

MERCER

Health & Benefits



April 7, 2006

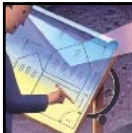
National Conference of State Legislatures *Consumer Driven Health Insurance – New Solutions in 2006?*

Tracy Watts, Washington DC

Tracy.watts@mercer.com



Marsh & McLennan Companies



Today's Discussion...

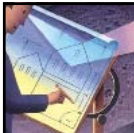
- **Current Trends in Employer Sponsored Health Plans**
- **Employer Strategies for Next Five Years**
- **Role of Consumerism and CDHPs**
- **Employer Efforts on Pricing and Quality Transparency**



Mercer Annual Survey of Employer Sponsored Health Plans

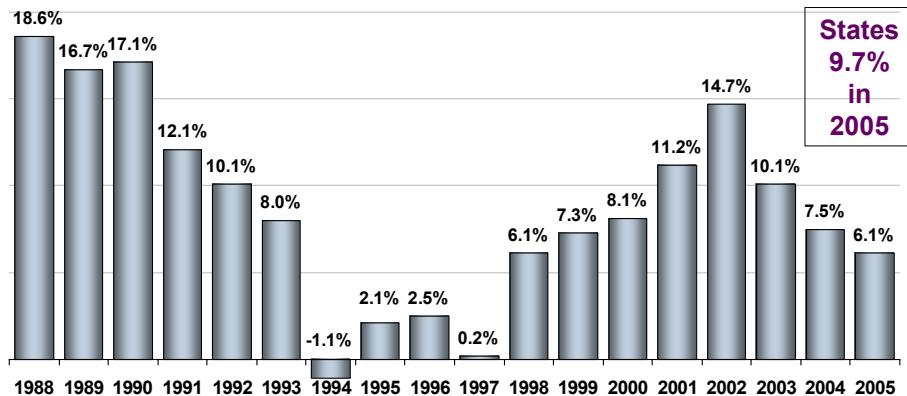
About the survey

- Largest and most comprehensive annual survey
- Established in 1986, national probability sample used since 1993
- 2,999 employers participated
- All employers with 10 or more employees are surveyed; size groups examined separately in this presentation include:
 - small employers – 10-499 employees
 - large employers – 500+ employees
 - jumbo employers – 20,000+ employees
 - **special cut: State governments (n=32)**



Total health benefit cost increase slows for the third straight year – **Good News?**

All employers

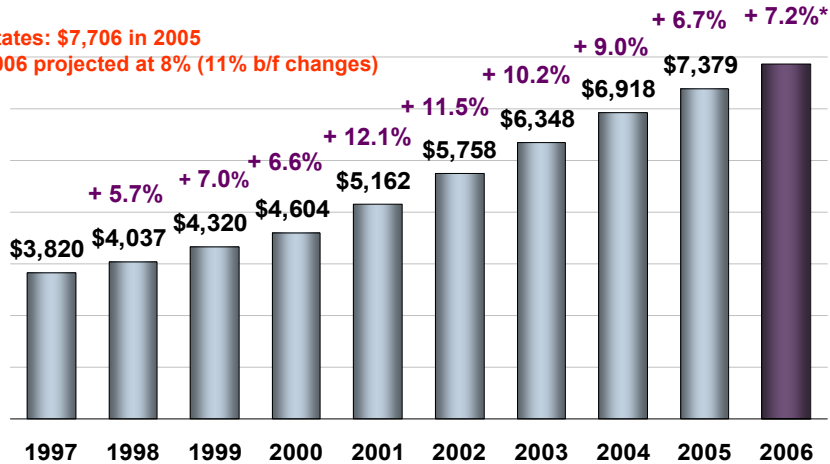




Total health benefit cost for active employees up 6.7%

Large employers

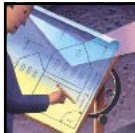
States: \$7,706 in 2005
2006 projected at 8% (11% b/f changes)



*Average increase projected for 2006 after changes; increase of 9.9% predicted before changes

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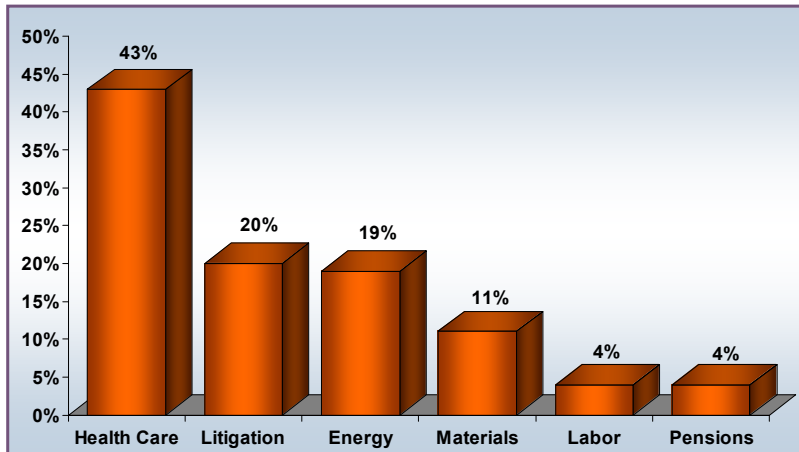
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Industry Issue

Ask a CEO in the U.S....

What business expense is your company's biggest concern in 2005?



Note: Percentages do not equal 100% due to rounding.

Source: Business Roundtable questionnaire of 131 CEOs of companies with a combined workforce of more than 10 million employees and \$4 trillion in annual revenue.

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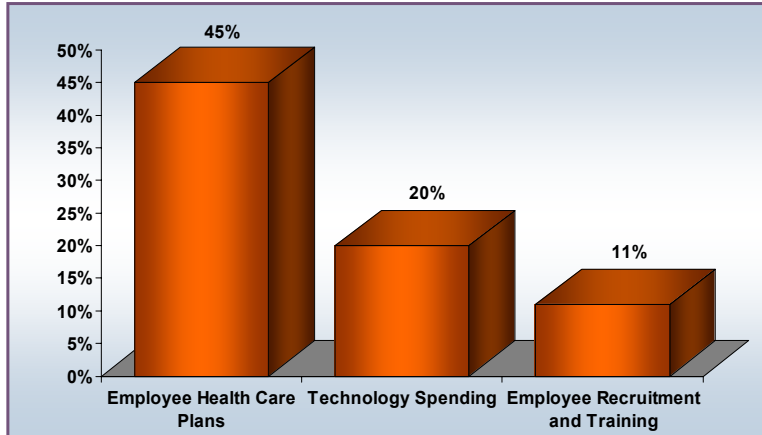
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Industry Issue

Ask a CFO in the U.S....

What will be the biggest cost increase to your company in the next 12 months?



Source: Robert Half Management Resources survey of 1,482 chief financial officers at companies with revenue of \$500,000 to \$1 billion. Margin of error ±3 percentage points.

