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## ACB-ACHS 2008 Joint Meeting

November 12, 2008

Breakout Session 2B: Consumer Driven Health Insurance

Dave Tuomala, FSA, MAAA, FCA  
Senior Consultant  
Reden & Anders



## Agenda

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- American Academy of Actuaries  
“Consumer Driven Health Plan Emerging Data Report” – excerpts from SOA Annual Meeting
- How is Consumerism Impacting the Future of Healthcare?  
Cost/Quality Transparency & Other Issues – excerpts from CCA Annual Meeting

## Background on AAA CDHP Emerging Experience Workgroup

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- Consumer Driven Health Plan Emerging Data Report (expected November/December 2008)
  - Logical next topic to consider given prior publications from CDHP workgroup
  - Experience on CDH performance largely unpublished (presentations versus reports or journal articles)
  - Frequent citation of out-dated AAA Monograph on MSAs as the “actuarial opinion” on CDH plans
  - Perception among policy-makers that CDH plans are “new” and that data is unavailable
  - Lack of a comprehensive actuarial assessment of multiple CDH experience studies and results

## Characteristics of Studies Included

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- Available by early April 2008
- Based on actual experience and claim data
- Credible methodology
- Results detailed and relevant
- Studies meeting criteria:
  - Making an Impact – Aetna health Fund (2008)
  - CIGNA Choice Fund: Two Year Experience Study, 2005 to 2006 (March 2008)
  - Reden & Anders – Consumer Directed Health Care: A Look at Current Experience (November 2006)\
  - Uniprise – 2008 CDHP Results Discussion (March 2008)

## Key Questions Evaluated

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- Do CDH designs result in any first year cost savings and/or favorable impacts on cost trends beyond the first year?
- Are the apparently positive results presented by market participants real, or merely the result of favorable selection?
- Are cost savings generated at the expense of necessary care or the result of delayed or inappropriate avoidance of care?
- Are CDH plans merely a device for employers to shift more of the total benefit cost to employees?

## Results/Findings

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- First year savings appear to be well-established by multiple studies from multiple carriers with large volumes of membership
  - Savings is generally consistent with typical stand-alone high-deductible plan assumptions
  - Result is consistent with standard actuarial models and expectations
- Ongoing trend savings is less-established, but some studies indicate a differential trend result for CDH versus traditional plans
  - Fewer carriers and fewer members studied
  - Not currently a standard actuarial model assumption (but maybe should be?)
  - Very promising result if additional data supports initial findings

## Results/Findings

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- Risk selection effects are a confounding factor in analyzing CDH results
  - Included studies have taken reasonable steps to control for these effects
  - Results appear to be credible – not incidental results due to selection effects
  - No evidence that carriers have selectively reported results
- Quality of care appears to be maintained with CDH plans
  - Preventive care generally higher (many studies)
  - Numerous other metrics used to measure quality (no consensus)
    - Use of recommended care for chronic conditions
    - Evidence-based care measures
    - Prescription drug utilization
  - Generally same or better quality with CDH versus traditional plans

## Results/Findings

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- Member cost share impact is generally same or better
  - CDH can be used as a cost-shifting mechanism – big concern for policy community
  - Limited data available, but CDH does not appear to be a cost-shifting plan design in practice
  - Overall cost-sharing levels (including HRA/HSA funds) are similar to traditional plans

## Where Are We Now? 2008 versus 2001 Perspective

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- 2001 Perspective:
  - CDH carrier market dominated by start-ups
  - Will CDH work? Theoretical/actuarial justification vs. evidence
  - Will mainstream employers buy it? Some early adopters identified
  - Will IRS allow it? Legal arguments vs. safe harbor
  - Will it lead to poor health outcomes (or how will consumers react)?
  - Cost shifting, risk selection, issues/concerns
  - Infrastructure/capabilities under development, but not fully operational

## Where Are We Now? 2008 versus 2001 Perspective

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- 2008 Perspective:
  - Emerging CDH data is positive
    - First year costs lower
    - Some evidence of lower ongoing trends
    - Quality is similar
  - Widespread/rapid employer adoption
    - Limited product evolution (HRA/HSA)
    - Total market penetration – critical mass?
  - Regulatory status clear/expanded
    - Politically sensitive

