

SOME OPPORTUNITIES DO EXIST

For Managing Health Costs

BY GAREN L. CORBETT

Across the country, both public and private sector employers are challenged by overwhelming increases in health-related costs. Double-digit increases for health insurance premiums are the norm this year. Municipalities in Massachusetts are feeling the squeeze, especially as revenues have not kept up with increases in fixed costs and local aid has not recovered from recent cuts.

Garen L. Corbett is a benefits consultant at The Segal Company specializing in public sector human resources and benefits issues.



Isolated efforts to control health costs no longer provide sufficient relief, and limitations imposed by state laws (M.G.L. Ch. 32B and Ch. 150E) and collective bargaining agreements make certain cost-sharing and plan design options difficult to implement. Notwithstanding these challenges, there are approaches that municipalities can adopt to address rising costs. Success depends on a combination of strategies from three broad categories: vendor management, plan management, and individual health management.

Possible approaches range from minor changes to a thorough plan redesign. Some solutions are new, while others borrow from approaches used in the past. The exact combination of strategies used will differ for each plan depending on the philosophy of the employer financing the plan. By paying attention to all three categories of cost management, public sector plan sponsors can address the factors contributing to alarming increases in health care costs that are, at least in part, within their control. (It should be noted, of course, that many factors contributing to high health care costs remain outside the control of employers.)

Vendor Management

Many health plan sponsors have long focused their efforts to contain health costs on vendor management. As experienced buyers of health benefits services, sponsors of public sector health plans have done a commendable job of seeking out networks with the greatest provider discounts, the best claims system, and the most robust support services. But more can be done. Plan sponsors can reduce costs by managing and negotiating terms more aggressively. Here are some suggestions:

- Inspect discounts closely. In some areas, The Segal Company has found that network provider discounts can vary among competing networks by as much as 20 percent. Discount evaluations must go beyond comparisons of the percentage off billed charges and must look at absolute dollar amounts for the same setting, same area and same procedure.

- Evaluate the vendor's efforts to monitor and improve the quality of network providers. For example, local and national initiatives to reduce hospital errors can improve the quality of patient care while also reducing catastrophic costs. A variety of employers in Massachusetts have been pursuing improvements in health care quality and safety, with positive results.

- Negotiate insurance terms such as trend, margin and risk charges aggressively. It is possible, and often advisable, to challenge an insurer's proposal after performing independent renewal projections using different methods and assumptions. Frequently, these alternative projections uncover carrier mistakes or noncompetitive terms that the insurer will reconsider.

- Reduce vendor fees to a minimum percentage of program costs. In general, at least 90 percent of total program costs should fund claim liabilities. Smart purchasing has enabled some plan sponsors to keep administrative costs to 10 percent or less of total costs. In particular, components of the administrative expenses of health maintenance organizations require close scrutiny because they almost always are proposed to exceed the 10 percent level.

- Require vendors to provide access to timely utilization data. Health plan account managers should provide information about your plan's unique claims experience. Two questions you should ask are: Where are services being utilized? And are there equally effective, but less costly alternatives? Data can be used to flag areas that need particular cost-management attention and to identify underused services that can be reduced or eliminated. For example, some clinical intervention programs offered by pharmacy benefit managers—paid for by plan sponsors—have provided little evidence of savings or improved outcomes, and may actually promote alternative drug products and therapies that produce greater revenue for the pharmacy benefit manager.

- Be sure to audit claims processing results. Professionally administered claims audits have frequently uncovered situations in which the payers of claims misinterpreted recent plan changes, and were, therefore, paying benefits improperly. Audits enabled the plan sponsors to rectify these problems and experience the cost reductions originally intended by the plan changes.

therefore, paying benefits improperly. Audits enabled the plan sponsors to rectify these problems and experience the cost reductions originally intended by the plan changes.

- Require vendors to agree to performance guarantees. These guarantees can be tied to efforts to detect fraud, as well as to high-accuracy results and the timeliness of payments, both of which have the added advantage of contributing to employee satisfaction. Strong performance standards for pharmacy benefit managers can be helpful in assuring high generic fill rates, reasonable rebate disbursements, favorable price discounts, and effective clinical intervention programs. Strong performance guarantees in the health plan program(s) can help to ensure that employees and retirees are receiving better care management and support. Ongoing performance against the guarantees should be actively monitored to ensure that the program receives the service level for which it contracted.

