



Forum Session Meeting Announcement

Thursday, July 28, 2005
11:45am — Lunch
12:15pm–2:00pm — Discussion

Containing Health Care Costs for Active Employees: What's New in Health Plan Design?

A Discussion Featuring:

Meredith Baratz

Vice President, Market & Product Development
Definity Health, a UnitedHealth Group Company

John Bertko

Vice President
Chief Actuary
Humana, Inc.

John Freedman, MD

Assistant Vice President
Medical Director, Medical and Quality Management
Tufts Health Plan

With Comments From:

Walton Francis

Founder
CHECKBOOK's Guide to Health Plans for Federal Employees

Location

**Reserve Officers Association
of the United States**
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen Senate
Office Building)*

Registration Required

Space is limited. Please respond
as soon as possible.

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Containing Health Care Costs for Active Employees: What's New in Health Plan Design?

Overview

This Forum session will examine three health plan designs employers are using to contain health care costs for active workers: health savings accounts, high-performing networks, and tiered networks. A consumer perspective on these approaches will also be offered.

SESSION

Health care costs for active employees continue to rise. In 2004, the average total cost of all health benefits for active workers was \$6,679, up from \$6,215 in the previous year and \$4,430 in 2000. Overall, 2004 annual per-employee costs for active employees were up 7.5 percent over the previous year.¹ On a positive note, this was the lowest increase in five years.

Some have predicted that such increases might lead employers to stop providing health benefits; however, most employers have instead attempted to moderate cost increases through changes in health plan design. Many of these changes emphasize engaging employees to become better consumers of health care and insisting on greater transparency of providers' costs and performance.

The most visible cost-containment strategies have targeted consumers' wallets. Many firms have shifted more of the financial burden for health care to employees by either increasing copayments, deductibles, and/or share of premium or by moving from deductibles and copayments (fixed charges such as \$20 for a doctor's visit) to coinsurance (a percentage of costs rather than a fixed dollar amount). Coinsurance ensures that employees' out-of-pocket costs rise in step with health care cost increases. According to a recent survey, 7 percent of all employers and 20 percent of large employers have replaced copayments with coinsurance.²

Point-of-care cost sharing, in which an employee's choice of provider, drug, procedure, or site of care determines the level or amount of cost-sharing, is another strategy that has become more prevalent.³ Tiered pharmaceutical benefits, used by 49 percent of all employers, and tiered hospital/provider networks, are prime examples of this point-of-care approach.⁴

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Most recently, employers have turned to consumer-directed health plans—high-deductible plans coupled with spending accounts such as health savings accounts (HSAs) or health reimbursement accounts (HRAs)—to encourage employees to be more cost-conscious consumers of health care. These accounts generally allow employers or employees to set aside monies to cover a portion of out-of-pocket expenses. A gap between the amount funded by the account and the deductible, however, is intended to promote price-sensitive consumerism. Over 3.5 million individuals were enrolled in high-deductible health plans as of March 2005, with more than 1 million in HSAs.⁵

Other consumer-focused strategies include providing employees with information and decision-support tools such as report cards, automated health risk appraisals, nurse advice lines, health coaches, and other self-management tools.

In addition to approaches targeted directly to employees, employers and health plans are using cost and quality data to drive improvements in provider performance. For example, some plans are using cost and quality data to develop so-called high-performing networks that exclude inefficient providers altogether. Pay-for-performance initiatives are also aimed at improving performance through greater transparency and differential rewards. Hospitals, physician groups, or physicians participating in a pay-for-performance program typically are scored according to some combination of clinical practice, patient satisfaction, and efficiency measures with rewards for superior performance based on a rate of improvement or achievement of a specified threshold.

This session will examine in greater depth three approaches aimed at containing health care costs for active employees: HSAs, tiered networks with differential copayments, and high-performing networks. Speakers will describe these approaches, discuss the environmental conditions where each is likely to take hold or be successful, and offer evidence of their short- and long-term savings potential. A consumer perspective on these new approaches will also be offered.

