

Consumer-Directed Health Plans (CDHPs):

Background, Structure, and Policy Issues

by

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Executive Summary

Consumer-Directed Health Plans (CDHPs) are a new model of health insurance, designed to give consumers greater control over the quantity and quality of the health care they receive. CDHPs provide consumers with financial incentives to manage their health care expenditures more efficiently. They also increase consumers' power to choose among different treatment options.

- CDHPs are designed to slow the rapid and unsustainable rate of expenditure growth in health care and to increase consumer satisfaction with their care.
- The RAND Health Insurance Experiment (HIE) of the late 1970s and early 1980s demonstrated that if consumers bear higher costs of health care, they will reduce their consumption. With few exceptions, they will do so without negative effects on their health.
- CDHPs combine elements of several insurance arrangements which unsuccessfully sought to restrain health care expenditure growth. These included deductibles, copayments, managed care, and medical savings accounts.
- Almost all CDHPs share three characteristics: a high deductible; an employer-financed, employee-controlled personal spending account; and an information system that assists consumers in making informed choices. Spending accounts at present include Health Savings Accounts or Health Reimbursement Accounts.
- Some CDHPs offer tiered premiums, benefits, copayments, and deductibles.

Because CDHPs are so new and because they are still a small part of the insurance market, there is insufficient evidence to back strong claims by either critics or supporters. Only an extended trial period and a broad expansion of CDHPs can provide such data. Responses to some critics' concerns include:

- There is insufficient evidence that CDHPs will lead to risk segmentation. And there is insufficient evidence to demonstrate that segmentation would lead to deleterious effects on health.
- CDHPs have been shown to appeal to people across income levels. The earliest purchasers have tended to be relatively wealthy, probably because the earliest customers are sufficiently educated to accept the challenge of a dramatically different financial product.
- CDHPs will likely shift control of health care, rather than the cost of health care, from employers to employees.
- CDHPs are not panaceas that will solve all the health care system's problems. They are unlikely to tame expenditures by those with expensive illnesses. They may not assure universal insurance coverage. In this, they are like every other type of health insurance available today.
- The RAND HIE does not provide evidence that CDHPs will harm the health of the poor. Nor can critics demonstrate that enrollees will skimp on vital care.
- Information systems for CDHPs are only beginning to develop. Like the Internet, they will grow, evolve, and improve as the CDHP market develops.
- Consumer surveys indicate that CDHP enrollees are relatively satisfied with their plans and would likely recommend them to friends.
- Legislation currently under consideration would allow CDHPs to expand and adapt.

Introduction

CDHPs are a new model of health insurance, designed to give consumers greater control over the quantity and quality of the health care they receive. CDHPs provide consumers with financial incentives to manage their health care expenditures more efficiently. They also increase consumers' power to choose among different treatment options.

Two big motivations underlie the development of CDHPs. First, non-CDHP insurance gives consumers little motivation to manage their health care expenditures efficiently. Second, managed care (HMOs, PPOs, etc.) has sharply limited consumers' capacity to determine the type and quantity of medical treatments they receive.

Most health insurance today encourages consumers to underspend on some kinds of care and overspend on other kinds because in both cases someone else bears the financial costs of their choices. For example, consumers may devote too few resources to preventive care because they expect insurance to cover the costs of health problems that occur years later. They may also choose expensive medications over equally effective but far cheaper drugs, once again because someone else will pay.

Managed care has taken many decisions out of the hands of the consumer and placed them with health care providers and with insurers. Health plans tell consumers which doctors, hospitals, drugs, and treatments are covered and which are not. Often the ultimate decision on coverage comes in the form of a "no" from a voice on a 1-800 number. Rather than accepting one-size-fits-all modes of care, CDHP consumers can tailor their treatments to their own individual preferences.

CDHP consumers are generally freer than participants in other plans to choose among different providers and treatment options. In exchange for greater freedom, consumers face direct financial ramifications of their choices; more spending means less money in their pockets. Yet CDHPs are structured financially so that these choices do not force them to bear catastrophic financial risks. This

arrangement is likely to be a critical component in controlling the rise in health care expenditures, now amounting to 16% of U.S. GDP.

The term “consumer-directed health plan” includes a variety of institutional structures, but most policies share a few common characteristics – a high deductible, an employee-controlled, employer-funded personal spending account, and an information system to assist consumers in making educated health care choices. Many offer tiered premiums, benefits, copayments, and deductibles under different circumstances, thus encouraging – but not requiring – one choice over another. As of 2005, CDHPs had over three million enrollees, and the rolls were growing rapidly.¹

There is strong evidence that, given the proper tools, consumers are competent to make many medical choices, particularly if they are asked to make some of them when they are in good health, rather than asking them to make such choices after they are already in the midst of a health crisis. The classic RAND Health Insurance Experiment (HIE) provided powerful evidence that costs strongly affect health care consumers’ choices. When consumers bear the marginal cost of treatment, they spend less on health care. The HIE also indicated that these consumer-driven cutbacks have little negative impact on health for most people.²

CDHPs have opponents in the public policy community, and the pages that follow will outline and respond to these criticisms. In summary:

- CDHPs are too new and too few in number provide strong evidence about their efficacy or shortcomings. Existing evidence is contradictory, but many early indications are highly favorable;
- Some arguments raised against CDHPs are equally applicable to other forms of health insurance. These arguments are no more unfavorable to CDHPs than they are to HMOs, PPOs, etc.;
- Claims that CDHPs might harm the poor and the sick are, again, based on weak evidence, contradicted by other evidence. Even if there are such problems at present, it is not difficult to argue that the solution comes not in stifling CDHPs, but rather in improving the information

systems designed to assist the poor and sick and in allowing the disadvantaged group to move up the learning curve. For a model, one can remember that cell phones and the Internet were originally devices for the elite; only with time were these technologies adopted by lower-income users.

- Critics fear the CDHPs will absorb low-cost patients and leave high-cost patients in policies with high premiums. Once again, no strong evidence of this has emerged. Even if risk segmentation is a fact, there are ways to protect those in non-CDHP plans. And one can argue that such segmentation has already occurred with non-CDHP policies.
- CDHPs are only one tool in reforming our health care system and cannot solve all problems. So it is important at the outset for supporters to recognize that CDHPs are not panaceas. They alone will not perfect a health care system in need of many repairs. CDHPs are one promising tool, perhaps an extremely important one, but not the answer to all problems. An old maxim warns against allowing “the perfect to be the enemy of the good.”³ Whether purposely or inadvertently, many critics of CDHPs do exactly that.

