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Health & Benefits Perspective

October 2010

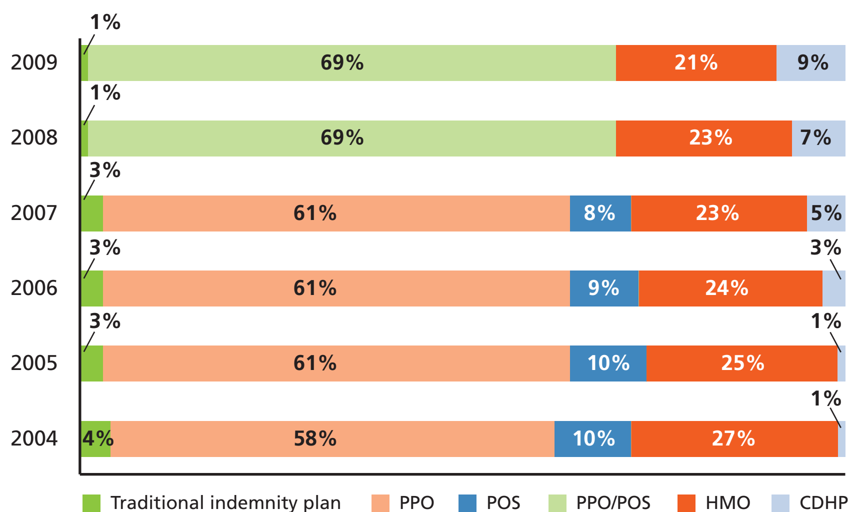
This *Perspective* focuses on the success of consumerism plans based on a study by Mercer.

Can consumer-driven health plans reduce costs and help with health reform compliance: A case study

Pioneering consumerism in the public sector

In 2006, the State of Indiana joined a small group of pioneering employers that were adopting consumer-driven health plans (CDHPs) as a strategy to control the cost and trend of their health programs. As is the case with many new programs, the adoption rate is slow at the outset, and the majority of employers will have to wait to see whether the concept actually achieves the desired result. Interest in CDHPs, which are defined as a combination of high-deductible health plans with savings or reimbursement accounts, began in the late 1990s. Initially, enrollment was not high enough to record (on national surveys) as a percentage of overall health plan enrollment until 2005. Around this time, the State of Indiana introduced its first CDHP option. Since then, enrollment in consumer plans has grown steadily, both nationally and among State of Indiana employees.

Percentage of all covered enrollees by type of plan



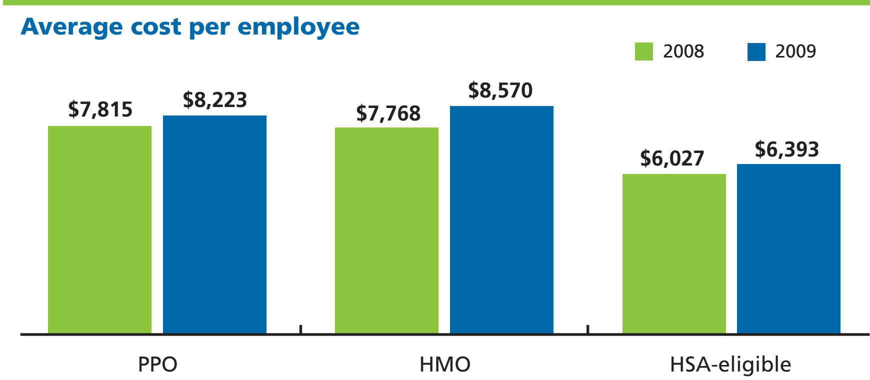
Source: Mercer National Survey of Employer-sponsored Health Plans 2009

Consulting. Outsourcing. Investments.

Large employers were more likely to offer CDHPs as an option, which often resulted in low enrollment unless the employer provided a strong financial incentive for employees to select the CDHP option. By 2009, the average enrollment in a CDHP was only 15%. One theory for the low enrollment is that the average contribution for employee-only coverage was 20% of cost for CDHPs, 24% for preferred provider organizations (PPOs) and 23% for health maintenance organizations (HMOs). The cost differential may not be enough to drive employees to switch from a more familiar type of coverage.

From an employer's perspective, one of the attractions of CDHP plans is the lower cost and/or lower trend that they have been able to achieve. Mercer's 2009 annual survey showed that the average expense for a CDHP plan with a Health Savings Account (HSA) was considerably lower than the average PPO or HMO cost.

Average cost per employee



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The early CDHP adopters have been continually asked to demonstrate why this cost differential exists. Is it purely cost shifting? Are there risks that individuals are not receiving essential care? Is it a better risk pool? The State of Indiana sought an independent assessment to address how its CDHP strategy had affected cost and utilization between 2006 and 2009.

Why Indiana implemented a CDHP strategy

Prior to 2006, the State offered two PPO options and two HMOs to 30,000 employees and their dependents. The legacy plans were very generous and shielded employees from the actual cost of health care. Newly elected Governor Mitch Daniels was a strong advocate for getting consumers more engaged in their health care decisions. The goal was to improve health outcomes and make more efficient use of health care dollars over the long-term by empowering employees to keep themselves and their families healthier.

