

Understanding the Consumers Who Will Be Attracted To Consumer Driven Health Plans (CDHP)

For more information:
PATH Institute Corporation
(800) 501-PATH (7284)
contact@pathinstitute.com
www.pathinstitute.com

Frederick Navarro, MA
President, PATH Institute Corporation

According to recent reports, the penetration of consumer driven health plan (CDHP) options is going well. The number of employers asking for and exploring consumer driven products is steadily increasing.

The adoption of CDHPs among *employees* is another matter, however. While the employees joining these plans now number in the millions, the numbers as a percentage of the total covered are still small.

Some experts site the aversion that many consumers have to high deductible plans as a key reason for low adoption rates, particularly among those with high medical claims or those who *anticipate* high medical claims. Consumers know that a high deductible means that a large sum of money will have to come out of their pocket to cover needed medical care should a health condition arise before the deductible is reached and the insurance kicks in. For this reason, experts acknowledge that those with high health status and low risk are the best prospects for CDHPs. For these adults, their experience tells them they probably won't be faced with paying large out-of-pocket costs for care. Those consumers with high cost, chronic health conditions, however, are more likely to shy away

from these plans. They know that if they choose the consumer driven plan with a health reimbursement account (HRA) or health savings account (HSA), they will be paying the higher out-of-pocket costs until they reach the deductible. Given this, if one considers that 80% of consumers don't generate excessive of medical care spending, then the CDHP option should have a big market.

... the primary cause of the reduction is not likely to be the change in behavior allegedly motivated by the CDHP design, but the already existing behaviors of those types of members who join.

Given the current benefit structure of most CDHPs, what portion of the health consumer market will find the plans appealing? Which portion will shy away from them? Can a deeper knowledge of the health care consumer help to make this determination?

The main components of a CDHP include a high deductible upwards of

\$3,000 dollars, an HRA/HSA that employees can draw from to pay medical expenses to a certain point, and then a gap between the HRA/HSA and the deductible where covered individuals must pay for medical services until the deductible is met. Generally, this amount is somewhere between \$500 to \$1,000 dollars. After this amount is spent, then medical services are covered at 90% to 100%. In addition, members of CDHPs are given information (e.g., resources on available medications, physicians, and hospitals and comparative costs), mainly over the Internet, they can use to make more informed healthcare choices.

Anticipated Effects of HRA/HSA Health Plans

It is believed that health plans with HRA/HSAs and high deductibles will act to create more *discretion* in how consumers choose health care options because they have a greater financial stake. These effects are anticipated to show up in the following ways:

- ? Consumers will forego unneeded physician office visits (assuming they can distinguish between a needed and un-needed physician office visit)
- ? Consumers will refuse duplicative services (assuming they can tell which services are duplicative and which are not)
- ? Consumers will select lower cost providers
- ? Consumers will purchase prescription medications more conservatively (assuming again that low cost providers and conservation of medicines are not perceived as a threat to adequate care)
- ? Consumers will show greater use of health information (mainly via the Internet) and this will allow them to choose services

more effectively with respect to balancing cost, quality and efficacy.

These are the behaviors that the structure of the CDHPs should encourage on their members.

Traits of Consumers More Likely To Adopt HRA/HSA Health Plans

Using these anticipated effects on behavior, we can describe the traits of the health care consumers who should have the least trouble engaging in or adopting these behaviors, and therefore, the least trouble choosing the HRA/HSA consumer driven option:

- ? Consumers with a high propensity to avoid healthcare
- ? Consumers who want to save or stretch their health care dollars
- ? Consumers who do not equate price paid with quality received when it comes to medical services or prescription drugs (e.g., paying more does not mean you get better)
- ? Consumers who have low concern about the quality of medical care or medications (i.e., a high degree of trust in the belief that all medical care is about the same)
- ? Consumers who regularly seek health care information to help them choose health care options; frequent users of the Internet who are comfortable with its content
- ? Consumers who have less discretionary money to spend on medical or health care, including the cost of health insurance.
- ? Consumers who have little experience with the actual costs of treating any kind of major or chronic illness; in other words, low risk healthy adults.

