Consumer Directed Health Care: A Look at Current Experience

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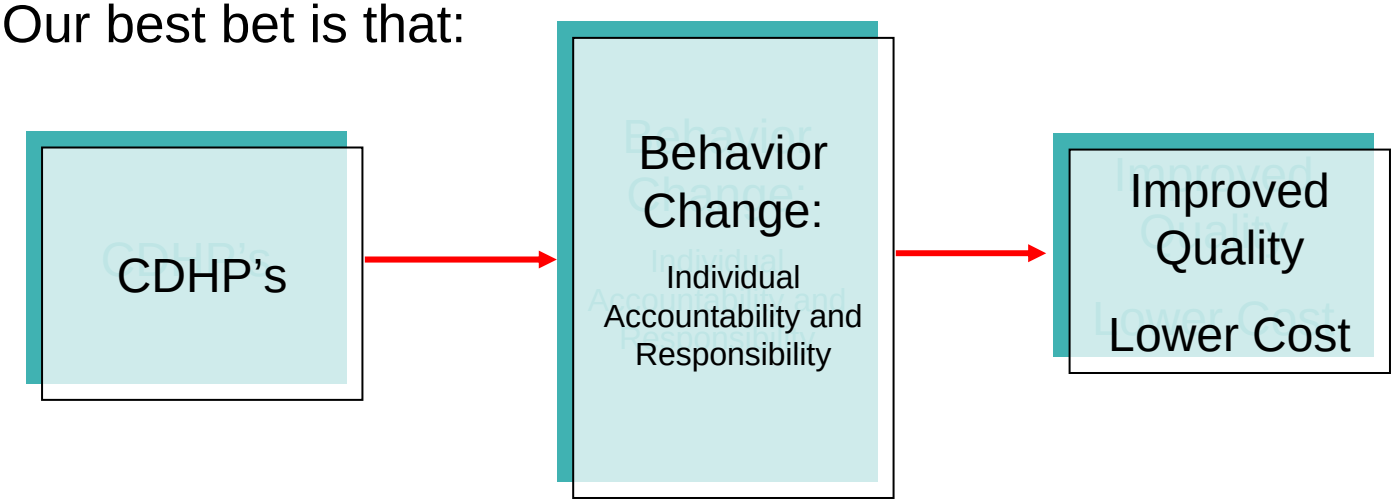
Discussion Topics

- A quick look at historical and current trends
- At the beginning – what we knew then
- What we know now – a review of two new analyses

A Few Things to Keep in Mind

- Consumerism and consumer activation are *processes*, not outcomes
- We have not described these processes or behaviors all that specifically yet
- Consumer directed health plans are one mechanism that we think will influence consumerism and therefore cost and quality
- Our best bet is that:

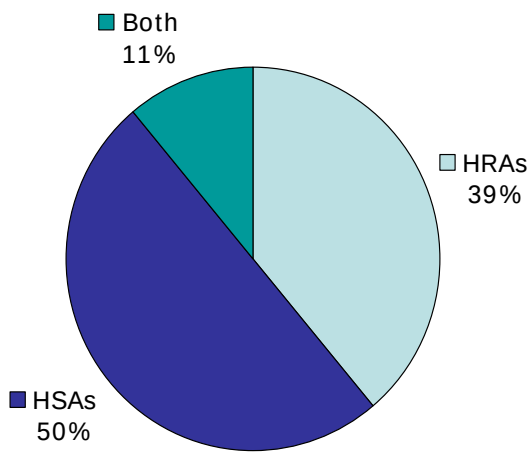


But we don't know for sure

But Which Model? – CDH in 2006

- HRA and HSA serve different needs and philosophies of employers and employees
- Among large employer implementations for 2006 (5,000+ employees):
  - HRA 39%
  - HSA 50%
  - Both 11%
- 2006 membership growth projections slightly favor HSAs (55%)

2006 Large Employer Plans



By Any Measure, Account-Based Plan Designs Are on the Rise

- 5 million — Approximate CDH members at 1/1/06
  (Source: Inside Consumer Directed Care)
- 820,000 — HSA accounts at 1/1/06
  (Source: Inside Consumer Directed Care)
- 54% — Employers will implement CDH by 2007
  (Source: Forrester)
- 24% — Enrollment (40m lives) by 2010
  (Source: Forrester)

What We Knew Then:
Enrollment Drivers and Selection

What Drives Higher Levels of Enrollment in a CHDP in a Choice Environment?

