



# Consumer Directed Plans Implications For Stakeholders

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# Agenda

- Why Consumer directed plans
- Market reaction/Early Results
- Expected impact on
  - Employers
  - Employees
  - Providers



## About Sterling HSA...

- **PRIVATE COMPANY FOCUSED EXCLUSIVELY ON HSAs**
- **DEEP DOMAIN EXPERTISE IN HEALTH INSURANCE**
- **INDEPENDENT; SUPPORTS ALL HEALTH PLANS**
- **REVIEW MEDICAL BILLS**
- **RECORD-KEEPING FOR CLIENTS**



## About Sterling HSA. ..

- **ALLOWS SELF-DIRECTED INVESTMENTS**
- **SUPPORTS EMPLOYER AND EMPLOYEE RECORDKEEPING/ACCOUNTING**
- **FIRST TO ENROLL TAFT HARTLEY GROUP (TEAMSTERS)**

## Defining CDHP

- Financial Incentives to Control Utilization/improve health status
- Customized Benefit Design, including networks
- Self Service (decision support tools)
- Internet as a Key Enabler for decision-making
- **Not just a product!**

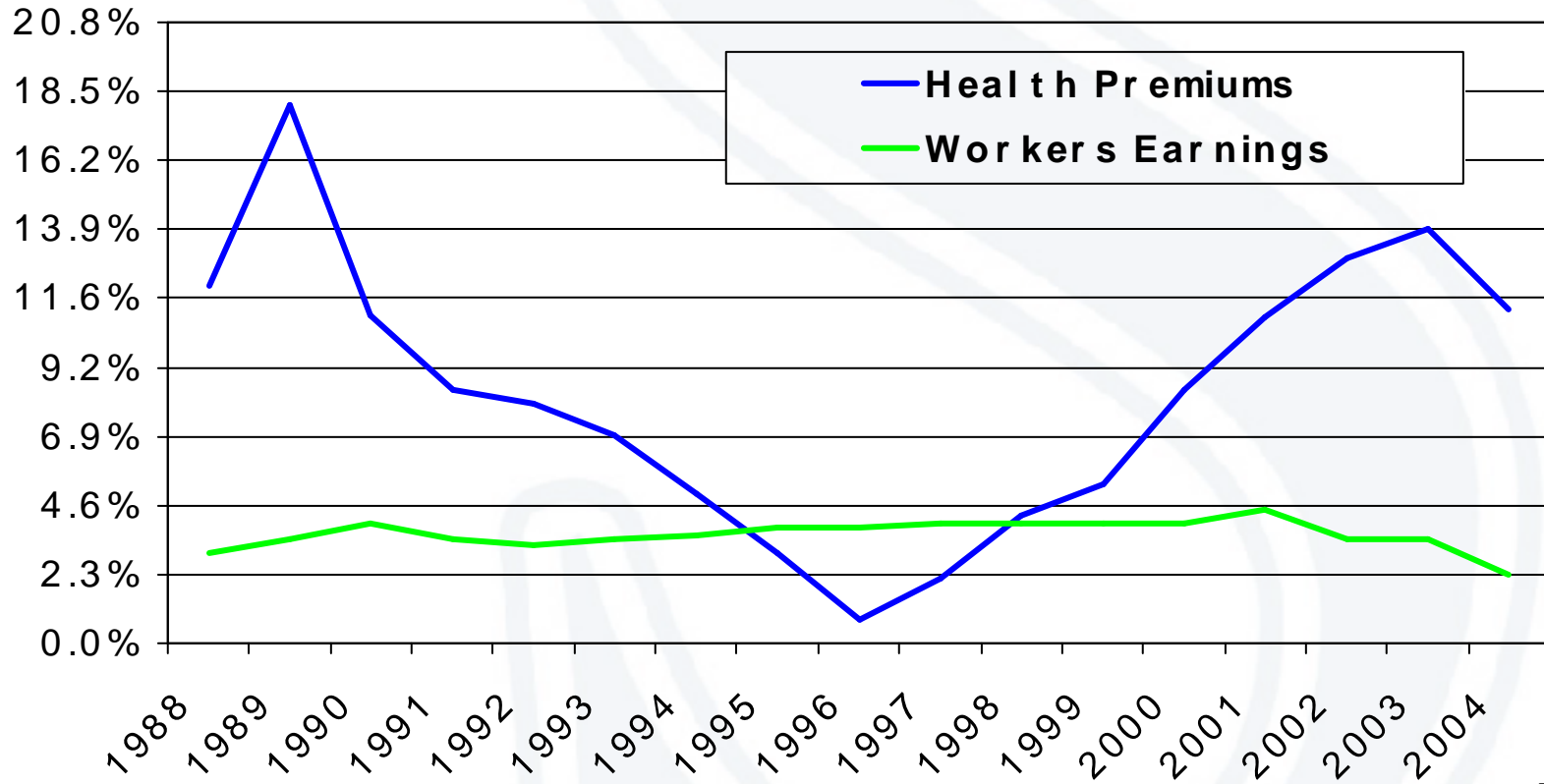


## Forces Behind CDHP

- HEALTH CARE COST INFLATION
- REDUCE EMPLOYER COST/LIABILITY
- ENCOURAGE CONSUMER COST-CONSCIOUS BEHAVIOR
- EMPLOYER INTEREST IN RE-ENGINEERING HEALTH CARE
- PROVIDER BACKLASH AGAINST MANAGED CARE

# Spiraling Health Care Costs

Average Annual Growth Rates  
Health Insurance Premiums vs. Workers Earnings



# Questionable Medical Spending

- 44,000 to 98,000 avoidable deaths each year

Source: Institute of Medicine, 1999

- “Our study suggests that perhaps a third of medical spending is now devoted to services that don’t appear to improve health or the quality of care – and may make things worse.”

Elliot S. Fisher, Professor of Medicine, Dartmouth Study, 2003





## Health Status Determined Predominantly by Behaviors

- **6% - 14% of medical costs attributed to smoking**
- **49% lower cost if:**
  - Non-Smoker
  - Non-Obese
  - Engage in physical activity 3 days/week

Source: National center of Policy analysis, May 2003; Journal of the American Medical Association, 1999

# Transforming Medical Care Financing

From Supply to Demand Economics

## **Supply**

Impact Providers

Strategies designed  
To control MD/  
Hospital utilization

## **Demand**

Impact consumers

Financial incentives  
to control use



# CDHP Features

- Offered as full replacement or “slice” business
- Financed by insurance or self-funding
- Benefit structure includes:
  - High Deductibles
  - Maximum Out-of-Pocket
