



HOME EXPERTISE PERSPECTIVE WHY MILLIMAN NEWS & EVENTS

Typ

Perspective

Perspective

Insight magazine  
Spotlight on Risk  
Healthcare Reform

Topics  
Articles  
Podcasts & videos  
Featured story

Return to  
Articles index

## Growing pains: Consumer-driven healthcare savings and the need for better information

by Jack P. Burke | Bruce S. Pyenson | Rob Pipich  
May 1, 2008

Anyone paying attention has heard an awful lot of talk about the cost of healthcare. In recent years, a number of healthcare plans stepped forward with an innovative new strategy, which they dubbed a consumer-driven health plan (CDHP). The primary idea behind a CDHP is that an informed consumer of health services makes for a healthier, wiser, and more prudent consumer of those services. Enlisting the very people who benefit — and suffer — most from the fluctuating quality of health services would, according to CDHP theorists, introduce economic efficiencies throughout the healthcare system, to the benefit of everyone in terms of both health and costs.

E-mail  
Print

With several years of actual CDHP data now on the books, we can begin to assess the impact and the efficacy of CDHPs. Milliman's "Consumer-driven impact study" (CDI), a risk-adjusted analysis of the impact of CDHPs at six U.S. companies, produced an interesting and varying picture of how these plans are doing. The high-level view may not be particularly surprising: a bunch of good news, a little bad/disappointing news, and a number of pending issues. In short, the future of CDHP looks promising but work remains to be done.

### CDHP: A summary

So what are CDHPs? Even if you work for an employer who already offers the option, you may not have a clear understanding. Healthcare plan policies, after all, are not known for their popularity as leisure reading.

CDHPs come in a variety of forms. For this discussion, CDHPs have, in theory, the following three core elements:

- **A high-deductible health plan (HDHP) with a funding account.** The funding account is either a health reimbursement arrangement (HRA) funded by the employer, or a health savings account (HSA) if accompanied by a qualified HDHP. HSAs can be funded by the employer or member and are portable, meaning that members take the funds along with them even if they go on to another job. The money in these accounts is designated to use for medical and health-related costs, with certain requirements and exclusions. An HDHP that accompanies an HSA is "qualified" if it meets criteria established in the Internal Revenue Code permitting the HSA to be tax-advantaged.
- **Patient education resources.** This is information made available to members, often via the Web and increasingly through various wellness programs, that helps them make better health choices for themselves. Most of the information falls into the category of prevention strategies, or even more simply, common sense: Stop smoking. Lose weight. Exercise. Buckle up that seatbelt. Most importantly, CDHP resources provide the critical and less obvious "here's how" piece, plus ongoing support.
- **Consumer research tools.** These tools, also often available via the Web (or employer intranet) or by phone, are intended to help members compare and

AU



Off  
Phc



Off  
Phc



Offi  
Phc

AD  
RE

C  
a  
R  
s  
C  
st  
V.  
C

FRE



They provide information about the quality of the providers as well as the costs, across a spectrum of specialties and procedures, offering members the opportunity to comparison shop and spend their healthcare dollars as wisely as possible.

### **Are we saving money yet?**

With the costs of healthcare verging on crisis, the first thing employers understandably want to know about CDHP is, has it stopped the bleeding? That is what the study intended to discover.

At first glance, CDHPs do appear to deliver dramatic savings. Looking more closely, however, many of the cost reductions are the result of favorable risk characteristics. When certain adjustments are made, the claims of savings actually begin to appear much more modest. But that doesn't mean there isn't good news in the overall mix:

