Consumer Health Care Finances and Education: Matters of Values

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Issue Brief

- This *Issue Brief* analyzes recent literature about trends in the employment-based health care benefits system, proposed "market-driven" approaches to health care financing, and implications for consumers of the effect of rising costs on employment-based benefits. It examines the readiness of consumers to become more responsible for making health care financing decisions on their own.

- This is of particular concern in light of research on population literacy levels and the difficulty many people have in understanding the current health care system and health insurance documentation. This report also explores the availability of resources to help consumers become literate and savvy in health care decision-making.

- As health plan sponsors are exploring ways to offset the recent surge in rising premiums and administrative costs, two perspectives can be found in the literature on the future of health care financing. Some benefits consultants and health plan sponsors predict the readiness of empowered consumers to assume their own health care decision-making. But others express concern about problems likely to be encountered in implementing health insurance approaches where consumers select and buy their own health care coverage. The emergence of "educated, empowered consumers" in health care holds the promise (although not yet the reality) of a consumer-driven, patient-centered marketplace.

- Research indicates that consumers often do not know what type of health plan they are *currently* enrolled in. In general, they do not know how managed care plans work and are not knowledgeable about the intricacies of health benefits. Many are also unaware of, or indifferent to, the potential for financial disruption in their lives following a sudden illness or injury. Understanding the differences in coverage, enrollment options, and the possible financial consequences of failing to plan adequately for health care can be difficult for anyone, but they are incomprehensible to the estimated 42–90 million Americans with low functional literacy.

- There is urgent need for health benefits education that considers personal values, financial consequences, and literacy levels in programs that support the current system and the new models of health coverage that are emerging. Since the working public looks primarily to employers to meet their health insurance needs, the nation's health care financial preparedness rests to a large extent on the willingness of organizations to continue to act as innovators, brokers, and mediators in the health care system as well as health care education "champions" of American workers.

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Introduction

Increasingly since the mid-1990s, public- and private-sector organizations have been urging all Americans to become better prepared financially for future life events. Policy, campaigns, and other initiatives have focused on helping consumers increase personal savings, invest in employment-based 401(k)-type plans, build assets, and become responsible personal money managers. People are being recruited to attend work place, faith-based, and community-sponsored financial literacy education programs. They also are being given the tools to become more self-reliant through innumerable Internet offerings and other publications about personal finance.

As a result of work place financial education, many Americans appear to be saving more (e.g., Bernheim and Garrett, 2001).[1] From financial educators at work, in schools, and in faith-based and community organizations, consumers are learning to take more responsibility for their present and future financial well-being. When financial education is consistent with cultural and personal values, it can transform attitudes and help people across all socio-economic groups to become more self-reliant (Vitt et al., 2000).

However, noticeably absent from the discourse on personal financial responsibility is the subject of health care finances—a complex and largely unexplored topic in many financial education programs. Apart from having health insurance (which is most often received as a benefit of employment[2]), many consumers do not otherwise plan or budget for health care expenses until serious sickness or injury occurs. In fact, medical problems and health care costs have become much more important contributors to financial crises in the lives of middle-class Americans than was formerly known (Sullivan, Warren, and Westbrook, 2000). As the post-World War II baby boom generation ages, medical costs

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are likely to become increasingly important, especially in light of the decline in post-employment health insurance coverage for mid-life Americans not yet eligible for Medicare (Fronstin, 2001c). When unexpected illness or injury occurs, the collective impact of consumer debt, interruption of income, and unexpected health care costs can trigger financial collapse and even bankruptcy (Sullivan, Warren, and Westbrook, 2000).

Financial health care planning includes both selecting health care coverage and budgeting for unforeseen future health care costs not covered by insurance, but consumers have only a vague understanding of the need for financial preparation in the event of a medical problem. Most workers with health insurance are in some form of managed care, although few know they are in a managed care plan, or understand the health care system (McDonnell and Fronstin, 1999). Today, employment-based health insurance benefits are by far the most common source of health insurance in the United States, covering nearly 160 million Americans under age 65, (about two-thirds of the population) (Fronstin, 2001d).

Today, employers are under new pressures that could force workers to assume more responsibility for selecting, purchasing, and managing their own health care and coverage—functions that until now have been arranged by employers. Such a shift in responsibility would be consistent with public policy and work place trends during recent years that increasingly have made individuals more accountable for their own general financial stability and retirement preparedness (Vitt et al., 2000). The move toward defined contribution retirement plans (such as 401(k)s), debates about privatizing Social Security, the 1997 SAVER Act, and recent legislation expanding individual retirement accounts (IRAs) all signal a shift in accountability for retirement preparedness to individuals from employers or government. Large public- and private-sector organizations have been moving steadily since the mid-1980s from paternalistic hiring and benefits policies to approaches that transfer much more choice about benefits—and responsibility for them—to employees.

Similar to the shift from defined benefit pensions to defined contribution retirement plans, employers are now showing some interest in consumer-directed and consumer-managed health benefits arrangements, referred to in some quarters as "defined contribution" (DC) health care, or consumer-driven health care (Fronstin, 2001a). Unlike retirement plans, however, consumer-driven or DC health benefits are difficult to define, more complicated in operation, and carry associated but very different risks (such as adverse selection and higher premiums), and other potential personal costs (Fronstin, 2001a). The degree to which workers may be asked to assume responsibility for health plan choice, payment, and risk varies depending upon the types of health benefit approaches open to employers. However, any shift in responsibility for health coverage from employers to employees may bring with it the need for "health care literacy" and decision-making skills that many consumers are ill-prepared to take on.

This report analyzes recent literature about 1) trends in the employment-based health care benefits system, 2) proposed "market-driven" approaches to health care financing, and 3) the current implications for consumers of the impact of rising costs on the employment-based system (including the underinsured and the uninsured, as well as a shift away from traditional employment-based benefits). This report uses a "values" framework within which to review the literature in order to better define some frequently used vague concepts. For example, this report considers briefly the meaning of *responsibility*, since the health benefits literature refers often to a "shift in responsibility" for payment and selection of health care services from employers and other employment-based plan sponsors to individual consumers (e.g., Fronstin, 2001a).

It also reviews the concept of *values* in order to better search for linkages between cultural and personal values as they may be applied in the literature to health and health care financial decision-making.

This report also examines the readiness of consumers to become responsible—as defined in the following section—for making health care financing decisions on their own in light of population literacy levels and the difficulty many people have in comprehending health insurance documentation. It explores the availability of resources to help consumers become literate and savvy in health care decision-making, and suggests a research and education agenda for the purpose of increasing both employer and consumer awareness of not just money values, but also the underlying societal and personal values affecting the health of the population and health care financing. This report finds that personal values, financial consequences, and literacy levels must be considered in fashioning communications and education programs to support the new models of health coverage that are emerging.

