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Consumers May Have More Control Over Health Care Costs Than Previously Thought

The historic RAND Health Insurance Experiment found that patients had little or no control over their health care spending once they began to receive a physician's care, but a new study shows that this has changed for those enrolled in consumer-directed health plans.

Patients with health coverage that includes a high deductible and either a health savings account or a health reimbursement arrangement reduced their costs even after they initiated care. Overall, the study found about two-thirds of the reduction in total health care costs was from patients initiating care less often and the remaining third was from a reduction in costs after care is initiated. The findings were published online by the journal *Forum for Health Economics and Policy.*

"Unlike earlier time periods, it seems that today's consumers can have greater influence on the level and mix of medical services provided once they begin to receive medical care," said Amelia Haviland, the study's lead author and a senior statistician at the RAND Corporation, a nonprofit research organization. "We found that at least part of the savings in cost per episode reflects choices for less-costly treatments and products, not just a reduction in the number of services."

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Researchers from RAND, Towers Watson and the University of Southern California examined the claims experience of many large employers in the United States to determine how consumer-directed health plans and other high-deductible plans can reduce health care costs. The study was funded by the California HealthCare Foundation and the Robert Wood Johnson Foundation.

According to Haviland, at least three factors influenced the cost of care once the patient had initiated care: lower use of name-brand medications, less in-patient care and lower use of specialists. Researchers speculate that patients may talk to their doctors about their higher deductibles and ask them to help keep costs low.

"It is not surprising that deductibles of $1,000 or more reduced health care consumption, but we found that savings occurred even when employers helped employees offset these out-of-pocket costs by making contributions to their accounts," said Roland McDevitt, a study co-author and director of health research at Towers Watson, a human resource and employee benefits consultancy. "This was true for both health savings accounts and health reimbursement arrangements."

Health reimbursement arrangements and health savings accounts create different incentives for employees. Health reimbursement arrangements allow employers to pay for qualified medical expenses, including those that fall under the deductible. These payments or reimbursements are excluded from the taxable income of the employee. Unused portions may roll over at the end of the year, but any account balance is owned by the employer and employees generally forfeit the account balance if they leave the employer before retirement.

Health savings accounts create a stronger incentive for employees to manage their health care costs, because the employee owns the account. This type of account was shown to have the largest impact on cost reductions. It can earn interest and it follows employees when they change jobs.

Health savings account contributions are only allowed for those enrolled in high-deductible health plans as defined by law, but account balances may be used for qualified medical expenses at any time. The minimum health savings account deductibles for 2011 are $1,200 for single coverage and $2,400 for family coverage.

The study found that both the level of the deductible and the level of the employer account contributions influence the extent of savings. Higher deductibles of $1,000 or more together with employer account contributions of less than half the deductible produced the greatest cost reductions.

"It is clear that high-deductible health plans with personal medical accounts produce overall health care cost savings and not simply a cost shift," said co-author Neeraj Sood, associate professor at the Schaeffer Center for Health Economics and Policy at USC and a RAND economist. "This is mostly due to patients initiating less care, but a full third of the reduction is due to shifts in the mix of care they are receiving."

The authors cautioned that there was some reduction in the rate of cancer screenings and childhood immunizations during the first year of enrollment in a high-deductible plan. They found this first-year effect was relatively small, but expressed concern about the early trend. They say more research is needed to determine the extent to which these cost reductions come at a price of forgoing necessary medical care.

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You Are What You Measure

The adage "you are what you measure" is more than applicable in today's economic environment. With employee benefit programs making up a large portion of an employer's expenses, it is crucial that employers have mechanisms and processes in place to measure their efficacy. If corporate programs are not yielding the intended return on investment, then those resources ought to be reallocated where they are the most efficient.

Two emerging trends that quantify the impact of employee benefit programs have been gaining traction with employers:

- Incentive-based wellness programs
- Health plan claims analytics

Incentive-based Wellness Programs

In recent years there has been much fanfare about incorporating wellness programs into an employer's benefit plan design. One of the biggest reasons is to control health care costs. Many of the wellness programs instituted over the years have been reliant upon employees self-reporting their results. Not surprisingly, self-reported wellness programs have not yielded the desired outcomes (e.g., reduced health care costs) sought by employers. Consequently, a shift has been taking place among employers toward implementing incentive-based wellness programs in conjunction with medical and laboratory screenings.

