McGraw Wentworth

The ViewsLetter

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Triage for Health Plan Management

Health plan costs continue to be a serious concern for organizations across our country. The good news is health plan increases have been in single digits for the last several years. The bad news is costs grew so significantly at the beginning of this decade that employers are struggling to handle even the single digit increases. In some organizations, controlling health care cost is a critical problem that needs to be addressed in order to survive.

Various organizations frequently survey employers about their health plan cost control strategies. Many have analyzed their data to examine what "best performing" companies are doing differently to reduce cost increases. The surveys show these companies are focusing more on employee health management and consumerism. Many organizations are trying to find ways to focus on employee health and consumerism that will fit in their corporate culture. Improving employee health and well-being affects health plan cost as well as productivity.

SHPS, a benefits and human resources outsourcing provider, recently released the results of a survey it conducted with 115 employers in 2007. Participating employers had to have at least 1,000 benefit eligible employees and typically reflected the Fortune 500. The survey asked about health care costs, employee health outcomes, benefit strategies, cost-shifting practices and so on. The survey tool measured the effectiveness and relative financial advantages of each of these strategies.

The results support a lesson most have learned: one size does not fit all, and certainly no single solution will work for all companies. All organizations differ and their employees differ as well. Rather than increasing copays, deductibles and employee contributions incrementally, employers are now analyzing the needs of their plan participants. Employers are looking for strategies that will motivate employees to be wiser consumers or improve their lifestyles so that they spend less on health care.

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About the ViewsLetter

We welcome you to the fourth quarterly issue in Volume Ten of the McGraw Wentworth ViewsLetter. It is our mission to be the leader in the employee group benefits brokerage and consulting industry to mid-sized organizations.

We have established the ViewsLetter as an integral part of our commitment to keep you informed of benefit trends, legislative and marketplace developments that may affect your group benefit programs.

We welcome your comments and suggestions regarding the ViewsLetter. You can pass your comments directly to your McGraw Wentworth Account Director or Account Manager, or you can reach us at www.mcgrawwentworth.com.

Triage for Health Plan Management, cont.

Most strategies simply focus on decreasing the demand for health care services. However, the SHPS study showed that health care costs for companies with targeted, clinically-based care management programs were 18.2% lower than costs for companies without these programs. These clinically focused strategies are not simple wellness strategies. These multi-pronged strategies that are aimed at the following:

- ***Catastrophically ill or injured employees -***
  Because just a few participants can generate 20-30% of annual plan cost, it makes sense to dedicate resources to them. In a targeted, clinically based management approach, a dedicated nurse case manager is assigned to these cases. The nurse serves as a patient advocate, counsels patients on their conditions, and recommends proper care. These nurses can also identify specialists with the expertise necessary to treat the condition. In critical cases, a quality provider can dramatically decrease health care costs. This approach may be the best use of resources in a health plan. It is cost effective, improves outcomes and quality of life for the plan participant.
- ***Chronically ill employees -***
  Very few plan participants fall into the catastrophic health needs category. A larger portion of health plan participants suffer from chronic conditions requiring regular care and better lifestyle choices. A detailed examination of your claim data can provide useful information on plan participants with chronic conditions. If these participants manage their conditions properly, they can often prevent costly complications. Plans successful with these employees examine the data closely to determine which participants are skipping medications and not scheduling regular check-ups. These participants are strongly encouraged to enroll in disease management programs, take their medications and get needed exams; some employers even offer employees incentives to motivate them.
- ***Healthy employees -***
  This approach does not ignore healthy employees. The strategy includes wellness programs, annual health risk assessments and biometric screenings. To help employees make lifestyle changes, the strategy also includes health coaching.

The most effective health plan strategy helps plan participants manage their individual needs. In many health plans, some of the above services may already be a part of the plan. For example, many health plans already offer case management services. However, the quality of these services varies. You may want to review your health plan's case management process to find out how it manages catastrophic health claims. Make sure your plan participants can contact a dedicated case management nurse if they have questions. If you are not happy with your present case management process, look for independent vendors to provide this service. An independent vendor may be more expensive, but a strong aggressive case management program delivers the best quality care for the lowest cost.

