Consumer-Directed Health Plan Report – Early Evidence Is Promising

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Consumer-Directed Health Plan Report – Early Evidence Is Promising

Insights From Primary Consumer Research

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To gain early insights into what is, arguably, the most important development in health insurance since the widespread introduction of HMOs in the 1980s, McKinsey & Company recently completed extensive primary research on Consumer-Directed Health Plans (CDHPs). To our knowledge, this is the first research of its type to eliminate the possibility of major adverse selection bias because it studied the behavior of consumers whose employers had made the bold move of offering only a CDHP to their employees (i.e., they offered full-replacement accounts). Overall, this research demonstrates the potential for CDHPs to alter consumer behavior in ways that could fundamentally change how consumers think about their health – and how they utilize health care resources.

The introduction of tax-advantaged Health Savings Accounts (HSAs) into the marketplace last year created enormous momentum for Consumer-Directed Health Plans (CDHPs), a type of health insurance that, broadly speaking, gives consumers more responsibility for managing their health care spending. Industry observers estimate that the number of Americans covered by such plans more than doubled in the past 6 months, to more than 1 million by March 2005.[1]

Proponents of CDHPs are observing this growth with great anticipation. They argue that CDHPs will lead to better informed and more discerning consumers; as a consequence the plans will reduce unnecessary utilization, increase healthy behaviors, and ultimately reduce the growing burden that health care costs place on the U.S. economy. Skeptics contend that these changes are not feasible and the impact of CDHPs will not be equitable. They claim that many consumers will be unable to change their health care consumption, will be forced to do so in ways that would compromise their health, or will exceed their maximum deductibles too quickly to provide any real incentive for behavioral changes. The impact of CDHPs will therefore be limited, and the adjustment burden will fall unfairly on the poor and chronically ill.

It will be a number of years before accumulated actuarial experience is available to confirm the hopes or concerns of CDHP observers. To fill this void, McKinsey & Company conducted primary research, including consumer focus groups; one-on-one interviews with employees, benefit managers, and payors; and an

1. "HSAs More Than Double in Six Months," press release from AHIP (America's Health Insurance Plans), May 4, 2005.

in-depth study of more than 2,500 adult Americans with widely varying types of commercial health coverage. The study included more than 1,000 consumers with employer-based, full-replacement CDHPs, as well as a control group of traditionally insured consumers. (By focusing our study on consumers with full-replacement plans, we avoided the risk that our results would be influenced by the selection bias that has been observed when consumers had a choice between plan types.)

We would like to stress, however, that the results are based on self-reported, rather than true actuarial data. We must also note that most of the CDHP participants in our study were not covered under HSAs, but under a similar, though less tax-advantageous, type of account called a Health Reimbursement Account (HRA). (We wanted to examine the thinking and behavior of consumers who had been in CDHPs for at least 1 year, but the first HSAs became available only in 2004). Because savings balances in HRAs are only notional, and not portable should an employee move on, we suspect that the behavior changes we observed would become more accentuated with HSAs (these accounts, like 401k plans, truly belong to the consumer).

PROMISES AND PITFALLS

Our results suggest that CDHPs are delivering on their promise to increase consumer engagement and reduce utilization. The CDHP consumers in our study responded to increased financial accountability in many favorable ways (e.g., they reported that they made more careful, value-conscious utilization decisions). Evidence is also emerging that these plans have an impact beyond what one could expect from increased financial accountability alone: the CDHP consumers reported a heightened level of engagement in overall health and wellness.

We hypothesize that a confluence of factors – ranging from a growing awareness of health issues and costs to the availability of technology-driven tools and, perhaps, a greater social emphasis on wellness – combine with the increased financial accountability to trigger real engagement. In fact, the CDHP consumers in our study displayed heightened engagement even when immediate financial

incentives had been exhausted. For example, the CDHP consumers we studied who had exceeded their out-of-pocket limits (and therefore faced incentives similar to those associated with typical traditional plan coverage) reported behaviors suggesting greater "ownership" of their health (e.g., they were more likely to perform independent research to identify treatment options). These behaviors raise the possibility that in the long run, CDHPs could help lower medical cost trends and improve health outcomes.

