SOCIETY OF ACTUARIES

SOA '10 Health Meeting
June 28- 30, 2010

Session # 25 PD: Consumer-Driven Health Plans and Developments in Product Design

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2010 SOA Health Meeting, Session 25 PD

Consumer-Driven Health Plans and Developments in Product Design

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UnitedHealthcare

CDH from a large employer's viewpoint

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Is CDH still a viable option?

What is a typical plan design?

Is consumerism real?

- Selection
- Cost shifting
- Are consumers better purchasers?

What about quality?

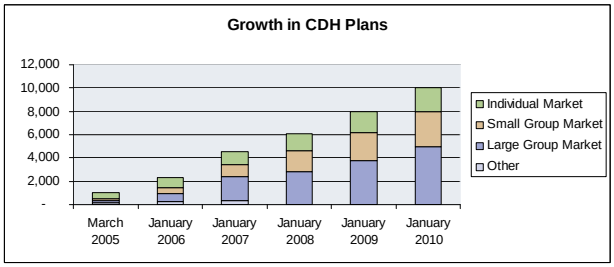
What should I think about in implementing a plan?

- Planning
- Budgeting

What are leading edge employers thinking about?

Impact of health care reform

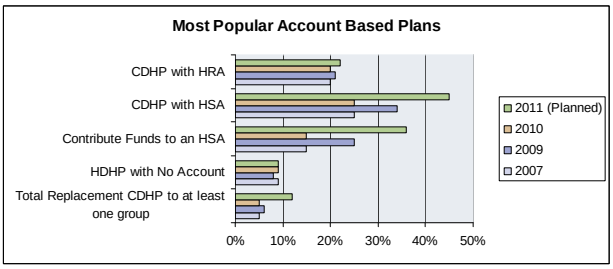
CDH plans are still growing, especially in the large group market



•As of January 2010 ~ 10 million people covered by HSA/HDHP, a 2 million increase since January 2009

•Source: AHIP, 2010

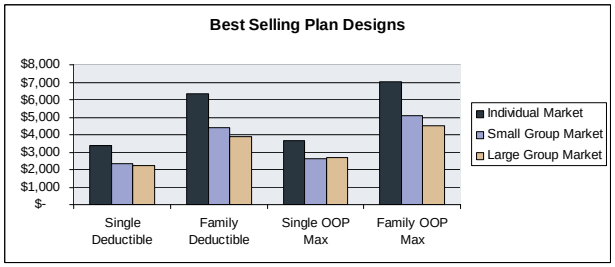
Increasingly, HSA plans are the most popular CDH plan



Note: Companies were allowed to pick more than one option

•Source: Towers-Watson/National Business Group on Health, 2010

Deductibles and OOP are higher in the individual market than in the small or large group markets



Singles/Empty Nesters are more likely to choose CDH plans

CDH Population	Young Singles	Young Families	Older Families	Empty Nesters/ Older Singles	Chronics	Combined
Pct of Total Subscribers:	23%	13%	11%	28%	25%	100%
Pct of Total Spend : [3]	5.6%	13.4%	12.3%	20.5%	48.3%	100%
Average Contract Size:	1.0	2.9	3.7	1.4	2.5	2.0
Average Subscriber Months/Year:	9.0	9.8	10.5	10.3	10.9	10.1
Average Risk Scores:	0.6	1.1	1.4	1.5	2.6	1.5
Key Demo/Socio Factors:						
·Avg Subscriber Age:	28.9	32.6	46.9	53.2	48.2	43.0
·Pct Female Subs	45%	44%	36%	53%	45%	46%
Top 3 Cultural Ethnicity: [1]						
·European	67%	70%	78%	77%	75%	73%
·Hispanic	13%	12%	7%	8%	9%	10%
·African American	11%	10%	7%	9%	9%	9%
Non CDH Population						
Pct of Total Subscribers:	18%	13%	11%	26%	32%	100%
Pct of Total Spend : 3	4.6%	13.2%	10.9%	18.3%	53.1%	100%
Average Contract Size:	1.0	2.9	3.7	1.4	2.5	2.1
Average Subscriber Months/Year:	8.9	9.7	10.4	10.2	10.8	10.1
Average Risk Scores:	0.8	1.2	1.5	1.7	2.9	1.8
Key Demo/Socio Factors:						
·Avg Subscriber Age:	29.5	32.8	46.7	53.4	48.5	44.1
·Pct Female Subs	48%	43%	35%	53%	45%	46%
Top 3 Cultural Ethnicity: 1						
·European	65%	68%	76%	77%	74%	72%
·Hispanic	14%	13%	9%	9%	11%	11%
·African American	11%	9%	6%	9%	9%	9%

•Within a life stage, risk scores are slightly lower for CDH members

•Based on UHG National Accounts, 2009

Cost-shifting may or may not exist depending on benefit design, contributions, etc
In this example, HSA is the best plan for 77% of single EE's

