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## consumer-directed health plans what happened?

**Many who want to reform the U.S. health system suffer from a dreadful and poorly understood illness: "silver-bullet-itis." Reform advocates glimpse in a single promising, often disruptive, innovation the solution to the health industry's ills. Health maintenance organizations, integrated delivery networks, "focused factories," and now pay for performance and consumer-directed health coverage are all examples of such "silver bullet" solutions.**

Tracking the arc of these ideas will show they all pass through a health system version of Gartner's famous "hype cycle"—explosive introduction, bleeding-edge adoption, rapid attainment of the "peak of inflated expectations," then the sickening fall into the "trough of disillusionment," and, for some, the long, slow climb up the "slope of enlightenment" to the "plateau of productivity," where the innovation actually realizes its promise. The innovations that rise from the trough and become ubiquitous undergo a process of re-engineering and "civilization" on their way to becoming indispensable.

Right now, the consumer-directed health plan (CDHP) resides in the trough of disillusionment—a victim of not only its own design flaws, but also a savage counter-attack from the left wing of the health policy community, tepid reaction of the health insurance "supply chain," and a loss of urgency by employers. Four years ago, with insurance premiums approaching annual renewal rates of 15 percent, CDHPs were expected to enroll 15 million to 20 million people by 2007. The latest data for early 2007 show perhaps 4.5 million have enrolled, at most 3 percent of the privately insured population.

Although they will not solve all our nation's healthcare problems, CDHPs are a good idea, since they represent a thoughtful attempt to sort out, at the consumer's direction, the subsidy flows in health insurance, with the goals of getting people to buy the right amount of health insurance for their needs, use health services more conservatively, and take better care of themselves.

### Barriers to Adoption

Humana's experiences in introducing its high-tech CDHP product were instructive. Humana did its homework. The company invested more than \$1.5 billion in creating the IT infrastructure to support its consumer-directed product, and successfully alpha tested it on its own large employee group. Humana associates used an elegantly designed, web-based decision-support tool to build their own coverage, tested various coverage options, and decided how much insurance risk they

### AT A GLANCE

- > CDHPs can stabilize growth in health costs, but the health plan-subscriber relationship should be more transparent.
- > CFOs should ensure that increased cost exposure in CDHPs is paired with broad, deep disease management and employee assistance support.
- > Hospitals should plan for the likelihood that, one way or another, consumers will be paying more of their healthcare bill.

## The slowdown in health insurance premium growth has been the most decisive inhibitor of CDHP growth.

wanted to assume and how much they wanted to pay out of their paychecks. Humana paid a lot of attention to the communication process with associates, to ensure that they understood how the product worked and how it differed from past forms of health coverage.

CDHPs cut Humana's own rate of premium growth from 19 percent per year to about 5 percent in a year's time and kept it there. In the first several years of adoption, Humana's associates behaved exactly as you might expect an intelligent consumer to behave: They had fewer emergency department visits and more primary care physician office visits, tilted toward generic drugs, and had fewer expensive tests and somewhat shorter hospital stays. Moreover, they supported the CDHP product, and increasing percentages voluntarily chose it at each renewal cycle. Humana's newly designed "personal nurse" program helped the associates who had complex health problems navigate the health system and improve compliance with prevention and drug therapy strategies.

However, in presenting this new idea to the employer and broker community, numerous barriers to adoption surfaced. For one thing, CDHPs are extraordinarily complicated, with a lot of moving parts. You cannot explain them in an elevator or in a couple of sentences to your mother-in-law. In addition, the broker community, gatekeepers to the small group health insurance market, were resistant to CDHPs, for the self-interested reason that CDHPs would reduce dramatically the "churn" in their small business book. CDHPs are sticky products, and many brokers make money moving their flock from plan to plan. Reduced mobility between plans would markedly reduce their commission income. So the brokers sat on their hands.

Finally, the corporate human resource (HR) community resisted surrendering control of benefit design to its workers. Many corporate HR managers felt their employees would not understand the choices presented to them, and would either opt out of coverage altogether or pick plans that did not work for them. After unhappy experiments with various forms of managed care during the 1990s, HR executives were wary of what looked to many of them like the next "new, new thing." It was far easier to push up cost sharing in their traditional forms of coverage (often without regard for the income or financial resources of their workers) than to shift to a new paradigm of health coverage.

But of the above-mentioned factors, however, the slowdown in health insurance premium growth has been the most decisive inhibitor of CDHP growth. Health insurance premium renewals for 2007 settled into the mid-single digits for many larger firms. Disrupting employee relations and teaching people a new coverage paradigm in the midst of historically tight labor markets inclined many preternaturally cautious HR executives to wait until their health costs were on fire again before pressing for adoption of CDHPs.

