As CDHPs increasingly penetrate the commercial market , their greatest contribution might lie in funding health services for retirees and in reducing the number of uninsured people by offering affordable insurance.

Consumer-Directed Health Plans: Enrollee Views, Early Employer Experience

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ABSTRACT

Purpose. Consumer-directed health plans (CDHPs) are a new health insurance product that is of growing interest to employers who are struggling to cope with rising health insurance premium costs and to consumers who are desiring more choice and engagement in their health care. This paper presents the results of a study of California consumer awareness of, and attitudes toward, CDHPs in the context of several national surveys and the experiences of some early-adopting employers.

Design and methodology. California Health Decisions conducted a telephone survey of 800 insured adult California residents in November 2002.

Principal findings. Few respondents had heard of CDHPs. They appealed more to younger, single, less educated, and healthier respondents and those who did not understand them well. The most attractive CDHP features were greater provider choice and health savings accounts' portability and flexibility. Concerns centered on personal financial exposure.

Conclusion. While CDHPs' commercial market penetration is increasing, their greatest potential future contributions might be to reduce the number of uninsured Americans by offering an affordable health insurance product and to fund additional health services for retirees. As CDHPs further evolve, more consumer involvement in their refinement, implementation, and evaluation is essential.

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INTRODUCTION

Consumer-directed health plans (CDHPs) are an emerging commercial health insurance product offering employees wider benefit choices and financial incentives to select less expensive coverage. Employers are attracted by CDHPs' potential to limit their health insurance expenses without reducing benefits or explicitly shifting more costs to employees.

California Health Decisions, of Orange, Calif., is a nonprofit organization that involves the public in policies and practices affecting health care. In late 2002, the agency studied consumer awareness and understanding of CDHPs (Colbert 2003). This paper presents the results of this first known attempt to ask consumers directly about CDHPs, in the context of other more recent national surveys and early employer experiences.

BACKGROUND

There are several types of CDHPs. The most common is a customized plan, in which the employer makes a fixed premium contribution and the employee selects from products priced according to the breadth of the provider network and the richness of the benefit package. In highly customized "design your own" plans, individual employees choose a personal network and benefits combination.

Federal policy supports consumer-directed health care through two similar mechanisms, health reimbursement accounts (HRAs) and the newer health savings accounts (HSAs) authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Both combine a dedicated and highly flexible tax-free account for medical care with a high-deductible insurance product. Unspent funds can be spent in future years or invested for use after retirement. HRAs must be entirely employer-funded; individuals or employers can contribute to HSAs. HSAs are fully portable, but employers may retain unspent HRA funds when employees leave.

National consumer surveys

The Kaiser Family Foundation's 2003 Health Insurance Poll included questions on new workplace health insurance options. When presented with information about CDHPs, 73

percent of respondents expressed an unfavorable opinion and 78 percent said they would feel vulnerable to high medical bills (Kaiser 2004a).

The Employee Benefits Research Institute's 2004 Health Confidence Survey found greater dissatisfaction with cost of health care than in past years, although 49 percent of respondents expressed general satisfaction with the health care that they received. While few of the insured respondents (24 percent) were interested in switching to a CDHP and 76 percent preferred to receive $6,200 in employer-sponsored coverage rather than the same amount in pay, 49 percent of uninsured respondents expressed interest in a CDHP (Helman 2004).

Hewitt Associates (2004), in a national survey of more than 39,000 employees, found that workers were willing to take more responsibility for their health care but felt challenged to do so. Over 80 percent failed to estimate their annual health expenses, 79 percent doubted their ability to take any personal action to control these costs, and 57 percent had never researched provider costs or quality.

A 2004 Watson Wyatt survey of 1,000 commercially-insured adults focused on their knowledge and perceptions of HSAs. Only 29 percent had heard of HSAs, and just 33 percent of these adults understood how they work. After hearing an explanation, a majority of respondents expressed strong support for the portability aspect (60 percent) and lower monthly premiums (55 percent); many (45 percent) also considered the rollover feature extremely important.

