Health Savings Account Update An Analytical Perspective

Trends with Consumer-Driven Health Plans and HSAs

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Health Savings Account Update
An Analytical Perspective Agenda

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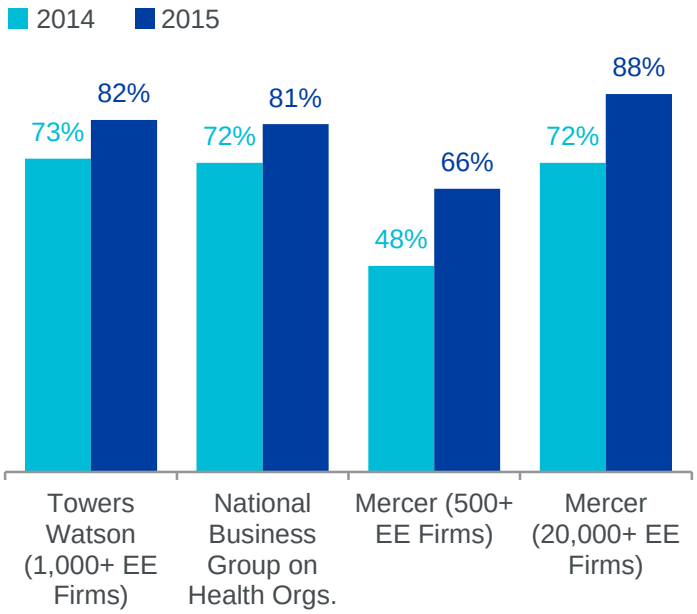
- Overview of (HSAs) in the market place - Industry trends
- Impact (HSAs) on cost and quality of healthcare
  - Has it had the desired effect?
  - Is there positive behavior change – are employees making better decisions ?
- Impact of Communication and Education
- Industry trends
- HSA quiz with giveaways!

Advanced Health Savings Accounts Concepts

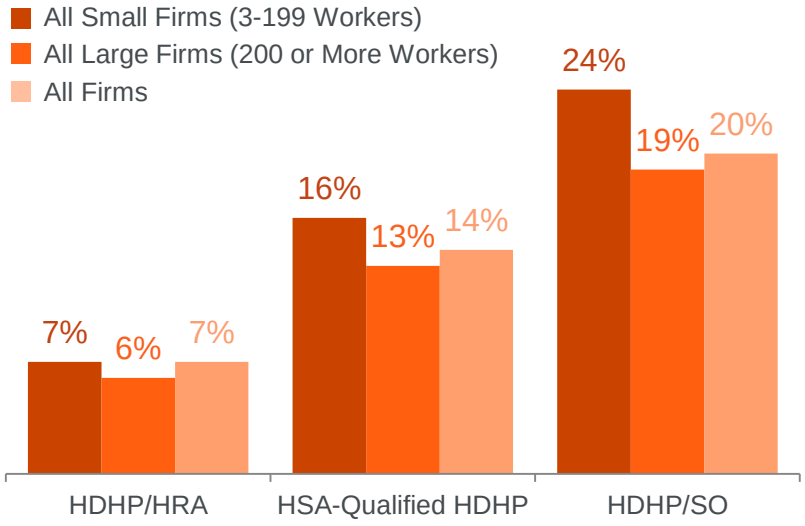
CDHP in the Market Today

20% of covered employees were enrolled in a CDH plan in 2014 (more than double the percentage five years ago)[3]

Majority of Large Employers Are Offering Consumer-Driven Health Plans[1,2,3]



Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, by Firm Size, 2014



Source: 1) 19th Annual Towers Watson/NBGH Employer Survey on Purchasing Value in Healthcare, May 2014; 2) Large Employers' 2015 Health Plan Design Survey, National Business Group on Health, Aug. 2014; 3) Modest Health Benefit Cost Growth Continues as Consumerism Kicks into High Gear, Mercer Press Release, Nov. 19, 2014; Note: Tests found no statistical differences between All Small Firms and All Large Firms within each category ($p<.05$).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

Large Employers Also Continue the Shift to Consumer-Driven Health Plan Designs

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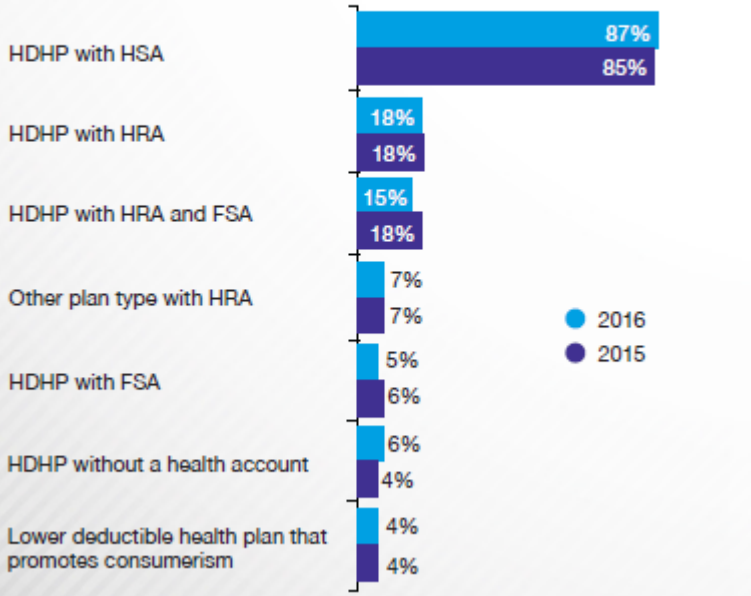
HSA Plans in the market today

Figure 19: Prevalence of Consumer-Directed Health Plan Types[2]