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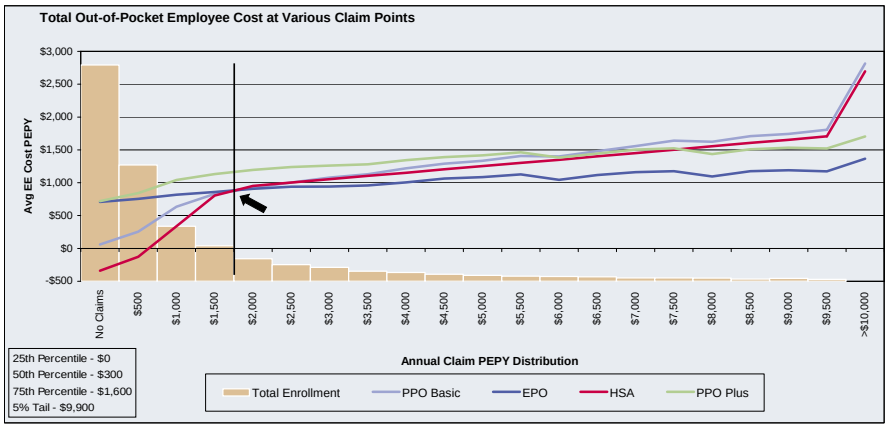
Employee Only



* Medical and Rx: EE Cost reflects cost share less ER-funded HSA for the HSA plan plus EE payroll conributions.
* Cost based on CY2008 experience, trended to 2011

- **In this example, the HSA wins for approximately 77% of single EE's**

Most employers see selection when CDH is offered on a slice basis

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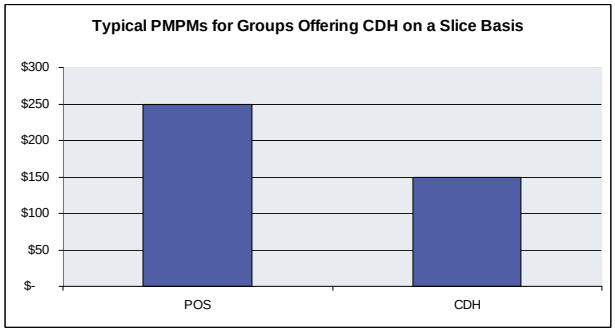


- Typically, only about 5% to 20% of members will choose CDH without a strategy designed to steer members to CDH
- Typically, the CDH experience is about 50% to 70% of the cost of a POS plan, even after adjustments for age-sex, area, benefits, etc
- Those who choose the CDH generally do so wisely, but those who choose the POS plan would often be better off under a CDH plan
- Keys to a successful steerage strategy
    - •Contribution (monthly payroll) steerage
    - •Communications
    - •Senior management involvement

There appears to be at least 2% residual savings on CDH plans

Studies

- Milliman study, actuarial methods, 2% to 4% savings
- Academic-type studies by companies show much higher savings
  - From *Emerging Data on Consumer-Driven Health Plans*, American Academy of Actuaries, 2009
- UHG customer level analysis show savings in the 2%+, but varies by customer
- Some academic peer-reviewed papers show CDH members likely to delay care – is that a bad thing?

Why the differences

- Continuously enrolled vs. all in
- Large claims
- Methods
  - Many studies are based on regression analysis – lose ability to drill down
  - Actuarial studies – lose impact of individuals by applying too many averages
- One customer vs. many
- Key variables not always available
  - Contribution strategy a key determinant of selection, which drives results
  - Income

Quality is about the same for CDH and non-CDH

Preventive care usually higher than non-CDH

- About 90% of CDH plans cover preventive care at 100%

Chronic care

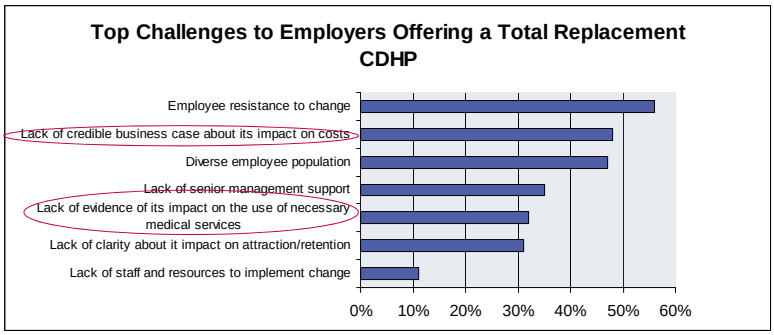
- About the same as non-CDH
- Varies by measure, study, etc

Prescription drug compliance

- Mixed results by study
- Expect improvement with preventive drug lists, which allow copays for certain classes of drugs on HSA plans

