

CDHC Prognosis

It may be too early to know whether CDHC is truly the wave of the future or just another failed insurance experiment.

Fast Facts

- ▲ *A poll published in the November 2007 AARP Bulletin indicates that adults trust their healthcare providers more than their insurance companies. Page 98.*
- ▲ *In a series of studies comparing spending and healthcare utilization, researchers found that many CDHC patients exceeded their deductible threshold, and spending was actually lower with the POS plan than with the CDHC plan. Page 102.*
- ▲ *Some analysts have suggested that patients' out-of-pocket expenses should be inversely proportional to the value—not the cost—of each medical service. Page 106.*

Despite the increasing numbers of patients with CDHC plans, the future of these plans remains uncertain. The 2007 Kaiser Family Foundation Annual Survey of Employer Health Benefits found that the number of employers offering HSA-eligible CDHC plans had not significantly increased since the prior year.

In both 2005 and 2006, the Employee Benefit Research Institute (EBRI)/Commonwealth Fund Consumerism in Health Care Survey showed that people using high-deductible and CDHC plans were less satisfied with their health plan than people who had more comprehensive health insurance, and were less likely to recommend their CDHC plan to a friend or colleague.

“We don’t get a sense that people are embracing these plans,” says Sara R. Collins, PhD, assistant vice president for the Pro-

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gram on the Future of Health Insurance at the Commonwealth Fund. “When we ask people if they would change out of their CDHC plans, a majority would do so—much more than people in other plans. The fact that there was virtually no increase in CDHC plan enrollment from 2005 to 2006 reflects the low satisfaction people report about these plans.”

Patients are also much more satisfied with their physicians than their insurance companies. A recent issue of the *AARP Bulletin* included a September 2007 poll of over 1,000 adults over age 18. Only 34 percent of respondents had a favorable opinion of HMOs, and only 43 percent had a favorable opinion of health insurance companies. In contrast, the respondents gave thumbs-up ratings to their hospitals, doctors, and pharmacists.

A Stronger Doctor-Patient Partnership

At its ideal, CDHC has the potential to strengthen the relationship between patients and their physicians. Consumer-driven healthcare is also consumer-centric healthcare, meaning that the patient’s needs, preferences, and choices should play a central role in treatment decisions. Doctor-patient communication is the key to making this concept work.

“I think CDHC plans pose interesting challenges as well as interesting opportunities for physicians,” Roger Feldman, PhD, Blue Cross professor of health insurance at University of Minnesota in Minneapolis, says. “Patients in these plans are going to come to the doctor with a whole lot more questions—should I have this or that?—because they have to pay for it themselves. They’re going to find more information on prices and quality; it’s clear that CDHC plan members are doing this. So doctors will have more responsibility to deal with informed patients. But [with CDHC] doctors will also be free of managed-care programs, so they can manage patient care on their own without outside regulations affecting them.”

Grace-Marie Turner, president of the Galen Institute and a CDHC consultant, says doctors tell her they find it refreshing that patients are better informed. “When consumers have more access to healthcare information, doctors can do a better job of explaining things. That is especially important in helping people with chronic illnesses become partners in their care,” she says.

Patients Give Physicians the Thumbs Up

Do you have a favorable or unfavorable opinion of:			
	Overall	Under age 50	Age 50+
Your local hospital			
Favorable	71%	65%	80%
Unfavorable	23%	30%	12%
HMOs			
Favorable	35%	37%	34%
Unfavorable	43%	44%	40%
Health insurance companies			
Favorable	41%	40%	43%
Unfavorable	47%	49%	43%
Pharmacists			
Favorable	81%	78%	86%
Unfavorable	11%	14%	7%
Drug companies			
Favorable	38%	41%	33%
Unfavorable	48%	45%	53%
Doctors			
Favorable	81%	79%	84%
Unfavorable	13%	16%	9%

Source: AARP Bulletin, November 2007. Survey of 1,019 adults age 18 and older conducted by ICR between Sept. 26 and Sept. 30, 2007.

According to Ms. Turner, the crucial relationship between the doctor and patient has been disconnected until now. “In the third-party payment system—or even fourth-, fifth-, or sixth-party payment systems—there are too many people with decision-making power that get between the patient and the doctor,” she says. “One payer may say, ‘Doctor, this patient can’t have that procedure because I won’t pay for it.’ Or they can’t have that medicine ‘because it’s not on my formulary list.’ That causes a disconnect between what the doctor believes is best for the

patient and the care the patient wants to get from the doctor.”