- Amount and types of education and communication done with respect to plan offerings
  - Length of time communicating prior to enrollment
  - CEO/CFO and local HR manager support
- How plan is priced relative to other options
- Existing employees still see value in higher priced plans
- Employee *dissatisfaction* with current coverage/carriers drove higher levels of CDHP enrollment but employee satisfaction with these things did not drive lower levels of enrollment

Source: Institute on Health Care Cost and Solutions sponsored CDHP Study, NBGH, 2004/2005

What Does Not Drive Higher Levels of Enrollment in a CHDP in a Choice Environment?

- Things that were *not* factors:
  - Premium differences for current employees
    - Likely to have not met the premium “floor” necessary to drive differences
  - Provider access
  - VP of HR, benefit manager or vendor communication
  - Active enrollment
  - Workforce characteristics (age, health)

Source: Institute on Health Care Cost and Solutions sponsored CDHP Study, NBGH, 2004/2005

Population Selection in CDHPs

- Across studies, the data consistently shows three, related selection biases for CDHPs in a choice environment
  - Higher incomes
  - Lower levels of illness burden (but starting to shift)
  - Larger contract size
  - In two cases where it was examined, more mental health conditions
- Be careful!
  - A look at high cost claimants and illness burden in at least two studies showed that they were out-of-sync
  - Suggests that some early CDHP designs attracted claimants who use services in “excess” of their illness burden

What We Know Now:
Process and Outcome Results

Two Primary Analyses

1. Reden and Anders Study
   - Recently released
   - A continuation and expansion of a study conducted last year summarizing CDH's first year claim experience.
   - Five CDH groups totaling 30,000 CDH members and 73,200 non-CDH members in 2004
   - Includes three groups with a total of 24,500 CDH members who were enrolled for two years beginning 2003
   - Also reviewed detailed HRA information from eleven groups totaling 117,400 CDH members in 2004.
2. Definity Study
   - Just released
   - Includes 4 self-funded employer plans
   - Employers offered both CDH and PPO plans in all 3 years
   - CDH and PPO plan designs included deductible/coinsurance. The CDH plan was slightly more generous (3 -5%) and offered more outreach and health support services.
   - Excludes employees over 65
   - Data were adjusted for age, sex, illness burden, outlier events, and geography

To Control or Not to Control. . .

- Control for selection if you want to answer the question:
  - If my company implemented a CDHP on a total replacement basis, what impact would it have?
  - Relative to other types of plans, what impact does CDHP have on cost and quality?
- Do not control for selection if you want to answer the question:
  - What would the impact be of offering a CDHP along with other health plan options?

A Review of Behavior Change Results

The Ability to Measure Effectiveness Varies

- Member information and access
- Actuarial
- Quality of Care
- Patient participation/compliance

