# Impact of Consumer Driven Health Plans: *Findings from the SHPS Health Practices Study*


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# Agenda

- Introduction
- SHPS Health Practices Study
- Discussion / Conclusions
- Questions

# About SHPS

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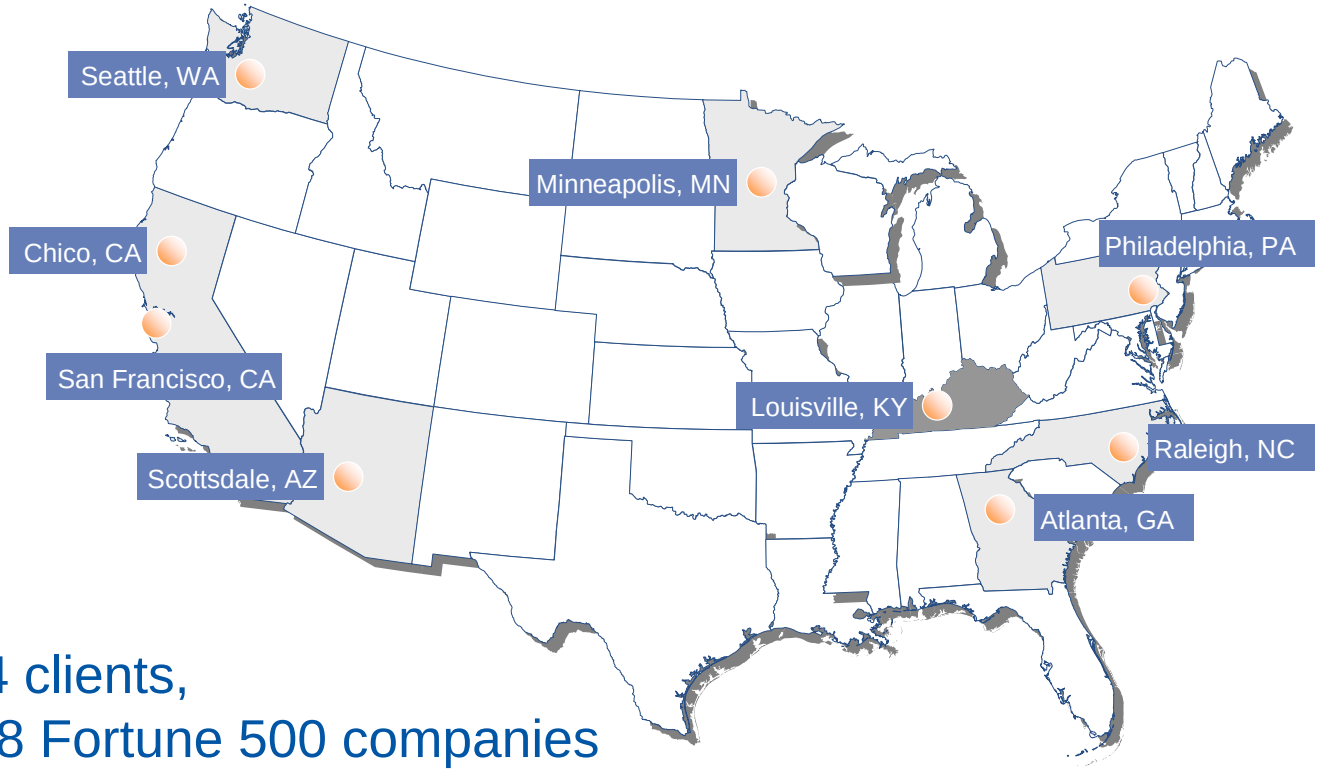
# SHPS, Inc.




- Serves 774 clients, including 78 Fortune 500 companies
- Programs touch more than 8.1 million participants
- Employs 1,800 clinical employee benefits specialists and information technology professionals in multiple facilities across the United States
- Owned by Welsh Carson, a leading private equity group

