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HEALTH

Perspectives

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Determining if a CDHP Makes Sense for Your Business

by Thomas Kess

Many employers wonder if a Consumer Driven Health Plan (CDHP) will work for their company. The potential CDHP plan might be any healthcare benefit

option that includes either a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA).

The strategic decision for choosing or not choosing a CDHP, requires a) clear objectives, b) a determination of financial feasibility, and c) an assessment of the organization's and employees' readiness for adopting a CDHP.

CLEAR OBJECTIVES

While employers often have multiple reasons for considering a CDHP, it is important to identify and prioritize these objectives since they will determine both the criteria for deciding for or against a consumer driven health plan and the program design, should a consumer driven strategy be selected. Five common objectives are:

- cost control
- competitive benefits
- tax savings
- health and productivity
- test the concept

If cost control is a primary objective, financial feasibility needs to be carefully assessed. For long-term cost control, the CDHP needs to be viewed as part of a broader healthcare strategy designed to change employee and family member behaviors. The most cost effective healthcare benefit strategies involve multiple, well-integrated programs to improve health. A cost control objective will require a careful examination of the current programs, the size of the gap between what exists and what is needed, and the company's willingness to close this gap.

If the primary objective is to offer a benefit option that will improve the employer's ability to compete for talent, the strategic decision will be based on whether a CDHP is an efficient way to attract and retain employees. An employer will need to examine employee compensation preferences and the value of offering a CDHP to create a "leading edge" image. A CDHP may appeal to some new hires by offering a medical benefit option that maximizes current spending power (e.g. through low premium, high deductible plans). For other new hires, the ability to accumulate tax advantaged savings through the medical plan may attract them to this particular employer.

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For some employers, the main reason for considering a CDHP may be to provide savings for healthcare needs in retirement using available tax advantages. Financial feasibility for this purpose means the ability of account balances to accumulate over time while maintaining acceptable levels of healthcare benefit costs. With greater tax advantages, Health Savings Accounts (HSAs) will be the likely vehicle of choice. The analysis will need to consider employer funding and employee contributions in the context of employee income levels, health spending patterns, and current levels of employer/employee cost sharing.

A number of employers are convinced that the indirect costs of poor health on productivity and absenteeism are considerably larger than direct healthcare benefit costs. For these employers, the primary reason to consider a CDHP might be its potential, through financial incentives, to get employees actively involved in improving and maintaining their health.

Other employers not driven by any of the preceding primary objectives for considering a CDHP may simply wonder if the concept might impact costs or attract employee interest. Curiosity and a desire to test the concept define this approach. Unfortunately, this reason for considering a CDHP has the greatest potential for failure, and may underlie many of the low CDHP enrollments reported by early adopters. Without a clear objective, employers who simply want to test the concept are less likely to make the investments necessary for an effective CDHP.

DETERMINE FINANCIAL FEASIBILITY

Financial feasibility is a way of quantifying the potential of a given strategy to meet the employer's various objectives. As such, determining financial feasibility is a key part of the decision making process when an employer is contemplating a CDHP. The employer should also consider organizational factors and employee impact.

Clear objectives focus a financial analysis on relevant issues and determine the criteria for assessing feasibility. For example, a cost control objective directs attention to the ability of a CDHP to reduce healthcare costs or hold the line on increases, whereas a goal of generating savings for healthcare expenses in retirement emphasizes account balance accumulations. Similarly, the standard for assessing the ability of the CDHP to impact healthcare costs will be more stringent for a cost control objective than for an objective of improving health and productivity or of being competitive in the marketplace.

Regardless of the primary objective, determining financial feasibility of a CDHP is an important step. Employers do not need to base an important decision about healthcare benefit strategy on the hope that what worked for another company will also work for them, or on the "best-guess estimates" offered by a well-meaning advisor (broker, banker or consultant). Actuaries equipped with data and tools can provide reliable cost projections that enable an employer to make an informed decision.

