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RHETORIC VS. REALITY: EMPLOYER VIEWS ON CONSUMER-DRIVEN HEALTH CARE

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Because of rising premiums, employers are investigating new health insurance approaches that maintain workers' broad choice of providers while raising awareness of health care costs through increased patient financial responsibility. Employers' knowledge of new health plan products, including consumer-driven health plans and tiered-provider networks, has grown considerably in recent years, according to findings from the Center for Studying Health System Change's (HSC) 2002-03 site visit to 12 nationally representative communities. But employers are concerned that consumer-driven health plans would take considerable effort to implement without much cost savings. They also are skeptical that tiered-provider networks can adequately capture both cost and quality information in a way that is understandable to patients.

Little Interest in Consumer-Driven Health Plans and Tiered Networks

As health insurance premiums continue to rise, employers are searching for new long-term strategies to hold down their health benefit costs. Employers are interested in approaches that offer broad choice of providers but raise cost awareness by shifting more financial responsibility to workers. Consumer-driven health plans and tiered networks are the two new health benefit designs currently receiving the most attention, although employers more often have simply increased patient cost-sharing requirements in existing health plan designs.

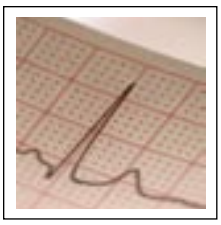
Consumer-driven health plans typically refer to high-deductible health plan products tied to spending accounts, or health reimbursement accounts, funded by employers.[1] Once the consumer has exhausted the spending account, there is a gap in coverage—for example, $500—where the consumer must pay for all care before the high-deductible policy kicks in and provides coverage. Consumer-driven plans also offer consumer information on provider price and quality.

Tiered-provider networks typically categorize hospitals or physician groups by price and quality and assign lower premiums or patient cost sharing to consumers who opt for the preferred tier.[2] In a tiered-hospital network product, for example, health plans label some hospitals as "preferred." Patients pay less out of pocket if they choose a preferred hospital than if they go to a nonpreferred hospital in the network. Tiering improves health plans' bargaining leverage with hospitals because hospitals in the nonpreferred tier will lose some patient volume.

Both consumer-driven health plans and tiered networks are considered a step beyond simply raising patient cost sharing because they aim to combine financial incentives with information that supports cost-effective patient decision making. Few of the employers in the 12 communities had adopted or planned to adopt consumer-driven health plans or tiered-provider networks, according to findings from HSC's 2002-03 site visits (see Data Source). HSC researchers interviewed a variety of local health care market stakeholders to gain an overall view of health benefits in the 12 communities. In particular, researchers asked health benefit managers for large public and private employers to describe their perspective of consumer-driven health plans and tiered-network products and reasons for choosing to implement or not implement these approaches. Consultants and brokers were asked about the products' role in local health markets, their opinions about consumer-driven health plans and tiered networks and how they are advising their clients about these products.

Awareness Higher

Employers were more knowledgeable about consumer-driven health plans—in stark contrast to three years ago when few knew of the concept and those who were aware gave widely varying definitions of the



Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix, Seattle; and Syracuse, N.Y. In 2002-03, HSC researchers interviewed health benefit managers of large companies of 500 or more workers, health benefit consultants and brokers about consumer-driven health plans and tiered-provider networks.

concept, ranging from cashing out of health benefits to moving to a fixed-dollar contribution.[3] Only a handful of respondents did not know about consumer-driven health plans. At the other end of the spectrum, some health benefit managers had used their health care claims data to estimate the potential cost savings from moving to a consumer-driven health plan or had conducted employee surveys to assess feasibility.

Of the handful of employers who reported implementing or planning to implement a consumer-driven plan in the near future, all planned to offer the product as one option among other health benefit offerings.

Employers knew more about tiered networks in markets where health plans offered or were developing tiered-network products. In a few instances, employers were involved in the development of tiered networks. In contrast, some employers did not view tiered networks as being substantially different in concept from the preferred provider organizations (PPOs) they currently offered, where employees pay extra to use out-of-network providers or where employers offer a range of health plans such as health maintenance organization (HMO), point of service (POS) and PPO options with different costs to employees.

Show Me the Money

When considering consumer-driven health plans, employers doubted the approach would slow the growth of their health care costs. One key concern was that by providing a spending account to all employees, employer payments might increase for their healthy workers. One employer noted that 70 percent of the firm's covered employees had health care costs of less than $1,000 a year. Concerned that a spending account would encourage healthy workers to use more services despite being able to rollover unused funds to the next year, this employer expected that a $1,000 spending account would raise costs, not lower them.

Another employer said that 30 percent of its workforce did not take up the company's health insurance, reportedly because the predominantly female workers were covered under their spouses' insurance. But a personal spending account option might prompt more workers to opt for coverage and increase the firm's costs.

Another concern was that consumer-driven health plans had no better high-cost case management tools than other managed care options. Employers believed there were more opportunities for cost savings by managing high-cost cases rather than reducing utilization among the majority of workers who already use little care. In addition, many noted that spending accounts did not provide a "high-end user" with any incentives to control costs because individuals with catastrophic illnesses typically are fully covered by the health plan after the deductible and any out-of-pocket maximums are met.

Employers also weighed the trade-off between choosing a consumer-driven health plan offered by a national firm and their current HMO or PPO from a regional health plan. A few employers noted that provider discounts under a prominent national consumer-driven health plan were not as large as those available through local health plans, so potential savings from lower utilization might be offset by smaller provider price discounts.