Background

Consumer-driven health plans are the culmination of several decades of grappling with rapidly rising expenditures on health care. From at least the early 1970s, the growth rate of health expenditures has been a concern to employers, governments, and individuals. Because of demographic trends and technological progress in health care, growth rates, if left unchecked, are expected to consume startlingly high percentages of GDP and of government budgets as the century progresses. CDHPs are one means – and only one means – of restraining this problematic rate of growth.

In the late 1970s and early 1980s, the RAND Corporation conducted a massive experiment to examine how out-of-pocket costs affect consumers’ health care choices and how those choices affect their

health. The Health Insurance Experiment (HIE) helped give rise to a series of financial arrangements aimed at restraining health care expenditure growth. Among them are deductibles, managed care, and medical savings accounts (MSAs). None of these arrangements alone succeeded in slowing growth for more than a short period of time.

Now CDHPs combine elements from all of these arrangements. To understand CDHPs, it helps to understand the Rand Experiment and the financial arrangements that led up to the development of CDHPs.

Health Care: Rising Expenditures, Consumer Dissatisfaction: The primary motivation for CDHPs is to help control the growth of health care expenditures, which have risen from around 5% of U.S. GDP in 1965 to around 16% in 2006. That figure is forecast to hit 20% within around a decade, as the baby boomers age. By mid-century, forecasts are that, left unchecked, health would consume one-third of GDP.⁴ There is also a widespread perception that the current level of spending is too high. Joseph Newhouse wrote, “The players may have changed over the years, but the game remains the same: how best to stem the persistent tide of rising health care costs.”⁵ To put it in dollar terms, the average American is projected to spend \$6,830 per year on health care in 2006; in 1960, the figure was \$143, or \$978 in 2006 dollars.⁶

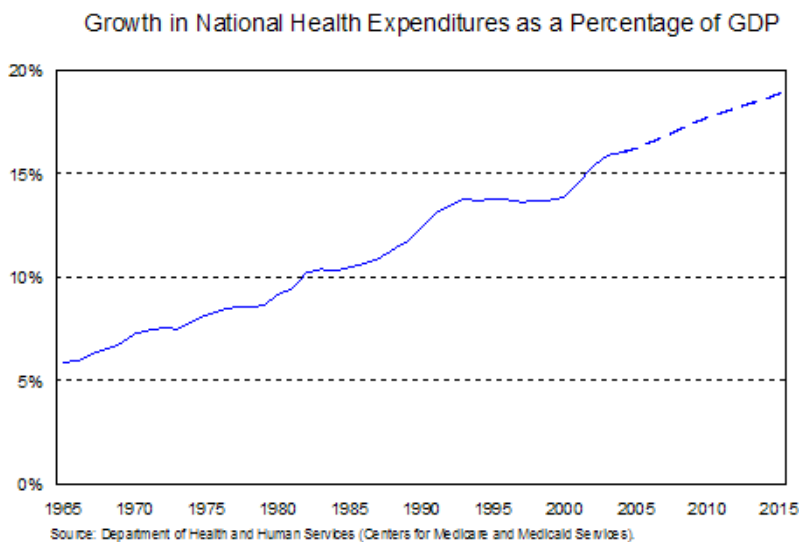


Figure 1⁷

It is probably safe to say that most observers believe that health expenditures are rising too quickly. They differ on whether the blame lies with price, quantity, or quality. Prices for given services may be rising too rapidly. We may be buying too many units of health care. We may be purchasing higher-quality services than is necessary or optimal. And they differ on what to do about it.

The current growth path of health care expenditures is unsustainable. Left unchanged, the level of services promised under current Medicare law would consume most of the federal budget by mid-century.⁸ Medicaid expenditures are already crushing state budgets, setting in motion a game of cost-shifting among the states, the federal government, private employers, and individuals.⁹ Employers face rapidly rising health insurance bills for their employees.

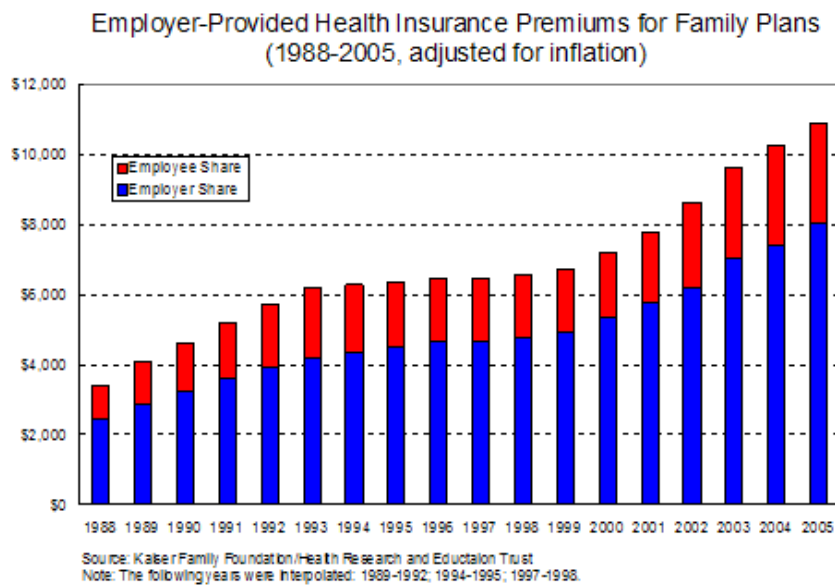


Figure 2¹⁰

Thus, expenditures on health care are set to rise considerably faster than are the currently expected public and private revenues into the system. Theoretically, there are five ways to fill this gap, most of which would not likely succeed. Higher economic growth rates would provide relief, but cannot be manufactured by fiat. Massive tax increases would reduce economic growth, undermining their capacity to fill the health care gap. Forcing down health care industry profits and incomes could lead many providers and insurers to exit the market. Cost-reducing technological progress in health care can be

hoped for and worked toward but, like higher economic growth, cannot be relied upon or willed into being. Restrained demand for health care services is the likeliest means of balancing health care revenues and expenditures.