## Where Are We Now? 2008 versus 2001 Perspective

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- 2008 Perspective (continued):
  - Market maturation
    - Surviving start-ups acquired/integrated by major carriers
    - Product/capability innovation slower? Or temporarily slowed by acquisition/integration?
    - CDH concepts/capabilities migrated to other products
  - Incentives/wellness/other initiatives
    - Expansion of CDH or substitution?
  - Transparency
    - Price/quality information is more available, but remains limited – may not be usable
    - Provider payment largely unchanged – still negotiated FFS networks

## (Some) Principles of CDH Evolution

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- Fund (ownership) can be a substitute for member cost-sharing
- We never said fund-based products were the full solution – but a critical element (necessary)
- Healthcare market versus healthcare system
  - We have a healthcare market now (for better or worse)
  - We do not have (nor necessarily want) a healthcare system
  - We generally know what the characteristics of an efficient healthcare market would look like

## (Some) Principles of CDH Evolution (cont'd)

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- Elements of a consumer healthcare market (necessary, but not sufficient)
  - Demand-side (consumer) financial engagement (ownership)
  - Price/quality transparency (provider financial/clinical engagement) and competition
  - Supply/demand balance/adjustment
  - Price elasticity/discovery
  - Inter-related factors – significant change in any one **could be** sufficient to move the market

## Key Questions for CDH Evolution

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- Does it build on what we have learned?
- Is there a value proposition for employers? For consumers?
- Can it be demonstrated/modeled/justified?

Why: All health care product and delivery innovations are ultimately focused on cost and trend because that is the core problem.

## Foundational Improvements – Identifying what works and where to focus

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- Necessary/unnecessary care models
- Health Risk Assessment Evaluation
- Incentive Program Evaluation
- EBM and Pharmacy Adherence Modeling
- Member Messaging Effectiveness
- Common Consumer Tool Effectiveness

## Plan Design Evolution

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- HRA/HSA is the beginning rather than the end
- There are other possible extensions of fund/ownership concept
- CDH remains politically sensitive
  - Do we need to find another vehicle for mainstream adoption?
  - HMO => POS => PPO transition model
  - What will be the PPO equivalent for CDH?

## Plan Design Evolution

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- Examples:
  - Value-based benefit designs
  - Episode-driven cost-share designs
  - Non-Fund/HDHP designs
  - Variable contribution/cost-share models
  - Evolution of fund/HDHP models (increasing the scope of consumer control of benefit dollars)
    - Higher deductible/higher fund designs
    - Multi-year plan/fund
    - Alternate funding mechanisms/structures

## Wellness/Incentives/Other Initiatives

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- Wellness alone may not have ROI
  - Without systemic changes population healthcare use may not change (shifted to other conditions)
- Incentives are unlikely to be focused without foundational improvements
- Defined contribution/employer exit strategies have limited life-span without fundamental trend changes

## Provider Payment/Delivery System Evolution

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- Effective transparency initiatives must:
  - Reflect how consumers actually purchase care
  - Create incentives for efficiency improvements
  - Address price elasticity and allow for price discovery
  - Allow for supply/demand adjustment
  - Achieve a critical mass of membership sufficient to overcome the significant inertia of status quo and public sector payment volume
  - Include effective demand-side components (supply side probably not sufficient by itself)

# Consumer Driven Health Insurance



**Joan C. Barrett, FSA**

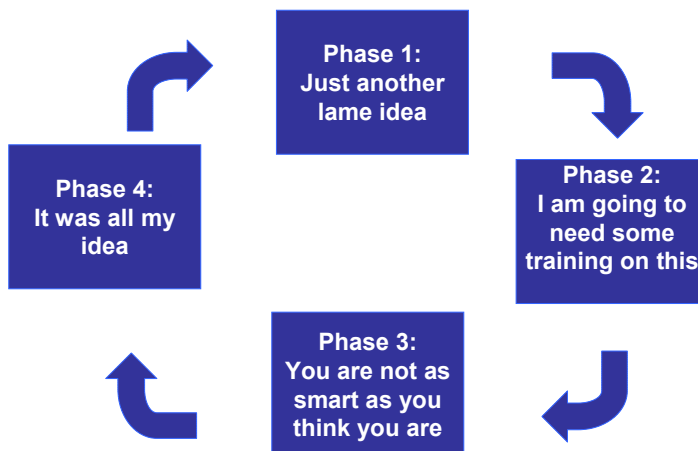
*Senior Actuary, Uniprise  
a UnitedHealth Group Company*