Responsibility, Values, and Health Care Finances

There is a large and complex literature on perceived responsibility that presents philosophical, legal, and psychological analyses of the meaning the term, including distinctions among the different ways in which responsibility has been defined, and related research findings (see Feather, 1999). The concern here is how "responsible" and "responsibility" are used or implied in the literature on health care benefits and health care finances. The *Oxford English Dictionary* lists several meanings, which include "liable to be called to account" and "capable of rational conduct." The term also refers to a responsible person as one who is "of good credit or position or repute, respectable, apparently trustworthy." *The Random House College Dictionary*, in its first meaning, defines responsible as being "answerable or accountable, as for something within one's power or control." Meanings that incorporate a common-sense approach to the concept of responsibility are summarized by Fincham and Jaspars (1980):

> *"...the central notion of responsibility in common sense is the idea that a person can be held accountable for something; he is answerable to someone or some social institution for his actions or the outcomes of those actions...he may [also] be regarded as someone who is not accountable for some act because he lacks the capability of fulfilling certain obligations."*

Research suggests that Americans *like* feeling responsible. When they know what is expected of them, and when they are given the tools and the opportunity to become successful at whatever they undertake, Americans accept—and even seek—responsibility (Gans, 1998; Vitt et al., 2000; Vitt, forthcoming). Having responsibility, feeling responsible, and being regarded as responsible by others are components of an important value held by most Americans (Rokeach, 1973; Vitt et al., 2000).

Values

Values determine people's beliefs and attitudes about the way things are, judgments about the way things should be, the choices they make, and the actions they take. Consumers make health care decisions—to carry health insurance (or not), avoid poor health behaviors, have routine check-ups, choose or stay in a job that provides health care benefits, save for unanticipated health care costs—based on what they value. *Consciously* or *unconsciously*, they engage in a values-driven decision process by matching perceived health care needs to perceived health care satisfactions (e.g., choosing a health care

Research shows that most Americans favor expansion of employment-based coverage for currently uninsured working adults.

plan) or other solutions (e.g., declining health care coverage). They move toward satisfying other perceived health care needs as well—to feel safe, be treated fairly, maintain connections to trusted medical providers, be in familiar surroundings, enjoy some privacy and independence, feel financially secure, and many other such standards that consumers set for themselves. Safety, autonomy, fairness, comfort, community, financial security—these are values. They are the conditions that are conceived explicitly or implicitly as *desirable*, and they influence all of people's major life choices (Keeney, 1992; Vitt, 1993; Vitt, forthcoming).

Values and Health Care Finances

Values drive decisions about health, health care, and health care financing both for individuals and for society. In most cultures and for most people, financial resources for the population's health and health care are finite, and governments, private interests, and individuals allocate health and health care resources on the basis of available money. Other health and health treatment values transcend money. They are concerned with quality of life, and they reflect deeply held cultural and personal meanings. Although consumers understand little about managed care (Employee Benefit Research Institute, 2001), several studies indicate that a majority lacks confidence in the quality, cost, and accessibility of medical care and the health care system overall (Employee Benefit Research Institute, 2001; Miller, 1998). An analysis of 23 public opinion polls on health care (Miller, 1998) showed that even consumers who believe their own coverage is satisfactory are troubled by what they see as an erosion in quality and inequities in care, access, and coverage for the population at large. Consumers, from middle-class and low-income populations, share anxieties and concerns often grounded in personal experience about rising costs, decreasing coverage, and declining quality in health care (Miller, 2000).

Research shows that most Americans favor expansion of employment-based coverage for currently uninsured working adults (Duchon et al., 2000; Schoen, Strumpf, and Davis, 2000); they believe government should play an important role in helping the elderly and the poor get access to health care services government (Morrison, 2000); and a recent Kaiser Family Foundation report shows that seniors and middle-aged adult focus groups believe that a prescription drug benefit should be available to all seniors, not just to those in most need (National Council on Aging, 2001).

Cultural Values and Health Care Finances

In one formulation of values surrounding health care, Ian Morrison (2000) compares global values with those of the United States. Morrison argues that U.S. values are different from those of other Western societies—in some cases they are "diametrically opposed." Americans, according to Morrison, value competitiveness, ambivalence toward government, individual freedom and choice, technological progress, volunteerism and philanthropy, whereas most other developed countries value universality, equity, acceptance of government, skepticism about capital markets, rationing of resources, and technology assessment and innovation control (Morrison, 2000). Herbert Gans (1998) observed that it is "*American striving*"—the desire to get ahead, the ambition to achieve respectability—that distinguishes Americans. Gans called the "American Dream" a set of "*user values*" that includes having work that provides satisfaction, the chance for advancement, the feeling of usefulness, and economic security in later life—in short, having the opportunity to be and to feel successful (Vitt, 1993).

Government and business decision-makers have significant influence over the future strength of America's families and communities through the health care financial policies and benefits they offer (or fail to offer), impose, or regulate. In large part, health care systems are the product of the culture, an embodiment of societal values (Morrison, 2000). When there is little awareness or discussion of cultural values in either government or business financial decision-making,

tension can occur between what is stated as desirable and those actions taken to achieve the ends desired. When values are consistent with the desired goals, however, people from all social levels can be helped through education to accept and support progress and change (Morrison, 2000; Vitt, 1993; Vitt, forthcoming).

Values Research in Health Care Decision-Making

While literature on the assessment of personal values does exist in medical decision-making, much of it is limited to health itself as a value or to end-of-life treatment decisions (Abood and Conway, 1992; Howard et al., 2000; Karel, 2000; Kelly et al., 1996; Smith and Wallston, 1992). Emerging knowledge in this area holds that consumers apply health care decisions inconsistently (Irwin and Baron, 2001); make different value decisions in public versus private contexts (Pauly, 2001); and behave unpredictably when values, such as cost and available care, conflict (Irwin and Baron, 2001). However, greater understanding of the process by which people integrate value components in health care and health care is required in order to learn how consumers "*trade off values and maximize utility*" in health care financial decision-making (Irwin and Baron, 2001).

Employers and Health Care Finances

Health benefits are made available to workers and their families in the form of added compensation to attract and retain employees, but also to promote health and increase productivity (Fronstin, 2000b; Maxwell et al., 2001). When asked, most employees say they are comfortable with their current mix of pay and health insurance benefits, and that they are confident their employer, not they, can select the best available plan (Duchon et al., 2000; Fronstin, 1999 and 2001a; Lave et al., 1999; Schoen, Strumpf, and Davis, 2000). Nevertheless, changes under consideration by some employers include the restructuring of health benefits into defined contribution health plans that would shift varying degrees of responsibility for both selection and payment of health care services from employers to employees (Fandray, 2001; Fronstin, 2001a; Mead, 2001; Reese, 2000; Scott, 2001; Trude and Ginsburg, 2000).

