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Issue Brief

Will Consumer-Directed Health Care Improve System Performance?

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ABSTRACT: Consumer-directed health care plans have attracted attention as a method for managing rising health care spending by giving consumers greater financial control over their health care. However, increased cost-sharing—the principal tool used by these plans to achieve lower spending—may also cause patients to consume less care, even when that care is essential. Research studies have found that lower-income individuals and those with serious health concerns will particularly be at risk, as these consumers bear the burden of higher out-of-pocket costs. Instead of focusing solely on financial incentives, the real goal should be to encourage quality and efficiency among health systems, physicians, and hospitals.

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Although consumer-directed health care plans have yet to generate broad consumer interest and enrollment, they have garnered much recent attention for their potential to lower health spending by reducing utilization of health services. However, patient cost-sharing—the principal tool used by these plans to achieve lower spending—may also discourage consumers from getting necessary medical care.

While it is still too early to reach any definitive conclusions, current evidence raises significant concerns about relying on consumer-directed health care to address high costs, quality-of-care issues, and other fundamental problems in the health care system.

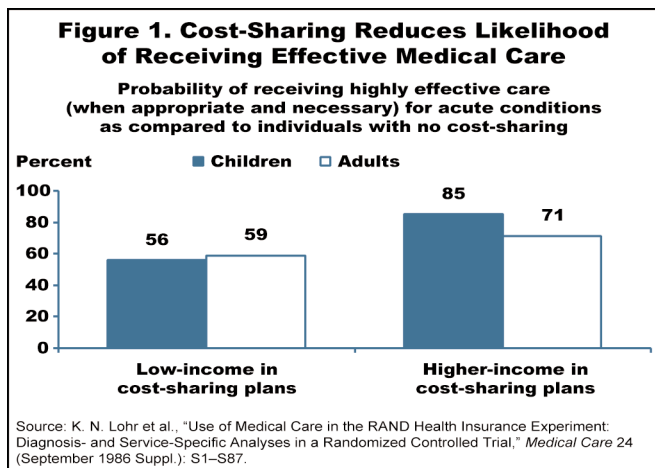
The consumer-directed approach is based on the notion that health care services are over-utilized; that giving financial incentives to consumers will reduce the use of marginal services; and that exposure to greater financial risk will motivate patients to seek lower-cost providers. There are various products available, but most of the discussion has centered on combining a high-deductible health insurance plan (e.g., \$1,500) with a health reimbursement account (HRA) to cover part of out-of-pocket expenses (e.g., \$500).

What has been largely left out of the debate is that if patients pay more health care bills directly, they consume less care—even when it is needed. Increasing patient cost-sharing can increase the net price for patients; reduce