With a middleman saying yes or no, what doctors and patients have is “Mother May I medicine,” Ms. Turner says. “It’s so

“We want patients to participate,” Dr. Russell told *The New York Times*. “When they see the surgeon, they should be prepared to ask questions—not softball questions, but hardball questions: How often do you do this? What are your outcomes? What are the risks? How do you plan to do this operation? Is this a safe outpatient facility? It’s no longer acceptable to do this on blind faith,” he said.

demoralizing to physicians not to be able to do what they were trained to do. They wind up having health plans that are directing their practices and keeping them from spending the time they want, and need, to take care of their patients.” She finds, “Patients are sick of it, too. They want to be able to deal directly with their doctor to get good advice and care.”

Writing in the July/August 2006 issue of *The American*

Journal of Bioethics, G. Caleb Alexander, MD, MS, and colleagues at the University of Chicago explain, “The growing literature regarding patient-physician communication...provides an example of how physicians can rise to the challenge of simultaneously serving their patients’ best economic interests while safeguarding their quality of care.”

What can physicians do to encourage direct communication with their patients? Many physicians have been doing it for years: Open the lines of communication. Patients often initiate comfortable discussions with family physicians and internists they visit regularly. But when patients visit a specialist, the relationship often reverts to the old “doctor knows best” approach. Physicians may have to take the lead in encouraging discussion.

Thomas R. Russell, MD, executive director of the American College of Surgeons, actively encourages patient participation. In a 2007 interview with *The New York Times*, he explained: “We want patients to participate. When they see the surgeon, they should be prepared to ask questions—not softball questions, but hardball questions: How often do you do this? What are your outcomes? What are the risks? How do you plan to do this operation? Is this a safe outpatient facility?”

If the surgeon doesn’t answer questions satisfactorily, Dr.

Russell advised patients to go back to their physician and ask for a referral to another surgeon. “It’s no longer acceptable to do this on blind faith,” he said.

Is Dr. Russell’s attitude an exception, not the rule? “I think most surgeons embrace it,” he says. “Most of us believe that patients who are informed and really know what they’re getting into do better. They know what the goal of surgery is, and they know they have to participate postoperatively to get the result.”

Steven H. Woolf, MD, professor of family medicine at Virginia Commonwealth University, believes the best approach is to couple information with high-quality “decision counseling” that helps patients understand the potential risks, benefits, and uncertainties of clinical options. Following that, physicians must assist patients in selecting the option that best accommodates their personal preferences and values.

In a 2005 *Annals of Internal Medicine* report, Dr. Woolf and his physician colleagues explain that conventional counseling isn’t working. They cite one study that showed that 60 percent of seriously ill Medicare beneficiaries preferred comfort care over aggressive interventions, but only 41 percent of these patients believed their care reflected this preference. “Unwanted costly interventions might become less common if they were preceded by well-informed discussions with patients and loved ones,” the authors say.

In a research report by Ronald M. Epstein, Brian S. Alper, and Timothy E. Quill published in the *Journal of the American Medical Association*, the authors from the Rochester Center to Improve Communication in Health Care recommend discussion strategies such as starting every visit by asking about the patient’s expectations, fears, and ideas, then offering information in small “digestible amounts.” It also helps to pause frequently, to assess the patient’s understanding.

Some other techniques include the following:

- Take more time to discuss treatment and planning.
- Ask patients if they have any questions, or determine if they have any questions by asking them what they think.
- Help patients recall more of the information by using charts or diagrams—encouraging note taking, and asking patients to repeat back in their own words the instructions or findings.

Will CDHC Lower Healthcare Costs?

Research studies support the idea that healthcare costs aren't controlled by the same economic rules as other consumer costs. "Since the early 1960s, economists looked at the healthcare market and wondered why it doesn't behave like a normal marketplace," explains Lawrence D. Brown, professor of health policy and management at Columbia University's Mailman School of Public Health in New York City. "They used the 'moral hazard' theory to explain unnecessary healthcare utilization and high medical costs. That is, if you give people third-party insurance coverage, they know insurance will pay for their medical care, so neither the consumer nor the provider has much incentive to be frugal."

According to Dr. Brown, economists thought that people with first-dollar coverage of medical costs are more likely to over-consume and consume wastefully. CDHC's emphasis on consumers' having to pay many first-dollar costs was designed to decrease spending.

But it doesn't necessarily happen that way, says Dr. Feldman. In a series of studies comparing spending and healthcare utilization associated with CDHC, PPO, and point-of-service plans, Dr. Feldman and his colleagues found that so many CDHC patients exceeded their deductible threshold, especially for hospital costs, that there was no incentive to decrease spending after that. Spending was actually lower with the POS plan than with the CDHC plan. According to Dahlia K. Remler and Sherry A. Gleid's 2006 *Health Affairs* report, people with high expenditures continue to incur high healthcare costs for many years. Like the patients in Dr. Feldman's study, they exceed their insurance deductibles and so are not affected by current cost controls.