It has been estimated that half of the growth in health care expenditures is attributable to technological innovation.¹¹ That in itself is not a problem; consumer electronics purchases have risen rapidly, thanks to technological innovation, but no one complains about a “consumer electronics crisis.” In the case of consumer electronics, however consumers have to weigh the marginal cost and marginal benefit of each purchase. A \$300 MP3 player means \$300 less to spend on other things. Every consumer knows this, and it takes no special education to understand the concept. No such control exists in much of health care spending. With consumers willing to freely spend other people’s money, the medical community has an excessively strong motive to develop and disseminate expensive technologies, even when cheaper, adequate technologies already exist.¹² This is where CDHPs can change incentives.

A maxim attributed to the late economist Milton Friedman is that: “Nobody spends someone else’s money as carefully as they spend their own.” Humorist/political columnist P. J. O’Rourke echoed this notion more flippantly: “If you think health care is expensive now, wait until you see what it costs when it's free.”

The paramount motive behind CDHPs is to motivate consumers to restrain their health care expenditures, by using lower-cost providers, by choosing less expensive services over similarly effective expensive services, and by limiting the use of services that provide relatively little benefit on the margin. That notion is predicated on the idea that health care is overutilized.¹³ And the idea that health care is overutilized has had strong empirical support for thirty years in the evidence derived from the RAND Health Insurance Experiment (HIE).

Rand Health Insurance Experiment: Though thirty years old, the RAND HIE is probably the single most important piece of research in all of health economics. From 1974 to 1982, 5,809 individuals were randomly assigned to different health insurance policies, differing primarily in the degree of cost-sharing

between insurer and insured. The subscribers were assigned to policies which required patient copayments equal to 0%, 25%, 50%, and 95% of the cost of care, with a deductible of \$1,000 (over \$3,000 in CPI-adjusted 2006 dollars). The policies also included a stop-loss limit of \$1,000 (lower for low-income subscribers). The RAND HIE was one of the largest randomized experiments in the history of economics, and the data developed through the study still generate new results. Three overarching findings emerged.¹⁴

- **Higher costs lead consumers to reduce expenditures on health care:** For example, those paying 95% copayments used 25-30% less care than those with a 0% copayment. Patients with higher copayments saw doctors less frequently and were hospitalized less often. Less was spent by all income groups.
- **The reduced expenditures on health care have little or no negative impact on the health of consumers:** The RAND researchers maintained records on subjects' physical, mental, social, and dental health, including disability days, symptoms, and health habits. For most variables, there was little or no change across the different groups. A paper published by the researchers stated: "Our results show that the 40 percent increase in services on the free-care plan had little or no effect on health status for the average adult."
- **Economizing generates some negative impacts on poor and sick consumers:** Among those who were both poor and sick, the reduced health care spending did have some impact on health status, including poorer maintenance of hypertension, oral health, and corrected vision.

The mixed message from the latter two results enabled the HIE data to become something of an oracle in which "Those on the political left generally espoused the view that the services were necessary; those on the right, that they were unnecessary."¹⁵ Despite the resulting debate on whether cost-sharing diminished "necessary" vs. "unnecessary" expenditures, the RAND HIE can be characterized as the starting point for CDHPs.

Managed Care: The past three decades have seen three distinct developments, all aimed at damping the rise in health care spending. In the early 1970s, before and during the RAND HIE, the emphasis was on finding the optimal copayments and deductibles. This meant subjecting patients to enough of the marginal cost of care, so that they would temper their demand for health care. But “optimal” also meant that the copayments and deductibles would not be so large as to subject patients to financial hardship. Reducing the risk of such hardship, after all, is the primary purpose of insurance.¹⁶

By 1980, rising health care expenditures had become a serious concern. Cost-sharing, in the form of deductibles and copayments, had not stopped the rapid increase in health care expenditures. The deductibles and copayments were still small relative to the total cost of services, so consumers only felt a small impact of the cost of a service. In response, U.S. employers turned to managed care, which sought to restrain expenditure growth from the supply side, rather than from the demand side.

Under managed care, providers and insurers, rather than consumers, would determine the quantity and quality of health care that patients received. Plans fell into several categories, whose characteristics can generally be described as follows:¹⁷

- **Health Maintenance Organizations:** HMOs require few out-of-pocket expenses and provide a comprehensive array of services. They are designed to hold down costs along both price and quantity dimensions. All care must be delivered through a pre-determined network of providers, and an HMO uses market power, financial incentives, and provider oversight to force prices down. The patient’s primary care provider (PCP) must authorize use of most services, thus limiting the quantity of services consumed.
- **Preferred Provider Organizations:** PPOs feature tiered networks. Subscribers are reimbursed at a high rate when they use the services of a provider who belongs to the PPO. They are reimbursed at a lower rate if they use an outside provider. The lower out-of-pocket costs encourage subscribers to use in-network providers. The in-network providers charge lower rates in exchange

for this higher expected volume of business. Providers often agree to utilization review by the PPO in cases of hospitalization and other expensive services.

- **Point-of-service Plans:** POSs combine features of HMOs and PPOs. Like HMOs, POSs assign a gatekeeper to each patient. Like PPOs, POSs featured tiered coverage for subscribers using in-network and out-of-network providers.

In sum, managed care was designed to economize by taking the power to make health care decisions away from consumers, transferring this power to providers and insurers. Consumers faced strict limitations on which providers they could see, which services they could receive, and how much of each service they would be allowed to consume.¹⁸

Medical Savings Accounts: Managed care did restrain health care spending for a while. In the period 1993-1997, the rate of increase in inflation-adjusted health care expenditures dropped to its lowest point since World War II, but this was short-lived.¹⁹ After a few years, expenditure growth returned to its previous high rates. And the restrictions on consumer choices created a permanent source of conflict between consumers, providers, and insurers.

After the Clinton health care proposals failed, attention returned to demand-side solutions. Medical Savings Accounts (MSAs) were authorized under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).²⁰ Employers contributed funds to an IRA-type account. Employees could use these funds to purchase high-deductible catastrophic insurance and to pay non-reimbursable out-of-pocket costs. Employees owned the residual funds. As with an IRA, they could use the funds for any purpose upon retirement or some other pre-determined date. And they could be withdrawn prematurely, with payment of taxes and a penalty.²¹ MSAs were designed to discourage consumers from purchasing health care of marginal value. Each health care expenditure from the MSA reduced retirement savings, thus providing a powerful motive to economize.²²

MSAs enjoyed only modest success, in large part because HIPAA severely limited their viability. The law authorized a maximum of 750,000 MSAs, available only to the self-employed and those working for firms with 50 employees or fewer. Relatively few households signed up, and new enrollees are now prohibited. While MSAs did not flourish, they set the stage for today's more promising CDHPs.

