



BENEFIT *Advisor*

In This Issue

In this eighth issue of the McGrawWentworth Benefit Advisor for 2004, we will examine trends in health care costs. Health care costs are increasing as a result of many reasons. To affect cost, employers will need to address a number of these cost drivers. There is not one "right" answer to controlling health care costs. Employers are adopting many strategies in 2005 to better manage health care 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 McGrawWentworth web site at www.mcgrawwentworth.com.

"Trends"

It is the time of year many benefit professionals dread: time to start projecting costs for the 2005 plan year. Since 2000, benefit planning has become an arduous task; cost increases have exceeded budget targets for most organizations. Plan changes, which once occurred every two or three years, are now an annual event. Employers struggle over how to structure benefit plans to meet employee needs while still keeping within budget constraints.

Every year at the beginning of the planning phase, benefit professionals ask these questions: Why are costs growing so rapidly? How will our organization structure our plans to provide needed benefits at a reasonable cost?

Neither of these issues is easily addressed. This Benefit Advisor discusses cost increases and strategies to manage these costs long-term.

Why are Medical Plan Costs Skyrocketing?

According to Mercer, 2003 ended with employer medical plan costs increasing just 10.1%. The 10% increase occurred after plans had made changes to decrease costs. Towers Perrin is estimating the 2004 gross cost increase will end up between 12% and 14%.

In 2002, Detroit led most metropolitan areas in yearly health care cost for each employee. According to Mercer, Milwaukee led Midwest cities in yearly health care cost for each employee. Detroit's costs were just 1% lower. Employers will be faced again with double digit increases. Many employers have made gradual

changes to manage the increases. But this strategy is wearing thin with employees who are wondering when the plan changes and contribution increases will slow down.

The environment is ripe for the push to consumer driven arrangements. An understanding of the primary cost drivers may help you choose the best options to manage rising costs:

- **Health of the General Population:** The general health of our population as a whole is declining. Here are a few of the many factors influencing our declining health status:
 - **Baby Boomers are Aging:** The workforce is aging and aging has a significant impact on health care cost. Health care costs increase significantly between the ages of 45 and 69. This age segment



will grow at a faster rate than any younger segment.

You may notice the aging of your employees if you have low turnover and fewer new jobs. Your health care costs will increase as the average age of your employee population increases.

- **Obesity is Becoming an Epidemic:** It is predicted that obesity will overtake tobacco as the leading preventable cause of death within the next two years. The IRS and the Social Security Administration recognize obesity as a disease. Health care costs for overweight and obese individuals are rising. A *Los Angeles Times* 2002 study found obesity is associated with a 36% increase in health-related spending and a 77% increase in the need for medications. A Centers for Disease Control and Prevention study found overweight and obese individuals cost 37% more than people of normal weight.

Obesity contributes to the development and severity of chronic conditions, such as high blood pressure, diabetes, as well as many other serious health problems. The epidemic is not limited to adults. Children are also heavier and more sedentary than in the past, and more children are now being diagnosed with Type 2 (adult onset) diabetes.

- **Chronic Conditions Are on the Increase:** Chronic conditions are severe medical conditions that require ongoing treatment. A high percentage of your health plan costs are allocated for treating chronic health conditions. (See table below.)



Increasing obesity, along with a sedentary lifestyle, is causing increases in diabetes, a costly chronic health condition. Diabetics

incur on average 35% more health care expenses than non-diabetics. They are also at risk for devastating complications, such as coronary artery disease, hypertension, kidney problems, blindness, and amputations.

- **New Technologies and Prescription Treatments:** New procedures are available for treating many conditions. Although these are amazing life-saving technologies, they come at a high cost. Techno-

logical advancements include artificial organs, Diffusion Tensor Magnetic Resonance Imaging, and Positron-

Emission Tomography (PET) scans.

Genetically engineered drugs and tests are being designed to treat specific conditions in certain individuals. These treatments are being approved and will be very expensive. Direct to consumer advertising will increase employees interest in the new treatments even if existing therapies are just as effective from a treatment standpoint. Employers need to decide how their plans should cover these new treatments.