Employers have long been linked to American health values through worker sick leave, safety, disability, and fitness policies. Most importantly, employers, as the predominant sponsors of health insurance benefits to workers and their families, have become effective care and coverage *intermediaries* for their employees and their families. Employment-based health care coverage today protects about 67 percent of nonelderly Americans (under age 65) from the financial losses that can accompany unexpected serious illness or injury (Fronstin, 2001d; Zuckerman et al., 2001), but the system is undergoing changes that may upset the future willingness of employers to continue in their role as health benefits provider to most of the nation's workers. Structural changes that have led to shifts in health insurance coverage patterns and trends include deindustrialization and rapid growth in the service sector (Renner and Navarro, 1989; Waitrowski, 1995); increased use of part-time employees and other forms of contingent labor (Rassell and Appelbaum, 1997; Thorpe and Florence, 1999); and lower levels of unionization among workers (Cubbins, 1998; Seccombe, 1993). It can be argued that the nation's health care financial preparedness currently rests predominantly on the long-standing traditions that established employers as guardians, financial agents, managers, and ombudsmen in the U.S. health care system.

Employment-Based Health Benefit Trends

Within the past five years, employment-based providers of health benefits largely completed the long transition to managed care from traditional indemnity insurance plans that began in the 1970s, undertaken to control soaring costs of employee health benefits. The arrangement of benefits under "managed care" now includes various types of programs. According to a recent study of health purchasing practices of large companies (Maxwell et al., 2001), Fortune 500 firms during 1999 offered a mix of managed care plan models with health maintenance organizations (HMOs) (36 percent mean enrollment), preferred provider organizations (PPOs) (32 percent) and point-of-service plans (POS) (20 percent). For a while, managed care delivered the cost savings that employers sought, but recent premium inflation is again causing benefits managers to look for ways to economize (Fronstin, 2001a).

Recent double-digit health care cost increases have been attributed to, among other things, consolidation in the health care industry, escalating prescription drug costs and utilization, and pent-up increases in the managed care market—all driven primarily by an aging population, consumer demands for greater access to care, and health provider demand for higher reimbursement (Crutcher, 2001; Deloitte & Touche, 2000; Miller, 2000). Not surprisingly, health plan sponsors again are exploring ways to offset rising premiums and administrative costs. However, unlike the last round of cost-control strategies, this time plan sponsors must contend with the prospect of facing new legal liability through patients' rights legislation currently under debate in Congress. As a result, employers are considering alternative strategies that would distance them from health care decision-making on behalf of employees (and the potential liability costs that new federal laws might create) and from making open-ended commitments to cover services that employees need and/or demand.

Divergent Future Perspectives

Two perspectives can be found in the literature on the future of health care financing, essentially reflecting the market and social policy debates that underlie most discussions about current economic security issues. On one side, some policymakers, benefits consultants, and health plan sponsors optimistically predict the readiness of empowered consumers to assume their own health care decision-making (Jerussi and Savan, 2000; Kochaniec, 2000; Managed Care, 1998). Harvard's Regina Herzlinger, for example, argues that health care delivery is ripe for a consumer-driven transformation. She sees impatient and demanding baby boomers who will lead the charge, and market forces that will fix the health care system just as they fixed other parts of the economy (Managed Care, 1998). For proponents of this perspective, the convergence of rising health coverage costs for health benefit plan sponsors, consumer dissatisfaction with managed care, and the Internet provides an important, potential market opportunity for the way future health care plans can be designed, financed, selected, and delivered (Crutcher, 2001; Havlin and Maloney, 2001; Robinson, 2001; Wiebe, 2001).

But other policymakers, researchers, and health plan sponsors are not so sure. They express concern about problems likely to be encountered in implementing health insurance approaches where consumers select and buy their own health care coverage (Cunningham, Denk, and Sinclair, 2001; Garnick et al., 1993; Kiefer, 2001; Tillman, 2000). In a 1999 PricewaterhouseCoopers study, employers thought employees were not ready to assume responsibility for managing their own health benefits since most employees don't understand the current system (Fronstin, 2001a). Some consumer research supports this assessment. For example, focus group findings conducted in 42 large companies (more than 1,000 employees) found strong preferences for employment-based health plans *as they are now*. Employees reported that they don't understand health coverage well enough to make an informed decision, nor

do they want to deal directly with the complex health insurance market. They want employers to advocate on their behalf and do not want to act as their own agents. They don't want vouchers to purchase an insurance plan in the private market and don't see a need for health care plans that are less comprehensive than what they now have (Lave et al., 1999).

Evolving Strategies

Despite reservations, even cautious employers are seeking answers to the pressing problem of escalating health benefits costs. They are looking for alternatives that are in line with giving more choice, control, and flexibility to employees in their purchase and management of health insurance (Fandray, 2001; Fronstin, 2001a; Mead, 2001; Reese, 2000; Scott, 2001; Trude and Ginsburg, 2000). The currently most-popular alternative—defined contribution health care benefits—is being evaluated in a wide variety of arrangements to help plan sponsors cope with spiraling costs; make plans more individually focused; and distance employers from the potential liability involved in group health plan design, purchase, control, and management. (For a full discussion of these approaches, including their advantages, disadvantages, and other concerns, see Fronstin, 2001a.)

Three primary explanations are given for shifting more control over care and coverage decisions to consumers. First, employers need to keep health care cost increases in line with overall inflation. Second, employers are concerned that the consumer "backlash" against managed care will cause a new regulatory climate and litigation that would further increase their health care costs. Third, employee choice, control, and flexibility in purchasing and managing health insurance are in line with trends in labor market practices in general and in retirement benefits in particular (Crutcher, 2001; Fronstin, 2001a; Jerussi and Savan, 2000).

The Internet and Other Technologies

Utilizing the Internet to improve employee understanding of personal health issues, health benefits choice, and administration is a logical key strategy currently in use or under consideration by many employers. This is in line with increased reliance on Internet and intranet communications in many organizational arenas, although medical privacy concerns may affect how health care providers use the Internet for the storage and transfer of medical records (Christensen, 2000). Health care benefits managers expect to generate savings from more efficient benefits administration via the Internet and to help employees become more informed "patients" and health care consumers (Emery and Cather, 2000; Fandray, 2000; Fleugel, 2001; Wiebe, 2001):

> *"Our goal is to develop customized intranet Web sites that help employers control rising health care costs...in effect e-Health directly supports companies' growing interest in 'consumerism'—giving employees increased individual responsibility, choice and decision-making in health-related matters" (Towers Perrin, 2001).*

Already, there are numerous health-related sites on the Internet that are linked to employee benefits sites and many more that are available to all consumers (Crutcher, 2001; Fandray, 2001; Kochaniec, 2000; Center for Studying Health System Change, 2001). While the bulk of these sites provide health and wellness information, others are full-service e-businesses that provide employers a range of health care coverage sb'Fices to member-employees and retirees. Members can review plan comparison tools, select and enroll in an employment-based health plan, learn plan basics, access health and wellness information, and utilize consumer support services. New Internet companies are offering to make defined contribution or consumer-directed health care accessible to employers, with some companies that began regionally expanding to national markets.

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Myhealthbank, Inc., Definity Health, Choicelinx, Lumenos, and HealthMarket are all growing in enrollment (Scott, 2001).

