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In This Issue

In this seventh issue of the McGraw Wentworth Benefit Advisor for 2003, we will discuss the global forces affecting the cost of medical and prescription drug benefits. Unfortunately, there is no silver bullet to better manage cost; we will also discuss short and long-term strategies to address spiraling costs.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

"Trends"

As the mid-point of the plan year approaches for many, organizations are reviewing 2004 cost estimates. This year cost increases for medical benefits are expected to be substantial; organizations must strike the appropriate balance between budget constraints, alternative plan design options and employee contribution modifications.

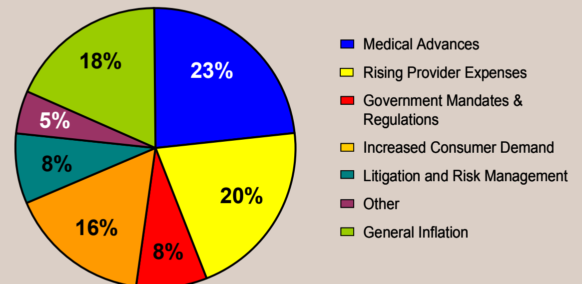
We will analyze trends in medical and prescription costs, projected cost increases and strategies organizations are reviewing to better manage these costs long-term.

Medical Plans

Towers Perrin recently released its 2003 Health Care Cost Survey findings and the news is not good. Medical plan costs continue to skyrocket. The average increase for large employer plans is 16% for 2003, the largest annual percentage increase Towers Perrin has recorded since it began its survey over a decade ago.

According to the Hewitt Health Value Initiative for 2002, the Detroit Metropolitan area leads all major metropolitan areas in employee health costs. Detroit also ranked in the top five metropolitan areas for percent increase in health care cost for 2002 (see page 2).

Major Drivers of Healthcare Cost



Source: PricewaterhouseCoopers, April 2002

The expected cost increase for 2004 is 15-16% for most medical plan options. The double digit increases have been occurring year after year since 2000. What is driving up the cost of health benefits at such an alarming rate?

Although the question seems simple, the answer is complex:

- **The Population Is Aging**: The workforce is aging and aging has a significant impact on health