"For a CDHC plan to work, it will have to involve a lot more cost sharing," Dr. Feldman concludes. In addition, he's concerned about the increasing costs of modern medical technology. "CDHC plans, like any health plan, help people finance healthcare when they need it, but the plans don't control the rising trend of healthcare costs," he says.

Quality and Value Initiatives

CDHC proponents argue that the concept has the potential not

Physicians' Prudent Judgment

Physicians know that their willingness to have a working partnership with patients sometimes conflicts with patients' strong beliefs that doctors make the decisions. Physicians may be reluctant to share insights due to fear of lawsuits and a genuine desire not to influence patients, but a research report from the Rochester Center to Improve Communication in Health stresses that physicians owe their patients the benefit of their clinical opinions. "Patients and families should not be deprived of the clinician's prudent judgments, grounded in the knowledge of the patient, his or her family, the illness, and the relevant medical literature," the authors say.

In certain situations, it's not just patient preferences but patient competence and alertness that make shared decision-making difficult. For example, patients with psychiatric disorders, Alzheimer's disease, or end-stage terminal illnesses may have impaired judgment and cognition. Informed consent rules still apply in such situations, but someone other than the patient may be making the decision. Writing in *The New England Journal of Medicine*, Paul S. Appelbaum, MD, of Columbia University explains, "Valid informed consent is premised on the disclosure of appropriate information to a competent patient who is permitted to make a voluntary choice. When patients lack the competence to make a decision about treatment, substitute decision makers must be sought." If a healthcare proxy is not available for this, Dr. Appelbaum says, physicians can provide appropriate care under the presumption that a reasonable person would have consented.

only to cut healthcare costs, but also to increase quality and value for the healthcare dollar. PPOs, HMOs, and the government are also putting increasing emphasis on quality measures and tying reimbursements to performance and health outcomes.

According to Paul Grundy, MD, MPH, director of healthcare technology and strategic initiatives for IBM Global Wellbeing Services and Health Benefits, the emphasis on quality is not a function of who pays for care, but of transforming what is available for purchase—no matter who's footing the bill. He complains that, in many areas of the U.S., patients really can't buy "meaningful" high-quality healthcare. Low reimbursement rates exacerbate the problem, since they are forcing some doctors out of practice, Dr. Grundy says. He points out that services—such

as e-mail and phone conversations with patients—that can raise the quality of care are not reimbursed at all in many situations. “We want to change all that.”

Although insurers provide some general data on costs and quality, many health experts see a more important need for providers to compete on results and efficiency over the full cycle

of patient care—from prevention and monitoring through diagnosis, preparation, intervention, recovery, and long-term management. According to Michael E. Porter, PhD, MBA, and Elizabeth Olmsted Teisberg, PhD, MS, ME, in their book *Redefining Health Care: Creating Value-Based Competition on Results* (Harvard Business School Press, 2006), this requires a

A CDHC Success Story

One of the potential advantages of CDHC may come in the customization of the insurance product to meet the needs of a specific population. As an example, here’s the story of how one employer adapted its new CDHC plan to meet the needs of its workers—resulting in healthcare savings, better employee retention, and better health.

A study at the University of Pennsylvania showed that up to 28 percent of commercial driver’s license holders showed some symptoms of obstructive sleep apnea (OSA). This potentially life-threatening sleep disorder often goes undiagnosed and leads to falling asleep at inappropriate times, depression, irritability, morning headaches, lack of concentration, and memory impairment—all of which can be especially dangerous to those who drive for a living. Both the Federal Motor Carrier Safety Administration and the American Trucking Association have identified OSA as a major cause of highway accidents. In addition, OSA increases the risk of hypertension, cardiovascular disease, stroke, diabetes, obesity, and other debilitating health conditions. However, treatment for OSA is available through the use of an expensive but effective continuous positive airway pressure (CPAP) machine while sleeping. With OSA treatment, people with OSA often find their overall health improves.

Schneider National, Inc., one of the nation’s largest trucking transportation companies, decided to take action. In 2005, the company had introduced a CDHC insurance plan that provided some first-dollar preventive care. While screening for OSA would be considered preventive care, the company wanted to go further to provide coverage for treatment for the condition. Could the insurer be persuaded to cover screening and treatment for the sleep disorder?

