THE ZITTER GROUP

Market Research

The Consumer-Directed Health Market: Implications of New Benefit Designs

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Executive Summary

- Consumer-directed plans create financial incentives that put more consumer "skin in the game" and have already shown promise in increasing generic drug use.
- Their impact on historically asymmetric information between patient and provider remains largely unknown.
- CDHPs continue to attract enrollees but without a major push from employers willing to enroll all their employees will likely remain an option for only a select group of enrollees.
- At present, demand for CDHPs has come from educated, wealthy professionals capable of taking advantage of the tax benefits and lower premiums, but who use the smallest portion of health care services and dollars.
- Because CDHPs primarily attract members using the fewest health care resources, their impact on overall health care cost trends appears limited.
- Costs associated with hospitalization and the adoption and use of new medical technology, the largest segments in overall health costs, may not be altered by plan design or consumer-type behavior.
- The higher patient cost-sharing burdens associated with many CDHPs represent a significant challenge. Historically, it has reduced compliance for both necessary and "discretionary" care.
- CDHPs have the potential to create perverse incentives to refrain from seeking necessary care, resulting in higher costs downstream.
- While the outlook for near-term demand for CDHP-type products remains favorable, the consensus among health plans decision-makers is that consumer-directed products will fill a niche, rather than emerging as the predominant offering in the market.

Research Limitations

This document summarizes a qualitative research project conducted with a sample of 11 managed care medical directors and product managers, and two benefit design consultants. The analysis has been augmented with an extensive review of secondary materials, and several important sources have been noted in the text. These findings provide a directional assessment of current industry views on the CDHP market. As a qualitative analysis, this research cannot substitute for a larger, quantitative study.

Overview

Two years ago, Forrester Research predicted that by 2005, consumer-directed health plans (CDHPs) would account for 2% of enrollment and 24% by 2010.[1] Since then, health plans have invested heavily in designing and marketing CDHP offerings. A recent Kaiser Family Foundation study estimates that 20% of employers now offer a high deductible policy option, and 2.4 million people have enrolled in these plans.[2] A recent report by the financial services analyst firm Celent Communications predicts HSA enrollment will grow to 15 million by 2010 and 30 million by 2015; 17% of the enrolled population.[3] If borne out, these growth projections suggest substantial changes in the health insurance market loom ahead, with important implications for patients, manufacturers, employers, and insurers.

Distinct from other benefit designs, CDHPs contain financial incentives for enrollees to moderate utilization of health services while providing them with comparison tools for cost and quality that enables them to act as "smart shoppers" of health care. In practice, this has translated into high deductibles to discourage 'frivolous' spending and low premiums and tax-free savings account to encourage conservation of health funds. While preliminary assessments of CDHP impact have been positive, important questions remain, particularly surrounding their longer-term impact on patient health. In addition, the assumptions underlying CDHPs face challenges, especially on economic grounds.

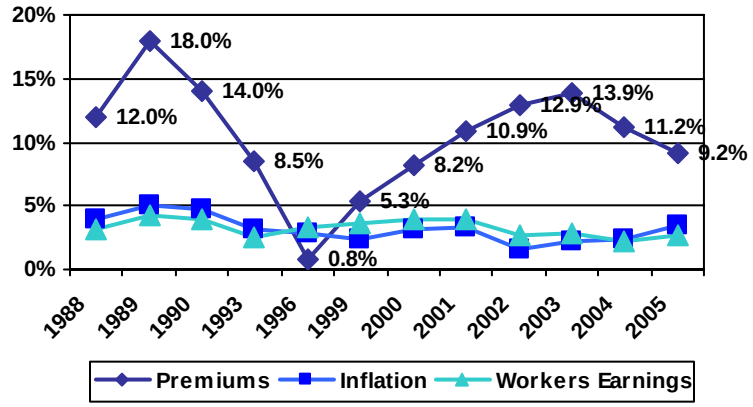
To explore these issues, The Zitter Group undertook in Fall 2005 a primary qualitative analysis of current consumer-directed health plans in the commercial health insurance market. The Zitter Group conducted in-depth, structured interviews with a sample of eleven medical directors and marketing executives at managed care organizations, as well as two benefit design consultants. Participants represented both organizations with established CDHPs and those planning CDHP launches in the near future. The study explored four areas of interest: the factors driving the growth of these plans; the profiles of current and future enrollees, the impact on utilization; and the impact on patient health. Despite a limited sample size, these findings provide some important insights into strengths and weaknesses of consumer-directed care.

