Healthcare Sustainability

Today, our topic is . . . the future financing of health care. Hey, where ya goin'? Remember, Al Gore gave a PowerPoint presentation on climate change, a presentation full of charts and data, and he won an Oscar and a Nobel Peace Prize, and he mobilized an entire movement. But if you had asked them going in, most people would have said, "Global warming? No thanks, I'll pass on that one." Well, there is a fundamental similarity between what Vice President Gore talked about and what we're embarking on here, and that is *systemic change rooted in human behavior*.

Let's start with the assumption that a sizable percentage of you are covered by health care policies where you work. Your company has picked the plan for you and is picking up some, or all, of the cost. The greenhouse gases of health insurance, if you will, are the rapidly rising costs that are choking the system and making it more and more difficult for employers to offer decent benefits. Think about it. The costs of medical benefits are increasing by double digits every year. Were Al telling this tale, he would now come to his first inconvenient insurance truth: If you make $40,000 a year today and get an annual pay increase of 3%, in just 15 years you'll actually have to pay more for health insurance than you earn.

It's a system that is completely unsustainable. When we talk about sustainability, whether in ecology or economics, we're referring to the potential longevity of a vital support system – a state that can be maintained at a certain level indefinitely. Typically, it is a system that is self-contained and maintains an interior logic and systemic integrity. It's a system that makes sense, that stands up, that holds together.

So, here's our next inconvenient insurance truth: if you bought your own individual health care policy, you would be spending about half as much on the premium as you and your employer are paying now for your employee health care benefit. An industry study of something like 3 million policies shows that individuals going into the insurance marketplace and spending their own money take somewhat less coverage and somewhat higher deductibles, and save in the neighborhood of 50% on the premiums.

What this tells us is that employers, already hacking and choking on rising benefits costs, tend to overspend on medical insurance and over-insure most of their employees. It also says that the employees' varied needs might be better served by a benefits marketplace where they can pick their own plans and coverages. And it suggests that many employees may need a little help in making the necessary trade-offs. Address these behaviors and we will cause a fundamental change in the way health care insurance is purchased and used. And everyone will breathe a lot easier.

Interestingly, the same study of 3 million policies showed that over 85% of consumers purchase either Preferred Provider Organization (PPO) or Point of Service (POS) plans, while only 6% purchase either Health Maintenance Organization (HMO) or indemnity plans. By contrast, over three times as many people (21%) who are covered by insurance offered by their employer are in a network-restricting HMO. This discrepancy seems to be due to the fact that in a group setting HMO plans are typically offered alongside PPO or POS plans, so choosing an HMO plan is the only way an employee can reduce the cost of coverage.

And that brings us to compelling insurance truth number three: a lot of what passes for employee health care insurance today is not actually insurance. It used to be. Back in the 1950s and 60s, when the atmosphere was clear and simple, those old indemnity policies were pure insurance coverage – shifting most, if not all, of the financial risk of sickness or injury to the insurance company. But by the late 60s and early 70s, rising health care costs made indemnity policies too expensive and unwieldy. And in 1973, Congress passed the HMO Act, changing the nature of the relationship from insuring the risk of contingent loss to pre-paying for medical services. This managed care model based on prepaid medical expenses has led to stricter and stricter rationing of health care to control costs. In this regard, POS and PPO plans are in fact HMO derivative – a POS plan can really be described as an HMO with a costly out-of-network option, and a PPO is really an HMO-like network based on discounts for services. Any significant cost savings created by an HMO and its derivatives have long since been realized. And over the last ten year, especially with the development of the consumer-driven health (CDH) plan, we have seen a movement toward health care insurance once again.

The sustainable health care solution begins by releasing the employer from the burden of picking health care plans for employees. This is particularly valuable to small and mid-sized business, let's say those under 2,500 employees which is 63% of all U.S. businesses, who are feeling the full weight of today's burden. It changes the way they perceive and pay for benefits. At the risk of straining the comparison, these employers can reduce their "benefits footprint". They can define their contribution to employee benefits and allocate a benefits budget to each employee – a dollar amount which is set by the employer rather than the insurance company – it is an amount employers can live with and manage, not just today but year over year. Imagine, instead of facing double-digit premium increases every year – usually unpredictable increases, about the only thing certain is that they will go up – your employer can now budget for benefits costs over several years and build in a reasonable, acceptable annual increase.

In stark contrast to today's *planned* economy of employee benefits – a huge industrial machine which is driven from the top in the hands of the big insurance carriers and which has created

inefficiencies and higher costs at reduced quality – health care now enters a consumer-centric era based on a *market* economy where businesses and consumers decide of their own volition whether and what they will purchase. Practically speaking, employers no longer pick the insurance plans; they instead offer their employees a range of choices in a benefits marketplace where employees can address their own demands and needs for health and wealth benefits. This brings up inconvenient insurance truth number four: The experience of over 3 million individuals shows that consumers purchase a wide range of health insurance policies in the open market to meet their clearly differing needs – far more variety than in a typical employer-based insurance offering.

