

Consumer-Directed Healthcare: *The Next Trend?*

*In behavioral health,
movement could have
economic, therapeutic benefits*

By **Richard H. Dougherty, Ph.D.**

A recent conference in Las Vegas, sponsored by the Emergent Group, focused on the newly emerging field of Consumer-Directed Health Care (CDHC). In many ways it was a flashback from the mid-to-late 1980s, when managed behavioral healthcare was just emerging as a field. Many of the same things are happening now in CDHC as they were then for managed care — the field is being invented as it grows, and there is a sense of a “movement” afoot.

Many healthcare industry leaders are saying that we are at another key “inflection point” for healthcare services. Arnold Milstein, medical director of Mercer Human Resource Consulting and the Leapfrog Group, says the first key inflection point occurred with the advent of employer-sponsored healthcare post-World War II. The second was the advent of managed care in the '80s.

The insurance industry is already changing in response to the new products that have emerged with this third inflection point, and over the next decade we will likely find that all of our healthcare begins to incorporate many elements of consumer-directed care.

CDHC refers to a number of changes in health plans that increase the role of consumers in purchasing healthcare services. These new health plans seek to increase the knowledge and choices that consumers have in purchasing services, including consumer decisions to purchase services from one of several types of spending accounts.

The simple premise is that the involvement of third-party payers has artificially removed consumers from any sensitivity to the costs of their care. As Greg Scandlen of the Galen Institute states, “For too many years, Americans have been divorced from the consequences of Behavioral Healthcare Tomorrow · June 2003



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their health care decisions. ... We have ceded the responsibility for those decisions to someone else (a third party) ... After fifty years of reliance on ever-growing third-party payment, and the resulting cost increases, rationing, and political intervention, we have reached the edge of a precipice" ("Consumer Driven Health Care: New Tools for a New Paradigm." Health Issues: Galen Institute, Alexandria, Va., 2003).

To understand the implications of this new type of health benefit for behavioral health, we must begin by understanding the history and the trends that led to the emergence of CDHC.

Over the past 20 years, the healthcare system in this country has gone through dramatic changes. Cost growth during the early '80s resulted in employer-driven efforts to restrain costs through provider contracts and the implementation of managed care. The MCOs became a fourth party in a third-party payment system.

While managed care has successfully restrained costs, the fundamental economic model of managed care is "inefficient"; it is built on the belief that, in order to control costs, providers must be constrained from providing unnecessary services. Many have argued, however, that a much more efficient and market-based model would exist if we removed the third party and consumers had more direct financial incentives to purchase more cost-effective health care.

The nature and scope of CDHC

Consumer-directed services are intended to allow informed consumers to assess their own needs (perhaps with the help of a health adviser), determine how and by whom these needs should be met, and monitor the quality of services they receive.

There are two major elements of consumer-directed plans. First, they involve new and generally web-based decision support tools for consumers that increase the transparency of cost and quality. Second, they modify the incentives for consumers, so that health insurance changes from an absolute entitlement to an asset that can and should be managed.

These plans generally change the incentives by developing spending accounts, or health reimbursement arrangements (HRAs), from which consumers using the Internet directly purchase a portion of their health services.

Central to the success of any CDHC initiative is effective education of consumers about the choices they can make and how to make them. Many have argued that it may not be possible to implement truly effective consumer education with many populations, particularly the disabled and poor. Yet CDHC start-ups have found that many more consumers are able to be effective purchasers on their own behalf than was predicted, and

we systematically underestimate the capacity of the disabled to make their own decisions. In fact, the education of disabled consumers or their “proxies” can become an important part of empowering them and reducing dependency.

Organizations such as Definity Health, Vivius, Destiny Health, HealthMarket and Lumenos are the new start-ups (the “pure plays”) in a market that is so far largely focused on employer-sponsored health plans. Estimates are that only 1 million people are currently covered by these plans, in their various forms. However, in response to growing employer and consumer interest in these plans, most of the major insurance carriers are expected soon to offer some form of plan that they describe as “consumer-directed,” and rapid growth is predicted.

The simple premise is that the involvement of third-party payers has artificially removed consumers from any sensitivity to the costs of their care.

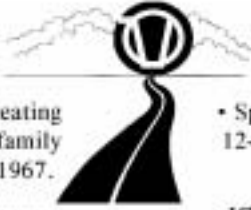
Of course, as with many newly emerging markets, there are many forms of consumer-directed health plans and there is considerable disagreement about whether some of the plans truly deserve to be called “consumer-directed.”

At the heart of changing the consumer’s role in healthcare delivery are consumer education services. Consumers need both education and new decision support tools to help them understand how their choice of provider will influence the cost of service and what the evidence-based recommendations are for certain conditions.

We can make the greatest impact on cost by providing information to consumers at the point that they are making critical medical decisions (i.e., prior to the development of a chronic condition, during efforts to treat their initial symptoms).

