Taking the Pulse of Consumer-Driven Health Plans

By Maureen Glabman

Thomas Weisman, MD, might be the last person you'd expect to be a foot soldier in a trendy new war on medical costs known as "consumer-driven health plans."


Weisman

Weisman, 59, has a chronic disease that requires frequent visits to doctors and pharmacies. Nonetheless, in January, he switched from an Anthem Blue Cross and Blue Shield HMO to the company's consumer-driven health plan (CDHP).

CDHPs, a nebulous euphemism for high-deductible PPO health insurance plans with savings account components, are considered niche insurance products for the young and healthy who eschew physicians and hospitals. They are not supposed to attract the middle-aged who expect greater out-of-pocket expenses.

But Weisman, an internist who is medical director for Anthem/WellPoint in the Northern Ohio region, did the math. Adding up payroll deductions for premiums of both plans, plus co-payments, deductibles and tax advantages, he computed saving about $700 annually. "I voted with my feet," he says. So did 15 percent of WellPoint employees when the CDHP was first offered this year.

It is this type of calculation that WellPoint and other insurers are betting will drive adaptation of the plans across ages and health status, reducing employer medical costs by an average 25 percent and attracting some of America's 46 million uninsured.

"I don't think this is a fad, and neither does my company, the largest health insurer in the country," Weisman says. "At the highest executive level, we have instituted a process to make sure we have a CDHP across all of our markets by January 2007. Our belief is that it's here to stay."

Insurer bandwagon

Clearly, enrollments are accelerating as more employers are requesting a CDHP alternative from insurers to offer to their workers. The largest U.S. health care companies—UnitedHealth, Aetna, Blue Cross, Cigna, Humana—are scrambling to feature them along with HMOs, PPOs and standard indemnity plans.

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With consumer-driven health plans quickly gaining popularity, there are key issues and potential problems that physicians need to consider.

"Every large request for proposal is asking for a CDHP offering," says William Marino, president and CEO, Horizon Blue Cross Blue Shield of New Jersey.

Some insurers eager to jump on the CDHP bandwagon are buying HSA companies to give them a ready made product they don't have to invent from scratch, such as WellPoint's 2005 purchase of Lumenos, and United's purchase of Definity in 2004 and Golden Rule in 2003.

Twenty-nine percent of employers will offer CDHPs to employees in the next year, according to a June survey of 1,000 member agents and brokers of the National Association of Health Underwriters, Arlington, Va.

A few employers have even done "full replacements." For instance, Baylor Health Care System in Dallas had a full menu of plans in 2005 but made available only a CDHP to 14,000 employees for 2006. Wendy's International, Inc., did the same a year ago for its 12,000 eligible workers, switching from a single PPO plan in 2004 to multiple CDHPs in 2005.

And CDHP/HSAs will get a huge boost in January 2007 when the Centers for Medicare & Medicaid Services begins offering medical savings accounts/HSAs to Medicare Advantage beneficiaries as a demonstration project.

Advantage plans are generally insurance products where beneficiaries assign their benefits to an HMO or PPO. Medicare MSAs work similarly to Medicare HSAs except that HSAs are more flexible, offering coverage of preventive care and other features.

"My personal opinion is that this is really going to be the dominant insurance model. It has very compelling features," Weisman says. "People are always suspicious of new things, especially when it comes to insurance. It will take a while for people to realize this will protect them."

Under consumer-driven health care, patients who predict their family physician will send them to a specialist may skip primary care and go directly to the specialist to avoid charges for two office visits.

Despite the growing availability of the plans, relatively few workers are enrolled, notes the Kaiser Family Foundation and HRET in the 2005 Employee Health Benefits Annual Survey. Less than 5 percent of Americans with private health insurance have CDHPs.

"Our members report that high-deductible health plans are becoming more common than they were a year ago—but (there's) still not a groundswell," says William Jessee, MD, president and CEO, Medical Group Management Association, Englewood, Colo.

MGMA, for example, offered a HDHP to its 140 staff members in 2005 and 2006. "The same five people that participated last year continued…. Clearly, our employees are generally much more comfortable with our PPO plan," Jessee says.

The experience is similar at Kaiser Permanente. The company tried its first test CDHP in 2005 in Colorado and other regions outside California, coming away with only several thousand members—half of whom joined Kaiser just for the CDHP, half who were already members and switched from other plans. Kaiser extended CDHPs to California this year.

Despite the voluminous amount of data being collected, it is too early to determine if CDHPs will surpass HMOs in popularity as some have prognosticated, or if they will remain simply an alternative plan. Viewpoints differ wildly.

"It's a niche market. We expect it will remain a relatively small portion of total enrollment," says Arthur Southam, MD, Kaiser senior vice president for product and market management.

