

Individual Insurance Markets and The Future of Hospital Payments

Gail R. Wilensky
Project HOPE
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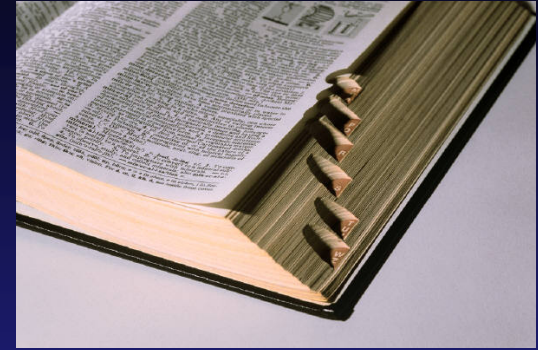


Issues

- ◆ Growth in HRAs / HSAs
- ◆ Near term effect
- ◆ Next steps
- ◆ CDHP and Health Care Spending
- ◆ CDHP and Managed Care
- ◆ CDHP and Hospital Pricing Issues



Some Definitions



2 Essential Components

- ◆ High deductible health insurance plan
- ◆ Tax advantaged savings accounts

2 types of Savings Accounts

- ◆ HRAs – owned by employers
- ◆ HSAs – owned by employees

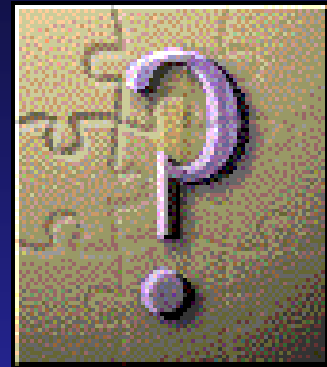
HSA_s

Authorized by MMA in 2003

- ◆ 1 million by March 2005
- ◆ > 1/2 individually purchased
- ◆ Approx. 400K group market
 - 1/2 in small firms
 - 1/2 in large firms



HRAs / HSAs – 3 million total?



- ◆ If offer at all, most offer both
- ◆ HRAs/HSAs differ by market
 - HSAs mostly in individual/small group market
 - HRAs mostly in self-funded, large group market
- ◆ 95% of enrollees have access to negotiated rates/ networks
- ◆ Cost and quality data is a problem

Future Growth – Looks Promising (short term!)

- ◆ 70% of employers claim will offer CDHP
- ◆ Unlike MSAs, lots of large insurers are in
Aetna, UnitedHealth, Cigna, Blue Shield
- ◆ 80% of insurers say CDHP “here to stay”



Early Evidence – Spending Effects

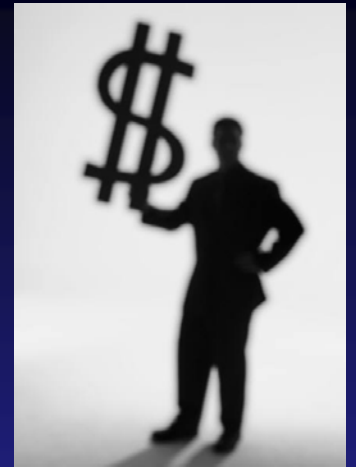


Mercer: late 2004, CDHP much cheaper than indemnity: \$5,233 to \$6,707

Humana: CDHP options to employees; cost ↑
4.9% 2002; 2.7% 2003

Aetna: 3.7% YOY ↑ in 2003; 2004: 6% ↑ YOY?

Spending Effects



Will lower rates last?

Anecdotal evidence: rates may creep , *but* --

Mostly seeing HRAs now

HSA experience?

Early Evidence – Effects on Use



Some ↑ in preventive care / chronic care use

Little / no drop in somewhat serious / very serious care

Aetna: no change in diabetic screenings or exams
no significant change in meds for hypertension,
asthma, cardiac care

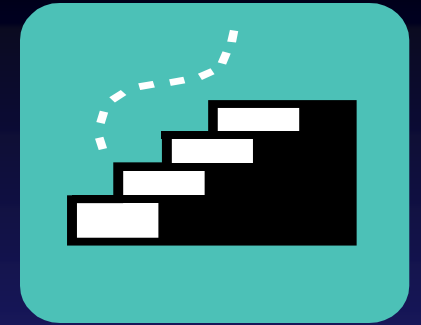
McKensey: preventive care ↑; chronic care compliance ↑
especially hypertension

Early Results -- Satisfaction



- ◆ Not as favorable as \$ or use
 - 44% as or more satisfied than with traditional plans
- ◆ *Part* dissatisfaction because of ↑ costs
- ◆ *Most* dissatisfaction: inadequate information
 - Same as Towers / Perrin findings

Next Steps ---



- ◆ Need good data on prices and quality
 - Especially for CDHP but even if no CDHP --
- ◆ CDHP participants uncomfortable going to plans for data
- ◆ Data that's available too often not provider-specific
 - < 30% of cost information for specific services/specific providers
- ◆ Quality data is worse
 - 11% on both physicians and hospitals
 - 50% no data

CDHP and Health Care Spending

- ◆ Effect could be small, because ---
 - Uncertain future growth of CDHP
 - Uncertain if/how hospital \$ will be affected
 - Concentration of spending



But --


- ◆ Rand HIE showed 25/30% drop in services
 - 23% less likely to be hospitalized with a high deductible plan

CDHP and Managed Care



- ◆ Complementary rather than substitutes?
- ◆ HIE showed high cost-sharing effects probability of event; not \$
- ◆ Managed care – disease/case management, tiered pricing can affect cost of episode
- ◆ Maybe ↑ case involvement with HSA will ↑ tolerance for good care coordination

CDHP and Hospital Pricing

- ◆ CDHP will  pressure on transparency in pricing already in focus because of uninsured
- ◆ Transparency in pricing pressure could change how hospitals price services; more *uniform pricing*
“price discrimination” issues – efficiency, equity
- ◆ Will push hospitals to more aggressively track what services cost

Concluding Thoughts

- ◆ Too soon to know if CDHP has “staying power”
- ◆ Early results on spending is promising but ---
- ◆ Early effects on use are okay to good
- ◆ Combine CDHP with managed care strategies?
- ◆ Really need good information on quality and prices
- ◆ Hospitals should expect price transparency pressure

Big problems still to be solved!