Many Employers Expect to Fully Replace Their Traditional Plans with CDH Plans

Source	% of Employers Moving to Full Replacement CDH Plans
Towers Watson[4]	17% doing in 2015 49% considering for 2018
NBGH[5]	32% doing in 2015 (39% among Fortune 100 respondents)
Aon Hewitt[6]	15% doing today 42% considering for next 3 to 5 years
PwC[7]	18% doing today 44% considering for future
Mercer[3]	18% of large firms (500+ EEs) considering for 2017 26% of jumbo firms (20,000+ EEs) considering for 2017

Source: 1) 19th Annual Towers Watson/NBGH Employer Survey on Purchasing Value in Healthcare, May 2014; 2) Large Employers' 2015 Health Plan Design Survey, National Business Group on Health, Aug. 2014; 3) Modest Health Benefit Cost Growth Continues as Consumerism Kicks into High Gear, Mercer Press Release, Nov. 19, 2014; 4) 2015 Emerging Trends in Health Care, Towers Watson, April 2015; 5) Large Employers' 2015 Health Plan Design Survey, National Business Group on Health, Aug. 2014; 6) 2014 Aon Hewitt Health Care Survey, Oct. 2014; 7) Medical Cost Trend: Behind the Numbers 2015, PricewaterhouseCoopers, June 2014.

Drivers and Effective Tactics of Rising Health Care Costs

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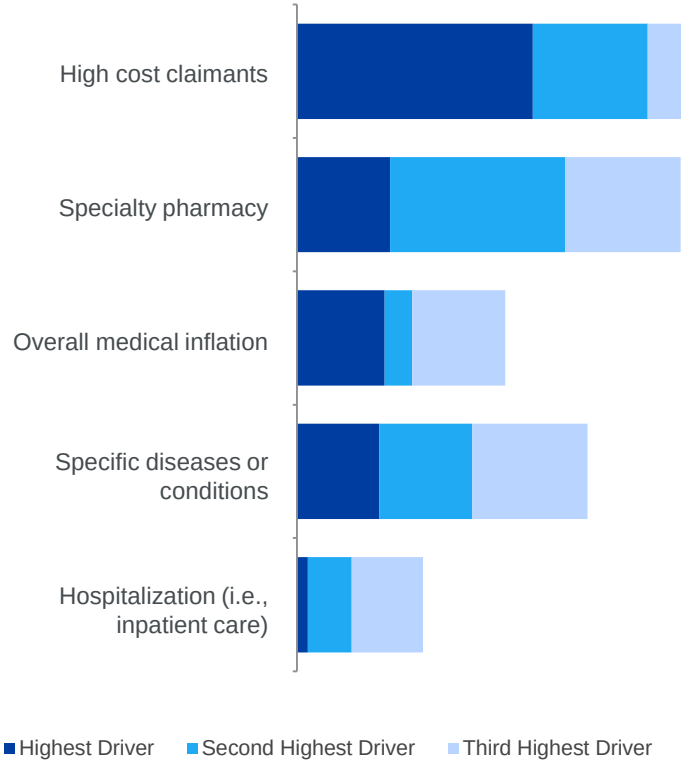
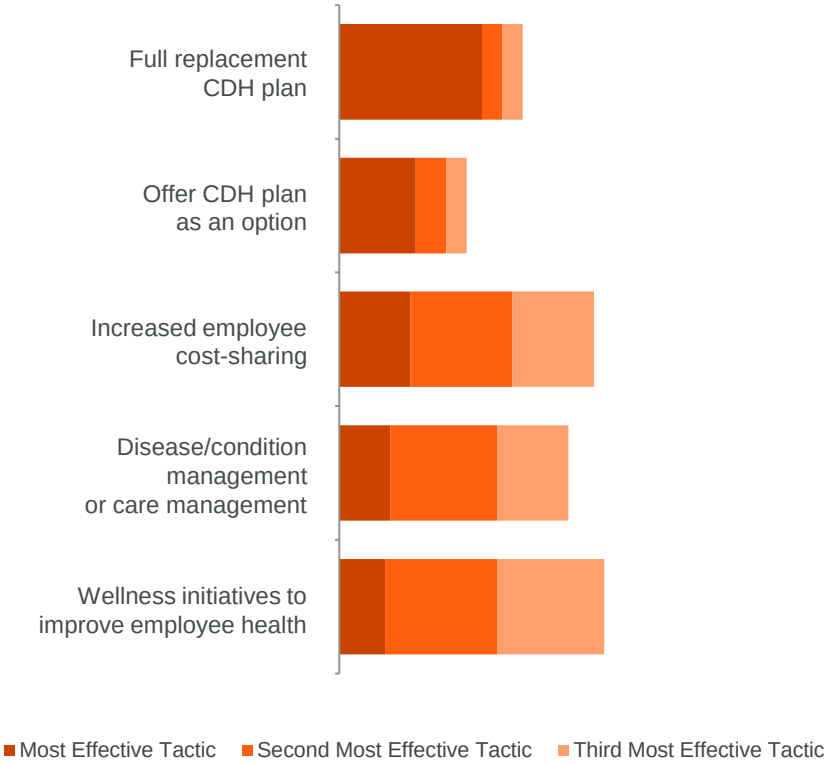
Top Cost Drivers of Rising Health Care Costs



Note: Other responses included: pharmacy; maternity; chronic diseases; and an aging workforce.

Most Effective Tactics to Control Health Care Costs



Note: Other responses included: specialty and traditional pharmacy management techniques; elimination of low-performing programs; price transparency tools; vendor management; and promotion of consumerism.

