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Consumer Directed Health Benefit Plans Could Greatly Improve Quality of Care and Health Insurance Affordability; Early Attempts will Fall Considerably Short of Their Potential; There are Budget-Neutral Opportunities for Congress to Help

Testimony of Arnold Milstein MD, MPH

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I am Arnold Milstein, a physician consultant at Mercer Human Resource Consulting, and the Medical Director of the Pacific Business Group on Health, which serves 44 large and over 9000 small California employers. My testimony summarizes the initial findings of a Robert Wood Johnson Foundation funded study that I lead in partnership with Professor Meredith Rosenthal at the Harvard School of Public Health; it does not represent the positions of these organizations. A more detailed summary of the findings of the *Mercer/Harvard Study* will be released in the second quarter. Professor Rosenthal will publish additional findings in scientific journals over the next 12 months.

We studied consumer-directed health benefit plans by surveying in the first quarter of 2003 over 600 for-profit and not-for-profit regional health plans of all types, serving employers of various sizes. They included regional components of national insurers as well as regional insurers; they included diverse plan types such as HMOs, PPOs, and indemnity plans, offered on both insured and self-insured bases. Over the past several months, we also have been conducting 15 in-depth case studies of consumer-directed health benefit plans of diverse types, serving multiple U.S. regions and populations. These case studies include interviews with health plan executives and purchasers, with follow-up review of print and electronic documentation. We defined consumer-directed health plans as health benefit plans that incentivized insureds to select more affordable and/or higher quality health care options and provided cost and/or quality information with which consumers could compare available options. Case study interviews are ongoing and will add detail; but the broad shape of our findings is not likely to change.

A. Increased Consumerism Could Greatly Improve Quality of Care and Health Insurance Affordability

This conclusion is drawn from evidence internal and external to our research. The external evidence is that (1) as summarized in my January 25, 2004 testimony to the Senate HELP Committee, up to 40% of what we are currently spending on American health care could be eliminated over a 10-year period, and thereby slow the rate of biotechnology-driven health insurance cost increases without impinging on quality of care, clinical outcomes, or patient

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satisfaction; (2) as documented in the Institute of Medicine's 1998-2001 reports on quality of care, quality reliability is seriously flawed, even among our best providers; and (3) as described in both of these sources, inter- and intra-community variations in quality and cost-efficiency are wide among hospitals, among physicians, and among different treatment options for the same condition. Such wide performance variation offers substantial opportunity for informed and incentivized consumers to preferentially select better performing physician, hospital and treatment options, including better self-management of health risk and avoidance of services offering no health value. In addition to capturing immediate gains in quality and cost-efficiency, this expression of the market's invisible hand would generate ongoing gains by more strongly motivating all providers and treatment innovators to discover "better, safer, leaner" methods of transforming health benefit plan dollars into improved health.

The internal evidence that we uncovered in our research is that, if carefully explained and encouraged, many enrollees, including sicker individuals, are willing to enroll in consumer-directed health benefit plans, seek performance information and select more affordable health care options. The 600+ plans that we surveyed had enrolled over 2 million enrollees in consumer-directed health benefit plans for 2003 and more than 4 million for 2004. These overall consumer-directed plan numbers included approximately 500,000 enrollees of account-based (also known as Health Reimbursement Accounts or HRA) models in 2003 and 1 million account-based model enrollees in 2004. While these absolute numbers are small, the consumer-directed health benefit movement is early in its adoption curve, the growth rate is high (we anticipate another doubling of enrollment by 2005), and many mainstream health plans are beginning to integrate consumer-directed features, such as hospital or physician quality and/or affordability comparisons, into their other offerings.

B. Early Attempts to Implement Consumer-directed Health Benefit Plans will Fall Considerably Short of their Potential

1. Structural Limitations

My prediction of substantial shortfall is partly based on insurers' near-term goals. The stated motivation for insurers and purchasers that offer consumer-directed models are varied. The majority of health plans we interviewed indicated that their main objective was to increase consumer engagement in health care decision making, rather than wholly rely on physicians and hospitals. These plans believed that improved cost-efficiency and quality of care would eventually follow, but argued that these goals were secondary in the near-term. In contrast, most employers prioritized immediate slowing of increases in health benefit costs.

