



## Will Consumer-Driven Health Care Take Off?

Early empirical experience is encouraging, but success will depend on the commitment to truly reward behavior changes rather than simply shift costs

By Tilman Ehrbeck, Ph.D., and Kimberly O'Neill Packard, McKinsey & Co.<sup>1</sup>

The introduction of tax-advantaged, portable Health Savings Accounts (HSAs) in the context of the Medicare Modernization Act in December 2003 spurred major activity in the field of consumer-driven health care (CDHC) last year. Most major health insurers rushed to develop HSA products for the 2005 contract and open enrollment seasons. Early 2005 enrollment numbers indicate that with the new HSAs, the total number of individual health care savings accounts has more than doubled within one year to over three million.<sup>2</sup>

The theoretical promises and challenges of CDHC have been debated for a number of years. The introduction of these products has created a new reality, with which all participants in the health care industry have to reckon, as demonstrated by:

- The early popularity of the new HSAs
- The determination of several large employers to change the traditional health care insurance paradigm<sup>3</sup>
- The very visible commitment of leading health insurance companies that switched their own employees to CDHC products and made significant investments in 2004

The questions are now: What are the early results, and as a result, where and why might CDHC take off?

### Early Evidence on the Promises of CDHC

The central proposition of CDHC is that the financial structure of high-deductible plans combined with individual savings accounts will increase transparency and create incentives for more value-oriented, cost-conscious health care decision-making. In addition, many public policy-makers like the private sector flavor of the solution to

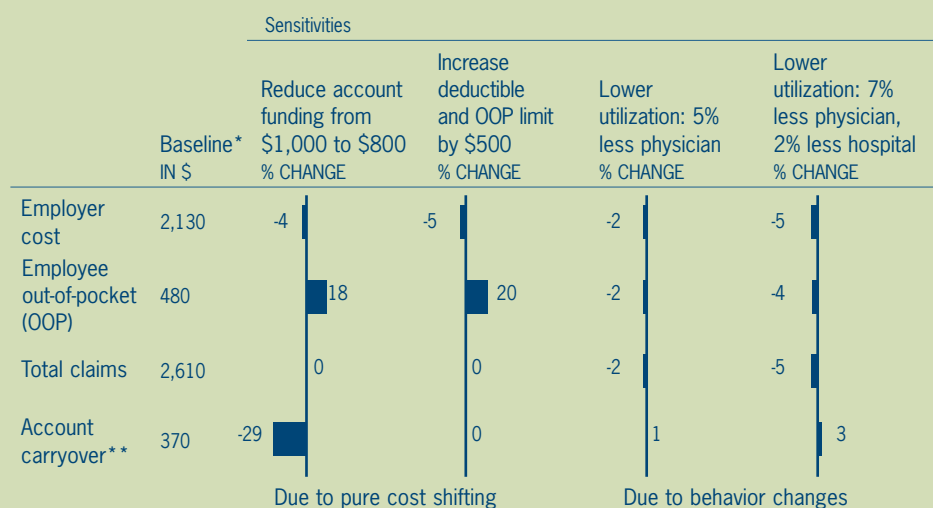
health care cost inflation and hope that CDHC can provide a framework for broader, at least catastrophic, coverage.

The early evidence from HSA predecessor products has been encouraging: Aetna reports that the total medical cost increase for a test group of 13,800 lives covered by CDHC plans during 2002-2003 was 2% compared to 16% of a control group covered by traditional health plans.<sup>4</sup> Other health plans report similar, more anecdotal success. While these savings might be the result of early, positive selection and thus might not be sustainable, the cost

reduction potential is too attractive to ignore for employers, who have largely borne the brunt of the sustained double-digit health care cost increases in recent years.

With regard to broader coverage, early industry reports are similarly positive: Assurant, WellPoint and others report that 40% to 60% percent of the applicants for their individual high-deductible plans were previously without coverage, serving the pool of the 15 million of America's 45 million uninsured who, according to the U.S. Census Bureau, have an annual household income over \$50,000.

**FIGURE I: Employer Savings Potential from Cost-Shifting vs. Changes in Utilization Behavior**



NOTES: \*Annual average for single coverage with \$1,000 funding of account, \$2,000 deductible, 20% co-insurance and \$3,000 out-of-pocket (OOP) limit.

\*\*OOP expenses and carryover do not add up to \$1,000 because model uses company averages and assumes some employee attrition.

SOURCE: American Academy of Actuaries

## Early Evidence on the Challenges

Concerns regarding CDHC center around the possibility of adverse selection, the uneven impact on consumers and the risk of a reduction in utilization of needed care, especially for poorer families and children.