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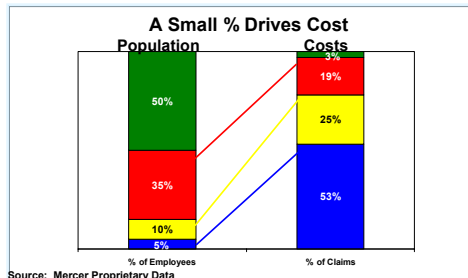
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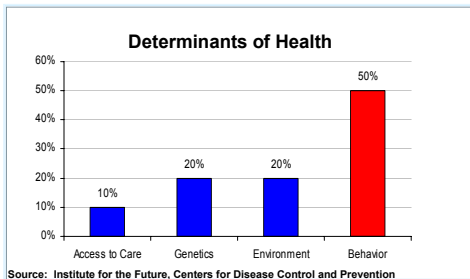
The Employer Challenge...

Analysis of visible and underlying cost drivers is vital

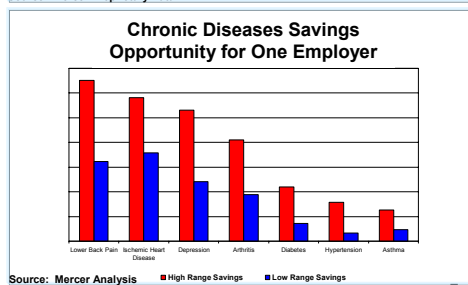
- A small percentage of population drives current year cost
- Lifestyle choices drive health status
- Areas of focus vary based on population demographics



Source: Mercer Proprietary Data

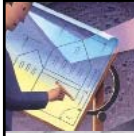


Source: Institute for the Future, Centers for Disease Control and Prevention
Mercer Health & Benefits



Source: Mercer Analysis

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Health Care Cost and Quality Vary Widely

Few know or care . . . until it happens to them. We need everyone to know and care to create opportunity to stabilize cost.

Cost Varies Widely

Cost Range in Medium Size Service Area

Service / Rx	Cost Range
Chest X-Ray (Two Views, Basic)	\$120 – \$1,519
Complete Blood Count	\$47 – \$547
Comprehensive Metabolic Panel	\$97 – \$1,732
CT-Scan, Head/Brain (without contrast)	\$881 – \$6,599
Percocet one tablet, 5–325 mg	\$6.50 – \$35.50
Tylenol (or Acetaminophen) one tablet, 325 mg	\$0.00 – \$7.06

Mercer Analysis

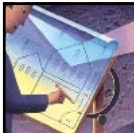
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Quality of Medical Services Varies Widely

- 55% of recommended care actually gets administered
- 90,000 people die of hospital-acquired infections annually
 - More than half of these deaths may be preventable
- 180,000 elderly outpatients die or are seriously injured by drug toxicity
 - Half of these incidents may be preventable
- \$2,000 annual cost to employers per insured worker, due to poor-quality care

Compiled by Forbes Magazine

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Over the past three years, what has driven the slowdown on cost increases?

- Employers continue to shift cost through plan design change, especially large employers
- Health management working – more employers report measurable ROI
- Large employers reducing the number of plans offered
- Continuing focus on Rx strategies that inform consumers of relative costs – three-tier copays and coinsurance
- Three years of cost-shifting may be slowing utilization

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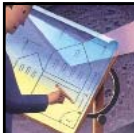
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Employers see care management, consumerism as top cost management strategies for the next five years

Strategy will be significant or very significant

	Large employers	Jumbo employers	State Gov't
Care management	62%	81%	51%
Consumerism	55%	71%	59%
Data transparency	35%	54%	53%
High-performance networks	33%	51%	56%
Collective purchasing	25%	24%	19%
Scaling back benefits/shifting cost to employees	24%	17%	13%



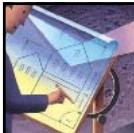
Growth in use of care management programs Percent of large employers offering program

	2005	2004	States
One or more disease management programs	67%	58%	69%
Health risk assessment	46%	35%	57%
Behavior modification program	30%	21%	33%
Nurse advice lines	64%	59%	65%
Health advocate services	37%	31%	33%
Complex case management	65%	----	84%
Catastrophic case management	66%	59%	84%
End-of-life case management	40%	----	45%



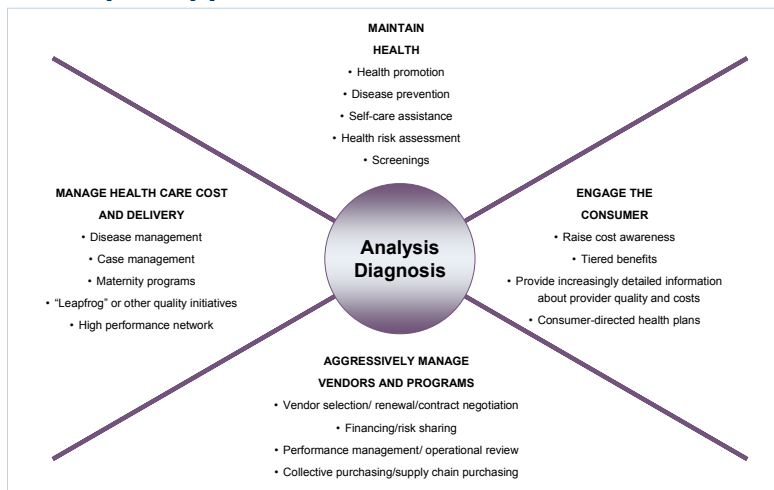
Jumbo employers making progress in measuring disease management ROI

	Employers offering care management programs	
	Large employers	Jumbo employers
Have attempted to measure return.....		
Using vendor/carrier reports only	17%	32%
Using own data in addition to vendor/ carrier reports	5%	13%
Of those measuring ROI, percent who report a return on investment	44%	49%



Consumerism in Context

Engaging the consumer is one of the primary approaches for controlling cost – and often the least developed approach





Consumer-directed health plans gain momentum

Percent of employers offering plan and likely to offer in future

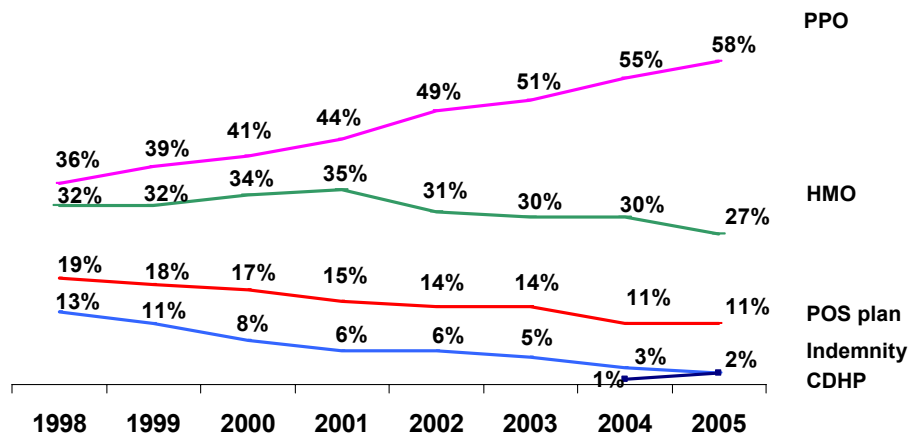
	2003	2004	2005	Likely to offer in 2006*	Likely to offer in 2007*
Large employers (500+)	1%	4%	5%	13%	17%
Jumbo employers (20,000+)	9%	12%	22%	29%	31%
State Gov't Employers			6%	22%	22%

*Selected 5 on a 5-point scale in which 1 = not at all likely and 5 = very likely. Includes employers that currently offer; 2007 figure includes employers likely to offer in 2006.



