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Consumer-Directed Health Plans

Current Trends, Emerging Opportunities

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Consumerism and Health Care Transformation

Many industry observers believe that the U.S. health care system is in the midst of a transformational change centered on consumerism – the process of enabling and engaging consumers more directly in selection and purchase decisions about the health care services they use. Consumerism is regularly cited in the news and is the subject of public and private discussion, both positive and negative. Concurrently, employer interest and employee enrollment in consumer-directed health plans (CDHPs), including Health Savings Accounts (HSAs) and Healthcare Reimbursement Accounts (HRAs), is growing.

Based on its observations and research, the Deloitte Center for Health Solutions (the "Center"), part of Deloitte & Touche USA LLP, agrees that a health care transformation is under way and that consumerism is its driving force. The Center believes that engaging consumers more directly in decisions about their health and health care is a trend that is good for the U.S. health care system. Transitioning from a patient-centric to consumer-centric system should challenge the industry to strive for innovation, efficiency, quality and service delivery. Further, consumerism could be the bridge from a system that focuses on health care for the sick and injured to one that emphasizes local and regional systems of total care – preventive, chronic, acute, and long-term.

Many employers, health plans, and policy-makers concur with the Center's opinion of consumerism's potential and believe that the majority of consumers are capable of making rational judgments if given tools and incentives to do so. They also cite the disconnect between health care buyers (consumers) and sellers (hospitals, physicians, drug and device companies, et al) as an intrinsic, systemic defect that has resulted in soaring health care costs, variable quality levels and poor service delivery.

Admittedly, there are opposing views, and evidence that, at least historically, patients have not fully engaged in truly consumer-focused behaviors. Among hospitals and physicians, in particular, there is skepticism: They reason that "patients" don't want the responsibility and don't have the capacity to make informed health care purchase decisions. These health care suppliers perceive patients as being ill-equipped to navigate among treatment options and prone to simplicity when comparing prices for health services. They are leery of the notion that health care is a "consumer market" wherein transactions (purchases) are made by the actual users (consumers) based on quality, service, price and other attributes they deem important.

Underscoring care providers' assessment are data showing that consumers do not understand health care costs and that they equate quality with service, rather than appropriateness and outcomes. From recent Deloitte Center for Health Solutions studies, two compelling facts emerge:

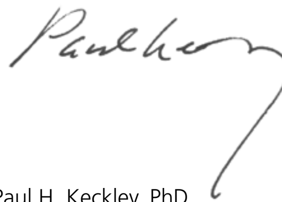
- Most consumers rely on their physician to make decisions on their behalf, believing that health care is too complicated to make decisions on their own.[1]

- Most consumers do not know what they paid for health care services recently purchased and most are not inclined to investigate.[2]

Nevertheless, it is clear when looking at health plan enrollment statistics that – ready or not – consumerism is coming to U.S. health care and that health plans and providers must respond. Since 2003, more than three million HSAs have been purchased through benefits programs, and CDHPs are even prevalent in traditional PPO, HMO, and POS offerings. While these CDHPs take many forms, all share a common purpose: to provide a financial incentive for individuals to be more deliberate about their health purchases when considering cost and quality. Today, virtually every health plan offers some form of CDHP. Many also have invested millions of dollars in systems, tools, and network enhancements to support the new consumer-focused paradigm.

The trend seems clear: Most Americans will be playing a larger role in purchasing health services, either directly through individual health insurance policies and high-deductible plans, or indirectly by using tools to make comparisons among doctors, hospitals, treatment options and insurance products.

While articles and opinions on health care consumerism and CDHPs appear on a daily basis, there are relatively few empirical or academic studies on the subject. Also, there appears to be a significant amount of misinformation circulating in the marketplace. This report analyzes available trade and peer-reviewed studies to update readers about the current state of CDHP enrollment and operations, provides a summary of the studies and the reported experience of CDHP participants, and offers a strategic perspective for executives considering CDHPs' impact on their organizations.



