



BENEFIT *Advisor*

In This Issue

In this sixth issue of the McGraw Wentworth Benefit Advisor for 2008, we discuss trends affecting health plan costs and how health plans are impacted by increasing costs. Organizations are struggling to absorb even single digit increases in health plan costs.

McGraw Wentworth's Mid-Market Benefits Survey shows that some organizations are successfully managing health plan costs year over year. We will discuss the strategies these organizations are adopting that may be helping them more effectively manage health plan 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.

“Health Plan Trends”

Another year has gone by and the McGraw Wentworth Mid-Market Employee Benefit Survey shows Southeast Michigan employers have managed to keep health plan cost increases in the single digits, at 7% for 2008. West Michigan's employers health plan cost increases are a percent lower at 6%. This seems like progress, especially since cost increases in Southeast Michigan were 11% just five years ago. With annual PPO costs for singles just over \$4,800 and annual costs for families at just over \$13,000 a year, even single digit increases can be difficult to absorb.



The good news is that some employers are successfully controlling cost increases. Our survey refers to these organizations as the TrendBenders™. TrendBenders™ cost increases have averaged 2% or less for 2007 and 2008. The McGraw Wentworth survey shows these TrendBenders™ are achieving lower costs and lower increases by making more aggressive choices with plan management.

Health plan cost is a serious concern for most organizations, especially in Michigan where the economy is struggling. If companies intend to continue offering health benefits to employees, they will need to make tough cost management decisions.

This *Advisor* discusses the following:

- Issues Affecting Medical Care and Cost in This Country
- Strategies To Control Health Plan Costs

Employers have actively attacked rising health plan costs over the last few years. Doing nothing to reduce costs is no longer an option. Although raw trends vary depending on the source, they generally show yearly medical cost increases can range anywhere from 10% to 15%.

Managing health plan costs has gotten much more difficult over the last five years. In many cases, employers have picked the “low-hanging” fruit when it comes to the health plan. Increasing deductibles, prescription drug copays, office visit copays, and so on, are fairly easy changes for employers. Employees have likely seen these changes before and while they may not appreciate the increased cost when they seek care, they do understand these plan changes.

The new strategies employers are considering today are a bit more complicated than easy cost sharing changes. Employers are now considering options requiring significantly more employee participation and education. These new cost control strategies place more financial responsibility on plan participants and at the same time strongly encourage them to make better health and lifestyle choices.

Issues Affecting Medical Care and Cost in This Country

Americans will hear quite a bit about the health care crisis from the candidates seeking office this year. The candidates have plans to improve the current situation, although they mistakenly refer to these plans as universal health care. Universal health care implies a government-sponsored health care system.

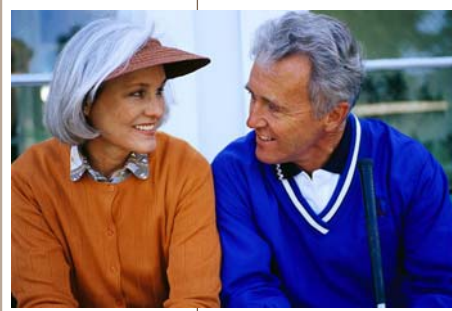
The candidates, however, are not proposing a government sponsored system, but rather a system to decrease health plan costs by offering low cost health plans for the uninsured and underinsured. Most health care received by the uninsured is charity care.

To ease the burden this charity care creates, health care providers simply shift the cost of this care to their insured patients.

Unfortunately, paying health care costs for the uninsured is not the only problem facing our health care system. We also need to consider the following issues:

- **Health:** Mike Huckabee, a former Presidential contender, used to say quite frequently, "We do not have a health care problem in this country, we

have a health problem in this country." He is right. In fact, he is in a unique position to understand this issue. Just a few years ago, like many Americans, Mike Huckabee was obese, had poor nutrition habits and was quite sedentary. He realized his health was not good and he made some very difficult lifestyle changes. He improved his health habits, lost a significant amount of weight and made physical activity a part of his daily life. If even half of Americans made these difficult decisions to improve their health, the health care system in this country would not be so strained.