Easiest

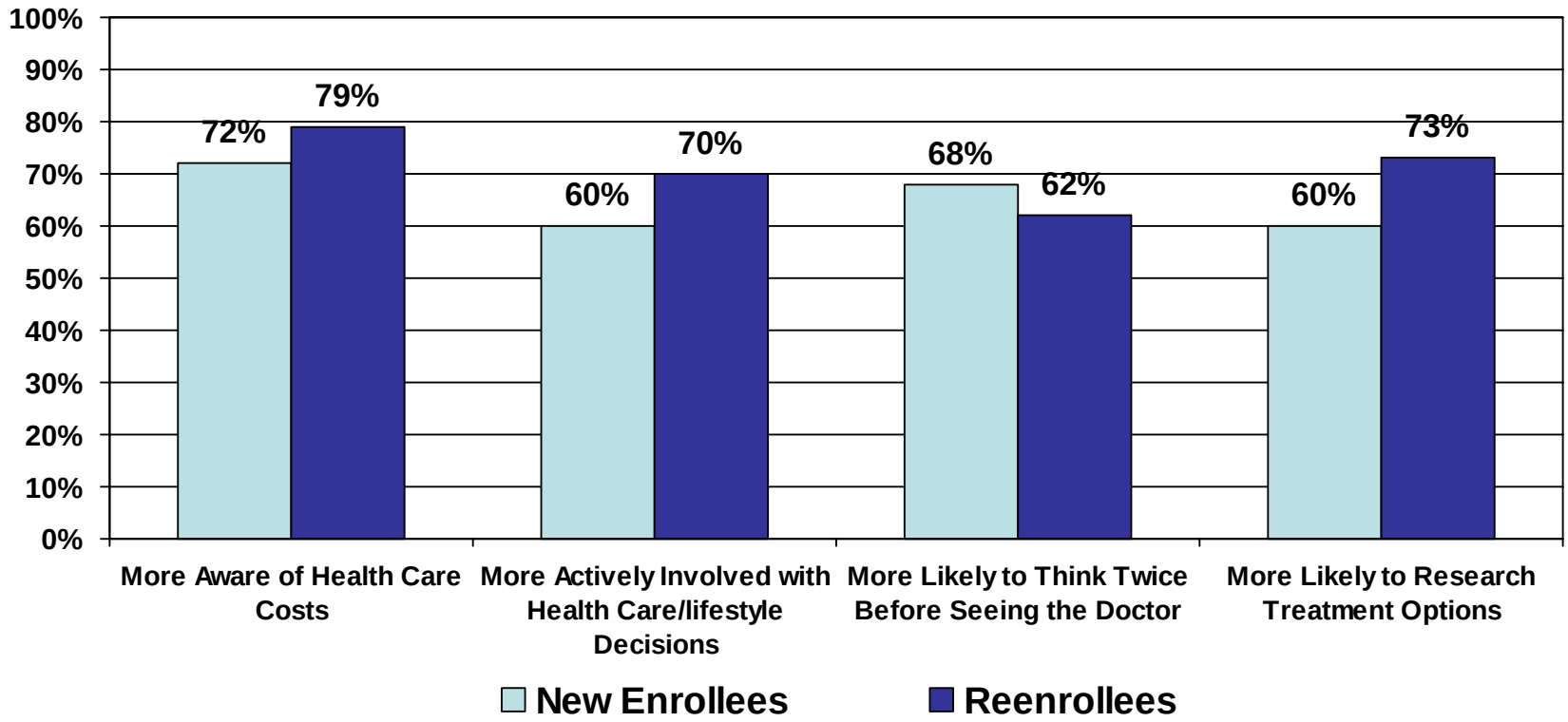
Hardest

Summary

- There is some evidence of a general attitudinal change among employees operating in a CDHP environment.
- There appears to be a relationship between claims costs and use of personal messaging.
- Employees that terminate don’t appear to exhibit “use it or lose it” mentality.
- Utilization of health care services is generally lower for CDHP enrollees, even after adjusting for risk differences.
- Preventive care and outpatient mental health services may be used at higher rates among CDHP enrollees.
- These utilization differences appear to change over time – there are larger differences in the first year of enrollment compared to the second.
- The relationship between CDHPs and hospitalization and length of stay need more exploration.

Consumer Attitudes Reflect Deepening Engagement

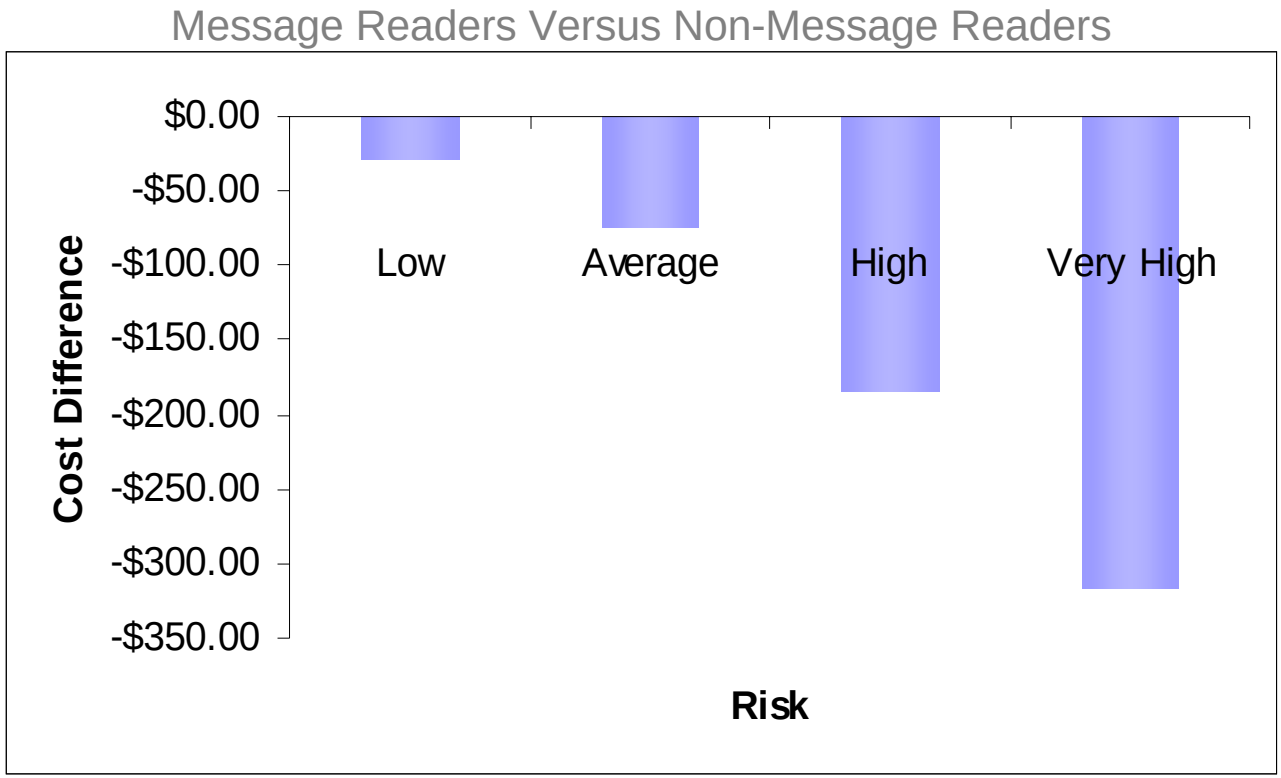
Those with more exposure to the plan and support services are more likely to report involvement in key health decisions:



60% of CDH enrollees access web tools, versus 45% in traditional plans.

Third-party survey of CDH and Definity Health members.

Personalized Consumer Messaging and Claim Costs



Difference in annual claim costs between those who read health messages and those who do not.

Source: Definity Study, 2006

“Ownership Potential” CDH HRA Balances

- The percent of contracts with an HRA balance at year-end depends on value contributed to HRA.

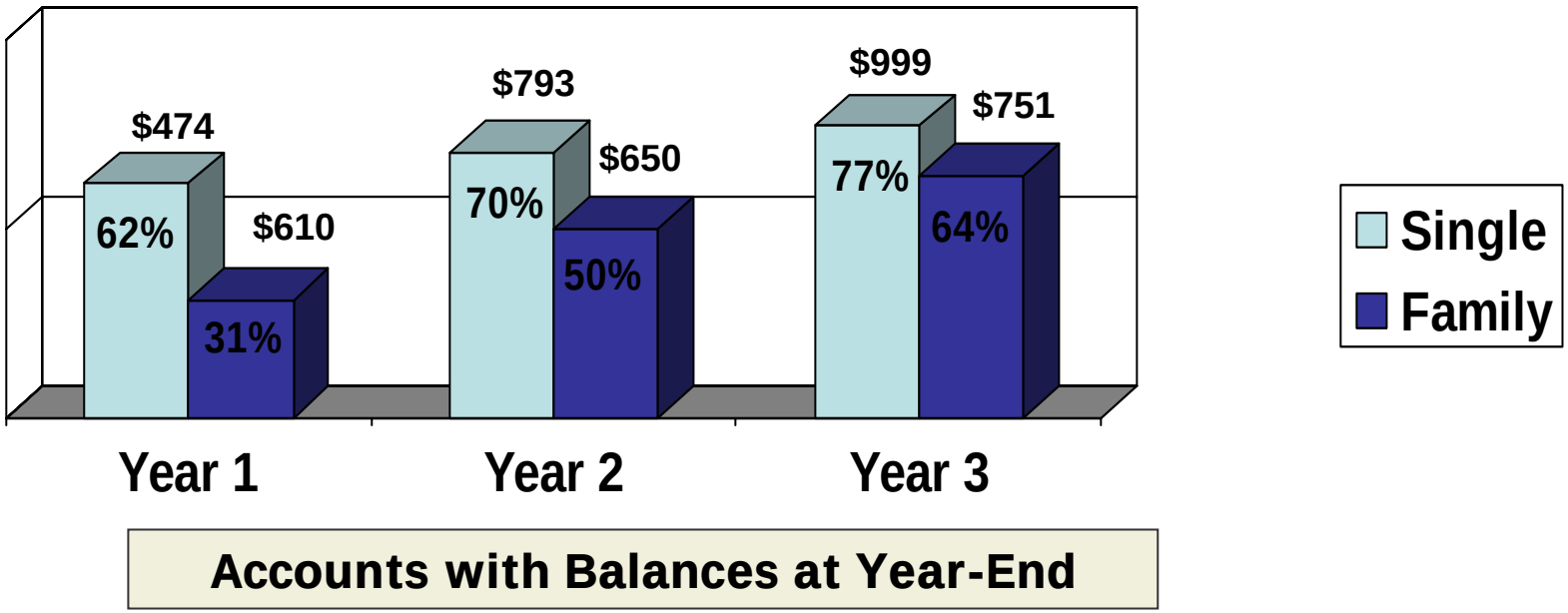
Single HRA ER Contribution	Contracts with Balance
≤$500	<50%
$501 - $700	43% - 73%
$701 - $900	55% - 83%
>$900	83% - 98%

- The most common employer contribution is between $500 and $700 for a single.
- This commonly represents less than 50% of the deductible.