The Structure of Consumer-Driven Health Plans

There is an open discussion as to whether CDHPs are a substitute for or a complement of managed care. Managed care is largely a supply-driven concept, with providers and insurers imposing choices on consumers. The emphasis in CDHPs is demand-side, with the responsibility for choices resting largely with consumers. CDHPs and managed care can be viewed as complements, or partners. The RAND HIE showed that high out-of-pocket costs affected how likely one was to seek medical attention, but had little impact on how much they spent once they sought care.²³ Managed care, on the other hand, focuses mostly on controlling costs once a patient receives help, rather than on discouraging unnecessary visits.²⁴

CDHP seeks to do both of these things – to control the number of visits to providers and the amount spent after walking through the door. Today's CDHPs combine elements of all the prior plans described above. Like the plans of the 1970s, they use deductibles and copayments to discourage frivolous, unnecessary, or low-value health care. Like managed care, they involve networks designed to guide consumers toward efficient consumption of services. CDHPs have spending accounts similar to MSAs, so that consumers feel the marginal cost of health care spending without facing undue financial risk. Like HMOs and POSs, these plans may employ gatekeepers. Like PPOs and PSOs, they may differentiate between in-network and out-of-network providers.

There is no universally agreed-upon definition of a CDHP, but virtually all share three elements: a high deductible; a tax-free, employer-funded, employee-managed account; and an information system to

guide consumers in making their health care decisions.²⁵ And many employ tiered premiums, tiered benefits, and tiered deductibles and copayments.

High deductibles: On the margin, consumers in CDHPs bear a substantially higher financial burden for health care spending than do subscribers on more traditional managed care plans. In 2004, the average deductible for covered workers in employer-based plans was \$221 – a 50% increase in real dollar terms over the 2000 level. In contrast, CDHPs have minimum deductibles of \$1,000 for individuals and \$2,000 for families.²⁶

Employer-funded, employee-managed accounts: The CDHP subscriber bears the marginal cost of the high deductible, but only after the employer creates a health spending account and places it under the control of the employee. There are two main types of health accounts offered today – Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).²⁷

- **Health Savings Accounts (HSAs)** were established in 2003 under the Medicare Prescription Drug, Improvement, and Modernization Act. They are structurally similar to an IRA. Either the employer or the employee can contribute to the fund, which earns interest that is not taxable until the funds are withdrawn. Funds can be withdrawn tax-free to pay for medical expenses. Prior to age 65, funds can also be withdrawn for non-medical purposes, though taxes and penalties will apply. The employee owns the HSA. Unused funds can be rolled over to later years, and the accounts remain the property of the employee if he changes jobs. HSAs must be combined with a deductible of at least \$1,000 for an individual and \$2,000 for a family. The maximum annual contribution is the lesser of the deductible or \$2,600 for an individual and \$5,150 for a family. HSAs are available to all individuals and employer groups.
- **Health Reimbursement Accounts (HRAs)** were authorized by the U.S. Treasury in 2002. Similar in motive to HSAs, they differ in some substantial ways. Unlike HSAs, HRAs are employer-funded only. They are the property of the employer and unused funds must be surrendered by the employee if he changes employers. Unused funds do carry over from year to

year, but can only be used for health care. HRAs are typically offered in conjunction with a high-deductible plan, but there is no legal requirement that this be the case.

Health care information system: To return to where we started, these cost-sharing arrangements are designed to give consumers the incentive to cut costs. A corollary to this is that it pre-supposes that consumers can figure out how to cut costs and, in particular, how to do so with little or no negative impact on his health.

The RAND Health Insurance Experiment (HIE) demonstrated that, with the proper incentives, consumers would cut their health expenditures and that they would generally do so without peril to their health status. Importantly, the RAND researchers provided little in the way of information for subjects to use in making such decisions. And they did so in a time when health care information was difficult for a layman to obtain.

Today's consumers live in a world in which some information on health care is plentiful and inexpensive. webMD.com and other Internet sources provide consumers with cheap, easy access to cost and health information. Many provider report cards are available online.

CDHPs provide their subscribers with additional information, not easily accessible by the general public. The purpose is to simplify the task of comparing costs and comparing the health outcomes of different treatment options. While CDHP information systems differ widely, some of the common features include:²⁸

- Information on health risks and available screenings and diagnostic tools. Examples are mammograms, prostate checks, blood-sugar and cholesterol tests, prenatal genetic tests and sonograms.
- General health education information. Examples include information on specific illnesses.
- Risk-reduction and lifestyle behavior suggestions. Examples would be advice on alcohol, tobacco, and drugs; advice for pregnant women, fitness guidelines, driver safety information.

- Information on self-care, such as breast self examinations.
- Information on group wellness activities, such as Weight Watchers.
- Disease management information for those with illnesses or high risks of illnesses.
- Lists of options available to those with specific health care needs.
- Directories of providers, pharmacies, hospitals, therapists, clinics, etc.
- Lists of websites containing useful information.
- Information on insurance benefits and claims history.
- Online personal account information, including available funds and usage of services to date.
- Online access to providers for appointment scheduling, drug refills, consults, and test results.

Tiered costs and reimbursements: High deductibles, personal spending accounts, and information systems are present in almost all CDHPs. Many also employ tiered arrangements for costs and reimbursements across several dimensions:

- **Tiered benefits across providers:** Like PPOs, some CDHPs reimburse at different rates for providers within the plan's network and those outside of the network. Higher out-of-pocket costs for out-of-network providers encourage consumers to choose in-network providers, with whom the plan has typically negotiated lower costs. Similarly, CDHPs employ tiered pharmaceutical lists, as do many non-CDHPs.
- **Tiered premiums across networks:** Some plans charge low premiums for a narrow network of providers and higher premiums for a larger network. As with tiered benefits, the lower costs for the narrow network encourage consumers to use the lowest-cost providers.
- **Tiered copayments and deductibles across services:** Some plans waive deductibles or copayments for preventive services, thus encouraging consumers to take actions which prevent

expensive illnesses later on. Some employ lower copayments for services over which the consumer has relatively little discretion.