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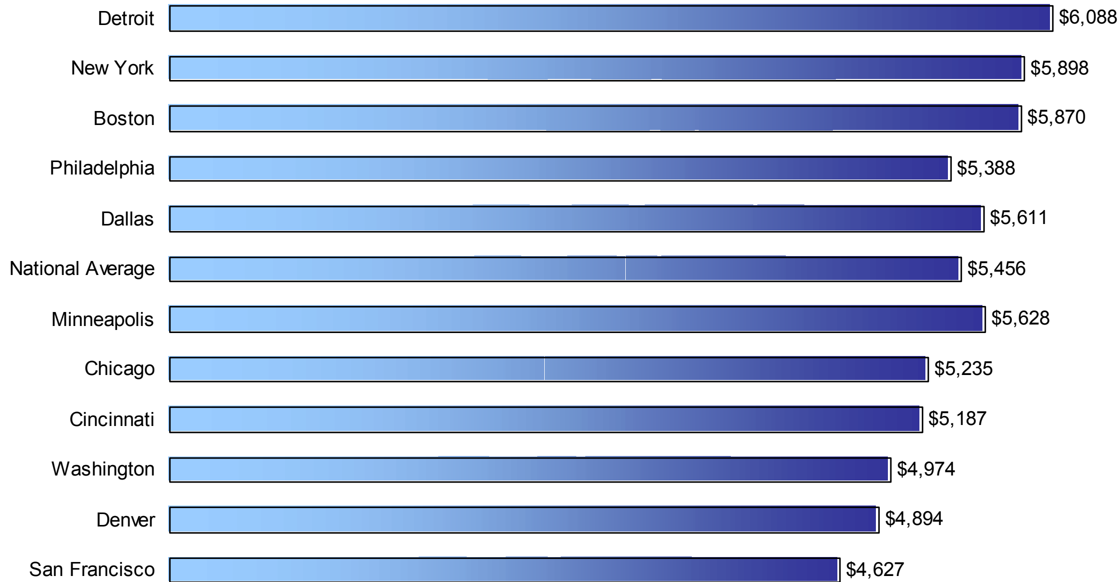
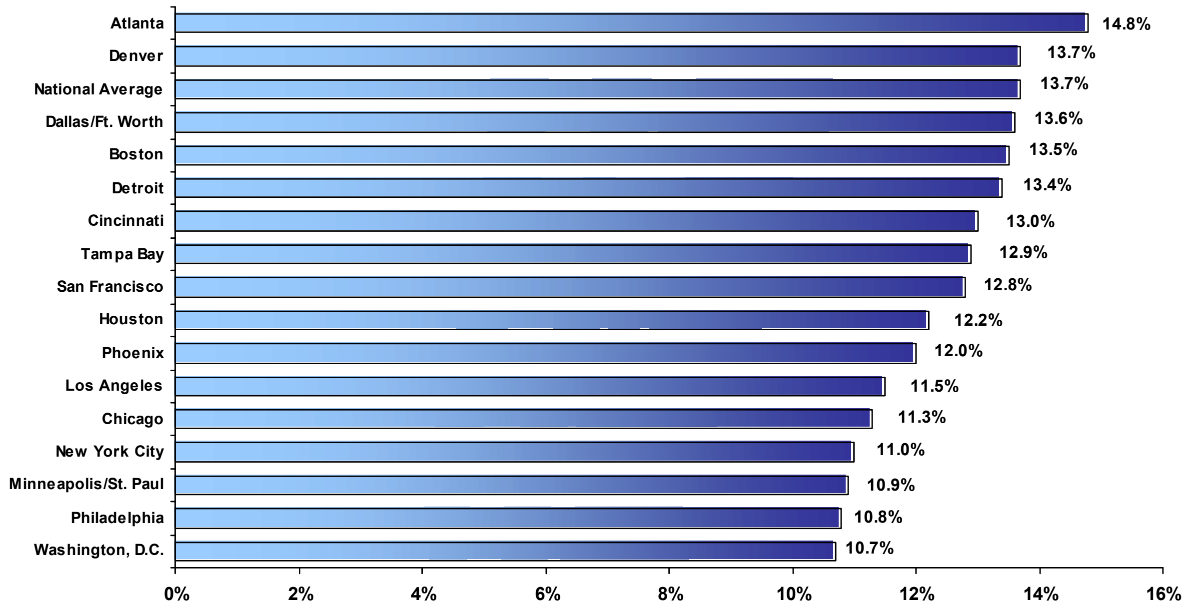
Regional Health Care Costs Per Employee



Source: Hewitt Health Value Initiatives™, Press Release 2002

2002 Health Care Cost Increases Major Metropolitan Areas



Source: Hewitt Health Value Initiatives™

care cost. The cost for providing health care triples between age 40-44 and age 65. Between 2000 and 2010, the number of people between 45 and 69 years old will grow at a faster rate than any younger segment. The average age of your employee population will most likely increase in the next decade. As the average age increases, so will your plan costs.

- **The Prevalence of Chronic Health Conditions is Increasing:** The overall health of our nation is declining. Chronic health conditions are no longer just confined to the elderly. In general, people do not manage their health habits well and rely on drugs to treat any resulting health problems. Rather than improving their lifestyles to promote better health, more people simply look for a pill or treatment to manage their conditions.

  In some cases helping employees adopt healthful lifestyles may be an uphill battle. In a recent Oxford Health Plans' study of 1,450 adults, 17% of respondents said they were in excellent health despite the fact they tended to be overweight smokers who drank alcohol regularly, ate fatty foods and didn't exercise. The study labeled this group "the health status deniers" because of the serious disconnect between the perception of their own health status and their lifestyle choices.

  Of the health status deniers:

  - 55% were at least 25 pounds overweight
  - 31% smoked
  - 21% drank three or more alcoholic beverages a day
  - 29% consumed four or more cups of coffee or tea daily
  - 36% never exercised

- **Government Health Programs:** Medicare, Medicaid and the Federal Employee Health programs pay 27% of all health care costs in the country. These government programs set "approved payment amounts" and payment guidelines that providers must accept. The approved amounts are significantly lower than the retail cost to provide these services. The services provided to these program participants are no less costly, providers simply get paid less when treating these patients. Providers try to close their income gap by charging private patients more for the same services.

