



## Consumer-Directed Care:

# Static or Buzz?

By Richard H. Dougherty, Ph.D.

The excitement over consumer-directed health care (CDHC) continued this past year. In addition to industry hype, CDHC has strong support from the Bush administration. But with all this support, why has enrollment growth been slow, particularly with unions and large employers? Is this health-reform buzz or is it static?

Given the complexity of the products, some might find it surprising that consumer-directed care has not disappeared altogether. Consumers are confused about the different types of accounts that exist and the tax consequences of each. Medical Savings Accounts (MSAs), Flexible Savings Accounts (FSAs), Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs) all have different rules, advantages and restrictions. Open enrollment occurs annually in most companies and the education of health purchasers is slow. Health providers and advocates have mixed opinions. We shouldn't be surprised at the delays. This is an enormous undertaking!

However, there has been a growing acceptance of these plans from brokers, mainstream health plans and industry. Leading health plans are adopting their own consumer-directed plans (more than 89 percent now offer one), and some, such as UnitedHealth and WellPoint, have acquiring leading CDHC companies.

No one wants to "miss the boat," and that is a good sign! Still, growth is slow. The next two years are critical.

The market transformation for CDHC is bound to be significant when it reaches a certain tipping point because consumer-directed plans minimize third parties and restore traditional market forces to health care. People can help to control health care costs if they have the right incentives. Research has shown that informed patients participating in decisions about their own care have better outcomes.

Since this phenomenon is bound to affect behavioral health, it's important to review the commercial, Medicare and Medicaid market trends, discuss some issues for behavioral health, and identify the barriers that need to be overcome for more widespread adoption.

### Industry issues

*Commercial sector:* The expansion of consumer-directed plans has continued at a steady pace. More than 1 million individuals are currently using HSAs. As many as 800,000 are enrolled in HRAs. HSAs are owned by the individual — even if the employer contributes — and must be accompanied by a high-deductible plan, while HRAs remain the property of the employer and there is somewhat more flexibility in plan design. Each has different advantages and disadvantages.

Employers are often wary of offering CDHC alongside more traditional plans because of fears that the healthiest, low-cost employees will enroll in CDHC. Because of these enrollment issues, most consumer-directed companies advocate a total conversion to one or more CDHC plan. This "all or nothing" approach has limited growth. One sign of anticipated growth is that banks are increasingly targeting this market.

**Medicare:** As much as 95 percent of Medicare spending is for treatment of problems after they occur. In response, the Centers for Medicare and Medicaid Services (CMS) has increased prevention efforts with screening and tools to provide information to consumers, including a drug pricing website, information on hospital charges, and quality data. Medicare is developing personal health support tools and beneficiary portals that are slowly being implemented across the country.

While there has been some talk of introducing personal HSA-like accounts, there are no current examples. Expect some demonstrations soon, however. As CMS Administrator Mark McClellan noted, "Nothing can contribute more to the effectiveness of our health care system than a healthy and empowered consumer."

**Medicaid:** Costs are rising at double-digit rates in virtually every Medicaid program. The time has come for a dramatic rethinking of the traditional approaches to cost control.

Consumer-directed services actually began with Medicaid programs for the disabled, such as Cash and Counseling and Home and Community Based Waiver programs. These small programs have used flexible spending accounts for selected benefits only, and they do not include high-deductible insurance policies, a current requirement of the HSA legislation. Evaluators report increased recipient satisfaction and cost neutrality.

Florida and South Carolina are leading the efforts of states to establish CDHC for the Temporary Assistance for Needy Families (TANF) and "expansion" populations. Both states have announced their intent to seek Medicaid waivers:

- Florida's initial proposal seeks to establish three levels of services: a set of basic benefits that all Medicaid-eligibles would receive; enhanced benefits; and catastrophic coverage. Individuals would have the opportunity to earn enhanced benefits by demonstrating healthy lifestyles. Flexible spending accounts would be available to purchase additional services.
- Under South Carolina's proposal, all members would be given a personal health account to purchase coverage from one of three types of plans: a consumer-directed plan with a high deductible; private insurance; or a medical home network. Private rates would be competitive and consumers would select based upon cost and quality. Medical home networks involve a primary care clinician and fee for service. Under this plan, consumers would be charged the full amount of their personal account. Those enrolled in the consumer-directed plan would have a portion of the funding set aside to purchase a limited-benefit major medical plan that covers inpatient, emergency and related services. The balance would be in personal accounts for ambulatory and related services. The state would recoup unused funds after a 12-month period.