To provide reliable answers, an effective

analysis of financial feasibility will be all of the following:

- data-driven
- customized
- multi-year
- dynamic

An actuary conducts a data-driven analysis by using the employer's historical claims, enrollment and member data, and applying well-researched statistical relationships among key variables to project utilization and costs. A customized analysis starts with the employer's own data, and applies the employer's health plan options and pricing to develop enrollment and cost projections. A data-driven, customized analysis considers healthcare spending patterns, member characteristics such as age, gender, health risk and location, and the cost sharing provisions and contribution requirements of the CDHP and other plan options.

Multi-year analyses are more important for CDHPs than for traditional healthcare benefits because growing healthcare account balances can affect member behavior. The impact of a high deductible plan with a sizeable gap between account funding and the deductible can be expected to be different in the first year than in subsequent years if account balance accumulation significantly reduces or eliminates the gap.

Adopting a new benefit strategy can involve a degree of uncertainty. An effective financial feasibility analysis considers the impact of different assumptions and combinations of inter-related plan and member variables. Both the range of

likely potential outcomes and the degree of risk are evaluated. Reliable projections are developed based on a set of selected assumptions including plan design and pricing decisions. A dynamic, modeling capability is needed to run multiple scenarios and test the sensitivity of assumptions.

Determining feasibility often does not result in a “yes” or “no” answer. An effective feasibility assessment should identify the conditions necessary to achieve the desired results. The employer needs to consider what it will take to close a gap between the current state and the conditions identified. Evaluating the gap and the organization’s willingness to close the gap are the focus of assessing organizational and employee readiness.

ASSESSING ORGANIZATIONAL AND EMPLOYEE READINESS

Once the financial feasibility assessment identifies the conditions and assumptions necessary for the projected financial results to be obtained, an employer needs to consider how well it currently meets those conditions. If the gap between the necessary conditions and the current state is significant, the employer may decide against a CDHP or may determine that a multi-year implementation strategy is needed.

Typically, a CDHP will necessitate changes in the organization’s infrastructure such as data and payroll systems, since these systems will need to capture and transmit account funding and contributions to outside vendors. New or different vendors may be

needed to administer the CDHP and, in the case of HSAs, process account transactions and investments. Additional resources, including education, information, and comparison tools may be needed to meet the needs of engaged consumers. A CDHP will also require establishing administrative policies and procedures for such matters as processing account balances when life events such as divorce or death occur.

A systematic evaluation of an employer’s infrastructure can determine what is already in place and what is needed to support a consumer driven healthcare strategy. A consultant with practical, hands-on CDHP implementation experience can assist the employer in making a comprehensive assessment.

In addition to system and administrative changes required by a CDHP, healthcare support programs may need to be enhanced, both in the breadth of program offerings and in the intensity of the programs. An effective CDHP often requires strong programs for promoting wellness, healthy lifestyles and preventive care as well as effective programs to assist members with chronic diseases or complex medical needs.

Organizational and employee readiness also involves less tangible matters such as executive understanding and support of CDHPs and employee awareness and perceptions. Key questions include: how do executives view the use of employee time to research medical costs and information, do employees understand their own potential to affect their health and impact healthcare

benefit costs, and are employees willing to assume a healthcare consumer role? Interviews, focus groups, and surveys can be used to evaluate perceptions and determine the gap in understanding and information.

The readiness of the organization and its employees help determine whether to adopt a consumer driven strategy and, if so, what needs to be done, and the time and resources it will require. If a large investment is needed to close the gap, an employer may decide to stay with a more traditional healthcare benefit strategy. If a CDHP is a feasible way to achieve a clearly identified objective, organizational and employee readiness will impact the implementation plan and its timetable.

