

Consumer Driven Health Plans

Health Savings Accounts and High Deductible Health Plans

Concerned and frustrated with health care costs that increase annually at rates much higher than the CPI, many employers are considering Consumer Driven Health Plans (CDHP). The following analysis and discussion of CDHP products is provided by the principals of the Past Presidents Consulting Group (PPCG). Contributing to the analysis are Linn Baker, Len Leto, and Jim Sarver, all principals with PPCG.

CDHPs allow members to use personal Health Savings Accounts (HSAs) or similar medical payment products to directly pay for their own medical care, while a high-deductible health insurance policy protects them from catastrophic medical expenses. High-deductible plans are considerably less expensive. The employee or plan member pays medical claims using a pre-funded spending account, often with a special debit card provided by a bank or insurance plan. If the balance on this account runs out, the plan member is out-of-pocket until the deductible is reached. If a plan member has any unused balance at the end of the year the money may be kept in the account to increase their current balance, or to invest for future expenses.

The theory behind these plans seems sound. The employer reduces insurance premiums by purchasing a high deductible health plan. The employer may contribute some amount at or below the deductible amount to a health savings account to be used by the employee for eligible health care expenses. With an HSA, the employee may also contribute pre-tax monies to the employee's account. Any money in the account that remains unused is allowed to accumulate from year to year, giving the employee an incentive to become a "wise consumer" of health care services. The employer saves money and the employee shops more carefully for health care services. It certainly seems like a "win-win" situation. But there are dynamics that can occur that can be detrimental and costly both to the member and the employer. This paper is intended to illuminate those dynamics and the pitfalls that can occur with a CDHP.

Data to review when considering a Consumer Driven Health Plan.

It is essential to carefully review previous years' claims experience to determine if a CDHP will save money over time when compared to traditional health plans.

A meticulous review of prior claims experience will enable the employer to:

1. Select the appropriate deductible amount to be used in concert with the amount to be contributed to the HSA.
2. Understand what medical services used by members are discretionary and what services are necessary.

- Understand how risk will likely be distributed once a CDHP is implemented especially if a CDHP is going to be offered alongside an existing traditional plan,

The following is an example of a distribution of annual claims costs in amount levels.

Member Claims Distribution

Claims	Members	%	Dollars	%
Over \$100,000	204	0.11%	\$53,200,000	11.00%
Over \$50,000	445	0.24%	\$48,400,000	10.00%
Over \$25,000	1,112	0.60%	\$59,000,000	12.20%
Over \$10,000	3,670	1.98%	\$84,600,000	17.50%
Over \$5,000	7,266	3.92%	\$79,800,000	16.50%
Over \$2,500	10,714	5.78%	\$58,500,000	12.10%
Less than \$2,500	161,948	87.37%	\$100,100,000	20.70%
TOTAL:	185,359	100.00%	\$483,600,000	100.00%

- 2.93% of the members used 50.7% of the claims dollars
- 12.63% of the members used 79.3% of the claims dollars

The above is actual annual claims data for 185,359 members in a large state health insurance program. A quick look at the utilization indicates that if a CDHP is offered alongside the traditional coverage it is most likely that the high utilizing employees, amounting to almost 13% of the membership, would not opt for the CDHP, but would remain in traditional coverage. They would realize that their usage of medical care will cause them to be significantly out-of-pocket and not be able to save anything in their HSA. The lowest utilizers will likely join the CDHP since their current utilization pattern, if continuing; will likely be very advantageous for them. If and when this new distribution occurs the traditional plan coverage will require significant premium increases in subsequent renewals since they will have retained the high utilizers and lost the low utilizers.

If the employer elects to continue covering basically the same services, they need to determine how much money would be available to fund the HSA for each employee. Based on the above distribution, the funding levels for the HSA will need to be much less than \$2500 to ultimately save the employer claims dollars since only 20% of the membership are below this amount. If funding levels are too low, many employees who would have considered joining the CDHP may elect to stay in traditional coverage to eliminate further risk.

Benefit Design

When determining benefits for members of a high deductible health plan it is very important that those with chronic medical conditions are not discouraged from receiving important care.

A study by Medco Health and Harvard School of Medicine published in the New England Journal of Medicine reflects how a four-fold increase in drug co-payments impacted employee drug use.

- 16 % of patients using tier three ACE inhibitors for cardiovascular disease stopped taking their medications
- 21 % of patients using tier three cholesterol lowering statins stopped taking their medications

It is important to consider the financial impact on those employees with chronic medical conditions. For example in the plan mentioned above, for the 2007 plan year, a diabetic's monthly claims were \$876.31 compared to the average members claims costs of \$263.01.