[1] HealthLeaders Magazine: In the driver's seat? December 1, 2003.
[2] "Survey Finds Steady Decline in Business Offering Health Benefits to Workers Since 2000", www.kff.org, September, 2005.
[3] "Health Savings Accounts: How Will the Stars Align?" Celent Communications, LLC, September,2005.

The Rise of Consumer-Directed Health Benefits

Since 2000, premium cost growth has far outpaced inflation and wage growth [see Figure 1], reflecting in part the move by managed care organizations from supply-side controls towards attempts to influence demand. In the wake of recent legislative changes and the creation of tax-favored health saving accounts (HSAs), CDHPs have emerged as possible solution to seemingly inexorable cost growth. Their proponents believe that promoting consumer-type spending behavior and shifting more responsibility and cost to users will alter demand, doctors' treatment practices, and ultimately, the utilization of health care. Skeptics view consumer-directed benefits simply as cost-shifting and express concerns about the ramifications of removing the healthy and affluent from the general insurance pool, while leaving sicker, more costly enrollees behind to face ever-increasing costs.

FIGURE 1: Premium Growth, 1988-2005



Source: Kaiser/HRET Survey, www.kfg.org, 9/14/05

As a health plan option, the high deductible health plan (HDHP, also called a "catastrophic" health plan) that forms the backbone of CDHPs has existed for years, but generated little enthusiasm among consumers. Originally designed to cover catastrophic health events, high deductible plans appealed to individuals lacking coverage through their employer and unable to afford richer individual plans. The medical savings account (MSA) pilot project in the 1980s first married these health plans with a tax-favored savings account. Subsequently, federal legislation and IRS policy have engendered the tax-favored Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA) – stand-alone savings accounts that may or may not be attached to a HDHP – and most recently, the HSA which may be opened only in conjunction with a HDHP. The key differences between these savings accounts are described in Table 1.

Together, FSAs, HRAs, and HSAs and their accompanying high-deductible plans comprise the consumer-driven marketplace. In addition to savings accounts, many plan providers have created wrap-around benefits for CDHPs so that enrollees pay only a portion of expenses after reaching the deductible, bridging the "doughnut" hole between the deductible and out-of-pocket max. Some plans

also feature coverage for preventive care, disease management programs, and access to a health coach in an effort to promote healthy behavior.

TABLE 1: Key Differences in Current CDHP Products

	FSA	HRA	HSA
Current enrollment	20 million, 12% of commercial population	3-4 million, 2% of commercial population	1 million, less than 1% of commercial population
Source of contributions	Employee and Employer	Employer only	Employee and Employer
Taxability of contributions	Pre-tax or non-taxable	Non-taxable	Pre-tax or non-taxable
Contribution limits	Not limited	Not limited	Can contribute up to plan deductible
Rollover contributions	None	None	One per year permitted from other HSAs or from Archer MSA
Tax-free distributions	For reimbursement of medical expenses during the period of coverage.	For reimbursement of medical expenses during and after the period of coverage.	For reimbursement of medical expenses during and after the period. May include COBRA premiums, premiums while unemployed, and long-term care premiums. May use for non-medical expenses after 65
Taxable distributions	None	None	Taxable if not used for qualified medical expenses
Carry over contributions	None – "use it or lose it"	Yes	Required
Account portability	None	Expenses may be reimbursed after employment	Yes – may rollover to individual or another employer HSA

Sources: AHIP Center for Policy Research Report, 5/05. "What High-Deductible Plans Look Like: Findings From A National Survey Of Employers," *Health Affairs*, 10/05. Leiber, Ron, "The Easy Money People Ignore," *Wall Street Journal*, 10/1/05; author's analysis.

Factors Driving Growth of CDHPs

Industry analysts expect CDHPs and HSAs to continue growing, an opinion shared by every participant in this study. Nevertheless, participants voiced a great deal of skepticism about the CDHP "revolution." Interestingly, one rate-limiting factor is employers. One marketing director at a large plan noted, "They understand the concept, but they don't buy it." HDHPs have an obvious cost saving potential in the short term – recent research by the Kaiser Foundation estimates that an employer could save $500 or more per employee annually by switching to a consumer-directed plan[4] – but few employers have been willing to force employees into a particular health care plan. Instead, consumer-directed offerings remain just another option. In addition, the long-term impact on costs remains controversial. "What you save now may cost you more in the future," said a medical director at a national MCO, "people have financial limits, [they] may not go after care or follow-up care."

[4] Kaiser/HRET Survey of Employee Sponsored Health Benefits, 2005.