CDHC decision support systems build on many of the recent efforts of organizations such as the National Committee for Quality Assurance (NCQA), the California Healthcare Foundation and other new start-ups that have been developing systems for reporting on provider quality — increasing the transparency of quality in healthcare. Health Grades, Inc., Health Watch, Web MD, WorldDoc and other firms provide web content and various methods to address price and quality issues.

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The other area where transparency is needed is pricing. In fact, the current system has been built in many ways so as *not* to inform consumers about price. The system of third-party payers that we have constructed makes our insurance seem like an entitlement. This is particularly true in Medicaid and other government-funded services. Copayments are not the answer.

CDHC plans, in their pure form, allow the consumer to review the physician's actual charge for services that will be billed to the health reimbursement account. When these charges are filed they actually draw down the balance in the account and the record is available to consumers online. While merely sharing pricing information can reduce some costs of care, ultimately it will be the changed incentives in CDHCs that will cause the more dramatic shifts in care and cost.

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The chief method being used for changing the incentives is the health reimbursement arrangement. This outgrowth of the “medical savings account” and “flexible spending account” was acknowledged by the Internal Revenue Service (IRS) in the summer of 2002 under Section 105. Consumers can roll over account balances across each year (unlike flexible spending accounts), and tax-exempt spending from the account is now more clearly defined.

A standard consumer-directed plan might provide for full coverage of preventive care — the annual physical, mammograms, screening tests, etc. Initial medical costs are paid by funds from a consumer account that is funded on a monthly basis by a portion of the monthly premium. The annual account balance varies in size, depending on the benefits the employer wants to provide. Typically, the amount for a single plan ranges from \$750 to \$1,200 per year.

If services exhaust these funds, then there is general-

ly an out-of-pocket amount (bridge) that consumers pay; this might be anywhere from \$500 to \$750 per year. Once these funds are fully paid out, any continuing health service needs are covered by a traditional preferred-provider organization (PPO) insurance plan. This covers any further hospitalization costs, additional procedures or other expenses and may include co-insurance with the consumer up to a maximum out-of-pocket expense.

All these levels are essentially transparent to the consumers, who see the bills from physicians and can manage the account and the benefits at all levels of the coverage.

Implications for behavioral health

So what does this really mean for behavioral health when covered by these commercial plans? Behavioral healthcare services are certainly part of the new CDHC plans. However, most of these self-funded CDHC plans have limits on the number of days of coverage or on the services covered. The implementation of CDHC has unfortunately not changed these policies. Mental health parity legislation may change these limitations for group health plans, though this legislation continues to exempt many of the self-insured employer plans.

We can describe the potential impact for behavioral health in four main areas: treatment initiation; treatment retention; outcomes; and special populations.

Initiation: At the point of intake, providers may find that they have to justify their services and pricing. Consumers will increasingly begin asking for care that follows available clinical guidelines, as long as these are not felt to be overly restrictive, and variations from these guidelines will have to be explained.

Inpatient providers, because of the seriousness of the conditions they treat and their high cost, will also be questioned on their rates and quality, and potentially on the alternatives to care. The debate will shift from blaming managed care for restrictions on access to how to improve marketing to and education of consumers on the importance of behavioral health services.

The demand for ambulatory behavioral health services is more elastic than physical healthcare (e.g., the decision to seek services is highly influenced by a variety of external characteristics). If consumers are more directly involved with the purchasing decisions for their behavioral health services, what different decisions might they make? To the extent that alternative treatment approaches are eligible, will consumers choose them for some of the

more chronic conditions?

While answers to these questions are not well-understood at this time, future research may help to clarify them. However, it is safe to say that we are likely to see a rise in the availability of lower-cost alternatives when the decisions to purchase are being made by consumers whose incentive is to manage their resources like an asset rather than an entitlement.

Retention: As a result of the financial incentives and the personal involvement in the purchasing decisions, consumers may be less likely to stay with professionals whom they are not satisfied with or whom they do not feel are being effective. However, for those who make the decision to stay involved, it is also reasonable to expect higher rates of satisfaction and engagement with services because they have been actively involved in the decisions. Consumers who pay for care are more likely to think favorably about the care than are consumers for whom the payment is not much of a factor.

Outcomes: To the extent that consumers are more engaged in the decision to seek and purchase behavioral health services, it seems reasonable to expect that outcomes may improve. However, the research in this area is not conclusive.

Other outcomes, at a system level, concern the degree to which CDHC can deliver on its promise of cost control and quality. Since behavioral health services, by their very nature, depend to some degree upon the motivation and energy of consumers to follow through on care, we would expect that any approach that seeks to enhance these factors would improve success rates.

Special Populations: There has been a lot of concern in the implementation of CDHC that it would result in a biased selection of consumers — that the healthiest employees would be the ones who enrolled. Enrollment data from some of the early start-ups in this area suggest that this may not be true based upon ages of enrollees, but truly independent research has not been done.

