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THE PERFORMANCE AND POTENTIAL OF CONSUMER-DRIVEN HEALTH CARE

HEARING

BEFORE THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

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FIRST SESSION

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C O N T E N T S

THE PERFORMANCE AND POTENTIAL OF CONSUMER-DRIVEN HEALTH CARE

WEDNESDAY, FEBRUARY 25, 2004

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC

The Committee met at 10:02 a.m., in room SD-628 of the Dirksen Senate Office Building, the Honorable Robert F. Bennett, Chairman of the Committee, presiding.

Senators present: Senator Bennett.

Representatives present: Representatives Ryan, English and Stark.

Staff present: Tom Miller, Leah Uhlmann, Donald Marron, Colleen J. Healy, Mike Ashton, John McInerney, Wendell Primus, and Frank Sammartino.

OPENING STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN

Chairman Bennett. The hearing will come to order.

Mr. Stark is on his way, I understand, and other members of the Committee will come and go as their schedules permit.

We'll get started because we potentially have a Senate vote that may interrupt us.

But we're grateful to the witnesses who are here to examine this issue, which is a very important issue.

We're facing a significant challenge in this country to keep health care affordable. For many years, our health care spending has grown at a significantly faster rate than the economy, and all projections are that this will only continue.

And I believe it was Herb Stein, the economist, who said "When something can't go on"—as people are saying about increasing health care costs—"it won't." Something that can't go on will, of its own weight, fall. And I would rather that we do something about health care spending to bring it under control than to just let it go forward until it does fall of its own weight with catastrophic results.

Now in recent years, we've enjoyed amazing advances in medical technology that have extended and greatly improved our lives. And medical procedures, as we've experienced this technological revolution, have become less expensive and less invasive.

But as we discovered at our last hearing on this subject last summer, we found an interesting paradox. And it seems counter-intuitive, but the data are clear—as costs for medical procedures go

down, and the delivery of health care correspondingly becomes more efficient, overall costs go up.

Now much of this disconnect can be attributed to the difference between the amount consumers pay and the actual cost of the technology, because we found as we got into that, that as the cost of individual procedures go down, the number of procedures go up more dramatically than the cost comes down, which means more people choose it, which means overall costs rise.

Now some people might not choose expensive procedures if there was an economic incentive that entered into their choice. And because of comprehensive insurance and other programs, we've created the notion in people's minds that, "someone else," is paying for our health care.

And we therefore have an economic incentive to use more and more health services.

In other words, insured people are buying greater amounts of medical services, which contributes to the higher insurance premiums and the overall health care costs. And, paradoxically again, as this happens, we're buying more and more insurance, more and more people can't afford it, or their employers feel that they can't afford it, and so the number of uninsured goes up.

Now we have a chart here that illustrates, I think, the two trends. The dark blue line is a figure in dollars that shows the amount of per capita health care costs overall, starting with the 1960s, the decade in which we went to Medicare.

[The chart entitled "Out-of-Pocket Spending Falls as Per-Capita Spending Climbs," appears in the Submissions for the Record on page 36.]

And the overall costs have been going up very dramatically, higher than the economy is growing, higher than our incomes have grown, higher just about than anything else.

And we are now at the point where everybody says our number-one cost problem is increasing health care.

The orange line is in percentages, not dollars. So at first glance, this might be a little misleading. The orange line shows the percentage of the at-point-of-service, out-of-pocket costs that people pay.

In 1960, it was about 50 percent. When you went to the doctor or you went to the hospital or you went somewhere, you paid about 50 percent of the cost yourself and the other 50 percent was covered by your health care plan.

And as we can see the orange line coming down, that number is about 15 percent today.

So if there was an economic incentive back in 1960 either to stay healthy in the first place, or to make wise choices as to what costs you would incur in the second place, that incentive has gone down very dramatically.

I'm not sure we can make a direct cause-and-effect relationship between these two lines. It's always dangerous to put two lines on a chart and say one is causing the other.

But, nonetheless, it's something that we should consider and pay some attention to.

Given the rapid rise of the line on the bottom, the dark blue line that every employer talks about as his biggest economic challenge

today, including the Federal Government, we have to look for ways of limiting costs that are not Draconian.

We want to limit costs while improving access and the quality of health care.

Now, as we've seen in other areas, cutting costs by government fiat causes all kinds of market distortions. The government can't keep up with the marketplace and cost controls, regardless of the area, have never worked over time.

If prices are set too low, there's a shortage of providers who say that they can't make a living at those low prices. If prices are set too high, insurance companies are forced to raise premiums and ration services to the patients.

So there are those who believe, and I am one of them, that a better approach is consumer-driven health care.

We've had 2 years of experience now to look at the initial attempts at getting consumer-driven health care off the ground. And the purpose of this hearing is to look at that evidence, look at that experience and see what it can tell us.

A consumer-driven approach to health care does restore to consumers a degree of direct control over their health care dollars which has been missing.

It provides them with better value and greater choice, improved health and recognition of the true cost of the services they demand.

So you can see, if the cost at purchase goes from 50 percent down to 15 percent, the true cost of what they're getting gets lost in the minds of the consumer.

Consumer-driven health care offers a broad range of options that encourages employees to take a greater role as informed health care consumers in choosing their health plans and benefit packages to health care providers and medical treatment alternatives.

Another promise of consumer-driven health care is that it can reverse a long-term trend that has combined more third-party payment of health care bills with substantial hikes in health care spending.

Now, in last December's Medicare Prescription Drug Improvement and Modernization Act, health savings account options that were severely limited before the passage of that act have been expanded. And they give consumers even greater ownership and control of their health spending dollars, which might very well reshape the health care market.

So today's hearing will examine the performance of the consumer-driven health care market over the last 2 years to see how this new approach is developing in terms of levels of enrollment, plan options, consumer satisfaction, and projected growth.

And I'm very grateful to the witnesses that will be here to help us understand what experience we've had and give us their opinions as to what might happen in the future.

Our panel will include a number of perspectives on this: Dr. Arnold Milstein, who is a physician; Mr. John Bertko, who is an actuary; the benefits manager at a firm that has adopted the consumer-driven health approach, Mr. Howard Leach; and a health policy analyst for Consumers Union, looking at it from the outside to see what the insiders may have missed, Ms. Gail Shearer.

And we're grateful to all of you and look forward to what you have to share with us today.

[The prepared statement of Senator Robert F. Bennett appears in the Submissions for the Record on page 35.]

Chairman Bennett. Mr. Stark.

OPENING STATEMENT OF REPRESENTATIVE PETE STARK, RANKING MINORITY MEMBER

Representative Stark. Thank you, Mr. Chairman, for delving into this area.

I'm troubled by the title "The Performance and Potential of Consumer-Driven Health Care," because, having spent some time in the health care policy area, I have yet to observe any, "consumer-driven health care" that's performed well.

Basically, the policies that the Administration is suggesting we use are—what they really are are tax shelters that require people to pay more for their health care so that insurance companies' stockholders can get rich.

The high deductible defined contribution plans are not consumer-driven, nor do they offer very much choice.

They simply shift costs to the consumers and force the consumers to pay more out-of-pocket, often in many cases making it difficult for the patients to actually get the care they need.

I know the Chairman knows a great deal about the market, free markets and the open markets that we have in this country. But I know that he also knows, I think as an academic as I once was in the field of marketing, that the consumers need reliable information.

And I'm going to challenge the Chair, which I rarely would do, and all of our witnesses, including Dr. Milstein, who might have reason more than any others, and anybody else in the room, to take the Stark Test, as I call it, and get a 95 percent score, those of us who are somewhat experts in the area of delivery of health care, to see if you could define for me what your own health plan provides.

Tell me, first of all, how much it costs each month. You may know your share of the payment, if any, but I doubt if anybody in this room knows the cost—you and I don't—of our own health plan. And then, what are the benefits?

We may know vaguely, Mr. Chairman, that it provides 80 percent or 90 percent of medical costs. Maybe 100 percent if we go to an approved doctor. Roughly that it provides some hospitalization.

I think, unless you or I or our family members, or the panel's family members have been ill recently, you wouldn't know. I could sure stump you on mental health benefits—how many days do you get? Or unless you have a child who has handwriting problems like mine, occupational therapy.

Most people don't know. They just don't know.

And I just approved it. I've arranged at Georgetown Hospital—and I have a sign-up sheet here for all of the panelists and for you and me, Mr. Chairman, and any of the people here in the room today, as a courtesy of Georgetown Hospital Medical Center, to get a half-price colonoscopy or pap smear.

Do you want to sign up?

[Laughter.]

We don't do this.

Chairman Bennett. I got mine at Bethesda Naval Hospital.

[Laughter.]

Representative Stark. And you didn't pay anything. But we don't want to buy this stuff. We want to buy a new car or a new suit or a tie with elephants on it. I want to get one with donkeys on it.

[Laughter.]

But if a doctor tells us to take a test, we'll take it and hope we pass. But we don't know what the test is.

And I'll bet you in many cases—I don't know what specialty Dr. Milstein has—but I'll bet you outside of his specialty, he doesn't know what tests cost. And we patients don't.

What I'm suggesting is that, yes, the Internet is informing us more and we're learning more. And with the all the advertising that the pharmaceutical companies are presenting us, we're asking our physicians to improve our life so that we can leap through the tulips or get up there with the football players or whatever.

But I suspect that it's annoying the doctors as much as perhaps it annoys me for giving us that little bit of knowledge which could be dangerous.

So while I believe in the free market, had some success in it, I just do not feel that it is possible for us to learn quickly or to take the information that is now available and make reasonable choices.

The high deductible plans, in fact, will attract, because of their tax features, those of us who are younger or who are not very sick. But it may shift the responsibility and cause additional illness and increase costs, because if people are deterred from getting the care they need, they may end up being sicker which will be more expensive in the long run.

So you can do better, Mr. Chairman. The problem that we ought to look at, for instance, in pharmaceuticals, which is driving most of the increased health costs for the past year or two. And we ought not to refuse to allow the Secretary of Health and Human Services to bargain and use his market clout to buy pharmaceuticals for us at a lower cost.

He showed that he could do that in one drug not so long ago and got a 50-percent discount. I want the Secretary's discount. I don't want one of these cockamamie Buck Rogers Rocket Rangers discount cards.

I want Secretary Thompson out there getting me discounts at 50 percent when I walk into Giant or Rite Aid.

I want him on my side. That's how we'll save some money.

But I look forward to what the witnesses have to say, and this is an area which is very interesting to me and I look forward to a stimulating hearing.

Thank you, Mr. Chairman.

[The prepared statement of Representative Pete Stark appears in the Submissions for the Record on page 37.]

Chairman Bennett. Thank you very much.

I normally don't comment on Mr. Stark's comments, but I must make this personal observation when he says we don't know what things cost and we don't know what we ought to do.

Since Bill Frist has become the Majority Leader of the United States Senate, every Senator, regardless of party, philosophical orientation, state, what have you, gets a letter from the Majority Leader telling him what tests he ought to have, what screening he ought to go through, what he needs to do to keep himself healthy.

And my only defense is that I keep telling Senator Frist that he drinks too much coffee.

[Laughter.]

With that, we go to our witnesses. Let's go in this direction, start with Dr. Milstein, and just go down all four. And when we've heard from all four, then the question period and discussion period will start.

Dr. Milstein, your resume is on the record. I won't take the time to go through the credentials of each of you, because we will stipulate that every one of you is brilliant and properly prepared.

We appreciate your willingness to come here and share with us your experience.

OPENING STATEMENT OF DR. ARNOLD MILSTEIN, M.D., MPH, PHYSICIAN CONSULTANT, MERCER HUMAN RESOURCE CONSULTING, SAN FRANCISCO, CA

Dr. Milstein. Thank you for the opportunity to summarize early results from a study of consumer-directed plans that I lead with researchers from the Harvard School of Public Health and staff from Mercer.

We surveyed and received responses from more than 600 U.S. health benefit plans and have been conducting in-depth interviews with 15 consumer-directed plans that had preliminary results.

We studied plans that incentivized consumers to select more affordable and/or higher quality physicians, hospitals or treatment options, including more self-management of health problems, and that provided consumers with comparative information on cost or quality.

We examined both portable account plans, such as health reimbursement accounts, as well as tiered benefit plans in which consumers pay either a lower premium or a lower cost at the point of service if they select a more favorably-rated provider or treatment option.

A summary of our more detailed findings and other related published research is as follows.

Our first general finding is that the potential gain from consumer-directed plans is large. If consumers were first well informed about which physicians, hospital service lines, and treatment options offered superior affordability and quality, and second, were incentivized to select superior options, they could both improve their quality of care and offset biotechnology-driven increases in insurance premiums.

Additional gains from a more performance-sensitive consumer market would be ongoing, as safer, more affordable health care became a market imperative for physicians, hospitals and treatment innovators.

Ongoing gains would include acceleration of the complete process re-engineering of in-patient and ambulatory care as described in the Institute of Medicine's "Crossing the Quality Chasm" report.

In my testimony last month at the Senate HELP Committee, I document why I estimate these potential sources of efficiency capture equal 40 percentage points of current spending.

Our second general finding is that early attempts to implement consumer-driven plans are indeed slowing health insurance premium increases, but are falling short of this potential.

Early returns suggest that consumers are accessing available performance information, reducing their use of services, and substituting less costly services for more costly services.

Annual savings based on comparisons with concurrent increases in other health benefit plans in the same geographies center around 10 percentage points, net of reductions in benefits coverage.

Lack of independent scientific scrutiny of the data underlying these reported results and information voids about important questions, such as the impact on quality of care, indicate that there is more to learn before projecting the results likely to occur for the entire U.S. population.

We estimate that enrollment in consumer-driven plans will double in 2004 to something approaching 4 million individuals.

Of these, about one-quarter will be enrolled in HRA or spending account type plans.

We also found that consumer-directed features such as performance comparisons of doctors and of treatment options were beginning to penetrate mainstream health plans.

Two structural limitations explain why early results are not approaching their full potential.

First, many plans are making cost savings a lower priority than the simpler goal of increasing consumers' use of performance comparisons and consumer self-confidence in using those comparisons to select better options.

Second, very few health plans have enough claims experience with most individual physicians or individual hospital service lines to quantify validly for consumers the comparative quality of care or cost efficiency when treating a longitudinal period of illness.

Imagine trying to select baseball players for an important game if performance information was limited to one-quarter of your players and for those players you had fielding averages, but not batting averages.

Let me close by pointing out that there is an important budget-neutral opportunity for Congress to reduce the significant informational barrier to capturing the full potential of consumer-directed plans.

Congress could clarify to CMS that nothing in the current Privacy or HIPAA statutes was intended to block routine access by private-sector health plans, whether sponsored by self-insured employers, labor unions or health insurers, to the full Medicare claims database as long as such access assures all statutory beneficiary privacy protections provided for under HIPAA and the Privacy Act, such as encrypted beneficiary identifiers.

Such information access would enable all American health plans to compare for consumers the quality and longitudinal cost efficiency of physicians, hospitals by particular service lines, and treatment options.

Precision in performance comparisons could be further enhanced if CMS were to require modest expansion of hospital and physician billing data as recommended by the Quality Work Group of the National Committee on Vital and Health Statistics.

Thank you for the opportunity to summarize my more detailed written testimony.

[The prepared statement of Dr. Arnold Milstein, M.D. appears in the Submissions for the Record on page 37.]

Chairman Bennett. Thank you very much. And your testimony, as submitted, will appear in the record.

Mr. Bertko.

OPENING STATEMENT OF JOHN M. BERTKO, F.S.A., MAAA, VICE PRESIDENT AND CHIEF ACTUARY, HUMANA, INC., LOUISVILLE, KENTUCKY

Mr. Bertko. Good morning and thank you for the invitation to present early experience with our consumer-centric health insurance products.

I'm the Chief Actuary of Humana, which is one of the country's largest regional insurers. We have about 6 million total members and 3 million commercial members in about 15 major states.

Today, Humana has over 200,000 under-65 members enrolled in our consumer-centric products, which is roughly 7 percent of that business. The number has grown dramatically in the last year from roughly 40,000 a year ago.

We believe that Humana ranks second in membership in these true consumer-centric products. And we agree with Dr. Milstein that there are about a million Americans today enrolled in these consumer products that have a spending account.

Chairman Bennett. Let me interrupt you to be sure I have the numbers right.

A year ago, you had 40,000 enrolled. And now you have——

Mr. Bertko. 200,000.

Chairman Bennett. 200,000. Okay.

Mr. Bertko. So the growth rate——

Chairman Bennett. I heard million in there and I didn't know quite what—all right. So it's gone from 40,000 to 200,000 in a year.

Mr. Bertko. Yes, sir.

Chairman Bennett. Good. Thank you.

Mr. Bertko. We expect that in the next year, that these numbers will again double and that by January 1st, 2005, Humana is likely to have between 400,000 and 500,000 members in these products.

Our product is called SmartSuite and we believe in the social contract of insurance, that the healthy must subsidize the sick and it's critical that all employees, both healthy and high users, remain in the same risk pool for insurance coverage. And that to maintain the integrity of this risk pool, the employer must provide a subsidy for high-use employees and blend these funds with contributions from employees that have either average, high, or low utilization.

So we market what we call a total replacement solution, where the employer chooses a bundle of products and then each employee chooses one option from the bundle.

In employee choice, we have found in early experience that employees make meaningful choices if given the good information and tools, like the kind that Dr. Milstein described.

Our employees and members use a wizard to help them learn about their plan choices and estimate the cost of services they might use in the coming year based on the previous year's claim experience.

Then the employer or family makes a decision as to whether they wish to pay for their coverage through lower payroll deductions and higher costs at the point of service or vice-versa, choose higher payroll deductions today, but have lower costs from cost-sharing.

Our initial and ongoing educational communications are critical to the success of the consumer-centric approach. Employees and dependents are provided with web-accessible decision support tools that show how much they've spent, different costs for services, and to the extent available, quality information about providers.

With Humana employees as the pilot group, and now with our customers and their employees, we've learned many lessons. But I'd like to stress that it's still early and these should be viewed as indicators rather than fully credible proof.

Currently, we have 125 employer customers with these 200,000 members and by the end of 2003, 28 percent of them have chosen the consumer-centric option. The remaining 72 percent remain in traditional products.

Cost trends have been significantly reduced by enrollment in these products.

In our Humana employee pilot, we reduced cost trends in the first year for Louisville employees to 4.9 percent. And in year two, when we extended it to the 14,000 non-Louisville employees and their dependents, we achieved a trend of 1.4 percent.

And these are well under the mid-double-digit trends that are exhibited in the rest of the market.

When we extended these to our customer block of business, as of January, 2004, we have credible claims experience on 43 employers covering roughly 50,000 insured members. And the average trend for those groups today is about 6 percent.

Again, well under the double digits.

All of Humana's detailed cost and utilization evidence that I'm going to provide now is only on our Humana employees. It's a bit too early to give detailed experience on our customers. We'll have that later this year.

An important question is: Why did claim trends decrease to these single-digit levels?

Our early experience indicates that there are several types of behavioral changes that accounted for most of the trend reduction.

First, employees themselves chose among the options to migrate to lower cost options, thus reducing their payroll deductions.

Another significant factor appears to be a change in the site of care for receiving services. Visits to emergency rooms and use of other hospital out-patient services decreased while use of physician office visits and preventive care increased somewhat.

We believe that Humana's employees chose to make greater use of the physicians and office settings where the doctor's knowledge of his or her patient likely leads to better quality care, while elimi-

nating unnecessary and costly emergency room visits or other hospital out-patient services.

And Exhibits 2 and 3 of my written testimony provide a summary of this.

We also strongly stress the need for employers to embrace and communicate the message of employer participation.

For employers, we provide a package of communications. For employees, we make use of on-line enrollment applications, a wizard to assist employees in making their health care option decisions, and a PlanProfessor to provide those kinds of background information needed to know what your details of your plan are.

To date, we've had 102 of our employer customers make use of the wizard with nearly 100,000 unique users—that is, the employees and members—sign on to this.

So, in my opinion, the health insurance industry has embraced consumer-centric options. Health Savings Accounts will have enormous appeal in the individual health insurance market where most of the products sold today do have high deductibles to qualify.

In addition, Health Savings Accounts are likely to replace the medical savings accounts for small employers—those under 50 lives.

In the larger end of the market, it appears to me that health reimbursement accounts may continue to have somewhat greater appeal due to their greater flexibility and plan design and the ability of employers to use them to increase employee retention.

Thank you, and I'd be glad to answer questions later.

[The prepared statement of John Bertko appears in the Submissions for the Record on page 52.]

Chairman Bennett. Thank you very much.

Mr. Leach.

OPENING STATEMENT OF HOWARD LEACH, HUMAN RESOURCES MANAGER, LOGAN ALUMINUM, INC., RUSSELLVILLE, KENTUCKY

Mr. Leach. Good morning, Mr. Chairman, and members of the Committee. I'm Howard Leach, head of human resources for Logan Aluminum, a world-class manufacturer of aluminum sheet products located in Logan County, Kentucky, with a workforce totaling one thousand employees.

Thank you for the opportunity to testify before you today.

I'm delighted to share with you the practical side of consumer-directed experience at Logan Aluminum.

Like many employers, in recent years, our business experienced annual health-care cost increases of 20-plus percent, which, simply put, is not sustainable and not in the best interest of our business or our employees.

Traditional approaches to the management of health care costs have been limited primarily to employers absorbing costs, shifting cost to employees, or reducing benefits.

Logan realized these solutions would not be effective long term, and it was just a matter of time until neither employers nor employees could afford the cost of health care.

