



Translating Research into Practice

Cost-Sharing and “Consumer Driven Purchasing”:

Part 2: Is There Promise for Cost Control?

August 2004

Volume 5 Number 5

Donna Friedsam.

Note: *This Issue Brief is the second of a two part series. Part I considers the economic challenges these trends pose to consumers.*

Employers have not simply increased patient cost-sharing requirements in existing health plan designs. Many look to add consumer decision support and incentives through consumer-driven health plans and tiered networks. Employers are interested in approaches that offer a choice of providers but raise cost awareness by shifting more financial responsibility to workers.

Consumer-driven plans typically refer to high deductible plans tied to spending accounts; or health reimbursement accounts (HRAs), funded by employers. Plans also offer information on provider price and quality to support consumer decision-making. The intent is to reduce cost by motivating consumers to choose lower cost and/or higher quality providers and, usually, to reduce overall utilization.

Sponsors of consumer-directed health benefits maintain that enabling “consumerism” in health care is the primary objective. These plans also provide a way for employers to reduce or share with enrollees double-digit premium increases, and fix the employer’s future contributions at a set level.

The momentum behind this movement is strong. One influential Wisconsin corporate

leader writes of the combination of consumer-driven plans, Health Savings Accounts, and transparency on price and quality as the potential “silver bullet” employers have been seeking.¹

But others suggest a need to take a more circumspect approach to such plans. Critics argue that consumer-directed health plans shift more costs on to sicker consumers and are disproportionately onerous on lower income workers. As well, they maintain that decision-making tools are not sufficiently developed or are too complex.

This issue brief reviews recent research surrounding consumer-driven purchasing, placing it in perspective relative to where the costs are incurred in the health care system.

Employer Skepticism Remains

Milliman USA reportedly estimates that consumer plans will rise from covering about 500,000 people in the U.S. in 2003 to 1-2 million this year and 5 million in 2005.

But the national Center for Studying Health System Change reports² that many employers are concerned that consumer-driven health plans would take considerable effort to implement and are skeptical about the potential for cost savings.

Employers report concerns that it would take substantial efforts to educate workers about how the plans function and to provide the necessary decision support for choice of provider and treatment options. They particularly noted these challenges with diverse workforce demographic, including less literate or non-English speaking populations.

Employers described tiered networks as “design running ahead of information.” There were questions about whether employees would be willing to pay more to see higher quality providers, or whether tiers or utilization choices would be based on cost alone.

Many 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. For these high cost members, cost-sharing can do little to curb essentially non-discretionary utilization, as their care, for chronic illness or catastrophic events, easily exceeds deductibles and out-of-pocket limits.

Data in Wisconsin support this notion. The Madison-based Dean Health Plan’s CEO reported last year that, of 180,000 commercial plan members, 14% “cost nothing,” while two-thirds account for only 10% of costs. Meanwhile, 10% of members claim two-thirds of costs, and 1.7% of members claim 37% of costs.³

Nationally, population-wide in any given year, about 20% of the population incurs no health care costs at all. About 70% of the population incurs 10% of the total costs, while 5% use over 50% of the costs and, within this, 1% incurs 30% to total costs.⁴

Again, spending accounts are not a relevant cost-control approach for “high-end use” because individuals with catastrophic illnesses will readily exhaust the deductible and out-of-pocket maximums, and then be fully covered by the health plan.

Patrick Remington, MD, MPH, Director
D. Paul Moberg, PhD, Associate Director
David Kindig, MD, PhD, Senior Consultant

Department of Population Health Sciences
University of Wisconsin Medical School
Suite 760, 610 Walnut Street
Madison, WI 53726-2397
Phone: (608) 263-6294 • Fax: (608) 262-6404
[Http://www.pophealth.wisc.edu/wphi](http://www.pophealth.wisc.edu/wphi)

What effect on utilization decisions?

Researchers have found that, despite recent gains in “price transparency,” decision support remains inadequate for enabling consumers to be successful in selections that are cost efficient or that promise to improve health.⁵ And longstanding data from the RAND Health Insurance Experiment show that consumers ration necessary care to the same degree as unnecessary care in the face of greater cost sharing.⁷

Indeed, while decision support is quite limited, only one-third of plans report that they monitor claims against established clinical guidelines and report back apparent underuse.⁶

Data also demonstrate that higher cost-sharing mechanisms may substantially reduce needed medical care use by lower-income employees and increase financial hardship for seriously ill workers, while having little impact on higher-income employees in the same plan.⁸

Non-Financial Incentives for Effective Decision-Making

Financial incentives are not the only means of motivating change in consumer utilization and health behaviors. In fact, time is itself currency, part of the marginal cost associated with health care utilization decisions. And lower income families often lack child care, leave time, transportation, or must fit visits in between two jobs.

