

## Literature Review

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“Advancing quality in a consumer-directed world: ‘may you live in interesting times’” (*Am J Manag Care*. 2005;11(5):287-8), by Lewis G. Sandy, and Dawn Bazarko

“Managed consumerism in health care” (*Health Aff*. 2005;24(6):1478-89), by James C. Robinson

“Consumer directed health care: ethical limits to choice and responsibility” (*J Med Philos*. 2005;30(2):207-26), by Linda M. Axtell-Thompson

“Do consumer-directed health benefits favor the young and healthy?” (*Health Aff*. 2004;23(1):186-93), by Dwight McNeill

The health insurance marketplace is an ever-evolving organism and, as Sandy and Bazarko insist, employers are driving the current revolution of consumer-focused and consumer-directed health care (CDHC). The idea of CDHC has emerged to promote patient choice and market competition while reducing the roles of employers and insurers in the health care decision making process. By engaging patients in their own health decisions, they are given greater awareness, control, and hence, responsibility for their health care spending. This concept is premised on the notion that health care cost and quality information should and will become increasingly transparent, allowing empowered patients to make more informed decisions, which will lead to a decreased use of unnecessary services. Sandy and Bazarko assert that if we focus on health outcomes, move toward increased transparency and improved accountability for use of health care resources, publicly report provider performance, and accumulate knowledge and experience during this time of experimentation, we will move closer to an ideal health care system.

The idea of CDHC does not come without caveats. Axtell-Thompson declares that “while CDHC is gaining attention in the popular press, business publications, and academic journals, it is not without controversy about its relative merits and demerits.” In addition, Robinson recognizes that belief in CDHC rests on an optimistic view of consumers’ ability to make cost- and quality-conscious choices at the time of seeking care. CDHC could even further disadvantage certain populations, thereby widening existing disparities in health care access and outcomes. In addition, McNeill argues that CDHC favors young, healthy patients and disadvantages the moderately sick. He also states that although the primary objective of CDHC is to reduce unnecessary health services utilization, less use is not always better use. Consumers interested in minimizing out-of-pocket costs by delaying or avoiding preventive treatment could make decisions that lead to

potentially deleterious health outcomes in the long run. Regardless of its potential implications, CDHC is here and is garnering a lot of interest.

“Early experience with employee choice of consumer-directed health plans and satisfaction with enrollment” (*Health Serv Res*2004;39(4 Pt 2):1141 -58), by Jinnet Briggs Fowles, Elizabeth A. Kind, Barbara L. Braun, and John Bertko

In a survey study, researchers in Minnesota sought to determine who is more likely to sign up for CDHC plans, and why they choose them. They found that those selecting CDHC plans were less likely to be black, less likely to have a chronic health problem, and more likely to have had no recent medical visits. The investigators also found that those who were attracted to the CDHC plans were more likely to believe that lowest premiums were the most important plan attribute, and they were more likely to think that there were big differences in the premiums of available plans.

“Awakening consumer stewardship of health benefits: prevalence and differentiation of new health plan models.” (*Health Serv Res*2004;39(4 Pt 2):1055-70), by Meredith Rosenthal and Arnold Milstein

“A report card on the freshman class of consumer-directed health plans.” (*Health Aff.* 2005;24(6):1592-1600), Meredith Rosenthal, Charleen Hsuan, and Arnold Milstein

While the popularity of CDHC is growing, these types of models still constitute a small fraction of all employer sponsored insurance coverage, according to a 2004 study by researchers at the Harvard School of Public Health. The investigators examined the prevalence of three types of CDHC plans: health reimbursement accounts (HRAs), premium-tiered plans, and point-of-care tiered benefit plans. In addition, they examined the extent to which these plans supported consumer choice and consumers' involvement in managing their own health. The authors found that decision support in these plans is still limited. They recommend that careful attention be paid to how well beneficiaries are informed about the consequences of their selections, such as the potential repercussions of passing up preventive care.

In the second report, the investigators acknowledge three fundamental but correctable weaknesses of CDHC plans. The first weakness is that most plans do not make available enough comparative cost and quality information to help patients discern higher-value health care options. Secondly, financial incentives for consumers are weak and do not necessarily encourage consumers to choose higher-value options. The third weakness the authors mention is that none of the plans they examined made cost-sharing adjustments to preserve freedom of choice for low-income consumers. The authors offer suggestions on how to correct these weaknesses and conclude that in order for CDHC plans to thrive

and to improve the quality and affordability of U.S. health care, major refinements are required.