People often do not even know they have a chronic condition. In many cases, these conditions

Many factors influence an employee's health, including:

- **Age:** Our population is aging, and with increased age comes increased health care cost. The largest segment of our population is the baby boomers, and soon a significant number of these baby boomers will be eligible for Medicare. This influx of beneficiaries to the government supported system will surely strain Medicare's financial resources. Employers cannot do anything about the aging of the population or Medicare costs, but they can improve their employees' overall health at any age.

- **Chronic Medical Conditions:** A substantial portion of our population suffers from at least one chronic condition, such as asthma, diabetes, heart conditions, high blood pressure, and so on. Physicians prescribe medication and lifestyle improvements to keep these conditions in check. When patients do not follow the recommended treatments, they may suffer costly complications.

are first identified when patients get a routine physical exam or when they see a doctor for another reason and the physician runs various medical tests. Many of us do not get recommended preventive exams and can go years without visiting a doctor. The longer the chronic condition goes untreated, the more likely expensive and potentially life threatening complications will occur.

Chronic conditions are all too common among Americans. Recently Medco Health analyzed prescription drug records from 2001 to 2007. The popula-

tion sample included 2.5 million men and women of all ages. The results are scary:

- ◆ Almost two out of three women over age 20 took at least one prescription for a chronic condition.
- ◆ One in four teenagers and children took at least one prescription for a chronic condition.
- ◆ Just over half of adult males take at least one prescription for a chronic condition.
- ◆ Three out of four people age 65 or older take at least one medication for a chronic condition. Among the senior population, 28% of women and 22% of men take five or more medications regularly.

➤ *Poor Lifestyle Choices:* To manage a chronic condition, a patient must not only take the proper medication, but also make lifestyle changes. It is estimated that 50% of all health problems are related to patients' poor behavior choices. These choices include smoking, poor eating habits, little physical activity, drinking too much alcohol and ignoring safety procedures. It is rare that people acknowledge the relationship between their lifestyle choices and their health. Smoking may be the only exception since the health risks associated with smoking are clearly documented and regularly

published. Many people rate their health as excellent despite a poor diet and lack of exercise in their daily lives. Improving lifestyle choices will benefit the employee as well as the employer.

• **Practice Patterns and Quality**

Care: In the last decade health care providers have been monitored more closely than ever for their role in increasing our health care costs. Every few years Dartmouth studies examine the differences in practice patterns across the country and the effect of those care decisions. These studies regularly show at least 30% of health care services are not necessary and in many cases, can actually cause a patient harm.

Physicians are in a difficult position. The

complexity of health care has increased exponentially over the last several decades. There are so many diagnostic options and treatment possibilities that it can be difficult to determine the right course of action. In addition, patients' expectations are very high. They expect a cure; it is rare that an individual leaves the physician's office without a prescription.

It is a challenge for providers to keep abreast of all the recent developments in health care. In addition, evidence to

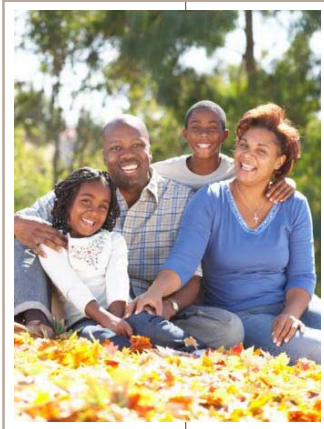
support the effectiveness of many new treatment options is not clear. Under the current system, physicians get paid regardless of the quality of the care they deliver. Recently, however, health care plans have adopted a policy not to pay for "never events," in other words, treatment errors that simply should not have happened. For example, a surgeon may intend to operate on a patient's left shoulder, but may accidentally operate on the right shoulder instead. Although these events are rare, health care plans have paid for these surgeries in the past. Now most carriers and government plans clearly state they will not pay for "never events."