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Both states are seeking to use market forces to control spending. In both plans, however, the devil is in the details of plan design, and there will likely be provider resistance.

### **Consumer-directed behavioral health care**

To date, the impact of CDHC on behavioral health has been minimal, partly because of the limited enrollment. In CDHC plans, the major impact will come in the utilization of behavioral health outpatient services where there is a more elastic demand for services.

Individuals with more serious conditions are likely to exhaust their individual spending accounts quickly and have to meet coinsurance minimums before they are covered by the high-deductible plan. Because of this, many advocates fear adverse consequences for vulnerable populations because they may have reduced choice as account balances are quickly exhausted and services will have to be paid for out of pocket.

There has been an increasing interest in self-direction and consumer-directed purchasing in public-sector behavioral health plans. Several parallel efforts in the public sector deserve mention:

- In March 2004, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a National Summit on Consumer Direction to develop recommendations for the federal agency. The proceedings are available at <http://mentalhealth.samhsa.gov/>. People with SMI and families of children with SED are very excited about the prospect of greater control over the services they purchase.
- SAMHSA's Center for Substance Abuse Treatment (CSAT) issued \$100 million in Access to Recovery grants for 14 states to expand service availability with vouchers. The goal is to increase consumer choice where little exists.
- CMS issues Real Choice Systems Change Grants and actively promotes self-direction as a part of Home and Community Based Waivers. To date, few of these programs involve mental health.
- The President's New Freedom Commission on Mental Health recommended that services should be "consumer and family driven," include individualized plans, and ensure the protection of rights of people with mental illness.
- The Institute of Medicine (IOM) *Crossing the Quality Chasm* report proposed that care should be "person centered" and that the "patient is the source of control." The IOM has been meeting to apply the report's recommendations to behavioral health.

Very small demonstrations, in Florida, New

Hampshire and Oregon, of self-directed care plans for individuals with serious mental illness have used flexible spending accounts to pay for coaching and other community services. They have left other benefits, such as emergency services, pharmacy, inpatient care, preventive health and ambulatory medical services, in grants or fee for service. Available services might include health coaching, respite, personal care, training and education, transportation and other rehabilitative services.

Clear financing models and more web-based account management tools are needed to bring these small demonstrations to scale. Under consumer-directed behavioral health care, case management becomes coaching; treatment for mental illness becomes services for mental wellness. Consumers have more control. It can be the beginning of a major transformation in our public systems.

### **Conclusion**

Proponents of CDHC, including most consumer groups in behavioral health, remain optimistic, but there are obstacles to adoption:

- Extreme care should be taken to distinguish between the implementation of CDHC and cuts in overall benefits. CDHC doesn't have to be structured to reduce benefits.
- Incentive programs can easily be too complex. Keep it simple, particularly for Medicaid and other populations.
- Considerable care needs to be exercised in the design of coinsurance, particularly with vulnerable populations. Paying for services directly may be such a hurdle for many individuals that it is a barrier to needed services.
- Pricing needs to be transparent. The myriad of network discounts, drug rebates, and cross-service subsidies needs to stop. The current system is not equitable.
- Treatment decisions need to be transparent, too. This is not the rule now.
- Public-sector administrators of plans for those with chronic conditions need some financing models and technology tools to facilitate widespread adoption.
- We need to move from an illness model to a wellness model. Preventing serious conditions through timely, evidence-based services where the consumer is the source of control is the key to long-term savings.

In behavioral health, consumer-directed care empowers the individual and family, putting them more in charge of their destiny and facilitating their resilience and recovery. Isn't that what we all want? I hear a "buzz"! ☺

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