



CONSUMER-DIRECTED HEALTH CARE

Introduction

This memorandum will discuss a new approach to health care delivery that transfers more responsibility to the consumer by requiring that consumers make decisions about if and how they want to spend their health care dollars. This new approach is consumer-directed health care. The theory behind consumer-directed health care is to transfer more responsibility to consumers for decisions regarding the cost and quality of their health care, creating an incentive for wise consumption. The consumer-directed health care concept is being marketed by insurance companies as an alternate method of coverage for employers. With a consumer-directed health plan (CDHP), an employer contributes an annual set amount per employee into a health account for routine health care expenses which can carry over from year to year. The employee controls those untaxed funds and uses them for purchasing health care services. Once those funds are depleted, the employee is responsible to pay any further costs until a deductible is met. When the deductible is met, the employer provides insurance protection under a traditional health care plan. Web-based management tools and information help employees make decisions about benefits, cost, providers, and treatment. The concept is also being tried in the public sector to serve the elderly and those on Medicaid. The fundamental principle is that consumers of health care must understand the true cost of health

care services and take increased financial responsibility for health care purchase decisions. When consumers are paying for health care with their own money, they will be more careful about how their dollars are spent, or even if the dollars are spent.

Background

Several current trends are driving the desire to look for new ideas for the delivery of health care. Employers and consumers are increasingly frustrated by the resurgence of double digit inflation rates for health insurance premiums and health care costs. A Deloitte & Touche survey illustrates this. The Deloitte & Touche 2003 Consumer-Driven Health Care Survey analyzed responses of 287 companies that participated in a survey on consumer-driven health care. Over 70 percent had double-digit health care cost increases. One in three reported cost increases of over 15 percent. Many employers are faced with either containing premium increases or dropping the insurance coverage benefit entirely.

The current model of managed care has not delivered on its promises. Many physicians are frustrated with the restrictions and complexity of managed care. Consumers resent their lack of choice and the bureaucracy of getting permission from gatekeepers to access health services. Even though industry tried to get volume discounts from health

care providers, costs continue to climb and savings are not always being realized. Issues such as government mandates and regulations, litigation, fraud, and stockholder pressures have put pressure on the savings hoped for by contract discounts.

These trends are bad for both employers and consumers. Employers are paying the majority of the costs and consumers are finding benefits and quality dwindling as their financial responsibility increases through higher deductibles, coinsurance, and a larger share of the premium.

As consumers are sharing more costs, they are also making more choices and taking more responsibility through cafeteria plans and flexible spending accounts. This shift to consumerism fits well with consumer-directed health care. This move is also being stimulated by the pharmaceutical sector through direct-to-consumer advertising and information and by the focus on patient safety.

All these factors are leading employers to look for other options. Of the companies responding to the Deloitte & Touche survey, interest in those alternative health care delivery models that encourage employee consumerism is growing: 11 percent offered CDHPs as of January 1, 2003; 8 percent will offer CDHPs in 2004 or 2005; 35 percent are reviewing CDHPs for the future; 32 percent are interested and will consider a new delivery model if long-term savings and employee acceptability can be demonstrated; and 14 percent are not considering a consumer-driven option.

Components

There are five components to consumer-directed health care. The first is consumer benefit choice. An integral

feature is an on-line wizard to guide decision-making based on health care needs and budgets and to suggest the best alternative. The second component is consumer financial responsibility. Decisions about benefits, care, and who will deliver the care shift to consumers as will financial responsibility for those decisions. Employers or government programs no longer shield consumers from the true costs of care and consumers must become more responsible for those costs. Consumer choice of provider is the third component. Provider cost, quality, and satisfaction data are necessary to guide consumers to the right care options. A key to this is provider profiling so there is greater information transparency and much greater decision support for consumers. The fourth component is consumer self-management. Under consumer-directed health care, consumers are active participants in managing their own care. To be successful, plans may offer voluntary disease and health management programs as the numbers of individuals with chronic conditions grow. The fifth component of consumer-directed health care is information transparency. Consumer-directed health care requires electronic connectivity for access to consistent and accurate information. This component depends on the consumer's comfort with the Internet and the utility of Internet-based tools.

Private Sector

In a CDHP, there are three tiers of payment. The first tier is usually a tax-exempt account contributed by the employer to pay health care expenses. Generally it provides more flexibility than managed care as to what providers can be seen and what services are covered. The second tier of payment is any out-of-pocket payment for health care expenses

after the money in the account is used up and before the deductible is reached on a high-deductible insurance plan. The third tier is triggered if allowable health care expenses for the year exceed the deductible amount of the high deductible insurance policy. The employer usually pays a high percentage or all of health care expenses over the deductible. Sometimes this insurance has restrictions similar to managed care plans. Key to this tiered structure is Internet-based support for the consumer. Consumers must be able to track and manage health care bills; manage and improve health with useful information and preventative services; get information about provider quality; and get group rate prices from providers. In addition, plans usually offer immediate catastrophic coverage. Many also cover wellness so those expenses do not count against the initial amount in the health account.

Here is an example. An employee gets an annual tax-free health care fund of \$1,000. The employee may spend that on any medical expenses he or she chooses with any doctors, from eye examinations to alternative medicine. There are no copayments, gatekeepers, or paperwork for reimbursements. If any money is left over, the employee can roll it over into next year. The employee has an incentive to research health providers, choose generic drugs, and make sure doctor visits are necessary. If expenses go above \$1,000, there is a deductible of \$500 which the employee must pay. After \$1,500 the employer coverage takes over with 100 percent employer-paid coverage within a network or an 80 percent/20 percent split for out-of-network services.