The CDHP enrollment pause is an excellent opportunity for health plans to re-engineer this concept, and many plans are doing so. Health plans can be expected to strengthen incentives inside CDHPs for subscribers to make healthier decisions. They will offer compelling financial incentives, in the form of payments into subscribers' health savings accounts (HSAs), for those who refill their prescriptions, screen regularly for identified health risks, lose weight, or exercise. They will eliminate copays for drugs that reduce health risks, such as insulin, beta blockers, and statins. They will also begin grading cost exposure to associates' incomes, to reduce financial barriers to lower-income associates' enrolling, as well as varying the employer's HSA contributions to the associates' income level.

### What Hospitals Should Do

Hospital CFOs who wish to blame CDHPs for their rising bad-debt problems must look elsewhere—to the nation's immigration crisis, and the related growth

## CONSUMERISM AND PRICING

*Consumerism and Pricing: New Strategies and Skills* is a new collection of 10 articles from recent *hfm* magazine issues and two HFMA newsletters—*Consumer-Directed Health Care* and *Revenue Cycle Strategist*. In this collection, experts explain various facets of consumer-directed health care and how to develop a defensible pricing strategy. For more information and to order, visit [www.hfma.org/hfm/hfmMagazine/Collections.htm](http://www.hfma.org/hfm/hfmMagazine/Collections.htm).

in the number of uninsured; shrinking Medicaid eligibility standards; higher copays for more traditional forms of coverage, such as preferred provider organizations; and growing consumer resistance to hospital costs. Public attitudes toward the hospital itself may be changing. Hospitals are enjoying record prosperity—four years of record profits perhaps ending in 2007—and have responded with a highly visible wave of capital construction.

For many hospitals, however, there is only an *appearance* of prosperity, while they are actually struggling financially—and their patients too readily succumb to the temptation to put the latest hospital bill at the bottom of the pile to be paid later. When people are actually asked to pay a significant portion of the hospital bill, they are shocked by the costs. That shock is deeper and the reaction angrier if their hospital experience made them feel like they were not valued customers.

If the experience with managed care plan growth is any guide, expect CDHP enrollment to resume growing 12 months to 18 months after a resurgence in health insurance premium renewal quotes. That moment may be the time for many hospitals and health systems to consider adopting these plans, if they have not already done so. Hospital employees are “power users” of the health system, not only because their work is highly stressful and exposes them to infection risk, but also because they know how to manipulate the system to get the care they feel they need.

My belief is that CDHPs will be proven to stabilize growth in health costs in future years. However, CDHPs are not all the same. Properly designed CDHPs are not mere cost-shifting devices; they anticipate their subscribers’ health problems, and work to change risk behavior and how people use their benefits. Merely changing economic incentives is not enough to change behavior toward health risks. Many health plans simply have not invested the energy to connect with their CDHP subscribers on their health issues, nor have they been willing to make their own plans’ administrative processes (eligible services, claims management, etc.) more accessible and easier for subscribers to understand. Demystifying the benefit and making the relationship between

the health plan and subscriber more transparent are vital ingredients of a successful CDHP.

CFOs should assure themselves that increased cost exposure in CDHPs is paired with broad and deep disease management and employee assistance support for their associates who struggle with manageable health risks. The introduction of CDHPs should be a teachable moment for the entire associate community, not just an opportunity to engage those who never get sick and need minimal health coverage. Introducing the CDHP provides an opportunity for employers to engage associates on the contribution their behavior makes to their own health, and to help people manage their own health better. This opportunity extends to associates for whom CDHPs are *not* appropriate. CDHPs should not be forced on associates as the sole available benefit; rather, they should be a part of a suite of health insurance coverage options.

For hospitals to give lip service to consumerism in health care because the CDHP threat has not yet materialized is bad strategy. Americans have conflicted feelings about their hospitals. They understand that the hospital is a vital part of the community’s infrastructure (a belief reinforced by disasters such as Hurricane Katrina). But many Americans also feel they are expected to surrender their autonomy, dignity, and safety, as well as their savings, when they pass through the hospital’s front door.

Hospitals need to plan for the likelihood that, one way or another, consumers will be asked to pay more of the bill themselves. Hospitals need to redesign care processes to improve the patient’s and family’s clinical experience. That durable culture of, “Here’s a clipboard. Fill out the forms, and take a number. We’ll call you when we’re ready” must yield to a more responsive, IT-enabled, dignified, and safer care experience. The kind of care we expect when our own children get sick is the kind of care all patients should receive. If people are asked to pay more for hospital care, whether through CDHPs or simply the brute force expedient of pushing up copays, they are going to expect value for their money. ●

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