As a business facing intense competition and cost pressures, we chose consumer-directed health because we saw its potential to help hold the line on a disturbing cost trend.

But we also made this decision for the benefit of our employees.

To fully appreciate our enthusiasm for the consumer-directed approach, it helps to understand our company's culture. While employing roughly one thousand people in our Russellville, Kentucky plant, we have established a team-based culture that emphasizes employee involvement in nearly every facet of the operation.

We look at our employees as partners. With the help of a 20-member employee committee, we engage our people in thoughtful discussions several times a year about health care costs.

These employees, in turn, disseminate information about these issues with other smaller groups of employees in the workforce. This helps keep every employee aware of the health care issues affecting our business.

We are proud of the fact that we have historically offered employees an excellent, competitive benefits package, including comprehensive medical coverage.

We have been very fortunate in not having to ask employees to pay a percentage of premium, and under the new consumer-directed health care plan, we still don't.

When health care costs became more of a concern in the early 1990s, we decided the best way to tackle rising costs was to get at the root causes through a strong focus on prevention.

We implemented a wellness program—managed by an on-site wellness director—that emphasizes regular health care screenings and critical lifestyle changes.

We have an on-site medical department that includes a part-time doctor and two nurses.

Employees are encouraged to routinely take advantage of health care screenings, including an annual physical, on-site and at no cost. The program also supplies our employees with a variety of information designed to help them better understand how they can improve their health outlook through a healthy lifestyle.

Because we want our employees to be actively involved in managing their health, we follow up these educational efforts with health risk appraisals that are evaluated by an outside vendor.

The individual results are confidential—only the employees see their individual assessments. High-risk employees are identified and then contacted by the vendor and encouraged to participate in an intervention program.

Through follow-up health risk appraisals, we know we have had an impact. Results show improvements in body mass index, tobacco use, seatbelt use and exercise activity across our employee population.

Consumer-directed health care, in fact, reinforces the importance of healthy lifestyle choices and becoming a wise consumer of health care. Employees are also encouraged to set individual wellness and team wellness goals, which are rewarded with additional company incentives.

Throughout the implementation process of the consumer-directed model, we emphasized that Logan Aluminum's philosophy remains

unchanged. We want our employees to be healthy, wise consumers, and we are providing the tools needed to help make that happen.

We continue to provide access to free, on-site physicals. We also provide incentives to employees who participate in the health risk appraisal program and in wellness programs—up to $250 in cash per employee per year if certain aggregate goals are met.

Our results from 2003 show the average employee out-of-pocket costs did go up in the consumer-directed health plan from $240 to $665. However, the net effect after wellness incentives was an increase of only about $200 per employee.

While expanding our efforts to promote wellness and informed decision-making, we saw a reduction of 18.7 percent in our total medical costs in 2003. This represents an improvement of $925,000 to the company's bottom line.

We're also encouraged by utilization data that shows employees continue to enjoy access to the care they need. One of the best indicators of that could be hospital days of care, which increased 4.4 percent for one thousand members in 2003.

In-patient surgeries were up 4.2 percent, an additional indication that employees are getting appropriate treatment for serious health events.

Logan Aluminum is committed to providing its employees with quality health care benefits in a cost-effective manner, and we remain committed to the active involvement of our own employees in helping to manage these costs through better management of their own health. Consumer-directed health care is helping us do that.

Logan Aluminum very much appreciates the opportunity to testify before the Committee today. I hope the perspective of a company on the front lines of today's fast-evolving health care landscape has been informative and useful.

Thank you.

[The prepared statement of Howard Leach appears in the Submissions for the Record on page 58.]

Chairman Bennett. Thank you very much.

Ms. Shearer.

OPENING STATEMENT OF GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. Shearer. Thank you very much, Chairman Bennett, for providing me an opportunity to present a consumer perspective on this important topic.

So-called "consumer-driven" health care plans, which have defining features of high-deductible coverage and possibly tax-advantaged employer contributions to health reimbursements or savings accounts, may create serious problems for the U.S. health care system.

Consumers Union believes that this type of coverage is misnamed, misguided from a policy perspective, and a dangerous distraction from the need to solve the health insurance crisis that faces 43.6 million uninsured consumers and tens of millions of underinsured consumers.

Our testimony also addresses issues raised by health savings accounts, as included in the recently enacted Medicare bill, and the President's new proposals. These proposals are likely to accelerate

the erosion of current coverage by adding tax benefits for high-deductible coverage.

First, I need to point out that we take issue with the term "consumer-driven," to refer to the transformation of the health care system to one characterized by high deductibles.

"Defined-contribution" health care, in our view, would be a more accurate shorthand way to refer to a health care approach that essentially increases deductibles and shifts costs to sicker employees.

Many employees with chronically ill or seriously ill family members will not view this transformation as consumer-friendly, despite the name.

The recent expansion and renaming of medical savings accounts and the President's proposal for a new tax deduction are more likely than previous efforts to transform the health insurance marketplace to one characterized by high deductibles.

The Economic Report of the President makes it clear that this is the intention, the Administration frames the problem in the health insurance marketplace as too much rather than too little insurance.

The Report establishes the ideal health insurance marketplace as one in which high-risk consumers face health insurance premiums consistent with their risks, explicitly rejecting the current goal of health insurance markets of spreading risks broadly across the community.

At the same time, the Report ignores the reality that the uninsured and the underinsured face severe health consequences, even bankruptcy or death, because of the lack of adequate insurance.

The Administration's proposals, which boost consumer-driven health care, will shift more of the costs to those who are sick.

While the Administration proposals will undermine employer-based health insurance and shift more to the individual health insurance market, that market underwrites risks carefully and does not make affordable, comprehensive coverage available to individuals who have pre-existing conditions.

The underlying nature of the population's health status—in which risks vary widely—makes the health insurance market different from other markets such as the market for cars or toasters.

Individuals with underlying health risks benefit from employer coverage or other large pooling arrangements such as public programs, since this spreads risks broadly.

For those covered by employer health plans now, the average cost in 2000 was about $2,600. But those in the top tenth of spending had average costs of over $16,700.

Because of the combination of variation in risks—which lead to different health insurance selections—and higher tax brackets and ability to meet high deductibles, HSAs will appeal disproportionately to the healthy and to the wealthy. Many economic analyses, including that of the American Academy of Actuaries, have reached the conclusion that this type of high-deductible health insurance will fragment the risk pool, shift costs to the sick, and ultimately drive low-deductible coverage out of the market since it cannot exist side-by-side in the marketplace with high-deductible coverage because of the underlying nature of the health insurance market.

"Consumer-driven" health care is likely to aggravate the problem of the underinsured since individuals with moderate income are

likely to face out-of-pocket health care costs and premiums that exceed 10 percent of their income.

The focus on transforming our health care marketplace to one characterized by high-deductible policies is a dangerous distraction from the urgent national goal of extending affordable, quality health coverage to all.

And in closing, I just would like to make two points of agreement with earlier witnesses.

First, I would agree that the research that exists to date is of a very preliminary nature when it comes to this type of health insurance.

And second, I would agree that we urgently need more studies, more research that compares the clinical effectiveness of different approaches. And if we did more of this, we would be able to get more value for our health care dollars.

One specific area that was part of the Medicare bill was an authorization for the Agency for Healthcare Research and Quality authorized to spend $50 million comparing the effectiveness, the clinical effectiveness, of different prescription drugs in various therapeutic categories.

This type of research would help us get much more bang for the prescription drug buck. And I would urge you to support appropriating that money quickly.

Thank you.

[The prepared statement of Ms. Shearer appears in the Submissions for the Record on page 61.]

Chairman Bennett. Thank you very much.

We are well into a Senate vote. So I'm going to have to leave and do that.

Normally, I would say, I will turn the gavel over to Mr. Ryan and let him go forward. But if I may be so selfish, I am so interested in the clash that will now occur, that I want to be here.

[Laughter.]

So if everybody could take a short pause, I will go save the Republic from whatever it is we're doing on the floor and return as quickly as I can.

[Laughter.]

The hearing will stand in recess until that time.

[Recess.]

Chairman Bennett. The hearing will come to order.

My apologies. I thank you all for your indulgence. The Senate does have a habit of getting in the way of our schedules by requiring us to vote from time to time.

As I hear this panel of witnesses, I think there are a few things that we can stipulate right up front so that we don't have to argue over them.

And that is that the information presented is preliminary. There is no hard evidence that can justify a significant extrapolation into the future with firm numbers.

At the same time, the early indications from people who have tried this kind of health care activity is that it has two features. It does bring costs down. And so far, it increases employee satisfaction and employee health.

Is it fair to say that?

The gentlemen are nodding. I haven't gotten a reaction from the young lady yet.

Ms. Shearer. I thank you, Senator. I believe that it is really premature to make that kind of conclusion at this point.

Chairman Bennett. Well, that's why I made the stipulation.

But so far, on the anecdotal evidence that we have, costs are coming down and employees are satisfied and appear to be healthier.

Ms. Shearer. And I just think it's important to keep in mind that when you're measuring employer costs, you have to also be sure to keep in mind, have the costs been shifted and what are the employee costs as well?

So it's not clear to me from the research that's been presented today that we have all the data we need about the whole picture.

Chairman Bennett. Well, again, with the understanding that this is just an indication and not something on which we're going to make long-term extrapolation, the early indication is that it's bringing total costs down.

Mr. Bertko. Mr. Chairman, may I add something there?

Chairman Bennett. Sure. Please.

Mr. Bertko. I think Ms. Shearer has brought up several valid issues. We have looked in our first group at what we call the distribution analysis, how people's choices affected their out-of-pocket spending. Across the board, the costs do go up some.

Now it turns out that folks in the low end of the bracket, myself, for example, might end up paying out-of-pocket costs, not payroll deduction, perhaps $10 to $100 more a year.

We found out, though, that the people with the highest costs, those with $10,000 or more, in our program where we have, they can choose between a traditional HMO and PPO and consumer-centric, they made excellent choices. And looking at a last-year to this-year basis, their cost-sharing actually dropped because they chose the right kind of plans to be in.

And so, I would say, again, preliminary evidence is that folks make good choices. They have an ability to predict what their next-year's costs are going to be, and they choose the right kinds of plans to be in.

Chairman Bennett. Now, Mr. Leach, you have the only experience—well, no, I guess that's not true. But you have a direct experience within a company.

I want to focus on this question of health.

In all of the debate we have about health care in the Congress, we almost never talk about health. We talk about coverage. We talk about insurance premiums. We talk about costs. We talk about negotiations. We talk about everything other than the fact that we want people to be healthy.

If I heard your presentation correctly, you are saying that the introduction of this program in your company has not only had an impact on costs, but it has had an impact on behavior that leads people to be healthier.

Not only is that your perception, but if you can, speak for your employees. Do they have the perception that this plan serves their needs better than the previous one and that there are healthier choices being made?

Mr. Leach. Yes, Mr. Chairman. I would say that, in our opinion, it does meet both the needs of employees and the needs of the company.

What we've seen and what we try to do is to measure health. And I know that's a difficult thing to do. But we, through health risk appraisals, where it's employee information, look at aggregate data from one year to the next—in this case, we look at aggregate data from 2002 and compared that with aggregate data from 2003.

And employees did say their health is better over the course of one year than it was the previous year.

Now I agree that one year is not a trend, but our data shows that employees like the plan. There's more involvement. Employees are interested.

I think all of us want to have good health. And what we have attempted to do is give employees a set of tools to help them measure, monitor, and take control of their health. And we believe that we have good preliminary results.

Chairman Bennett. All right. I have a lot more. But what I would like to do, as my yellow light is on, just turned red, is stay within the 5-minute requirement for members for this first round. I'd ask Mr. Stark and Mr. Ryan to do the same thing. And then perhaps go into more of a roundtable sort of discussion since we do not have a large number of members and have a little back and forth with all seven of us on some of these issues.

So if the members are agreeable to that, Mr. Stark, I'd recognize you for 5 minutes and then Mr. Ryan for 5 minutes, and then we can go into that mode, unless there is objection.

Representative Stark. Mr. Chairman, I'd just like to get a definitional issue out of the way here, because—and I think I learned this a long time ago from somebody far wiser than me. What we're talking about this morning is medical care.

If you get up in the morning, on a sunny spring day in Wisconsin or in California, and you get out of bed and you're excited about going to work and your spouse looks about as good as he or she did to you 10 years ago. And your sex life is all right and you're healthy.

Chairman Bennett. I'm not touching that one.

[Laughter.]

Representative Stark. All right. But if you get up out of bed and try to put your underwear on and you fall over and sprain your ankle, you need medical care.

And I guess what I'm seeing is that health, as we define it, can include the environment and our economic well-being and the state of our communities, and it goes somewhat beyond the medical care that excellent providers, physicians and hospitals provide.

And I think it's important that particularly when we're talking about costs, some of Mr. Leach's programs, which I think are amazing, may go to the overall good feeling and well-being of their employees, but it would be hard to define the costs.

And I'd just bring that out as something that could get confusing.

I did want to talk to Dr. Milstein, because he brings up a couple of issues in his written testimony and in an article which I've looked at which he also wrote, I guess in the *New England Journal of Medicine.*

[The article entitled "The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending," appears in the Submissions for the Record on page 43.]

But I think you do suggest, Doctor, in your written testimony, that there is a good bit of risk selection, but we don't know quite how much.

Is that fair?

I mean, risk selection is a result of people selecting these plans. And you're unable to quantify it at this point.

Is that a fair analysis of your testimony?

Dr. Milstein. Yes. We examined multiple plans as part of our study.

For some of them, such as one of the plans that Mr. Bertko described, there are no questions about risk selection, because they pertain to an entire employee population. For some of the other plans that we examined, there were issues of risk selection.

Representative Stark. And often, in employees, one of the troubling things, companies that employ lower income individuals, because I want to then lead to your article where you conclude where you're dealing with prescription plans, that by—if I can paraphrase you, if you'll allow me a little bit—by changing the formulary or administration, which could include co-pays and the rest, that in some instances, you could lead enrollees to discontinue therapy, which is something that I would think would also take place in other kinds of medical care.

It's like titration. I know Dr. Milstein's done this. You drop that stuff in there and all of a sudden, it all turns blue and we're never quite sure how many drops you have to put back before it gets clear again.

And there is the risk, and I think we'll talk about it later, that we could deter people from getting necessary care, which is what I mentioned in my opening comments.

And I don't know as we know yet. Kaiser, in northern California has done some studies about, if they go from 5 to 10 bucks as a co-pay, whether it deters or just stops over-utilization.

I worry about that in some of these plans, because it could be an easy way to save money. Just bump that co-pay up and particularly among lower-paid employees, you're going to have far less utilization.

But I wanted to say, that is a concern, besides the fact that I don't think the plans are going to work. But I just wanted to talk about some of the more gentle problems here.

I yield back, Mr. Chairman.

Chairman Bennett. Mr. Ryan.

Mr. Ryan. I wanted to get into—I think my questions are probably for Mr. Bertko and Mr. Milstein.

I wanted to ask the two of you about the differences between HRAs and HSAs and the market perceptions.

HSAs are so new, so it's difficult to make any kind of conclusions. But what is your impression as to what large employers are saying and doing and thinking with respect to HRAs versus HSAs?

And are there some deficiencies with the regulations surrounding HSAs that need to be addressed so that it is an easier decision for large employers to make the decision to go with HSAs versus

HRAs, because, for me, the most attractive difference is that HSAs are portable. It's part of the employee's property that they can take with them, but they can't do that with HRAs.

Could you go into that issue as to—and if anybody else would have a comment, that would be great.

Mr. Bertko. Sure, Mr. Ryan. Let me start and Dr. Milstein can add.

HRAs have been around a little bit longer. We got clarification from Treasury a little over 2 years ago. And the reimbursement accounts are fairly flexible.

There really are fewer limits in terms of the size of the deductible and how the accounts roll over and the plan design itself.

So many larger employers might choose HRAs. They also can use notional dollars, like airline credits.

Mr. Ryan. Yes.

Mr. Bertko. As opposed to filling with real cash.

HSAs, Health Savings Accounts, need actual cash contributions. I think to the point of employees, they would find those more attractive. They clearly are portable.

It's my understanding from listening to things from Treasury, for example, that there are some constraints on our ability to define the deductible, and particularly the family deductible.

That might make them slightly less attractive.

Plus, we're big believers, I think like the rest of the panel, in preventive care. And to some degree, we think that, for example, prescription drugs might need to be folded into the way that preventive care is described so that we can make those easier to be obtained.

I think HSAs will be very, very attractive to individuals and to purchasers and to the small group end of the market. That's the 2-to-50-market. HRAs may continue to be somewhat more attractive to the companies of a thousand or more.

Mr. Ryan. Is that pretty much because it's more mature of a product and the employer which has the resources in a big company can control it more so?

Mr. Bertko. That would be my guess, in my opinion.

Dr. Milstein. There was a single paragraph in my testimony that addressed this and indicated that there were some areas in which clarification for employers would help them feel more comfortable.

Mr. Ryan. I didn't actually get that. Could you just relay it real quickly?

Dr. Milstein. Some of those were, for example, the possibility, if any, of rolling over balances in HRAs into HSAs.

Mr. Ryan. Yes.

Dr. Milstein. And in particular, the relationship between HSAs and some of the carve-out benefit programs that some employers offer, such as carve-out pharmacy or mental health programs.

Mr. Ryan. Okay. Ms. Shearer, I just want to ask you a quick question.

Are you an advocate of a single-payer system, a single-payer plan? Is that kind of ideally, if you were king or queen for a day, you would do that?

Ms. Shearer. We are a strong advocate of universal health care. We have supported a lot of different approaches to getting there.

We're pretty open-minded about how to do it as long as you cover everybody and you finance it in a fair way.

We have supported single-payer many times because it's the most efficient way to do this. But we are very open-minded.

We think that the most important thing for this Committee and other committees in Congress to do is to chart a course to get us to universal coverage.

Mr. Ryan. Let me ask you this question, then, because I read your testimony and listened to your testimony on the criticisms you point towards HSAs and the consumer-based system.

How do you propose to keep down costs in a single-payer universal care system other than establishing a global budget and rationing care?

Ms. Shearer. Well, that's a huge question. Let me just talk about one specific way.

I think that if we had more information about comparative effectiveness of drugs and then allowed, for example, the Federal Government to do what it does for the Department of Veterans Affairs, to negotiate deep discounts for prescription drugs, that would be one way.

That's part of our health care spending where there is an obvious——

Mr. Ryan. That sounds like a form of rationing as well.

Ms. Shearer. Well, if I may say.

Mr. Ryan. Sure.

Ms. Shearer. Other countries do this. What they do is they look at a therapeutic category.

For example, they might pick statins, cholesterol reducers, and realize that there are several drugs that have a similar impact.

If they then go and negotiate with—pick a benchmark drug—negotiate a good price, everybody's getting quality health care at a lower price.

This is what the Department of Veterans Affairs does for its members and it's a way to use our health care dollars much more effectively.

Mr. Ryan. Okay. But at the end of the day, because we're seeing in single-payer systems throughout the world that they're running up against their global budgets and then they have to end up rationing care.

And those ace inhibitors and those statins aren't actually being delivered to those people.

I see that I'm out of time. I had a quality question, but I'll ask it when we go around the next round.

Ms. Shearer. And if I could just say, the key is what kind of budget is the government allocating.

If you look at Canada, for example, they're spending a much lower share of their GNP on health care.

If they put in the funds, it would be much lower than the share that we're spending, but then people would get the health care and it would be delivered more efficiently and effectively.

Mr. Ryan. And they're rationing. Thank you.

Chairman Bennett. Well, let's not get into a debate over Canada, because that might get the blood pressure up to a point where we avoid the purpose of this hearing.

Mr. Bertko, you're an actuary. And Ms. Shearer referred to a study by actuaries. I wondered if you had an opinion on her comments about the study.

Did you participate in that study? Are you aware of it?

Mr. Bertko. I'm aware of it, Mr. Bennett, and in fact, I was one of the peer reviewers of the study.

Chairman Bennett. Good. Then let's get into it.

Mr. Bertko. Ms. Shearer quotes some of the things that were, I believe, worded in the study. I didn't review that this morning before coming over.

I would suggest, though, that that study was describing things that were on a theoretical basis, and that what's emerging right now is what Mr. Leach and Dr. Milstein and I are suggesting, which are actual empirical data are now emerging.

And so, there clearly is a worry.

I mean, I would agree with the issues raised by Ms. Shearer. But at the same point, our solution in terms of keeping the risk pool intact is a way around this.

Large employers, in fact, in their own ways, whether self-insured or insured, can keep those risk pools together in much the same way.

So as long as the employer remains the basis for the risk pool, I think that that could be managed and somewhat minimize the worries of the selection issues that Ms. Shearer raised.

Chairman Bennett. That's true, apparently, as long as the employee stays with the employer.

One of the biggest problems that we have with the uninsured is that Americans no longer stay for significant periods of time with the same employer.

COBRA is an attempt to deal with that problem as you move from one employer to the other. But as one who has moved from one employer to the other, dealt with COBRA, it's very expensive.

And then, as one who has ended up in the uninsured pool—fortunately, I stayed healthy, so that I didn't have need for medical care. And I think staying healthy is an important part of the cost equation—I finally got another employer where I did get covered.

But how does this consumer-based health care plan deal with the tremendous shifting that is going on in America and will only accelerate. We're only going to see more of people moving every 2 or 3 years from employer to self-employed to a different kind of employer to their own business to working for the government and so on.

By my own case, the 11 years I've spent as a Senator is the longest period of time in my entire employment history that I've drawn a paycheck from the same place.

