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Consumer-Driven Health Care: Medtronic's Health Insurance Options

In June, Dave Ness, vice president of Compensation and Benefits of Minneapolis-based Medtronic, was wrestling with the decision about the health care insurance choices he should offer employees next year. He had launched Definity Health, a new program, two years ago, on an experimental basis. Definity Health, also Minnesota-based, was founded to offer a new kind of consumer-driven health plan. Unlike many other health insurance plans, it was consistent with Medtronic's human resource and business strategy of encouraging consumer-driven health care.

Definity Health's plan consisted of three elements.

- A Personal Care Account, sometimes described as a health reimbursement account (HRA). Employers contributed to the account and employees used the money to pay for health care expenses from their chosen provider. Funds remaining in the HRA at the end of the year were rolled over to the next year. Preventive care was 100% paid for by the plan and was not charged against the employee's HRA balance.

- Comprehensive Health Coverage. The plan had three levels of deductibles from which employees could choose, ranging from $1,500 (low) to $3,500 (high) for a single employee, and $3,000 and $7,000 for family coverage.

- Health Tools and Resources. A broad array of resources to support member health and wellness decision-making available online and by phone. Members could research providers across many criteria, review pricing for medical services or conditions, talk with nursing professionals or a pharmacist 24/7, delve into medical information, and track their Personal Care Account and Comprehensive Health Coverage activity.

The plan paid for all preventive care to encourage participants to receive periodic physical exams, immunizations and other services designed to maintain health and to ensure early detection and treatment as necessary. Because the plan had no "gatekeepers" and allowed much broader types of expenditures under its health account and preventive care policy, it permitted employees to make more decisions about their health care.

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To date, Ness's objective of being cost-neutral appeared to be realized. Medtronic self-insures the majority of its health care plans and contributes from 75% to 80% of the cost of coverage, depending upon the plan. Although costs were not the primary reason to offer the Definity Plan, they were an important aspect and it was expected that over the long term, health care costs under this plan would be lower than traditional plan offerings.

In the first year, approximately 10,500 employees were offered the Definity Health option and 13% signed up. Although Ness anticipated that Definity would appeal to younger employees who were less concerned about their health insurance, enrollment statistics were almost identical to Medtronic's other more established plans when comparing coverage levels, pay rates and job types. The enrollment data did, however, indicate a higher than expected percentage of males enrolled during the first year. During the second year, the distribution between males and females was as expected, approaching 50% each.

Ness was quite pleased with initial enrollment because it showed that a significant number of employees were interested in participating in an entirely different type of health care plan. He was among the 1,300 employees who chose the Definity option and like the others, was well satisfied. Last year's enrollment was 4,040 participants,

The time had come to decide. What, if any, changes should be made in the Definity plan for next year? Ness also wondered what additional metrics he should use to measure the plan's success or failure. He thought back to some of the first meetings about consumer-driven health plans and how far they had come since then. He also wanted to revisit the decision not to include BHCAG among Medtronic's offerings. (See **Exhibit 1** for more about Medtronic's health insurance plans.)

Medtronic

Medtronic auspiciously entered the second 50 years of its history with best-ever results.[1] The company was a recognized leader in medical devices with a long line of therapeutic products used in the cardiovascular, neurological, cardiac surgery and vascular arenas. Although the firm had grown at a respectable rate for its first 35 years of existence, the last 15 years had brought it to the forefront of the sector: the firm achieved an annual growth rate of 19% for revenues and 23.2% for earnings per share. The stock price had grown 37.5% per year for the past 15 years, enriching the 90% of Medtronic employees who, through stock ownership programs and 401(k) investments, owned 3% of the firm's outstanding common stock.

Medtronic's Human Resource Philosophy

William (Bill) W. George, former chairman of the Board of Medtronic, had led many of the changes that accounted for Medtronics' success. An important change was the added emphasis on the role of human resources in supporting various business units around the world.