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1 "Seven Core Beliefs of Health Consumers," Deloitte Center for Health Solutions, October 2006

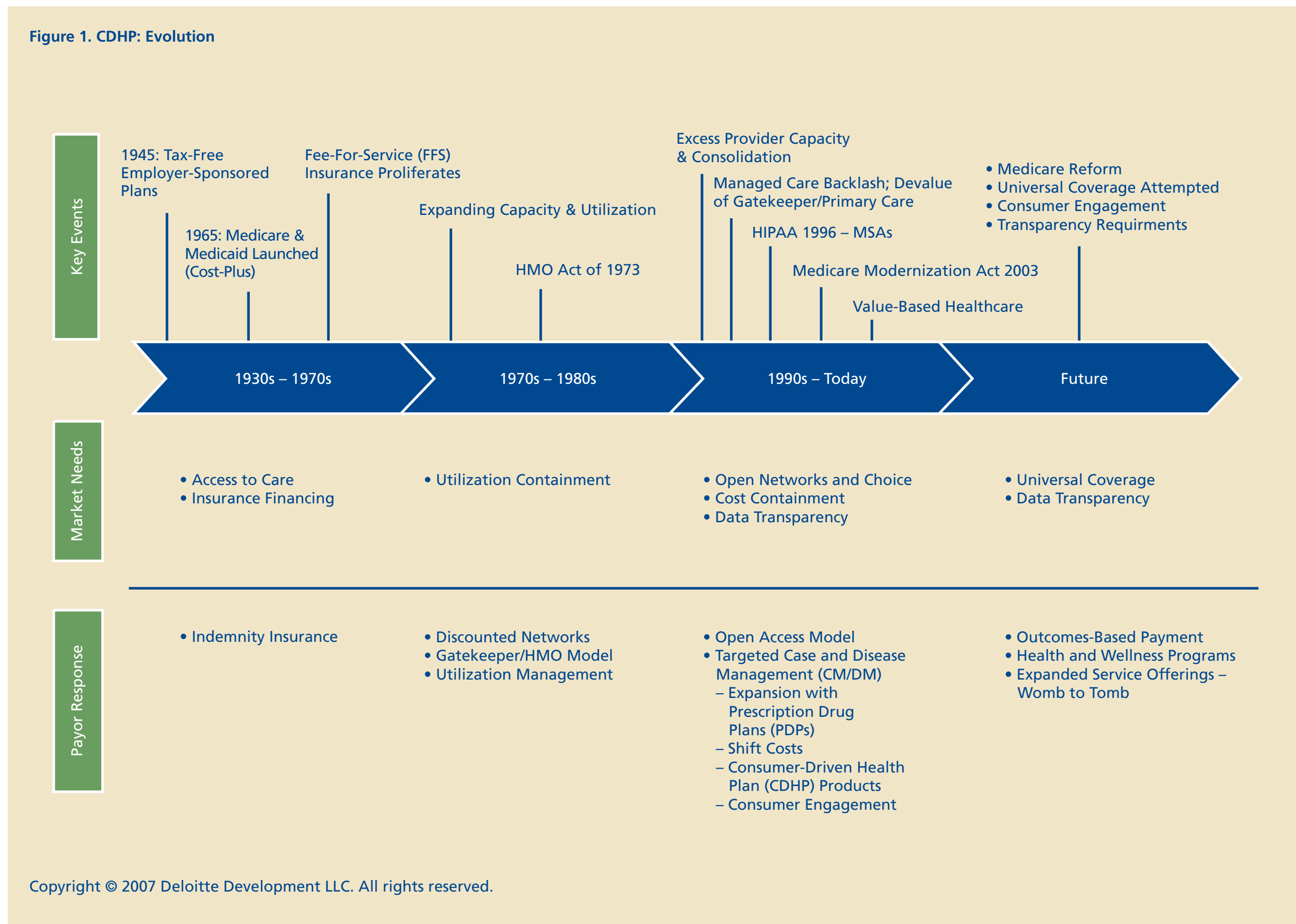
2 *2007 Survey of Healthcare Consumers*, Deloitte Consulting LLP, October, 2007

The Evolution of Consumer-Driven Health Plans

Although it is not yet clear whether consumerism will prove to be an interim or long-term solution, it already is having a transformational impact on the U.S. health care system. According to America's Health Insurance Plans (AHIP), 4.5 million people were covered by qualified High-deductible Health Plans (HDHPs) in January 2007, an increase of nearly 1.4 million from January 2006.[3]

Figure 1 traces some of the key events in the U.S. evolution of health care consumerism/CDHPs and offers some considerations for the future. Three notable events were the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Medicare Modernization Act of 2003, and the Value-Based Healthcare Initiative.