A hybrid employment-based approach, created by employers and managed care companies, can be illustrated by the Health Plan Navigator (HPN) in Michigan. HPN links member-employees to customized health care plans offered by their employers (McCafferty, 1998). HPN offers a directory of participating providers, links to community-based quality assessment tools and reports, and comparison charts of employee benefits. Consumer information about how to select a health care plan and a physician, as well as general health and condition-specific information, is also available. Several corporations are using interactive computer programs similar to video games for benefits communication and enrollment (Ceniceros, 1999). Employees have access to an array of interactive tools, including on-line or CD-ROM benefits data that can be personalized and games that can lead to prizes. Interactive sites help consumers take a more active role by seeking out information that would otherwise have been handed to them. Benefits managers hope that this will create a greater sense of engagement and self-determination in employees. Companies also see this form of "edutainment" as a way of reaching a younger generation of employees that has grown up with video game technology.

A New Emphasis on Market-Based Health Care

The emergence of "educated, empowered consumers" in health care holds the promise (although not yet the reality) of a consumer-driven, patient-centered marketplace. As a result, the health benefits industry envisions health insurance plans and providers that can be expected to compete on the basis of both cost and quality (Jerussi and Savan, 2000; Lubalin and Harris-Kojetin, 1999; Schone and Cooper, 2001), with and without employers acting as intermediaries for their employees. Ideally, in such a market, consumers would be responsible for choosing their own health insurance or health plan. Employers, assuming acceptance of this model, would make a "defined contribution payment" for the health care arrangement chosen by employees. If the employer is not an intermediary and insurance coverage is obtained outside of the work place, consumers would not have to change health care benefits coverage if they changed jobs and were not covered by COBRA (Crutcher, 2001; Fronstin, 2001a). Under current law, individuals who receive health insurance benefits through their employers pay no taxes on the employer contribution or the benefits received. However, health insurance coverage obtained individually would not carry the tax benefits on contributions provided by employment-based coverage (Crutcher, 2001; Fronstin, 2001a; Center for Studying Health System Change, 2001).

One assumption in the literature is that informed consumers will flock to the highest-quality, lowest-priced plans or providers. As a result, it is assumed that plans and providers would compete on the basis of both cost and quality, thereby creating a "consumer-driven" market for health care. Some policymakers, plan sponsors, and the health coverage industry refer to this as *consumerization* of health care and try to predict how it might transform "health care markets" that traditionally have not behaved like consumer markets, and how it might transform "health care products" that historically have not been consumer goods. Efforts are under way to learn what consumers value in their health care, what they are willing to pay for when it comes out of their own pocket, and how consumer behavior may be affected by their attitudes toward managed care (Booske, Sainfort, and Hundt, 1999; Edgman-Levitan and Cleary, 1996; Lubalin and Harris-Kojetin, 1999; McLaughlin, 1999; Veit, Tannenbaum, and Bredesen, 2000; Yegian et al., 2000).

Research indicates that consumer ignorance is a powerful factor in health care decision-making. When consumer presumptions of "preference" and "choice" are closely examined, they are shown to be simplistic and optimistic.

Consumerism and Health Care Benefits

Conflicting images of medical service consumers are found in the literature, essentially reflecting what David Lewis and Darren Bridger (2000) refer to as "Old Consumers" and "New Consumers." Old Consumers are conformist and traditional, motivated largely by a desire for convenience. They tend to be poorly informed on consumer matters, and are generally trusting of suppliers of consumer goods and services. In contrast, New Consumers are independent and individualistic, seek authenticity and high quality, have an informed view of the marketplace, and are generally distrustful of vendors and suppliers. New Consumers are portrayed as transcending age, gender, and even income categorization. According to Lewis and Bridger (2000):

> *"New Consumers check labels, study contents, compare prices, scrutinize promises, weigh options, ask pertinent questions and know their legal rights."*

Although the term "consumerism" is used in consumer studies to describe a social movement that is meant to protect consumers against defective or deceitful products and services, in the health care literature "consumerism" more often refers to:

> *"…the rise of consumers as part of a value shift in health care. It reflects rising education levels, rising incomes and increased sophistication in communication. New consumers are emerging across the globe. They are demanding better customer service, they want to be involved in medical decision making, and they will reach out to alternative therapies as part of their medical care" (Morrison, 2000).*

The popular and medical literature suggests there is an increasing degree of consumerism in health care, driven by several underlying factors:

- The reluctant self-empowerment of some consumers to cope with a health care system that is perceived as fundamentally profit-driven (Miller, 1998; Robinson, 2001).
- The move by large employers and public-sector programs to offer consumers both a greater choice of plans and a shift away from a defined-benefit model to a defined-contribution model. This health care model, while patterned after the pension plan defined contribution model, is primarily related to the notion of managed competition—a system in which consumers can trade up at their own choice and expense to a higher lever of coverage, better benefits, or perceived improvements in quality or customer service (Morrison, 2000). Proponents of managed competition argue that this will promote more efficient use of health care resources by consumers (Schone and Cooper, 2001).
- Coverage of health care issues in the news media, which has made consumers better informed (Morrison, 2000).
- The growth of Internet use by consumers as a resource for health care information (Morrison, 2000; Robinson, 2001).

However, research indicates that consumer ignorance is a powerful factor in health care decision-making. When consumer presumptions of "preference" and "choice" are closely examined, they are shown to be simplistic and optimistic. Consumers often do not know what type of health plan they are currently enrolled in or how their health care actually will be affected by the type of plan they have chosen (Cunningham, Denk, and Sinclair, 2001; Hibbard and Jewett, 1997; Isaacs, 1996; Korczyk and Witte, 2000); and they are vulnerable to manipulation by information that frames their choice in a particular way (Lubalin and Harris-Kojetin, 1999). In addition, not much is known about how consumers make health care financial decisions, what demographic and other differences exist in information preferences and

decision styles, and other information in the choice process (Booske, Sainfort, and Hundt, 1999; Lubalin and Harris-Kojetin, 1999).

In general, consumers do not know how managed care plans work (Hibbard and Jewett, 1997; Isaacs, 1996; EBRI, 2001; Olmos, 2001; Root and Stableford, 1999) and are not knowledgeable about health benefits (Cunningham et al., 2001; Garnick et al., 1993; Garnick and Swartz, 1999). Not only do they expect not to understand health-related information (Root and Stableford, 1999), they accept and ignore what they don't understand (Hibbard and Jewett, 1997). Most also have difficulty anticipating health care needs, underestimate their health risks, tend to be optimistic, and focus primarily on only their current circumstances (Lubalin and Harris-Kojetin, 1999). Many consumers are unaware of, or indifferent to, the potential for financial disruption in their lives following a sudden injury or illness (O'Neill, 2001).

Financial Consequences to Consumers of Health Care Costs

Today, the employment-based benefits system is the most common source of health insurance coverage in the United States. As has been discussed elsewhere (see Fronstin, 2001a), there are potentially significant risks involved in a shift away from the current system to a more individual-based type of system as envisioned by some models of DC health coverage or consumer-driven coverage—the major risk being adverse selection, in which unhealthy individuals are more likely than healthy individuals to seek out coverage, ultimately making the insurance system economically unsustainable.