The change to a CDHP environment will not come without some frustration for consumers, however. The CDHP consumers we studied were not as satisfied with their new plans as they had been with their previous, more generous health benefits. They also indicated that they did not have sufficient information to support them as they made their decisions about health care consumption; in particular, they noted the absence of information about price differences between providers of health care services.

Our findings therefore begin to highlight a number of opportunities for employers who are considering a switch to CDHPs, for health insurance plans offering them, and for medical providers, who will likely feel the impact of a much more engaged consumer.

EMERGING PERSPECTIVES

Our research suggests five key findings:

1. **Value consciousness:** The CDHP consumers we studied appeared to be more value conscious (both in deciding whether to consume health services and in selecting appropriate care) than were the participants with traditional types of health insurance. In comparison with the traditionally insured, for example, the CDHP consumers were:
   - Over 50 percent more likely to ask about cost
   - 33 percent more likely to independently identify treatment alternatives (and this difference in behavior was greater among those who had exceeded their out-of-pocket maximums)
   - Three times more likely to have chosen a less extensive, less expensive treatment during the past 12 months (this difference was seen even among those with chronic conditions).

2. **Wellness/prevention:** The CDHP consumers reported enhanced attention to wellness and prevention. In comparison with the traditionally insured, the CDHP consumers were:
   - 25 percent more likely to engage in healthy behaviors
   - Over 20 percent more likely to say they would participate in company sponsored wellness programs
   - Over 30 percent more likely to get an annual check-up because they thought it would save them money in the long run.

3. **Cost control:** The CDHP consumers also reported behavioral changes that could significantly reduce not only the short-term rise in medical costs but also long-term medical cost trends. The new value-conscious behaviors persisted even when the CDHP consumers were faced with financial incentives similar to those faced by the traditionally insured. In comparison with that group, the CDHP consumers were:
   - Over 20 percent more likely to follow treatment regimens for chronic conditions very carefully
   - Twice as likely to inquire about drug costs (even though the two groups had similar levels of drug coverage).

4. **Satisfaction:** Overall, only 44 percent of the CDHP consumers stated that they were as or more satisfied with these plans than they had been with their previous, typically more generous, health benefits. Many were dissatisfied with the information available to help them make health decisions and indicated that they were turning to intermediaries other than payors (e.g., health Web sites and financial institutions) to help them manage their increased responsibility. The CDHP consumers were:
   - Not likely to turn to their health insurer for medical advice (they were more than twice as likely to visit an external medical Web site than they were to go their health insurer's Web site for treatment information)
   - Not satisfied with the extent of provider information available to them (80 percent indicated that they did not have sufficient information on the prices doctors charge)
   - Sensitive to the approach employers used when introducing the CDHPs (the percentage of employees satisfied with the CDHPs in comparison

with their previous health plan ranged from a low of 24 percent at one company to a high of 54 percent at two others).

5. **Employer approach:** The CDHP consumers we studied appeared to be more responsive to employers who switched to these plans not simply to shift costs but also to encourage employees to take more control over their long-term health.

We describe each of these findings in greater detail below:

Value consciousness

We asked all participants in our study to consider a health issue that they – or someone in their family covered by their plan – had experienced during the past 12 months, to rate the severity of the condition, and then to detail both the number of treatments received for the condition and the reasons why treatments were selected or refused. In comparison with the study participants with traditional insurance, the CDHP consumers were twice as likely to report forgoing care for conditions they perceived as less serious (i.e., something they would describe as "a nuisance"). However, they were no more likely to report that they would forgo treatment for serious conditions (Exhibit 1). The primary reason CDHP consumers cited for their decision to forgo care was economic (i.e., the treatments "cost too much"), whereas traditional plan participants were more likely to emphasize convenience issues.