Disease management is another important component of an effective health care strategy. The quality of disease management programs varies widely. Specifically examine the actions your vendor takes to identify potential disease management participants. Is your vendor analyzing your specific claims data to identify participants with targeted conditions, and is your vendor also reviewing claims activity to identify potential gaps in care? Can your vendor access medical and pharmacy claims data? The vendor needs to analyze these claims to successfully intervene with disease management protocols.

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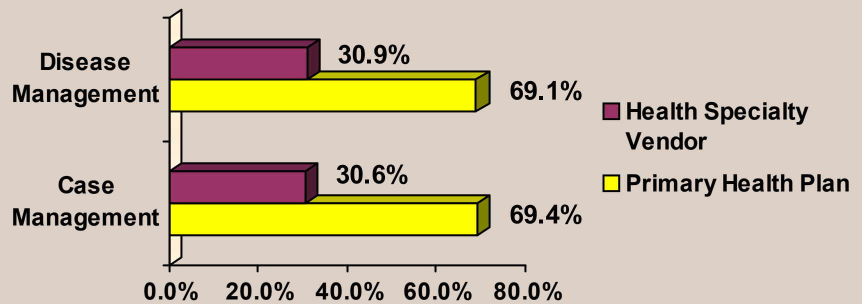
DID YOU KNOW?

- The average medical spending for the typical family with PPO health plan coverage reached $14,500 in 2007; an increase of $1,118 over 2006.
- Medical spending includes employer and employee contributions for health plan coverage, and employees' out-of-pocket expenses when any family member receives care.
- On average, employers paid $8,909 (62% of total medical costs) and employees paid $5,591 (38% of total medical costs).
- Of the employees' share, roughly $3,171 is accounted for by employee contributions for coverage and $2,420 is for cost sharing, including copays, deductibles and coinsurance.

Source: 2007 Milliman Medical Index

Triage for Health Plan Management, cont.

Care Management Vendor for Employers



Source: 2007 SHPS Health Practices Study

Once you identify potential participants, look at the outreach communication you are using to explain your disease management program. Some employees will participate in the hope of better managing their conditions while others will not be interested. Your organization may want to offer incentives to motivate any unwilling participants. For example, many organizations offer employees participating in a diabetes disease management program free diabetic supplies. It may be worthwhile to review your disease management programs to ensure they are effective. It also makes sense to ensure your disease management programs are targeted to your organization's key health issues.

If your disease management vendor is not successfully identifying participants or encouraging participation, your organization may want to find a more aggressive independent vendor.

Targeted care management programs are receiving more attention as more organizations are trying to manage health plan costs and increase productivity. While passive measures are not always effective, these new aggressive approaches to help manage care are showing success.

To identify employees' needs, these programs carefully analyze all the health claims and prescription drug data that health plans and wellness vendors collect. Just having plans available doesn't seem to be enough; vendors need to actively draw participants into the plan.

The SHPS study provided insight into the strategies employers are using to manage health care cost and the average cost savings for each approach. It was a bit of surprise that clinically focused care management plans are the most effective strategy to control costs. These plans are more successful than consumer driven health plans and health plan incentives for healthy behavior.

Employers need to find ways to manage health care cost. At some point, merely increasing employee contributions for coverage or asking employees to share more of the cost when they use the plan will hit a breaking point. Employers are now using risk management health plan strategies in an effort to reduce the risks for covered medical conditions.

This new era in plan management requires more thought and more work. However, controlling cost and improving employee health can benefit all aspects of an organization. MW

TREND TIDBITS

- $ Projected trend in 2008 for PPO plans with or without prescription drug coverage is 10.6%.
- $ Projected trend in 2008 for HMO plans with or without prescription drug coverage is 10.7%.
- $ Projected trend in 2008 for High Deductible Health Plans with or without prescription drug coverage is 10.9%.
- $ Projected trend for carved out pharmacy benefits is 10.7% for retail services and 10.6% for mail order services.
- $ Projected trend for speciality drugs (brand name drugs that require special administration or shipping and storing requirements) is 20.5% - that is 10 points higher than retail trend. Specialty drugs account for 17.9% of total drug spending and a significant number of new medications in the pipeline are specialty medications.

