

Debunking the Myths of Consumer-Driven Healthcare

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Destiny  HealthTM

Debunking the Myths of Consumer-Driven Healthcare



As health and medical insurance costs continue to rise at multiples of consumer inflation, a new generation of consumer-driven healthcare plan (CDHP) is emerging as a mainstream solution. Forrester Research Inc., a leading independent industry analyst, predicts 24% of Americans will be covered by such plans by 2010—a 7,500% increase over the current market share of just 0.3%.

Still, some employers and consumers remain cautious. Their perception of consumer-driven healthcare is based on first-generation plans that were little more than catastrophic coverage coupled with a member savings account.

The good news is that today's CDHP bears little resemblance to its early 1990s forebear. Today's plan is a sophisticated product offering members access to state-of-the-art decision-making tools, benefits tailored to the individual and incentives that make the product as good for the healthy as it is for the sick.

The dramatic growth trend projected by Forrester and others reflects a growing body of evidence that by positively motivating people to take responsibility for their healthcare spending, CDHPs promote healthier lifestyles and more cost-conscious healthcare shopping habits. Importantly, these behaviors also lead to a lower rate of premium inflation and an overall reduction in individual healthcare expenditures.

Not surprisingly, the data is prompting increasing numbers of employers to conclude that CDHPs represent a win/win alternative to the current win/lose practice of simply cutting benefits or shifting more of the premium payment to their employees.

CDHPs have come of age, and word is spreading that the criticisms of yesteryear hang on only as myths.



Myth 1: Consumer-driven plans are only good for the healthy

First-generation CDHPs were simple in their design, with catastrophic coverage augmented by a member “savings account” that was utilized for all expenses below the deductible. For sicker members, particularly those requiring hospitalization or ongoing medication for chronic conditions, this meant that their savings dwindled quickly, leaving little or nothing available for more discretionary services. The impact on the health plan itself also was negative, as sicker members did not have an adequate financial incentive to act prudently. Only healthy members had unused funds at the end of the year that they could use in the future.

Today’s CDHP distinguishes between uncontrollable and controllable costs, providing comprehensive coverage for hospitalizations and medications for chronic conditions and reserving the consumer-controlled savings account for discretionary and less costly services. It works as follows:

Health Event	Coverage Pattern
Hospital and Surgery	Comprehensive coverage (with potentially no impact on personal fund)
Medication to treat chronic health conditions	Comprehensive coverage (with potentially no impact on personal fund)
Day-to-day	Combination of member empowerment (through personal fund with the member keeping unused balances) and insurance protection against large cumulative costs

The advantages relating to each component of this structure are outlined below:

1. Day-to-day benefits

The combination of a personal fund that members can utilize according to their healthcare needs with insurance protection against high cumulative costs delivers two primary benefits:

- Healthy members that do not fully utilize the money available in their personal account can carry these funds over for future use. This “use-it-or-keep-it” principle is unique to CDHPs and yields value to healthy members who *don’t often* use their health plan.
- Sick members have comprehensive financial protection through access to insured benefits in the event that they experience large cumulative expenses.
- Compared to a traditional PPO plan, the CDHP model provides significantly more benefits to members who incur relatively low costs (typically around 65% of members). These members are on average around \$300 per year better-off with the CDHP model than under a traditional PPO Plan.
- Importantly, however, the CDHP model is at least equal to PPOs in the benefits provided to members who incur high day-to-day healthcare expenditures.



2. Chronic medication benefits

CDHPs can be tailored to the individual. For example, in order to preserve the personal funds of a diabetic, the CDHPs would be set up to deliver first-dollar chronic coverage for insulin and other required medications, typically subject to a drug co-pay. The result is comprehensive coverage for members with chronic conditions without impacting a member’s personal funds.

3. Hospital and Surgery benefits

Once again, CDHPs offer members coverage for hospitalization and surgical events, typically subject to a low deductible and/or coinsurance, without impacting a member’s personal funds. This ensures that the incentives for prudent day-to-day benefits are not affected by uncontrollable hospitalization or surgical events.

The combined effect of these coverage patterns ensures that while CDH plans are naturally good for the healthy, they are also good for the sick.

