

Consumer-Driven Health Benefits as a Strategy to Control Costs

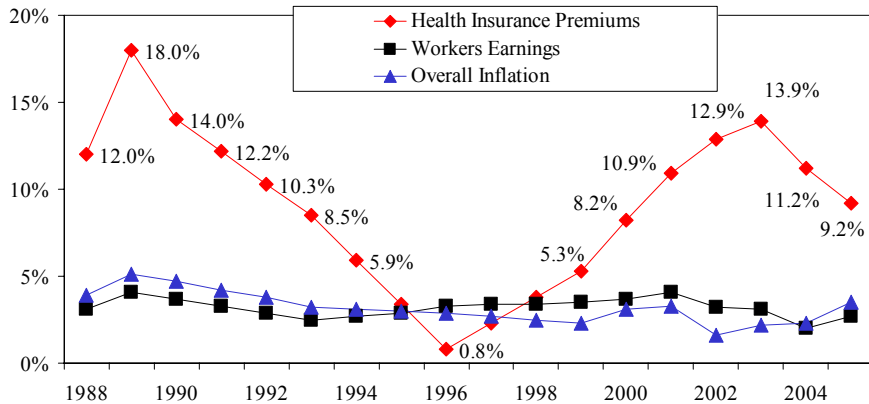
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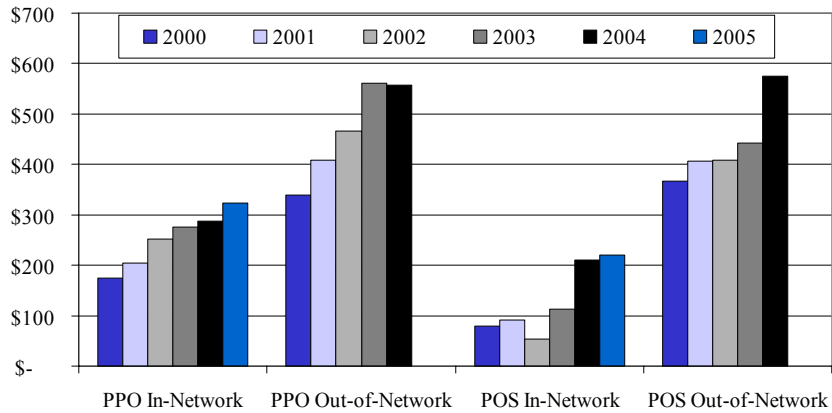
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Premiums Rising 4-5 Times Faster than Inflation and Wages, 1988-2005



Source: KFF/HRET and Bureau of Labor Statistics.

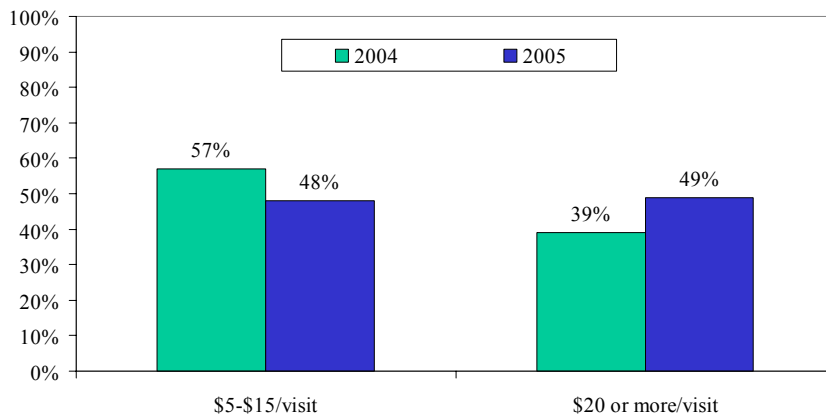
Average Annual Deductibles for Employee-Only Coverage, 1996-2005



Source: KFF/HRET.