Cost-sharing, hypothetical example: Figure 3 shows the cost-sharing profile for a hypothetical CDHP consumer as his health care expenses rise from \$0 to \$6,000 over the course of a year. This policy features a \$1,000 HRA, a \$2,000 deductible, 20% cost sharing for covered services, and a \$1,400 out-of-pocket maximum for the year. These features yield four distinct segments:

- **HRA:** The employer deposits \$1,000 in the employee's HRA, and the employee's first \$1,000 in expenses are paid from this fund. At this point, the employee is even for the year. He has accumulated no funds to roll over for the future, but he has not paid any out-of-pocket expenses.
- **The doughnut hole:** A common characteristic of CDHPs is the "doughnut hole," a range of health care costs in which the consumer has exhausted his HSA or HRA, but has not yet met the deductible. Thus, in this range, all expenses are paid out-of-pocket by the insured. In this case, the employee pays 100% of the cost of the second \$1,000 in expenses – up to the point that the \$2,000 deductible is reached.
- **Cost-sharing:** After the deductible is reached, the insurance policy's reimbursement kicks in and begins reimbursing the consumer for expenses. Here, we suppose that the catastrophic policy covers 80% of costs in this region, leaving the remaining 20% as out-of-pocket costs for the consumer. In a real policy, the cost-sharing arrangement over this segment may be considerably more complex. Coverage may be higher for some services than for others, a possibility discussed a few paragraphs below this one. In the diagram, this segment continues until overall expenditures for the year total \$4,000. At this point, the consumer's out-of-pocket expenses total \$1,400, which is the sum of the \$1,000 doughnut hole and the consumer's \$400 responsibility for the next \$2,000 worth of health care costs.

- **No cost-sharing:** Once the out-of-pocket maximum is reached, the consumer bears no additional costs on the services he uses. In this segment, the catastrophic policy covers 100% of the costs of services received.

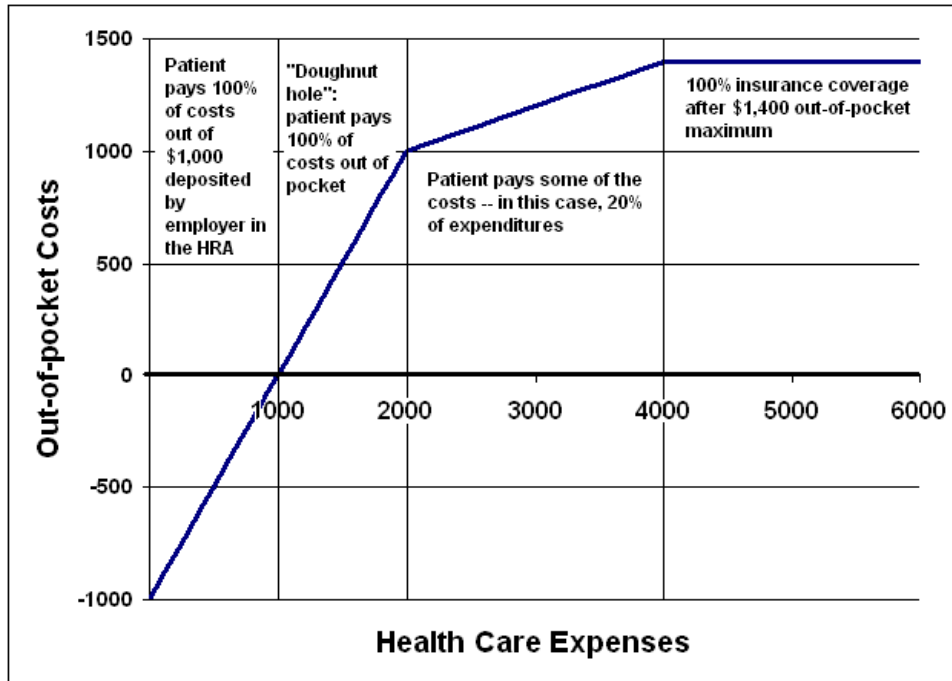


Figure 3

Again, the policy described here is hypothetical. In today's market, an employer might deposit \$600-\$1000 per year into an individual's personal spending account. The deductible might be in the \$1,000-\$2,000 range, leaving a doughnut hole of \$400-\$1000. A typical out-of-pocket maximum would be in the range of \$1,500-\$3,000.²⁹

CDHPs: Concerns and responses

CDHPs are highly controversial in public policy circles. This section reviews major criticisms offered by opponents and offers arguments to the contrary. The first thing to understand is that there are not yet enough people enrolled in CDHPs and not enough time has yet passed since the inception of these plans to provide substantial evidence to back up the critics' worries. In fairness, data are also too scant and too new to demonstrate conclusively that CDHPs will accomplish what their backers hope. But that is normally the case with innovative products.

For supporters of CDHPs, now is a time for innovation and experimentation. The CDHP contracts of five years from now may look very different from those of today. CDHPs may encounter problems along the way, but that is no reason to inhibit their development. Fears were voiced about every previous version of health insurance, as well. Greg Scandlen notes that market mechanisms are adaptable and problematic models can be changed.³⁰ The important thing, he notes, is for supporters and opponents to keep their minds open to the evidence that we accumulate, rather than selectively picking the nuggets of information that play to our biases.

Again, the CDHP market has barely begun to emerge. Expectations were for around three million enrollees in CDHPs by the end of 2005. Insurers are interested, with Aetna, Lumenos, Definity, and Anthem among the early entrants. BCBSA is increasing its activity nationally. Large employers are attracted to the idea of CDHP as a means of holding down costs.³¹ However, most are offering CDHPs as an option, rather than as a mandate for their employees.

We can group critics' concerns into three areas: effects on cost and coverage, effects on health and care, consumer satisfaction. In other words, will these plans actually hold down costs and improve coverage? Will they help or harm enrollees' health? Are subscribers pleased with the plans?