So let's go back. As an employee with your employer-allocated benefits dollars in your pocket, you enter the new benefits marketplace which is sponsored by your employer and which offers a range of plans and programs to choose from. One of the important features of this new marketplace for benefits consumers is that it broadens the number and types of available options and yet still offers many of the advantages of group insurance – negotiated rates, coverage guarantees, and the like. Think of this as a *virtual* marketplace that you get into through the Internet. In this new marketplace, right there among all the other more traditional coverages, you find an interesting new medical insurance plan – a consumer-driven health (CDH) plan. It makes pretty good sense, offering a much lower premium and a higher deductible before the insurance coverage kicks in. Now, let's say that there are decision support tools on the Internet to help you understand these new plans and see if they're right for you.

Ready for the fifth inconvenient insurance truth? For 60% to 70% of all consumers, a CDH plan will save them money. This stands in stark contradiction to the industry data which shows that fewer than 10% of employees actually enroll in these plans today. But most people have healthcare expenses that are well under the CDH deductible, and more importantly, the scale of their savings in the CDH plan is far more significant than the possible risk. Combine this with the fact that CDH plans generally come with a health savings account (HSA), and consumers can now set aside pretax dollars to cover their deductible. These savings accumulate year to year, even earning their own interest, so the consumer has money for health care when they retirement. Which is important, when you consider that according to Fidelity Investments, the average couple will have medical expense of around $225,000 in retirement.

But you might ask how all this add up to a sustainable health care system? Remember at the beginning we said that the goal was to examine a *systemic change rooted in human behavior*. Well first, CDH plan enrollees are more likely to have annual physicals, participate in wellness programs and meet preventive care guidelines that those in other types of plans. One study demonstrated that people in

CDH plans are 25% more likely to follow healthy behavior guidelines, 20% more likely to participate in company-sponsored wellness programs and 30% more likely to have annual physicals. When asked why, CDH members routinely said that preventive medicine saves them money in the long run. And they are right, wellness programs and preventative care procedures are early interventions which promote healthy lifestyles, catch conditions early, and reduce overall medical care costs.

And too, various studies over the past couple of years provide direct evidence that people in consumer-centric plans become active health care consumers. CDH members are 50% more likely to inquire about cost, 33% more likely to identify treatment alternatives, and 3 times more likely to choose a less expensive, less extensive treatment. Hospital admissions go down, although cost per admissions increases slightly, indicating that consumers are not foregoing high-cost, non-discretionary spending. The number of office visits is similar between CDH and non-CDH members, but the cost per visit is over 10% less, suggesting that consumers spend their money more wisely and are more cost-conscious. In the area of prescription drugs, compliance rates are 23% higher among CDH participants than people in traditional plans, and medication compliance for chronic conditions improves significantly. CDH members are 20% more likely to report that they follow overall treatment regimens for chronic conditions very carefully. And there is a significant reduction in emergency room visits. By every measure, consumerism results in dramatic reductions in what people pay to receive health care services – 12% lower in one study relative to the costs for HMO and PPO members.

Most importantly, every study concluded that the greater consumer sensitivity of the CDH member results in a significant reduction in health care *premiums,* as well. The inflationary trend in premiums for CDH plans has shown to be less than half the trend of traditional plans. Debunking the concern that CDH plans have lower trend because they are attracting only healthier people, one insurance industry study showed that employers who moved all employees into CDH plans had the lowest annual trend – only 1.6%. Another study demonstrated that CDH members had 5.6% annual trend, versus 14.1% for similar members in traditional plans. And yet another showed that after adjusting for demographics, health status and geography, the cost trend for CDH plans was a 3%-5% *decrease* versus an 8% to 10% increase in the PPO plans.

Human behavior *does* change the system. But we face the same challenge that Al Gore does: how to get people to behave in a new way, to embrace change, and to make decisions for their own good? The answer . . . tell them the truth, give them all the numbers, give them new tools to understand the numbers, give them recommendations, and most important, give them credit for being intelligent and acting rationally. Ultimately, people need a convenient way to act on the decision they

make. Treated this way about 70% of an employee population will make the decision to enroll in a consumer-centric plan.

But is it *green* . . . is the system sustainable? Well, employers reduce their costs and establish a solution that makes their benefits budgets predictable for the next ten years or more. Employees reduce their premiums and begin saving for future health care needs. And consumers act in ways that reduce the inflation in the system. It all holds together because it has an interior logic, the pieces fit and support one another. There is an integrity to it that is lacking in today's system.

As Al Gore said, "The good news is we know what to do. The good news is, we have everything we need now to respond to the challenge. We have all the technologies we need, more are being developed, and as they become available . . . they will make it easier to respond. But we should not wait, we cannot wait, we must not wait."