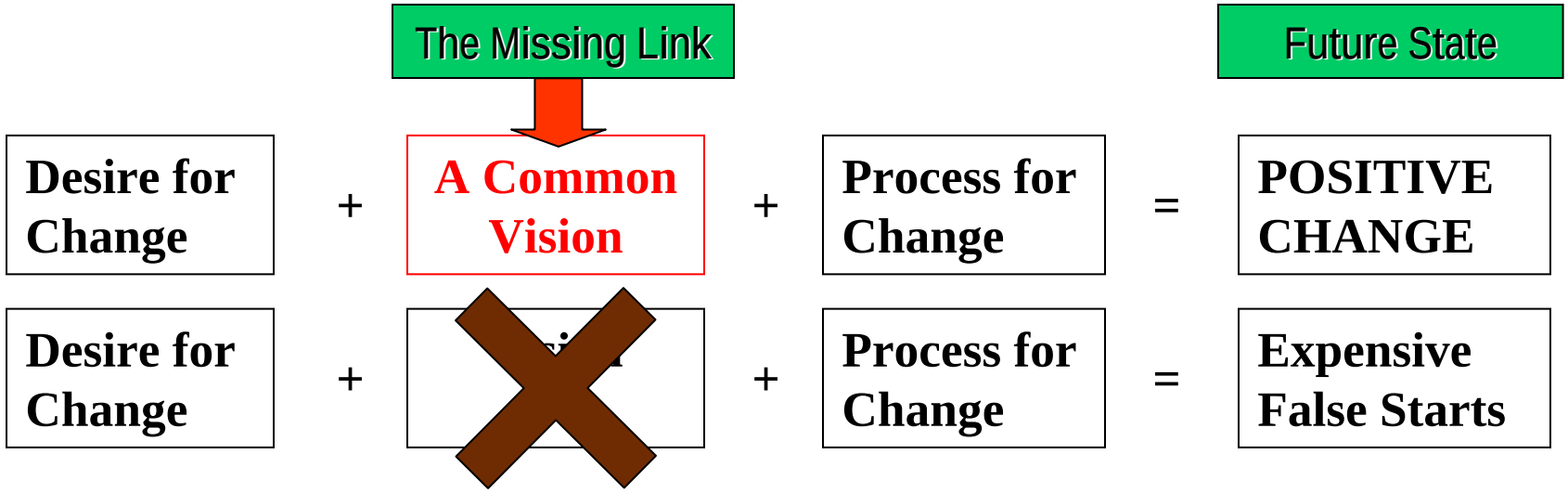
Creating a Healthcare Benefit Strategy

for

The 21st Century Intelligent Health System

Creating a Healthcare Strategy Starts with a Clear Vision



A Vision for Transformation

NOT Cost Shifting, Tweaking, or Reform

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Supply Controls or Demand Controls

Plan Sponsors and Members have two basic choices to control costs:

1. **Managed care & HMOs - The "supply of care" is limited by a third party who controls the access to medical services (e.g. utilization reviews, medical necessity, gatekeepers, formularies, scheduling, types of services allowed), or**
2. **Consumerism - The member controls their "demand for care" because of a direct and significant financial involvement in the cost of care, rewards for compliance, and the information to make wise health and healthcare value driven decisions.**

Supply Controls Are Failing

High Healthcare Costs Climbing Higher

Patients have lost control of their own healthcare, and are not truly engaged in the process of managing their health

Patients are frustrated with managed care "rules" and the impact on time and productivity

Patients don't understand healthcare costs – costs are not transparent

"After long relying on managed-care companies as their weapon against health costs, U.S. employers are considering a fundamental change in strategy: turning the fight over to their employees."

- *Wall Street Journal, February 2000*

Mega Trends
Leading to Demand Control

1. **Personal Responsibility**
2. **Self-Help, Self-Care**
3. **Individual Ownership**
4. **Portability**
5. **Transparency (the Right to Know)**
6. **Consumerism (Empowerment)**

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Healthcare Consumerism

Healthcare Consumerism is about transforming a health benefit plan into one that puts economic purchasing power—and decision-making—in the hands of participants.

It's about supplying the information and decision support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering health and healthcare purchasing behaviors.

Bridging to Consumerism – Everybody has a New Role

	Managed Care System		Future Healthcare
Focus	*Supply side & Healthcare*	➡	*Supply & demand side Health & Healthcare*
Employer	*Financier & manager*	➡	*Financier & Facilitator*
Employee	*Passive, sheltered & entitled*	➡	*Active, informed & incented, a consumer*
Provider	*Dominant & in distress*	➡	*Accountable caregiver*
MCO	*Provider oversight & care gatekeeper*	➡	*Case Manager, SMM insurer*
Quality Metrics	*Health plan level*	➡	*Consumer level*
Administration	*Disconnected*	➡	*Integrated*
Banks	*Not sigificantly involved*	➡	*Funds manager*

The Core of Consumerism

The Unifying Theme

for a

Health and Healthcare Strategy is:

Behavioral Change

"Implement only if it supports behavioral change consistent with the strategy"

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Screens for Successful Behavior Change

Does the program initiative change behaviors in a positive way to:

1. **Improve the quality of care**
2. **lower costs through value purchasing**
3. **Increase treatment choices and access to care**
4. **Increase transparency of costs**
5. **Provide member with meaningful information**
6. **Increase employee satisfaction**
7. **Support healthy lifestyle or reward compliance with effective treatments**
8. **Create long term sustainable results.**

Consumerism Choices involve Options for Behavioral Change rather than Optional Plan Designs

Consumerism Choices:

- **Wellness**
- **Preventive care**
- **Early Intervention**
- **Lifestyle Options** (diet, exercise, smoking, safety)
- **Self-help, self care**
- **Discretionary Expenses** (e.g. OV, ER, Rx)
- **Value purchasing** (e.g. DXL, o/p vs. in/p)
- **Participation in Disease Management Programs**
- **Compliance with Evidence Based Medicine Treatment Plans**