Incentive-based wellness programs are wellness programs wherein employees are incentivized to participate in medical and lab screenings to identify high-risk health conditions, such as cholesterol and high stress levels. Incentives are awarded to employees who not only participate in wellness programs, but also attain defined targets, such as a reduction in cholesterol levels. Typical incentives range from prizes and vacation days to cash compensation.

Studies and literature have shown three positive outcomes with respect to incentive-based wellness programs:

- Employee participation in wellness programs increases when incentives are incorporated.
- Greater levels of employee participation are achieved when incentives valued between $350 and $600 are introduced.[1]
- The greater the participation rate, the more health risks are uncovered per participant.[2]

Incentive-based wellness programs yield measurable returns on investment; however, employers are advised to consult with their workforce before designing a program. The feedback received from employees will not only enable employers to better tailor wellness program incentives, but also result in a greater probability of yielding the desired outcomes.

Health Plan Claims Analytics

Analyzing a health plan's claims analytics has been commonplace for many large employers for some time now. In the last few years, with small to mid-size employers having to bear increases in their health plan costs, it is not surprising that they too have taken a greater interest in obtaining and analyzing health plan claims data. Historically, small to mid-size employers have had difficulty with not only accessing claims data, but also having the resources for analyzing it. Analyzing health plan claims data with the tools and resources now made readily available by benefit carriers or third-party vendors can provide valuable insight and make the analysis process easier.

Analyzing health plan claims data can provide direction on how to address plan design and cost issues such as:

- Who is going to the doctor? Are they using in-network or out-of-network providers? Why are they going?
- Which segments of the employee/dependent population are utilizing preventive services most?
- Which diagnostic procedures incur the most claims? The highest claims?
- How often are generic drugs being utilized when available?
- What cost-cutting opportunities exist by adjusting key plan provisions, such as copayments, deductibles and out-of-pocket maximums?
- What are the cost and employee utilization effects of changing medical plan designs (e.g., from PPO to health savings account)?

While procuring and analyzing claims data empowers employers to better gauge health plan risks, implementing a strategy and continually monitoring a plan's efficacy are just as important. By leveraging the reporting capabilities made available in most claims analytics systems, employers have at their disposal resources to track trends and patterns to determine which plan design changes are positively affecting the company's bottom line.

How Do You Measure Plan Success?

Generally speaking, if 401(k) plans are meant to be used to augment retirement income, they may be considered a success. However, if they are expected to serve as the primary source of retirement income (along with Social Security), success is proving elusive for most participants.

The realities of this conclusion have been evidenced in various studies and analyses. Conclusions drawn from this investigation are leading to more candid conversations regarding potential solutions for dealing with participants' retirement readiness. These conversations, in turn, are leading to the implementation of plan-level changes.

A recent Employee Benefit Research Institute study[3] focuses on retirement feasibility for baby boomers and Gen Xers. The conclusions are not encouraging. One takeaway is that even if these groups delayed retirement past age 65, or even into their 70s, they would still have insufficient income to cover their basic retirement expenses. Moreover, even assuming members of these groups intend to delay retirement significantly, the study indicated that factors like layoffs, mergers and poor health might prohibit employees from working past age 65.

Over the 25-plus years since the inception of 401(k) plans, plan design, technology and investment options have improved, and service providers have grown and improved. The only entity that has not shown substantive improvement over the years is the participant — the ultimate consumer for whom the product was developed. Multiple credible industry studies indicate that, left to their own devices, today's participants are making all the same retirement planning and investment mistakes they were making 25 years ago.

With the effective demise of defined benefit plans, much of the attendant costs, administrative complexities, and regulatory, investment and funding responsibilities have been removed from the employer's shoulders and essentially shifted to the participant. Now it is the participant who is expected to know how to "do the right thing" for their retirement. Unfortunately, to date, all evidence indicates that this is not happening.

