

# BENEFIT

## *Plan Developments*



A report covering plan design and legislative changes

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## HSA Enrollment Swells To 4.5 Million

The number of Americans with high-deductible health insurance plans (HDHPs) linked to tax-advantaged health savings accounts (HSAs) rose 43% to 4.5 million between January 2006 and January 2007, according to a census of 87 U.S. health insurance carriers conducted by industry association America's Health Insurance Plans (AHIP).

The census looked at rates of adoption of HSA/HDHP products between January 2006 and January 2007, but it did not include data on coverage associated with health reimbursement arrangements (HRAs).

In the individual health insurance market, enrollment in HSA/HDHPs rose from 855,000 to 1.1 million over the period studied. The census found that HSA/HDHP products accounted for 25% of all new purchases of individual health insurance policies between 2006 and 2007. Of the new

enrollees in HSA/HDHPs, 27% had been previously uninsured, and 46% were age 40 or older. The average annual deductible for the HSA/HDHP policies sold on the individual market over the period was \$2,668 for single coverage and \$5,264 for family coverage, while the average annual out-

of-pocket limit was \$3,449 for singles and \$6,881 for families.

Over the same period, HSA/HDHP enrollment in the group insurance market rose to almost 3.4 million, from 1.4 million the previous year. From January 2006 to January 2007, HSA/HDHP products accounted for 17% of all new plans purchased in the small group market and 8% of all new plans sold in the large group market. The average annual deductible for HSA/HDHPs sold in the small group market was \$2,282 for single coverage and \$4,541 for family coverage, while the average out-of-pocket limit for HSA/HDHPs in the group market was \$3,404 for singles and \$6,611 for families.

As part of the census, AHIP researchers asked 69 insurance carriers (representing an HSA/HDHP enrollment of 3.6 million) about the preventive benefits coverage and disease

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management services offered as part of their HSA-eligible plans. Of these respondents, 63 reported offering HSA-qualified plans that cover preventive care before the deductible is met. In addition, 65 indicated they offer disease management benefits for HSA/HDHP enrollees, and 11 said they cover some types of prescription drugs as a preventive benefit not subject to the deductible.

When all the companies offering HSA/HDHP products were asked to identify the types of consumer decision support tools they provide, 88% indicated they offer health care cost information, 86% provide enrollees with hospital-specific quality data, and 50% provide physician-specific quality data.

## Long-Term Care Crisis Looms For Baby Boomers And Their Parents

Many members of the baby-boom generation are not preparing adequately for their own potential long-term care requirements or the needs of their elderly parents, according to two recently published research reports.

A survey of 400 women between the ages of 30 and 64 conducted by Securian Financial Group showed that 60% of respondents agree that it is a child's duty to care for aging parents. When asked who in their family might provide that care, 70% of the women surveyed whose parents are both living said that they will likely become the responsible family member.

Among respondents with two living parents, 22% predicted they will take time off work to care for aging parents, while 52% said they did not expect to take time off. Securian researchers noted, however, that a study by the AARP and the National Alliance for Caregiving found that at least 60% of employed adult caregivers adjust their work schedules to accommodate their

eldercare responsibilities, while 9% leave the workplace and 10% reduce their hours.

The Securian survey also revealed that many women are unprepared to handle the sudden onset of a parent's health problems: 84% of respondents with a parent who has received nursing care indicated that no plans were made until the care was needed.

Almost half of all the women surveyed told researchers they are concerned about the quality of nursing home care their parents will receive because their own financial resources are limited, and 32% said they are worried about the quality of care because of their parents' financial limitations.

"Most women will face the challenge of caring for their parents at some point in their lives," said Kim Anderson, product manager for long-term care insurance at Securian. "Our survey indicates that women can do more to prepare themselves and their families for it—financially, emotionally and in terms of time demands and where the care will be given."

Results further showed that a large percentage of women are not saving enough for their own retirement years. The survey found that 62% of respondents are concerned that their money will not last through retirement, and 57% reported that they have little money to put away for retirement after meeting their financial obligations.

"It's important for women to plan, as much as they are able, for this phase of their lives and their parents' lives," said Sherri DuMond, national recruiting vice president, Securian. "That includes having discussions with family members about their wishes and planning financially so realistic goals can be set."

A recently released study by economists at the Urban Institute attempted to predict future demand for long-term care among the baby-boom generation and looked at how changing family structure will likely affect institutions and paid caregivers. The analysis combined results from models of current long-term care arrangements with simulations of the size and characteristics of future population.

When researchers assumed that overall disability rates among the people age 65

and older will decline at an annual rate of 1%, they concluded that, between 2000 and 2040, the size of the disabled older population will grow by more than 50%, the number of elderly people using paid home care will expand by three-quarters, and the number of older people in nursing homes will increase by two-thirds. When researchers ran the simulation without assuming any particular trend in current disability rates, results showed that both the number of seniors receiving paid home care and the number of older people living in nursing homes will more than double between 2000 and 2040.