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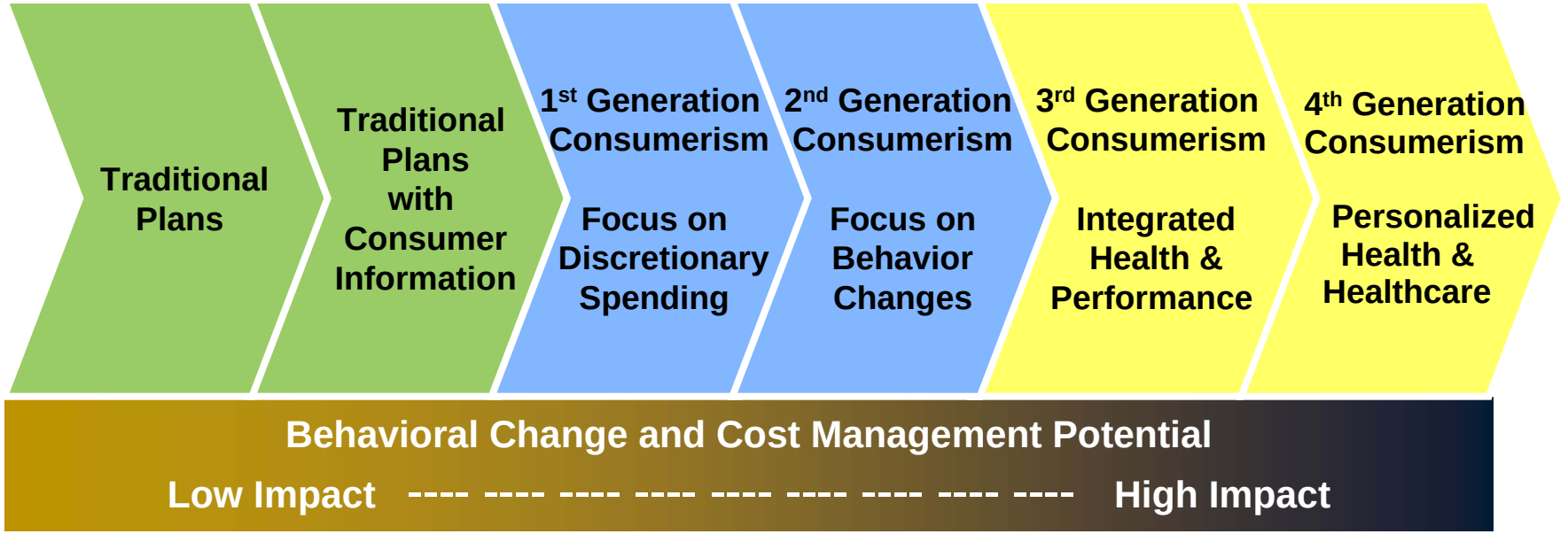
Two Basic Principles for Successful Consumerism

1. Must work for the Sickest Members, as well as the healthy

2. Must work for those not wanting to get involved in decision-making, as well as the “techies”

The Evolution of Healthcare Consumerism

Future Generations of Consumerism



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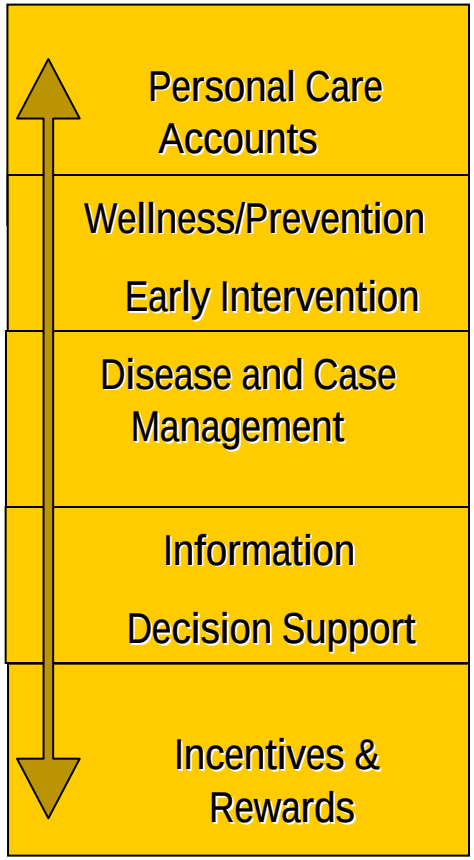
mjt2 mjthompson001, 3/2/2004

The Promises of Consumerism

Major Building Blocks of Consumerism



The Promise of Demand Control & Savings

The Promise of Wellness

The Promise of Health

The Promise of Transparency

The Promise of Shared Savings

It is the creative development, efficient delivery, efficacy, and successful integration of these elements that will prove the success or failure of consumerism.

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The Consumerism Grid

	1st Generation Consumerism Focus on Discretionary Spending	2nd Generation Consumerism Focus on Behavior Changes	3rd Generation Consumerism Integrated Health & Performance	4th Generation Consumerism Personalized Health & Healthcare
Personal Care Accounts	Initial Account Only	Activity & Compliance Rewards	Indiv. & Group Corporate Metric Rewards	Specialized Accts, Matching HRAs, Expanded QME
Wellness/Prevention Early Intervention	100% Basic Preventive Care	Web-based behavior change support programs	Worksite wellness, safety, stress & error reduction	Genomics, predictive modeling push technology
Disease and Case Management	Information, health coach	Compliance Awards, disease specific allowances	Population Mgmt, Integrated Hlth Mgmt, Integrated Back-to-Work	Wireless cyber – support, cultural DM, Holistic care
Information Decision Support	Passive Info Discretionary Expenses	Personal health mgmt, info with incentives to access	Health & performance info, integrated health work data	Arrive in time info and services, information therapy
Incentives & Rewards	Cash, tickets, Trinkets	Health Incentive Accounts, activity based incentives	Non-health corporate metric driven incentives	Personal dev. plan incentives, health status related

Potential Savings from Full Implementation of Consumerism

Achievement of savings and improved outcomes is dependent upon both the Type and Effectiveness of the programs implemented.