When George arrived, he valued the dedication of the people who had built the firm; but he recognized that Medtronic must also attract new, multi-dimensional managers to achieve the growth through acquisition and globalization that he envisioned. He recruited a new cadre of managers: young talent from business schools, experienced managers from firms such as General Electric, and others who could help broaden Medtronic's managerial expertise. To encourage longevity and

[1] See Regina E. Herzlinger and Mark Allyn, "Medtronic: Patient Management Initiative," HBS Case No. 302-005, Rev. 2012 (Boston: Harvard Business School Publishing, 2001).

productivity, George's human resource team focused on career development for all employees and invested in many resources to support employees in the different career stages. For example, the strategy recognized employee diversity and their needs with mentoring programs and career development initiatives that included continuing education, leadership training, values and ethics courses, flexible work hours, and on-site child care centers.

This strategy succeeded well, resulting in an employee turnover rate of 15.3%, lower than the industry average and among the lowest in all industries. Medtronic's competitive compensation patterns, interesting work, and opportunities for advancement all contributed to employee retention. Human Resources felt that the variety of health care insurance options, and the real choices they offered, was also a critical factor. For that reason, Medtronic offered three employee health care plans.

The staff also wanted human resource programs consistent with Medtronic's strategy that viewed the patient as "whole in mind, body, heart, and spirit." To implement the strategy, Medtronic was designing new medical devices that enabled consumers to take an active role in the management of their chronic diseases.[2] The human resource group was committed to helping support the strategy with a philosophy to "treat employees the way you would want the patients to be treated." Noted Ness: "We want them to be fully present in their work, unencumbered by concerns about issues such as child or health care that might otherwise be on their minds and therefore make them less capable of performing their job as well as expected."

Yet, Medtronic always balanced the benefits of these human resource policies against their costs. When it came to health care, Medtronic's costs had grown at a compounded annual rate of less than 5% annually over the past five years. But, Ness was concerned that the double-digit health care cost increases that were affecting other companies would eventually affect Medtronic as well.

Definity Health

Founded by Tony Miller, chief executive officer and other senior personnel, its principals thought Definity such a compelling concept that they worked without salary for one and one-half years before receiving capital funding. Six years later, it had financing of $85 million, driven by the appeal of the concept and the strength of its experienced management team. Its backers included Merrill Lynch, Kohlberg Kravis Roberts, and Aon Corporation. Definity Health had more than 90 employer accounts and 320,000 members, with revenues of $65 million and EBITDA of $5 million.

The significant price elasticity of health care expenditures had long been established. A study noted: ". . . the absence of cost-sharing results in significantly greater emergency department use than does insurance with cost sharing. A disproportionate amount of the increased use involves less serious conditions."[1] In early trials of concepts similar to Definity's, two thirds of employees who were given detailed price information, chose lower priced lab tests, physicians whose fees were below the mean, and generic drug options in disproportionate numbers. Participants in Medtronic's consumer-driven health plan used the nurse line more than did those in traditional plans and had higher use of generic substitutes for brand name drugs for analysis of survey results of changes in price for CDHPs (See **Exhibit 2**).

In 1979, Flexible Spending Accounts (FSAs) were introduced as a way to encourage people to save for health care expenses (and nonhealth care items such as dependent care, copayments, deductibles

[2] See Regina E. Herzlinger and Mark Allyn, "Medtronic: Patient Management Initiative," HBS Case No. 302-005, Rev. 2012 (Boston: Harvard Business School Publishing, 2001).

and some dental and vision procedures and equipment no covered by insurance). The FSA balance had to be used up by year end, or lost (the "use it or lose it rule"). By 2000, Health Reimbursement Accounts (HRAs), administered by employers, and, by 2004, Health Savings Accounts (HSAs), for qualified medical and retiree health expenses were also offered by employers, financial institutions and insurers. All these accounts were funded with pre-tax employee income.

In 2002, the Treasury Department and the Internal Revenue Service (IRS) upheld the tax-favored status of unused HRA balances. Among other requirements to qualify for exclusion from gross income, an HRA may provide only benefits that reimburse substantiated medical expenses and must be funded solely by employers. Moreover, they were generally not subject to the complex design requirements established for health care FSAs. The guidance specified that unused amounts in an HRA may be carried over (rolled over) to subsequent years.