Likewise, we can also describe the traits of the health care consumers who would be the most resistant to engaging in the behaviors encouraged by CDHPs. These traits include:

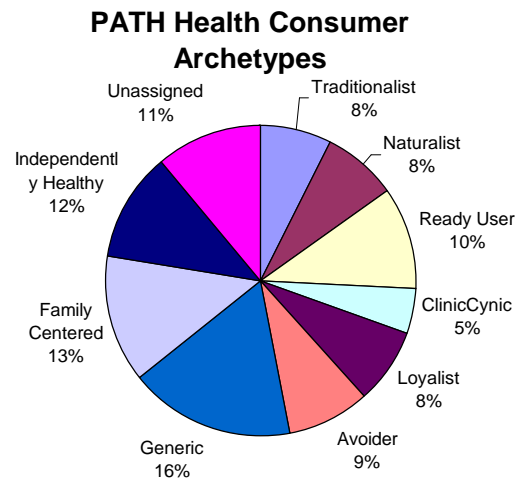
- ? Consumers with a low propensity to avoid healthcare (i.e., every physician office visit is needed)
- ? Consumers who have a low concern with saving health care dollars
- ? Consumers who equate price paid with quality received when it comes to medical services or prescription drugs (in other words, you get what you pay for).
- ? Consumers who have high concern about the quality of medical care or medications (i.e., not all medications or physicians are equal)
- ? Consumers who rarely seek health care information to help them choose health care options; and/or infrequently use the Internet for this
- ? Consumers who have discretionary money to spend on medical or health care, including the cost of health insurance.
- ? Consumers who have experience with the actual costs of treating any kind of major or chronic illness; that is to say, those with lower health status and/or chronic health conditions.

With these profiles of the traits of the best and worst consumer prospects for purchasing a consumer driven HRA/HSA plan, can we use them to identify the prevalence of these traits or similar ones among the health care consumers in the market today?

Yes, we can.

The Health Care Consumer Archetypes

The health consumer archetypes revealed in the PATH (Profiles of Activities and Attitudes Toward Healthcare) model were identified in 1987 through research that validated their existence and proved that health consumer archetypes exist across geographic areas throughout the United States¹. These nine health consumer archetypes describe the diversity of health behaviors among adults in the U.S. The estimated prevalence of each of the archetypes among the adult population is shown in graph below.



Using a multi-dimensional approach, the PATH research showed that health care consumers in the United States display common patterns of health care behaviors, traits, and intentions in a space defined by eleven distinct dimensions. These common patterns reflect the presence of self-sustaining health consumer archetypes that have since been validated in subsequent research with over a quarter million adults nationwide. Although the PATH research did not look at the typical risk factors that define high risk or produce high claims, such as smoking or being a diabetic, the examination of claims,

utilization, disease prevalence, and health risk factors across the archetypes identified by the PATH model reveal substantial variances in these factors. This means that the *archetype effect itself* is another source of health risk not identified by any other assessment or collected data.

Many of the dimensions used to describe the health consumer archetypes in the PATH model have a definite correspondence to the consumer behaviors targeted for change by CDHPs. The propensity to avoid healthcare, level of health care information seeking, level of being health proactive, level of involvement in health care decision-making, concern for the quality of health care, and the level of concern for health care costs are all factors that describe traits of the different health consumer archetypes. In addition, the health consumer archetypes' demonstrated relationship to health status and health risk, including the potential for both high and low claims, can help to further tune the search for those most likely to become CDHP customers. For this reason, the PATH model of health consumer archetypes can be an effective tool for identifying those consumers most open to the CDHP option and for getting a potential estimate of the size of the market.

Which Consumers Should Choose CDHPs?

Because high health status and low risk play such a key role in determining a consumer's responsiveness to a CDHP, the identification of the most likely health consumer archetypes in the PATH model can be narrowed to the three with the lowest claims: Generic, Family Centered, and Independently Healthy. Adults displaying each one of these archetypes tend to have medical

claims that are 20% to 30% below the average.

