penalties for using non-preferred providers (35% coinsurance and separate out of pocket maximum), for using inpatient hospital or other specialized services without precertification (no coverage), or for using behavioral health services not precertified by the Family Assistance Program. Even if enrollees stay within the preferred network of providers, however, they bear a significant portion of the out of pocket financial responsibility for services they choose, including a $300 per person per year deductible and 15% coinsurance. The prescription drug program has tiered pricing with substantially lower copayments for use of generics. There is also a financial incentive to seek early prenatal care. Members who enroll in the Maternity Management Program as soon as

their pregnancy is confirmed have deductibles waived for both themselves and their newborns. Employees also have up to $100 of their deductible waived for an annual examination by a physician.

Table 5

Abco Health Plan Summary

Data are for fiscal years ended June 30	2007	2006	2005
Monthly employer contribution per eligible employee	$725	$640	$561
Medical expenses per active employee per month	516	404	399
Deductible per covered person*	300	300	300
Coinsurance-preferred providers	15%	15%	15%
Coinsurance-out of network*	35%	35%	35%

*Deductibles increased from $200 during 2004 and out of network coinsurance increased from 15% at the same time.

Billco

Billco is a collection agency with offices in Utah, Idaho, Oregon, and the state of Washington. The company typically has between 80 and 100 full-time employees on its payroll. Billco is owned and managed by Ben Black. Ben's daughter, Barbara Barney, manages the accounting, human resources, and other administrative functions of the company. Billco was selected for the study because it is a service business in the middle size range (50 to ten0 full-time employees) among small businesses, has employees in a wide spectrum of compensation from less than 10 dollars per hour clerical staff to more than $100,000 per year managers and collection specialists, data were available regarding insurance plans during recent years, and both Ben and Barbara were interested in participating.

Table 6 shows that Billco has experienced health insurance premium increases during the last three years ranging from 13% in 2005 to 8% in 2006 and 2007. These are quite comparable to national average increases over that period. No changes in plan design were made during that time, although they did change carriers in 2004 to provide a better network for their employees in Idaho, Oregon, and Washington.

Table 6

Billco Health Plan Summary

For plan year starting October 1	2007	2006	2005
Monthly Premium:			
Employee only	$356	330	305
Employee plus one	$768	711	659
Employee plus children	discontinued	643	595
Employee plus family	$1,095	1,014	940
Increase from prior	8%	8%	13%
Employees enrolled	80	94	97
Empoyee rate per month			
Employee only	$89	89	61
Employee plus one	$192	191	132
Employee plus children	discontinued	172	119
Employee plus family	$274	272	188
In-Network:			
Office Copays	$10	$10	$10
Copays ER/Urgent Care	$75/35	$75/35	$75/35
Deductible	None	None	None
Coinsurance	10%	10%	10%
Out of pocket maximum	$1,500/3,000	$1,500/3,000	$1,500/3,000
Out of Network:			
Deductible	$300/600	$300/600	$300/600
Coinsurance	30%	30%	30%
Out of pocket maximum	$2,000/4,000	$2,000/4,000	$2,000/4,000

Office visit copayments are quite low at $10 and there is no deductible for services received within the preferred network. There is a deductible for out of network services as well as higher coinsurance and out of pocket maximums. The plan design is

much more typical of traditional managed care plans than consumer-driven plans, although the 10% coinsurance on inpatient admissions and outpatient procedures within the network does put significant personal financial responsibilities on the employees for those services. This personal liability is increased to 30% if out of network providers are used.

The interview was conducted at Billco's main office with both Ben Black and Barbara Barney present. Perhaps the most significant information revealed during the interview was the relative youth of the workforce at Billco. Barbara estimated the average age at 26 years and gave her opinion that most "live paycheck to paycheck". This feeling impacts Ben and Barbara's outlook on health benefits in several ways. They have no deductibles (in network) and low copayments of only $ten in order to minimize the financial impact on employees of unexpected medical needs. They changed plans a few years ago specifically to broaden their network so employees would have less chance of needing or using an out of network provider. They believe that only a small number of more mature employees would see the value of a high deductible/health savings account plan and therefore probably less than 10 would prefer that design. They also recognize that the young workforce probably helps keep their insurance costs moderate even though they have a fairly rich combination of no deductible, low copayments, and broad network.

They believe that employees are quite satisfied with the current health insurance benefit. They based this on comments from new employees that the amount withheld from paychecks is reasonable and on hearing few complaints about the plan from existing employees. The main factors they consider when evaluating health insurance plan design

are ease of use for employees and predictability of costs for employees. The only significant change made in recent years was to broaden the provider network and Billco has been willing to shoulder significant premium increases rather than institute an in network deductible and/or higher copayments and coinsurance.

Ben and Barbara were familiar with consumer-driven plan concepts and agreed with the theoretical benefits on demand management but were highly skeptical of their young employees' ability to manage their personal finances or to make informed choices among alternative treatments and providers. For these reasons they have not seriously considered high deductible plans or health savings accounts and are not all interested in that approach at the present time. Ben indicated that he does not foresee any circumstances that would cause him to discontinue health insurance benefits. Even if faced with premium increases of 20% to 25% in one year he would make only modest changes such as "a little bigger deductible" or a 5% increase in the portion of premiums paid by employees.

Crane Corp

Crane Corp is a not for profit entity providing job training, coaching, placement, and supervision for individuals with disabilities. Their offices and training facilities are in a local industrial park. They employ 54 full-time workers eligible for the health insurance benefit plus about 30 part time workers. They were chosen for the study because they are a not for profit social service organization; they fall into the middle size range (50 to 100 full-time workers) among small employers; rates of pay range from entry level clerical, to midlevel professional and supervisory, to management with salaries in excess of $50,000;

data were available regarding their health plan for recent years; and because the company President was supportive and asked the Human Resources Director, Carly Carr, to provide data and be available for interviewing.

Crane offers two choices of health plans to their employees; something that is not normally available to small employers but both plans are offered by the same insurance company and the company has made an exception for Crane because of its long tenure as a customer and because of its not for profit status. Participation in the health insurance benefit has been quite steady, generally ranging between 29 and 33 employees, with a low point of 25 during three months of 2006 and a maximum of 36 for one month of 2008. Select: Med is a tightly controlled, traditional HMO plan design with modest deductibles and copays but no coverage for any services received out of network, except for emergencies. Table 7 shows that Select: Care Plus is a PPO product with coverage identical to Select: Med for in network services plus coverage for out of network providers but with higher deductibles and copays. Over the last five years, 80% to 90% of participating employees have chosen Select: Med because its premiums have been about 20% lower than those for Select: Care Plus, as shown in Table 8. Premium increases over the last four years have been modest, ranging from zero in 2006 to ten.2% in 2005 and averaging about 5.5% per year. Carly attributed this favorable experience primarily to the heavy participation in the tightly controlled Select: Med plan.

Table 7

Crane Corp Health Plan Summary

Plan Feature (Design elements unchanged since 2004)	Select Med and Select Care Plus in Network	Select Care Plus Out of network
Deductible (person/family)	$250/$750	500/1,500
Out of pocket maximum	1,000/2,000	2,000/4,000
Inpatient services coinsurance	10%	20%
Primary care copay/coinsurance	$20	20%
Specialty care copay/coinsurance	$30	20%
Outpatient coinsurance	10%	20%
Emergency copayment	$75	125

Table 8

Crane Corp Health Plan Premiums

	2008	2007	2006	2005	2004
Select Med					
Single	$325	$314	$296	$296	$268
Family	818	789	743	743	674
Health Care Plus					
Single	404	389	367	367	333
Family	1,018	981	924	924	838
Percentage increase	3.7%	6.2%	0	10.2%	
Employee portion of premium	25%	25%	25%	25%	25%

The interview with Carly Carr was conducted at her office in the Crane Corp facility. She and Crane Corp are primarily concerned with offering a benefit that will be a substantial supplement to the relatively low wages that are paid in the social services field and will also help them attract and retain staff. They have mixed feelings about the health insurance plans they have offered for many years: fortunate that the carrier continues to offer them some design elements that are normally available only to larger employers but somewhat trapped because of their small size which limits their ability to shop for

alternative carriers. Carly's perception is that employees are generally pleased with the plans although she does regularly hear that some would like more choice of providers without the higher premiums or copayments. Crane Corp makes strong efforts to involve employees in the review of design options and alternative carriers so they will be aware of the costs and requirements of possible changes.

Carly mentioned at the very outset of the interview that management has looked at health savings accounts and continued to mention that approach several times. They recognize that higher deductibles and coinsurance would lower premiums and that health savings accounts would be a tool that could be used to help employees cope with the higher out of pocket costs at the point of service. She has observed an entitlement culture among some employees that manifests itself in overuse of health plan benefits as well as sick pay benefits and feels that a high deductible plan might cause employees to take better care of themselves and to make more effective use of health care services. Management is concerned, however, about the impact on lower paid employees, especially single parents, who might drop their health insurance or go without needed services in the face of high deductibles. They will continue to investigate consumer-driven plan designs but are likely to implement them only if two criteria are met: the company can save enough on premiums to substantially fund health savings accounts so that employees can build up a balance in the first year and a committee of employees rendering a favorable overall opinion on the package.

Darden Inc.

Darden Inc. is a linen service company providing laundry and linen services to restaurants, hotels, and other businesses primarily along the Wasatch Front in Utah including clients in the Logan, Ogden, Park City, Salt Lake City, and Provo areas. Darden employs about 100 workers. This firm was chosen for the study because it is a service business; has a health insurance benefit for employees; falls into the larger size category among small businesses; has wage rates ranging from $8.00 to $12.00 per hour for laundry workers to more than $50,000 per year for drivers, sales staff, supervisors, and managers; had relevant data available for recent years; and the owner, Dan Darden, was interested in participating.

Darden offers a high deductible health plan that meets federal standards for inclusion of a Health Savings Account, but that is not offered at this point because of lack of interest among employees. Darden also pays the full single premium for the Peak plan for all full-time employees who have been with the company at least one year. Employees who want two party or family coverage or wanting to upgrade to the Peak Plus plan must pay the difference in premiums. Because of the high deductible design and because all employees are included in the plan, premiums for family coverage are only $668 per month for 2008 (Table 9) as compared with more than $1,000 per month for other plans. Premium rate increases were about 9% in 2008 and 7% in 2007. The number of participants has increased from 67 in 2005 to 80 in 2008 as the number of workers employed by Darden has grown over that time. In 2008 only six of the 80 opted for two party coverage and only six more purchased family coverage. None of the

employees chose to purchase the Peak Plus plan. Table 10 shows the deductibles and copayments for the plan.

Table 9

Darden Inc. Premiums

	2008	2007	2006	2005
Single	$171	$157	$147	$146
Two party	211	193	181	413
Family	668	613	575	413
Percent change	9%	7%	*	NA
Employee portion	$171	$157	$147	$146
Number of participants	80	72	70	67

*Percent change could not be calculated because Family and Two Party were combined in 2005 but separated in 2006.

Table 10

Darden Inc. Health Plan Summary

(Plan design has not changed since 2005.)	Participating Providers	Non-Participating Providers
Deductible (single/family)	$2,000/4,000	$4,000/8,000
Out of Pocket Maximum	$2,000/4,000	$3,000/6,000
Copay (primary/specialty)	$20/30	40%
Copay-emergency room	$100	$200
Hospital coinsurance	20%	40%

The interview with Dan Darden took place in a private meeting room at the Ogden Golf and Country Club at his request because he had just finished another meeting at the same facility. Dan described choices he has made over the years to maintain a health plan that protects all employees against catastrophic costs but is affordable for the business. He has moved away from highly restrictive managed care designs that became “unusable” but has had to increase deductibles to keep the premiums at a level his business can handle. He attributes Darden’s relatively low premiums to the high

deductible but also to several other factors. By including all of his employees in the plan, adverse selection is minimized causing the insurance companies to offer a discount. The workforce is relatively young and claims experience has been quite low. Dan noted that loss ratios for his company have historically been only about 50%. He is concerned about premium increases for 2009, however, because he currently has two employees with very serious medical conditions.

Dan feels that the consumer-driven design of his plan does encourage employees to be more concerned about their own health and to make more careful choices when using the health care system. He has not been successful, however, at interesting employees in a health savings account. It is a bit frustrating that older workers tend to see the benefits of a health savings plan while younger workers often do not, even though the younger workers have a much better opportunity to accumulate substantial funds in such an account. Dan noted that he also has very low participation in his company's retirement plan even though it is tax advantaged and the company matches employee contributions. Dan also clearly sees the difficulty that lower paid workers have in coping with the high deductible health plan. He has observed an interesting impact of low income and ethnicity among his workers who are Mexican and Asian Americans. They have learned that if they go to the Emergency Room for care they will receive treatment and if they do not reveal that they have health insurance, they will not be billed and thus can avoid the deductible.

It was very interesting to note that while few employees purchased two party or family coverage, none purchased the Peak Plus plan, and there was very limited interest in a health savings account, employees still clearly value the preventive services and

catastrophic protection provided by the standard Peak plan. Dan was surprised last year that when he suggested a monthly cash payment in lieu of the health plan premium payments by the company, there was almost unanimous rejection of that option by the employees. Dan does not foresee circumstances where he would discontinue offering a health insurance benefit to employees. He does, however, expect that if double digit percentage annual premium increases resume, the company will have to require employees to pay 25% of the premium. The greatest concern he expressed for the health care system is the large and growing number of people without health insurance. He recognizes that a substantial portion of the premium increases borne by he and other employers who do offer health insurance benefits go to cover the uncompensated services provided to uninsured individuals. He favors a governmental approach that would require everyone to have health insurance, similar to the Massachusetts model.

Franklin Foods

Franklin Foods is a family owned retailer of groceries, hardware, pharmaceuticals, and other household goods. It was purchased six years ago by Fred Field who is President of the company. Franklin employs 32 to 35 full-time and approximately 50 part time workers. The company was chosen for the study because it is a retail business, has a health insurance plan, falls into the smallest size group with less than 50 full-time employees, has a spectrum of compensation ranging from $9 to $13 per hour for cashiers and stockers to $32,000 to $50,000 for department heads such as butchers or produce managers, and Mr. Field was interested in participating.

Franklin offers a high deductible health plan which, at $1,000 per person, falls just short of the 2008 federal standards for inclusion of a tax preferred Health Savings Account. The plan also includes 20% coinsurance and significant copayments as illustrated in Table 11. The company pays approximately 60% of monthly premiums for single, two-party, or family coverage with the employee responsible for the remaining 40%. A little over half of employees eligible for the health benefit have chosen to participate. Premium increases (Table 12) have been very low during the past three years since the company changed insurance carriers in 2005, increased the deductible from $500 per person to $1,000, and increased physician service copayments by $10 per visit.

Table 11

Franklin Foods Health Plan Summary

	In Network	Out of Network
Deductible (single/family)	$1,000/2,000	$1,500/3000
Hospital coinsurance	20%	40%
Primary/Specialist copay	$25/$35	40%
Out of pocket maximum (single/family)	$3,000/6,000	$4,000/8,000
Emergency room deductible	$100	$200

Table 12

Franklin Foods Premiums

	2008	2007	2006	2005
Age 30-34				
Single	$268	$264	$256	$256
Two-party	550	543	527	527
Family	904	885	859	859
Age 50-54				
Single	436	421	409	409
Two-party	818	795	772	772
Family	1,136	1,111	1,079	1,079
Increase from prior	1.5%	3%	No change*	
Employee share of premium	39.4%	40%	40%	40%

*In 2005 Franklin changed insurance carriers, doubled the deductible, and increased copayments by $10 per visit.

The interview with Fred Field took place in his office at the rear of the store. Fred clearly and consistently focused his remarks on the need to keep premium increases at a reasonable level by making whatever changes are necessary in plan design to accomplish that requirement. He noted that he is a very small business in competition with giants (such as Wal-mart and Kroger) in an industry where prices have been rising and margins falling. He stated repeatedly that while he will do everything possible to continue offering a health benefit plan, it could be necessary to discontinue the coverage in order to fund other necessary costs of doing business. In 2005 he was faced with an 18% increase from his insurance carrier, United Health. He instructed his agent to get proposals from other carriers and they were ultimately successful in negotiating a new plan with Intermountain Health Care (IHC) at no premium increase, although they did double the deductible and

increase copayments. United was offered a chance to bid on the same design and still priced the premiums at a 13% increase from the prior year.

Field has been very satisfied with the provider network in the new plan and especially the premiums which increased by only 3% in 2007 and 1.5% in 2008. He attributed the relatively low increases partially to the higher deductibles and copayments but mainly to competition in the marketplace where he perceived that IHC is making a concerted effort to gain share among smaller businesses. Fred clearly saw the benefit of consumer-driven design elements in reducing premiums but did not volunteer any comments about other benefits or drawbacks to this model. When asked specific questions, he did expound on the likelihood that employees would be more careful in their health care spending when they were paying more out of their own pockets at the point of service and also on the possibility that some, especially lower income employees, might forego needed services for the same reason. He blamed insurance carriers and health care providers for the high cost of health insurance citing corporate greed, fraud, and frivolous lawsuits as some of the main causes. He was opposed to state mandated insurance coverage because it would unfairly penalize small businesses and felt that the federal government should step in to investigate both carriers and providers and should put caps on provider price increases and premium increases.

Gray Mortuary

Gray Mortuary offers funeral and interment services in the Ogden, Utah, area. The business is family owned and employs 18 full-time staff who are eligible for health insurance benefits. The company was chosen for the study because it is a service

business, has a health insurance plan, falls into the smallest size group with less than 50 full-time employees, has a spectrum of compensation ranging from $11 to $13 per hour for clerical and support staff to more than $50,000 for professional funeral directors, and Mr. Gray was interested in participating. Gary Gray is the President of the firm, succeeding his father who is still active in the business on a part time basis.

Gray offers a package of health plan options provided by Intermountain Health Care (IHC). At the time of the interview with Gary, eight employees were enrolled in one of the three options. Other eligible employees had elected not to enroll either because they were covered under the plan of a family member or because they felt they could not afford their portion of the premium (50%). The three plans have identical designs in terms of deductibles and in network coinsurance but have progressively broader networks and higher premiums. Select Value has the most restrictive provider network and lowest premiums; Select Care Plus features the broadest choice of network providers but has the highest premium; Select Med Plus is between the other options on both network size and price.

In 2006 Gray narrowed its array of choices for employees from five plans to three and also doubled its deductible from $250 to $500. As shown in Table 13, these changes helped cause a slight reduction in premiums for 2007 and, in Mr. Gray's opinion, were factors in holding the 2008 increase to less than 2%. The plans offered by Gray do not include maternity coverage. Premiums for each employee depend on three factors: age, plan, and tier (single, family, or two party). Select Med Plus was chosen for presentation in the following table because it has consistently been the choice of all but two of the participating employees.

Table 13

Gray Mortuary Health Plan Summary

	2008	2007	2006
Family premium Age 30-34	$773	768	774
Single premium Age 55-59	$564	553	557
Premium change	0.6% to 2.0%	-0,8%	NA
Deductible per person	$500	500	500*
Copayments primary/specialist	$15/$25	15/25	15/25
Coinsurance In network	20%	20%	20%
Coinsurance Out of network			

*Deductible increased from $250 at beginning of 2006.

The interview with Gary Gray took place in his office at the mortuary. He was the least talkative of any of the case study participants. He was very tentative in responding to the interview questions and seemed to rely very heavily on his independent insurance broker for information and advice. Just as all of the other participants, Gary quickly expressed concern about the cost of premiums but he seemed more concerned about his employees' ability to pay their half than he was about the cost to the company. His responses to questions about higher deductibles, health savings accounts, or other design changes were all couched in terms of how they might impact his employees' ability to participate in the plan. Further evidence of this priority came when Gary indicated that while maternity coverage is excluded from covered benefits to help keep premiums down, Gray directly helps employees who incur childbirth expenses.

This was the smallest of the participating entities and that may have been a factor in the owner's relatively more shallow knowledge of health benefit matters. Gary

frequently alluded to the difficulties faced by businesses of his size and by their employees in maintaining health insurance coverage. He was clearly very pleased that IHC offers what he considers to be a high quality and easily accessible array of in network providers to businesses of his size. He suspected that his premiums are higher than large businesses, but did not express that as a major issue. The flat level of his premiums over the last three years was likely to also help move those concerns from the front of his mind. This may also have been a factor in his shorter responses to questions concerning potential changes in the plan or strategies for maintaining the plan if premiums jump. He was not familiar with health savings accounts or disease management programs, but asked questions about both and made notes to follow up on those concepts with his agent.

Summary

Cross case analysis revealed consistent findings in relation to the expected findings. All of the participants expressed unprompted concern over the cost of health insurance premiums and its impact on their ability to operate their businesses and to continue offering health benefits. Only one of the participants indicated that he could be forced to discontinue coverage, but even he did not see that as likely. Only one of the participants was familiar with the term consumer-driven health care but all listed elements of consumer-driven design among their main strategies for managing health plan premiums including: higher deductibles, higher coinsurance, and/or health savings accounts. Each of the participants recognized the term health savings account, but their levels of understanding varied greatly. None had implemented a health savings account;

one was seriously considering it; and one indicated that he would be asking for information in reviewing health benefit plans for 2009. Each of the participants offered only one insurance carrier to employees. Four of the six offered alternative plans from one carrier but only one had significant numbers of employees selecting an option other than their basic plan. While each of the participants expressed support for the concept of greater consumer financial responsibility for health care at the point of service, none of them indicated confidence that this approach alone would manage the cost of their own health benefits or that it would solve the problem of rapidly increasing national health care expenditures. Each of the participating entities has incorporated some elements of consumer-driven design into their health benefit plan but each also retains strong elements of managed care controls.

Findings from the cross case analysis were also detailed in this chapter in relation to the research questions. Each of the participants indicated that employees would be likely to consume fewer and less expensive health care services when they have higher out of pocket cost at the point of service. Five of the participants demonstrated strong belief in this theory but one company felt that its young employees simply did not have the expertise or the interest to make health service decisions on the basis of cost or effectiveness. Each of the participants saw broadening the network of preferred providers and reducing managed care restrictions as an important factor in choosing a health plan, but none of them saw a strong connection between consumer-driven design and an increase in employee choice. Each had strong managed care elements in its health plan and intends to continue with that approach. None of the respondents spontaneously mentioned concern about adverse impact of consumer-driven plan designs on older or

less healthy employees but most quickly expressed concerns about lower income employees. Only one company expressed, without prompting, strong doubts regarding its employees' ability to make good decisions about health care services. Other participants had comments in response to the direct question on this topic, but only one indicated that this concern would have a negative impact on implementation of consumer-driven concepts. The dominant opinion was that the participants would rely on preferred provider networks developed by health plans to manage the cost and quality of services.

Chapter 5 will draw conclusions from the data and interpret the findings in relation to the research questions and relevant theories. Implications for social change will be described as well as recommendations for action and further study. The chapter will end with personal reflections on the study and a final summary of conclusions.

CHAPTER 5: IMPLICATIONS

Introduction

The purpose of this study was to describe attitudes of small businesses toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. The study stemmed from the problem that the number of persons in the United States without health insurance has been growing rapidly in large part because increasing numbers of small employers are not offering health benefit plans to their employees. Employers who have continued to offer health benefits have shifted toward consumer-driven designs that include greater out of pocket costs for employees at the point of service. Based on these trends, research is needed regarding the ways in which small employer perceptions of consumer-driven models will be used in related decision making.