Figure 1. CDHP: Evolution



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3 "FAQs on HSAs: Frequently Asked Questions on Health Savings Accounts," American Academy of Actuaries, *Issue Brief*, October 2007, http://actuary.org/pdf/health/hsa_oct07.pdf. Downloaded November 28, 2007

HIPAA's Medical Savings Accounts (MSAs) were the precursors to today's CDHP (HRA/HSA) products. The Medicare Modernization Act included a provision that enabled individuals to buy HSAs. Its intent was to encourage consumers to become involved in their health care decisions and to create a mechanism whereby employers could encourage employees to consider HSAs as an option to their conventional health insurance programs.

In August 2006, the Bush administration further increased the focus on consumerism through an Executive Order and subsequent launch of the Value-Driven Health Care initiative by the Department of Health and Human Services (HHS). The initiative is a public-private collaboration to encourage stakeholders to commit to the following four cornerstone actions for health care improvement:

1. Use health information technologies (HIT) that meet recognized interoperability standards whenever HIT systems are adopted or updated (electronic medical records)
2. Report provider performance on quality measures based on agreed-upon standards (quality transparency)
3. Report provider charges for specific services to patients (price transparency)
4. Participate in incentive programs that reward high-quality, cost-effective care, and encourage consumers to actively seek out the care that meets their needs (i.e., CDHPs).

To date, more than 6 million Americans – almost 4 percent of the commercially insured population – participate in a CDHP program.[4] There is reason to assume that CDHP enrollment growth will continue, and it is highly possible that Medicaid and Medicare versions will become available. In fact, Forrester Research is predicting over 40 million enrollees in CDHPs by 2010.[5]

Increasingly, health care consumerism is being recognized for its potential to fundamentally change the orientation of the U.S. health care system from "patient-centric" to "consumer-centric." There are clear distinctions between the two, as reflected in Figure 2:

Figure 2: Patient-centric versus Consumer-centric Health Care

	Patient-centric	Consumer-centric
Primary Role	Passive user	Active and engaged decision-maker and user/purchaser of their health care
Value-based Purchasing Equation	Access to my preferred providers + reasonable out-of-pocket co-payments	Perceived and demonstrated quality + total costs + service attributes
Decision Maker	Physician and health plan	Individual
Decision Support	Limited	Customized, Internet and personal coaching
Role of Physician	Decision maker, trusted source (recommendation)	Coach, trusted source supplemented by others, member of a collaborative health care delivery team
Provider Accountability	Limited incentives for quality	Increased incentives through transparency
Competition	Health plans	Providers

4 http://www.forrester.com/Research/Print/Document/0,7211,41892,00.html
5 http://www.forrester.com/Research/Print/Document/0,7211,41892,00.html

Key Findings: Major Industry and Peer-reviewed Studies

Each of the major health plans and companies that specialize in individual consumer policies have sponsored studies that assert CDHPs' value proposition. Not surprisingly, the studies show that consumers who choose CDHPs as their health plan option are more price-sensitive and more engaged in decisions about the care they receive. Many of these companies also provide the results of actuarial studies that show significant cost savings and lower health care trend rates for CDHPs.

Independent research organizations and think tanks are likely to provide a more objective perspective of CDHPs' value than companies that sell such plans. The Deloitte Center for Health Solutions, therefore, analyzed major studies from "neutral" organizations to assess the prevailing view about CDHPs.

