

How Consumer-Driven Health Plans Will Affect Your Practice

This new way of paying for health care could realign the doctor-patient relationship and reduce the role of third-party payers, but only if it's done right.

Brandi White

The U.S. health care system has a lot going for it – tremendous resources, a talented workforce and cutting-edge science and technology – yet by many accounts, it is a mess.¹ In 2004, medical spending in this country reached a staggering \$1.9 trillion and grew 7.9 percent over the previous year.² Although this was the slowest growth rate since 2000, health care spending still rose faster than wages and inflation and now accounts for 16 percent of the gross domestic product,² which is far more than in any other industrialized nation.³ These world-class costs might be excusable if they corresponded with world-class outcomes, but all too often they don't.^{1,3,4}

As employers and other payers begin to find these costs unsustainable, they are embracing new models of health care financing that give consumers more control and more responsibility. ►



Illustrations by Simon Shaw

"If we fail to understand and shape this movement, that we're complaining yet again

The case for consumerism

Those who believe in consumer-driven health care say it puts the focus where the focus has been lacking: on patients, who are currently disconnected from the cost of their care yet whose lifestyle choices contribute to medical inflation and poor health outcomes. To help patients make better decisions, "we've all tried wheedling, cajoling and pleading," wrote Doug Iliff, MD, a family physician and member of the *FPM* Board of Editors, in a September 2005 editorial in *FPM*. "Personally, I think it's time to hit them in the wallet."

■ Consumer-driven health plans will account for 24 percent of the market by 2010.

Too harsh? Perhaps, but Iliff explains: "Until there is moral hazard built into health insurance, I don't think Americans are going to pay attention to our advice, work with us to make cost-effective decisions or become full partners in the wholistic system envisioned by the Future of Family Medicine."

■ Health savings accounts and health reimbursement arrangements are the most popular approaches.

Not everyone believes the moral hazard argument,⁵ but the fact is that consumer-driven health care is gaining momentum. A Deloitte study released in November found that 22 percent of large employers have a consumer-driven health plan in place and another 21 percent will be offering one in the next two years. According to data from Forrester Research, consumer-driven plans will capture 24 percent of the market by 2010, although "these numbers are smaller than the broader market implications," says Katy Henrickson, senior analyst for the firm.

■ When patients are more connected to the cost of their health care, they tend to be more active participants and wiser stewards.

The type of plan gaining the most attention these days is a health savings account (HSA) combined with a high-deductible health insurance policy. HSAs were introduced in January 2004 as part of the Medicare Modernization Act. In less than a year, enrollment in high-deductible health plans compatible with

HSAs has roughly tripled to 3 million members, according to data from America's Health Insurance Plans. (See "How HSAs work," page 74.) Another 3 million members are enrolled in health reimbursement arrangements (HRAs).

Some physicians are even embracing these plans personally. Family physician Doug Morrell, MD, recently established his own policy. "I chose an HSA because my health insurance premium was getting prohibitive and I am self employed," he explains. "My wife and I both had surgery last year, and it went very well. The savings account took care of the deductible and the secondary insurance paid its part, so I did not have to pay anything from my personal accounts. I was really pretty impressed with how well it went."

Morrell likes that he can deduct the HSA from his taxes "and if I don't use it by the time I am 65, I get it back," he says.

Even if physicians aren't interested in switching policies themselves, consumer-driven health care deserves their attention. "This realignment of the patient as purchaser is the first major change in health care financing since the creation of Medicare," says Michael Parkinson, MD, MPH, a family and preventive medicine physician by training and chief health and medical officer of Lumenos, which offers primarily HRA products to self-insured companies. "Physicians should become leaders and advocates for this movement done right. We were not at the table when managed care rolled out in the early '80s. If we fail to understand and shape this movement, then we'll wake up in seven years and find that we're complaining yet again about how the system operates."

A new kind of patient

Proponents of consumer-driven health care believe it could rejuvenate the doctor-patient relationship. As the theory goes, when

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patients are more connected to the cost of their health care, they become more active participants, "and that leads to dramatic changes," says Parkinson.