# Introduction

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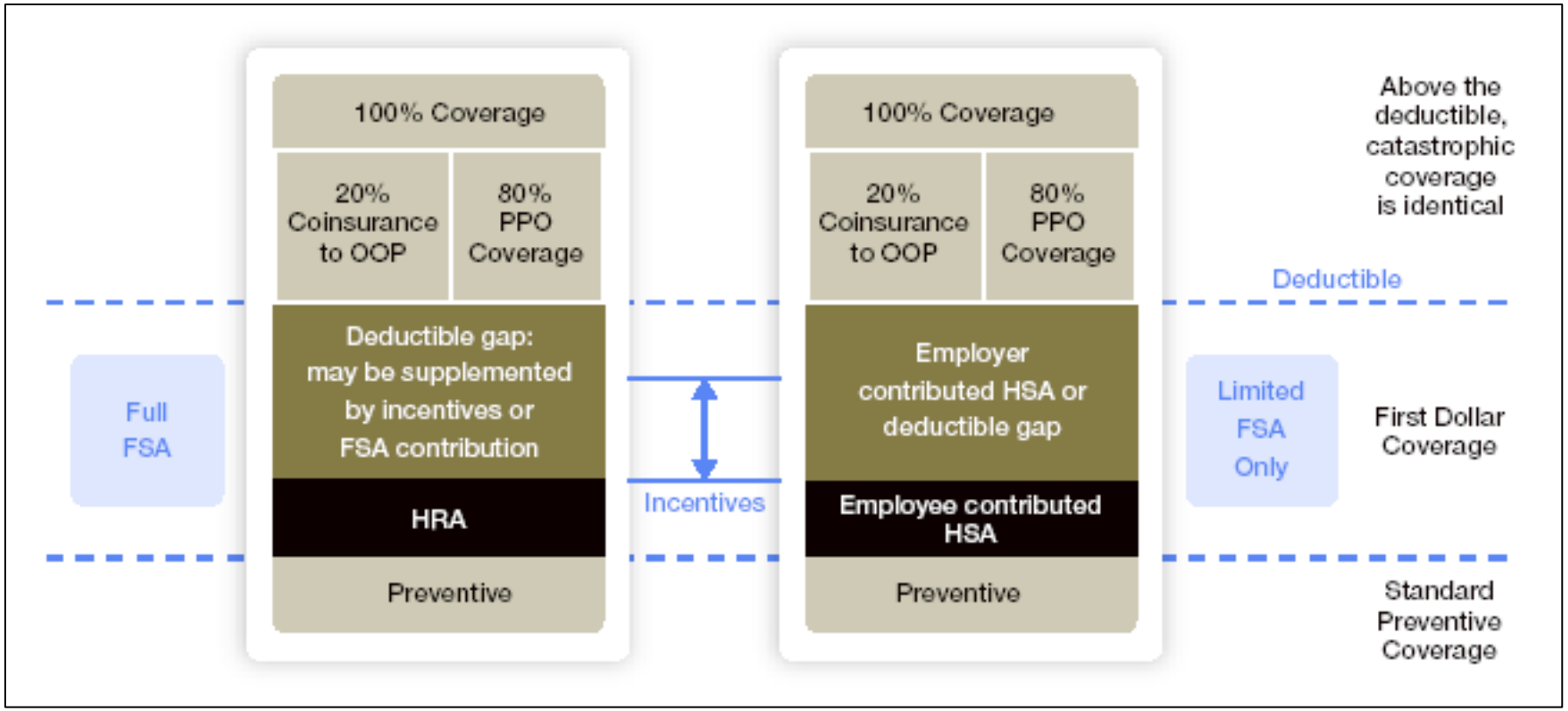
# Rising Costs!

## Answer: High Deductible Health Plan



# Initial Response: High Deductible Health Plans

- Diverse implementations:
  - HRA vs. HSA
  - Full replacement vs. one of many
  - Employee communications
  - Management support
  - Integration with other health initiatives

- Mixed feedback:
  - Penetration
  - Employee response
  - Claims of success (or failure)
  - Immediate reductions in prescription, routine care
  - Impact on chronic disease unclear
  - POS: member and provider confusion

# SHPS Health Practices Study

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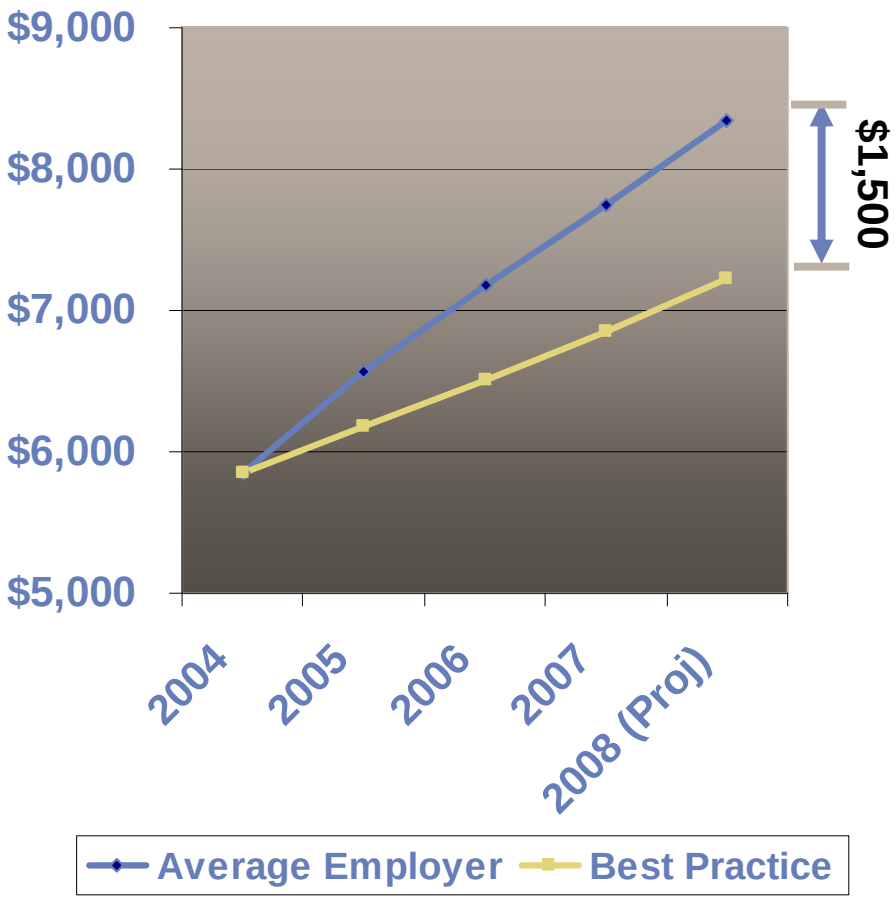
# Why Do Some Employers Pay More?

