

Consumerism's Sea Change:

How It Will Affect Your Company in the Coming Years

by Alexander "Sander" Domaszewicz

Consumerism and care management are the cost-containment strategies most employers say they will focus on over the next five years. This article reviews the growth of these strategies and the different ways employers have implemented them. The author then delineates the ten key ways that consumerism may affect companies over the next five- to ten-year time period, as these strategies continue to move health benefits toward greater transparency, flexibility and accountability.

For years, employers have relied on cost shifting as a key strategy for coping with annual double-digit cost increases in health benefits. In fact, when annual health benefit cost increases peaked three years ago at nearly 15%, an unprecedented flurry of plan redesigns resulted. According to the 2005 *National Survey of Employer-Sponsored Health Plans*, conducted annually by Mercer Health & Benefits LLC, cost shifting has helped to slow the trend each year since then, with costs rising just 6.1% in 2005 and a similar increase of 6.7% predicted for 2006.

However, this latest research with information from nearly 3,000 employer participants suggests that the era of steady cost shifting has largely run its course. Cost shifting cannot provide much more control over costs that continue to surge due to medical technology and therapeutic advances, an aging population, lack of quality standards, inadequate information technology and an uninformed, often unmotivated population. In its place, employers envision a new age of consumerism, coupled with care management, to control health benefit cost increases. Partnering with service providers that can help them manage and maximize the benefits of consumerism,

far-sighted companies will be well positioned to face the cost pressures of the coming decade.

In the 2005 Mercer data, employers were asked which of six different cost-management strategies would be important to their organizations over the next five years. "Scaling back benefits or cost shifting" received the lowest scores, with just 21% of all employers saying this strategy would play a key role. Instead, the two strategies that the most employers say they will focus on are *consumerism*, defined as "promoting informed and responsible spending by employees for health care," and *care management*, a range of programs designed to improve or better manage employee health, including risk-reduction programs, and disease and case management.

"Many employers see these strategies as two sides of the same coin. Care management programs require the active involvement of employees in their own personal health habits, while consumerist strategies engage the employees in managing health care cost," observed Blaine Bos, a Worldwide Partner with Mercer Health & Benefits, one of the study's authors.

Over a third of all employers (34%) said consumerism will be significant or very significant to their cost-management efforts over the next five years, while 32% said care management will be signif-

icant or very significant. Interest in both strategies is higher among large employers, which gave the highest rating to care management (62%), followed by consumerism (55%).

Indeed, employers implemented a range of consumerist strategies in 2005. Two-fifths of all employers now provide employees access to a Web site with information on provider quality and cost, and 17% provide a tool to help them select the plan that will best meet their needs based on expected health care utilization. Many of the nation's largest employers took the step of implementing a consumer-directed health plan (CDHP). Among jumbo employers (20,000 or more employees), CDHP offerings rose sharply from 12% to 22% and are projected to increase to 29% and 31% in 2006 and 2007, respectively.

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In the context of the study, a CDHP is defined as an account-based health plan with either a health reimbursement arrangement (HRA) or health savings account (HSA) as a central feature. HRAs were blessed by IRS guidance in June 2002 and allow an employer to create a benefit program feature to earmark dollars for employees to spend on health care. HSAs were created by the Medicare Modernization Act of 2003 and created a new type of tax-advantaged, portable, personal financial account with contributions from an employer, an employee or both. Both types of health accounts allow dollars to accumulate and roll over year to year, allowing participants to see a personal reward for seeking value when accessing health services and spending health dollars wisely.

Still, the sea change of consumerism will take time to affect the mainstream. According to the Mercer study, health coverage provision of any kind dropped among small employers between 2003 and 2005, despite the availability of HDHP/HSA options. CDHPs saw only modest growth among employers with ten or more employees—Only 2% offered CDHPs in 2005, while only 5% of employers with at least 500 employees offered them. As for enrollment, it remains low, at only 1% of employees nationally. Large companies expected to accelerate adoption of CDHPs in 2006, with 11% likely to adopt. Yet the business world is increasingly drawn to the idea of benefit programs that allow an employer to draw a very clear line of sight between an employee's actions and the potential positive or negative financial and health consequences. Reducing one's health risks, leading a healthy lifestyle, using preventive care services and being a rational user of health services are the basic tenets of becoming better consumers. What leading-edge employers want to do is to reinforce the upsides of these behaviors. A major question is just how far they can go to penalize those individuals who fail to emulate these positive behaviors

Importantly, care management programs grew strongly in 2005, lending support to employers' assertion that this will be a key strategy for the next five years. Use of all types of disease management programs grew, and the percentage of employers offering at least one program jumped from 32% to 41%. Two-thirds of large employers now offer one or more disease management programs: 67%, up from 58%.

In addition, health risk assessments, sometimes used to identify employees who could benefit from a behavior modification, disease management or other care management program, are offered by 46% of large employers, up from 35%. The use of behavior modification programs (such as smoking cessation or weight management programs) rose sharply as well, from 21% to 30% of large employers. Employers are beginning to offer incentives to encourage employees to participate in care management programs and tie these incentives to consumerism initiatives, with large employers taking the lead.