The answer to the question; will a CDHP work for my company is unique for every organization. By clarifying the primary objective, assessing financial feasibility, and evaluating organizational and employee readiness, an employer can make an informed business decision. Since healthcare costs are possibly the employer’s fastest growing expense, a reliable basis for making this strategic decision is important. With the actuarial tools and resources available, an employer can obtain reliable, customized, data-driven answers and need not rely on rough estimates or the hope that what worked in another company will work for them as well.

Administrative Staffing and Cost Trends: Which Direction Do the Arrows Point?

by Andrew Naugle



Since 1996, Milliman has been collecting and analyzing administrative staffing and cost information from managed care organizations, insurance companies,

and third-party administrators. Today, the Milliman Health Plan Operations Benchmark Database contains functional-area staffing and cost information from more than 100 organizations representing a diverse sample of industry participants.

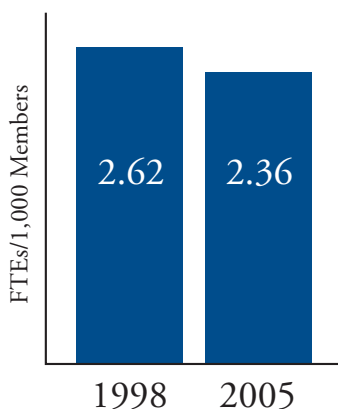
Milliman uses the database's data to perform benchmarking analyses and operational assessments for Milliman clients, and to conduct research regarding administrative staffing and cost trends. In one of our most recent studies, Milliman examined administrative staffing and cost trends by major functional area for the period between 1998 and 2005. Highlights of our analysis are provided in this article. Full study results will be published in an upcoming Milliman Research Report that is anticipated for release in early 2007.

ADMINISTRATIVE STAFFING OBSERVATIONS

Our first step was to analyze total staffing in full-time equivalents per 1,000 members (FTEs/1K) by comparing aggregate 1998 staffing levels

to aggregate 2005 staffing levels. During this defined period, total staffing decreased by approximately 10% or 0.26 FTEs/1K as shown in Figure 1.

*Figure 1
Overall Staffing Trend
1998 to 2005*



This staffing decrease is not surprising. Managed care organizations have heavily invested in technologies, made policy changes, and improved processes with the goal of streamlining their administrative operations.

To better understand the departments that contributed to the overall decrease, we analyzed staffing by functional area. We identified significant variance among the different administrative functions. Figure 2 shows the distribution of functional areas by magnitude of total staffing trend over the period studied.

Staffing in the Claims Administration and General Administration areas showed the greatest percentage decreases, while staffing in the Information Technology, and Enrollment and Billing areas showed the greatest percentage increases. We also observed moderate increases and decreases in other departments. Results by functional area are shown in Figure 3 on page 5.

This analysis showed that although there was a 10% net decrease in total staffing (0.26 FTEs/1K), staffing actually increased in some functional areas and decreased in others. We next analyzed the contributions that each functional area made to the overall staffing decrease. We identified four functional areas where staffing increased

*Figure 2
Magnitude of Staffing Trends by Functional Area*

Administrative Staffing Trends by Trend Magnitude (1998 - 2005)			
Greater than 25% Decrease	1% to 25% Decrease	1% to 25% Increase	Greater than 25% Increase
Claims Administration General Administration	Other Healthcare Services Finance and Underwriting Provider Administration Sales and Marketing	Customer Service Medical Management	Information Technology Enrollment and Billing

(“Growth Areas”) and six functional areas where staffing decreased (“Shrinkage Areas”). These ten functional areas and the staffing change in FTEs/1K are shown in Figure 4.

As shown in Figure 4, total staffing among all functional areas decreased by 0.26 FTEs/1K. This net decrease is the result of six functional areas showing a total decrease of 0.42 FTEs/1K, offset by four functional areas exhibiting a total increase of 0.16 FTEs/1K.