By conducting an Internet search for CDHP-related studies published between 2005 and June 2007, the Center identified seven major studies from reputable think tanks and university researchers as being particularly relevant. Five of these studies focused on consumer attitudes, beliefs and purchasing factors. Two focused on employer and health plan roles, opinions and plans relative to CDHP offerings. Figure 3 summarizes the methodology used and results and conclusions drawn from these seven studies.

Figure 3: Leading Studies about Consumer-Directed Health Plans by Thinks Tanks and Research Organizations

Sponsor	Methodology	Results & Conclusions
"Early Experience with High-Deductible and Consumer-Driven Health Plans" EBRI/Commonwealth Fund, 2nd annual survey, 2006 http://papers.ssrn.com/sol3/papers.cfm?abstract_id=951806	Internet survey of a nationally representative sample of 3,158 privately insured U.S. adults 21-64 years of age stratified into those with CDHPs and those with deductibles that qualified for an HSA (defined as $2,000 out-of-pocket for family). The sample was randomly drawn from Synovate's online sample of 1.5 million Internet users where the base sample was complemented with an additional random over-sample of either adults with a high-deductible health plan and either an employer-funded HRA or an employer- and/or employee-funded HSA, or adults with a high-deductible health plan without an account but with deductibles high enough to meet the qualifying threshold to make tax-preferred contributions to such an account or that are generally associated with HRAs. High deductibles were defined as individual deductibles of at least $1,000 and family deductibles of at least $2,000. This survey enables comparisons among individuals with these plans, individuals with deductibles high enough to meet the threshold that would qualify them to make tax-preferred contributions to such an account but who currently do not have an account, and adults enrolled in more comprehensive health plans or those with lower or no deductibles. The final sample included 722 in high-deductible health plans with accounts (CDHPs), 930 in high-deductible health plans without accounts (HDHPs), and 1,506 in more comprehensive health plans.	Enrollment in CDHPs remains low. CDHP users reported lower levels of satisfaction and delays in seeking care compared to the non-CDHP population; non-CDHP users reported the primary reasons for non-enrollment were financial: lack of adequate funds for out-of-pocket payments. Fear about self-management was not a major concern reported. For most medical service categories, individuals in CDHPs and HDHPs exhibit essentially the same cost-conscious behavior in their health care decision-making as individuals with more comprehensive health insurance. A notable exception is when purchasing outpatient prescription drugs. Despite the emphasis on informed choice surrounding consumer-driven health care, people in CDHPs and HDHPs were less likely to report that their health plans provided information on the cost and quality of providers than those in more comprehensive plans. Adults in HDHPs and CDHPs are significantly more likely to say that the terms of their health plan made them consider costs when deciding to see a doctor when sick or fill a prescription; to report that they had checked the price of a service prior to receiving care; and to ask their doctor for a less-costly prescription.

