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Consumer-directed Health Care: What's the Next Stage?

Special Report

As health care costs continue to escalate, more employers are looking to consumer-directed health care (CDHC) as a cost-savings measure. However, other employers may be reluctant to jump on the CDHC bandwagon because of conflicting, and even negative, data and opinions. A leading benefits expert explains how employers should scrutinize the policy debate surrounding CDHC, with the goal of ultimately focusing on how CDHC can have practical benefits not only for health plan design, but also for larger societal concerns.

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Consumer-directed Health Care: What's the Next Stage?

By Terry Humo, Esq.

Early on in its infancy, the key question regarding consumer-directed health care (CDHC) was: Does it work? For the last two years, this has been the debate among key speakers at an annual national summit held in Washington, D.C. For example, during the 2007 summit, Rep. Pete Stark, D-Calif., and at least two other featured speakers voiced skepticism about CDHC.

But whether or not CDHC works is now the wrong debate. In fact, continued focus at policy levels on CDHC's functionality appears to be driven more by politics than genuine efforts to achieve realistic health care reform, and draws attention away from capitalizing on those aspects of CDHC that do work. There is ample evidence of successful CDHC programs; on the other hand, evidence exists that some *do not* work. Both sets of evidence can be true, as far as they go. But because CDHC is now part of the health benefit landscape — with more and more employers adopting it, and still more interested in it, as an option — what's really needed is an analysis of the data and the circumstances to determine:

- What are the factors that make some CDHC programs successful?
- How can those successes be copied by others?
- What were the factors that contributed to lack of success in other programs so that they can be avoided?

After such an analysis and nationwide sharing of successful strategies, the next step in the debate would be to focus on what other ways CDHC concepts can be applied to health care and other societal issues. For example:

- Can health savings accounts (HSAs) be used to promote national savings in ways that will reduce demands on Medicare?
- How can HSAs be used to promote retirement savings generally?
- How can CDHC generally help reduce dependence on foreign oil and general use of fossil fuels (as alluded to in the Columbia pilot project discussed later in this report)?
- How can CDHC developments in retail clinics and MinuteClinics help address problems in geographic distribution of health care providers?
- How can CDHC address the shortage of primary care physicians, lack of medical care in rural areas and lack of caregivers reflective of the cultural diversity of patients?

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In addition, comments voicing skepticism of CDHC must be scrutinized to ensure that the focus is on the success stories — and not on discussions on cost-shifting and misinformation — so we can ultimately move forward to helping resolve these larger societal issues.

The Cost-shifting Debate

One of the key arguments raised by CDHC skeptics continues to be more shifting of health care costs to consumers. The debates seem to come down to one of personal belief: Whether or not individuals should take some responsibility — financially, behaviorally or otherwise — for their own health and health care, and how that rings *politically*. But the *reality* of the health care market shows that:

CDHC Works, Says One Study

CDHC compared against preferred provider organizations (PPOs) is credited with:

- a 40-percent reduction in hospital admissions;
- a 10-percent reduction in emergency visits; and
- a 4-percent increase in preventive care visits.

Source: *CDHP Utilization, Pricing and Experience as Compared to Traditional HMOs and PPOs*, from consulting firm Reden & Anders, presented by Senior Consultant Kismet Toksu at the National CDHC Summit, September 2007)

- *There is cost-shifting without CDHC, from health care consumers/users to non-users such as employers and other taxpayers.* Costs are shifted to individuals and employers one way or another for health care of non-payers and those who need care beyond their tax or premium contributions. And as the following quote notes:

  > Whether Uncle Sam or corporate execs pay the bill, it's still your money. Corporations pay with workers' wages, and government pays with citizens' taxes. In either case, we pay [for our health care]. (Health As Human Capital Foundation, Entry 21-2007, Oct. 7, 2007, "It's Your Money.")

- *Universal coverage appears to be gaining much broader if not near universal acceptance (no pun intended) as a method under which individuals would be required to obtain coverage.* This November, The Commonwealth Fund issued a report calling for universal coverage. This begs the question, who will pay for the coverage? According to the report:

  > The Commission believes that the most pragmatic approach to achieving universal coverage in the near future is to have the financing be a shared responsibility of federal and state governments, employers and individual households, and other stakeholders.