New research out of the UCLA Anderson School of Management show that poor families (those on Medicaid), when provided easy-to-understand health care guidance, reduced by 48% the number of unnecessary trips to an emergency room and by 38% visits to a clinic for routine illness, such as cold, cough or mild fever. This translated to a dramatic drop in the number of lost days at work (43%) and at school (41%).⁹

Such health literacy training allowed these consumers to become better informed and dramatically improved their confidence in their own judgment. It also demonstrates how, with the right training and tools, business goals can be met and overall cost reductions attained, without unduly harming lower income and at risk families.

Seeking Common Ground

Without a doubt, the move to consumer-driven health plans is increasing provider

competition and is leading to the development of more accessible and relevant consumer information in the health care marketplace.¹⁰

Yet many current reforms, it appears, target the majority of consumers who incur relatively few costs, making them only marginally more efficient in using the care system. In this way, the promise of consumer driven purchasing has been overstated.¹¹

Many industry observers suggest that system reform should focus more on the higher cost populations, particularly those with chronic illness—preventing their disease, avoiding their complications, and providing optimal, cost-effective, efficient care so they are maintained at the highest possible levels of health and functioning.

Wisconsin employers, armed with such data, are beginning to look toward comprehensive strategies that encompass employee education, health promotion, incentives for informed decision-making and healthy lifestyles, and targeted disease management programs.^{12,13} This may indeed be the place of common ground for employers and employees where evidence-based cost-containment begins.

In the meantime, it appears that no single innovation will be employers “silver bullet.” There remains a need for a range of products, programs, and tools that fit the diversity of Wisconsin’s employer and workforce characteristics.

References.

1. Torinus J. Health marketplace being born. *Milwaukee Journal Sentinel*. July 17, 2004. <http://www.jsonline.com/bym/news/jul04/244400.asp>
2. Trude S, Conwell L. *Rhetoric vs. Reality: Employer Views on Consumer-Driven Health Care*. Center for Studying Health Systems Change. Issue Brief 86. July 2004.
3. Weier A. Experts tell how to control costs, 10% of patients cause 2/3 of cost. *The Capitol Times*, October 10, 2003. <http://www.madison.com/toolbox/index.php...storyURL=/captimes/news/stories/58532.php>
4. Milliman USA. *Health Care Costs Guidelines – 2001 Claim Probability Distributions*, cited in Halvorson and Isham, 2003, op. cit.

5. Rosenthal M, Milstein A. Consumer-Driven Plans: What’s Offered? Who Chooses? *HSR: Health Services Research* 39:4, Part II (August 2004): 1055-1070.
6. Rosenthal M, Milstein A. Consumer-Driven Plans: What’s Offered? Who Chooses? *HSR: Health Services Research* 39:4, Part II (August 2004): 1055-1070.
7. Newhouse JP. *Free for All?: Lessons from the RAND Health Insurance Experiment*. Rand, 1996
8. Trude S. *Patient Cost Sharing: How Much is Too Much?* Issue Brief No. 72. December 2003. Washington, DC. Center for Study Health System Change.
9. Herman AD, Mayer GG. Reducing the use of emergency medical resources among Head Start families: A pilot study. *Journal of Community Health*, Vol. 29, No. 3, June 2004: 197-208. <http://www.kluweronline.com/issn/0094-5145/contents>
10. Manning J. Health group to disclose prices. *Milwaukee Journal Sentinel* July 14, 2004. <http://www.jsonline.com/bym/news/jul04/243712/asp>
11. Trude S, Conwell L. *Rhetoric vs. Reality: Employer Views on Consumer-Driven Health Care*. Center for Studying Health Systems Change. Issue Brief 86. July 2004. <http://www.hschange.org/CONTENT/693>
12. Manning, J. Business seeks cure for health care costs, Keeping workers healthy is goal of ‘lifestyle’ initiatives. *Milwaukee Journal Sentinel*. June 12, 2004. <http://www.jsonline.com/bym/news/jun04/236261.asp?source=tmj4>
13. Bartlein, B. Not all wellness programs are created equal. *Milwaukee Business Journal*. April 19, 2004. <http://milwaukee.bizjournals.com/milwaukee/stories/2004/04/19/smallb5.html>