

# Personal Responsibility in Health Benefits:

## Looking Backward, Looking Forward

by Alexander “Sander” Domaszewicz

Consumerism and care management continue to make inroads as cost-containment strategies for employers, as well as for employees who have endured the steady rise in benefit cost-shifting. The latest statistics and trends point the way to a new era of personal responsibility in health benefits. The author describes how this trend has grown, and where it is leading.

**T**he numbers may not be staggering, but the trend is unmistakable. Organizations are offering consumer-directed health plans (CDHPs) at a significant rate—more proof that the era of consumerism in health care and the increasing employee acceptance of personal responsibility for benefits choices is an emerging solution to the unsustainable cost-shifting and premium increases of past years. But in order to appreciate this phenomenon, it's vital to take a comparative look beyond the latest raw numbers.

According to the 2006 *National Survey of Employee-Sponsored Health Plans*, a survey conducted annually by Mercer Health & Benefits LLC that included nearly 3,000 employer participants in 2006, the rise of CDHPs is very real. (See Figure 1.) In fact, the percentage of all surveyed employers offering a CDHP based on either a health reimbursement account (HRA) or a health savings account (HSA) tripled in 2006, from 2% to 6%, as small employers began adapting the new plan type in significant numbers for the first time. Meanwhile, growth was strong among large employers, with CDHP offerings rising from 5% in 2005 to 11% among employers with 500 or more employees and from 22% to 37% among jumbo employers (20,000 or more employees). Na-

tionally, enrollment in CDHPs rose from 1% to 3% of all covered employees. (See Figure 2.)

While these single-digit percentages do not represent a great volume of employee enrollment, it's important to consider more than just the numbers, rather than draw the wrong inference.

“Some industry watchers look at the low enrollment in CDHPs and conclude that employees aren't accepting the model,” said Blaine Bos, one of the study's authors. “But a threefold increase in one year suggests otherwise.”

Perhaps more to the point, the increase points the way to cost-sustainability. CDHPs delivered substantially lower cost per employee than either preferred provider organizations (PPOs) or health maintenance organizations (HMOs) in 2006. (See Figure 3.) CDHP costs averaged \$5,770 per employee, compared to \$6,616 for HMOs and \$6,932 for PPOs (but just \$6,019 for PPOs with comparable deductibles of \$1,000 or more). While the average CDHP cost is only 5.3% higher than last year's average cost of \$5,480, the lowest of all plan types, it should be noted that CDHP cost includes the employer account contribution and many of the new plans added in 2006 were HSAs, which don't require an employer contribution.

If anything, the personal responsibility trend is a twin-edged sword in terms of cutting costs. On one hand, there's consumerism and CDHPs; on the other,