SPEAKERS

Meredith Baratz, vice president of marketing and product development for Definity Health, a UnitedHealth Group company, will provide an overview of the firm's HSA product line. Ms. Baratz provides conceptual and development leadership for Definity's consumer health solutions. Driving consumer engagement solutions at UnitedHealth since 2002, she led related marketing and product design functions. Ms. Baratz has worked with large employer groups for more than 20 years and has served in account management and sales and marketing leadership roles with MetLife, MetraHealth, and Uniprise.

John Bertko, vice president and chief actuary for Humana, Inc., will describe Humana's high-performing networks and the approach used to construct such networks. Mr. Bertko manages the corporate actuarial group and directs the coordination of work by actuaries in Humana's major business units, including public programs, commercial and individual insurance, and TRICARE. In his current role, he is responsible for Humana's actuarial use of risk adjusters and conducts discussions with the Centers for Medicare & Medicaid Services. Mr. Bertko serves as a commissioner on the Medicare Payment Advisory Commission.

Walton Francis is a self-employed economist and policy analyst who writes on a wide range of subjects, including program evaluation, statistical analysis, managed health care, and retirement benefits. He pioneered the systematic comparison of health insurance plans from a consumer perspective, beginning with the 1979 edition of CHECKBOOK's *Guide to Health Plans for Federal Employees*, and later co-designed the online version of the guide. Mr. Francis will comment on the impact of new plan designs on consumers.

John Freedman, MD, assistant vice president and medical director for medical and quality management at Tufts Health Plan, will describe *Navigator by Tufts Health Plan*, a metrics-driven and value-based tiered network product. At Tufts, Dr. Freedman is responsible for clinical data collection, analysis, and reporting, including HEDIS, the public Physician Group Quality Profile and Pay-for-Performance provider incentives. He also provides medical support to programs such as disease management, utilization management, and high-risk case management.

KEY QUESTIONS

- What are the key characteristics and design features of HSAs? What kinds of employers are most interested in offering HSAs? How many employers are offering HSAs as their only health plan choice? What is the evidence that HSAs are an effective cost-containment tool for employers?
- What types of employees enroll in HSAs? What is the evidence that consumers enrolled in HSAs are not forgoing needed care? Do employees who switch to HSAs have lower total costs (premiums and out-of-pocket) than before? Do consumers who pay for health services from HSAs have access to discounted rates, as they would if enrolled in a preferred provider organization plan?
- What criteria are used to categorize providers into tiers or high-performing networks? How do providers respond? How do market dynamics play into the decisions by employers and plans to use tiers or high-performing networks as cost-containment tools? Is there a process by which providers excluded from a network can regain entry?

- Are tiering mechanisms successful in steering patients to low-cost, high-quality providers? What factors, such as age or diagnosis, influence a patient's willingness to change providers? Does tiering differentially affect the choices and decisions of consumers with acute versus chronic conditions? What impact does network differentiation have on provider behavior?
- What kinds of cost savings can employers achieve with tiering or high performing networks? What kinds of savings might employees achieve?
- Are techniques similar to those described by speakers being used in public plans, such as those serving state employees or Medicaid beneficiaries? What new cost-containment strategies are on the horizon?

ENDNOTES

1. Mercer Human Resource Consulting, "US health benefit cost rises 7.5% in 2004, lowest increase in five years," press release, November 22, 2004; available at www.mercerhr.com/summary.jhtml/dynamic/idContent/1162645;jsessionid=1RC4RWYBUVLQGCTGOUFCHPQKMZ0QUI2C.
2. Mercer, "US health benefit cost rises."
3. Institute on Health Care Costs and Solutions, "Ten Steps to Easing Health Care Costs," National Business Group on Health, updated May 31, 2005.
4. Mercer, "US health benefit cost rises."
5. Center for Policy and Research, "Number of HSA Plans Exceeded One Million in March 2005," America's Health Insurance Plans, May 4, 2005; available at www.ahipresearch.org/pdfs/HSAExceedMillion050405_full.pdf.



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