Shortfall in results will also arise from two primary informational gaps that severely handicap consumer-directed health benefit plan innovators: (1) valid, easily understood performance comparisons among physicians (e.g., a surgeon's complication rate), among hospitals by specific service lines (e.g. a hospital's average total lung cancer treatment cost), and among treatment

options (e.g., patient satisfaction ratings from open vs. closed biopsy of a suspected breast tumor) are generally lacking; and (2) we lack research evidence on the form and size of incentives minimally required to motivate consumers, *especially the 20% sickest consumers who spend 80% of health benefits dollars*, to switch from an MD, hospital, or treatment with which he or she (or someone whom they trust) is familiar to a less familiar alternative, when the alternative offers better quality and cost-efficiency.

Of the 15 plans we studied in depth, only one offered consumers clinical quality of care comparisons for physicians (medical groups in this case) across a variety of measures using audited data. Six others provided information only on patient satisfaction or patient-reported quality of care. Twelve plans offered comparative quality information on hospitals across a large number of service lines either through a vendor or, in one case, by creating a unique hospital report card. Information on the quality implications of major treatment options was provided by seven plans. Only one plan offered consumers detailed cost comparisons (in this case, based on the negotiated fee or unit price) for physicians and hospitals by service line. Three other plans made available qualitative performance ratings on physician or medical group cost (e.g., an indication of above or below a threshold using stars or dollar signs); to rate economic performance, these three plans used a measure of cost-efficiency rather than unit prices.

With respect to hospital quality of care comparisons, we found plans were primarily relying on hospital billing data or unaudited hospital reported survey responses. The consensus of the scientific community and a recent measures endorsement process by the National Quality Forum is that hospital billing data is generally an inadequate basis on which to compare hospital quality.

We found a different but equally severe handicap with respect to most cost comparisons. The most commonly offered cost comparisons, which are limited to drug options and procedures, were based typically on the unit price(s) charged by the physician, hospital, or pharmacy, rather than on their longitudinal cost-efficiency. Longitudinal cost-efficiency in this context refers to the effect of a doctor, hospital, or treatment option on the *total cost* of treating an episode of acute illness or a year of chronic illness. In the case of a physician, it reflects not only the cost of his/her services but also, for example, the cost of differences in the average frequency with which their patients with the same chronic illness are scheduled for return office visits or are admitted to the hospital. Use of unit price as an index of cost-efficiency is problematic because researchers such as Elliott Fisher at Dartmouth and teams at Premera Blue Cross have independently documented that unit prices are *misleading* signals of relative cost-efficiency. Indeed, researchers such as Tom Rice at UCLA have documented that lower unit prices typically induce physicians to provide a greater volume of services, either services billed by them or by others, such as laboratories, radiologists, or hospitals.

This substantial informational barrier to consumer identification of the most affordable providers is not caused by a lack of analytic methods with which to compare the longitudinal cost-efficiency of doctors or hospitals. Rather, most health plans lack enough claims experience with individual doctors or individual hospital service lines to allow statistically valid comparisons.

This barrier is especially problematic because most plans are hesitant to pool their claims data with competing plans, out of fear that negotiated unit price advantages they may hold with some physicians or hospitals would be revealed and then replicated by a competing insurer. To address this problem, many plans rate large physician groups or all of a hospital's service lines in a bundle. Such bundling obscures important performance differences and depresses the gains from better engaged consumers. Other plans are responding to this barrier by limiting their ratings to the minority of providers with whom they have adequate claims experience.

The main obstacle to comparisons of cost-efficiency and quality for treatment options is our insufficient federal investment in AHRQ, on which most stakeholders rely to quantify the comparative performance of treatment options. Many large purchasers support much better funding of AHRQ to generate these comparisons.