► **FIGURE 1**

**EMPLOYERS LIKELY TO OFFER CDHP IN 2007 OR 2008**

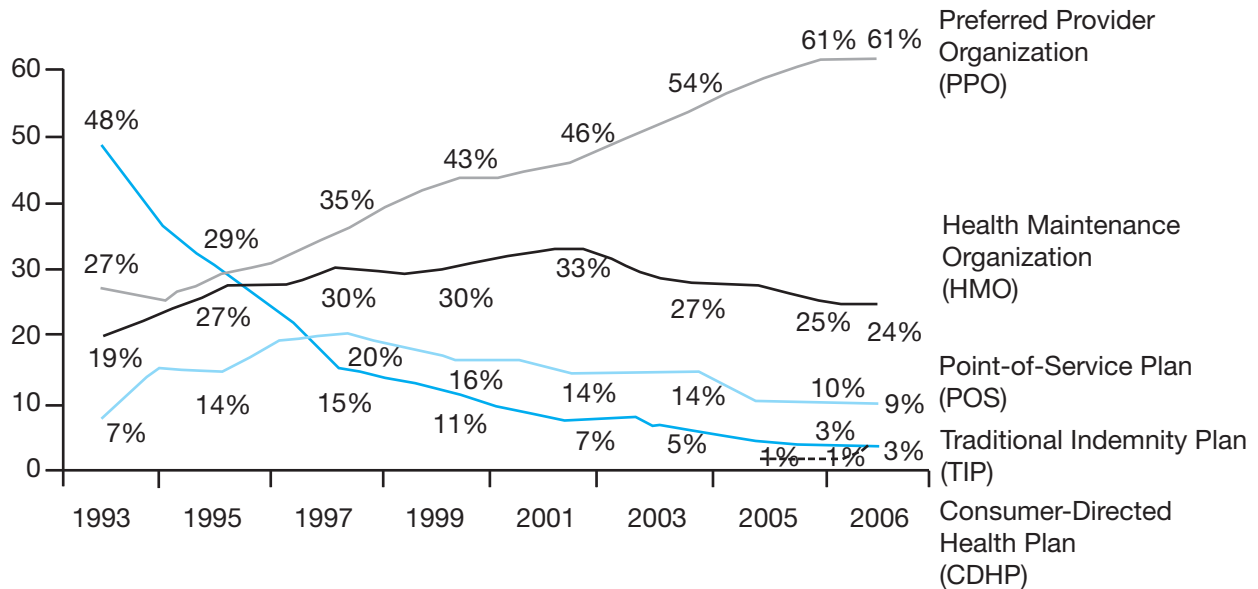
	<b>Offered in 2005</b>	<b>Offered in 2006</b>	<b>Likely to Offer in 2007*</b>	<b>Likely to Offer in 2008*</b>
All employers	2%	6%	14%	16%
Small employers (1-499)	2	5	14	16
Large employers (500+)	5	11	14	19
Jumbo employers (20,000+)	22	37	39	43

\*Selected 5 on a five-point scale, where 1 = not at all likely and 5 = very likely. Includes employers that currently offer; 2008 figure includes employers likely to offer in 2007.

Source: Mercer's National Survey of Employer-Sponsored Health Plans.

► **FIGURE 2**

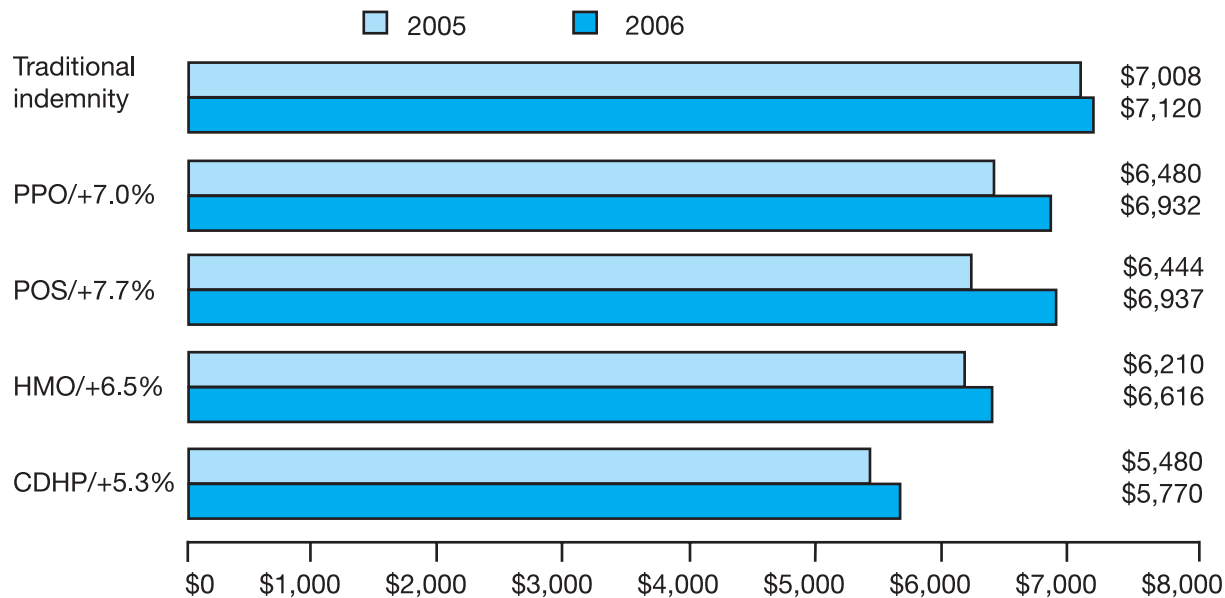
**NATIONAL EMPLOYEE ENROLLMENT, 1993-2006  
PERCENT OF ALL COVERED EMPLOYEES**



Source: Mercer's National Survey of Employer-Sponsored Health Plans.

