Managing Health Care Costs: Back to Basics

By: J. Michael Deneen & Mark A. Abate

The cost of employer-sponsored health care benefits continues to increase at an alarming rate. In its 2002 Annual Survey of Employer Health Benefits, the Kaiser Family Foundation reports an annual rate of increase of 12.7% for employer-sponsored health insurance costs. Kaiser’s findings are corroborated by the survey findings of the large employee benefit consulting firms. Mercer Human Resource Consulting reports an annual rate of increase of 14.7% in its recently-released Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2002. Most industry experts agree that employers will face double-digit increases in their health care costs for at least the next 3-5 years.

What is fueling these increases? Unfortunately, the marketplace is experiencing a double whammy. Prices are increasing as providers have become less focused on competition and more focused on profitability. The demand for health care services is increasing as a result of the aging of the workforce and advances in medical treatment and technology. Prescription drug costs are also increasing at a rate of 18% per year, with no apparent offset in medical or surgical costs.

The predicament facing employers is how to balance their methods of addressing rising health care costs and employee morale and productivity. Many employers have begun to increase cost-sharing through increased contributions or reduced benefits, but how many times can this be done in a 5-year period before employee satisfaction begins to erode? Additionally, affordable health care is a significant concern for lower-paid employees; which is a critical cohort of employees for a company’s operating efficiencies.

The health care marketplace is abuzz with new initiatives around consumer-directed health care. If they have not already done so, most larger health plans (national and local) are unveiling their new consumer-directed product portfolio. All consumer-directed health plans include three basic elements: employee choice of plan or provider; financial incentives for members to use cost-effective plans or providers; and decision support tools to arm members with information necessary to make their decisions. All these elements should be part of every employer’s health care cost management strategy, but consumer-directed health plans are not a panacea.

In order to manage health care costs, employers must adopt a broad range of tactics that are configured and prioritized based on the unique demographics, population health status, culture and objectives of each employer. These tactics include the following:

- Diagnostic review of costs and utilization
- Aggressive plan benchmarking
- Plan consolidation
- Maximize network utilization
- Health and disease management
- Early risk detection and intervention
- Employer collaboration
- Promote consumerism
- Manage vendor performance
- Aggressive pharmacy benefit design

These tactics are described in detail in the remainder of this article.

**Diagnostic Review of Costs and Utilization.** This should be every employer’s starting point in its effort to manage health care benefit costs. The purpose of a diagnostic review is to determine (to the extent possible) the most likely factors influencing health care cost increases. With this information, an employer is able to prioritize its cost management tactics and develop a cost management strategy that will yield a more significant and immediate return.

For example, ABC Company, with average age of 50, may think its health care costs are high compared to other area employers, and the likely cause is an older population. Therefore, ABC Company’s cost management strategy should focus on addressing the health issues associated with an older population (e.g., aggressive management of heart diseases and digestive system disorders, and early detection of certain types of cancer).

The scope of a diagnostic review will include a review of the following:

- Employee and member demographic information
- Key plan cost and utilization indicators for inpatient and outpatient care, and comparison to industry norms.
- Large claim activity, including frequency and severity
- Paid expenses and encounter data by Major Diagnostic Category, and comparisons to industry norms
- Plan design to ensure that there are no gaps and overlaps in coverage and the benefit levels and covered services support contemporary cost management techniques
- Pharmacy data to corroborate prevalence rates of certain diagnostic categories and comparison of pharmacy cost and utilization indicators to industry norms

The results of a diagnostic review will be a useful tool for prioritizing the remainder of the cost management tactics presented below and for estimating a financial impact for certain initiatives.