Prescription drugs are one case in point. Lumenos, which was recently acquired by Wellpoint, provides patients and doctors with cost information on prescription drugs, encourages patients to talk to their doctor about what's best for them, and then takes a hands-off approach. The result? "We get a 92-percent generic substitution rate when a generic is available, a 15-percent reduction in drug spending in the first three months, and the patients and the doctors love it," he says. "In nearly five years, I've not had a single complaint from a doctor or patient about a drug issue. I can assure you if you're the medical director of a health plan with a five-tier formulary with carve-ins, carve-outs and different administrative rules, you can't claim that. The employer's paying more, the consumer's paying more, one way or the other, and the doctor's hiring more staff to fight with the pharmacy benefits manager."

The data on the effectiveness of consumer-driven health care is just beginning to come in, but so far the evidence looks promising. In the June 2005 "Consumer-Directed Health Plan Report," McKinsey and Company described the results of its recent survey of more than 1,000 consumers. The study found that individuals with HRAs were 25 percent more likely to engage in healthy behaviors and 30 percent more likely to get an annual checkup. Just over half of them agreed that "If I catch an issue early, I will save money in the long run." These patients were also 20 percent more likely to follow treatment regimens for chronic disease care.

The same study found that these patients were 50 percent more likely to ask about costs and three times more likely to choose less extensive and less expensive treatments,



which has some critics concerned. The worry is that cost-conscious patients will limit not only inappropriate care but also necessary care. The recent "Consumerism in Health Care" survey from the Commonwealth Fund and the Employee Benefit Research Institute found 35 percent of those enrolled in consumer-driven plans reported delaying or avoiding medical care, compared with 17 percent of those in traditional plans.

To counter this problem, physicians will need to be more aware of patients who may be declining care because of cost concerns, and they may need to counsel patients out of "economizing too much," as family physician Benjamin Brewer, MD, puts it. In a Jan. 24, 2006, column in the *Wall Street Journal*, Brewer describes a recent situation where he had to convince a mother that her child with suspected pneumonia really did need the chest X-ray and blood work being recom-

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■ To prevent patients from "economizing too much," family physicians may need to counsel patients and explain why a test or procedure is necessary.

Consumers are “desperate for the

mended. In the end, the child received the needed care. It took an extra 10 minutes of Brewer’s time, but he didn’t mind. “I would rather advocate for needed care than try to convince someone that they really had no medical reasons to get a test they felt ‘entitled’ to,” he writes. “I’ve had those conversations, too, and they are much less pleasant.”

Another way physicians can make sure that cost-conscious patients are receiving needed care is by establishing effective follow-up sys-

tems, if they don’t already have such systems in place. For example, a computerized tracking system could quickly generate a list of all patients due for a diabetes checkup or a well-woman exam. Such systems will become critical, says Max Reiboldt, managing partner and CEO of the Coker Group, an Atlanta-based health care consulting firm. “The onus is likely going to be much more on the practice to get back in touch with the patient and to make sure the patient is scheduled for follow

■ Effective follow-up systems can help family physicians ensure that their patients are receiving the necessary care.

■ Cost-conscious patients may be more likely to seek care via telephone or e-mail.

■ Health plans that are truly consumer-focused are offering tools and information to help patients make good decisions related to their health care.

HOW HSAs WORK

Health savings accounts (HSAs) were introduced in January 2004 as part of the Medicare Modernization Act. They are tax-advantaged savings accounts that individuals can use to pay for “qualified medical expenses.” Individuals and their employers can deposit tax-free money into the account, and at age 65 the individual can deduct any dollars not used, although it will then be subject to income taxes. Those under 65 can also withdraw money for non-health-expenses, but they would be subject to income taxes plus a 10-percent penalty on the amount withdrawn.