In 2004, Health Savings Accounts (HSAs) were legislatively introduced as savings accounts to which both individuals and employers may contribute for present or future health expenses. The funds may be used for qualified medical expenses for the individual, spouse, or dependent at the discretion of the individual. Before creating an HSA, the participant or employers must purchase a high-deductible insurance policy to cover major medical expenses. Payroll contributions and the interest and earnings (and withdrawals) from complementary investment options for qualified medical expenses were all tax-free. In addition, HSAs may be rolled over from year to year and, because they belong to the participant, were portable from one employer to another.

Consumer-Driven Health Care

> Some insurance industry analysts were predicting a shift in employer-based health insurance away from paternalistic, uniform, cookie-cutter health plans to those that could be tailored to the employees' individual needs and encourage their active involvement. It was dubbed as "consumer-driven health care" (CDHC) by Harvard Business School Professor Regina E. Herzlinger in her 2004 book "Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers."[2] Tom Policelli of UnitedHealth Group noted: "The early adopters of CDHC plans could be characterized as hard charging, with a hands-on CEO. Although their motivation and politics vary, their actions were similar. For example, *Forbes*, Interstate Batteries, and Whole Foods all had leaders with strong views who were used to cutting against the grain."

This movement paralleled the shift in the pension area that occurred in the 1970s as employers offered defined-contribution plans, in which employees could invest the monies they and their employers contributed in a variety of mutual funds and other investment vehicles that reflected their individual risk preferences and retirement needs. This shift away from defined-benefit plans, in which employers managed the retirement funds on behalf of their employees, created a seismic change in the financial community. The number of individuals who invested in the stock markets increased dramatically, as did the variety of mutual funds and intermediaries that could help them to invest. Important consumer-oriented firms such as the low-cost Vanguard family of mutual funds, discount broker Charles Schwab, and Morningstar mutual fund rating service were all supported by the shift to defined-contribution retirement plans.

The shift to consumer-driven health care was spurred, in part, by the virtual collapse of the tight managed-care movement.[3] HMOs were not only disliked by their enrollees and health care providers, because of their bureaucratic policies for referrals to specialty care, but some had also failed to control health care costs. Employers were, once again, facing the health care cost increases that they had hoped the managed-care movement would banish. Consumer-driven health care plans, in contrast, enabled employees to choose from a larger and more diverse menu of plan options, thus restoring their autonomy, and controlled cost through their direct management of health care expenditures. The last impetus for consumer-driven health care was the growing power of health care consumers who searched the Internet for health care information and spent more than $80 billion out of their own pockets for alternative health care services, such as acupuncture. Combined, some hoped that these consumer driven initiatives would help resolve complaints the traditional system had failed to cure.

Buyers Health Care Action Group (BHCAG)

Medtronic had decided not to participate in Minneapolis-based BHCAG. Ness revisited his decision by reviewing its background.

BHCAG ("Bee-Kag"), an employer coalition whose members comprised less than 15% of the Minneapolis/St. Paul health care consumer market, including employees from Honeywell, Target, General Mills, 3M, Pillsbury, and other Minnesota-based organizations, rolled out a unique program, Patient Choice. This program featured competition at the provider organization level for patients, based on provider cost and quality. The intent of the program was to create a retail market where providers proved their value directly to their patients.

In the heavily consolidated Minnesota market, all health insurance plans featured the same providers. As a result, differences among the plans were not based on differences in the cost and quality of care, BHCAG essentially disintermediated the insurers to strengthen the connection between providers and their patients. It contracted directly with integrated networks of physicians and enabled consumers to choose providers, with the help of readily accessible out-of-pocket price and satisfaction information.

Ann Robinow, its president, explained the motivation behind the program: "BCHAG employers realized that there were substantive performance differences among providers, but they were all presented to consumers as one plan. There was no market incentive for good physicians to provide efficient, high quality care because their performance went unrecognized in the market and effectively subsidized the poor performers. The BCHAG experiment provides consumers with real choice by presenting them with information on cost, satisfaction and other performance differences among providers. For example, employees can pay more if they choose a provider group in a high-cost category instead of a provider group in a low-cost category."