Enrollment shifting away from HMOs; CDHP at 2% of total

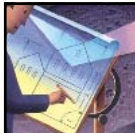
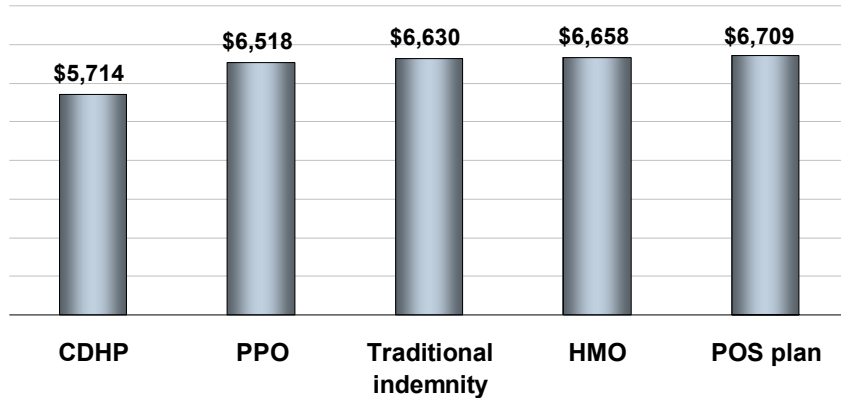
Percent of all covered employees—large employers





Large employers saving money with CDHPs

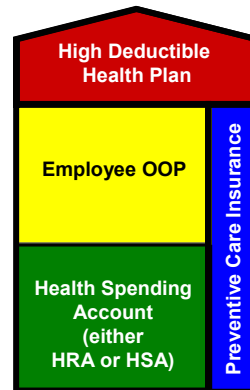
Average cost per employee



Current and Emerging Consumer Directed Approaches

Consumerism is based on assumption that patient who is disconnected from the cost is not efficient consumer

- Robust education, prevention and care management programs combined with high deductible health plan (HDHP) and health care spending account typical in successful consumer directed plans
 - Plan design and consumer education focused to enable consumer to become more efficient purchaser
 - Initially “health spending accounts” were Health Reimbursement Arrangements (HRAs); beginning in 2004, Health Savings Accounts (HSAs) become available

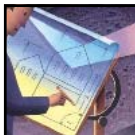




HRAs vs. HSAs

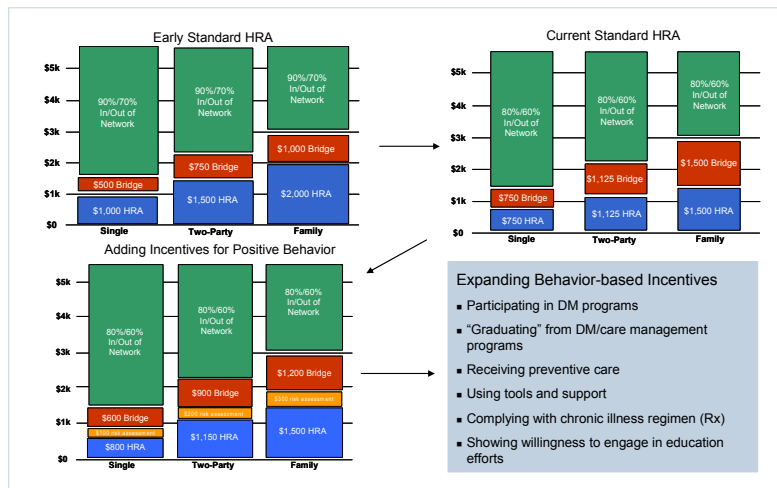
CDHPs include one of two types of employee controlled accounts: HRAs or HSAs

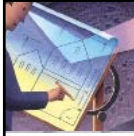
- **With an HSA**
 - A qualified high deductible health plan is required
 - The employer and/or employee can contribute
 - Contributions are tax deductible, earnings are not taxed, and disbursements for health care are tax free
 - Contributions are vested and fully portable
 - Significant regulatory requirements apply
- **With an HRA**
 - Only employer contributions are allowed
 - Significant employer control and flexibility
- **Popularity varies based on size of employer**
 - 62% of large employers offering a CDHP used an HRA
 - 76% of small employers offering a CDHP used an HSA



HRA-based CDHP Designs Continue to Evolve

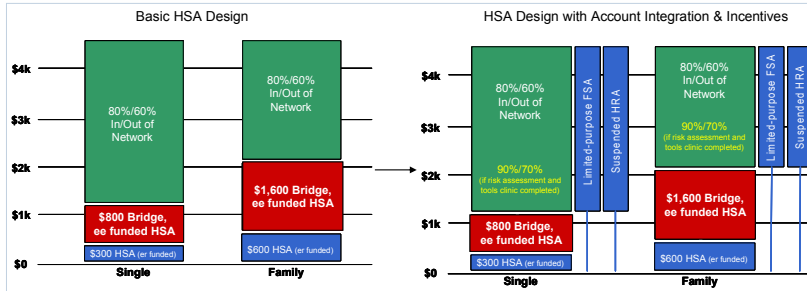
*Programs changing to better align with goals
Unfunded accounts allow for greater ongoing sponsor involvement and cash control*



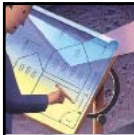


HSA-based Designs Gain Traction

Becoming widespread and morphing quickly, individual financial vehicles can create greater ownership opportunity, employee value proposition and move towards employer disengagement



- The advent of HSA-based CDHPs allows for true account ownership while adding more layers of consumerism program design opportunities and complexities
- Combining HSA, HRA and FSA functionality can add value and target specific plan sponsor goals, but communications and understandability are an issue
- HSAs with more than 2 tiers are allowed; all tiers except for single must satisfy family HDHP requirements

