

# American Health Care Consumerism Gets a Second Opinion

by  
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Most health policy experts agree that the American health care system is broken. However, there is no shortage of pundits claiming to have a solution. The latest revolutionary idea that is sweeping the nation is "consumerism." Advocates claim that Individuals need a greater financial stake in health care buying decisions to be better consumers while critics argue that financial hurdles are a barrier to proper care. After several years of experience by employers who were early adopters of so-called consumer directed health plans or CDHPs, many employers are now seeking a second opinion.

Unlike most industrialized countries with national health systems of one sort or another, the United States health care system is employer-based. Unfortunately, the number of employers providing health benefits has been declining in recent years (from 69% in 2000 to 61% in 2006).<sup>1</sup> Nevertheless, nearly two-thirds (62.9%) of the more than 250 million non-elderly Americans get their health insurance through their employer.<sup>2</sup> Federal and State Government programs provide coverage to millions more Americans but the ranks of the uninsured continue to swell with 17.9% of the under age 65 population without health insurance in 2005.<sup>3</sup> People without insurance are less inclined to seek timely treatment, are more likely to receive care in the emergency room, and frequently receive uncoordinated or episodic care resulting in inefficient use of resources. Wellness and disease prevention are not terms commonly used when discussing current outreach programs and treatment modalities for the uninsured. Hospitals and providers that deliver uncompensated care for the uninsured simply pass the costs along to the employer in the form of higher fees.

As if subsidizing the uninsured were not enough, employer medical insurance costs continue to trend upward due to inflationary pressures, new costly technologies, and increases in utilization. In 1991 national health care costs of \$785 billion accounted for 13.1% of GDP. In 2004 the expenditure had climbed to \$1,878 billion and 16.0% of GDP<sup>4</sup>. Dire predictions by the U.S. Government Centers for Medicare & Medicaid Services that health care expenditures will reach \$4 trillion and 20% of GDP by the year 2015 have business leaders and politicians scrambling to find a solution.<sup>5</sup>

In a global economy, this significant health insurance cost burden places US employers at a distinct competitive disadvantage. Although trend for employer premiums has been moderating in recent years (down from 13.9% in 2003 to 7.7% in 2006), health care costs continue to outpace inflation of 3.5% and worker's wages of 3.8% by a wide margin.<sup>6</sup> Surveys show that much of the moderating trend has been due to employers passing on a greater share of the costs to their employees. But shifting costs to employees is like changing seats when the theater is on fire. There has to be a better way to manage costs without compromising quality.

The decades long search for the holy grail of health care cost containment has seen a few modest successes. And yet each new initiative is followed by the return to double digit annual increases. In the early 1970s, the health maintenance organization (HMO) was seen as the path to managing health costs. But employers and employees were slow to warm up to this type of integrated delivery system with its limited provider network and its rules on how to access care. Providers responded by forming preferred provider organizations (PPO) that gave employees the option of getting their care at a lower cost from a network provider while retaining the option of going to any hospital or doctor, albeit at a higher out-of-pocket cost. These initiatives were followed by the age of managed care where employees had to select a physician gatekeeper who would direct the patient's treatment plan and control access to specialists and hospital-based treatment. Each of these concepts met with limited initial success before running head-on into the real nemesis to true reform – the entitlement mentality of the American consumer.

Most employers are particularly sensitive to competitive practice as well as cost considerations when they review their medical plan offering and employee premium sharing formula each year. When the economy is strong and qualified workers are in demand, it is very difficult for an

employer to announce a reduction in benefits, a new health plan with a restricted delivery network or an increase in monthly premium contributions. By the same token, when business is difficult and it is important to keep your best employees, it is toxic to inform employees of reductions in benefits at the same time you are announcing a wage freeze. Couple the employee's natural resistance to change with the widely held belief that more health care is better and the highly valued ability to choose any physician or hospital for your care and you have a no-win situation for the benefits manager. The tension between the CFO looking to improve the bottom line and the Benefits Manager challenged to attract and retain the best employees is very real and often irreconcilable.

Recent efforts to reduce medical insurance costs focused on increasing deductibles and copayments as a way to shift costs to the employee. While this certainly has merit as a short-term tactic or even as a mechanism to keep pace with inflation, it fails to get at the root cause of health care costs, namely, getting the right care at the right time in the appropriate setting. Or, better yet, helping individuals avoid the need for health care in the first place by improving their health through diet and exercise. During the last several years the term "consumerism" has found its way into the employee benefits vernacular. As far back as the 1960s, researchers at the Rand Corporation found, not surprisingly, that the greater the share of medical costs born by the individual, the fewer medical services were purchased. Based on this simple principle, the Consumer Driven Health Plan (CDHP) was born.