Generic (17% of consumers)

Adults with the Generic health consumer archetype have many things in common with the description of the optimum CDHP customer.

First, these adults have a high propensity to avoid seeking healthcare, and some of this has to do with the cost of care. Since this high degree of cost consciousness already exists within them, Generic adults should already emulate the frugal behavior fostered by the CDHP design.

Second, Generic adults display a high level of healthcare information seeking, and show no aversions to using the Internet for this purpose. The involvement in getting information about providers, including cost information, is already a part of the Generic adult's behavior.

Third, the cost of healthcare is a specific concern to these adults. Their level of concern about the cost of healthcare is just as strong as their concern about the quality of healthcare. But, more than that, adults with the Generic archetype are the least likely to equate quality of care received with price paid. This means Generic adults are the least likely to believe that the quality of medical care they receive will suffer because they choose to be frugal.

Although adults with the Generic archetype can be found at all income levels, they tend to cluster most heavily in the mid to lower income strata. This means that a good number of them are less likely to have large caches of discretionary income. To the extent that CDHPs offer employees lower premium costs, this will also make the CDHPs more attractive because Generic adults

can save on the known costs of insurance rather spend more money on the uncertain costs of an illness or disease.

Finally, a key thing driving Generic adults' potentially greater acceptance of CDHPs is their low claims rates and lower incidence of disease. These low rates mean that fewer adults with the Generic archetype have been exposed to the high cost of medical care. They are less likely to have experienced how fast health care costs rise. Because of this, they are less likely to admit the possibility of large medical expenses that could eat through their HRA/HSA and their own money before reaching the deductible. To Generic adults, the real financial risk is the cost of insurance risk right now, which takes precedence over some probable future financial risk of a major disease or illness.

Furthering Generic Opportunities.

Generic adults tend to have a high propensity to experiment with health care alternatives to traditional medical care. This means health plans that offer special benefits for those choosing alternative care therapies will be more attractive. In most discussions of CDHPs, the issue of alternative therapies is rarely if ever mentioned. Bringing it into the fore with respect to the discussions of CDHPs should make the option more appealing to adults with the Generic archetype.

This tendency to experiment with health care alternatives among Generic adults extends to the consideration of new health plan designs. This makes Generic adults among the early adopters of health care delivery innovations such as CDHP designs.

Warning. The key draw back of members with the Generic archetype is their greater propensity to disenroll

faster than adults with any other archetype. This means that unless the CDHP targets them with retention/loyalty building efforts, the CDHP will experience a rapidly spinning revolving door of new Generic adults coming in to replace the Generic members going out.

Family Centered (12% of consumers)

Many facets of the Family Centered archetype emulate the traits of the ideal CDHP customer. The fact that they also display a willingness to experiment with health care alternatives means they are more likely to be among those early adopters of the CDHP option.

Adults with a Family Centered archetype tend to avoid seeking health care for themselves, even though they may seek it for other family members. Some of this avoidance has to do with saving money, but also to do with a Family Centered adult's greater willingness to ride out an ailment rather than seek treatment from a doctor. Either way, this behavior favors the consumer driven option, except with respect to treatment for family members.

Adults with the Family Centered archetype are concerned about the quality of health care, but are also concerned about the cost. This means that Family Centered adults don't have a strong belief in the dictum "you get what you pay for." These adults are likely to accept lower cost health care because they believe that the quality of that lower cost care is not that substantially different from the high priced alternatives. This factor is in line with the "frugal" message of CDHPs.

As with adults with the Generic archetype, a key thing driving Family Centered adults' potentially greater acceptance of CDHPs is their low claims rates and lower incidence of disease.

These low rates mean that fewer Family Centered adults have been exposed to high cost medical care. They are less likely to have ever had to share in the payment of large expenses for medical treatment. Because of this, they are less likely to admit the possibility of large medical expenses that could eat through their HRA/HSA and their own money before reaching the deductible. So, they are much more willing to take the financial risk inherent in a CDHP.

