Promoting Appropriate Utilization in an Era of Increasing Patient Cost Sharing: Early Experience and Future Benefit Design Strategies

Conference Report

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In October 2005, the Health Industry Forum sponsored a one-day meeting, "Promoting Appropriate Utilization in an Era of Increasing Patient Cost Sharing: Early Experience and Future Benefit Design Strategies." This meeting brought together representatives from health plans, pharmaceutical firms, consumer groups, employers and academic researchers to debate the potential benefits and risks of consumer directed health care plans (CDHPs). In particular, meeting participants were asked to focus on the concern that expansion of cost sharing under CDHPs could cause individuals to forego necessary medical services with the largest impact felt by those with lower incomes and chronic medical conditions. Because these programs are relatively new, limited evidence about their impact is currently available. Because of the growing interest in how these programs actually work under current conditions we asked health plans with several years of experience to discuss their most recent utilization data for CDHP enrollees.

Stuart Altman, Ph.D., Brandeis University began the meeting by noting that there has been a return to relatively unconstrained healthcare spending following the backlash against managed care. Recently, a there has been growing interest in new kinds of health plans that increase the financial stake for consumers and patients. These consumer-directed health plans generally include a high deductible and some kind of cost sharing after the deductible.

Dr. Altman noted that some critics strongly oppose use of financial incentives to change consumer behavior in health care – believing that financial incentives don't work, but even if they did they would have a negative impact on the health care system because of their disproportionate impact on low income individuals. Critics also believe that consumers often lack adequate information to make informed choices about alternative providers and treatment options.

The challenge, in his opinion, is to design health benefit options that do not discourage appropriate utilization, but still moderate the increase in spending.

Jack Rowe, MD, Chairman and CEO of Aetna, presented Aetna's experience with high deductible plans. He stated that we are now reaching a point where there is sufficient evidence to begin evaluating these plans. A central question is whether the findings from the RAND Health Insurance Experiment -- which found that increasing cost sharing resulted in lower utilization, particularly for low-income individuals -- is still valid today. The risk of new high deductible plans is that the poor and the sick will not get needed care. This is a primary concern of Aetna, which is working to establish plan designs to

help ameliorate this issue. Dr. Rowe noted that CDHPs are flexible, and that benefit designs will evolve, as more data is gathered about the impacts of these plans. For example, Aetna has designated 7 classes of pharmaceuticals (mostly preventive in nature) that are covered outside of the deductible to increase the likelihood that individuals will continue to use these medications.

Dr. Rowe began his presentation by noting that Forrester Research has estimated that 6.3 million individuals may be enrolled in CDHPs by 2008. He also noted that according to the Kaiser Family Foundation, 33 percent of "jumbo firms" offered CDHPs in 2005. Moreover, fully 50 percent of the employers that Aetna works with have requested a CDHP for January 2006.

Aetna's first full year of offering CDHPs was 2003. Overall, costs for members in these plans increased 3.7 percent over 2002, but in most areas (inpatient admissions, ER visits, office visits), utilization decreased. The only area in which utilization increased was for specialist visits. The trend in medical spending was less than the PPO control group.

Further analysis of the Aetna data showed that use of preventive care increased in the CDHPs compared with PPO enrollees or a control population. Members with chronic conditions showed no significant changes in utilization. Consumer satisfaction surveys show that members are satisfied with the plan, with 87 percent likely to renew the plan. Dr. Rowe also presented data that showed many of the enrollees in these plans were previously uninsured.

Leonard Schaeffer, Chairman, WellPoint, began by noting that that the percentage of health care costs paid by consumers has dropped dramatically since 1970. He outlined the objectives of CDHPs: to use financial incentives to sensitize consumers to the costs of care; to use consumers to promote provider competition based on both quality and cost; to encourage consumers to take an active role in their own health care; to foster physician-patient shared decision making; and to reduce spending on unnecessary care, such as treatments with marginal clinical value.