Even if consumer-directed health benefit plans had reasonably accurate performance comparisons for consumers, we currently know little about the economic and non-economic incentives that are minimally required to induce selection of better performing, but unfamiliar, physicians, hospitals, and treatment options. In the absence of these planning inputs, consumer-directed health benefit plan designers have often relied on blunt incentives such as higher deductibles, higher co-insurance, and portable spending accounts that generally discourage use of *all* services, including services that are essential to maintaining patient health (e.g., beta-blocker use by patients recovering from a heart attack). That blunt, overall reductions in benefit coverage can discourage use of clinically valuable services was most recently documented in the attached Harvard Medical School research findings. A promising exception to this general picture is that four account-based plans exempted recommended preventive care from the relatively strong incentives to control spending from the first dollar and one plan *reduced* the out-of-pocket cost for chronic medications for individuals who participate in a chronic illness registry, a clinical innovation shown to improve patient health outcomes.

Consumer incentives to select cost-efficient options are concentrated at the low end of the distribution of annual per capita health care costs. The majority of the plans provide the strongest incentives to choose low-cost hospitals, physicians, and treatment options only up to $2,000 to $3,000 for a person with single coverage. Beyond that point, coverage mimics typical PPO coverage and is almost always accompanied by an out-of-pocket maximum. For large self-insured employers, who make up the majority of current consumer-directed plan enrollment, out-of-pocket maximums are as low as $1,500 (for small employers, we encountered some as high as $5,000.) Thus, a typical enrollee of an account-based plan that anticipated minor surgery or a maternity stay would have no incentive to control other spending during the year. Finally, even for the one of 15 plans that calibrated out-of-pocket costs at the point of service to the comparative cost-efficiency of the health care provider selected by the consumer, this incentive did not extend beyond the plan's out-of-pocket limits, even for affluent enrollees. Only the three "narrow provider network" plans created incentives to select more efficient or higher quality providers at all levels of spending, because they offer no coverage for services delivered by providers excluded from the network based on poor performance.

Failure to encourage even affluent individuals to select more cost-efficient options at higher levels of annual personal health care spending will severely limit the savings from most early consumer-directed health benefit plans; this is because roughly 55% of total commercial health insurance spending is by enrollees who exceed their annual out-of-pocket limits.

Finally, we found only one plan that specifically aims to assure that they do not shift a greater share of out-of-pocket cost onto sicker enrollees. This account-based plan provides first-dollar coverage with low coinsurance for all cancer care and hospital admissions. As a result of this design, the aforementioned plan has demonstrated that sicker individuals disproportionately benefited economically from the consumer-directed plan relative to a typical PPO plan. If widely adopted, this approach could offset the quality loss described in the attached study or the concern that the consumer-directed plans approach will impoverish the sick. Failure to attract sicker individuals whose selection decisions offer the largest opportunity for health benefit plan savings threatens realization of the full potential of consumer-directed health plans.

2. Early Evidence on Risk Selection and Impact

Because consumer-directed plans are relatively new to the market, there have been limited opportunities to study their effects. Most of the available evidence on savings, recently summarized at a briefing by the Galen Institute, has come from the plans themselves and should be regarded as preliminary until independently confirmed by health service research.

Risk Selection

Consumer-directed plans are offered to employers both as a total replacement for all prior options (often, but not always in the fully-insured segment of the market) and as an additional option alongside prior options. In the latter case, plans have indicated mixed results in terms of risk selection. One major HRA plan found evidence that individuals selecting their plan were much healthier than those choosing competing HMO and PPO options. Another similarly-designed plan found that enrollees who chose their plan were slightly sicker than average. Many plans have also reported that the type of employer that chooses to offer a consumer-directed plan is highly varied and includes many employers with predominantly low-wage employees. More data will be needed to address this question and selection patterns will likely change as more information about the new model is disseminated.

