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In This Issue

In this sixth issue of the McGraw Wentworth Benefit Advisor for 2006, we provide our annual examination of the trends in health care cost and health plan management. Health care plan costs as a percent are cooling as a result of employers shifting more cost to employees. However, health plan costs remain substantial.

This Advisor discusses many options organizations can consider to help manage their health care cost. Improving employee health and providing care management assistance are two leading strategies in 2006.

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.

"Health Plan Trends"

It is that time of year again. The time many employers begin discussing their group health plans. The good news is Mercer's *National Survey of Employee Sponsored Benefit Plans* shows for the second straight year employer health plan cost increases are in the single digits. The reported cost increases after employer plan changes were only 7.5% in 2004 and just 6.1% in 2005. Employers are expecting a 6.7% increase in 2006.

While the single digit increases are a welcome relief for many employers, the increases are still 2 to 3 times the rate of inflation. In addition, Towers Perrin reports cumulatively over the last 5 years employers are paying 78% more for their health care plans. Employees also are not immune from the impact of rising health care plan costs. Employees are paying 68% more than they were just 5 years ago. In many cases, employees are paying more for plans with reduced benefit levels.

In absolute dollars, even with single digit increases, Towers Perrin expects the cost of providing health plan benefits to employees will increase $582 for each employee in 2006. Most employers cannot sustain this increase. Employers have been very active with health plan cost control over the last several years; many have shifted more of their health plan costs to their employees. Many organizations are at a point where they are analyzing their cost shifting measures and wondering if they are approaching the limit.

It is no wonder organizations and their employees are very frustrated with their health plan costs. However, the plan costs need to be managed carefully. They really are a business expense and very few businesses can absorb a 78% increase of any fixed cost over a five year period. With all the press coverage regarding health care costs and the difficult business environment in Southeast Michigan, it seems we are at point where many options can be considered to help manage health plan cost. Many strategies involve the employee in the problem and hold the employee accountable for life style choices.

This *Advisor* discusses the general trends in the employer-sponsored health plans, the areas that are driving health plan costs higher and the strategies employers can consider to help better manage health plan costs.

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Medical Plan Cost – Critical Issues

Even with two years of single digit cost increases to health plans, the absolute plan costs are substantial. Mercer reports the 2005 average plan cost was $7,089 for each employee.

Health care costs are complicated. Many factors contribute to rising health care costs including:

- **Health**: The general health of your workforce and their covered dependents affects your health plan costs.
  - **Population is Aging**: A health plan cannot control the aging of its participants. Older workers typically cost more to cover on a health plan than younger workers. However, older workers do bring leadership and life experience to most organizations.

    Hiring younger workers is not the solution to an aging workforce; in fact, in many cases that may be considered a discriminatory hiring practice. If you have an average age that is significantly higher than the general population, it makes sense to expect higher health plan costs. Your workforce will appreciate cost control measures that help maintain overall health or help them manage certain diseases.

  - **Obesity Remains an Issue**: Obesity is a medical condition that strongly affects health. It contributes to the development and severity of numerous chronic health conditions. These chronic health conditions include high blood pressure, diabetes, heart problems and so on. These conditions require regular care and monitoring which results in greater cost for your organization. A recent study by Leade Health reports medical costs for obese individuals are 77% higher than those of healthy weight individuals. Medical expenses associated with obesity cost employers approximately $8,700 per patient per year.

    The prevalence of obesity has steadily increased since the seventies, and obesity in children has increased markedly over the decade. Physicians are treating more and more children for adult onset diabetes, unheard of just 20 years ago. This alarming situation means the next generation of workers may have many more chronic health conditions than the current one. Breaking children out of the obesity cycle will be difficult because parents heavily influence many of their children's lifestyle choices.