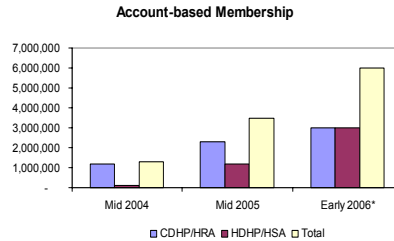


Account-based Health Plan Adoption

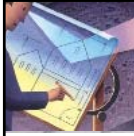
HSAs gaining in popularity

	Mid 2005		Total Members
	CDHP/HRA Members	HDHP/HSA Members	
Definity & United (Dec 04 United acq. Definity)	688,000	345,000	1,033,000
Lumenos + WellPoint (May 05 WellPoint acq. Lumenos)	400,000 (combined)		400,000
Aetna	340,000	50,000	390,000
CIGNA	188,000	100,000	288,000
BCBS of MN	51,000	50,000	101,000
First Health	96,000	n/a	96,000
PacificCare	84,800	6,500	91,300
Great West	73,600	9,500	83,100
Health Care Service Corp.	45,000	35,000	80,000
Humana	67,000	0	67,000
Destiny Health	46,000	n/a	46,000
Principal Financial	16,500	16,000	32,500
Medica	5,000	18,000	23,000
Vested Health	14,000	n/a	14,000
Wausau Benefits	13,500	n/a	13,500
Mutual of Omaha	6,100	5,900	12,000
HealthPartners	3,800	6,200	10,000
Assurant			
UICI/HealthMarket	35,000		35,000
Others (Blues, TPAs):	500,000 (combined)		500,000
Totals	2,300,000	1,200,000	3,500,000

Source: 2005 Inside Consumer Directed Health, Mercer Estimates

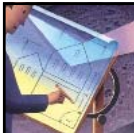


* Estimated



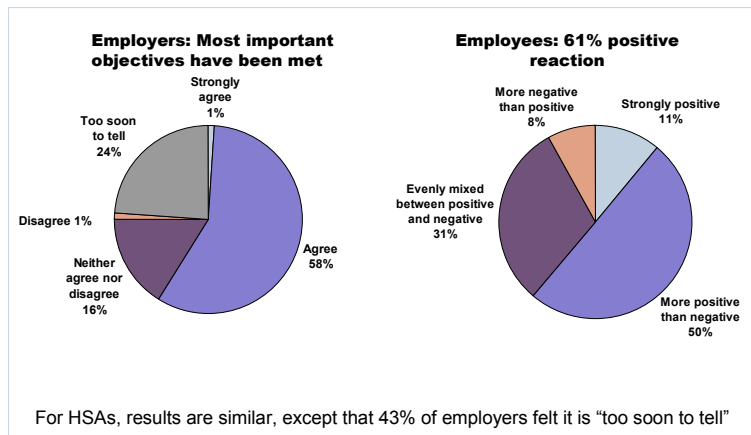
Q and A: What have we learned so far...

- Employer objectives met?
- Employee satisfaction?
- Positive impact on consumer behavior?
- Appropriate care, at the appropriate time, in the most appropriate setting?
- Do these plans really save money?



Employer and Employee Reaction to HRA-based plan

Most employers feel objectives met; majority of employees are positive





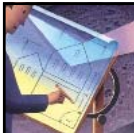
Strong Anecdotal and Self-reported Evidence that CDHPs are Positively Changing Behavior

2005 McKinsey study of consumers in full-replacement CDHPs versus consumerism in traditional plans

Findings included:

- 50% more likely to ask about the cost of a procedure
- 33% more likely to independently identify treatment options
- Three times more likely to choose a less extensive and expensive treatment option
- 25% more likely to have healthy behaviors
- Twice as likely to discuss prescription drug costs and options with their physician
- 20% more likely to follow recommended protocols for chronic conditions
- 44% were as satisfied with the CDHP as they were with their prior plan
- 80% indicated insufficient information on the costs of health provider services (i.e. prices charged by different doctors)

Source: 6/2005 Consumer-Directed Health Plan Report – Early Evidence is Promising, McKinsey



Growing Hard Evidence that CDHPs are Positively Changing Behavior

Plan sponsor with HRA-based CDHP and 10% first year enrollment (now 30%+ for 2006, with 2005 year over year study scheduled)

First year showing promising results from adopters

Small enrollment = small impact

If 10% of your population saves 10%, you've saved 1% overall

Utilization decreased - but preventive care increased

	PPO 2003	CDHP 2004
CDHP Adopters - before and after joining CDHP	667	667
Adult preventive exams/1,000 EEs	319.3	403.3
PCP office visits/EEs	3.4	3.4
ER visits/1,000 EEs	197.9	79.5
Inpatient claims/EEs	\$518	\$333
Inpatient admissions - number	46	15
Inpatient average length of stay	3.43	2.93
Rx claims paid PEPM	\$40	\$25
Total # Prescriptions PEPM	0.97	0.43
% of Generic Prescriptions	37%	43%
Total claims paid (medical and Rx) PEPM	\$213	\$173



Early Reported CDHP Results

Carrier and individual employer results are promising

	Carrier book of business studies (mostly slice offerings)				Individual Employers (full replacement offerings) (66% enrollment)			
	Aetna (HealthFund) based on 13,800 members	United (Plan) based on 20,000 members	Definity (Definity Plan) based on 320,000 members	BCBSMN (Options Blue) based on 12,000 members	St. Luke's (HealthMAP) ~1,500 employee	Whole Foods ~15,000 employees	Taxtron ~25,000 employees	Sengraph ~1,000 employees
Financial								
Claims Cost					↓ 12.7%	↓ 13%		
Primary Care Cost	↓ 11%							
Rx Cost	↓ 5.5%				↓ 20.4%			
Total Cost	↓ 6.3% (from trend)	↑ only 1%	↑ only 3.2%		↓ 20%	↓ 13.9% (from trend)		↓ 1% over 1 1/2 yrs
Utilization								
Claims		↓		↓ 7%	↓ 11.3%		↓ 13%	
Primary Care	↓ 10.9%				↓ 3.6%			
Preventive Care	↑ 23%*	↑		↑				
Inpatient Admissions	↓ 5.2%		↓ 26% (from trend)			↓ 22%		
Emergency Room Visits	↓ 3%	↓		↓ 10%	↓ 4.4%			
Specialist Visits	↑ 3%*	↓						
Rx	↓ 13%							
Re-enrollment/ Member Satisfaction	90%	90%	95%			95%		

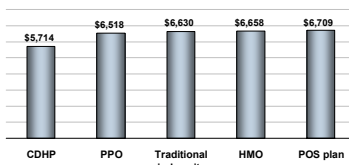
* There was only an 8% increase in Preventive Care and a 7% increase in Specialist Visits for a similar population in a traditional managed care plan



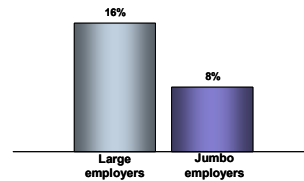
CDHP Compared to Other Plan Options

Lower costs, slowly increasing adoption by employees when CDHP offered as a choice; education is vital

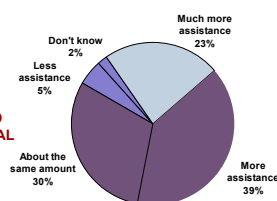
LARGE EMPLOYERS SAVING MONEY WITH CDHPS



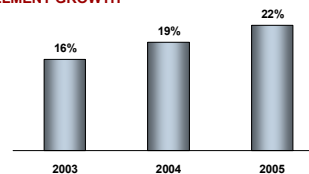
AVERAGE CDHP ENROLLMENT WHEN OFFERED AS AN OPTION



AMOUNT OF ASSISTANCE REQUIRED BY EMPLOYEES ENROLLING IN CDHP, COMPARED TO OTHER MEDICAL PLANS



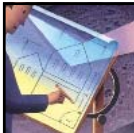
PANEL OF 28 EMPLOYERS OFFERING HRA-BASED CDHPS SINCE 2003 REPORT ENROLLMENT GROWTH





Other consumerist strategies used...