  A substantial portion of health care expenses flow through those programs where providers receive decreased reimbursements; this practice means the private sector pays a substantially greater proportion of premium cost.

- **New Technologies and Prescription Treatments:** Medical advances continue to emerge rapidly. New medications and technology improve the quality of life for many, but

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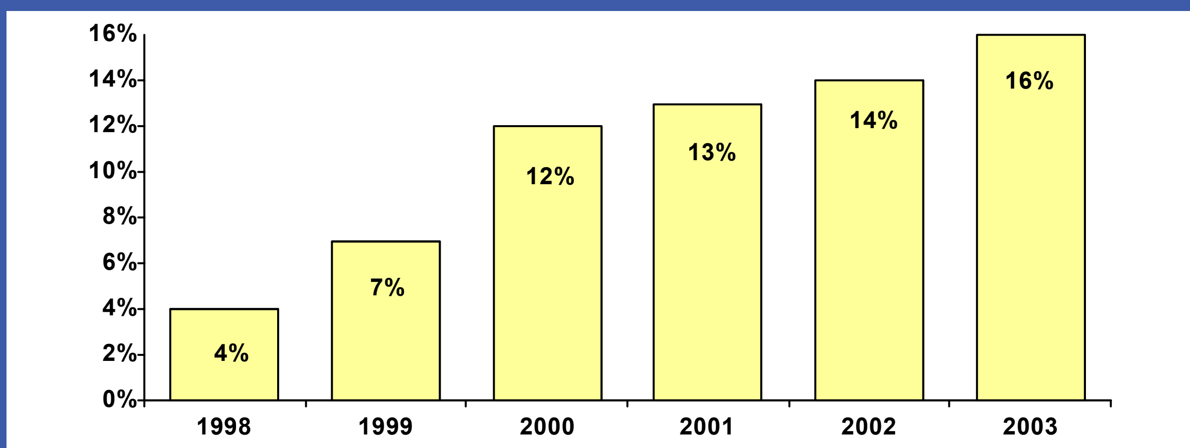
Combined Average Growth in Health Care Costs
All Plan Types & Participant Groups



Source: Towers Perrin 2003 Health Care Cost Survey

these advances are made at a cost. The next concern employers will face is whether to cover genetically engineered drugs and tests. Genetically engineered drugs and tests are tailor-made treatments prescribed when traditional forms of treatment are not effective. These treatments are on the verge of approval and their cost is substantial.

- **Uninsured Individuals Drive Up Cost for Health Plans**: In today's economy, it is not uncommon for businesses to downsize in order to operate more efficiently. COBRA covers most people who are laid off; however, COBRA premiums are substantial and many can't afford the coverage. Emergency rooms, the most expensive place to receive treatment, cannot deny care because of insurance coverage status. Uninsured individuals choose the emergency room because they are not required to pay for services they receive at the time of service. Often hospitals are not paid for the care they provide the uninsured. The health care providers will offset these costs by charging insured patients a more substantial fee for service.

- **Defensive Medicine**: Providers are in the business of health care. It is important to understand that providers expect to earn a profit. One key issue challenging providers is the cost of malpractice insurance. The costs have been increasing substantially throughout the country and providers are struggling to manage this expense.

  To help reduce potential litigation costs, providers are practicing defensive medicine. They order extensive tests to reduce any likelihood that they may face lawsuits because of treatment decisions or protocols. Taking a conservative approach to medicine means many tests that are ordered may be unnecessary but are simply done as a defensive measure.

- **Government Mandates**: The amount of federal and state legislation governing the operation of group health plans has increased dramatically in the last ten years. Some laws, such as the Women's Health and Cancer Rights Act, require treatment for certain conditions be covered; other laws, such as the Mental Health Parity Act, control the limits plans can place on benefits.

  A steady stream of legislation affects how health plans are managed. There is a cost to implementing programs to manage legislative initiatives effectively.

- **Attitudes Toward Healthcare Increase Utilization**: The introduction of PPOs and the incentives offered for using in-network providers has caused a misconception in Americans about the true cost of health care. The out-of-pocket cost for an employee as a percentage of the total cost has declined significantly between 1970 and 2000 (see page 5). Plan participants do not weigh benefits against costs when they seek health care and do not have a realistic view of the relationship between plan usage and health benefit cost increases.