A multiple case study design was chosen for this research because the research questions called for a rich understanding of the attitudes of small employers toward the current phenomenon of consumer-driven health care and how these attitudes may impact health plan design. Several well established theories are at work here and were used to develop the inquiry: moral hazard, price/demand equilibrium, decision theory, and the diffusion of innovations. Data were acquired from multiple sources including participant documents, archival records, and interviews. The relatively small number of participants prevented the development of statistically valid measures that could be projected on to larger populations. While this approach limited the breadth of findings, the use of multiple sources of data as well as cross case analysis enhanced the depth and richness of

the findings. While participating employers are diverse in terms of size and type of business, homogeneity of their cultural and economic environment are delimiting factors that could impact the attitudes of participating small business owners and managers. This chapter will draw some conclusions from the findings described in chapter 4, interpret the findings, and explain the implications for social change.

Conclusions

Research Question 1

The first research question posed in this study asked the extent to which small employers implicitly or explicitly believe the theories and findings on which the movement toward consumer-driven models is based. Researchers from Janis (1977) to Isen (2001) and Robinson (2003) found that people will be more diligent in their decision making when they perceive greater personal risk. The literature review in chapter 2 also documented a large array of studies holding that people will spend less when they have significant out of pocket costs at the point of service (Feldstein, 2003; Fuchs, 2005; Hadley & Holahan, 2003; Moran, 2005; Neuhauser, 2003; Nichols, 2004; Scheffler & Felton, 2006).

To the small business owners and managers participating in this study the connection between higher deductibles and reduced demand was eminently clear. Most of them had experienced the dampening effect that even a modest increase in deductibles had on their health insurance premiums and several had seen proposals for deductibles in the range of $1,000 per person that would reduce premiums by 25% to 30%. Art Adams probably expressed the closest alignment of these theories when he stated that both his

company and the employees would be better off if they recognized that they could have more comprehensive insurance and better protection against catastrophes if they opted to pay more directly for minor items. Ben Black and Barbara Barney were at the opposite end of the spectrum. They gave implicit credit to the economic theory when they mentioned that premiums would go down significantly with a high deductible plan and that employees do not care what they are spending because they are not paying for it. They were explicitly adamant, however, in their rejection of the application of decision theory because of their belief that the large majority of their employees would not make good health care choices, even with greater out of pocket liability for those choices. Other participants expressed mixed feelings about improved decision making by employees. Carly Carr mentioned the need to change a culture of entitlement and overuse; Fred Field spoke of wasteful overuse of emergency and urgent care services; and Gary Gray mentioned hypochondriacs who overuse health care services and run up costs for everyone else. At the same time, however, most of the participants commented on the complexity of the health care system and all demonstrated their lack of faith in employee decision making by maintaining managed care provider networks and restrictions in their benefit plans.

The third foundation of the first research question came from diffusion theory as documented in chapter 2: people rebel against limitations on their choices and are more satisfied with decisions when they participate in selecting the alternatives (Christianson, 2002; Isen, 2001; Janis & Mann 1977; Nichols, 2004; Nolin & Killackey, 2004). There was clear evidence of belief in this theory from the participants, but these beliefs did not necessarily result in support for the concepts of consumer-driven health care. All of the

participants expressed satisfaction with the broadening of provider networks and relaxation of managed care restrictions during recent years. None of them, however, had eliminated managed care controls from their plans.

Conclusions with regard to the first research question are as follows. While there appears to be a convergence of decision theory with economic theory here that supports consumer-driven health plan designs, the participants in this study appeared to view these as separate questions. There was clear agreement that plans with higher deductibles and coinsurance will cause employees to reduce their demands for health care services, but there was also substantial skepticism that this would result from more careful and thus better decision making. The participating employers believed that if health plan premiums or deductibles and coinsurance were perceived by the employees to be too high, the employees would circumvent the health insurance benefit by behaviors such as deceiving providers or opting out of the plan completely.

Research Question 2

How do the attitudes and beliefs described above impact the participating small employers' decisions regarding the broadening of provider networks, relaxation of managed care controls, and divergence from the tradition of offering only one health benefit plan? Two of the participants (Billco and Darden) had specifically requested broader networks or reduced controls from their insurance agents. Each of the others had welcomed these changes when implemented by their health insurance plans. All of the participants, however, continued to use managed care plans as the base model for their health insurance benefits. Four of the six participants expressed serious concerns that if

deductibles or coinsurance are perceived to be too high, employees will simply opt out of the health insurance plan. This was already an acute phenomenon at Franklin and at Gray where employees pay 40% to 50% of the premiums; was a primary concern at Crane to the point where they would only implement a high deductible health plan if they could fully fund health savings accounts using funds saved from premium reductions; and was the main driver causing Billco to shun consumer-driven design. A fifth participant, Dan Darden, had witnessed rebellion against limitations in a different way. He believed that employees were circumventing the high deductible by seeking care at emergency rooms and deliberately failing to reveal that they had health insurance coverage.

While some of the participants expressed desire to offer a consumer-driven plan as an alternative concurrently with their managed care plan, none felt that it was feasible for a small business to do so.

Research Question 3

The literature review in chapter 2 documented several widespread concerns regarding potential adverse impacts of adopting consumer-driven health plans. These were the basis for research questions regarding the extent to which small employers' decisions regarding health benefits design might be impacted by the potential negatives.

None of the participants mentioned adverse impact on older or chronically ill workers as a negative in moving toward higher deductible, consumer-driven style health plans. Only Abco had implemented programs specifically designed to address the needs of these populations including both a disease management program and adjustments to their prescription drug coverage. Conversely, the ability of lower income employees to

afford health insurance coverage and the out of pocket cost of health care services was mentioned spontaneously by each of the participants. Darden, Field, and Gray (whose plans had the highest deductibles among the participants) expressed regret that their lower income employees were unable to fully participate in the benefit plans offered. At Franklin Foods and Gray Mortuary employees pay 40% or 50% of the premiums respectively, and only about half of the eligible employees had opted to join the plan. Darden pays the full single premium for all employees, but only 12 out of 80 participants had opted for two party or family coverage. While each of these employers lamented the negative impact on low wage earners, they felt that in order to offer a health benefit that was affordable for the company and for at least some of the workers they had to use a combination of high deductibles and premium sharing. All of the employers were caught in this balancing act and all listed increasing deductibles and/or employee premium sharing among their likely tactics to moderate premium increases (Table 3). Concerns over low income employees were most prominent at Crane Corp where Carly Carr expressed that they would not move to a high deductible health plan unless they were able to fund health savings accounts from the funds provided by reduced premiums. Billco executives had the most paternalistic orientation, stating adamantly that they would keep deductibles and coinsurance low in order to protect their employees, especially the lower income and younger ones, from unplanned out of pocket costs.

It appeared that Billco's position was driven even more by the belief that their employees would not make good decisions about the use of health care services and choice of providers. While Ben Black and Barbara Barney were the only participants to spontaneously express the challenges facing employees in health care decision making as

a deterrent to consumer-driven plan designs, it appeared that this belief was not quickly mentioned by the other participants simply because it was so firmly engrained in them as a fact of life. In the interviews, each of the participants seemed surprised by the question regarding availability of information on cost and quality, each puzzled for a few moments over what the question was getting at, and in the end all responded that while complexity existed it was not really an issue in employee decision making because they or their agents had taken care of those concerns by contracting with a managed care network.

Conclusions with regard to the third research question are summarized as follows. While possible adverse impact on older or chronically ill employees was not given much consideration by the participants, disproportionate burden for lower income employees was a major consideration. Concerns about employees' decision making based on their inability to obtain and understand useable information about the cost and quality of health care services and providers also had a clear impact on benefit plan design by all of the participating companies. One of the strongest conclusions from this study, with implications that will be discussed in the next section of this chapter, was that these small employers had not moved away from managed care and had no intention of eliminating strong managed care elements from their health benefit plan designs.

Interpretation of Findings

Managed Care

Chapter 2 cited extensive documentation of the decline in the effectiveness of managed care as evidenced by resurgent inflation in health insurance premiums and total health care expenditures since the year 2000. The strong societal backlash against

restrictive managed care controls was connected to violations of decision theory and diffusion theory. People are more likely to hold themselves accountable for decisions when they perceive that choices were made freely (Janis & Mann, 1977). Early adopters of managed care plans were highly satisfied with them but later, as 95% of people in the United States who had commercial health insurance were forced into managed care designs without a viable option for staying with their traditional indemnity plans (Ginsburg, 2005), the seeds of rebellion were planted. Authoritative innovation decisions have been the most quickly adopted, but were also often resented and circumvented by members of the group (Rogers, 1983). This appears to have been the case with managed care in the United States.

Much of the hope for success of consumer-driven health plans as an effective replacement for managed care has been pinned on their congruence with this high value that American society places on autonomy and freedom of choice. However, none of the participants in this study have eliminated managed care controls from their health benefit plans. It appears that another essential element of decision theory has superseded the value of free choice. People can not make good decisions about health care choices if accurate and understandable information about the cost and quality of services and providers is not available to them (Wynia et al., 2004). The business owners and executives participating in this study have all taken the approach of using managed care contracts to predetermine which providers offer acceptable levels of price and quality and which services require prior authorization by a third party beyond the patients and their physicians. They did not do this out of a desire to limit choices but rather based on their

belief that information needed by employees to make good choices was not available to the individuals in useable or understandable form.

The participating organizations had already broadened their provider panels and relaxed some of the managed care controls prior to significantly increasing deductibles and coinsurance. They did not seem to perceive a connection between the two and had not even considered the further reduction or elimination of managed care restrictions as they raised deductibles and coinsurance. They were simply focused on moderating premium increases. The implication is that even in the presence of reasonable alternatives for consumer directed plans, employers may not extend additional autonomy to employees for choices among providers and health care services in exchange for higher deductibles and coinsurance. The presumption of both ability and willingness of employers to adopt the consumer directed model is one of the central principles of consumer-driven theory, and clearly not in keeping with the results of this study.

Resistance to Change

The second implication drawn from the data found in this study is closely related to the first. It is also based on fundamental principles from decision theory and diffusion theory. Cognitive dissonance results from restrictions on choice. As people perceive that their freedom to choose has been taken away they take steps to restore their ability to choose including passive resistance, ignoring restrictions, public action, or simply walking away from the decision (Janis & Mann, 1977). Such behaviors were evident in the backlash against managed care. Consumers demanded the services they wanted regardless of restrictions and most physicians reported exaggerating symptoms to get

approvals for tests or treatments on behalf of demanding patients (Sultz & Young, 2006). Employers were overwhelmed by employee demands for greater choice and sabotaged managed care plans' ability to control costs by broadening networks and reducing other restrictions such as gatekeeper requirements (Nichols, 2004).

Among the expected findings listed for this study were that participating small employers would offer only one health insurance plan and that they would also be likely to reflect the attitudes of large employers and health insurance firms who lack confidence in consumer-driven plans as the sole solution to health care issues. As described in chapter 4 these expectations were met. There was an additional finding, however, that was not anticipated but flows logically from the integration of these expected findings with the elements of theory described in the preceding paragraph. Several of the participants reported evidence of passive or active resistance to increasing deductibles and coinsurance.

Probably the most dramatic example came from Dan Darden. He believed that his employees had been circumventing the high deductible by seeking care in emergency rooms and failing to reveal that they had any health insurance coverage. Perhaps "failing to reveal" is too passive; it is likely that they were asked by hospital staff if they had coverage and actively denied it. Other examples of resistance were more passive but nonetheless had the impact of undermining the move toward consumer-driven designs. About half of the eligible employees at Franklin Foods and Gray Mortuary declined to participate in their employer's health benefit plan. While Fred Field and Gary Gray both acknowledged that some of these employees may have coverage through a spouse's health insurance plan, both indicated that some eligible employees simply declined to

have coverage because they perceived the deductibles and premiums to be too high. Crane Corp was clearly anticipating the same phenomenon if it went to a high deductible plan and Billco would not even consider increasing deductibles or coinsurance in expectation of the same kinds of employee resistance.

The implication is that one should expect to see the effects of cognitive dissonance manifested in the form of both active and passive resistance if employees are forced into high deductible, consumer-driven health plans without perceiving that they have a viable choice or even that they had some influence over the decision and received some value in exchange. The diversity, creativity, and power of this resistance should not be underestimated especially in light of the evidence that consumer resistance succeeded in emasculating the cost containing effects of managed care (Ginsburg, 2005; Nichols, 2004). Even in this study, delimited by the dominant conservative and autonomous culture from which the participants were drawn, the impact of this resistance resulted in small business entrepreneurs calling for federal interventions such as mandated participation in health insurance (Darden); subsidies for lower income workers (Carr); and caps on insurance premiums and provider prices (Field).

Predictors of Deductible Level

Table 14 is a Case Ordered Predictor Outcome Matrix (Miles & Huberman, 1994) constructed to assist in the explanation of why participants had chosen varying levels of deductibles for their health benefit plans. Participants were divided into those with deductibles of $1,000 or more per person (Darden, Franklin); those with moderately high deductibles that had been substantially increased in recent years (Gray); those with

moderate deductibles that had been slightly increased or not increased at all recently (Abco, Crane); and those with low deductibles (Billco). Possible predictors were gleaned from the data and listed down the rows of the matrix. Indicators where all participants exhibited the same characteristic such as concern over rising premiums or continuation of managed care plan designs were not listed. Two predictors were listed that included only one case on each row. Abco's union contract and Ben Black's strong feelings toward employee decision making in health care matters were such overriding factors in each company's choice of health plan design that it was important to show those on the matrix.

Table 14

Predictors of Deductible Level

Level of Deductible→	High	Substantially Increased	Low/ Slightly Increased	No Deductible
Participants by Level of Deductible →	Darden Franklin	Gray	Abco Crane	Billco
Number of employees				
ten0-200	D		A	
50-99			C	B
<50	F	G		
Median pay				
>$15 per hour		G	A	
<$15 per hour	D,F		C	B
Median age				
>30 years	F	G	A,C	
<30 years	D			B
Reasons for continuing plan				
Union contract			A	
Competition for workers			A,C	B
Employees need it	D,F	G	C	
Owner's family needs it	F	G		B
Unprompted expression doubting employee decision making				B

The strongest relationship between predictive factors and the level of health plan deductibles appears to be found in the reasons given by participants for continuing to offer a plan. Each of the three companies listing competition for workers as one of the main factors had either low deductibles or no deductible. All three employers who did not mention competition for workers as a major reason for keeping their health plan were on the other side of the matrix offering high or substantially increased deductibles. Also, all of those participants with the higher deductibles stated their belief that employees need health insurance coverage as one of their chief reasons for offering a plan.

At first glance there does not seem to be a pattern relating level of deductibles to other factors such as number of employees, age of workforce, or median earnings of employees. Both of the smallest employers appear on the left half of the matrix having higher deductibles, but so does one of the largest employers. Companies with lower median pay are scattered across the matrix from high to low deductibles as are those with higher median age. The two employers with the youngest workforces are at opposite ends of the spectrum from the highest deductible to no deductible. However, looking at combinations of predictors does produce a pattern. National data indicate that the smallest employers are those least likely to offer health insurance benefits (Kaiser, 2007). Among these cases, the two smallest employers both offered higher deductible plans, had older workers, expressed a strong personal belief that workers need health insurance and employers have an obligation to offer a plan, stated that family members of the owners needed coverage, and did not indicate that they were faced with strong competition for workers.

Summary

Despite the strong consumer backlash against managed care plans in the late 1990s, none of the participants in this study have eliminated managed care controls from their health benefit plans. The business owners and executives participating in this study have all taken the approach of using managed care contracts to predetermine which providers offer acceptable levels of price and quality and which services require prior authorization by a third party beyond the patients and their physicians. Each of these employers relaxed managed care controls in recent years but do not intend to extend additional autonomy to employees for choices among providers and health care services in exchange for higher deductibles and coinsurance. The participants in this study did not seem to perceive a connection between the two and had not even considered the further reduction or elimination of managed care restrictions as they raised deductibles and coinsurance. They were simply focused on moderating premium increases. The implication is that the trade of greater freedom of choice in exchange for higher deductibles and coinsurance will not be available.

The second implication drawn from the data found in this study is closely related to the first. It is also based on fundamental principles from decision theory and diffusion theory. Janis & Mann (1977) documented the increase in cognitive dissonance resulting from restrictions on choice. As people perceived that their freedom to choose had been taken away they took steps to restore their ability to choose including passive resistance, ignoring restrictions, public action, or simply walking away from the decision. Several of the participants in this study of small employers reported evidence of passive or active resistance to increasing deductibles and coinsurance. The implication is that one should

expect to see the effects of cognitive dissonance manifested in the form of both active and passive resistance if employees are forced into high deductible, consumer-driven health plans without perceiving that they have a viable choice or even that they had some influence over the decision and received some value in exchange. The diversity, creativity, and power of this resistance should not be underestimated especially in light of the evidence that consumer resistance succeeded in emasculating the cost containing effects of managed care. Even in this study, delimited by the dominant conservative and autonomous culture from which the participants were drawn, the impact of this resistance resulted in small business entrepreneurs calling for federal interventions such as mandated participation in health insurance, subsidies for lower income workers, and caps on insurance premiums and provider prices.

In this study, the companies who had implemented higher deductible health plans had some predictive factors in common. Each spontaneously expressed a strong belief in the responsibility of employers to offer a health insurance plan for employees and none indicated that they were continuing to offer health benefits because of competition for workers. The two smallest employers both offered higher deductible plans, had older workers, expressed a strong personal belief that workers need health insurance and employers have an obligation to offer a plan, stated that family members of the owners needed coverage, and did not indicate that they were faced with strong competition for workers. In contrast, all of the employers offering low or no deductible insurance plans listed competition for employees among their main reasons for offering a health plan. Two of the cases where lower deductibles were offered had one characteristic that seemed to override all other factors: Abco’s benefit offerings were governed by a union

contract and Billco's owners strongly and repeatedly expressed their belief that their workers would not make good decisions about use of health care services and selection of providers. The implications of this pattern of predictors are that there may be two consistent factors in explaining small employers choices of deductible levels in their health plans: (1) the personal philosophy of the owner regarding responsibilities to employees and (2) the executives' perception of the intensity of competition for needed workers in their particular job market. For very small employers (fewer than 50 employees) a third major factor may be whether family members of the owners need coverage. This may be quite different from large employers where the main drivers are more likely to flow from shareholder expectations for benefit designs that are competitive with industry standards at or below competitive premium levels and where the ability to offer alternative plans and carriers to employees is much greater. The potential for consumer-driven designs to succeed managed care as the dominant model for distribution of health insurance coverage is predicated on adoption by both large and small employers. The results of this study raise serious doubts about that assumption.

Implications for Social Change

This study was designed to describe attitudes of small businesses toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. This study is important for social change because access to health care is one of the most complex social problems in the United States. Uneven distribution of health insurance coverage and its impact on access to health care services is one of the leading social and political issues in the United

States. Consumer-driven plans have been touted as the replacement model for managed care. However, this approach is also at high risk of failure unless these benefit plans are designed based on a clear understanding of how consumers will make health care choices and the factors that small business owners will consider in making decisions about health benefit offerings.

The literature reviewed in chapter 2 clearly indicates movement among health insurance companies and large employers toward consumer-driven health plans that significantly increase consumers' personal responsibility for payment at the point of service. The federal government also expressed support for this approach with the expansion of Health Savings Accounts enacted in 2003. If it is likely that the United States will continue with a health care system that is primarily privatized and employment based but where consumers have greater freedom of choice and bear greater financial responsibility at the point of service, it is important to understand the attitudes of small employers toward consumer-driven health plans.

The implications for social change stem from the findings in this study that small employers may not be expanding consumer choices as they increase health plan deductibles and coinsurance. The participants in this study were focused primarily on reducing premiums without consideration for eliminating or further relaxing managed care controls and without offering the higher deductible plans as options to employees rather than as replacements for managed care plans. This is consistent with some of the studies cited in chapter 2 where high deductible plans were seen mainly as a mechanism for shifting costs from employers to employees and skepticism was expressed over the effectiveness of consumer-driven designs in managing total costs (Kaiser, 2007: Nichols

et al., 2004; Regopoulos et al., 2006). It appears that small employers do not see increasing deductibles and coinsurance as part of a move toward greater consumer choice but rather as a necessary step to control premium increases that have accelerated in response to broader freedom of choice already given in the past.

The resulting implication is that society in the United States may be headed for a repeat of the consumer backlash that diluted managed care controls resulting in reacceleration of health care expenditures. This study found some indication of cognitive dissonance among individuals whose employers moved to higher deductible health plans without offering employees any other options. Many employees simply walked away from the system by going without health insurance while others sabotaged the system by seeking emergency room care while avoiding payment of the deductible by denying that they had health insurance coverage. Once again these active and passive behaviors against forced change were consistent with studies cited in chapter 2 (Janis & Mann, 1977; Nichols, 2004: Sultz & Young, 2006).

This goal of this study was to advance social change by adding depth to the understanding of small employers that will be valuable to the newly formed commission for the study of health insurance reform in Utah, to firms designing health insurance plans for small businesses, and to the development of future quantitative studies regarding trends in health benefit offerings among small employers. The commission should recognize that while the demand management aspects of consumer-driven designs may be essential to the financial viability of a health insurance model, consumers and perhaps small employers will resist and find ways to circumvent those designs unless they perceive value in forms such as expanded freedom of choice, enhanced

comprehensive coverage, and accessibility/participation for all. It appears that when contemplating consumer-driven design elements, such as higher deductibles, insurance carriers and employers need to find ways to offer trade offs that are perceived by the employees to have value. Exempting preventive services from deductible requirements is a step in the right direction. Other possibilities include offering a high deductible health plan from the same carrier as an option rather than as a requirement; using premium savings from implementing a high deductible plan to fund health savings or health reimbursement accounts; or involving employees in analysis of health plan results and alternatives for benefit plan changes. Recommendations for dissemination of results to these stakeholders will follow in the next section of this chapter.

Recommendations

Dissemination

Findings from the study will be disseminated to both practitioners and educators in the disciplines of health services administration, health care finance, and health policy using several methods. Articles summarizing the findings and their implications will be prepared and submitted to professional journals in the fields of both health services and education of health care administrators. Findings will also be incorporated into presentations to colleagues in the College of Health Professions at Weber State University, both graduate and undergraduate students majoring in health administration at Weber State, and to organizations of business and community leaders in the Ogden, Utah, area. The author will also meet with State Senator Sheldon Kilpack, chair of the Utah

Health System Reform Task Force, to present results of the study and to offer to prepare a presentation for the Task Force.

Policy

The main thrust of these articles and presentations will be that American society needs to take a comprehensive approach to demand management in reforming its health care system. Findings from the literature review and multiple case study will be used to illustrate the point that unilateral increases in deductibles by employers and insurance plans are not, by themselves, likely to succeed in reforming the health care system in the United States. While this approach is consistent with generally accepted economic theory on moral hazard, implementing it while ignoring equally well substantiated findings on decision theory, social change, and the diffusion of innovations will result in strong and effective resistance from the general public. Political leaders and business leaders are facing pressure to both increase access to health care services for the uninsured and to decelerate health expenditure growth. Legislators and administrators at both the state and federal levels should recognize that either limits on supply or mandated participation in High Deductible Health Plans are likely to be strongly resisted by the public. Policies based on personal responsibility for health and the financing of health care will have greater chance of success when coupled with expansion of choice supported by improved information systems, disease management programs, and incentives for effective decision making.