One of the CDHC companies (HealthMarket) has an interesting approach to working with complex conditions. It establishes a diagnosis-related rate (such as a case rate or DRG) for consumers who can then administer spending in a separate HRA type account. Known as a SMARTFUND, this account may be a useful way to think about serving other high-cost populations, such as adults with serious mental illness, children with serious emotional disturbance and people with disabilities.

Implications for public purchasers

For the last decade or more, public behavioral health purchasers have dramatically increased the role of consumers in

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many or most of the areas of care. However, there are very few examples of consumers and family members actively taking a direct role in purchasing services on their own behalf (or on behalf of their child). The time for change has arrived.

The tools for developing, implementing and administering consumer-directed purchasing for adults with SMI, children with SED and other disabled populations are here. While the current plan designs would need to change, the concept of giving consumers a flexible spending account for community support services can work with virtually all public populations.

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The Medicaid Systems Change Grants that were issued largely in response to President Bush's New Freedom Initiative provide an indication of the government's interest in this area. These grants gave states funds to plan more effective ways to facilitate community living for consumers who had been unnecessarily placed in institutional settings. There was an overwhelming response to these grants to give consumers more choice in the services they receive. One example of a relatively small (100 slots) but significant project in self-directed purchasing for adults with mental illness is the Adult Mental Health Self Directed Care program (AMHSDC) in northeast Florida (www.floridasdc.info/Pages/Home.html).

There also are promising examples of efforts to implement consumer-directed purchasing for community living for individuals with mental retardation and/or developmental disabilities, many of which have emerged from the research and demonstrations of the Robert Wood Johnson Self-Determination projects from the mid-'90s. In Massachusetts, the Department of Mental Retardation procured an Intermediary Service Organization to administer accounts for individuals and their service coordinators for purchasing their community support services. This pioneering program now serves

several hundred consumers.

The models that will probably first emerge for the public sector will be CDHC for expansion populations (which Vermont recently announced it will be pursuing through a Medicaid waiver) and individual accounts for wraparound and ambulatory services for children with SED and adults with SMI based upon individualized care plans, similar to the Florida program. These accounts can be managed by consumers and care managers as long as consumers are eligible for services in the community.

So what is necessary for the public sector to bring the kinds of reforms envisioned in CDHC to scale, particularly in behavioral health?

- First, they must often seek federal Medicaid waivers, either an 1115 Research and Demonstration Waiver or Home and Community Based Services waiver, for the use of flexible Medicaid funds in the community. This is somewhat easier now as a result of the Olmstead ruling and the New Freedom Initiative. Waivers should specify that certain funds may be used for community support services rather than just medical expenses as long as they do not exceed a maximum amount that would have been spent on long-term care.
- Second, funds must truly follow the consumers and not be locked up in provider contracts. This is a big step for many states to take, because of the obvious fiscal effect on providers who are already struggling, and because of the political implications of this kind of change. The experience of most projects is that most providers will only change once the financial incentives have been changed.
- Third, states must be able to implement accountable information systems to document service plans, manage consumer accounts, pay providers and account for the funds. The advent of CDHC has demonstrated that these tools are here. Vendors such as CareGain can deliver software solutions on a full licensing basis or as an ASP for very reasonable rates per member per month. Multi-state collaborations on software development can make the needed modifications more cost-effective.
- Fourth, states must ensure that they implement a plan that truly changes the incentive in the behavioral health system and is not just an overlay on the existing system. Unspent balances in accounts should be able to be rolled over from year to year, shared with other eligible consumers and used for non-traditional services.

- Fifth, states must develop effective methods for consumer education. While the Internet can be an effective tool for most employed individuals and their families, there is obviously not the same level of access for Medicaid-covered individuals. However, many of these individuals can be provided access at libraries and mental health centers and with their care managers. Written materials should be made available, and presentations must also be made. A “train the trainers” kind of approach with the use of peer supports in social clubs and other sites will likely be the most efficient and empowering approach.

Provider resistance will be expected. Change is never easy. But as with managed care, many providers have made the change and have prospered because they have made their services more responsive to consumer needs.

Providers will have to “market” their services to consumers, and for many this will be a big change and will require new skills. The key to overcoming this resistance and bringing these types of efforts to scale is to start slowly and to deliberately take steps to expand.

Conclusion

CDHC has enormous promise to transform our service systems. Similar to the promise of managed care, it can improve quality at the same time that it saves money. Unlike managed care, it promises to engage consumers in a meaningful role in the oversight of their care.

As the field emerges, it will be important to identify plans that truly create quality and savings through the meaningful involvement of consumers in their own care. Savings will be a byproduct of the successful involvement of consumers in managing their healthcare assets. The shift in values from “entitlement spending” to “healthcare asset management” is perhaps most important and most likely to yield reward in the public sector.

In behavioral health and other disabilities, the act of empowering consumers also has a rehabilitative and perhaps therapeutic benefit. This should be part of a new research agenda. It is hoped that the true innovators in federal and state leadership positions can develop pioneering projects as the first steps to bring this new approach to scale in many of our communities. ©

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