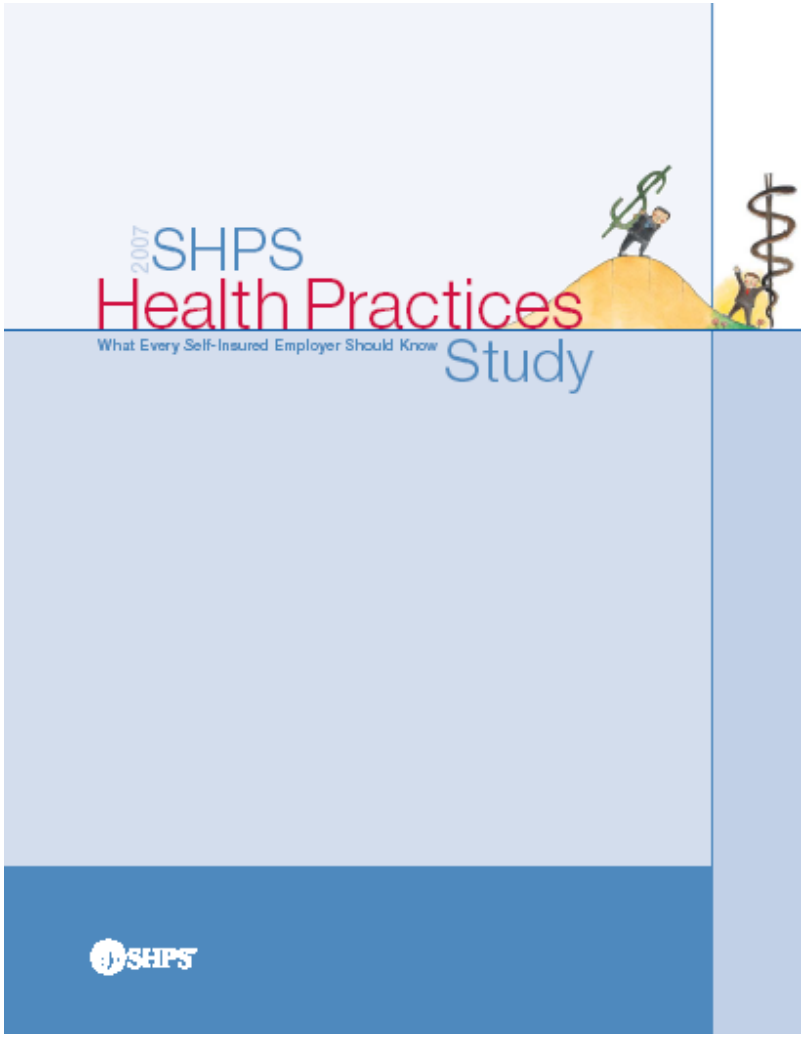



- Some employers consistently out-perform their peers in managing health costs
  - Best Practice: 1 – 2 X inflation
  - Norm: 3 – 6 X inflation
  - Cost differential for actuarially similar employee groups: up to $1,500
  - The cost differential continues to grow over time

**Why the difference?**

- *SHPS Health Practices Study* designed to measure and quantify these observations

# Study Design




- 115 respondent companies > 1,000 ee
  - 50% of employers > 5,000
  - 23% of employers > 10,000
  - 3.7 million total members
- 230 questions on health benefit practices:
  - Plan Design / Incentives
  - Network / Vendor Selection
  - Employee Health
  - Administrative
- Accounts for variations in workforce composition, location and size
- Identifies key cost drivers of total health cost per eligible employee

# Study Findings

- Employers spent an average of $7,710 in healthcare costs per benefit-eligible employee, actuarially adjusted for age, sex, and member/employee ratios

- Certain practices can explain enormous differences in per employee costs – as much as 30-50% between two comparable employers
  - Low Cost Companies: focus on optimizing employee health
  - High cost companies: focus on procurement and transactional cost

- Practices with no measurable impact:
  - Consumer-driven health plans
  - Pay for performance networks
  - Premium cost-sharing