Mr. Schaeffer noted that WellPoint offers a number of different plan designs, including two that provide 100 percent coverage for preventive care. He also commented, like Dr. Rowe, that plan designs are changing as firms get more experience with CDHP utilization patterns. WellPoint covered just over one million individuals in these plans as of March 2005, with a substantial number (20-35 percent) previously uninsured. He stated that he believes these plans will be 24 percent of the insurance market by 2010.

Mr. Schaeffer presented data from a Blue Cross/Blue Shield Association Workgroup Preliminary HSA Survey, which showed that CDHP enrollees tend to be more highly educated and have higher incomes that those enrolling in non-CDHP plans. The data also showed that individuals over the age of 55 were less likely to enroll in these plans. Enrollment by health status, however, did not vary; their data did not show, as many critics have contended, that these plans are merely for the healthy and wealthy. Mr.

Schaeffer also presented survey data showing that CDHP enrollees were no more likely to delay going to the doctor than individuals enrolled in traditional health plans.

Mr. Schaeffer also discussed a recent study by McKinsey that showed that CDHP enrollees were 50 percent more likely than the comparison group to ask about the cost of medical services and three times more likely to select a less expensive treatment. These enrollees were also 25 percent more likely to engage in healthy behaviors.

Lumenos, a recent acquisition of WellPoint, has offered CDHPs for many years. Their data has shown a 30 to 40 percent reduction in year over year cost trend. Enrollees in their plan have had both a decrease in outpatient visits and an increase in preventive care services. AnthemByDesign, a WellPoint CDHP that uses an HRA design, has seen claim costs for ER and inpatient hospitalizations decrease, and the number of office visits increase, suggesting that patients are getting care when they need it. Interestingly, 80 percent of HRA enrollees carried over a balance in the HRA at the end of 2004; 85 percent of these individuals had a balance of $1,000 or more.

However, not all the results have been positive. Mr. Schaeffer referred to the McKinsey survey which indicated that only 44 percent of respondents were equally or more satisfied with their CDHP versus their previous health plan. Mr. Schaeffer commented that the transition to CDHPs must be thoughtful and well designed, and that enrollees should be properly educated about the new structure of these plans.

Mr. Schaeffer then turned to WellPoint's initiatives to increase consumer understanding of CDHP benefits. He stated that the success of these plans depends on making information easy to get, accurate and relevant to enrollees. For example, WellPoint's website provides guided programs for active and high risk members, and uses each member's profile to customize the site with relevant content. Lumenos, the WellPoint subsidiary, also provides personalized recommendations based on their claims history, such as suggesting that enrollees discuss switching to a generic pharmaceutical with their physician. WellPoint also provides "Healthcare Advisor," a website that provides user-friendly information, including the ability to research more than 150 different medical conditions and procedures, and compare hospital quality. Lumenos offers a website where patients can type in their prescriptions and their home address, and get comparative price information from local pharmacies, allowing enrollees to search easily for the best prices on their prescriptions.

Mr. Schaeffer warned that even these efforts may not be sufficient to meet the needs and expectations of enrollees who will be looking for "Amazon-like support" and personalized, relevant, easy to use information on the Web. In his opinion, whatever firms are best able to offer this kind of information support will ultimately be most successful in the CDHP market.

Tony Miller, President of Definity Health, began his remarks by noting that Americans spend more on entertainment than on health care, but that health care costs are now

negatively affecting corporate profits, leading to the current interest in restraining the growth in health care spending.

Mr. Miller said that Definity's consumer-directed products have been able to restrain costs while increasing the use of preventive services. He presented data from one of Definity's full replacement clients that showed decreases ranging from 6 percent in pharmaceutical costs to 18 percent in physician visits. Overall, utilization decreased by 11 percent (expressed as a weighted average of all categories of health care services). Definity's data suggests that enrollees are cutting back unnecessary utilization and continuing or even improving their use of preventive services. Prescriptions for patients with asthma increased 10 percent between 2003 and 2004, while emergency room visits decreased 9 percent. Diabetes patients increased their usage of preventive services such as HA1C and lipid tests, while decreasing their emergency room visits.