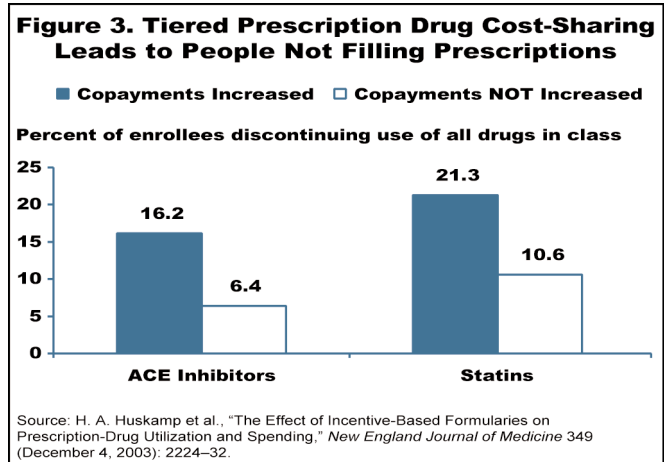
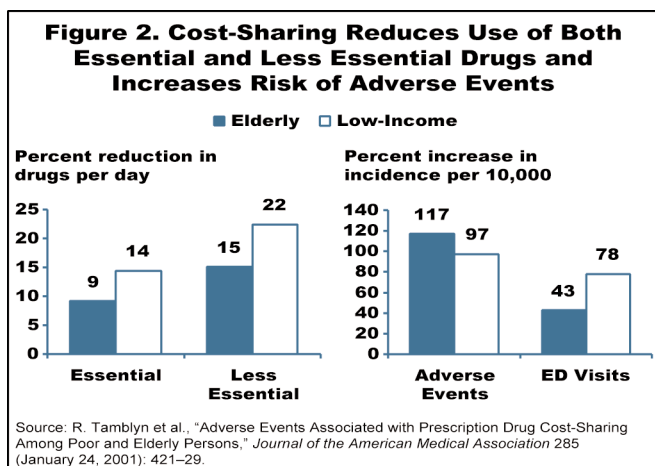
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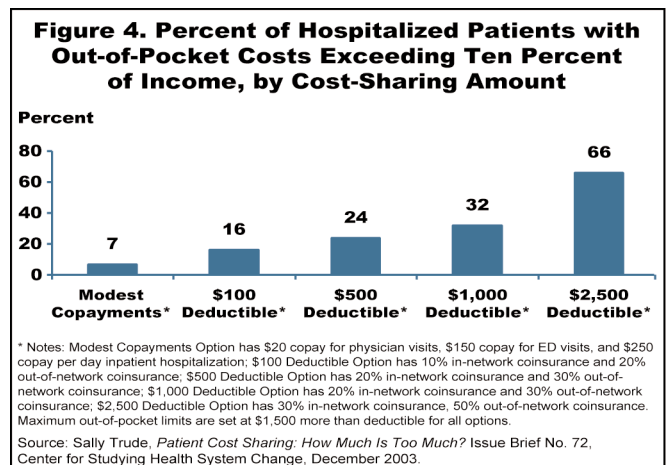
utilization; lower total health spending; and lower the cost of insurance due to a lower percent of bills covered and declined utilization. The landmark RAND Health Insurance Experiment in the 1970s, which examined the effects of cost-sharing, confirmed the observation that when consumers face higher cost-sharing they consume fewer services. But, studies of the RAND experiment found that cost-sharing also reduced the likelihood of receiving effective medical care, particularly for low-income children and adults (Figure 1). Even higher-income children and adults had a lower probability of receiving effective services than those in “free care” plans.



Over the years, other studies have confirmed the RAND findings. A study in Canada found that prescription drug cost-sharing led to a reduction in the use of essential drugs and an increase in adverse events (Figure 2). Additionally, in the United States, a move to tiered prescription costs and increased cost sharing by one employer led to discontinued use of medicines like ACE inhibitors and statins (Figure 3).

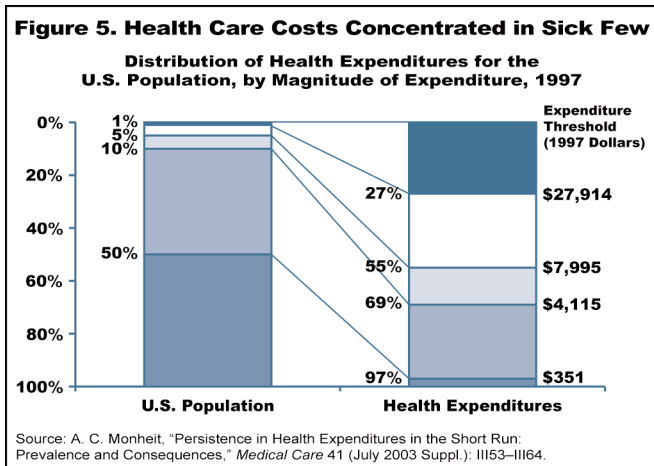


There are grave concerns regarding the effect of increased cost-sharing on lower-income individuals and those with serious illnesses, as they will bear the burden of higher out-of-pocket costs (Figure 4). Most health expenditures are incurred by a few very sick people. Ten percent of individuals account for 69 percent of health care costs (Figure 5). Care management for high-cost patients may be more effective and more equitable in controlling costs and improving care use than large insurance deductibles.