  - Link to Financial Vehicles (HRAs, HSAs, FSAs)
  - Preventive Care Incentives
  - Individual Choice



# Shift in Role of Medical Providers

## FROM

Contracted supplier

One Network Tier

## TO

competing at the consumer  
level

Choosing to participate  
at a specific network tier

# Shift in Role of Employer

## FROM

primary purchaser

vendor selection/  
management

extensive benefits

## TO

financial contributor

information provider

promote self service



# Shift in Role of Employees

**FROM**

**TO**

Passive Participant

Empowered Consumer

Compliant Patient

Active Partner in Own Health  
Care



# Funding Vehicles

- HRAs (Health Reimbursement Accounts)
- HSAs (Health Savings Accounts)
- FSAs (Flexible Spending Accounts)



## HSAs, HRAs & FSAs

	Health Savings Accounts	Health Reimbursement Accounts	Flexible Spending Accounts
Who regulates?	Treasury Title IV	Dept. of Labor Title I	Dept. of Labor Title I
Who owns the money?	Employee	Employer	Employer
Can employees invest the proceeds?	Yes	No	No
Can employees take the money if they leave?	Yes	No	No
Do funds roll over?	Yes	Yes	No
Who can contribute?	Employer & Employee	Employer	Employer & Employee
What kind of health plan do you need?	High Deductible	Any Qualified	Any Qualified



# HSAs

## **Advantages of HSAs**

- Employee control of funds
- fosters cost-conscious behavior, leading to lower insurance rates
- portable
- triple tax advantages
- No ERISA requirement
- Non-medical expense OK (long term care premium, dental, vision services, alternative care, etc.)

## **Disadvantages of HSAs**

- Tied to HDHP
- Employer has no control over funds

# Market Reaction

## Adoption Rates of CDHP

2004	1%
2005	3%
2006	12%
2010	24%

40% will come from PPOs; 20% from HMOs

Source: Forrester Research, 2004



# Market Trends

## National Market Potential of HSAs

2005:	1.5 million accounts*
2006:	3.5 million accounts*
2007:	5.5 million accounts*
2008:	12 million accounts **

Adoption curve similar to IRAs and 401(k)s

\* United Health Care Investor Presentation Q3 2004

\*\* HSAInsider, February 2005



## Early Results with HRAs

Employers sponsoring CDHP with HRAs

50% report decreased overall medical spend

46% report medical claims/cost decreased

54% report RX cost declined

65% report increase in generics

29% report decreased Physician visits

Source: May, 2005 Segal Company survey of 27 large employers employing 680,000 employees