► **FIGURE 3**

**MEDICAL PLAN COST PER EMPLOYEE BY PLAN TYPE, 2005-2006**



Source: Mercer's National Survey of Employer-Sponsored Health Plans.

there is the preventive and restorative thrust of care management. The 2006 Mercer survey shows that employers continued to add care-management features to their programs at a healthy clip—in particular, health risk assessments, now offered by 22% of all employers and 53% of large employers—and to add incentives for employees to use care management. Survey results suggest that employers are increasingly able to measure a return on their investment (ROI) in care management. Nearly 25% of all large employers and 50% of those with 20,000 or more employees have attempted to measure ROI on various care-management programs. Of those, the great majority (79%) are satisfied or very satisfied with ROI.

When respondents were asked to rate the importance of cost-management strategies to their organization over the next five years, care management and consumerism were each rated “important” or “very important” by 43% of all employers. The strategic focus on care management and consumerism ramps up rapidly for larger employers with over 500 employees. In this group, about two of every three rated these strategies “important” or “very important.” In stark contrast, only 31% of all employers and 37% of large employers believe shifting cost to employees or scal-

ing back benefits will play an important role in controlling cost in the near future. (See Figure 4.) It is heartening that employers are more interested in such longer term, sustainable solutions as care management and consumerism than the easier “strategy” of simply shifting cost to employees.

**CDH VS. CDH**

Within consumerism, however, the authors observe a disturbing trend that could be called “CDH vs. CDH.” The first *CDH* is shorthand for cost-driven health care. This is actually a cost-shifting effort masquerading as consumerism. Some potential hallmarks of this less-sustainable form of CDH are:

- A benefits manager told to “do consumer-directed health care” by executives for the primary purpose of saving the company money immediately
- An HSA-compliant plan dropped in alongside current plan offerings
- Little or no company contribution to the health account
- Little or no investment in tools, information or support for those being asked to participate
- Only passing attention paid to communication

► **FIGURE 4**

**EMPLOYER COST-MANAGEMENT STRATEGIES FOR THE NEXT FIVE YEARS**

	<u>Strategy Will Be Significant or Very Significant</u>	
	<u>Large Employers</u>	<u>All Employers</u>
Care management	71%	43%
Consumerism	64	43
High-performance networks	41	34
Collective purchasing	37	45
Scaling back benefits/shifting cost to employees	37	31
Data transparency	34	34

*Source: Mercer's National Survey of Employer-Sponsored Health Plans.*

- No longer term educational component to the program.

Predictable results can include very low adoption by workers or, if the offering is forced, significant employee relations issues. Cost-driven health may also foster poor choices or unintended health consequences for those in the program. There may be a short-term dip in company costs achieved through cost shifting to workers, followed by a longer term, cost-increase trend driven by poor health and lagging productivity issues.

The other side of the “CDH vs. CDH” spectrum is consumer-directed health care. This *CDH* falls rightly under the umbrella of consumerism and typically requires more effort, energy and involvement by all stakeholders to successfully launch and sustain. Hallmarks of this *CDH* can include:

- Adoption of a documented multiyear health strategy
- Addition of account-based or consumerist health plans as significant or the only options over time
- Meaningful contributions to any health account so most participants can reasonably expect to be able to manage their health with the funds provided
- Concerted efforts to provide support, tools and information to help participants navigate and seek value in the health and care purchasing worlds
- Investment in helping employees understand, value and use their benefits program, both as a new option and over time as they learn to become more involved and informed health care consumers.