	Large employers	Jumbo employers
Provided access to website on health conditions	69%	84%
Provided access to website on provider quality and cost	49%	53%
Provided utilization modeling tool to help with plan selection	21%	47%
Replaced co-payments with coinsurance	22%	50%



Let's talk about transparency... Care Focused Purchasing

- **What is Care Focused Purchasing?** Care Focused Purchasing (CFP) is an employer-led initiative involving close to 40 national employers that selected Mercer as its project manager.
- **What is its goal?** Acting together, employers are working to make a transparent healthcare delivery market that rewards better physicians, better hospitals, and better treatment options.
- **What is the magic?** The central engine of CFP is standardized information on provider quality and efficiency which will create performance sensitive sellers of care. This will act as a catalyst to speed up embryonic changes underway in the health care system, leading to a more transparent, rational market.

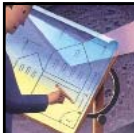


CFP Employers

HR leaders of US-based companies,
representing over 3 million enrolled health plan members,
joining together to achieve real improvements in health care cost and quality

Representative List of Employers

- Analog Devices, Inc.
- Assurant (formerly Fortis, Inc.)
- BellSouth Corporation
- The Boeing Company
- Capital One Financial Corporation
- Corning Incorporated
- CSC
- Freightliner
- Hannaford Bros. Co.
- J.C. Penney Company, Inc.
- Lowe's Companies, Inc.
- The Kroger Co.
- Marsh & McLennan Companies, Inc
- Merrill Lynch
- Northrop Grumman
- The Pepsi Bottling Group, Inc.
- PepsiCo Inc.
- The Procter & Gamble Company
- Sprint Corporation
- Texas Instruments Incorporated
- VNU, Inc.
- Weyerhaeuser
- Xerox Corporation



CFP Carrier Partners

- Aetna*
- CIGNA*
- Empire BCBS*
- Fiserv*
- HealthPartners
- Humana*
- PacifiCare
- Preferred Care
- Premera**
- Regence BlueShield*
- UnitedHealth Group
- WellPoint**

Discussions with other carriers in progress

- **Carrier Partners will contribute insured data for over 20 million members**

What does it mean to be a partnering carrier?

Agreeing to:

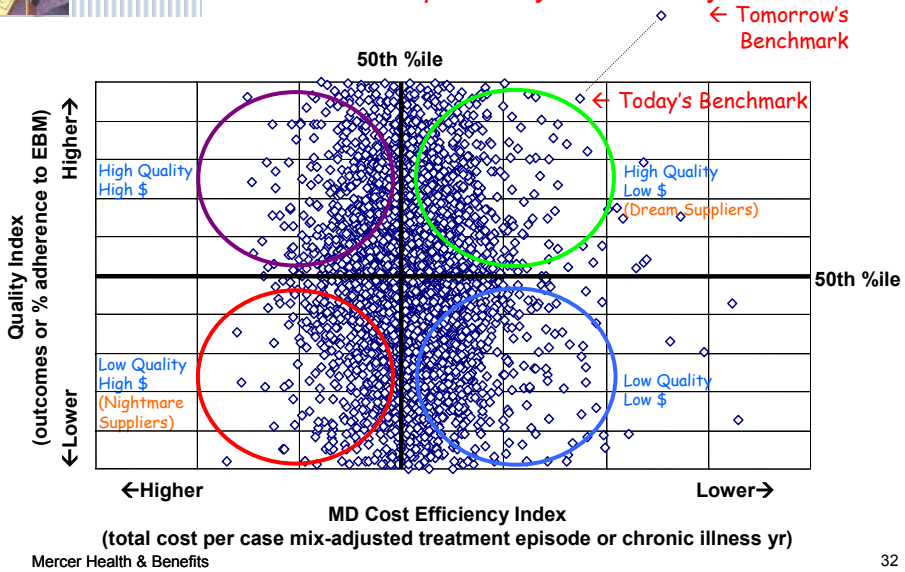
- Approval of common measures
- Publicly support the CFP project
- Fund 3-year data aggregation contract
- Contribute BoB insured commercial (now) and Medicare data (potential future state)
- Participate in CFP Governance and Carrier Data Advisory Group



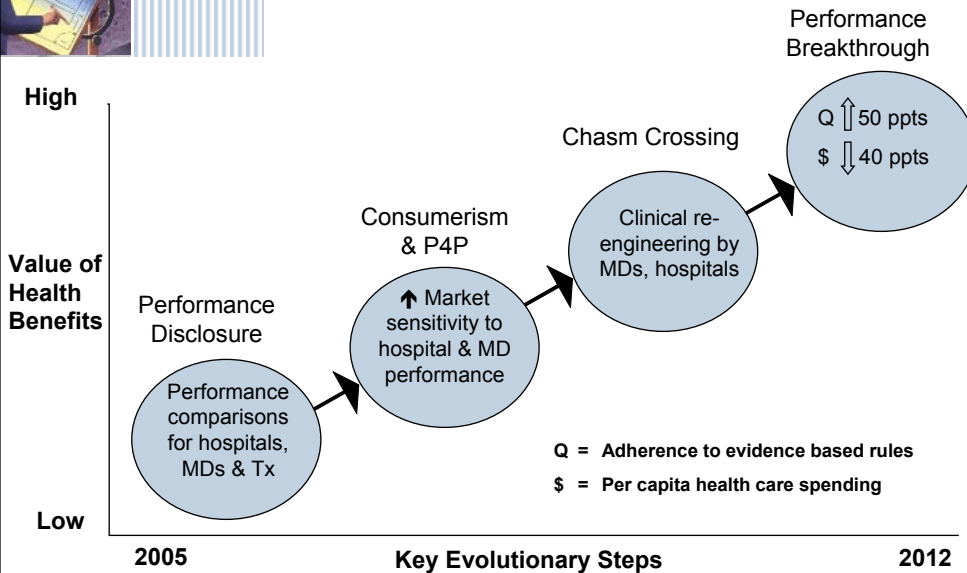
Why work together?