Sponsor	Methodology	Results & Conclusions
"National Survey of Enrollees in Consumer-Directed Health Plans" Kaiser Family Foundation, November 2006 http://www.kff.org/kaiserpolls/pomr112906pkg.cfm	Screening survey of a nationally representative sample of 22,560 adults 18-64; of these, 272 (1.2%) had a CDHP (plans with an HSA or HRA) and an accompanying savings account with the following criteria: 1. Currently covered by private insurance, either through an employer or purchased themselves 2. Have a deductible of at least $1,050 for individual coverage or $2,100 for family coverage 3. Say that their health insurance coverage is coupled with a personal savings account that they can use for health expenses 4. Say that the money in the account doesn't have to be used by the end of the year 5. Answer "yes" to at least one of the following questions: a. Does your health insurer or employer refer to this coverage as an "HSA Plan?" b. HSAs are tax-advantaged savings accounts that individuals and employers can fund and can be used to pay for qualified medical expenses. By law, HSAs must be paired with health coverage having a deductible between $1,050 and $5,100 for individuals, and from $2,100 to $10,200 for family coverage. These accounts belong to the individual consumer and may be taken with them to a different job, as well as rolled over into the next year. An HSA is NOT the same thing as an FSA. Do you believe that this statement describes the type of health care coverage that you have? c. Does your health insurer or employer refer to this coverage as an "HRA Plan?" d. HRAs are tax-advantaged savings accounts funded ONLY by an employer, not the worker. By law, HRAs must be paired with health coverage having a deductible between $1,050 and $5,100 for individuals, and from $2,100 to $10,200 for family coverage. These accounts may be rolled over into the next year, but the funds are NOT portable from job to job. An HRA is NOT the same thing as an FSA. Do you believe that this statement describes the type of health care coverage that you have? An additional 402 people (1.8%) met all of the above criteria EXCEPT they said the money in their account has to be used by the end of the year. These people were NOT included in the CDHP group because their accounts didn't meet the HSA/HRA definition which requires that money roll over from year to year. For comparison purposes, a "control group" consisting of 715 respondents with traditional employer-sponsored insurance was used (Control vs. Random Sample Comparative Analysis). People in the control group didn't have a high-deductible plan coupled with a savings account; however, they may have said yes to EITHER the high-deductible question or the savings account question.	The motivations to enroll in a CDHP were (1) lower premiums, and (2) the ability to build a tax-preferred savings account; CDHP enrollees are healthier, wealthier and better-educated than non-enrollees; CDHP users are more aware of prices in purchasing services, but feel less protected, more vulnerable, and report more problems accessing care due to cost. CDHP participants report higher levels of some cost-conscious attitudes and behaviors. 71% agree that the terms of their health plan make them consider cost when using health care services, compared with 49% of those with non-CDHP employer coverage. In addition, people in CDHPs are more likely to ask about the cost of a visit before making a doctor's appointment or talk to their doctor about whether lower-cost alternatives exist. They are also more likely to have chosen a lower-cost option for a recommended test or treatment. Among those who have used services under their plan, 55% say that having a CDHP has changed their approach to using health care. CDHP users report it has made them more cost-conscious in general.