In 2005, 17% of large employers that offer health risk assessments provided an incentive, as did 7% of those offering one or more disease management programs. These incentives are often cash, but some employers tie them to the medical plan, offering lower copayments or premium contributions. Others provide token rewards or gifts. This suggests that care management has moved beyond the lip service stage and is a mature strategy, playing a role in slowing

health benefit cost increases that is likely to grow as more employers measure the ROI (return on investment) of such programs.

All of these care management initiatives are critical and central to health care consumerism, and vice versa. Consumerism without significant tools, information and support is little more than a means of placing undue financial responsibility and accountability on employees who may be ill prepared to take on the challenge. And while care management initiatives are valuable in their own right, there is a multiplying effect around their engagement and impact when combined with consumerism.

Looking ahead, then, there are several areas in which the trend toward consumerism is likely to play a role in organizational change, especially as it becomes more integrated with corporate process and policy. From that perspective, we have isolated ten key ways that consumerism may affect your company over the next five to ten years.

1. Support Organizational Initiatives for a More Performance-Based Culture.

Health and benefits consumerism may be easily linked to other organizational initiatives, especially as more companies implement achievement cultures that include pay-for-performance systems, incentives and rewards for cost-saving behavior. At the same time, the movement toward greater employee self-service and transactional self-reliance connects to health care consumerism in obvious ways, as employees are empowered to become more informed about health care providers, procedures and policies through online information clearinghouses and other self-service systems. The strength of these systems will parallel the availability of credible, standardized data on individual provider performance, relative to efficiency and quality, to support consumer decision making.

2. Improve Attraction and Retention.

In the CDHP model, HRAs could become analogous to “golden handcuffs,” especially for employees who have significantly reduced medical expenses or exposure at a company because they’ve accumulated a sizable account over time. These workers would be less likely to leave for a marginally better salary or job. Indeed, as employers grow more adept at communicating the advantages of HRAs in reducing medical expense through accumulation of wealth over time, the allure of job hopping may fade. Alternately, the availability of HSAs may prove to be a decision point for employees considering a new employer. As HSAs become more prevalent and workers begin to build balances to offset future care expenses, joining an employer that will enable them

to house and continue to grow their accounts will be increasingly important.

3. Meet the Retiree Health Challenge.

Employers continue to drop programs for retiree medical coverage. CDHPs designed with a strong retiree focus or component could go a long way toward supplementing savings for retiree medical coverage. The concept of saving while you are a healthy, active employee for a time when you may need more care after retirement is appealing and easily communicated to employees as an aspect of plan design and as a long-range benefit. This also meshes well with employers wanting to keep or add some retiree health benefits despite significant cost pressures in this area. In fact, one municipality has an HRA-based CDHP with a vesting schedule that allows employees to earn the right to spend their HRA balance after retirement on premiums or direct qualified medical expenses. Another employer has an HRA designated for retirement purposes that grows through years of service, earns notional interest and can even be used to convert unused paid time off into tax-free health benefits at retirement.

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4. Simplify Benefits Administration by Consolidating Multiple Benefit Programs.

Tying in other benefits to CDHPs will provide a distinct advantage to companies in terms of transactional efficiency and cost savings. Increasingly, organizations will incorporate coverage for ancillary services under one account, such as an HRA that covers prescription drug, mental health, dental, vision, chiropractic and acupuncture services in lieu of tradi-

tional separate programs for these coverages. Some employers have included dental and vision services as eligible expenses under their HRA programs and scaled back traditional coverage in these areas by marginally increasing their dollar allocation to the account. HSAs are a natural extension of funding all IRS-designated qualified medical expenses from one source, because of the mandated coverage for all these services under their umbrella. A number of employers are evaluating how much additional funding could be provided in an employee's HSA if ancillary benefits were reduced or eliminated.

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5. Increase the Variety of Plan and Program Design and Features.

Rather than offering more types of health plans, some employers are providing more types of design alternatives within a single type of plan design. HRAs and HSAs are ideal vehicles for giving people alternative designs and features. These alternatives include:

- Permitting hardship withdrawals as an active from retiree-only accounts
- Crediting accounts for different types of illness, such as diabetes or pregnancy
- Combining the accounts' communication along with 401(k) and other retirement statements or tools
- Seeding or prefunding accounts to provide retirement coverage for those who might not have had time to build up an account as an active employee
- Promoting the participation and use of health management tools and services through financial incentives. For example, an employer could credit the employee's account \$50 for completing a health risk assessment.

With HSA plans that become central or the only health benefit option, program variations will include granting employees credit to manage unforeseen medical expenses in the short term while they build their account balances, or limited, event-driven insurance supplements that may, for instance, pay \$1,000 as a one-time payment for hospitalization.