Positive behavior changes, improved companywide health status and cost-savings can often be seen over time when using this model. Care must still be taken to monitor the program, adjust elements as necessary and guard against unintended consequences such as care avoidance or disproportionately impacting lower-paid or ill workers. Benefit and health plan management basics, such as vendor negotiations and network discounts/access, must also be addressed at the same time for this more sustainable and employee-friendly form of *CDH* to yield positive results for the company.

Conscientious advisors encourage plan sponsors with consumerism strategies to adopt as many elements of this second *CDH* as is organizationally possible, while limiting the first *CDH*, cost-driven health care, to its appropriate role.

“We need to help employers prioritize cost-savings

► **THE AUTHOR**

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over time as an important goal of their health strategy, one of the top three,” said Leonard Grover, a zone consumerism lead at Mercer. “But we also need to help them make it goal number three, coming only after providing quality care (and, thus, improved health) and employee satisfaction, in order to maximize consumerism success.”

## PAST IS PROLOGUE

Obviously, the days of rampant cost-shifting to employees or scaling back benefits seem to be on the wane, which illustrates how trends can change in the health benefits world. We needn't be reminded that the perceived panacea of HMOs in the 1980s began with great promise and posted steady cost-control success until the savings were eroded by double-digit, health care cost-inflation. This proved that the HMO solution, despite its advantages, was all too vulnerable to market forces. Similarly, cost-shifting, which was initially and begrudgingly accepted by employees who recognized that the burden of health care inflation must be shared, is proving an unsustainable solution for obvious reasons. This is especially true in an era when more and more low-wage workers feel they no longer can afford to participate in their employer health plans at all.

Efforts to get employees informed and involved in health care are nothing new. An early and increasingly popular retro trend is to expose participants to the true cost of care through the use of coinsurance, not just for big-ticket items but also for office visits and prescriptions. The use of tiered pharmacy copays is also aimed at differentiating the value of services in the eyes of the buyer. Section 125 cafeteria, or flex, plans that allow workers to “shop” for care once annually with notional “credit” dollars from a menu of benefits with arbitrary, employer-set “price tags,” was another effort to get participants in the game. The rise of HSAs and, to a lesser extent, HRAs reflects this ongoing evolution in health benefit solutions and may prove the most sustainable for the long term as employee education and care management encourage an increasing level of personal benefits responsibility.

While HRAs have been around since 2001, HSAs were introduced as part of the Medicare Prescription Drug, Improvement, and Modernization Act at the very end of 2003, too late for most employers to offer in 2004. Last year, HRA-based CDHPs were far more common than HSA-based plans. But in just one year, HSAs have pulled ahead. According to the Mercer survey, 4% of all employers offered one in 2006, while just 2% offered an HRA-based plan. Small employers are showing a clear preference for HSAs, which don't

require an employer contribution to the account and allow a more hands-off employer approach.

However, even among large and jumbo CDHP sponsors, there is now an even split between the two account types—6% each for all employers with 500 or more employees and 22% for HSAs and 21% for HRAs among those with 20,000 or more employees. In 2007, HSAs will be offered more often by both small and large employers. Of small employers, 14% say they are very likely to offer a CDHP in 2007, including those who currently offer one. This figure rises to 16% for 2008.

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This would represent a significant increase from the 5% of small employers offering a CDHP today. Even if not all these employers follow through in 2007 (respondents complete the survey in late summer, when many small employers in particular have not yet finalized plans for the upcoming year), it is a good indication of their enthusiasm for the new plan type.

While CDHPs initially grew fastest among larger employers, survey results indicate a cooling trend for the next two years. Among employers with 500 or more employees, CDHP offerings are predicted to rise from 11% this year to 14% in 2007 and 19% in 2008, showing good but not spectacular growth. Among jumbo employers, where CDHPs have been embraced the most enthusiastically, growth will be modest, from 37% this year to 39% in 2007 and 43% in 2008.