    The good news is obesity is not necessarily fatal and is readily treatable. A healthful diet and increased exercise can significantly affect the quality of life for your employees and their families.
  - **Chronic Conditions**: Chronic conditions are moderate to severe medical conditions requiring continued treatment. Diabetes, high cholesterol and many back problems are often chronic conditions. Treatment for chronic conditions is costly. These conditions often require daily medication and regular physician visits.

    In addition, if individuals do not manage their conditions carefully, they can suffer serious, even deadly, complications. Managing these complications can be expensive. If plan participants follow appropriate treatment protocols, they can help keep health plan costs down.

    Treatment for chronic conditions accounts for almost 80% of medical expenses in the United States. As employees' share of health care costs rise, many employers are concerned that employees with chronic conditions will abandon their treatments. In fact, studies have shown that as prescription drug copays increase, the number prescriptions filled for chronic conditions decreases. To prevent complications and the resulting emergency room visits and inpatient hospital

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stays, chronic conditions must be properly managed. Treating complications is generally more costly than simply taking prescribed maintenance medications.

- **Pharmacy Increases are Slowing**: Prescription drug benefits get a fair amount of press when the issue is rising health care costs. Increases have slowed over the last two years because generic prescriptions are readily available for many conditions. Manufacturers are losing the exclusive rights to their blockbuster medications and patients are quickly moving to generic alternatives.

  The real concern in the pharmacy arena is specialty biotech medications. Many of these very expensive medications are currently being developed. If the FDA approves these drugs, more people will use them. The increased number of high cost medications will likely send prescription trends higher in the next decade.

  For more information on managing pharmacy cost, please read our *Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2006/BA_Issue_4.pdf.

- **Provider Practice Patterns and Quality**: A great deal more attention was paid to provider quality over the last year. Employers, health plans and third party administrators are all investigating "pay for performance" measures. Some payers are implementing these measures; however, it will take some time to develop the best way to measure quality.

  Pay for performance focuses on providing the right care for every person at every treatment encounter. The goal is to provide safe, effective, patient-centered care. If that goal is met, health care will be less expensive. The government is very interested in pay for performance measures because these measures may have a significant impact on the cost and quality of care. Pay for performance programs to manage the health care process and treatment outcomes are currently being developed. Our system may move from one that pays for quantity of health care consumed to one that pays for the quality of health care received.

  Many health care payers are also reviewing provider practice patterns. Dartmouth studies regularly identify large discrepancies among treatments offered in different geographic regions. For example, Caesarian deliveries occur almost twice as frequently in the East as in the West. The question is - are treatments driven by need or practice patterns?

  Quality and accountability in health care have taken center stage this year in many discussions on controlling health care cost.

- **Medicare**: Medicare Part D is beginning to affect some employer retiree health care costs. About 65% of employers chose to apply for the government subsidy instead of changing their retiree prescription plan. However, the subsidy process is complicated, and the plan options available under the Part D program are attractive. Many more employers may choose to eliminate prescription coverage for retiree health plans over the next few years.

  Medicare Advantage plans also have given employers and retirees new options to consider for retiree health care coverage. Medicare Advantage plans may compel employers to overhaul their retiree health care options to save money.

These key areas influence health plan cost in most organizations. This year it seems employers are investing more time and money in reviewing options to better manage their employees' health as a strategy to manage health plan costs. Employers are still looking at cost shifting strategies to meet budget goals. Employers are beginning to understand that they need to take steps to control escalating costs if they wish to continue offering their employees health coverage. Many long-term strategies propose holding employees accountable for their lifestyle choices and their overall health.

How Are Employers Managing Costs?

Employers are taking action to manage their health plan costs. The following are tactics and strategies em-

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ployers are using to help manage their health plan costs:

- Plan Design Changes
- Eligibility Strategies
- Contribution Strategies
- Value-Based Benefit Plans
- Consumer-Driven Health Plans
- Wellness and Disease Management

Plan Design Changes

Most employers have made changes to their plan designs to manage plan cost. Plan design changes shift more cost to individuals using the plans. These changes include increased deductibles, copays and coinsurance levels for employees using the plan. The Mercer survey indicates median deductibles for PPO plans increased in 2005. The median deductible rose from $250 to $300 for individuals and the family deductible rose from $625 to $750.