Figure 3
Staffing Trends by Functional Area

Total Staffing (FTEs/1K)	Percent Change in Staffing (1998 - 2005)
Enrollment and Billing	27%
Information Technology	26%
Medical Management	16%
Customer Service	15%
Other Healthcare Services	-7%
Finance and Underwriting	-14%
Provider Administration	-16%
Sales and Marketing	-22%
Claims Administration	-25%
General Administration	-43%

Of the growth areas, approximately 31% of the increase was attributable to staffing increases in the Information Technology area. The remainder was distributed among Enrollment and Billing, Customer Service, and Medical Management.

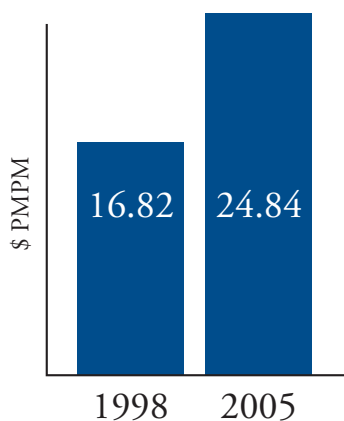
Of the shrinkage areas, approximately 83%

of the total decrease was attributable to staffing decreases in Claims Administration, General Administration, and Sales and Marketing. The remainder was distributed among Other Healthcare Services, Finance and Underwriting, and Provider Administration.

Figure 4
Contribution to Total Staffing Trend by Functional Area

Functional Area	Real Change in Staffing (FTEs/1K)	Percent of Change
Information Technology	+0.05	31.25%
Enrollment and Billing	+0.04	25.00%
Customer Service	+0.04	25.00%
Medical Management	+0.03	18.75%
All Growth Areas	+0.16	100.0%
Other Healthcare Services	-0.01	2.38%
Finance and Underwriting	-0.03	7.13%
Provider Administration	-0.03	7.13%
Sales and Marketing	-0.10	23.75%
General Administration	-0.11	26.37%
Claims Administration	-0.14	33.24%
All Shrinkage Areas	-0.42	100.0%

Figure 5
*Overall Administrative Cost Trend
1998 to 2005*



ADMINISTRATIVE COST OBSERVATIONS

Notwithstanding a decrease in total staffing, total administrative cost per member per month (PMPM) increased by approximately 48% (\$8.02 PMPM) during the period of the study as shown in Figure 5.

Again, we identified significant variances among the functional areas and their contributions to the overall cost increase. Figure 6 shows the distribution of functional

areas by magnitude of administrative cost trend over the period studied.

Not surprisingly, the Information Technology area showed the most significant cost increase on a percentage basis. Cost increases for Medical Management and Other Healthcare Services were also very significant. We observed more moderate cost trends in other functional areas. Results by functional area are shown in Figure 7 on page 7.

In contrast to the staffing analysis shown in Figure 4 on page 5, none of the functional areas exhibited a decrease in administrative costs, although cost growth for the Claims Administration area was flat. The ten functional areas and their contribution to the overall administrative cost increase are shown in Figure 8 on page 7.

Approximately 74% of the total cost increase was driven by cost increases in Information Technology, Medical Management, Other Healthcare Services, and Customer Service. The remaining 26% of the increase was driven by the five

remaining areas.

CONCLUSIONS

Although it is difficult to infer specific market conditions or dynamics that contributed to the various staffing and cost trends observed in this study, there are a few factors that likely had a significant impact:

- **Impact of Y2K and HIPAA on Information Technology:** A comparison of staffing and cost trends by year suggests that the Y2K and HIPAA system conversion projects contributed to significant increases in staffing and cost for the Information Technology functional area. It is interesting to note that although staffing reductions in the Information Technology area appear to begin in 2003, 2005 IT staffing levels remain approximately 26% higher than 1998 levels, implying that organizations are continuing to invest in IT infrastructure and system maintenance.
- **Impact of Consolidation on Sales and Marketing, and General Administration:** A year-to-year analysis of staffing in the Sales and Marketing and General Administration

Figure 6
Magnitude of Cost Trends by Functional Area

Administrative Cost Trends by Trend Magnitude (1998 - 2005)			
Less than 50% Increase	50% to 100% Increase	100% to 150% Increase	Greater than 150% Increase
Claims Administration Provider Administration Sales and Marketing General Administration	Enrollment and Billing Finance and Underwriting Customer Service	Medical Management Other Healthcare Services	Information Technology

areas reveals a steady decline in both areas leveling off in 2003. This may be a result of consolidation in the managed care industry and the spreading of overhead FTEs over larger memberships.