These survey participants were most concerned about costs related to HSAs — especially prescription drugs (66 percent) and higher deductibles (57 percent). Although 51 percent said that financial incentives would influence their health care service consumption, in a separate question, 59 percent of respondents foresaw no change in their use of health services if they enrolled in an HSA, while 16 percent expected to use fewer services (Watson Wyatt 2005).

Early employer experiences

Large insurers were among the first companies to adopt CDHPs. Humana piloted a CDHP with 7 percent of its workforce in 2000–2001. These early enrollees were disproportionately less likely than workers selecting other health plans to be African American, to have only Humana coverage, to have a chronic health problem (or a chronically ill dependent), or to have had a recent physician visit (Fowles 2004). Total claims were less than 50 percent of the employer group average, suggesting that the CDHP may have segmented Humana's risk pool (Tollen 2004). In 2002, 18 percent of Humana's 14,000 employees enrolled in the CDHP, which helped reduce annual health insurance premium increases from 19 percent to 10 percent in that year (Booz Allen Hamilton 2003).

Aetna's 2002 claims data analysis for its internally piloted CDHP showed significant cost savings per CDHP enrollee — 13 percent less than for HMO members, 37 percent less than point-of-service (POS) subscribers, and 43 percent less than preferred provider organization (PPO) enrollees. Nevertheless, the pilot covered less than 1 percent of workers. Subsequent modifications (a lower deductible, more benefits, and improved online tools) increased CDHP enrollment to 4 percent of the workforce in 2003 (AIS 2003) and guided modification of Aetna's general commercial product offerings. Nineteen employers offering the HealthFund CDHP option had a 4 percent average medical cost increase, versus double-digit increases for a benchmarked member population in traditional plans; one employer offering a full replacement CDHP saw costs decrease 11 percent (Aetna 2004). After Whole Foods Market implemented a CDHP replacement in 2002, the 159-store grocery chain reported a 13 percent decrease in medical claim costs in 2003 for its 30,000 employees (Lieber 2004).

A study of the University of Minnesota's experience provides additional insights into demographic predictors of CDHP selection during 2002, when 4 percent of the university's 16,000 employees enrolled in the new coverage option. These employees were not disproportionately younger or healthier than the overall workforce, but they were more likely to be faculty and administrators than union members and had significantly higher incomes ($71,000 vs. $48,000) (Parente 2004).

A 2003 survey of employers in 12 communities found a growing awareness of CDHPs but skepticism about their ability to reduce costs. These companies worried that offering a CDHP would increase their overall costs by enrolling more workers with spousal coverage and by encouraging more spending in the majority of healthy workers whose current spending levels already were modest. They also had concerns regarding the costs to educate employees about CDHPs and to provide the necessary decision-support tools (Trude 2004).

Research on cost sharing

The landmark 1973 RAND Health Insurance Experiment was the first major long-term empirical study of cost sharing. Its principal finding was that consumers with cost-sharing requirements used fewer health services overall, and that reduced use of preventive and primary care by cost-sharing patients did not result in more hospital care and higher costs in the long run. The RAND experiment has long been used to justify cost sharing for services considered discretionary. Nonetheless, less well-known studies based on the RAND experiment indicate that cost sharing can be a barrier to receipt of effective medical care and preventive services, particularly for low-income patients (Davis 2004).

A simulation model of out-of-pocket spending in CDHPs versus HMOs and PPOs found that younger and healthier consumers and those with serious health problems saved money in CDHPs, while those characterized as slightly and moderately sick had higher expenditures (McNeill 2004). The American Academy of Actuaries (2004) also found that low users of health care services fared better under CDHPs than those with medium or high care-utilization levels when compared to PPO participants. The Academy predicted, though, that more consumer engagement in CDHPs would lead to the selection of more efficient providers and reduced hospital utilization, thereby producing savings for both employers and employees.

Consumer concerns

Employers have responded to health insurance premium increases by shifting more costs to employees, requiring increasingly larger worker contributions for premiums, deductibles, and copayments (Gabel 2003). Yet there is evidence that consumer trust in the health care system declines as out-of-pocket costs increase (Taylor 2003).

