

Consumer as Gatekeeper

Evidence: Consumer Healthcare Works

CONSUMER-DRIVEN Health (CDH) offerings have grown dramatically since their introduction five years ago. As of January 1, more than 3 million people were covered by Health Savings Accounts (HSAs), according to America's Health Insurance Plans (AHIP). "The big enrollment surge is a very significant success story," says Karen Ignagni, AHIP President and CEO.



Recent surveys indicate significant savings are possible for participants in high-deductible consumer-driven health plans (CDHPs) and for

the employers that sponsor them. The data also suggest that participants in CDHPs will not forgo needed medical care, including needed prescription drug purchases.

For example, a CIGNA analysis of 42,000 first-time users of CDHPs found that these participants experienced an 8 percent decrease in medical costs, compared with a 4 percent increase in medical costs for those enrolled in a health maintenance organization (HMO) or preferred provider organization (PPO) plan. In addition, the study found that consumers made positive changes in health behavior, such as increasing their use of medications to treat chronic healthcare conditions.

Data from Mercer's *2005 National Survey of Employer-Sponsored Health Plans* show an even more impressive level of cost savings. For example, in 2005, the average per-employee cost of CHDPs was 18 percent lower than the per-employee (Continued on back)

Revolutionary Plan Design

Value-Based Benefits Initiative Allocates Resources to Employee Health Programs



MICHAEL CRITELLI, CEO of Pitney Bowes, recently told business executives at The Health and Human Capital Management Congress in Washington that it is always better to allocate corporate resources for actual employee health programs rather than just searching for ways to

reduce such costs. "This pays substantial dividends for all concerned in the long run," says Critelli.

While controlling the spiraling costs of U.S. corporate healthcare benefits is the top concern for the seventh straight year, according to a survey conducted by Deloitte Consulting and the International Society of Certified Employee Benefit Specialists, Pitney Bowes has begun a revolution in the design and management of employer-sponsored health benefits with the objective of realizing much greater value from these benefit plans, for both themselves and their employees. While many companies proclaim publicly that "our people are our most important asset," they fail utterly in treating them (Continued on back)

The Best vs. the Rest

Companies Target Raises to Top Performers

IT'S A TREND playing out across industries from chemicals to software: pay tied to workers' performance. "The high performers are making more, but it's going to come from the lower performers," says Ravin Jesuthasan, Towers Perrin managing principal.



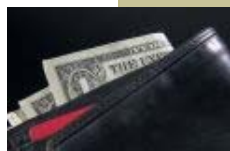
Employers know they have to reward key talent or risk defections as overall budgets for raises stay low while competition for the best workers heats up, particularly with unemployment falling below 5%. The result is a widening gap between raises for the best and the rest. Those most likely to get fatter raises: higher performers; employees with high potential; and workers whose skills are in demand, such as nurses, engineers, and some tech workers. For nonexecutive white-collar workers, employers last year gave their best performers 9.9% pay raises on average, according to a Hewitt Associates survey. Average performers got 3.6%, and poor performers, if they got any raise at all, got 1.3%.

Consequently, talent management is a top priority at organizations, according to the Society for Human Resource Management's *2006 Talent Management Survey Report*. HR professionals noted that building a deeper pool of people who could move up at every level topped a list of areas where their organizations needed to improve talent management practices. ■

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cost of PPOs (\$6,480) and 13 percent lower than the average HMO cost. Including employer contributions to participants' HSAs or HRAs, the cost of CDHPs was \$5,480, while the cost of PPO plans was \$6,480 and HMOs, \$6,210.



To hold down 2005 spending increases, employers shifted cost to employees at the time of service vs. requiring higher premium

contributions. Mercer notes that more than 20 percent of large employers and 47 percent of small employers required no employee premium contribution for employee-only CDHP coverage.

Likewise, a Deloitte Center for Health Solutions study found that health plans that encourage members to be better healthcare consumers grew at a significantly slower rate in 2005 than other types of plans. According to the study, the cost of CDHPs increased by an average of 2.8 percent from 2004 to 2005. That compares to an 8 percent increase in total premiums for HMOs; 8.5 percent for point-of-service (POS) plans; 7.2 percent for PPOs; and 6.4 percent for Traditional or Indemnity plan costs.

"Employers are increasingly turning to consumer-driven health plans to reduce costs and help workers and their families make better healthcare decisions," says Tommy G. Thompson, former Secretary, U.S. Department of Health and Human Services.

"Employers need to think strategically about ways to control their healthcare costs, and they need to evaluate all proposed changes for evidence of effectiveness," says Ted Nussbaum, Watson Wyatt, director of healthcare consulting. "This requires looking at the differing needs in the workforce and offering targeted solutions that encourage all workers to review their healthcare choices more critically." ■

'Value-Based' Initiative . . . (Continued from front)



that way when it comes to a vital component of their asset value—their health. "It has been one of the biggest strategic mistakes made by most companies in the management of their human resources," says Critelli. Pitney Bowes, a provider of business services, has used predictive model-

ing to take a very different approach to its health benefits by re-designing them on the basis of value rather than just cost. For example, while most companies erect barriers to obtaining costlier medications of choice, Pitney Bowes has done just the opposite by removing higher copays for those drugs used to treat diabetes, asthma, depression, and cardiovascular disease.

The returns on this initiative come from reducing health risks and better managing chronic illness to increase functionality, and thereby productivity. "As health plan costs increase, employers can no longer rely on historical experience to predict next year's costs," says Dan Bacon, UBA Director, Analytics and Training. "Predictive-modeling software can help an employer uncover the harbingers of high health plan costs to come and suggest a plan for containing them, thus improving employee health and productivity." ■

Bulletin Briefs

◆ April 21 HIPAA Security Compliance Deadline Nears for Small Plans

The deadline for small health plans (defined as a plan with annual receipts of \$5 million or less) to comply with the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is April 21. HIPAA security standards specify a series of administrative, technical, and physical security procedures for covered entities to use to ensure the confidentiality, integrity, and availability of protected health information (PHI) in electronic format.

◆ Employers to Post Injury/Illness Summary Beginning Feb. 1

OSHA reminds employers to post Form 300A from February 1 to April 30. The form shows the total number of job-related injuries and illnesses that occurred in 2005. Employers with no recordable injuries or illnesses in 2005 must post the form with zeros on the total line. All summaries must be certified by a company executive. Employers with 10 or fewer employees and employers in certain industry groups are normally exempt from federal OSHA injury and illness recordkeeping and posting requirements. A complete list of exempt industries in the retail, services, finance, and real estate sectors is posted on OSHA's website: <http://www.osha.gov/recordkeeping/index.html>.

◆ New Jersey Extends Dependent Medical Coverage to Age 30

Insured medical plans in New Jersey must either extend dependent coverage until age 30, or, alternatively, adopt a complicated scheme permitting dependents who lose medical coverage before age 30 to elect to continue their benefits (in a COBRA-like fashion) until age 30. The new law will apply to insurance contracts, policies, or plans that are issued or renewed on or after May 12, 2006. ■

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