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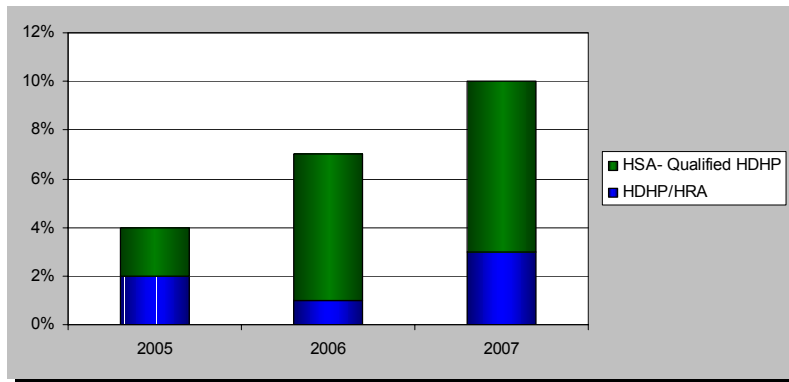
## The 4 Stages of Product Acceptance



- Overall, CDH is in phase 3: we are finding out exactly what works and what does not work
- This presentation will cover
  - Experience update
  - Lessons learned and to be learned
  - A look ahead

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## Growth in CDH: % of Firms Offering CDH Plans

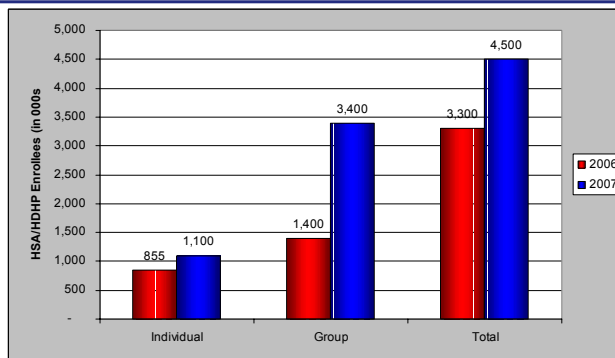


- % firms offering CDH plans among firms offering health benefits
- Approximately 3.8 million covered workers or roughly 8 million members
- Source: KFF/HRET 2007 Employee Benefits Survey (telephone survey)

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## HSA/HDHP Enrollment (AHIP April 2007) – in 000s



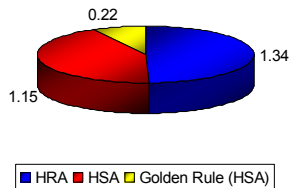
- ❑ Does not include HRA plans, where most people are covered
- ❑ Individual market:
  - 27% of new enrollees were previously uninsured
  - 25% of new purchases of health insurance were HSA/HDHP plans
- ❑ Group market
  - Slightly over 1 million were enrolled in the small-group market and 2 million in the large-group market
  - HSA/HDHP products accounted for 17% of new policies in the small-group market and 8% of new policies in the large group market

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## 2008 UHG Experience

### CDH Enrollment (In Millions) 2.7M total membership



#### □ 22,500+ employer clients

- 170 Uniprise clients (Jumbo)
- 20,600 Small employers
- 1,700 Key, Public entities
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#### □ Full replacement (as of 12/07)

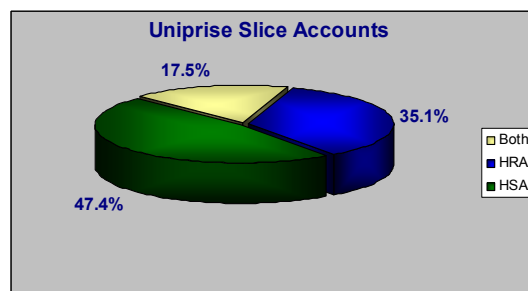
- 600,000 members in full replace plans
- 13 Uniprise clients
- 340 Key/public clients
- 8,000 Small clients

#### □ Approximately 16% of Uniprise members are enrolled in CDH plans

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## Uniprise Accounts



- 92% of the Uniprise CDH accounts offer CDH on a slice basis
- Almost 50% of the customers offer HSA only
- 60% of the members are in HRA plans, however
- For most slice customers, the % CDH is < 20%, but can be as much as 60%+. Key differences are
  - Contribution strategy
  - HRA/HSA funding level
  - Communications
- ~ 60% of plans have in-network deductibles > \$2,000, most of which are under \$3,000
- Over 50% have a 20% in-network coinsurance level