A 2003 Towers Perrin survey of employees in large U.S. companies found that although workers are aware of rising health care costs, they do not consider it fair for their employers to require them to pay more out of pocket (Landro 2003). Subsequent 2004 surveys confirmed employees' objections to absorbing more costs and found that the tension between controlling costs and maintaining workforce satisfaction has become a high priority issue for most large employers (Towers Perrin 2004).

Consumer advocacy and labor organizations are extremely wary of CDHPs. Families USA, a not-for-profit consumer advocacy group, (2003) critiqued them as driven by employers' desires to shift costs to employees, and expressed concerns about adverse selection and incentives for lower paid employees to forego medical care. Labor advocates have warned that the gap between the employer contribution and the deductible will grow over time to seriously erode workers' health benefits (Booz Allen Hamilton 2003).

The castigation of employer cost shifting by the AFL-CIO emphasized the hardships that this practice causes low-wage workers, who find dependent coverage increasingly hard to afford (AFL-CIO 2004). A Consumers Union official noted that the key feature of CDHPs is that they limit employer liability for health care costs, and argued that by encouraging adverse selection in lower deductible health insurance products, CDHPs ultimately could drive these products from the market (Shearer 2004).

Vendors addressed adverse selection concerns about CDHPs at a U.S. Senate briefing in February 2004. Definity Health reported that its plans have fewer younger enrollees than the standard population and a higher percentage of claims from enrollees with significantly greater health risk factors and for catastrophic events (Galen Institute 2004). At a subsequent briefing in May 2004, Assurant Health (2004) reported that 70 percent of its CDHP purchasers were over 40 years old.

Because a generic CDHP could result in greater financial risk to some groups, participants in a recent colloquium to encourage a responsible approach to consumer-driven health care recommended that CDHP designs be modifiable to adjust for, or carve out, vulnerable populations, such as lower wage workers and individuals with chronic illnesses (McDermott Will & Emery 2004).

METHODS

In 2002, California Health Decisions commissioned Lake Snell Perry, a leading public opinion research firm, to query 800 California English-speaking residents, ages 18 to 64, with employer-sponsored insurance. Respondents were divided evenly by gender; data were weighted slightly by age and race to reflect the attributes of the actual population of California as reported in the 2000 Census. The margin of error was +/–3.5 percentage points (Lake Snell Perry 2002).

The survey began with questions about respondents' current coverage and whether they had heard of CDHPs. After describing the product, the interviewer asked questions designed to assess employees' attitudes about CDHPs' specific attributes and their interest in a CDHP option.