Whether any part of the uninsured population, currently 45 million Americans[5], is able to access health care through a consumer-directed plan remains debatable. Some reports, such as recent data from Assurant and the Blue Cross Blue Shield Association, suggests that a sizeable population of their new CDHP enrollees in the individual insurance market were uninsured prior to enrolling[6], but these findings have not held up to scrutiny.[7] High deductible plans have been available for many years; the increased media attention will help educate those who were previously unaware of their existence.

Effects on Utilization

Savings from slower premium growth represent only one side of the equation. How will consumer-directed benefits affect the biggest drivers of health care costs: expensive advances in health technology and hospitalization? There is at present little evidence that CDHPs will fundamentally change utilization patterns in health care, and considerable evidence that higher out-of-pocket costs serve to create financial disincentives for seeking necessary and appropriate care.

Lowering utilization and turning health care users into "smart shoppers" are two goals of the consumer-directed health movement. Traditionally, patients have faced strongly asymmetric information. Physicians and health plans hold all the knowledge about treatment options and cost and patients were expected to be compliant. In theory, CDHPs create incentives for individuals to take a more proactive role in healthcare decision-making, and many CDHP offer enrollees comparison tools and informational resources with which to inform their decisions. Nevertheless, opinion among industry analysts and thought leaders is mixed regarding the viability of this system. "People will have to adapt," says the medical director of a large regional plan. "They'll forget what it used to be like."

It is precisely this "adaptation" process that could bring problems. Many healthcare experts worry that consumer-directed plans will cause people to skip necessary care in order to save money. This issue has taken on greater significance recently, reflecting growing discontent with some of the fundamental assumptions underlying health insurance. Since 1968 health economists have assumed that because health insurance effectively lowers the price of care to consumers (but leaves costs unchanged), the additional care consumed by insured persons is inefficient, and represents a net welfare loss to society. Most economists have assumed that this additional care is discretionary – plastic surgery, Viagra, etc. – which would otherwise go unpurchased.[8] More recent

[5] "Covering the Uninsured – Growing Need, Strained Resources",www.kff.org, November, 2005, "The Uninsured in America", BCBS Association Report, February, 2005.
[6] "Blue Cross and Blue Shield Association Consumer Survey Shows High Rate of Satisfaction With HSAs", Keeping Healthcare Affordable, BCBS News, September 28, 2005.
[7] Park, Edwin and Greenstein, Robert. "Latest Enrollment Data Still Fail to Dispel Concerns about Health Savings Accounts," Center on Budget and Policy Priorities, October 26, 2005.
[8] See Pauly, M.V. 1968. The economics of moral hazard: Comment. *American Economic Review*, 58(3):531-37.

research has shown that this traditional view of moral hazard is wrong, and much of the additional care consumed – possibly the majority – is necessary.[9] This view appears to mirror the recent experience of Pitney-Bowes and other manufacturers that have lowered cost-sharing requirements and seen prescription adherence rise and total costs decrease.[10]

Since CDHPs are still in their infancy, there exist few data available to confirm or refute that this is taking place. The participants interviewed for this study mirror this: half believe the plans will bring improvements to health care, the other half think they will have no effect, or will even worsen health outcomes. Recent analyses of benefit design changes provide some insight into how CDHPs could affect patient utilization of drugs and other services. While most published studies have been too short to capture longer-term effects on health outcomes, most have documented both a shift in utilization toward lower-priced therapies[11] (particularly generics)[12] and an overall fall in use as patients have elected to forego prescribed medication.[13] More recent studies have identified broader effects, including reduced utilization of therapies in response to price changes for unrelated products[14] and significantly increased risks of worsening health status.[15]

As expected, consumer-directed plans have shown positive results in motivating generic drug use. It's an easy win as generic drugs are generally an underutilized alternative. The director of a top health benefit consultancy firm typically sees pharmacy spending drop by as much as 15% in the first year and attributes this entirely to a switch to generic medication. On a large scale, this can result in a large cost savings for health plans – with important and potentially negative implications for the manufacturers of branded products.

So far, there is little evidence that consumer-directed plans have had any effect on "unnecessary" or discretionary care, especially on the medical benefit side. Participants believe that this area will be much less affected than pharmacy

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[9] Nyman,, J.A. 2003. *The Theory of Demand for Health Insurance*, Stanford, CA: Stanford University Press.

[10] Mahoney J, "Innovative Pharmacy Plan Design: Pitney Bowes Produces Results." Presented at AMCP Fall Educational Meeting, Baltimore, MD, October 14, 2004.