Definity does not see evidence of selection bias; their data shows a normal distribution of enrollees with a slightly higher average age and slightly higher dependent scale. Definity has opened up its data to researchers, including Stephen Parente of the University of Minnesota and Judith Hibbard of the University of Oregon.

Mr. Miller stated that excellent communication between employers and employees and between health plans and their members is the key to implementing a successful CDHP. Definity uses multiple modes of communication – email, phone, regular mail and web based – to reach enrollees and provide them with useful, actionable information. For example, Definity can send an email to enrollees, advising them of availability of a generic equivalent for a drug, and explain their cost savings from switching. Alternatively, they can put messages on monthly statements that are sent to enrollees via regular mail. Their data shows that enrollees are changing behavior in response to targeted communications. For example, a survey showed that 73 percent of enrollees found a specific message helpful, and 51 percent planned to take action on the message. "Message readers" were more likely to use mail order for pharmaceuticals and more likely to split pills to save money than non-message readers.

Mr. Miller then turned to the financial structure of Definity's plans. He presented a graph that showed the inverse relationship between premiums and deductibles; as the deductible rises, the premium drops. Mr. Miller also noted that through plan design, it is possible to limit the financial exposure of enrollees to their exposure under a traditional plan through an annual "out-of-pocket" maximum.

In the discussion, Dr. Rowe again noted that plan designs are not static, and that CDHPs will evolve over time. Tiering, disease management, and other innovations will likely be added to CDHPs as health plans get more experience. Myrl Weinberg of the National Health Council noted that there is no specific data about the experiences of CDHP enrollees who do not use the web, or who have multiple, chronic conditions. Panelists noted that these individuals probably aren't great candidates for CDHPs, but might find themselves in these plans, if employers implement a full replacement CDHP. Panelists also noted that the underlying philosophy of CDHPs is a belief in personal control, but

there are vulnerable populations, especially those with low literacy levels and low incomes. While CDHPs are probably not appropriate for certain patients, this should not render them unavailable for all patients.

Marc Berger, Merck & Co, Inc., asked whether offering CDHPs alongside traditional coverage would lead to favorable risk selection leading to higher insurance rates for those in traditional plans. Dr. Rowe agreed that this was a concern, but also noted that CDHPs currently have only 2 percent of the insured population. Moreover, Dr. Rowe noted that patients who enroll in CDHPs will experience changing health expenditures as they age or become ill.

Others in the audience expressed concern that patients with chronic conditions could experience extraordinarily high out-of-pocket expenditures. Joseph Newhouse, Harvard Medical School, suggested that these issues could be addressed through plan design. For example, a program could be put in place for enrollees who experience high costs for several years in a row (a "circuit breaker") that could reduce their out-of-pocket expenditures.

Mr. Miller expressed his hope that CDHPs will lead to competition in hospital and physician markets that will ultimately increase the value of health care services. Dr. Altman noted, however, if provider prices vary because of the amount of uncompensated care delivered to uninsured patients, those that serve a disproportionate share of low income patients will have difficulty competing on price.

Gail Shearer, Consumers Union, began her presentation by noting that biggest challenge facing health care is not the level of insurance deductibles, but rather how to cover the uninsured. Ms. Shearer presented data from previously-published studies showing that CDHPs disproportionately attract individuals with high incomes and better health status. She expressed concern that enrollees will not get needed care, and presented data showing that enrollees in high deductible plans are more likely to fail to fill a prescription because of cost. She also noted that most health care costs are incurred by a few individuals with serious health problems, and that CDHPs do little to address their costs. She suggested that these products employers may merely shift costs to employees.

Ms. Shearer noted that the quality of information is crucial to consumer decision-making. Under its "Best Buy Drugs" program, Consumer Reports has begun to provide comparative data on the cost and effectiveness of several commonly-used pharmaceuticals. Consumer Reports is extremely interested in the evidence-based medicine initiatives that are under discussion.