Angela Fish, Schneider National’s director of benefits, was able to obtain an agreement with the insurer to cover a pilot program. She also developed a partnership with a pulmonary diagnostics group to screen drivers at the group’s Houston, Tex., home center or at their

other branches throughout the country. Drivers were told to stop at whichever facility was closest to their trucking route. An education campaign raised awareness of the condition—and the treatment—among employees.

“If a driver isn’t near one of their facilities,” Ms. Fish explains, “we can route the driver through Houston with a load and get them tested there. If they test positive, they get CPAP equipment.” From April to December 2006, 547 Schneider drivers were tested for OSA; 445 were diagnosed with the condition and provided with CPAP equipment. Drivers enrolled in Schneider National’s CDHC plan never pay anything for this program. Any bills go to the company.

After the first year of the sleep apnea testing and treatment program, analysis of pre- vs. post-program data showed a significant improvement in driver accident frequency and in employee retention. More importantly, company records revealed a dramatic reduction in healthcare costs. “We found a \$538-per-member-per-month savings for those who were treated,” Ms. Fish reports. “Our subsequent year results are even a little bit better.”

As the prevention program continues, Schneider National’s medical screening questionnaire for new driver applicants now includes questions relevant to sleep apnea (e.g., “Do you snore?”). The company requires sleep apnea screening for all their current drivers and new hires. Drivers who test positive must show that they’re being treated.

Ms. Fish acknowledges that some drivers are hesitant to be tested, for fear they’ll be pulled out of service, and others are frustrated by CPAP treatment. However, “Some who were resistant at first now thank us,” she says. “We’ve had many occasions where associates—and even spouses—call us to say, ‘Thank you so much.’”

Although drivers get no monetary rewards for compliance, many of them tell Ms. Fish, “I’ve turned my health around, lost weight, and have been able to get off high blood pressure medication. I’m feeling so much better!”

shift towards payment for quality, safety, and performance. “It simply is not acceptable to have preventable medical errors as a leading cause of death,” they say. “Moreover, and this is less understood, poor quality almost always raises costs through inefficiency, prolonging the need for care, and requiring remedial treatments or surgeries.”

The National Committee for Quality Assurance (NCQA) has already adopted new accreditation measures, which include assessment of how all insurance plans are adjusting their physician-and-provider payment strategies to promote quality.

Drs. Porter and Teisberg believe that guidelines are important to coach doctors and spread knowledge about best practices; but rewards for excellence must be tied to results, not compliance. “If extra pay is tied to conformance with a number of hospital processes, rather than to outcomes and results, the wrong incentives are created,” they write. “The only truly effective way to address value in healthcare is to reward ends or results, rather than means, such as process steps. Providers should have to compete for patients based on value and not be rewarded for delivering just acceptable care.”

Other researchers have suggested that patients’ out-of-pocket expenses should be inversely proportional to the value—not the cost—of each medical service. In a 2007 *Journal of General Internal Medicine* article, A. Mark Fendrick, MD, and Michael E. Chernew, PhD, of the University of Michigan, call this concept “value-based insurance design (VBID).” This approach is based on the idea that the value of various clinical services differs across patient groups. For example, a colonoscopy for a 55-year-old who has a first-degree relative with colon cancer provides more value than it would for a low-risk 35-year-old.

Drs. Fendrick and Chernew recommend adding an evidence-based “VBID waiver” to high-deductible CDHC plans so that certain highly valued services would be provided to beneficiaries with little or no out-of-pocket expense. “Ideally, high patient deductibles would discourage only the utilization of low-value care,” they propose.

Ideas like this may find support among both physicians and industry professionals. “We need to get some form of rational technology policy decisions that we are going to cover certain

services and not cover other services, in order to control unnecessary costs,” agrees Dr. Feldman. He points to expensive procedures, such as back surgery for sciatica, that have not been proven effective, yet are still recommended by physicians—or demanded by patients.

What Doctors Think

While most physicians may agree that the American health-care system is in need of a fix, there is a wide range of opinions about what that fix may entail and about what the future will bring.

Some experts are predicting a comeback by managed-care companies that may offer “hybrid products,” which feature CDHC-style high-deductible coverage. Some standard health insurance policies have already added CDHC-type features, producing what one writer has called “managed consumerism.”

The role of government in healthcare is a subject of hot debate among physicians. Some physicians believe true healthcare reform in the U.S. can be achieved only with single-payer, universal coverage, often citing the effectiveness of European health systems and certain Medicare, Medicaid, and Veterans Administration concepts.