Practitioners

Substantially increasing out of pocket costs to the consumer at the point of service will decrease health care expenditures for a health insurance plan. This approach was implemented and is planned for further use by five of the six organizations studied. This strategy along with increasing the employee portion of premiums and shopping for a new carrier (Table 3) may well assist some small businesses in holding down their share of premiums to a level that they can afford, but may not advance positive social change. If more employees choose to drop coverage because they feel they cannot afford the increased costs the number of uninsured people will increase rather than decrease. If employees circumvent the plan designs through deception or other means, inefficient use of health care services will continue.

Health insurance carriers and small employers should minimize the negative impacts of resistance to change by taking a more comprehensive approach to demand management, offering additional choices to employees at the same time that deductibles and coinsurance are increased, and inviting employees to participate in the review and analysis of health plan experience and possible adjustments. Exempting preventive services such as annual medical examinations, periodic mammograms, and vaccinations from deductibles would encourage personal responsibility for health maintenance (especially for lower income workers) and show good faith on the part of the employer. Sliding scale deductibles should also be considered to make the deductible level proportionate to income. A disease management program could increase the quality of life for employees with a chronic condition, reduce their out of pocket costs, and reduce health plan expenditures on acute episodes of care.

Offering different insurance carriers side by side is not an option for small businesses but it appears that individual carriers will make available an array of plans. Offering a high deductible plan at a lower premium and/or with reduced managed care restrictions as an option to previously existing lower deductible plans would allow employees to choose a consumer-driven design rather than being forced into it. Using the employer's savings from reduced premiums to fund health savings or health reimbursement accounts would further enhance the value of the consumer-driven option for the employees. Employers should also consider involving employees, or a representative group of employees, in annual review of the health insurance plan. This would increase employee understanding of the financial issues, enhance acceptance of changes, and perhaps lead to some creative suggestions for improving the plan.

Further Study

This was a qualitative study involving six small employers in the Ogden, Utah, area. The relatively small number of participants prevents the development of statistically valid measures that could be projected on to larger populations. While this approach limited the breadth of findings, the use of multiple sources of data as well as cross case analysis enhanced the depth and richness of the findings. Participating employers were diverse in terms of size and type of business, but homogeneity of cultural and economic environment are delimiting factors that could impact the attitudes of participating small business owners and managers. The study produced results that are conceptually representative (rather than statistically) of health insurance attitudes within the context of

small employers. Opportunities abound to advance social change by expanding both the depth and breadth of understanding of these issues.

Clearly the field of health insurance reform is fertile for additional studies, both qualitative and quantitative. The qualitative approach employed here found attitudes toward health plan design, impact on small employers and their employees, and employee reactions that would not have been described by a quantitative study. However, the results also indicate opportunities for further studies, both quantitative and qualitative. The degree to which employers of various sizes are staying with managed care plan designs while adopting High Deductible Health Plans could be quantified, perhaps even through study of existing databases. Employee reactions to rising deductibles and coinsurance without corresponding relaxation of managed care controls could also be explored. Both attitudes and behaviors could be further described by qualitative studies and measured by quantitative research. Larger studies similar to the one conducted here could describe small employer attitudes across broader populations and quantitative studies could be designed to measure small employer attitudes toward consumer-driven health care and project the impact of those attitudes on health benefit plan designs. It appears that these studies should be stratified at least to the three levels shown in this design and perhaps to even smaller layers.

Reflections on the Study

As a veteran of about 24 years in the administration of health care systems, I came to this study with a deep understanding of the challenges and motivations impacting hospitals, physicians, and other health care providers every day. There is no doubt that

my experience created a bias against frequently seen assumptions that hospital inefficiency, physician greed, and insurance plan bureaucracy are the main causes of high health care costs in the United States and that this problem can be resolved simply by cutting payments to providers and insurance carriers. While I had an understanding that the supply side of health care could become more efficient, I also believed that the spiraling problems of very high expenditures and dissatisfaction with access were driven mostly by demand. Government policies and societal practices in the United States have driven demand well ahead of supply for the last several decades. These societal actions included a wide variety of policies and practices such as the federal income tax code, employer sponsored first dollar health insurance coverage, Medicare and Medicaid, and a litigation oriented tort system.

In depth study of economic principles during the literature review, especially moral hazard, refined and strengthened my belief that realistic health care reforms needed to focus more on demand management. Multiple studies touted increasing personal financial responsibility for the cost of health care services through the adoption of consumer-driven health plans as the potential successor to managed care as the dominant health benefit design in the United States. However, the literature review also provided me with a tremendously enhanced understanding of decision theory and the workings of social change, especially as impacted by the diffusion of innovations. These findings brought the decline of managed care into clearer perspective and raised doubts about the success of consumer-driven health care.

There were some surprises during the study. The participants' continuing strong reliance on managed care networks to monitor both the pricing and effectiveness of

health care services was not listed among the expected findings. Neither was the disconnect between raising deductibles and increasing freedom of choice for employees. In hindsight, the behaviors of these small business executives make perfect sense: broadening of choice and relaxation of barriers to access had already occurred; they resulted in reacceleration of utilization and premiums; now the business owners were raising deductibles not in exchange for even greater choice but as a mechanism to dampen demand and reduce premiums. Probably the most significant finding from the study was also a surprise. Several of the participants described various active and passive behaviors strongly resisting the implementation of High Deductible Health Plans. As doucmented in the findings and implications described in earlier sections of this chapter, these reactions are highly consistent with elements of both decision theory and social change theories regarding the diffusion of innovation.

More than anything, I came away from the research with an understanding of the importance of the process. Thorough review of relevant theory and recent studies does provide the broad understanding necessary to design and implement a meaningful research study. Careful crafting of the purpose of the study and research questions is essential to developing a design that will result in understandable findings. Consideration of various designs, selection of the one most appropriate to the purpose of the study, and development of a detailed protocol are necessary to assure the gathering of relevant data. Lastly, while adherence to the protocol is essential for consistency of data gathering and analysis, flexibility in following the data when it indicates new threads is also key to comprehensive findings and clear assessment of implications.

Summary and Conclusion

Health system reform is one of the most important social issues in the United States. The current financing system is employer-based with about half of all workers employed by small businesses. Chapter 2 documented that these small employers are much less likely than larger businesses to offer health benefit plans and have been dropping them at a steady rate. The purpose of this study is to describe attitudes of small businesses toward consumer-driven health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees. In depth understanding of the ways in which small business decision makers perceive and evaluate the purported advantages and challenges of consumer-driven health plans will be critical in predicting their adoption patterns and in designing and presenting benefit plans. Research questions for this study center around theoretical issues that have been identified in several fields and applied to the design of health insurance plans by several researchers. Specifically, to what extent do small employers implicitly or explicitly believe the theories and findings on which the movement toward consumer-driven models is based? How does this impact small employers' decisions regarding the broadening of provider networks, relaxation of managed care controls, and divergence from the tradition of offering only one health benefit plan? And, to what extent will the potential negatives impact the employers' consideration of consumer-driven health plans?

The case study method was chosen to increase the depth of understanding of small employer attitudes toward health insurance plans and toward consumer-driven designs in particular. A research protocol was developed to govern the selection of participants, gathering of data, and maintenance of records. This protocol included an

interview template designed to provide consistency in the interviews and to draw out data related to the research questions. Participating organizations were chosen for variety in terms of number of employees, to represent business types from both the manufacturing and service sectors, and a range of employees from lower paid service or semi-skilled workers to more highly compensated skilled, technical, or professional staff. Each participating organization provided documents showing trends within their health insurance benefits during the last three to five years. Interviews were then conducted with general management of each organization using the interview template.

Information provided by the interviews was coded using predetermined master themes following the pattern coding approach recommended by Miles & Huberman (1994) and Yin (1994). Master themes were modified during the data gathering process using iterative pattern matching methodology (Yin). Integration and analysis of data from the several cases were organized in three ways: first, in comparison with the expected findings that were gleaned from the literature search and listed in chapter 3; second, around the research questions formulated in chapter 1; and, finally, with reference to the master themes established before and during coding of the data.

Key findings were that the participants did not believe employees could or would find adequate information about the quality and cost of health care services and alternative providers that would allow them to make effective choices. As a result all of the participants had maintained managed care controls on available providers and access to expensive services. The implication is that consumer-driven health plans may not be offered by small businesses as an alternative to managed care or even as a replacement. Rather, high deductibles may simply be layered on top of managed care controls without

a corresponding expansion of choice for employees. Several of the study participants had already observed employees engaged in both passive and active resistance to the imposition of high deductibles. While consumer-driven designs appear to be consistent with economic and ethical principles regarding moral hazard, they are also based on decision theory and social change theories that require employees to believe they are freely choosing this innovation and that it provides value to them in the form of greater autonomy. The take away message is that small employers may not be providing enhanced value or choices to employees in exchange for High Deductible Health Plans and that therefore employees are likely to actively rebel against these plans just as they did the imposition of managed care controls during the 1990s. Policy makers, insurance carriers, and employers should minimize the negative impacts of resistance to change by taking a more comprehensive approach to demand management, offering additional choices to employees at the same time that deductibles and coinsurance are increased, and inviting employees to participate in the review and analysis of health plan experience and possible adjustments.

REFERENCES

Ackoff, R. L. (1974). *Redesigning the future: A systems approach to societal problems.* New York: John Wiley and Sons.

Anderson, G. F., Reinhardt, U. E., Hussey, P. S., & Petrosyan, V. (2003). It's the prices, stupid: Why the United States is so different from other countries. *Health Affairs, 22*(3): 89-105.

Anderson R.A. & McDaniel R. R. Jr. (2000). Managing health care organizations: Where professionalism meets complexity science. *Health Care Management Review, 25*(1), 83-92.

Andrews, L.W. (2005). The nexus of ethics. *HRmagazine*. *50*(8), 52.

Argyris, C. (1960). *Understanding organizational behavior.* Homewood, IL: Dorsey Press.

Ashmos, D. P., Duchon D., & McDaniel R. R. (2000). Physicians and decisions: A simple rule for increasing connections in hospitals. *Health Care Management Review*, *25*(1), 109-15.

Ashmos, D. P., Duchon, D., & McDaniel, R. R. (1998). Participation in strategic decision making: The role of organizational predisposition and issue interpretation. *Decision Sciences*, *29*(1), 25-50.

Ashmos, D. P., Huonker, J. W., & McDaniel, R. R. (1998). Participation as a complicating mechanism: The effect of clinical professional and middle manager participation on hospital performance. *Health Care Management Review, 23*(4), 7-20.

Babbie, E. (2004). *The practice of social research.* Belmont, CA: Wadsworth.

Beauvais, B. & Wells, R. (2006). Does money really matter? A review of the literature on the relationships between healthcare organization finances and quality. *Hospital Topics: Research and Perspectives on Healthcare, 84*(2), 20-28.

Berenson, R. A. (2005). Which way for competition? None of the above. *Health Affairs, 24*(9), 1536-1542.

Berkowitz, E. (1996) *Essentials of Health Care Marketing*. Gaithersburg, MD: Aspen.

Bertalanffy, L. (1968) *General system theory.* New York: George Braziller.

Boscarino, J. A., & Adams, R. E. (2004). Public perceptions of quality care and provider profiling in New York: implications for improving quality care and public health. *Journal of Public Health Management and Practice, 10*(3), 241-250.

Bloche, M. B., & Studdert, D. M. (2004). A quiet revolution: Law as an agent of health system change. *Health Affairs, 23*(2), pp. 29-42.

Boylan, M. (2000). *Medical ethics: Basic ethics in action.* Upper Saddle River, NJ: Prentice Hall.

Brown, L. D. & Eagan, E. (2004). The paradoxical politics of provide reempowerment. *Journal of Health Politics, Policy, and Law, 29*(6) pp. 1045-1071.

Burchfield, D. C. & Battistella, R. M. (2003). Consumer-driven health care: Three options, one reality. *Employee Benefit Plan Review, 57*(12), 13-16.

Bureau of Labor Statistics (2007). *Union affiliation of employed wage and salary workers by state.* retrieved from www.bls.gov/news.release/union2.t05.htm.

Canadian Institute for Health Information (2005). *Medical imaging in Canada, 2004.* Retrieved from http://secure.cihi.ca.

Carosella, E.D. & Pradeu, T. (2006). Transplantation and identity: A dangerous split. *Lancet*. *368*(9531), 183.

Carpenter, C. E. (2006). Consumer-driven health plans—a progress report. *Journal of Financial Service Professionals.* July, 21-22.

Center for Studying Health System Change (2008). *Design and methods for the community tracking study.* Retrieved from http://www.hschange.com/index.cgi?data=01.

Centers for Medicare and Medicaid Services (2005). *National health care expenditures, 2003.* Retrieved from http://www.cms.hhs.gov/statistics/nhe/

Christianson, J. B., Parente, S. T., & Taylor, R. (2002). Defined-contribution health insurance products: Development and prospects. *Health Affairs, 21*(1), pp. 49-64.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage Publications.

Cunningham, P. & Hadley & Holahan, J. (2004). Expanding care versus expanding coverage: How to improve access to care. *Health Affairs, 23*(4), pp. 234-244.

Cunningham, P. & Kirby, J. (2004). Children's health coverage: A quarter-century of change. *Health Affairs, 23*(5), pp. 27-38.

Department of Workforce Services (2007). Unemployment and employment. Retrieved from http://jobs.utah.gov/opencms/wi/pubs/une/.

Dombeck, M-T. & Olsan, T. H. (2002). Ethics and managed care. *Journal of Interpersonal Care, 16*(3), 221-233.

Dowie, J. (2002). The role of patients' meta-preferences in the design and evaluation of decision support systems. *Health Expectations, 5*, pp. 16-27.

Edmondsen, A. C., Bohmer, R. M., & Pisano, G. P. (2001). Disrupted routines: Team learning and new technology implementation in hospitals. *Administrative Science Quarterly, 46*, 685-716.

Feldstein, P. (2003). *Health policy issues: An economic perspective*. Chicago: Health Administration Press.

Flynn, E. P. (2000). *Issues in health care ethics.* Upper Saddle River, NJ: Prentice Hall.

Fuchs, V. R. (1993). *The future of health policy.* Cambridge, MA.: Harvard University Press.

Fuchs, V. R. & Emanuel, E. J. (2005). Health care reform: Why? what? when? what it might take to effect comprehensive change. *Health Affairs, 24*(6), 1399-1414.

Gabel, J., Claxton, G., Gil, I., Pickreign, J. Whitmore, H., Finder, B., Hawkins, S., & Rowland, D. (2005). Health benefits in 2005: Premium increases slow down, coverage continues to erode. *Health Affairs, 24*(5), pp. 1273-1280.

Gabel et al., J. R., Whitmore, H., Rice, T, & Le Sasso, A. T. (2004). Employers' contradictory views about consumer-driven health care: Results from a national survey. *Health Affairs.* Web exclusive, *W4*, 210-218.

Galotti, K. M. (2002). *Making decisions that matter: How people face important life choices.* Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Garrett, T. M., Baillie, H. W., & Garrett, R. M. (2001). *Health care ethics: Principles and problems.* Upper Saddle River, NJ: Prentice Hall.

Geertz, C. (1973). *The interpretation of cultures; Selected essays.* New York: Basic Books.

Getzen, T. E. (2004). *Health economics fundamentals and flow of funds.* New York: John Wiley and Sons.

Ginsberg, M. E. (2004). Cost effectiveness: Will the public buy it or balk? *Health Affairs Supplementary Web Exclusives,* Jan-June 2004, pp. 297-299.

Ginsburg, P. B. (2005). Competition in health care: Its evolution over the past decade. *Health Affairs, 24*(6), 1512-1522

Hadley J. & Holahan, J. (2003). How much medical care do the uninsured use, and who pays for it? *Health Affairs-Web Exclusive,* pp. 66-81.

Hadley J. & Holahan, J. (2003). Covering the uninsured: how much would it cost? *Health Affairs-Web Exclusive*, 250-265.

Helfand, J., Sadeghi, A, & Talan, D. (2007). Employment dynamics: Small and large firms over the business cycle. *Monthly Labor Review,* March, 2007, 39-50.

Herzlinger, R. (2004). Consumer-driven health care: lessons from Switzerland. *JAMA, 292*(10), 1213-1220.

Hoadley, J. F., Cunningham, P., & McHugh, M. (2004). Popular Medicaid programs do battle with state budget pressures: Perspectives from twelve states. *Health Affairs*, *23*(2), pp. 143-154.

Hogarth, R. M. (1987). *Judgment and choice: The psychology of decision.* New York: John Wiley and Sons.

Isen, A. M. (2001). An influence of positive affect on decision making in complex situations: Theoretical issues with practical implications. *Journal of Consumer Psychology, 11*(2), pp. 75-85.

Janis, I. L. & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment.* New York: Free Press.

Justison, P., Harrison, J., Pullin, T., & Anderson, K. E. (2000). Lessons in scenario planning. *Health Forum Journal, 43*(3), 42-45.

Kahneman, D. J., Slovic, P., & Tversky, A. (1982). *Judgment under uncertainty: Heuristics and biases.* Cambridge, England: Cambridge University Press.

Kaiser Family Foundation and Health Research and Education Trust (2007). Employer health benefits 2007 summary of findings, retrieved from http://www.kff.org/insurance/7672/index.cfm

Kernick, D. P. (2000). The impact of health economics on healthcare delivery: A primary care perspective. *Pharmacoeconomics, 18*(4), pp. 311-315.

Kotler, P. & Clarke, R. (1986). *Marketing for health care organizations.* Englewood Cliffs, NJ: Prentice Hall.

Landon, B. E., Reschovsky, J., & Blumenthal, D. (2003), Changes in career satisfaction among primary care and specialist physicians, 1997-2001. *Journal of the American Medical Association, 289*(4), pp. 442-449.

Lee, P. R. & Estes, C. L. (2003). *The nation's health.* Sudbury, MA: Jones and Bartlett.

Marmor, T. R. (2006). U.S. health reform failures: The elusive quest for explanations. *Health Affairs, 25*(3), 872-874.

McDaniel, R. R. (1997). Strategic leadership: A view from quantum and chaos theories. *Health Care Management Review, 22*(1) 21-37.

McDaniel R. R., Jordan M. E., & Fleeman B. F. (2003). Surprise, surprise, surprise! A complexity science view of the unexpected. *Health Care Management Review, 28*(3), p. 266-278.

Menzel, P. T. (1983). *Medical costs, moral choices : A philosophy of health care economics in America.* New Haven: Yale University Press.

Menzel, P. & Light, D. W. (2006). A conservative case for universal access to health care. *Hastings Center Report,* July-August, pp. 36-45.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis.* Thousand Oaks, CA: Sage Publications.

Miller, W. L., McDaniel, R. R., Crabtree, B. F., & Stange, K. C. (2001). Practice jazz: Understanding variation in family practices using complexity science. *The Journal of Family Practice*, *50*(10), 872-878.

Moran, D. (2005). Whence and whither health insurance? A revisionist history. *Health Affairs, 24*(6), 1415-1425.

Natt, R. L. (2005). HSAs: Small businesses still can offer an attractive employee benefits program, despite rising health care costs. *Employee Benefit Plan Review.* April, 215-216.

Neuhauser, D. (2003). The coming third health care revolution: Personal empowerment. *Quality Management in Health Care, 12*(3), pp. 171-184.

Nichols, L. M., Ginsburg, P. B., Berenson, R. A., Christianson, J., & Hurley, R. E. (2004). Are market forces strong enough to deliver efficient health care systems? Confidence is waning. *Health Affairs, 23*(2), pp. 8-21.

Nolin, J. & Killackey, J. (2002). Redirecting health care spending: Consumer-directed health care. *Nursing Economic$, 22*(5), pp. 251-257.

Noon, C. E., Hankins, C. T., & Cote, M. J. (2003). Understanding the impact of variation in the delivery of healthcare services. *Journal of Healthcare Management, 48*(2), 82-97.

Orlikoff, J.E. & Totten, M.K. (2006). Conflict of interest and governance. *Healthcare Executive*. *21*(5), 52.

Peirce, J. C. (2000). The paradox of physicians and administrators in health care organizations. *Health Care Management Review, 25*(1), 7-28.

Pham, H. H., Devers, K. J., May, J. H., & Berenson, R. (2004). Financial pressures spur physician entrepreneurialism. *Health Affairs, 23*(2), pp. 70-81

Plsek, P. E. & Greenhalgh, T. (2001). Complexity science: The challenge of complexity in health care. *British Medical Journal, 323*, 625-628.

Plsek, P. E. & Wilson, T. (2001). Complexity science: Complexity, leadership, and management in healthcare organizations. *British Medical Journal, 323*, 746-749.

Regopoulos, L., Christianson, J. B., Claxton, G., & Trude, S. (2006). Consumer directed health insurance products: Local market perspectives. *Health Affairs, 25*(3), 766-773.

Remler, D. K. & Glied, S. A. (2006). How much more cost sharing will health savings accounts bring? *Health Affairs, 25*(4), 1070-78.

Rhodes, R. (2004). Clinical justice guiding medical allocations. *The American Journal of Bioethics. 4*(3), 116-119.

Richardson, M & Schneller, E. S. (1998). Out of the box: Health management education in the 21st century. *Journal of Health Administration Education*, *16*(1). 87-97.

Robinson, J. C. (2003). Hospital tiers in health insurance: Balancing consumer choice with financial incentives. *Health Affairs, 22*(1) pp. 135-146.

Robinson, J. C. (2005). Health savings accounts—the ownership society in health care. *New England Journal of Medicine, 353*(12), 1199-1202

Romar, E.J. (2004). Managerial harmony: The Confucian ethics of Peter F. Drucker. *Journal of Business Ethics*. *51*(2),

Rona, J. M. (2005). 97.1 Percent perfect: Healthcare leadership's pinto. *Journal of Healthcare Management, 50*(2), 87-93.

Rogers, E. M. (1983). *Diffusion of innovations.* New York: The Free Press.

Rogerson, K. F. (1991). *Introduction to ethical theory.* Fort Worth, TX: Holt, Rinehard, and Winston, Inc.

Ruchlin, H. S., Rogers, D. C. (1973). *Economics and health care,* Springfield, IL: Thomas.

Saleh, S. S. & Levin, P. (2005). Another evolvement of the cost and risk shifting model: Consumer-driven health plans. *JHHSA.* Winter, 386-397.

Scheffler, R. M. & Felton, M. C. (2006). Consumer-driven health plans: New developments and the long road ahead. *Business Economics.* July, 44-48.

Senge, P. (1990). *The fifth discipline: The art and practice of the learning organization.* New York: Doubleday.

Shewchuk, R. M., O'Connor, S. J., & Fine, D. J. (2005). Building an understanding of the competencies needed for health administration practice. *Journal of Healthcare Management, 50*(1), 32-47.