Contrarily, Horizon's Marino says, "We think it's slow but it will take off."

Melodie Blacklidge, MD, medical director for the 100-doctor Cincinnati multispecialty group, Group Health Associates, says less than one percent of the practice's patients have shown up with CDHPs.

James Yoder, practice administrator at the seven-doctor Northeast Obstetrics and Gynecology in Fort Wayne, Ind. has seen just a few CDHP patients come through as well. As a result, he has not purchased the special credit card reader that would indicate deductibles, or instituted a strict collection policy that experts warn is essential in the CDHP age.

But as open enrollment season gets under way this fall for the nation's estimated 160 million to 174 million covered employees to choose next year's health insurance benefits, the lure of lower premiums and fewer restrictions on provider selection measured against higher gas prices may be tempting. HDHP premiums are up to 33 percent lower than other plans for consumers, reports JoAnn Liang in, *The Small Business Guide to HSAs.*

WellPoint's Weisman says CDHPs will catch on if they are designed well, with lots of built-in incentives. For example, his CDHP has a $3,000 deductible, but WellPoint contributes $2,000 to his HRA to cover some of the expense. In addition, preventive care, like immunizations and PSAs are totally free to him. "If employers want it to be a success, they must make plan designs attractive," he says.

A majority of U.S. companies make HRA/HSA contributions to employee accounts to encourage enrollment, according to ACS/Mellon, a Dallas human resource consulting company.

For instance, Northeast Obstetrics' Yoder sweetened the pot for the practice's 52 employees by

How Do CDHPs Work?

Generally, patients with consumer-driven health plan (CDHPs) have at least $1,050 in individual deductibles; $2,100 for families. Most plans attach a health savings account (HSA) or health reimbursement account (HRA), a cross between a flexible spending account, a 401K and an IRA. These are made possible through partnerships between health carriers that enroll employees and administer the insurance, and financial institutions that manage the accounts.

HRAs, accounts set by employers only, were enabled by a U.S. Department of the Treasury ruling in June 2002. Sister HSAs were established as part of the Medicare Modernization Act, available to employers as well as individual consumers in January 2004.

The tax benefits are substantial. Employees or employers, or both, contribute to HRA/HSA accounts with pre-tax dollars that can be used to pay for eligible medical expenses that fall under deductibles. After the deductible is met, traditional insurance kicks in, usually with employees picking up 10-20 percent of the costs until the out-of-pocket maximum is reached.

A hefty $2,700- $5,450, or 100 percent of the annual policy premium, whichever is less, can be placed in an HSA account. HRAs have no limit. The funds aren't taxed and are not included in employee taxable income. Also, once the money is withdrawn, it is not taxed if it is used for qualified medical expenses. Interest on HRA/HSA funds accumulates and is also tax-free. If HRA/HSA monies are not used, they roll over year after year to cover bigger medical bills later in life.

The main difference between an HRA and an HSA is that an HSA is portable, following an employee from job to job; HRA funds generally remain with employers as an employee retention device.

The plans come in many flavors with hundreds of permutations. Some employers make their CDHC offerings as attractive as traditional plans, stacking them with incentives, like first dollar coverage for preventive care, such as yearly physicals, immunizations and mammograms, which do not count against deductibles. You can have a CDHP without an HSA, but not the reverse.

Because of their complexity, CDHP plans were initially slow to catch on, despite the push from President George Bush whose health care agenda for diminishing health care costs includes the plans. A mere 438,000 Americans enrolled in the first HSA year, 2004. By January 2006, the number had climbed to 3.2 million, reports the Washington, D.C.-based trade association, America's Health Insurance Plans, which represents 1,300 insurers.

Between six million and 25 million people are predicted to have HSA accounts by 2010, depending on which of the many forecasts you read. Consumers can only have an HSA with an accompanying high deductible plan.

contributing $600 to each HSA. Ten employees, including six of seven doctors, signed up when Yoder introduced the CDHP in 2005—20 in 2006. The rest remained with the practice's HMO plan. "People were anxious about the immediate impact of the out-of-pocket expense," Yoder says. "By funding their HSAs, their initial expense is offset."

Overall, Northeast's group premiums declined the first CDHP year from $17,000 to $12,000 monthly. In 2006, the HMO increased premium rates to the practice, but the CDHP did not, so his premiums were flat. "We may drop the HMO altogether," Yoder says.

Yoder, 55, who belongs to the practice's CDHP, used none of his deductible the first year but had to dip into his HSA the second year to pay for a physical and a colonoscopy. By then it had amassed a $1,200 practice donation, plus his personal contribution. He used an insurer-supplied debit card to pay the deductible and still has HSA funds left. "I hope to have a big pot here for medical expenses when I retire," he says.