Sponsor	Methodology	Results & Conclusions
"Consumer-Directed Health Care: Early Evidence Shows Lower Costs, Mixed Effects on Quality of Care" RAND Corporation, 2007 http://www.rand.org/pubs/research_briefs/2007/RAND_RB9234.pdf	A team of RAND analysts reviewed recent studies and gathered data from insurance carriers and employers. The analysts also examined enrollment trends, selection issues, the impact of CDHPs on utilization and costs, and trends in consumer access to information. They also interviewed experts from the insurance industry, employers, and provider groups about the issues surrounding CDHPs and their impact to date.	CDHP enrollment is growing rapidly, more than tripling from 2005 to 2006, to 3.2 million. CDHP participants appear to be in slightly better health and have slightly higher incomes than those in other plans. Consumers in CDHP plans generally experienced lower service use across a range of categories, including primary care visits, emergency room visits, hospital days, and office visits. There were mixed effects on quality of care – some report higher use of preventive services but there was some evidence that enrollees might be forgoing needed care. CDHP enrollees report lower levels of satisfaction than those in traditional plans. Furthermore, CDHP participants appear to make greater use of health information, but express frustration with the lack of sufficient information to support their decisions about costs or provider performance. They are more likely to ask providers about costs and to pay attention to preventive services.
"Report to the Chairman, Committee on the Budget, House of Representatives" United States Government Accountability Office (GAO), April 2006 http://www.gao.gov/new.items/d06514.pdf	The GAO was asked to review the prevalence of CDHPs, how the associated accounts are funded and used, and the factors that may contribute to the growth or limit the appeal of these plans. The GAO examined survey data on CDHP enrollment and interviewed or obtained data from employers, insurance carriers, individuals, financial institutions and other CDHP experts.	Enrollment and employer sponsorship of CDHPs is increasing: 1) From January 2005 to January 2006, the number of enrollees and dependents covered by a CDHP – either an HRA-based plan or an HSA-eligible plan – increased from about 3 million to between about 5 and 6 million, while the number of employers offering them to their employees increased from about 1 percent in 2004 to 4 percent in 2005. Enrollees participate in CDHP to gain greater control over their health care decisions, lower their health insurance premiums, and to accumulate account balances.
"What Employees Think About Consumer-Directed Health Plans" Vishal Agrawal, Paul D. Mango, Kimberly O. Packard, McKinsey & Company, 2005 http://www.mckinsey.com/clientservice/payorprovider/Health_Plan_Report.pdf	March 2005 survey of 2,500 with varying types of commercial health coverage. The survey included 1,000 consumers with employer-based, full-replacement CDHPs. Full-replacement enrollees were studied to avoid adverse selection bias that may occur when employees are in a non-full-replacement environment. CDHP participants had to have at least 12 months' coverage under the plan. Most of the 1,000 CDHP participants were covered under national HRAs, rather than HSAs (only first made available in 2004). This was not a random sample, but the authors felt the underlying demographics reasonably represented the commercially insured U.S. population.	CDHP members report frustration getting adequate information about prices and quality, were inclined to delay needed care, and were less satisfied with the plan than traditional coverage. CDHPs are delivering on their promise to increase consumer engagement and reduce utilization. CDHP consumers are responding to increased financial accountability in many favorable ways (e.g., they reported that they made more careful, value-conscious utilization decisions). Evidence is also emerging that CDHP has an impact beyond what one would expect from increased financial accountability alone: The CDHP consumers reported a heightened level of engagement in overall health and wellness even when immediate financial incentives had been exhausted. When CDHP consumers exceeded their out-of-pocket limits (and, therefore, faced incentives similar to those associated with typical traditional plan coverage), they reported behaviors suggesting greater "ownership" of their health (e.g., they were more likely to perform independent research to identify treatment options). The CDHP consumers studied appear to be more value-conscious (both in deciding whether to consume health services and in selecting appropriate care) than traditional plan participants. They are more likely to ask about cost, identify treatment alternatives, choose a less-extensive/expensive treatment during the past 12 months; they also reported enhanced attention to wellness and prevention (more healthy behavior engagement, more likely to participate in company wellness programs, and more likely to get an annual check-up because they thought it would save them money in the long run). CDHP consumers appear to be cost-conscious, reporting that they are more likely to follow treatment regimens for chronic conditions very carefully and twice as likely to inquire about drug costs. CDHP consumers appear more likely to make clinical value trade-offs. Among respondents who had had a non-pharmaceutical medical treatment within the past year, the CDHP consumers were three times more likely to have selected a less-extensive (and less-expensive) treatment than were the traditionally insured (e.g., the CDHP consumers were more apt to visit urgent care centers rather than a hospital emergency room). These clinical value trade-offs were noted even among the patients with chronic illnesses (e.g., hypertension or diabetes). Nearly half of CDHP consumers said they would be willing to travel 2 hours for a 2-day inpatient procedure (assuming that the level of clinical quality was the same in both places) if the extra drive would save them a relatively modest amount of money. CDHP consumers are more likely to receive preventive care, including annual check ups, basic blood work, mammograms, and prostate exams. CDHP consumers demonstrated strong value-conscious shopping behaviors when choosing prescription drugs. When compared to those with traditional insurance, CDHP consumers were nearly twice as likely to talk to their doctor about less-expensive substitutes, to ask their doctor or pharmacist about a prescription cost, and to ask their pharmacist whether a less-expensive substitute was available.

Sponsor	Methodology	Results & Conclusions
"A Report Card on the Freshman Class of Consumer-Directed Health Plans" Meredith Rosenthal, Charleen Hsuan, and Arnold Milstein, *Health Affairs*, Volume 24, Number 6: November/December 2005 http://content.healthaffairs.org/cgi/content/abstract/24/6/1592	Analysis of 14 consumer-directed health plan results with CDHPs; financial support provided by Robert Wood Johnson Foundation's Changes In Health Care Financing and Organization (HCFO) initiative.	Plans report an 11% absolute reduction in total spending in the first year; three fundamental weaknesses noted across all plans: (1) lack of adequate price and quality information for enrollees, (2) challenges in structuring adequate incentives for enrollees to drive price-sensitivity, and (3) lack of cost-sharing adjustments to preserve freedom of choice for low-income consumers.
"Core Beliefs of Health Care Consumers" AHRQ-funded study, Vanderbilt Center for Evidence-based Medicine, December 2006 http://www.deloitte.com/dtt/article/0%2C1002%2Ccid%25253D182545%2C00.html	Sixteen focus groups with 195 participants were conducted in San Diego, CA; Chicago, IL; Columbia, TN; and Teaneck, NJ. The participants were from different social, ethnic, and economic backgrounds.	Consumers want more information about prices and quality; they are dependent on physicians for information about quality (and believe physicians do a poor job in this regard) but have no resource to access pricing; consumers respond favorably to self-determination in making purchase decisions in health care. Participants said that they lack needed tools and would like them to be integrated with the care they receive from their primary care practitioners.