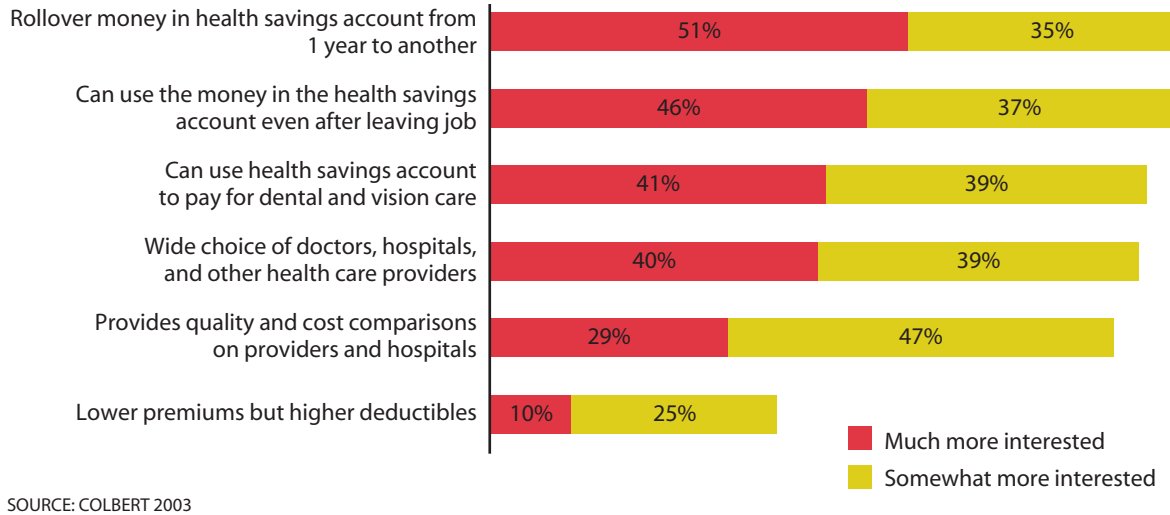
FINDINGS

A majority of respondents were very (53 percent) or somewhat (35 percent) satisfied with their current health plan; just 9 percent expressed dissatisfaction. Nevertheless, 40 percent had considered switching to another plan, and 38 percent expressed a desire for more insurance choices from their employers. The majority (75 percent) reported two or more choices; 52 percent had three or more options.

Just 14 percent of respondents had heard of CDHPs, and only 3 percent knew someone who was enrolled in one. About half (47 percent) found them very (4 percent) or somewhat (42 percent) appealing; 46 percent found them not too (21 percent) or not at all (25 percent) appealing. CDHPs appealed more to younger, single, healthier respondents and those with lower educational levels. Respondents who initially stated that they did not understand CDHPs well found them more appealing than did those who indicated a good understanding of this new type of health product.

As shown in Figure 1, respondents liked the flexibility of CDHPs' HSA for timing, portability, and purchase of ancillary health services, broader choice of providers, and the ability

FIGURE 1 Level of interest in attributes of consumer-directed health plans



SOURCE: COLBERT 2003

to compare provider quality and cost. The only plan feature with limited appeal was the tradeoff of lower premiums for higher deductibles.

These California consumers recognized the need to consider tradeoffs to sustain employer-sponsored health benefits, as Figure 2 shows. Most respondents were willing to take more responsibility for researching (54 percent) and managing (63 percent) their health benefits. Fewer (34 percent) were willing to pay higher fees to see out-of-network providers or to pay out of pocket for expenses exceeding the allocation in their HSAs (30 percent).

Respondents expressed keen interest in learning more about CDHPs through such information tools as comparative information about CDHPs and other types of health plans (92 percent); a workbook by a neutral party to calculate potential costs and benefits of CDHPs (89 percent); an interactive Web site allowing insertion of information on personal and health needs to learn about potential costs of CDHPs (88 percent); and workplace seminars featuring interactive presentations by experts on CDHPs (86 percent).

Most (70 percent) respondents felt that employees lacked opportunities for giving input to their employers about health insurance options, and 81 percent would want to provide input on plan structure if their employer were considering offering a CDHP. An overwhelming majority expressed strong (51 percent) or moderate (44 percent) support for their employers adding CDHPs as another health insurance option, with African Americans and older persons of color less likely to be in favor of this action.

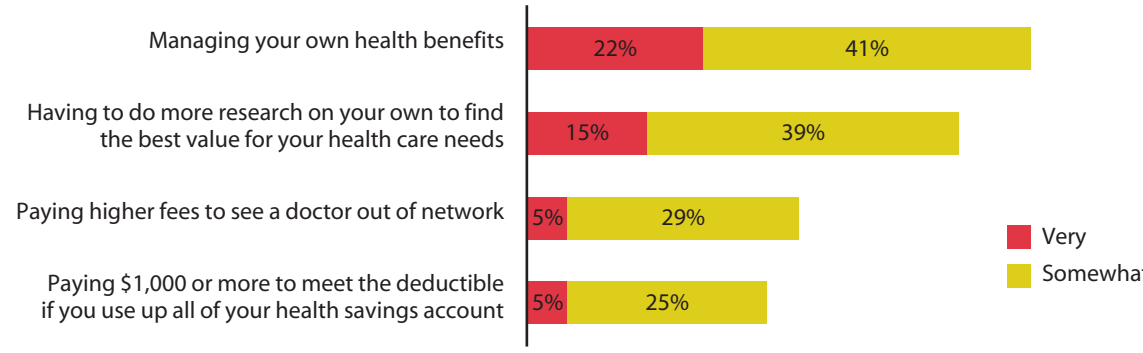
DISCUSSION

The California Health Decisions survey took place in 2002, when CDHPs were a new product, and it has some acknowledged limitations. First, the respondent population only included insured adults, and it was considerably better educated than the California adult workforce and the general population. Also, the description of the benefits model was limited and did not include later variations of CDHPs, which could appeal more to some respondents.