Gross* Savings as % of Total Plan Costs
(Programs Applicable to All Members)

Effective Programs Implemented	Traditional plans: Passive	Consumerism Plans: 1st Generation	Consumerism Plans: 2nd Generation	Consumerism Plans: 3rd Gen & Future
Basic	2%	3%	7%	10%
Expanded	**3-4%**	**5-8%**	**12-15.0%**	**20.0+%**
Complete	4%	7%	17%	25%
Comprehensive (Future)	5%	10%	20%	30%

***Excludes Carry-over HRAs/HSAs and any added Administrative Costs of Specialized Programs**

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Health Savings Accounts, Landmines & the Future

Are HSAs the right vehicle for large employer groups?

Yes, If…….

Or

No, Because…….

Need to Understand the Consumer Movement & the Transformation that is Underway

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HSAs and HRAs Very Different

HSA – A law, with specific requirements and benefit design requirements.

Most TAX ADVANTAGED vehicle ever created

****

HRAs – No Law, this is a regulatory creation based upon an IRS ruling.

Most FLEXIBLE vehicle ever created

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Incentive Awards - Three Very Different Personal Care Accounts

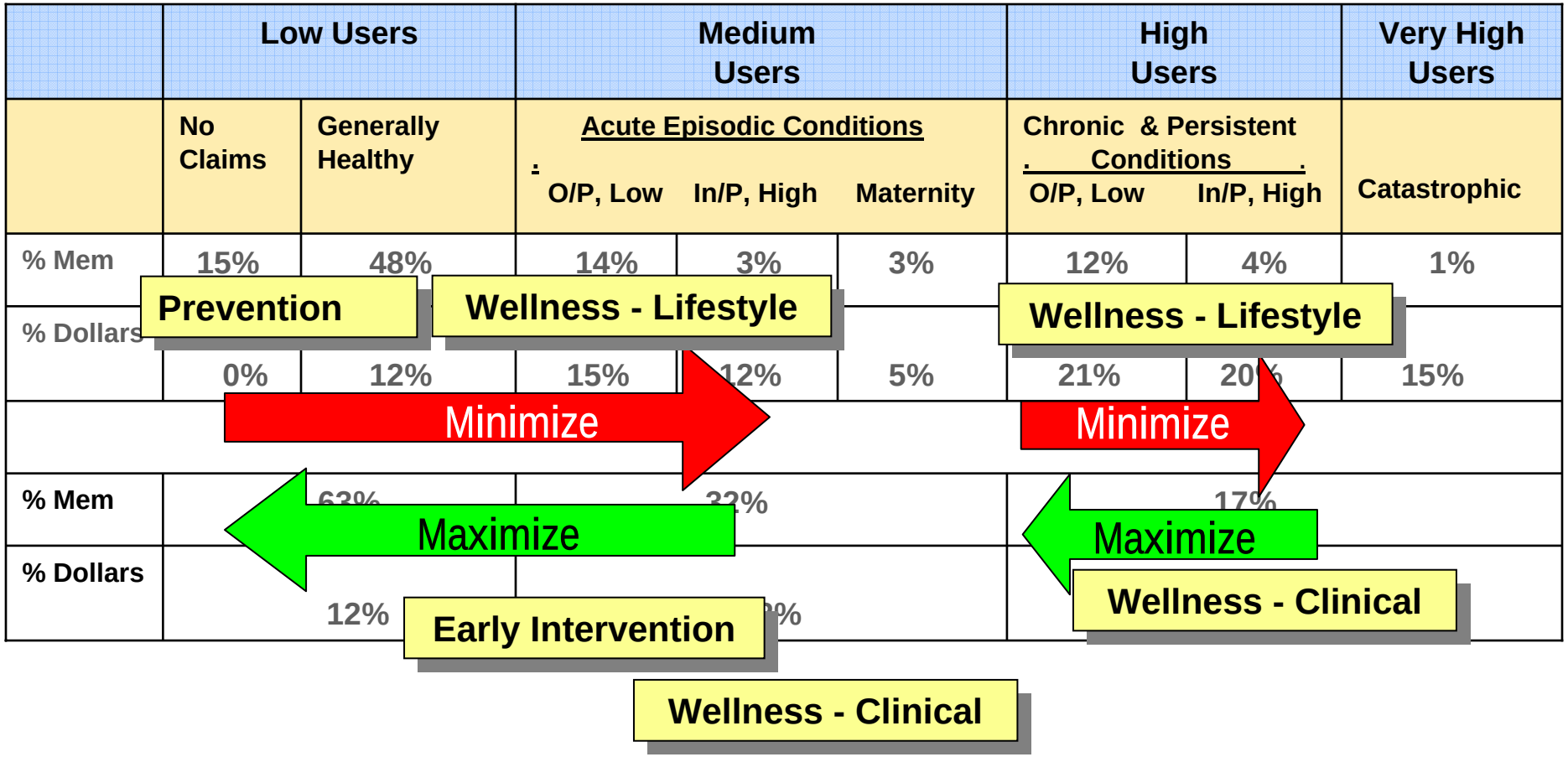
FSAs – Traditional Group Plans

Health Reimbursements Arrangements (HRAs) – Employers' choice for cash flow flexible incentive based medical plan benefit designs (best suited for self-insured groups)

Health Savings Accounts (HSAs) – Employees' choice for funded portable triple tax advantaged with "High Deductible Health Plans" (best suited for individuals and small groups)

Combination Accounts – creative but confusing

Using Information & Incentives To Address Wellness & Disease Management Behavioral Changes



Disease Management Programs Designed and Financially Aligned for Success

Program Type:	Passive	Assertive	Aggressive
	Phone and mail out- reach, no incentives	Incentives (i.e., waiving Rx copays)	Incentives (i.e, waiving Rx copays, premium differential
DM vendor pricing method	Per employee per month, all employees	Low PEPM on all ees plus hourly or per case rate on participants only (rate varies based on participant risk status)	Low PEPM on all ees plus hourly or per case rate on participants only (rate varies based on participant risk status)
Percentage of chronic diseased participating in program	10%	50%	75%
Return on investment of disease management programs	0 - .5	1.5 - 2	1.5 - 3