The risk of adverse selection is significant. According to a *Benefits Quarterly* survey of CDHC offerings, only 20% of employers switched their entire employee base to a CDHC-type plan; the remaining 80% offered a choice of two or more plans including traditional designs. The experience in these so-called slice account environments indicates that prior year usage of medical services by consumers is highly correlated with subsequent plan choice. In one case study, employees who opted for a high-deductible plan with lower premiums had 40% lower health care costs in the previous year than the average.<sup>5</sup>

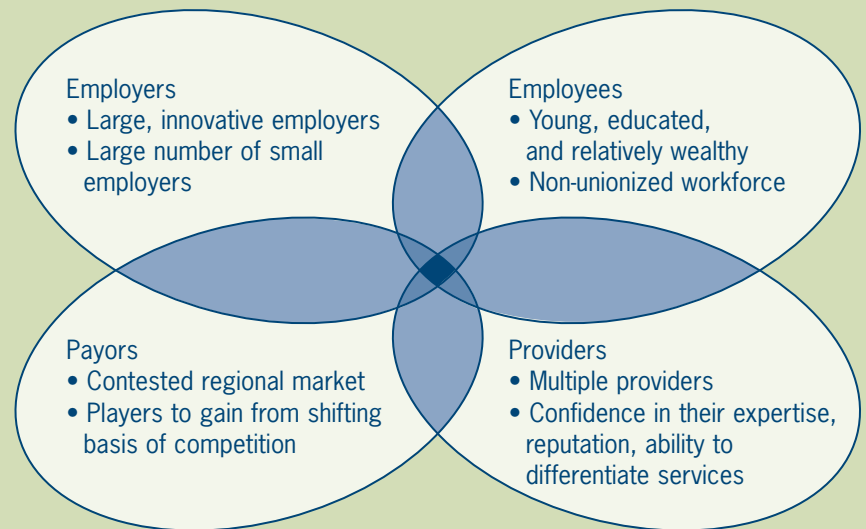
The recent self-reported industry data does not break down health care cost reduction by consumer health status or income. Model simulations by the American Academy of Actuaries, however, illustrate how moderate users of the medical system would gain (up to the amount of their employer's HSA funding if they do not have medical expenses at all), while intensive users might spend 35% more depending on the design of the new CDHC and the previous, traditional plan. As depicted in Figure 1, the same simulations also show that behavior changes have to be significant before the employer savings potential from consumer behavior/utilization changes could start to match that from simple cost shifting to employees.<sup>6</sup>

## Where and Why CDHC Might Take Off

For all participants in the health care system, CDHC adoption has pros and cons. For example:

- Many employers like the cost savings potential and see no viable alternative, but fear employee backlash
- Employees, in particular the healthier and wealthier, like the real tax advantages and more control but realize they are at risk of paying more out-of-pocket over time<sup>7</sup>
- Some health plans see an opportunity to change the basis of competition away from lowest provider unit costs – somewhat attributable to the negotiating leverage large health plans have – in their favor, but are apprehensive of the operational complexities and risks

FIGURE 2 : Likely Characteristics of Early-Adopting Markets



• Providers see the potential of differentiating themselves on the basis of brand, service levels and efficiencies but fear the transparency around pricing and quality required for CDHC success and the possibility of additional bad consumer debt exposure.

As illustrated in Figure 2, CDHC is likely to be adopted early in local health care markets with a positive confluence of these varying perspectives.

Subsequent success in such early-adopting local markets will largely depend on employer commitment to CDHC. The greatest likelihood of success will be in markets where employers shift their entire employee base to CDHC and work on plan designs that truly reward behavior changes and reduce costly and unproductive health care consumption. These markets will be characterized by superior risk pooling, relatively high savings account funding and a higher degree of employee acceptance. By contrast, in markets where CDHC is largely offered with a pure cost-shifting intent, only healthy and wealthy consumers will be attracted, and employers risk significant consumer backlash.

## The 401(k) Analogy

It will take a few years to tell how the CDHC adoption dynamics will play out. However, one analogy from the world of employer-sponsored pension plans illustrates the potential of HSAs to become a major, if not the dominant, tool in private U.S. health insurance. Despite initial hesitation, 401(k) defined-contribution pension plans took off

about five years after their introduction in 1981 when employer concerns about the costs and viability of traditional, defined-benefit plans and the desire of a more flexible workforce for portability and control over the pension plans combined to create a powerful force. Today, virtually every new private pension plan in the U.S. is of the 401(k) variety, and the total number of 401(k) defined-contribution plan participants has exceeded 60 million versus 22 million in traditional defined-benefit pension plans.<sup>8</sup> ■

<sup>1</sup> This essay is based on a presentation to the NIHCM Board of Directors in November 2004.

<sup>2</sup> Inside Consumer-Directed Care, Vol. 3, No. 1, January 2005. This figure includes HSAs and various, less advantaged predecessor products, most notably Health Reimbursement Accounts (HRAs).

<sup>3</sup> For example, in its public demand for change, General Motors has reported that health care expenses add \$1,500 to the cost of each of its cars produced in the U.S., see "U.S. Firms Losing Health Care Battle, GM Chairman Says," The Washington Post, February 11, 2005.

<sup>4</sup> "Consumerism in Health Care," Aetna investor presentation, March 2004.

<sup>5</sup> L. A. Tollen, M.N. Ross, S. Poor, "Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc.," HSR Special Supplement, August 2004.

<sup>6</sup> "The Impact of Consumer-Driven Health Plans on Health Care Costs," American Academy of Actuaries, January 2004.

<sup>7</sup> See Watson Wyatt survey on "Consumer Awareness of Health Savings Accounts," January 2005.

<sup>8</sup> "How America Saves," The Vanguard Group, September 2004.