Impact on Provider Discounts and Administrative Overhead

One of the most important factors in providing cost-effective health care benefits to employees is procuring discounts from the medical providers in the community. In exchange for accepting a discounted payment from the health plan or insurer, a provider is assured that he will be receiving a large portion of his reimbursement from the health plan, reducing his billing costs and uncollected debts. With high deductible health plans, use of the provider by plan members may diminish and the provider will not be able to afford to offer deeply discounted health care services. The provider's administrative overhead will also increase when he loses the benefit of EDI (electronic claims submission) with a specific claim payer and has to bill the patient who now is paying directly.

Proponents of HRA's and HSA's admit that the benefit structure of these plans create difficulties for providers.

Impact on Utilization Review

Health plans save a considerable amount of money through early intervention and management of the disease states of their members. Often this is accomplished through benefit plan features and requirements designed to bring these conditions to the health plan's attention at the earliest possible stage. When a plan has a high deductible (\$1,000 or more), often the opportunity to intervene at the early stages is missed, because claims payment edits are not applied, resulting in higher costs for the plan and the member.

Ability of Members to “Shop”

Whether the purchaser of healthcare services is a member, an employer or an insurance carrier, they seldom know what an episode of care will cost before it is delivered. An episode of care is a course of care that includes all the necessary services for a quality outcome. Comparison data on the cost and quality outcomes of healthcare providers compiled by most insurance carriers to negotiate contracts and structure provider panels, would be difficult for an individual to duplicate. Those members who develop the highest medical costs often have life threatening conditions whose total costs are impossible to predict. These are the very medical conditions that are most responsible for out of control costs.

CDHP products received a boost in the U.S. in 2003, with passage of federal legislation providing tax incentives to those who choose such plans. Proponents argue that most Americans will pay less for health care in the long haul under CDHP, not only because their monthly premiums will be lower, but also because the use of HSAs and similar products increases free-market variables in the health care system, fostering competition, which in turn lowers prices and stimulates improvements in service.

Critics argue that CDHPs will cause consumers, particularly those less wealthy and educated, to avoid needed and appropriate health care because of the cost burden and the inability to make informed, appropriate choices. "Consumer-driven health care is badly named, because it's certainly not driven by consumers," said Jonathan Oberlander, political scientist at the University of North Carolina, Chapel Hill. It's "really just shifting the cost of health care onto the backs of the patients." People with chronic illnesses, such as diabetes, will be hurt, because with a deductible of \$3,000 to \$4,000, such people will never be able to save anything in their savings accounts. "Employers like it because they're going to save money," but they're not going to fund these health care accounts adequately, he said. "Conservatives tend to support consumer-driven health care. They believe, as do a fair number of health economists, that people use too much health care, and use too much health care of little value. If you move to high-deductible plans, people will think twice. If I have a sore throat, instead of going to my physician, I'll have a cup of tea instead."

The Kaiser Family Foundation studied how CDHPs cover pregnancy. They found wide variations in cost sharing. Pregnant women could face exposure to high out-of-pocket costs under consumer-driven health plans, particularly when complications arise. In one scenario, a complicated pregnancy, with gestational diabetes, pre-term labor, caesarian section and neonatal intensive care, would cost \$287,000. Under some consumer-directed health plans, the cost to the family could be as high as \$21,000 much higher than most traditional plans.

Information needs and providers

Key to CDHP's success is ready access of plan users to information about health products, services, and pricing. Critics of CDHP argue that the system will only saddle consumers with more expenses because free-market variables can never exist in health care due to lack of “pricing transparency”. “Despite the theory (as expressed in the Economic Report of the President) that health insurance with higher deductibles will lead to consumers shopping around

for health services (based on price and quality), the reality of...inadequate information in the marketplace about health care quality and prices precludes the workability of a 'consumer-choice' type of model," Gail Shearer, director of health policy analysis for Consumers Union, told the Joint Economic Committee of the U.S. Congress in February 2004.

Jessie Gruman who interviewed 200 patients and families about how they used scientific information after devastating medical diagnoses, said, "I fear that the trend toward consumer-driven health care will disproportionately damage the health of the less educated and less wealthy, and that the net effect on the nation's health has already proved negative." She concluded that most patients are unable to make critical decisions about their health care in the consumer-driven model. People turn to the Internet, become overwhelmed, or don't understand the significance of the information. "Most health information is bad news," is stressful, and makes decisions even more difficult.

According to Robert Reischauer, president of the Urban Institute and vice chairman of the Medicare Payment Advisory Commission, "Accessible information on the quality, price, effectiveness and efficiency of health-care services and providers is developing rapidly, but is nowhere near the minimum standard assumed by well functioning CDHP".