I've changed jobs over 20 times since I turned 20.

So I'm personally very concerned about this. Those of you who are saying, the empirical evidence says this is—yes, I can't keep a job. That's my problem.

[Laughter.]

But I've got this one and I'm trying to get a 6-year extension on the contract come November.

[Laughter.]

Address that from the experience that you've had. And Ms. Shearer, we'd like your comments, too, because this is a very major problem for an employer-based system.

Anybody—and then my colleagues, jump in with your questions and your comments.

Mr. Bertko. Mr. Bennett, if I can start, perhaps, I think that consumer-centric health plans can address it in two ways.

The first one is perhaps the more obvious one. If we can actually maintain lower trend rates, something in the neighborhood of 5-, 6-, 7-percent, versus the high ones, it keeps the total premium more affordable.

The second part of this is, and perhaps to address Mr. Stark's question earlier, COBRA represents the actual 102 percent of the full rate.

And so that's what things actually cost employers like Mr. Leach's company.

If there's an HRA or an HSA, I'm at least aware of many employers who are willing to provide the roll-over account and is able to pay for either COBRA coverage or retiree medical coverage.

And to the extent that people can accumulate those, that then is some pot of money for a while. It won't be a complete solution, but say in between jobs, if you have a 6-month gap, it could be used to pay for COBRA coverage.

Chairman Bennett. Anybody else want to comment?

Yes, Ms. Shearer.

Ms. Shearer. If I could just say—I think that this issue of an employer-based health care system is key here.

Now people are beginning to understand that if they get a pink slip, they lose their health insurance because, in most cases, if you lose your source of income, you cannot afford to pay a premium that is 102 percent of the premium level.

Another concern that we have in talking about transitions is that, especially with the President's new proposal for a tax deduction for premiums paid in the individual market for a high-deductible policy, that many employers may find that this means that their employees have a choice, have an alternative outside of the employer-based market. And they may actually stop their employer coverage.

And if they have employees who are not very healthy, they're going to really have a struggle in the individual market.

So there are a lot of transition issues that are relevant now, I think.

Chairman Bennett. Mr. Leach.

Mr. Leach. Mr. Chairman, I would say on behalf of the employer's side, I don't have experience with a person leaving our organization to go to another organization and work.

But what we do have experience on is retirees, those people who elect to take early retirement.

I think the fact that employees can take those accounts and use them into retirement is a very positive feature. And the early retirees at our company have found that particularly attractive.

So that if I have a good year this year, I can roll over dollars to next year. And if I have a good year next year——

Chairman Bennett. By good year, you mean a healthy year.

Mr. Leach. Yes, healthy year.

Chairman Bennett. Yes, right. So that's another incentive to stay as healthy as you can.

Mr. Leach. I think that's the key, people staying healthy and not spending all their dollars in their account. Then they can take that account with them to the point in the future, if they have a year where there are serious health issues, they have dollars to cover that.

Chairman Bennett. And could they take the account with them if they left you to go to work for General Motors?

Mr. Leach. The retirees would.

Chairman Bennett. But somebody who just leaves you to go to work for somebody else would not.

Mr. Leach. That's correct.

Chairman Bennett. Okay. We're joined by Mr. English. We are in a roundtable kind of thing. So far I have dominated it.

[Laughter.]

But I will step back from that.

Representative Stark. Mr. Chairman.

Chairman Bennett. Yes, sir.

Representative Stark. I just wanted to cover a couple of issues here.

My distinguished friend and colleague from Wisconsin was talking about rationing. And he's correct. There is rationing in our system. As there is in every system in the world.

The only question that I think comes up is on what basis do we ration?

Mr. Ryan. Or who does the rationing?

Representative Stark. Yes. Do we do it clinically, as they do in Canada, let the physician decide who goes to the head of the queue, or do we do it financially, which says that the rich people can get care more quickly, or get a fuller platter of benefits?

Because reducing benefits, as some managed care plans may choose to do, or limiting a selection of pharmaceutical products, saves money, but is a form of rationing.

I would make the case that Medicare rations, but it is the most efficient program that we have so far in the United States. It has had the least average increase in costs over the years and has, for seniors, a pretty broad selection of choice and benefits, particularly now that managed care plans are available under Medicare, as they were not some years ago.

The issue I think will come into play is that employers like Mr. Leach and/or our automobile companies are going to join with me and Ms. Shearer—I have a plant that makes most of the Corollas in my district. And my Toyota/General Motors partner people tell me it's about a thousand bucks a Corolla for—I think that's health benefits. It may include some retirement benefits.

I know that General Motors said that it costs them—they saved $800 on every Chevy Impala they made in Canada because they didn't have to load in the health care costs.

It could very well become—and then we have experts like Wal-Mart who have made a science out of not paying their employees benefits.

At some point, we may have to even that out and demand—our former colleague in California, John Burton, has a pay-or-play plan that says that every employer has to provide medical benefits.

I think we're going to get there in time, because I don't think we can sit and watch 45 million people basically go without health care, because they don't have insurance.

I would hope that you'd stipulate to that.

How we get there will be a question of some debate. I would say that I'd just make it—that would be my constitutional amendment. Let's say that everybody has the right to medical care and then it won't only be prisoners under Article 8. It will be all of us.

Mr. Ryan. Bring an amendment to the floor.

Representative Stark. I've always said, "what's good enough for Rostenkowski and the Watergate burglars is good enough for me." If I have to go to jail to get my health care, that's where I get it under the Constitution.

Maybe that's where we should go. Thank you, Mr. Chairman.

Mr. Ryan. Can I chip in?

Chairman Bennett. Let's let Mr. English, because he didn't have his 5 minutes.

So let's do that and then Mr. Ryan.

Representative English. Thank you, Mr. Chairman. But rather than interrupt the inexorable forward movement of this discussion, I will pass.

Chairman Bennett. All right.

Mr. Ryan.

Mr. Ryan. I wanted to get into some of the quality stuff. But I just can't let the opportunity pass to comment on what my friend, Mr. Stark, said.

You're right. Rationing is occurring in every model that we have. And the question comes down to who does it?

Is it the individual with the freedom of choice, with the consent of the physician? Or is it some third party like an HMO bureaucrat or a government bureaucrat?

And I think if you actually look at the Canadian system, look at the studies that they've had, the rationing and the decision-making on who gets ahead of the queue isn't really based on need.

The well-connected, the wealthy, the politically-connected are the people that are getting ahead of the queue.

So even in those seemingly perfect systems, you're having rationing that isn't, quote, unquote, fair. More importantly, you are seriously seeing people being denied care, especially when they need it.

In Ontario, a couple of years ago they took 121 coronary bypass patients off the list waiting for care because they got too sick while waiting for care.

Twenty percent of the patients looking for dialysis—in England I think it is, I think it's dialysis—get too sick while they're waiting on the list.

So the question is, we all want to get to full insuring of everybody. We all want to get our hands around this issue of under-in-

sured and uninsured. And do we want to have an arbitrary third-party system, whether it's government or HMOs denying care to people, especially when they need it.

So we've got to figure this.

And in figuring this out——

Chairman Bennett. If I could exercise the Chairman's prerogative.

Having now had the statement on both sides of Canada, can we focus again——

Mr. Ryan. I'm sorry. I'm from Wisconsin. We actually look at this thing.

Chairman Bennett. Mr. Stark did it. You did it. And it's perfectly appropriate for both of you.

But I can see if I don't step in, we're all going to get into it, including me, and I don't want to do that.

Mr. Ryan. Okay. The quality stuff. That's important.

If a person is going to be a good consumer in health care, they've got to get access to quality data.

If they're going to shop around, they need to know on an apples-to-apples comparison what things cost, who's good, who's bad, where's the best deal, where's the best quality.

Mr. Milstein, you had excellent recommendations in your testimony on things that Congress can do that are budget-neutral, either through the regulatory side of things or through the statutory side of things on how we can help wrestle that quality data out that we collect into the public.

Does anybody else have any comments on how we could do that? And if you could quickly summarize for everyone else's benefit, what are the things that we could do just this year to help get that quality and price data out to the public?

Dr. Milstein. Sure. I think, first and foremost, would be to liberate the Medicare claims database, in a way that fully protects the privacy of Medicare beneficiaries.

As I mentioned in my testimony, most health benefit plans, whether they're operated by unions or large companies, don't have enough at-bats per doctor, to use the metaphor, or at-bats per hospital for narrow service lines such as surgery A versus surgery B, to run a stable calculation of whether the hospital or the physician is more efficient or less efficient, higher quality or lower quality.

And the Medicare claims database would, except for pediatrics and OB, obstetrics, would allow all health benefit plans in the private sector to be able to more reliably and more precisely compare doctor and hospital performance.

The second thing I mentioned, which would be hugely important, would just be at the margin to consider the recommendations of the Quality Work Group of the National Committee on Vital and Health Statistics to slightly increase the information that's submitted on hospital bills and physician bills so that we'd have a little bit better ability to not blame doctors and hospitals for what looks like bad performance when it actually relates to differences in the severity of the illness of the patients that they're treating.

Representative Stark. Would you yield there?

Mr. Ryan. Sure.

Representative Stark. You're talking about what I would call outcomes research, that we have the data to be able to.

Dr. Milstein. Yes. But I'm saying we didn't foresee a mess due to the outcomes research. If we could free up the database, then the private sector and CMS could do the research.

Mr. Ryan. Am I correct in assuming that to liberate, as you say, the CMS claims database, that doesn't require a statute change. They can do it regulatorily over at CMS.

Correct?

Dr. Milstein. Yes. I believe it requires a letter of clarification from the Congress that neither HIPAA nor the Privacy Act was intended to prevent such release.

Mr. Ryan. Okay. Thank you. If anybody else wants to comment on that issue, please do.

Mr. Bertko. Yes. I'd like to second what Dr. Milstein has said.

When I was a consultant, we had access under very limited abilities to what's called a 5-percent sample of the database. And there's a data use agreement with a great deal of protection.

But to be able to look in certain areas, particularly rural areas where, using a metaphor again, the at-bats for either a hospital or an individual or group of physicians, that would be extremely useful.

We also support transparency, whether in quality or cost data. There's a few states—I think Wisconsin, in fact, is one of the leaders in that. And if that were to be present in more states, it would be very valuable.

Representative Stark. If I could ask my colleague to yield again.

Mr. Ryan. Yes, sure.

Representative Stark. I think this is an area where we would find a great deal of agreement.

Now I'm not sure that we would find it among all insurers or all providers. There is no question that when you begin to both, say, standardized medical records. Or I remember the scream when we said, "Well, every doctor will have to have a computer." And they said, "Oh, we can't afford that." I find that somewhat disingenuous.

But, in other words, there will have to be some standards set, whether it's government or the medical educators or however, before we can go ahead and make determinations of what would be useful treatment and how much it would cost and the outcomes.

And I for one feel that that is an area in which we're going to have to step in as government setting some standards, protecting some privacy, but deciding where it's more important for us to have information than for some of us to keep it secret.

And I would hope—as I say, we've had a variety of opposition. Sometimes it's the insurance companies. Sometimes it's the hospitals. Sometimes it's the physician.

Chairman Bennett. Sometimes it's the privacy advocates.

Representative Stark. Absolutely. But I would love to join with my colleague from Wisconsin to walk down that road with the people who are concerned about having this.

Mr. Ryan. Yes.

Representative Stark. I think it would take 5 or 10 years for the information, the real outcomes to be available to be used, but

I think we could say that we've done a great service to providing medical care in this country.

Mr. Ryan. Would you yield, Pete?

Representative Stark. Yes. I'm done. Thanks.

Mr. Ryan. That's really encouraging. I'm very encouraged to hear you say that.

I hope, given the technology today, we could do it a lot faster than that.

But are you open to the idea of doing just what Mr. Milstein said? There's three of us here on the authorizing committee over in the House, getting the CMS to release this data, providing that privacy and all those considerations are dealt with?

Representative Stark. I think that the more data that's available, the better off we'll be.

As I say, other than what I've always said is, look, release the data. The heck with privacy. Go after the person who uses it to harm you.

Chairman Bennett. Can I quote you?

[Laughter.]

Representative Stark. No, seriously. I mean, it's so important in this world today—is it important to know who has AIDS or who has a heart condition and what they've done to get there?

I don't know if it's important to know who the individual is.

Mr. Ryan. Right.

Representative Stark. But I do think if somebody discovers that and uses it to embarrass or hurt you or keep you from getting a job, the courts could take care of that.

I would err on the side of getting the data uniform and collectible in a database that's available to researchers.

Mr. Ryan. And shoppers and consumers. Great.

Chairman Bennett. Doesn't that go back, Mr. Bertko and Mr. Leach, to your experience, that the more data that are available to your employees, the better choices that they make?

And Ms. Shearer, you're in the business of getting data into the hands of consumers. I would think that you would endorse this idea.

I'm a little puzzled as to why you don't like the idea that consumers get to make more and more choices under these kinds of plans. And you're supporting that either the government or an employer continues to make these choices.

When I came to the Senate, of course, HillaryCare was on the floor and this was the major issue that dominated the first session. And people would stand up and say—remember the unions would be chanting at us wherever we went—"we want the same plan that you've got. We want the same plan Senators have."

And my reaction was, I want the plan I had before I came to the Senate.

[Laughter.]

Which was better. And the reason it was better was because I was the CEO of the company and I got to pick. And now I'm a government employee and all I get is what the government employees group—and I don't know who they are.

I would fail the Stark Test here. I don't know who they are that determines what my plan is. I'm a government employee. I get whatever a government employee gets.

But when I was the CEO, I got to pick the plan for the whole company and it was great. I picked a plan that fit my needs and then hoped that it would fit my employees' needs.

Now that's a little bit of an overstatement for the dramatic impact of it, but that's where we are.

The people who are making the choices are not the people who are consuming the services.

That's a fundamental fact of our present system and would be a fundamental fact under a single-payer system, and that is, in my view, where the problem is.

The people who are using the services, the consumers, are locked out of any impact on the decision.

And I like the idea that we're getting, at least anecdotal evidence that when you put the consumer into the decision-making stream, the results get better. Not only the cost results, but more important for, Mr. Leach, your employees are healthier.

They begin to understand now that they are in the game, now that it's their money on the line—it's all their money. The premium is their money. The idea that the employer pays for this is nonsense.

It's the employee's money because he earned it for you. If you can't get enough value out of an employee to cover the whole cost of his benefits, you can't afford him. And just because it doesn't show up on his W-2 doesn't mean that it's not his money and it doesn't mean he hasn't earned it with his work for you.

But when you get the employee, you get the consumer in the game where he or she begins to see, this is what it costs me if I don't have the annual physical because I'm going to pay for it later on. This is what it costs me if I don't do the screening.

All right, I'll pay for the screening because it's going to save me money down the way, and also, I'm going to get healthier. We get a healthier population.

That will have as much of an impact on bringing down the medical care costs as anything we can do.

So, in the spirit of seeing Mr. Ryan and Mr. Stark get together, which is something that you don't happen to see every day, Ms. Shearer, can you and Mr. Leach get together and say, let's find a way to get the consumer of medical care into the business of making some of the decisions regarding the cost of medical care?

Ms. Shearer. Well, where to begin?

First of all, let me say that I certainly can agree that more quality information in the marketplace can only be a good thing for consumers. But it's also important to keep in mind that it's not a be-all and end-all.

When you're having a heart attack, you don't have a lot of time to do research into the quality of the doctor that may be treating you.

So you can only take it so far. But also, I do need to come back to this question about consumer choice.

This is not a marketplace for toasters. When I go buy a toaster, whoever is selling it to me doesn't care anything about who I am.

Someone selling me health insurance cares what my underlying health status is. And the thing that concerns me, it's great if we can encourage people to stay healthy and to be healthy and preventive measures.

Those are great things. I think everybody would agree on that.

But people get sick, often through no fault of their own. And we have to make sure that we have a health care system that doesn't over-punish people who get sick and throw them into tremendous financial burdens, including bankruptcy, or possibly even deter them from getting the care they need because they face huge financial barriers.

So I think the key thing, because of this variation in risk, we have to be thinking about a system that includes everybody and that subsidizes—I was pleased to hear that Humana adjusts the payment based on the employee's risk. That make a huge difference. I think that that would probably be unusual in this particular type of marketplace. But that's something to try to replicate.

Thank you.

Chairman Bennett. Well, I'm a little surprised that Consumers Union takes that posture because your whole history has been to empower the consumer in areas where the consumer is ignorant.

You're saying that, gee, when you have a heart attack, you don't want to make a cost decision, and that's true.

But I can tell you, if I had a heart attack in Utah, I know what I would say to the 911 people who show up. I'd say, "Don't take me to that hospital. Take me to this one." Because maybe it's just reputation. Even in the pain of a heart attack, I know that there are some certain places I don't want to be taken, I don't want to go.

Health care is not a commodity. It is not exactly the same everywhere.

And the more customers know, the more they're going to want to exercise that knowledge. And Consumers Union ought to be in the foreground of saying, these are the hospitals that are good. These are the ones that are unacceptable.

I don't know anything about cars except how to turn them on and how to push the brake and how to push the accelerator.

And I go to your magazine to tell me, "This one is going to turn over." There's no way I know it's going to turn over. It's a life-threatening kind of thing. "This one is going to turn over. This one has got a high repair rate," all the rest of it.

I'm dependent on you to help me make a choice.

The same thing with car repairs. I go to the consumer advocates who say, "These people will take you to the cleaners and these people will give you"—or I go to another repair man and say, "Where do you take your car?" Somebody whom I trust.

Consumers are not doctors, but they're not stupid, either, and they need to be informed. And as they get informed, I think the experience is that they begin to make intelligent choices.

And I would think, yes, you don't like the uninsured problem, and neither do we, and we ought to work together on that.

But on this issue, I would think that you'd be in the trenches with the others trying to get as much data as possible to see if this

really works instead of just saying, theoretically, "Well, we're afraid that there's going to be adverse selection here and therefore, let's not try it."

Ms. Shearer. I am agreeing on the issue of quality data, of quality of hospitals. I think that that can be very helpful.

I think, really, the other witnesses have acknowledged that there is a potential for tremendous risk selection. And I don't think that you can ignore all of economic theory based on some very preliminary findings.

And I would predict that there would be more findings that would come out over the next few months that may tell a different story.

Chairman Bennett. But are you opposed to getting those findings in case you're wrong? Are you opposed for us pursuing this, to find out whether or not these first indications really are not an anomaly? They are, in fact, indications of something very solid.

Ms. Shearer. Of course not. More research, more findings are good.

What I opposed was the expansion of medical savings accounts, the draining of $41 billion out of the Federal Treasury to encourage a kind of health insurance that all economic theory indicates will separate the healthy from the sick.

Chairman Bennett. Yes. But such initial evidence as we have says it's working.

Ms. Shearer. Senator, with all due respect, I find that evidence extremely preliminary and I don't believe the results will hold up over time.

Chairman Bennett. All right. But let's see over time whether you're right or not.

The world is filled with people who say, "Well, this isn't going to work." And somebody says, "Let's try it." And the first indications come in and say, "Well, it is working." And others say, "Well, that's still not conclusive enough," and they try to kill it.

If it turns out that it's clearly not going to work, I will abandon it. I want to solve the problem. But the early indications are—you talk about economic theory. The economic theory that I subscribe to—and then I'll shut up and let my colleagues talk—the economic theory that I subscribe to says, "markets make better decisions than governments do."

And here is an opportunity to get some market forces into this, get consumers empowered to impact the market in ways that they have never been able to before.

And I think that's an economic theory worth testing. I'll get off my soapbox.

Mr. English, you've been very quiet here and I don't want you to feel——

Representative English. Well, I thank you, Mr. Chairman.

Ms. Shearer, listening to your points, I guess one of the problems I have is that the line of argument that the Chairman has made I think is unassailable.

And quite apart from the ideological claim that by allowing people to pay for their own out-of-pocket on a tax-advantage basis is somehow a spectacular drain on the Federal Treasury.

And you and I may just simply have a different view on how that works philosophically. I think it's their money. And I think in the long run, providing tax advantages for health care expenditures or savings directed towards health care expenditures is probably actually a great dynamic to have in the economy.

Is your greatest concern with consumer-driven health care systems the shift of risk potentially allowing individuals to avoid having to pay—I suppose what some might consider to be their share as part of a group?

Or is it a lack of adequate consumer information? And are not both of those solvable problems in the long term?

Ms. Shearer. Well, the lack of information is relatively solvable, I believe. And I think there's quite a bit of agreement on that issue today.

What isn't really solvable is the underlying nature of risk in the health insurance marketplace and the fact that someone in the top 10 percent will have expenditures of $16,000 in any one year and someone in the bottom 10 percent, about $30 on average.

As we move towards a system, if people have choices in an employer market between a high deductible and a low deductible plan, economic analysis shows us that the low deductible plan will be crowded out over time.

And so, while many proponents sell this in terms of choice—"let's give people a choice"—the reality is that over time, unless there's careful risk adjustment, the low deductible plan will disappear.

So that's really my concern. Transforming the marketplace to a high deductible system is thereby shifting costs to many employees who have chronic health conditions, who run through that health reimbursement account.

Representative English. I understand that. And may I intervene, because you've made a couple of good points?

Are there not also opportunities, though, to identify those risks that you're concerned about that may create a crowding out, and actually direct our research and our medical solutions dealing specifically with some of those problems?

Aren't many of those high-risk cases—it's very easy to deal with these in very broad categories. But are they not individuals who may have conditions that are ultimately solvable with a combination of public research and also an active private marketplace?