It seems that employees do not feel they should be affected by the increasing costs. A recent Towers Perrin survey found that 63% of employees believe the dramatic increases in health care costs over the last few years affect employer profits. However, less than half of those respondents believe that employers have trouble absorbing these increases or think it is fair to ask employees to pay more. Younger employees tend to hold these views more firmly. Only 28% of workers under 35 believe it is fair to share in the cost increases with their employers and a shocking 54% believe that the rising costs do not have a significant impact on the bottom line.

In addition, Americans' attitude toward health care is that only the best is good enough. In the coming election year, universal health care programs will become a hotly debated topic. However, a national health care program will not address many of these complex issues that are driving costs up. Most national programs control cost through rationing care (we do not ration care for elderly, chronically ill patients, nor do we ration expensive diagnostic or therapeutic treatment). Rationed care is the exact opposite of how care is given and also what Americans' expect from the health care industry.

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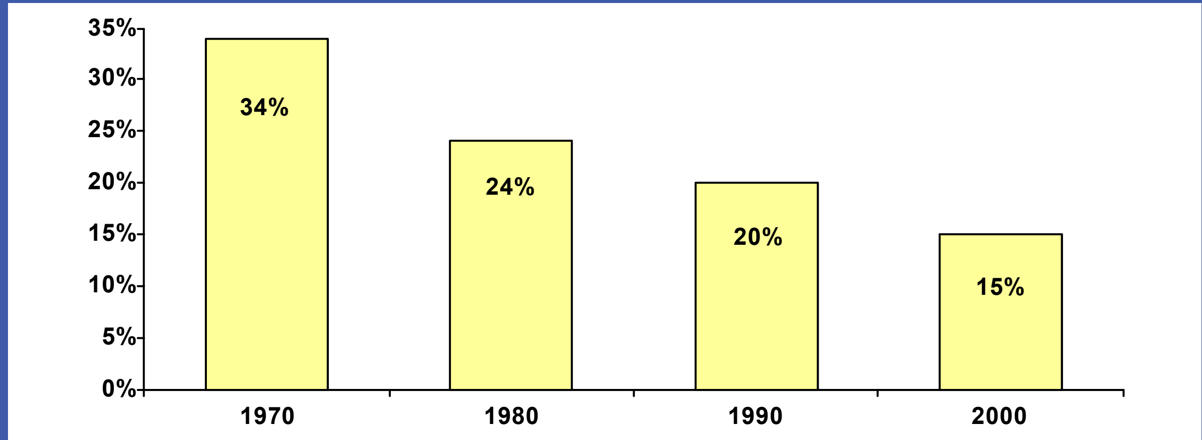
Employee Out-of-Pocket Cost as a Percentage of Total Health Expenditures



Source: EBRI Brief #247, July 2002

Employers need to address these complex issues to implement long-term strategies to control costs. The cost of providing health benefits to employees is expected to double within the next five years. Health care plan costs will increase significantly as a budgetary expense in the next five years. Employers are challenged with containing costs in light of these very complicated mitigating factors.

How Are Employers Managing Costs?

Traditionally, employers have focused on short-term strategies for managing costs. Short term strategies include:

- **Plan Design Changes** – These changes include offering different plan options, increasing copays, adding deductibles and decreasing coinsurance levels. These types of changes usually create a one-time cost savings by implementing gatekeeper controls or shifting more cost to employees when they use the plan; however, their effect is diminished in subsequent years. You have a leveraging situation if you maintain a flat benefit provision. For example, if my plan has a $250 deductible, and for three years straight I maintain that deductible but my plan cost increases 13% year over year, my $250 deductible represents a smaller percentage of claim cost and adds to the increased costs my plan absorbs.
- **Vendor Evaluation** – Periodically, employers will review their vendor's performance and evaluate other vendors. These changes usually generate savings in year one; but substantial increases return in the years following these changes.
- **Contributions** – Requiring employees to pay a greater share can reduce net plan cost. According to the most recent Tower Perrin's survey, employees contribute 19.3% of the cost for single coverage and 22.2% of the cost for family coverage. The increase in employee contributions has not kept pace with the employer cost increases for medical benefits.
- **Financing Arrangements**- Employers have investigated plan funding alternatives; for example, moving to a self-funded arrangement rather than fully insuring the benefits. These funding changes can have a long-term impact on cost, providing experience remains favorable.
- **Consumer Driven Health Alternatives** – Many companies are investigating consumer-driven health plan alternatives for their employees. Consumer-driven health care plans may take on a variety of forms. The core concept of these plans is to create a more substantial financial impact on health plan participants when they use the plan. One popular approach creates a large up-front

