

Benefit Insights

Consumer-Directed Health Plan Update: Enrollment Grows, Enrollees Satisfied with Coverage

The number of people enrolled in consumer-directed health plans continues to grow, and satisfaction with these plans remains high, according to several recent surveys. Furthermore, many of those covered by consumer-directed plans say they wouldn't have health insurance coverage otherwise, indicating that consumer-directed plans should be considered a key element of any health care reform proposals.

The Kaiser Family Foundation/Health Research & Educational Trust reports that 13% of firms that offered health benefits in 2008 had a consumer-directed option—a high deductible health plan (HDHP) paired with either a health reimbursement arrangement (HRA) or a health savings account (HSA). This is up from the 10% of employers that offered a consumer-directed plan in the previous year. Enrollment in these plans grew from 5% in 2007 to 8% in 2008, with most of the increase occurring among workers in small firms (three to 99 employees), where 13% of eligible employees now were enrolled in consumer-directed plans.

An annual census of health insurance carriers conducted by the industry trade group America's Health Insurance Plans shows similar growth. The survey, which focused on HDHP/HSA arrangements only, reported enrollment in these plans in the group market rose to over 4.6 million in 2008, up from 3.4 million in 2007. Almost a third—31%—of new coverage issued in the small group market was for HDHP/HSA products.

The growing number of employees covered by consumer-directed health insurance products report that they are, by and large, satisfied with their coverage, and they also are likely to be actively engaged in their health care. A survey by

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OptumHealth of individuals enrolled in HSAs found that 82% were satisfied with their accounts. Most of these individuals—80%—had set up HSAs in order to be able to save for future health care expenses, and 70% had an annual income of \$75,000 or less. Also, 30% said they would not have health insurance if it weren't for their consumer-directed plan coverage.

Both the respondents to the OptumHealth survey and those to a survey by HSA Bank reported behaviors indicative of engaged health care consumers. For example, 64% of the OptumHealth survey respondents said they inquired about generic options for medications and 47% said they asked their health care provider about charges for services. Furthermore, a large majority—83%—agreed people should approach purchasing health care services as they do other major consumer purchases, and research their options in an effort to try to get the best price. Among the respondents to the HSA Bank survey who were in a consumer-directed product:

- 26.2% of those who had visited a doctor in the past 12 months had inquired about the cost of the visit prior to making the appointment.
- 32.9% of those who had visited a doctor in the past 12 months had asked about lower cost alternatives for recommended treatments.
- 79.5% of those who were prescribed a prescription drug asked for a generic instead of a brand name product.

With continued growth of consumer-directed plan enrollment, and cost-conscious consumer habits, these types of plans hold great potential for effectively controlling a company's health plan cost growth.

What a great time for you and your employees to incorporate a Wellness Program within your organization! Get out and enjoy the summer weather - a brisk walk, gardening in your backyard or bike riding are all great ways to keep you heart-healthy and active. Please have a safe and fun summer!





Employees' Health Risks Linked to Lower Productivity, Financial Cost

While logic tells us that healthier workers are likely to be more productive than those with health risks, a recent study confirms this, finding that individuals with a number of health risks have seven times more lost productivity than those with no identified health risks. Health risks most strongly associated with on-the-job productivity loss were back pain, mental well-being (depression) and stress. Also, the chances of productivity loss rose as the number of health risks increased.