"Employers feared that employees wouldn't understand this consumer information," said Robinow. "The reality was that they did and used the data to make purchasing decisions." Initially, 70% of Patient Choice members sought care from high-cost provider groups. Four years after the BHCAG initiative began, only 17% of members were enrolled in the high-cost care systems and 50%

[3] See Regina E. Herzlinger and D. Scott Lurding, "THG Management Services," HBS Case No. 9-197-011, Rev. December 2012 and its companion reading Regina E. Herzlinger and Thomas Nagle, "Note on Managed Care Reimbursement of Health Care Providers: Case-Based, Per Diem, and Capitation Payments," HBS Case No. 9-194-141, Rev. 2012 (Boston: Harvard Business School Publishing, 2006).

in the low-cost systems. The data also influenced provider behavior. Noted Ann Robinow, "While there certainly has been significant consumer migration to low-cost plans, some of the care systems have also changed cost categories over the four-year period." Roger Feldman, a professor of Health Economics at the University of Minnesota, studied the BHCAG initiative extensively. He said, "The bottom line is that employees are sensitive to price differences in health care."[3] Provider groups could expect a 16% drop in market share for every 10% increase in out-of-pocket premium. Feldman noted that consumers with chronic diseases were as sensitive to price as others. Ann Robinow qualified this price sensitivity: "We've seen patients migrating from higher-cost to lower-cost provider groups, but less so for the high-cost groups that have a strong quality ratings." In a four year period, health care costs for Patient Choice grew at an annual rate of approximately 7%, while health care costs for other BCHAG-affiliated health plans grew by over 10%.

BHCAG provider reimbursement system Patient Choice contracted with integrated provider groups, akin to Accountable Care Organizations (ACOs), comprised of primary care physicians, specialists, hospitals, and other health care professionals. Each provider group determined its own policies (i.e., requirements for specialist referrals) and independently governed the delivery of health care. BHCAG combined provider fee levels and resource use, adjusted for the illness level of the group's patients, to place them in a cost tier. Consumer premiums for provider groups were based on the cost tier placement of the provider group. The providers were held accountable for quality and resource utilization, not through the top-down controls that characterized the culture of managed care, but through a competitive market based on informed consumer choice and the providers' organic decisions about how to provide health care.

For example, consider two Minneapolis/St. Paul multidisciplinary provider networks—Group A and Group B. Group A bids $100 per patient per month to take care of patients (the estimated total cost for all services needed to manage their patients assuming their illnesses are of average severity). Group B bids $150 per patient per month. Group A will be assigned to the low-out-of-pocket cost category and Group B the high-out-of-pocket cost category. Based on the evidence presented above, Group A will likely attract more patients because of its lower out-of-pocket cost.

BCHAG also held the provider groups accountable for the bids. In the initial years, provider groups were held accountable to their bid on a quarterly basis, by adjusting their fee levels based on each quarter's performance against their bid. Each quarter, the most recent 12 months of total cost performance of each group was analyzed as adjusted for the severity of illness of their patients, using a risk-adjusting algorithm. For example, if Group A treated patients at an average monthly total cost of $100, but its patients were 20% healthier than average, their risk adjusted cost performance would be $80. In this case, reimbursement levels for the next quarter would be adjusted downward, because Group A had bid $100 to care for its patients. Similarly, if Group B cared for patients 30% sicker than average at a monthly cost of $130, its risk adjusted reimbursement level would be raised.

As a result of the risk adjustment process, providers attracting sicker patient populations were judged on their ability to manage those patients effectively. There was no market advantage for providers who attracted healthier patients. Unlike most insurance-based reimbursement schemes, the BCHAG system financially rewarded provider groups who took on the high-risk patients and managed them efficiently.

BCHAG employers' experience Fred Hamacher, retired vice president of Compensation and Benefits at Target Corporation noted: "It's not an experiment; it's the answer. I've been in this business for 27 years and it's the only system that feels right, smells right, and has the incentives lined up. We can give our employees the information they need to make rationale decisions." [4] But

his sentiment is not universal: the program lost 20,000 employees when Wells Fargo Company and American Express withdrew to accept aggressive offers from traditional health plans.