Some employers do not believe it is their responsibility to ensure their employees' well-being in retirement. Many adopt the philosophy that "We provide the plan, and [in most cases] a matching contribution, and we provide for plan management and incur fiduciary responsibilities. Isn't that sufficient?"

However, there appears to be a significant number of plan sponsors concerned about their employees' retirement readiness. These are the sponsors interested in considering ways to improve the successful outcomes of their plans. Some of the potential solutions require a commitment of time, effort and additional cost. But few, if any, of the solutions require costs equivalent to those incurred if employers still offered defined benefit plans. In other words, employers need not incur all the time, effort, cost and complexity of a defined benefit plan, but neither need they offer a less-than-effective 401(k) plan. For sponsors desiring more inspired outcomes, solutions exist within the 401(k) world.

The 401(k) Plan Diagnostic is a tool that helps you measure the overall health of your plan by evaluating it against a benchmark. This, in turn, helps you to manage fiduciary risk and service the unique needs of your plan and participants by highlighting areas that could be improved. Your NFP retirement consultant can help you utilize this tool to maximize the effectiveness of your plan.

Compliance FAQ

What is the "$2 fee" established by PPACA that is effective for plans ending after Sept. 30, 2012?

The "$2 fee," originally called the "comparative effectiveness fee," was established through the Patient Protection and Affordable Care Act (PPACA) and is designed to fund the Patient-Centered Outcomes Research Institute, which will perform research to determine the effectiveness of various forms of medical treatments, procedures, drugs and other strategies. The fee is determined on an annual basis and is equal to $2 times the average number of covered lives under the policy or plan (the multiplier is $1 in the case of policy or plan years ending before Oct. 1, 2013). For later years, the fee will increase based on the percentage increase in the projected per capita amount of National Health Expenditures (as published by the U.S. Department of the Treasury).[4]

The fees are payable by insurers of specified health insurance policies and by sponsors of applicable self-insured health plans for plan years ending after Sept. 30, 2012.[5] Fees stop applying for plan years ending after Sept. 30, 2019.[6] Thus, for calendar-year plans, the fees would apply for years 2012 through 2018.

"Specified health insurance policy" is defined as an accident policy or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the U.S.[7] "Applicable self-insured health plan" is defined as a plan providing accident or health coverage, any portion of which is provided other than through an insurance policy, and which is established or maintained for employees or former employees by an employer, a union or specified groups of employers (including multiple employer welfare arrangements).[8]

The fees do not apply if substantially all of the coverage is of excepted benefits.[9] Excepted benefits include, among other things, certain limited-scope dental and vision coverage and certain supplemental coverage.[10] No formal guidance has been issued on this provision yet. However, IRS Notice 2011-35, released June 8, 2011, requested comments (through Sept. 6, 2011) on many aspects of this provision, including:

- What constitutes a reasonable method to determine the average number of lives covered under the policy
- Whether each issuer and plan sponsor to report and pay the fees should do so annually or quarterly
- Whether the reporting and payment should occur on the same calendar date regardless of the plan year of any individual issuer or plan sponsor
- The definition of "plan year" or "policy year"
- Whether there should be any transition rules for the first plan or policy year

We anticipate that future guidance will provide clarification on these and other questions relating to this provision. Watch for NFP's e-newsletter *Compliance Corner* for future updates.

Endnotes

[1]Pam Montalto. Quest Diagnostics. "The Role of Incentives in Biometric Screening Program Participation." 2010.

[2]*Ibid.*

[3]Helman, Ruth, Craig Copeland and Jack VanDerhei. Employee Benefit Research Institute. "The 2011 Retirement Confidence Survey: Confidence Drops to Record Lows, Reflecting 'the New Normal.'" Issue Brief. No. 355. March 2011. www.ebri.org/pdf/briefspdf/EBRI_03-2011_No355_RCS-2011.pdf.

[4]Code § 4375(a) and § 4376(a)

[5]Code § 4375(b) and § 4376(b)

[6]Code § 4375 and § 4376

[7]Code § 4375(c)

[8]Code § 4376(c)

[9]Code § 9832(c)

[10]Code § 4375(c)

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