1) NBGH 2016 Large Employers Health Plan Design Survey

CDH Trend Summary

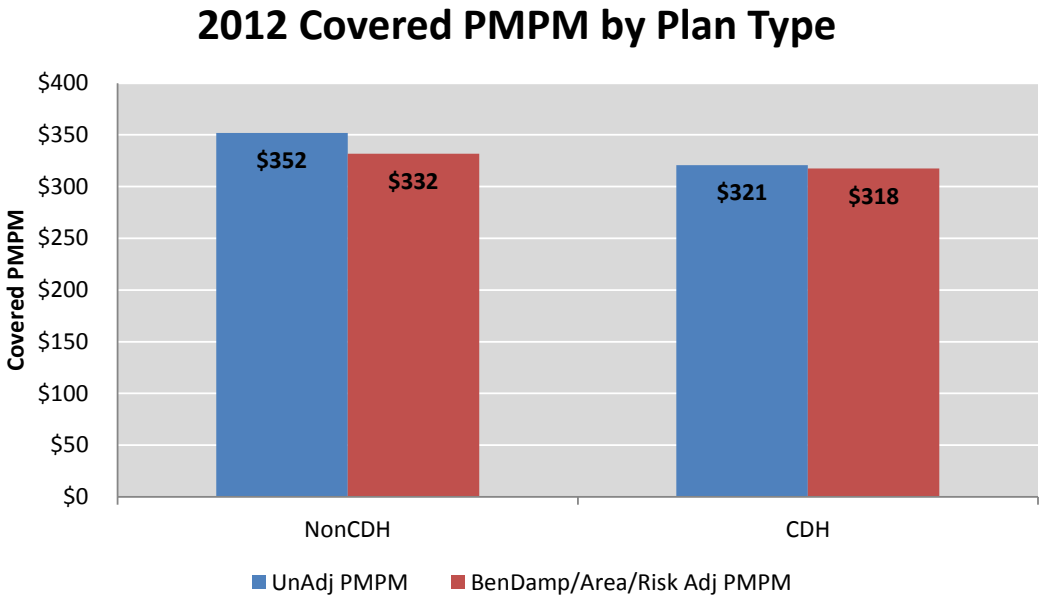
- CDH covered PMPM, after adjusting for risk, area, selection and benefit dampening, are on average *4%* lower than nonCDH – it's not just about shifting cost to employees but bending the cost curve

- CDH members are *more activated* that nonCDH
  - CAI scores for CDH members are 2.5% higher than nonCDH; HSA activation is 4.0% higher than nonCDH
  - Activation highest for clinical wellness and resources; EBM compliance for diabetes, CAD, asthma similar between CDH and nonCDH

- Consider the *benefit rush/hush/crush* in trends one year before through one year after CDH implementation - more pronounced for full-replace vs. slice offering

- After the crush effect in year 2, covered PMPM trends for CDH is similar to nonCDH, after accounting for normal fluctuation
  - Net paid trends for CDH may be slightly higher due to leveraging effect of deductible; may be offset by any increase in member activation
  - While trends are similar, PMPM levels continue to be lower for CDH vs. nonCDH, even beyond 2nd year of implementation

Well-designed CDH plans have ~4% lower *covered* PMPM on an "all other things being equal" basis



- On a mature basis (after 3 years), CDH plans cost 4% less ($318 PMPM vs. $332 PMPM) than non-CDH plans after adjusting for area, risk factor, selection and other factors
- Other studies may show higher savings than this, but they usually reflect other variables: implementation of a steered network design, addition of clinical programs, decrease in benefit richness (cost share), and selection impact if CDH is offered alongside nonCDH plans in slice situations

Based on a study comparing stable customers with full replace CDH (defined as clients with >75% CDH membership) for 3 or more years as of 2012, compared to stable customers with at least 90% membership in nonCDH in 2012

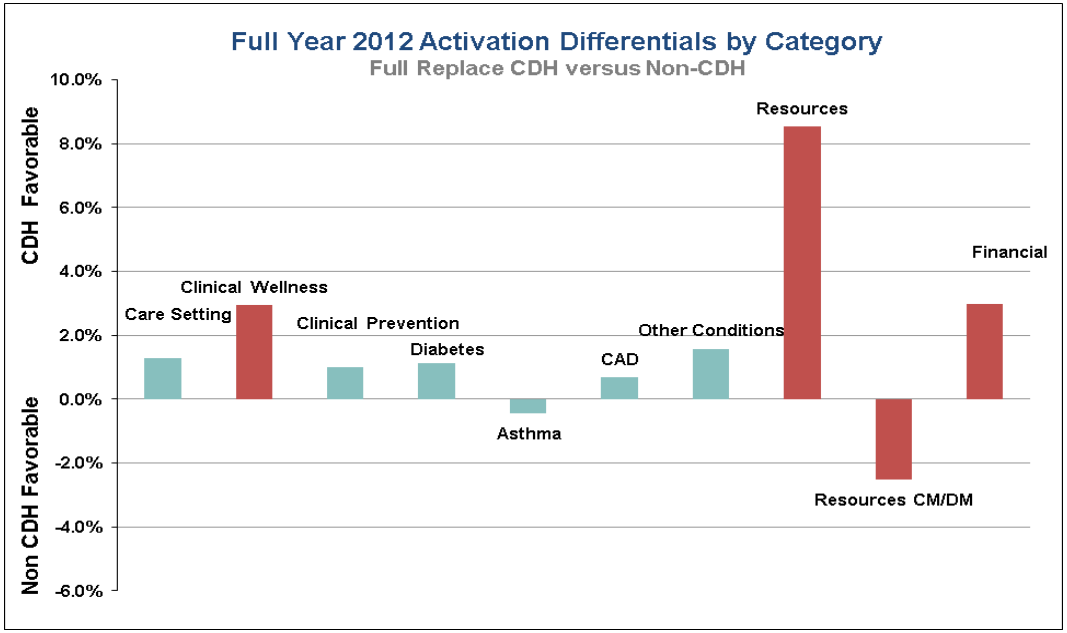
Overall, CDH members make better decisions

Activation score is 2.5% higher for CDH vs. non-CDH

- Categories with the highest favorable scores include
  (CAI% CDH vs. Non-CDH):
  - Resources (45.3% vs. 36.8%)
  - Clinical Wellness (53.6% vs. 50.6%)
  - Financial (92.6% vs. 89.6%)
- Categories with the most unfavorable scores include:
  - Resources CM/DM (47.7% vs. 50.2%)
- For all other measures, there is no material difference between CDH and non-CDH plans
- Utilization of preventive care office visits are 1.2% higher for CDH than non-CDH plans