Myth 2: Consumer-driven plans result in cost shifting, not cost saving

“Cost shifting” occurs when the total cost of healthcare remains constant, but consumers end up burdened with paying a greater share. Correctly structured CDHPs, on the other hand, have achieved genuine cost savings through changes in members’ claiming behavior.

By aligning incentives between the member and plan sponsor, a CDHP avoids the inflationary pressures that accompany traditional 3rd-party, fee-for-service models that have the effect of keeping consumers ignorant of and disconnected from the true costs of medical services.

Because the CDHP model encourages consumer involvement, members exercise increased prudence and behavioral changes. In this way, CDHPs, unlike traditional health insurance plans that focus solely on managing the supply of healthcare, help reduce healthcare cost inflation by managing demand.

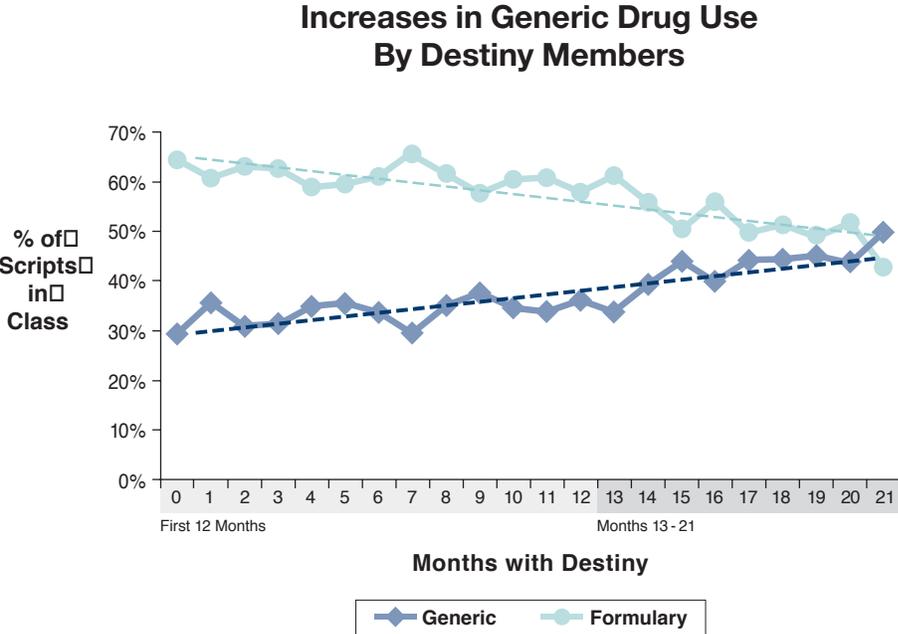
The positive effect of appropriate member empowerment on spending patterns has been demonstrated in a paper published by the National Center for Policy Analysis. This paper focuses on the effect of empowerment on prescription drug costs, one of the nation’s biggest drivers of healthcare costs.

The findings of the paper, which compares spending patterns when members use their own healthcare savings account money versus the insurer’s funds, are summarized as follows:

	% increase when insured vs. funded through savings account
Cost per prescription	7.1%
Number of prescriptions per month	19.1%
Total change in monthly cost of prescribed medication	27.6%

Overall, member empowerment was found to reduce prescription drug spending by almost 30%.