[11] Meissner BL, Moore WM, Shinogle JA, Reeder CE, Little JM. Effects of an increase in prescription copayment on utilization of low-sedating antihistamines and nasal steroids*. J Manag Care Pharm*. 2004;10(3):226-33.

[12] Briesacher B, Kamal-Bahl S, Hochberg M, Orwig D, Kahler KH, Three-tiered-copayment drug coverage and use of nonsteroidal anti-inflammatory drugs. *Arch Intern Med*. 2004;164(15):1679-84.

[13] Huskamp HA, Deverka PA, Epstein AM, Epstein RS, McGuigan KA, Frank RG. The effect of incentive-based formularies on prescription-drug utilization and spending. *N Engl J Med*. 2003;349(23):2224-32.

[14] Goldman DP, Joyce GF, Escarce JJ, Pace JE, Solomon MD, Laouri M, Landsman PB, Teutsch SM. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA*. 2004;291(19):2344-50.

[15] Heisler M, Langa KM, Eby EL, Fendrick AM, Kabeto MU, Piette JD. The health effects of restricting prescription medication use because of cost. *Med Care*. 2004;42(7):626-34.

benefits. The asymmetry of information between consumer and doctors is greatest around medical procedures and, as one product manager notes, “patients associate cost with quality on the medical benefit side.” Patients believe, that the most expensive treatment is the most valuable and many are unlikely to question their doctor’s decision to perform an MRI or request less expensive alternatives to surgery.

In general, the degree of influence that doctors have on their patients’ health care appears unlikely to be dampened by a consumer-driven plan design, a potentially serious limitation. Direct-to-consumer marketing by pharmaceutical companies and internet sources such as WebMD and plan provider sites have made drug and treatment information readily available, but several of those interviewed believe people typically will defer to their doctor’s recommendation regardless of the cost. Many are afraid to even question their physician’s advice. At worst, patients will not fill their prescriptions or undergo needed care because of the expense (as suggested by existing data). Some plans have patient advocacy help lines with suggestions about communicating with doctors, and may even act as a liaison when patients are having a particularly hard time. These services are not offered by all CDHPs and those that do, acknowledge that only a small fraction of enrollees is able to utilize them.

Winners and Losers

Patients and Consumers

With their low monthly premiums and catastrophic coverage, consumer-directed health plans appear tailored predominantly for the young and healthy. With few health problems, they can accept more risk and save some money each month on their premium. Those with chronic diseases or risk factors for disease would steer clear of these plans in favor of the richer, traditional design. With a $3,000 to $5,000 out-of-pocket obligation, choosing a CDHP unwisely could have serious financial ramifications for the wrong person.

One health plan medical director joked that to navigate today's health system, what is most needed is a medical degree.

Since CDHPs presuppose a more activist enrollee role in care decisions, CDHPs appear of greater benefit to better-educated, more sophisticated beneficiaries. Indeed, an additional impediment to broad adoption is the level of sophistication needed to understand the components of the CDHP and set up a financially beneficial arrangement, particularly in an industry in which information is so routinely asymmetric. One health plan medical director joked that to navigate today's health system, what is most needed is a medical degree, noting that "most consumers are not sophisticated and they choose to be this way," a sentiment shared by several other interviewees. The CDHP product director for another MCO agrees that sophistication is important to make a CDHP beneficial. More than anything else, he believes that most consumers need simplified information about how a plans work, even as basic as how to submit claims.

Because of their financial benefits – enrollees can make pre-tax contributions to their savings accounts, lower their tax burdens and build their savings accounts until retirement – CDHPs have also attracted the attention of older beneficiaries. In 2004, the IRS allowed people over 55 but not yet enrolled in Medicare to deposit up to $400 over their deductible in their HSA account and an additional $500 in 2005. Between August, 2004 and March 2005, HSA enrollment doubled.[16] Although it's currently a highly contentious issue, the majority of those interviewed share the belief that HSA enrollees are attracted principally to the tax benefit and savings potential, (a phenomenon that has not escaped the notice of the financial services industry[17]). A medical director from a medium-sized state-level plan identified this group as "educated, with disposable income, and healthy." The key is that they must be healthy. If enrollees spend the money in

[16] "HSAs More Than Double in Six Months," press release from AHIP (America's Health Insurance Plans), May 4, 2005.
[17] Hanessian BG, Huber CP, Singhal S. The Coming Convergence of US Health Care and Financial Services. *McKinsey Quarterly*, June 2005.

their HSA accounts, you're defeating the purpose: accumulating tax-free savings for retirement.