Ms. Shearer. Well, I think the situation varies. The high-risk person might be someone who needs a bypass surgery or it could be someone who needs chronic care.

More research is certainly a good thing and can help lower those costs. I'm not sure if I'm answering your question exactly, but more research on diseases and more focus on specific diseases can certainly be a good thing.

That's not the part of consumer-driven health care that I take issue with.

Representative English. Dr. Milstein, you've heard my exchange with Ms. Shearer. Would you like to comment?

Dr. Milstein. Yes. I think one of the reasons that this discussion is tough is there are two different visions of consumer-directed health care that are floating out there and that carry different implications for some of the concerns expressed.

One vision would simply increase cost-sharing for everybody. And that obviously falls disproportionately on sicker people and tends to create some of the cost-shifting challenges towards sicker people that most people don't want.

I think your point is right that, as Mr. Bertko said, there are ways of solving that problem by making more generous allowances or contributions towards the plans that attract people who are sicker.

That's vision one. And I consider that a "blunt solution." You're just increasing deductibles and now you have skin in the game, and we'd like you to be more careful.

There's a second vision. And if you look at the enrollment numbers that I mentioned, it's the majority vision of current consumer-driven health care plans. The second vision is more precise in raising consumer cost-sharing.

It doesn't necessarily involve increasing the deductible or coinsurance; instead it varies how much people pay at the point of care depending on the efficiency and quality ratings of the selections made.

The article that I attached from *The New England Journal of Medicine* illustrates these two different approaches. They achieved two very different results.

One solution simply increased drug cost-sharing. It resulted in a total cost savings, but some sick people stopped using medications that were helping them.

That's vision one for consumer-directed health care.

They also evaluated the second vision, the other vision for consumer-directed health care, in which there was no increase in what people had to pay for the drugs that offered more favorable quality and cost-effectiveness ratings. But there was an increased consumer cost share for alternative drugs that had a less favorable quality and cost-effectiveness rating.

The second approach did not discourage people from taking helpful drugs and it reduced total costs both for the consumers and for the employers.

The second vision of consumer-directed health care allows the most common ground among the points of view expressed this morning.

Representative English. I yield.

Representative Stark. Thanks.

Doesn't that presuppose that you will have a completely objective selection of how the formula is determined? And if market-based forces get involved and one pharmaceutical company wants a bigger market share and drops the price, the market—when you say one drug is more efficacious or better, somebody has to make that decision on—not on a market-driven basis, but on a professional knowledge.

And that's where it——

Dr. Milstein. Absolutely. It very much pivots on having a reasonable scientific determination as to which physician, or which drug offers——

Representative Stark. I guess I would say scientific rather than market-based.

Dr. Milstein. Yes.

Representative Stark. Okay.

Mr. Ryan. Can I ask a quick question?

Mr. Bertko, you say that in your testimony, Humana has over 200,000 under-65 members enrolled in your consumer-centric product. And that's up from 40,000 from just a year ago?

Mr. Bertko. Yes. There is a great uptake in this.

Mr. Ryan. Wow. I just met with one of your counterparts at another company who was involved in rolling out HSAs as of January 1, and they had a phenomenal increase in application. And 30 percent of their applications for HSAs were people who were uninsured.

Do you have any data to that effect as to the jump from 40,000 to 200,000? How many of those people were people who were uninsured?

Mr. Bertko. Well, let me say that this is a different market from what I believe you were talking about, the individual health insurance markets.

So ours are primarily employers who——

Mr. Ryan. Employers converting over to a consumer-based thing?

Mr. Bertko. Yes, exactly.

Mr. Ryan. Okay. Thank you.

Chairman Bennett. Okay. We're reaching the witching hour.

I found this very stimulating and very helpful and I'm grateful to all the members of the panel. I want to make one final point.

When we talk about statistics, which we always do in the Congress, we forget that people move. I've already talked about people moving from employers. People also move from one quintile to the other, to use the economist's term.

Once again, to be personal about it, in my lifetime, on the income range, I have been in the bottom quintile and I have been in the top quintile, and in the process, moved back and forth.

Since I got to the Senate, I dropped out of the top quintile and come back into other areas.

But the reason I make that point is that much of the rhetoric around taxes are, well, it only benefits the people at the top, as if the people at the top have always been there and always will be.

And the benefit of people who are moving up and down—I use myself as having moved both up and down. Donald Trump moved down very dramatically at one point. Now he's back.

That principle, the understanding of that, makes the tax system look different than if you assume that everybody at the top has always been there. We are the most fluid society in the world economically as people move up and down.

I make that point because the same is true in health care. If we leave the older seniors out and the Medicare problem—80 percent of Medicare costs go for the last 60 days as people are dying—and so on. If we leave that out of the equation and talk about the people under 65 who are employed, with some obvious exceptions, the general rule is that somebody who has a serious health problem that requires high cost in one year, recovers and goes back to the low costs in the next year.

In other words, you don't have a pile of people, to use your figures, Ms. Shearer, who are $16,000 and a pile of people that are $30, and they stay that way.

Somebody in the $30 a year can have an incident that takes him up into the $16,000 a year area, get well and go back.

That means if there is an incentive—I keep coming back to this—is there an incentive for smart purchasing and for improving one's habits, and therefore, one's health.

Over a lifetime, you can fund the years where you have the high health problem and still get the benefit at the end of your life of the money you have accumulated by making wise choices.

And I think we ought to keep that in mind as we look at the equation of what happens when we're trying to incentivize and inform customers and allow the consumer of the service to make some choice as to what happens to the service.

We come back, Dr. Milstein, to your second vision, which is the vision that I embrace, that an informed consumer can have an impact on the whole system.

And my big problem with the present system is, as I say, the consumer is frozen out of any decision-making. The decision as to which plan he's going to be in is made for him by his employer.

And increasingly, the decision of which doctor he can go to is made by the plan, and so on. And he ends up with whatever he gets.

And then the other comment I will make just for the record, for all of these discussions, there's a woman in Utah who listened to me speak very authoritatively on this subject.

After the luncheon, she came up and said, "You're a very nice man, and you don't understand anything at all about the problems of the poor."

And she is an advocate to the poor, works among them immensely, and she made this point as she brought me down to earth.

She said, "The problem with the poor in health care has relatively little to do with money. The system is so impenetrable that the poor cannot navigate through it." She said, "You've got to pay more attention to community health centers, because the main function of a community health center is when somebody walks through the door, they can find their way to what they need."

She said, "You want to create this system and then just give the poor enough money to survive in it, and they won't know how to use that money. They just can't navigate the system."

And she appropriately humbled me, and I've spent some time looking at that. And the community health centers, at least in Utah, do a fabulous job. And somebody who is homeless, somebody who is on Medicaid, walks into one of those, the most important service they provide is navigate through the bureaucratic shoals and get them what they need.

And the flip side of that, if I may—Mr. Stark has left. I'm not taking advantage of that. He would get upset about this. But he'll be back.

The flip side of that, I have another woman in Utah who said to me, "You know how I deal with Medicare?" She said, "I take care of my mother's affairs. I have an 85-year-old mother. I am a profes-

sional woman. I am a college graduate. I think I'm pretty smart. The Medicare forms absolutely baffle me. And any thought that my 85-year-old mother would be able to handle this——"

So she said, "I have figured out how to deal with Medicare. I throw away everything unopened and once a month I call the Salt Lake Clinic and say, 'what do I owe you?'

"I write the check, send it in. They may be over-charging me. They may not. But the peace of mind not having to deal with the system is worth whatever financial problems I might have had.

"I don't even open it. I just throw it away. And once a month I call the Salt Lake Clinic where she goes for her treatment and say, 'what do I owe you?'"

That is part of the problem and that is what a system designed to get the consumer informed and empowered will, I think, begin to impact not only the federal bureaucracy, but for most of these people the private bureaucracy.

Let me again thank you all for coming. It's been a most stimulating morning. And we hope that those of our colleagues who are on the tax-writing committees will benefit from the record that we are building here in this Committee.

The hearing is adjourned.

[Whereupon, at 12:05 p.m., the hearing was adjourned.]

Submissions for the Record

PREPARED STATEMENT OF SENATOR ROBERT F. BENNETT, CHAIRMAN

Good morning and welcome to today's hearing on consumer driven health care.

The United States faces a significant challenge to keep health care affordable. For many years, our health care spending has grown at a significantly faster rate than the economy, and all projections indicate that this will only continue.

In recent years, we have enjoyed amazing advances in medical technology that have extended and greatly improved our lives. Medical procedures have become less expensive and less invasive. However, as we discussed at our hearing last summer on technology and innovation in health care, we have found an interesting paradox. It seems counterintuitive, but the fact is that as the cost for a medical procedure goes down—as the delivery of health care services becomes more efficient—overall costs actually go up.

Much of this disconnect can be attributed to the difference between the amount consumers pay and the actual cost of the technology—and health care as a whole. Because of comprehensive insurance and other public programs, we have created the notion that "someone else" is paying for our health care and so we use more and more health services. In other words, insured people are buying greater amounts of medical services which contributes to higher insurance premiums and overall health care costs.

So today we are looking for ways for market forces to limit costs while improving access and quality of health care. As can be seen in other areas, cutting costs by government fiat creates market distortions. The government can't keep up with the marketplace, so cost controls have never worked. If prices are set too low, there will be a shortage of providers, and if they are set too high, insurance companies are forced to raise premiums and ration services to patients.

I believe a better approach is consumer driven health care. We have two years of experience to look at and see that this approach is gaining some traction.

A consumer driven approach to health care restores to consumers direct control over their health care dollars. It provides them with better value, greater choice, improved health, and recognition of the true cost of the services they demand. It offers a broad range of options that encourage employees to take a greater role as informed health care consumers in choosing health plans, benefit packages, health care providers, and medical treatment alternatives. Another promise of consumer driven health care is that it can reverse a long-term trend that has combined more third-party payment of health care bills with substantial hikes in health care spending.

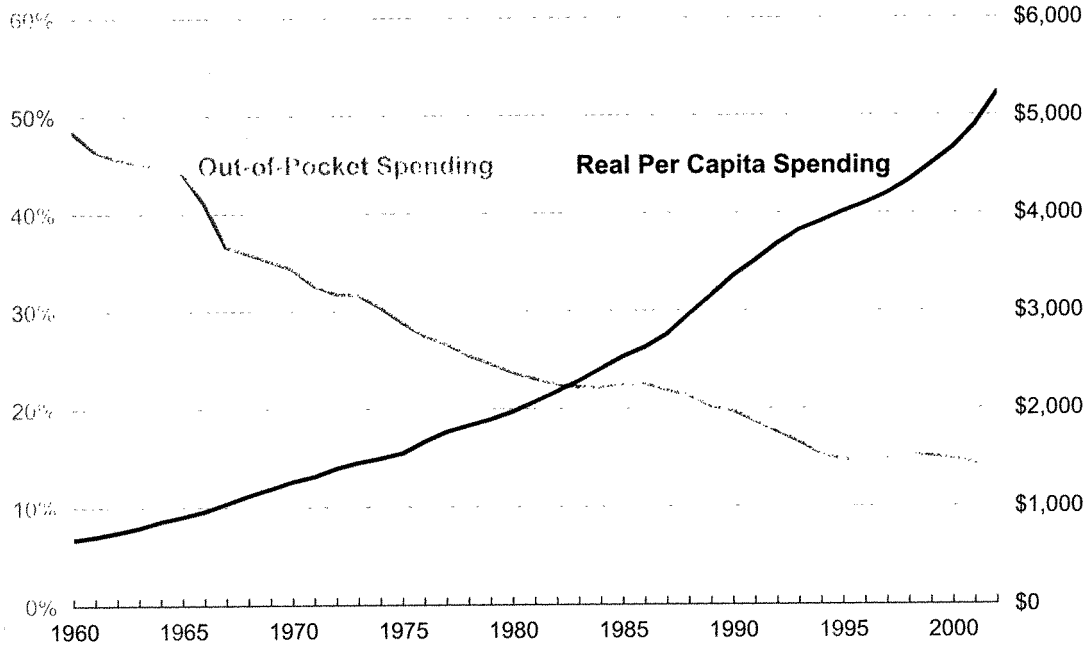
New health savings account options, included in last December's Medicare Prescription Drug, Improvement, and Modernization Act, give consumers even greater ownership and control of their health spending dollars, which could reshape the health care market.

Today's hearing will examine the performance of the consumer driven health care market over the last two years. We can see how this new approach is developing in terms of levels of enrollment, plan options, consumer satisfaction, and projected growth. I believe the Congress should learn more about what works, and what can be improved upon.

With that, we welcome our panel that will provide a number of perspectives on consumer driven health care, including a physician, Dr. Arnold Milstein; an actuary, Mr. John Bertko; a benefits manager at a firm that has adopted a consumer driven health care approach, Mr. Howard Leach; and a health policy analyst for Consumers Union, Ms. Gail Shearer. We look forward to your reports on the performance—to date—of consumer driven health care.

Out-of-Pocket Spending Falls as Per Capita Spending Climbs

(Out-of-pocket spending as a percentage of total spending, real spending per capita)



Source: Center for Medicare and Medicaid Services, National Health Expenditures

PREPARED STATEMENT OF REPRESENTATIVE PETE STARK,
RANKING MINORITY MEMBER

Thank you, Chairman Bennett. I have to say I'm extremely skeptical about the title of today's hearing—"The Performance and Potential of Consumer Driven Health Care." Having spent much of my Congressional career in health care policy, I have never known so-called "consumer driven" health care to perform well or to have much potential. Rather than hide behind euphemisms, we should just call these policies what they really are: tax shelters that require people to pay more for their health care, so that insurance company stock holders can reap the benefits.

These high deductible, defined contribution plans are not consumer-driven, nor do they offer much choice. Instead, they simply shift costs to so-called "consumers" and force patients to pay more and more out-of-pocket, making it difficult for patients to get the care they need.

These so-called "consumer driven" health plans rely on consumers obtaining reliable information on treatment choices, quality and charges of providers. Yet, this information doesn't even exist in our system today. I am very pleased that Gail Shearer is here today from Consumers Union—the preeminent source for consumer information—to talk about this fact.

The concept of "empowering" consumers to make more responsible choices about their health care decisions is misleading rhetoric. Purchasing health care is not like buying a car or a toaster. This is true not only because the information is not available, but also because health care needs are often unanticipated and patients rely on their doctors' expertise—not their own—to guide medical decision-making.

Having a heart attack is not like having your car break down. If your mechanic makes the wrong decision about your engine repairs, it is not life or death. People cannot generally predict when they need health care. And even if they could, there is nowhere to seek out credible information on where to go for care or what to ask for and what to expect to pay.

The President has now proposed to spend $41 billion on high deductible plans, which will at best extend coverage to a minute fraction of the 44 million who don't have coverage today.

In fact, the Administration has finally admitted that these policies are not about insuring the uninsured, but an attempt to insert more "cost consciousness" into the system to reduce consumption. However, I would argue that these policies fail to meet even that objective.

While it may shift responsibility of costs under the deductible, most of our national spending is on behalf of people who are very sick. High-deductible plans are unlikely to alter the overall level of spending, but instead shift more costs to people who can barely afford their current obligations. Who knows? These plans could have the perverse effect of increasing overall spending as people delay care until their treatment is even more costly than it would have been if treated early.

Given that this is the first hearing on health care in the JEC this session, and that this was what my colleague Ways and Means Chairman Bill Thomas shared as his vision for the U.S. health system, it is clear that Republicans view high deductible plans as a sort of magic bullet for our health system.

We have a lot of issues that can and should be addressed. Certainly, the rising cost of health care is a growing problem that is forcing more and more people to become uninsured. Of course, a significant part of the rising cost of health care is due to prescription drug spending. If Republicans were really interested in controlling costs, they would have given the Secretary authority to negotiate for discounts in the Medicare program, but that's another story.

These health plans being discussed today force individuals to negotiate prices on their own. This dilutes purchasing power. These plans don't reduce cost, they discourage people from using health care services.

PREPARED STATEMENT OF ARNOLD MILSTEIN, M.D., MPH
PHYSICIAN CONSULTANT, MERCER HUMAN RESOURCE CONSULTING

CONSUMER DIRECTED HEALTH BENEFIT PLANS COULD GREATLY IMPROVE QUALITY OF CARE AND HEALTH INSURANCE AFFORDABILITY; EARLY ATTEMPTS WILL FALL CONSIDERABLY SHORT OF THEIR POTENTIAL; THERE ARE BUDGET-NEUTRAL OPPORTUNITIES FOR CONGRESS TO HELP

I am Arnold Milstein, a physician consultant at Mercer Human Resource Consulting, and the Medical Director of the Pacific Business Group on Health, which serves 44 large and over 2000 small California employers. My testimony summarizes the initial findings of a Robert Wood Johnson Foundation funded study that

I lead in partnership with Professor Meredith Rosenthal at the Harvard School of Public Health; it does not represent the positions of these organizations. A more detailed summary of the findings of the Mercer/Harvard Study will be released in the second quarter. Professor Rosenthal will publish additional findings in scientific journals over the next 12 months.

We studied consumer-directed health benefit plans by surveying in the first quarter of 2003 over 600 for-profit and not-for-profit regional health plans of all types, serving employers of various sizes. They included regional components of national insurers as well as regional insurers; they included diverse plan types such as HMOs, PPOs, and indemnity plans, offered on both insured and self-insured bases. Over the past several months, we also have been conducting 15 in-depth case studies of consumer-directed health benefit plans of diverse types, serving multiple U.S. regions and populations. These case studies include interviews with health plan executives and purchasers, with follow-up review of print and electronic documentation. We defined consumer-directed health plans as health benefit plans that incentivized insureds to select more affordable and/or higher quality health care options and provided cost and/or quality information with which consumers could compare available options. Case study interviews are ongoing and will add detail; but the broad shape of our findings is not likely to change.

A. INCREASED CONSUMERISM COULD GREATLY IMPROVE QUALITY OF CARE AND HEALTH INSURANCE AFFORDABILITY

This conclusion is drawn from evidence internal and external to our research. The external evidence is that (1) as summarized in my January 25, 2004 testimony to the Senate HELP Committee, up to 40% of what we are currently spending on American health care could be eliminated over a 10-year period, and thereby slow the rate of biotechnology-driven health insurance cost increases without impinging on quality of care, clinical outcomes, or patient satisfaction; (2) as documented in the Institute of Medicine's 1998-2001 reports on quality of care, quality reliability is seriously flawed, even among our best providers; and (3) as described in both of these sources, inter- and intra-community variations in quality and cost-efficiency are wide among hospitals, among physicians, and among different treatment options for the same condition. Such wide performance variation offers substantial opportunity for informed and incentivized consumers to preferentially select better performing physician, hospital and treatment options, including better self-management of health risk and avoidance of services offering no health value. In addition to capturing immediate gains in quality and cost-efficiency, this expression of the market's invisible hand would generate ongoing gains by more strongly motivating all providers and treatment innovators to discover "better, safer, leaner" methods of transforming health benefit plan dollars into improved health.

The internal evidence that we uncovered in our research is that, if carefully explained and encouraged, many enrollees, including sicker individuals, are willing to enroll in consumer-directed health benefit plans, seek performance information and select more affordable health care options. The 600+ plans that we surveyed had enrolled over 2 million enrollees in consumer-directed health benefit plans for 2003 and more than 4 million for 2004. These overall consumer-directed plan numbers included approximately 500,000 enrollees of account-based (also known as Health Reimbursement Accounts or HRA) models in 2003 and 1 million account-based model enrollees in 2004. While these absolute numbers are small, the consumer-directed health benefit movement is early in its adoption curve, the growth rate is high (we anticipate another doubling of enrollment by 2005), and many mainstream health plans are beginning to integrate consumer-directed features, such as hospital or physician quality and/or affordability comparisons, into their other offerings.

B. EARLY ATTEMPTS TO IMPLEMENT CONSUMER-DIRECTED HEALTH BENEFIT PLANS WILL FALL CONSIDERABLY SHORT OF THEIR POTENTIAL

1. Structural Limitations

My prediction of substantial shortfall is partly based on insurers' near-term goals. The stated motivation for insurers and purchasers that offer consumer-directed models are varied. The majority of health plans we interviewed indicated that their main objective was to increase consumer engagement in health care decision making, rather than wholly rely on physicians and hospitals. These plans believed that improved cost-efficiency and quality of care would eventually follow, but argued that these goals were secondary in the near-term. In contrast, most employers prioritized immediate slowing of increases in health benefit costs.

Shortfall in results will also arise from two primary informational gaps that severely handicap consumer-directed health benefit plan innovators: (1) valid, easily understood performance comparisons among physicians (e.g., a surgeon's complication rate), among hospitals by specific service lines (e.g. a hospital's average total lung cancer treatment cost), and among treatment options (e.g., patient satisfaction ratings from open vs. closed biopsy of a suspected breast tumor) are generally lacking; and (2) we lack research evidence on the form and size of incentives minimally required to motivate consumers, especially the 20% sickest consumers who spend 80% of health benefits dollars, to switch from an MD, hospital, or treatment with which he or she (or someone whom they trust) is familiar to a less familiar alternative, when the alternative offers better quality and cost-efficiency.

Of the 15 plans we studied in depth, only one offered consumers clinical quality of care comparisons for physicians (medical groups in this case) across a variety of measures using audited data. Six others provided information only on patient satisfaction or patient-reported quality of care. Twelve plans offered comparative quality information on hospitals across a large number of service lines either through a vendor or, in one case, by creating a unique hospital report card. Information on the quality implications of major treatment options was provided by seven plans. Only one plan offered consumers detailed cost comparisons (in this case, based on the negotiated fee or unit price) for physicians and hospitals by service line. Three other plans made available qualitative performance ratings on physician or medical group cost (e.g., an indication of above or below a threshold using stars or dollar signs); to rate economic performance, these three plans used a measure of cost-efficiency rather than unit prices.