- **Fixed Copay Leveraging:** Whenever a health plan maintains a fixed copay (such as a deductible, office visit copay, or emergency room copay) not indexed for inflation, the plan will cost

Allocation of Claim Dollars

| % of Population | % of Total Claim Dollars | Type of Care |
|-----------------|--------------------------|--|
| 1% | 25% | Catastrophic Care |
| 17% | 63% | Chronic Care & More Expensive Acute Care |
| 82% | 12% | Routine Services/Non-Users |

more each year. For example, suppose your plan has a fixed \$15 office visit copay. The logic in developing the copay is that it is approximately 20% of a \$75 office visit charge. That copay may remain a flat \$15, year over year, but the office visit fee may steadily increase. In three years, the average office visit may cost \$100; the \$15 office visit copay will now cover only 15% of that cost. Your plan must pay the additional 5%.

- **Physician Malpractice Concerns:** Malpractice insurance cost is approaching the unaffordable range for many physicians. While it is not a thought that is comforting, even though physicians are mainly concerned with providing care, they are also running a business. They want limits on malpractice awards. Some physicians are simply practicing without malpractice insurance protection.

Physicians also manage their practices to prevent lawsuits. These physicians may run unnecessary tests to rule out all

possible conditions instead of focusing on the most likely diagnosis. It is estimated that as much as 30% of the health care received in this country is considered unnecessary.

- **Government Mandates:** Federal and state law affects health plan costs. Some direct mandates can require

you to offer certain benefits or to offer a specific coverage level for benefits.

HIPAA's Security Rule is the latest piece of legislation that will affect plan costs. Employers may be able to comply at a reasonable cost, but insurers, Third Party Administrators, PPO networks and providers are likely to incur significant costs to meet the requirements of this Rule. These costs may be passed along through increased administrative and service fees.

- **Price Inflation:** The balance of power in the health care industry is shifting back to providers. Hospitals have more power. Hospital consolidation has improved their leverage. This leverage allows them to negotiate higher fees than in the past.

Key hospitals also have gained market strength. In every region, certain flagship

hospitals are recognized as "must have" hospitals in networks. Consequently, these

hospitals can negotiate higher fees with networks and plans.

Finally, recent changes in Medicare and Medicaid reimbursement practices will affect private plans. The government negotiates very aggressive discounts for its plans. The services are no less expensive and providers look

to private insurers to make up the difference.

Organizations are struggling with these complex factors as they decide the best short- and long-term strategies to manage health plan costs. In addition to dealing with these factors, employers also need to contend with their employees' attitudes regarding their health coverage. Many employees feel they are entitled to health care benefits. These attitudes may make it difficult for employers to alter benefit plans. In fact, health care has been a huge labor issue over the last year. Union employees have insisted more strongly on maintaining health benefits than on any other traditionally bargained contract provisions, and these negotiations are covered in the evening news.

Employees also expect their employers to provide comprehensive health coverage at a reasonable cost. Employees do not want to consider the impact their own lifestyle decisions have on the cost of the plan. To manage long-term health plan costs, employers must help employees understand the impact their decisions have on health care costs and help them improve their lifestyles.

Combating the factors that drive costs up is not easy. Some are beyond the employers' control. However, employers should look at these factors to determine what steps they can take to help rein in health plan costs.

How Are Employers Managing Costs?

Almost every employer has attempted to control costs in the last five years. According to 2003 IOMA study, employers rank the follow-



ing as their most successful cost control strategies:

- Increased Employee Cost-Sharing (employee contributions for plan).....67.2%
- Increased deductible, copays, lifetime limits....57.4%
- Changed to a 2-, 3- or more tier prescription drug program....41.5%
- Self-insured the benefit program....24.6%
- Added/enhanced voluntary benefit programs....20.2%
- Adopted mail order pharmacy program....19.7%
- Automated benefit administrative functions....16.4%
- Set up a flexible spending account....15.3%
- Started a wellness program....13.1%
- Implemented a cafeteria plan for benefits....12.0%

While the study encompassed all benefits, most responses concerned the health plan.

Employers can take several approaches for cost control:

- Cost-shifting/vendor management
- Improving health status
- Improving buying habits

Cost-Shifting/Vendor Management

For years employers have used these strategies to manage their plan costs:

- **Plan Design Changes** – Changes to plan design include offering different plan

options, increasing copays, adding deductibles and decreasing coinsurance levels. These changes have a major financial impact. Because plan participants must pay more, they tend to seek care less often. Typically, plan use goes down as plan cost-share go up.