- ▶ HSAs must be combined with a high-deductible health care policy. For 2006, deductibles can be no less than \$1,050 for individuals and no less than \$2,100 for families. The higher the deductible, the lower the monthly premium.
- ▶ Individuals pay for their health care out of their HSA until they have met their deductible. Then, the high-deductible health plan takes over, usually providing full coverage.
- ▶ Most of the major health care insurers have already begun offering high-deductible policies, usually with benefits resembling their PPO products. The HSA portion is generally administered by a bank.
- ▶ According to data from America’s Health Insurance Plans, 37 percent of HSA purchasers were previously uninsured and nearly half are over the age of 40.
- ▶ In 1996, Congress created medical savings accounts (MSAs), but complex rules slowed their adoption.
- ▶ Health reimbursement arrangements (HRAs) are similar to HSAs, but they are funded solely by an employer and are not portable if the individual changes employers. Like HSAs, these accounts can roll over from year to year. For details on the differences between these plans, visit <http://www.irs.gov/publications/p969/ar02.html>.

For a Q&A on HSAs, visit the U.S. Treasury’s Web site: http://www.treasury.gov/offices/public-affairs/hsa/faq_using.shtml.

role a good family physician plays.”

up and obtains other needed services,” he says.

Reiboldt also advises practices to be prepared for the likelihood that more cost-conscious patients will attempt to seek care via telephone or e-mail because doing so could save them from paying for an office visit. Physicians may need to begin charging a small fee for these “visits” and should take steps to educate patients about the value of seeing their family physician, he says.

“HSAs are going to require some adjustments at the practice level and some different ways of thinking,” says Reiboldt. “It’s important not only that physicians understand these new plans but that their staff be trained to handle them and that they have the information systems to support them. If you have all those things in place, then I believe that HSAs will be a welcomed option for both patients and the practice.”

However, physicians, their staff and their patients aren’t the only ones who need to adjust. Health plans will need to find their way as well. “There’s a right way and a wrong way to do consumer-driven health care,” says Tim Kotas, vice president for product development for Lumenos. “We don’t believe the right way is just to take your 20-year-old PPO product and slap a high deductible on it.”

The health plans that are doing it right are offering tools and information to help patients make good decisions about their health care, and they’re also offering monetary incentives for healthy behaviors, Kotas says. For example, Lumenos adds \$50 to \$100 to patients’ accounts for completing a health risk appraisal and discussing it with a “health coach.” The goal is to create patients who are informed and empowered to improve their health.

Can you compete?

Ultimately, consumer-driven health care will increase the demand for cost and quality data. “Patients will get increasingly frustrated when they own the resources in their accounts but

don’t know exactly how much that 15-minute visit costs or how much those laboratory tests that were ordered cost,” says Parkinson. He believes that the push for transparency is “positive friction that will drive changes in business practices and clinical practices that, for the most part, physicians will want to embrace.”

Aetna recently took a step toward price transparency when it launched a Cincinnati-area pilot project that involves listing the rates primary care physicians charge for particular services. Patients can access this information through the company’s Web site.

As patients get their hands on more of this information and start shopping, there’s some concern that family physicians will find it hard to compete with cheap and accessible “convenience clinics” on the one hand and high-tech specialties on the other. But Parkinson believes cost-conscious patients will find family physicians to be of great value. “I can tell you, after five years of having consumers on the Lumenos plan, they are desperate for the role a good family physician plays. They need help to understand their health care needs, navigate this maze of multiple specialties, multiple lab tests, direct-to-consumer advertising and all the rest,” says Parkinson. “They’re not going to get that from the MinuteClinic down the street.”

Still, to stay competitive and justify their prices, family physicians will need to examine whether they are providing excellent care and service and will need to generate the data to back it up. They might also need to expand their services or office hours, advocate for reimbursable e-mail consultations, create group visits, or establish innovative programs for managing risk factors and chronic diseases.

“If you as a doctor begin to think like a patient with his or her own money, and then look objectively at the things that you’re doing and whether they are consumer-friendly and evidence-based, I think you could begin to innovate in a way that will make

■ As patients begin to control more of their health care dollars, they will demand information about the cost and quality of physicians and other providers.

■ Family physicians will need to provide excellent care and service and be able to demonstrate their value.