- The actual paid claims per member per month (PMPM) for CDHP populations are very low. In fact, CDHPs in the analysis paid in claims about half of what the richer benefits offered by the same employer paid. This is consistent with reported results in the media to date. But most CDHPs come with very high deductibles, which are expected to pay out less in claims. A better comparison is "allowed claims," the total that the plan and the member pay to providers.
- The actual allowed claims PMPM for the CDHP population are also low. Allowed claims for CDHPs are about 41% lower than allowed claims in other health plans. These results were consistently lower across each CDHP, with reductions in claims ranging from 27% to 48%. This would appear to be a great result for CDHPs.
- The risk profile of the population choosing CDHPs is younger and healthier. □ This is not surprising and could well be cause for further caution. Many new health plan products show favorable initial experience for this reason. With time, some of the risk score difference between CDHPs and other plans, and thus their apparent savings, may diminish.
- Overall, CDHP results are modestly better at cutting costs than other plans. After normalizing for risk factors, the actual CDHP allowed claims are about 4.8% lower than would be predicted by typical risk and benefit design factors. Because high-deductible plans would be expected to lower utilization by 3.3% for these plan designs, the excess savings beyond those anticipated by all actuarial factors are about 1.5%. The savings, while modest, show that CDHPs have some inherent cost-reducing potential.

### **Enrollment to date: It's still early**

The quantitative data in the CDI report come from six employers offering their employees a choice of CDHPs or non-CDHPs, involving a total of some 225,000 members. Of that, just more than 30,000 enrolled in a CDHP, for an average CDHP penetration of about 13.7%. The actual CDHP penetration ranged from 4.4% to 76%.

For employers, these modest rates of migration to CDHPs from non-CDHPs are consistent with historical models of change in healthcare products. The healthcare industry has seen similar patterns with the introductions of HMOs and other health plan strategies related to managed care, including point of service, PPOs, disease management programs, and, most recently, the move to wellness.

### **Information gaps remain**

As for the impact of patient education resources and consumer research tools in CDHPs, that picture is still murky, at least insofar as the CDI study was concerned. For all the employers we looked at, patient education resources promoting healthy lifestyles were directed at all employees. That meant that any impact on health status or savings would likely affect all participants equally, not just those choosing a CDHP. There are many indications, however, that wellness programs and the related widespread availability of useful health information to consumers are having only positive effects on both costs and health.

Perhaps the most significant gap at this point is in the availability and usefulness of consumer research tools. None of the employers in the study reported that their employees had access yet to information on provider quality, and only one employer said its employees had access to comparison information about provider costs. These are, obviously, critical components for health plans that call themselves consumer-driven. There are many good reasons for the lag in development of consumer research tools, not least of which are the security and privacy considerations involved in making this information available and useful on a wide scale.

But until these tools are produced and become available so that members can truly compare and shop for providers based on quality and cost, realized CDHP savings are likely to remain primarily limited to the patterns we are used to seeing in high-deductible plans.

#### **Further savings achievable**

Milliman's CDI study is the first multiemployer, multicarrier, actuarially adjusted study of CDHPs. It found that, after adjusting for expected savings across a variety of plan designs, employer practices, workforce characteristics, and carriers, actual savings from CDHPs are modest overall. Some plans, however, show significant savings, even after considering adjustments for known risk and plan design characteristics.

Ultimately, the study supports several predictions that others have made for CDHPs:

- Young and healthy members, when given a choice, are choosing CDHPs.
- The allowed claims and especially the paid claims reflect the lower risk.
- The higher cost sharing encourages moderately lower utilization of healthcare.

We believe that further savings will be seen with the ongoing advent of patient education resources at many levels of availability. We also believe that significant savings are attainable when members are given consumer research tools to help them access good data on medical costs and quality. The early adopters in this study have likely seen only the benefits we would expect to see associated with high-deductible health plans. More is still to come. Stay tuned.

---

Jack Burke is a principal and a consulting actuary with the Philadelphia office of Milliman. In addition to his work on CDHPs, Medicare, and the individual market, he has extensive experience in all aspects of the small employer managed-care market.

Bruce Pyenson is a principal and consulting actuary with the New York office of Milliman. He consults to the healthcare industry on issues ranging from market strategies and capitation to healthcare reform.

Rob Pipich is a consultant with the Philadelphia office of Milliman. His expertise is in healthcare, including large and small group pricing, reserving, risk selection, plan design, and predictive modeling.