With respect to hospital quality of care comparisons, we found plans were primarily relying on hospital billing data or unaudited hospital reported survey responses. The consensus of the scientific community and a recent measures endorsement process by the National Quality Forum is that hospital billing data is generally an inadequate basis on which to compare hospital quality.

We found a different but equally severe handicap with respect to most cost comparisons. The most commonly offered cost comparisons, which are limited to drug options and procedures, were based typically on the unit price(s) charged by the physician, hospital, or pharmacy, rather than on their longitudinal cost-efficiency. Longitudinal cost-efficiency in this context refers to the effect of a doctor, hospital, or treatment option on the total cost of treating an episode of acute illness or a year of chronic illness. In the case of a physician, it reflects not only the cost of his/her services but also, for example, the cost of differences in the average frequency with which their patients with the same chronic illness are scheduled for return office visits or are admitted to the hospital. Use of unit price as an index of cost-efficiency is problematic because researchers such as Elliott Fisher at Dartmouth and teams at Premera Blue Cross have independently documented that unit prices are misleading signals of relative cost-efficiency. Indeed, researchers such as Tom Rice at UCLA have documented that lower unit prices typically induce physicians to provide a greater volume of services, either services billed by them or by others, such as laboratories, radiologists, or hospitals.

This substantial informational barrier to consumer identification of the most affordable providers is not caused by a lack of analytic methods with which to compare the longitudinal cost-efficiency of doctors or hospitals. Rather, most health plans lack enough claims experience with individual doctors or individual hospital service lines to allow statistically valid comparisons.

This barrier is especially problematic because most plans are hesitant to pool their claims data with competing plans, out of fear that negotiated unit price advantages they may hold with some physicians or hospitals would be revealed and then replicated by a competing insurer. To address this problem, many plans rate large physician groups or all of a hospital's service lines in a bundle. Such bundling obscures important performance differences and depresses the gains from better engaged consumer. Other plans are responding to this barrier by limiting their ratings to the minority of providers with whom they have adequate claims experience.

The main obstacle to comparisons of cost-efficiency and quality for treatment options is our insufficient federal investment in AHRQ, on which most stakeholders rely to quantify the comparative performance of treatment options. Many large purchasers support much better funding of AHRQ to generate these comparisons.

Even if consumer-directed health benefit plans had reasonably accurate performance comparisons for consumers, we currently know little about the economic and non-economic incentives that are minimally required to induce selection of better performing, but unfamiliar, physicians, hospitals, and treatment options. In the absence of these planning inputs, consumer-directed health benefit plan designers have often relied on blunt incentives such as higher deductibles, higher co-insur-

ance, and portable spending accounts that generally discourage use of all services, including services that are essential to maintaining patient health (e.g., betablocker use by patients recovering from a heart attack). That blunt, overall reductions in benefit coverage can discourage use of clinically valuable services was most recently documented in attached research findings. A promising exception to this general picture is that four accountbased plans exempted recommended preventive care from the relatively strong incentives to control spending from the first dollar and one plan reduced the out-of-pocket cost for chronic medications for individuals who participate in a chronic illness registry, a clinical innovation shown to improve patient health outcomes.

Consumer incentives to select cost-efficient options are concentrated at the low end of the distribution of annual per capita health care costs. The majority of the plans provide the strongest incentives to choose low-cost hospitals, physicians, and treatment options only up to $2,000 to $3,000 for a person with single coverage. Beyond that point, coverage mimics typical PPO coverage and is almost always accompanied by an out-of-pocket maximum. For large self-insured employers, who make up the majority of current consumer-directed plan enrollment, out-of-pocket maximums are as low as $1,500 (for small employers, we encountered some as high as $5,000.) Thus, a typical enrollee of an account-based plan that anticipated minor surgery or a maternity stay would have no incentive to control other spending during the year. Finally, even for the one of 15 plans that calibrated out-of-pocket costs at the point of service to the comparative cost-efficiency of the health care provider selected by the consumer, this incentive did not extend beyond the plan's out-of-pocket limits, even for affluent enrollees. Only the three "narrow provider network" plans created incentives to select more efficient or higher quality providers at all levels of spending, because they offer no coverage for services delivered by providers excluded from the network based on poor performance.

Failure to encourage even affluent individuals to select more cost-efficient options at higher levels of annual personal health care spending will severely limit the savings from most early consumer-directed health benefit plans; this is because roughly 55% of total commercial health insurance spending is by enrollees who exceed their annual out-of-pocket limits.

Finally, we found only one plan that specifically aims to assure that they do not shift a greater share of out-of-pocket cost onto sicker enrollees. This account-based plan provides first-dollar coverage with low coinsurance for all cancer care and hospital admissions. As a result of this design, the aforementioned plan has demonstrated that sicker individuals disproportionately benefited economically from the consumer-directed plan relative to a typical PPO plan. If widely adopted, this approach could offset the quality loss described in the Epstein study or the concern that the consumer-directed plans approach will impoverish the sick. Failure to attract sicker individuals whose selection decisions offer the largest opportunity for health benefit plan savings threatens realization of the full potential of consumer-directed health plans.

2. Early Evidence on Risk Selection and Impact

Because consumer-directed plans are relatively new to the market, there have been limited opportunities to study their effects. Most of the available evidence on savings, recently summarized at a briefing by the Galen Institute, has come from the plans themselves and should be regarded as preliminary until independently confirmed by health service research.

Risk Selection

Consumer-directed plans are offered to employers both as a total replacement for all prior options (often, but not always in the fully-insured segment of the market) and as an additional option alongside prior options. In the latter case, plans have indicated mixed results in terms of risk selection. One major HRA plan found evidence that individuals selecting their plan were much healthier than those choosing competing HMO and PPO options. Another similarly designed plan found that enrollees who chose their plan were slightly sicker than average. Many plans have also reported that the type of employer that chooses to offer a consumer-directed plan is highly varied and includes many employers with predominantly low-wage employees. More data will be needed to address this question and selection patterns will likely change as more information about the new model is disseminated.

Impact on Spending and Service Utilization

Reports of the impact of consumer-directed plans on spending are similarly sparse because only a few plans and employers have enough claims experience to assess the impact of these new models. It is also important to note the difficulty of assess-

ing the impact on spending of consumer-directed plans because of issues such as risk selection. Moreover, none of these findings have been validated by independent researchers. Three of the studied consumer-directed plans reported reduced spending growth compared to ambient health insurance trend. The reported savings net of reductions in benefits coverage were on the order of ten percentage points. Consumer out-of-pocket spending was reported to have grown more slowly than comparison plans as well. Most of this effect is attributed by the plans to behavioral changes such as substitution of generic for brand name drugs and substitution of office visits for emergency room visits. Two of the account-based plans we examined also report that preventive care use increased relative to comparison groups. Because these findings relate to specific populations and plan designs (both the consumer-directed plan and the plan with which it was compared) it is not yet possible project early results to the insured population at large.

Other Effects

Several account-based plans have reported high retention rates for both employers and employees with a choice of plan. This suggests relatively high satisfaction with the plans. The impact of account-based and other consumer-directed models on important outcomes such as clinical quality and longer run cost-efficiency is not yet known.

In summary, significant structural limitations in the early forms of consumer-directed health plans have not blocked directionally favorable early results. Most pioneers report decreased rates of per capita health spending and increased consumer information seeking. However, (1) none of these early self-assessments have examined impact on health outcomes or robust measures of quality; and (2) reported savings, ranging up to a 15 percentage point offset of concurrent insurance premium trends, have not yet fully accounted for more favorable enrollee health status, leaner covered benefits, cost transfers to sicker beneficiaries or to the employer-purchaser, and the economic value of health or quality losses that consumers did not intend.

3. How Will HSAs Alter This Picture?

Through our interview with plans and other interactions with Mercer clients and contacts, we assessed the market's early reaction to the Health Savings Account (HSA) provisions of the recent Medicare reform legislation. All but one of the account-based plans are developing or had developed a product that would meet the more restrictive definition of an HSA. Large employers, however, appear to be cautious about HSAs, waiting for clarification on a number of fronts. One plan reported that the main question from its employer clients was whether HRAs could be converted into HSAs. This plan indicated that its clients and potential clients wanted to experiment with an HRA before offering an HSA, which cedes to employees more control of benefit dollars. Other employers had unresolved questions about the relationship between HSAs and both FSAs and pharmacy benefit carve-outs.

C. THERE ARE BUDGET-NEUTRAL OPPORTUNITIES FOR CONGRESS TO HELP

There is a short list of budget-neutral interventions available to Congress to address some of the structural barriers facing consumer-directed health benefit plans and allow realization of their full potential for improving the quality and affordability of American health benefit plans.

1. Give employer-, union- and insurer-sponsored health plans real-time access to the full CMS claims database, holding back data only to the extent necessary to protect the privacy of individual Medicare beneficiaries. The Medicare claims databases are a severely underexploited national information asset that would allow all private-sector health benefit plan sponsors to compare more validly the longitudinal cost-efficiency and quality of physicians, hospitals by service line, and treatment options. Current CMS rules restrict access to research that will benefit CMS. However, wider access is, in the view of most external legal experts, not restricted by the statutory language of HIPAA or the Privacy Act, if beneficiary privacy is fully protected. Congress could clarify this and encourage CMS to revise its regulations to allow real time access, subject to full protection of beneficiary privacy via encryption and other methods specified in existing law.

2. Encourage CMS to support rapid expansions of minimally required hospital and professional billing data, as recommended by the Quality Work Group of the National Committee on Vital and Health Statistics. This would enable much better performance comparisons of providers and treatment options by CMS and private-sector health plans, especially in reducing the confounding effect of differences in patient severity of illness on provider performance comparisons.

3. Encourage the Secretary of HHS to speed up adoption of the National Provider Identification program. This will allow all benefit plans to better identify individual

providers and more accurately compare their performance via analysis of CMS and private sector claims data.

No health care professional, government official, or well intended health benefit plan manager can better determine the most personally satisfying tradeoff for consumers between health care spending and anticipated health improvement than well informed consumers can for themselves. Especially when paired with robust pay-for-performance programs for physicians and hospitals, consumer-directed health benefit plans can be a vehicle for great improvement in both the affordability and quality of American health care. Expect initial shortfalls in the results from early consumer-directed health benefit plans; and encourage CMS to help all American health benefit plans gain access to information that they need to deliver maximum potential consumer gain.

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SPECIAL ARTICLE

The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending

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ABSTRACT

BACKGROUND

Many employers and health plans have adopted incentive-based formularies in an attempt to control prescription-drug costs.

METHODS

We used claims data to compare the utilization of and spending on drugs in two employer-sponsored health plans that implemented changes in formulary administration with those in comparison groups of enrollees covered by the same insurers. One plan simultaneously switched from a one-tier to a three-tier formulary and increased all enrollee copayments for medications. The second switched from a two-tier to a three-tier formulary, changing only the copayments for tier-3 drugs. We examined the utilization of angiotensin-converting–enzyme (ACE) inhibitors, proton-pump inhibitors, and 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statins).

RESULTS

Enrollees covered by the employer that implemented more dramatic changes experienced slower growth than the comparison group in the probability of the use of a drug and a major shift in spending from the plan to the enrollee. Among the enrollees who were initially taking tier-3 statins, more enrollees in the intervention group than in the comparison group switched to tier-1 or tier-2 medications (49 percent vs. 17 percent, $P<0.001$) or stopped taking statins entirely (21 percent vs. 11 percent, $P=0.04$). Patterns were similar for ACE inhibitors and proton-pump inhibitors. The enrollees covered by the employer that implemented more moderate changes were more likely than the comparison enrollees to switch to tier-1 or tier-2 medications but not to stop taking a given class of medications altogether.

CONCLUSIONS

Different changes in formulary administration may have dramatically different effects on utilization and spending and may in some instances lead enrollees to discontinue therapy. The associated changes in copayments can substantially alter out-of-pocket spending by enrollees, the continuation of the use of medications, and possibly the quality of care.

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INCENTIVE-BASED FORMULARIES ARE AN innovation designed to curb the increasing costs of prescription drugs.[1] An incentive-based or tiered formulary provides financial incentives (i.e., lower copayments) for enrollees to choose drugs that are preferred by the payer.[1,2] In contrast to closed formularies, which specify a limited number of drugs that are available for coverage in each class, incentive-based formularies are intended to preserve choice for patients and physicians by providing some level of coverage for most drugs while encouraging patients and their physicians to select the drugs that are more cost effective for the plan. At the same time, the use of incentive-based formularies results in increased bargaining power for plans to negotiate rebates with drug manufacturers by promising an increased volume of prescriptions for the preferred drugs.[3]

There is wide variation in the design of incentive-based formularies, with varying numbers of tiers, different drugs assigned to each tier, and a range of copayments required. A three-tier formulary, now the most common type, typically requires the lowest copayment for generic drugs (the first tier), a higher copayment for the brand-name drugs that are preferred by the organization (the second tier), and the highest copayment for brand-name drugs that are not preferred by the organization (the third tier). As of spring 2002, 57 percent of workers in the United States who had drug benefits were enrolled in plans with a three-tier formulary.[2]

Previous studies have found that the adoption of an incentive-based formulary and the accompanying changes in copayments resulted in lower aggregate utilization of and spending on drugs.[4-10] However, there have been few studies investigating whether patients who have been using medications that are typically used to treat chronic illness continue to use their previous medications and pay higher copayments, switch to lower-cost medications, or stop using their prescribed drugs entirely.[5,11] To examine this question, we studied responses to the introduction of two different incentive-based formularies used by a large health plan and a national pharmacy benefits manager.

METHODS

STUDY POPULATION

We studied the use of prescription drugs by employees and their dependents who had health care coverage from two large employers that contract with a large health insurer. The insurer subcontracts with Medco Health Solutions for the management of its pharmaceutical benefits.

In 2000, both employers made major changes to their pharmaceutical benefits that involved the implementation of a three-tier formulary. Employer 1 made a relatively dramatic change in benefits, moving from a one-tier formulary (requiring the same copayment for any drug) to a three-tier formulary and increasing the levels of copayments for all tiers (Table 1). Employer 2 made a more moderate change from a two-tier formulary (involving one level of copayment for generic drugs and a second level for brand-name drugs) to a three-tier formulary that involved increases in the copayments only for the nonpreferred brand-name drugs that were assigned to tier 3 (Table 1). In both cases, the list of drugs available for coverage did not change, just the copayments required for specific drugs. The assignment of specific drugs to different tiers was the same for both employers (Table 2).

We compared the patterns of utilization and spending for Employers 1 and 2 before and after these changes in policy with patterns in a comparison group of enrollees covered by the same insurer who were not affected by the policy changes. This approach enabled us to control for trends in drug utilization that were unrelated to changes in the formulary. For each employer that adopted a three-tier formulary, we used a comparison group representing a similar population of enrollees whose health plan had similar characteristics.

SELECTION OF COMPARISON GROUPS

We identified two comparison groups of enrollees for Employers 1 and 2 from a pool of more than 1000 employer-clients of the insurer. Separate comparison groups of enrollees covered by employers that had a two-tier formulary that was stable throughout the study period were identified for Employers 1 and 2 with the use of the JMP clustering algorithm (SAS Institute). This method is similar to propensity-score matching, in which an exact match on each item is not required.[12] Matches were made on the basis of overall similarity with regard to the following characteristics: the type of medical benefits (both preferred-provider–organization and point-of-service plans for Employer 1 and point-of-service plans only for Employer 2), the copayment levels for the first and second tiers ($8 and $15,

Table 1. Summary of Changes in Pharmaceutical Benefits.*

Employer No.	Characteristics of the Company†	Old Design of Pharmaceutical Benefit	New Design of Pharmaceutical Benefit
1	Large firm with mostly hourly workers	One-tier benefit: Retail — $7 generic or brand-name Mail order — $15 generic or brand-name	Three-tier benefit: Retail — $8 generic, $15 preferred brand-name, $30 nonpreferred brand-name Mail order — $16 generic, $30 preferred brand-name, $60 nonpreferred brand-name Three-tier formulary structure plus across-the-board increase in copayments
2	Large firm with mostly salaried workers	Two-tier benefit: Retail — $6 generic, $12 brand-name Mail order— same as for retail	Three-tier benefit: Retail — $6 generic, $12 preferred brand-name, $24 nonpreferred brand-name Mail order — same as for retail Three-tier formulary structure only

* Typically, an enrollee receives a 90-day supply of a drug when purchasing it through a mail-order program, as compared with a 30-day supply when purchasing it in a retail setting.
† We do not provide additional details about the characteristics of the employers in order to protect their anonymity.

respectively, for Employer 1 and $6 and $12, respectively, for Employer 2), age and sex distribution, and geographic distribution.

DATA

We used eligibility files and pharmacy data obtained from Medco Health Solutions for the three-year period beginning January 1, 1999, and ending December 31, 2001. We studied persons who were enrolled continuously during this period. The study period began more than one year before the policy changes were made for each employer and ended more than one year after these changes. (We do not reveal the exact implementation date for each employer in order to protect the employers' anonymity.)

STATISTICAL ANALYSIS

For each employer, we conducted two types of analyses. First, we conducted descriptive analyses of the rates of switching from one drug in a class to another or terminating the use of all drugs in the class within six months after the policy change took effect. Second, we conducted multivariate analyses of the use of drugs in the classes we studied and, among enrollees who used these drugs, the level of spending for the drugs by the plan and the enrollee, as well as the total spending, over a 33-month study period beginning April 1, 1999. We focused on three classes of commonly used medications: angiotensin-converting–enzyme (ACE) inhibitors, proton-pump inhibitors, and 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors, or statins.

Descriptive Analyses of Changes in Medications and Terminations of Treatment

We studied enrollees who filled at least two prescriptions for a given class of drugs during the six months before each employer's policy changes took effect and determined whether enrollees who used only tier-3 drugs (i.e., those who faced the largest increases in cost sharing) continued to use tier-3 drugs, switched to drugs of a lower tier, or stopped using any medication in the particular class of drugs during the six-month period after the changes were adopted. Because the withdrawal from the market of cerivastatin in August 2001 occurred approximately one year after both employers implemented their policy changes, this withdrawal should have little effect on the results with regard to statins. We also examined whether enrollees who stopped taking tier-3 drugs switched to alternative classes of medications (beta-blockers, calcium-channel blockers, H_2-receptor blockers, or other cholesterol-lowering agents, such as cholestyramine, gemfibrozil, or niacin).

Multivariate Analyses of Utilization and Spending

In analyzing trends in utilization and spending for each class of drugs, we first examined raw data. Since clear breaks in trends were apparent at the time the policy changes were implemented, we estimated the effect of these changes by including a dummy variable to denote the prechange and postchange periods. In the multivariate analyses of spending, we compared changes in the interven-

Table 2. Drugs Available in Each Tier.*

Class of Drugs	Tier 1	Tier 2	Tier 3
ACE inhibitors	Captopril Enalapril maleate	Accupril (quinapril) Capoten (captopril) Lotensin (benazepril) Prinivil (lisinopril)	Aceon (perindopril erbumine) Altace (ramipril) Mavik (trandolapril) Monopril (fosinopril) Univasc (moexipril) Vasotec (enalapril maleate) Zestril (lisinopril)
Proton-pump inhibitors	None	Nexium (esomeprazole), after 11/01 Prilosec (omeprazole)	Aciphex (rabeprazole) Nexium, before 11/01 Prevacid (lansoprazole) Protonix (pantoprazole)
Statins	Lovastatin	Baycol (cerivastatin), after 10/00 Lipitor (atorvastatin) Pravachol (pravastatin) Zocor (simvastatin)	Baycol, before 10/00 Lescol (fluvastatin) Mevacor (lovastatin)

* ACE denotes angiotensin-converting enzyme.

tion group with changes in the comparison group in order to control for general trends in use and spending.[13]

We estimated two-part models because of the large number of enrollees who were not using each class of drugs.[14] We first fit a logit model of the probability that an enrollee would obtain a prescription for a drug in a particular class during a given month. Then, among the enrollees who used a particular drug in a given month, we estimated three regression models of spending on drugs in that class (spending by the plan, spending by the enrollee, and the sum of the two, or total spending). The person-month was the unit of analysis. We considered an enrollee who filled a 90-day mail-order prescription to have used the drug for the subsequent 3 months, with spending spread out over the 3-month period. A logarithmic transformation of the level of spending was used to address skewness in the distribution of the spending measures.

The key independent variables were an indicator for the period after the policy changes, an indicator for the intervention group (relative to the comparison group), and the interaction between these two variables. We included several covariates: the age at the end of the study and its square, the month of the study and its square to account for secular trends in the dependent variable, sex, and indicators of employee or spouse status ("dependent" was the omitted category). The squares of age and month were included to address potential nonlinearity in the effect of these variables on the study outcome. We used Huber–White corrections to adjust the standard errors for the clustering of multiple observations for each enrollee.[15,16]

RESULTS

CHARACTERISTICS OF THE ENROLLEES

Table 3 provides descriptive information regarding the enrollees in each group. There were small differences in most of these measures between the enrollees covered by each employer and the comparison group with which they were compared.