Material Variability in Physician Performance

Distribution from a Comparatively Efficient City

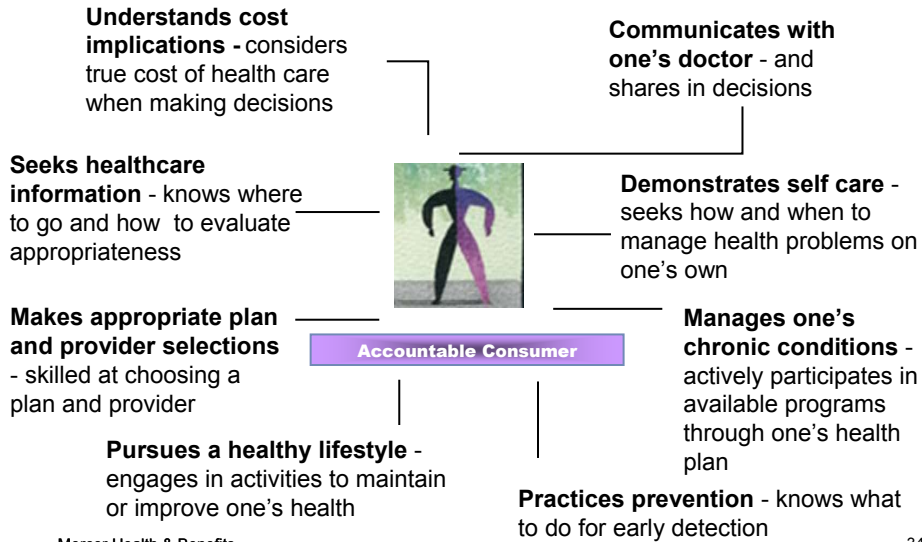


The Payoff: Long Term Return



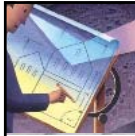


Changing Behavior: The Accountable and Effective Healthcare Consumer



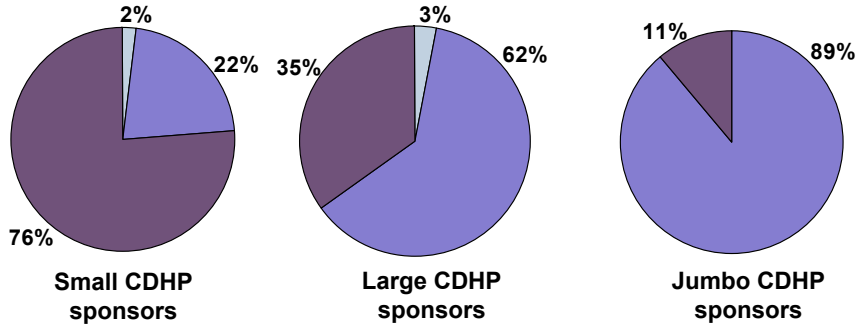
Appendix: More on Consumerism and CDHPs





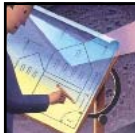
Small employers favor HSAs, large employers HRAs in 2005...

- HRA-based CDHP
- HSA-based CDHP
- Both



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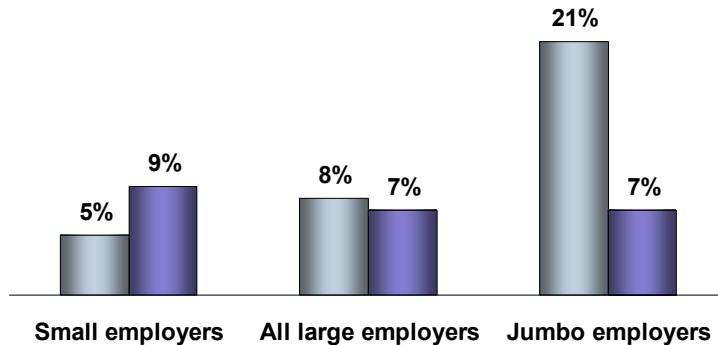
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...but HSAs may gain some ground with large employers in 2006

Percent of employers likely to offer in 2006*

- HRA-based CDHP
- HSA-based CDHP



*Selected 5 on a 5-point scale in which 1 = not at all likely and 5 = very likely. Includes employers that currently offer.

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Policy changes that employers say would make them more likely to offer an HSA

	Small employers	Large employers
Allow unspent FSA balances to be rolled over into HSA	49%	60%
Coordinate HSA with FSA so employees could spend FSA funds first	41%	57%
Allow Rx expense to <u>not</u> be subject to high deductible	49%	53%



Employee contributions for CDHP coverage lower than for PPO and HMO coverage

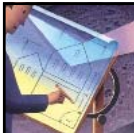
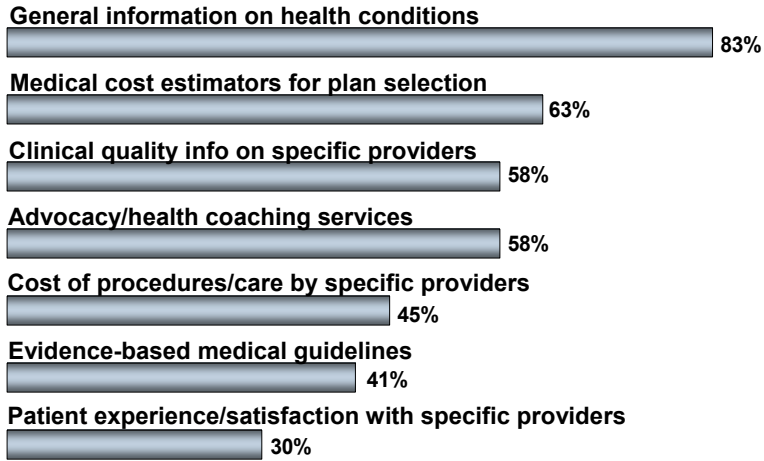
Large employers

	No contribution required	Average monthly dollar amount	Average contribution as a % of premium
CDHP			
Employee-only	23%	\$57	26%
Family	7%	\$206	35%
PPO			
Employee-only	13%	\$78	23%
Family	5%	\$290	33%
HMO			
Employee-only	15%	\$67	23%
Family	5%	\$266	33%



Decision-support information and tools provided in CDHP

Large employers

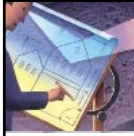


CDHP plan design—HRA

Large employers

	Employer contribution (median)	Deductible (median)	Out-of-pocket maximum (median)
Employee-only	\$750	\$1,250	\$2,500
Family	\$1,500	\$1,600	*