Overall Consumer Activation Index score Non-CDH vs CDH (HRA/HSA) Plan	
CDH Plan Population	**59.9%**
Non-CDH Plan Population	**57.3%**

+2.5%



Resources: Web Activation, Call Center; Resources Co-manage condition: Optum UBH support programs
Clinical Wellness Prevention: Cervical Cancer Screening, Osteoporosis Screening, etc
Clinical Wellness Visits: Adult Preventive, Child Preventive, Newborn Visits, etc
Care Settings: INN Usage, Premium Usage, Inappropriate ER visits
Clinical Diabetes: Annual Eye Exam, Annual HDL Monitoring, Annual Serum creatinine test, etc.
Clinical Asthma/COPD: Annual physical, Inhaled Steroid therapy, Long-acting bronchodilator, etc.
Clinical CAD: Ace inihibitor Therapy/CHF, Annual Lipid LDL, Monitoring, etc.
Other Conditions: Hyperlipidemia LDL, Hypertensive Serum Creatinine etc.

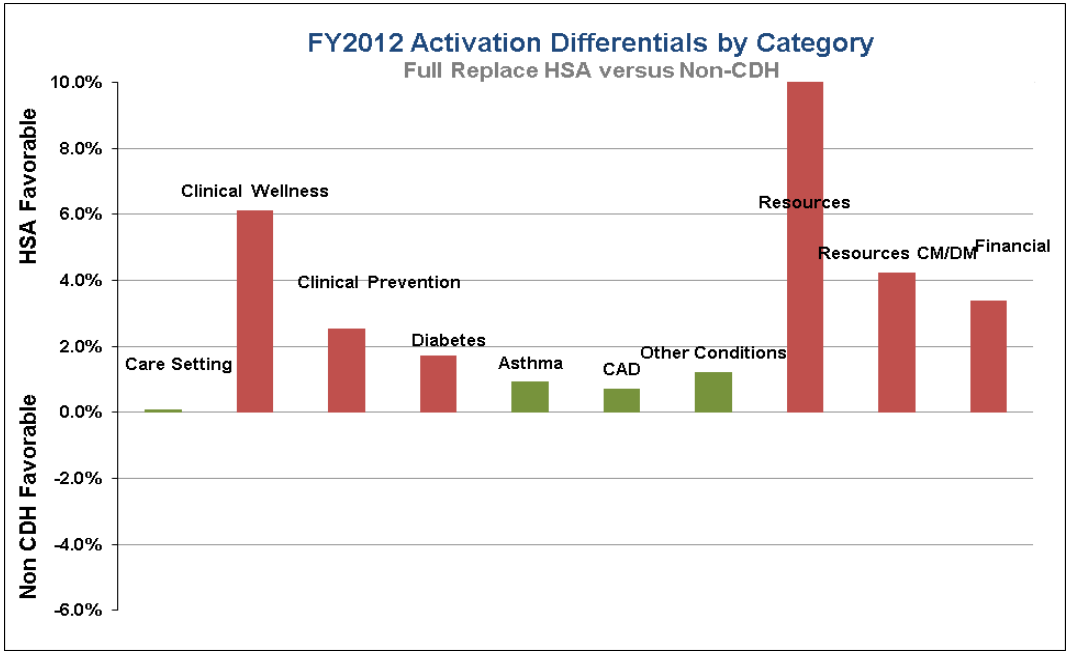
HSA Plans Produce Highest Activation

Activation score is 4.0% higher than non-CDH

- HSA activation exceeded Non-CDH in all categories
  - Care setting, asthma, CAD, other conditions similar between HSA and NonCDH
- Categories with the highest favorable scores include (CAI% HSA vs. Non-CDH):
  - Resources (49.6% vs. 36.8%)
  - Clinical Wellness (56.8% vs. 50.6%)
- HSA members have 5.0% higher utilization of preventive office visits, and significantly lower inappropriate ER visits (-23%), suggesting they use care more appropriately

Overall Consumer Activation Index score Non-CDH vs HSA Plan	
CDH HSA Plan Population	61.3%
Non-CDH Plan Population	57.3%

+4.0%



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Individual Activation Matters

Lower Cost. Lower Trend.