In some areas of the country where employers are pulling out the stops to attract workers, CDHPs may not realize large participation. "CDHPs have no traction in this market," says Peter O'Neill of Sierra Health Services, Las Vegas, a health plan and group practice. "This is a very unique low unemployment area. Jobs are plentiful and employers are designing health care packages to be attractive to employees with minimal out-of-pocket deductibles."

Of Sierra's 800,000 members, only 1,000 selected the plans. However, Sierra does not simplify the HRA/HSA. Employers have to find HRA/HSA companies and make their own arrangement to connect the CDHP. Most larger insurers already have established those relationships.

Physician/patient perspective

CDHPs derive their name because having responsibility for a large share of upfront medical costs is considered a consumer incentive to comparison shop for health care, just as you would for houses and cars. An additional incentive is that unspent money in HRA/HSAs rolls over and accumulates year after year until it is withdrawn tax free for health care expenses.

But employees accustomed to thinking a doctor's visit costs a $15 co-payment are in for sticker shock once they start writing checks for deductibles. Harris Interactive conducted a 2005 telephone poll of 2,000 adults covered by employer-sponsored health care plans, entitled, "Consumer Attitudes toward Health Care." It found employees guessed the price of a new Honda Accord within $300 but were off by $8,100 in their estimation of the cost of a four-day hospital stay. Some 63 percent of those who received medical care in the last two years didn't know the cost of the treatment until the bill arrived.

"They will become economically sensitive," predicts John Roglieri, MD, employee health medical director, New York Life Insurance, a company that offers an HSA as well as other plans to staff.

"Consumerism has been rampant in American society in everything but medicine. Now I think patients will ask doctors more questions about their treatments. Patients will migrate to the doctor with the lowest published fees, given equal credentials.

"Really savvy patients will check board certification, where the doctor went to medical school, years in practice and malpractice report databases."

New York-based McKinsey & Company reported last June that CDHP plan holders were 50 percent more likely to ask about costs and three times more likely to have chosen a less extensive, less expensive treatment option. They were also much more likely to visit an urgent care center than a hospital emergency room.

"It puts some pressures on us," says Kaiser's Southam. "There now ensues a discussion. The patient says, 'My knee hurts, can I wait a week for the test?' We must make sure out-of-pocket costs don't become a barrier to good decisions by patients or their doctors."

Kaiser insists that front offices handle patient cost questions. "We want our doctors to practice medicine, not give out pricing information."

Patients and doctors may begin to clash when doctors order tests for defensive medicine purposes and patients decline for financial reasons. Clinicians are advised to keep "against medical advice forms" at the ready to protect themselves.

Clearly, requests for discounts, less expensive therapies and generic drugs are already starting. Rockford, Ill. author/consultant William DeMarco of DeMarco and Associates, whose 10 employees have CDHPs, negotiates discounts with doctors, goes for second opinions to confirm they require expensive procedures, even journeys to other states to save money.

One of DeMarco's staffers is a weekend warrior who tore her rotator cuff. "She compared repair procedure prices online with doctors in her home state of Illinois and in Wisconsin. Then she went back to her Illinois doctor who agreed to halve the cost," says DeMarco, who wrote a 1998 book titled *Physician Driven Health Plans*.

It's not just about price. Quality and service matter too. "There's a pharmacy in my town where the cost of medication is unquestionably cheaper, but I don't go there," WellPoint's Weisman says. "Check out takes forever, they accept cash or check only, and the store is dirty."

By the Numbers

- **Total U.S. Population:** 299 million
- **Total Number of Americans with CDHPs:** 3.2 million
- **Total U.S. Population with employer-sponsored health insurance:** 160 million -174 million
- **Total U.S. uninsured:** 46 million
- **Total U.S. with Medicaid and state children's insurance programs:** 51 million
- **Total U.S. Medicare:** 43 million
- **Total number of employers who provide any health benefits for employees:** 60% in 2005.

(**Note:** Some overlap occurs because some people could have both Medicare and an employer-sponsored health insurance plan)

(**Sources:** Kaiser/HRET Survey, U.S. Census Bureau, National Coalition on Health Care)

Managing Receivables with CDHPs

The key to financial practice security is to have well-trained patients and persevering staffs. Doctors need to be aware of, but not get involved in, the payment process.