While the healthy and wealthy are able to take immediate advantage of CDHP's financial perks, much of the remaining population has steered away from these plans. CDHPs are not a wise choice for people with children, chronic illness, multiple risk factors, or who have other reasons to shy away from the financial risk. There is also a small group, 15% of the population, who rack up 75% of the health costs each year and they are highly unlikely to accept a high deductible arrangement. "You can't create a CDHP plan for these people" said a state-level director, and went on to say most people are not eligible to capitalize on the CDHPs savings. The majority of those interviewed agreed. Whether due to a lack of sophistication or insufficient financial resources, most people feel more comfortable with a traditional HMO or PPO-style health plan.

Employers

As the cost of providing employee health benefits has grown, many employers have simply stopped offering them. Since 2000, the number of employers providing benefits has dropped from 69 to 60 percent.[18] The consumer-directed health movement posits CDHPs as the solution: keep providing benefits by substantially reducing monthly premiums and raising the deductible. This led one analyst to conclude that the limit to insurance expansion has been reached, and that new offerings will attempt to thin coverage.[19]

"Real changes won't occur until CDH plans are mandatory. Currently, healthy people are attracted to these plans; the high utilizers are not. When employers make CDH plans the only option, then they'll start saving money."

Overall, employers have not flocked to consumer-directed plans, despite their potential for immediate cost reduction. Many larger firms remain skeptical about the cost-savings, and fear a backlash from employees facing "thinned" benefits. Smaller employers, on the other hand, were the first to enroll employees in CDHPs. One marketing director for a national CDHP explained that smaller employers are more price sensitive than larger employers. In addition, for some smaller employers, a consumer-directed plan may be the difference between offering their employees health benefits or none at all.

More recently large employers like Wal-Mart and American Express have begun offering consumer-directed plans along side their traditional health plans, a

[18] "Survey Finds Steady Decline in Business Offering Health Benefits to Workers Since 2000", www.kff.org, accessed 9/14/05

[19] Moran DW. "Whence and Whither Health Insurance? A Revisionist History", *Health Aff (Millwood*) 2005; 24 (6):1415-25.

strategy of questionable merit. Several medical directors emphasized that CDHPs will not generate substantial savings for employers until they make a mandatory switch. According to one, “real changes won’t occur until CDH plans are mandatory. Currently, healthy people are attracted to these plans; the high utilizers are not. When employers make CDH plans the only option, then they’ll start saving money.”

Getting employees to sign up for a HDHP is only the first step, however. Studies have shown that the level of employer commitment to promoting healthy behavior and responsible financial management has a direct effect on the behavior of plan participants and how much money is saved in the HSA.[20] Employers can opt for plans with rich “wrap-around” policies such as first-dollar preventive services, DM, health counselors, and comprehensive web-based information, but these additional services reduce the potential near-term savings by driving up premium costs.

Ultimately, employers will get out as much as they put in. The medical director at a large national health plan stresses that “without a lot of employer participation and monitoring, these plans will go wrong and end up costing money.”

Manufacturers

Consumer-directed health plans have already resulted in higher utilization of generic drugs, and one consultancy expects that employers will see significant first-year savings as a consequence. With several plan providers offering enrollees price comparison tools, patients can easily identify the price differences between branded products and generics. Previous analyses reinforce the sensitivity of demand for branded agents to changes in patient out-of-pocket costs – even in traditional managed care designs – suggesting that generic manufacturers will be early beneficiaries of increased CDHP uptake, even with relatively modest enrollment.

The potential impact on manufacturers of branded agents is less clear. Those facing generic competition should expect to lose sales as a result of increasing CDHP enrollment. As patients are encouraged to choose the least expensive option to conserve their health care funds, they will naturally gravitate to generic drugs. Moreover, the effects of asymmetric information appear less robust on the pharmacy benefit side of the equation, a point identified by several participants in this research. While doctors will continue to wield some influence over their patients’ therapeutic choices, this effect may be muted somewhat, particularly for less serious, chronic conditions, such as hypertension or asthma.