## Early Results with CDHPs

- HDHP spend (even without spending accounts) Results in a One-Time Reduction in Utilization of about 4% to 15%
- 10% of businesses today offer plans with at least \$1,000 deductible
- 75% of insurers offer HSA compatible Plans

Source: Rand Study of Consumer Driven Plans, June 2005



# Healthcare Utilization

Among Aetna's consumer directed plans:

- Adult Preventive Services Up 23%
- Specialist office visit up 3%
- ER Visit down 3%
- Inpatient Admissions Down 5%
- # of Rx down 13%
- Use of generic drugs up 7%

Source: Aetna, "managing Benefit Plans", September 2004

# Early Consumer Survey

- Most Appealing Features of HSAs
  - Keep Unspent Funds
  - Tax Deductibility
  - Funds Accumulate Over Time
  - Personal Control Over Investments
  - Personal Control Over Spending
- Least Appealing Features
  - High Deductible

Source: Highmark Study, 2005



## Early market responses to HSAs

- 7 out of 10 Americans with Private Health insurance favor HSAs  
Source: AHIP study 2004
- 7% of 360 Employers surveyed offer HSAs in 2005; 36% plan to offer in 2006  
Source: Mellon Financial Corp, May 2005
- What do consumers like about HSA?
  - Personal Control
  - Choice
  - Lower Cost Source: AHIP Study 2004





## HSA-Compatible Plan Members Demographics (June 2005)

**45.0%** are over 40 years old (19% are 50 or over)

**42.9%** are Families

**42.3%** have incomes of \$50,000 or less

**49.5%** previously uninsured (with incomes less than \$15,000)

**15.0%** reduction in overall monthly premiums for HSA eligible plans (from 2004)

Source: eHealthInsurance: Health Savings Accounts: The First Six Months of 2005

# Sterling HSA Demographics. . .

By Age

25 or younger	6.50%
26-40 yrs old	28.46%
41-55	45.49%
56-64	19.55%
Total	100.00%

## How Often Are Sterling HSA Funds Disbursed...

# of Disbursements/Accountholder

0 71%

3 or less 14%

4 to 6 9%

Over 7 6%



## Use Of Sterling HSA Funds...

Meets HP Deductible	39%
Meets IRS Med Expense Criteria	50%
Does Not Meet IRS Med Criteria	11%



## How Are Sterling HSA Funds Used. . .

In Order of Frequency

- Drugs
- Doctors
- Dental
- Hospitals



## Sterling Employer Support . . .

% of Accountholders by Level of Employer Contribution Towards the Deductible

No Contribution	18.65%
25% of Deductible or Less	34.28%
50%	36.69%
75%	4.38%
100%	6.00%



## Where Are Sterling HSA Funds Being Invested. . .

Liquid instruments  
(CDs, passbook accounts) 98%

Possible conclusions:

- Clients not willing to risk first year's deductible savings
- Deposit size too small to engage in investment planning/execution



## Employer Funding of HSA. . .

Decision rests on:

- Size of employer group
- Expected savings from switching to CDHP
- Employer interest in speeding adoption of CDHP





## Employer Contribution

- If savings realized through lower cost HDHP, employers often willing to share some or all of the savings with employees
- Employer contribution to employee's HSA speeds adoption
- Over half of Sterling employer clients fund in one lump sum

# CDHP Impact on Employees

Empowered but confused

- Need to invest time/energy to understand CDHP
- Will force transparency in pricing/outcomes
- Older employees likely to use savings accounts for asset accumulation/long term care needs

## CDHP Impact on employers

- **May need to provide financial subsidy to accelerate movement to CDHP, e.g., contribute to HSA**
- **Requires investment in ongoing education of employees**
- **For the short term, may need to provide employee support to navigate among choices**

## CDHP Impact on Providers

- Compel transparency in pricing/quality outcomes to attract patients
- Forced to deal with variations in outcomes
- Foster pay- for- performance programs
- Expect more direct-to-consumer advertising

## Summary

- CDHP IN THE VANGUARD OF TRANSFORMING MEDICAL CARE FINANCING
- PROMISE OF COST SAVINGS/GREATER INDIVIDUAL ACCOUNTABILITY MUST BE TEMPERED BY NEED FOR EDUCATION/CONSUMER SUPPORT
- Empowered but confused consumers will retard growth
- PROVIDER COMPETITION AT THE CONSUMER LEVEL IS A GOOD THING
- WILL FORCE SHIFTS IN THE ROLES OF EMPLOYER/PROVIDER/PAYOR (NOT A BAD THING!)



Questions?

Thank You!

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