The State introduced the first of two CDHP options in 2006 along with all of the existing health plans, thereby increasing the number of options from four to five. The first CDHP option was intended to have the higher

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cost sharing of the two plans. The sequence of plan changes between 2006 and 2009 was, as follows:

- 2007: The second CDHP, with lower participant cost sharing, was introduced and the two PPOs were consolidated to one PPO plan. The available options included two CDHPs, two HMOs and one PPO.
- 2008: The primary HMO with almost a third of the State's enrollment was terminated at the end of 2007 when M-Plan withdrew from the market place.

Mercer's evaluation

Mercer was asked to validate the sources of savings and overall experience of the two CDHP plans compared to the remaining PPO. The CDHPs have achieved significantly lower cost than the PPO.

- The total average cost for the PPO was $12,317, compared with $5,462 for CDHP1 and $9,444 for CDHP2.
- The two CDHPs had combined savings of 10.7% per year and are projected to save $17-$23 million for the state in 2010.
- Additionally, state employees and their families enrolled in the CDHPs are projected to save $7 to $8 million in 2010.
- Both CDHPs had lower than average age populations, but a higher average family size compared to the PPO.
- The actuarial values of the CDHP plans were somewhat lower than the PPO plans, meaning that employees would pay more out-of-pocket than if they enrolled in the PPO. But, the CDHPs were not significantly lower in value:
  - CDHP1 to PPO: 0.926 to 1.000
  - CDHP2 to PPO: 0.996 to 1.000
- Individuals who moved to either CDHP option had reduced utilization and intensity of services.

A critical question is whether the savings happened because of delayed care. Did participants avoid using services because they lacked an adequate funding in their HSA to pay for the out-of-pocket expenses attributed to their high-deductible plan?

The State's strategy was to fund an employee's HSA in the amount of 55% of their deductible, with half of the state's contribution being prefunded in the first paycheck of the year, and employees could contribute their own pre-tax dollars to the fund. This amount would allow employees to build up a reserve, yet they would have access to a safety net of funds to pay for services if they were needed. Mercer's findings are as follows:

- The majority of employees who enrolled in CDHPs in 2009 have significant HSA balances, averaging $2,072 for the CDHP1 and $1,196 for the CDHP2.

- Twenty percent of employees have HSA balances exceeding $3,500 in CDHP1 and $2,000 in CDHP2.
- Employees were not reluctant to use the accounts – 82% accessed their accounts to make tax-preferred payments.

Mercer's conclusion was that Indiana did not overfund the accounts and individuals stand a reasonable chance of increasing their accounts over time due to consumerism.

There is no evidence that participants in the CDHPs are avoiding care. Sources of savings appear to come from better use of health care resources and more cost-conscious decision making.

2009 health care utilization	PPO	CDHP2	CDHP1	State of Indiana average
Emergency room visits (per 1,000)	308.1	210.4	163.0	238.6
Outpatient visits (per 1,000)	3,242	1,841	1,182	2,253
Physician office visits (per 1,000)	5,012	3,612	2,701	3,936
Generic dispensing rate	65.5%	68.4%	75.2%	67.7%
Average cost per prescription	$65.20	$53.89	$40.25	$59.04
Hospital admissions (per 1,000)	113.9	64.3	36.2	77.2
Average length of stay	4.9 days	4.1 days	3.8 days	4.6 days

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Among the major factors leading to reduced cost were:

- Substituting generics for brand drugs
- Avoiding unnecessary visits to the emergency room
- Using primary care physicians more frequently than specialists

Potential savings for the State's remaining PPO population could be significant if the behavior changes could carry over to that population as well.

Mercer's findings are consistent with other studies of CDHP experience that suggest that savings are due to:

- Increased awareness of the need to take responsibility for making health care decisions
- Improvements in consumer skills and abilities to access health information, research health conditions and treatment alternatives, and understanding the associated costs and quality impacts of those alternatives
- Increased awareness of personal health status, factors affecting health status and means of reducing risks

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- Increased dialogue with providers about cost and alternative treatments

The above factors are interrelated and believed to leverage one another. Health care cost can be positively influenced if patients are motivated to be better consumers, empowered with information about provider quality and treatment options, and given access to the tools and support required to understand and improve their health status. Obviously, these individuals and their employers also benefit from improved health status, energy and productivity.

Implications for controlling long-term cost and complying with reform

A CDHP plan is one means of improving consumer engagement and controlling cost. There are opportunities for the State to further control trend and improve outcomes in all of the health plans by working with both consumers and providers. Further gains could come from improving consumer knowledge of their health risks and conditions, reducing health risks, complying with medication and treatment plans, and selecting the best providers for treatment of complex illnesses. On the provider side, there is significant opportunity to focus on raising quality levels, providing more intensive care management for individuals with complex conditions, and channeling complex high-risk care to providers that demonstrate the best outcomes.

Lessons learned by the State of Indiana are valuable for employers considering their strategic options for complying with health reform. Traditional cost management techniques that shifted cost to employees will be more limited under PPACA. Design options will be limited by PPACA's health plan standards and contributions will have to meet the requirements for affordability. More intensive consumer and provider interventions will be needed to keep costs under control and avoid the risk of paying an excise tax on high cost coverage.

To learn more about this exciting new initiative and how it may benefit your bottom line, contact your Mercer relationship manager or one of the following Mercer colleagues:

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03700-HB 131010

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