DRUG UTILIZATION

Employer 1

Table 4 shows the predicted change in the probability of the use of a drug in each class by enrollees in the intervention group after we had accounted for any changes in the probability of use by the comparison group; these predictions are based on the logit models. The policy change adopted by Employer 1 resulted in a significantly slower rate of growth in the probability of the use of any drug in a given class than the rate in the comparison group (a difference of 24 percentage points for ACE inhibitors, 34 percentage points for proton-pump inhibitors, and 24 percentage points for statins; $P<0.001$ for all three comparisons between groups).

Table 5 shows changes in utilization patterns among enrollees in the health plan offered by Employer 1 and the corresponding comparison group who used only tier-3 drugs during the six months

Table 3. Characteristics of the Study Population.*

Characteristic	Employer 1			Employer 2		
	Intervention Group (N=55,567)	Comparison Group (N=55,951)	P Value	Intervention Group (N=11,653)	Comparison Group (N=27,051)	P Value
Age as of 12/31/01 (yr)	29.6±16.7	33.5±17.2	<0.001	37.5±17.6	34.8±17.1	<0.001
Male sex (%)	54	52	<0.001	47	47	0.99
Employee status (%)						
Employee	36	41	<0.001	52	47	<0.001
Spouse	25	23	<0.001	20	22	<0.001
Dependent	39	36	<0.001	28	31	<0.001
ACE-inhibitor use (no.)	2231	2596		659	1087	
Average monthly probability of use in 6 mo before policy changes (%)	2.2	2.2	0.99	3.1	2.2	<0.001
Enrollees who bought medications only through retail outlets before policy changes (%)	83.6	88.3	<0.001	85.4	96.3	<0.001
Proton-pump–inhibitor use (no.)	3547	3850		837	1822	
Average monthly probability of use in 6 mo before policy changes (%)	2.5	2.3	0.02	2.7	2.5	0.13
Enrollees who bought medications only through retail outlets before policy changes (%)	91.9	92.7	0.10	96.0	99.1	<0.001
Statin use (no.)	2608	3391		933	1513	
Average monthly probability of use in 6 mo before policy changes (%)	2.2	2.5	<0.001	4.1	2.7	<0.001
Enrollees who bought medications only through retail outlets before policy changes (%)	80.7	88.9	<0.001	89.8	96.7	<0.001

* The total number of enrollees in each group includes those who were enrolled continuously from January 1, 1999, through December 31, 2001. Plus–minus values are means ±SD. ACE denotes angiotensin-converting enzyme.

before the policy change. Many enrollees in the intervention group switched to a drug of a lower tier with lower copayments after the policy changes (41.6 percent of the enrollees taking ACE inhibitors, 35.1 percent of those taking proton-pump inhibitors, and 49.4 percent of those taking statins). A lower proportion of enrollees in the comparison group who used a tier-3 drug switched to medications of a lower tier (4.2 percent, 1.5 percent, and 17.3 percent, respectively; P<0.001 for all three comparisons between groups). A sizable proportion of the enrollees in the intervention group who had used tier-3 drugs before the policy change continued to use a tier-3 medication (42.3 percent for ACE inhibitors, 32.9 percent for proton-pump inhibitors, and 29.2 percent for statins).

Perhaps most important in clinical terms, enrollees covered by the health plan of Employer 1 who had used a tier-3 drug before the policy changes were significantly more likely than enrollees in the comparison group to stop using a drug in the class (P<0.001 for the comparison between groups in the use of ACE inhibitors and proton-pump inhibitors; P=0.04 for the use of statins). In the case of ACE inhibitors and statins, enrollees covered by Employer 1 were twice as likely as their counterparts in the comparison group to discontinue the use of drugs in the given class altogether.

Employer 2

For each class of drugs studied, enrollees covered by Employer 2 who had been using a tier-3 drug before the policy changes were more likely than enrollees in the comparison group to switch to drugs of a lower tier (P<0.001 for all comparisons) but, in contrast to the enrollees covered by Employer 1, were not significantly more likely than enrollees in the comparison group to stop using a medication in the same class (Table 5). In fact, enrollees in the intervention group who used ACE inhibitors were significantly less likely to stop using an ACE inhibitor than users of ACE inhibitors in the comparison group (8.3 percent vs. 15.8 percent, P=0.03). There was no statistically significant change in the probability of use of a drug in any of the classes after we had accounted for any changes in the probability of use by the comparison group (Table 4).

Table 4. Effect of Policy Changes on the Probability of Use of Drugs and on Enrollee, Plan, and Total Spending for Prescriptions Filled.*

Variable	ACE Inhibitors	P Value	Proton-Pump Inhibitors	P Value	Statins	P Value
Employer 1						
No. of users						
Intervention group	2231		3547		2608	
Comparison group	2596		3850		3391	
Change in probability of use in intervention group minus change in probability in comparison group (percentage points)	−24	<0.001	−34	<0.001	−24	<0.001
Change in spending for prescriptions filled in intervention group minus change in spending in comparison group (percentage points)						
Total spending	−0.3	0.59	−3.2	<0.001	−0.7	0.301
Spending by the plan	−58.2	<0.001	−15.3	<0.001	−13.7	<0.001
Spending by the enrollee	+141.8	<0.001	+148.0	<0.001	+117.9	<0.001
Employer 2						
No. of users						
Intervention group	659		837		933	
Comparison group	1087		1822		1513	
Change in probability of use in intervention group minus change in probability in comparison group (percentage points)	−5	0.26	−5	0.32	−2	0.69
Change in spending for prescriptions filled in intervention group minus change in spending in comparison group (percentage points)						
Total spending	+3.1	<0.001	−0.4	0.66	+2.0	0.03
Spending by the plan	−5.6	<0.001	−2.3	0.02	+1.9	0.07
Spending by the enrollee	+7.5	<0.001	+4.9	<0.001	+0.3	0.79

* The estimated percent changes in the probability of use for each class of drugs are predictions based on logit-model results. For the regression models of total, plan, and enrollee spending for prescriptions filled, we transformed the coefficients from the interaction variable for the postchange-period and intervention-group variables to obtain estimates of the percent change in spending. ACE denotes angiotensin-converting enzyme.

Use of Alternative Drugs

We found no evidence that enrollees in the intervention group who had been using tier-3 drugs and who stopped taking all medications in the class after the policy changes switched to alternative classes of drugs more frequently than the enrollees in the comparison group. For example, of the 19 enrollees covered by Employer 1 who had been using tier-3 statins and who stopped treatment, 2 used another cholesterol-lowering drug before the policy changes were implemented, and 1 did so after the changes were implemented; of the 11 enrollees in the comparison group who stopped using statins, 1 used another cholesterol-lowering drug before the policy changes, and 1 used another drug after the changes.

Sensitivity Analyses

We also estimated logit models of the probability of stopping treatment in the intervention group relative to that in the comparison group, with control for age. The results were consistent with those obtained from the descriptive analyses, so age differences between the two groups were not confounding the results regarding the discontinuation of use of a given class of drugs. Finally, in analyses involving a less restrictive definition of use (i.e., including as a user any enrollee who filled at least one prescription during the six months before the policy changes were implemented), the results were qualitatively similar.

Table 5. Drug Utilization after Policy Changes among Enrollees Who Used Tier-3 Drugs before the Changes.*

Drug Class	Continued Use of Tier-3 Drug			Switched to Drug of Lower Tier			Discontinued Use of All Drugs in Class		
	Intervention Group	Comparison Group	P Value	Intervention Group	Comparison Group	P Value	Intervention Group	Comparison Group	P Value
	no./total no. (%)			*no./total no. (%)*			*no./total no. (%)*		
Employer 1									
ACE inhibitors	238/563 (42.3)	421/471 (89.4)	<0.001	234/563 (41.6)	20/471 (4.2)	<0.001	91/563 (16.2)	30/471 (6.4)	<0.001
Proton-pump inhibitors	108/328 (32.9)	219/275 (79.6)	<0.001	115/328 (35.1)	4/275 (1.5)	<0.001	105/328 (32.0)	52/275 (18.9)	<0.001
Statins	26/89 (29.2)	75/104 (72.1)	<0.001	44/89 (49.4)	18/104 (17.3)	<0.001	19/89 (21.3)	11/104 (10.6)	0.04
Employer 2									
ACE inhibitors	79/156 (50.6)	154/222 (69.4)	<0.001	64/156 (41.0)	33/222 (14.9)	<0.001	13/156 (8.3)	35/222 (15.8)	0.03
Proton-pump inhibitors	44/68 (64.7)	111/141 (78.7)	0.03	12/68 (17.6)	3/141 (2.1)	<0.001	12/68 (17.6)	27/141 (19.1)	0.79
Statins	14/33 (42.4)	22/25 (88.0)	<0.001	16/33 (48.5)	2/25 (8.0)	<0.001	3/33 (9.1)	1/25 (4.0)	0.45

* For each class, the analysis includes only the enrollees who filled at least two 30-day prescriptions for tier-3 drugs only in the class in question during the 6 months before the adoption of a three-tier formulary (i.e., a small number of enrollees who had used drugs from multiple tiers before the policy changes were excluded). The rates of continued use of a tier-3 drug, switching to a drug of a lower tier, and discontinuation of use of all drugs in the class apply to the six months after the policy changes. If an enrollee switched to a different drug in tier 3, this was counted as continued use of a tier-3 drug. ACE denotes angiotensin-converting enzyme.

SPENDING ON DRUGS

Employer 1

Table 4 shows the percentage changes in spending for enrollees in the intervention group who filled a prescription as compared with the levels of spending in the comparison group. The estimate of the percentage change is a transformation of the coefficient for the interaction between the variable for the period after the policy changes and the variable for the intervention group from the regression models. In terms of total spending on a given class of drugs for those who filled a prescription, the policy changes had either no statistically significant effect (for ACE inhibitors and statins) or a significant but very small negative effect (a decrease of 3 percent for spending on proton-pump inhibitors, P<0.001) (Table 4). However, the changes had a large effect on the distribution of spending between the plan and its enrollees. After changes in monthly spending by the health plan for enrollees in the comparison group had been accounted for, there were decreases in monthly spending by the health plan for enrollees covered by Employer 1 of 58 percent for ACE inhibitors (P<0.001), 15 percent for proton-pump inhibitors (P<0.001), and 14 percent for statins (P<0.001). Conversely, after changes in monthly spending by enrollees in the comparison group who filled a prescription had been accounted for, there were increases in monthly spending by enrollees in the intervention group who filled a prescription (of 142 percent for ACE inhibitors, P<0.001; 148 percent for proton-pump inhibitors, P<0.001; and 118 percent for statins, P<0.001).

Employer 2

By contrast, the policy changes implemented by Employer 2 had smaller effects on the use of and spending on prescription drugs (Table 4). There were small decreases in monthly spending by the health plan for enrollees who filled a prescription relative to the spending levels in the comparison group for ACE inhibitors (5 percent, P<0.001) and proton-pump inhibitors (2 percent, P=0.02), and there were commensurate increases in spending by enrollees (7 percent and 5 percent, respectively; P<0.001 for both comparisons).

DISCUSSION

The use of incentive-based formularies is intended to prompt consumers to opt for more cost-effective drugs or to pay more for the drug they prefer when it is considered by the payer to be less cost effective. Our results show that two different changes in for-

mulary administration had quite different effects on the utilization of and spending on drugs.

The simultaneous switch by Employer 1 from a one-tier to a three-tier formulary and the implementation of an across-the-board increase in copayments resulted in a shift in the distribution of spending from the plan to the enrollee in all the classes of drugs we studied. Although a sizable minority of patients did change to less expensive tier-1 or tier-2 alternatives, our results show that some enrollees stopped taking medications in these classes altogether. In some situations, such as that of treatment with a proton-pump inhibitor for acid reflux, terminating the use of the medication may be clinically appropriate for many patients. However, the observation is worrisome with regard to patients who have been taking statins and presumably require cholesterol reduction on an ongoing basis.

By contrast, the switch by Employer 2 from a two-tier to a three-tier formulary with no increases in cost sharing for drugs in tiers 1 and 2 had little effect on the probability of the use of a drug, the distribution of spending, or the likelihood of the discontinuation of the use of a medication. The difference between the effects of the two policy changes may reflect the fact that the increases in the copayments implemented by Employer 2 were more limited than those implemented by Employer 1. Although it is common for employers to move to an incentive-based formulary at the same time as they increase copayments, many employers choose, like Employer 2, to make more incremental changes to the design of their benefits.

Our results are consistent with a study by Rector et al., which showed that the adoption of a three-tier formulary was associated with shifts by enrollees from tier-3 to tier-2 brand-name drugs; that study did not examine whether patients discontinued the use of medication altogether.[11] We have no explanation for the finding that enrollees in the comparison group who used ACE inhibitors were more likely than those covered by Employer 2 to discontinue the use of that class of drugs.

Our study had several limitations. We were unable to incorporate proprietary information on changes in the magnitude of rebates from manufacturers that may have resulted from the changes in the formularies, so our estimates of the effects on spending by the health plan and total pharmaceutical spending are likely to be underestimated. Second, the filling of a prescription does not guarantee that an enrollee continues to take the medication for the specified period. It is also possible that the apparent discontinuation of the use of a drug is attributable in part to the filling of prescriptions under a spouse's benefit by enrollees who maintain dual health care coverage, so any adverse effects on the continuation of the use of medications may be overestimated. Third, our findings may not be generalizable to other groups of employers that contract with different insurers or pharmacy benefits managers. Finally, as compared with Employer 2, Employer 1 employs a larger proportion of hourly workers, who are more likely to have lower incomes and thus to be more sensitive to increases in copayments. We cannot be sure that the groups do not differ in terms of unobservable characteristics, such as income, that could influence the effect of the policy changes.

In conclusion, we found large effects on the continuation of the use of medications and out-of-pocket expenditures for enrollees associated with the switch by one employer from a one-tier to a three-tier formulary involving across-the-board increases in cost sharing. In contrast, there were only small effects on these outcomes with the shift by another employer from a two-tier to a three-tier formulary without similar increases in cost sharing. The discontinuation of the use of medications such as statins and ACE inhibitors that are needed for the treatment of chronic illnesses raises important questions about potentially harmful effects of formulary changes and the associated changes in copayments. The different effects observed in the two groups of enrollees covered by different employers show that, when it comes to efforts to understand the effect of formulary design on the utilization of and spending on drugs, the devil is in the details. As three-tier formularies become increasingly prevalent, we need much greater knowledge about these details in order to reap the advantages in cost savings without causing deleterious consequences for patients.

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REFERENCES

1. Gabel J, Levitt L, Holve E, et al. Job-based health benefits in 2002: some important trends. Health Aff (Millwood) 2002; 21(5):143-51.
2. Kaiser Family Foundation and Health Research and Educational Trust. Employer health benefits: 2002 summary of findings. (Accessed November 13, 2003, at http://www.kff.org/content/2002/20020905a/3252a.pdf.)
3. Frank R. Prescription drug prices: why do some pay more than others do? Health Aff (Millwood) 2001;20(2):115-28.
4. Description and analysis of the VA national formulary. Blumenthal D, Herdman R, eds. Washington, D.C.: National Academy Press, 2000.
5. Motheral B, Fairman KA. Effect of a three-tier prescription copay on pharmaceutical and other medical utilization. Med Care 2001;39:1293-304.
6. Motheral BR, Henderson R. The effect of a closed formulary on prescription drug use and costs. Inquiry 1999/2000;36:481-91.
7. Huskamp HA, Epstein AM, Blumenthal D. The impact of a national prescription drug formulary on prices, market share, and spending: lessons for Medicare? Health Aff (Millwood) 2003;22(3):149-58.
8. Horn SD, Sharkey PD, Phillips-Harris C. Formulary limitations and the elderly: results from the Managed Care Outcomes Project. Am J Manag Care 1998;4:1105-13.
9. Joyce GF, Escarce JJ, Solomon MD, Goldman DP. Employer drug benefit plans and spending on prescription drugs. JAMA 2002;288:1733-9. [Erratum, JAMA 2002; 288:2409.]
10. Thomas CP, Wallack SS, Lee S, Ritter GA. Impact of health plan design and management on retirees' prescription drug use and spending. (Accessed October 6, 2003, at http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.408v1.pdf.)
11. Rector TS, Finch MD, Danzon PM, Pauly MV, Manda BS. Effect of tiered prescription copayments on the use of preferred brand medications. Med Care 2003;41:398-406.
12. D'Agostino RB Jr. Propensity score methods for bias reduction in the comparison of treatment to a non-randomized control group. Stat Med 1998;17:2265-81.
13. Cook TD, Campbell DT. Quasi-experimentation: design & analysis issues for field settings. Chicago: Rand McNally College Publishing, 1979.
14. Manning WG, Newhouse JP, Duan N, Keeler EB, Leibowitz A, Marquis MS. Health insurance and the demand for medical care: evidence from a randomized experiment. Am Econ Rev 1987;77:251-77.
15. Huber PJ. The behavior of maximum likelihood estimates under non-standard conditions. In: Proceedings of the Fifth Berkeley Symposium on Mathematical Statistics and Probability. Berkeley: University of California Press, 1967:221-33.
16. White H. A heteroskedasticity-consistent covariance matrix estimator and a direct test for heteroskedasticity. Econometrica 1980;48:817-30.

PREPARED STATEMENT OF JOHN M. BERTKO, F.S.A., MAAA
VP AND CHIEF ACTUARY, HUMANA, INC.

Thank you for your invitation to present early experience with consumer-centric health insurance products from Humana, Inc. and additional observations relating to the experience of the health insurance industry. My name is John Bertko and I am the Vice President and Chief Actuary for Humana, Inc. Humana is one of the country's largest regional health insurers and is a leader in design and implementation of consumer-centric health products. With over 6 million total members and 3 million commercial members in 15 major states, Humana has a cross-section of the country's insured consumers in its variety of traditional and consumer-centric products.

Today, Humana has over 200,000 under-65 members enrolled in our consumer-centric products, roughly 7% of our total non-governmental business. This number has grown dramatically in one year from the roughly 40,000 enrolled as of January 1, 2003. From our market research, we believe that Humana ranks second in membership in true consumer-centric products, if defined as products with a spending account. Overall, we estimate that there are roughly 1 million Americans enrolled in some form of consumercentric product with a spending account. (This number at least doubles if various choice products with multiple options but no spending accounts are included in the total.)

We expect that this number will at least double again during 2004, perhaps growing even faster as more employers and consumers become interested in consumer-centric products and more insurers enter the market. At this point, we believe that most employers that offer these products are the "early adopters." By January 1, 2005, we expect Humana will have from 400,000 to 500,000 members enrolled in its consumer-centric products.

The good news, at least from Humana, is that the consumer-centric concept succeeds by giving individuals incentives to choose health care services and options that are right for them in a total replacement solution by providing the information and tools to make their choices easier. Before providing a summary of our early experience, let me give a very brief description of the Humana consumer-centric solution.

HUMANA'S CONSUMER-CENTRIC SOLUTION—SMARTSUITE SM

First, Humana believes in the social contract of insurance—that the healthy must subsidize the sick. It is critical that all employees, those who use few or no services (the healthy) and those who use many services (the high users) remain in the same risk pool for insurance coverage. In order to maintain the integrity of this risk pool, the employer must provide a subsidy for the high use employees and blend these funds with contributions from employees with average, high or low utilization of services.

Based on this premise, Humana, unlike its competitors, markets a "total replacement" solution. Employers choose from a variety of bundles of products containing traditional products (i.e., HMOs and PPOs) and high deductible or "consumer-centric" products for which we create rates to maintain affordable coverage for all products. Each employee then chooses his or her own option from the products offered in the bundle.

Humana's consumer-centric options typically have an allowance or spending account of between $500 and $1000 for the employee to "choose and use" health care services. Each employee has control over those dollars, to spend on preventive care, office visits, imaging or lab tests or other services. After this allowance is exceeded, the employee must meet a deductible, generally in the range of $1500 to $3000. Expenses above this deductible are then covered by true catastrophic insurance with low cost-sharing (generally 10% or less).

EMPLOYEE CHOICE

Experience shows that today most employees do not make an active choice of health insurance coverage each year. Most employees default to the coverage they had the previous year. Humana experience reveals that when employees have to make an active choice each year, they make more meaningful choices if given good information and tools. In the Humana scenario, each employer is strongly encouraged to have a "positive open enrollment" for its employees during which time employees examine all options. Employees use a "wizard" to help them learn about their plan choices and estimate cost of services they or their family might use in the coming year based on previous year's claims' experience. Then, based on this information, the employee or family makes a decision as to whether they would pre-

fer to pay for their coverage through lower payroll deductions and higher costs at the point when they need services or choose higher payroll deductions and lower costs at the time they seek services.

IMPORTANCE OF COMMUNICATIONS

Initial and ongoing educational communications are critical to the success of the consumer-centric approach. In our approach, employees and dependents are provided with Web-accessible decision-support tools that show how much they have spent, different cost levels and, to the extent available, quality information about providers. We want our members to think about what services they obtain, at which site of care they want to seek services and the quality and efficiency of their providers.

Also critical in the educational process is the public availability of comparative cost and performance data. States like Pennsylvania, New York and Wisconsin have taken the lead in publishing this kind of consumer information on their Web sites. The Centers for Medicare and Medicaid Services (CMS) has begun to publish some data for health plans, nursing homes and home health agencies. Just as they do in all other areas of their lives, consumers make better choices when they can compare cost and quality information. We encourage you to advocate for faster disclosure of this kind of information at the federal level.

EARLY EVIDENCE OF SUCCESS

Through our experience, first with Humana employees as a pilot group, and now with customers and their employees, we've learned many lessons. We have provided a significant amount of this information to health services researchers as part of outside independent assessments of our data. However, I need to point out that it is still "early" and the data should be viewed as good indicators rather than fully credible proof that the concept works.