Source: 2008 Segal Health Plan Cost Trend Survey

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Prescription for Pharmacy Benefits

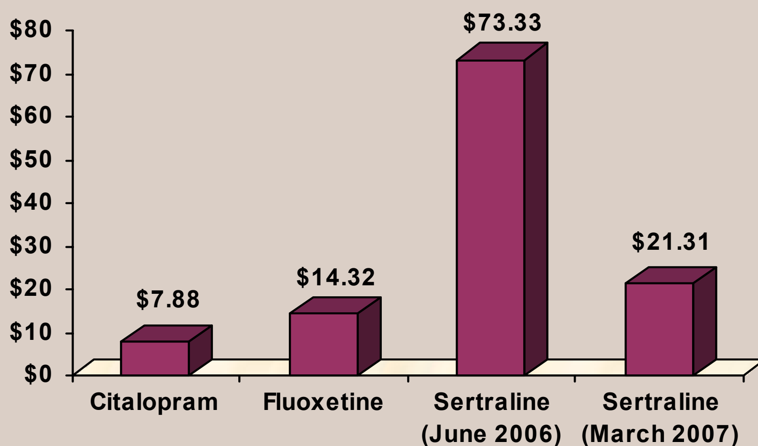
Pharmacy benefit costs have increased dramatically since the beginning of this decade as well. They have cooled over the last several years, but the projected trend is still roughly 11% for 2008. Effective plan management is the key to managing pharmacy benefit expenses.

Employers should consider the following three key areas:

- ***Cost:*** Many components of your pharmacy benefit contract affect medication cost; for example, negotiated discounts at each individual pharmacy, your mail order program discounts, and dispensing fees. Although rebates are also a consideration, employers should not rely on them. Drugs with aggressive rebates may still cost more than other therapeutically equivalent medications available. The better approach is to encourage employees to use the most cost effective medication.
- ***Usage:*** Drug pricing is a bit odd. A 40 mg dose of a medication may cost the same as an 80 mg dose of the same medication. In other words, taking a 40 mg pill twice a day can cost roughly twice as much as taking the 80 mg tablet. If there is no reason for the 40 mg/twice a day prescription, it is clearly more effective to require the 80 mg once a day. In some cases, the 80 mg tablet could be split in half for the twice a day 40 mg prescription. Not all medications can be split, but many can. You should ask your pharmacy benefit manager about the programs they offer to encourage cost-effective dosage options.
- ***Services:*** The mix of services your plan offers significantly affects costs. The mix of services refers to the types of drugs the plan covers, such as generics, preferred brand, non-preferred brand and specialty medications. If only 40% of your employees' prescriptions are using generic drugs, encouraging more employees to use generics will save substantial dollars. In plans actively encouraging employees to use generics through education and plan design, the generic utilization rate can be as high as between 70% and 75%.

Employers can influence drug costs and the most effective strategy may be to encourage employees to use generic drugs. New generic versions of blockbuster medications will continue to become available through 2009. They are an exciting opportunity for health plans and members, but you need to be cautious. You may not save as much as you expect during the first six months a medication is on the market.

For example, a generic for Zocor was released in June 2006. The first generic to the market was called Sertraline. The first generic to market is granted a 6-month exclusivity period. Having an exclusive hold on the market, there is not much market pressure to significantly reduce cost. An example of a Zocor situation is shown in the table at the bottom of the page.



Citalopram and Fluoxetine are generic antidepressants used as alternatives to Zocor. The initial price for the generic of Zocor was very expensive, but once the exclusivity period expired, the price dropped dramatically. When a new generic is released, your plan may want to wait six to eight months before encouraging employees to use the generic.

Some organizations encourage employees to use generics by requiring significantly higher copays for brand name drugs. It is generally thought a $15 difference between generic and brand name drug copays will compel participants to actively look for the generic drug. However, the income level of your workforce will also influence the decision to use generics.

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Prescription for Pharmacy Benefits, cont.

A highly paid workforce may not be tempted to use generics if the price difference is inconsequential. In this case, it may take a $25 cost difference to encourage your employees to use generics.

Encouraging employees to use generics will remain a cost effective strategy as more medications lose their patent protections in the next few years. The FDA approved the first generic alternative for Ambien in April of this year. Other medications losing patent protection over the next couple of years include Fosamax, Zyrtec, Serevent, Prevacid, Topamax, and many more. The patent expirations affect drugs used to treat many conditions including diabetes, insomnia, allergies, gastro-intestinal disorders, seizures and hypertension. These conditions represent a sizable amount of current drug costs (see table to the right).