  Such universal coverage mandates implicate that individuals will be forced to at least help pay for coverage. The implication of households sharing the cost also necessarily implicates mandated premium contribution by at least some households. That also necessarily means cost-shifting, or in The Commonwealth Fund's terms, out-of-pocket (OOP) expenses. Without getting into the pros and cons of universal coverage, what is the policy rationale behind apparent criticism of individuals sharing responsibility for health care costs through choice (as to type of coverage and cost level) like through CDHC, or being mandated to pay for a mandated level of universal coverage?

Also, an underlying assumption that there always is a "cost shift" due to CDHC can be challenged as well.

As case studies in Thompson's *Guide to Consumer-Directed Health Care* show, CDHC also may represent "savings shift" to individuals. As noted in a small employer case study, employer

premium savings by moving to a high-deductible health plan (HDHP) were sufficient to enable the employer to fund HSAs to a level to cover the plan deductible.

It's a given that the employer will not always be able or willing to cover the entire deductible through premium savings. But the case study does help illustrate that the real issues plaguing our health care cost and affordability problems need to be addressed.

Underlying the issue of cost is a more fundamental question: Should every person have some level of coverage available, and should that availability be regardless of who pays? Even if it is a plan with a high deductible? The question may be best put in context with the analogy of the glass partially filled with water: Is it half full or half empty?

Does a health policy with a high deductible that lowers premiums in order to be affordable offer a reasonable option for coverage to someone who cannot otherwise afford the premium? If the person is protected from major medical costs, which helps keep him or her from years of indebtedness or even bankruptcy, is that better than no health coverage?

This brings us back to the fundamental issue of whether individuals have some responsibility for their health and health care, and how that responsibility should be expressed.

Misinformation

Data are much more real than a personal belief. However, even data can be shaped by personal perspective. That's why it's key to carefully analyze data and observations about CDHC's potential. The need for doing so can be demonstrated based on information shared at the CDHC summit.

For example, in voicing his skepticism before summit attendees, Rep. Stark noted that Medicare beneficiaries had not chosen to take up HSAs, a key component of CDHC. He did not mention that, generally, Medicare beneficiaries are not eligible for HSAs.

An economist with The Commonwealth Fund, among other findings, cited OOP expenses for Americans enrolled in HDHPs or CDHC that are much higher than for residents of several other countries, including Scandinavian countries. There was no mention of individual income tax brackets as high as nearly 60 percent in some of those countries, such as Sweden (Source: Modern Welfare States: Scandinavian Politics and Policy in the Global Age). In the context of the presentation at the CDHC summit, the direct implication is that CDHC creates financial hardship unique to Americans.

These examples illustrate how data and observations — although accurate as far as they go — can misrepresent the big picture. Regarding the Medicare beneficiary issue, a more appropriate debate would be why aren't Medicare beneficiaries able to continue to establish and contribute to HSAs? With Medicare reported to be facing financial problems —and some seniors struggling with OOP expenses — wouldn't both Medicare fund protection and aid to seniors through use of tax-free dollars for medical expenses help address both problems?

And regarding the allegedly higher OOP examples, whether you pay OOP or through taxes, you still pay. Let's say you earn $70,000 a year. Would you prefer to pay $42,000 in taxes (at a 60-percent tax bracket) or $5,600 OOP – the maximum allowable OOP for an individual under an HSA-compatible HDHP? An HSA's maximum allowable OOP cost for 2008 is $5,600 for an

individual. To be fair, this is not a valid comparison any more than was the economist's comparison because the entire $42,000 would not be health coverage costs. But it does help show how some arguments supposedly supported by data warrant much more scrutiny.

The HSA Conundrum

Another example of misleading information involves reports on the level of HSAs' popularity among enrollees. Some reports say HSAs are not popular with individual consumers. Others report the opposite and show that HSA use is expanding due to popularity.

For example, one report indicated that the number of HSAs as of December 2006 was 3.1 million — representing a net gain of two million over the course of the year — and projects that 4.75 million HSAs will be opened by January 2008 (CDHP Utilization, Pricing and Experience as Compared with HMOs and PPOs, Reden & Anders, presented by Kismet Toksu, senior consultant, National CDHC Summit, September 2007).