■ By expanding services and innovating, family physicians will be able to compete in a consumer-driven marketplace.

“Unless our patients tell us they have met and we collect the money

you not only survive but thrive in consumer-driven health care,” says Parkinson.

Is the third party over?

Consumer-driven health care may eventually reduce the role of third-party payers in health care transactions, but they’re not going away any time soon. Most of the large health plans have begun offering high-deductible policies to accompany HSAs, so physicians aren’t off the hook in dealing with them. And while the market is moving toward patient payment at the time of service, it is not there yet, says Parkinson.

For now, the main administrative headache for physicians’ offices will be figuring out how much, if anything, they can collect from the patient at the time of service. Three questions will help guide physicians through this issue.

The first question physicians need to ask is, “Am I a participating provider with the patient’s health plan?” If not, then the transaction is fairly straightforward: “You can proceed as you would with any other non-contracted insurance,” says Reiboldt. In other words, collect the full charge before the patient leaves the office. Many patients with consumer-driven plans will have debit cards that deduct the money directly out of their HSA; other patients may have to pay out of pocket and get reimbursed from their account.

It’s possible that physicians will be participating providers without realizing it. For example, if a physician has a contract with Aetna’s PPO, it may be by virtue of that contract be a participating provider in Aetna’s high-deductible products as well.

Physicians who do participate with the patient’s insurance will need to ask a second question: “Does my contract with the health plan prohibit me from collecting from the patient at the time of service?” While many health plans are learning that they need to change their policy in this regard, some contracts still prohibit point-of-service payment.

In these cases, the practice will have to submit a claim to the insurance company, wait for the explanation of benefits (EOB) to indicate how much the insurer owes and how much the patient owes, and then bill the patient for any remainder due.

If the contract does not prohibit point-of-service payment, the practice needs to ask a third question: “Has the patient met his or her deductible?” Some insurers currently make this information available online. If the information is not available, practices may have to rely on their patients to determine whether their deductible has been met. If the patient has met the deductible, the practice must bill the health plan. If the patient has not met his or her deductible, the patient should pay at the time of service. (Note that preventive services are an exception. Many health plans pay for them even if the patient has not met his or her deductible, so practices will likely need to bill the health plan, not the patient, for these services.)

When collecting from patients at the time of service, it’s important for physician offices to remember to collect the contracted rate, not the billed charges, says Kotas. “When physicians bill their patients up front, typically what they’re using is their billed charge, not the allowed amount,” he explains. “Ultimately, that means the practice will owe the patient a refund, and the practice will have to have a process in place to pay the patient back because they didn’t bill the right amount on the front end.”

This underscores the importance of knowing what your contract says and what your contracted rates are for each health plan, which is no small task.

Physicians should also be aware that some health plans actually cap the amount practices are allowed to collect at the time of service from patients with high-deductible policies. For example, Blue Cross Blue Shield of North Carolina allows physicians to estimate the patient’s out-of-pocket costs and collect the lesser of the

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estimated cost or \$50 at the time of service.

If all of this is mind-numbingly complicated, Morrell offers a simpler approach that he uses in his practice: “Unless our patients tell us they have met their deductible, we assume they have not and we collect the money at the time of service. Our policy is to collect deductibles at the time of service, and my office has not had a problem.”

When the patient is payer

When practices have to collect from the patient, rather than the insurer, there’s some concern that the physician will be more likely to be stuck with the bill. But Morrell says this hasn’t been his experience. He finds that the kinds of patients who purchase HSAs, many of them farmers in his area, are good about paying their bills. He adds, “I would much rather deal with people who have HSAs than with an insurer like Anthem.”

If adequately funded, HSAs can actually improve a physician’s accounts receivable, compared to traditional high-deductible plans. The same is true for HRAs, which are always employer-funded and usually cover preventive services, which means patients should have enough money to cover standard medical expenses and roll over dollars to the next year.

Reiboldt believes physicians could actually fare better under consumer-directed plans. “Physicians just need to understand that they’re going to have more responsibility to collect from their patients. And in some respects, that’s good. You certainly have more leverage with patients than with some third parties,” he says.