Quality of care often gets little attention but it is an important problem in our current health care system. Patients regularly seek medical help without consid-

ering whether they're receiving quality, effective care. Outcome data is not easily accessed. Very few patients check for treatment quality and effectiveness. Physicians do not necessarily want to report outcomes and they certainly are not thrilled with the idea that outcome data will be published. While many physicians are not opposed to publishing outcomes, they dispute the methods organizations use to determine treat-

ment quality and effectiveness. One of their key concerns is the patient's actions are not taken into account. A physician can offer the right treatment, but if the patient fails to follow through on lifestyle changes or take the recommended medications, the treatment is recorded as ineffective; the record, however, fails to reflect the patient's responsibility.



Improving quality of care should be a key focus in upgrading the current health care system. The federal government and many health plans are working on provisions to link quality care to payment amounts. Quality of care initiatives also include publishing quality scores or creating high performance networks based on quality standards.

These are just the initial strategies that pull quality into the payment equation. As more research is done on quality health care, we will likely see strategies that emphasize the quality and effectiveness of various treatment options.

These are just a few of the pressures on our current health system. Everyone recognizes that the health care system in our country needs to be improved. We spend far more on health care than any other developed nation and our outcomes are just mediocre.

Employers, as the primary payers for health care in the country, may not be able to resolve all our current health care problems. However, in their role as a payer, employers can change their benefit plans to help improve certain aspects of the health care system.

Strategies to Control Health Plan Cost

Some employers are controlling costs more successfully than others. When employers shift more cost and accountability to their employees, the employees tend to become more actively involved in health care decisions. Employee engagement is important if your organization expects employees to act responsibly when they seek health care.

Employers are focusing on the following strategies to help control health plan cost increases:

- Eligibility Strategies
- Wellness and Disease Management Strategies
- Consumer-Driven Health Plan Options
- Contribution Strategies
- Value-Based Plan Designs

No single strategy is likely to help employers meet their health plan budget goals. Instead, employers are implementing many short- and long-term strategies to help control cost. For example, an organization may offer a consumer-driven health plan to help meet short-term budget goals and at the same time invest in a comprehensive wellness program that should help reduce long-term strain on the health plan.

Eligibility Strategies

Eligibility strategies are divided into two categories:

- Plan Eligibility Provisions
- Eligibility Administration Practices

Both of these topics are hot issues with employers today.

Plan Eligibility Provisions

Employers have tremendous flexibility when it comes to determining which dependents the health plan will cover. Most employers cover full-time employees, their spouses and dependent children up to age 18 or 19. They also typically cover dependents beyond 18 or 19 if the dependent is a full-time student. Some employers even cover part-

NOTABLE THOUGHTS

THE ONLY WAY TO ENJOY ANYTHING IN THIS LIFE IS TO EARN IT FIRST.

GINGER ROGERS (1911-1995)

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time employees and domestic partners. The more enrolled dependents, the higher the employer's cost.

In Southeast Michigan, medical plans have historically had rich benefits with relatively low contributions when compared with the national marketplace. The result has been the employer pays more for each employee and this burden is made even greater when many family members enroll. These employers' plans become the "plan of choice" at open enrollment. In many cases, the employer's plan is so comprehensive many employees do not even bother to consider coverage options available through a working spouse. The result has been a much higher cost for employers sponsoring "plans of choice."

How do you know whether your employees view your plan as a plan of choice? Your family enrollment percentage is usually a pretty good sign. According to Mercer's 2007 National Survey of Employer-Sponsored Health Plans, 56% of employees (in the large employer segment) choose dependent coverage. If your plan has a family enrollment rate significantly above 56%, it is likely your plan is the plan of choice.

Employers do not necessarily want to cut back benefits and dramatically increase contributions to make their plans less attractive. They can, however, choose to limit spousal enrollment. The spousal limitation provisions described below are very popular in Michigan:

- **Spousal Restrictions:** Spouses eligible for coverage through their own employers are simply not eligible for

coverage under the employee's plan. Restrictions are a popular eligibility strategy; 12% of organizations in Southeast Michigan, 17% of TrendBenders™ and 19% of West Michigan employers include them in their plans. According to Mercer, only 6% of large employers nationally have a spousal restriction.