Providers' experience[5] Tom Luchi, CEO of Family Health Services of Minnesota, an Excellence in Quality Award recipient, described the balanced reactions of his multi-specialty provider network: "The physicians are excited about the ability to shape their own destiny - the opportunity to set prices and fulfill their patients' goals under that price." Yet, Luchi noted that physicians, especially primary care doctors, were frustrated by the lack of true integration among specialties in provider networks: "We are trying to manage contracts with other providers when there really is not a partnership."

Current status Over time, a combination of service issues with a previous claim administrator, changes in employer leadership with a shorter term focus, and competition from very large, well funded plans in the consolidated Minnesota market eroded enrollment. Ultimately, Patient Choice sold the Minnesota program to a regional HMO, hoping to become a more mainstream product with greater sales and marketing resources.

Consumer-Driven Health Care from the Eyes of a Consumer

To help him think through the issues, Ness analyzed the situation of Judith Barnes, a long-term Medtronic employee.[6] Barnes was a healthy 41-year-old woman whose health insurance also covered her 44 year-old husband and two children, a daughter, age 17, and a son, age 13. Judith had been enrolled in the Medica Health Plan for some time now, but she was intrigued by the plan that would allow her and her husband to participate more directly in the management of their health care. And, it seemed as if it might save her money.

Judith could choose from three different health insurance plans offered by Medtronic (see **Exhibit 3**).

1. HealthPartners. A standard gatekeeper model health care plan that provided full coverage, in most cases, after a co-payment ranging from $15 for office visits to $100 for inpatient hospital care. The annual cost to the employee ranged from a maximum out-of-pocket cost of $1,500 for a single employee to $3,000 for a family, depending on the services required. This plan required Judith to receive care with one of Health Partners' network of clinic-based providers. If she paid significantly more, however, she could select any doctor outside of the network. For Judith, family coverage for an in-network policy would cost $146 per month.

2. ***Medica Choice.*** A standard health care plan, with the same co-payment for an office visit as HealthPartners ($15) with 90%/10% coinsurance after deductible for emergency room and hospital. Medica's maximum out-of-pocket costs were lower than HeathPartners. Medica Choice emphasized employee choice but from a network of providers; no referrals were needed to see a specialist in the network. As a result, Medica Choice would cost Judith more than Health Partners' $146 per month. The Medica Choice plan enabled Judith and her family the choice to receive health care either through network providers or, if she preferred, to use out-of-network providers and pay more of the total cost herself.

3. ***Definity Health.*** The monthly payments varied with the deductible amount the employee chose. The deductible varied from $1,500 for a single employee with a low deductible option to $7,000 for family coverage with the high deductible option.

As Judith studied the options, she noted that each plan allowed her to choose her own doctor but out-of-network doctors were not fully covered. But the similarities stopped here. Not only did each plan *charge* different amounts but they also differed in the *deductible* that Judith and her family would have to pay before the insurance coverage began; the *maximum out-of-pocket* payments; and in *the ability to access* providers for primary care. One plan used the gatekeeper model while the other was more flexible by allowing self-referrals to specialists and other providers as long as they were in the provider network.

In considering her decision, Judith assessed her family's situation. All in all, they were fortunate, both personally and economically. They were healthy and earned a family income of $200,000 a year. Their assets were mostly tied up in their homes and retirement funds but they did have about $300,000 in liquid assets, set aside for the children's educational needs. Yet, Judith knew that they had a number of medical needs that would have to be met out of these savings or out of their current income, paid for with after-tax money. For one, the college football injury to her husband's knee was bothering him. Sooner rather than later, he would need surgery. He wanted to have surgery in what he jokingly referred to as the "old jocks knee hospital," a "focused factory" for orthopedic surgery; but that hospital was not included in her current plan's network. It was included under the Definity Health option, however, which encouraged the use of centers of excellence. She also liked the idea that the amount credited to her PCA was done in a tax effective manner and that the balance remaining at the end of the year could be carried over to the following year. , But while she wondered if the Definity plan would require more of her time in managing her and her family's health care needs, she liked the freedom it offered.

She knew the enrollment deadline was near and that she needed to make a decision soon.