These findings suggest the need to look beyond reductions in utilization or spending to examine whether these reductions are appropriate and whether they may lead to adverse health consequences. The current research on consumer-directed health leads to the following four main conclusions:

- *Enrollment.* Consumer-directed health care products are still in their infancy and constitute a rela-



tively small part of the employer health insurance market. Fewer than one million individuals have an HRA, out of over 160 million people covered by employer plans.

- *Favorable risk selection.* Studies find that healthier, higher-income individuals are more likely to enroll in consumer-directed plans, leaving sicker and lower-wage employees in higher-cost alternatives.
- *Effect on utilization.* In their case study focusing on Humana employees, Laura Tollen and colleagues found over 85 percent of consumer-directed plan enrollees spent less than \$1,000 on health care, compared with two-thirds of enrollees in the HMO and PPO options. However, this was mainly attributed to better health status, and not price sensitivity.
- *Satisfaction.* Reenrollment in the new plans is relatively high, usually about 90 percent, with a high proportion of enrollees reporting satisfaction. However, only a relatively small proportion—30 percent—would unqualifiedly recommend the plans to others.

These conclusions raise serious concerns. It seems clear that consumer-directed health plans enjoy favorable risk selection, which may lead to increasing market segmentation, with lower-income and sicker individuals served by managed care plans and higher-income, healthier individuals enrolled in the new plans. As a result, enrollment in managed care plans could undergo a long-term decline while premiums for these plans steadily increase.

Rather than focusing solely on consumer financial incentives, the real goal should be to promote the spread of high-performing health systems, hospitals, and physicians. New studies are finding wide variations of cost and quality across hospitals and physicians, yet few private insurers, managed care plans, or public programs reward superior quality or efficiency. The following are steps toward achieving a high-performance health system:

1. *Public reporting of cost and quality data.* While there is some limited reporting of quality-of-care data, the routine collection of comprehensive quality measures across a broad range of providers is necessary to improve performance.
2. *Investment in IT.* Other countries, aided by investments from their governments, are quickly surpassing the United States in adopting electronic medical records and electronic prescribing.
3. *Development of guidelines and standards.* Establishing a new National Institute on Clinical Excellence and Effectiveness could provide a scientific basis for the effectiveness of drugs, consultations, procedures, and tests.
4. *Rewarding performance.* Medicare and private insurers tend not to reward better care, including better management of high-cost conditions. Medicare can and should be a leader in promoting more effective care, and should help to encourage private payers to reward higher quality, as well.
5. *Investment in research.* The federal government pays \$455 billion for health care in the United States, but devotes only \$300 million to the budget of the Agency for Healthcare Research and Quality. More research regarding ways to improve care, eliminate waste and ineffective care, and promote greater efficiency is crucial to the goal of improving the performance of the U.S. health system.

If consumer-directed care is used primarily as a tool for shifting costs from employers to employees, it will quickly be discredited. Instead, the long-term strategy should focus on identifying, demanding, and rewarding performance from providers, with positive incentives for consumers taking a complementary role.

This issue brief is based on the author's commentary in a special issue of *Health Services Research (HSR)* on consumer-driven health care. Supported by funding from the Health Research and Educational Trust (HRET), this special issue is a compilation of articles and commentaries from the "Consumer Driven Health Care: Evidence from the Field" conference on September 15, 2003, in Washington, D.C. Conference cosponsors were The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative and The Commonwealth Fund. Guest editors for this special issue are Carolyn M. Clancy and Anne K. Gauthier.

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Karen Davis, Ph.D., president of The Commonwealth Fund, is a nationally recognized economist with a distinguished career in public policy and research. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980 and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*.

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