Sinnett, W. M. (2004). Rising healthcare costs: Searching for a cure. *Financial Executive, 20*(4), pp. 50-52

Slomka, J. (2004). Fairness in context: The real versus the ideal. *The American Journal of Bioethics. 4*(3) 115-6.

Stango, M.R. (2006). Ethics, morals, and integrity focus at the top. *Healthcare Financial Management*. *60*(6), 50.

Starr, P. (1982). *The social transformation of American medicine.* New York: Basic Books, Inc.

Sultz H., & Young, K. (2006). *Health care USA: Understanding its organization and delivery.* Boston: Jones and Bartlett.

Sztompka, P. (1993). *The Sociology of social change.* Cambridge, MA: Blackwell.

Tai-Seale, M. (2004) Voting with their feet: Patient exit and intergroup differences in propensity for switching usual source of care. *Journal of Health Politics, Policy, and Law. 29*(3), pp. 491-514.

Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health.* San Francisco: Jossey-Bass.

The World Bank Group, (2001). *Life expectancy.* Retrieved from www.worldbank.org.

Tunis, S. (2005). A clinical research strategy to support shared decision making. *Health Affairs, 24*(1), pp. 180-184.

U. S. Census Bureau (2005). State and county quick facts. Retrieved from http://quickfacts.census.gov/qfd/states/49000.html

U. S. Department of Labor (2007). Health plans and benefits: Plan information. Retrieved from http://www.dol.gov/dol/topic/health-plans/planinformation.htm

U. S. Office of Personnel Management (2007). High Deductible Health Plans with health savings accounts. Retrieved from http://www.opm.gov/hsa/

Utah Code (2007). Section 31A-22-807. Retrieved from http://le.utah.gov/~code/TITLE31A/htm/31A17141.htm

Webster, P. (2006). U.S. big businesses struggle to cope with health-care costs. *The Lancet, 367*, 101-102.

Weintraub, A. (2006). What's ethical and what isn't? *Business Week. 3967*, 76.

Wheatley, M. (1992). *Leadership and the new science: Learning about organization from an orderly universe.* San Francisco: Berrett-Koehler

Winter, M. (2000). Cutting health care spending. *Human Ecology, 28*(2) pp. 8-11.

Wisnicki, H. J. (2005). Information highway helps patients make decisions. *Ophthalmology Times, 30*(9), pp. 40-41.

Wynia, M. K., Cummins, D., Fleming, D., Karsjens, K., Orr, A., Sabin, J., Saphire-Bernstein, I, & Witlen, R. (2004). Improving fairness in coverage decisions: Performance expectations for quality improvement. *The American Journal of Bioethics. 4*(3) 87-100.

Yin, R. K. (1994). *Case study research: Design and methods.* Thousand Oaks, CA: Sage Publications.

APPENDIX A: INTERVIEW TEMPLATE

1. How long have you offered a health insurance plan(s) to your employees?

2. How do you feel about the plan(s) you currently offer?

3. How do your employees feel about the current offerings?

4. Are you currently considering any changes?

5. What factors are considered when you make decisions about health benefits?

6. Which are most important?

7. If the interviewees mention high deductibles or consumer-driven plans, ask for their understanding of these terms. If those terms have not been mentioned, ask if they are familiar with those terms, then pursue their understanding.

8. If the interviewees mention Health Reimbursement Accounts or Health Savings Accounts, ask for their understanding of these terms. If those terms have not been mentioned, ask if they are familiar with those terms, then pursue their understanding.

9. Have you considered these types of accounts? Will you consider them?

10. What elements of high deductible/consumer-driven plans are attractive, intriguing, confusing, or cause for concern or caution?

11. How likely are you to seriously consider this type of plan? Implement?

12. What will be the key factors in your consideration?

13. Pursue each advantage or concern mentioned. If key theoretical benefits and concerns have not been mentioned, ask about them specifically:

    (1) Reduced premiums because of cost shifting to employees.
    (2) Reduced costs because employees make better decisions.
    (3) Fewer restrictions on choice of providers and services.
    (4) Inadequate quality and cost information for employees to make good choices.
    (5) Disproportionate impact on lower income employees; employees foregoing needed services to avoid out of pocket cost.
    (6) Disproportionate impact on older and chronically ill employees who may not be able to accumulate funds in savings accounts.

(7) Loss of incentive for employees who exceed annual deductible or out of pocket maximum.
(8) Increased administrative burden.

14. If disease management programs have not been mentioned, ask for their understanding and opinion of them.

15. Would you like to add any other comments about health insurance?

Do you foresee any circumstances where you would discontinue health benefits? Do you see high deductible/consumer-driven plans as a model that will help you continue to offer health benefits?

APPENDIX B:

CONSENT FORM

You are invited to take part in a research study of health insurance offerings by small employers. You were chosen for the study because you represent an organization that offers health insurance benefits and employs less than 200 people. Please read this form and ask any questions you have before agreeing to be part of the study.

This study is being conducted by a researcher named Richard J. Dahlkemper, who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to describe attitudes of employers with less than 200 workers toward consumer-driven (high deductible) health plans and factors that will be considered by small businesses in deciding whether to offer such a plan to employees.

Procedures:
If you agree to be in this study, you will be asked to:

- Provide access to health plan records for the past five years including summary plan descriptions, participation summaries, total claims paid, loss ratios, and agent proposals or consultant recommendations (if any).
- Participate in an audio recorded interview lasting approximately one hour regarding your perceptions of current health plan models and factors considered in making decisions regarding health plan offerings.
- Review a transcription of the recorded interview to verify its accuracy and add any additional comments.

Voluntary Nature of the Study:
Your participation in this study is voluntary. This means that everyone will respect your decision of whether or not you want to be in the study. No one at Walden University will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. If you feel stressed during the study you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:
There is a minor risk that information from your records could be disclosed. This risk will be minimized however by the fact that only the researcher will have access to the original data and only the researcher and the transcriptionist will know your identity and the name of your company.

This study will add depth to our understanding of small employers that will be valuable to the newly formed commission for the study of health insurance reform in Utah, to firms designing health insurance plans for small businesses, and to the development of future quantitative studies regarding trends in health benefit offerings among small

employers. As a participant, you may also become better informed about the potential advantages and challenges of high deductible consumer-driven health benefit plans. This knowledge may help you with decisions regarding modifications to the health benefit plans offered to your employees.

Compensation:
No compensation is offered for your participation. Participants will receive an executive summary of the study following its completion.

Confidentiality:
Any information you provide will be kept confidential. The information you provide will not be used for any purposes outside of this research project. Also, the researcher will not include your name or anything else that identifies you in any reports of the study.

Contacts and Questions:
The researcher's name is Richard J. Dahlkemper. The researcher's faculty advisor is Jim Goes, PhD. You may ask any questions you have now. Or if you have questions later, you may contact the researcher via telephone at (801) 626-7298 or email at rdahlkemper@weber.edu or the advisor at (541) 767-9759 or jim.goes@waldenu.edu.. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott, Director of the Research Center at Walden University. Her phone number is 1-800-925-3368, extension 12ten.

The researcher will give you a copy of this form to keep.

Statement of Consent:

☐ I have read the above information. I have received answers to any questions I have at this time. I am 18 years of age or older, and I consent to participate in the study.

Printed Name of Participant ______________________________

Participant's Written or Electronic* Signature ______________________________

Researcher's Written or Electronic* Signature ______________________________

Electronic signatures are regulated by the Uniform Electronic Transactions Act. Legally, an "electronic signature" can be the person's typed name, their email address, or any

other identifying marker. An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically.

APPENDIX C

INTERVIEW WITH ART ADAMS

Interviewer's questions shown in *italics*; participant's responses in regular font.

Art Adams is here with me and has graciously agreed to be interviewed for this study. I have explained to him the purpose of the study and what we are looking into. So, Art, if it is okay with you, I will run through these questions and make a few notes. Yes.

About how long have you offered health insurance plans to your employees? Probably for 40+ years. *This is just a curiosity question, is this a family business?* Yes. *Did your father start the business?* Grandfather. I am the third generation.

Just a general question to see what comes to the top of your mind, how do you feel about the health insurance plan that you currently offer? I think we offer one of the better plans out there. It covers more things. One of the biggest advantages to the employees is that I pay all of the premiums. If they use the PPO provider network, which is everybody but IHC, it pays about 85% after the deductible. We have a deductible of about $300.00 per person per year. On a catastrophic illness, once the person has paid $5,000 out of pocket, the plan will pick up ten0% of the benefits. We also offer a very attractive dental plan that pays for various things. For things like caps, crowns, and braces, there are set amounts; but, if you go in on your 6 month check-up, it pretty well pays for all of that. We also have a vision benefit as far as an eye exam, glasses, that sort of thing. If there is any problem, then it flips over to a medical thing. We also have what we call a family assistance program. If someone has a family member or the participant has a drinking or drug problem, legal problems, we have a benefit for that, which the participants are able to take advantage of. That is a general outline of what it covers.

So, you feel pretty good about it? It is comprehensive? The employees don't have to pay any of the premiums? No, it costs me about $8,400/year per employee.

You mentioned $300 per person deductible if they use a preferred provider; apparently, their co-insurance then is about 15%? That is correct. If they don't use a PPO provider, the plan will only pay 65%. Also, on the prescriptions, we go through an outside provider called RX America, which negotiates discounts to the pharmacy direct. So, when the participant picks up, whatever discount they would get has already been taken off. That is how that works.

Have the deductible and the co-insurance changed in recent years? Yes, not too many times in recent years. During that period after 911 and the Olympics. This is a construction based plan. There was a lot of unemployment and we had to cut some benefits, not much; but, one of the things we did was raise the deductible on that. That was probably in 2002 or 2003. We haven't changed it since then.

You raised the deductible and the percentage? We left the 85% alone for PPO providers. For non-PPO providers, i.e. Intermountain Health, we dropped it. They were both 85% and we dropped it down to 65%. That was a big savings to the plan. It kind of forced the people to use the PPO providers.

How would you say your employees feel about the plan currently? Well, the employees who have just recently been employed by Abco and have come from somewhere else, they think it is wonderful. The folks who have been here for evermore think they ought to have more benefits. But, I think it is one of the better plans in the state.

The longer term people, they feel like it is maybe less than it was a few years ago? Yes, I think so. I think the biggest complaint is there are more hoops to jump through. They still get coverage, but they have to do a lot more things to get it. *More prior approvals?* That type of thing, yes.

Is yours a gatekeeper plan where you have to go through a primary care physician to get referred to a specialist? That is correct, yes.

Are you currently considering any changes to the plan? No. *You mentioned, before I turned the tape on, that you were a union shop and there is a committee that oversees this. Is the plan renegotiated annually, every 3 years?* The only thing that is negotiated every 3 years is when the contract is up and the bargaining parties negotiate so many cents more an hour that would go into the health and welfare plan. And, as trustees, we take whatever they give us and make it work. And buy whatever you can? And buy whatever we can. So, in good years, we may increase the benefits; and, in bad years, we will make cuts or raise the deductible, depending on what money is allocated to us.

You may have already answered this next question, or at least you got onto it, what factors are considered when you make decisions about health benefits? Well, again, it is financial, what can we afford. Also, if you look through the books that I gave you, our consultant gives us a quarterly report on continuation value. What that means is if there would be no more money put into the plan, how long would the plan survive. As the trustees, if we get down to a 4 month continuation value, then we have a policy that we make cuts. We make cuts, we raise deductibles, and we do everything. So, when it reaches a certain point, then, we make changes.

You already mentioned that you have a preferred provider type of plan. What considerations go into that? How do you monitor the providers? How do you choose the providers? We use a company called Wise something or other. They go out and line up the preferred provider network; and, we pay them so much per participant and they run it. That is their thing to chase it down. Basically, it is everybody but IHC.

Is that because that is just the way it worked out or that was the best offer you had? Well, IHC has a monopoly in the state of Utah. I can't remember what percentage, but it is close to 70% to 80% that they control of health care in Utah; and, obviously, they don't

want to give any discounts to anybody. That is just the way it is. They have their own health care networks and the whole bit; so, they don't want to deal with you.

Are you familiar with the term consumer-driven health plans? No. *That is a term that, I don't know who put the label on, is labeled for these high deductible and high co-insurance type of plans. There seems to be a trend in that direction. Do your consultants talk to you about that or have they made recommendations for higher deductibles or co-insurance?* Well, they have and we have talked about these things; but, the problem is being a union plan, raising the deductibles is a mortal sin for the political folks on the committee. Unless we are in dire straits, it is a tough one to crack. You are right, if we went to higher deductibles, it would certainly help the plan out considerably and it would also give them a better deal when they have a catastrophic illness. That really, as far as our plan is, is the way I see it. Most of these people make pretty good income and routine office visits and things aren't going to kill them. What they need is coverage for the catastrophic things. It is hard to get that message across.

That is exactly the struggle that we are looking at nationwide. A lot of the studies that have been done, a lot of the literature feels that our traditional first dollar or close to first dollar coverage plans have really caused the consumers to feel like health care is free and that is a big part of the reason for the high utilization and the rapid growth in the costs. That is exactly right. A couple of things that we have had to do, for example, not the vast majority, but you have a very small percentage who have figured out if they went to the emergency room every time, then we would pay ten0%. So, we are constantly plugging the loop holes of these chronic folks that do those types of things. If we had higher deductibles and the people were paying a little bit out of their pocket every time, our health care plan would improve considerably. We pay it a lot more when the people have gotten into real trouble. That is why we are starting various wellness programs and that is why we have the family assistance program to try to wean these people off and get them where they need to be.

Are you familiar with health savings accounts or health reimbursement accounts? Yes. *What has been your contact with that? Do you have them in your plan or do you discuss them?* No. We have discussed them and the union trustees don't want anything to do with it. *The union reps?* That is the manager and the 2 business agents, it is the union officers. They vetoed that. Anytime something like that comes up, they don't want anything to do with it. It is a control issue on the members is what it amounts to.

So, the union trustees want to manage the fund, they don't want each employee to have their own savings account….is that what you are saying? That is correct. Our plan also covers the union retirees and also the management retirees who are in it. It is kind of the same thing; and, they may have to come around. The way our plan is written, they become eligible to go on retiree status when they start taking social security Medicare. So, when Medicare becomes their primary thing. So, if they keep ours going, they have to pay 55% of Cobra. That has taken the last couple of years. Because the way things are figured, that Cobra rate is figured, it has taken some drastic jumps. We have talked about

taking whatever money that is and letting them go out into the outside market and buy insurance on their own. Maybe they can save and maybe they can't; just get out of the retiree business. I don't know where that is heading. The first meeting, the union seemed fairly agreeable to continue the talks; but, I don't know what is going to happen when they talk to their retiree population who also has a vote in their meetings.

We have covered a little bit of this, but I want to get more specifically into the high deductible or the so called consumer-driven plans. That is really the focus of what I am studying. How are small employers reacting to those and what are the attitudes or concerns about it. So, what is it about higher deductible plans; and, by that I also include higher co-insurance, higher out of pocket at the point of service, that you find attractive or concerning? Well, I think it would be a good idea; but, like I stated before, if the participant had to pay out of pocket, he had to pay something to pay those first initial costs or the office visits or whatever, I think they would be less inclined to go to the doctor for every frivolous little thing instead of taking 2 aspirins and see what happens the next day or so. It would also, by cutting that down, it would make the plan a lot better as we would be able to cover more of the catastrophic type of things.

Some of this may or may not apply specifically to your plan; but, your opinions as a businessman are welcome too. Managed care has been around for a long time, HMOs and PPOs, and consumers have really rebelled against a lot of the restrictions. You mentioned earlier that is one thing your employees don't like. Would you see, either in your plan or any general comments you had, with higher deductibles and co-insurance, could that be a trade off for the restrictiveness of the plan? It could be; but, it couldn't be in Utah because of IHC and the large percentage of the market that they cover. Unless you could get IHC to go along with something like that, it wouldn't happen here.

One of the criticisms of the so called consumer-driven plans, or I guess I should say my concerns about them, is as the employees are expected to pay more out of their own pocket at the point of service, it is hard for them to make good decisions; because, they don't really have any information about the quality of the providers or even what individual providers charge. Is that something that has come up in your discussions, the concerns about that? Well, as far as what they charge and the rates, our PPO network, the rates and things are negotiated by this Wise whatever they are called. Anyway, they basically are negotiating the discounts with all of the providers, the St. Benedict's Hospital, St. Mark's……they negotiate the discounts with these people. So, that covers that.

One of the other concerns as co-insurance and deductibles go is that it has a disproportionate impact on lower income employees and that lower income employees might forego preventive services or services that are needed because they don't want to pay a $300 deductible or they don't feel they can afford 15% or so out of their own pocket. Is that a concern in your plan? Have there been discussions about that? Well, in our particular plan, it is not. If a guy just works 2,000 hours a year, he is making close to $55,000. So, for us, it is not a concern. But, I could see that as a concern with lower

income people; but, I don't know what you are going to do about it. What do you give folks? Do they try to improve themselves, get a better job, so on and so forth? I don't know what the answer to that is; but, in our particular business, it isn't a problem because they are very high paid individuals.

I probably should have asked this sooner, but now it occurs to me, is everybody other than management in the union or do you have janitorial and clerical staff who are not? Yes, non-bargained. There are bargained and non-bargained; and, they are in. *They are in the health plan?* Yes. If they are not a union employee, they can either accept or reject the coverage. Once they reject it, they don't get another opportunity. *So, if they accept the coverage, then you pay the premium just like you do for union people?* That is correct. It is slightly higher, maybe a couple of percentages. *So, you might have some $ten or $12 an hour people that are in the plan; but they have the same deductible and the same co-insurance?* Yes, that is correct. *Have you heard anything from them that maybe their deductible or co-insurance is more of a burden?* Those lower dollar people, the $ten to maybe $15 an hour people, they are generally young, unmarried, and healthy. *They don't feel like they need it?* The only problem they have is when they crash on their motorcycle or something like that.

That leads right into the next question. Another one of the concerns about these higher deductible plans is that there is a disproportionate impact on older or chronically ill employees; because, they have to pay more out of their pocket. As trustees, it is a big discussion all of the time; because, these people are costing us money. Yes, they are paying out as they are chronically ill. For example, on this wellness thing, on their prescription things, this RX America, they have to use generic now unless they jump through a tremendous amount of hoops to get the regular thing. They will also look at what they are taking. We just signed up for a 2 year thing to see how it is going to work with a company called Dobson and Associates. They work with these chronically ill people to see if there are better ways to manage their health. So, we are very concerned about it from a trustee standpoint; because, these people are costing us big time money. We would like to see if we can cut what they cost us; but, at the same time, help them out to find an alternative thing that is cheaper and maybe help them. In other words, maybe what they are doing isn't the best thing for them; so, that is what we are doing. They do a computer print out and see what is being done. It is a purely volunteer thing to do; but, that is what we are doing as trustees to try to not only cut our costs but help the people out.

In the industry, that is often called disease management. Now, did you say you have hired them or you are looking into it? Yes, we hired them about 6 months ago.

So, I am assuming that they are looking at people who are diabetic or have high blood lipids and so on, specifically working with them to try to help them manage that better? That is correct. Out of our thing, they just did it about 3 months ago, they sent out letters to all of these people. Out of our 1,200, they identified about 260 people. Some people told them where to put it and the others said to come over and talk about it. We opted not

to do it over the phone. We opted to have a face to face. These people go out and go through their medical things and work with their existing physicians and that type of thing to see if there is a better way. We debated this long and hard; because, we were always looking at cutting our costs. We finally decided we would give these people a 2 year contract. We finally decided that short term, there was no real way to measure any cost savings or health benefit increases; and, we figured we needed to give it at least a 2 year trial. So, we will see what happens at the end of 2 years.

Now, the funds that pay for Dobson and Associates, does that come out of the health and welfare fund? Yes. *So, that had to be negotiated into…..*No, the trustees did that themselves with their existing money. We decided that this was a benefit that we would pursue. *Again, the trustees, there are union representatives and management representatives?* Yes, three of each. *So, the union leadership apparently supported this approach.* Yes. *Tell me more about it.* It was just one of those things as trustees, the 6 of us, decided we had to try. Yes, it would cost us some money; but, we needed to give it a couple of years' trial on the thing. Again, like I say, the trustees basically make all of the decisions. The only thing that interferes from the outside is how much money the bargaining parties add to what we are already paying. It could be a lot and it could be nothing. So, we work with what they give us. You will see that in there as it is all broken down in cents. So many cents for this and so on and so forth. It is all broken down that way of how it goes. *Then, you, the trustees, monitor the expenditures month by month to see how the trend is comparing to the amount of money you have available?* That is correct. A lot of things, the employment situation is a big factor, how many hours are being worked. The other thing is, until this year, the last few years have been very good. We have been increasing ours. We look at how many months our funds can go. This last year (the year we are in now), which just ended, our fiscal year is June 30th, we had a tremendous amount of large claims. That brought up another subject. About half a dozen of these claims were guys getting hurt on motorcycles, ATVs, that cost us big time and dipped into our co-insurance. After we pay $160,000 out on a claim, then our insurance takes over and pays that off. You're reinsured for those catastrophic events? Our insurance went up this year because of all of these accidents. We spent a lot of time discussing what we were going to do about these people on these recreational vehicles. There's not much we can do, we can't discriminate, we can't say we'll only pay half if you get hurt on your motorcycle. But, anyway, it is a big concern. We were shocked at the amount of injuries we had this year. *Those lifestyle issues, it is like smoking, obesity, and risk taking.*

One of the big concerns also about this movement toward these so called consumer-driven plans is that once employees reach their deductible or certainly once they reach their out of pocket maximum, they are right back where they started; because, they have lost the financial incentive to be more careful about the services they use. But, you have covered that already. Disease management is really one of the major tools that more and more people are using to try to address this. It is kind of like the old 80-20 rule; and, it is worse than that in health care. Quite often, 10% of the population will use 70% or 80% of the costs. So, disease management, the Dobson and Associates contract is one of the

things you are doing to try to address that. Anything else? Well, you brought it up before. I think these health savings accounts, like you say, if these folks have a health savings account, then they have an incentive not to go to the doctor; and, they can put the money in their pocket and can save it for whatever. I think that would help. The other thing, if you had the deductible a little higher than we've got it, I think eventually a lot of the people would get into the habit of not doing it. You are absolutely right, once they hit that deductible, they probably go for it. *Or at least they lose some of the incentive.*

Anything else you would like to add, any comments on your plan, or your opinions about health insurance? Well, on health insurance, there is a big push in the country, or at least the politicians who want, to have national health. As bad as the problems are with our current system, I think the people would be even more unhappy with a national health plan. I think all you need to do is see what goes on up in Canada. When those folks need an operation, they hustle on down here and pay for it; because, they are on a waiting list. A number of years ago, I lived in England for 2 years. I didn't ever get sick too often; but, the people I was with, I used to have to take them to the doctor; and, the national health plan was horrible. At that time, this was in the mid 60s, they had just instituted it. Many of the doctors were leaving the country; so, they were being replaced by Indian and Pakistanian doctors. They were good doctors, there was nothing the matter with those guys, but their own English doctors were moving to this country and the other country because they didn't like the national health. You would go to a clinic, I can always remember this. They had benches that went in a serpentine. There were 4 doctors; and, they had 4 different colored lights. So, you would slide around this serpentine until you got to the front of the line. Then, it was your turn to go in. The places were dirty. They didn't keep them very clean; and, it was the same way in the hospitals. Now, I think they have modified the thing and changed it since then. You know, people complain about how much the doctors get paid and everything else; but, they put a lot of years into this thing. I still think we have one of the very best health care systems in the world. I think a lot could be done to reduce the costs. A lot of things could be done electronically that could really cut the costs of the paperwork and all the other things. It is a sore subject with everybody; but, we spend so much time as trustees, making sure we are covered with this HIPPA, this privacy thing. There are so many rules from the Department of Labor, especially on our plan. There are so many hoops; and, we waste so much time and energy on these things. Of course, the doctors, they are going to run every test in the world; so, they don't get sued. I don't know what the answer is to doing that kind of stuff; but, I think there are solutions short of national health.