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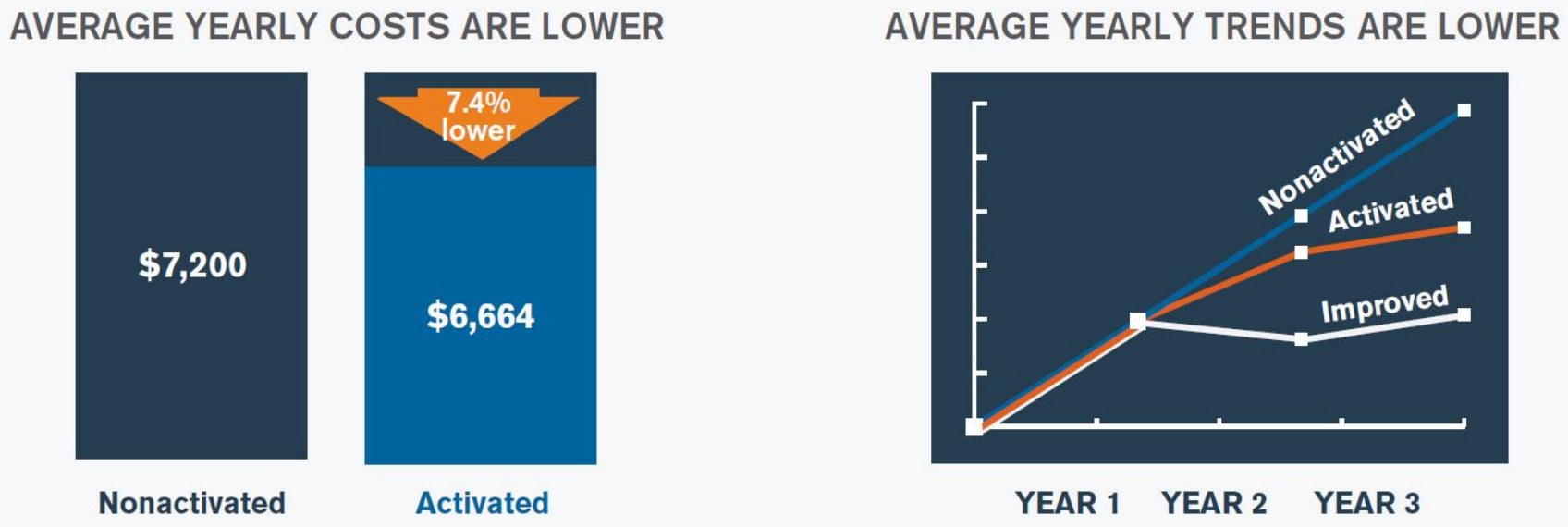
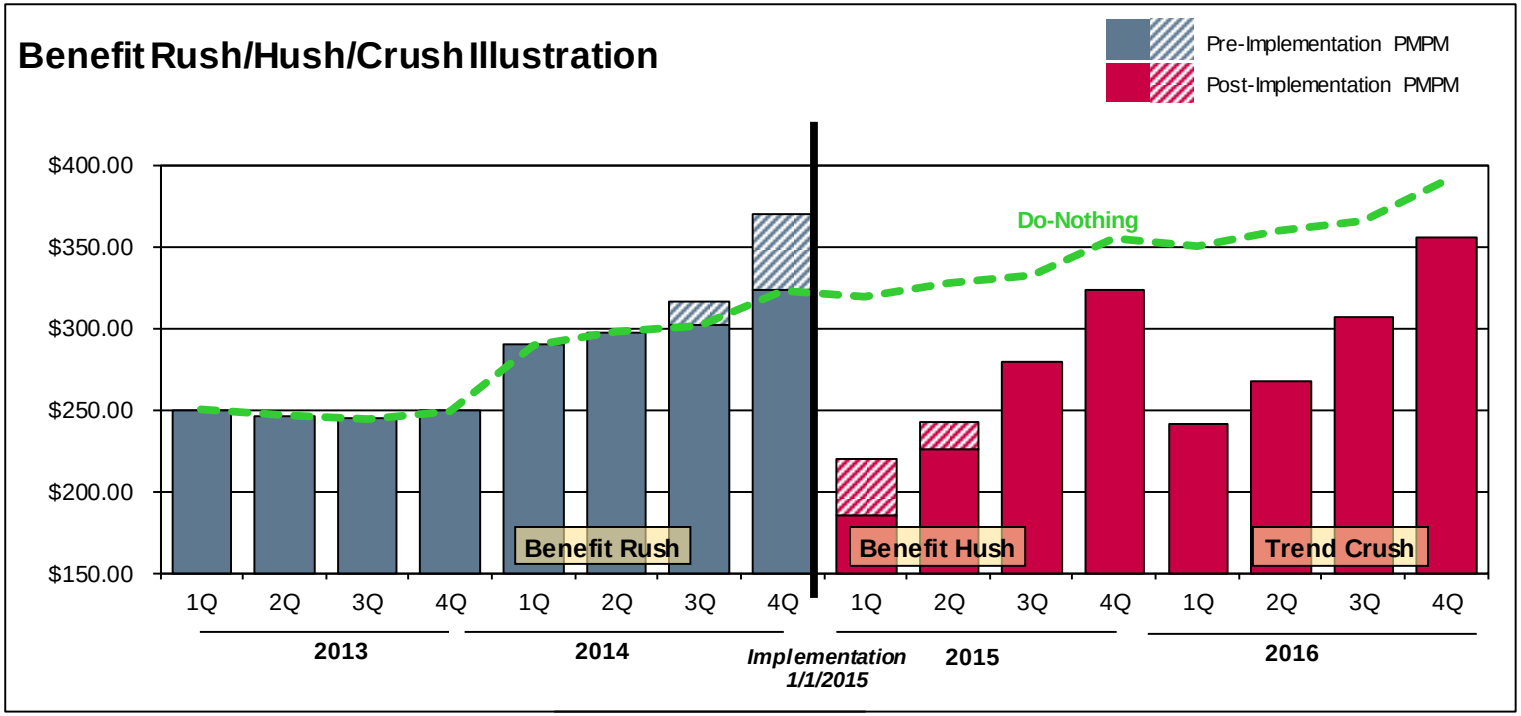
3-Year Study of Members with Chronic Illness (chronics typically account for ~40–50% of medical spend)