***Source*:** Reden & Anders, 2006

"Ownership Potential"
CDH HRA Balances

- Both percentage and HRA balance increase over time.
- Unclear whether this increase in the balance drives more "ownership"

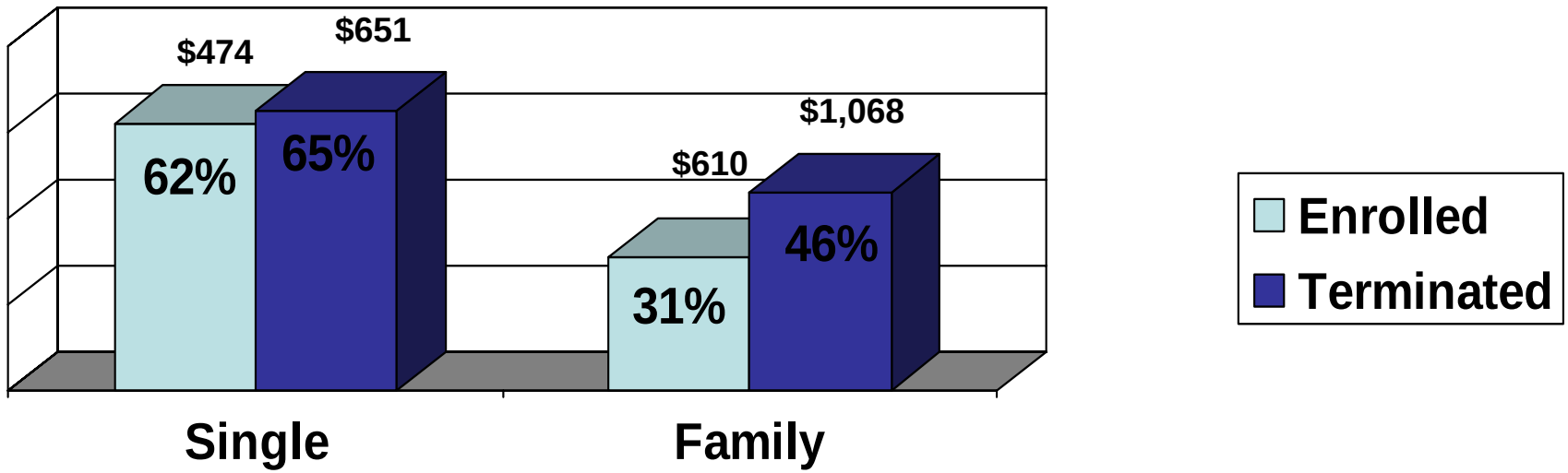


Continually enrolled members with Rx
Balance amount is average for all contracts with a balance.