- **Outsourcing of Other Healthcare Services:** The data shows a 7% decrease in staffing for wellness and other non-medical management related activities focused on reducing care utilization and cost. This

Figure 7
Cost Trends by Functional Area

Administrative Cost (PMPM)	Percent Change in Administrative Cost (1998 - 2005)
Information Technology	168%
Medical Management	122%
Other Healthcare Services	121%
Customer Service	82%
Enrollment and Billing	77%
Finance and Underwriting	56%
Provider Administration	22%
General Administration	15%
Sales and Marketing	6%
Claims Administration	0%

decrease is coupled with a 121% increase in costs for this function. Outsourcing of programs such as smoking cessation, healthcare information, and other wellness programs may be a contributor to these cost increases.

- **Investments in Customer Service and Medical Management:** Both staffing and cost increases were observed in Customer Service and Medical Management. This implies that organizations continue to invest in these functions. While investments in Medical Management tend, in theory, to be offset by reductions in healthcare cost and

utilization; investments in Customer Service tend to be driven by customer demands.

In conclusion, the results of this analysis suggest that although organizations have been successful at reducing administrative staffing levels, administrative cost levels have continued to rise. These cost increases are partially attributable to the rise in wages over the period studied; however, this explains only a portion of total increase. More detailed findings from this study will be available in early 2007 as a Milliman Research Report.

Figure 8
Contribution to Total Cost Trend by Functional Area

Functional Area	Real Change in Cost (PMPM)	Percent of Change
Information Technology	\$2.52	31.42%
Medical Management	\$1.39	17.34%
Other Healthcare Services	\$1.09	13.59%
Customer Service	\$0.92	11.47%
Finance and Underwriting	\$0.73	9.10%
Enrollment and Billing	\$0.50	6.23%
General Administration	\$0.37	4.61%
Sales and Marketing	\$0.25	3.12%
Provider Administration	\$0.25	3.12%
Claims Administration	\$0.00	0.00%

Long-Term Care Coverage: Employers' Perspective

by Jonathan Shreve and Jill Van Den Bos



While most Long-Term Care (LTC) insurance is sold on an individual basis, more employers have begun to make it available to employees and their families. Almost 25% of policies sold in 2001 were sold through employers, according to the Health Insurance Association of America. Clearly, LTC products for employers represent



a dynamic element of the current LTC insurance market.

LTC insurance offered through the workplace may be in the form of traditional group products, or in the form of worksite marketing of individual LTC insurance products. Group products usually include much lower commission rates and a lower level of underwriting for employees. Otherwise, these “group” or “true group” LTC insurance products mimic individual products.

What if insurers approach the design of LTC insurance products more like the design of other group products such as medical and pension benefits? What might such products look like and what would their advantages be over currently available group products?

CURRENT GROUP PRODUCTS - WHAT IS MISSING?

Current employer products provide a few attractive features for employers and employees. First, they provide ease of enrollment through mass education at the workplace and convenience of payroll deductions as a means of paying for coverage. Second, obtaining LTC coverage through an employer is less expensive than purchasing an individual policy due to the savings in commissions.

While attracting quality employees and reducing employee turnover are commonly stated goals of employee benefit plans, most employee benefits have the primary purpose of providing a financial safety net for employees. In particular, LTC insurance is a key protection for retirement savings. In current dollars, a five-year nursing home stay would cost over \$300,000, and it could easily eat up all or most of the benefits a

couple has accumulated in their retirement accounts. Thus, the lack of a LTC benefit can seriously undermine the value of retirement benefits.