**Aggressive Plan Benchmarking.** In many industries, there is intense competition for talent, and employer benefit programs can play a pivotal role in tipping the scale. Many employers actively benchmark their plans against industrial and regional peer organizations. Historically, many employers have used readily-available survey data to benchmark their plans. This has becoming increasingly difficult due to large-scale movement to shift more cost to employees. According to the *Kaiser* survey, 43% of all
firms and 78% of large firms (200 or more employees) indicate that they will “likely increase what employees pay for coverage in 2003” {FOOTNOTE}. Employer attitude surveys are becoming increasingly popular as benchmarking must be done against predicted, future plan designs rather than historical or contemporary designs. Employers who benchmark in the traditional manner will have dated plans before they are actually implemented.

**Plan Consolidation.** Employers have been moving toward plan consolidation in recent years to mitigate the impact of adverse selection. Historically, many employers have offered one or more local HMOs in many of their locations in addition to their core plan (e.g., PPO, POS or indemnity for the few hold-outs). Over time, the HMOs attracted most of the healthier employees, leaving a small, expensive population in the core plan. The result was anti-selection and it cost many employers a significant amount of money with no return on investment.

As the HMO marketplace matured, the differences in provider networks diminished and the national health plans got into the game; resulting in more options, alternative funding methods and a more competitive market. In response, employers have begun to reduce the number of HMOs, self-insure them, or eliminate them entirely. This is an effective way to generate savings, eliminating adverse selection, without changing benefit design or employee contributions.

**Maximize Network Utilization.** The goal of this tactic is to maximize utilization of a network of providers (hospitals, physicians and others) who have agreed to discount their services. The network of providers should ideally provide excellent geographical coverage and aggressive discounting of services. The plan design should be structured to encourage use of network providers through substantial financial incentives.

**Health and Disease Management.** Effective health and disease management programs can offer a significant return on investment if implemented effectively. In order to maximize ROI from these programs, employers must consider three factors. First, because ROI from these programs is not immediately realized, employers benefiting from these programs should have low turnover; employers with high turnover should look at other tactics. Second, an employer must use its own cost and utilization data to pinpoint the top two or three most prevalent disease categories and should focus health and disease management efforts on those conditions only. And third, because these programs are voluntary, employers should provide financial or non-financial incentives to encourage participation.

Many health plans (national and local) have implemented health and disease management programs for their entire membership. For the most part, these programs focus on asthma, diabetes, heart disease and fitness and nutrition. Employers have the ability to supplement these core programs at their own cost. It is critical that supplemental programs are effectively coordinated with the health plans to ensure maximum return. Additionally, some boutique vendors may be willing to put a portion of their fees at risk to guarantee a return on investment.
**Early Risk Detection and Intervention.** Early risk detection is a relatively recent managed care tactic and has been enabled principally by advances in technology and the need for more aggressive and proactive care management. The principal behind early risk detection and intervention is the old “80/20” rule, or the fact that (roughly) 80% of an employer’s health plan expenses are generated by 20% of its population. Early risk detection and intervention focuses on the 20% who generate the claims.

Early risk detection – also known as “predictive modeling” -- uses state-of-the-art software to scan an employer’s detailed claim data (medical and prescription drug) and identify plan members who are at risk for potential future deterioration in their health status.

With the information, the health plan or member’s attending physician can work proactively with the member to mitigate the risk of his/her health deterioration. Many national and local health plans have recently redeployed their clinical staff and have implemented a “health coach” program using the nurses to aggressively “coach” the at risk population to reduce the risk of higher claim costs.

**Employer Collaboration.** Employer collaboration may not have a direct impact on health care costs, but it is an effective means to exert pressure on the health plans to develop new products, continuously improve their program management and share data. Collaboration is prevalent in the small group marketplace for the purposes of collective purchasing. It is not common today to see larger employers collaborating on purchasing.

Like with everything else, there is one exception. Collective purchasing of prescription drug benefits has been the rage for the past couple of years. Several large geography- or industry-specific pharmacy purchasing coalitions have sprung up recently. Employers who self fund their medical programs, are willing to “carve-out” their drug programs, and are willing to take the chance on joining a pharmacy purchasing coalition can save up to 10% of their pharmacy plan costs (depending on their size).