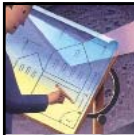
*No data available



HRA funds roll-over

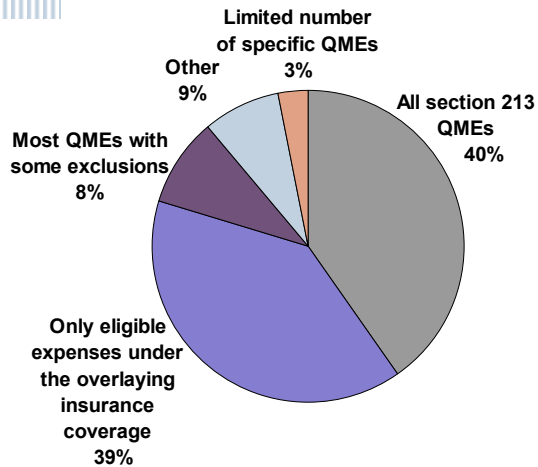
Large employers

- 20% of sponsors set a maximum on amount that may be rolled over
- 23% of sponsors allow HRA funds to be carried forward to purchase retiree medical coverage



Eligible expenses for HRA dollars

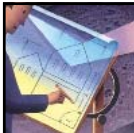
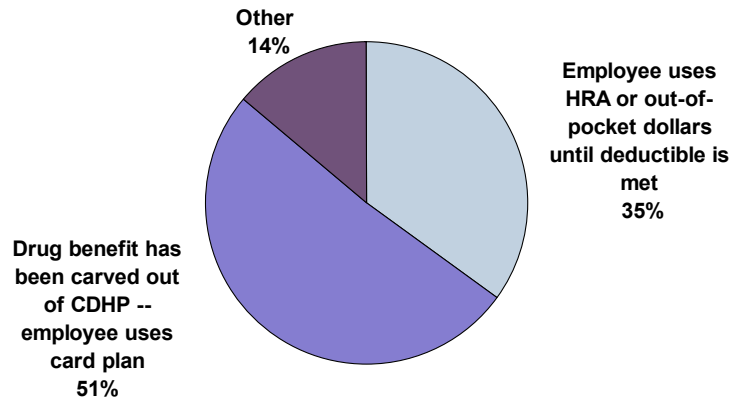
Large employers





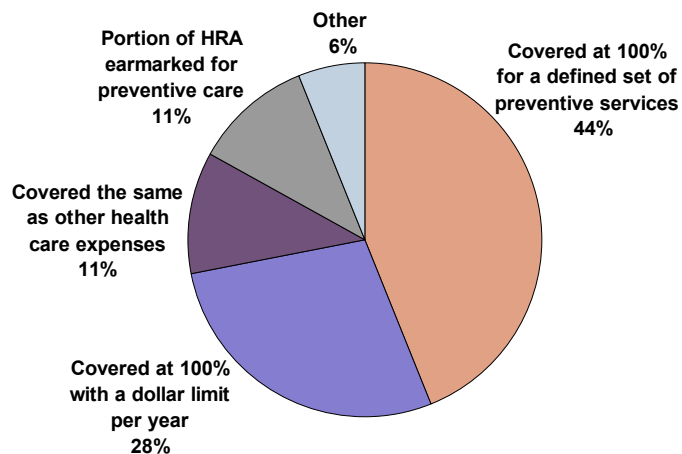
Prescription drug coverage under HRA-based plan

Large employers



How preventive care is covered in the HRA-based plan

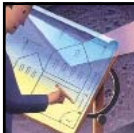
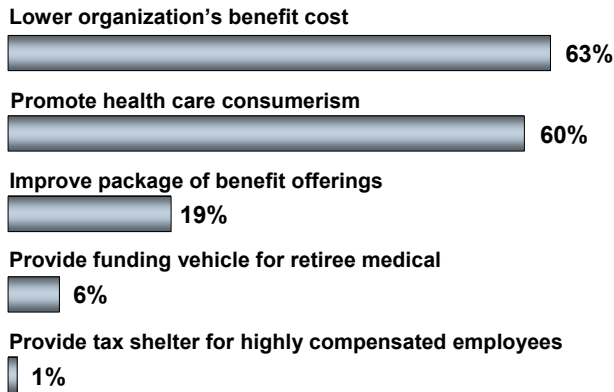
Large employers





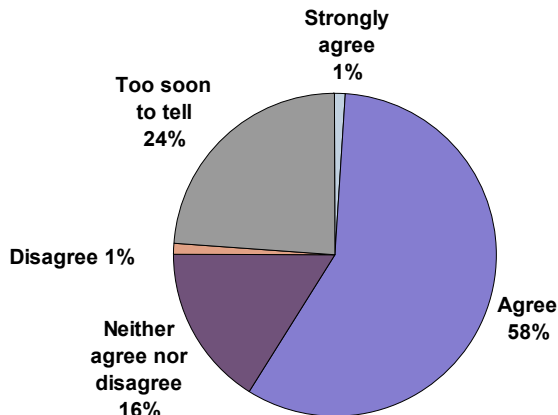
Objectives for HRA-based CDHPs

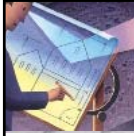
Percent of large sponsors rating objective “very important”



Employer reaction to HRA-based plan: “Most important objectives have been met”

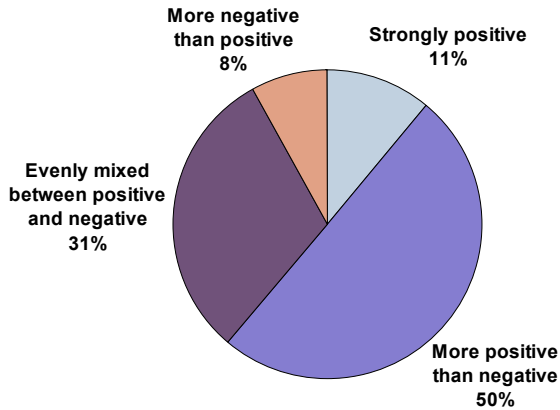
Large employers





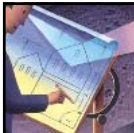
Employee reaction to HRA-based CDHP

Large employers characterize the response of employees enrolled in the plan



Mercer Health & Benefits

48



CDHP plan design—HSA

Large employers

	No employer contribution (percent of sponsors)	Deductible (median)	Out-of-pocket maximum (median)
Employee-only	38%	\$1,200	\$3,500
Family	31%	ID	*

ID = Insufficient data

*No data available

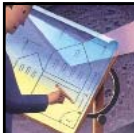
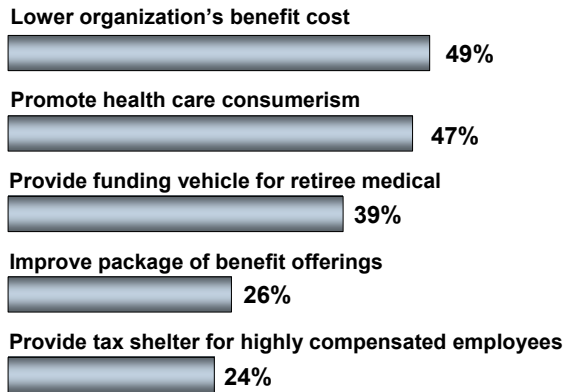
Mercer Health & Benefits