On the other hand, physicians are already dissatisfied with diminishing reimbursements from federal insurance programs. Some equate universal coverage with “socialized medicine” and see this as only increasing the government’s deleterious role in healthcare, rather than moving it to a more free-market system. Voicing this view, John Hunt, MD, a Virginia pediatric pulmonologist, allergist, and immunologist, says, “The voters of the United States must now and forever get it out of their heads that they have any right to force other Americans to participate in a socialized medical system.” Dr. Hunt recognizes that the current health insurance paradigm needs to be fixed, but he believes, “The American way is to encourage freedom, not socialism. Freedom is the fix.”

“If extra pay is tied to conformance with a number of hospital processes, rather than to outcomes and results, the wrong incentives are created,” Drs. Porter and Teisberg write in their book. “The only truly effective way to address value in healthcare is to reward ends or results, rather than means, such as process steps.”

But others believe that healthcare is not like other services or products available on the free market, and that physicians must play an active gatekeeper role in the allocation of scarce resources to keep costs under control and ensure that the maximum number of patients are served by the system. The availability of expensive diagnostic technology only compounds this problem. “In the late 1970s, care was wasteful and spending was profligate,” Alan Felsen, MD, a New Jersey internist, says. “Once the insurance companies got into managing healthcare expenses, the amount of waste was cut significantly. But this system just keeps cutting—through the fat, past the muscle, into the bone, and sometimes through the arteries. Market-driven forces have been unleashed without any of the checks to prevent the market from distorting the product we’re dealing with, which is healthcare.”

Pediatrician Paul Martin, MD, expects “a rebellion against the current way of doing things, because it is patently un-American to shut the healthcare door to hard-working people and their dependents.” He sees the health insurance problem from two perspectives, his U.S. training as a Board-certified pediatrician and his current position as the chief medical officer at the Ministry of Health in St. Kitts and Nevis, in the eastern Caribbean.

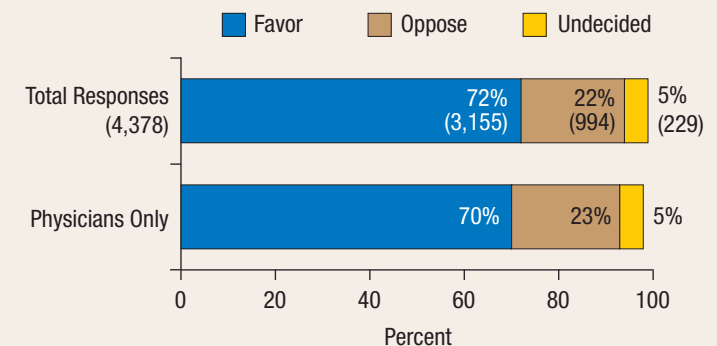
Although business interests will protest, Dr. Martin hopes a Medicare-style model will prevail. To control unnecessary use of expensive care, Dr. Martin focuses on physician management. Clinician performance monitoring and evaluation are the key items on his agenda. Physicians play a key role in controlling healthcare costs since a physician’s order is needed for most tests, procedures, and treatment. “Medical costs start with a physician’s order,” he says. “Because we physicians are a recalcitrant lot, if required, we have to be brought kicking and screaming to the consultation table where all health stakeholders sit and speak equally.”

Arnold Relman, MD, a prominent physician and former editor of *The New England Journal of Medicine*, proposes a compromise in his book *Second Opinion: Rescuing America’s Health Care* (PublicAffairs, 2007). “I am convinced...that the control of medical practice by market economics does not serve the healthcare needs of patients very well and is not compatible

Poll Shows Physicians Favor Universal Health Insurance

In a poll conducted by the online service Medscape in late September and early October 2007, respondents overwhelmingly favored some form of universal health insurance. Even those who identified themselves as physicians were in favor. Here’s the question and the breakdown of responses:

Last week, U.S. presidential candidate Hillary Clinton unveiled a universal health insurance proposal. The proposal would cover the 47 million Americans currently uninsured and would seek to make insurance more affordable for all while maintaining a role for private insurance. Do you favor or oppose some kind of universal health insurance in the U.S.?



Source: Medscape Poll conducted September 25 to October 2, 2007.

with a strong, ethically based profession,” he believes. “Furthermore, the practice of medicine in a system that treats medical care as if it were a market commodity cannot meet the expectations that drew most [physicians] into a life in medicine.” Dr. Relman recommends the creation of multispecialty, group practices in which physicians receive salaries rather than fee-for-service payments.

A recent editorial in *The New York Times* on “The High Cost of Health Care” concludes that “it should be clear that there is no silver bullet to restrain soaring healthcare costs...so we need to get cracking on a range of solutions.”