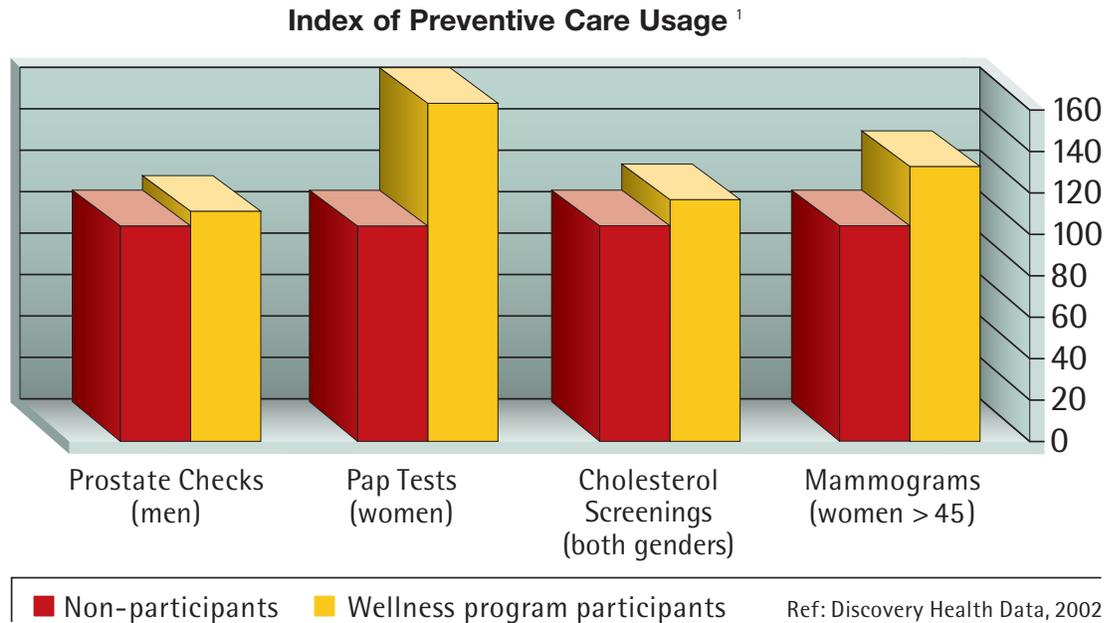
The same phenomenon has been demonstrated by Destiny Health members who have shifted their claiming patterns from formulary to generic drugs over the lifetime of their membership.



CDHPs therefore change behavior in a positive way by reducing unnecessary and wasteful health-care expenditures and rewarding members for prudent claiming patterns. This results in long-term cost savings and a more sustainable plan.

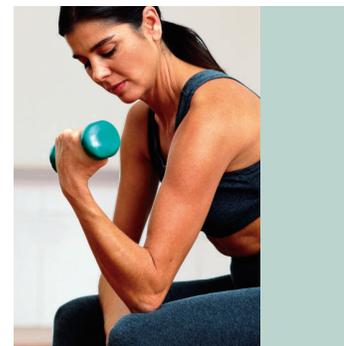
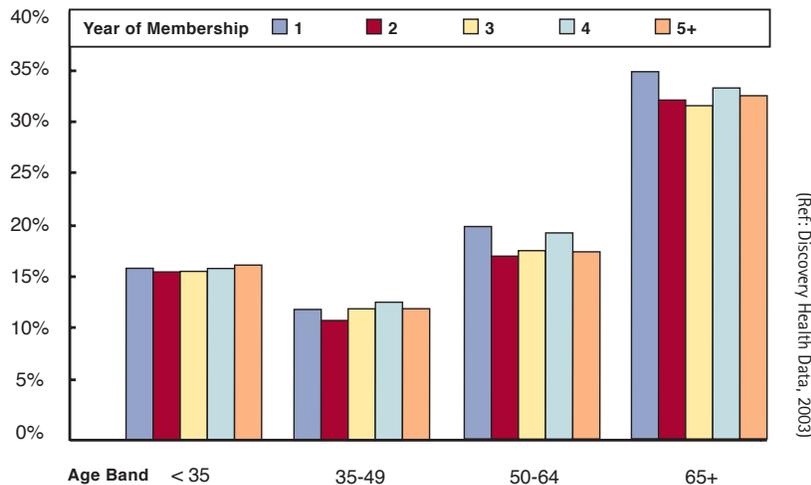
Myth 3: People with consumer-driven plans cut back on preventive care

It has been suggested that because many CDHP members fund their own preventive care, they will reduce their spending in this area and suffer long-term ill effects. Experience demonstrates this is not the case. On the contrary, through carefully designed wellness and education programs, preventive care usage actually increases. The following chart reflects data from South Africa, where CDHPs have been a major factor since 1993. Members sought more preventive care than members of other plans in every area that was measured.



Additionally, if members did forgo necessary care, you would expect an increase in hospital admission rates the longer a member is insured under a CDHP. The data above from South Africa shows quite the contrary, where experience shows across all age bands that the incidence of hospitalization does not increase by length of membership under a CDHP.

Hospitalization Incidence by Duration



¹Data collected by Discovery Health through the analysis of more than 1.5 million members of which approximately 70% were enrolled in a wellness program.