Effects on cost and coverage:

- **Criticism:** CDHPs will attract only the lowest-risk, lowest-cost consumers. Riskier, sicker consumers will be left behind in other plans, whose premiums will have to be high. At worst, CDHPs may drive low-deductible policies out of the market.³² **Response:** This same "cherry-picking" argument was raised against HMOs when managed care first began to spread.³³ There is insufficient evidence to demonstrate that such risk segmentation is occurring with CDHPs. Where there is evidence of some segmentation, the effects do not appear to be large or even permanent.³⁴ Much of the data – all of which should be considered preliminary – suggests that those choosing plans are more interested in factors like the size of the provider network.³⁵ Finally, it bears mentioning that risk segmentation does not require CDHPs. In today's market, some younger,

healthier employees choose to go without health insurance, rather than subsidize higher-risk coworkers. A more desirable solution may be to encourage risk segmentation and then for governments or other agencies to subsidize the insurance for those with greater risks.³⁶

Employees in firms already sort themselves into different risk categories by selecting different sorts of firms to work for or different insurance policies offered by individual firms.³⁷

- **Criticism:** CDHPs are only for the wealthy. **Response:** The U.S. Government Accountability Office (GAO) found HSAs to be more attractive to the wealthy; 51% of enrollees had incomes of \$75,000 or more. But the GAO's figures also show that 30% had incomes under \$50,000 and 15% had incomes under \$30,000.³⁸ Further, the GAO was examining figures for the first year of HSAs' existence. Those who are early purchasers of a new financial product are likely to be more educated than most, and, hence, are likely to be wealthier than the general population. So, the GAO figures may have been based on education, which happens to be correlated with income.³⁹
- **Criticism:** CDHPs simply shift costs from employers to employees.⁴⁰ **Response:** Health care costs are already borne by workers, since the cost of benefits is simply a portion of wages that is diverted beforehand toward a particular use. Humana, a health care firm, reported its employees were spending about the same on care through their CDHP as they had through more traditional policies the year before.⁴¹ A Cato Institute report put it this way: "Rather than shift *costs* to workers, HSAs shift to worker greater *control* over the health benefits portion of their compensation."⁴²
- **Criticism:** CDHPs will not reduce expenditures on big-ticket health care spending. **Response:** To a large extent this argument is true, but it in no way precludes the desirability of CDHPs. The argument is that spending on expensive procedures will be unaffected by cost-sharing, since the policy deductible and out-of-pocket maximum will be passed early in the year by those using the most health care. It is true, as critics note, that a large portion of health expenditures come from such people. So this particular segment of health expenditures will not likely be restrained by

today's CDHPs. But much care is not of this type, and savings are to be had among those whose spending is not so great. CDHPs will solve some problems, but not all. The problem of high-price, low-value treatments will have to be dealt with via different mechanisms to be developed later.⁴³

- **Criticism:** CDHPs will not lead to universal health care coverage: **Response:** Data are scarce and evidence weak. There is evidence that CDHPs attract some previously uninsured. But once again, CDHPs are not designed to solve all the health system's problems.

Effects on health and care:

- **Criticism:** CDHPs will harm poor peoples' health. **Response:** This argument rests on an out-of-context interpretation of some results from the RAND HIE. RAND data from the 1970s and 1980s indicated that cost-sharing led poor individuals to spend too little on hypertension, dental care, and corrective vision. However, the RAND policy lacked some important elements of today's CDHPs. Today's policies often waive patient cost-sharing for preventive measures. CDHPs have associated information and education systems, whereas the RAND participants were on their own. The RAND results do provide some good advice for those designing CDHPs. Information systems may need to be specially geared to better serve lower-income individuals.⁴⁴ More intensive education on the value of preventive measures might be called for, for example. Furthermore, it may be that CDHPs are appropriate for some demographic groups and not for others.
- **Criticism:** CDHP enrollees will skimp on vital care. **Response:** The RAND HIE indicated that people were capable of limiting their purchases of health care without harming their health. And that was in a model that lacked any decision support mechanisms.
- **Criticism:** CDHP enrollees are not using the plans' information systems.⁴⁵ **Response:** As with most of these criticisms, this claim is based on data over a short period of time, concerning an

entirely new approach to health care. The information systems are new. Consumers are only beginning to learn how to navigate such information. And, full effectiveness of an information system requires a large enough critical mass of participants. In the mid-1990s, for example, the Internet was still somewhat mysterious to most Americans. Its potential wasn't realized until users had neighbors and classmates and colleagues with whom they could discuss its use. CDHPs are only beginning to reach such a stage. Greg Scandlen suggests that, like other Internet applications before, health care information systems will grow exponentially; he says that, "We are white-water rafting here and the river changes by the minute. The experience of two years ago is important, but it is already out-of-date."⁴⁶ A U.S. GAO report worried about this problem, but offered the following: "Any increase in consumerism that may be exhibited by CDHP enrollees will likely require time, education, and improved decision-support tools that provide enrollees with more information about the cost and quality of health care providers and services." It is worth noting that in only a decade or so of intense use, the Internet is not a top source of medical information for consumers. Downloaded pages are often first topic of discussion between doctors and patients' families.

- **Criticism:** Health care is too complex for consumers to evaluate.⁴⁷ **Response:** Critics stress the difficulty of consumers making health care choices while in the midst of a health crisis. But this ignores the fact that many choices can be made while the consumer is in good health.⁴⁸ For several decades, and particularly since the advent of the Internet, consumers (patients and their families) have taken increasingly strong roles in determining the shape of their medical care. And the evidence is that they handle the information rather well.

Consumer satisfaction:

- **Criticism:** CDHP plans are not popular. **Response:** Many of these claims are contradictory, based on weak evidence, and selective in their conclusions. One critic notes that an overwhelming majority of employees have chosen other plans over CDHP plans.⁴⁹ This ignores the fact that

CDHPs are new and that most employers do not yet offer them. (As a side note, it also makes for a curious pairing with the criticism, described earlier, that CDHPs might force other types of policies out of the market.) This same critic commented that consumer surveys showed enrollees to be less satisfied than enrollees in other plans. This is a *non sequitur*; it is unclear why this would be important. Those enrolled in CDHPs chose to be in them and so, apparently prefer them over other plans. Those enrolled in traditional plans apparently prefer them over CDHPs. In fact, many of the consumer surveys indicate strong satisfaction with the plans. The GAO report cited by CDHP critics found enrollees to be “generally satisfied” with their plans.⁵⁰ Another study found half the participants reported a positive experience, versus 25% who reported a negative experience.⁵¹ Other studies indicate primarily positive sentiments by CDHP enrollees.⁵²

- **Criticism:** Many CDHP enrollees like the plans for themselves but wouldn’t recommend them to everyone. **Response:** If this criticism were a serious objection, it is doubtful that any health insurance policy, any insurance policy, or anything period could stand up to the scrutiny. It is difficult to imagine any product that anyone would recommend to *everyone*. The GAO report from which this criticism arose found that “Most participants reported satisfaction with their HSA-eligible plan and account, but said they would not recommend these plans to everyone.”⁵³ Another study showed that 30% of CDHP participants would definitely recommend the plan to friends and that an additional 57% would recommend them under specific circumstances.⁵⁴

Conclusions

Consumer-Driven Health Plans are a new type of health insurance contract that gives consumers the power to shape their own care and the incentives to economize. They promise to be an important tool in taming the unsustainable growth forecast through this century for health care expenditures. CDHPs combine elements of a number of earlier instruments that had that same aim.