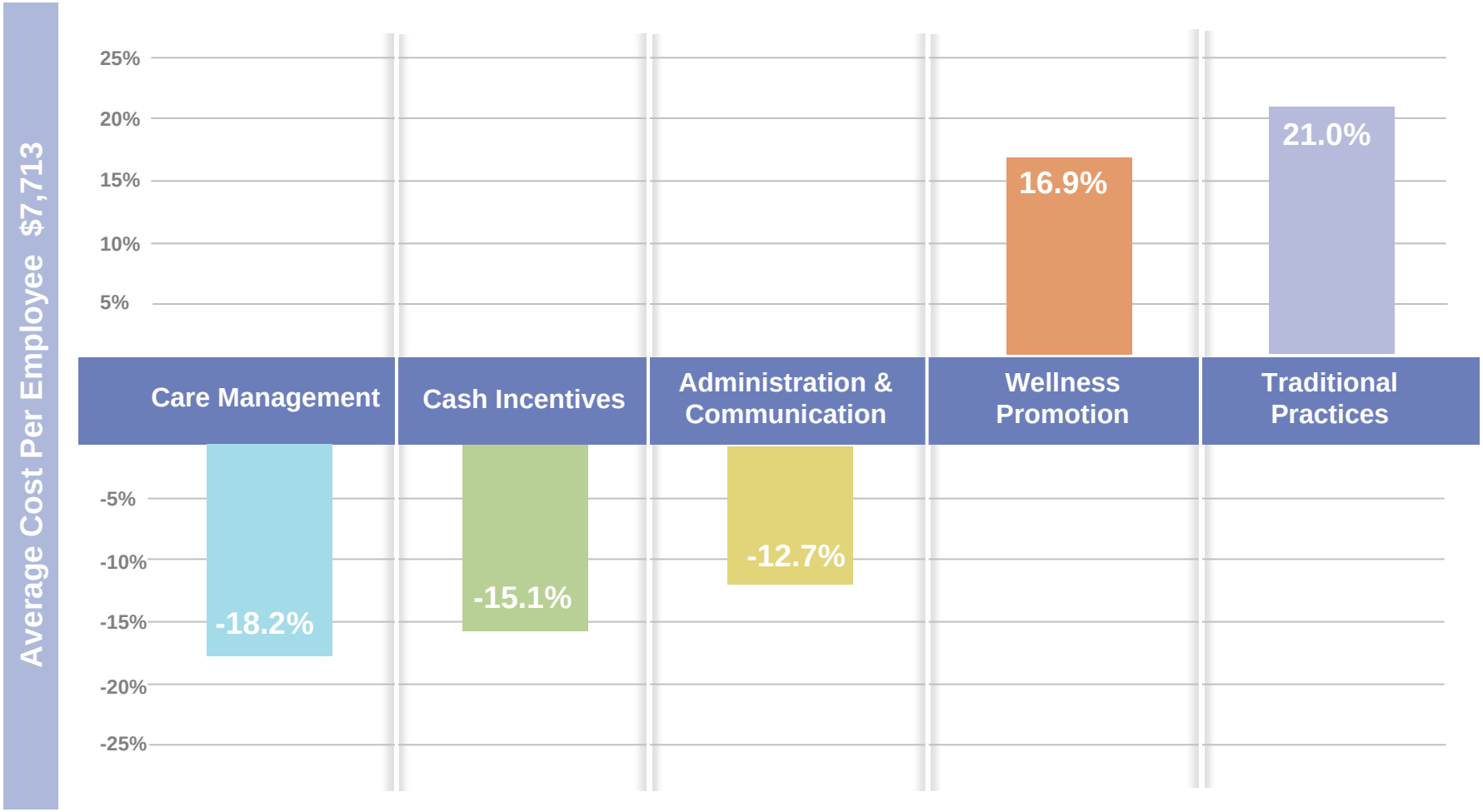
# Employer Self-perception

- No correlation between perceived effectiveness of benefit programs and actual spending levels