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## AHIP Survey HSA Plans

Market	Feature	Single	Family
Small-Group	Avg Deductible	\$2,282	\$4,541
	Avg Out-of-Pocket	\$3,404	\$6,611
Large Group	Avg Deductible	\$1,952	\$3,996
	Avg Out-of-Pocket	\$3,290	\$6,247

- Most companies responding to the census offered HSA/HDHP options with preventive benefits
- Most companies offered disease management programs, with asthma, diabetes, CHD and COPD being the most common
- Consumer information tools
  - Over 90% of HSA/HDHP enrollees had online access to account information
  - 95% had on-line access to health education tools
  - 86% had access to quality information about specific hospitals
  - 50% had access to physician specific quality information

## HSA Account Balances: Do people save?

- ❑ AHIP Survey, Average 2006 account balance
  - 14% had \$0 balance
  - 74% had balances greater than \$0, less than \$2,500
  - 4% had balances greater than \$5,000
- ❑ UnitedHealth Group 2006 experience
  - About 60% of consumers on average in an HSA-eligible plan open an account
  - 91% of consumer open the account when their employer makes a contribution
  - 70% of UnitedHealth Group's employer clients contribute to their employees' HSA; the average contribution is \$895
  - 80% of eligible low-income individuals (earning less than \$25k per year) opened an HSA and 56% made their own contribution to the account

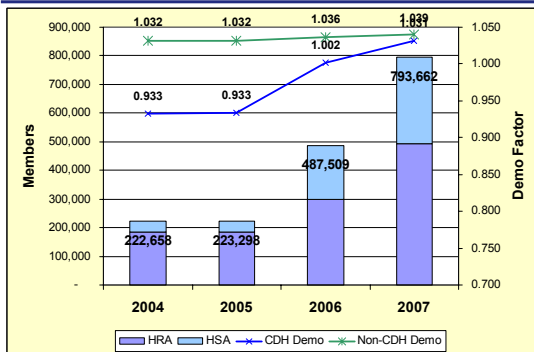
## CDH vs. Non-CDH Characteristics – Legacy Uniprise Book (June 2007 Membership)

Metrics	Young Singles	Young Families	Older Families	Empty Nesters/Older Singles	Chronics	Combined
<b>CDH</b>						
Active Subscribers:	83,213	44,972	36,877	99,218	60,547	324,828
Pct of Total Subscribers:	26%	14%	11%	31%	19%	100%
Pct of Total Spend (FY 2006): <sup>3</sup>	6.2%	15.0%	12.5%	23.3%	43.1%	100%
Average Contract Size:	1.0	3.0	3.8	1.5	2.5	2.0
Average Subscriber Months/Year:	8.0	8.8	9.2	9.1	10.1	8.9
Average Risk Scores:	0.7	1.0	1.3	1.5	2.5	1.5
<b>Key Demo/Socio Factors:</b>						
-Avg Subscriber Age:	28.5	32.4	46.6	53.0	48.5	42.3
-Pct Female Subs	44%	42%	33%	51%	42%	44%
<b>Top 3 Cultural Ethnicity: <sup>1</sup></b>						
-European	69%	72%	80%	81%	79%	77%
-Hispanic	14%	13%	8%	8%	9%	10%
-African American	8%	6%	4%	5%	5%	6%
<b>NON CDH</b>						
Active Subscribers:	812,277	466,597	401,277	1,046,292	812,815	3,339,258
Pct of Total Subscribers:	18%	14%	12%	31%	24%	100%
Pct of Total Spend (FY 2006): <sup>3</sup>	4.9%	14.8%	12.3%	20.6%	47.5%	100%
Average Contract Size:	1.0	3.0	3.8	1.5	2.5	2.1
Average Subscriber Months/Year:	7.9	8.7	9.5	9.6	10.1	9.2
Average Risk Scores:	0.8	1.2	1.5	1.8	2.8	1.8
<b>Key Demo/Socio Factors:</b>						
-Avg Subscriber Age:	29.4	32.9	46.6	54.0	48.7	44.3
-Pct Female Subs	46%	41%	31%	46%	41%	42%
<b>Top 3 Cultural Ethnicity: <sup>1</sup></b>						
-European	69%	71%	79%	82%	78%	77%
-Hispanic	12%	13%	8%	7%	10%	10%
-African American	8%	6%	4%	6%	6%	6%