Pros and Cons

Proponents argue that consumer-directed plans will encourage consumers to make

better medical care decisions by reestablishing the link between service use and the consumer's financial liability. If consumers respond to these incentives and use Internet tools not just to make decisions regarding their plan but to select providers based on quality, make informed treatment decisions, and manage chronic conditions, quality of care should improve. The plans give consumers a choice in providers and services and restore independence to the physician-patient relationship. Further, having better-informed consumers will lead to savings by eliminating unnecessary trips to emergency rooms, excessive doctor visits, and money spent on expensive brand-name drugs as opposed to generics. Finally, more freedom of choice, less bureaucracy, and eliminating the primary gatekeeper will lead to greater customer satisfaction.

Opponents argue the plans are too complicated for consumers. The difficulty of the decision making required and the skills needed to successfully manage within these plans may be beyond the ability of many consumers. The amount of effort, skill, and knowledge required to make choices could discourage voluntary enrollment by those with lower decision-making and literacy skills, perhaps leading to selection bias. Consumers may not have access to online service or may lack the desire to learn about their plans, leading to additional problems. Also, because the information is online, a degree of computer literacy is required. There are also fears that if consumers are given too many incentives to reduce health-care costs, they may forgo needed checkups to save money or begin self-diagnosis, and those who are seriously ill will postpone necessary care, ultimately driving up costs.

Public sector

The concept of consumer-directed health care has also entered the public sector. Arkansas, New Jersey, and Florida were the first states to be granted Section 1115 waivers to participate in a demonstration project designed to allow certain disabled Medicaid beneficiaries to purchase needed services with a cash allowance. This program, at the national level, is called the Cash and Counseling Program. Its purpose is to evaluate how Medicaid beneficiaries function in a system that allows them to purchase their own personal and community-based services, assisted by a consultant, with a defined contribution from their state's Medicaid program.

Some of the drawbacks of traditional delivery systems are eliminated by this approach. Contracting with a home care agency usually means that the beneficiary has little or no say in how, when, or by whom the services are delivered. This is especially problematic if the beneficiary prefers care at odd hours or on weekends and the agency hired is not available at those times. In addition, for services requiring intimate assistance such as bathing and grooming, the beneficiary must rely on a stranger or someone else's choosing to perform such tasks. Finally, under traditional delivery systems, it may be difficult for a beneficiary to fire a bad provider and hire someone else. In contrast, in Florida, for example, a beneficiary may hire nontraditional providers, including family members and friends.

Although the program is known by different names in each state, in all three states the beneficiary must be enrolled in Medicaid, meet age and eligibility requirements, and require personal assistance services such as

housekeeping, bathing, meal preparation, dressing, and grooming. Each beneficiary receives a cash allowance based on the level of professional assistance needed. Under the waiver, the program must be budget neutral so the amount provided to the beneficiary is generally equal to the value of services purchased by the state. In Florida, two methods are used to determine the amount of money for each beneficiary. First, the beneficiary's expenditures in the Medicaid waiver for the previous six to twelve months are averaged. However, if the beneficiary has not been in the program for that length of time, a dollar value of care is calculated. Although the beneficiary has flexibility with regard to service providers, the money must be spent on health care needs. A counselor or consultant reviews the list of services to ensure that the money is spent properly. The state also provides a fiscal intermediary to cut checks, pay taxes, handle associated paperwork, and be the final check on spending decisions to check for fraud or abuse.

A few other states have developed consumer-directed health care programs. For example, the Colorado Department of Health Care Policy and Financing (HCPF) developed a program, the Consumer Directed Attendant Support (CDAS) Program, which enables people with disabilities to manage their own attendant services. The same department implemented a consumer-directed care program for the elderly under which eligible people can receive a voucher to purchase home and community-based services or supports. A physician must certify that individual is able to direct his or her own care and the individual must demonstrate an ability to manage the financial aspects of the plan. The voucher program also covers assisted living.

Public programs utilizing the consumer directed health care approach are not suitable for everyone. For example, they are not intended for Medicaid waiver recipients who need case management assistance and cannot accept responsibility for their own care. Despite these caveats, proponents of the Cash and Counseling Program contend that it could provide considerable savings by inserting market forces where they have not previously been.

Conclusion

In general, consumer-directed health care is any program that includes significant incentives for consumers to stay healthy, consume health care carefully, and shop for health care in an aggressive way – all done with the goal of controlling costs. Since other attempts to control costs have failed, it is too soon to predict if this approach will have better success.

Consumer-directed health care has potential advantages for consumers in both the private sector and public sector. Consumers have more freedom of choice, less restrictions, and greater control over their health care. Consumer-directed health care offers serious challenges to consumers as well. Difficulty of decisions required and skills to successfully manage within plans may be beyond the level of effort consumers want to, or are able to, expend. If so, consumers may not make the decisions necessary to achieve individual or group goals.

The way information is presented is very important in any delivery system utilizing consumer-directed health care. Well-designed decision support tools, information displays that allow for evaluation, and other things that help consumers weigh their options are essential for success.

This issue memorandum was written by Jacquelyn Storm, Principal Legislative Attorney, and Sue Cichos, Senior Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.