At present, CDHPs are too new and their enrollees too few in number to provide solid evidence of either their strengths or weaknesses. Such data will only emerge as the market fully develops. The evidence we now have is thin and ambiguous. Stressing that point, a recent RAND paper concluded that, “Although evidence is limited, early indications are that consumer-directed plans are having a moderating effect on costs and cost increases.”⁵⁵ The authors summarized current evidence as follows:

- “[T]here may be some modest favorable health selection among early adopters of [CDHPs] that warrants monitoring.” The patterns of selection, though, did not lend themselves to simple generalizations.
- The literature suggests a 4-15% one-time drop in health care spending if everyone switched to high-deductible policies, but this drop might be less with policies that combined high-deductibles and HSAs. There is anecdotal evidence of cost reductions.
- Cost sharing did not reduce the use of highly effective care among non-poor children. The authors note that “[s]everal studies report increased use of preventive care in [CDHPs] and increased compliance with prescribed treatment regimes.” The RAND Health Insurance Experiment found that high deductibles adversely affected certain aspects of health status among the poor. But today’s CDHPs include provisions to negate that finding. For example, CDHPs often waive deductibles for preventive care, and they provide information systems to help consumers make informed choices.

It is crucial to remember that CDHPs are evolving and are still at an early stage in that process.

Numerous ideas exist on how to construct policies that mollify critics’ fears.⁵⁶ They include:

- Differential cost-sharing arrangements for high-risk consumers, such as the sick and poor.
- Broad definitions of preventive care to be encouraged.
- Substituting coinsurance and higher out-of-pocket maximums for deductibles. This would encourage economizing over more expensive treatments.

- Increase cost-sharing for discretionary care, and reduce it for nondiscretionary care.

The idea of CDHPs rests on the notion that consumers can make educated choices. For this reason, the development of user-friendly, high-quality decision-support systems is essential to the success of CDHPs. John Goodman notes that our current reimbursement system discourages effective information-sharing.⁵⁷ He notes, for example, that doctors are nearly unique in their inaccessibility by email. They are also difficult to reach by telephone. In contrast, attorneys, accountants, and others are more willing to communicate and explain because they get paid for those services. Goodman also notes the lack of electronic medical records, inadequate advice on drugs and other therapies, inadequate patient education, and lack of competition for patients. All of these shortcomings have their roots in the same cause: doctors are not paid for doing these things. In contrast, attorneys, accountants, and other professionals are paid for these activities and, hence, are willing to do them.

Finally, President Bush, in his 2006 State of the Union address, proposed strengthening CDHPs. The Administration's legislative proposals include:⁵⁸

- Expanding HSAs by [1] giving individuals that purchase HSAs on their own the same tax advantages as those with employer-sponsored insurance; and [2] eliminating all taxes on out-of-pocket spending through HSAs.
- Increasing portability of health insurance by [1] enabling portable HAS insurance policies; and [2] permitting the purchase of health insurance across state lines.
- Making information on price and quantity of health care more transparent.
- Allowing employers to make higher contributions to the HSAs of chronically ill employees.

¹ Melinda Beeuwkes Buntin et al., "Consumer-Directed Health Care: Early Evidence about Effects on Cost and Quality." *Health Affairs*, October 2006.

² Described in Joseph P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1996).

³ The quote is from Voltaire.

⁴ Christian Hagist and Laurence Kotlikoff, "Health Care Spending: What the Future Will Look Like?" NCPA Policy Report No. 286, June 2006, www.ncpa.org/pub/st/st286

⁵ Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs*, v23, n6, p107.

⁶ Sherman Folland, Allen C. Goodman, and Miron Stano. *The Economics of Health and Health Care*, 5th edition (Upper Saddle River, NJ: Pearson/Prentice-Hall, 2007), p.6. 1960 figure adjusted by CPI-U.

⁷ Chart from <http://www.whitehouse.gov/stateoftheunion/2006/healthcare/>, downloaded 10/12/06.

⁸ Thomas R Saving. "Medicare Now and in the Future." Testimony before the Senate Budget Committee, February 17, 2005. Downloaded at <http://www.teamncpa.org/main/news.php?ItemsID=114> on November 15, 2006.

⁹ Louis F. Rossiter and Randy F. Neice, "Medicaid, State Finances, and the Bottom Line for Businesses," *Business Economics*, July 2006.

¹⁰ Chart from <http://www.whitehouse.gov/stateoftheunion/2006/healthcare/>, downloaded 10/12/06.

¹¹ Joseph P. Newhouse, JP. "Medical care costs: how much welfare loss?" *Journal of Economic Perspectives*, 1992; Vol 6 (3): 3-21 and M.S. Freeland et al. "The impact of technological change on health care cost increases: A brief synthesis of the literature," Office of the Actuary, Health Care Financing Administration, June 1998.

¹² This process was described in Burton A. Weisbrod, June 1991. "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature*, 29, 2, 523-552.

¹³ Karen Davis, an opponent of CDHC notes this in Karen Davis, "Consumer-Directed Health Care: Will It Improve Health System Performance?" *Health Services Research*, August 2004 August; 39(4 Pt 2): 1219-1232.

¹⁴ For a description of the HIE, see Emmett B. Keeler, "Effects of Cost Sharing on Use of Medical Services and Health (1992) <http://rand.org/pubs/reprints/2005/RP1114.pdf>, downloaded on 10/12/06.

¹⁵ Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs*, v23, n6, p107.

¹⁶ Feldstein, Martin S. 1973. The welfare loss of excess health insurance. *Journal of Political Economy* 81:251-280.

¹⁷ Folland, Goodman, and Stano, (op cit.), p 245.

¹⁸ See Sherry Glied, "Managed Care" in *Handbook of Health Economics, Volume 1A*, Anthony J. Culyer and Joseph P. Newhouse (eds.) (Elsevier Science, B.V. 2000) for a comprehensive review of managed care.