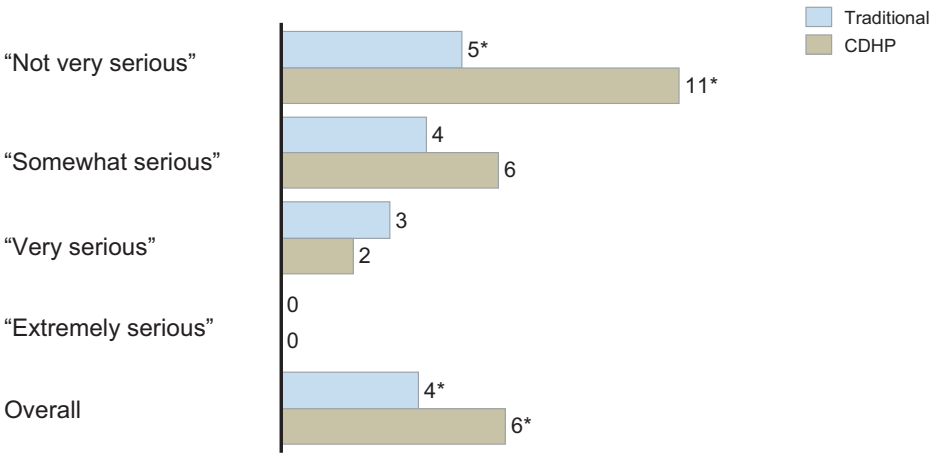
Our research also showed that the CDHP consumers were more likely to make what appeared to be clinical value trade-offs. Among the respondents who had had a non-pharmaceutical medical treatment within the past year, the CDHP consumers were three times more likely to have selected a less extensive (and less expensive) treatment than were the traditionally insured (e.g., the CDHP consumers were more apt to visit urgent care centers rather than a hospital emergency room). These clinical value trade-offs were noted even among the patients with chronic illnesses (e.g., hypertension or diabetes).

Because our findings are based on consumers' self-reported behavior, we cannot determine whether their decisions to forgo care or to select less

Exhibit 1

CDHP MEMBERS SELF-REPORT LOWER UTILIZATION FOR LESS SERIOUS CONDITIONS

Patients forgoing all care by perceived seriousness of health issue
Percent



* Statistically significant
Source: McKinsey CDHP Consumer Research

extensive treatments were medically appropriate. Furthermore, it remains to be seen whether CDHP plans with HSAs inhibit the appropriate use of maintenance drugs and treatments for behavioral conditions (these are not allowed to be carved out in the current HSA benefit design, although they can be with HRAs).

Nevertheless, our findings have important implications for providers: If CDHPs become more widely available, providers will begin to feel the impact of consumers shopping for value and choosing to limit their health care consumption. To ready themselves, providers should determine how they can best communicate their value to consumers – and this need will become particularly important once price and quality transparency widens the geographic scope of competition. The airline industry has already seen that consumers are willing to drive further from home to take advantage of lower-cost fares. Similarly, nearly half of the CHDP consumers we studied said that they would be willing to travel 2 hours for a 2-day inpatient procedure (assuming that the level of clinical quality was the same in both places) if the extra drive would save them a relatively modest amount of money.

Wellness/prevention

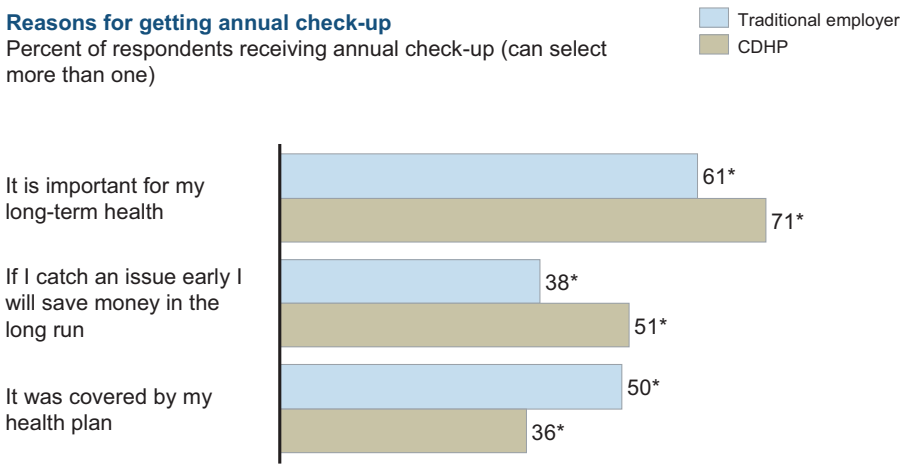
The CDHP consumers we studied were as or more likely to receive preventive care, including annual check-ups, basic blood work, mammograms, and prostate exams, than were those with traditional insurance. They were also more than 20 percent more willing to participate in company-sponsored wellness programs – and this difference persisted even among patients with very high (above $5,000) annual medical expenses.