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## Change in Legacy Uniprise CDH Populations



**\* Analysis of CDH performance is still heavily impacted by demographic, geographic and health status attributes prior to inferring true residual savings for activation.**

- CDH members still younger, healthier than non-CDH, but differences are narrowing
- On a case by case basis, when there is low CDH participation
  - People that choose the CDH generally choose the best plan from a financial perspective (true selection)
  - People that choose a copay or low deductible plan are less likely to choose the optimal plan for themselves. They appear to prefer financial certainty at the point of service
- When there is high CDH participation for a customer, there is less true selection

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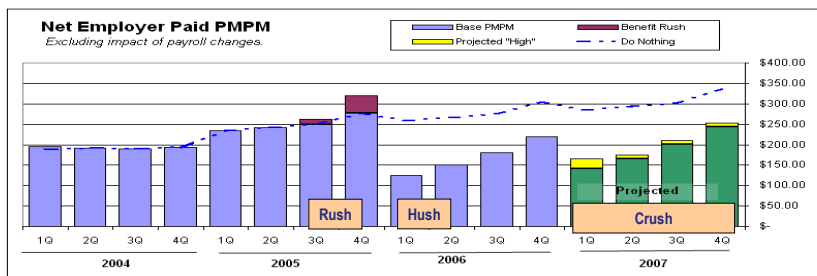
## CDH Populations – From Published Sources

- ❑ Cigna (October 2006)
  - Average age for CDH (Choice Fund) = 32 compared to 33 for HMO
  - Overall traditional average age = 35
- ❑ eHealthInsurance (June 2006)
  - 42% of HSA-eligible plan purchasers in 2005 were age 40 or older
  - 45% of HSA-eligible plan purchasers earn \$50,000 or less annually
- ❑ 2007 EBRI/Commonwealth Fund Consumerism in Health Survey
  - Self-rated health status in 2007:
    - 65% excellent/very good for CDHP plans vs 49% for Comprehensive plans
    - 15% of CDHP members smoke vs 24% for comprehensive
    - 17% of CDHP members report no regular exercise vs 15% for comprehensive
    - 25% of CDHP members self-report obesity vs 27% for comprehensive

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## Sample Benefit Rush: CDH Implemented 1/1/06



- The benefit rush (1-2 quarters before implementation)
  - Once a major change is announced, members tend to "rush" out to use benefits at the higher level
  - Mostly discretionary services
- The benefit hush (1 to 2 quarters immediately following implementation)
  - Many services received prior to implementation
  - Members getting used to plan
  - Deductible impact
- Trend crush
  - Lower than average base period
  - Deductible leveraging
  - Plan familiarity
- Overall costs lower than "do nothing"
- Impact of rush depends on magnitude of change

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## Trend and Cost Comparisons

### ❑ CIGNA (October, 2007)

- 1<sup>st</sup> year: CDH 12% lower costs than HMO and PPO members
- 2<sup>nd</sup> year: CDH 5% lower costs than HMO and PPO members
- 2<sup>nd</sup> year: CDH trend = 4.4% vs. 9.8% for traditional members

### ❑ UnitedHealth Group (multiple studies)

- CDH trends tend to be about 3% to 8% lower than non-CDH plans, based on a number of various studies, including
  - Continuously enrolled members only
  - Traditional actuarial methods

### ❑ Aetna and BCBS report similar results

### ❑ Milliman showed results in the 1% to 3% range

- Variation in study results caused by differences in methods and assumptions used to account for benefit richness and selection
  - Risk scores only tell part of the selection story
- Plan design also key. Richer plans tend to have fewer savings

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## Recent Pricing Trends

Product	Buck-2nd half 2007	AON-Spring 2008		Oliver Wyman - 2008	Segal - 2008	
		w/Rx	w/o Rx		w/o Rx	w/Rx
PPO	10.75%	10.70%	10.90%	10.30%	10.60%	10.60%
POS	10.54%	10.50%	10.50%	11.00%	10.50%	10.50%
CDH	10.36%	10.50%	10.30%	9.00%	10.90%	10.90%

- ❑ According to recent pricing trend surveys, on average the industry is pricing CDH in line with other products