Assignment

Dave Ness must resolve these issues before the Executive Committee meeting next week, when he would present his recommendation on the health care plans. To help him,

1. Conduct a Six Factors analysis of Medtronic (i.e. its alignment with the Structure, Financing, Consumers, Technology, Public Policy, and Accountability of the U.S. health care system). What are the implications of your analysis for David Ness' decision? [4]
2. What kind of innovation is Definitity: consumer-forcing, integrator, or technology?
3. Use the detailed explanation of benefits in **Exhibit 1** and the analysis of the changes caused by consumer-driven plans in **Exhibit 2** to evaluate the pros and cons of the three health plan options from Judith Barnes' point of view.
4. Evaluate Definity and BHCAG—the other consumer-driven health care venture that might meet the company's needs in terms of their alignment with the Six Factors, business models, and viability.
5. Prepare a recommendation for Dave Ness.

[4] Regina E. Herzlinger, "Innovating in Health Care—Framework," HBS Case No. 314-017, Rev. 2014 (Boston: Harvard Business School Publishing, 2005).

Exhibit 1 Medical Insurance Premiums—Consumer-Driven Health Care: Medtronic and Plan Design Comparison—Minnesota Employees

Medtronic

Medical Insurance Premiums – MN Employees

Medical Plan and Level of Coverage	Full-Time or Part-Time 32 Hours or More/Week Employee Cost Monthly Cost	Part-Time Scheduled under 32 Hours/Week Employee Cost Monthly Cost
HealthPartners		
Employee only	$ 49.00	$153.13
Employee plus one	$ 99.00	$310.00
Employee plus two or more	$146.00	$458.25
Medica		
Employee only	$ 78.25	$195.63
Employee plus one	$156.75	$391.88
Employee plus two or more	$242.75	$606.88
Definity Health		
Employee only—$1,000 PCA		
Low Deductible $1,500	$ 44.00	$165.63
Medium Deductible $2,500	$ 28.00	$151.88
High Deductible $3,500	$ 11.45	$143.13
Employee plus one—$1,500 PCA		
Low Deductible $2,250	$ 83.40	$347.50
Medium Deductible $3,750	$ 51.10	$319.38
High Deductible $5,250	$ 24.05	$300.63
Employee plus two or more—$2,000 PCA		
Low Deductible $3,000	$115.20	$480.00
Medium Deductible $5,000	$ 70.60	$441.25
High Deductible $7,000	$ 33.20	$415.00

Directories: For a provider directory, access the HealthPartners, Medica or Definity Health website or call them directly for a listing of providers.

Medical Plans: With HealthPartners, you must select a primary care clinic, from which you will receive most of your care. Under the Definity Health and Medica plans, you can choose, at the time of service, to receive care from either a network provider or from an out-of-network provider.

Premiums: Medical premiums are deducted as a pre-tax payroll deduction.

Source: Dave Ness, Medtronic.

Exhibit 2 Summary of First-Year CDH versus Traditional Plan Price Trend Results

Study	CDH Trend (1)	Traditional Trend (1)
CIGNA	-4%	9%
Aetna	-10%	8%
Uniprise	-15%	7%

Reported Indicators of Consumer Behavior Change/Effect on Quality of Care
CDH over Traditional Plans

Study	Preventive Care	Recommended Chronic Care	Evidence-Based Care	Prescription Drug Utilization
Cigna	+12% - 14%	Increased use of maintenance medications	92% of 300 rules for evidence-based care same or higher	Cost and utilization slightly higher*
Aetna	+23%	Similar diabetic testing and chronic care script utilization	N/A	Generic utilization and substitution higher
Uniprise	Higher	Better compliance for chronically ill	Better compliance with evidence-based care	Prescription trends 3% higher

*Second CDH year

(1) % Difference is calculated as [1 + CDH trend)/(1 + traditional trend) - 1] x 100%

Source: American Academy of Actuaries, Emerging Data on Consumer-Driven Health Plans, May 2009, pp. 9, 11, http://www.actuary.org/pdf/health/cdhp_may09.pdf, accessed November 15, 2011

Exhibit 2 (continued)