One last question, do you foresee any circumstances where you would discontinue your health benefit program? No, because it is about impossible to get out of our union contract. So, no, as long as we are in business, this is the plan we've got; and, we are going to continue with it even though I am paying close to $1 million dollars a year on this thing for health coverage.

Do you see, either for you or for small business in general, do you see high deductible consumer-driven plans as a model that might help businesses continue to offer health

benefits? I think that is correct. For those who are tied in like me, you don't have a choice. But, I think to compete now, a small business, especially if it is technological, they need those types of workers; and, they have to have benefits. I find that the younger workers, they don't care. They quit for 50 cents down the road, even though I am paying about $4.00 an hour for health insurance. The guy down the road is paying about $1.50; and, they don't have any. They don't care. As soon as they get married and start having kids or they have a sick kid, then it shifts. You know about the mid to late 20's, health insurance becomes extremely important when they have to start paying this out. I think to compete, small businesses have to find a way to offer health insurance to their employees in order to get the kind of people that they need.

Higher deductible plans that have lower premiums would help them do that? Yes, definitely. More and more of my competitors didn't have health care 10 years ago. I know a couple of them real well; because, they used to work for me and they broke off and started their new businesses. They used to just beat the heck out me. But, when health insurance really started to rise in the last few years, it became more important. Their workers got a little older; and, I went and stole their people from them; because, these people need it. Some of these people came to work for me for $2.00 to $3.00 an hour less; because, I had health coverage and they had families. So, it becomes a competitive situation. I think more and more small businesses will be able to afford it; because, they are forced to and that forces their competition to do it.

Anything else you want to add? No.

APPENDIX D

INTERVIEW WITH BEN BLACK AND BARBARA BARNEY

I think you told me on the phone that you have had a health insurance plan for a long time.

(Ben speaking) I think since the first. I knew I needed it. You are not old enough to remember the Gem insurance company. I just thought of that last night. It was Gem Insurance. It was a Utah company. That, I remember. Barbara wasn't even born yet, she is my daughter. Somebody bought Gem, it became something else; and, then, we went with IHC about 15 years ago. We then switched about 5 years ago to United Health Care. I may be jumping ahead. I needed it and we deal with people every day who don't have it. So, I think it is an important part of the package. Who would want to work somewhere where they don't have health insurance?

Just a general question. How do you feel about the plan that you currently offer?

(Ben speaking) Of course this may be George Heiner, our independent insurance agent, pulling our leg, but I think our employees seem to think it is great. I think for the size of business we are, it is probably a very good plan. You are talking to a guy who hardly pays any attention to it. I go to the doctor once or twice a year and bills go home and get paid. So, somebody asks me an insurance question and I say, I don't know, I never use it, go ask Barbara. I know I have to get $ten bucks out of my pocket if I go to the doctor's office; but, I think it is great, especially for our size of business. (Barbara speaking) I have new employees who come in and I give them their sheet of how much they will pay; and, they are just amazed. They say, "That is all I pay each month?" A lot of people who have insurance will come on our plan because it is cheaper.

Cheaper for them out of their pocket?

(Barbara speaking) Yes, most places have deductibles; and, they don't have a deductible.

You both anticipated my next question, which was how do you think the employees feel about it? Apparently, you are paying most of it; so, they are paying a small portion of it. They like the no deductible aspect of it. Anything else, any other feedback on how the employees feel about it?

(Barbara speaking) I think they probably feel good. I always get a lot of good feedback. I don't have anybody come to me saying, "They won't pay this or who do I call." I may get one a year where somebody has a problem or a question. I don't hear a lot about it. So, to me, that means it is good and they are not having a problem; because, they don't have to come to me.

Are you currently considering any changes to the plan?

(Ben speaking) Every year, good old George Heiner comes out of semi-retirement. So, he will say, United Health Care is going up 8% or 20%, who knows. Last year, didn't he do Blue Cross and IHC? He says, "What do you want to do?" He leaves it up to us. When you get old, you hate change. So, we leave it the same. Unless United Health Care goes up 30% or whatever and somebody else comes in with a great offer, I wouldn't change. It is too big of a hassle. You have to have new forms, you have to get new insurance people come and do their "ta-da!" If they are anywhere near, I would just leave it.

When you are looking at different plans, and not necessarily just because they are different numbers, when you are looking at possible changes in the plan, what would you say are the main factors that you look at?

(Ben speaking) Well, the one thing, we mentioned IHC, we have no problem with the IHC plan. In fact, IHC is a client of ours; so, that is very nice. But, when we opened these offices in Idaho, Oregon, and Washington, employees there did not get it. It was out of their area; so, the doctor bill was $ten0 and they are paying $60 of it and employers were paying $40. So, it was great for Utah employees but not great for the out-of-state employees. So, that is why we originally switched to United Health Care.

So, having a network that is covered where there are preferred providers where all of your employees are is a big factor?

(Ben speaking) Yes. So, people in one state aren't getting hammered for insurance where we are getting a free ride here in Utah. That is why we changed to United Health Care. I don't have any special affinity for them. In fact, I am still mad at Doctor what's his face who took $6 million dollars and retired! IHC is working on a network. So, if IHC had the same network and the same prices, I would go back to IHC; because, they are our client. But, other than that.

So, the network and the price?

(Ben speaking) Yes.

Is your network pretty restrictive, pretty broad?

(Barbara speaking) Very broad. One of the things about United Health Care, they can go out-of-network, they just don't get as good of a benefit. So, if they choose to go out-of-network, they can; but, they are going to pay a little bit more out of pocket and then their deductibles will kick in. But, United Health Care is IHC network, basically. Most all of the doctors. So, that is one of the reasons that we kind of went with United Health Care; because, nobody would really have to change providers. There were very few people who had to find a different doctor.

Are you familiar with the term "consumer-driven health plan?"

(Barbara speaking) Yes. We talked to George about them. With the prices, they would be hard to sell to our employees.

What does "consumer-driven health plan" mean to you?

(Barbara speaking) That they are more responsible for it. They kind of get a better deal or better benefit. Kind of like if you were to buy a car, you are going to shop around. (Ben speaking) Our average employee is probably 26 years old; and, they might be good on the phone collecting money, but they are not insurance wise.

How about health savings accounts? Are you familiar with those?

(Barbara speaking) Most of them live paycheck to paycheck. We are holding out their amount for the month and then they pay their $ten co-pay, and they are happy about that; but, they don't look at the big picture. We would be great on that. We would probably come out ahead. But, since they usually have to come up with it upfront, they would have a hard time with it.

They have to come up with it up front meaning there is a high deductible?

(Ben speaking) Yes. I would love it, if it were me, cross my fingers, I would have a $ten,000 deductible plan. But, I couldn't do that for my employees. (Barbara speaking) We read about how everybody's rates are jumping so much. Our rates go up a little bit but not enough that we would have to say, "Look, if we keep you on this plan, you would have to pay $500/month." Then, maybe they would consider something like that; but, it is hard to sell that type of a plan when you have the plan we currently have. (Ben speaking) I pay very little attention to it, but, I know I asked once. I was shocked at how little difference the price was. You take our plan and you say, okay, I want to make the deductible $1,000 instead of cutting the premium in half, it seemed like it cut it one-third. That is no deal.

Well, it looks like, from the stuff you gave me, it looks like they offered you a high deductible plan as an option the last time around? Am I reading this right? So, at least your broker is making you aware of that possibility and you had the opportunity to look at it. The premium was $ten0 less a month on the employee portion. So, not quite one-third less. That was my next question, have you considered these types of accounts? Clearly, you have; because, you were presented with an option, and you already described your reasons for not going with them for now. You already partially answered this, but, let me go on with it. What element of the high deductible "consumer-driven" plan would you consider to be attractive or interesting to you as an employer?

(Ben speaking) For us, it would be a money saving issue. If we could have two different plans, there could be 10 of us that would pick this one, and, all of the rest would pick the

other one; but, you can't do that. So, it doesn't look attractive to me because the employees say we have good health coverage here.

You really answered the next part of the question, which is, what element of it gives you cause for concern? You already talked about the bulk of the employees living paycheck to paycheck and having concerns about their ability to meet the deductibles, plan ahead, and so on and so forth. Their ability or willingness or whatever the case might be. The next question, I think you already answered. They say, if you design a good questionnaire, it just naturally flows. So, how likely are you to seriously consider this type of a plan? I think you have already answered that, not very likely, at least for now. Now, let me ask you another thing about this. It says, with your current plan, 90% coinsurance. So, if the employees have to go to the hospital or if they have outpatient surgery, they are paying 10% out of their own pocket up to $1,500 for the single and $3,000 for the family out-of-pocket maximum?

(Barbara speaking) Yes. I think that is in-network.

That is correct. The out-of-network, they would pay 30%. That is significant. That is kind of a different way of going about the consumer-driven approach. Because, you don't have a deductible; but, they do have to pay a significant amount out of their own pocket when they need service. That is how I am reading the data that you gave me.

(Ben speaking) I don't know. I don't know where they come up with that. I had my first colonoscopy last month. They paid every dime of it. I paid a $ten co-pay and they paid every dime of it. So, I don't know anybody who has paid any. (Barbara speaking) I have this year's little book. That might be office procedures and then if they have something more like a stay, depending on the service. (Ben speaking) See, you don't know that much about it either! I can't remember any more than $ten for anything.

Your summary plan description that you give to employees probably spells out what they have to pay, coinsurance, and what they don't. If it is okay with you, I would like to look at that. But, maybe, sometimes preventative services like colonoscopies or mammographies, sometimes those are exempt; because, you don't want to discourage people from doing that. That is something that I need to look at, as it is important to what I am talking about here. Because, if they are paying 10% out of their own pocket, then, that really is a type of "consumer-driven health care." I love that term. It is a euphemism. It means you are going to pay more upfront out of your own pocket. I am clear that you are really not interested in switching to this kind of a plan right now; but, I still would like to ask you about some of the specific things that are counted in the literature either as an advantage or a disadvantage of those kind of plans. Meaning, where the employee has to come up with a significant amount of money either high deductible or coinsurance or both out of their own pocket. The theory is that this will reduce costs overall; not just for your plan but for the U.S. health care system. If people are spending some of their own money out of their own pocket, they will make better decisions. That is the theory. What is your reaction to that?

(Ben speaking) It is a great theory. But, here again, our average employee is probably 26 years old. They are good at what they do; but, I don't know how experienced of a consumer they are. Some of them could not afford a high deductible. I see it the same as our profit sharing plan, an advantage to Billco. We are in competition with other businesses, call centers, other collection agencies, and if they know these guys have great benefits. I know we are ruining everything because now you can run to the doctor for $ten bucks; so, everybody goes to the doctor everyday. But, I don't see how that would work here. I really don't. (Barbara speaking) I don't think the majority of our employees would really understand it or shop around as much. (Ben speaking) I think they would go to the emergency room. We have IHC in South Ogden instead of the emergency room and it is only $50 bucks instead of $75 for urgent care.

One of the other advantages listed is that managed care plans, HMOs, and other kinds of managed care plans, consumers kind of rebelled against those because they had so many restrictions, tight networks, prior approval requirements, and so on. So, one of the advantages of consumer-driven health care is, on the one hand, you have to pay more upfront out of your own pocket, but on the other hand, we are going to broaden your choice. How do you react to that? Do you see that as an advantage?

(Ben speaking) No, at least not here. I don't know anybody that isn't in the network, I really don't.

So, United has broadened your network to the point where it is really not an issue?

(Ben speaking) I haven't heard anybody say, I can't go to my favorite doctor because they are not on the list.

It is interesting, managed care was hated during the 1990s. During that time, 95% of employed American workers who had health insurance claimed to be in managed care plans, meaning there were some restrictions on the network and so on, and, costs flattened. They didn't go down in the1990s; but, they really flattened out. Well, consumers basically hated that. They didn't like to have to go to their family doctor. They wanted to go directly to a specialist if they wanted to. They didn't want to choose from a restricted network. They wanted to be able to go to the doctor or the hospital of their choice. They didn't want to have to get prior approval. So, there was a lot of backlash. There was even legislation in a lot of states forcing loosening of the controls. So, by about 2000, managed care got rid of restrictions, broadened the network, which has been your experience. Guess what happened to the costs? They have gone up. Now, I am talking a national average, they have gone up more than 10% per year every year but one since 2000. In the 1990s, they were going up 4% to 6% per year. So, there is a tradeoff there. That is why there is a considerable amount of interest in this consumer-driven approach. We are saying, managed care has kind of lost its teeth, but, we can't afford 12% to 13% increase every year; so, what are we going to do next? So, that is what all of the hubbub is about with regard to high deductible plans, and so on. Let me

just get your opinions, your reactions to some of the concerns that are expressed about high deductible plans or consumer-driven plans. One is, there really isn't enough information out there about the quality of the various providers and even what it costs for a particular service so people could compare and make a good decision. That is one of the knocks on it. How would you react to it?

(Ben speaking) What do I care what it costs? I am not paying for it.

But, you are the employer. See, that would make the argument for them saying they should be paying more for it. Again, you sort of answered this earlier. Do you think your employees would have enough information to make good choices?

(Ben speaking) Some of our higher paid managers would, more experienced. The old people over 30. I don't think it would ever cross the mind of our average collector clerk who makes $25,000 to $30,000.

Another knock on this is, and this goes directly at what you have been talking about, it really has a disproportionate impact on lower income employees. That employees might forego services that they really need if they have to pay more out of their own pocket. Would that be a concern for you with that kind of a plan?

(Both) Yes.

Now, this one will be interesting. You have kind of talked to the other side of it. But, one of the knocks is that there is also a disproportionate impact on older or chronically ill employees who might not be able to accumulate funds in a savings account. You said, your average employee is 26 years old. The flip side of that would be, chances are, they are going to have very little health care costs. If they could take the $ten0 that you are now spending on premium and put it into a savings account, that might be to their advantage in the long run. But, employees who are 50 to 55 years old and have chronic conditions, they wouldn't be able to accumulate anything in the savings account; because, they would be using it up every year.

(Ben speaking) That is true. We have one employee in his 60's and maybe two in their 50's. Everybody else is in their 20's. We have done this ten0 times, not on insurance but on profit sharing. Say, you are 23 years old and you make $12/hour. I say to you, "I tell you what, I will either give you a $20/week raise or I will put $200/month in your profit sharing plan for your retirement. What will you take?" The $20. Maybe 1 in 20 would think that is a good deal and would take advantage of it. That is my opinion.

It is interesting that you compare it to retirement accounts; because, that is really one of the drivers behind this concept. Barbara, you don't remember, but Ben and I do. Twenty to thirty years ago, you had a pension plan, if you were lucky and worked at a place that had a pension plan; and, it was a fine benefit. However, the longer you worked and however much money you made, there was a formula. When you retired, you got a

benefit. Well, that whole industry now has shifted dramatically to the defined contribution approach where the employee will put some in and the employer can match. You are now more responsible for your own retirement plan. That is the theory behind the health savings account is to say, wow, 401k's were so popular that they basically drove out the defined benefit pension plans. Maybe the same thing will work with health insurance. Again, I don't want to sound like I am saying you should be doing this or I am arguing for it, I am just giving you some background on it. One more criticism that is leveled against this kind of an approach is to say it is a nice theory that if people are spending money out of their own pocket, they will be more careful. But, once they go over their deductible, once again, it doesn't matter to them anyway. Now, we need to look at your benefit summary, but you have a 10% co-pay on coinsurance on expensive services, that would be designed to overcome this argument. Some would say that is better than a deductible; because, it doesn't stop until you hit the out-of-pocket maximum. So, I think once we can look at your summary plan description, I think maybe your plan is designed to try to prevent that anyway. Another knock, I think this is the last one, particularly in the health savings account approach, is that it is an administrative hassle, and that it is expensive to administer. I don't know how closely you have looked at it. Did you have concerns about that? Did you get into what it would take to administer a health savings account?

(Ben speaking) Yes, it does create a lot more work for somebody. We didn't even get that far because we knew we weren't going to do that. We knew it wouldn't work. If there were 10 of us who make more than $12/hour, we could do that. But, like you said, my $ten,000 deductible plan wouldn't hurt me anymore than his $500 deductible plan. We haven't even gone that far. No need to even think about it. Yes, it would be more work.

Have you heard of disease management programs?

(Barbara speaking) Actually, United Health Care just sent us a guide. It was a story about how this man's insurance helped him get better faster with his disease.

Probably diabetes or high blood pressure. Those are common ones that they focus on. Has United or your broker talked to you about more assertive or more aggressive programs to help your employees that have a chronic condition manage those more effectively?

(Ben speaking) If they have, I haven't paid any attention.

This is another trend. A lot of people like this approach better. It has more potential even then the high deductible approach, which is to say people with type 2 diabetes, not only can they have a poor quality of life, but they can run up a tremendous amount of costs. Those problems might be avoided if we spend some money. There are, of course, firms out there that do disease management. You pay them a fee annually and they aggressively call, send letters, emails, etc. to your employees who have that kind of condition and try to help them with that approach. It is interesting to me, in the literature. These are talked

about as an alternative. I don't know why you couldn't have a high deductible health plan with a disease management plan. They work together as far as I am concerned. In fact, the last employer that I interviewed for this project, they do have both. They are pretty aggressive about both of them side by side. So, I am not here to give advice; but, that might be something you could think about. Then again, with your extremely young workforce, maybe that is why it has never really been brought to you because maybe you don't have a very high incidence of that kind of situation with your work force. Okay, any other comments about health insurance in general? This is your chance to give your opinions about health insurance in the U.S.

(Ben speaking) Like I say, because I don't have many issues, I pay little attention to it. Yes, it is going to be real interesting what President Obama is going to do. If I don't care how much some of this costs, then there is going to be no end. Either the government is going to have to take it over or somebody smart is going to have to come up with something. There will be no end to the spiraling costs, I don't think.

It sounds like from your perspective, if we look at it just from your company, it sounds like your company has been successful enough and continues to be successful enough that you can afford to do this and it is not something that is a major financial burden upon you; and, therefore, you are happy at where you are. Is that a fair summary?

(Ben speaking) Yes. I could probably be retired by now if I had the premiums of $50,000. But, I just think it is something we have got to do. If George comes back and United Health Care is going to go up 20% and IHC would be 25% more, well, maybe we will consider a little bigger deductible or we will pay 5% less of the premium and you pay 5% more; but, that is all I see right now.

I really have only one more question, which you at least started to address. Do you perceive any circumstances under which you would discontinue your health benefits plan?

(Ben speaking) Not discontinue. I really don't. We could maybe alter the amount, percentage that the employee pays if times get really tough. We may do that. I really can't. If things got that bad, I would retire and make Barbara the manager. I would take the money and run.

So, you can't foresee discontinuing it all together; but, you did mention earlier that if the costs jump substantially, one of the things you would do would be to look at higher deductibles or having the employees pay a bigger percentage of the premium?

(Barbara speaking) We tell them that every open enrollment. If they go up a little bit or we have to adjust a little bit, we let them know. We tell them to stay healthy and make wise choices. Because, if the costs go up, we may have to put the costs back on to the employees. We have been lucky and have had a pretty healthy group.

Especially if they are that young. That is to your advantage. But, still $1,ten0 bucks/month for family coverage is nothing to sneeze at. I saw in here somewhere what the employees pay and it says per pay period. Is that two weeks? Twice a month, okay. So, I was not sure what portion they were paying. So, an employee with the single plan is paying $89/month right now out of $355. So, that is less than 30%. That is still pretty significant. They are bearing some of the burden. Did you have anything else that you wanted to add that I didn't cover? Any predictions, gripes, complaints about health care?

(Barbara speaking) I am just glad that I have it, that it is offered to me and that I have the insurance, especially with children. I can't imagine not having insurance or having a plan that didn't pay for immunizations and things like that.

I did notice, if I am reading this right, that you had a drop in participation? You had 97 in 2005 and 94 in 2006 and 80 in 2007. Did you reduce your workforce or did you just have some people drop the plan?

(Barbara speaking) Yes, we have had some reduction in force, not a lot. How we changed the tier a little bit, how they went from employee, employee +1, employee plus family. We used to have employee plus spouse and employee plus children. So, that changed a little bit. That wouldn't really reflect any of these numbers; but, some people at that time felt if you put it that way, it is better for my spouse to take insurance. But, most of it would be a reduction in our force by a little. We also had a couple of people whose spouses did take up insurance and they did end up going on their plan. Most of it is just reduction in force.

APPENDIX E

INTERVIEW WITH CARLY CARR

About how long has "Crane Corp" offered a health insurance plan to employees?

I have been here 28 years. Crane Corp has offered benefits ever since then.

How do you feel or how does management feel about the plans you offer now? Do you feel good about them? Do you have some concerns?

The management really has not had any concerns about the health plans. Of course, we are always concerned about making sure that we can continue to provide that benefit to the employee because of the cost. They are getting pretty costly. In fact, one of the plan's premium is over $1,000/month now for family coverage; so, that is pretty costly. The company pays 75%. So, at the present time, we are looking at other options like a health savings account. That is where we have been looking; however, we also need to look at the income level of our staff to see if the health savings account would benefit everyone or just a few.

That is going to lead right into some of the main questions that I am going to ask. So, we will get to that. How do you think the employees feel about the current health plan? What kind of feedback do you hear from them?

I think, basically, the employees like the health plan we have. A lot of them would like to go to other doctors besides those who are on the preferred provider list; however, they are either unwilling or unable to pay for the higher premiums to do that. The employees ask for other carriers. When we give the renewal and get the premium rates, we do present it to at least a subcommittee of the employees; so, they can get an idea of what the rates will be. We get a consensus from them; because, they will go back and talk to staff. We get consensus from them as to their feelings. It has been that we just continued on with the plans that we have had. We have had a lot of staff who do not want to give out their health information. So, we say if you want a different provider, then we need to have you fill out the health questionnaire so their plan can evaluate it. Just getting those questionnaires back has been difficult.

You already touched on this; and, that will probably happen throughout the interview. The next question I have is, are you currently considering any changes?

Just the health savings account. However, our staff is getting to the point where we may be able to qualify for a large employer account with other providers. That way, we would have more flexibility in looking at other plans. But, right now, the way it stands, we are just looking at the health savings account.

What factors do you consider when you are making decisions about health care plans?

Number one, management, at least the committee that looks at the insurance, the President and Vice President, look at the income level of the staff. We are very concerned. The health issue is so critical and the wages in social services are so low, that we feel the health benefit is almost a plus to getting the employee. So, we want to be able to provide that health benefit at a reasonable rate for them. So, we look at do we need to increase the employer's participation in order for us to continue attracting new staff; because, when you are making $8 to $9/hour, $50 to $ten0/pay period, the deduction hurts. Repeat the question. I got off on another tangent.