TRUE GROUP LONG-TERM CARE

Today's employers face a dilemma on how to offer LTC insurance. They can choose to offer it as a voluntary, employee-paid benefit. The high cost to the employees, however, results in low participation. Or they can offer it with an employer contribution toward the cost to achieve higher enrollment, resulting in high cost for the employer. The problem is that current LTC designs are not consistent with other employer-sponsored lifelong benefits offered only to longer term employees that include a partial employer contribution to cost. Employer-sponsored LTC insurance is more likely to gain momentum if it is redesigned into a “true group” employee benefit. Group features common for retiree

Table 1
Contrast of True Group and Voluntary Long-Term Care Plans

True Group Long-Term Care	Convenience Long-Term Care
Employer Contribution	No Employer Contribution
Targeted at long-term employees using waiting periods and/or vesting	Participation available to all employees immediately
Plan offered to dependents, if it meets employers' objectives	Plan offered to spouses, parents, retirees, others to maximize insurance company prospecting
Benefit design set by employer and may be changed	Benefit design set by insurer and immutable
Possibly self-funded or alternate financing	Always fully insured
High participation expected, providing meaningful safety net	Participation as low as 1-2%; in best cases up to 15%

medical and pension benefits, for example, include waiting periods, vesting, employer contributions toward cost, and possibly self-funding or alternate funding.

A summary of the differences between true group (as we define it) LTC coverage and current employer LTC coverage is presented in Table 1 on page 8.

VESTING AND WAITING PERIODS

In a true group LTC plan, the employer takes on some of the financial responsibility for the LTC benefits of its employees. As a result, the employer can share cost with employees and limit its exposure only to those employees who are employed for a longer term, thus reducing its costs. The plan design features that achieve all these objectives are employer contributions, waiting periods, and vesting.

A waiting period stipulates that employees be employed for a certain time period before they can participate in the plan. Waiting periods take place prior to the beginning of vesting periods and reduce administrative costs for short-term employees as well as overall costs because fewer employees participate. They are also fairly easy to administer. Typical waiting periods for pension plans are 3 months, 6 months, 9 months and 12 months.

Vesting rules determine the “ownership” of the employer contributions to the plan made on behalf of an employee once an employee leaves employment. Vesting rules indicate whether departed participants are

Table 2
Vesting and Waiting Period Savings (No Employee Contribution)

Vesting Period	Savings Over Plan Without Vesting or Waiting Period		
	No waiting period	1 year waiting period	2 year waiting period
0 years	0%	12%	25%
5 years	44%	44%	46%
10 years	51%	51%	52%
20 years	61%	61%	62%
10 years & Age 50	55%	55%	55%

Source: Milliman Inc., Milliman Long-Term Care Model

eligible for benefits funded by employer contributions. Generally, cliff vesting (100% of employer contributions after entire vesting period of employment, and none otherwise) is advisable for a group LTC plan due to ease of administration and communication to participants. Reasonable choices are five and ten year cliff vesting.

Waiting periods and vesting requirements can have a significant impact on cost. For a standard group LTC benefit plan, some options and the approximate resulting savings are presented in Table and Table 3 on page 10. All savings are stated relative to a plan in which the employer pays 100% of the benefit cost, without waiting periods or vesting. The actual values will vary, depending on an employer’s turnover rates and age distribution.

In designing a true group plan, the employer would almost certainly want to pay contributions only for the expected working life of the employee - to age 65, for example. The employer may choose to have employee participants pay premiums for life. This

enables the employer-paid benefits to be fully accrued during the employee’s working life while keeping premium payments for the employee as low as possible.

For example, a rich benefit plan with immediate vesting, no waiting, and no employee contribution might cost \$250 per employee per month – exorbitantly expensive. However, with 50% employee contribution, a 10-year vesting period, and a 1-year waiting period, the employer cost would be reduced by 85% to \$37.50 per employee per month. Other benefit design changes could further reduce this amount.