However, more accounts may be opened in large part because employers are encouraging their use through financial contributions. This does not mean that the HSAs are increasingly popular proportional to the increase in numbers of accounts.

What might be a more productive debate, therefore, is why are HSAs successful and popular with some employers and employees and not with others?

Informal discussions with sole proprietors indicate anecdotally that those who sell or promote HSAs sometimes do not understand the details and turn off individuals to setting up the accounts. However, when armed with accurate information, HSAs become attractive.

Successful HSA programs, for example, have been associated with aggressive involvement by senior management of employers offering the programs, and extensive education and communication programs. (Reden & Anders, CDHP Utilization, Pricing and Experience as Compared With HMOs and PPOs, presented by Kismet Toksu, Senior Consultant, National Summit 2007.)

Similar results were reported by employers selected for case studies in Thompson's *Guide to Consumer-Directed Health Care*. With a mid-sized employer, 21 percent of employees representing a demographic cross-spectrum of all employees who had a choice of PPO, HMO and HSA options (which means they also had an HDHP option) chose to participate in HSAs. As a first-year offering, that participation percentage exceeded national norms and even the employer's expectations. The extraordinarily high participation rate was attributed to senior management endorsement and an aggressive communication and education program.

What About Wellness?

There's also a lot of misinformation about wellness, which is a critical and burgeoning area of CDHC. Wellness programs cover a broad spectrum of designs, from case and disease management with individual care monitoring and individual health coaching to simple, inexpensive programs. With such programs typically come the following questions:

- Why wouldn't employers want to have a healthier workforce?
- Why is it necessary to have a bank of data saying that employer, if you do this healthy measure, your employees' health will increase by X and your health care costs will go down by Y?

But these are the wrong questions to ask because some programs that intuitively would seem to work may not in reality, and bring undesired results. Some programs may actually cost way beyond any return. Having accurate and full data can help ensure that the right programs are established for the right people.

Several studies have shown that incentives get people engaged in healthy lifestyles. At least one study has shown the correlation of increasing levels of incentives and levels of engagement in healthy lifestyles. Examples run from very modest programs, such as holding healthy behavior meetings, to significant employer contributions to HSAs.

Among success factors that appear to be emerging among employer wellness programs are simple exercise programs that include employer incentives and active leadership from employees themselves. And they appear to be among the cheapest types of wellness programs. Nutrition and smoking cessation programs, which are modest in price by comparison to disease and case management programs, for example, still are more costly than exercise programs. To illustrate:

> In western Montana, a local medical facility introduced an award-winning wellness program that included a walking/hiking program called "Going to the Summit Challenge," a take-off from the nearby Going to the Sun Road in Glacier National Park. While a number of trails offered for hiking enabled participants to gain points, volunteers set up courses through the campus and — to accommodate what can be cold and snowy winter weather — included "trails" through various buildings to take advantage of staircases. The objective was to get employees to exercise through walking.
>
> Participants earned 10 points a day for each day of 30 minutes exercise up to 50 points a week. Prizes such as hiking poles and hydration packs were awarded and helped provide incentive.

The Montana program underscores certain issues remaining for employers in CDHC. How is the health value of such a program measured? While numbers of employees hiking as a ratio of total employee population is a measure of participation, it does not measure the health benefits gained. What may be measured over time are:

- reductions in paid sick days
- reduced rates of presenteeism
- improved employee attitudes and reduced incidents of depression
- reduced weight, lower BMI ratios, lower blood pressure, lower blood sugar levels, etc.

The refining of wellness programs illustrates the maturation of CDHC, which has moved from general discussion and more heavily theoretic to ground-level experience and success. With the financial successes and improved health outcomes now in evidence from CDHC, and from wellness programs in particular, the more appropriate topics for debate include:

- What programs work and work best?
- What other measures are emerging?
- With the availability of measures, why aren't employers applying them?
- If measures are being applied, are they being applied effectively?
- What factors make the programs successful?

- Which elements produce the best results and may be transferable to other programs or other employer groups?
- How do we as a society capitalize on those success factors or, in other words, how do we develop local, state or national policy to help spread those successes more broadly around the nation?