From Humana's perspective, we view our results as representing the effects on "health systems in miniature"—using an employer as a risk pool and measuring what happened from year to year. The following evidence represents a summary of the last 2½ years of experience, for both Humana's pilot initiative for its own employees and then for Humana's "early adopter" customers.

ADOPTION AND ENROLLMENT IN CONSUMER-CENTRIC OPTIONS

As of mid-February 2004, Humana has 125 employer customers, with over 200,000 members in consumer-centric solutions and products of all kinds. These customers are evenly distributed across our major states and in a variety of industries, from financial companies to hospitals to school districts to restaurant industry companies.

As I previously mentioned, in Humana's solution, individual consumers choose between traditional products and consumer-centric options. While early enrollment in the consumer-centric option was a low percentage at both Humana and its competitors in 2001, by 2003 nearly 28% of members were enrolled in consumer-centric options, with other employees remaining in traditional options. Humana believes that most employers will want to continue offering both traditional and consumer-centric options, while encouraging efficient behavior.

COST TREND EXPERIENCE

Cost trends have been significantly reduced by enrollment in these products. And, because Humana views these trends across the whole "employee health system," we've seen a significant impact on traditional as well as consumer-centric options. In our Humana employee pilot, we started with 10,000 Humana Louisville employees and their dependents on July 1, 2001. As measured a bit more than a year later in late 2002, our average health care trend was 4.9% (the year-over-year total increase) versus an average trend in the Louisville market of around 15% (after benefit buydowns). In Year 2, we extended this solution to our 14,000 non-Louisville employees and dependents and achieved a trend of 1.4%, attributable in part to "word of mouth" and a greater 20% enrollment in the consumer-centric option. The same year, Humana offered its Louisville employees a next generation solution with even more customizable features, including Health Reimbursement Accounts. This solution's trend was 2.7%. All of these trends compare to mid-double digit trends in the rest of the traditional marketplace in 2001 through mid-2003.

Similar cost trends are now emerging in our customer block of business. As of January 2004, we have credible claims trend experience on 43 of the 125 employers (many just enrolled as of January 1, 2004), covering 48,000 insured members. The

early evidence for these groups points to an average trend in a range between 5% and 8%. We update this experience monthly and the results have been consistent through 2003.

EARLY EVIDENCE OF UTILIZATION AND BEHAVIORAL CHANGE

All of Humana's detailed cost and utilization evidence is derived from analysis of the experience of our 24,000 employees and dependents. It is too early to look at the results of covered customer members since analysis of actuarially credible data requires 12 full months of data, plus a minimum of three months of "run-out" claims to allow for processing of utilization "in the system."

Based on the Humana experience, we first find that there is significant favorable selection by the "early movers" into consumer-centric options. In Year 1, these "early movers" (6% of employees and dependents) of Humana members had prior claims that averaged only 53% of the average cohort. In Year 2, with now 20% of members in the consumercentric option, these healthy individuals averaged around 50% of the average cost. They are clearly healthier, although were approximately the same age, on average.

The next question is "Why did claim trends decrease to single digit levels?" Our early experience indicates that several types of behavioral change accounted for most of the trend reduction. First, employees chose themselves to migrate to lower cost options, thus reducing their payroll deductions, in some cases from approximately $20 per pay period for a single employee to $5 per pay period.

Another significant factor appears to be a change in site of care for receiving services. Visits to emergency rooms and use of other outpatient services decreased relative to Humana's market averages, while use of physician office visits increased somewhat. In addition, more prescription drugs were used, generally consistent with more office visits. We believe that many of Humana's employees chose to make greater use of their physicians in office settings, where the doctor's knowledge of his or her patient likely leads to better quality care, while eliminating unnecessary costs associated with emergency room visits or other outpatient services. Exhibits 2 and 3 provide a summary of the behavioral changes that shows the consumer-centric solution (SmartSuite SM) vs. Humana's market averages.

In addition, about 200 employees chose to waive coverage. We checked with all of them and all but one had coverage elsewhere (generally through spousal coverage). Reduction of duplicative coverage frequently means that use of unnecessary services is diminished.

Last, there was some element of buydown of coverage in this pilot, since Humana added a hospital copay to all of the traditional benefit options.

USE OF COMMUNICATIONS AND SHARED-DECISIONMAKING TOOLS BY CONSUMERS

Humana strongly stresses the need for employers to embrace and communicate the message of employee participation in their health care decisions. For the employer, we provide a package of communications materials tailored to explaining the consumercentric solutions, from messages from senior management to payroll inserts to newsletters to posters.

For employees, Humana makes use of on-line enrollment applications, a wizard to assist employees in making health care option decisions, and a "PlanProfessor SM" to provide background information on how to maximize their benefits and options. To date, we have had 102 of our employer customers make use of the wizard and had nearly 100,000 unique users log in. The wizard leads consumers through a series of questions about their prior utilization of services, their preferences for physicians and hospitals and the tradeoffs between lower payroll deductions and lower point-of-service cost-sharing. This tool provides options to:

- "Narrow My Choices"
- "Tailor My Benefits"
- "Balance My Cost"
- "Tell Me How Much Will I Spend?"

The wizard and the on-line application allow specific information to be provided to consumers without overwhelming them with data. Access to the applications can be provided through work desktop computers, home computers, kiosks at work locations or through the Internet at libraries or other public facilities.

THE HEALTH INSURANCE INDUSTRY HAS EMBRACED CONSUMER-CENTRIC PRODUCTS

In my opinion, the health insurance industry has generally embraced consumercentric products. Humana and nearly all of our major competitors offer some version of a product with health spending accounts or multi-option choice product. These

products come in many variations but all make the point of increasing consumer involvement in the "choose and use" health services process.

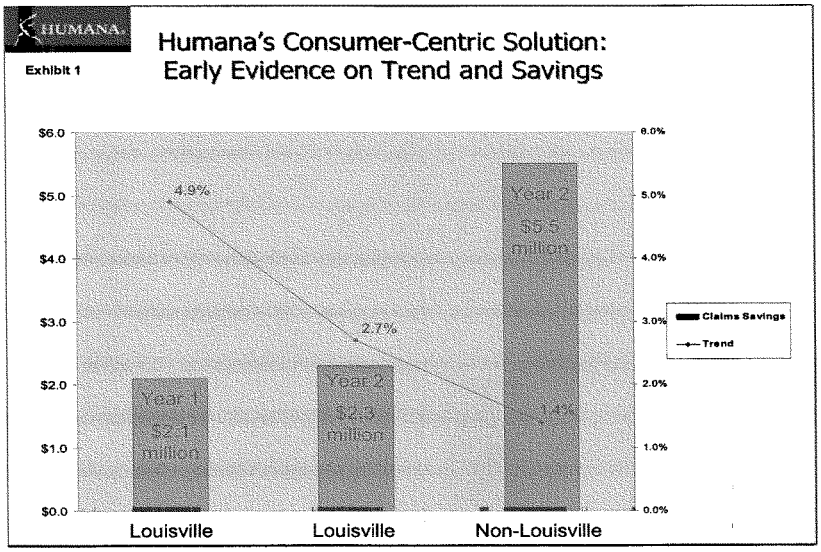
Since the Department of Treasury issued a statement clarifying the position of Health Reimbursement Accounts (HRAs) in June 2001, most large insurers have included these accounts in their products. HRAs have considerable flexibility in plan design and generally use "notional" dollars in accounts that are available to employees but allow balances at the end of a year to roll-over to be used in future years. "Notional" dollars are accounting credits, like airline frequent flyer miles, that can be used later but are not cash contributions. Between 30% and 50% of employees have some of their HRA amounts remaining to be rolled over. Use of the rollover amounts depends on the employer's plan provisions, but they may be used for paying down deductibles or coinsurance in future years, for COBRA coverage or for retiree benefits. Generally, I don't believe most employers allow the accounts to be portable.

As you know, Health Savings Accounts (HSAs) were included in the Medicare Modernization Act (MMA) signed into law in December 2003. Many health insurers either already have HSA products on the markets or are in the process of developing and filing these products today. HSAs use actual cash contributions into an account (in contrast to the notional dollars used with HRAs) and are truly portable for consumers. There are, however, certain legislated constraints on plan design that may reduce the appeal to some consumer segments.

In my opinion, HSAs will have enormous appeal in the individual health insurance market where most products sold today have deductibles large enough to qualify as high deductible health plans to meet the HSA requirements. In addition, HSAs are likely to replace the Medical Savings Accounts available to small employers. In the larger employer market, it appears to me that Health Reimbursement Accounts (HRAs) may continue to have somewhat greater appeal, due to their greater flexibility of plan design and the ability of employers to use them to increase employee retention.

SUMMARY

Consumer-centric products will be the focus of attention in employer-sponsored and individual health insurance over the next few years. Getting consumers involved in the "choose and use" decisions about their health care coverage is essential to reducing the health care cost burden. HRAs and HSAs are likely to emerge as common product features available to most American workers and their families and will be a necessary component of a strategy of communication, shared decision-making and choice.



The trend reduction translated to savings of $2.1 million. The trend reduction translated to savings of $2.1 million. More than half of that amount - a total of $1.4 million - was the result of changes in employee behavior.

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SmartSuite Year 1 • Early Evidence

Exhibit 2

Change in Utilization for Louisville Employees/Dependents

Category	Statistic	SmartSuite℠ Change	Market Change
Hospital Inpatient	Adm/1000	-14.4%	2.0%
Hospital Outpatient	Units/1000	-0.1%	8.2%
Physician	Units/1000	16.9%	13.3%
Rx	Scripts/1000	5.5%	1.9%

Note: Preventive Services increased by 14% over the prior year

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SmartSuite Year 2 • Early Evidence of Behavioral Change

Exhibit 3

Change in Utilization for Humana Non-Louisville Employees/Dependents

Type of Service	Utilization Change SmartSuite℠	Utilization Change Market
Inpatient	-18%	-1%
Outpatient	+1%	-1%
Office Visits	+19%	+14%
Physician -- Total	+10%	+11%
Medical – Total	**+5%**	**+13%**
Rx	0%	+4%

PREPARED STATEMENT OF HOWARD LEACH, HEAD OF HUMAN RESOURCES, LOGAN ALUMINUM, INC.

Good morning, Mr. Chairman and members of the Committee. I am Howard Leach, head of human resources for Logan Aluminum, a world class manufacturer of aluminum sheet products located in Logan County, Kentucky, with a workforce totaling 1,000 employees. Thank you for the opportunity to testify before you today.

I am delighted to share with you the practical side of the consumer-directed experience at Logan Aluminum. Like many employers, in recent years our business experienced annual health-care cost increases of 20+ percent, which, simply put, is not sustainable and not in the best interest of our business or our employees. Traditional approaches to the management of health care costs have been limited primarily to employers absorbing costs, shifting costs to employees or reducing benefits. Logan realized these solutions would not be effective long term, and it was just a matter of time until neither employers nor employees could afford the cost of health care.

As a business facing intense competition and cost pressures, we chose consumer-directed health because we saw its potential to help hold the line on a disturbing cost trend. But we also made this decision for the benefit of our employees. Now, with more than a year's experience in a consumer-directed plan, I am here to testify to the fact that we made the right call and, just as important, I believe our employees feel we made the right call. Looking back at our experience in 2003, we have determined that this approach has more than met our expectations in several important regards, specifically:

- Consumer-directed health care is a perfect match for any company, such as ours, that is motivated by a desire to control long-term health care costs through a healthier, responsible workforce. We provide incentives for our employees to complete an annual health risk appraisal, and we now have a 99.7 percent completion rate.
- By encouraging employees to be wise consumers of health care services, consumer-directed health care can help reverse unsustainable health care cost trends. As a self-funded benefits plan, we were able to realize an 18.7 percent reduction in our total medical costs in 2003 over 2002.
- And, most importantly, consumer-directed health care did not negatively impact our employees' use of preventive health services and the care needed for serious medical issues. In fact, hospital days of care were up 4.4 percent in 2003.

A TEAM-BASED CULTURE

To fully appreciate our enthusiasm for the consumer-directed approach, it helps to understand our company's culture. While employing roughly 1,000 people in our Russellville, Kentucky plant, we have established a team-based culture that emphasizes employee involvement in nearly every facet of the operation.

We look at our employees as partners. With the help of a 20-member employee committee, we engage our people in thoughtful discussions several times a year about health care costs. These employees, in turn, disseminate information about these issues with other smaller groups of employees in the workplace. This helps keep every employee aware of health care issues affecting our business.

We are proud of the fact that we have historically offered employees an excellent, competitive benefits package including comprehensive medical coverage. We have been very fortunate in not having to ask employees to pay a percentage of premium, and under the new consumer-directed health care plan, we still don't. In the past, the only out-of-pocket costs employees were liable for was a $15 co-pay for in-network doctor visits.

When health care costs became more of a concern in the early 1990s, we decided that the best way to tackle rising costs was to get at the root causes through a strong focus on prevention. We implemented a wellness program—managed by an onsite wellness director—that emphasizes regular health care screenings and critical lifestyle changes. We have an onsite medical department that includes a part-time doctor and two nurses.

Employees are encouraged to routinely take advantage of health care screenings, including an annual physical, onsite and at no charge. The program also supplies our employees with a variety of information designed to help them better understand how they can improve their health outlook through a healthy lifestyle. Because we want our employees to be actively involved in managing their own health, we follow up these educational efforts with health risk appraisals that are evaluated by an outside vendor.

The individual results are confidential—only the employees see their individual assessments. High-risk employees are identified and then contacted by the vendor

and encouraged to participate in an intervention program. About 250 employees have been identified as at-risk, and 90 percent of them are now participating in health management activities. Logan Aluminum sees aggregate results only, helping us to identify health-related issues across our employee population as a whole. This allows us to concentrate our educational efforts and incentives on developing health issues.

Through follow-up health risk assessments, we know we have had an impact. Results show improvements in body mass index, tobacco use, seatbelt use and exercise activity across our employee population. Right now 25 percent of our employees are using the company fitness center, and 10 percent are in weight reduction programs. Anecdotally, we have all been extremely gratified to hear that health screenings have caught cancers early while still treatable. However, despite these significant trends in the '90s, we did not get all the behavior changes we had hoped for. And, when costs began to rise dramatically several years ago, we knew we had to respond aggressively.

Late in 2001, we assembled a task force made up of seven individuals with the expertise needed to examine the problem effectively. After extensive research and analysis, the group reported back to senior management the following spring that it was recommending a consumer-directed health care model. The task force reasoned that consumerism offered not only a solid chance of helping to slow costs but of fitting well with our focus on wellness and behavior modification. Consumer-directed health care, in fact, reinforces the importance of healthy lifestyle choices and becoming a wise consumer of health care. Employees also are encouraged to set individual wellness and team wellness goals, which are rewarded with additional company incentives.

CONTINUOUS INFORMATION IS KEY

We very quickly communicated with our employees about the need to make a change in health care benefits. Initially, there were many questions and a few concerns about adopting a consumer-directed approach, but we responded as best we could with the promise of more information to come. When management approved the health benefits change, we returned to employees with more information about how the plan would work. A couple of months later, we went back again with more detailed information and reading materials to help familiarize our employees, their dependents and retirees with the specifics of the plan.

We selected Aetna HealthFund as our consumer-directed health care plan. Having enjoyed a long relationship with Aetna, we determined that this would minimize disruption to employees and allow us to continue to utilize Aetna's extensive PPO network in our area.

Throughout the implementation process, we emphasized that Logan Aluminum's philosophy remains unchanged. We want our employees to be healthy, wise consumers, and we are providing the tools needed to help make that happen. We continue to provide access to free, onsite physicals. We also provide incentives to employees who participate in the health risk appraisal program and in wellness programs—up to $250 in cash per year, per employee, if certain aggregate goals are met.

Consumer-directed health care complements these efforts by encouraging employees to assess the value and quality of health care services available to them. Preventive care is included as is treatment for more serious medical conditions, after the deductible has been met. In fact, with employees in the health plan now having access to a health reimbursement account, we implemented an additional $200 incentive to be applied to the employee's account if he or she completes the health risk appraisal. As a result, 99.7 percent of our people now complete the health risk appraisal, and we are paying out $418.75 in total incentives to each employee for 2003.

With the help of online tools provided by Aetna, employees now are getting a better understanding of the true costs of health care. This information is helping them make informed choices among the options recommended by their physicians. Our employees generated more than 15,000 hits to the online Aetna site in 2003.

The end result is that, over the course of 2003, employee concerns and questions virtually dried up. Our annual employee survey at the end of 2003 showed virtually none of the health care concerns expressed in 2002, before the plan was implemented.

While the deductible in the plan does have the potential to increase out-of-pocket costs, employees still do not pay monthly premiums. And, employees know that if they maintain good health they can save some portion or all of their health reimbursement accounts and roll them over to another year—decreasing the potential out-of-pocket exposure in the following year. Again, they also know that full cov-

erage kicks in once the Aetna HealthFund reimbursement account is exhausted and the deductible is met.

Our results from 2003 show that average employee out-of-pocket costs did go up in the consumer-directed health plan from $240 to $665. However, the net effect after wellness incentives was an increase of only about $200 per employee. And, the results compare favorably with national averages. Hewitt Associates (October 2003) projected that the average employee contribution toward health care expenses would reach $1,565 in 2004, up from $1,276 in 2003.

SIGNIFICANT IMPACT ON COSTS

As I alluded to earlier, we are seeing truly impressive results after just one year in Aetna HealthFund. While expanding on our efforts to promote wellness and informed decisionmaking, we saw a reduction of 18.7 percent in our total medical costs in 2003. This represents an improvement of $925,000 to the company's bottom line. It's all the more remarkable when you consider that 13 and 14 percent increases are currently routine for alternative health care plans.

Similarly, we implemented a new, three-tiered pharmacy plan in 2002 that charges employees a co-pay for generic prescription drugs, a higher co-pay for preferred brand-name drugs and a higher-yet co-pay for non-preferred, brand-name drugs. After five years of near-20 percent increases in our pharmacy costs, we saw a 5 percent reduction in the first year under the new plan and an additional 3 percent reduction in 2003.

We recognize that these results represent only a short period of time, but we are very encouraged that we are moving in the right direction.

EMPLOYEES GET NEEDED CARE

We also are encouraged by utilization data that shows employees continue to enjoy access to the care they need. One of the best indicators of that could be hospital days of care, which increased 4.4 percent per 1,000 members in 2003. Inpatient surgeries were up 4.2 percent, an additional indication that employees are getting appropriate treatment for serious health events.

Use of health care services in some other settings, however, did drop off. For example, office visits per 1,000 members fell 6.3 percent. Emergency room visits dropped 2.1 percent. Since emergency rooms are a high-cost environment in which to receive care and should be used for true emergencies only, we think these results actually demonstrate that employees are giving serious consideration to their health care options and are making appropriate choices.

CONCLUSION

Logan Aluminum is committed to providing its employees with quality health care benefits in a cost-effective manner, and we remain committed to the active involvement of our own employees in helping to manage these costs through better management of their own health. Consumer-directed health care is helping us do that.

It's hard to overemphasize how big a threat rising health care costs have become to the competitiveness of American businesses today. Consequently, quality, affordable health care is extremely important to us from a business standpoint. But our passion and excitement for consumer-directed health care comes not just from a business objective met, it comes from a truly innovative solution that allows us to continue being the kind of company in which we have always taken pride.

In consumer-directed health care we have found an approach that provides employees with the health care services they need, helps make our employees wiser, more educated consumers, and holds the line on costs. I call that a win-win by any measure.

We will continue to watch the results of our new health plan. We will continue to talk to our employees to make sure the plan continues to meet our collective needs and that employees have the information they need. But if I'm certain about one thing it's that consumerism needs to move forward so that its potential for helping all of us to become better, more intelligent consumers of health care is realized.

Logan Aluminum very much appreciates the opportunity to testify before the Committee today. I hope the perspective of a company on the front lines of today's fast-evolving health care landscape has been informative and useful. We know how promising the consumer-directed health care movement has become to us. We would very much encourage Congress to do what it can to ensure that this important new approach to health care is given every chance to demonstrate what it can do. We

all need to be participants in a health care benefits solution. Consumer-directed health care readies us better than anything I can think of for this new era.

Thank you.

PREPARED STATEMENT OF GAIL SHEARER, DIRECTOR OF HEALTH POLICY ANALYSIS, WASHINGTON OFFICE, CONSUMERS UNION

So-called "consumer driven" health care plans, which have defining features of high-deductible coverage and (possibly) tax-advantaged employer contributions to health reimbursement or savings accounts, may create serious problems for the U.S. health care system. Consumers Union believes that this coverage is misnamed, misguided from a policy perspective, and a dangerous distraction from the need to solve the health insurance crisis that faces 43.6 million uninsured consumers and tens of millions of underinsured consumers. Our testimony also addresses issues raised by health savings accounts, as included in the recently enacted Medicare bill and the President's new proposals. These proposals are likely to accelerate the erosion of current coverage by adding tax benefits for high-deductible coverage.

We take issue with the growing use of the term "consumer-driven" to refer to the transformation of the health care system to one characterized by high-deductibles. "Defined contribution" health care would be a more accurate shorthand way to refer to a health care approach that essentially increases deductibles and shifts costs to sicker employees. Many employees with chronically ill or seriously ill family members will not view this transformation as consumer-friendly, despite the name.