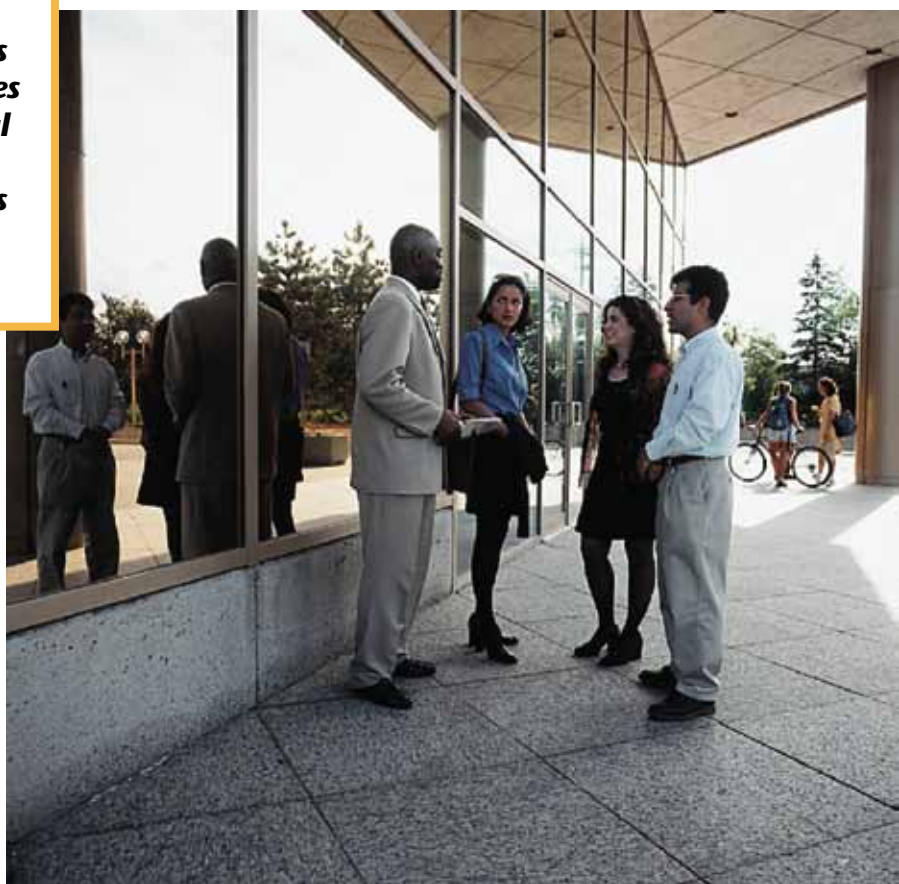
The study, published in the *Journal of Occupational and Environmental Medicine* and conducted by StayWell Health Management researchers and John Riedel, a health and productivity expert, included data from 106 companies in five industry sectors, representing responses from nearly a quarter of a million individual employees. Questions on health and work performance were incorporated into the companies' health risk assessments to collect the data. Employees considered to be at low risk were classified as a NIF (Normal Impairment Factor) group. According to the study, "NIF captures the amount of productivity loss experienced by individuals who are at low risk... thus representing the level of productivity loss that health improvement initiatives targeting these risks will not affect." Thus, the NIF essentially serves as a benchmark to gauge the amount of productivity loss that could be eliminated through various health risk reduction strategies.

The study included eight health risk areas: alcohol use, back pain, driving, physical activity, stress, tobacco use, weight and mental well-being (depression). Productivity loss was consistently associated with "at risk" health status for all of these factors, with the greatest productivity loss observed for those at risk for back pain, stress and mental well-being. Individuals at elevated risk for back pain reported 13% more productivity loss than those at low risk; those at risk for depression reported 7.4% greater productivity loss; and those at risk for stress reported 4.8% greater productivity loss. When measured as lost time, ongoing back pain was responsible for 5.7 weeks of lost productivity each year, depression for 2.4 weeks, and stress for 1.1 weeks. Thus, according to the study, these three areas present the greatest potential for productivity improvement through intervention, such as targeted wellness initiatives.

For employers, a study such as this one provides ample financial justification for investments in wellness initiatives.

Greater productivity loss also was observed among individuals who had multiple health risks. Individuals in the study had an average of 2.4 health risks each, and each additional risk increased productivity loss by 2.4%. An individual with all eight risk factors experienced a productivity loss of 24%.

How do these estimates of productivity loss impact an employer's bottom line? The researchers calculated that an employee with low health risks experiences an average of \$1,472 per year in lost productivity, while a "more typical" employee with three health risks averages \$5,952. The study



estimates that if 100 people with three health risks were to eliminate just one health risk, this could mean productivity gains worth \$149,400 for an employer.

For employers, a study such as this one provides ample financial justification for investments in wellness initiatives. Looking at the dollar cost of productivity losses brought about by employees' health risks, it's easy to see that targeted interventions aimed at reducing employees' health risks for identified conditions or behaviors can readily result in a return that exceeds the investment made in such initiatives.

What Goes into Determining the Cost of a Prescription Drug?

Prescription drug costs continue to be one of the fastest growing components of total health care costs. According to a 2008 report from the Kaiser Family Foundation, spending in the United States for prescription drugs in 2006 was \$216.7 billion, more than five times what it was in 1990. Though spending for prescription drugs was one-third of that for hospitals and half of that for doctors' services, the annual rate of increase for spending on prescription drugs has exceeded that for these other services in all but one of the last 11 years.

Nearly half (44%) of spending for prescription drugs is paid for by private insurance, and since employers are the principal source of health insurance coverage in the United States, they fund a major portion of the spending for prescription drugs. Therefore, it's worthwhile for employers to understand the factors that go into the ultimate cost of the prescription drugs that are paid for, in part, by employee benefit plans.