Myth 4: Consumer-driven plans result in short term savings

CDHPs have demonstrated the ability to generate savings and rein-in medical inflation in a very short space of time. The obvious question is whether these are short-term savings or sustainable in the long term? Data drawn from CDHPs that have been operating for extended periods demonstrate that, in fact, the savings not only last, they grow over time.

The reason is that well-developed CDHPs combine the most effective supply-side and benefit-management elements of the managed-care era with the consumer-empowerment characteristics of 1st generation CDHPs to achieve the optimal combination:

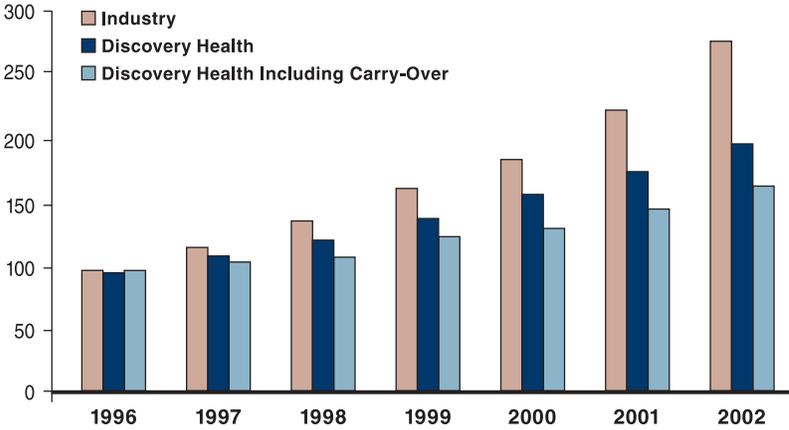
- When spending their “own money,” members are empowered and rewarded for prudent spending in areas in which they have control under the “use-it-or-save-it” approach of CDHPs.
- When spending the “insurer’s money,” insured benefits are structured to ensure the most effective provider remuneration structures and benefit-management techniques are employed.

The results of this approach are now being borne out at Destiny Health and other CDHPs where the medical inflation trend is being recorded at significantly lower levels than the national average.

While the short-term results experienced in the US are promising, the longer term results of this approach can be seen in the following graph that depicts the increases experienced by Discovery Health, the leading provider of CDHPs in South Africa, with more than 1.5 million members, relative to the rest of the industry over the last 7 years.

The compounding effect of continual below-average medical inflation increases, combined with the effect of members accumulating funds in their personal accounts, has resulted in a significant premium advantage relative to the market over time for the Discovery Health plans.

Discovery Health Premium Advantage Over Time

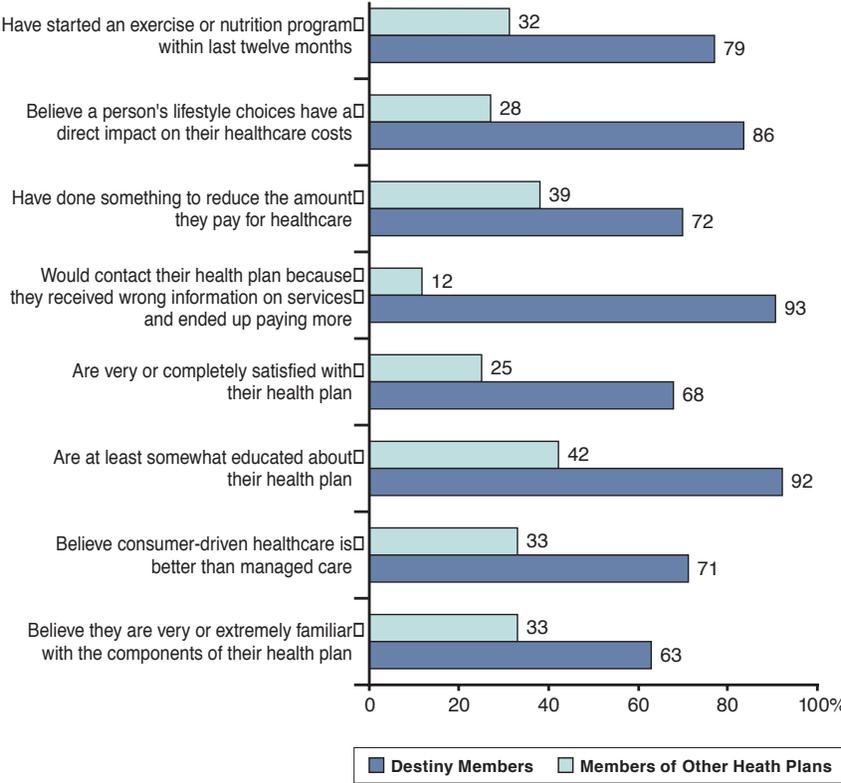


Myth 5: Consumer-driven plans will never work because people don't want to take the time to become well-informed

