Consumer-directed health care: One step forward, two steps back?

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The way to manage rising health care costs—espoused by some analysts and the current administration—is to give consumers greater control over health care decisions through a concept termed consumer-directed health care (CDHC). Sounds good. But how would the likely implications really play out?

CDHC IN A NUTSHELL

Herzlinger, a CDHC proponent from the Harvard Business School, describes the concept's key principles:

- Insurers and providers freely design and price their services to offer good value for the money.
- Consumers receive excellent information about the costs, quality, and scope of services, so they can make better health care purchasing decisions.
- Consumers buy health insurance plans, sometimes with employer funds, knowing their full costs so they can obtain good value for the money.[1]

In the US, CDHC combines a high-deductible health plan (HDHP) with a health savings account (HSA). In 2004, the consulting firm Mercer estimated that just 1% of all covered employees were in consumer-directed health plans, but 26% of all employers were likely to offer a CDHP within the next 2 years.

Recently, Humana introduced a health plan that could be combined with an HSA. UnitedHealth Group bought Definity Health, which specializes in HSAs. Blue Cross/Blue Shield announced it would offer HSA-compatible health plans nationwide by 2006, and Kaiser said it would do the same by 2005.[2] The American Medical Association has made the provision of HSAs a key part of its health policy agenda.[3]

High-deductible health plans

An HDHP is a health insurance policy with a minimum deductible of $1050 for self or $2100 for family coverage. The minimum deductible amount will likely increase yearly. The policy's annual out-of-pocket expenses, including deductibles and co-pays, cannot exceed $5000 for self or $10,000 for family coverage (**Table 1**).

The program may offer medical services through the variety of managed care options such as health maintenance organization (HMO), preferred provider organization (PPO), or point of service plans with in-network and out-of-network providers. Persons using in-network options save money by receiving price discounts on services.

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Companies may offer HDHPs with no deductible for preventive services (eg, physicals, immunizations, screening tests, prenatal and well child care) and higher deductibles and co-pays for using out-of-network providers.[4]

Health savings account: how it works

An HSA is a tax-exempt personal savings account used to pay for qualified medical expenses. Think of it as an IRA for health. Legislation to establish HSAs was included in the Medicare Prescription Drug Bill of 2003.

To set up an HSA, a consumer must have an HDHP, have no other health insurance, and be ineligible for Medicare. Individuals can sign up on their own through insurance companies (including the American Medical Association insurance company) or banks, or may be offered an HSA option through their employer. Contributions to the account can be made by individuals, by an employer, or both. If made by the individual, contributions are tax exempt; if by the employer, they are not taxable as income to the employee.

The maximum deposit that can be made in 2005 is the lesser of either the HDHP deductible or $2650 for the individual or $5250 for family coverage. These amounts will be indexed to inflation yearly. Individuals aged 55 to 65 can make catch-up contributions. Once eligible for Medicare, you can no longer contribute to an HSA.[4,5]

Funds in an HSA are usually controlled by the individual who sets up the account. Withdrawals are tax-exempt if used for qualified medical expenses. If used for other expenses, withdrawals are taxed and subject to a tax penalty. Monies in an HSA can accrue tax-exempt savings from investments (stocks, bonds, etc) and be rolled over each year with no maximum cap. Since the individual owns the account, it is portable. If a person moves, the account moves too. However, contributions to an HSA must stop if the person is no longer enrolled in an HDHP.

TABLE 1
Allowable limits on HDHP and HSA accounts

High-deductible health plan (HDHP)	
Minimum deductible:	
Individual	$1050
Family	$2100
Maximum out-of-pocket spending	
Individual	$5000
Family	$10,000
Health savings account (HSA)	
Maximum annual contribution	
Whichever is lesser: the HDHP deductible, or	
Individual	$2600
Family	$5150

After age 65, a person may continue to use an HSA for medical expenses or to pay insurance premiums like Medicare Part B and Medicare HMOs, or the funds can be taxed and used for non-medical expenses. In addition to the usual services covered in a traditional health plan, the list of qualified medical expenses is quite extensive (**Table 2**). Cosmetic surgery is generally not a qualified expense. The general goal is to have enough funds in the HSA to cover all medical expenses before the deductible in the health insurance plan is met.[4,5]

Public opinion generally unfavorable

A recent survey by the Kaiser Family Foundation found that 73% of respondents with employer-sponsored insurance had an unfavorable view of a health plan that combined an HDHP with an HSA, and 78% said they would feel vulnerable to high medical bills with this type of coverage.[6]

IMPLICATIONS OF CDHC

Advocates of CDHC believe the financial disincentives of co-pays and high deductibles will encourage consumers to reduce their use of marginal services and to seek lower-cost, higher

TABLE 2

Qualified CDHC medical coverage beyond traditional services

Certain alternative medicine therapies
Substance abuse therapy
Ambulance service
Medical equipment and home remodeling related to medical requirements
Reproductive health services
Vision, hearing aides, and dental care
Certain health insurance premium costs
Long-term care
Medications and home oxygen
Mental health services

Source: Internal Revenue Service Publication 502. Available at: http://www.irs.gov/publications/p502/ar02.html#d0e516. Accessed on February 1, 2005.

quality providers. They cite early studies showing CDHC participants decreased their use of certain medical services while increasing their use of preventive services and maintaining a balance in their HSA from one year to the next.[1]

Opponents of CDHC emphasize research that shows patients who pay more of their health care bills consume less care, including essential care. The RAND study of the 1970s confirmed that greater cost-sharing by patients reduced the chance they would receive effective medical care. This was particularly so for low-income patients. A recent study showed that increased medication cost-sharing led patients to stop using important drugs like statins and ACE inhibitors.[7]

How accessible/usable are health data?

Herzlinger cites informed consumer choices as a strength of the CDHC concept. However, the amount of information on cost and quality of health care is limited, albeit growing. More worrisome perhaps, there is little evidence that most patients can use this kind of information to make good health care decisions.

Who would benefit, who would not?

Another concern is that HDHPs and HSAs will more likely appeal to healthier, well-off people who can take full advantage of the tax incentives and more readily fund their accounts. If a significant number of consumers in this group moves toward CDHC plans, it would leave more unhealthy people in the traditional insurance system. This, in turn, would lead insurers to increase premiums for those less healthy consumers, thus making their insurance more expensive and, ironically, increasing the numbers of uninsured. CDHC plans may also appeal to the uninsured and those who have difficulty paying the usual health insurance premiums. This group is likely to have more difficulty fully funding their HSAs and, consequently, they will need to pay more of their deductible costs out-of-pocket, which can create a disincentive to seek needed care.

In an alternative analysis of CDHC, Robinson sees HSA products representing an evolution from collective insurance in which those in good health help finance the care of unhealthy enrollees with high expenditures (traditional health insurance with its “use it or lose it” design) to one in which unspent balances are retained by healthy enrollees rather than diverted to pay for the care of others (an HSA account with its “use it or save it” design).

In this scenario, healthy (and often well-off) consumers are favored by low-premium, high-deductible products. The savings are also financially protected from chronically ill users who would pay more in deductibles and coinsurance. The negative consequence is further diminishment of the already fragile social pooling effect of the current health insurance system and the potential for increasing the plight of the uninsured and underinsured.[8]

While it is likely that CDHC will attract more participants, it remains to be seen whether the public will support the concept if reports start appearing of significant numbers of patients refusing recommended services when faced with high deductibles and large out-of-pocket costs. CDHC will likely look attractive to healthy and well-off consumers, but its ability to control costs and improve quality in our already stressed health care system is suspect.

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