The recent expansion and renaming of medical savings accounts and the President's proposal for a new tax deduction are more likely than previous efforts to transform the health insurance marketplace to one characterized by high deductibles. The Economic Report of the President makes it clear that this is the intention; the Administration frames the problems in the health insurance marketplace as *too much* rather than *too little* insurance. The Report establishes the ideal health insurance marketplace as one in which high-risk consumers face health insurance premiums consistent with their risks, explicitly rejecting the current goal of health insurance markets of spreading risks broadly across the community. At the same time, the Report ignores the reality that the uninsured and underinsured face severe health consequences, even bankruptcy or death, because of the lack of adequate insurance. The Administration's proposals, which boost "consumer-driven" health care, will shift more costs to those who are sick.

While the Administration proposals will undermine employer-based health insurance and shift more to the individual insurance market, that market underwrites risks carefully and does not make affordable, comprehensive coverage available to individuals who have pre-existing conditions. The underlying nature of the population's health status—in which risks vary widely—makes the health insurance market different from other markets such as the market for cars or toasters. Individuals with underlying health risks benefit from employer coverage or other large pooling arrangements (e.g., public programs), since this spreads risks broadly. For those covered by employer health plans now, the average cost (in 2000) was about $2,600, but those in the top tenth of spending had average costs of about $16,700.

Because of the combination of variation in risks (which lead to different health insurance selections), and higher tax brackets and ability to meet high deductibles, HSAs will appeal disproportionately to the healthy and wealthy. Many economic analyses, including the American Academy of Actuaries, have reached the conclusion that this type of high deductible health insurance will fragment the risk pool, shift costs to the sick, and ultimately drive low-deductible coverage out of the market since it can not exist side-by-side in the marketplace with high-deductible coverage because of the underlying nature of the health insurance market.

"Consumer-driven" health care is likely to aggravate the problem of the *underinsured* since individuals with moderate income are likely to face out-of-pocket health care costs (and premiums) that exceed ten percent of their income.

The focus on transforming our health care marketplace to one characterized by high-deductible policies is a dangerous distraction from the urgent national goal of extending affordable, quality health coverage to all.

CONSUMERS UNION TESTIMONY ON "CONSUMER-DRIVEN" HEALTH CARE

INTRODUCTION

Employers, who provide health insurance for about 60 percent of the U.S. population, are increasingly under pressure to constrain their spending on health insur-

ance premiums, which have been growing in recent years at an annual rate of 5 to 8 percent. This pressure is aggravated by the recent weakness in the economy. One way to reduce the employer premiums for health insurance, and to make payments more predictable, is to switch to a "defined contribution" approach to health insurance, similar to the shift in recent decades from defined benefit pensions to defined contribution pensions. In the employer health insurance market, a key distinguishing feature of its effort to move toward a defined contribution model is high-deductible coverage. As indicated by the title of the Joint Economic Committee hearing, the term that insurers and employers have coined to name this new trend in the marketplace is "consumer-driven health care." Consumers Union, [1] which appreciates the opportunity to present our views to the committee, is troubled by this trend in the marketplace. In our testimony, we plan to explain why we believe this type of coverage is misnamed, misguided from a policy perspective, and a dangerous distraction from the health insurance crisis that faces 43.6 million uninsured consumers and tens of millions of underinsured consumers.

MISNOMER: "CONSUMER-DRIVEN" HEALTH CARE IS BETTER CALLED "DEFINED CONTRIBUTION" HEALTH CARE

Defining features of so-called "consumer-driven health care" plans tend to be high deductible policies (e.g., $5,000), combined with a contribution by the employer to a health care savings account, at a level that leaves the consumer exposed to some out-of pocket costs before the high-deductible is met. For example, the employer might provide $2,000 toward a family's health reimbursement account, and offer a deductible of $5,000. (Often, the employer provides additional access to information about health care choices, such as information about managing certain diseases.) "Consumer-driven" implies that consumers have a full range of choices, and are in the driver's seat calling the shots. The problem with this is that too many consumers are not in control of their health care out-of-pocket costs or health coverage. An employee with a seriously, chronically ill child, for example, will not be able to accumulate a nest egg in a health reimbursement account, and will face high out-of-pocket costs each year. A consumer with an income in the range of $25,000 to $30,000 will suffer financial hardship if they face out-of-pocket costs as high as $3,000 a year. An employee with existing health conditions such as high blood pressure or diabetes will face very limited choices in the individual marketplace if his employer decides to "cash out" its health insurance plan and send employees into the individual market for coverage. This type of policy appears to be driven largely by the employer's desire to curb its health care expenditures. The term "consumer-driven" may well mislead employees and the public about the true impact of this type of coverage.

THE MEDICARE BILL AND ADMINISTRATION PROPOSALS ACCELERATE THE TRANSFORMATION OF THE MARKETPLACE TO ONE CHARACTERIZED BY HIGH DEDUCTIBLE COVERAGE

The year 2003 may well go down in health care history as the year that the health care system began to rapidly evolve toward a system characterized by health insurance deductibles in the range of $1,500 to $2,000 for individuals and $2,500 to $5,000 for families, instead of deductibles that are around $250 for individuals and $500 for families. "Consumer-driven health care" plans in the employer benefit system are one mechanism for movement toward high deductibles. The expansion of medical savings accounts (renamed as Health Savings Accounts or HSAs) in the Medicare Modernization Act is another major step toward high deductible coverage as the norm. Because employer and employee contributions to HSAs (when accompanied by a high deductible policy) will be shielded from taxes, it is likely that this financial incentive will stimulate substantial rapid expansion.

The Administration's additional proposal for making premiums paid for high deductible policies tax deductible is likely to boost the popularity in the marketplace substantially and dramatically exacerbate market segmentation. While supporters of

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the state of New York to provide consumers with information, education and counsel about good, services, health and personal finance, and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with more than 4 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support

MSAs, HSAs and "consumer driven health care" initially argued that consumers should have a choice of this type of high-deductible coverage, recently they have spoken more openly (to their credit) about their intention to transform the health care system to one in which high-deductible policies are the norm. This is a more honest approach to pretending that high-deductible and low-deductible policies can exist side-by-side in the marketplace, when the nature of varying risks in the marketplace, and adverse selection, make this impossible. This year's Economic Report of the President [2] clearly indicates the Administration's opposition to health insurance coverage for relatively routine health care needs; a key policy recommendation (for tax deductions for premiums for high deductible policies) clearly indicates the Administration's preference for a high-deductible health insurance system. Similarly, former House Speaker Newt Gingrich has spoken about his goal of transforming America's health care system into one characterized by high deductible coverage.

Despite the theory (as expressed in the Economic Report of the President) that health insurance with higher deductibles will lead to consumers shopping around for health services (based on price and quality), the reality of health care needs (often requiring timely care, often requiring decisions by doctors, not patients) and inadequate information in the marketplace about health care quality and prices, precludes the workability of a "consumer-choice" type of model. Even if perfect information about price and quality were available on an instant basis, it is the doctor who ultimately makes judgments about needed care. Another problem with the theory is that most health care expenditures are incurred in the course of very serious illness, after the deductible (and probably the stop-loss) have been met, thereby negating any curbing of expenditures that would be based on patients' financial incentives. Instead of reducing aggregate expenditures, such policies are more likely to shift even more costs to consumers.

THE PRESIDENT'S ECONOMIC REPORT FAILS TO RECOGNIZE THE COSTS INCURRED WHEN CONSUMERS ARE UNINSURED AND UNDERINSURED

The focus of the President's Economic Report chapter on health insurance is more on the alleged problems of over-insurance rather than the problems associated with the lack of insurance and underinsurance. The chapter could be a primer for a Health Economics 101 course on the virtues of an unfettered free market for health insurance: the reader learns about different consumption choices that consumers make when they have insurance. It posits that patients might over-consume services if they face too little cost-sharing. *Insurers* might be disadvantaged because applicants know more about their health status than the company does. The lack of insurance is a matter of choice for the uninsured who opt out of employer coverage or fail to enroll in public coverage.

The report suggests that in an ideal world, the insurer would have complete information about the applicant's health status, and this would enable the insurer to more easily discriminate in pricing between the healthy and the potentially sick: "If insurers could distinguish among different types of consumers, policies could be tailored to specific types and priced accordingly." As Paul Krugman pointed out in *The New York Times* recently, this approach would lead to insurance companies denying coverage for dialysis if new insurance company tests indicate that they are likely to experience kidney problems later in life. [3]

Nowhere in this chapter is there recognition of the reality that faces millions of Americans every year: For the most part, people are not uninsured out of choice, but because they can not afford to pay health insurance premiums. Every day, uninsured and underinsured Americans are dying because of the lack of insurance. An Institute of Medicine study reported that an uninsured woman diagnosed with breast cancer is 30 to 50 percent more likely to die than a woman with private health insurance. The record is clear: uninsured people get inadequate care. Cancer patients die sooner when diagnosis is delayed; uninsured people with diabetes are at greater risk of uncontrolled blood sugar levels and hence are at risk of additional chronic disease and disability; and adults with mental illness who lack mental health coverage are less likely to receive mental health services consistent with clinical practice guidelines.[4] When the marketplace shifts to one characterized by pricing to risk, as suggested by the President's Economic Report, this leads to escalating premiums for the very people who can least afford them—people who face serious

[2] P. 200, Economic Report of the President, February 2004.
[3] Paul Krugman, "The Health of Nations," *New York Times*, February 17, 2004.
[4] *Care Without Coverage: Too Little, Too Late,* Institute of Medicine, 2002, pages 3-11.

health challenges. In addition, unreimbursed health care costs are a leading cause of bankruptcy, and contribute to half of all bankruptcies.[5]

The United States is the only industrialized country in the world that would consider "pricing to risk" instead of spreading health care costs broadly across the population. A World Health Organization report found that the U.S. had the highest per capita health care spending, but rated 54th (of all the countries in the world) when it comes to fairness of financial contribution.

I would like to share a personal story that is a stark reminder of the irony that a country as rich as ours fails to provide health coverage to all. A cab driver, who came from Egypt over 20 years ago, had experienced health care in Egypt (with a per capita income about one tenth the level of the United States) with health care in America. He reported to me how a U.S. doctor marveled over his high-quality scar from stitches received in a major abdominal operation, all at no cost to him. In contrast, his wife, recently diagnosed with breast cancer, is receiving court notices for her failure to pay bills for a mastectomy, even though there had been assurances that her treatment would be covered by subsidies. He posed the question to me: how can a country this rich put such a financial burden on people who are seriously ill?

The Administration's proposals, which boost "consumer-driven" health care, by design, shift more costs to those who are sick. The result will ultimately be a health care system that distributes costs of health care even less fairly than it does today.

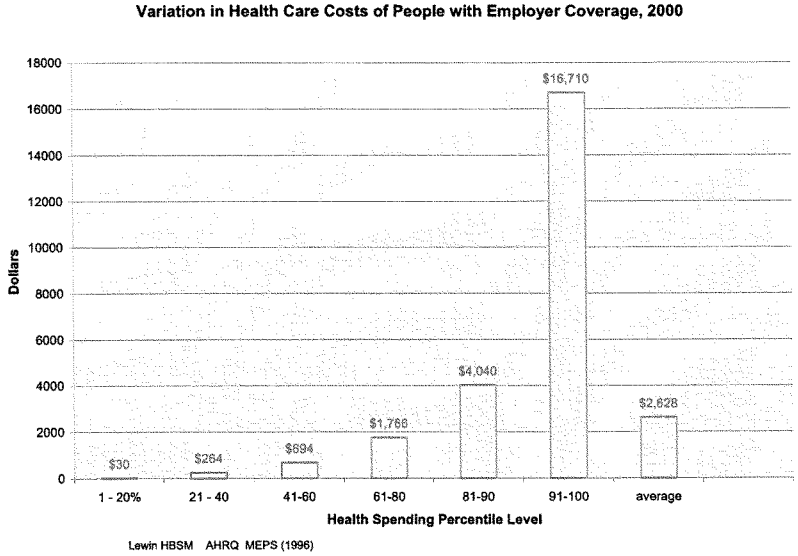
HEALTH INSURANCE RISKS VARY

There is tremendous variation in health care costs incurred by those covered by employer health insurance, as shown in the Figure below. Based on survey data from the Medical Expenditure Panel Survey (MEPS) and adjusted to 2000 levels (by the Lewin microsimulation model), the average health care costs of those with employer based coverage was $2,628 in 2000. However, the average masks a large degree of variation: those in the lowest fifth of spending incurred on average $30 of health care expenditures, while those in the top tenth of spending incurred costs of $16,710.[6] This variation of risk goes to the heart of the need to find a way to spread costs broadly in order to keep costs affordable to those at the highest risk level.

[5] *Consumer Bankruptcy: Issues Summary.* Leo Gottlieb, Professor of Law; Elizabeth Warren, Harvard Law School, January 7, 2003.

[6] Gail Shearer, Consumers Union, *The Health Care Divide: Unfair Financial Burdens*, August 10, 2002, Table 10.

Figure



Studies show that those with pre-existing conditions do not fare well in the health insurance marketplace

In one form of "consumer-driven health care," and in the model suggested in the President's Economic Report and proposal for tax deductibility of insurance premiums for high deductible coverage, employers would "cash out" health benefits, providing employers with a cash contribution for health insurance. Employees would go out and shop on their own for health insurance. **The problem with this approach is that it undermines the spreading of costs across the population, just as Medicare spreads the cost of senior and disabled health care, and other countries spread the cost and spare the sick with large financial burdens.**

A study by the Kaiser Family Foundation (using hypothetical consumers shopping for coverage) found that individuals with existing health conditions do not fare well in the individual health insurance market[7]:

- A 62-year-old overweight smoker with high blood pressure was rejected 55 percent of the time, and was offered coverage with benefit limits or premium surcharges 42 percent of the time, at average premiums of $9,936/year.[7]
- A 48-year old breast cancer survivor was rejected 44 percent of the time, and was offered coverage with benefit limits or premium surcharges 38 percent of the time.
- Even a 24-year old with hay fever faced rejection 8 percent of the time, and benefit limits or premium surcharges 87 percent of the time.

Yet the Economic Report of the President suggests that instead of spreading risks broadly so that health coverage will be affordable to those with existing conditions, "pricing to risk" is a primary goal of the health insurance marketplace. This approach sacrifices any notion of community and sharing of our neighbor's burden, in favor of marketplace efficiency. Clearly, a shift of the insurance market away from

[7] How Accessible is Individual Health Insurance for Consumers in less-than-perfect health? The Henry J. Kaiser Family Foundation, June 2001, *www.kff.org.*

employers and toward the individual insurance market, as encouraged by the President's proposal, will add financial burdens and challenges to all those that have any existing health conditions.

HEALTH SAVINGS ACCOUNTS (HSAS) DISPROPORTIONATELY BENEFIT THE HEALTHY AND WEALTHY AND FRAGMENT THE RISK POOL

Expansion of medical savings accounts (MSAs) under the new name of Health Savings Accounts (HSAs) add a new wrinkle to "consumer-driven health care" plans by making the contributions to the health reimbursement account tax deductible. This new tax policy, combined with high deductible health coverage, is likely to appeal disproportionately to the healthy and wealthy.[8]

- The healthy benefit because they have the new prospect of a tax-sheltered investment in which money is not taxed when put in or when withdrawn.
- The wealthy, with higher tax brackets, benefit disproportionately because the tax savings are larger at higher tax brackets than lower tax brackets.

Because of the divisive impact of high-deductible health insurance, it is also likely to aggravate already serious health marketplace disparities that result in inferior health care for blacks and Latinos, another troubling possibility at a time when the nation is finally beginning to address these problems. Because of the variation of risks, and different selections made by people of different health status, high deductible plans can not exist in the long-term in a marketplace that offers low-deductible plans as well. Ultimately, low-deductible plans will be driven out of the market, with "premium spirals" driving out comprehensive coverage.[9]

At the same time that this type of policy drives low-deductible coverage out of the marketplace, it is expected to do so with considerable federal expenditures. While the 10-year estimate of the HSA provision in the Medicare bill is $16 billion, adding the cost of the President's proposal to make premiums deductible brings the 10-year cost to $41 billion.[10] Beyond draining the federal treasury (and these cost estimates may well be low), it is important to keep in mind what other experts have said about the impact of such high deductible coverage:

"Fundamentally, those who would likely win from shifting to MSA/catastrophic arrangements are the healthy who will 'take back' some of their 'excess' contributions that effectively help to subsidize others." [11]

"The great savings will be for the employees who have little or no health care expenditures. The reatest losses will be for employees with substantial health care expenditures." [12]

"Insurers view high deductible plan enrollees as presenting a lower claims risk than enrollees in traditional low deductible plans . . . Insurers expect relatively better health status and lower service utilization by enrollees selecting high deductible plans and price their products accordingly." [13]

"If MSAs become widely popular among consumers with relatively better health, an adverse selection cycle could be triggered that would drive up the cost of conventional, more comprehensive insurance. The resulting premium increases are likely to be large enough to make such insurance unaffordable and unavailable for substantial numbers of Americans." [14]

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[8] Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, President Proposes to Make Tax Benefits of Health Savings Accounts More Lucrative for Higher-Income Individuals, February 9, 2004.

[9] Daniel Zabinski, Thomas M. Selden, John F. Moeller, Jessica S. Banthin, Center for Cost and Financing Studies, Agency for Health Care Policy and Research, "Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection, *Journal of Health Economics,* 18 (1999) 195-218.

[10] The $25 billion estimate is from: "General Explanations of the Administration's FY2005 Revenue Proposals," Department of Treasury, February 2004, p. 26. The HSA provision of the Medicare Modernization Act was initially estimated (by the Joint Committee on Taxation) to cost $6.4 billion over 10 years. The Administration budget estimated this cost to be $16 billion. OMB, *Analytical Perspective: Fiscal Year 2005,* p. 292, cited in Edwin Park and Robert Greenstein, Center on Budget and Policy Priorities, *President Proposes to Make Tax Benefits of Health Savings Accounts More Lucrative for Higher-Income Individuals*, February 9, 2004, p. 3.

[11] Len M. Nichols, Marilyn Moon & Susan Wall, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A numerical Analysis of Winners and Losers," *The Urban Institute,* Washington DC, April 1996, p. 12.

[12] American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995.

[13] "Medical Savings Accounts: Results from Surveys of Insurers," U.S. General Accounting Office, December 31, 1998, GAO/HEHS-999-34, Appendix, p 14.

[14] Iris J. Lav, Center of Budget and Policy Priorities, "MSA Expansions in Patients' Bill of Rights Could Drive up Health Insurance Premiums and Create New Tax Shelter," February 23, 2000.

A recent study of "consumer-directed health benefits" concluded that the young and healthy are potential winners, and that older people are less likely to choose high-deductible plans.[15]

Another concern about the President's proposal to make premiums for high-deductible health insurance policies tax deductible is the likely erosion of employer-based health coverage. When employers realize that employees have alternatives to employee coverage (i.e., through tax credits or deductions on the individual market), they may decide to discontinue offering their employees health insurance. Economists have estimated (in the case of tax credits) that for every 100 individuals who become newly insured through tax credits, 42 individuals would become uninsured because their employer dropped coverage.[16]

In sum, high deductible coverage, combined with the new tax shelter, drive up premiums for those wanting low deductible coverage, are likely to lead to elimination of low-deductible coverage, strain the federal treasury, and will lead to shifting of costs to those who are sick while benefiting the healthy and those in high tax brackets.

"CONSUMER DRIVEN HEALTH CARE" WILL NOT SOLVE THE PROBLEM OF THE UNINSURED WHILE AGGRAVATING THE PROBLEM OF THE UNDERINSURED

Approximately one in six (16 percent) families (with head of household under 65) incurred out-of-pocket health care costs (including premiums they pay directly) that exceed 10 percent of their income.[17] Economists have used a risk-based definition of the underinsured—in which individuals are "underinsured" if they have private insurance and yet, because it is not comprehensive, run the risk of having out-of-pocket costs exceeding 10 percent of their income if they face a catastrophic illness.[18] As the President's Economic Report clearly points out, high-deductible (and "consumer-driven") health care plans are designed to increase out-of-pocket costs for those who have health care expenditures. The gap between money in a health savings account and the high-deductible (this gap could be very high, in a range of $2,000 to $5,000 for families) is likely to cause a large number of families with relatively modest income to fall into the category of being "underinsured": they are at increased risk (especially when including premiums and health care expenses not even covered by their policy) of having out-ofpocket costs exceeding 10 percent of their income. This concern is aggravated by the fact that many costs (e.g., charges that exceed allowed rate levels, charges for non-covered services) will not count toward meeting the deductible or toward any stop-loss in the policy. In our view, shifting this kind of financial burden to families with moderate incomes is undesirable. This segment of the population is also at risk of facing loss of employer coverage (if employers drop out of the health care market) and higher premiums for low-deductible coverage (if high-deductible policies are available).

Focusing on transforming our health care marketplace into a high-deductible marketplace is a dangerous distraction from the urgent national goal of extending affordable, quality health coverage to all.

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[15] Dwight McNeill, "Do Consumer-Directed Health Benefits Favor the Young and Healthy?" *Health Affairs*, January/February 2004, p. 186-196.

[16] Estimate calculated based on Jonathan Gruber's testimony before the Subcommittee on Health, House Ways and Means Committee, February 13, 2002. See also: Edwin Park, Center on Budget and Policy Priorities, *Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Insurance,* February 18, 2004. *www.cbpp.org.*

[17] Gail Shearer, Consumers Union, *The Health Care Divide: Unfair Financial Burdens,* August 10, 2002, p. 14.

[18] Pamela Farley Short and Jessica S. Banthin, *New Estimates of the Underinsured Younger Than 65,* JAMA, 274: 1302-1306.