Many things we buy in health care are pieces of larger packages which are undefined when the decisions are made concerning whether to purchase and where to purchase. For example, when one goes to the doctor because of a particular set of symptoms, the doctor ask a number of questions which leads to a series of recommended tests whose results then determine an appropriate treatment regime. One could select the doctor to visit on the basis of price and quality but that is no guarantee that the package of tests and treatments that resulted would be the lowest cost or highest quality.

A revealing example of the weaknesses of CDHP is the case where a patient needs a stent to repair an artery blockage. In a CDHP, the patient doing their research on the costs of cardiac stents, finds there is a newly advanced stent at a top dollar price. They are now faced with the decision to purchase an older type stent without the newer advances that will much less costly or to opt for the more advanced, more costly model. CDHP advocates will tell you that the patient will shop and to save money choose the older model stint. The reality of this situation is that when faced with a life threatening condition, most people will only opt for the best, most advanced option and spend very little time trying to save a few dollars on a less expensive model that is not as good. The consumer will always opt for the best care possible. It is one of the reasons why a CDHP may not work effectively.

Summary of Pros and Cons

Pros:

- HSA account earnings and contributions are not taxable
- Money not spent stays in the account and earns interest, giving individuals in good health funds for future medical expenses
- Employees may take their HSA's from one job to another
- People who are 65 and older may withdrawal money from their HSA's for any purpose without penalty (though the money withdrawn does become taxable)
- Encourages patients to be better "consumers"
- Employers with younger and healthier employees will clearly benefit

Cons:

- May cause traditional insurance premiums to rise if younger, healthier workers opt out in favor of HSA's
- Have no real impact on non-discretionary care, which constitutes over 80% of total spend
- HSA's disadvantage those with low incomes, who are chronically ill, who are older, and those with large families
- HDHP's are likely to increase administrative costs for providers and payer's
- HDHP's may increase bad debt for providers
- Ability of health plans to negotiate discounts may be negatively impacted due to lack of directed care
- Opportunities for large case management may be missed because claims edits are not applied to claims going towards deductible
- Savings from early intervention may be lost
- Individuals don't have the necessary data to "shop" their care.

Consumer satisfaction

Consumer satisfaction results have been mixed. While a 2005 survey by the Blue Cross and Blue Shield Association found widespread satisfaction among HSA customers, a survey published in 2007 by employee benefits consultants Towers Perrin came to the opposite conclusion. Towers Perrin found that employees currently enrolled in such plans were significantly less satisfied with many elements of the health benefit plan compared to those enrolled in traditional health benefit plans.

Some policy analysts say that consumer satisfaction doesn't reflect quality of health care. Researchers at Rand Corp. and Department of Veterans Affairs asked 236 elderly patients at 2 managed care plans to rate their care, then examined care in medical records, as reported in *Annals of Internal Medicine*. There was no correlation. "Patient ratings of health care are easy to obtain and report, but do not accurately measure the technical quality of medical care," said John T. Chang, UCLA, lead author.

Opinion-Past President's Consulting Group

From the above, it is clear that overall opinions on the effectiveness of CDHP are mixed. PPCG feels that the decision to implement a CDHP should be based on various goals.

An employer is solely interested in saving health care dollars and is offering a CDHP as a total replacement product.

It is clear that if you properly review your health data and can determine the ideal contribution level, etc., then such a product does make sense. You will reduce cost but you will shift cost to your members. Your savings will likely surpass the following quality and financial drawbacks:

1. The employer may have some negative impact on the ability to negotiate provider discounts due to a lack of directed care.
2. Opportunities for large case management may be missed because claims edits are not applied to claims going towards deductible.
3. Savings from early intervention may be lost.

The employer is adding a CDHP to a traditional array of existing health plans.

Having choices in the mix of programs will make this addition highly risky and may not fulfill the goal of cost savings. Member movements will likely result in low utilizers joining the CDHP leaving existing plans with high utilizers. This will result in higher costs for the existing plans plus the additional cost of the HRA contributions. Overall

administrative cost will also increase. For those who do join the CDHP the negatives mentioned above will be present.

Even with significant changes in benefits designed to attract more of the higher utilizers to the CDHP, the negative risk shifting will likely occur.

The recommendation of the PPCG is that employers should only consider a CDHP as a total benefit program replacement. The CDHP should not be added to an existing array of traditional type plans. Although we understand that a CDHP may be necessary to reduce an employers costs, especially in the current economy, the reduction in the quality of care, the scarcity of price information and the negative impact on those with low incomes, the chronically ill, individuals who are older, and those with large families are issues that make offering a CDHP an option to be carefully considered by an employer prior to implementation.