Plans design changes are especially important with fixed plan parameters. For many years in the 1990s, employers did not make changes to their deductibles, copays and so on. When changes are not made to the fixed portion of the cost, but medical costs increase annually, employers absorb all the inflationary increases and their portion as a percentage of the total cost rises. Employers must make changes to fixed parameters to share the impact of inflationary increases of medical cost.

Plan design changes over the last few years have also focused on creating incentives for employees to seek appropriate care. Many employers are implementing separate copays for primary care and specialty care. The Mercer survey indicates that 24% of large employers charge different copays in PPO plans for primary care and specialist visits. The median copay for primary care visits is $20 and the specialist visit copay is $30.

Another interesting plan design option currently gaining ground is eliminating copays for physician visits and applying the deductible and coinsurance to office visits. The Mercer survey indicates only 16% of large employers used this strategy in 2003 and that rose to 18% in 2004 and up to 22% in 2005. If your organization is considering applying the deductible and coinsurance to office visits, check to make sure your health plan administrator can manage this plan design option.

Coinsurance is becoming a popular strategy in the pharmacy arena as well. In 2004, 11% of large employers used coinsurance for pharmacy benefits; in 2005, 14% of large employers used coinsurance. More employers are looking at coinsurance alternatives for pharmacy benefits. These alternatives have appeal because coinsurance offers a strong incentive for plan participants to investigate their prescription treatment options. Since participants pay a portion of the cost, they have a strong incentive to ask about generic treatment options as well as potential therapeutic equivalents. The drawback of coinsurance is participants do not know how much the medication will cost until they buy it.

Employers are making incremental plan design changes to keep their health plan costs in the single digits. It is getting to the point where plan design changes need to be considered carefully to make sure the plan is not making necessary health care unaffordable for low wage earners.

Eligibility Strategies

Eligibility strategies limit the individuals the plan covers. The more individuals a plan covers, the higher the overall plan cost. One well-publicized eligibility strategy is spousal surcharges and restrictions. Spousal surcharges and restrictions can be structured in several ways:

- **Spousal surcharge**: Charge an additional employee contribution to cover a spouse under the plan if that spouse has coverage available through his or her employer.
- **Spousal restriction**: The two primary ways of implementing a spousal restriction are:
  - If a spouse has coverage available through another employer's plan, the spouse is not eligible for coverage under your organization's group health plan.
  - If a spouse has coverage available through another employer's plan, the spouse is eligible for coverage under your organization's group health plan, only if the spouse enrolls in his or her employer's plan.

Nationally, according to the 2005 Mercer survey, interest in spousal surcharges and restrictions re-

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mained relatively flat. Seven percent of employers used this eligibility strategy in 2004 and 2005. Southeast Michigan has seen an increased interest in this strategy as indicated in the McGraw Wentworth Mid Market Group Benefit Survey. Of our survey respondents, 7% used a spousal restriction and 5% charged a spouse surcharge. Ford Motor Company recently adopted the surcharge for its salaried workforce this plan year. It will be interesting to see if this strategy gains in popularity locally.

Employers are also reconsidering group health plan coverage for part-time employees. Only 25% of large employers according to the Mercer survey extend coverage to part-time employees. Of those that do offer benefits to part-timers, 23% require part-time employees to pay different contributions for coverage under the plan and only 7% offer a different level of benefit to the part-time employee. Employers who offer benefits to part-time employees should reexamine their options.