I just asked what factors you consider.

We do consider the income level in our staff. We also look at our budget to see what we can afford. Like I mentioned earlier, it is getting expensive. We probably pay out an average of $20,000/month on just the medical portion. So, it is a big chunk of the budget.

So, mainly, financial issues, which is understandable. Any other factors that you consider when you are looking at a health plan?

I look at the ease in administering it. Recommendations from other employers.

Are you familiar with the term "consumer-driven health plans"?

No.

Okay. It is jargon that is thrown around. It is normally used to refer to high deductible plans. Sometimes, high deductible plans that have a health savings account that go along with them. To me, it is certainly a euphemism. "Consumer-driven health plan" sounds sort of positive. But, what it really is about is saying that people should be personally responsible for more of the cost of health care; and, in exchange for that, they should have a little more freedom of choice of providers and which services to have and so on. So, that is the concept. It has become kind of popular with big companies and with insurance companies since there was so much backlash against managed care in the late 1990s and around 2000. A lot of employees sort of rebelled against restrictions. So, companies relaxed them and broadened the network and got rid of some of the gatekeeper requirements; and, the cost started to jump faster. So, when you hear me say that or you see it in the literature, that is what they are talking about, "consumer-driven health plan." Now, you did mention health savings accounts. So, you have heard of that? What is your understanding of, what are your thoughts about health savings accounts?

I haven't done a lot of research on it. I have kind of left that to the broker that I work with. With him knowing the demographics on the agency, I had the feeling that it only would benefit a few employees rather than the whole.

What elements about high deductible/consumer-driven plans do you think might be attractive or might be positive for your company?

For the company, I think we could lower the premiums we are paying out. For the employees, that is one complaint that I get, “I can’t afford the deductible.” So, when they have a $250 per person deductible and I am looking at increasing that to $500 or higher, there would be less participation, at least I think there would be.

Of course, the flip side of that is the premium should go down.

The premium should go down. Without having the loss ratio, I have a pretty good idea anyway of the employees who are using the most benefits. Of course, those are the same employees who are complaining about the deductible.

I noticed, just in glancing through the information you gave me, that you do have 10% coinsurance on hospital services, outpatient services, and so on, that has an element of consumer-driven health plan to it; because, they are paying for a hospital stay or even for an outpatient surgery. They do have to pay a significant amount of money out of their own pocket. I didn’t look at that, but, has that 10% coinsurance been standard for the past 3 or 4 years?

It has probably been standard for the last 10 years. That is one area we looked at in reducing the costs is changing that from 90/ten to 80/20 or even 75/25; but, it has maintained at 90/10.

Again, you touched on this a little bit; but, the flip side of consumer-driven type of plans, what would be your concerns about going to that kind of a plan?

I look at the 90/10 now as a very rich policy; and, in some cases, it is abused because it is a rich plan. Where, if the employee had to pay a little more, had to take care of their own health and pay more, then it wouldn’t be used as much.

So, that would be a positive.

That would be a positive for the employer. It might be for the employee too; because, they may look at themselves and take better care of themselves. Maybe.

You mentioned earlier concerns, particularly for the low income employees, about being able to afford the deductible or higher coinsurance and so on. How likely do you think Crane Corp would be to seriously consider a consumer-driven type of plan; and, again, that would be higher deductibles or higher co-pay, possibly a health savings account, or some combination? A move that would cause the employees to pay more upfront out of their own pocket?

The person and I talk about that every year when it comes up for renewal. It is a tough market right now. Depending on budget, that may be next year.

You are really getting to the next question. What would be the key factors in making a decision like that?

It would be financial. It would be how much profit did the company make. Can the company continue to provide that type of a benefit? On the other hand, we look at our competitor companies and know that we have to provide either a higher benefit or at least a higher wage. So, that is looked at as well. Definitely, the economy and finances is the big deciding factor.

You mentioned earlier, let me go back just a little bit, you mentioned that you have a significant number of sort of entry level employees. I don't need specific pay rates; but, what kind of ranges do your employees fall in? You have some that are at $8 or $9/hour. Do you have sort of a skilled component that would be more in the $15 to $20/hour range?

The majority of our staff are between probably $8 and $12/hour.

The rest would be supervisory, management folks?

Correct.

There are some specific advantages and concerns that people who are for or against or writing about consumer-driven plans talk about that are in the literature. So, let me go through each one of those and see how you feel about those, whether those would be factors, maybe they are factors that you have talked about when you talk about changes. Again, some of this is a little redundant as you have touched on them; but, some of them you haven't. One thing that consumer-driven plans do is they reduce premiums because they shift more of the costs to the employees. So, is that something that you talked about as a positive? Is it a concern?

We have talked about it. It is a concern knowing our population of employees. We have many single mothers. If their deductible were too high, they probably would just get on state assistance for their children. So, it is a catch 22. If the deductible was too high, they would not sign up for the insurance. They would not have any or see if they could get on any of the CHIP programs or others.

The main theory behind this approach is to say that if employees are paying more out of their own pocket at the point of service that they would make better decisions. They would be more careful with how the money is spent. So, they won't be saving just their own money, they would be making better health care decisions and saving the company and themselves money. What is your reaction to that? Have you talked about that?

We have talked about it. It just seems like the culture is "We are entitled to that, you owe us that."

The culture in the country? The culture among your own employees?

The culture of my own employees.

It is not just you guys. It is kind of the culture in the country. In my opinion, it is the main reason why our health care costs are so high and they keep going up so rapidly. It is, "I should be able to get whatever I want, whenever I want, and it should be 'free'."

I am just sidetracking a little. We had that same issue because we provide both sick leave and vacation. The employees feel that the sick leave can be taken whether they are sick or not because that is mine. They don't get paid their vacation if they leave. They don't get their sick leave when they leave; so, they are going to use their sick leave. It is the same with the insurance. They feel it is "mine" and I am going to go to the doctor for every little cold and every little thing that comes along. So, you start looking at increasing the employee's portion of it.

So, I am hearing that your concern would be alienating the employees and bucking this culture by trying to institute more of a consumer-driven plan?

Yes.

On the other hand, if you did institute that type of plan, it might force them to make better decisions about better health care. I don't want to put words in your mouth.

You are not putting words in my mouth. I think I mentioned that earlier.

Another characteristic that is often advanced as a positive for these kinds of plans is you can have fewer restrictions on choices of providers and choices of services. Is that something that would be a good advantage?

I think that would be an advantage. There are a lot of staff who do not want to go to Intermountain. So, it would be an advantage. They could go to any doctor.

You mentioned this when you were going over the documents with me, before I turned the recorder on. So, the plan that most of your employees are in is quite restrictive?

It is a standard HMO.

So, no out-of-network coverage except for emergency out of area and very limited panel to choose from?

Correct. I wouldn't say the panel is extremely limited; because, if you look at the panel, I feel it is a broad panel. It isn't like you just have a small group of doctors to choose from. There is quite a large panel. It is not as large as if they went with the Care Plus plan. With the Care Plus plan, there are many doctors that provide service there but will not provide to Select Med even though they work for or are contracted with Intermountain. So, there is that benefit with going with Care Plus that you have a bigger panel of doctors plus all of the other doctors that did not contract with Intermountain.

So, the Select Med panel is a restricted HMO panel; but, it is quite a large panel because Intermountain is so big in the area?

Correct.

Now, some of the things when people express concerns about consumer-driven health care, I want to see if you have talked about these things or what your reactions are to these things. Concern that there really isn't good information available about the quality of different health care providers and the cost of different procedures for people to really make good decisions?

I think that is correct. Because, I also work with providing a benefit plan for our government contract workers. When we brought in the representative to go over this plan, he said, "Find out what that procedure costs." Everyone looked like, "How do you do that?" So, that is a problem. They don't know that if you went here, the procedure would cost this, if you went across the street, it would cost much less. Does your insurance cover both and which one would be better? That information is probably out there but hard to find.

This one, you certainly have touched on already; but, let me repeat it and see if you have anything else to say. There is some feeling that consumer-driven plans have a disproportionate impact on lower income employees; because, it is harder for them to meet the deductibles. Therefore, they might forego needed services in order to avoid the higher out-of-pocket costs.

I would agree with that, mainly because I have had employees just this year drop the insurance they have now; because, they can't afford it. They cannot afford the premium. If they can't afford the premium, they can't afford the deductible.

There is definitely a trade off there. We will get to that sort of at the summary here. I will come back to that point. Also, there is concern that these consumer-driven plans might have a disproportionate impact on older or chronically ill employees; because, they are going to have to spend the deductible every year. Even if they have a health savings account, they are going to have to use it up every year. They won't be able to accumulate money in there as a younger person might who maybe doesn't need any health care from year to year.

I would say that is true.

Is that something that you have talked about as a concern? I don't know what the age distribution of your work force is.

It is half and half. Half are very young and half are in that upper group. So, it has been a big concern. We need that middle group. That would be a real concern; because, when you get older, things start happening.

There is also concern that once an employee exceeds their deductible, the incentive is really gone. The consumer-driven plan loses its effect; because, once you have spent the deductible, you might as well keep going. You addressed that a little bit with your 10% coinsurance, at least up to the out-of-pocket maximum. That is something that could be a concern. When you looked at health savings accounts, were you concerned about the burden of administering those?

I don't think it was the burden of administering it, I think the number one concern we were looking at was, how can the company find that deductible the first year to get things rolling for the employee? Can we find that or what are the rules and regulations? So, there were a lot of things that we needed to know about it. Because, we knew that this change would put a burden on the employees right now. In order to make that transition, we were looking at how we can help that.

So, if you saved $100/month on the premium, one option would be to put the $75 that would be the employer's portion into the employees' health savings plan?

Correct. That was an option we were looking at.

That could make some sense. That could overcome a lot of the concerns you had especially for younger or healthier lower income employees.

Right. We are still seriously looking at the health savings account. It is still a serious consideration.

Let's kind of try to summarize. I have a couple more questions; but, they are on a little bit different topic. So, if a higher deductible/health savings account type of a plan is still a serious consideration, just summarize for me, what would be the main factors in making that decision?

I guess, the first thing is we would need more information. We would need help walking through it. We need to look at budget to see where we are financially. Basically, we would also put together a panel with some of the employees; so, we can have them make that decision. So, it was not management saying "This is what you will do" but employee-driven, so to speak. We feel that the health savings account would be very positive if we can get past that first year. Like I said, I know there are a few staff that

would definitely buck the trend; but, overall, if we could get past that first year, I think it would be a good plan.

Again, I am reading that what you mean by "get past the first year" is could we save enough of the premiums to help the employees fund their savings account for the first year?

Correct.

Then, it would go back to a couple of the other advantages/disadvantages that I mentioned, once you get rolling. If the people who had a good year "healthwise", they would start to accumulate money in their savings account, and they would be off and running. But, what about the ones who are diabetic or on chronic medications and they would use up their savings account every year?

That will happen. You just have to weigh the pros and cons. Is the majority benefiting? If the majority benefits, then continue on.

I have given you a chance to think about it and say things about it; and, I don't want to put too many words in your mouth. That is kind of the central question here. It has been real interesting as I have talked to other employers. I have had an employer say straight out, "If they are using more, they should be paying more. That is the way it is." I have had another employer say, "I don't think we would ever do that. I just don't feel right about doing that. I don't think we should be increasing that front end out-of-pocket unless we absolutely have to." So, there is no right or wrong answer here. There are different philosophies.

I can see both sides of it. It is the heart and the dollars.

Have you heard the term "disease management programs?"

No.

Again, that is jargon here. There is another trend; and, they are kind of running parallel. A lot of companies are investing in programs that are aimed at helping their employees who have chronic conditions better manage those. The hope for outcome is better quality of life for those people and lower health care expenditures, help for them and for the employer. So, I wonder, has your broker talked to you or have you looked at any kind of a program like that? Maybe it wasn't called disease management.

I would have to say no. We haven't looked at that. It would be something that should be looked at, though.

It probably is something that you might want to ask about. There are companies out there who specialize in this. They charge a fee. They are going to charge either a flat fee or so

much per member per month. I am not sure exactly how they do it. They charge a fee and then they administer the program. They figure out which employees have chronic problems. Obviously, you have to give them permission to look at your records. Then, they provide information, coaching, they encourage people to better manage their condition.

That would be a good thing to look at in the overall benefit package.

One thing that puzzles me is that a lot of times in the literature that I have looked at, the authors will talk about disease management vs consumer-drive health care. To me, it seems like they would work together. Why not? Why do you have to pick one or the other? It seems like both would go together. That is just my personal thought. Only two more questions. One is just general. Are there any other comments you would like to add about health insurance? Not necessarily your specific plan but just health insurance in general.

Health insurance in general is just such a hot topic. You can please a few but you can't please them all. You can provide a pretty nice package and some employees will think it is not enough. Health care is just a hot issue. It is expensive no matter what.

You mentioned that your broader choice family premium is over $1,000/month. That is pretty typical. That is what I see with other employers that I have talked to. That leads to my last question. Do you see any circumstances where Crane Corp would discontinue offering health benefits?

At the present time, I don't see us discontinuing it. It is one of our selling points to bring employees in. Because, many of our competitors do not provide that or do provide it for full-time employees; but, they only hire part-time employees. I don't see us discontinuing it. I just see maybe the health savings account. We just have to look at everything out there. I still get bids every year from other companies even though we may fit in the small employer group and it would have to be health care premiums based on the health of the employees. But, I don't see us discontinuing the insurance. It is just too critical.

So, as the costs rise or if they continue to rise substantially, if discontinuing isn't really an option, what options would you look at?

The options would be probably reducing. Making the plan not quite so rich, maybe an 80/20 plan, maybe a higher employee premium. So, maybe not 75 contributed by the employer, but maybe 60. We have looked at that in the past. That may come down to what would happen. The employee would have to pay more.

The last question, and you have really already answered it without using the terminology, do you see consumer-driven plans as a model that might help you be able to continue coverage?

Short and sweet, yes.

You have already answered it. If you go to 80/20 rather than 90/10 or if you go to higher deductibles in order to make the premium more reasonable, that is what you are doing. You are going to more of a "consumer-driven" plan. You have already said several times that you have seriously looked at and you will continue to look at health savings accounts; so, that is really the other part of the answer to this question. Anything else you would like to add? Anything I didn't cover that you are burning to get your opinion out on?

I have no idea what you would ask me! The opinion on health care, like I said, is such a hot topic. Government subsidized. You know, it is just a hot topic.

APPENDIX F

INTERVIEW WITH DAN DARDEN

Have you offered a health insurance plan to your employees for a long time? Do you know how long?

I have. I would guess probably in the neighborhood of 20 years. When we initially offered a plan, it wasn't required. It was just something I thought was the right thing to do. My initial plan was $100 deductible. It cost me $9.80 per head. So, I thought for $10/month per employee, it was something I should do. So, I had health insurance for a long time.

How do you feel about the plan that you offer?

I think the plan I have right now is a good plan. Historically, the problem we have had is we keep getting less and less insurance for more and more money. The inflation on health insurance has been in double digits since day one. I think we went from $9.80 to $12.80, which doesn't seem like a big deal; but, percentage-wise, it is huge. That percentage continues. That is the problem I see that is most crucial about health insurance today is we have to put a stop to this at some point or it is going to literally bankrupt us.

How do you think your employees feel about the plan?

You know, I didn't think that they thought it was much of a value. So, last year, I offered them a cash option in lieu of health insurance and thought maybe I would just insure my key employees; because, we pay for insurance for every employee after they have been here one year. I was surprised. Even the ones that I thought would place little value on the health insurance almost unanimously did not want cash in lieu of health coverage.

That shows some foresight on their part. They realize they need that protection.

It certainly does.

Are you currently considering any changes to your health plan?

No, unfortunately, we are kind of locked in. We historically have had under a 50% claims ratio; so, we have been able to shop for insurance. I think we have a very competitive rate at the present time. It will probably change dramatically this year; because, we have had a couple of major claims. That is what you buy insurance for; but, I think that is going to make it very difficult for me to change for the next year or two. In one instance, I have a 28-year-old with cancer. He is fighting for his life. So, I think I am more in that for the next foreseeable future.

Are you considering any changes to the design of the plan?

I don't think so. I think $2,000 is a pretty good-sized deductible. We actually got a quote for a $10,000 deductible last year and it was really not significantly less money; because, the cost of health care is in these big claims. I am certain that this young guy that I have who has cancer, I am certain that the bills are going to be in the six figures. So, whether you have a $2,500 deductible or a $10,000 deductible, it is still going to be more than I pay in premiums.

When you think about making changes, not just perhaps changing vendors but making changes to the plan itself, what are the factors that you consider?

We have basically had the same plan for years and years with the exception of the deductible. It used to be that you could get incredible coverage for almost nothing. We still have a pretty comprehensive policy. I think it is a $1 million maximum per individual. I would think that the major change that has happened over the years for me has been in the deductible.

I noticed when you showed me the summary plan description, I obviously noticed the high deductible. That is what I am going to get into. I will ask some questions specifically about that. Have you raised the deductible recently or has it been at this level for a while?

We have been at $2,000 for at least three years.

Other factors that you might consider……obviously, you are weighing the trade off of the deductible vs. the premium. What about the network that is available? Any other considerations that go into your decisions?

The plan I am on now with Altius, there is an upgraded plan. If anyone wants to be able to step out of the plan we offer as a network, they can do it for a very minimal amount of money. I think there is one called the Altius peak plan and then there is the peak plus or some sort of a thing. Anyway, there is an obvious difference, I am certain. I think it is $5 or $10 a month difference. So, you can elect to have a plan where there is no network, where you can step out and still have benefits if you wanted to go to the Mayo Clinic or whomever. The basic plan we have does have a lot of flexibility with the exception that you have to stay within that network; but, it is a big network.

If they want to step out of the network, they still have some coverage; but, they would have higher deductibles and higher co-pays?

That is correct.

I can see that in the summary plan description. Are you familiar with the term "consumer-driven" health plan?

Not really.

This is not a test of your knowledge. It is really the term that is being used to talk about, actually, what you have. It is a term that is used to talk about plans that make the employees responsible for more of the cost out of their own pocket, higher deductibles, co-pays, and so on. It is kind of a euphemism I think, "consumer-driven" health plan. The idea is that you get more choice; but, you also have more personal financial responsibility out of your own pocket.

Virtually, that is what is going to happen anyway. You go to a higher deductible, that comes out of your pocket. We are not in a position where we have to offer health insurance. I would think that if our health insurance continues to go up double digits, instead of us going on 100%, we are probably going to start asking the employee to contribute. I don't think we will do that this year; but, economically, we don't want to get into the situation of General Motors where it literally bankrupts the company. That can happen! If health care continues to escalate in costs in double digits, that is the next logical step to me is to make it 75/25 or something such as that where the employee participates. I hope we don't have to do that.

I was going to ask you later, but since you brought it up, why do you pay 100% of the single? That is kind of unusual but clearly it is something you made a decision to go with.

Like I said, when I started this, that wasn't the monumental decision; because, I think at the time, 20 some odd years ago, I had 25 different employees. So, for $250/month, I could offer something that I thought was of great value. I thought it was the right thing to do; and, I still do! But, I also don't want to go broke. I will be surprised if they come up with a health care plan that would require businesses to provide health care. If they do, I would be surprised that it would be 100% coverage on the employer's part. They have been talking about having some kind of a national health care plan for 25 years. I think they are still in the same boat there. I think we will just have to see what happens.

Is it a concern that maybe since your plan is 100% paid (for the employee), maybe you would have some employees that would be covered by a spouse or have some other kind of coverage and yet you are still paying premiums for them?

The reason we do that is we cover 100% of our employees who have been here a year. The rate is different than at the elect out. I have a couple of people whose spouses work at McKay-Dee Hospital. So, they automatically have an IHC plan and they are literally double insured; but, if I drop them out of our plan, it costs me money. It doesn't save me money. So, it is something that should be addressed.

So, Altius, or the other vendors that have given you quotes, they are already factoring that in? They give you a discount if you cover everyone; because, they know that is going to happen?

That is absolutely right.

Interesting. Let me ask you how familiar you are with another term, "health savings accounts"?

Fairly familiar with it. We have actually looked at it a time or two. It hasn't come to the forefront yet; but, it might. We have looked at everything over the years, i.e., health savings accounts. We actually went to a self-insured plan where we paid all claims under $25,000 for a period of time. We have tried everything to try to contain the costs of health care coverage with minimal success.

Join the club, I guess! Maybe you are doing better than some others. Let me stick with health savings accounts. You clearly know what they are and have considered them. Why haven't you offered them so far?

I didn't think we would have adequate participation to make it viable. Because, most of our employees, I think we have 85 to 95 employees that have been here over a year. We have about 100 employees. The others haven't been here a year. I have a small portion that I think would participate. My production employees are typically either Southeast-Asian or Mexican. They are great people; but, I don't think the health savings account would have any participation from that group of people, which would probably be 70 of the 90. For the salesmen, drivers, office, clerical, that sort of thing, I think we would have better success. We may look at that again this year.

So, you think maybe it is a function of how much money they are making and therefore how much they would have available to put in or do you think it is a cultural thing or both?

I think it matters how much money they make. Our minimum wage is typically about $1.00 above the federal minimum wage; but, still, at $8, $9, or $10 an hour, if you are trying to raise a family and have a couple of kids, I think that food on the table takes precedence over health savings accounts.

I am not trying to talk you into doing health savings accounts; but, at the same time, if they have some out of pocket costs anyway, because of the high deductible, at least they would have some money in a health savings account to help pay it.

I believe that is true. But, I think in a lot of cases, my production employees may use the health insurance system enough to not claim it even on my policy. I think that is one

reason why, historically, we have had a low claims ratio. They can go up and use the system and not pay.

Interesting. Just to repeat briefly, you clearly do already have what the literature is now calling a consumer-driven health plan. It fits the definition. There is a lot written about some of the advantages and some of the disadvantages of this high deductible, more of a personal responsibility approach. So, let me ask you about some of those things that are considered to be pluses or concerns and see how you feel about those. I got ahead of myself, I apologize. Let me ask you just a general question first and then get into the specifics. What do you consider to be the advantages or the draw backs of the high deductible approach, both for you and for your employees?

From the employee standpoint, there is no advantage to a high deductible policy because of the higher out of pocket cost. From my perspective, obviously, it is cost, which is the overriding concern. Even at this big deductible, health insurance is one of my largest bills. It is definitely something that can't continue to go up double digits every year.

Now, let me get into some of the specifics and see what your feeling is and what your reaction is to some of these. One, you have clearly talked about. One of the advantages is that the premiums are reduced; because, they are shifting more of the first dollar costs to the employees. Another advantage that is talked about is that the overall costs go down or stay down; because, the employees make better decisions about when to seek care and what kind of care to get.

I think that is true. The plan is probably designed to go into your average physical, for your $30 co-pay, you don't end up with a several hundred dollar bill for a preventative type of thing. But, the small scratch that may or may not need to go to the emergency room, I think they stay away if it is questionable. So, that does reduce the overall impact of the health care system.