The effects on branded manufacturers without generic competition will vary. Traditional health insurance theory predicts that patients forced to pay a greater

[20] “Consumer-Directed Health Plan Report – Early Evidence is Promising: Insights from Primary Consumer Research,” McKinsey & Company, June 2005.

share of a treatment's costs will forego discretionary or "unnecessary" care offering only marginal benefit. There is thus a strong relationship between the severity of the condition and the elasticity of demand. As consequence, manufacturers of branded agents for less serious conditions, such as erectile dysfunction or psoriasis, will likely face more severe erosion of demand. In contrast, manufacturers of therapies for life-threatening or disabling conditions – multiple sclerosis, cancer, etc. – will likely face less dramatic demand consequences. For biotechnology products – particularly those with annual price tags in excess of $10,000 – the increased cost exposure will be mitigated somewhat because patients will relatively quickly reach their catastrophic coverage level.

Of course the broader market dynamics explored in this research suggest that near-term consequences on manufacturers will generally be modest. Even the most optimistic projections foresee only a fraction of covered lives enrolling in CDHPs. Moreover, those individuals most likely to select a consumer-directed benefit tend to consume comparatively few healthcare resources. High utilizers and those for whom certain medications are necessary will continue seek out more traditional insurance products. Unless employers offer CDHPs as the only option – and this research suggests few employers will require CDHP enrollment – these patients will resist making the switch.

TABLE 2: Winners and Losers in the CDHP World

	Winners	Losers
Patients	▪ Young, healthy patients ▪ Healthy pre-retirement aged patients seeking financial benefits ▪ Proactive health "managers"	▪ Unhealthy of all ages ▪ Low income and low education levels ▪ Passive health managers
Employers	▪ Small employers offering limited benefits ▪ Large employers willing to move majority of enrollees ▪ Employers willing to pay for auxiliary health promotion services	▪ Large groups able to transfer only some enrollees ▪ Employers unable or unwilling to pay or auxiliary services ▪ Heavily unionized firms
Manufacturers	▪ Generic manufacturers ▪ Branded products for serious conditions	▪ Branded agents facing generic competition ▪ Branded agents for "lifestyle" conditions

The Outlook for Consumer-Directed Health Products

"Major costs will come when minor ones are avoided," says a medical director at a state-level MCO. Several interviewees expressed concern about the savings brought by consumer-directed plans. What employers save on monthly premiums will be lost if CDHPs result in higher long-term costs due to delayed careseeking, or reduced adherence – two outcomes already well documented in higher cost-share environments. Plans work to mitigate this possibility by providing patients with health information and resources such as disease management and health coaches. "Without prevention, the cost will go up," says the medical director of a regional health plan. Yet preventive services may add to the cost of providing a benefit, increasing the possibility that employers will opt out.

The consensus among those interviewed – as well as industry opinion leaders and analysts – is that without a great deal of employer involvement and readily available preventive services, consumerism will have a detrimental effect on health care. As one health plan medical director noted, "CDHPs are seen as a silver bullet for the rising cost of healthcare…problems may arise when employers make it a single solution but then don't follow up with other activities." Even those employers that offer additional services may find promises of lower cost and better health unfulfilled. According to those interviewed, case managers typically reach no more than 5 percent of plan members. Free or inexpensive preventive care helps, but is both notoriously underutilized and frequently undersupplied.

A range of published studies shows that increased cost sharing results in decreased compliance.[21] A literature review published in *Journal of Managed Care* in late 2005 found over the last 20 years, higher cost sharing has resulted in treatment disruption for chronically ill patients and in a general decrease in pharmaceutical use for essential medication along with less essential.[22] Many consumer-directed plans do not have the safeguards in place to protect against the effects of higher cost sharing. In the event that enrollment explodes, this will become a very real challenge.

Those interviewed agreed that the burden of monitoring enrollees and ensuring the success of CDHPs falls squarely on employers. One medical director notes, "If employers enroll their employees in CDHPs without simultaneously launching programs that promote health and financial management, people will get sicker and tax the health care system even more." These additional activities cost money and require infrastructure that some employers lack. Larger employers have the infrastructure but for many of them, spending more time and money to

[21] "Does Cost Sharing Affect Compliance? The Case of Prescription Drugs." NBER Working Papers National Bureau of Economic Research, Inc., September 2004.
[22] "The Effects of Prescription Drug Cost Sharing: A Review of the Evidence" *The American Journal of Managed Care.* November 2005, pg 730-740.

help their employees manage their health and finances would defeat the purpose of enrolling them in a CDHP.

With steadily rising costs and failing utilization and access management strategies, the current health insurance system may be coming close to a financial breaking point. CDHPs have a part to play in the coming changes, but the overall value of CDHPs remains controversial, and their long-term impact likely only modest. Even the most optimistic experts see CDHPs as a temporary or interim intervention, rather than a solution to the continued explosion of healthcare costs in the U.S.