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## Quality of Care

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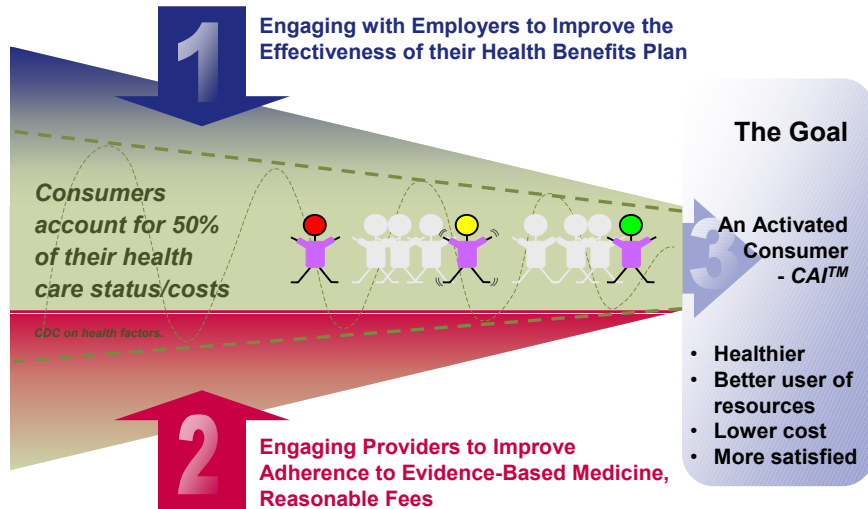
- ❑ UnitedHealth Group experience from various book-of-business studies show CDH members have more favorable care patterns than benchmark populations
  - 16% more likely to have cervical cancer screenings
  - 10% more likely to receive cholesterol screenings
  - As likely to receive a mammogram screening
  - 16% more likely to receive HbA1C tests (diabetics)
- ❑ Other carriers report similar results
- ❑ On a case by case basis, however, differences do not tend to be as pronounced, especially if
  - Membership is split more or less evenly between CDH and non-CDH
  - Employer provides wide range of activation tools
  - Employer promotes a culture of wellness

## Lessons Learned and To Be Learned

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- ❑ Timing's everything
  - Benefit rush a key variable in measuring trend impact and overall value of CDH
- ❑ There are some true residual savings but the reported percentage varies from study to study. Key variables include
  - % choosing CDH when offered on a slice basis
  - Study methods
  - Activation interventions
- ❑ The CDH bundle – how much of the reported results are due to
  - Account “ownership”
  - Activation tools
  - Preventive care at 100%
- ❑ Plan Design – the Must Have
  - Favorable trends are only available if the consumer keeps some “skin in the game”

# The next idea: Consumerism Beyond Account-Based Plans



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# Engaging the Consumer to Make Informed Choices

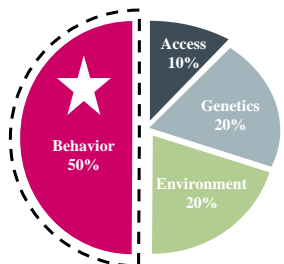
**Definition: Activation**

- When faced with a healthcare decision, does the consumer make the optimal decision, whether financial, clinical or service
- Definition enables measuring change over time, comparison to norms, etc

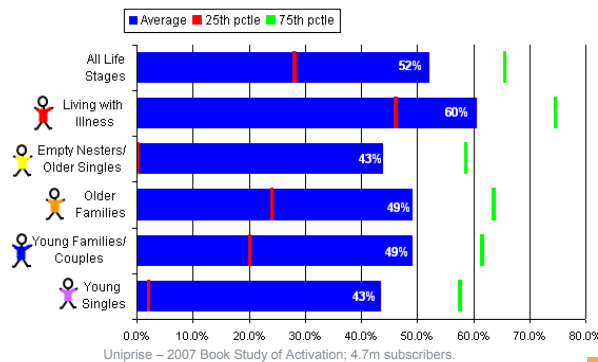
**The Consumer Activation Index™**

- A review of 53 targeted decisions over 12 months shows that 48% of these decisions are sub-optimal as measured through the Consumer Activation Index™

**Driver of a person's overall health status**



IFTF, Center for Disease Control and Prevention



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## What's Next For Successful Early Adopters

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- ❑ Target communications campaigns
  - Specific behaviors, groups
- ❑ “Know your numbers”
  - Health fairs
  - Biometric screenings on site
- ❑ Targeted incentives
  - Health risk assessments
  - Value-based plan designs