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Important Differences between Use of HRAs and HSAs for Supporting Behavioral Change

Personal Care Accounts	Generation 1 Initial Account Only	Generation 2 Activity & Compliance Rewards	Generation 3 Indiv. & Group Corporate Metric Rewards	Generation 4 Specialized Accts, Matching HRAs, Expanded QME
Health Reimbursement Arrangements	1. Any Amount 2. Notional Acct 3. Employer Determined 4. Employer Only Contributions	1. Flexible Activity & Compliance Rewards 2. Employer Determined 3. Can not be cashed out 4. Must be used for healthcare	1. Flexible Indiv & Group Rewards 2. Employer Determined 3. Can not be cashed out 4. Must be used for healthcare	1. Specialized Notional Accts, 2. Can terminate by employer rules 3. Potential IRS Expanded QME
Health Savings Accounts	1. Amounts Set by law 2. Real Dollars in Acct 3. Er or Ee Contrib 4. Contributions up to plan deductible of $1000-2650 Single $2000-5250 Family 5. Non-substantiation	1. Ltd Potential – (But For Rule) 2. Must give Cash Option 3. Awards must be same $ amt or same % of deductible 3. HSA can be used (with 10% penalty) for non-healthcare expenses	1. Ltd Potential – (But For Rule) 2. All participants must receive same amount or same % of deductible 3. Difficult to use for Group Incentives	1. Ltd Potential – (But For Rule) 2. 100% Vested & Portable 3. Can use matching HRAs, 4. Potential IRS Expanded QME

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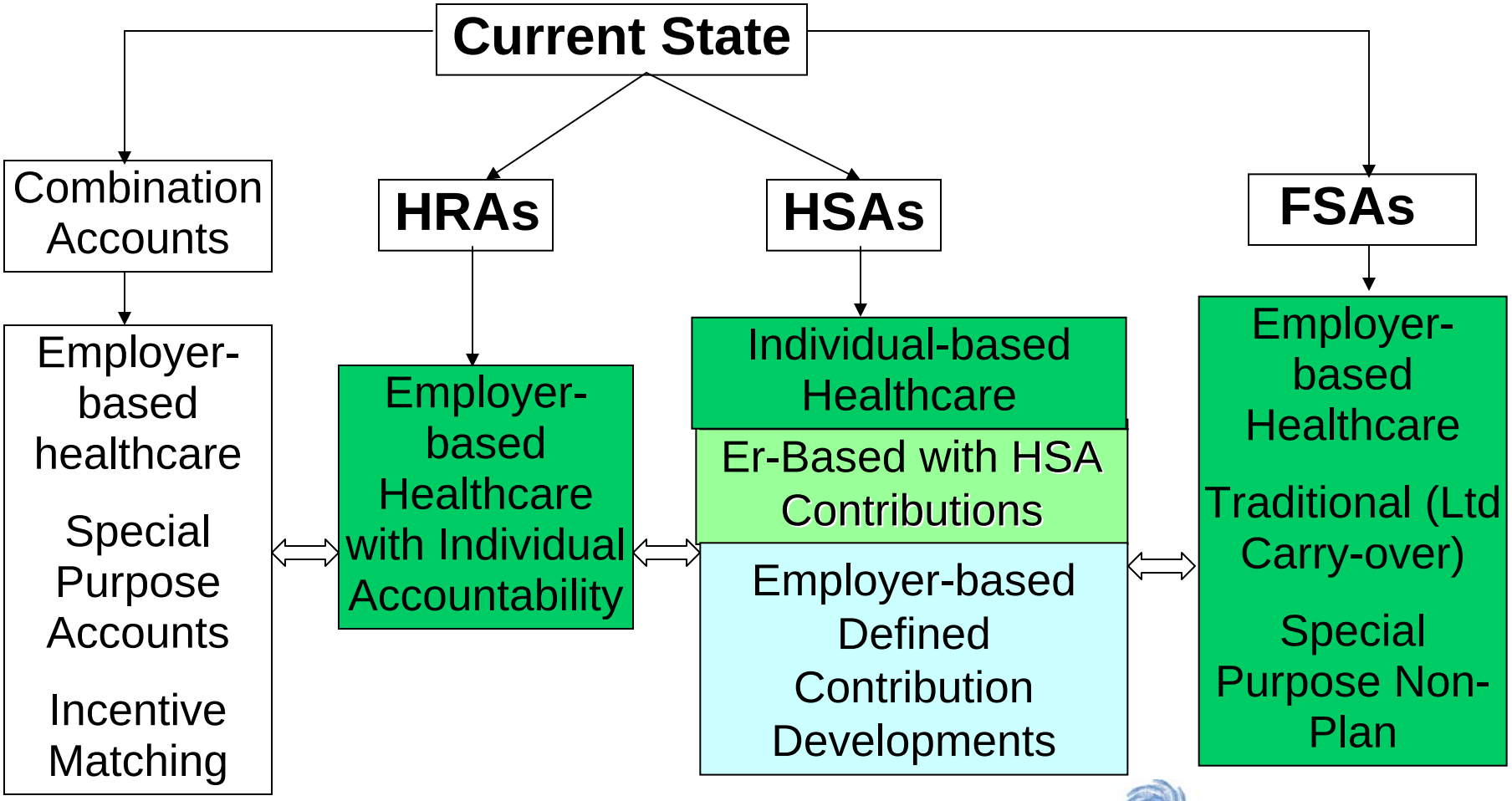
HRAs – Best for Larger Groups?
HSAs – Best for Individuals and Small Groups?



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What will the proposed cross-state selling of insurance mean for HSAs?