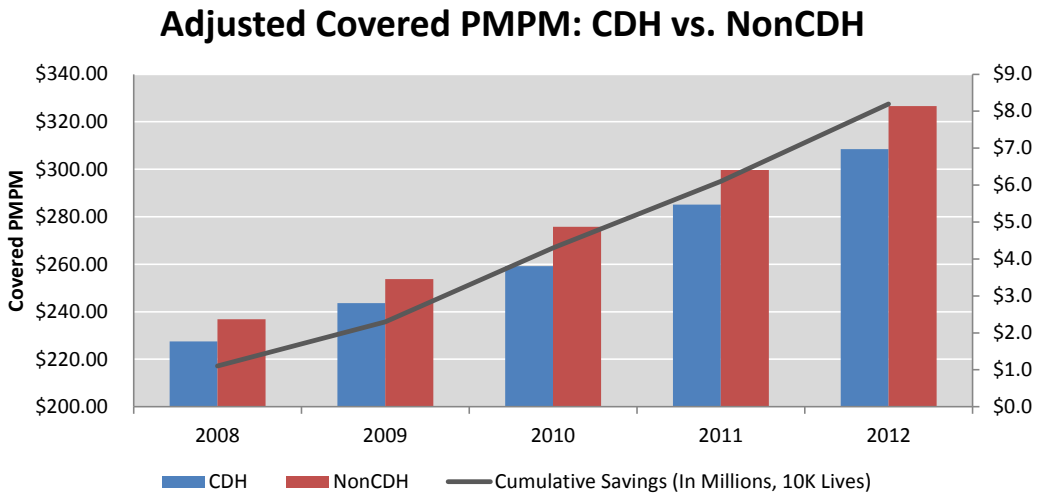
Comparative analysis of 3-year costs (2007–2009), for continuously enrolled chronic members with either diabetes, CAD or both. Cohort costs normalized for gender mix, risk and demographics. Activated (n = 26,971) defined as an individual having a CAI of 75% or higher in each year, and Nonactivated less than 75% in each year (n=92,388). Improved means Nonactivated individuals in 2007 and Activated by 2009 (n = 29,772).

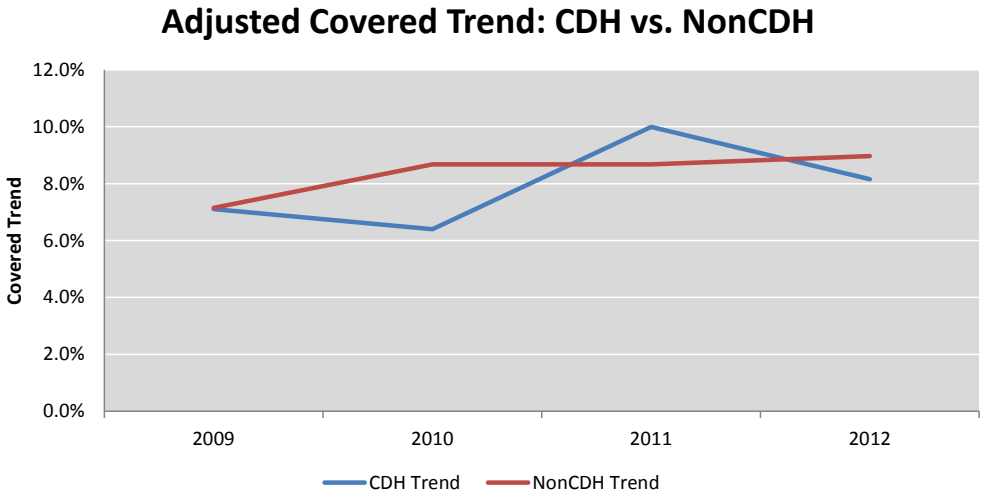
Consider the benefit rush-hush-crush effect for budgeting purposes – ILLUSTRATIVE ONLY



- Pre-implementation Year (1/2014): Members rush to get certain procedures (eg. elective surgeries) before the plan change. Benefit rush occurs whenever there is a big change that creates uncertainty – a new carrier, major change in benefit offering, etc.
- Year 1 of new benefit (1/2015): Benefit hush occurs as a counter effect of the previous year's rush – leads to significantly lower trend and cost
- Year 2 (1/2016): Trend crush occurs as utilization levels go back to normal level, but trending off a lower base line.
- Years 3 and 4: Steady state trend levels. Watch out for deductible leveraging, especially for high deductible plans – may want to index deductible and OOP max to counter this effect.

Non CDH PMPMs are 4-6% higher than CDH, and have similar trends as CDH after year 2





- CDH plans continue to have lower Covered PMPMs after adjusting for geography and risk
- Cumulative savings from 2008-2012 for a 10K-life group is about $8M
- After the first 2 years of implementation (when benefit rush/hush/crush is in effect), and after accounting for normal fluctuation, covered trends for CDH is similar to nonCDH
  - 2009 CDH trend also reflects some benefit crush (for plans effective 2008)
  - Net paid trends can be slightly higher for CDH than nonCDH due to deductible leveraging; may be offset by any increase in member activation

Covered Dollars adjusted for Risk and Geographic differences. Based on a longitudinal study comparing stable customers with full replace CDH in effect 2008 or earlier to stable customers with no CDH options from 2009 - 2012

What's Next - Market Indicators Supporting Full Replacement

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Source	Considering Moving to Full Replacement CDH Plans
Towers Watson[4]	**49%** considering for 2018
Aon Hewitt[6]	**42%** considering in next 3 to 5 years
PwC[7]	**44%** considering for future
Mercer[3]	**18%** of firms (500+ EEs) considering for 2017 **26%** of jumbo firms (20,000+ EEs) considering for 2017

Claim and Administrative Benefits

- Increased member engagement leads to cost-conscious health care choices
- Less administration cost
- Eliminate anti-selection through single plan structure design

Tax Savings

- Employer and member tax savings using payroll deductions with HSAs
- Member tax benefits including tax-free HSA balance growth and distributions (on qualified expenses) for members

The Excise Tax

- Implementing a qualified high deductible health plan with an HSA may delay the impact of the upcoming Excise Tax

Source: 1) 19th Annual Towers Watson/NBGH Employer Survey on Purchasing Value in Healthcare, May 2014; 2) Large Employers' 2015 Health Plan Design Survey, National Business Group on Health, Aug. 2014; 3) Modest Health Benefit Cost Growth Continues as Consumerism Kicks into High Gear, Mercer Press Release, Nov. 19, 2014; 4) 2015 Emerging Trends in Health Care, Towers Watson, April 2015; 5) Large Employers' 2015 Health Plan Design Survey, National Business Group on Health, Aug. 2014; 6) 2014 Aon Hewitt Health Care Survey, Oct. 2014; 7) Medical Cost Trend: Behind the Numbers 2015, PricewaterhouseCoopers, June 2014.

