



BENEFIT *Advisor*

In This Issue

In this sixth issue of the McGraw Wentworth Benefit Advisor for 2007, we provide our annual examination of trends in health care cost and health plan management. Health care cost increases have remained at a level 6% for 2006 and 2007 in Southeastern Michigan.

The 6% increase is after the employer has made plan changes to manage cost. Employers need to actively manage their health plan in an effort to control increasing health plan costs. This Benefit Advisor discusses numerous strategies your organization can consider to help manage your plans and increase your employees involvement with the health plan.

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 seems health plan conversations are now ongoing discussions in many organizations. Because health plan costs affect profitability and competitiveness, many organizations are examining options to help keep 2008 cost increases manageable.

McGraw Wentworth’s 2007 Southeast Michigan Mid-Market Group Benefits Survey results are encouraging. The survey showed employers in Southeastern Michigan have had some success in managing their health plan cost. The median for cost increases after the employer made plan changes was a flat 6% in 2006 and 2007. Other sources report raw trend increases generally range between 10% and 13%. To keep increases in the single digits, employers must take an active role in managing their plans.

Local results are similar to national benchmarks. Mercer’s National Survey of Employee Sponsored Benefit Plans shows employer health plan cost reported after employer plan changes increased by only 6.1% for both 2005 and 2006.

Single digit increases are a welcome relief for many employers who struggled with double digit increases for many years. Unfortunately, the 6% increases are still twice the inflation rate. In addition, in absolute dollars,

for the first time locally, the median monthly PPO family cost is just over \$1,000 a month.

Health plan costs have increased dramatically since 2000. Most organizations are struggling to manage these costs because they have been unable to absorb the increases each year. What’s more, today’s cost drivers are

difficult to control. For example, employee lifestyle choices contribute significantly to the problem. Employees’ health and lifestyle choices as well as their health care purchase decisions definitely

affect health plan cost.

This *Advisor* discusses the following:

- Critical issues that affect medical plan cost.
- Effective strategies to manage health plan cost.

The single digit cost increases for the last two years show employers are using effective strategies to keep costs down. Employees are also beginning to understand the cost of care and the relationship between overusing their health plan and rising health plan cost. Some employees are even starting to understand health plan cost is a business expense affecting the overall success of the organization.

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Most organizations are informing employees about health plan costs; as a result, many employees are trying to avoid overusing their health plan benefits. Employers need to continue to inform employees and engage them as partners in keeping health plan costs down.

Medical Plan Cost – Critical Issues

Even with cooling cost increases, the dollar amount to provide health care benefits is substantial. Mercer reports the 2006 average annual plan cost for all employers and all plan designs was \$7,523 for each employee. In 2005, the cost of the health plan as a percentage of payroll averaged 15.1% for all employers.

Among the many factors influencing health plan costs are the following:

- **Employee Health:** The general health of your workforce and their covered dependents affects your health plan costs.
 - **Population is Aging:** Baby Boomers are the largest segment of the population and the predominant segment of the workforce. Baby Boomers bring valuable experience and leadership to your organization, but as they age, they will likely need to use more health plan services.

If your workforce is significantly older than the general population, it makes sense to expect higher health plan costs. To manage cost with an older workforce, offer

wellness and disease management programs. These programs will help older workers maintain their health and manage chronic conditions effectively.

- **Obesity Affects Many:** Obesity has a major impact on overall health. It contributes to the development and severity of numerous chronic conditions, such as high blood pressure, diabetes, heart problems and so on. The regular care and monitoring of these conditions increases health plan costs for your organization. One common factor affecting obesity is a sedentary lifestyle. Inactive people are likely to gain weight and develop other health problems as well.

One of the most frightening aspects of the obesity epidemic in this country is that it steadily increases every year.

Over 60% of the population in the United States is overweight or obese. What's more, obesity is not just a problem for adults; it also affects many children. Physicians are treating more and more children for adult onset diabetes, unheard of just twenty 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; their exercise and diet habits need to be changed dramatically to improve their lifestyle.

The good news is obesity is not necessarily fatal and is readily treatable. A healthful diet and increased exercise can significantly improve the quality of life for your employees and their families.