FUNDING ALTERNATIVES

Except for the largest groups, there has only been one option available to employers who wish to provide LTC coverage, and that is a fully-insured option. Self-funding, common for other employee benefits such as pension, provides some flexibility and possibly cost savings for an employer. Over time, we expect to see more self-funding or “alternate funding” arrangements for employer LTC coverage.

Table 3*Vesting and Waiting Period Savings (50% Employee Contribution)*

Vesting Period	Savings Over Plan Without Vesting or Waiting Period		
	No waiting period	1 year waiting period	2 year waiting period
0 years	70%	74%	77%
5 years	83%	83%	84%
10 years	85%	85%	85%
20 years	88%	88%	88%
10 years & Age 50	86%	86%	87%

*Source: Milliman Inc., Milliman Long-Term Care Model***SELF-FUNDED PLAN**

A self-funded plan is one in which employers and/or employees contribute to a fund, using a schedule of contributions over time. The money in the fund is invested to help grow the fund over time, and LTC benefits are paid out of the fund. Such a fund would necessarily need to purchase certain administrative services such as medical underwriting, benefit eligibility determination, and case management. Other needed services would also include ongoing help in actuarial valuation and investment management. Insurers (or firms that provide services to insurers) are the most likely candidates to provide such services since the personnel and expertise are already in place.

ADVANTAGES OF A SELF-FUNDED PLAN

The advantages of a self-funded plan to an employer are control and cost. Self-funded plans can have non-standard benefit designs, and can even change these benefits over time. Contributions for a self-funded plan can be flexible as well. If fund experience

is favorable, then an employer could decide to increase the level of benefits or decrease contributions.

DISADVANTAGES OF A SELF-FUNDED PLAN

The disadvantages of a self-funded plan to an employer are risk, hassle, and possibly taxes. Self-funding a coverage with a long time horizon, such as LTC coverage, allows time for an employer to make corrections to benefit and contribution levels and ensure adequate assets for claims payment. However, it is still riskier than a fully-insured product.

Another major disadvantage of self-funding is the hassle factor for the employer. The fund needs assistance (either internal or external) with administrative and monitoring services. If these services are not purchased by employers as part of an insured arrangement, then they will have to be purchased separately.

Current tax laws are not very favorable for self-funding. If an employer is a taxable

entity (generally, other than a government entity, Taft-Hartley fund, or non-profit), then it must pay taxes on the investment income it earns for the long-term funding of benefits.

ALTERNATIVE FORMS OF SELF-FUNDING

Most self-funding methodologies assume that an employer is operating separately from an insurer. In most other coverages, employers and insurers have entered into “alternate funding arrangements.” In such arrangements, the insurer passes aspects of the risk to the employer, while keeping the catastrophic risks and much of the benefit administration. Functions that an insurer could take on with an alternate funding arrangement include administrative functions, investment management, holding the fund balance, and taking a portion of the risk. Because of tax limitations on many employers, this approach may be the most tax effective.

WHY BOTHER?

In presentations that we have given to employers, they become much more interested in contributing to LTC plans if the cost can be lowered to a small amount per employee per month while providing meaningful coverage. The individual market products have convinced employers that the benefit is too expensive. Moving to true group coverage could open a significant market for insurers among employers.

The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) defined how LTC coverage can be

Milliman 2006 Group Health Insurance Survey

by Christopher Wanta and Doug Proebsting

offered as a tax-preferred employee benefit. More employers, including the federal government and many state governments, are making LTC insurance available through payroll deduction. But these “convenience” benefits are not consistent with the safety net provision goals of the employer due to the low participation rates among eligible employees. This low participation undermines the reasons for providing benefits in the first place, and offers little in the way of a safety net for the employee population. It seems to be only a matter of time before alternative approaches to offering and funding LTC coverage will be sought.