¹⁹ Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs*, 2004, v23, n6, p109.

²⁰ Anne K Gauthier and Carolyn M Clancy, "Consumer-Driven Health Care—Beyond Rhetoric with Research and Experience," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1055–1070.

²¹ For a brief description of MSAs, see Greg Scandlen, "MSAs Can Be a Windfall for All," NCPA Policy Backgrounder # 157, <http://www.ncpa.org/pub/bg/bg157/bg157.pdf> downloaded 10/12/06

²² MSAs reached the public's attention in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis*, Washington, D.C.: Cato Institute, 1993 and in Pauly, Mark V. and John C. Goodman, "Tax credits for health insurance and medical savings accounts," *Health Affairs* 14(1):126-139, Spring 1995.

²³ Keeler (op cit)

²⁴ Newhouse (2004, op cit.) expresses this view.

²⁵ John Bertko, "Commentary—Looking at the Effects of Consumer-Centric Health Plans on Expenditures and Utilization," *Health Services Research*, Volume 39 Page 1211 - August 2004

²⁶ This and many of the facts as follows are described in "Consumer-Directed" Health Plans: Implications for Health Care Quality and Cost," RAND Corporation, June 2005.

²⁷ RAND (op cit), p. 10.

²⁸ This list is derived from RAND (Ibid., pp 21ff).

²⁹ Ibid.

³⁰ Greg Scandlen, "Commentary – How Consumer-Driven Health Care Evolves in a Dynamic Market," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1113-1118.

³¹ Stephen T. Parente, Roger Feldman, and Jon B. Christianson, "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization." *Health Services Research*, August 2004 August; 39(4 Pt 2): 1189–1209.

³² Gail Shearer, "Commentary – Defined Contribution Health Plans: Attracting the Healthy and Well-Off," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1159-1166.

³³ Ibid, p. 1093.

³⁴ Stephen T. Parente, Roger Feldman, and Jon B. Christianson, "Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization." *Health Services Research*, August 2004 August; 39(4 Pt 2): 1189–1209.

³⁵ Stephen T. Parente, Roger Feldman, and Jon B. Christianson, "Employee Choice of Consumer-Driven Health Insurance in a Multiplan, Multiproduct Setting," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1091–1111.

³⁶ This possibility is suggested by Michael F. Cannon, "Health Savings Accounts: Do the Critics Have a Point?" Cato Institute, *Policy Analysis*, No. 569, May 30, 2006.

³⁷ Ibid.

³⁸ U.S. Government Accountability Office, *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans*, GAO-06-798, August 2006.

³⁹ This was the argument of David Hogben, "Unhealthy Criticism," *The American Spectator*, http://www.spectator.org/util/print.asp?art_id=10422, downloaded 9/29/06.

⁴⁰ This argument is mentioned in Jon B. Christianson, Stephen T. Parente, and Roger Feldman, "Evidence about Consumer Experiences," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1123-1139.

⁴¹ Humana, "Health Care Consumers: Passive or Active: A Three-Year Report on Humana's Consumer Solution," 2005.

⁴² Cannon, op cit.

⁴³ One idea, for example, is to offer patients a choice between an expensive treatment and a somewhat less expensive cash indemnity. This idea was suggested in Frank D. Gianfrancesco. 1983. "A proposal for improving the efficiency of medical insurance." *Journal of Health Economics* 2:175-184; Susan Feigenbaum. 1992. "Body shop economics: What's good for our cars may be good for our health." *Regulation: The Cato Review of Business and Government* 15(4), and Robert F. Graboyes, "Our Money or Your Life: Indemnities vs. Deductibles in Health Insurance," *Federal Reserve Bank of Richmond Working Papers*. August 2000.

⁴⁴ Jinnat Briggs Fowles, Elizabeth A. Kind, Barbara L. Braun, and John Bertko, "Early Experience with Employee Choice of Consumer-Directed Health Plans and Satisfaction with Enrollment, *Health Services Research*, August 2004 August; 39(4 Pt 2): 1141-1158.

⁴⁵ Shearer, op cit. and Meredith Rosenthal and Arnold Milstein, "Consumer-Driven Plans: What's Offered? Who Chooses? *Health Services Research*, August 2004 August; 39(4 Pt 2): 1055-1070. take this view.

⁴⁶ Greg Scandlen, "Commentary – How Consumer-Driven Health Care Evolves in a Dynamic Market," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1113-1118.

⁴⁷ This view was voiced in David Wessel, "In Health Care, Consumer Theory Falls Flat," *The Wall Street Journal Online*, 9/7/06.

⁴⁸ See Hogberg, op cit.

⁴⁹ Shearer, op cit., p 1161.

⁵⁰ U.S. Government Accountability Office, *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans*, GAO-06-798, August 2006.

⁵¹ Jon B. Christianson, Stephen T. Parente, and Roger Feldman, "Evidence about Consumer Experiences," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1123-1139.

⁵² These include the previously cited Humana study and a survey by the Blue Cross and Blue Shield Association, (press release: "Blue Cross and Blue Shield Association Survey Shows HSAs Are Popular Among a Wide Cross Section of Americans", 9/15/06).

⁵³ This criticism emerged from the previously cited GAO report GAO-06-798. A lengthy critique of this study, "'Not Representative: CHCC Analysis of Recent GAO Report", by Greg Scandlen, can be found at <http://www.aba.com/aba/documents/HSA/CHCCChoicesGAOAnalysis.pdf> (downloaded 10/13/06)

⁵⁴ This argument is mentioned in Jon B. Christianson, Stephen T. Parente, and Roger Feldman, "Evidence about Consumer Experiences," *Health Services Research*, August 2004 August; 39(4 Pt 2): 1123-1139.

⁵⁵ Melinda Beeuwkes Buntin et al. "Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality," *Health Affairs* 25 (2006): w516-w530, published online 10/24/06.

⁵⁶ These suggestions appeared in Jill Mathews Yegian, "Coordinated Care in a 'Consumer-Driven' Health System," *Health Affairs* 25 (2006): w531-w536, published online 10/24/06.

⁵⁷ John C. Goodman, "What Is Consumer-Directed Health Care?" *Health Affairs* 25 (2006): w540-w543, published online 10/24/06.

⁵⁸ <http://www.whitehouse.gov/news/releases/2006/01/20060131-7.html>