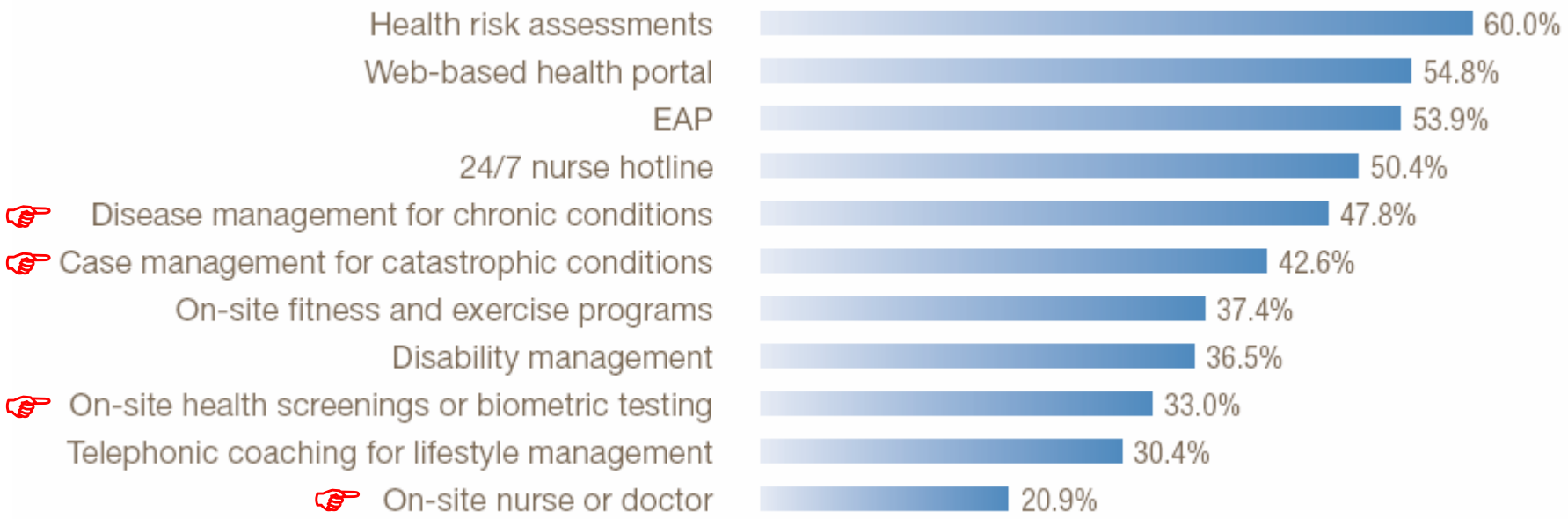
- Positive perceptions closely associated with program "optics":
  - Wellness Programs / Health Portals / Workout facilities
  - Multiple plan choices
  - Focus on achieving "employer of choice" status
  - Excellent administrative and communications practices

***Major disconnect between employer perceptions and underlying reality.***

# Study Findings

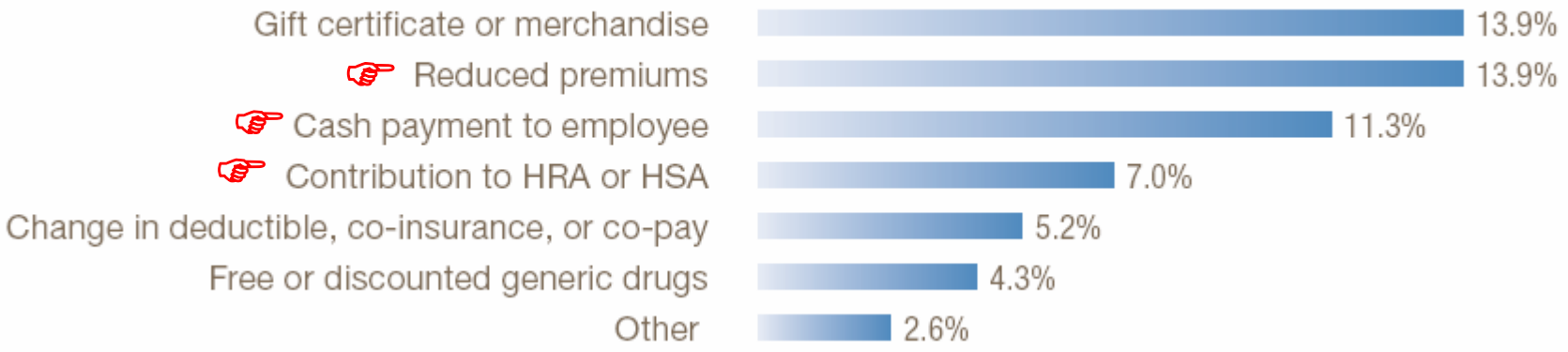


# Finding One: Clinically Focused Care Management




**Low cost employers focus on catastrophic and chronic illness first. They use biometric screenings to drive prevention and wellness.**

# Finding Two: Cash-Based Incentives




**Low cost employers use cash incentives aligned with specific behavioral outcomes to drive program effectiveness.**

# Finding Three: Member Experience

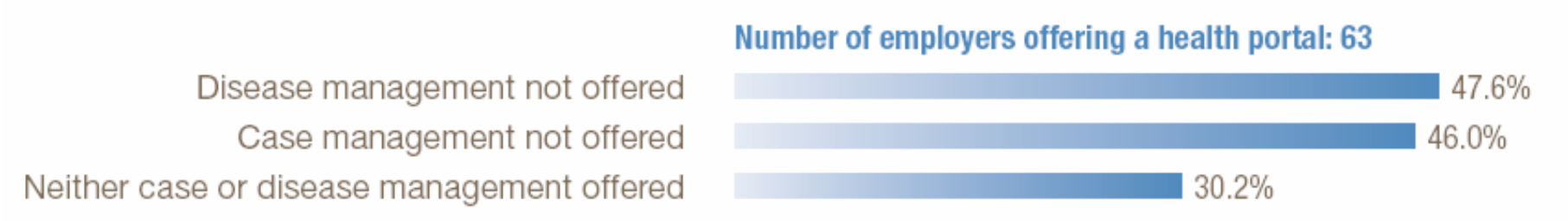
| | Unacceptable 1 | Poor 2 | Fair 3 | Good 4 | Excellent 5 |
|---|---|---|---|---|---|
| 1 Vendor sharing of information and data with each other | ○ | ○ | ○ | ○ | ○ |
| 2 Ability of vendors to provide a seamless experience for members | ○ | ○ | ○ | ○ | ○ |
| 3 Ensuring member eligibility is accurate and up-to-date | ○ | ○ | ○ | ○ | ○ |
| 4 Having a unified, coordinated process for data processing and recordkeeping | ○ | ○ | ○ | ○ | ○ |
| 5 Health-related communications have a common theme, 'look' or 'brand' | ○ | ○ | ○ | ○ | ○ |
| 6 There is a specific communications vehicle devoted to promoting employee health | ○ | ○ | ○ | ○ | ○ |
| 7 Health communications target both employees and spouse/families | ○ | ○ | ○ | ○ | ○ |