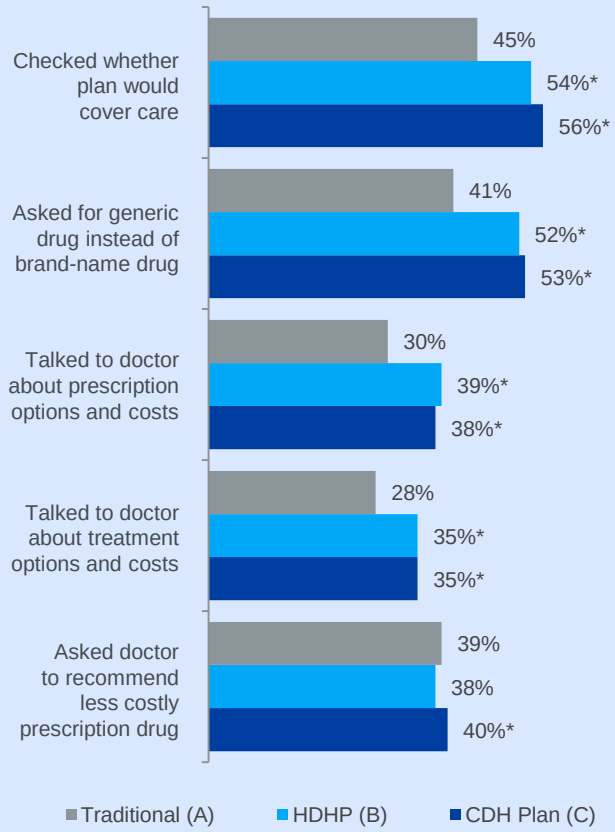
HSA Employer and Member Benefits with HSA Plans

Savings through engagement and behavior change

- Employees are more engaged in healthy behaviors and decision making with an HSA plan
  - 5% lower overall costs for Health Savings Account (HSA) consumers after 2 years[1]
    - Full Replacement HSA slightly better with 7% lower overall costs
  - 6% lower total health care costs for CDH plan members with adequate health literacy[2]
  - 3.7% lower overall pharmacy costs for consumers in CDH plan combined deductible plans[3]
  - 4.0% better decision making by HSA consumers across 55 decision points[3]
- EBRI study also shows proven behavior change among different plan types (Figure 6)
  - 54% of HDHP members check for covered care (vs. 45% in traditional plans)
  - 53% of HDHP members ask for generic drugs (vs. 41% in traditional plans)

Cost-Conscious Decision Making, by Type of Health Plan, 2012

(Percentage of privately insured adults 21–64 who received health care in last 12 months)



Source: EBRI/MGA Consumer Engagement in Health Care Survey, 2012.
A Traditional = Health plan with no deductible or <$1,000 (individual), <$2,000 (family)
B HDHP = High deductible health plan with deductible $1,000+ (individual), $2,000+ (family), no account
C CDHP = Consumer-driven health plan with deductible $1,000+ (individual), $2,000+ (family), with account
* Difference between HDHP/CDHP and Traditional is statistically significant at p ≤ 0.05 or better
1) Health Services Research Aug. 2010; 2) Health Communications Journal Research Oct. 2011; 3) Internal UnitedHealthcare study.

Full Replacement HSA Employer Advantages

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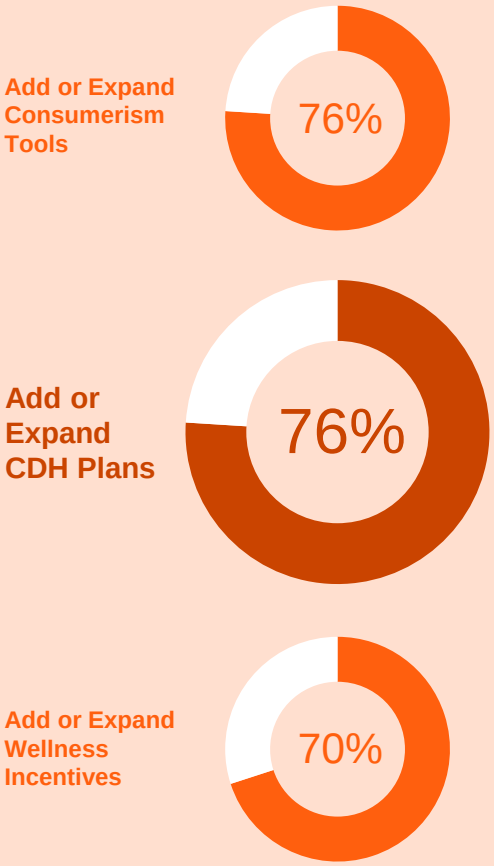
You are already familiar with the tax advantage savings for you and your employees with a CDH plan.

- Expanding to full replacement will create those tax advantages for your entire population
- More employees will continue to have a triple tax advantage, with tax-free
  - Contributions
  - Balance growth
  - Distributions

In 2018, the Excise Tax will go into effect.

- 40% excise tax on the value of health benefits exceeding: $10,200 for individual coverage and $27,500 for family coverage*
- 76% of employers are saying they will add or expand their CDH plans to help address the upcoming Excise Tax (effective 1/1/2018)[1]

Most Popular Actions Taken by 2016 to Delay the Excise Tax



1) NBGH 2016 Large Employers Health Plan Design Survey
* Denotes impact to insured and self-funded plans

Case Study: Effectively Transitioning to Full Replacement Consumer-Driven Health Plans

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Effectively introducing consumer-driven health plans

- Rising medical costs were putting this energy producer's future at risk
- Introduced a consumer-driven health plan with an HSA
- Plan design offered attractive options like no premium; cover preventive care at 100% and a $560 individual or $1,120 family contribution to their HSA
- Communications started a year before the plan design change
- Multi-channel communications targeted both employees and their family members

Employees in the new CDH plan:

Seek preventive care at a higher rate

Use the nurse hotline more often

Use emergency room less often

Purchase generic drugs more often

Results

Nearly **80%** of employees enrolled in the consumer-driven option (full replacement is **>75%** enrollment in CDH plan option)

93% of employees who have Health Spending Accounts contribute to them; **80%** contribute $1,000 or more a year

Long-term strategy with the goal of creating a culture of wellness

Health Savings Accounts Trends

Optum Bank Contribution Summary

Employer Contribution Information

- 36% of employers contribute to the HSA Account—Varies greatly by segment:
  - ❑Small Business only 12% of employers contribute
  - ❑For National Accounts, 92% of employers contribute to the HSA Account
- 2014 average employer contribution for an individual was $343.90
- 2014 average employer contribution for a family was $602.82

2015 Updated Optum Detailed Report

					Twelve months ended October 31, 2015		
Employer Contribution Class	Employers		Accts		Employer Contributions	Account Holder Contributions	Average Current Balance
A. ERCnt1Yr $5000+	56	0.3%	605	0.0%	$ 6,135	$ 277	$ 5,114
B. ERCnt1Yr $3000-$4999	177	1.0%	3,736	0.2%	$ 3,638	$ 372	$ 4,410
C. ERCnt1Yr $2000-$2999	442	2.4%	26,829	1.6%	$ 2,396	$ 310	$ 2,987
D. ERCnt1Yr $1000-$1999	1,191	6.5%	124,241	7.6%	$ 1,294	$ 670	$ 1,818
E. ERCnt1Yr $500-$999	1,573	8.6%	525,921	32.1%	$ 694	$ 1,120	$ 1,747
F. ERCnt1Yr $60-$499	1,611	8.9%	734,198	44.8%	$ 230	$ 516	$ 1,175
Total Funders	5,050	64.4%	1,415,530	86.4%	$ 548	$ 750	$ 1,489
Non-Funders	2,789	35.6%	204,806	12.5%	$ 26	$ 2,553	$ 2,532
Total	7,839	100.0%	1,620,336	98.8%	$ 481	$ 816	$ 1,620

Highlights from 2015 Devenir HSA Research Report

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General Information

- 16.7 million HSA accounts
- $30.2 billion in assets
- 22% increase in number of accounts from 2014 to 2015
- Devenir projects by end of 2018 $50 billion in HSA assets and 30 million accounts

Employer Contributions

29% of all HSA dollars contributed to an account came from an employer

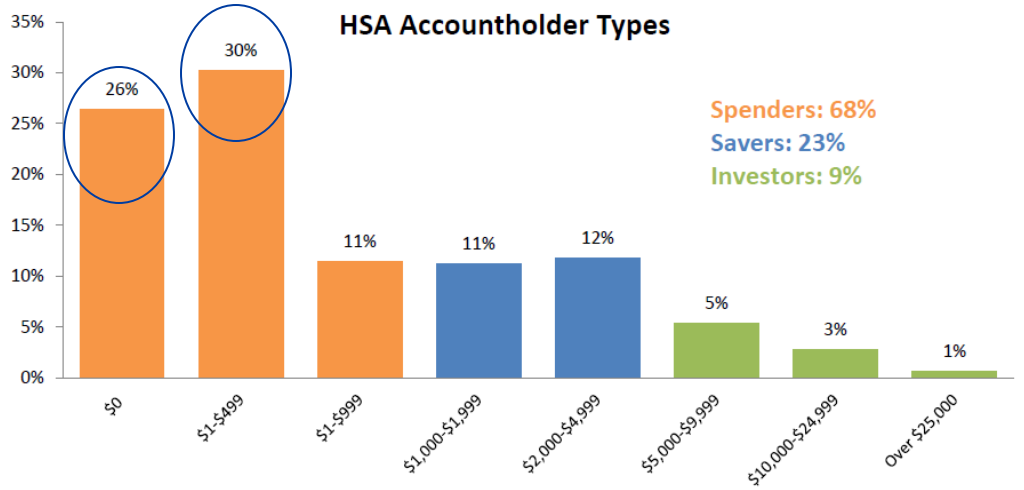
The average employer contribution was $938

Employee Contributions

- 45% of all HSA dollars contributed to an account came from an employee
- The average employee contribution was $1546

Account Opening

- 26% of employees in an HSA qualified plan never open an HSA account
- 30% have a balance below $500j



Distribution of Firm Contributions to the HSA for Single and Family Coverage Relative to the Average Annual Firm Contribution to the HSA, 2015

Contribution Range, Relative to Average HSA Contribution	Single Coverage		Family Coverage	
	Contribution Range, Dollar Amount	Percentage of Covered Workers in Range	Contribution Range, Dollar Amount	Percentage of Covered Workers in Range
Less Than 60%	Less than $341	39%	Less than $595	38%
60% to Less Than 80%	$341 to <$455	6%	$595 to <$793	8%
80% to Less Than Average	$455 to <$568	16%	$793 to <$991	4%
Average to Less Than 120%	$568 to <$682	7%	$991 to <$1,190	15%
120% to Less Than 140%	$682 to <$796	5%	$1,190 to <$1,388	8%
140% or More	$796 or More	27%	$1,388 or More	27%

SOURCE:

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

NOTE: The average annual firm contribution to the HSA is $568 for single coverage and $991 for family coverage. The distribution includes workers in firms who do not make any contribution. The HSA account contribution distribution is relative to the average single or family account contribution. For example, $455 is 80% of the average single HSA account contribution and $682 is 120% of the average single HSA account contribution. The same break points relative to the average are used for the distribution for family coverage.

The average annual firm contrbution to an HSA for covered workers at firms who make a contribution is $809 for single coverage and $1,412 for family coverage.

Advanced Health Savings Accounts Concepts

This course was approved by the applicable state department of insurance and is administered for that state by the Compass Resources Inc, an approved CE provider

THANKS