Peter Lee, the Pacific Business Group on Health, began by stating the promise of CDHPs: to engage consumers more effectively and to align healthcare's demand side with the supply side. Mr. Lee noted that most employers are looking for more than just a high deductible plan, and they are increasingly concerned about expending vast sums of money without knowing much about the quality of services they are purchasing. Mr. Lee acknowledged that "blunt cost sharing" is an issue, and some employers are just shifting

costs to employees. In his opinion, though, most employers are looking for better value for their health care dollars.

Mr. Lee outlined several areas of concern. First, high deductible plans could create barriers to care for low income enrollees. Methods to make CDHPs more appropriate for low-income workers include making sure that the employer funds an account on the employee's behalf, providing first dollar coverage for preventive care, and offering CDHPs as one option in a multiple choice program.

Mr. Lee also discussed the concern that CDHPs might decrease access to care for the chronically ill. Plan design can address this issue, through appropriately funding accounts, pharmaceutical plan design, and disease management programs that include web based tools, printed materials, and telephone-accessible health coaches.

Mr. Lee noted that some have expressed concerns that the savings seen in CDHPs are a one-time, one year reduction. Moreover, he asked whether these plans will undermine integrated care delivery systems, such as the Kaiser model. For these reasons, he recommended that employers offer a variety of plans. Finally, he noted that the CDHP concept relies on enrollees utilizing information to make better health care decisions and to seek cost-effective care. However, much of this information is not yet available. In his opinion, this is an issue that is broader than CDHPs; consumers need better information to support health care decision-making.

Peter Juhn, MD, Johnson & Johnson, noted that CDHPs have the potential to bring consumers into the medical marketplace and to make them more sensitive to the trade-offs of cost and quality. These plans also give consumers a direct financial incentive to "shop" for health care and will force consumers to set priorities. These plans have the potential to promote greater alignment of need and spending, and may lead to reductions in low or no-value health care.

Dr. Juhn presented data from the EBRI Health Confidence Survey showing that the increase in health care expenses has caused 81 percent of consumers to choose generics drugs, 74 percent to try to take better care of themselves, and 45 percent to delay going to the doctor. Dr. Juhn outlined some challenges for CDHPs. Patients with chronic diseases may be tempted to decrease needed maintenance care. Preventive care utilization may depend greatly on plan design, with some plans offering first dollar coverage of preventive care. Consumers will have to learn to shop for health care, and will need appropriate tools to do so. The impact of CDHPs on vulnerable populations – low income, low education, poor health status – is unknown. Finally, Dr. Juhn noted that selection may have a negative impact on the insurance pool, as the healthy move to CDHPs, leaving the sick in traditional pools.

Dr. Juhn also shared data from a Harris Interactive poll, showing that enrollees in high deductible plans were more likely to engage in potentially risky behaviors such as not filling prescriptions, not visiting the doctor when a specific medical problem emerged, and not receiving a medical treatment.

To illustrate the potential negative impacts of increasing consumer cost sharing, Dr. Juhn drew from a JAMA article showing that doubling pharmaceutical co-payments for patients with diabetes, asthma, and gastric acid disorder led patients to reduce the days of medication they purchased. Most troubling, the article showed an increase in hospital days and emergency room visits in the study population. Dr. Juhn also discussed data from a New England Journal of Medicine article showing that increasing co-payments led patients to discontinue use of pharmaceuticals.

Dr. Juhn presented an alternative approach used by Pitney Bowes that reduced financial barriers for pharmaceuticals to patients with asthma, diabetes, and cardiovascular diseases. According to Pitney Bowes, these change led to an increase in drug possession rates and a reduction in total costs for enrollees with these diseases.

Dr. Juhn concluded by noting that there are a number of unknowns about the behavior of employers, patients, and providers. Will employers promote employee health? Will patients avoid unnecessary care? Will patients shop for high-value care? Will providers compete for patients? Will short-term savings result in long-term costs?

Steven Parente, Ph.D., from the University of Minnesota, was the final presenter on this panel. Dr. Parente has been conducting research on CDHPs for several years, working with data from Definity Health. Dr. Parente noted that they are approaching the half-way point of their research, and that preliminary results have been published in peer-reviewed journals.