New generic drugs will affect roughly 50% of the above drug costs over the next several years.

Encouraging employees to use generics can help you control your pharmacy costs. This strategy is a win for the health plan and a win for the participants because generics reduce costs for both. The new generic drugs offer a tremendous chance for employers to lower health plan costs. Your plan needs to manage pharmacy benefit costs efficiently as pharmacy plans become even more challenging in the next few years. In fact, the next hurdle will be specialty medications. These medications are generally expensive and have higher projected year-over-year trend rates. What's more, a substantial number of these medications are in the development pipeline. Savings on generics may be redirected to cover specialty medications designed to treat cancer and other serious illnesses. MW

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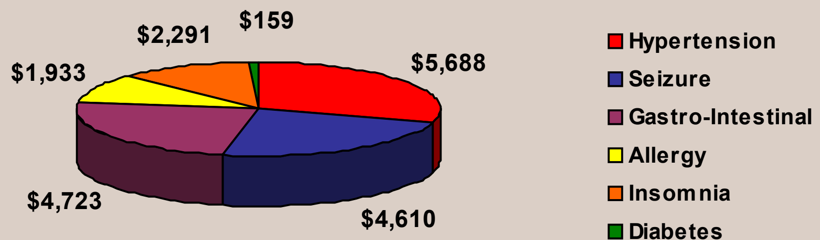
Conditions and Associated Brand Name Drug Costs (Millions of Dollars)



Source: Towers Perrin, 2007

YOUR QUESTIONS

Q. We currently have a former employee on COBRA. She got married last weekend and would like to add her new spouse to her COBRA coverage. Is our plan required to add her spouse to the COBRA coverage?

A. The simple answer is yes. The Health Insurance Portability and Accountability Act (HIPAA) grants special enrollment rights to all plan participants, including COBRA participants. The special enrollment rights require the health plan to allow any newly acquired dependent (new child or new spouse) to enroll in a plan mid-year if the dependent is added in a reasonable length of time. The length of time is usually specified by the plan and is typically 30 to 60 days.

However, COBRA coverage for the new spouse is linked directly to the qualified beneficiary's status. While the new spouse can be added to COBRA, he is ***not*** considered a qualified beneficiary. Therefore, if the former employee becomes covered under a new employer's group health plan, COBRA coverage for her and her spouse ends. Even if the new employer's health plan has a longer waiting period for dependents under the plan, the spouse will still lose the COBRA coverage. If the qualified beneficiary is no longer eligible for COBRA, the spouse is also not eligible.

Technical Corner

Using Technology for a Total Health Management

Employee health is a critical aspect of your organization. Employees in good health and good spirits are more productive than those suffering from chronic conditions or depression. The impact of employee health on an organization is becoming a key consideration in many organizations.

As employers look to improve employee health, they are analyzing key data to help them decide which measures have the most impact. Employers also use data to help them assess the benefits of health improvement programs for the entire organization.

To design a total health management program, collect key employee health and productivity information and analyze the following:

- Health plan use—look particularly at preventive care usage and chronic conditions driving your health plan cost.
- Disability and absence management data—determine what conditions or situations are causing lost time.
- Workers' compensation claims—determine what conditions are causing your workers' compensation claims.
- Results of wellness screenings and health risk assessments—determine the areas where your employees can benefit from changing their lifestyle or managing their health.

If possible, merge these data sources to form a comprehensive picture of your organization's total health. Unfortunately, it is not easy to merge this data. Instead, many organizations will need to review this key information in separate silos and draw conclusions from general trends.

For example, if you have many claims for back injuries under your health plan or workers' compensation program, and your wellness assessment shows a corresponding high level of sedentary behavior, your organization may want to consider wellness options that strongly encourage physical activity. It should stress increased aerobic activity, offer a disease management program on back care, and perhaps even offer an in-house yoga class.

You can also use this data to measure the success of your health management or lifestyle improvement programs. By integrating data from a host of different sources, your organization can identify behaviors that may increase costs and measure their impact in all areas of your organization. You can then use this data as a baseline to help you determine whether your targeted programs are effective in the future.

Managing current employee health is essential to managing future medical cost. Organizations are using many different approaches to health management. Analyzing the data from a variety of sources will help you target the key cost drivers in your organization. MW

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