However, while the current system offers many advantages over an individual-based system, rising costs may transfer more of the financial burden for employment-based coverage to individuals.

In recent years, private-sector plan sponsors have largely absorbed growing insurance premium costs (Fronstin, 2001b). Today, however, there is a growing fear that in the current economic recession many employers will pass on to employees much or all of the rapidly increasing costs of health care benefits regardless of the coverage model established for employees. Higher personal costs in turn may increase the numbers of uninsured and underinsured. The data are somewhat mixed in terms of the share of health costs that workers are bearing. For instance, in recent years it appears that workers' share of the premiums paid for health benefits has been decreasing, especially for employee-only coverage (Fronstin, 2001b). However, it also appears that in recent years the dollar amount paid by employees has risen significantly (Miller, 2000; Sheils, Hogan, and Manolov, 1999). Coverage rates vary by organization size, geographic location, and type of industry (McLaughlin, 1999; Perman and Stevens, 1989; Seccombe and Beeghley, 1992; Waitrowski, 1995); hourly and part-time workers are frequently not covered (Rassell and Appelbaum, 1997; Thorpe and Florence, 1999); many smaller firms must be coaxed into offering insurance coverage at all (Feldman et al., 1997; Gabel, Ginsburg, and Hunt, 1997; Gabel et al., 2001; Retsinas, 1995; Thorpe et al., 1992); and the self-employed are denied the tax and cost benefits of group coverage. Furthermore, Americans with *access* to employer-based health coverage are finding it increasingly difficult to *afford* that coverage, according to 1998 poll results that ranked rising health care costs among their top concerns (Sheils, Hogan and Manolov, 1999). In one survey profiling California's nonpoor uninsured during the same period, 75 percent of respondents reported forgoing health insurance altogether because it was unaffordable (Yegian, Pockell and Murray, 1999).

The following section looks at (1) the increasing

Nearly half of the more than 1 million consumers who filed for personal bankruptcy in 1999 did so at least in part because they could not cope with medical bills or other financial consequences of an illness or injury.

costs of consumer payments for coverage; (2) the financial effects of a medical crisis when one is financially unprepared; (3) the plight of the uninsured and underinsured; and (4) literacy levels of health care consumers.

Increasing Consumer Costs for Health Care Coverage

After adjusting for inflation, the average employee contribution for health coverage increased 189.4 percent from 1988 to 1996, or an average of 14.2 percent annually (Miller, 2000). Total premiums for families during these years outpaced those for individuals—9.8 percent and 7.5 per-cent, respectively—placing an even greater burden on families (Sheils, Hogan, and Manolov, 1999). Several other studies during this same period indicate that the declines in health insurance coverage that occurred were due to fewer individuals accepting health insurance rather than fewer employers offering coverage (Cooper and Steinberg Schone, 1997; Fronstin, Goldberg, and Robins, 1997; Long and Marquis, 1999; Sheils, Hogan, and Manolov, 1999).

From 1994 to 1999, the number of companies contributing more than 90 percent of health care premiums for workers dropped by 13 percent. Those contributing between 60 percent and 80 percent of health care premiums increased from 20 percent to nearly 33 percent (Maxwell, Temin, and Watts, 2001).

In 1999 (and 2000), the number of uninsured nonelderly Americans decreased, but if the labor market should continue to soften and employee costs continue to rise, this recent trend is likely to reverse itself (Fronstin, 2001a; Center for Studying Health System Change, 2001; Robinson, 2001).

Consumer costs for employment-based health coverage are rising, as are all costs for health coverage (Center for Studying Health System Change, 2000; Miller, 2000). Although the percentage of premiums that workers have been asked to pay has not been increasing according to Fronstin (2001b), other authors report that employers have offset some of their premium increases by passing some of the higher costs on to their employees (Maxwell, Temin, and Watts, 2001; Wells, 2001). In a 2000 survey of employers, 70 percent indicated that they were raising employee contributions for health benefits to help offset rising costs, and more than half of all employers (58 percent) stated that they would absorb at least some of the premium increases themselves (Huth, 2001).

Financial Effects of a Medical Crisis

Each year, several million U.S. households face a severe medical crisis. Some people experience a chronic and/or debilitating illness, while others become injured in automobile, household, or work-related accidents. Almost as critical to individuals as the medical problem itself are the financial after-effects, which can be devastating. Nearly half of the more than 1 million consumers who filed for personal bankruptcy in 1999 did so at least in part because they could not cope with medical bills or other financial consequences of an illness or injury (O'Neill, 2001). Studies of debtors in bankruptcy concluded that illness or injury is either the central theme or part of the story for most bankruptcy petitioners (Jacoby et al., 2001; O'Neill, 2001; Sullivan, Warren, and Westbrook, 1999 and 2000).

Post-bankruptcy can be an even more troubling period: Families who have filed bankruptcy and do not have health care coverage may find that they are facing demands for advance payments for medical treatment, or they may be relegated to emergency rooms and clinics for primary health care—if they can qualify for treatment there. Most health care providers are reluctant to grant credit to consumers who do not have health care coverage, leaving them to the minority of hospitals and health care professionals that provide uncompensated health care. In addition, doctors who have not been paid be-

cause of bankruptcy may not themselves be eager to absorb the costs of continuing to provide free medical services (Sullivan, Warren, and Westbrook, 2000).

Even with health care coverage, the cost of a medical catastrophe can exceed 10 percent or more of family income (O'Neill, 2001; Short and Banthin, 1995). Family caregivers to the seriously or chronically ill can lose substantial wages, career advancement opportunities, and savings and pension benefits, and they can incur heavy out-of-pocket expenses (National Alliance for Caregiving, 1999). Concern about health care expenses and the *adequacy* of medical care coverage has been found to be predictive of psychological well-being during and following serious illness (Schulz et al., 1995).

Uninsured and Underinsured Consumers

Consumers with no health care coverage, and those who are inadequately insured, are risking not only their financial stability but also their health. They may experience crushing medical bills and financial devastation in the wake of serious illness or injury (Houts et al., 1984; Jacoby et al., 2001; Schulz et al., 1995; Sullivan et al., 1999 and 2000); have a higher probability of filing bankruptcy (Domowitz and Sartain, 1999; Jacoby et al., 2001; Ramsay, 1999; Sullivan et al., 1999 and 2000); and experience substantial increases in future medical care costs (Patrick et al., 1992). Without a regular source of care, uninsured consumers are likely to postpone or entirely forego getting needed health care (Center for Studying Health System Change, 1999; Perry and Kannel, 2000; Rowland, 2001) and to have reduced access to the health care system just when they need it most (Kinney et al., 1997; Lieberman, 2000; Stewart et al., 2001; Stroupe et al., 2000).