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2011

FIRM SIZE	Conventional	HMO	PPO	POS	CDH
3-24 Workers	3%	13%	43%	18%	24%
25-49 Workers	1%	16%	42%	22%	20%
50-199 Workers	1%	12%	47%	16%	24%
200-999 Workers	1%	21%	52%	13%	14%
1,000-4,999 Workers	< 1%	14%	66%	6%	14%
5,000 or More Workers	1%	20%	60%	3%	16%
All Small Firms (3-199 Workers)	1%	13%	45%	18%	23%
All Large Firms (200 or More Workers)	1%	19%	60%	6%	15%
REGION					
Northwest	2%	18%	55%	9%	15%
Midwest	1%	9%	56%	9%	25%
South	1%	12%	64%	8%	15%
West	< 1%	31%	40%	13%	16%
INDUSTRY					
Agriculture/Mining/Construction	2%	12%	62%	13%	11%
Manufacturing	1%	12%	52%	10%	25%
Transportation/Communications/Utilities	2%	20%	54%	11%	14%
Wholesale	1%	13%	60%	6%	20%
Retail	< 1%	15%	56%	13%	16%
Finance	< 1%	15%	55%	7%	23%
Service	1%	21%	53%	9%	18%
State/Local Government	4%	23%	54%	10%	8%
Health Care	1%	15%	58%	10%	16%
ALL FIRMS	1%	17%	55%	10%	17%

Source: Kaiser/HRET Employer Health Benefits: 2011 Annual Survey, p. 62, www.kff.org, accessed November 16, 2011.

Exhibit 3 Medtronic Plan Design Comparison: Definity Health Plan, HealthPartners and Medica

	Definity Health				HealthPartners		Medica	
	In Network	Out of Network			In Network	Out of Network	In Network	Out of Network
Annual Deductible and Personal Care Account (PCA) The Definity Health PCA is an account provided by Medtronic for you to use for traditional, as well as a few nontraditional medical expenses. This account works together with your deductible, as eligible expenses paid out of the PCA account reduce your deductible. Unused balances remaining at the end of the year can be carried over for future health care needs.	**Deductible Options**	**Low**	**Medium**	**High**	None	None	None	
	Employee							Maximum of $300 deductible per calendar year
	Deductible	$1,500	$2,500	$3,500				
	Personal Care Account (PCA)	-1,000	-1,000	-1,000				
	Deductible Not Covered by PCA	$ 500	$1,500	$2,500				
	Employee + 1							Maximum of $600 deductible per family, per calendar year
	Deductible	$2,250	$3,750	$5,250				
	Personal Care Account (PCA)	-1,500	-1,500	-1,500				
	Deductible Not Covered by PCA[a]	$ 750	$2,250	$3,750				
	Family							
	Deductible	$3,000	$5,000	$7,000				
	Personal Care Account (PCA)	-2,000	-2,000	-2,000				
	Deductible Not Covered by PCA[a]	$1,000	$3,000	$5,000				
	[a]This assumes that all services are eligible expenses under the health plan.							

	Definity Health						HealthPartners		Medica	
	In Network			Out of Network			In Network	Out of Network	In Network	Out of Network
Copays Office Visit Emergency Room Inpatient Hospital	No Copays—Charges paid out of your PCA Account if available. Plan pays 100% coverage after PCA and deductible.			No Copays—Charges paid out of your PCA Account if available. Plan pays 80% coverage after PCA and deductible to Usual & Customary.			$10 $75 $100	70% after $30 copay $75 $100	NA	$10 $50 $100
Calendar Year Out-of-Pocket Maximum—(including Deductible not covered by PCA)	Low	Medium	High	Low	Medium	High				
Employee + 1 Family	$500 $1,000	$1,500 $3,000	$2,500 $5,000	$2,000 $4,000	$3,000 $6,000	$4,000 $8,000	$1,500 Single $3,000 Family	$3,000 Single $6,000 Family	$1,000 $3,000	$2,500 $6,000
Lifetime Maximum	$2,000,000 (combined network/nonnetwork)						$1,000,000 (combined network/nonnetwork)		$1,000,000 (combined network/nonnetwork)	
Preventive Care—This benefit can be used toward the cost of any preventive medical service, such as annual mammogram, prostate exam, cholesterol screenings, immunizations, blood pressure screenings, etc. Preventive Care cannot be used for such things as health club memberships, exercise equipment, or any other service or equipment which is not consistent with a standard regimen.	Plan pays 100% These services are not charged against your PCA account			Plan pays 80% after PCA and deductible up to Usual & Customary			Plan pays 100% after $10 copay	No coverage	$10 copay	Plan pays 70% of usual charges after deductible is met $250 per maximum for routine physical and eye exams