Dr. Parente began by presenting data about CDHP enrollment. The data show that all states have a CDHP take-up rate above 5 percent, with the exceptions of New York, the New England States, Indiana, Arizona, and California. This is likely due to dominance of managed care in Arizona and California. Dr. Parente also suggested that the preferences and experiences of insurers in the Northeast may have led them to take a slower approach to offering or promoting CDHPs.

Dr. Parente's study results, as published in *Health Services Research* in 2004, showed mixed results for CDHPs. CDHPs did not have the lowest cost or utilizations rates when compared to a POS option and a PPO option. CDHPs were most successful in containing costs in the area of pharmacy and least successful in containing the costs of hospital admissions (partially explained by "pent-up" demand for elective procedures and by provider pricing differences). Utilization results showed no dramatic differences across plan types for physician services and pharmacy. By the second year, CDHP hospital admissions were dramatically higher.

Dr. Parente concluded by discussing research opportunities. It is not known, for example, how best to deliver information to consumers, or how to make sure that the information is presented in way that it is intelligible to consumers, and inspires them to improve their health status.

With the floor opened for discussion, Dr. Newhouse began by stating that developing better information about providers, particularly physicians, should be a concern across all plans, and not just for CDHPs. He also commented that the threshold for setting a deductible that will influence consumer behavior is not well understood. Setting deductibles according to enrollee income is one approach worth considering.

Barbara McNeil, M.D., Harvard Medical School, asked the panel about "pent-up" demand and whether reductions in utilization as these plans are implemented disappear over time. It may be possible that the utilization is simply deferred, and that enrollees are not really choosing to reduce unnecessary utilization. Dr. Parente responded that it is not clear what happens in years 3 and 4, and that the cost savings might decline, as utilization reaches some kind of equilibrium.

Mr. Miller of Definity Health responded, saying that plan design is crucial. The plan might choose to be more generous for the chronically ill. It would be possible, for example, to increase the account balances for chronically ill patients who comply with evidence-based guidelines. Dr. Newhouse added that CDHPs could easily work with and even benefit the chronically ill by creating new incentives, such as greater account balances for chronically ill patients who enter disease management program or who agree to use hospitalists.

Mr. Schaeffer commented that patients are not always compliant, and do not always optimize health behaviors. In the real world, patients can be irrational. It may be necessary to utilize additional means (beyond financial incentives) to get patients to change behavior. A variety of techniques may be needed, such as health coaches. Dr. Altman noted that price elasticity is important here, that low income patients may respond differently to financial incentives.

The final speaker was Scott Spiker, President and CEO of Destiny Health, a subsidiary of Discovery health, a South African firm. Discovery Health has offered CDHP-type plans for nearly a decade, and Mr. Spiker presented data on the experiences of enrollees in Discovery's consumer-directed products.

Mr. Spiker discussed how health status and health expenditures change over time. While it is well known that a small percentage of the population accounts for a large percentage of health expenditures, Mr. Spiker pointed out that these are not fixed populations. While many who are healthy remain healthy, for example, some healthy individuals will develop medical problems and will see their health status decline. Conversely, some of those with serious health problems will improve, and become healthy. This shifting population is important, because it highlights the fact that the impact of enrolling in a CDHP will vary for individuals over time, as their health status and health expenditures change.

Mr. Spiker presented data showing that utilization of pharmaceuticals and "discretionary" health care providers (dermatologists, dieticians, homeopaths, and physical therapists) all decreased in the CDHP population when compared to the traditional insured population.

Decreases were also seen in overall health expenditures in each age group. However, their data suggest that health status in CDHPs is equivalent to the traditionally insured, as they do not see a “boomerang” effect of delayed utilization leading to excessive hospitalization, when compared to the control group. Some gains in the use of preventive care were also seen in the CDHP population. Finally, their wellness program showed that health care expenditures can be reduced, and these reductions can be maintained for several years and are not just a “one time” reduction.