

Health Policy Newsletter

Volume 18 Number 4

December, 2005

Article 7

Consumer Driven Health Plans: Wave of the Future?

Sara L. Thier, MPH*

* Thomas Jefferson University

Copyright ©2005 by the author. Health Policy Newsletter is a quarterly publication of TJU, JMC and the Department of Health Policy, 1015 Walnut Street, Suite 115, Philadelphia, PA 19107.

Suggested Citation:

Thier SL. Consumer driven health plans: Wave of the future? Health Policy Newsletter 2005; 18(4): Article 7. Retrieved [date] from <http://jdc.jefferson.edu/hpn/vol18/iss4/7>.

Consumer Driven Health Plans: Wave of the Future?

Consumer Driven Health Plans (CDHPs) are emerging as the new health benefit option that promises to give employees and consumers more choices in how they select and use health care. It is important to examine the lessons learned from innovators and consider the designs of the newer CDHP options being launched in the near future.

What are Consumer Driven Health Plans?

Consumer Driven Health Plans (CDHPs) are the newest iteration of healthcare benefits that some employers are now offering to employees as a coverage option. (See Box for Common Elements of CDHPs) The dual aims of CDHPs are to put provider choice in the hands of consumers and to make the direct cost of health care more transparent. The CDHP design is based on the belief that increasing consumers' financial and decision-making responsibilities will lead to their reduced utilization of healthcare services, particularly those of limited or questionable value; those often classified as "overused."^{1, 2}

With the push toward measurement of performance, efficiency, and patient-centeredness, the amount of data on health care is growing. This information -- analyzed, formatted and distributed appropriately -- promises to be a key factor in pushing the healthcare system toward a market-driven model. Existing CDHP products are predicated not only on the assumption that consumers will make wiser healthcare decisions when faced with paying the entire bill for a visit out of pocket (not simply a \$20 co-payment, but the contracted cost of the visit), but also will base these decisions on quality and cost (value) information available on particular providers, procedures, or medications.

Common CDHP Elements

- High Deductible Health Plan (HDHP)
- Health Reimbursement Arrangements (HRAs), employer-funded; or Health Savings Accounts (HSAs), can be both employee/employer-funded
- Catastrophic Coverage
- Preventive Care Coverage
- Health Management Tools (e.g., online information, call centers)

Lessons Learned Can Direct CDHP Designs Moving Forward

Who is likely to Enroll in a CDHP?

Until recently, healthier and wealthier employees have been more likely to enroll in a CDHP. Such disparity in enrollment has the potential to create adverse selection, leaving options with lower premiums, such as HMOs or PPOs, and employers with the brunt of the healthcare costs. To date, sicker employees and those with lower

incomes have been less likely to enroll in CDHPs, since the potential outlay of “employee gap” dollars (i.e., costs to meet the deductible paid out of pocket by the employee after the employer contribution is exhausted) may cause financial hardship.^{3, 4} Premium payments and co-payments are more predictable and budgetable, and more traditional coverage does not place significant risk sharing on consumers. Employers designing CDHPs are looking to address this issue by offering competitive cost-sharing and cost-saving options for employees, e.g. tiered provider network with no cost to employees for using a selected primary hospital or health system.

Consumers’ Use of Information

Consumer advocates are adamant in their belief that consumers are wise enough to interpret quality data and to choose providers and services on that basis.⁵ Although this sounds like a promising strategy for transforming health care into a market-driven product, the information is very limited, and in the case of physician-specific quality data, almost nonexistent. While many organizations around the country are working to create consumer-friendly information, there are concerns that consumers cannot interpret the information provided. Additionally, even if consumers can understand the data, there is still the concern that consumers are more interested in information, such as office hours and the friendliness of office staff, which is not directly related to the common clinical measures of quality of care typical collected.

Health Care Utilization

The RAND Health Insurance Experiment (HIE) in the 1970s and 1980s set the stage for many of the cost-sharing practices that are now the foundation of the CDHPs model. Its landmark findings suggested that increased cost sharing (i.e., greater out-of-pocket costs) reduces the use of services. The decrease in utilization seen in this and other studies did not differentiate between essential and non-essential care. A closer look at these results also revealed some negative effects of these new utilization patterns on health outcomes.⁶ There remains an underlying concern that those hoping to save out-of-pocket costs in their CDHP plans may delay or forgo needed care. Moving forward, employers plan to promote the use of call centers and online condition and treatment specific data by their employees to encourage them to receive appropriate and timely care.

Planting the Seed for Change: Two Additional Considerations

Pharmacy Benefits: Where allowable, employers may carve out prescription drug plans from the CDHP - how will this affect the cost and out-of-pocket costs for consumers? The alignment of prescription drug benefits will be an essential consideration for creating a strong benefit.

Providers: While hospitals and health plans have become more adept at reporting data to their respective accreditation organizations, physicians have not. Performance measures, including patient satisfaction measures such as physician-level CAHPS, continue to evolve.⁷ However, with less than 15% of physician offices using electronic medical records (EMR), data collection of performance measures for non-EMR offices will remain onerous.

The Bottomline

CDHPs are expected to proliferate over the next few years. Will employers heed the lessons of past experiences? And how will future design modifications effect enrollment, service utilization, the threat of adverse selection, employers' health benefit costs, and ultimately employee health and productivity? At this time, CDHPs may not be the right choice for all employees, or even employers. Yet, employers who are willing to be the early adopters should be commended, as should enrollees who will assist in demonstrating the potentials of market – driven care.

About the Author

Sara L. Thier, MPH, is a Project Director for the Department of Health Policy, Jefferson Medical College, Thomas Jefferson University.

References

1. Davis K. Consumer-directed health care: Will it improve health system performance? *Health Serv Res.* 2004;39(4 Pt 2):1219-1234.
2. *Improving Health Care Quality.* Fact Sheet. AHRQ Publication No. 02-P032, September 2002. Agency for Healthcare Research and Quality, Rockville, MD. Available at: www.ahrq.gov/news/qualfact.htm. Accessed on June 13, 2005.
3. McNeill D. Do consumer-directed health benefits favor the young and healthy? *Health Affairs.* 2004; 23(1):186-193.
4. Parente ST, Feldman R, Christianson JB. Employee choice of consumer-driven health insurance in a multiplan, multiproduct setting. *Health Serv Res.* 2004;39 (4 Pt 2):1091-1111.
5. Herzlinger R. *Consumer-driven health care: implications for providers, payers and policy makers.* San Francisco: Jossey-Bass, 2004.
6. Keeler, Emmett B. Effects of cost-sharing on use of medical services and health. *Medical Practice Management.* 1992;317-321. (RAND Pub. no. RP-1114)
7. Hays RD, Chong K, Brown J, Spritzer KL, Horne K. Patient reports and ratings of individual physicians: an evaluation of the DoctorGuide and Consumer Assessment of Health Plans Study provider-level surveys. *Am J Med Qual.* 2003;18(5):190-196.