Impact on Spending and Service Utilization

Reports of the impact of consumer-directed plans on spending are similarly sparse because only a few plans and employers have enough claims experience to assess the impact of these new models. It is also important to note the difficulty of assessing the impact on spending of consumer-directed plans because of issues such as risk selection. Moreover, none of these findings have been validated by independent researchers. Three of the studied consumer-directed

plans reported reduced spending growth compared to ambient health insurance trend. The reported savings net of reductions in benefits coverage were on the order of ten percentage points. Consumer out-of-pocket spending was reported to have grown more slowly than comparison plans as well. Most of this effect is attributed by the plans to behavioral changes such as substitution of generic for brand name drugs and substitution of office visits for emergency room visits. Two of the account-based plans we examined also report that preventive care use increased relative to comparison groups. Because these findings relate to specific populations and plan designs (both the consumer-directed plan and the plan with which it was compared) it is not yet possible project early results to the insured population at large.

Other Effects

Several account-based plans have reported high retention rates for both employers and employees with a choice of plan. This suggests relatively high satisfaction with the plans. The impact of account-based and other consumer-directed models on important outcomes such as clinical quality and longer run cost-efficiency is not yet known.

In summary, significant structural limitations in the early forms of consumer-directed health plans have not blocked directionally favorable early results. Most pioneers report decreased rates of per capita health spending and increased consumer information seeking. However, (1) none of these early self-assessments have examined impact on health outcomes or robust measures of quality; and (2) reported savings, ranging up to a 15 percentage point offset of concurrent insurance premium trends, have not yet fully accounted for more favorable enrollee health status, leaner covered benefits, cost transfers to sicker beneficiaries or to the employer-purchaser, and the economic value of health or quality losses that consumers did not intend.

3. How Will HSAs Alter This Picture?

Through our interview with plans and other interactions with Mercer clients and contacts, we assessed the market's early reaction to the Health Savings Account (HSA) provisions of the recent Medicare reform legislation. All but one of the account-based plans are developing or had developed a product that would meet the more restrictive definition of an HSA. Large employers, however, appear to be cautious about HSAs, waiting for clarification on a number of fronts. One plan reported that the main question from its employer clients was whether HRAs could be converted into HSAs. This plan indicated that its clients and potential clients wanted to experiment with an HRA before offering an HSA, which cedes to employees more control of benefit dollars. Other employers had unresolved questions about the relationship between HSAs and both FSAs and pharmacy benefit carve-outs.

C. There Are Budget-Neutral Opportunities for Congress to Help

There is a short list of budget-neutral interventions available to Congress to address some of the structural barriers facing consumer-directed health benefit plans and allow realization of their full potential for improving the quality and affordability of American health benefits.

1. Give employer-, union- and insurer-sponsored health plans real-time access to the full CMS claims database, holding back data only to the extent necessary to protect the privacy of individual Medicare beneficiaries. The Medicare claims databases are a severely underexploited national information asset that would allow all private-sector health benefit plan sponsors to compare more validly the longitudinal cost-efficiency and quality of physicians, hospitals by service line, and treatment options. Current CMS rules restrict access to research that will benefit CMS. However, wider access is, in the view of most external legal experts, not restricted by the statutory language of HIPAA or the Privacy Act, if beneficiary privacy is fully protected. Congress could clarify this and encourage CMS to revise its regulations to allow real time access, subject to full protection of beneficiary privacy via encryption and other methods specified in existing law.

2. Encourage CMS to support rapid expansions of minimally required hospital and professional billing data, as recommended by the Quality Work Group of the National Committee on Vital and Health Statistics. This would enable much better performance comparisons of providers and treatment options by CMS and private-sector health plans, especially in reducing the confounding effect of differences in patient severity of illness on provider performance comparisons.

3. Encourage the Secretary of HHS to speed up adoption of the National Provider Identification program. This will allow all benefit plans to better identify individual providers and more accurately compare their performance via analysis of CMS and private sector claims data.

No health care professional, government official, or well intended health benefit plan manager can better determine the most personally satisfying tradeoff for consumers between health care spending and anticipated health improvement than well informed consumers can for themselves. Especially when paired with robust pay-for-performance programs for physicians and hospitals, consumer-directed health benefit plans can be a vehicle for great improvement in both the affordability and quality of American health care. Expect initial shortfalls in the results from early consumer-directed health benefit plans; and encourage CMS to help all American health benefit plans gain access to information that they need to deliver maximum potential consumer gain.