49



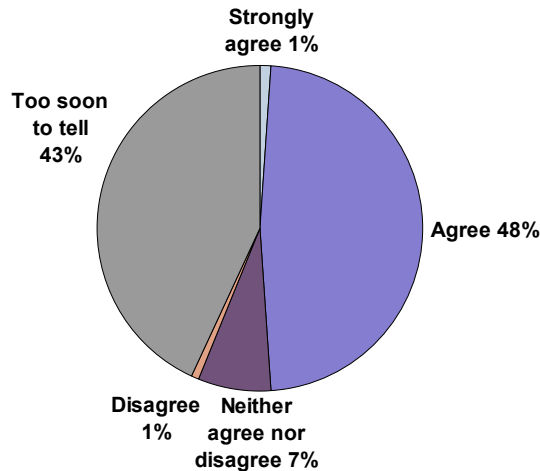
Objectives for HSA-based CDHPs

Percent of large sponsors rating objective “very important”



Employer reaction to HSA-based plan: “Most important objectives have been met”

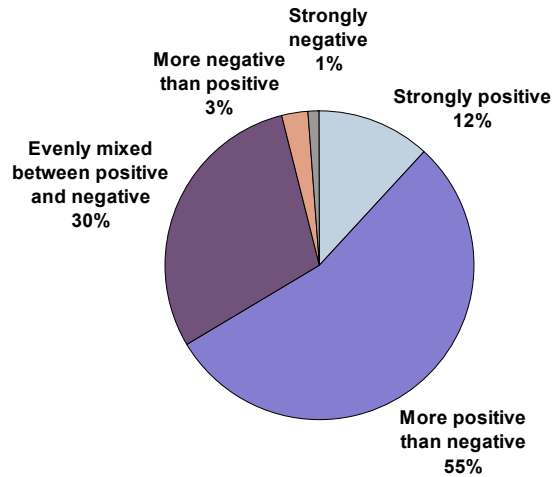
Large employers





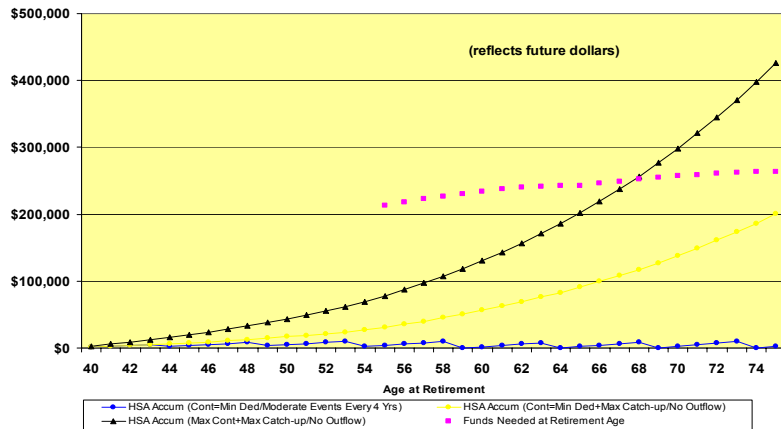
Employee reaction to HSA-based CDHP


Large employers characterize the response of employees enrolled in the plan



The Potential Impact of an HSA at Retirement

HSA Accumulation Under Various Savings Scenarios
2004 Age = 40



Use incentives to encourage participation in care management programs

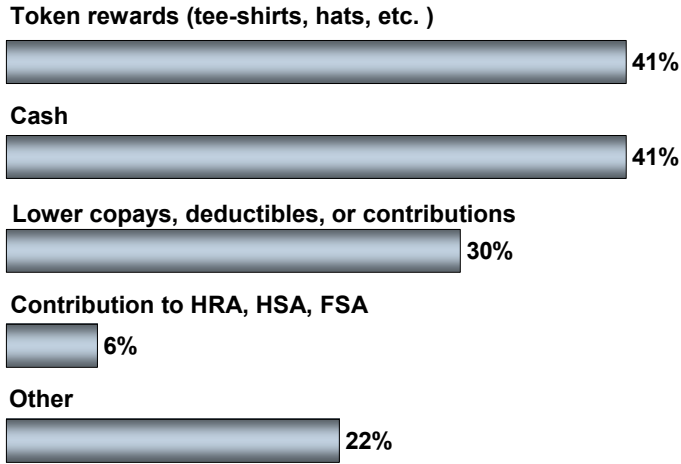
	Large employers	Jumbo employers
Completing a Health Risk Assessment	17%	23%
Participation in a disease management program	7%	11%
Participation in a behavior modification program	12%	9%
Completing a behavior modification program	11%	6%

Mercer Health & Benefits 55

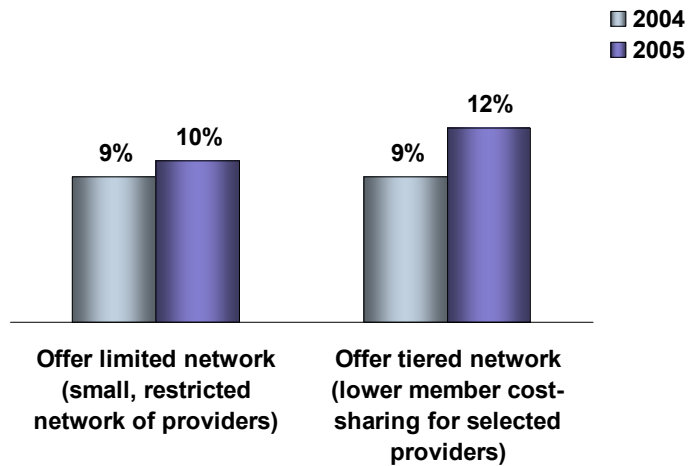


Types of incentive used

Among large employers providing incentives

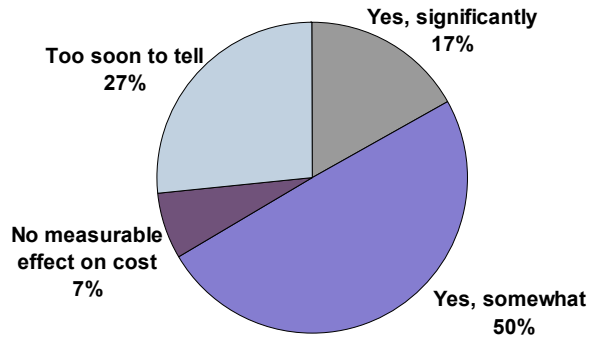


Jumbo employers adding high-performance networks





Has the use of a limited or tiered network helped reduce health plan cost?



Based on employers with 20,000 or more employees offering limited/tiered network