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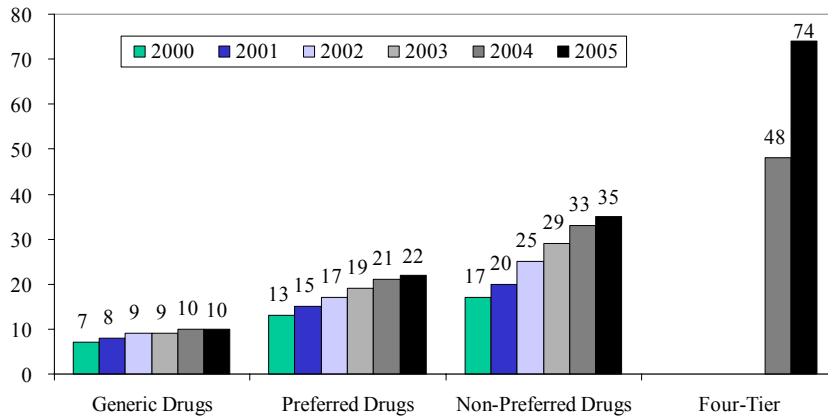
Distribution of Physician Office Visit Copayments, 2004-2005



Source: KFF/HRET.

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Average Co-Pay for Drugs, 2000-2005



Source: KFF/HRET.

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Consumerism: Potential & Concerns

Potentials

- Lower costs
 - Reduction in use
 - Use of lower cost services
- Better engaged consumer
- More satisfied consumer
- Better health outcomes/more appropriate care
- Improve affordability

Concerns

- Low health literacy
 - Reduce necessary care
 - Induce demand for unnecessary care
- Lack of tools & resources to make decisions
- Impact on high cost users uncertain
- One-time savings

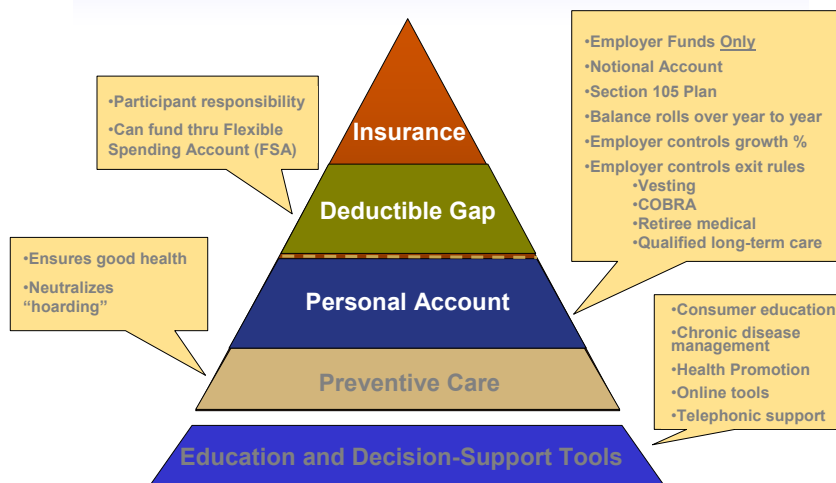
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Health Reimbursement Arrangement (HRA)

- Employer provided notional account that allows for pre-tax reimbursement of medical expenses.
- Typically combined with a high-deductible health plan.
- Employee contributions not permitted.

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HRA Prototype



Source: PriceWaterhouseCoopers.

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Health Savings Account (HSA)

- Allows for tax-free accumulation of savings.
 - Tax free contribution.
 - Tax free accumulation.
 - Tax free withdrawals for health care services, COBRA and LTCI premiums, retiree health premiums for Medicare-eligible retirees.
- Qualified health plan.
 - Self-only: Minimum \$1,050 deductible, \$5,250 OOP max.
 - Family coverage: Minimum \$2,100 deductible, \$10,500 OOP max.
- Contributions
 - Self-only: limited to level of deductible up to \$2,700 max.
 - Family coverage: limited to level of deductible up to \$5,450 max.
- Catch-up contributions allowed once age 55 of \$1,000.
 - Phased-in by 2009.