- **Spousal Surcharges:** Surcharges are a bit less restrictive. With a surcharge, spouses eligible for coverage through their own employers are charged an additional premium to enroll in the employee's health plan. In Southeast Michigan, 7% of employers use spousal surcharges, 4% of employers use one nationally and only 3% of West Michigan employers use the spousal surcharge. The surcharge amounts are not small; the average surcharge is \$82 a month and the median amount is \$99 a month in Southeast Michigan.

Restricting spouse eligibility as a cost control strategy is much more popular in Michigan than it is nationally. It makes sense; employers aiming to preserve rich benefits as long as possible embrace ways to encourage employees to consider other coverage options.

Employees, on the other hand, generally do not embrace spousal restrictions and surcharges. Most employees believe they are being pe-

nalized because their spouses work and have coverage available elsewhere. Employers must carefully explain the decision to add a spousal limitation. Employees need to understand how these limitations keep health plan costs in check.

Eligibility Administration Practices

Eligibility management practices have received a significant amount of press as well in the last year. Many employers are planning to conduct eligibility audits in the next two or three years. These audits verify the dependents covered by the plan meet the eligibility requirements.

Employers can take many approaches when they conduct a dependent eligibility audit. Next month's *Advisor* will describe in detail

the various approaches and key employer considerations.

However, audits are not the only eligibility management strategy employers are investigating. Many employers may tighten their administrative processes to make sure employee additions to the plan are legitimate dependents and to verify dependents are still eligible.

Most employers in the survey verify student status (if it is a requirement for covering dependents between 19 and 25) at least once a year and most employers request documentation when an employee adds a dependent mid-year.



Employers can take the following steps to tighten up the administrative process:

- Request documentation whenever a dependent is added to the plan, especially when new hires enroll and when dependents are added at open enrollment.
- Verify the dependent is still a student at the beginning of each school term.
- Use a detailed affidavit with a strongly worded fraud statement to verify annually that covered dependents still meet the definition of eligible dependent.
- Survey COBRA participants at least twice a year to determine whether they have experienced a COBRA terminating event.

It may take a little more time to monitor eligibility aggressively. Once you build the more aggressive approach into your administrative process, it will not be difficult to continue the new process. It can decrease your total cost because your organization is being more diligent in making sure your plan covers only eligible dependents.

Wellness and Disease Management Strategies

Health management is the top strategy nationally for controlling health care cost. This strategy is also becoming more common in Southeast Michigan. According to our survey, while 14% of all respondents sponsored full-fledged wellness programs in 2008, 18% of TrendBenders™ sponsored these plans. West Michigan is even more focused on employees health with 29% of organizations offering full-fledged wellness plans.

This number may not seem overwhelming, but full-fledged wellness programs typically involve an investment from an organization. They often include a health risk assessment paired with biometric screenings. Full-fledged wellness programs also include coaching to help high risk employees improve their health and coaching to help change or improve an unhealthy lifestyle habit.

We also asked about “a la carte” approaches to wellness. In the current economy, employers may feel committed to wellness, but may not be able to invest in a comprehensive wellness plan. To overcome this problem, over half of survey respondents sponsor “a la carte” wellness programs. This approach involves offering a variety of separate programs designed to improve employee health, such as:

- Smoking cessation programs.
- Weight Watchers at Work sessions.
- Health related lunch-and-learn sessions.
- Programs to increase physical activity, such as walking paths, fitness challenges, in-office exercise programs and so on.
- Healthful food options in cafeterias or vending machines.

These are only a few examples of “a la carte” wellness plans. Your options are only limited by your imagination and maybe your budget.

You may want to offer incentives to increase employee participation in your wellness program. Most employees will not participate in wellness programs without some incentive. Our survey showed 45% of employers offered incentives and an average of 45% of their employees participated in the programs. The remaining employers did not offer incentives and only 26% of their employees participated.

Incentives are a key factor in creating a successful wellness program.



Dr. Edington from the Health Management Research Center at the University of Michigan believes a “best in class” wellness program should achieve an 85% to 95% participation rate after three years.

Our survey shows most organizations are generally not achieving this high level of participation. If your organization is aggressively trying to enroll employees in your wellness programs, reconsider the incentives you are offering and also ask employees why they are not participating. Once you understand the reasons, you can determine how to improve the participation rate.