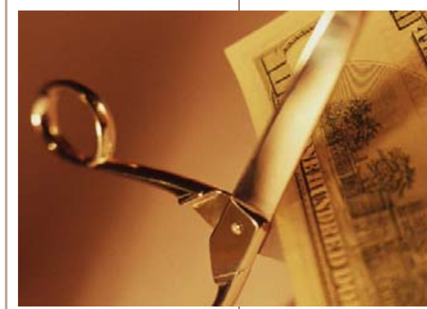
Contribution Strategies

Contributions strategies concern employee contributions for coverage. Typically, contributions vary based on the plan your employees choose and the coverage they elect. Employers, in many cases, set employee contributions to steer employees to the most cost-effective plan option. Some employers set a base subsidy and allow employees to pay the extra amount for whichever plan option they select.

These strategies worked well when plan option costs were significantly different. Just five years ago, most employers offered either HMO or PPO plan options with significant cost differences between the two. The Mercer study reported for the first time HMO plan costs on average were higher than PPO plans, although the cost difference was averaged and HMO plan costs did vary widely throughout the country.

Many employers are considering two new strategies:

- **<u>Income-based contributions</u>**: In this strategy, contributions vary according to the employee's income level. Those with higher salaries can pay more for their health plan coverage than those with lower incomes. Income-based contributions are difficult to administer but this option helps employers concerned with providing affordable health care to all employees. Expect an increased interest in income-based contributions; Chrysler recently announced it is implementing income-based contributions for salaried employees.
- **<u>Smoker surcharges</u>**: Many companies are charging smokers more for health insurance. Smokers typically have more health issues and drive up the medical plan cost. The logic of smoker surcharges is that smokers increase plan cost and therefore should pay a higher premium amount. Many organizations feel smoking is a lifestyle decision. If individuals decide to smoke, they should pay more for health insurance.



Employers need to be cautious in their plans to apply smoker surcharges. HIPAA non-discrimination rules will require certain steps be followed in launching a smoker surcharge. In addition, your organization should consult an attorney to make sure you are not violating any state law protecting smoker rights.

Employers are considering a myriad of options when it comes to employee contributions.

Value-Based Benefit Plans

Value-based benefits have also received a lot of press lately. These plan designs lower the cost of certain medications. Value-based designs attempt to remove any barriers to care for certain chronic conditions. Value-based designs don't affect all benefits the plan pays. The plan identifies the chronic conditions prevalent in the claim base. The conditions must have a proven treatment regimen that maintains the individual's health and minimizes complications. Typical conditions falling into this category are asthma, diabetes, and heart conditions.

This approach focuses on maintaining the health of those with chronic conditions. Studies have shown that as employers increase the copayments for medications, patients discontinue their treatment regimens because of the cost of medication. Unfortunately, complications can lead to more expensive treatments such as emergency room visits and inpatient hospital stays. Value-based plan designs lower the

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employee cost for critical medications necessary to control chronic conditions. The list of value-based medications will not be very long and would probably include diabetes medications, cholesterol-lowering medications, blood pressure and asthma medications.

Consumer-Driven Health Plans

Many very large employers have implemented Consumer Driven Health plans as one of their benefit plan options. Because employers continue to express interest in these plans, they are likely to become much more prevalent.

Consumer driven plans increase employees' cost for health care. These plans have a high deductible and in many cases, cover only preventive care before the deductible is satisfied. Employees pay for many services out of their own pockets until they reach the deductible limit and then the plan picks up either the entire cost or part of the cost until the out of pocket limit is reached. Employers may offer accounts to help offset the high cost of the deductible.

Several account options are available:

- Health Reimbursement Arrangements or HRAs
- Health Savings Accounts or HSAs
- Medical Reimbursement Flexible Spending Accounts or FSAs

Each account must meet separate IRS requirements. The account chosen will impact the plan design parameters.

Currently, most plans use the Health Reimbursement Arrangements. HRAs are attractive to employers because they allow complete flexibility in plan design. HRAs can also coordinate fairly easily with medical flexible spending accounts. This coordination allows employees to maximize tax savings on additional out of pocket costs with the high deductible health plan. However, HRA accounts can be funded only by employer contributions. In addition, HRAs are not actual accounts but really just unfunded employer plan liabilities. The funds accumulated in an HRA are paid out only when the employee has incurred an eligible expense.