If these predictions prove accurate, they suggest that the rapid growth in CDHP adoption by employers seen in 2005 and 2006 will slow somewhat over the next two years.

“That's not unusual with a new plan,” Bos said. “By now, the early adopters have already acted. We

can expect a pause while employers with more of a 'show-me' mindset wait for results."

After making the corporate decision to offer a CDHP, it is clear that many of these employers will now work to make the plans more attractive to workers and increase the employee adoption of the plans within their programs. Indeed, survey results suggest that enrollment in the plans already established is likely to continue to rise. Among large employers with CDHPs in place in both 2005 and 2006 (excluding full-replacement plans), average enrollment rose from 22% to 27% of eligible employees. In-program growth could be the second, big CDHP wave if employer adoption rates moderate as projected.

However, when asked to think ahead five years and predict what medical plan choices will most likely be offered to their employees, large employers send a clear message: 60% say employees will be offered one or more account-based plans, including 10% that say they will offer only account-based plans. More than a third of small employers (36%) believe they will offer account-based plans five years down the road.

## RETIREE HEALTH AND PLAN DESIGN

As employers integrate CDHPs into their benefits offerings, the impact on such difficult social issues as retiree medical coverage is likely to be felt. With employers continuing 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 costs. The concept of saving while still a healthy, active employee for a time when more care might be needed after retirement is appealing and easily communicated to employees as an aspect of plan design and as a long-range benefit. This meshes well with employers wanting to keep or add some retiree health benefits despite significant cost pressures.

Even so, the future of employer-sponsored retiree medical coverage is far from clear. Just 78% of large employers responding to the survey that offer a retiree plan to new hires believe they will still do so five years from now. In 2006, 7% of retiree medical plan sponsors offered an HSA to help employees save for postretirement medical expenses; 20% say they are considering adding an HSA for this purpose.

Perhaps in response to the new Medicare Part D prescription drug benefit, the percentage of large employers providing a medical plan for Medicare-eligible retirees on an ongoing basis dropped from 21% to 19% in 2006. An additional 10% provide coverage to a closed group of current or future retirees but do not offer coverage to new hires.

Survey results suggest that many large retiree plan sponsors changed their approach to providing coverage to their Medicare-eligible retirees in 2006 as they took more time to react to the introduction of the Medicare Part D benefit. Last year, 43% continued to provide coverage to retirees without seeking a subsidy, perhaps because of the difficulty or expense of performing the tests required to receive it. By 2006, this figure fell to just 25%. Conversely, sponsors receiving the subsidy rose from 44% to 51%, and more employers (13%) also chose to provide coverage that wraps around a prescription drug plan (PDP), up from just 4% last year.

There was no change in the percentage of large employers providing coverage for pre-Medicare-eligible retirees (29%). Again, an additional 10% provide coverage to a closed group.

## CONSUMERISM'S LEADING EDGE

Last year, the authors described a number of ways that consumerism would affect companies in the near future ("Consumerism's Sea Change: How It Will Affect Your Company in the Coming Years," *Benefits Quarterly*, second quarter 2006). The list included support of organizational initiatives as companies implement achievement cultures that reward cost-saving behavior, improved attraction and retention as a result of firms offering HRAs and HSAs, simplification of benefits administration by consolidating multiple benefits programs with CDHPs, providing strong program support through health advocates and health coaches, and increasing steerage to health care clinics that are near or within the worksite, among other things.

One particular area cited as a future trend that will be driven by consumerism garnered considerable notice during the past year: the increased global availability of high-quality health care. High-quality health care is no longer attributed solely to urban teaching hospitals, as technology now allows experts to partner with care providers throughout the world in diagnosing illnesses and even performing robotic surgery. But more than anything, the past year has seen the increasing emergence of so-called medical tourism, in which health care consumers seek cheaper yet high-quality alternatives by going outside the United States to lower-cost countries. By some estimates, it can be 50% less expensive to have surgery performed in India, China or Indonesia, while other estimates peg certain procedures in certain locales at a fraction of U.S. cost.