Some employers, however, did expect consumer-driven health plans to slow their cost growth. The key advantage of consumer-driven health plans, according to these employers and their representatives, is their potential to increase consumers' financial stake in their health care, to improve their understanding of the cost of care and to reduce utilization. Some hoped that consumer-driven health plans would help employers move away from first-dollar coverage and minimal copayments. With a health spending account, a worker still has first-dollar coverage but pays the full amount of the discounted bill for care instead of a copayment.

Although employers, consultants and brokers who favored consumer-driven health plans hoped that spending accounts would lead to lower costs through lower utilization, some thought the greatest cost savings would result from employers moving to a fixed-dollar contribution and stabilizing future employer contribu-

tions. In addition, with a "build it and they will come" viewpoint, a few respondents expected a move to consumer-driven health plans to increase provider competition and lead to the development of easily accessible and relevant consumer information in the health care marketplace.

Putting the Consumer in Consumer-Driven Health Care

Employers also were concerned about the amount of education they would have to provide to their workforce to implement a consumer-driven health plan. In particular, health benefit managers assumed that it would take a substantial effort on their part to educate workers about how consumer-driven health plans function, especially spending accounts, as well as to provide decision-support tools for choice of provider and treatment options. Indeed, employers gravitating toward consumer-driven approaches invested considerable effort in developing employee communication and education plans well in advance of offering the new plan.

Some employers also were concerned that regardless of the amount of education they provided, spending accounts were too complicated and their workforce "not savvy enough." Employers in markets such as Orange County and Miami described how difficult it would be to educate their workforce about coinsurance and personal spending accounts given their workers' long history and familiarity with HMOs and copayments. Some health benefit managers pointed to workforce demographics, predicting that workers with less education, language barriers, and lacking access to computers or the Internet at work or home would be unable to benefit from a consumer-driven health plan.

Tiered Networks Face Skepticism, Too

Tiered-provider networks were described as a "design running ahead of information," with employers questioning whether health plans had the information needed to identify higher-quality, lower-cost providers. Many employers assumed that health plans would design tiered-provider networks to save money and predicated their enthusiasm for tiered networks on whether the delineation of tiers would be based on both cost and quality information or on cost alone.

Furthermore, there was confusion across employers about whether consumers would have to pay more to see high-quality providers. Some assumed the ideal: That the preferred tier would include the highest-quality, lowest-cost providers. Employees choosing the preferred tier would get better care at a lower cost, and employees choosing a less efficient provider in the nonpreferred tier would pay more. However, some employers assumed that higher-quality providers would invariably charge more and patients would have to pay more for the tier with for the highest-quality providers. These employers questioned the fairness of tiered networks if high-quality providers would only be available to those with the resources to pay for them.

Views about the type of quality information that might be required varied considerably. Some employers thought that current claim information was sufficient, while others believed tiered networks would require standardized outcomes data. Others were concerned about the type of quality information available and questioned how employers could evaluate the tiers. They also questioned whether health plans would reveal their methodology for developing tiers and whether providers would cooperate.

Health plans considered tiered networks as a valuable tool for gaining leverage on provider payment rates and for encouraging provider efficiency. In contrast, employers considered tiered networks as a tool to shape employees' choice of provider. Employer decisions about whether or not to adopt a tiered network reflected current health plan offerings not their potential. Employers, therefore, wanted assurance that tiered networks adequately reflected both quality and cost before moving in this direction.

While employers viewed education about tiered networks to be the role of health plans, some did question whether

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this would be feasible. A few were wary that without adequate information about quality, consumers might equate high cost with high quality and, therefore, be more inclined to choose the high-cost tier. Some mentioned the challenge of communicating tier choices to employees, especially because the tiers would not be static as top-performing providers changed over time.

Implications

Contrary to vendors who tout their products as single solutions to rising costs, employers described a broad range of pluses and minuses of consumer-driven health plans and tiered networks. Given the diversity of employers and their workforces, it is unlikely that any single solution to rising health care costs will suffice. Large national firms with numerous sites will more likely prefer an option that can be offered nationally, while a firm with a single location may prefer a local option. Similarly, one option might appeal to a company with a highly educated workforce but be rejected by firms with less-skilled workers.

Rather than lemmings to the sea, most employers scrutinize their own particular workforce characteristics and company circumstances to assess potential cost savings of new product offerings rather than base decisions on other employers' actions.

However, the debate around these new product designs, especially consumer-driven health plans, continues to emphasize a single solution to rising costs, suggesting a tipping point where the remaining employers will follow the actions of "innovating" employers. Regardless of whether employers widely adopt consumer-driven health plans, there will continue to be a need for additional new cost-containment tools, including, for example, improved management of high-cost, medically complex patients and better ways to measure quality of care at the individual provider level.

Policy makers have sought to encourage employers' adoption of new products, for example, by revising regulations for spending accounts and developing tax incentives for high-deductible health plans. However, the diversity of employers and workers suggests that employers will scrutinize products through the prism of their own costs and that the health insurance market may require a range of innovative products rather than a single solution.

Notes

1. Christianson, Jon, Stephen T. Parente and Ruth Taylor, "Defined Contribution Health Insurance Products: Development and Prospects," *Health Affairs*, Vol. 21, No. 1 (January/February 2002).
2. Mays, Glen, Gary Claxton and Bradley C. Strunk, *Tiered-Provider Networks: Patients Face Cost-Choice Trade-Offs*, Issue Brief No. 71, Center for Studying Health System Change, Washington, D.C. (November 2003).
3. Trude, Sally, et al., "Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes," *Health Affairs*, Vol. 21, No. 1, (January/February 2002).