6. Provide Strong Program Support Through Health Advocates.

Increasingly, employers are recognizing that in the era of consumerism, they must do more than let their employees go it alone, or provide only a Web site to lean on as they move toward greater involvement with their health benefits and health care. Thus, the value of health "coaches" and advocates is on the rise, affording employees the advantage of turning to a real person, one who is both knowledgeable and empowered to act on a member's behalf across multiple issues over an extended period of time. One employer is taking a targeted approach to advocacy, giving employees a dedicated resource to reach out to and discuss prescription drug issues, such as pricing differentials between brand, generic and over-the-counter treatments, as well as therapy alternatives to discuss with their physician. Another employer is providing a single toll-free number to a dedicated team of health advocate nurses who assist with navigation of benefits, live transfer to care management programs, and take responsibility for co-management of care when multiple interventions and benefits are delivered to an individual.

7. Help People Understand the Value of New Technology—at Home, at Work and in Health Care.

Advances in medical detection and delivery technology are moving beyond the realm of science fiction. Technology both drives up the cost of health care and gives tools for better managing health decisions. Among the new forces present within health care today are:

- Nanotechnology—for the embedding of tiny devices within the body for health monitoring and/or the delivery of medication
- Gene therapy to detect and treat defective genes
- Full body scans to detect all invisible ailments
- Over-the-counter availability of condition-detecting and monitoring devices, which drive greater awareness of disease among the labor force.
- Home health monitoring devices are already available and in use for many chronic conditions.

As consumers are asked to take on more responsibility for their health, they will undoubtedly demand greater access to and use of these types of solutions. And Internet access to medical information is growing steadily, along with online access to electronic

medical records. In fact, many CDHPs already have limited, consumer-friendly personal health records incorporated into their architecture. It is only a matter of time until consumers start to demand more robust, integrated health records and the capability to conduct structured online visits with their medical professionals. Technology and consumerism will continue to converge, creating as many challenges as solutions for organizations.

8. Locate Health Care Clinics Within the Worksites.

Low-fee, convenience-oriented health clinics, usually staffed by nurse practitioners, offer routine medical services including immunizations, examinations and strep tests, and are rapidly expanding in retail outlets and pharmacies. As CDHPs grow, consumers with HRAs or HSAs will have more incentive to use these clinics for routine medical needs rather than wait to see their more expensive plan doctors. Large companies may elect to locate such clinics on site, expanding traditional occupational health departments or establishing new clinics where workers can be given pagers so that they may continue working while waiting to be seen. These on-site clinics can also be leveraged to provide support to remotely delivered behavior modification and disease management programs, integrating the delivery of care and tracking of population health.

9. Increase Global Availability of High-Quality Health Care.

High-quality care is no longer attributed solely to the urban teaching hospitals. Technology now allows leading experts to partner with care providers throughout the world in diagnosing illnesses and even performing robotic surgery. If quality can be constant through the use of partnerships and technology, then it opens up opportunities for people to seek care in their local communities. We're even seeing evidence of people becoming more aggressive in seeking lower cost but high-quality alternatives by going outside the United States to lower cost countries. Even with hotel and airfare costs, by some estimates it can be 50% less expensive to have surgery performed in India, China or Indonesia; other estimates peg certain procedures in certain locales at a fraction of U.S. cost. While issues of liability and quality assurance will complicate the trend, consumerism is likely to spur it. One byproduct of this could be that as claims experience improves, self-funded health plans may save on reinsurance rates.

10. Create Better-Educated Consumers.

More than anything, the rise of consumerism goes hand in hand with the emergence of better-educated consumers. Self-service and self-reliance are creating improvements, particularly because of easy access to health care information. Access to online information can make consumers aware of multiple treat-

ment options, while educated information about benefits and claims history will help families make better estimates of what they will spend on health care in a given year. Many companies are already expanding the type and access to information available to their workforce through online portals that aggregate health resource information. Another popular tactic is to move hard-copy health benefit information from an after-the-fact communication (in the form of an explanation of benefits after a service has been "purchased") to a regular, ongoing education through monthly health statements analogous to monthly financial statements.

CONCLUSION

There's no question that consumerism and CDHPs will continue to evolve so long as they focus on meeting the needs of employers, who are in a cost crisis, and the needs of employees, who have shown a willingness to shoulder more cost and responsibility as long as they can continue to receive the best care.

If anything, consumerism is bringing meaningful change to a health benefits world that has remained largely stagnant since the introduction of managed care and HMOs. At the same time, there are serious issues to contend with, concerning the credibility and depth of consumer information sources; plan design and risk equity for low-wage earners and the chronically ill; and the erosion of the insurance concept. There are also operational, educational and acceptance challenges for consumerism. The promising news is that consumerism and CDHPs offer a variety of first-generation solutions and tactics that make good progress in addressing these potential issues. Despite the challenges always accompanying significant and meaningful change, consumerism and CDHPs are moving us in the right direction toward greater transparency, flexibility and accountability. ◀

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