As noted in last year's article, "While issues of liability and quality assurance will complicate the trend, consumerism is likely to spur it."

Since then, several news reports in leading U.S. magazines have remarked on the rise of this trend, estimating that up to a half million Americans traveled overseas for medical treatment in 2006. While many of them may have been well-to-do consumers of pricey, plastic surgery in places such as Sweden, an increasing number are uninsured or underinsured Americans seeking affordable heart surgery, joint replacement and other essential procedures. News stories cite such vast cost differences as \$6,500 for heart valve surgery in India that could cost as much as \$200,000 in the United States. Bumrungrad International Hospital in Bangkok, Thailand reported treating 58,000 Americans in 2005, a 25% increase over the year before.

To many, this trend is disturbing and reflects the dark side of consumerism in which the high cost of American health care is being met by extreme alternatives—at least for the consumer. As Arnold Milstein, M.D., chief physician at Mercer, wrote recently:

These patients are not “medical tourists” seeking low-cost aesthetic enhancement. They are middle-income Americans evading impoverishment by expensive, medically necessary operations.<sup>1</sup>

The article goes on to suggest that this trend has its positive side as a byproduct of health care consumerism, from the standpoint of quality of care:

One important question about advanced foreign hospitals is whether their quality of care is similar to that in the average U.S. hospital. In recent years, many such hospitals have passed muster with one or both of two international quality-assessment organizations . . . Since the United States and most other countries do not require their hospitals to measure and report surgical outcomes or to participate in international performance-measurement systems, it’s hard to assess relative quality. We doubt, however, that the average U.S. hospital can offer better outcomes for common complex operations such as coronary-artery bypass grafting, for which several (internationally accredited) offshore hospitals report gross mortality rates of less than 1%.

While the trend of offshoring major medical procedures will be only a blip on the domestic U.S. health care landscape for some time to come, the trend highlights a critically important consequence of consumerism: If there is a better, faster, cheaper or more service-oriented solution available, it will begin to draw a market of involved and informed health care consumers. And while consumers may be reluctant to have heart surgery in Thailand, using a retail clinic at the back of their local drug store for routine care, instead of visiting their primary care doctor, sounds less

drastic and works on many of the same economic and market-based principals.

When the possibility that the retail clinic can automatically transmit medical records to insurers and primary-care doctors is included, this faster, cheaper solution has the potential to deliver superior total quality as well. Accessing medical advice through structured Internet visits for routine physician interactions would seem to be a natural extension. All of these innovations stand to improve quality and affordability in a health care system that is desperately seeking workable alternatives.

## CONCLUSION

While employees are taking on a greater share of personal responsibility for their health care benefits choices in past years, the unsustainability of continued cost-shifting to employees calls for newer solutions. As recent research points to the evolution and steady acceptance of CDHPs, it’s becoming clear that CDHPs can deliver substantially lower cost per employee than PPOs or HMOs. The broader efforts of health care consumerism to get people more involved with and better informed about their health and care is, if anything, growing faster than CDHPs, which are only the most visible and controversial consumerism tactic. The trend will continue to grow so long as it meets the need of employers, which continue to experience a cost crisis, and employees, who continue to willingly shoulder more responsibility in exchange for access to the best medical care. In some cases this care may prove more affordable and equally reliable in alternate settings and delivery modes.

At the same time, the issues that have dogged the advent of health care consumerism in recent years must still be contended with. These include credibility and depth of consumer information sources; plan design and risk equity for low-wage earners and the chronically ill; and operational, educational and acceptance challenges for consumerism. Employers need to muster the full arsenal of design and communication strategies to convey the benefits and ensure the effective execution of CDHPs and other aspects of greater personal responsibility in employee health care. Otherwise, this important solution to a longstanding social problem may begin to stagnate rather than thrive—when employers and employees need it the most. ◀

## Endnote

1. Milstein and Smith, “America’s New Refugees: Seeking Affordable Surgery Offshore,” *New England Journal of Medicine*, 355:16, www.nejm.org, October 19, 2006.