Behind these utilization differences is an underlying philosophical difference. The CDHP consumers were 25 percent more apt to report that they engaged in behaviors to keep themselves healthy and well. They also appeared to have a longer-term mind-set when making health decisions. For example, the CDHP consumers were more likely to indicate that getting an annual physical was "important for their long-term health" and would "save them money in the long-run." In contrast, a key reason cited by those with traditional insurance was that annual check-ups were "covered by their health plan" (Exhibit 2).

Exhibit 2

LONG-TERM CONCERNS ABOUT COST AND HEALTH MOTIVATE CDHP PREVENTIVE CARE

Reasons for getting annual check-up
Percent of respondents receiving annual check-up (can select more than one)



* Statistically significant
Source: McKinsey CDHP Consumer Research

These findings suggest that CDHPs offer payors and employers a strong opportunity to maximize their health benefit dollars – if designed well, these plans can permit them to move beyond today's "sick care" benefit to a more comprehensive health and wellness solution. The incentive structures within these plans need to be tailored appropriately to influence the health decisions of different consumer segments. Early CDHP adopters and leading payors are already experimenting with individual, team-based, and companywide incentives designed to improve aggregate employee health and productivity.

Cost control

The CDHP consumers we studied reported a variety of behaviors that could markedly lower short-term medical costs. Furthermore, companies participating in our study found that the switch to CDHPs lowered their total medical costs, even when the expenses now borne by employees were included in their calculations. Only several years' worth of claims experience data can determine whether these lower-cost trends can be sustained, but our research findings suggest that this might be possible.

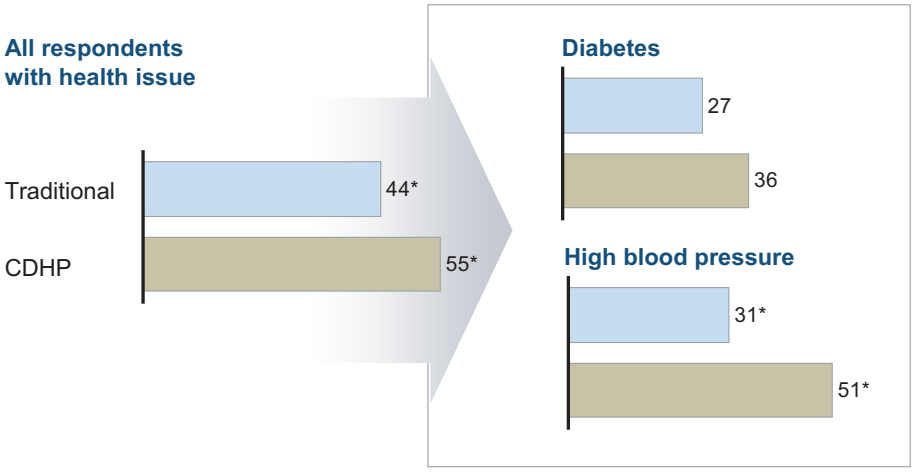
One striking finding was the increased likelihood of CDHP consumers with chronic diseases to report that they were taking greater responsibility for their health. In comparison with chronically ill patients with traditional insurance, for example, the CDHP consumers were over 20 percent more likely to say that they carefully followed their treatment regimens (Exhibit 3). Given the economic burden that chronic disease places on our health system and the widespread concerns about patient compliance, even modest improvements in consumers' ability to manage health risks could have a significant long-term impact on their health status – and on overall health care costs.