Age, Gender, and Ethnicity—Midlife Americans ages 45 to 64 are particularly vulnerable to: denial of coverage for reasons associated with the actual or projected probability of ill health, unemployment due to layoffs and/or early retirement, re-employment in temporary or part-time work that offers no employment-based coverage, individual market premiums that rise steeply with age and are likely to be unaffordable, and lessened ability to recover from a mid-life event that causes financial collapse (Budetti et al., 2000; Pol, Mueller, and Adidam, 2000; Powell-Griner, Bolen, and Bland, 1999; Simantov, Schoen, and Bruegman, 2001; Sloan and Conover, 1998). A 1999 survey of 5,002 adults (Budetti et al., 2000) found that 22 percent of mid-life adults rated their health as fair or poor. Sixty-two percent of this population reported going without needed health care because of cost, and among those not covered by a health care plan the rate increased to 72 percent. Among respondents in fair or poor health, 2-in-5 did not see a doctor when sick, did not fill a prescription medication, or skipped recommended medical tests or treatment they could not afford.

Eighteen percent of mid-life adults reported that they were out of the work force due to early retirement or disability. Half of adults ages 45–64 who were in fair or poor health or not working reported that they faced collection agencies for unpaid medical bills or experienced a time when they could not pay these bills (Budetti et al., 2000). While advancing age can increase the cost of health coverage beyond what many mid-life adults can afford on their own, young adults are twice as likely to lack coverage as older adults (Quinn, Schoen, and Buatti, 2000).

Sometime after age 19, young women and men who are not full-time students are frequently dropped from family health care plans and must obtain their own coverage. Unless young workers find jobs with health benefits, they are less likely to be able (or willing) to pay for health care coverage. Despite tight job markets during the past decade, the proportion of uninsured young adults rose from 22 percent to 30 percent (Quinn, Schoen, and Buatti, 2000). Young workers often hold part-time or temporary jobs, work for smaller firms—or in industries such as agriculture—that typically offer no health benefits (Cooper and Schone 1997). Even when employment-based health coverage is offered, however, it

is young workers who are more likely to refuse it (Cooper and Schone, 1997; Cunningham, 1998; Fronstin, 2000b; Quinn, Schoen, and Buatti, 2000).

Those who are young, are members of an ethnic minority, or have low income (below 200 percent of the poverty level), are more likely to be without health care coverage (Hoffman and Pohl, 2000; Kaiser Family Foundation, 2001; Perry and Kannel, 2000; UCLA Center for Health Policy Research, 2000). Poor Hispanic women workers are at especially high risk of being uninsured: 51 percent of low-income Hispanic women do not have health care coverage, compared with 42 percent of low-income Asian women, and 31 percent of low-income white and black women (The Kaiser Family Foundation, 2001). Women of childbearing age, regardless of their insurance status, pay 68 percent more than men in out-of-pocket health care expenses. Due to their lower income levels, twice as many women than men between the ages of 15 and 44 have out-of-pocket costs for health care services that exceed 10 percent of their income (Women's Research and Education Institute, 1994). Thus, even those women who are insured find themselves less protected than men.

Health Care of Uninsured Workers—According to one study—and contrary to popular belief—most uninsured workers do not depend upon the hospital emergency room as their usual source of care, but instead seek care from a private doctor or clinic (45 percent) or a public clinic (26 percent) (Duchon et al., 2000). Sixty-eight percent of those lacking health care coverage, however, report having problems with access to health care or with medical bills (Duchon et al., 2000). Some households that lack health care coverage to deal with a medical crisis can become overwhelmed (Houts et al., 1984; Jacoby et al., 2001; O'Neill, 2001; Rowland, 2001; Schulz et al., 1995; Shearer, 2000; Shirk, 2000; Sullivan et al., 1999 and 2000).

To understand how people without coverage fare in the health system, *Consumer Reports* conducted a special investigation (Lieberman, 2000) and found that the uninsured receive second-class health care, if they receive any at all. Care depends on "how old you are, what county you live in, what piecemeal programs exist, your diagnosis, how much money you can scrape together, and your perceived worthiness." The report also found that babies and children have better prospects for care than 20-year-olds. The report noted that uninsured women are 49 percent more likely to die than women with insurance during the four to seven years following an initial diagnosis of breast cancer (Lieberman, 2000; See also Hoffman and Schlobohm, 2000). Both the costs for coverage and the percentage of those populations having coverage vary widely from state to state (Hoffman and Pohl, 2000; Holahan and Kim, 2000; Valdez et al., 1993; Zuckerman et al., 2001).

Differences in Health Care Costs—Since individuals do not pay the discounted rates negotiated by managed care plans and are charged the actual cost of health care services, medical expenses tend to be higher for patients without insurance (Kolata, 2001; Wielawski, 2000). This burden often is greatest for low-income, non-English speaking patients, and also for the hospitals and health care providers that frequently wind up bearing the burden of uncompensated care.

Literacy Levels and Health Care Finances

In 1992, a total of 26,091 adults, ages 16–64, participated in The National Adult Literacy Survey (NALS), a study that assessed the literacy skills of the U.S. adult population. The NALS study estimated that between 42 million and 90 million adults in the United States (or between 16 percent and 35 percent of the total population) function at low or marginal levels on prose, document, and quantitative literacy measures (Kirsch et al., 1993; Kirsch et al., 2001; Sticht, 2001). When applied to the health and long-term care systems, low functional literacy translates into low health literacy, which can have serious consequences for individuals and families. People who cannot read or comprehend medical informa-

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tion may take medications incorrectly or not at all; make poor or uninformed choices on behalf of their spouses, children, or parents; and select health care options inappropriately (Center for Medicare Education, 2000a). Coupled with recent reports on deaths from health care mistakes (Institute of Medicine, 2000), efforts to improve consumer literacy are an obvious foundation in any public initiatives to improve both health literacy and health care.

Financial Literacy—Financial literacy also has become a public priority. In 1995, recognizing that education might influence saving behavior, the U.S. Department of Labor initiated the Retirement Savings Education Campaign to educate individuals about the importance of saving for retirement, and a financial education industry has grown to advance the public's knowledge and understanding of retirement saving and its critical importance to the future well-being of American workers and their families. Campaigns to save for education, for retirement, for homeownership, and for independence from public assistance have proliferated and gained national attention.

Health literacy and financial literacy initiatives, however, are proceeding on parallel tracks; they each have a separate literature, advocacy, and agenda. With few exceptions, health care educators do not talk about finances and financial educators do not concern themselves very much with health care finances. Yet the ability to value, comprehend options, choose, and implement a personal health care financing plan is nearly a universal requirement in today's complex society.