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deductible. Employers then fund a Health Reimbursement Arrangement, or HRA, that will account for the first portion of that deductible. If the participant does not use the funds in the account within the plan year, plans can allow for the balance to roll into the next year. The employer funds an amount in the HRA annually and any rollover amounts simply increase the fund's balance. However, if plan participants require a substantial amount of medical services, they are responsible for paying the difference between the employer funded amount (HRA) and the remainder of the deductible and any coinsurance requirements.

By creating a substantial financial impact on participants that use the plan, employers believe people will become more careful consumers of health care services. Many plans provide tools participants can use to determine what medical services are necessary, research medical conditions, help manage chronic conditions and encourage healthier life style choices. Over the long-term these plans hope to change plan participants' behavior to create healthier individuals and decrease plan costs.

The IRS issued a ruling on the HRA accounts in June 2002 to guide employers on structuring these accounts to allow for year-end rollover of account balances. These plans are so new to the market that there really are no reliable long-term studies that indicate they have been effective in managing plan cost.

These plans are being touted as the next generation of health plan. However, when reviewing the structure of these plans, employers should consider:

- In general, 80% of plan costs are generated by 20% of plan participants. Most of the 20% are managing serious health conditions. Even if the plan creates a more skillful consumer, it will not have a major impact on the chronically ill individuals who incur the majority of the cost.
- The greatest identifiable savings with a consumer driven program may be the actuarial cost shift generated from the change in plan design. The proposed change in how plans are used is unproven and will be difficult to quantify.
- Administering these plans is more complex; especially when organizations sponsor medical flexible spending accounts and HRAs. Your organization should expect an increase in fixed costs if a consumer driven health plan is implemented.

Consumer-driven health plans may solve many of the complex problems associated with rising health benefit costs. However, in practice, these plans may not be as cost effective as many people think.

Because costs are continuing to rise, employers are investigating strategies that affect their risk pools over the long-term. The challenge with these strategies is that they do not often generate immediate savings. They do not attack the one-time cost increase, but they do address many of the cost drivers outlined in the previous section:

- **Promote Health and Wellness** – Many employers are launching health and wellness programs for their employees. The most popular programs focus on:
  - **General Health** – These types of programs include health screenings and health risk appraisals. They are designed to help employees identify chronic health conditions or the risk of developing these conditions. By catching these conditions early, treatment can often be limited to lifestyle changes.
  - **Exercise/Nutrition** – These programs range from weight loss programs to seminars on preparing healthier meals. These programs promote long-term behavioral changes to improve employees' overall health.
  - **Smoking Cessation** – These programs provide support groups to help employees kick the habit and discounts on products designed to reduce cravings.
  - **Stress Reduction** – Stress management programs should not be overlooked;

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these programs include meditation, breathing exercises and yoga.

- **Disease Management Programs** - These programs are designed to help plan participants manage their chronic health conditions more effectively. The programs focus on conditions such as diabetes, heart disease, asthma, high blood pressure and others that can be costly if they are not effectively managed. Disease management firms will often examine a company's claims history to identify diagnosis codes associated with chronic conditions. Once plan participants with chronic conditions are identified, the disease management firm works with participants to make sure they are managing their condition and changing their lifestyle patterns if necessary. They also help participants with chronic conditions make smart treatment choices.

Prescriptions Drug Benefits

The high cost of prescription drugs is not news to anyone. Last year, prescription drug costs increased by more than 17% . Over the last several years many organizations have focused on prescription drug coverage as a key area for change. According to a 2003 Mercer study, most employers have established a 3-tier drug card program (see table at top of page).

Structure for Cost-Sharing	2000	2001	2002
Single copay for all drugs	9%	7%	5%
Split copay for generic and brand name drugs	52%	39%	31%
3-tier copay - one for generic, one for preferred brand and one for non-preferred brand	26%	40%	51%
Other form of copay	4%	3%	3%
Coinsurance	10%	10%	10%
No Cost Sharing Required	1%	1%	0%

Employees must become more sophisticated in their understanding of the prescription drug market as more organizations are moving to the 3-tier copay structure.

