Consumer-Directed Health Plans: What is the Impact?

Susanna E. Krentz and Tracey L. Camp

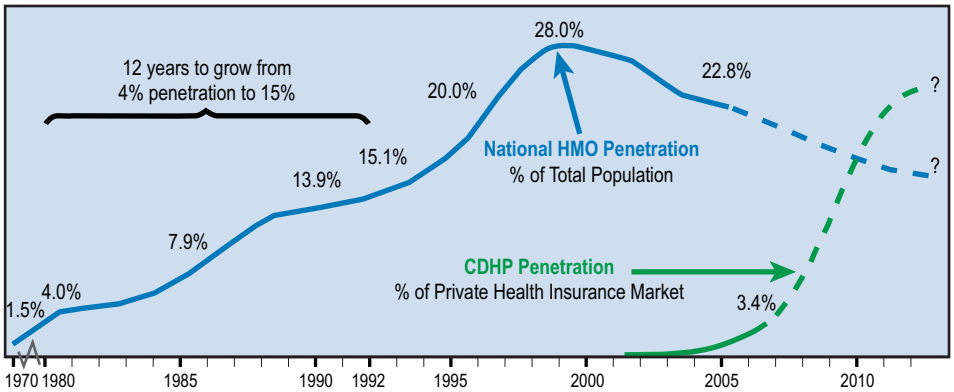
Are *consumer-directed health plans* a panacea for limiting health care cost increases or will they simply prove to have no legs to stand on because of unworkable economics or societal backlash? While it's still early in the consumer-directed health care product life cycle, many indications are that they will have a tenuous future, at best.

What Are They and How Have They Evolved?

The premise behind consumer-directed health plans (CDHPs) is to lower spiraling medical costs by placing consumers on the hook for a greater portion of health care costs, resulting in more rational decision-making and use of health care resources. CDHPs take primarily two forms: health reimbursement accounts (HRAs) and health savings accounts (HSAs).

CDHPs came onto the landscape at a critical time. Between 2000 and 2005, health insurance premiums increased a cumulative 73 percent while worker income increased only 15 percent.[1] According to Government Accountability Office (GAO) estimates,[2] enrollment in HRAs and HSAs is growing at a fast pace, nearly doubling in the last year from an estimated three million enrollees in January 2005 to five to six million enrollees in January 2006. But at a penetration rate of less than 4 percent, CDHP enrollment constitutes a small portion of the 177 million total private health insurance market.[3] Most experts agree that penetration rates must reach a 15 to 20 percent "tipping point" before they cause fundamental change in how payers and providers accommodate this population's needs.

Let's take a look at another touted panacea for controlling health care costs—Health Maintenance Organizations (HMOs). In 1970, the Nixon administration endorsed HMOs as the new national health strategy. As shown in Figure 1, it wasn't until 1980 (10 years after that proclamation) before HMO penetration reached 4 percent. It took another 12 years before HMO penetration reached 15 percent. Despite the oddly parallel example of President Bush recently encouraging the growth of HSAs, it is unknown whether CDHP penetration will have the protracted ramp-up of HMOs, or if it will quickly reach the sweet spot of 15 to 20 percent, which some pundits claim will occur by the end of this decade. If CDHPs are to be the construct for solv-



Source: HMO penetration based on data from InterStudy, the leading publisher of HMO enrollment information. CDHP penetration based on 2006 enrollment as reported in, *Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, GAO Report (GAO-06-514). Washington, D.C., April 2006.

Figure 1. Product life cycles: HMOs vs. CDHPs.

ing the health care cost crisis, the United States can't really afford to wait 12 years for CDHPs to reach that sweet spot.

There are differences in account features between the two CDHP types, as shown in Table 1, but the most important difference is that HRAs are completely funded by employers, while HSAs can be funded by both employers and employees using pre-tax dollars. As of January 2006, enrollees are almost evenly split between the two models. Large employers tend to offer HRAs, while small employers tend to offer HSAs. While HSA-eligible enrollees are required to subscribe to a high-deductible insurance plan, they are not required to open or contribute to an associated HSA. It's this key difference that presents perils.

What Can Go Wrong?

There are a number of things that could keep CDHPs from achieving their stated goals of reducing health care costs by encouraging more rational decision-making and use of health care resources.

People Don't Fund the HSAs

It is estimated that only 50 to 60 percent of all HSA-eligible enrollees had actually opened and contributed to an HSA.[4] In addition, only two-thirds of employers offering HSA-eligible plans made a contribution to the employees' accounts.[5] People who don't fund their HSAs are betting that they will be among the lucky ones who won't need any significant health care, simply feel they can't afford to set any money aside, or assume they will find the money when the time comes. This is a huge gamble when, in 2005, the national personal savings rate became negative for the first time since the Great Depression.[6]

People Spend a Higher Percentage of Their Income on Health Care Under CDHPs

According to a 2005 survey by EBRI/Commonwealth Fund, 31 percent of enrollees

Table 1. Comparison of HRA and HSA key account features and experience.