Health Financial Literacy—Understanding the differences in coverage, financing, and enrollment options can be difficult for anyone, but especially for those with low functional literacy. Consumers must be able to understand how their health coverage works, compare and evaluate complex plans, be aware of what rights they have under their plan, and how appeals processes work. New government regulations affecting denied benefit claims and both the Senate and House versions of the proposed Patients' Bill of Rights legislation would add new complexity to procedures for filing claims and appealing denials.[3] All this requires understanding complex terms and administrative procedures (Kiefer, 2001). Just knowing the differences in health care coverage options can be difficult, if not impossible, for anyone unable to understand the pricing, rules, and language of health care contracts:

> *"Managed care in itself is a conceptually dense, difficult-to-understand system for all of us, with endless new rules and regulations. The vocabulary and acronyms only add to an already overburdened medical lexicon" (Root and Stableford, 1999).*

A recent survey of 101 benefits management professionals at corporations with 500 or more employees revealed that 54 percent said most or some employees think the rules about coverage are difficult to understand; 48 percent said most or some employees find health plans too complex and hard to understand (D.S. Howard & Associates, 2001). An Internet evaluation study by RAND Health and the University of California, which included 14 search engines and 25 health Web sites, revealed that more than half presented material at the college level (Berland et al., 2001).

Another series of studies found that *all* English and Spanish health-related Web sites that were examined required a high school level or greater reading ability (Berland et al., 2001)—a level too complex if the Internet is to serve as an information source across different socioeconomic backgrounds. These findings are cause for concern, given that more than 60 million Americans went online looking for health information in 2000, and 70 percent of those using the Internet reported that the information they found influenced their health care decisions (Berland et al., 2001). Reportedly, health sites receive the greatest number of hits on the Internet (Kochaniec, 2000).

National Adult Literacy Survey scores were the lowest for document literacy (i.e., reading charts, tables, graphs, and similar materials), yet much health care plan information is presented in cross-tabulated form. Most health materials are written at a 10th-grade reading level or higher, and this tradition of providing necessary written materials at a level far beyond readers' abilities has continued with the shift to managed care (Berland et al., 2001; Center for Medicare Education, 2000b; Root and Stableford., 1999).[4] With a national population of tremendous cultural diversity, where millions of adults are functionally illiterate, millions more are only marginally literate (Kirsch et al., 1993), and where 75 percent of older adults read at the eighth grade level or below (Kirsch et al., 1993), how effective are health care financial education programs in creating informed consumers?

Consumer Health Financial Education

The functional literacy levels of consumers have generated much concern about consumer education in health care. In addition to NALS literacy data, studies indicate that most U.S. adults have difficulty reading and understanding the marketing brochures, patient care handbooks, news articles, and other sources that attempt to communicate about health delivery systems (Center for Medicare Education, 2000b; Kiefer, 2001; Kirsch, 1993; Pfizer, 2001; Root and Stableford, 1999). Employers that offer health benefits also have the job of educating their employees about health insurance options in an ever-expanding and confusing field of information. In helping employees make the transition to a defined contribution style system, the Internet (or "e-health"), which includes a range of on-line tools and services available to employees, is expected to be a key element. There is "an emerging consensus among employers that the Web must be used to foster high-quality, consumer-driven care that reduces administrative costs and supports a healthier and more productive work force" (Emery and Cather, 2000). Web-based tools are expected to provide health plan members with information, self-service transactions, and decision support and also improve providers' quality of services, clinical care, and the delivery of reports to employers, while also improving cost-effectiveness (Emery and Cather, 2000; Goff, 2001).

Web-based information for consumers seeking information about selecting health insurance currently can be found on a number of commercial and government sites.[5] The Agency for Health Care Research and Quality, a division of the U.S. Department of Health and Human Services, offers a number of downloadable in-depth consumer education tools and guides to understanding and choosing health care plans, providers, and long-term options. Most sites offer definitions of terms, frequently asked questions, interactive worksheets, and links to specific health information. A recent addition to the Web-based insurance constellation is www.ehealth insurance.com, which offers a large selection of plans that can be evaluated by both cost and benefits. The site also offers basic educational content such as links to government information sites on how to choose and evaluate a health plan.

Use of on-line education materials by employers is growing at an explosive rate. In 2001, on-line education materials were available to 47 percent of employees at firms with educational programs, contrasted with only 4 percent in 1998 (Bernheim and Garrett, 2001). During open enrollment for the 2001 plan year, more employees than ever before used Internet-enabled self-service tools to help them identify, select, and enroll in health plans (Goff, 2001). The Internet provides access to quality assessment tools and reports from research groups for consumers. The National Research Corporation produces the NRC *Healthcare Marker Guide,* which provides survey responses from thousands of households with

evaluations of quality of care, product-line preferences, consumer satisfaction, quality and image ratings, health plan satisfaction, physician access, and consumer trust and confidence.

Health care benefits were identified as the most important employment-based benefit by 64 percent of respondents according to a recent poll of 1,000 working adults by the Employee Benefits Research Institute (EBRI) and *WorldatWork* (Salisbury and Ostuw, 2000). In referring to this poll, a recent *HR Magazine* news item (April 2001) advised that there is a great need to educate employees about impending changes and challenges in the health care market—with "honest talk" about an organization's ability and desire to manage benefits effectively. It was suggested that companies research which portions of their health care plans are used and valued most by the majority of their employees and to consider allowing employees to vote on items that companies may be forced to drop. Blaine Bos of William M. Mercer, Inc., was quoted in the article as advising:

> *"It's up to employers to educate employees about their plans…not just at open enrollment but regularly throughout the year…The aim is to educate them about their own health care decisions so that they can get the most value from your plan."*

Plan sponsors are advised to structure consumer choice to promote "competition based on quality and cost-effectiveness" (Hoy, Wicks, and Forland, 1996). Before choosing a health plan, advises Elizabeth Hoy and her colleagues (1996), consumers should know:

- How plans differ with respect to price.
- The care that is covered.
- Credentials and philosophy of the organization providing coverage.
- Availability and range of medical providers and services that are included.
- Flexibility in choice of providers.
- Quality of structure, process, and outcomes.
- Degree of consumer satisfaction.

Many DC health advocates believe that education will help individuals and plan sponsors curb the rising cost of health care (Emery and Cather, 2000; Kochaniec, 2000). For consumers, effective education and communication are probably the most important factors influencing consumer acceptance of health care benefits and program utilization (Finkel, 1997; Jerussi and Savan, 2000), but historically, education and communication strategies have been an add-on for the purpose of aiding market effectiveness (Root and Stableford, 1999). Well-intended plan managers now show employees their health plan alternatives, characterize the decision they will make by the plans that are *available*, and refer to health care markets as moving toward increased *consumer choice*. To facilitate consumer choice, health benefits education is provided but such education generally consists only of details describing the rules and provisions of various available health care coverage plans. It is common to think about health care planning decisions in terms of available alternatives, choices, and financial constraints. Instead, researched educational tools are more likely to be effective in motivating and aiding people in their transition from the traditional, passive role of patient to the active role of consumer (Korczyk and Witte, 2000).

Summary and Discussion

The vast majority of the working public looks to employers to meet their health insurance needs. Employer benefit plans are popular, because they offer advantages over other forms of health insurance and types of delivery systems. Advantages include lowered risks of adverse selection, group purchasing efficiencies, the ability of employers to monitor quality of care, and employer advocacy (Fronstin, 1999), but there are disadvantages

Many consumers will be unprepared for possible financial upheaval in their lives if they remain unaware of, or indifferent to, the need for health care financial planning.

too. Disadvantages include possible job-lock, because health care plans are employer-specific and not portable, and health insurance choices are limited to the plan or plans offered by employers. Small companies often choose not to provide coverage; not all workers are eligible for health benefits; many workers choose to forego benefits when they are offered; and the self-employed are currently denied the full tax benefits of health care coverage (Fronstin, 1999). Nevertheless, the nation's health care financial preparedness rests to a large extent on the willingness of organizations to continue to act as "innovators, brokers, and mediators" in the health care system, as well as health care education "champions" of American workers.