The CDHP is designed to meet several key objectives:

- Manage costs and mitigate trend
- Provide unlimited provider choice
- Introduce marketplace economics into the health care buying decision
- Provide tools and information to help individuals make informed decisions
- Encourage wellness/healthy lifestyles as a means of avoiding future health problems and their related costs
- Protect the participant from significant financial hardship due to serious illness or injury
- Allow for participants to have "equity" in the plan that grows over time as a result of prudent health care buying decisions

Employers generally welcomed this new approach in theory, but there were very few early adopters who embraced the concept as a total replacement for their current traditional medical plans. A number of CDHP vendors entered the insurance market several years ago with high hopes of catching the wave and enrolling millions of members and eventually becoming the health plan of choice for employers. The last two years have seen the acquisition by the two largest national health insurance companies of the two largest of the independent CDHPs (Definity acquired by United HealthCare and Lumenos acquired by Wellpoint) and the growth of the Aetna's homegrown version: Aetna HealthFund. While there are still a few independent programs around, it is almost certain that they will either be acquired or fade away.

The CDHP is designed around several key elements:

- A reimbursement account funded with employer money (and in some cases by employees as well). Unused amounts can accumulate tax-free from year-to-year to reduce future out-of-pocket costs and/or to help pay for retiree medical benefits.
- A deductible amount funded by the employee after the reimbursement account has been used up.
- Catastrophic insurance protection for serious illness or injury.
- Decision support tools to help patients select network providers (with discounted fees-for-service), get health information about their condition (i.e., diet, exercise, pain management, etc.), and identify risk factors (through a health risk appraisal).
- Preventive care services may also be provided and can be covered at 100% to

encourage early detection and treatment of disease.

Because the consumer is no longer insulated from the market cost of health care services, he or she is far more likely to do some homework before going to the doctor. A couple of examples will help to illustrate the concept behind the CDHP:

- In a typical PPO, a visit to a network doctor might cost \$15 regardless of the discounted fee charged by the doctor to the health plan. In the CDHP, a network doctor might charge \$60 for a visit while another network doctor would charge \$90 for the same visit. The CDHP member would save \$30 by going to the less expensive doctor.
- With a typical prescription drug plan a generic drug might be \$10 while a brand drug would be \$25 even though the actual cost for the generic is \$25 with the brand drug costing \$135. Although \$15 savings in the typical Rx plan might be sufficient to select the generic drug, a savings of \$110 in the CDHP is a no-brainer. And, if there is an over-the-counter option for \$10 you might even see the consumer going outside the plan entirely.

As a total replacement plan the CDHP model can reduce plan costs by 15% or more. With the potential for savings of this magnitude the CDHP simply could not be ignored. As a result, surveys predicted explosive growth in the number of employers offering CDHPs capturing significant market share in just a few years. However, recall that employers, while enamored with the potential for savings, were also concerned with negative employee relations due to the complexity of the plans and the shift from entitlement to responsibility represented by the CDHP model. Consequently, many employers elected to offer a CDHP as an alternative to the current plans in the hope that the concept would gain traction and enrollment growth and cost control would eventually follow. A simple mathematical calculation illustrates the dilution on cost savings associated with this approach: A CDHP that will be 15% less expensive is offered as an option and 10% of the employees enroll in the plan. The savings are 15% lower costs for 10% of the population for overall savings of 1.5%. And, this calculation does not take into account possible adverse selection that could actually increase the cost for the less healthy employees remaining in the traditional plan.

The other challenge for employers looking for maximum savings through the total replacement strategy is the impact on the low wage earners in the workforce. For a high paid group of employees, the high deductible CDHP may be necessary to get their attention and engagement in the health care buying decision process. For lower income families, however, the economics of the plan could be a real barrier to getting timely care.

For the reasons given above, many employers are rethinking their benefits strategy and the role, if any, that CDHPs will play in the future. Surveys bear this out and are showing that earlier predictions may have been overly optimistic. For example, a year ago respondents to a survey conducted by the International Society of Certified Employee Benefits Specialists (ISCEBS) predicted that 23% of employers with more than 10,000 employees would offer a CDHP in 2006. This year's survey showed that only 12% of the large employers actually offered a CDHP. This is not to say that employers have abandoned CDHPs or are turning their backs on consumerism. In fact, important lessons have been learned from the CDHP plans. It is possible and highly desirable to engage employees and provide them with the tools to be better consumers of health care services. The internet and data mining technology have come a long way in recent years to identify populations at risk through individual self-reporting (i.e., health risk appraisals) and claims analysis. It is indisputable that economic self-interest can play an important role in health benefit plan design and the CDHP model is certainly built on that premise. However, many employers are giving CDHPs a second look and are electing to focus on the behavioral self-interest of prevention and disease management that may even pay bigger dividends by keeping employees healthy in the first place.

## NOTES

1. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006.
2. Urban Institute, 2006. Based on data from March Current Population Surveys, 2005, 2006. Note: Excludes persons aged 65 and older and those in the Armed Forces.
3. Urban Institute, 2006. Based on data from March Current Population Surveys, 2001, 2004, and 2006. Note: Excludes persons aged 65 and older and those in the Armed Forces.
4. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; NHE summary including share of GDP, CY 1960-2004; file nhegdp04.zip).
5. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Care Expenditures Projections: 2005-2015.
6. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1988-2006; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2006.

**About the Author.** Ken Drummer is a senior vice president and thought leader in Woodruff-Sawyer's health & welfare benefits practice. Ken specializes in helping employers design and implement health care cost management and absence management programs. During his career he has worked with companies of all sizes, in many different industries and in both the private and public sectors. Ken has more than 35 years of experience in the health care industry and in employee benefits consulting.