Another advantage that is talked about is that if you have a higher deductible, you can have fewer restrictions on which providers you can go to and prior approval requirements and all of that kind of stuff. Is your plan maybe less restrictive because of the high deductible or don't you think that is a factor?

I don't think that is a factor. I think our plan is not that restrictive. It is fairly open. We have had plans in the past where you have had to have permission from everybody from your mother to the primary care physician and if he moves out of town, it was almost impossible to get health care service. This plan is pretty good in that respect.

So, it is less restrictive than what you used to have?

Far less restrictive!

Did you ask for that or did the plan sort of evolve that way?

We asked for that; because, we literally had a plan one year where it was so restrictive, it was not usable.

By the way, that is very common. Managed care, the strict HMOs and all of that were pretty successful in the 1990s. Nationally, the inflation in health care costs moderated pretty significantly; but, the employees and the employers and everybody really kind of rebelled against the restrictions and asked for some of them to be lifted. Now, to some of the criticisms. One of the criticisms against this approach is that patients really can't make good decisions when or where to seek care; because, there really isn't much information out there about what things costs and which is better quality than another. Does that concern you? Have you seen that?

No. I am always amazed when I get claims ratio information. Sometimes you can't get that information; but, in this particular plan, I do get it. I am amazed at the percent of our claims that are prescriptions. Other than that, I think my employees use it with the possible exception of some of my Mexican employees. I think they use the system without paying anything; and, I think they are successful.

Are they going to private providers and asking for charity care or do they go to community clinics?

If you go to an emergency room, you are going to get care, whether you have insurance or not.

Actually, that is the law.

That is the law. If you don't hand them your insurance card and you are from Timbuktu, I think a lot of that cost is absorbed by the system. They get no bill, no deductible, no anything. I think that is something that does need to be addressed, but, not by the employer.

This next negative is really related to that. One of the criticisms of these high deductible plans is that they have an unfair impact or a disproportionate impact on lower income employees and that perhaps employees will forego needed services in order to avoid the out of pocket costs. Does that concern you? Have you seen it?

Health care in general concerns me. Certainly, that concerns me. If you need to go to the hospital, you have got to go to the hospital. That is all there is to it. I don't have a doubt that if someone thinks they are going to get stuck with a $2,000 bill, they probably do forego going to the hospital when they should. However, most plans, and this plan in particular, do try to address that in the fact that you can do your preventative and your emergency room care for $100 or something like that. So, it is not like you are going to get hammered for $2,000 if you show up to the emergency room. But, certainly, a $2,000 dedudictible probably keeps some of them away that should end up seeking medical help.

This refers more specifically to the health savings accounts. It is felt that they have a disproportionate impact on older and chronically ill employees; because, they are not going to be able to accumulate funds in the savings account. They are going to use them up every year. When you were looking at savings accounts, did that cross your mind?

No, that really didn't cross my mind. But, it is a valid point. For me to put money into a health savings account at my age, it would be out before it went in. The older you get, the more health care service you need, without a doubt. Most of my employees are young. If I could get reasonable participation in the health savings accounts, it would be a great deal for my employees. But, I think getting the participation is almost impossible.

Do you have a 401K plan?

We have a retirement plan, not a 401K plan. It is a simple plan. We do contribute into retirement for every one of our employees. If they do not elect to participate, we still write them a check for $50/month for a retirement benefit; and, I know some of them buy groceries with it.

Do they contribute or do they have the option to contribute?

They have the option of contributing up to 3% and we will match up to 3% of their earnings and/or $50.

What is the participation like in that?

Poor.

That would be an indicator to you of how the participation would be in the health savings account. It is really the same concept. You and I have been around long enough to remember the old defined benefit pension plans and the defined contribution plans really took over; because, it gave the employer better control over their costs and the employees now could control their own accounts better. They could contribute towards them and accumulate more money. The thinking is that, "hey, that was so successful with retirement plans, maybe the same thing will work for health plans."

You are absolutely right. If I had the same participation in health savings accounts as I do in retirement plans, it would be a total failure. I am amazed at it. I sit each employee down individually every year and explain, "You know, you made $50,000 last year. If you would have contributed $1,500 dollars and I would have matched it, you would have $3,000 in a savings account. It maybe would have cost you $700 or $800 when you take taxes into account. That is better than going to Las Vegas!" The answer, in a lot of cases,

is “I will start that next year.” I have a lot of young guys and they make, what I think is really decent money; but, some of them have child payments to make and this, that, or the other. Maybe they have been divorced; and, they never get around to it. I write them a check for $50. I only do that so that when I am drinking pina coladas one of these day, I won’t feel guilty.

You may have also touched on this one already. Another one of the potential criticisms is that the high deductible plan puts some economic incentives in there to watch your own money; but, once you reach the deductible, then the economic incentives don’t really apply anymore. It loses its effectiveness.

That is true; but, that sounds like a high deductible. When it comes to a medical procedure of any kind, that isn’t even removing a thumbnail. It is amazing to me. My wife had a knuckle replaced, which, certainly that is not something you are going to have done every day. It was not even over night. The bill for a procedure like that is over $10,000. It doesn’t take long to reach that $2,000 deductible.

Right. Once you do, essentially, you have full coverage again. Depending on what your co-insurance is.

It is 80/20, $2,000 deductible.

So, that really covers that criticism. Because, even once you have covered the deductible, you are still paying a significant part of it out of your own pocket, up to whatever the out of pocket maximum is.

I think the out of pocket maximum is the $2,000.

Okay, so I have to reverse what I said. Once they have spent $2,000 out of their own pocket, then, they have first dollar coverage. One of the other criticisms of the health savings account is that they increase the administrative burden for the employer. I don’t know if you have looked into them far enough to add anything about that.

I don’t think that would be a huge burden. It is not a lot different than retirement accounts. Certainly, is there some administrative factor in there? Yes. But, I don’t think it is a big deal. Quite honestly, the people that provided us the information on the plan we have now, that offered us health savings accounts, they were going to administer that for a minimal amount. So, I don’t think that would be a big consideration. Participation is why I don’t think we will have one.

I understand. One more terminology question. Have you heard or has your agent talked about disease management programs?

No.

Let me see if you have but maybe they didn't call it that. There is another trend, I guess, for cost containment looking at putting programs into place that help people who have chronic conditions, i.e. diabetes, high blood pressure, to help them understand better how to control that. Do you have something like that in your plan or has somebody talked to you about it?

They really haven't. My suspicion would be because we do have a reasonably young work force. It probably hasn't been a huge issue. I don't think we had a lot of claims based on that type of condition.

That may very well be the case. It is something I have put in there because it is interesting to me. A lot of times in the literature, they talk about disease management as an alternative to consumer-driven or high deductible plans. I don't really understand why they are alternatives. Why wouldn't they work together? If you had an older work force and had a lot of people who were diabetic and had other chronic problems, why wouldn't you do both? That term doesn't make sense to me. But, it doesn't really apply to your situation. Okay, only two more questions. The first one is just general. Is there anything else you want to add? Any other comments about your health benefit plan or just about the health insurance programs in general?

We have been talking about a national health care plan for my entire life. I don't know if that will ever come about. If we are ever going to get on top of our escalating costs of health care coverage, it is going to have to be we have fewer and fewer people covered by health insurance. Those of us who do have plans are picking up the tab for those who don't have plans. To me, it just makes sense that we can't continue to have 15% escalation in our health care premiums and fewer of us participate. It just compounds the problem. I think the federal government has to do something to increase the number of people who, directly through their employer, or shared, or something, participate in health care coverage so the health care providers don't end up eating all of these huge bills for uncovered employees. I thought we had something that was mandated by the federal government that employers have to participate to some level and that the employee would have to participate to some level. To me, it needs to happen. I think it will happen out of necessity; because, we are going to bankrupt the few of us that offer health care coverage. Well, I shouldn't say that. We will just discontinue them, which has been happening. The number of people insured keeps going down. That is crazy!

So, maybe something like the Massachusetts approach?

I think so. I give Mitt Romney credit for at least attempting something. You know, Utah is a pretty conservative and aggressive state. I wouldn't be surprised to see something tried in Utah. I hope it does; because, quite honestly, I am not going to eat a 15% increase in premium every year without doing something. If all of a sudden, I go 75/25, I won't have 100% participation, I can assure you. So, you are going to have more people showing up at the hospital that don't have health care coverage. Obviously, I am not allowing it. Like I say, some of our biggest corporations, General Motors and Ford come

to mind. One of the biggest problems they have is they volunteered 100% coverage for the employee and their families and they are so underfunded in their health care plans and the retirement benefit.

The retirement benefit is where they really got nailed.

I am not going to paint myself into that corner.

Well, you already touched on the last question. Do you foresee any circumstances where you would discontinue health benefits?

No. I will always offer health care coverage. But, I would be very surprised if I pay 100% in five years.

So, you have already gone to the high deductible. Maybe the next step is not paying the 100% of the single premium?

The only way I can see me not having to do that is if the government does something where it is mandated that employers contribute something. That may stabilize health care premiums. If they keep going up double digits, then, that will be the next step.

The answer to the last part of this question is obvious; but, let me get it on the record. Do you see high deductible/consumer-driven plans as a model that will help you continue to offer health benefits? You have already done it! By the way, you probably already know this as well; but, your premiums are quite a bit lower than what I see among a lot of other employers. When I look at your summary plan description, it is clear why; because of the high deductible and probably also because of the 100% participation. Any other small employer I have seen is over $1,000/month for family and yours is $600 or $700; but, it is clear why. Anything else?

Another reason why my plan is cheaper than most is they have made a lot of money off me over the years. We have had a 50% claims ratio. I am not a genius; but, if you are collecting $100,000 plus and paying out 50%, then, it is hard to come in and adjust by a 15% raise. So, I have been getting by with 8% to 10% raises when the market has been 15%; and, they have been making money on me. So, that is fine and dandy. I understand that.

Thank you very much. I appreciate it!

My pleasure.

APPENDIX G

INTERVIEW WITH FRED FIELD

How long have you offered a health insurance plan to your employees?

In the six years I have owned it, I have offered it. Prior to that, it has been offered; so, probably 30 years or better.

How do you feel about the plans that you currently offer?

As far as the plan we have, I think it is as good of a plan that is out there. I wish we could offer more. I wish we didn't have the deductibles as high as they are. I wish we could pay a bigger portion of the premium; but, it is not possible. At one point in time, we used to pay the whole premium; but, as time has gone on, we have had to have the employees be a bigger participant in the insurance.

I will get more into the deductible later; but, do you know the split on the premium?

Right now, we are paying 60% and the employees pay 40%.

And, that is whether they have single coverage or family coverage?

Yes.

How to you think your employees feel about the current health plan that is offered?

Not so much the past couple of years; but, when we were having the 18% increases, it was getting to the point of whether or not my employees would be able to afford it and whether or not I would be able to offer it to them. There are some employees who have opted to not participate in the insurance because they can't afford it, even though they only pay 40%.

Your agent told me that there is, I think, 19 employees currently participating. About how many employees do you have?

We are somewhere between 86 and 92 employees. Most of those are part-time; but, we probably have another 15 to 18 employees that would qualify. They have to be full-time to participate in the insurance plan. We probably have another 15 to 18 full-time employees that would be eligible but opted not to participate because of the cost.

So, you have about 35 to 40 full-time employees?

Roughly about 32 to 35. I couldn't give you a definite number right now, but that is close.

So, a little over half participate in the plan?

Yes.

Are you considering any changes to the plan now?

We just take it year to year. Right now, we are not going to make any changes this current year. The insurance will go up this year, I will absorb the cost as it is going up. We are actually starting the 2008-2009 year. I will actually pick up a little bit more of the premium than the 60%. I hate to pass on the increases to the employees; so, if I can help it, I try not to. There will come a time, and I have explained that to my employees, if the insurance industry keeps heading the way it is going, we may have to look at something possibly different. We may not be able to offer the insurance, or I will have to cut back on what I am able to contribute; because, my costs keep going up. There will come a point in time, unless we get it fixed, that I won't be able to offer it.

The information you gave me ahead of time, and, you and I have chatted a little bit before, you have made some changes in the last two to three years?

Yes. We have gone from a $500 deductible to $1,000 per person deductible. We also went from a $3,000 per family out of pocket expense. We also raised the co-pay. I believe we were at a $15 co-pay, $15 office visit, and a $25 specialist. We have gone from that to a $25 co-pay, $25 office visit, and $35 specialist. So, we have increased our co-pays. I think our prescription co-pays came down a bit. We used to have a $15 co-pay on prescriptions and that came down to a $10 co-pay on certain prescriptions, generics.

You mentioned to me that you switched carriers about three years ago.

Yes, we went from United Health Care to IHC Select Med.

When you made these changes that you have talked about or when you consider changes for the future, what are the main factors that you look at?

Basically, just the costs. When we switched from United Health Care to IHC, the determining factor was there. They wanted to raise our insurance rate 18%. When I explained to them that it was not acceptable and that we were going to get other bids, we actually went back to them and gave them a chance to lower their bid. They would only come down to only a 13% increase, which still was not acceptable. IHC came and kept us the same as what the rates were before they would have taken that increase. We opted to change. So, right now, IHC is very competitive; so, we have opted to stay with them. In the event that they become noncompetitive or start raising their rates at those percentage levels, then, we would shop around and look at making a switch again.

Are you familiar with the term consumer-driven health plan?

I have heard of it; but, I am not familiar with it.

It is some jargon that is becoming kind of popular. What it really refers to is plans that tend to give employees a broader choice, not as restrictive a network of providers, not as many prior approvals required; but, it requires them to pay more out of their own pocket at the point of service, higher deductibles, higher co-insurance, and so on. So, in effect, with your $1,000 deductible, the people who write things about health insurance plans would probably categorize yours as a consumer-driven plan or at least as having one that has some of the characteristics of that. How about health savings accounts? Are you familiar with those?

I am familiar with those. We have not looked into those; but, that might be something that we might have to look at in the future as well. Right now, we have not looked into those. Our agent talked about those; but, it was something we just talked about. It was not something that we really explored in further detail.

So, he just talked about it in general. He didn't recommend it to you at this point?

He just mentioned that it might be an option down the road; but, that wasn't something that I was interested in at that point. Still, as of right now, it wouldn't be something that I would be interested in looking at right now as I am fairly content with where we are right now as long as it stays fairly stable.

I am going to get into questions more specifically about this high-deductible/consumer-driven approach. Just in general, what do you think about having the employees responsible for more out of their own pocket? What is good about it? Are there things that cause you concern about having that kind of an approach?

Well, obviously, if we want to offer some kind of an insurance plan, I think anymore, the insurance plans that are out there would be something considered catastrophic if they had a major illness, these office visits and stuff like that**…** As far as the deductible, there may come a point in time when we may have to raise that $1,000 deductible to possibly a $2,000 deductible. I have heard of some companies that are having even a higher deductible than the $1,000. So, definitely, we need to keep our minds open to that.

If the deductibles are higher, it makes the premium more affordable. What else about that approach do you like or are you concerned about?

It is always a concern for employees. I know with everything else going up, there is a concern for them to have to pay that out of their pocket. I hate to see them do that; but, again, in the same token, we have costs here that continue to increase. So, we have to

keep our minds open that maybe that is a possibility that we may eventually again have to increase that. Like I say, I don't like the high pays. When it goes up, it obviously goes up to myself as well as far as an individual. But, it is something we need to look at these days.

Let me go into some of the specifics. Of course, there is a lot being written about these kinds of plans. Like you, a lot of employers are going to higher deductibles. There are a lot of things that are written that says, this is good because it does this or this is bad because it does that. So, let me go through some of the specifics that are written about and see what reaction you have to those. One of the positives that we have already talked about is that if you shift more of the front end costs to the employees, the premiums go down. We have already talked about that. Another factor that is listed as a positive is that the overall costs of the program go down or are better contained; because, if employees are spending more of their own money upfront, they are more careful about how they use it, and, they make better decisions. Have you seen that? Do you feel that your employees do that?

I do. Anything that the employee has to buy into or they have to be a participant of, then obviously, they are going to be more careful. So, I think that is a true statement.

Another thing that is listed as a positive is that there are sometimes fewer restrictions on choice, as I mentioned earlier. There is a broader network of providers, less prior approvals required if you have higher deductibles. I don't know if that has been your experience or not?

Yes, it has. In fact, when we switched companies over to IHC, there were some doctors that the employees were currently using that were not in the network providers that they use. So, we found that out. They have their group of doctors and hospitals. With the prior insurance, it went to Ogden Regional. IHC, of course, goes to IHC hospitals and facilities. The same with some of the clinics. There were clinics that were under the old insurance; and, we had to switch. They actually had to go to new clinics. But, as far as if the employee wants to save money, they use the doctors that are on the list. Most of the doctors were on the list, there were just a few that were not.

So, you didn't necessarily get a broader choice because you went to a higher deductible, you got a different choice because you went to a different insurance carrier?

That is correct.

One of the knocks on this approach is to say that, "well, there really isn't good information out there about the quality of providers and about what different providers charge for different procedures; so, it is difficult for employees to make good choices even though they are spending their own money because of that." Have you seen that? Do you have any reaction to that?

We haven't seen that as much. I think when we signed up for IHC, the employees were given a list of doctors, clinics, and hospitals. So, I think they were well informed about what doctors they could use. I think, based upon the list of doctors, I think the information that is out there available, as far as who the doctors are, I think they can make good choices based upon what they were given.

Another negative or alleged negative about this approach is that it has a disproportionate impact on lower income employees. Low income employees might really go without services that they really need in order to avoid the out of pocket costs.

That is probably a safe assumption. That is why even the employees that were eligible to sign up for the plan have not signed up because of costs. In the prescription area, some drugs are covered by the $10 co-pay and others are not. So, the difference between a $10 prescription versus $60 to $70, sometimes they have to go without medication; because, they can't afford it. So, there are some drugs that are covered and some that are not. I am sure that they go without. Or, sometimes if they are too sick, if they don't have an appointment, that goes up from an appointment visit of $25 to an urgent care of $35 or an emergency room visit of over $100. So, they sometimes just tough it out and are not able to go.

Sometimes that is maybe a good choice and sometimes maybe not.

Sometimes they put off going because they don't want to pay it and sometimes they do end up in the emergency room.

Can you give me a rough idea of the range of pay for your employees? Do you have some that are close to minimum wage?

The employees that are on the insurance plan, most of those range between $9.00/hr to $13.00/hr. I have some that are involved on the insurance that are salaried employees that range from $33,000/yr to $50,000/yr. So, it ranges from hourly wages all the way up to salary wages. Someone hourly, maybe they make $22,000. Those would be cashiers, stockers, etc. The higher end would be front end managers, etc.

What about more skilled people like butchers or buyers?

Those would be your department managers.

I appreciate that. Another knock on this high deductible approach is that it might have a disproportionate impact on older or chronically ill employees simply because they have more needs.

Yes. It could. We have a lot of experience with that. When we were looking at switching over, we went out and got some bids from other companies, Altius, Blue Cross, and others. We had an employee who had a problem with depression. With that, they looked

at her as a risk as she was on a lot of medications. So, two out of the three companies didn't even want to look at us because we had her on the plan. She has since left us; so, we don't have anybody now who currently has some of the illnesses like that. But, like I said, it does factor into it when you are looking for new insurance or with your current carrier, they may raise up your rates significantly to try to get you.

That is always a concern for a small group. If you happen to have somebody who develops a chronic condition or their child has disabilities.

Or if you have a cancer patient, they look at you very closely. If you have someone like our former employee who had some serious depression problems, they certainly look at that. They look at the medications she was on and really shied away from her.

From my experience, I ran a smaller business for a while myself, even when we happened to have 2 to 3 pregnancies at the same time, we had a problem with trying to shop for insurance. This disproportionate impact on the chronically ill or just the older employees pertains even more so to the businesses that had the health savings account. The concern is that younger employees can build up their savings account over years and years where they may have no health care needs at all. Whereas, older employees, chances are they don't ever build it up; because, they are going to use it every year. They are probably on some medications or whatever the case may be. One of the things in the literature says, maybe this isn't fair. Other people that I have interviewed have different philosophies on that. Some say that is not right and others say, well, people who use it more ought to pay more. That is the range of reactions we get regarding that. One of the other things, which I suspect you probably don't know much about at this point, is that there has been some concern expressed that the health savings account adds an administrative burden to smaller employers. Since you haven't really seriously looked at it yet, you probably haven't experienced that. I just wondered if you had been exposed to that?

No.

Just a couple more things. Have you heard of disease management programs?

I know IHC actually has a brochure that they send out either quarterly or twice a year where they talk about preventative health care measures as far as our diet, exercise, and proper nutrition. I don't know if this is what you are referring to; but, that is what our insurance has sent out. It is quite educational. In looking at that, just in talking with some of the employees, I think we need to look at more ways to stay healthy not only as a group but individually. We need to make sure we get proper rest, proper nutrition, and staying away from smoking. I don't believe anybody on our health care plan is a smoker. Again, it encourages them to do some of these things that the insurance company is recommending. Obviously, if we are healthier, we don't have to use the insurance as much. As far as dealings with IHC, that is what they have done; and, it is very helpful.

That is part of the disease management approach. What disease management programs do is they go further in being really aggressive about working with employees who have a chronic condition such as high blood pressure, diabetes, seriously overweight, those kinds of things. If you have a disease management program as part of your health plan, they will specifically contact that employee and work with them to better manage their condition.

We don't have anything, as far as to that extent, as part of our plan.

Sometimes, some of the businesses that I have talked to, they have gone out and actually contracted with a third party company to come in and do that. They felt like they were going to save more; and, it also improved the quality of life and the productivity of their employees.

I have heard of larger companies that have actually done that. They have put together programs. I have heard of some of them who are buying their employees memberships to the gym and encouraging them to be healthier. I have heard of that; but, as a small company, we haven't looked into that.

Only two more questions. One is just general. Do you have any other comments that you want to add either about your health insurance program in particular or just about health insurance in the country in general.

I think the only comment I would add is I would hope at some point, when you look at the insurance industry throughout our country, when you look at the health care, I am concerned that health care just continues to increase with the medical costs and the insurance costs. I would hope that eventually the government would get a handle on it. Something needs to be done about health care; perhaps, maybe putting a cap on the costs of medical care and insurance. I know that each year that goes by, there is going to come a point, as employers, we are going to have to cut some of the benefits back or drop the benefits all together, which is something you don't want to do. But, if they don't get a handle on the insurance industry, we could be heading for some trouble. It has slowed down a bit since we switched companies, but we had 3 years in a row with United Health Care of increases. The first year, it went up 21% and then close to 18% the other years. At that rate, there was no way we could have afforded to stay with them. So, I would hope that eventually, they would get a handle on it and get it turned around or it will stabilize.

It sounds like you think the government needs to do something?

Obviously, the year we left United Health Care, because they told us they couldn't afford to keep us, they gave their CEO a billion dollar bonus. That sounds a little extreme. Somebody who couldn't afford to keep us turned around and gave their CEO a billion dollar bonus. I believe that was the year that we left. I was flabbergasted that they would do that. They are charging the smaller companies and larger companies, raising the

premiums like that. The fact that they could turn around and give their CEO such a bonus, I was pretty upset.

I can imagine.

It was very upsetting. I think the government needs to get control of it. Because, I don't think the insurance companies themselves are going to do anything about it.

Are you thinking more federal government or the state?