For employers, there are at least five questions to ponder as they consider employee health care decisions:

1. Are employers aware of the known low levels of literacy and benefits knowledge that prevail among so many American workers?
2. To what extent do they believe consumers are prepared to take on the responsibility for their own health care financial decision-making and for the cost/benefit tradeoffs that are inherent in defined contribution health plans?
3. Do plan sponsors expect to continue negotiating and advocating on behalf of employees, or will they encourage consumers to navigate the huge and complex health care system on their own?
4. Are the U.S. employment-based health care system and improvements in the population's health *valued* by employers?
5. Are plan sponsors willing to invest in values-guided health care financial education for their employees?

A Different Kind of Financial Education

Most Americans' health benefits education starts when they first step into an orientation program to learn about the health plan offered to them by their employer or union. They typically continue this education many years later at a "pre-retirement seminar," or when a health care crisis requires them to come to terms with their health care plan, or when bills mount. Having adequate health care insurance coverage is a basic requirement for financial and personal security for most families and individuals today. But consumers also need in-depth, values-guided education about health care finances if they are to navigate the financial aspects of their lives successfully. Unlike general financial education, which is widely perceived as a means to a valued *end*—a better job, a home of one's own, a new business, education, retirement—*health care financial issues are not positively correlated with these rewards in the perceptions of consumers.*

Increasingly, it is up to consumers to learn the risks of being uninsured or having inadequate coverage, to understand their health care benefits options, to be able to choose health coverage wisely, and to incorporate health care into life and retirement planning. Many consumers will be unprepared for possible financial upheaval in their lives if they remain unaware of, or indifferent to, the need for health care financial planning. To avoid a health care financial crisis, they must be able to foresee the financial losses that can follow an injury or serious illness, and they must recognize the long-term health benefits of having a regular source of care supported by insurance coverage. If they get caught in the financial quagmire that often follows a health-related calamity, the nation's bankruptcy system will be tougher (and more costly) for them to approach for a fresh start. For long-term cancer patients—even those who have health care coverage—the inadequacy of health care coverage without substantial additional financial resources to fall back on is well-documented (Houts et al., 1984; Nielsen and Mayer, 2000): "The best health insurance policy in the world doesn't pay all the expenses associated with a fight with cancer!" (Nielsen and Mayer, 2000).

Need for Research and an Education Agenda

This report finds that personal values, financial consequences, and literacy levels must be considered in fashioning communications and education programs to support the new models of health coverage that are emerging. There also is urgent need for clear guidelines that can help Americans unravel the mysteries, frustrations, and complexities of the current health care system. These guidelines might begin with a better understanding of what both employers and consumers value about health care for themselves and for others, health care financing, and health care financial education. Based on this review of the literature, it appears that:

- Workers appreciate having health insurance, especially employment-based health care coverage, but they have little appreciation or understanding of what kind of coverage they have, how the health care system works, the connection between coverage and lifetime health, or how losses due to sickness and injury can negatively impact savings, education, retirement, asset accumulation, and other positive outcomes of financial planning.
- A serious limitation exists with respect to current health benefits education, given the functional literacy levels of many consumers. Nevertheless, prior research on financial literacy education (Vitt et al., 2000) has shown that when values are factored into financial education offerings, consumers from all backgrounds can and do take advantage of such education to become more self-reliant.
- Employers should consider using their negotiating strength to require the health benefits industry and regulatory agencies to simplify all brochures, contracts, handbooks, Internet information, and other health insurance documentation to meet the document literacy needs of American workers.
- While employers are interested in and investigating defined contribution health plans, they also are being cautious in adopting them. Higher health care benefits costs, however, are causing some employers to cut or eliminate health benefits, or to shift more costs to employees, which in turn risks potential increases in the number of the uninsured.
- Employers are increasingly looking to Internet and Intranet solutions to solve communication and administrative aspects of managing health care benefits. Despite rapid growth in Internet usage, evidence suggests there is a large population of people without computer skills, literacy, or access. Moreover, those most in need of education also tend to have the most difficulty accessing information on the Internet. One challenge will be to introduce a larger number of workers to computer usage through health benefits communications, especially for those whose jobs do not involve or require computer use.
- No extant research was found that could inform an education program based on consumer values about health, health care, and health care financing.
- No available research was found that illuminates how employers value health care benefits or health care financial education for their employees.
- The success of an employment-based health care system that is realigned with cultural and personal values depends upon increased public awareness of the issues; heightened sensitivity to the personal and financial chaos awaiting the uninsured and unprepared; and broadened educational offerings and other tools, based on researched links between what people actually understand and value, and what health care and financial professionals expect them to know and value.

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Endnotes

[1] Economists differ as to whether personal saving by Americans is growing. The Bureau of Economic Analysis, U.S. Department of Commerce, calculates personal income less the sum of personal outlays plus personal tax and non-tax payments as the rate of personal saving. By this measure, personal saving is not rising, but decreasing. This measure, however, does not include home equity and capital gains. It also does not account for the "wealth effect" that indicates dis-saving by very wealthy, high-income households, and skews the personal saving rate of middle-class and lower income Americans (see John M. Berry, "The Wealthy and the Wealth Effect Study of Spending, Saving Finds Answer Among the Very Rich," *Washington Post*, May 13, 2001.)

[2] Employee Benefit Research Institute data show that employment-based health insurance is the most common form of health care coverage in the United States. About two-thirds of Americans under age 65, or nearly 160 million people, are covered by employment-based insurance. Eleven million more individuals over the age of 65 also rely on employment-based coverage, albeit supplemented with Medicare (Fronstin, 2001b).

[3] For more information visit the THOMAS Congressional Database (http://thomas.loc.gov). The three current existing proposals are: The Bipartisan Patients' Bill of Rights Act of 2001, S. 889; The Patients' Bill of Rights Act, S. 6; The Patients' Bill of Rights Act of 2001, H.R. 2315.

[4] The U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), Center for Medicaid and State Operations has published *Writing and Designing Print Materials for Beneficiaries: A Guide for State Medicaid Agencies*, HCFA Publication Number 10145. Considerable experience with better informing consumers about complex health insurance choices has been accumulating in conjunction with Medicare (Center for Medicare Education, "Medicare Education and Health Literacy: Techniques for Educating Older Adults," Conference Proceedings, Washington, DC, June 13, 2001). No equivalent efforts are apparent in the private health care insurance industry.

[5] One, www.healthCHEC.org, established by the Consumer Health Education Council, offers a wide range of information about coverage and health for consumers, sponsors, and the policy community.

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