The start of a movement towards individual owned and portable health insurance

Defined Contribution Model Revived

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2005-2006
Bush Proposed Legislation

1. Top-line deductibility of HDHP premiums.

2. HSA subsidy for Low-Income Families - $1,000 directly to their HSA.

3. Premium Tax Credit for Low-Income Families - $2,000 refundable tax credit to help them buy a HDHP.

4. HSA subsidy for Low-Income Individuals- $300 directly to their HSA.

5. Premium Tax Credit for Low-Income Individuals - $700 refundable tax credit to help them buy a HDHP.

6. Non-HSA Premium subsidy for Families - $3,000 tax credit to buy standard medical coverage instead.

7. Non-HSA Premium subsidy for Individuals - $1,000 tax credit to buy standard medical coverage instead.

Proposed Legislation (continued)

8. The low income health care credits will be advanceable and available immediately to qualifying families.

9. Tax credit for contributions to the HSAs of small business employees - small business owners to get a tax credit on HSA contributions for the first $500 per worker with family coverage and the first $200 per worker with individual coverage.

10. $4 billion in grants to encourage states to create state run insurance pools to make sure low-income Americans get the most out of the credit.

11. Allow Cross State selling allowing individuals to buy the best coverage they can find anywhere in the country.

2005-06 Paradigm Shift
HSA & Market Solutions for Old Problems ?

1. Federal Support and Subsidies For HSAs & HDHPs

2. Major initiatives to address the 45 million uninsured problem in the U.S.

3. Major initiatives to restructure the individual and small group healthcare market place. Cross-state selling and new players entering the market.

4. Bush Administration targets 45-50% Individual Policy ownership in 5-10 years (currently 5-7%).

5. The development of Consumer-centric Medicare

Are HSAs the Wave of the Future?

Which Point of View Direction will We Take?

Yes, if….

1. we recognize the HSA legislation and regulations as a good start and another building block for consumerism and behavioral change.

2. there is additional legislation/regulation to support large Er interests in providing HSAs (use for healthcare only, Rx coverage problem, combination accounts).

3. there is legislative support for the common use of FSAs for targeted needs, HSAs as "Health Savings Accounts" and HRAs as "Health Reimbursement Arrangements.

No, because….

1. they were not legislated/regulated with large employers in mind.

2. of a desire to promote individual insurance over individual ownership (under employer and individual policies)

3. they are just a tool to cost shift to employees, they can not reward behavior change

4. they are only desirable to the young, healthy, and wealthy

The Fundamental Policy Question

Will Legislation/Regulation Use HSAs to

- **… mainly promote portable Individual & Small Group Insurance,**

OR

***… expand Personal Care Account ownership through in both an employer-based and individual-based healthcare system thru HSAs, HRAs, and FSAs.**

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Growth of Personal Care Accounts

	HRAs	HSAs
2000*	None	None
2001*	19,000	None
2002*	53,000	None
2003*	394,000	None
2004(est)	1-1.5M	400,000
2005(est)	3.2 M	???
2006(est)	6.0+M	???
2007(est)	12-15M	???

* Deliotte Consulting

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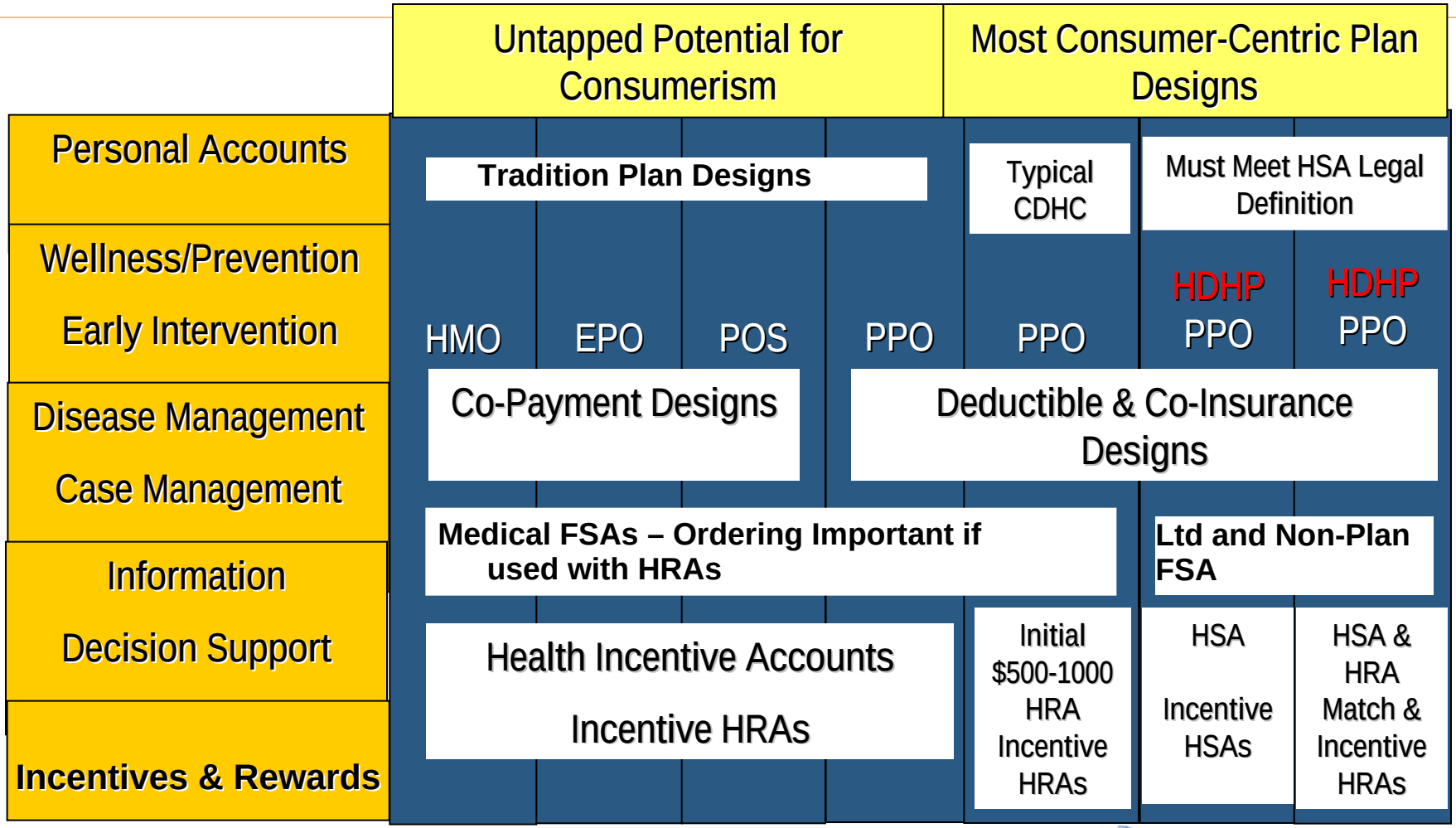
Potential Use of PCAs to Support Consumerism Plan Designs