Our research also suggests that CDHP consumers may develop a sustained shift in mind-set that increases their value consciousness in all health decisions, and this shift could have a significant impact on many different types of health care spending. For example, most of the CDHP consumers we studied had HRA plans with carve-out drug benefits comparable to those offered with typical traditional plans. Consequently, we were somewhat surprised to see that the CDHP consumers demonstrated strong value-conscious shopping behaviors

Exhibit 3

CDHP MEMBERS MORE LIKELY TO VERY CAREFULLY FOLLOW TREATMENT REGIMENS FOR CHRONIC CONDITIONS

Chronic disease patients who "very carefully follow treatment regimen"
Percent of respondents



* Statistically significant
Source: McKinsey CDHP Consumer Research

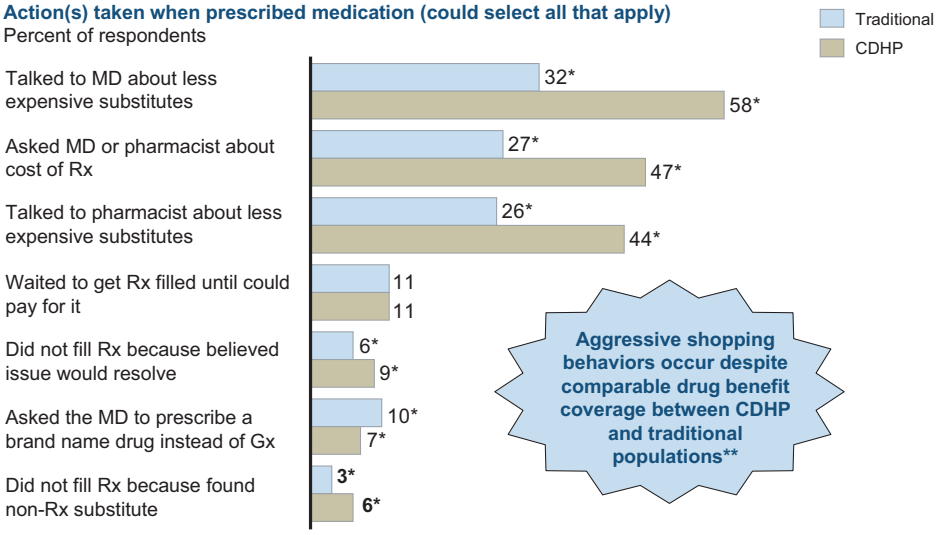
when choosing prescription drugs. In comparison with those with traditional insurance, the CDHP consumers were nearly twice as likely to talk to their doctor about less expensive substitutes, to ask their doctor or pharmacist about a prescription's cost, and to ask their pharmacist whether a less expensive substitute was available (Exhibit 4).

Satisfaction

Less than half of the CDHP consumers we studied reported that they were at least as satisfied with their current plan as they had been with their previous forms of health insurance. Interestingly, satisfaction levels did not vary by health status. They did, however, vary widely among the companies, even though all of the companies had offered only a CDHP product and had shifted some costs to employees (Exhibit 5). We believe that part of the explanation for this variation is differences in how each plan (or employer) helped the CDHP consumers handle the increased responsibility for health care decisions.