More recent national consumer polls indicate growing awareness of, and interest in CDHPs. While CDHP enrollment currently accounts for only a small segment of the private health plan market, more employers plan to offer them, employee interest is increasing, more insurers are adding CDHP products, and the Bush administration is promoting HSAs actively. The Federal Employees Health Benefit Program (FEHBP) recently added a CDHP to its panoply of insurance offerings. The Blue Cross and Blue Shield Association announced that its member plans in almost every state would offer PPO-linked CDHPs by 2006 (Kazel 2004). While just 4 percent of employers responding to the Kaiser Family Foundation (2004b) annual health benefits survey offered a CDHP in 2004, 27 percent were likely to do so in the future. Hewitt Associates (2005) found that 56 percent of employees at firms offering a customized CDHP for 2005 enrolled in it, with participation at some firms reaching 90 percent; just 3 percent of workers who were offered an HSA plan selected this option, however.

Overall, consumers are attracted by CDHPs' portability, rollover, and expanded choice, but they are concerned about whether this new type of coverage will increase their out-of-pocket costs. Consumers are interested in more actively managing their health care, but for many, a lack of experience and confidence indi-

FIGURE 2 Willingness to consider tradeoffs to keep employer health coverage



SOURCE: COLBERT 2003

cate a need for considerable education and assistance to do so.

Early employer experience shows slow initial enrollment in CDHPs, no clear trend of favorable selection by younger or healthier employees, and reduced costs — particularly for total-replacement plans. Most early-adopting employers offer CDHPs as an additional health insurance option rather than disrupting coverage arrangements that most employees find satisfactory, so there are limited outcome data on a small proportion of workers selecting CDHPs.

Most of the discussion and research on CDHPs has focused on the demographics, cost, and utilization experiences of early-adopting employers and enrollees. Given that early adopters may differ from the general population, these are important topics to pursue as CDHPs gain a larger market presence. But CDHPs also have the potential to help resolve two key health policy challenges — reducing the number of uninsured Americans and ensuring adequate retiree health benefits.

Early results of HSAs, which became available in January 2004, suggest that they are an affordable option for the uninsured. The online broker eHealthInsurance (2005) found that a third of HSA buyers in 2004 were uninsured for at least 6 months in the prior year, and 40 percent earned less than $50,000 annually. For 56 percent, the monthly premium was $100 or less. Assurant Health reported that 40 percent of approximately 175,000 individual applicants for HSAs in 2004 indicated no prior health insurance coverage (Galen Institute 2005).

Few private sector employers (13 percent in 2002) offer health benefits to retirees today, and a growing number of public sector employers face similar accounting standards and cost pressures that may force them also to cut back on retiree benefits in the future (Fronstin 2005). The rollover feature of HSAs could be a mechanism for younger workers to accumulate savings to pay for some postretirement health expenses not covered by Medicare (Fronstin 2004).

CONCLUSION

Just as managed care generated heated debate in its early stages, consumer-directed health care is controversial. Supporters praise CDHPs' structural incentives for enrollees to become more judicious and cost-conscious medical care consumers. Opponents critique CDHPs as another means to shift more costs to employees, and they express concerns that CDHPs favor healthier employees and that they might encourage less affluent enrollees to forego preventive services or to delay seeking necessary care. This debate is likely to continue. Additional experience will provide more definitive information on the effectiveness of CDHPs in reducing health care costs, as well as more complete data to support or refute opponents' concerns.

As CDHPs evolve, their value to all parties will increase with more consumer involvement in their refinement, implementation, and evaluation. This involvement will improve consumers' ability to understand what they are buying, how much they are paying, and how to use this product wisely.

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