**Promote Consumerism.** Everyone is talking about consumer-directed health care. Some are promoting it as THE answer to managing health care costs. Although real consumer directed health plans (a la Definity and Lumenos) may be a passing fad, their two key elements will likely become a permanent feature of most health plans. First, many employers are promoting the use of health education and decision support tools. The Internet has enabled many organizations to develop rich health information and decision support sites such as WebMD, DrKoop.com and Mayo Clinic. Health care consumers may visit these sites – free of charge – and research their conditions, treatment alternatives and (limited) provider quality data. They can then use the information to work with their doctors to develop treatment strategies and make the necessary decisions regarding their care.

Second, many employers are also modifying their health benefit design to encourage consumerism through financial incentives. This began a few years ago, when health
plans introduced a 3-tier copay design in their prescription drug benefit to encourage the use of preferred drugs. Now employers are re-introducing coinsurance for all health care services so that members can better understand the cost of health care services. The theory is that if employees feel the pinch of rising health care costs, they will use the web information and decision support tools and make informed decisions about their health care services and the providers they use.

**Manage Vendor Performance.** The success of any of these tactics is dependent upon their execution and strong service delivery from the vendor partners. As part of a long term plan management strategy, many employers routinely audit their health plan administrators to ensure that performance targets are being met and service to their employees meets expectations.

An effective vendor management program should include the following:

- At least *quarterly* meetings to receive claim experience updates, review key utilization statistics, receive updates on product and network changes and strategize about how the plans should be modified to maximize cost savings opportunities
- Formal schedule for receiving management reports
- Claims administration and clinical reviews every three years
- Periodic customer service reviews

Effective vendor management will generate direct cost savings through error avoidance and indirect cost savings by minimizing employees’ time resolving claim disputes and getting accurate information from the health plan on the first inquiry.

**Aggressive Pharmacy Benefit Design.** The prescription drug has been in a high-paced evolution for the past several years. Increases in total drug spend for most employers has been 17% to 20% for the past several years, and most experts agree that this trend will not diminish any time soon.

Employers’ response to the rising cost of prescription drugs has been aggressive plan management, including some or all of the following:

- Plan design incentives to use cost-effective drugs
- Carving out pharmacy benefits from the medical plan
- Aggressive clinical/utilization management techniques
- Close monitoring of marketplace developments (e.g., new-to-market drugs and drugs losing patent protection) and quick implementation of design changes
- Specialty pharmacy program for injectable drugs

Employers will only avoid unnecessary claims expense by staying ahead of the market and working in close partnership with their pharmacy benefit managers.
Conclusion: The Future. Although the future is uncertain and there are many variables out there that could influence health care costs over the longer term, we are likely to see the following:

- Sustained double digit health care cost inflation for the next 3-5 years
- Further cost-shifting to employees
- More employee choice; growth of catastrophic-level (e.g., high-deductible) plans
- Advances in technology will have a significant impact on the delivery of care and the health plans’ ability to manage utilization of services
- Prescription drug cost management opportunities will exist as many blockbuster drugs lose their patents and more biotech drugs enter the market

What this means is that employers must develop and implement a strategy to address rising health care costs today. Here’s a place to start:

- Know what you have: Summarize plan costs and determine primary cost drivers
- Know where you stand: Benchmark plan costs, design and cost-sharing against the marketplace
- Know where you’re going: Solicit management’s objectives for cost increases, employee relations and risk exposure
- Know how you’re going to get there: Identify and prioritize opportunities for further cost management
- Know when you’ve arrived: Evaluate marketplace alternatives and potential impact; continuously monitor; start your journey again.

Mark Abate and Mike Deneen are Principals of Strategic Benefit Advisors, Inc. (Hopkinton MA), a benefits consulting firm specializing in the design, funding and administration of group medical, dental, life and disability programs. They can be reached at 508-435-0500 or mark.abate@strategicba.com and michael.deneen@strategicba.com