- **Chronic Conditions:** Chronic conditions are moderate to severe medical conditions requiring continued treatment, such as diabetes, high cholesterol and sometimes, even back problems. Treatment for chronic conditions can be costly. However, if a chronic condition is properly treated with medication and lifestyle changes, the cost can be managed effectively.

On the other hand, when chronic conditions are not properly identified or carefully managed, the cost for treating complications can be substantial.

A review of your health plan usage will likely show a good percentage of your participant's claims are for treating chronic conditions. Employers need to be aware that managing chronic conditions is

important. If employers continually increase employee cost-sharing, it may impact how an employee manages a chronic condition. As a participant's cost of care rises, for example through consumer driven health plans, the danger is that the participant will stop taking medication and curtail physician visits to save money. It has been proven that as a participant's



cost for care increases, the participant's use of services (both non-essential and essential services) decreases. This practice could result in complications for employees with chronic conditions, and treating complications is generally more costly than simply managing the chronic condition with the appropriate medication.

- **Pharmacy Benefits are a Mixed Bag:** Prescription drug costs were a driving force contributing to the double digit increases in the early part of this decade. Increases have slowed over the last several years primarily because many blockbuster medications have lost their patent protections and generic alternatives are now available. Many plans now encourage employees to choose generic drugs.

The increased availability of generics is great news for

many organizations. Although prescription drug use has increased over the last five years for many plans, pharmacy costs are being held in check because more and more plan participants are using less costly generic alternatives.

The main concern in the pharmacy arena today is specialty biotech medications.

A good portion of the medications currently in development are high cost specialty medications.

A number of specialty drugs are available to treat cancer, arthritis and other debilitating conditions. Employers' next challenge will be to manage these pharmacy costs through prior authorization plans, step therapy requirements or specialty pharmacy benefit management vendors.

- **Provider Practice Patterns and Quality:** Government plans are leading the charge when it comes to provider quality and provider practice patterns. These issues definitely impact the cost for care. It is in every health plan's best interest to pay for the most cost effective treatment and the most competent providers. The government has launched several efforts in these areas. Health plans are also working on programs to gear patients to quality providers.

Pay for performance programs are designed to pay for 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. Pay for performance programs attempt to evaluate the health care process and treatment options. In this regard our system is broken; it pays based on the quantity of health care services performed without considering whether the treatment is effective or even necessary. Treatment options need to be examined more carefully to make sure providers are using proper treatment protocols.

Many health care payers are also reviewing provider practice patterns. Dartmouth studies regularly identify large discrepancies among treatments offered in different geographic regions. The key question for many health care payers is – are the differences in practice patterns because of different health needs or merely because providers learned treatment patterns from their mentors? The challenge with practice patterns is changing how providers decide on treatment options.

Health plans and the government continue to watch quality and accountability in health care. The government recently took a big step in supporting quality. On its Medicare site, in the hospital compare section, it is beginning to offer data on heart attack treatment outcomes at various hospitals. This information will certainly help patients choose the right hospital and the right treatment.

Health plans are still trying to figure out how to design pay for performance programs. Some plans have launched high performance networks that steer employees to cost effective, quality providers. High performance networks have not caught on in South-eastern Michigan. Humana is the only carrier currently offering a high performance network option.

These key areas influence health plan costs. Employers should look at strategies that manage these cost drivers. In the next section, we review a host of strategies organizations are using to help control health plan costs in the long term.

How Are Employers Managing Costs?

Employers are taking action to manage their health plan costs. Strategies intended to improve employee health and encourage care compliance have become popular in Southeastern Michigan. These strategies, along with consumer driven health plans, are also popular nationally. The following are tactics and strategies your organization can consider to help manage health plan cost:

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

Wellness and Disease Management

Improving employee health is important to employers at many levels. Employees with poor lifestyle choices and chronic conditions cost

your organization in more ways than just health plan cost. Several studies show high health risks raise absenteeism rates and lower productivity. These studies offer compelling evidence to employers that investing in employee health may provide long term value to the organization.

McGraw Wentworth's 2007 Southeast Michigan Mid-Market Group Benefits Survey shows organizations locally are very interested in a variety of wellness initiatives. Nationally, many surveys report improving employee health as a lead strategy in controlling health plan costs. Wellness strategies can be very diverse, but most have a common goal of keeping your healthy employees healthy.