**12.7% Reduction**

# Finding Four: Wellness Promotion and Education

- Web based health portals, health clubs, and wellness coaching correlated to higher health costs
  - Robust, independent variable across all regression models
  - Finding holds true for companies regardless of total revenue or workforce composition
- Key issues:
  - Used to enhance workplace climate, rather than improve health
  - Substituted for more rigorous care management programs
  - Cafeteria style offering
  - Push communications
  - Lack of focus on outcomes

# Employers Using Standalone Health Portal




***Do employers understand how to use wellness programs properly to manage health and health spending?***

# Finding Five: Traditional Practices

- Measured the impact of five specific benefits practices:
  - Managing provider quality through network procurement
  - Offering employees multiple plan design options
  - Using deductibles and co-pays to drive health behavior
  - Using healthcare benefits to become an ‘employer of choice’
  - Incurring undesirable turnover

# Health Practices That Matter

$6600 (Cost per EE)

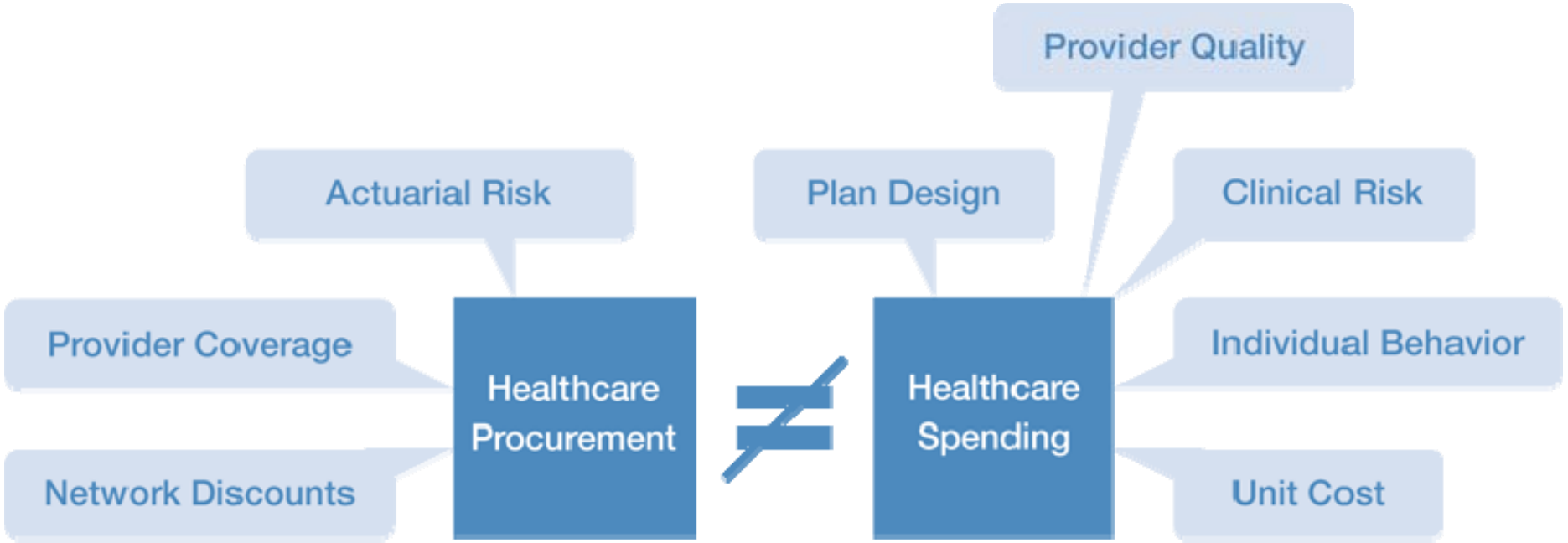
$7700 (Cost per EE)

$8800 (Cost per EE)

- **Targeted care management programs to manage clinical risk**
- **Sophisticated health analytics**
- **Cash incentives tied to behaviors**
- **Integrated administration and communications**
- **Focus on outcomes**

- **Superficial wellness programs**
- **Lack of accountability**
- **Manage quality and cost through procurement**
- **Offer multiple plan designs**
- **Implement non-cash incentive programs**
- **Misuse of health benefits to attract and retain**
- **Don't address undesirable employee turnover**

# Fundamental Misalignment




Employers need to align procurement with actual spending.
Financially based procurement does not impact longer-term healthcare spending.