For examples of successful employers in designing and setting up wellness programs from sophisticated case management programs to simple exercise and weight watcher programs, see the case studies in Thompson's *Guide to Consumer-Directed Health Care.*

The Cost Savings of Physical Activity

A successful component of wellness is physical activity. A Humana official at the national CDHC summit cited various sources in providing the following data, which might be a good topic for debate:

From the World Health Organization:

Physical activity programs can:

- reduce short-term sick leave by six percent to 32 percent;
- reduce health care costs by 20 percent to 55 percent; and
- increase productivity by two percent to 52 percent.

From the U.S. Department of Health & Human Services:

- In 2000, health care costs of more than $76 billion were associated with inactivity; while
- potential savings of $5.6 billion in heart disease costs are projected if 10 percent of adults begin a regular walking program.

A California study that measured both direct and indirect costs of inactivity, obesity and being overweight:

Lifestyle risk factors are costly, they report, to the tune (or sour note) of:

- $1.56 million per 1,000 lives for inactivity;
- $1.046 million per 1,000 lives from obesity; and
- $175,000 per 1,000 lives for being overweight.

While these data will be useful in the beginning stages of any debate, ultimately, a more heightened analysis might address:

1) What are the measures for determining cost savings (real and/or projected) due to improved health and over what period?
2) How are people motivated to engage in healthy physical activity in the first place?
3) Once engaged, what will continue to keep people motivated to stay physically active?
4) To what extent do we as a society expect individuals to assume at least some responsibility to take care of themselves physically, and how is that acceptance or failure to accept rewarded or penalized, respectively?
5) Tied to the latter, should nondiscrimination laws as expressed in the Americans With Disabilities Act and HIPAA be revised to permit penalties for failure to accept such responsibility among those capable of taking responsibility?

A More Appropriate Focus

As indicated by independent studies and presentations at the national CDHC summit, among other evidence, CDHC has matured and started refining focus on its components. Such refinement helps illustrate problems of misinformation in the past, and shows how a more appropriate focus can help achieve improved financial results and health outcomes.

A look at two recent studies on prevention, a fundamental component of CDHC, is illustrative.

Evidence that prevention as a means to curbing health care costs is not necessarily what it seems was presented in The National Coalition on Health Care's report "Prevention's Potential for Slowing the Growth of Medical Spending." As the report states:

> The evidence does not support the commonly accepted idea that prevention always, or even usually, reduces medical costs — although it sometimes does. Most preventive interventions add more to medical costs than they save, at the same time that they improve health.

Wait a minute; this is supposed to be about how prevention can slow medical spending. Are we being misled? No. The report needs to be put in context. As the report continues:

> But even that statement [quoted above] needs to be made more specific. Preventive interventions need to be evaluated individually. Some, like smoking cessation programs, may be good investments almost regardless of how they are applied — they bring additional good health at a very reasonable cost. Other interventions are good investments when used selectively — targeted at those people who benefit most from them — but not such good investments when used for more broadly defined groups of people.

The study gives one example: vaccinations. The cost to provide vaccines, $35 for a chickenpox dose in the mid 1990s, raised medical spending. But in the abstract, "when parents' time and children's future earnings were counted, the … vaccine 'would save' more than $5 for every dollar invested in vaccination."

This report points out the difficulty in showing savings that are soft, compared with costs that are hard and how, if taken out of context, a report can say one thing, but in full context can be more meaningful. And the report reflects the refinement that is starting to take place in the maturing CDHC environment.

Among issues this report puts on the table for debate include how do you put a value on the disease that is prevented, or on the extra months or years a person lives productively through changed behavior and adoption of a healthier lifestyle?

Already, there is a start to answering the question. A study from the Milken Institute extolling the virtues of prevention finds that the annual economic impact on the U.S. economy of the most common chronic diseases is more than $1 trillion, and could reach nearly $6 trillion by the middle of the century. Yet, the institute says, the news is not entirely grim because much of this cost is avoidable.