Wellness plans can have a number of goals but most organizations strive to make employees aware of their health and its impact on the organization as a whole. Wellness programs are fun because your organization can choose a variety of programs to help employees maintain good health or improve some aspect of their health. These programs can be offered individually, targeting specific behaviors. For example, many organizations offer smoking cessation programs, nutrition classes and health club discounts. These are important programs that will help your employees improve some aspect of their lifestyle.

However, many employees do not readily accept the idea that they need to change some aspects of their lifestyles. Because certain employees will not take part in recommended annual physical and health

screenings, they don't know they have high blood pressure, diabetes, high cholesterol and other conditions. The lack of awareness is dangerous because, in general, by the time the employee realizes a health problem exists, the condition may be serious enough to require expensive medical care and time off.

Employers can offer employees health risk assessments to counteract the potential harmful effects of these undetected serious health conditions. A health risk assessment combines information from a health questionnaire with the results of various biometric screenings, such as blood pressure screening, cholesterol, blood sugar measures and so on. The wellness vendor then gives the participant a complete report and recommends steps to improve overall health. Some organizations will offer health coaches to help employees improve a targeted behavior.

For certain employees, health risk assessments can be lifesaving. Many employees do not get annual physicals or recommended cancer screenings. If employers provide incentives to strongly encourage participation, these employees will know their current and potential health risks.

Incentives are an important part of the wellness equation. While health conscious employees are inherently drawn to wellness programs, employees not focused on their health are more difficult to reach. The most effective incentive is cash in one form or another. Some employers



offer a discounted health plan rate to employees participating in wellness programs. Other employers offer cash incentives. The general consensus is an incentive of roughly \$25 a month is enough to garner an 80% to 90% participation rate.

Disease management programs are a bit different from wellness plans. The goal of disease management programs is to help employees with chronic conditions manage those conditions effectively. Managing a chronic condition through diet, exercise and medication can prevent expensive and dangerous complications.

Most health plan vendors offer disease management programs as part of their services. When you review your vendor disease management programs, ask these questions:

- How are participants for various programs identified? Does the vendor focus on chronic conditions identified in your employee base or are their condition management programs based on the book of business experience?
- How are members contacted when they are identified? Is the process passive, or does the vendor automatically enroll eligible participants?
- What conditions does the disease management vendor target and what steps does the vendor take to help participants manage their conditions more effectively?



If your vendor does not put enough emphasis on managing disease, you may want to consider an independent vendor with more aggressive disease management strategies. Some organizations are getting more involved in disease management. Organizations that believe disease management makes a difference offer incentives to employees participating in the program. For example, some organizations offer free diabetic test strips for employees enrolled in a diabetes disease management program.

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.

Consumer-Driven Health Plans

Consumer driven health plans were significantly more prevalent nationally in 2006. Locally, McGraw Wentworth's 2007 Southeast Michigan Mid-Market Group Benefits Survey showed the number of employers offering consumer driven health plans increased by only 3%. Employers continue to express interest in

these plans, but not many organizations have implemented them.

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. The general belief is that if participants are reintroduced to

the cost of care, they will make better health care purchase decisions. When they are responsible for the bill, they may look for generic alternatives to a prescribed brand name drugs or question providers on cost and care options.

Employers may help offset the high deductible by offering one of the following options tax-favored accounts to help fund the deductible:

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

Each account must meet separate IRS requirements and has a different impact on the underlying health plan.

HRAs are not as popular in Southeastern Michigan where only a small percentage of consumer-driven health plans use these accounts. Nationally, approximately half of employers offering a consumer driven health plan use HRAs. HRAs are attractive to employers because they allow complete flexibility in plan design and do not have as many complicated requirements as HSAs. 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. On the other hand, only employers can fund HRAs. In addition, HRAs are not actual accounts; instead, they are really just unfunded employer plan liabilities. The IRS views them as self-funded medical plans. These accounts typically do not earn any interest because they are just book-keeping entries until a claim is incurred.