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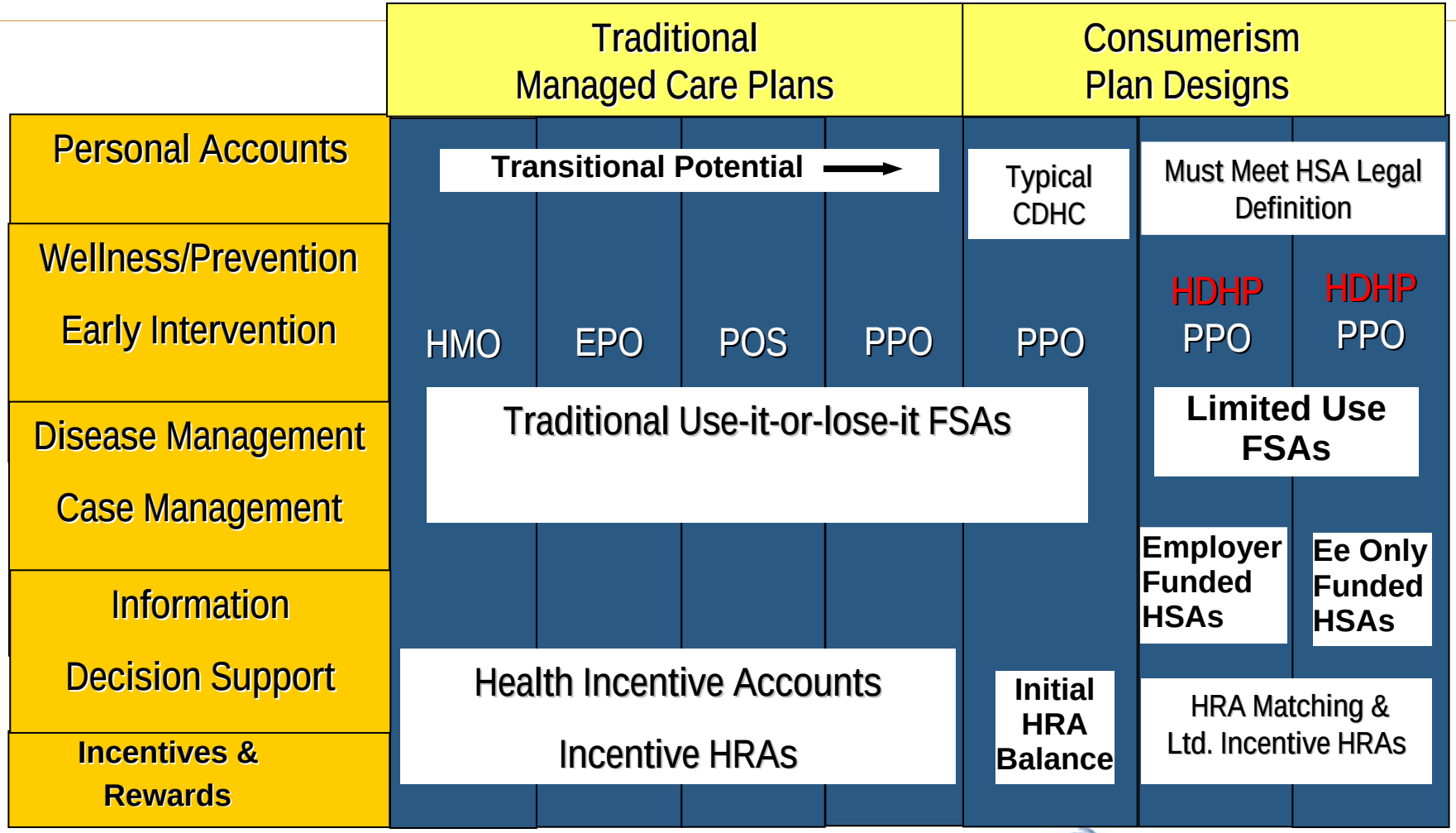
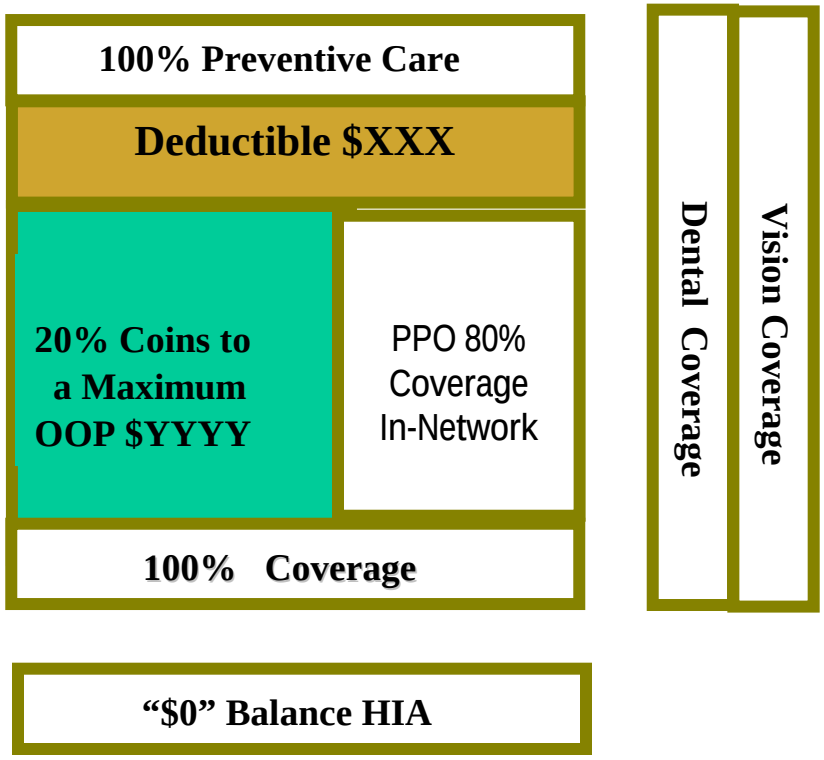
Personal Care Accounts
Can be Used With Any Medical Plan