Over the last year, Health Savings Accounts have become more popular, primarily with very large employers. Many employers initially launched CDHPs with HRAs. When HSAs were first introduced, employers did not have enough information to administer the accounts. Over the last several years, the IRS and Treasury Department have clarified key HSA issues. With these additional guidelines, employer interest in HSAs has risen.

A CDHP with an HSA will be a very complicated plan compared with traditional HMO and PPO plans. In order to be eligible to contribute to an HSA a number of plan design and contribution conditions must be met.

A primary challenge for many employers considering CDHPs with HSAs is a mid-year effective date. Not all plans use a January plan year; however, deductibles are usually measured on the calendar year. The difficulty with launching a mid-year plan is the full annual deductible is applied but the HSA maximum funding is pro-rated for the number of months the individual is covered by an HDHP. Therefore, in year one, the employee will be limited in the funding of the HSAs, even though the full deductible applies.

Other employers are not sold on these accounts but like the idea of employees being more financially involved when they seek health care. These employers are launching higher deductible health plans and offering medical flexible spending accounts for individuals to pay the additional out of pocket costs with pre-tax dollars.

Consumer Driven Health plans are complicated. Organizations should carefully consider whether to adopt these plans. For more information on CDHPs, please review out *Advisor* on Consumer Driven Health plans at http://www.mcgrawwentworth.com/Benefit_Advisor/2006/BA_Issue_3.pdf.

Wellness and Disease Management

According to Mercer, care management plans are a key strategy employers are considering for managing health plan cost. Care management strategies include wellness initiatives and disease management programs. Both wellness and disease management focus on the health of your employees and in many cases, their family members.

Wellness plans are intended to keep your low risk individuals, low risk. Employers have many options to consider when they choose wellness plans. Many organizations begin with Health Risk Assessments. These assessments usually include a health

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questionnaire and a series of routine blood screenings. The result is a report describing an individual's health along with recommendations for improvements. Many companies are launching wellness plans to improve employee health.

Disease management programs are specific to employees with certain health conditions. These programs help patients to manage their conditions properly by making sure the patient takes the necessary medication and makes appropriate changes to diet, exercise, and so on. Chronic conditions can be very expensive if the condition is not properly managed.

The following are cutting edge ideas health plans and employers in the care management realm are implementing:

- **Predictive Modeling**: Predictive modeling takes wellness and disease management to a different level. Predictive modeling involves analyzing health plan data and health information to determine which employees may develop chronic conditions. When these individuals are identified, the health plan begins to actively manage the "at risk" participants to improve lifestyle choices and hopefully avoid the chronic condition.

- **Coordinated Care Management**: One vendor is taking the concept of case management and applying the principles to all employees seeking care. The process of obtaining care for a medical condition can be frustrating. Often, a patient can go through a series of tests and office visits to rule out a number of conditions and at the end of the day be no closer to a diagnosis. The health plan pays for all the investigative tests. This vendor helps patients find appropriate care and coordinates communication with all the medical providers.

Employers will continue to become more involved in improving employee health. A few positive changes in employee health status can have long term payoffs in lower health plan costs as well as productivity gains and reduced absenteeism costs.

Conclusion

Now more than ever, employers need to take action to proactively manage health plan cost. Many organizations have made aggressive changes over the last couple of years. Some are now wondering whether at some point benefit plan changes will keep employees from getting the care they need.

This concern is leading many organizations to investigate cost control strategies aimed at improving health and effectively managing chronic conditions. It seems we are on the cusp of some major changes on the landscape of employer provided health benefits. These changes will make employees accountable for their lifestyle choices and give them incentives to stay healthy.

Employers need to actively manage plan cost. Health plan increases are in the single digits but only because employers are reexamining their plans and involving employees more in the cost of care.

If you have any questions regarding managing health plan costs, please contact your McGraw Wentworth Account Director. MW

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