Obstacles. Adults with the Family Centered archetype put the health of family members, especially children, over many other matters. While the frugality of a CDHP may not bother the Family Centered adult when thinking of care for themselves, the frugality may definitely fly in the face of the desire to have all health care options available for family members. A Family Centered adult may not want to risk the possibility that care might be denied or postponed for a family member because there are insufficient funds available to purchase the health care necessary before reaching the deductible. The force of this concern should not be minimized because it is often focused on young children. Many adults with the Family Centered archetype are young, newly married, and just beginning families. As such they will generate high demand for medical services related to pregnancy and the care of young children.

Opportunities. To improve the appeal of CDHPs to adults with the Family Centered archetype there should be a clear set of family benefits attached. Deductibles for adults can be raised while deductibles for children are narrowed. Preventive care expenses for minors such as shots and vaccinations should not only apply to deductibles but already receive some level of coverage. Maternity and pediatric care benefits should be highlighted, especially

services to reduce high risk pregnancies.

Independently Healthy (11% of consumers)

Adults with the Independently Healthy archetype also have many features in line with the optimum CDHP consumer. Like both Generic and Family Centered adults, Independently Healthy adults tend to avoid seeking health care for ailments or injuries, but not necessarily because of the cost. These adults tend to have high confidence in their body's ability to heal itself. For this reason, they give it ample time to do so before seeking professional care.

Independently Healthy adults are also avid seekers of health care information both on and off line. So the involvement in information seeking and purchasing decisions will not be daunting for them. Their focus, however, is not so much on medical treatment options but on health information sources that can help them maintain peak form and performance.

Adults with the Independently Healthy archetype are also more often among those folks who have yet to experience a serious medical ailment or disease or have first hand experience with getting care for such a problem paid for. For this reason, these adults should not be put off by the high deductible.

Obstacles. The focus on frugality and seeking low cost providers will tend to fly in the face of the Independently Healthy adult's desire for high quality health care. The dictum of "you get what you pay for" is stronger among these adults, so more often the focus on low cost will mean "inferior."

As noted earlier, Independently Healthy adults don't spend health care dollars easily. They want to be sure the medical expense is called for and can

deliver an assured outcome. This tendency coincides with the goals of a CDHP, even though the underlying reason is different from cost savings.

Unlike adults with the Generic archetype, adults with the Independently Healthy archetype tend to cluster in the upper income strata. This means that more of them have discretionary income available to purchase a high quality health plan with good benefits, or pay a large deductible. In some cases, they will view the odds of paying the large deductible as low. This means the consumer driven option becomes more attractive. However, their concern for quality may turn them off to the CDHP whose only focus is on frugality.

Independently Healthy adults are also very fitness and performance minded. They maintain excellent health status because their physical performance goals demand it. Presently, there is little in the CDHP option that supports or encourages this focus on enhanced health and performance, even though it is a key factor keeping claims down. That's one less thing that the CDHP can offer the Independently Healthy adult.

There are opposing forces working on the Independently Healthy adult: a few that pulls them towards a CDHP and a couple that pushes them away. The forces that draw them are the lack of concern about the high deductible that is part of a CDHP option, the greater control, and a potentially lower premium. The factors that push them away are the focus on frugality and choosing the low cost option, and the lack of any focus on real health optimization. In the latter case, the Independently Healthy adult will resist this. They can afford to do otherwise.

Because Independently Healthy adults also tend to cluster in the younger age groups, many are in the young family mode, getting pregnant, and carrying for young children like adults with the Family Centered archetype. This means that many of these adults will want the highest quality benefits related to pregnancy and raising young children, and be willing to pay for the plan design that offers these benefits.

Opportunities. The Independently Healthy adult should be a prime customer for the consumer driven option. The consumer driven option can be made more appealing to these customers if it is 1) positioned as a quality option, and 2) if benefits are added that recognize and reward health enhancing activities and behaviors.

Warning. The key draw back of members with the Independently Healthy archetype is, like adults with the Generic archetype, their greater propensity to disenroll faster. This means that unless the CDHP targets them with retention/loyalty building efforts, the CDHP will see Independently Healthy adults coming in and going out through the same revolving door as Generic adults.