Traditional PPO with Health Incentive Account (HIA)

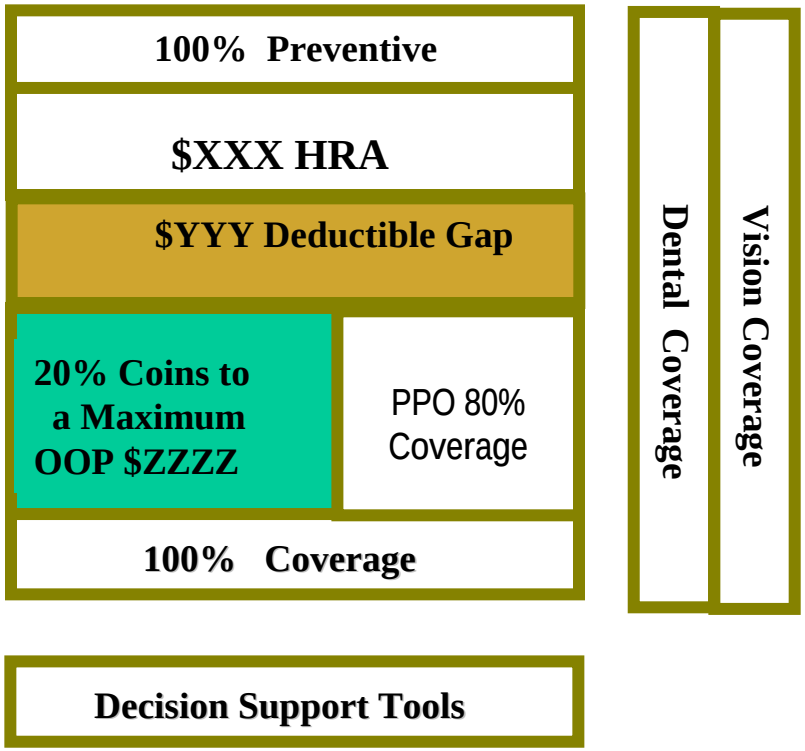
Plan coverage for all eligible Medical expenses, including Prescription Drugs, Mental Health and Substance Abuse Claims



1. **100% Preventive Care – Defined by the Employer**
2. **$XXX Front-end Deductible (can be funded with FSA accumulations)**
3. **20% In-Network Patient Coinsurance to a Maximum Out-of-Pocket of $YYYY**
4. **40% Out-of-Network Patient Coinsurance; No Maximum Out-of-Pocket**
5. **Plan Maximum is $1,000,000**
6. **Zero Balance HRAs (for incentive rewards)**

Traditional CDHC with HRA

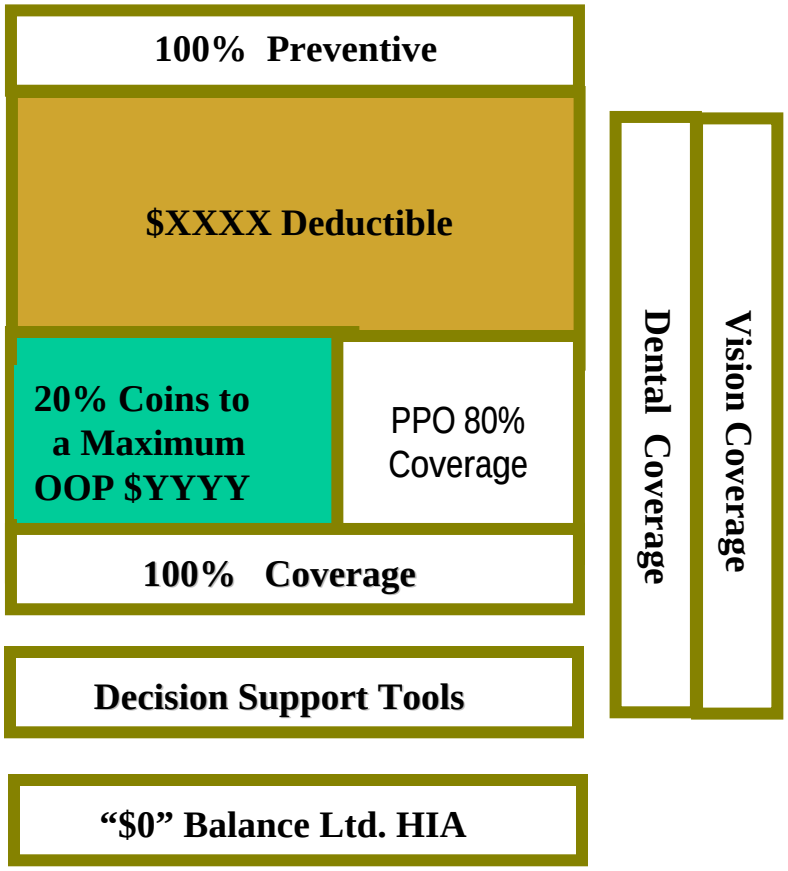
Plan coverage for all eligible Medical expenses, including Prescription Drugs, Mental Health and Substance Abuse Claims



1. **100% Preventive Care – Defined by the Employer**
2. **Health Reimbursement Accounts – Initial $XXX Balance.**
3. **$YYY Gap Deductible (can be funded with FSA)**
4. **20% In-Network Patient Coinsurance to a Maximum Out-of-Pocket of $ZZZZ**
5. **40% Out-of-Network Patient Coinsurance; No Maximum Out-of-Pocket**
6. **Plan Maximum is $1,000,000**
7. **Decision Support – Information tools, Nurse Coach Line, etc.**

HSA Eligible HDHP/PPO with Ltd. HRA

Plan coverage for all eligible Medical expenses, including Prescription Drugs, Mental Health and Substance Abuse Claims



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Survey Information on CDHC

Mercer 4/2004

Nearly three-quarters (73%) of employers asked by Mercer Human Resource Consulting said they were likely to offer the new accounts to their workers by 2006, according to a survey to be released this week.