- **Vendor Evaluation** – Periodically, employers should review their vendor's performance and investigate alternative vendors. Even if an employer chooses not to change vendors, often competitive alternatives can be used as a negotiating tool.
- **Contributions** – Employers have become more aggressive in their employee contribution strategies; however, employers still pay most of the cost for medical benefits. When they do increase employee contributions, employers often do not pass on the full percentage plan cost increase. Employers may want to consider having employees pay a percentage of the actual cost instead of a flat dollar amount. For example, employees may pay 25% of the cost and employers pay the remaining 75%. With this arrangement, employees know the amount they pay will change each year as they absorb 25% of the cost. Other contribution ideas include making sure your plan prices coverage options to encourage employees to enroll in the most cost-effective plans, requiring a larger contribution for family coverage, spousal surcharges, etc. Southeastern Michigan's



average plan contributions fall well under national benchmarks.

- **Financing Arrangements** – Employers may seek alternatives for funding plans. For example, they may move to a self-funding arrangement rather than fully insuring the benefits. These funding changes can have a long-term impact on cost, providing experience remains favorable.

Improving Health Status

According to the Mercer Health Care study, 88% of health plan dollars are spent on catastrophic care, chronic care and expensive acute

care for 18% of the health plan population. This result ties closely to the generally held belief that 20% of the population generates 80% of the plan cost.

Many employers are adopting strategies to improve plan participants' health and reduce their plan use. Following are a few of these strategies:

- **Wellness Initiatives** – Wellness plans today come in many forms. The primary goal, however, is to motivate the 30% to 40% of participants with low or moderate health risks to improve their lifestyle/health habits. Structured coaching programs would include weight loss management, smoking cessation, stress management, exercise programs, nutritional courses, and so on.

- **Disease Management Programs** – Disease management programs target specific medical conditions that can lead to serious complications if not caught early and treated properly. Proper treatment is not just the physician’s responsibility; the patient must follow the prescribed treatment plan.

Since disease management programs target specific conditions, employers often select the programs to install. Knowing which chronic conditions occur most often among your employees is important. Specific chronic conditions can vary greatly depending on age, gender, and lifestyle. Find a vendor who can offer programs targeted to the risks prevalent in your employee base. To identify these conditions, analyze your health plan and prescription claim data.

Disease management initiatives will increase over the next five years. If the program is managed effectively, it can positively impact plan cost.

- **Effective Large Case Management** – Large case management programs are integrated into most health plan administrative

functions. Case management programs help very sick individuals navigate the complex medical system. Effective case management often results in better

coordination among treating specialists, less duplication in services and more cost effective care management. These programs offer a medically trained coach to help patients manage their care.

While large case management is not new, the quality of your case management vendor can have a significant impact on cost. Often case management is simply provided by the health plan vendor, the mechanics of the program and the quality of the initiatives are rarely reviewed independently. However, there is a widespread disparity in performance of patient management vendors. Audit your large case management vendor’s performance if possible. If you are unhappy with the quality, review workable alternatives.

Improving Buying Habits

Right now, it is difficult to escape the publicity on Consumer Driven Health Plans (CDHPs). Articles are not only appearing in trade journals, but also in newspapers and

magazines. Many articles tout the amazing success of CDHPs, but it is too soon in their existence to determine whether these plans will be effective in the long run.

However, increasing your employees’ responsibility for health care cost is an attractive proposition. Since many individuals are unwill-

ing to pay high fees, they will consider cost when they seek care.

On the other hand, if employees must pay more for health care, they need reliable tools to help them determine the quality, cost, and necessity of that care. Buying health care is not like buying consumer goods. Appropriate care is imperative. If a plan is to improve the buying habits of its participants, it should provide:

- Accessible tools to help employees research medical symptoms, diseases and treatment regimens.
- Accessible reference guides to help employees find quality providers if they need treatment.
- Accessible resources to disclose the cost of various services from different providers.

These comprehensive tools have not been perfected, but they are being improved. It is difficult to measure quality and find resources that disclose cost. However, these services are in demand, and we expect these tools to become more sophisticated over the next five years.