Taking into account the decline in the average family size and the expected improvement in women's earning prospects, researchers further predicted that, between 2000 and 2040, the share of disabled adults receiving paid help will increase from 22% to 26%, while the share of disabled older people receiving help from children will decrease from 28% to 24%.

Given the projected growth in demand for paid long-term care services, the study's authors recommended that policy-makers promote private long-term care insurance and investigate expanding Medicaid and Medicare to make paid services more affordable.

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## Employer Interest In Wellness Programs Grows

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Recognizing that programs designed to help employees manage their health more effectively can boost productivity and lower health care benefit costs, many employers are looking to expand their companies' wellness initiatives, according to a survey conducted by United Benefit Advisors.

As part of an annual survey on employee benefits, researchers questioned 1,746 employers across all industry groups about the extent and effectiveness of their current and planned wellness and disease management programs.

Results showed that around one-quarter of employers currently provide wellness and/or health risk assessment programs, and an additional 50% are interested in implementing such programs in the future. The survey also found that most employers agree that an employee's involvement in managing chronic conditions should influence the employee's benefits and share of costs.

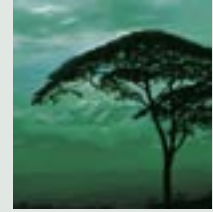
In addition, 73% of employers believe employees can become better health care consumers if given the necessary tools, such as provider cost and quality information, education on managing costs, and decision support tools.

When asked to compile a "wish list" of initiatives they would like to implement in the future, between one-third and one-half of the employers surveyed said they hope to add formal wellness and disease management programs, cost and quality information on health care providers and prescription drugs, early-warning tools to identify chronic conditions and potentially serious claims, and employee decision support tools.

Commenting on the survey's findings, UBA co-founder David LoCascio noted that employers of all sizes across all industry groups are implementing the same types of health management programs. "The increasing applicability of web-based solutions and the growing sophistication of benefits advisors has leveled the playing field, allowing employers of all sizes to have access to tools and services that were previously available only to large employers," LoCascio said.

"Employer involvement in helping to manage the health of its workforce has been rapidly gaining momentum," LoCascio added. "Employers are increasingly assuming more responsibility and control in an effort to impact both plan costs and employee productivity."

LoCascio observed that employers of all sizes have found that proactive health management programs and effective employee communication can have a direct and noticeable impact on plan costs. Employees, he said, "have a huge vested




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interest in helping contain costs in order to both stem the erosion in plan benefits and their share of higher premium costs; and most are willing and able to do so if provided the tools and information required.”

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## Current Health Care System Hinders Price Transparency

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Medical insurers, providers, and state and federal agencies are increasingly making health care price information available to the general public or to members of specific health plans, according to a recently released report. However, the study concluded, price transparency alone may not benefit consumers or reduce costs if individuals lack clout in negotiating with providers or have insufficient knowledge to make decisions about their own care.

Written by consultant Mark Merlis and published by George Washington University’s National Health Policy Forum, the study looked at the likely effects of price transparency on consumer behavior and provider competition, and it discussed the steps that insurers, providers, and government agencies might take to improve the price information available to consumers.

The wide variations in the way hospitals, physicians, and other health care providers charge their patients greatly complicates the issue of price disclosure, Merlis observed. The actual amount a patient pays out of pocket for a given service often depends upon whether he or she is using a provider that has a contracted price for the service with the patient’s insurer or is being asked to pay the provider’s “list

price” for the service. The patient’s share of the costs will also depend upon the health insurer’s requirements regarding co-payments and coinsurance.

In many cases, insurers, providers, or both are reluctant to disclose publicly their negotiated prices because these contracts are confidential, according to the report. Even if patients had access to price information, Merlis said, they may still have difficulties estimating in advance the total cost of care over the course of an entire illness episode, especially if the patient requires unanticipated treatments or receives care from multiple specialists. Patients may also be impaired in their ability to weigh their options if they are ill and their care needs are urgent, the author said.

In addition, Merlis questioned whether price disclosure would, in practice, promote competition and result in lower prices for consumers. For example, he noted, some providers might raise their prices for certain procedures in response to information about a competitor’s charges. The author also challenged the assumption that so-called “consumer-directed” plans necessarily promote greater price sensitivity, as members of these plans typically have access to negotiated network prices for their care and may incur little or no coinsurance costs after the deductible is met.

Despite these issues, price and quality transparency could prove useful in certain contexts, Merlis argued. For example, patients could be encouraged to shop around for the best deals when seeking routine services such as pediatric care or care for chronic conditions, or when purchasing commonly prescribed drugs. The author also recommended that physicians, health plans, and government agencies play a more active role in helping patients choose appropriate providers and services.




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