"We're looking at a major market change," says Linda Havlin, Mercer's Midwest health care practice leader, noting that a 73% interest in adopting a new program within two years "is unprecedented."

Forrester Research 9/2003

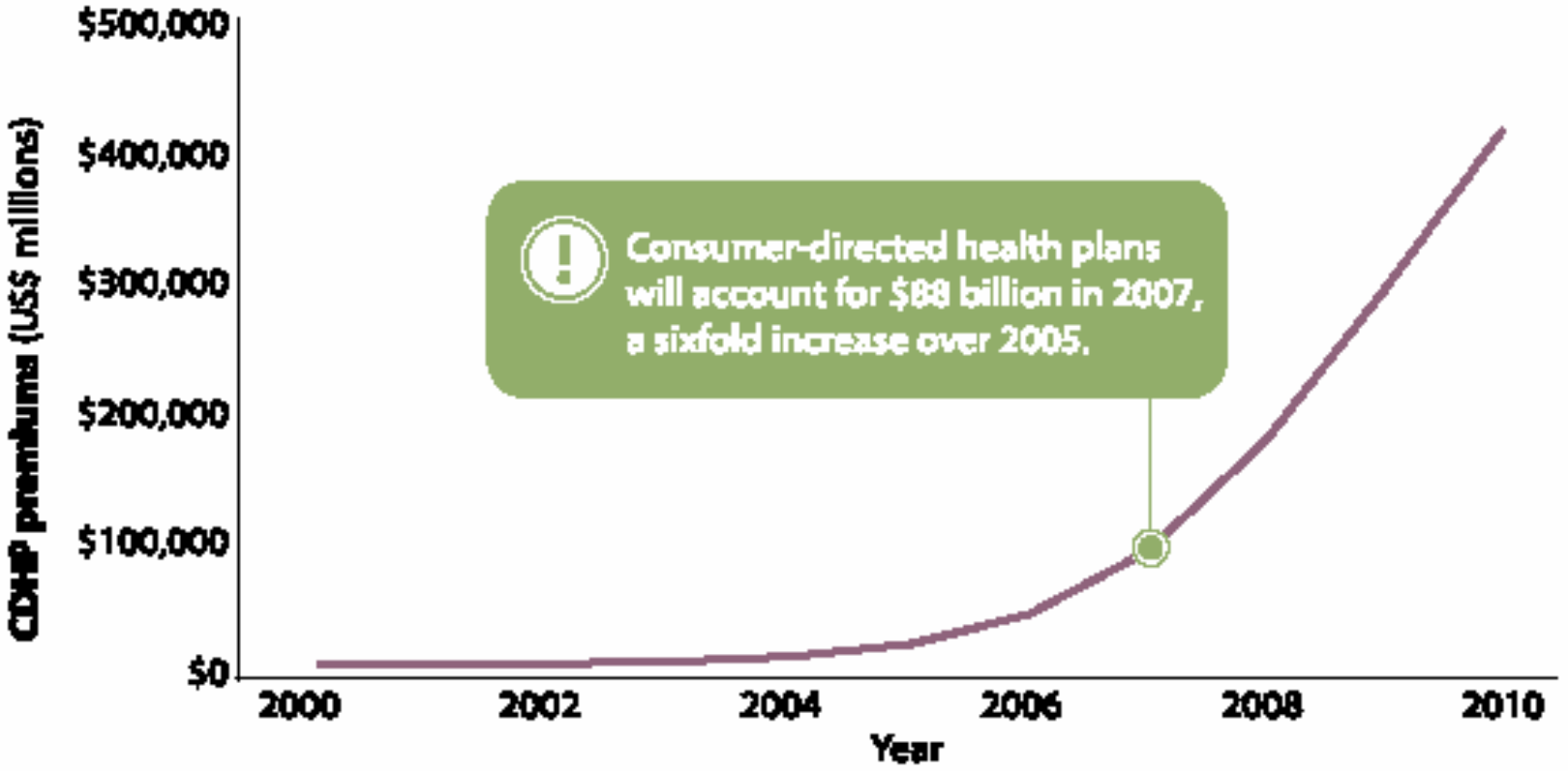
Consumer-Directed Health Plan Leaders Poised For Growth

Consumer-directed health plans will attract 2.7 million members and capture $16 billion in premiums by 2005. In our assessment of five early movers, we found that distinct product innovations and market strategies set these leaders apart.

Figure 1 Forecast: US Consumer-Directed Health Plan Adoption, 2000 To 2010

1-1 Consumer-directed health plan revenues skyrocket

Total annual revenues from consumer-directed health plans, in premiums and premium equivalents paid by employers and employees



Consumer-directed health plan premium growth (US$ millions) for the years 2000 to 2010

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
$152	$393	$1,018	$2,568	$6,482	$16,186	$39,100	$87,750	$173,241	$289,502	$413,331

Milliman 10/2004 CDHC Survey

89% of those responding expect to offer a CDHC plan to employers within the next year, up from 29% in last year's survey. Specifically, these 89% currently offer or plan to offer within the next year a high deductible plan with an integrated employee account (i.e., HRA or HSA).

Milliman Group Health Insurance Survey
CDHC Available Currently or Within 2005

	Offer a Tiered Provider Network	Offer a High Deductible Plan	Offer a CDHC Plan	% Prem From CDHC
2004 Survey	42%	96%	89%	7.8% (in 2005)
2003 Survey	17%	48%	29%	3.4% (in 2004)

Percentage of Respondents

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