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Health Savings Accounts are very popular in Southeastern Michigan. Over 80% of Southeastern Michigan employers offering a consumer driven health plan offer an HSA. 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 plan must meet a number of design

and contribution conditions. For more information on the requirements and complications of Health Savings Accounts, please

see our *Benefit Advisor* at http://www.mcwent.com/Benefit_Advisor/2007/BA_Issue_3.pdf.

HSAs are employee-owned custodial or trust accounts. While HSAs are complicated, they can offer significant benefits to employees. The contribution limits are generous and for most vendors once the account reaches a threshold amount, the account holder has a variety of investment options. The account funds and accumulated interest remain tax-favored as long as the funds are used to pay for IRS qualified medical expenses.

Consumer driven health plans are complicated. Organizations considering these plans should make sure employees understand the benefits and drawbacks early in the process. Organizations should also carefully consider plan options, potential adverse selection issues, plan pricing and potential account funding. The



jury is still out on whether these plans save money over the long term.

Value-Based Benefit Plans

Value-based benefits options continue to receive press and generate interesting discussions. When organizations review health plan cost and determine health plan strategy, many decision makers fear if the plan sets the cost of care too high, employees will not seek necessary treatment. This is a real concern since many studies support the concept that as employee cost sharing amounts rise, plans save money in two ways. The first way is that the employee pays more of the cost. The second is that the employee may not seek medical services if it costs the employee more. In some cases, employees may simply cease to seek non-essential care. But in other cases, employees may not even seek essential care. If the employee does not receive needed care, the resulting complications may cost the individual and the plan more money.

Value-based plan designs latch onto the concept that the plan should really pay the majority of cost for treatments that save lives and have a proven track record. Sounds easy, but it is really more complicated than it sounds. When you look at treatment options available for any medical condition, trying to distinguish which save lives from which enhance lives is difficult.

The launching of value-based plan designs is still in its infancy and these plan designs are focusing on prescription drug treatments initially. The plan designates a copay tier for high value medications, such

as medications for high blood pressure, diabetes, high cholesterol and typically asthma. The copays for medications treating those conditions are intended to be affordable. Other medications have higher copays. The affordable copays should not impose a financial barrier to care for critical, life-saving medications.

Value-based plan designs are pretty uncommon at this point, but the concept of these plans makes sense to many. Many health plan vendors are looking seriously at making these types of plan options available to employers.

Plan Design Changes

At one time or another most employers have made changes to their plan design to help mitigate cost increases. In general, plan design changes shift more of the cost for covered services to employees. Remarkably, the results of McGraw-Hill's 2007 Southeast Michigan Mid-Market Group Benefits Survey showed very little change in median amounts employees pay for deductibles, coinsurance and office visit copays. However, for most categories the average increased, showing some employers are increasing employee cost sharing requirements, but not enough are making changes to move the middle values.

When employers are considering various plan design options, it makes sense to consider using copays to discourage employees from seeking unnecessary care. Some employees tend to overuse health care services and also misuse certain types of health care providers. To the extent your plan re-involves employees in the cost of the care or provides incentives to seek cost-effective care, the plan can limit overuse.

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Some plan design options that reinvolve your employees in the purchase process include:

- Different copay amounts for primary care physicians and specialty care physicians. An office visit to a specialist can cost two to three times the amount of a visit to a primary care physician. A primary care physician can usually provide the treatment needed at a lower cost. Higher copays for specialist visits will prompt employees to think about whether their primary care provider can handle their health care need.
- Some employers have eliminated the office visit copay and subject all office visits to the plan deductible and coinsurance. This means an employee will likely pay for an entire office visit in some cases. When the office visit costs more than just \$15, employees do consider whether a visit to the doctor is truly necessary.
- Employers are also reconsidering plan designs for pharmacy benefits. Some plans are creating meaningful differences between generic and brand name drug copay amounts to compel employees to use and investigate generic alternatives for treatment. Some employers are getting more aggressive and requiring "mandatory generic" plan designs. Under these plans, the plan will pay only for the generic whenever a generic is available. If the employee chooses a brand name drug, the employee must pay the generic copay and the cost difference between the generic and brand name drug.

Employers are slowly changing plan designs to keep their health plan costs in line. If you are considering a change in your plan design, look for options that will compel employees to seek the most cost effective treatment options.