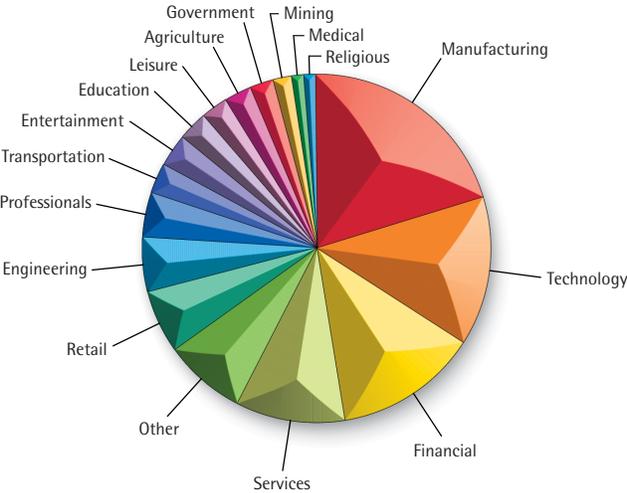
Initially, there was a belief that an "asymmetry of information" between doctor and patient made CDHPs appropriate only for the most well-informed consumers. However, through the appropriate financial incentives and consumer-focused interactive tools, experience with CDHPs is demonstrating that members across the board are embracing involvement in their healthcare purchasing decision and are taking charge of their personal health. The result is that members are deriving far greater value and satisfaction from their health plan. Independent member research clearly demonstrating this phenomenon has just been completed by Destiny Health (see chart at right).

Another benefit of CDHPs is their appeal to a variety of industries and different-sized employers. The following CDHP membership breakdowns show the diversity of both industries and employer group sizes.

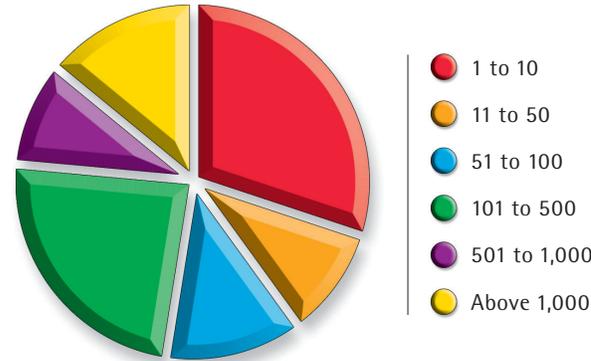
Behaviors/Opinions of Destiny Health Members vs. Members of Other Health Plans



Distribution of CDHP Membership Base by Industry



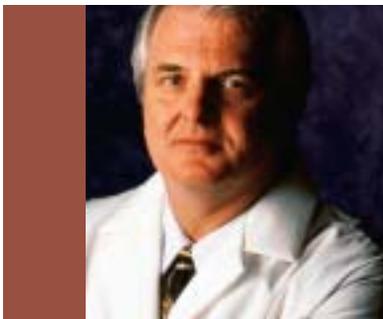
Distribution of CDHP Membership Base by Employer Size



Myth 6: Consumer-driven plans create conflict between doctor and patient

One of the major advantages of CDHPs is that by enhancing the role of the member in the healthcare purchasing decision, the doctor-patient relationship is actually enhanced:

- In the CDHP environment there are incentives for doctors to offer the best quality and value to patients as it is the patient who is in charge of the financial decision of when and where to purchase their healthcare.
- The member has the flexibility to purchase any service from doctors and is not constrained by benefit or protocol limitations.
- There are no perverse incentives such as the incentive to underserve or limit access to certain treatment protocols, as may be present in financing models such as capitation systems.



Notes



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