Six general themes emerge from a content analysis of these studies:

- Consumers (individuals as buyers/users of CDHP) are expressing growing awareness of the cost implications of their health care decisions. CDHP enrollees are more cost-conscious than others. CDHP designs promote cost awareness and cost-based decision making.

- CDHP plans show that health care utilization decreases across a wide range of medical services, resulting in plan cost savings.

- When consumers choose a CDHP, the overall cost of the plan (the premium) and the level of risk they might assume in purchasing a CDHP (the net deductible and out-of-pocket maximum) are key considerations. In the commercial insurance market, healthier, wealthier, and more educated consumers seem more inclined to purchase CDHPs than other populations.

- Consumers do not appear concerned about a quality differential when comparing a CDHP to a conventional PPO or HMO option. Consumers believe that access to their providers of choice is the key to quality; they do not express concern that care quality in a CDHP might be different than in other plans.

- Several studies suggest that consumers enrolled in CDHPs report lower satisfaction levels compared to enrollees in non-CDHPs. A major source of discontent appears to be a lack of useful tools to assist enrollees in purchasing health services. The studies suggest that consumers do not believe there is adequate information available about prices and quality upon which to make purchase judgments.

- There are mixed results regarding preventive health care. One study indicates that CDHP enrollees report they are more inclined to delay preventive health purchases (screening tests, routine wellness visits) than the general population. However, another study indicates that CDHP consumers are more likely to receive preventive care, including annual check-ups, basic blood work, mammograms and prostate exams. CDHP participants are also more likely to participate in company wellness programs.

Conclusions

It is safe to assume for all stakeholders in the U.S. health care system that consumerism is not a fad; it is a sustainable trend. In fact, CDHPs appear to be an important ingredient in the transition from a patient-centric to a consumer-centric health care delivery system.

In addition to increasing CDHP enrollment, other important manifestations of health care consumerism are becoming evident in the marketplace:

- Increased use of alternative, non-conventional therapies – sometimes called Complementary and Alternative Medicine (CAM)) – which are already utilized by more than 30 percent of the population
- Increased use of non-traditional care sites, such as retail medical clinics (i.e., RediClinics, et al) and in-home monitoring
- Legislative efforts in 34 states to encourage transparency via public reporting of hospital and physician performance and prices

- Line of credit features for HSA users to help alleviate employees' fears, which can pose complex barriers to entry even for large financial institutions
- Multi-wallet "smart card" to allow HSA/FSA/HRA stacking so that health care dollars come from different accounts based on expenditure
- More use of credit card-based incentives wherein financial service firms leverage their experience in incentive-based programs for market entry
- Increased direct-to-consumer advertising by drug companies, device companies, and alternative providers
- Increased numbers of employers and health plans that provide tools for enrollees to compare quality and prices for local hospitals and physicians along with treatment alternatives
- Increased numbers of employers and health plans that have restructured their traditional programs to increase co-pays, co-insurance and deductibles; that promote generics in place of branded drugs (tiered formulary); and that have built tiered networks based on distinctions between provider quality and efficiency/cost. (Notably, a tiering strategy built on differential quality metrics links well to preferential pricing and consumerism.)
- Increased metrics about lack of adherence among patients for whom appropriate self-care is key to optimal outcomes (i.e., post-acute complication avoidance, adherence to medication orders, et al)
- Federal support of increased consumerism via HHS' Value-Based Healthcare and CMS' pay-for-performance and transparency initiatives
- Intense interest in health care quality and cost in the 2008 presidential campaigns.