***Source*:** Reden & Anders, 2006

CDH HRA Balances Terminated Enrollees

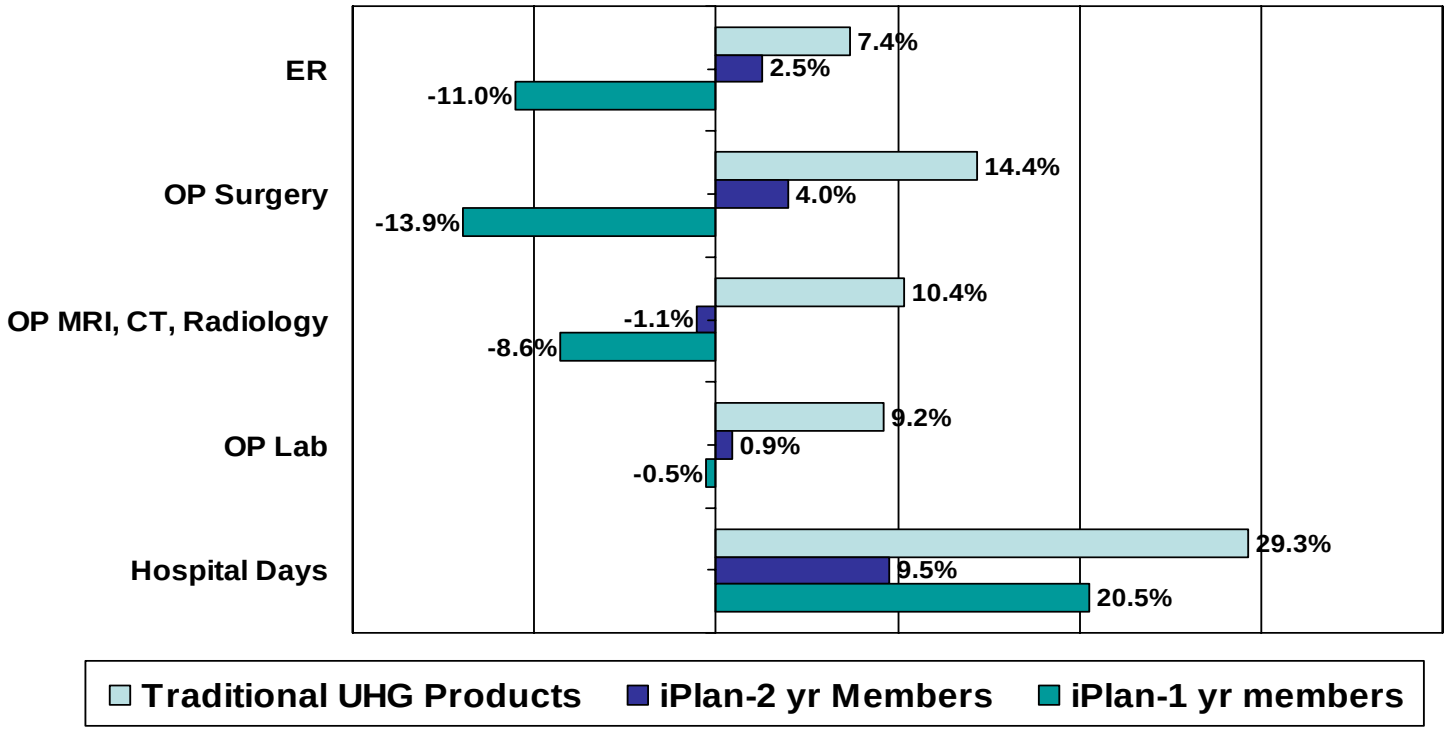
- Those that terminate do not exhibit a “use it or lose it” mentality.
- Terminated contracts have a higher percentage of accounts with balances, and a higher dollar balance.