What are Other Employers Doing?

According to McGraw Wentworth’s Michigan Mid-Market Survey, conducted in the spring of 2004, employers in this area are taking action. Employers are reviewing a host of strategies that are over-viewed on the following page.



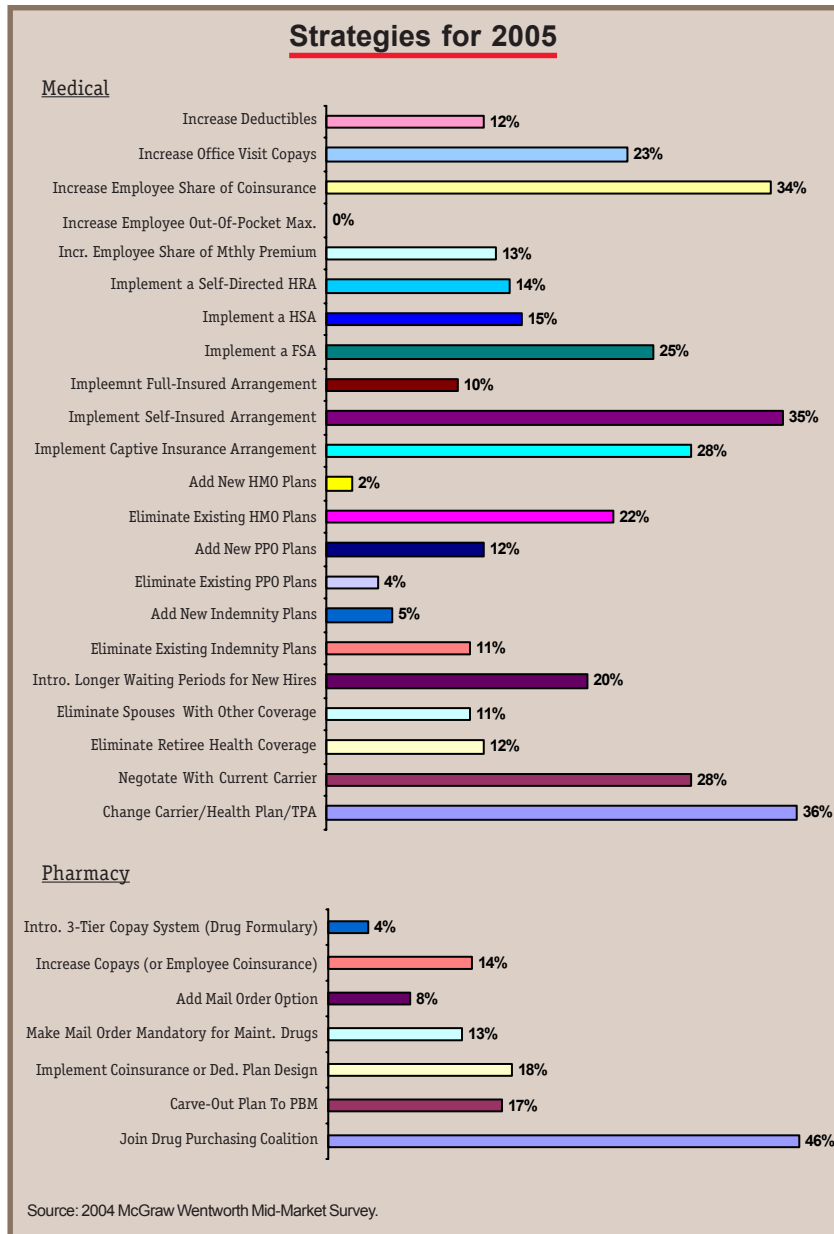
Conclusion

There is no one right answer for managing health care costs. Organizations need to review their own situations, culture and opportunities to best manage cost increases.

What is evident, however, is that health care plans need to be reviewed constantly to measure performance and seek opportunities for savings. The budget planning process, once an annual event, is becoming an ongoing discussion in organizations around the country.

Clearly this process is not easy. Medical benefits were never simple and their complexity is increasing dramatically. Keeping up to date on trends, benchmarks and cost issues could be a full-time job.

Organizations need to be aware of this increased complexity and make time to properly review options to control costs.**MW**



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