	Definity Health		HealthPartners		Medica	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Vision/Hearing	Exams covered under the Preventive Care Benefit No coverage for eyewear	Exams covered under the Preventive Care Benefit No coverage for eyewear	Plan pays 100% after $10 copay No coverage for hearing aids or eyewear	No coverage	Plan pays 100% after $10 copay No coverage for hearing aids or eyewear	No Coverage

The Definity Health Plan does not require any referral authorizations or approvals for services. A notification process is in place for all inpatient confinements and some limited outpatient procedures. The HealthPartners and Medica plans require referral authorizations for certain services.

Source: Medtronic.

Appendix

Key Characteristics	HSA	HRA	FSA
Funding Mechanism	-Funded accounts (asset) -Contributions by employer, employee, or both -Contributions cannot exceed deductibles—limit of $3,000 for individuals and $5.950 for families	-Notional accounts (liability) -Contributions by employer only -No contribution limit—limit is set by employers	-Funded accounts (asset) -Contributions by employer, employee, or both-usually employee -No contribution limit
Employee Eligibility and Health Plan Requirements	-Employees covered by qualified, high deductible plans -Deductibles of less than $1,000 for individuals and $2,000 for families -Maximum of out-of-pocket of $5,000 for individuals and $10,000 for families -Preventive care can be excluded from deductibles -Overlapping coverage for the same medical expense is not permitted, necessitating other plans to cover only those expenses not qualified under the high deductible plans such as dental care and vision care	-All employees -No specific health plan requirements	-All employees except self-employed -No specific health plan requirements
Qualified Medical Expenses	-Un-reimbursed Code 213(d) medical expenses -Cannot reimburse insurance other than premiums for COBRA, a qualified long-term care contract, or for a health plan while the individual is either receiving unemployment compensation or is over the age of 65 (other	- Un-reimbursed Code 213(d) medical expenses -Premiums for eligible health insurance and long-term insurance -Further limitations subject to employers' discretion	- Un-reimbursed Code 213(d) medical expenses -Cannot reimburse insurance premiums and long-term care services -Further limitations subject to employers' discretion

	than a Medicare supplement policy)	-Further limitations may apply for employees with a qualified HSA—no duplicate coverage of same benefits	-Further limitations may apply for employees with a qualified HSA—no duplicate coverage of same benefits
Roll Over of Balances to Next Year	-Yes- tax free roll over -No limit on amount	-Yes—tax free roll over -Amount of roll over subject to employers' discretion	-No—use it or leave it
Portability of Account to another Employer	-Yes	-Generally not portable but theoretically could transfer to another employer's HRA—not single account portability and amount is subject to employers' discretion	-No
Returns on Funds	-Choices of interest-bearing savings accounts and mutual funds	-Notional interests benchmarked to government securities -Notional interests may not be granted subject to employers' discretion	-Not applicable—no roll over balances
Tax Treatments	-Employer and employee contributions are pre-tax -Tax-free accumulation -Tax-free withdrawal for qualified medical expenses -Withdrawals for non-medical expenses are subject to income tax and a 10% penalty	-Employer contributions are pre-tax -Tax-free withdrawal- only allowed for qualified medical expenses	-Employer and employee contributions are pre tax -Tax free withdrawal- only allowed for qualified medical expenses

Source: Casewriters.

Endnotes

[1] See Kevin F. O'Grady et al., "The Impact of Cost Sharing on Emergency Department Use," *The New England Journal of Medicine*, 313 (8), August 1985.

[2] Regina E. Herzlinger, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*, San Francisco: Jossey-Bass Publishers, 2004.

[3] Personal communication, Seth Bokser with Roger Feldman, June 8, 2001.

[4] Personal communication, Seth Bokser with Fred Hamacher, June 5, 2001.

[5] Personal communication, Seth Bokser with Tom Luchi, May 30, 2001.

[6] Fictional character.