Accounts with Balances at Year-End and Termination

***Source*:** Reden & Anders, 2006

Utilization Changes:
Annual Facility Trends

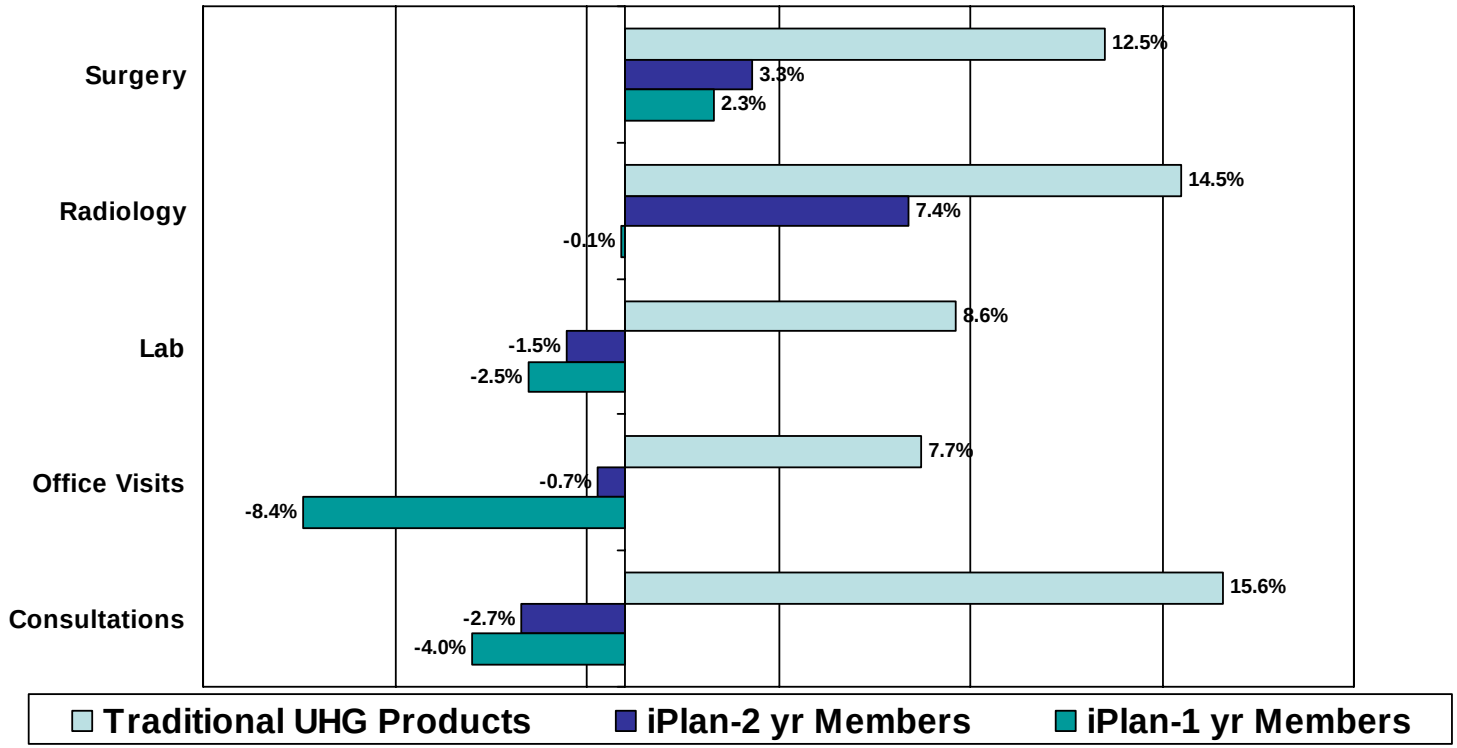


Notes:

1. Trends represent only the continuously enrolled population through 2004 and not UHG business in the aggregate
2. Represents raw data with no attempt to normalize for catastrophic claims. Since analyzing continuously enrolled membership, no need to normalize health status.
3. For CDH-2 yr members represents continuously enrolled between 2002 and 2004.
4. For CDH-1 yr members represents continuously enrolled between 2003 and 2004.

Source: Reden & Anders, 2006

Utilization Changes:
Annual Professional Service Trends



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Source: Reden & Anders, 2006

Utilization Change Differences

All Members, Adjusted for demographics, outliers

Medical Service	CDH Utilization Trend 2003 - 2005	PPO Utilization Trend 2003 - 2005	Absolute pmpy utilization CDH Compared to PPO
Hospital Admissions	-22%	-5%	-53%
Hospital Days	-29%	-2%	-55%
Emergency Room Visits	-14%	2%	-16%
Office Visits	-8%	6%	-8%
Preventive Visits (data not adjusted)	-1%	-2%	4%

Source: Definity Study, 2006

Utilization Change Differences:

Chronically Ill Members Only, Adjusted for demographics, outliers

Medical Service	CDH Utilization Trend 2003 - 2005	PPO Utilization Trend 2003 - 2005	Absolute pmpy utilization CDH Compared to PPO
Hospital Admissions	-18%	-12%	-29%
Hospital Days	-32%	-11%	-39%
Emergency Room Visits	-14%	-2%	-11%
Office Visits	-2%	4%	2%