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HRA & HSA Comparison

Account Feature	Ownership of funds	"Use-it-or-lose-it" by end of benefit year?	Access to account upon end of job	Who contributes
Health Reimbursement Arrangement (HRA)	Employer	No, funds rollover	Depends on employer	Employer
Health Savings Account (HSA)	Employee	No, funds rollover	Yes	Both

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HRA & HSA Comparison

Account Feature	Must be paired with high deductible	May be used with other accounts	Money can be used for non-health expenses	Tax treatment
Health Reimbursement Arrangement (HRA)	No, but often is	Yes, with limits	Yes, subject to tax and penalties	Not included in taxable income
Health Savings Account (HSA)	Yes	Yes, with limits	Yes, subject to tax and penalties	Reduces taxable income

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Evidence So Far

Aetna Study: Medical Claims

2003: 3.7% YOY Increase

2004: 6% YOY Increase

Change in utilization

- Inpatient -5.2%
- ER Visits -2.6%
- Outpatient -14.4%
- Office visits -3.3%
 - PCP -10.9%
 - Specialist +3.4%

Change in utilization

- Inpatient -6.7%
- ER Visits -15.9%
- Outpatient -4.6%
- Office visits -3.4%
 - PCP -12.3%
 - Specialist +3.6%

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Evidence So Far

Aetna Study: Pharmacy

- Overall Cost Increase
 - CDHP +13%
 - PPO +18%
- Generic Use
 - CDHP +2.1%
 - PPO +1.3%
- Mail Order
 - CDHP +3.5%
 - PPO +1.7%

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Univ. of Minnesota

- HRA enrollees has lower overall spending than PPO enrollees, but higher spending than HMO enrollees
- HRA enrollees had lower OOP spending than PPO enrollees, but HRA enrollees chose plans with relatively low OOP gaps.
- HRA enrollees had significantly higher hospital spending → price consciousness may have led them to avoid care until they were very ill and more costly to treat

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Univ. of Minnesota

- HRA had initial favorable selection, but concluded the study period (2 years) with a significantly higher burden of illness
 - Could reflect
 - impact on health status
 - Favorable selection is a proxy for pent-up demand not realized until enrollees had a greater choice of providers

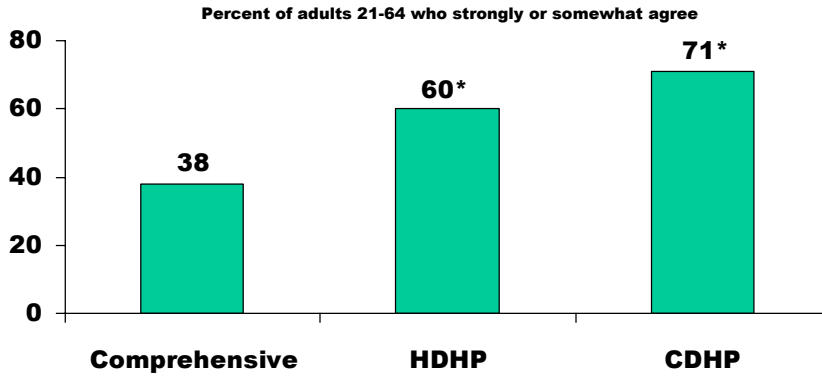
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EBRI/Commonwealth Fund Consumerism in Health Care Survey

- Low diffusion of consumer-driven plans
- Among adults with plans, lower satisfaction with quality of care, out-of-pocket costs, plan overall; few would recommend plan to friends/co-workers
- High out of pocket costs + premiums amount to substantial share of income, especially among those with lower income and health problems
- No differences in service use, but higher reported rates of cost-related delays, avoidance, or skipping care or Rx, esp. lower income and health problems
- More cost-conscious decision making behavior
- Little quality/cost information provided by plans