When a new drug is first brought to market, the company that developed it enjoys some patent protection for the drug, which gives that company the exclusive right to sell that drug in the market for a certain period of time. This protection is intended to help pharmaceutical companies recover some of the cost of drug research and development, which can be substantial. By providing patent protection for a period of time, companies are encouraged to take the financial risk associated with new drug development. Only after the patent protection has expired can competitors bring lower-cost generic versions of the same drug to market.

When a company develops a new drug, it decides what price to charge for it, taking into account factors such as the research and development costs associated with the drug; whether other, different drugs with similar therapeutic effects are available; market demand; the current economic and

competitive climate; and advertising costs and marketing strategy. While in some other countries governments play an active role in setting the prices for prescription drugs, this is not the case in the United States.

The price a drug manufacturer sets for its product is just the first piece of the equation that determines what the drug ultimately costs at the time it is dispensed to the consumer. Health plans and pharmacy benefits managers (PBMs) will negotiate with pharmaceutical manufacturers for discounts and rebates on their prescription drug products. The success of such negotiations and size of incentives achieved can vary significantly depending on a number of factors, including the utilization volume of the plan/PBM for the manufacturer's products, placement of the manufacturer's products on a plan formulary or preferred drug list, etc. Health plans and PBMs also can save costs by trying to achieve savings at the pharmacy level of the prescription drug distribution chain. This can be done by establishing networks of preferred pharmacies that agree to accept an established reimbursement rate in exchange for being included in the network, and by setting up or working with mail-order pharmacies.



Though these factors that establish the price of a prescription drug are out of an employer's hands, there are things that any company with a prescription drug benefit can do to have some impact on what prescription drugs will ultimately cost the plan. Effective plan designs that encourage the use of generics and other preferred medications and that succeed in getting employees to use preferred and mail-order pharmacies can dramatically lower plan spending on prescription drugs. Working with a PBM or health plan that is proven effective with these strategies can be key in getting the most for your prescription drug dollar.

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for the insured; renovations to adapt a home or auto to any disability brought about by the medical condition; or an extravagance, such as a family vacation following the insured's recovery.

Employees should see critical illness insurance as part of a sound financial plan: By providing a source of flexible income, it fills a gap that remains even if an individual has medical, life and disability coverage. Critical illness insurance is available in the individual market, but approximately three-quarters of these policies are sold in the work-site voluntary market, according to data from the Critical

Illness Insurance Market Survey, co-sponsored by Gen Re LifeHealth and the National Association for Critical Illness Insurance. Advantages to buying the coverage in the group setting can include premium discounts, relaxed underwriting, and the convenience of readily learning about the product through worksite marketing and of paying premiums through payroll deduction.

As noted above, it costs an employer nothing to add critical illness insurance as a voluntary coverage, yet to do so can help an employer become more competitive in attracting and retaining the best employees.

Critical Illness Insurance Gives Employees a Financial Safety Net

If you provide your employees with health, disability and life insurance coverages, they're receiving important protection against the financial burdens that can befall a family when an illness or injury strikes. Yet, these coverages alone may not be enough to prevent severe hardship, in the event that an illness or injury is extended or severe, requiring expenses beyond those covered by these other types of insurance.

Critical illness insurance, offered to employees on a voluntary basis, is a no-cost way for employers to help employees affordably prepare for the range of expenses—medical and non-medical—that can accompany certain potentially life-altering medical conditions. Critical illness insurance is more important today than ever before, as individuals are living longer and consequently more likely to experience a heart attack, stroke or cancer. Plus, as treatments for severe medical conditions have improved and people are more likely to survive, a range of costs associated with recuperation have replaced funeral costs.

What exactly is critical illness insurance? Critical illness insurance is a type of insurance with benefits triggered by the diagnosis or onset of a medical condition specified in the policy. Though these will vary policy to policy, covered medical conditions can include cancer, heart attack, stroke, kidney failure, paralysis, the need for an organ transplant, or blindness or loss of hearing or speech.

The key feature to understand with critical illness insurance—and what distinguishes it from medical insurance—is that benefits are paid when the triggering event occurs, not when the insured individual incurs any expenses associated with the medical condition and seeks reimbursement for them, and these benefits can be used for whatever purpose the insured sees fit. So, for example, critical illness insurance benefits can be used to pay for: experimental treatments that would not be covered under a health insurance policy; at-home care to assist with everyday activities, such as cooking and cleaning, for an individual recuperating at home from a heart attack; childcare to enable a stay-at-home spouse to spend time in the hospital with the insured; replacement wages to enable a working spouse to stay at home to care



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