Source: Definity Study, 2006

CDH HRA Expenditures

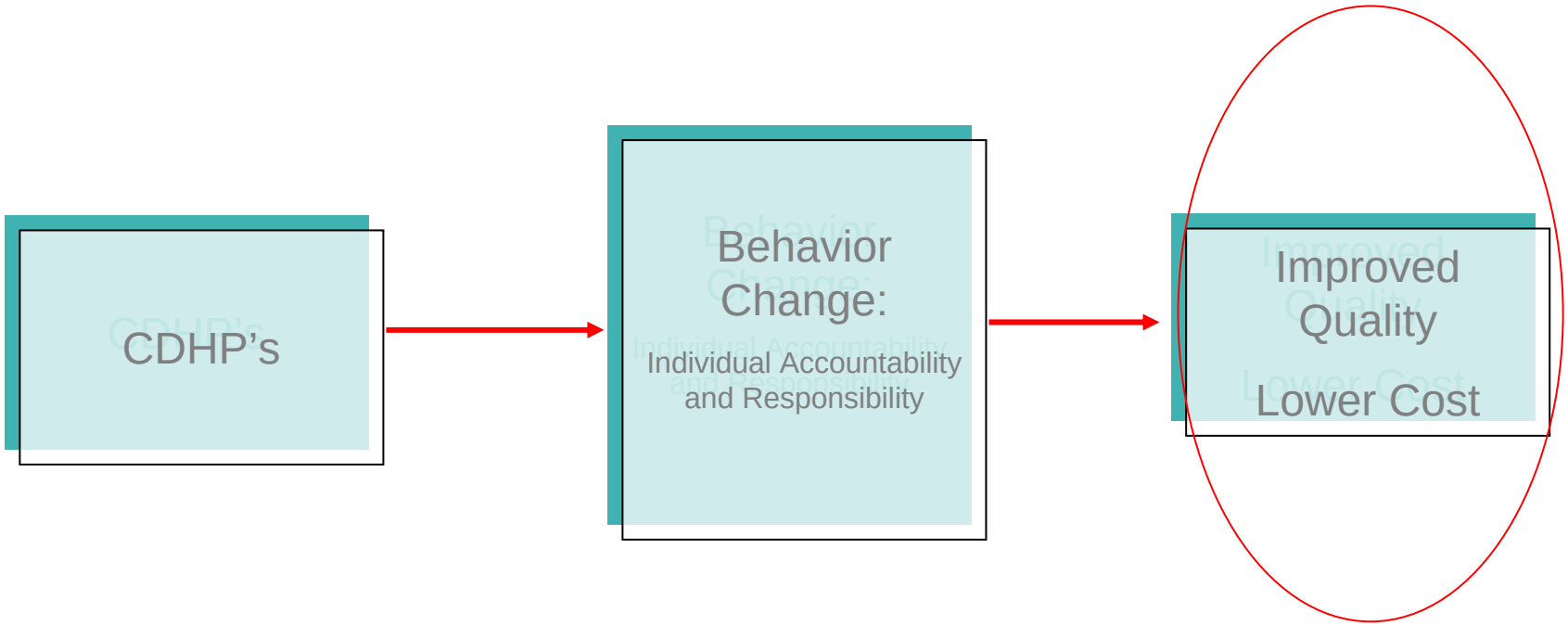
	Distribution of HRA Payments
Hospital Inpatient	1.2%
Hospital Outpatient	
• Emergency Room	4.7%
• OP Surgery	1.9%
• Other	7.1%
Subtotal	13.7%
Physician	
• Office Visits/Consults	17.6%
• Surgery	6.0%
• Radiology	5.9%
• Pathology	5.8%
• Physical Therapy	3.8%
• Other	9.4%
Subtotal	48.5%
Other	2.0%
Rx	34.6%
Total	**100.0%**

As one would expect, account dollars are most often spent at entry point of care:

- Physician
- Rx

Source: *Definity.*

A Review of Financial Results



Summary

- Consumers are “positively” changing behavior, most notably in the first year.
- Allowed medical cost trends for a CDH product appear to be significantly less than the traditional product, even after the results are normalized for differences in health status.
  - Magnitude of these differences varies widely across analyses
- CDH unit cost trends are generally higher than traditional products
  - Increased intensity
  - Historical network prices

CDH Medical Cost Trend

	Annual Allowed Cost Trend 2003 to 2004	2003 Risk Factor
Traditional Product Pool	16.3%	1.020
CDH – Total	7.4%	0.628

Source: Reden & Anders, 2006

Allowed Annual Trend by Risk Cohort

Continuously Enrolled

ERG Risk Cohort	CDH Enrollment Distribution [1]	2-Year CDH Annual Trend	2-Year Traditional Product Annual Trend [2]
14	3.3%	2.3%	22.0%
13	3.9%	-3.4%	14.1%
12	8.1%	12.5%	15.2%
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.			
3	6.3%	-4.0%	28.7%
2	8.3%	4.8%	17.6%
1	11.1%	9.5%	23.5%
0	15.7%	78.8%	70.9%
Average Medical Cost Trend	**100.0%**	**10.9%**	**24.2%**
Average Risk Score (2003)		**0.681**	**0.691**

Higher ↑ Health Risk ↓ Lower

[1] Population analyzed is a subset of Total CDH and represents continuously enrolled from 2002 through 2004 and is not reflective of total pool experience.

[2] Cost trends relational due to continuously enrolled, not reflective of entire pool.

Source: Reden & Anders, 2006

Final Comments

- Evaluation of CDHP is more complex than traditional products. Involves both quantitative and qualitative analysis.
- Can likely expect CDH cost trends to remain lower than traditional plans, but the gap may narrow over time because:
  - Cannot expect year over year decreases (not realistic).
  - As HRA balances increase, they may eventually be used and converted to “paid” claims.
  - Increases over a lower base just result in higher trend.
  - As more individuals switch to a CDH plan within an employer, the relative health risk will gravitate to the group’s norm.
- Still too early for “quantifiable” conclusions regarding savings, but studies do provide positive “directional” guidance towards savings.
- This is a long-term process that will likely have incremental improvements over time.