Feature/Experience	HRA	HSA
Features		
High deductible requirements	No requirement, but typically offered	Required, with a minimum deductible of $1,050 for single and $2,100 for family coverage, adjusted for inflation in future years
Maximum out-of-pocket limit	IRS does not specify a maximum out-of-pocket limit	Maximum of $5,250 for single and $10,500 for family coverage, adjusted for inflation in future years
Portability	Generally not portable	Accounts are fully portable
Ownership	Employer owned	Individual owned
Who is eligible?	Offered only by employers in the group market	Offered to employers in the group market and to individuals in the individual market
Who may contribute?	Employers only	Employers, individuals, and family members
Annual contribution limits	No limit, employers typically determine contribution amounts	Contributions allowed up to 100% of deductible, but not more than $2,700 for single or $5,450 for family coverage, adjusted for inflation in future years
Unspent funds	May roll over from year to year; some employers limit the maximum amount that may accumulate	May roll over from year to year without limit
Non-medical withdrawals	Not allowed—all withdrawals must be for documented medical expenses	Subject to income tax; additional 10% penalty assessed for non-medical withdrawals before age 65
Experience (based on limited national data)		
Annual employer contribution	Most commonly in 2004: $500–$750 single coverage $1,500–$2,000 family coverage	Average for 2005: $553 single coverage $1,185 family coverage
Percentage withdrawing some or all of funds from account	73% single coverage, 96% family coverage	72% overall
Percentage exhausting all funds from account	36% single coverage, 58% family coverage	20% overall
Amount of unspent funds rolled over	$470 single coverage, $401 family coverage	$950 overall

Source: *Consumer-Directed Health Plans Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, GAO Report (GAO-06-514), Washington, D.C., April 2006.

in CDHPs spent 5 percent or more of their income on out-of-pocket costs and premiums in the last year, compared with just 12 percent of those in comprehensive health insurance plans.[7] While this trend is exactly the point of CDHPs (i.e., people having more skin in the game), it may be hard to sustain if people don't set aside funds and alter their other spending habits.

People Forgo or Delay Care

According to the same EBRI/Commonwealth Fund survey, 35 percent of enrollees in CDHPs reported delaying or avoiding care due to cost, compared with just 17 percent of those in comprehensive insurance plans. Even more importantly, 40 percent of individuals who indicated their health was fair to poor or who had at least one chronic health condition delayed or avoided receiving care. To the extent that the forgone care was medically needed, not obtaining treatment could lead to more expensive treatments down the road for a more advanced clinical condition. This trend is certainly not a welcome outcome of consumer-directed health care.

As shown in Table 1, the percentage of enrollees who exhausted their funds is less for HSA enrollees than for HRA enrollees, and the amount left over in the fund is more for HSA enrollees than for HRA enrollees. This statistic supports many experts' views that some enrollees are simply using HSAs as a tax-advantaged savings account rather than as a health care spending account. This is fine only if these individuals have the wherewithal to pay for necessary care using other out-of-pocket sources.

People Can't Get the Necessary Information to Make Wise Choices

Making informed choices about where to obtain health care services requires readily-available, useful, and understandable information. Unfortunately, many of the new initiatives by Medicare, insurers, and providers to increase the availability and transparency of price and quality performance provide little useful information for consumers. Some cost information provides *average hospital and physician rates*, rather than the *specific, negotiated payment rates* for individual providers—information consumers need to make cost-effective decisions. Or hospitals provide "charge" data, which are simply based on a master of list prices that no one actually pays and that aren't aggregated into something meaningful for a consumer to judge the total cost of a service or episode of care. On top of that, because of the way claims are adjudicated under most plans, at the time of service consumers and providers don't even know how much will be withdrawn from the HSA or what the remaining balance will be.

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While laudable, today's price transparency efforts fall short of the bar for most consumers. Transparency is most meaningful for those services incurred up to the out-of-pocket maximum ($5,250 for single coverage or $10,500 for family coverage under HSAs). Price information will matter for services up to that out-of-pocket maximum, which will be mostly lower-cost elective services and other, largely outpatient, commodity services. But to date, a significant focus of cost and quality information is around expensive, inpatient conditions such as open-heart surgery or major orthopedic cases. While this information is very relevant for insurers making network decisions, it is mostly useless for consumers in a CDHP.

Also, how does one judge quality for some of these elective or commodity-like services? For example, is the quality of an MRI substantially different from provider to provider? Or, how does an expectant mother judge the quality of obstetrics services—the number one admission for many hospitals—even with the ample lead-time before delivering? Will mothers be willing to pay for the deluxe accoutrements that are now being marketed when they are on the hook for payment? Most of today's quality information is focused on fatal outcomes of acute inpatient care, not on the more "mundane" aspects of quality impacting us most of the time—such as accuracy in diagnosis and efficiency in delivering care.