Summary

The adults with the Generic archetype representing 17% of consumers are those consumers who already possess many of the traits encouraged by the CDHP and generally display low health risk. A sizable number of those choosing a CDHP should display the traits of this archetype. Adults with the Family Centered archetype representing 12% of adults are likely candidates as well, although the adoption rate among them may not be as high. The frugality features of the CDHP as well as the high deductible will go against the

Family Centered adults' desire to make sure the health care needs of family members will be met, their access to care has the least restrictions, and they have access to the highest quality of care. Finally, the 12% of adults with the Independently Healthy archetype should also be found with greater prevalence among the CDHP customers. However, their adoption rate should be lower because the frugality features will fly in the face of their desire for benefits that give them access to high quality health care.

Together, these three health consumer archetypes represent about 40% of adults. This percentage is quite shy of the 80% cited earlier. And, given the caveats cited for the adults with either the Family Centered or Independently Healthy archetype, this percentage is likely further reduced.

Those Who Are Least Likely To Adopt Consumer Driven Option

The PATH Institute's health care consumer research shows that there are many health care consumers who believe that you get what you pay for when it comes to healthcare. Most of the remaining health consumer archetypes share this opinion. Unfortunately, these consumers also generate higher claims. Their recognition of their own health risk will keep them away from the high deductible option in greater numbers. Adults from these archetypes are also the least willing to settle for the low price option when it comes to health care. More often than not, these consumers also have the financial resources to pay for the primary or secondary care they want—at least to the point of the deductible. They will resist the pressure to go cheap. This means that if they purchase a CDHP, these consumers are

more likely to blow past both the HRA/HSA and deductible amounts and start costing the health plan money for services that are now 90% to 100% covered.

Those health care consumers who do equate price with quality will more often go for the higher, name brand medications. As they purchase these medications they will eat up both the HRA/HSA and the deductible at a faster rate and exceed the deductible sooner. Then when the health plan fails to cover the member's preferred medications, dissatisfaction will result and they will switch to other available health plan options. The nature of the CDHP will de-select employees with higher demand for perceived quality and more expensive tastes.

Early Claims Reductions From CDHPs

The net effect of a probable greater representation of adults from the Generic, Family Centered, and Independently Healthy archetypes joining the CDHP will be the reduction of health care costs among the CDHP population. Claims will go down.

In the author's view, this is evidenced by data recently reported by HealthLeaders magazine². In the FactFile for July of 2005, data from the consumer driven health plan, Destiny Health, showed that their members were more likely to be aware of on-line options for reducing healthcare costs, more had started a nutrition program, more had started an exercise program, and more of them believed that lifestyle choices have direct impacts on healthcare costs when compared to members of other plans. While this appears to bode well for the power of the CDHP option in shaping health care behavior change, these findings are just

as likely explained by prevalence of the *kinds of healthcare consumers* attracted to the CDHP option.

There are health care consumers who will choose the low price option in an effort to save money. That's because they already do. A sizeable segment of adults already go for the low priced health care option. These consumers are already willing to consider the lowest priced doctor. They will show the behavior encouraged by the HRA/HSA because they already do it—HRA/HSA or not. The downside, unfortunately, is that most of the consumers who behave this way already generate lower claims levels. So any claims lowering effect generated by the HRA/HSA beyond the low level already caused by the consumer's own health care priorities is actually pulling it out of a smaller piece of the pie.

Conclusion

CDHPs as currently envisioned have a good fit with one health care consumer archetype, a less than optimum fit with two others, and a poor fit with the rest. Suggestions were

offered as to how the CDHP option might be made more attractive to adults representing the archetypes that are the best prospects.

As to encouraging behavior change, the implications of this review suggest that cost reductions and behaviors seen in CDHPs in the early going are less likely to be the result of change in health care behavior as a result of the plan design. They are more likely the result of attracting those consumers who already display many of these behaviors—and by coincidence, already produce low claims. This is why the promise of the CDHP is not likely to be applicable to the whole employee market without a better understanding of all the dynamics that exist among potential members.

References

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