I think the federal government needs to look into it. I think they need to do an investigation and see why it is going up as much as it is, why the medical costs are as high as they are. When pills costs $100 per pill, there is something wrong there. I think there needs to be an investigation. Those costs are too high in my opinion.

The last question, you have already touched on a couple of times; but, let me ask it anyway so we can summarize it for the record here. Do you foresee any circumstances where you would discontinue the health benefits?

I do foresee that. Increased costs. As a smaller business, we have our fixed costs that we cannot do anything about; but, we have a lot of other costs that keep going up as well along with health insurance. I think there may come a time when our margins, in this industry, will be shrinking. So, there will come a point in time where we have to look at everything and ways to cut our costs. Unfortunately, health care would be one of them. So, we would either have to not contribute as much to the cost of health care to the employees or look at discontinuing offering the health care program all together. I would hope that would never happen; but, it is always a possibility.

Do you see high deductible, consumer-driven, plans as a model that might help you continue to offer benefits?

It could. Like I said, when we went from a $500 deductible to $1,000 deductible and when we adjusted our office visit calls, when we adjusted those, we were able to keep our price increase, as far as health insurance, to a minimum amount. I would think that we would definitely look again before discontinuing our insurance program or perhaps ask the employee to pay more. As far as for the cost of the insurance, we may look at even a higher deductible than we currently have. Obviously, if we went from a $1,000 to a $2,000 deductible, there will be some savings there, as far as our costs upfront. So, that is something we may have to look at again. We have currently been with the current deductibles for three years. It doesn't look like it will change for this year; but, we will see what happens in the future.

As we talked a little bit earlier, your premium increases have been really low the last couple of years. Do you think the higher deductible is the main reason for that? Are there other reasons?

That could be part of it. I think probably the biggest part is that health care now is very competitive. I think IHC is trying to get a piece of the pie. I think they saw an opportunity to go after those smaller groups and pick them off from some of the larger insurance companies. I think that has probably been the biggest factor as far as us, as far as I can see. I think the deductibles helped a little bit. We were able to maintain the deductibles. They were willing to work with us. United Health Care didn’t want to negotiate. We gave them the chance. We told them we would stay with them if they would meet the quote that we had gotten. They didn’t even seem to care. When we went with IHC last year, we said if you could drop the rate down, we would stay with you. They did. So, we stayed with them. This year, they kept them minimal too; so, we stayed with them.

APPENDIX H

INTERVIEW WITH GARY GRAY

Let me ask a few questions about the information you sent me just to make sure I am understanding it correctly. It looks like your employees can choose from three different options. Am I reading that correctly?

Yes.

Not in detail, but in general terms, what are the differences among the three options?

The differences are just the expansion or the narrowing of the number of physicians or clinics that they can go to for service.

So, the deductibles, the co-insurance, all of that is the same across the board?

Across the board.

It is just a matter of how narrow or how broad your panel is?

Right.

So, Select Value would be the most restrictive and then it goes across the line?

Yes.

Can they go outside of the panel and have a higher co-pay or do they have no coverage if they go outside the panel?

They continue to have coverage to not an entirely broad group of physicians. It is still a little narrow; however, the co-pay changes. They pay an additional amount with the exception of a physician who is not within IHC health plan; then, they have no coverage, with the exception of an emergency situation, then they are covered.

We already talked about the clarification on the deductible. So, the deductible is $500/person. Then, on a two-person or a family contract, two people have to reach the $500 deductible?

Yes. Then, the whole family has to reach their deductible at the same time.

It is a little hard to compare the premiums; because, they are age-banded and because sometimes people changed their choice. It looked to me like your premiums went down a bit in 2007 and then only went up about 1% to 2% last year. Am I reading that right?

I haven't studied it that closely. I actually felt like they went up a bit. I guess it depends on the age of the individual too.

You have to make sure they don't move into a different age band. For example, I looked at yours; because, you had the same coverage. The premium for your family coverage only went up about 1%. That is pretty good. It is extremely good!

I think because we are a small group, the premiums have been a little bit higher than what some might be. We happen to have a few health problems in our group that creates some challenges too, as far as insurance goes.

But, yet, you were able to offer three different choices and you haven't had large premium increases, at least not in the last couple of years.

Yes, which is nice. Did you compare that to 2006 also?

I did. It looked to me like it actually went down in 2007 from 2006. I looked at a couple of them. Yours was one of them. Yours went down a few dollars.

The other thing that changed there too was in 2006. They offered five plans; and, they consolidated those five plans down to three plans in 2007. The Select Med Plus plan. I think that is one of the reasons why it went down. They brought everything into a more compact offering as far as their health plan offerings were concerned.

Do they talk to you about offering the options? Are your premiums higher because you offered the three options as opposed to just one?

Not to my knowledge. We have our insurance agent who writes our plan for us. He comes into the mortuary about, well, anytime now, as we are getting ready for our plan change in 2009. That changes on the 1st of January. He usually comes in around September to October and reviews the options with us. I don't think we pay any more because of the different plans, it just gives our employees a financial break if they want to have a limited amount of who they select for their health care providers.

Do you share the premiums with the employees or how does that work?

The company pays half and they pay half.

So, no matter what choice they make, they pay half?

Yes.

Let me get to my scripted questions here. How long have you offered a health insurance plan to your employees?

A lot longer than I have been here. A long time.

Some very general questions to start with. How do you feel about the plans that you currently offer?

Well, we are very pleased with IHC. We like the plan they do. We like the service we receive. It covers our geographic group quite well. That is positive about it. The health care they provide is very good; and, we are happy with that. Overall, I would give them good ratings.

Now, this is a little different question. How do you think your employees feel about the current offerings?

Well, I know exactly how my employees feel about it! Some of them are not happy with the premium costs; because, they feel that the premiums are kind of expensive. Most of them like IHC with the exception of one or two of our employees who are employed at Brigham City where they only have a clinic and not a hospital. So, the group in Brigham City always has to come to Ogden for hospital treatment. That has not been a big problem, though. Overall, I think most of them like IHC.

They like the choice and the quality of the providers, but, they wish you would pay more of the premium?

Again, that is a secondary thing. The premiums are a little more expensive because we are a small business. We pay a little bit higher premium because of that.

Are you currently considering any changes to your health benefit plan?

We look into changing our plan periodically. The last time I did it was 2007. We looked at going into another plan just to see what was out there. By the time our group was rated because of our health challenges and things, it didn’t help us at all to change any plans. The premiums were about the same.

So, you looked at possibly a different carrier?

Yes, specifically, we looked at United Health Care at the time and Blue Cross Blue Shield.

You mentioned an agent earlier. Is that an IHC agent; or, do you use an independent broker?

An independent broker.

That answers the question about changing to a different carrier. What about changes to the plan design? Are you considering any changes in deductibles or anything like that at the present time?

That seems to be the best way for us to reduce our premium costs is to raise the deductible. I am not sure how many of our employees would be interested in that. The savings is not a huge savings; but, it might help them a little bit. I haven't considered changing the deductible this year. We did in 2006. We went from $250 to a $500 deductible.

That might be part of the reason why your premium increases have been pretty modest in the last couple of years. That could be having an impact there. That was in 2006?

Yes.

When you think about making changes to your plan, whether it be the possibility of changing carries or changing the design, what would you consider to be the most important factors?

This year, 2009, it is maternity; because, we have two staff members who are planning on having children this coming year. So, that is going to be our most pressing issue is to add maternity. Right now, we don't have it.

I didn't notice that. Thanks for pointing that out. I should have noticed that.

So, what we have done to supplement that, we have helped our employees with some of their medical expenses. If they have had a child, we have helped them pay for it.

So, self-insured for maternity in the past?

A little bit.

What other factors are important to you when you consider a health plan?

Again, the IHC is very nice for us; because, the convenience of it is very nice. I wouldn't anticipate changing IHC unless we had a huge problem. I think most of all, our employees have really been very pleased with our overall plan. I can't think of anything else to be honest with you.

That answers the question. You like the breadth and the quality of the IHC network. Another factor is if your employees are happy with it, why make changes?

One other interesting side note, a number of our employees have spouses who are working. Some of them work for small businesses. I don't know how they do it; but, some of those other small businesses actually have better premiums than we do. So, they

have elected to be insured with their spouse's health care coverage instead of through Gray Mortuary. So, we currently have probably four people who would be eligible for our plan who are not insured because their spouses are insured. We have two full-time people who have elected not to be insured because of the cost of our plan. We told them that they pay half of the premium; and, they said they did not want to do it as they could not afford half of the premium.

Of course, you want them to have coverage; so, that is another factor, trying to keep the premium down both for yourself and for the employees as they are paying half of it. I told you this was not going to be a quiz. So, here is one question that sounds like a quiz; but, it really is not! Are you familiar with the term "consumer-driven health care?"

I am not.

Not a problem at all. It is a term that is thrown around a lot now. What it really refers to is plans that are designed where the employees have a broader choice, fewer restrictions; but, they pay more out of their own pocket at the point of service, usually higher deductibles, sometimes higher co-insurance or co-pays. That is the term that is kicked around. This one, I think you are familiar with, because, I saw it on one of the papers you gave me. It looks like in 2006 or 2007, you looked at the possibility of a health savings account?

Yes.

So, you are familiar with those. What do you think about that concept? Apparently, you did not go with it. So, I wonder why and whether you might consider it again in the future?

I don't remember all of the specifics. I can't remember if we had considered that we would fund part of that or the employee would fund it. I think it was employee funded if I am not mistaken. I don't remember why we elected not to go with that at all. I don't even remember the details of that plan to be real honest with you.

That is fine. I did look at the proposal that you were given. They were talking about a $1,500 deductible, $3,000 for family. It looked like the premiums were about 20% to 25% lower than the premiums for the plan you were with, the $500 deductible; but, obviously, the deductible is $1,000/person higher than it would have been under the other plan. In general, even though you don't recall the details of that particular plan, just looking at this concept (higher deductibles and higher co-pays), possibly with or without a health savings account, what would you consider to be advantages or disadvantages to that kind of plan as opposed to the more traditional plan?

Well obviously, the advantage is that the premiums are lower. I think that was something that some of our employees wanted to do at that time. We did not vote on that issue. We decided that the best way for us to go was to stay with the plan similar to the one we

have. I don't remember the details of why we decided that. Maybe it was the high deductible. I cannot remember. That is kind of an interesting thing, especially as you compare the plans again. We looked at a lot of options in 2006.

Do you think you would be likely or not very likely to consider that kind of a plan in the future, higher deductible?

Since you brought this to my attention again, I had completely forgotten that we did it, I would explore that again this year.

The health savings part of it?

Yes. If you look on our list, we are a small business; and, we have a number of family members who are insured in our business. I think there are only two family members who are insured through that right now. If my employees wanted to do a health savings plan like this one, that might not be a bad idea. It helps them save a little money upfront.

I am going to go through some of the things that have been written about as either advantages or disadvantages of this high deductible "consumer-driven" approach just to see what kind of a reaction you have to those. Sort of a side comment on looking at the health savings accounts, it seems to be a matter of some employees really liking the idea and some who don't. With a group as small as yours, if you have a number of employees who are interested in it, it might be worth looking at. It is something that you can either help fund or they can fund it entirely on their own. It works sort of like a 401K, which I am not sure you have a plan like that; but, it is kind of similar.

Yes, we do.

So, they can fund it, you can help fund it, or you can match what they do. There are options for it. Let me go through some of the things that are alleged to be pluses or minuses of this kind of approach just to see what kind of a reaction you might have. Obviously, you hit on the first one, which is the premiums are lower, because, you are shifting more of the costs to the employee. Related, but not the same thing, is the idea that overall expenditures of the program, overall costs of the program, will go down. If employees are spending more of their own money at the point of service, they might make better decisions or more careful decisions about health care. What do you think about that?

That makes perfect sense to me; because, the person who is a hypochondriac runs to the doctor for just anything. That will affect everyone else's premiums in a small group like this. That affects everybody. It also makes sense for the person who has high expenditures because of health. We have one woman who had a pacemaker implant put in over these past few years. It also makes sense for the people who are high users. They don't affect the group quite as much, I wouldn't think; because, they are still paying as much out of their pocket at the point of service.

I am going to go through a few things. These are what other people who have studied the concept have written. It doesn't necessarily mean they are absolutely right. A couple of the things that are listed as disadvantages relate to what you are saying now about the heavy users. I will get to that in a minute and we can talk more about that. One of the supposed advantages is that you can relax some of the restrictions, you can offer a broader provider network and do away with some of the pre-approvals. Supposedly, since people are going to be spending their own money when they go get the service, they are going to spend more carefully and you don't have to be as restrictive on the frontend. Make sense?

It makes perfect sense.

Now, some of the supposed disadvantages. There really isn't enough information out there for employees to make good decisions about the quality comparing one provider with another and about the costs of services. Have you had any experience with that?

Can you review that again? I didn't quite get that whole concept.

If an advantage is to say, "employees are going to make more careful choices since they are spending their own money", some people say that a disadvantage is, "just because they are spending their own money, doesn't mean they are going to make better choices." They feel the system is so complicated that they can't really compare one provider with another. It is too hard to find out who is more efficient or who charges less.

That makes perfect sense to me too. The other thing is that we have had our plan so long with IHC that I don't think many of our people compare prices that way anyway. They just go to their own provider whom they have been with for a long time.

They kind of rely on the plan to monitor the quality and the cost of the providers?

Right.

I told you that I have interviewed a number of other small business people around Ogden. That is what I am finding. Some of them have gone wholeheartedly toward this high-deductible approach. Others have not. Others have lower deductibles than you do and have their reasons for that; but, all of them are still holding on to the preferred provider network in combination. They just feel like they need to rely on the insurance plan to be monitoring the quality and the prices.

So, not many of them have switched over to the health savings plan?

I have not interviewed any that have gone with the health savings plan. Now, I haven't interviewed hundreds either. I have only interviewed a few. But of those that I have talked to, there were two out of six that do have high deductible plans. Their deductibles are

high enough that they could implement the tax preferred health savings account if they wanted to. They just haven't chosen to do it yet. One is very seriously considering doing it; but, others are not at the present time. However, they all reacted the same way you do to the question about the provider network. The reaction is, "I let the insurance plan handle that. I figure if they have providers in their preferred network, they are monitoring their quality and they are negotiating reasonable fees with them." So, it is a hybrid of the old managed care approach with the high deductible approach. Here are a couple more potential disadvantages that are mentioned. The high deductible or consumer-driven approach has an unfair impact on lower income employees. They may forego needed services in order to avoid the out-of-pocket costs.

Very true. My personal experience is not with our plan but people I know who have similar catastrophic health coverage plans where they have not had some minor surgical treatment that they needed because they were waiting. Of course, we don't see that in our plan; because, usually our employees get treated. But, I have heard of others who have not done that.

It is a real interesting phenomenon to look at. In some cases, putting off a minor surgical procedure might be the appropriate thing to do. If you don't really need it, why get it just because your insurance will pay for it. On the other hand, if it is something that is going to prevent more serious health problems, that is the concern. A lot of the plans are now exempting preventive type of services from the deductible: annual physicals, mammograms, prostate exams, those sorts of standard preventive treatments. They will say it is a $1,000 deductible; but, these preventive services are exempt from the deductible. You can get those and not have to pay for them. That is aimed at this concern. Here is the one that you were alluding to earlier. There is some feeling that these high deductible plans, even if there is a health savings account with it, is that they might have a disproportionate impact on older or chronically ill employees; because, they might not be able to accumulate funds in the savings account. It is just going to be a revolving door for them. Would that be a concern to you?

It would become a concern; but, you mentioned "tax deductible." I had kind of forgotten that as well. So, that is a nice way to do that. However, having said that, we try to help our employees recover some of their costs by operating a cafeteria plan that allows them to claim their health expenses in a tax deductible way.

That is the sort of "use it or lose it" approach, whereas, a health savings account carries over. If they don't use that, it accumulates even to the point where if they have money left in there when they retire, they don't have to necessarily use it for medical expenses. You can use it for other things.

Does the insurance company administer that money or is it through the employer?

You would have to make arrangements to have it administered similar to the way you would for a 401K or a cafeteria plan. I am not familiar with the details of how that is

done or what it costs. One of the other disadvantages for small businesses, I have heard, is there are some administrative headaches involved; but, I don't know whether that is the case or not. I have asked the other small employers about it. The ones who had looked into it more carefully have said they didn't see that as a big problem. One other concern, you have alluded to this one earlier too, is this deterrent effect is really lost once somebody exceeds the deductible; because, now, they are sort of back to having the insurance company pay for everything anyway. Most plans still have a co-insurance to overcome that; so, the employees are still paying something. They still get to an out-of-pocket maximum at some point. Some of the critics say, "well, 70% or more of the expenditures nationwide are by people with catastrophic losses;" and, this isn't really going to have that much impact on them. Have you heard of disease management programs?

I have not.

This is another trend or at least something that is going on in a lot of plans where either the insurance plan itself or a third party contractor works with employees who have chronic conditions and pro-actively, not treating their disease, works with them to help them better manage their disease. Do you have something like that in your plan? Has the agent mentioned it to you?

No, I am not aware of it at all.

That is something else that you might want to look at; because, it can save both money and improve quality of life.

A disease control plan?

Disease management is what they call it. It has different names. Typically, like a lot of plans, they go after the low hanging fruits. So, typically, they will immediately work with employees who are diabetic or have high blood pressure, chronic conditions like these. They try to help them manage it more efficiently and avoid progression of the disease or more expensive kinds of problems. Do you have any other comments or any comments about either your plan or just about the health insurance system in this country in general?

Well, the only comment that I would have is it is becoming very selective. That is sad. We don't have the coverage for certain people or they can't afford to have the coverage. As an employer, I would let all of my employees be covered; but, they can't afford it. It saves me a little bit of money; but, I would just as soon have them have the coverage as well and then pay for it. We leave the option up to them, though, if they want to opt out of it or not. It is a bit of a tragedy.

I am not quite sure I know what you mean; but, let's expand on it a little bit. When you say that the system is selective, who does it select against?

Those that don't have the money to pay for the premiums. All of them in our company are full-time people who have lower paying jobs who have opted out of the health insurance coverage.

So, you have a range of pay for people who would be eligible?

Right.

Just in round numbers, what would those lowest paid people be making?

Probably $11.00 to $13.00 an hour.

Then, as you move up through your professional staff, they are in a higher salary range; so, they tend to be the ones who take the plan?

Right. The other sad thing is a lot of the lower paid staff are probably women and some of the clerical. Some of them are one income families.

So, they can't jump onto their spouse's plan; because, they are not married. It is difficult. What should we do about it?

I wish I knew. I don't have any answers to that question. It is a perplexing one. The health savings plan may help a little bit to bring premiums down. I don't know if they would do the surgical procedures if they had the need with a plan like that. Interesting question.

I have one last question. It actually has two parts. Do you foresee any circumstances where you would discontinue offering health benefits?

No, not at all.

The second part of that is do you see this high deductible/consumer-driven approach as a model that might help you as a small business continue to offer benefits?

Potentially. I don't know that it is something we are going to jump on right away; but, if the need came up, that might be a real potential for us.

Anything else you would like to add?

This has been an interesting experience. I have learned a little bit, which is always good.

Thanks again!

APPENDIX I: CURRICULUM VITAE

RICHARD J. DAHLKEMPER
120 West 4300 North
Pleasant View, UT
801-626-7298
rdahlkemper@weber.edu

PROFESSIONAL SUMMARY

Excellent teacher with more than 30 years faculty experience at several universities. Successful health care executive with 24 years of senior management experience in regionally integrated networks. Extensive background in strategic planning, operations, provider recruitment and relations, board and community relations, financial management, and managed care. Six years experience in economic and business development.

FACULTY EXPERIENCE

Weber State University, Ogden, Utah, 1996-present

Assistant Professor, Health Administrative Services, 2002-present
Adjunct professor, Health Administrative Services, 2001-02
Adjunct professor, undergraduate Accounting, 1996-2001

University of Notre Dame, Notre Dame, Indiana 1987-1991

Adjunct professor, Master of Science in Administration
Taught health systems policy and strategy courses to graduate students concentrating in health care.

Indiana University, South Bend, Indiana 1976-1987

Adjunct professor, Masters and undergraduate programs
Taught Healthcare Financial Management in the Masters in Public Administration program and Accounting to undergraduates.

Saint Mary's College, Notre Dame, Indiana 1979-1982

Adjunct professor, undergraduate Accounting

EDUCATION

Ph.D. candidate (ABD) in Health Administration, Walden University, 2004-present
MSBA, Management and Administration, Indiana University, 1975
BBA, Accountancy, University of Notre Dame, 1971

HEALTH CARE EXPERIENCE

1991-1994
Executive Vice President, Holy Cross Health Services of Utah
Chief Operating Officer, St. Benedict's Hospital, Ogden, Utah

HCHSU included three hospitals and a network of 17 clinics/ambulatory centers as well as investments in managed care products and home care. In 1994 gross revenue totaled $241 million on 18,000 inpatient admissions, 470,000 outpatient visits, and other activities.

St. Benedict's was a 249 bed regional referral center with a full scope of secondary and tertiary services including open heart surgery, neonatal intensive care, and radiation therapy. In 1994, $86 million of gross revenue was generated from 7,200 inpatient admissions, 120,000 outpatient visits, and other activities.

Duties were full strategic and operational responsibility for St. Benedict's and senior executive responsibilities for the entire Holy Cross network in Utah. Responsibilities included operations management, strategic planning and marketing, physician network development, total quality management, and managed care.

1971-1991
St. Joseph's Care Group, South Bend, Indiana (Executive Vice President 1983-1991)
St. Joseph's Medical Center, South Bend, Indiana (Chief Operating Officer 1988-1991)

SJCG included two hospitals and a network of clinics/ambulatory care centers. In 1991 gross revenue of $174 million was generated from 13,000 inpatient admissions, 163,000 outpatient visits, and other activities.

SJMC was a 339 bed regional referral center with a full range of secondary and tertiary services. In 1991 gross revenue of $157 million was generated from 11,000 inpatient admissions, 118,000 outpatient visits, and other activities.

Duties included full operational responsibility for the Medical Center and senior executive responsibilities for the Holy Cross network in northern Indiana. From 1971-1983 rapidly progressed through various positions including chief financial officer and chief network development officer. Responsibilities included operations management, network diversification and acquisitions, strategic planning and marketing, managed care, human resources, and financial management.

OTHER EXPERIENCE

President/CEO, Ogden/Weber Chamber of Commerce 1995-2002

The Chamber provided economic development, convention and tourism development, networking, governmental advocacy, and other business services in the Weber County area. The CEO reported to a Board of Directors including business, education, and political leaders and supervised a staff of 30 providing services to 1600 members.

PROFESSIONAL AND COMMUNITY SERVICE

Fellow, American College of Healthcare Executives
Fellow, Healthcare Financial Management Association
Certified Public Accountant
Member, American Chamber of Commerce Executives
Board Member, Ogden/Weber Chamber of Commerce
Member, various committees of American, Utah, and Indiana Healthcare Associations
Director/Officer, Ogden Industrial Development Corporation, Ogden Breakfast Exchange Club, Notre Dame Club of Utah, St. Benedict's Foundation, American Cancer Society, American Heart Association, American Lung Association, United Way, Hospice, and Anti-Drug Coalition