The Healthy Are Pitted Against the Chronically Sick

According to a GAO report on the first year experience of federal employees covered under CDHPs (part of the Federal Employees Health Benefits Program), CDHPs are more likely to attract the younger, higher wage-earning, and presumably healthier population compared to traditional plans.[8] Over time, it is a concern that traditional health plans will become disproportionately composed of the chronically ill, making that population extremely expensive to insure. Because of this adverse selection, employers are unlikely to save any money by offering CDHPs if they also offer traditional health plans. Since cost savings is

a primary driver for employers, this could lead to more rapid adoption of CDHPs as the sole option for employees.

What Are the Implications for Providers?

Anxious is the adjective that best describes most providers' feelings related to CDHPs. Providers have largely benefited from the revenue stream of spiraling health care costs and from consumers being shielded from the costs associated with health care services. CDHPs are unlikely to solve the uninsured crisis since the lower income, and even middle class, population is less likely to fund HSAs or benefit from their tax savings.

Some of the key areas of concern for providers are:

- Increased bad debt if individuals don't fund their spending accounts or if individuals forgo insurance entirely.
- Revenue cycle headaches and costs associated with tracking and receiving payment in a general climate of suspicion about hospital pricing and collection policies.
- Loss of a patient base if people seek care elsewhere—in doctors offices or freestanding centers rather than hospitals; at alternative medicine providers rather than traditional providers; or at providers far from home rather than locally.
- Inability to predict volumes for price sensitive services—will overall utilization of some of these services decrease as consumers choose to forgo services completely (a decrease in total market demand), or will patients still seek care but somewhere else (a decrease in market share)?

What's a Provider to Do?

Providers should assume that some level of consumer-directed health care will be evident in their market—but it will vary significantly based on the decisions made by local employers. Given this assumption, what can a provider do?[9]

1. Focus on cost and quality information transparency that is *relevant* for consumers in a CDHP. This is likely a different information set than is currently on most organizations' radar screens, since it differs from the information that is of highest importance to insurers.
2. Consider selective use of "loss leaders" to attract patients into the system who will continue to use the provider for downstream services (e.g., provide discounts on outpatient imaging or other screening services to attract the higher-revenue inpatient admission).
3. In addition to loss leaders, evaluate the basis for pricing. Should services be priced in an a-la-carte fashion, which has been the norm to date, or should there be targeted bundling of services so it is possible to give a consumer an unambiguous answer about what a service will cost?
4. Hospitals should also be investing in the systems and processes to handle individuals covered by CDHPs so they aren't caught off guard when these people show up on their doorstep. Does the hospital operator know where to direct calls about how much services cost? Who has the authority to negotiate prices with an individual consumer?
5. Think about who the customer is and how to reach them. How useful are your Web sites in providing practical information? How far might an individual travel to save money on a service? Other countries are beginning to take advantage of this price sensitivity for some high-end cases by packaging medical vacations for plastic surgery or elective orthopedic surgeries. These offerings provide package pricing for all medical care related to the procedure—generally at costs between 50 and 80 percent less than in the United States.[10]
6. How important is investing in quality? Quality is fundamental to the health care industry—it is expected by consumers and the general public and poor quality is a problem. But, realistically, many people may be willing to trade-off the "best" quality for the "accepted community standard" (i.e., average quality) at a lower price.

Summary

The $100,000 question is: will the pain of spiraling health care costs become so great that CDHPs will be a short-lived phenomenon with a short-lived product life cycle that does little to solve the crisis and ultimately gets replaced by yet another innovation or some form of national coverage? Regardless, in the immediate future, people are going to pay more for health care themselves. As recently as 1960, consumers paid more than half of their health care expenditures directly. Today, approximately 85 percent of the cost is borne by third parties.[11] With CDHPs, the pendulum is beginning to swing back to the days of individual accountability and catastrophic coverage. To have any sustainability, CDHPs must combat years of entitlement, a complicated system, and inadequate and often misleading cost and quality information.❖

Endnotes

1. *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, no. 288, Dec. 2005.
2. *Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage*, GAO Report to the Chairman, Committee on the Budget, House of Representatives (GAO-06-514), Washington, D.C., April 2006.
3. Ibid.
4. Ibid.
5. Ibid.
6. *Negative personal savings rate: What does it mean?*, www.bankrate.com, Mar. 8, 2006.
7. *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, no. 288, Dec. 2005.
8. *Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, GAO Report to Congressional Requesters (GAO-06-271), Washington, D.C., Jan. 2006.
9. The six recommendations are based on Mitretek Healthcare's work with private sector health care providers across the country.
10. "Cost Saving Surgery Lures 'Medical Tourists' Abroad," *Seattle Post-Intelligencer*, seattlepi.nwsource.com, July 24, 2006.
11. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Susanna E. Krentz is the national practice director for strategy at Mitretek Healthcare and a senior fellow in Mitretek's Center for Health Innovation. Her experience includes strategy development, service line planning, affiliation planning, financial assessments and extensive process facilitation. She received her MBA from the University of Chicago's Graduate School of Business.

Tracey L. Camp is a senior consultant at Mitretek Healthcare and a principal investigator in Mitretek's Center for Health Innovation. Her experience includes service line planning and demand modeling, medical staff development studies, and market research. Previously she served as a technical researcher at the Center for Health Services and Policy Research at Northwestern University.