Exhibit 4

INCREASED CDHP VALUE MIND-SET APPLIES TO TRADITIONAL "CARVE-OUT" BENEFITS LIKE Rx DRUGS



* Statistically significant

** CDHP members in sample are on HRA plans with carve-out drug benefits similar to traditional plans

Source: McKinsey CDHP Consumer Research

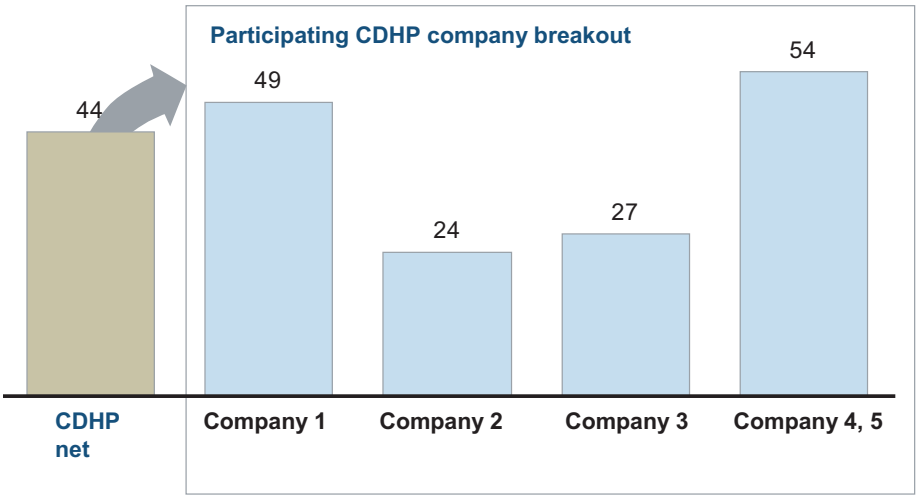
Taking ownership of health decisions is a complicated process. It requires consumers to obtain, interpret, and act upon information about the quality and cost-effectiveness of caregivers and recommended treatments; it also forces them to accept responsibility for managing the savings in their personal health accounts. The long-term success of CDHPs will be highly dependent not only on whether consumers receive appropriately transparent information to help them make decisions, but also on whether the information can be easily obtained.

The CDHP consumers we studied were not turning to their health plans, but rather to on-line health Web sites and other intermediaries to get information. Indeed, our research found that fewer than 25 percent of the CDHP consumers visited their insurance company's Web site for health information. Even fewer CDHP consumers (17 percent) were willing to trust their health insurer to help manage their personal health accounts; instead, they preferred to use their existing financial institution or bank.

Exhibit 5

SATISFACTION CONSISTENTLY LOWER ON CDHP PLANS, WITH STRONG VARIATION ACROSS EMPLOYERS

Relative member satisfaction with current plan vs. previous health plan
Percent of respondents that are "more" or "equally" satisfied



* Statistically significant
Source: McKinsey CDHP Consumer Research

In the near term, payors must carefully think through how they want to position themselves vis-à-vis these intermediaries: Do they want to work with – or compete against – them? In the longer term, payors will need to provide CDHP consumers with integrated solutions, which will require them to gain credibility in new areas (e.g., cash and asset management) and to develop an entirely new set of consumer-based skills and insights. For example, they will need to gain a better understanding of consumer behavior and segmentation, and they will need to become more adept at product design, distribution, and service. If payors cannot build a relationship that helps CDHP consumers navigate their increased responsibility for health care decisions, they run the risk of competing for an increasingly smaller and commoditized profit pool.

Employer approach

The perceived reasons why employers switch to CDHPs can also make a significant difference in employee satisfaction and, potentially, in the health-benefit value these plans can offer as well. Our results suggest that CDHP consumers are responsive to employers who switch to these plans not simply to shift costs, but also to encourage employees to take more control over their long-term health. As a consequence, employee communication, accountability, and enablement are the three critical components of success when implementing CDHP plans.

We observed widespread variation along these elements among the companies that participated in our study. One employer, however, achieved comparatively high levels of consumer engagement and satisfaction; we believe the company attained these results because it focused on each of the three critical components when it implemented its CDHP plan in early 2002. The company aggressively invested in communicating the rationale for the health-benefit change through team-based information sessions; for example, it used trained employee team leaders to advocate and explain the new plan designs to both employees and spouses. Furthermore, the employer continued the communications campaign after rollout by benchmarking the economics of its new plan (in terms of both employer and employee costs) against that of the plans offered by comparable companies locally and industry-wide. To instill employees with greater accountability for their own health, the company developed team and companywide incentives (e.g., each employee received a $200 cash contribution if certain health targets were met). It also scaled up its wellness offerings by adding new programs and an enhanced fitness center, and it created a “health advisory council” to prioritize other improvements, such as healthier cafeteria food. Finally, the company helped enable its employees to make better health decisions by developing on-line, company-specific testimonial tools that allowed employees to compare the quality and cost of different treatments/providers and by offering dedicated training sessions to help employees learn how to use their health plan’s decision-support tools.

We believe that CDHP implementation is no small task for most employers. They must carefully consider and develop plans along each of the three critical components to capture the benefits while minimizing potential employee backlash.