# Evolution of Health Benefits Delivery


| | Transactional | | Member Centric |
|---|---|---|---|
| **Strategic Imperative** | Lowest unit cost | → | Improved health |
| **Cost Management Strategy** | Financial | → | Clinical and Financial |
| **Operations Paradigm** | Transactional Efficiency | → | Total Value per Member |
| **Planning Horizon** | Annual | → | Three / Five Year |
| **Cost Focus** | Individual program cost | → | Total Cost per Member |
| **IT Platforms** | Stand-alone platforms, batch file exchanges | → | Modular platforms, data hub, unified member view |
| **Procurement Strategy** | Purchase in Silos | → | Best Total Solution |
| **Participant Experience** | Inconsistent | → | Integrated, Uniform |

**The delivery model for employer health benefits is changing rapidly, with profound implications for the entire health delivery value chain**

Note: Results from 2007 SHPS Health Practices Study

# Discussion / Conclusions

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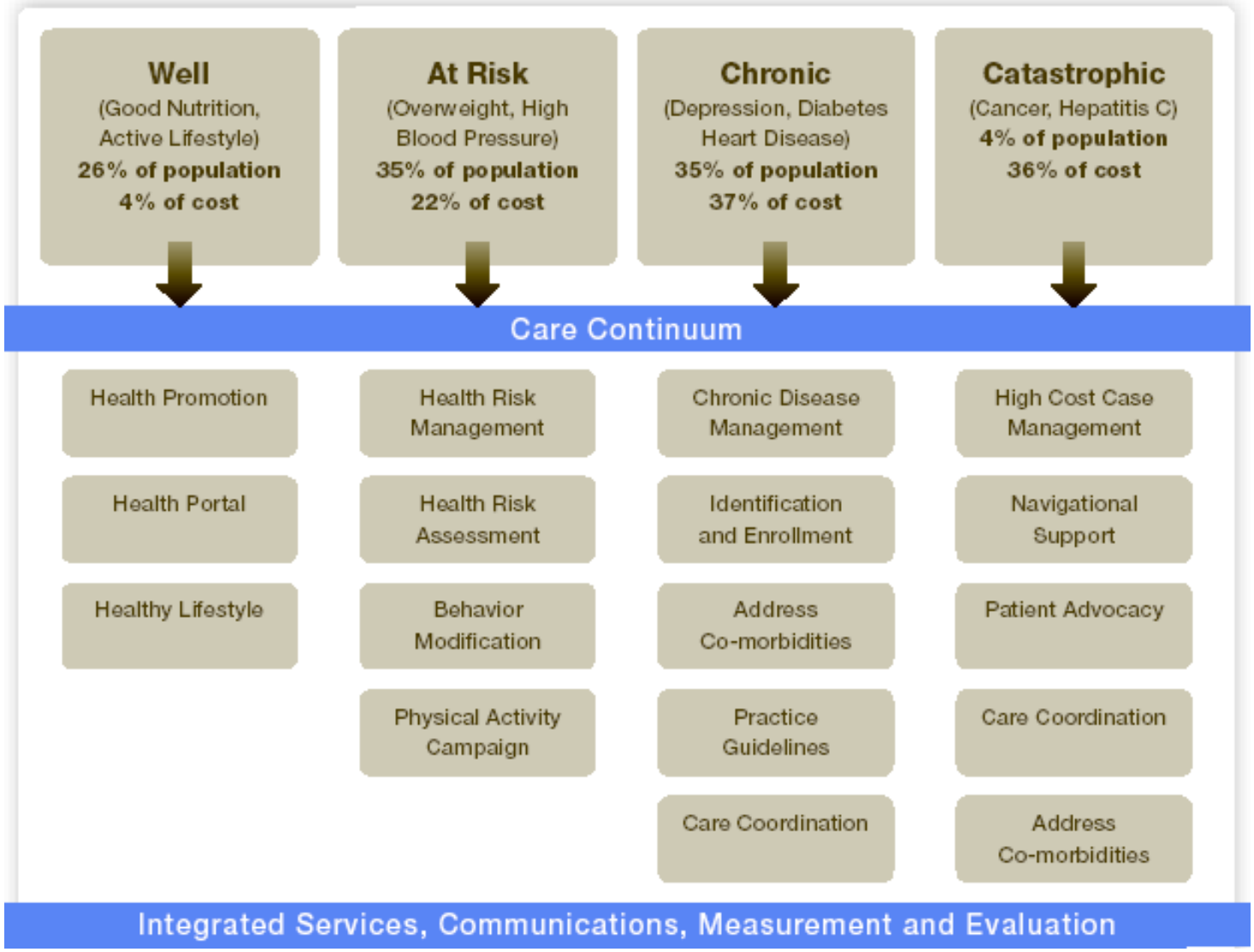
# Drill Down on CDHC Finding