Similar to other industries in which disruptive innovations to traditional business models gave way to non-conventional yet effective reform, health care consumerism is a transformational force that must be reckoned with. In the coming years, its impact on changing business models, value propositions and business strategies will be felt across the entire health care value chain of consumers, providers, health plans and life sciences companies. Knowing this, key stakeholders should prepare now to address the challenges and opportunities of consumerism.

Appendix

Appendix A: Useful Sources of Information about Consumer-Directed Health Plans

Organization	Services Provided	Website
America's Health Insurance Plans (AHIP)	Non-profit organization representing member companies that provide health insurance coverage. Consumer guides on health insurance, managed care, long-term care, disability; special guides for business owners.	http://ahip.org/
CA Healthcare Foundation	Resources to help consumers assess and compare their health coverage options, as well as resources for comparing the quality of health care providers.	http://www.chcf.org/
Healthwise	Consumer health content to help people make health care decisions Information Therapy (Ix®): Healthwise is leading a new trend in health care – information therapy. With Healthwise Information Therapy, hospitals, health plans, and disease management companies can give consumers the right information at the right time, to help them make better health decisions.	http://www.healthwise.org/index.aspx
Plan for your Health	*Plan for Your Health*, a new public education campaign from Aetna and the Financial Planning Association, gives consumers the information they need to make health benefits and financial choices that meet their current and future needs.	http://www.planforyourhealth.com/

Appendix B: Current Enrollment in Consumer-Directed Health Plans for Major Health Plans (June 2007)

Company	Total Enrollment	CDHP Products	Contracts	CDHP Enrollment
Aetna (www.aetna.com)	15.8 million	HRA, HSA, PPO	6,275	891,000
Assurant (www.assuranthealth.com)	~1 million	HSA	n/a	400,000
Coventry Health Care (www.cvty.com)	3.4 million	HRA, HSA	n/a	100,000
CIGNA Healthcare (www.cignachoicefund.com)	9.8 million	HRA, HSA, PPO	n/a	500,000+[6]
Destiny Health (www.destiny health.com)	~2 million	HRA-PPO	n/a	32,000
Fiserv (www.fiservhealthservices.com)	~4 million	HRA, HSA	84	60,000
Great West Healthcare (www.greatwesthealthcare.com)	~2.2 million	HSA, HRA	162	121,200
Harvard Pilgrim Health Care (www.harvardpilgrim.com)	~1 million	HSA, HRA	n/a	9,000
Health Net Inc. (www.healthnet.com)	6.3 million	HSA	n/a	23,000
Health Partners (www.healthpartners.com)	~635,000		1,132	36,200
Humana (www.humana.com)	7.8 million	HRA, HSA	n/a	406,800
Medica (www.medica.com)	~1.3 million	HRA, HSA	1,611	95,000
Medical Mutual of Ohio (www.medmutual.com)	~1.5 million	HSA	n/a	70,000
United Healthcare (http://www.uhc.com/home.htm)/Definity	28.7 million	HRA, HSA, PPO	18,000	2,000,000+[7]
WellPoint (www.wellpoint.com)/Lumenos	34.8 million	HRA, HSA, PPO	n/a	1,100,000+[8]
Blue Cross Blue Shield (www.bcbs.com)	99 million	HRA, HSA, PPO	1,650 (HSA accounts)	8,000,000[9]

6 http://www.cigna.com/about_us/investor_relations/release/1q07transcript.pdf

7 http://www.unitedhealthgroup.com/assets/shared/Definity_CDH_Fact_Sheet.pdf

8 http://media.corporate-ir.net/media_files/irol/13/130104/wlp_trans_070426.pdf

9 http://www.bcbs.com/news/bluetvradio/consumerdriven2007/plenary-vachonj092807-9-30am-cd-rev3.pdf

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Item #8011

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