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Our early research findings are surprisingly consistent with many of the arguments that CDHP proponents make. These findings suggest that the plans once again realign health insurance with the important insurance principles of avoiding (or discouraging) moral hazard. In doing so, CDHPs could begin to return health care coverage to the role of covering random, infrequent, and financially consequential events that are beyond the control of the individual. Under these plans, many types of medical expenses would revert to the control of market forces and consumer behavior. As a result, CDHPs could mitigate the seemingly inexorable increases in health care expenses – and health insurance premiums – while improving health outcomes.

Nevertheless, implementation will require a great deal of thoughtfulness, as we have shown. The design and implementation of CDHPs are still evolving, and several factors that could significantly influence the success of the plans are still under active debate. The key challenges will be to achieve the benefits demonstrated in our research while minimizing adverse affects on vulnerable groups, to ensure that CDHPs encourage clinically appropriate behavior, and to provide the right support that enables consumers to manage their increased responsibility for making health care decisions.

We believe the magnitude of the impact that CDHPs had on the behavior of the consumers we studied resulted from each employer's bold decision to offer only a CDHP product to its employees. The question of how effective these plans will be if employers continue to allow their sickest employees to opt for traditional insurance remains open. We would hypothesize that this type of "slice" introduction would fail to achieve the true promise of fuller consumer engagement and medical expense trend mitigation. If CDHPs are widely adopted, there could be major changes in how consumers think about their health, how they use health care resources, how they seek value, and the basis

on which they make their consumption decisions. In fact, we believe that our research findings and similarly encouraging early evidence will stimulate broader uptake. Stakeholders need to watch closely and prepare for the potential sea-change ahead.

RESEARCH METHODOLOGY

Our research was designed primarily to compare health care utilization behaviors (and the rationales for them) in two groups: commercially insured, working-age consumers with account-based CDHPs and similar consumers with other types of health care coverage. Most of the people in the latter group had traditional, employer-provider health plans.

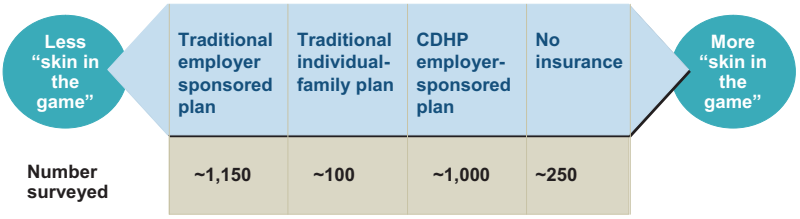
To get the most meaningful results possible, we made two important decisions regarding our CDHP sample. First, we looked only at companies that switched their entire workforce to CDHP coverage (i.e., full replacement). This avoids the adverse selection bias that may occur when employees are offered the choice between a CDHP and more traditional coverage. Second, we wanted employees to have at least 12 months' exposure to the new plan. In practice, this meant that most of the employees in our study were covered by HRAs rather than the more tax-advantageous HSAs, which have been available only since last year. With the help of three major health plans, we identified five companies that had had full-replacement CDHPs for at least 12 months and that were willing to participate in our study.

Although our sample of full-replacement employers was not random (there were fewer than two dozen companies of sufficient size who met the above criteria at the start of our work), we believe that the underlying demographics of the employees we studied were reasonably representative of the commercially insured population in the U.S. Participating companies were geographically dispersed, spanned both white- and blue-collar industries, and ranged in group size from 40 to 4,000. Furthermore, we statistically balanced the responses by age, gender, income, and health status to ensure appropriate comparisons between groups.

Our research began in March 2005, and to date we have received more than 1,000 responses from CDHP consumers. We believe this is the largest study as yet conducted that compares participants in full-replacement, account-based CDHPs with those covered by other health insurance options (Exhibit 6).

Exhibit 6

ROBUST EMPIRICAL APPROACH



Research strengths	Limitations
• Large sample size with statistical power	• Employer selection not random (too few companies to-date)
• 1,000 CDHP employees with minimum 12 months under new plan	• CDHP participation largely under HRAs (HSAs likely to accentuate results)
• CDHP employees in full-replacement environment	• Design can not address public policy concern of risk selection bias

Source: McKinsey CDHP Consumer Research

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