This study, according to its authors, brings to light for the first time what is often overlooked in the discussion of the impact of chronic disease — the economic loss associated with preventable illness and the cost to the nation's gross domestic product and American businesses in lost growth. The study is the first of its kind to estimate the *avoidable* costs if a serious effort were made to improve Americans' health in the context of certain identified chronic diseases.

Both reports illustrate the more refined and realistic evaluation of CDHC concepts and what can be achieved. A CDHC opponent could take the former study and, out of context, say, "I told you so. CDHC preventive measures actually contribute to costs." And the statement would be accurate, as far as it goes, but a misrepresentation when out of context.

The two reports also show that with proper focus on what works and how, more cost-effective steps can be taken that do improve health outcomes, such as by focusing efforts on specific chronic diseases, and targeting groups with special health care and/or behavioral needs that can produce greater return on investment. There also is evidence that measures are emerging to quantify at least to some extent the cost or savings from preventive steps.

The Grand Scheme of Things

Skepticism toward CDHC may stem in part from looking at it in a vacuum rather than as an integral part of greater national concerns and issues. Rather than framing the CDHC debate around a cost-shifting issue, the discussion could be on how do CDHC and overall health care system reform work in concert with other initiatives addressing different societal issues — such as the environment and transportation — that have other implications for health and health care. Consider the following:

> Columbia, Mo., home of the University of Missouri, along with three other communities received grants to develop transportation choices and change culture. A goal of the Columbia project is to reduce dependence on cars for transportation and instead get Columbians on a hiking and biking trail system ("Heels and wheels," *Mizzou* (the magazine of the Mizzou Alumni Association), Summer 2007). The system is being designed to encourage residents to do their grocery shopping, go to work, or see a movie using alternative forms of transportation, that is, legs and bicycles. In addition to transportation issues, the pilot project helps address an obesity epidemic and more general problems of excess weight. The project will include a series of programs to change behavior.

If we do not have individuals take responsibility for their health in both behavior and financing, if we do not have transparent health care quality and cost, if we do not push healthy lifestyles in meaningful and lasting ways, if we do not capitalize on the successes that CDHC is producing, what then? And how then do we get to the point where we address our society's larger concerns?

To misquote an old Chinese proverb: If we do not change our course (in health care), we are sure to reach where we are now headed. CDHC is a change in course. So while skeptics may create obstacles to CDHC, they also bring value by helping to galvanize those involved in CDHC, forcing critical self-evaluation by the CDHC industry, encouraging healthy (pun intended) debate on what is working and examining how efforts to achieve a healthier population in a more sound economic environment are succeeding. Ultimately, this can evolve into applying CDHC concepts on a broader scale.

The ‘Big Three’ Issues

Other, broad CDHC issues already are being addressed, particularly the seemingly endless issues regarding health information technology, transparency and health care quality.

In a significant and positive development, the Robert Wood Johnson Foundation is reported to have recently announced grants to find a national approach to measuring health care quality and cost.

The development raises other issues that also go to the core of the CDHC debate, to include:

1) Issues of health care quality and transparency have been around for well over a decade. Why is it taking so long to have national standards or at least established, universal and standardized national policy on health care quality and transparency?

2) What are the real obstacles to achieving transparency and quality measures?

3) How should those obstacles be addressed?

To illustrate issues and criticisms raised that need to be explored and discussed in a neutral, objective setting to establish policy, consider arguments against transparency by some physicians and other skeptics: that consumers do not have the requisite knowledge to make decisions about what is appropriate health care for them. This raises issues for debate such as:

- Is the health care illiteracy a function of not having had good medical information available in the past?
- Is there an underlying belief that consumers do not have the intelligence to understand information about their own health and medical conditions?
- Is there an underlying belief that patients, when offered medical information in an educational setting, are incapable of learning and understanding care and treatment related to their own medical conditions? That question necessarily has to be considered in the context of whether adequate medical or health personnel exist who are capable of educating consumers.
- Is keeping consumers uneducated the solution?
- Will providing accurate health information and education more likely help consumers manage their own health and health care?

Finding Out More

CDHC issues are covered in the *Employer’s Guide to Consumer-Directed Health Care* and the *Employer’s Guide to Self-insuring Health Benefits*, both published by Thompson Publishing Group. Both products will be doing follow-up articles based upon this special report.

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