By JoAnn Liang

1. Set rates for procedures by code and do not permit other doctors in the same group or practice to waver from it except in cases of financial hardship.
2. Insist staff gain insurance and payment information prior to patient appointment and advise patients of rate on arrival. For walk ins, post menu boards with rates or have cost of services printed and ready for patient review if this does not violate insurer contracts.
3. Print grid charts for use by entire practice and hospital staff on what different plans cover—or have online. Some plans allow preventive services before the patient deductible kicks in.
4. On arrival, ask patients to sign notification form of rate, establish method of payment, obtain HAS number, debit and credit card.
5. Upon completion of care delivery, provide patient with details of services rendered and charges.
6. Collect deductible before patient leaves office via automatic debiting, credit card, cash or check.
7. File claims immediately. If there is a problem with a claim, you will want to know soonest.
8. To gain HRA reimbursement from employers, patients will need a "sanitized" copy of bill, leaving out diagnosis if possible.

JoAnn Liang *is president and CEO of Information Stategies, Inc., in Fort Lee, N.J., a company that researches and tracks CDHPs and HSAs. Liang is author of* The Small Business Guide to HSAs, *published by Brick Tower Press in 2006.*

If a consumer revolution is just getting under way, doctors are ill prepared for it. "I asked my own doctor if he knows about it (CDHPs) and he said, 'Speak to my office manager,'" Horizon's Marino jests.

"Doctors have no concept of CDHPs," Weisman adds.

Physicians who previously worried little about filling waiting rooms because they were listed on managed care panels may have to retool and compete on posted quality reviews, price and service because of less "steerage" with CDHPs.

"Doctors offices will have to become consumer-friendly," Weisman says. "No waiting in a waiting room one hour for an appointment. Retail clinics will grow if doctors keep patients waiting."

Because of rising transparency, patients will find it relatively easy to shop for some medical care online. "Face lifts, lasik surgery, obstetrical care, colonoscopies—elective, well-defined procedures you can shop for," Kaiser's Southam says. "You can't shop for brain surgery, comprehensive cancer care or an undiagnosed medical problem. For instance, you can't say to a doctor, 'I have no energy. How much will that be to cure?'"

Faster payments

One large CDHP benefit for doctors and hospitals cannot be understated. Doctors and hospitals will not have to wait three or four weeks for insurance checks since patients will pay deductibles up front. It's a return to the mid 20th century when patient payments, not insurer payments, determined practice cash flow.

But first, providers have to figure out what patients owe and collect it. If not, they could have trouble meeting payroll. Lower income workers may not realize how large of a burden the deductible is until they are faced with paying it. "We've studied it for a year. It (CDHPs) could increase bad debt, cash flow and receivables. There's a concern by practice administrators," MGMA's Jessee says.

Several solutions have been offered to avert an accounts receivables mess. "Doctors will have to bill in advance just like hotels do for reservations," Illinois consultant DeMarco suggests. For larger cost items, like procedures, doctors may be asked to float credit for patients in the form of payment plans, though that may not be necessary.

Empire Blue Cross and Blue Shield, for example, distributes American Express credit cards to their CDHP insureds that allow them to take out a line of credit, enabling providers to collect their fees on the spot.

Another innovative idea is to have employees sign a contract with their insurers that would deduct provider payments from payroll checks, he adds.

Aggressive hospitals already employ "time of service" collection tactics, like the 181 HCA hospitals. HCA asks patients to pay their bills, or at least make a down payment, before receiving non-emergency treatment. They dispatch advisors to patient rooms to:

- Review co-payments and deductibles
- Guide patients to business offices prior to discharge to settle a bill or arrange a payment plan
- Request deductibles or a down payment prior to elective procedure
- Call patients in advance of their procedures to alert them what is due on arrival

Front office staffs in doctor's office will have to become equally assertive.

Besides the financial fallout from CDHPs, there could redirected utilization, not necessarily reduced utilization. It won't take long for patients to figure out they will pay less to see their internist than an otolaryngologist for an ear infection. On the other hand, patients who predict their family physician will send them to a specialist may skip primary care and go directly to the specialist to avoid charges for two office visits. They may also perceive they get more bang for their buck—more knowledge for the money, by seeing specialists.

Finally, there is the argument providers will see more patients previously uninsured. Some 31 percent of those purchasing HDHPs in the individual market were previously uninsured; one third of the policies purchased in the small group market were purchased by companies that did not previously offer coverage, according to a June report to the U.S. House Committee on Ways and Means by Karen Ignagni, AHIP president and CEO. "This indicates that these options are achieving success in expanding coverage to the uninsured," Ignagni says.

Kaiser's Southam disputes the claim. "High-deductible plans are not attractive to people with modest means. They are not buying the plans to protect their assets from a catastrophic health event because they don't have assets," he says.

And, adds Joel Miller, senior vice president, operations, National Coalition on Health Care, Washington, D.C.: Businesses that currently do not offer employees health coverage cannot even afford these CDHPs. "They still need significant subsidies to provide coverage."

Maureen Glabman *is a Miami-based health care reporter and recipient of the 2000 Reuters Fellowship in Medical Journalism at Columbia University's Graduate School of Journalism.*