Not only is plan design complexity increasing, but also the copay amounts are rising (see table at bottom of page).

The issues driving up prescription costs are complex as well. Aside from inflationary trends, people are taking prescription drugs more often and pharmaceutical companies are introducing new drugs to the marketplace.

In 2002, the average individual filled approximately 11 prescriptions. Just a few years earlier, the average was only 8 prescriptions a year. This increase is due primarily to the following factors:

- As our population ages, people simply need more prescriptions.
- Prescription treatment options available today were not available in the past.
- Television and print advertising makes people more aware of prescription treatments available for specific medical conditions.

Prescription drug costs have also risen because so many new drugs are now on the market. The list of available drugs is endless. Pharmaceutical companies spend a tremendous amount of money to research and develop new drugs. These companies try to recoup their expenses by inflating the price of new drugs during the initial patent protection period. If the prescription is in high demand, often because of direct to consumer advertising, the consumer or the group health plan pays the price; pharmaceutical companies recoup their investment and make a healthy profit.

Just five years ago, prescription drug cost represented 5-10% of medical plan cost. Now, it is closer to 25-40% of medical plan cost. This shift is dramatic. Many employers have

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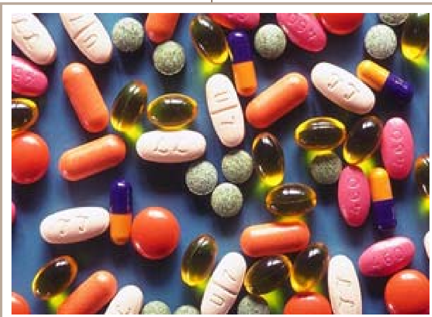
Average Copay Amounts	2000	2001	2002
2-Tier Copayments			
Generic	$7	$8	$8
Brand	$15	$16	$18
3-Tier Copayments			
Generic	$8	$9	$10
Preferred Brand	$16	$17	$19
Non-Preferred Brand	$29	$31	$35

implemented short-term measures such as increased copays or split copay plan designs. However, these measures primarily result in shifting costs to the employee.

To manage these increases effectively, many employers are now looking toward more long-term measures. Many pharmacy benefit managers (PBMs) offer programs to help plan participants choose less expensive drugs:



- **Increasing the use of Preferred Brands:** Even though your organization has implemented a 3-tier program to encourage people to choose preferred brands, pharmacy benefit managers can often increase the use of preferred drugs. Many can identify payments for non-preferred drugs. For maintenance medications, the PBM will ask the prescribing physician to change the prescription to the equivalent preferred brand-name drug.
- **Step Therapy:** These programs require the use of the most cost effective therapy in the initial treatment phase. For example, drugs such as Prilosec and Prevacid are popular for treating ulcers; however, these drugs are really considered the last treatment stage. There are less costly medications, such as Zantac and Pepcid, that should be considered first. A step therapy program would require an individual to try Zantac and Pepcid, and if these lower cost therapies do not produce the desired effect, then the plan will cover the more expensive, later stage therapies.
- **Prior Authorization:** Many plans require prior authorization. These plans identify medications that have a potential for misuse or abuse, medications that have a limited use in treatment protocols, or medications that are simply very expensive. This program decreases costs to the plan sponsor by reducing or eliminating the inappropriate use of certain drugs. Physician must demonstrate the medical necessity of the selected medication.

Many PBMs are focusing on programs that can help educate and steer employees to the most cost effective prescription therapy for their conditions.

In Conclusion

Employers should start looking toward long-term strategies to help improve employees' lifestyle habits. Without addressing the key drivers in cost increases for medical and prescription benefit programs, the significant annual trends will continue. The long-term strategies can have a meaningful impact on future cost.

However, long-term strategies cannot be effective without education. Plan participants need to understand the true cost of care. They need to feel responsible for properly managing their care. They can no longer sit on the bench and watch the game, they need to be involved. Plan participants need to take responsibility for their health and, if necessary, make lifestyle changes. Education is a key component in making long-term strategies successful. Improving the health and lifestyle choices of your plan participants will improve your bottom line over time.MW

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