Eligibility Strategies

Another effective cost saving measure is to re-examine your plan's eligibility provisions. Eligibility strategies are important, especially if your organization has a high family enrollment rate. Typically, the more people a plan covers, the more the plan costs.

In last year's McGraw Wentworth Benefit Survey, surcharges or restrictions on spouses were very popular. Roughly, 15% of survey respondents had plans limiting spousal eligibility. The prevalence of spousal limitations increased slightly in South-eastern Michigan in 2007, but is still double the prevalence of these provisions nationally.

The following are spousal eligibility limitations your organization can consider:

- **Spousal surcharge:** Increase the employee contribution to cover a spouse with access to coverage under another employer's health plan.
- **Spousal restriction:** The two primary ways of implementing a spousal restriction are:
 - Spouses eligible for coverage through their own employer's plan are not eligible under your organization's group health plan.

- Spouses eligible for coverage through their own employer's plan are eligible under your organization's group health plan only if they enroll in their employer's plan.

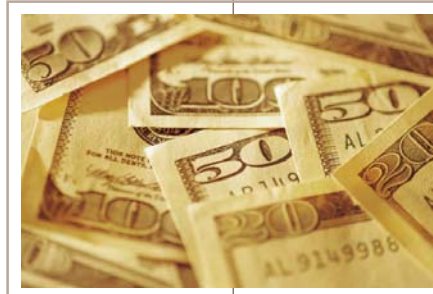
Another popular eligibility cost control strategy is conducting dependent audits. An organization can use internal resources or hire an outside vendor to audit dependent eligibility. The basic idea is that the employer restates requirements for eligible dependents under the plan and asks employees to prove their dependents are indeed eligible.

It is a bit of work, but most employers will find some currently covered dependents are no longer eligible.

Contribution Strategies

Increasing the amount an employee has to pay for the health plan will also decrease employer costs. Typically, employee contributions vary depending on the plan and the level of coverage. Employers should review their contribution strategy annually to determine whether the strategy is meeting the plan goals. For example, to encourage employees to enroll in a certain plan, review your contribution amounts. A lower contribution amount may induce an employee to choose a less expensive plan option.

When employers launch consumer driven health plans, typically, they want employees to enroll in the



consumer driven option. To encourage enrollment, some employers offer the plan for free. In many cases, however, the savings from a consumer driven plan will not offset the loss of contributions that employees pay for other employer-sponsored health plan options. As part of your annual analysis, review gross and net cost exhibits and assume different enrollment patterns in different plan options to model potential net plan costs. Contribution modeling is an important step in reviewing plan options.

Some employers are considering other contribution arrangements, including:

- **Income-based contributions:** 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 may be 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 implemented income-based contributions for salaried employees in 2007.

- **Smoker surcharges:** Smoker surcharges certainly have received a lot of press this year. However, the press has not translated to action. Only 3% of respondents in the McGraw Wentworth survey charged smokers higher premiums to participate in the medical plan.

Because HIPAA non-discrimination rules require employers to follow certain steps when they launch a smoker surcharge, employers need to be cautious. For more information on HIPAA's non-discrimination requirements, please see our *Benefit Advisor* at http://www.mcwent.com/Benefit_Advisor/2007/BA_Issue_1.pdf. In addition, your organization should consult an attorney before implementing a smoker surcharge to make sure you are not violating any state law protecting smoker rights.

Employers have increased employee contributions every year but the percentage employees pay for coverage

compared to total cost has remained fairly stable.

Conclusion

Organizations will always need to review and manage health plan costs. Health care cost contributes mightily to labor costs in our country and in many industries creates a severe labor cost disadvantage. Employers can no longer sit on the sidelines and not be actively involved.

Strategies that focus on improving the health of your plan participants are garnering the most attention with organizations. The return on investment of these options is not set in stone but employers believe improving employee health will decrease health plan cost and absenteeism rates while it increases productivity.

Nationally, the number of employers offering consumer driven health plans grew significantly. Locally, the growth was less pronounced. Any strategies your organization can consider that will re-involve employees in the cost of care or provide incentives to use care more efficiently will likely pay off.

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

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