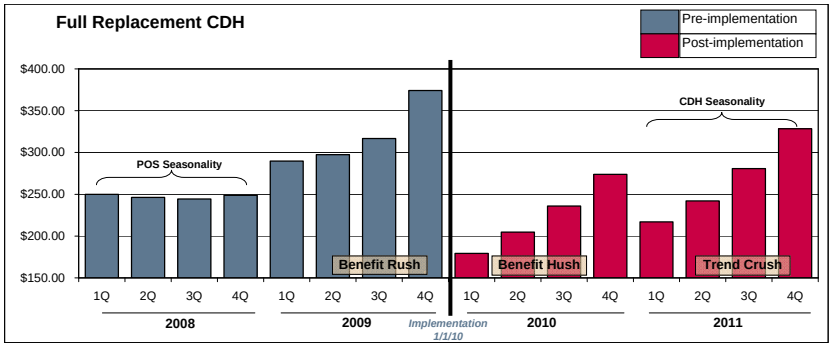
•Primary source: *Emerging Data on Consumer-Driven Health Plans*, American Academy of Actuaries, 2009

The biggest challenge to implementing a full replacement CDH is employee resistance to change



•**Have we done our job analyzing and explaining CDH?**

Employers need to budget for rush-hush-crush



- **Benefit rush occurs whenever there is a big change that creates uncertainty – a new carrier, major change in benefit offering, etc.**
  - **•Members rush to get their services before the plan change, which creates a hush as soon as the new plan is implemented.**
  - **•In the following year there is a trend crush which brings utilization levels back to a normal level.**

Plan ahead before introducing CDH

What are your objectives

- Cost
- Activation
- Employee health
- Competitive benefits

Are your employees ready for CDH?

- May want to introduce alternatives such as incentives before CDH
- May want to offer on a slice basis first – get employees comfortable with CDH
- Communications – will they know how CDH will hit their bottom line?

Run the numbers

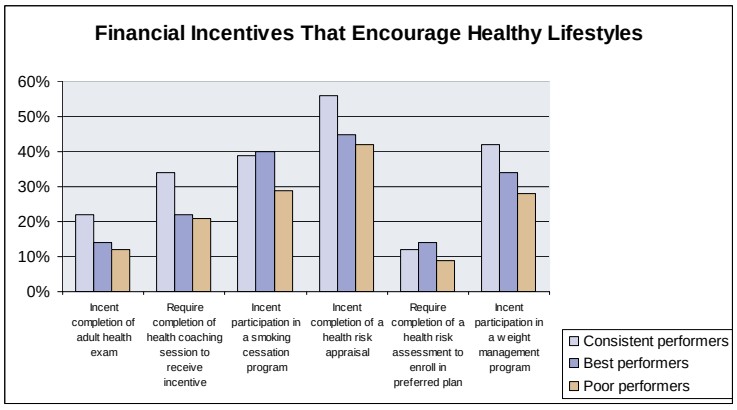
- Member impact, with close attention to low-paid and high paid employees
- Employer impact, short term and long term

Senior management support

- Endorsements
- Resource allocation

What are the measures of success?