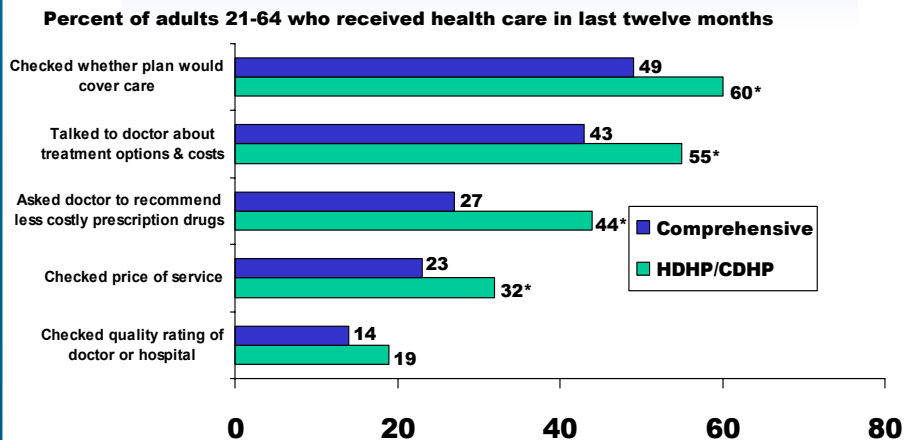
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Percentage of Adults who Agree that Terms of Coverage Make Them Consider Cost When Deciding to Seek Health Care Services



Note: Comprehensive = plan w/ no deductible or <\$1000 (ind), <\$2000 (fam); HDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), no account; CDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), w/ account.
 *Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.
 Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Cost Conscious Decision-Making, by Insurance Source



Note: Comprehensive = plan w/ no deductible or <\$1000 (ind), <\$2000 (fam); HDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), no account; CDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), w/ account.

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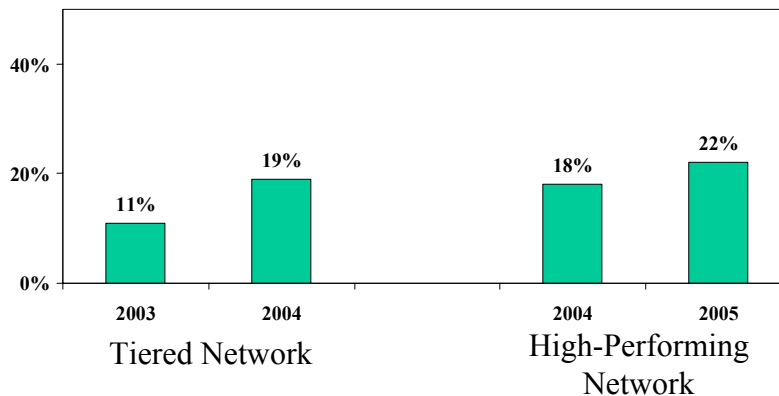
Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Tiered Provider Networks (TPNs)

- Hospitals & doctors.
- Tiers vary with cost & quality.
 - Similar to PPO (in vs. out)
 - Similar to Rx tiers.
- Cost sharing distinctions
 - Co-payment per hospital day.
 - Coinsurance rate per stay.
 - Overall deductible per stay.

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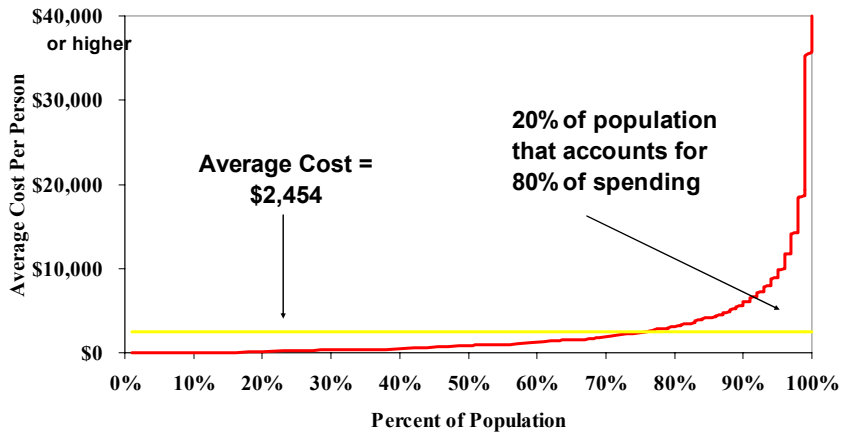
Use of Tiered & High-Performing Networks, Large Employers, 2003-2005



Source: Mercer.