Wellness is not always an easy sell to upper management. In theory, it sounds good; however, guaranteeing a return on investment is difficult. First, the results are not immediate. It takes anywhere from one to three years to see the effect of successful wellness programs. Second, there is no accepted method to determine return on investment.

There is an ongoing debate on how to measure the effect of wellness plans. Finally, it is difficult to isolate the impact of wellness in terms of the group health plan; especially if your plan covers less than 1,000 participants. If your organization does not have enough covered participants, it will be difficult to determine whether decreased health plan usage is due to the wellness program or perhaps another reason.

Employers do not need to measure the success of wellness plans only in terms of lower health plan costs. Instead, employers can measure other significant factors. For example, some organizations choose to compare absence rates before and after they implement wellness plans. Organizations also look at employee health at the beginning of the wellness program and review key health metrics each year for employees that continue in the wellness programs. They look at the biological measures such as high blood pressure, high cholesterol and high blood sugar. They also look at lifestyle concerns such as smoking, lack of physical activity, average sleep each night and stress levels. A good wellness vendor should give your organization a comprehensive report. The first year data will serve as your baseline and your organization should measure success in terms of improvement in key areas.

In short, the lead strategy for controlling health care cost nationally is health management through wellness and disease management initiatives. Employers believe im-

proving employee health will help keep health plan costs in line. It also has additional benefits including improved attendance, lower workers' compensation costs and increased productivity.

Consumer-Driven Health Plan Options

More employers are offering employees a consumer-driven health plan as one of the plan options. Our 2008 Southeast Michigan Mid-Market Survey indicates while 16% of survey participants offer a consumer-driven health plan, 25% of the TrendBenders™ offer these programs. West Michigan is even more aggressive with 28% of employers offering a consumer-driven health plan. Consumer-driven health plans shift a significant amount of cost to participants. They are typically paired with tax-favored accounts to help offset some of the employee's additional expenses.

Consumer-driven health plans have their challenges. Employees with lower incomes will have a hard time affording necessary care. These plans can also be very complicated, especially if the high deductible health plan is paired with a health savings account. Employers need to spend time teaching their employees about these plans and how to use tools to determine cost and quality of health care providers.

Our survey also showed an interesting enrollment trend in these plans. Employers typically offer consumer-driven plans with low or no em-

ployee contributions along with a health savings account the employee can fund through the contribution savings. The general trend has been to offer these plans as an option among other options and until now employee enrollment rates have been typically less than 5%.

This year, our survey showed a definite shift in enrollment. More employees are enrolling in these plans.

The increase in enrollment can be attributed to a number of factors. First, many employers are now in their second and even third year of offering consumer-driven health plans. Employees become more comfortable with these plans over time. A second possible reason may be cost. Consumer-driven health plans require a low employee contribution. When employees compare this amount to contributions for other plan options, the savings encourage employees to choose the consumer-driven health plan.

Employers are still waiting for the Academy of Actuaries to determine how much employers can generally expect to save over the long term when they offer these plans, and how much employers should expect to save as a result of consumerism. Consumerism is the effect of changes in participant behavior. In a consumer-driven plan, since employees pay more out of their own pockets, it is expected they will make better decisions about seeking care. Vendor reports suggest that employees do make better treatment decisions. These reports indicate employees in consumer-driven plans use generic drugs more frequently and use the emergency room less.



Currently it seems interest in consumer-driven health plans is cooling. The national market has adopted consumer-driven health plans more quickly than Southeast Michigan, but even nationally the growth of consumer-driven health plans has slowed a bit this year. In Southeast Michigan, interest in consumer-driven health plans as a cost control strategy has cooled as well. On the other hand, these plans are here to stay. Nationally, most employers expect to offer their employees consumer-driven health plans within the next five years.

Contribution Strategies

Increasing employee health plan contributions has been a top cost control category for the last several years. Although employers have not increased the percentage of cost employees need to pay, the contribution dollar amounts have increased annually.

Because some employers are concerned about whether their employees can afford coverage, they are adjusting contributions based on employee income. Locally, only 5% of employers have adopted this practice. Nationally that figure is 11%.