The best performing employers are incenting specific behaviors



Health reform impact unclear, but probably similar to other plans more or less

Definition of essential benefits

- For HSA plans, can not use benefit-specific copays to limit benefits

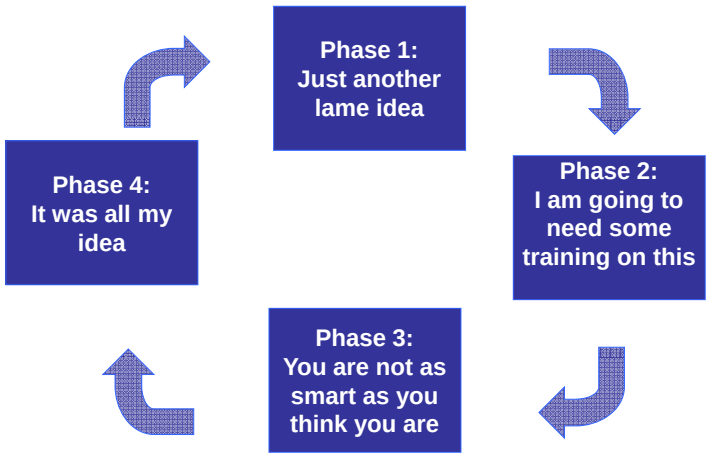
Exchanges, etc

- Selection may be more exaggerated, since it is already an issue

Cadillac tax

- Depends on plan parameters

The 4 Stages of Product Acceptance



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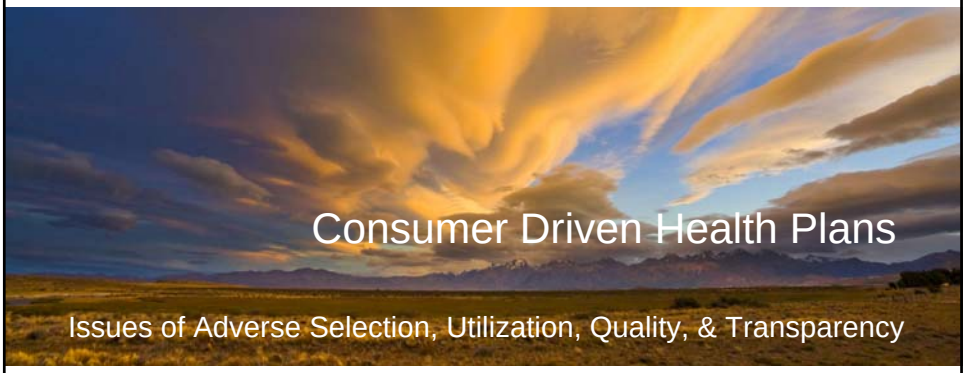

Consumer Driven Health Plans

Issues of Adverse Selection, Utilization, Quality, & Transparency

Seeing the big picture to solve the biggest problems in health care.

see more. solve more.

Four Primary Questions About Impact

- Is there adverse selection?
- Is utilization impacted?
- Is quality impacted?
- Does transparency to information change behavior

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Adverse Selection-Potential

- Attract educated and wealthy-tax advantages
- Attract the young and healthy
- Attract users of limited healthcare resources
- Risk of remaining traditional coverage pool will increase

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Adverse Selection-Actual Findings

- Appears to be a moderate effect
- CDHP enrollees compared to other health plans tend to be[1]:
  - > About the same age
  - > In a higher income bracket
  - > healthier[2]

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Impact on Utilization-Potential

- Traditionally, higher out of pocket costs have been associated with decreased compliance[3]
  - > Chronic care-necessary to prevent deterioration
  - > Preventive care- some consider discretionary
- Rand Health Insurance Experiment (HIE) study-most who cut back on health care use had little effect on health status, but poor and sick had adverse consequences
- Decreased compliance could result in greater costs as a result of disease progression and lack of prevention
- Less likely to impact hospitalization and new technology, which are big drivers of costs

Impact on Utilization-Actual Findings

- Short-term medical[1]
  - > Reduction in health care costs of from 4-15 %
  - > Reduction in hospital admissions and days (4-6%)
  - > Reduction in primary care visits (12%) and office visits (1%)
  - > Reduction in ER visits (3%)
- Pharmacy
  - > Increased use of generics
  - > Adherence lower for some drug classes[4]
    - Slight delay in time to fill first prescription
    - Compliance falloff greater for CDHP than traditional

Impact on Quality-Potential

- Potential to create the incentive to not get necessary care
- Based on the Rand HIE, greater cost sharing results in:
  - > Reductions in use of both effective care and that considered less effective
  - > Reduced use of ER for less urgent problems more than reduced use for more urgent
  - > Did not reduce use of effective care for poor children

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Impact on Quality-Actual Findings

- Results are mixed
- Some studies-increased use of preventive care and adherence with prescribed treatment
- Other studies show changes with potential to have adverse health consequences
  - > Failure to get follow-up lab tests
- CDHP enrollees appear to be less satisfied with coverage and care

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Does Transparency Impact Patient Behavior

- Study looked at a tiered rating system used by a large health plan[5]
- Older, sicker people and women tend to use a provider rating system more than others
- Putting a rating system in reduces expenditures for out of pocket and total medical spending, but not out of pocket pharmacy
- Preventive visits increase but not colonoscopy procedures

Benefit Design Implications

- Many plans already encourage health risk appraisals, chronic care self-management, and wellness activities
- Flexible plans to incentivize appropriate use for vulnerable populations
- Medication incentives for chronic disease
- Incentives for proven preventive procedures
- Improving transparency to cost effectiveness and quality

Bibliography

[1]Beeuwkes Buntin M, Damberg C, Haviland A, Kapur K, Lurie N, McDevitt R, and Marquis MS, "Consumer-Directed health Care: Early Evidence About Effects on Cost and Quality," *Health Affairs*, Web Exclusive, Vol. 25, No. 6, november/December 2006, pp. w516-w530.

[2]Tollen et. al., "Risk Segmentation."

[3]Sheehan J, "The Consumer-Directed Health Market: Implications of New Benefit Designs," The Zitter Group, January 2006.

[4]Chen S, Levin R, Gartner J, "Medication Adherence and Enrollment in a Consumer Driven Health Plan," American Journal of Managed Care, 2010; 16(2): e43-e50

[5]Parente S, Feldman R, "Does Access to Transparent Provider Quality and Cost Information Affect Health Care Cost and Utilization of Preventive Services?" December 31, 2008