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Annual Claims Distribution Adults Ages 18-64, 2001



Source: EBRI estimates from the 2001 MEPS.

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15 Most Costly Conditions Account for Over 50% of Spending

Heart disease	9%
Trauma	7%
Cancer	6%
Pulmonary conditions	6%
Mental disorders	5%
Hypertension	4%
Diabetes	3%
Arthritis	3%
Back problems	3%
Cerebrovascular disease	2%
Pneumonia	2%
Skin disorders	2%
Endocrine	2%
Infectious disease	2%
Kidney	1%
Total spending	56%

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Asheville Project

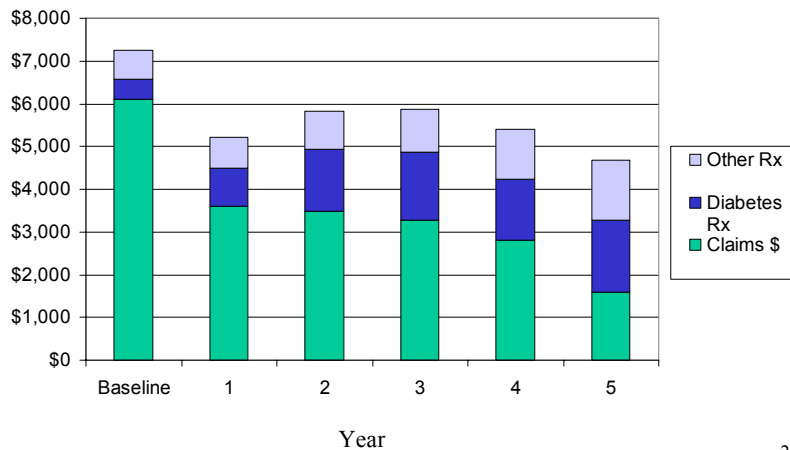
(J. of Amer. Pharma Assoc., 2003)

- No cost meetings with pharmacists
 - Education, home meter training, physical assessments
- Co-payments for diabetes-specific drugs and supplies were waived

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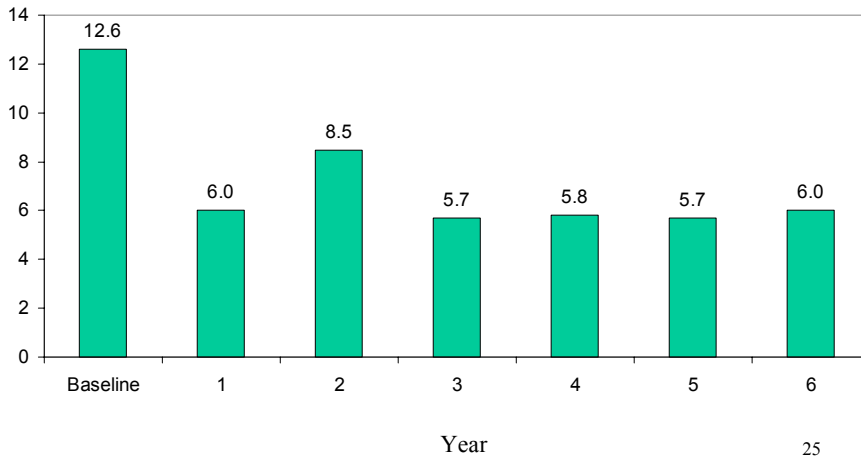
Asheville Project

Direct Medical Costs Over Time



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Asheville Project Ave. Annual Sick Days Among Diabetics



Cholesterol Lowering Drugs

- Recent Rand study, American Journal of Managed Care
- Increase in copayment from \$10 to \$20 associated with a 6-10 percentage point reduction in compliance.
- Full compliance associated with 357 fewer hospitalizations in sample studied.
- Elimination of copayments for certain patients would avert 80,000 hospitalizations and 31,000 ER visits nationally.
- National savings would be more than \$1 billion.