- No difference between:
  - Partial versus full replacement
  - Benefit strategy
  - Workforce composition
- CDHC employers not more or less likely to report:
  - Care management practices
  - Use of incentives
  - Administrative practices
- Bottom line:
  - Employers who reported using CDHC plans follow the same bell shaped curve as other employers

# Managing Population Health



# Characteristics of a Well Managed Population

- Direct measures of health status and treatment outcomes
- Reductions in acute in-patient events
- Low post-discharge complications
- Evidence-based treatment for well-defined conditions
- Evidence population is taking appropriate preventive steps
  - General biometric screening of population
  - Compliant with treatment protocols
  - Effective utilization of EAP or other mental health services
  - High usage of 24 hour Nurse line

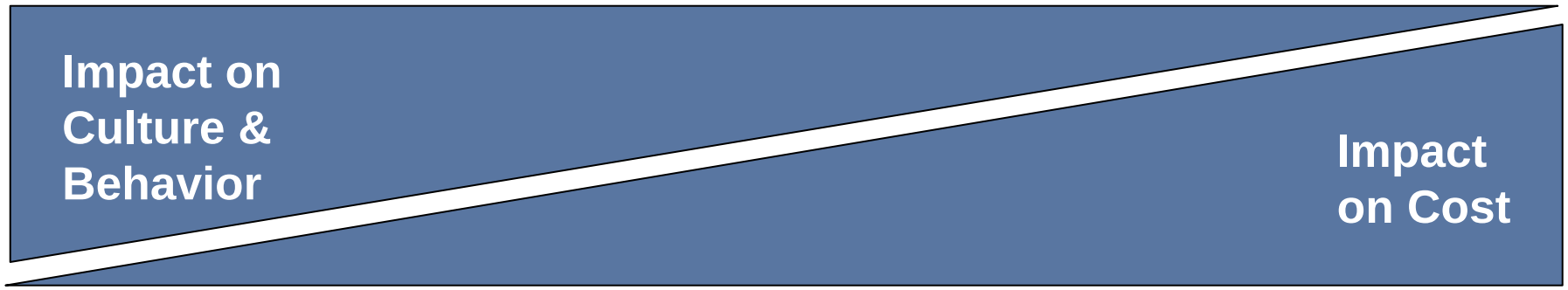
# Likely Cost Mechanisms

## CDH Plan

- Purchasing Behavior
- Non-acute utilization
- Participation in prevention
- Provider selection tools

## Care Management

- In-patient frequency/duration
- Re-admissions / post-discharge complications
- Medication compliance / quality of care
- Specialty networks/COE



# Plan Design in Context

| Typical Health Strategy | Year 1 Building a Foundation | Year 2 Integrated Health Management | Year 3 Focus on Behavior Changes | Year 4 Integrated Health and Productivity |
|---|---|---|---|---|
| Benefit Administration / Metrics | Eligibility reconciliation, Configurable E&E<br>Baseline Health Metrics | Health & performance info, integrated health work data | Personal health management, info with incentives to access | Interactive health diary, research bots, embedded incentives |
| Plan Design / Health Accounts | Introduction of value based plan design with simple HRA or HSA | Single plan design<br>Unlinked spending accounts | Unified, multi-purse spending account | Specialty Accounts, matching HRAs, Specialty networks |
| Care Management | Web-based Wellness<br>Catastrophic Condition Management | Total Population Health Management / Biometrics | Compliance Awards, disease specific allowances | Integrated Disability / Absence |
| Member Experience | Unified look and feel, SSO Portal, Contact Center | Simple personalized health communications | Highly personalized health communications, with portal link to care team | Use of Telemedicine / remote diagnostics / PHR |
| Incentives & Rewards | Cash, Tickets, Trinkets | HRA with contributions for participation | Zero balance account, with tiered incentives | Tiered, disease specific incentives linked to personal development plan |

# Why Mixed Results on CDHP?

- Variations in strategy and implementation
  - Offered as one of “many plans”
  - Adverse selection
  - Poorly communicated
  - Superficial wellness and condition management programs
  - Focus on managing cost below the deductible, without impacting acute and chronic conditions that drive majority of spending
  - Savings in pharmaceutical spending, co-pays and deductibles may be off-set by higher ER and acute care

# Conclusion

- No evidence that CDHPs *alone* will change long term health trends
- SHPS has worked directly with clients that have successfully used CDHP.
  - Appropriate for their population
  - Part of comprehensive health strategy
  - Outstanding administration and communication
  - Strong focus on driving and measuring health outcomes
- HRA and HSA are viable options depending on workforce

# Will CDHP Help You Create a Well Managed Population?

- CDHP has to be part of a comprehensive strategy to manage the health of your population
- Consumers and Employers need to put disciplines in place

| Consumer Behaviors | Employer Behaviors |
| --- | --- |
| Wellness Check Up | Comprehensive Care Management Programs |
| Medication Compliance | Financial Incentives |
| Nurse line | Clear, Single Branded Communications |
| Care Management Programs | Manage Eligibility |
| Biometrics | Health Advocacy |

# Questions

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