The key, says Reiboldt, is having the right policies and systems in place. “Patients should be aware of your practice’s financial policies and should sign off on them,” he says. “You should also let your practice management system do some of the work for you.”

Most systems offer collections modules or generate financial reports that can help a

practice examine its aged patient accounts on a regular basis and follow up on them. If patients have trouble paying, “You may have to make some deals with them,” says Reiboldt, “either by offering discounts for cash, spreading out their payments or coming up with other payment options.”

Trevor J. Stone, the AAFP’s manager of private sector advocacy, offers additional tips for securing timely payments from patients with consumer-driven plans:

- If one of your insurer contracts does not allow you to collect at the time of service, ask these patients to provide their debit or credit card to be charged the amount due once the EOB arrives. Some patients may be reluctant to do this, so you’ll need to assure them that their data will be stored securely.
- Urge your patients to enroll in automatic HSA debiting, which allows them to authorize money to be transferred from their HSA directly to your practice as soon as the insurer determines the patient’s financial obligation. ▶

Some worry that physicians will be stuck with the bill if practices have to collect more from patients.

Others find that patients are easier to collect from than many health care insurers.



“The relationships and the funding of health care are changing. I don’t think anyone can argue with that.”

- Collect any outstanding balances from patients who are in the office for another appointment. If possible, collect this at check-in, before they see their doctor.

- File claims with insurers electronically within 24 hours. This will speed up your reimbursement and enable you to bill the patient in a more timely manner for any remainder due.

- Consider dismissing patients who have significant overdue accounts.

(To access AAFP resources related to consumer-driven health care, visit <http://www.aafp.org/x35923.xml>.)

As physician practices become more accustomed to collecting from patients at the time of service, as health plans evolve to become truly consumer-driven and as patients begin to understand their new roles and responsibilities, these payment challenges are likely to decrease.

“My hope is that over time, as the system equilibrates, patients will be as willing to pay for an hour of their doctor’s time as they would be to pay for the plumber that comes to their house,” says Parkinson. “Third-party payment inadvertently has led to a system where we devalued the physician’s expertise and undermined the physician-patient relationship. Consumer-driven health care allows us to reconnect and encourages patients to consider, ‘What is the value proposition of seeing my family physician?’ I think as patients begin to grow these accounts, they will say, ‘Of course, I’ll spend a fair amount for your services. You’re a physician. You know me. I’ve been with you. I value your expertise and partnership in improving my health and managing my health care needs.’”

Into the future

Whether HSAs, HRAs and other consumer-driven plans will solve health care’s problems, no one can say for sure. What is clear, however, is that “the patient is becoming the payer. The products themselves may vary, but

that’s not the point. The point is that the relationships and the funding of health care are changing. I don’t think anyone can argue with that,” says Kotas.

Indeed, even proponents of a single-payer system acknowledge that consumer-driven health care is the likely next step, though they imagine it ending much differently: “The start of substantial [health care] reform will probably have to wait for CDHC [consumer-driven health care] to play itself out, just as investor-owned ‘managed care’ did in the last decade,” writes Arnold S. Relman, former editor of the *New England Journal of Medicine*, in the March 7, 2005, issue of *The New Republic*. “I expect the system to become so dysfunctional, and costs to become so onerous, that the availability of services to the poor will decline even more, the number of uninsured and underinsured will continue to grow, and the inequity between the care of the rich and the poor will reach scandalous proportions. At that juncture, public opinion will probably demand that health care move from market control to some form of government protection and guaranteed benefits.”

Of course, many would disagree with Relman’s assessment. But even if he’s right, physicians would be wise to pay attention to consumer-driven health care. Patients and insurers certainly are. **FPM**

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Practices should collect outstanding balances from patients when they arrive for an appointment.

As practices and patients become more accustomed to payment at the time of service, payment challenges are likely to decrease.

Consumer-driven health care could help patients reconnect with their family physicians and realize their value.