


Consumer Choice and Responsibility –  
Expanding Models for Consumer-Directed  
Health Care



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# Consumer-Directed Healthcare

## Current Marketplace

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- High Deductible Health Plan (HDHP)
  - HSA regulations require deductible of at least \$1100/single or \$2200/family.
  - Either full coverage above deductible or a copay until maximum out-of-pocket limit.
  - Plans must also include maximum annual out-of-pocket limit.
  - Preventive care can be exempt from deductible.
  
- Health Savings Account (HSA)
  - Contributions not subject to income tax.
  - Withdrawals (for medical spending) not taxed.
  - Account earnings tax-exempt.
  - Funds roll over from year to year and are portable.

# Consumer-Directed Healthcare in Theory

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- High Deductible Health Plan (HDHP)
- Savings Account
- Decision Support Systems
  - Comparison Shopping Tools
  - Information on Cost and Quality

# Insurance Continuum

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## No Insurance

- Pay full price for all health care
- Total financial risk

Consumers fully responsible.

Unlikely to get unnecessary care.

Do not spend "too much."

May also not get necessary care.

## Full Insurance

- All health care is free
- No financial risk

Consumers not responsible.

Likely to get "too much" care, spend "too much."

# CDHP's on a Continuum

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## No Insurance

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## CDHP

- Larger than usual deductible, but not too large.
- HSA that covers the deductible.

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## No Insurance

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## CDHP

- **Very** large deductible.
- Very small HSA.

## Full Insurance

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# Driver is Cost Containment

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- ❑ Cost savings predicted by theory (or common sense).
- ❑ No doubt that there would be cost savings relative to full insurance.
  - Rand Health Insurance Experiment evidence
    - ❑ Participants with very large deductible spent 30% less than participants with free care (full insurance).
- ❑ Relevant comparison is not full insurance.
- ❑ How will structure of plans and current spending patterns affect costs savings from CDHC?

# How much cost containment?

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- Once the deductible (or OOP limit) is reached, person/family is fully insured.

# CDHP's after the Deductible

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# How much cost containment?

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- ❑ Once the deductible (or OOP limit) is reached, person/family is fully insured.
- ❑ If people anticipate reaching the deductible (or OOP limit) due to, say, chronic conditions, they may not act “responsibly” from the start.
- ❑ Can this work properly without information systems in place?
  - Will consumers be able to lower costs if they cannot comparison shop?

# Other costs?

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- Will necessary care also get cut out?
  - Especially without good information systems in place.

# Good Evidence

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□ VERY SPARSE

# Most Convincing Evidence from Sparse Literature

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- *CDHP's Experience Favorable Selection*
  - *(at Least in the First Year)*
- *Frequent Reports of Lower Expenditures in CDHP's*
  - *but More Convincing Evidence is Needed*
- *Satisfaction with CDHP's Appears Lower*
  - *but Lack of Understanding due to Newness of Plans Could Be the Cause*

# Most Convincing Evidence from Sparse Literature

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- *Benefit Design Specifics Matter*
  - *but No Evidence Yet About Optimal Design*
- *Health Care Cost Comparison Tools Not Yet Well-Developed*
  - *CHCF Report Concludes "Because the tools do not enable consumers to shop around for services, they do not facilitate health care consumerism."*

# Questions to Put on the Table

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- Does this debate rely too much on rhetoric and ideology?
  - Still little conclusive evidence about the effects of CDHPs.

# Questions to Put on the Table

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- Are we getting ahead of ourselves?
  - Without decision-support tools, do these plans lose their punch?
  - By the time such systems are in place, will frustration have created a CDHC backlash?
  - Are we giving CDHC its best chance to work?

# Questions to Put on the Table

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- Are we putting too many eggs in the CDHC basket?
  - What other strategies may be needed to accomplish significant cost containment?
  - What other strategies may be needed to lower the number of the uninsured?