This strategy can be a challenge for employers. The typical approach involves basing the contribution amount on income level. Employees with lower incomes will pay less to participate in the health plan and employees with higher incomes will pay more. The theory is that higher income employees can afford to pay more for coverage.



Employers interested in tying contributions to income should consider the following:

- **Potential payroll vendor limitations when it comes to employee contributions.** If your organization sets up 4 separate contribution levels and offers 3 different plans, you are now offering 12 different contribution options. In addition to those options, you will also need single, two person and family contributions for all income levels and plan options. This complicated structure will need to be explained and administered properly.
- **Distribution of employees across the various income levels.** Most employers set

contribution strategies to achieve a net cost result. Your organization needs to set contribution amounts based on the number of

employees at each income level. If most of your employees are at the lowest income level and you decrease contributions for all your low income employees, employees at higher income levels will have to pay substantially more to make up for the fact most of your employees are paying less.

Contribution strategies remain a top cost control strategy for employers. However, most employers are not aggressively increasing employee cost to participate in the plan.

Value-Based Plan Designs

Value-based plan designs are not very popular in the local or national market yet. However, very large employers (10,000 or more employees) are extremely interested in evidence-based medical strategies. Very broadly, value-based plan designs consider the value or effectiveness of certain medical treatments. Most physicians will tell you there are a number of very effective treatment options. When patients use these effective therapies, they tend to have fewer complications.

Value-based plan designs are a first step toward varying health plan coverage based on a treatment's potential effectiveness. These plan designs have started in the pharmacy plan. Drugs used to treat certain conditions, for example, high blood pressure, diabetes, cholesterol and asthma, are highly effective. In a value-based environment, the copays for these drugs are much lower than the copays for other types of medications.

In theory, value-based plan designs make a lot of sense. Lowering treatment cost when a treatment has been proven effective in preventing complications means your plan is paying slightly more for something that can prevent more costly treatments. Many studies show when an employer raises copays for prescription drugs, some patients will simply stop taking the medication. Unfortunately, this tendency is not lim-

ited merely to life-enhancing medications. People stop taking life-saving medications as well. The goal in value-based plan designs is to eliminate any financial barrier that may keep patients from taking necessary life-saving medications.

Although this plan usually results in increased pharmacy costs, the ultimate goal is to reduce the extra emergency room visits and inpatient hospital stays that come about when patients do not follow their treatment regimens. Not many employers, however, have implemented these plan designs. In some cases vendors cannot manage them. These plans do make sense to some employers and many are interested in integrating this type of plan design because it ties nicely with a total health management approach to employees.

Larger employers are interested in this plan design as a future cost control strategy. However, many do not want to limit it to pharmacy benefits. What if a health plan evaluated the effectiveness of a myriad of treatment options for various conditions? The plan could pay a higher benefit for treatments that have a proven track record. For treatments where the effectiveness has not yet been established, the plan would still pay a benefit, but the employee will be required to share more of the cost.

These plans are interesting because they tie the plan payment to the effectiveness of the treatment. With so many treatments available to-

day, it is very uncommon for a health plan to determine payment based on effectiveness. If a plan could structure benefits this way, it would ensure affordable care for necessary treatments and introduce more cost sharing for less effective options.

Concluding Thoughts

Controlling health care cost remains a challenge for employers. Costs have increased substantially over the last ten years, and with the economy faltering, there is not much extra in the company budget. Many factors affect health plan cost increases, but employers need to focus on the areas they can influence as a primary payer for health care.



The TrendBenders™ identified in our local Mid-Market Benefit Survey have successfully controlled these increases more aggressively than the survey participants as a whole. To accomplish this feat,

TrendBenders™ take several approaches. First, they shift more cost to employees: these companies require employees to pay higher deductibles and higher copays for medical services. Next, they are more committed to consumer-driven health plans. Finally, they offer more comprehensive wellness programs.

Employers are considering a variety of ways to control health plan costs in the short- and long-term. However, you need to analyze these alternatives carefully to determine which options are best for your or-

ganization. If you have any questions about health plan trends and cost control options, please contact your McGraw Wentworth Account Director. **MW**