Health Practice's Upcoming Engagements

- 1/16/07 – Milliman Actuarial and Underwriting Training Seminar, Las Vegas, NV (Milliman Health Consultants)
- 3/22/07 – Cancer Research and Prevention Foundation National Conference, Baltimore, MD – Prevention and Early Detection: Making the Case (Bruce Pynson)



Results from Milliman's fifteenth annual survey of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) indicate a slowing of premium increases. Reported 2006 premiums for the benefit plan provided are up 6% from 2005 for HMOs, the smallest change since 1997. PPO premiums for a standard \$250

deductible benefit plan increased a modest 4% among plans responding in both 2005 and 2006.

Complete results for the Milliman 2006 Group Health Insurance Survey are now available and include premium rates and trends by component, hospital inpatient cost and utilization data, physician reimbursement levels, medical expense ratios, and profit levels. Results are provided by metropolitan area, state, region, and nationwide. Results also include information regarding the implementation of Consumer Driven Health (CDH) products and disease management programs.

Contributing factors to increasing insurance premiums may include an aging population, rising rates of conditions like obesity, diabetes and asthma, higher costs per service, and changing consumer attitudes

and demands toward healthcare. Survey results show hospital inpatient stays for HMOs have increased to 277 annual days per 1,000 members in the 2006 survey, up from a low of 230 in the 2000 survey.

For 2007 renewals, HMOs anticipate premiums to increase 10 to 11% while PPOs anticipate premiums to increase 12 to 13%. However, these anticipated increases are on book or manual rates. Actual rate increases will likely differ due to group experience, contract negotiations, changes in cost sharing, and market conditions.

The survey was sent to the nation's HMOs and fully insured PPOs that serve the commercial large or mid-group employer markets. Over one-third of those surveyed participated. The annual Milliman survey is unique in that it asks companies to respond to a given set of benefits and demographics, thus removing three factors that can skew the results of a typical survey on health costs: differences in benefit design scope, cost sharing levels and member demographics.

Survey results showed that the consumer could lower annual premiums by about \$565 per member per year by increasing the deductible from \$250 to \$1,000 and could lower annual premiums by \$900 per member per year by increasing the deductible from \$250 to \$2,000. A CDH plan can be an attractive option since a Healthcare Reimbursement Account (HRA) or Health Savings Account (HSA) is usually available to cover the higher deductible if medical expenses occur.

A vast majority of respondents are either currently offering or will offer a CDH product within the next year. However, a small but increasing number of employers/employees have thus far chosen these products. Among respondents, CDH premium revenue will be 3.6% of all commercial premium revenue in 2006 and plans expect this amount to increase to 5.1% in 2007. However, both in terms of percentage of total premium and percentage of insurers offering HRAs or HSAs, reported growth in CDH products has been slower than respondents predicted in prior years. Insurers are about three times more likely to offer spending accounts alongside a PPO plan than an HMO plan.

The number of plans offering provider quality information and treatment options

to their members continues to grow. Seventy-two percent and ninety percent either currently or will provide within the next year provider quality information and treatment option information, respectively. However, those sharing hospital and physician services pricing information has stalled around fifty percent. Access to pricing information (often referred to as price transparency) is the one major component of CDH that has yet to be implemented on a large scale. This is significant since access to pricing information to make informed decisions is an important aspect of CDH.

This year Milliman also explored issues related to disease management. Plans generally believe these programs are more successful in improving patient health than

reducing costs, though plans do expect some cost impact. Maternity, obesity, and diabetes programs are viewed as having the greatest impact on reducing long term future healthcare costs. Other common programs include asthma, coronary artery/heart disease, and congestive heart failure.

If you wish further information on the 2006 survey, please contact Christopher Wanta at chris.wanta@milliman.com. Those wishing to purchase the results from the 2006 survey or prior years should contact Marla Ross at marla.ross@milliman.com.

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