HEALTH PLAN SPONSORS CAN REDUCE COSTS BY MANAGING AND NEGOTIATING TERMS MORE AGGRESSIVELY.

Plan Management

Benefit plan design is probably the most controllable factor affecting health plan costs. The types and number of plan offerings are key variables. Plan sponsors that want to preserve effective levels of coverage without overpaying should consider the following:

- Establish meaningful cost sharing (i.e., deductibles, copayments, co-insurance and monthly contribution levels). Nominal copayments, which are frequently found in plans offered by municipalities, do little to discourage wasteful demand for questionable care. On the other hand, if the cost sharing is too high, it may deter employees from getting essential care. Plans can determine the "right" level of cost sharing by making comparisons to peers and evaluating the relationship between out-of-pocket costs and utilization behavior from other sources. At the least, employees need to gain a better sensitivity to the true costs of care.

- Establish appropriate cost-sharing differentials among treatment options and settings so employees are encouraged to seek the most cost-effective courses of treatment from the most efficient providers. Differences between network and non-network benefits, and the coverage for brand name and generic prescriptions that are significant enough to influence behavior, are important. Payment levels between competing therapies and inpatient/outpatient settings also need to differ. Plans with lower out-of-pocket costs for less expensive treatment options can change patient behavior, benefiting both employees and the plan's sponsor(s). Such cost management through cost sharing can even extend to employee contribution requirements. Plan offerings that have a proven track record of cost control and efficiency could be offered to employees at lower payroll deduction amounts.



- Provide coverage incentives for support services and complementary care to motivate employees to improve their health. Educational material about treatment options, home health aides, and access to support groups are examples of support services and complementary care that can be made available by mail, phone, the Internet and twenty-four-hour nurse lines.

- Evaluate plan designs that promote “consumerism.” One of the major flaws in our employer-provided health insurance system is that most consumers of health care do not face—or even know—the true price of health care. This situation generates excess use of medical services, which is partially responsible for escalating health insurance premium rates. Although public sector employers have shown little interest in defined-contribution health plan designs that transfer substantially more control over health purchasing to individuals, there is growing interest in plan designs that promote consumerism by giving participants more choices and information (and in many cases, a share of the costs) surrounding certain purchasing decisions. [A true defined-contribution health plan gives participants a fixed dollar amount to use for purchasing insurance and health services on their own.] Some plans incorporate health reimbursement arrangements—individual accounts funded by the plan sponsor that are used to reimburse participants for certain health care expenses. These arrangements must be combined with high-deductible insurance, but can include many traditional plan design elements. A redesigned plan can give participants greater vested interest in prevention and wellness services, and can include strong financial incentives to seek care in the network. This network, in turn, can be a smaller subset of providers and hospitals that have verifiably higher benchmarks in providing more efficient and safe medical care.

Individual Health Management

There is a growing body of evidence that many health care services are overused, ineffective, not properly adhered to by patients, and avoidable through prevention and health promotion. Plan sponsors should evaluate the effectiveness of the treatments being rendered to employees and create wellness programs (see related story) that educate patients and provide access to all available treatment options. The following strategies aim to encourage employee involvement in their own care and can help control costs:

- Introduce disease management programs for chronic conditions, such as diabetes, hypertension and depression. These programs identify providers, facilities and treatments that have the best track records for improved outcomes. Major insurers such as Cigna indicate that there is at least a two-to-one return on the investment in disease management programs. It is important to actively encourage your health plans to invest in and enhance the quality of their disease management programs. [According to AcademyHealth, an initiative of the Robert Wood Johnson Foundation, more than twenty states are already involved in Medicaid disease management programs. Most of these programs have not been operational long enough to yield data that can support savings, but there are reports that they are contributing to improving the quality of care.]

- Promote compliance with prescribed treatments. If a pharmacy benefit manager detects that a patient has neglected to refill a prescription for an essential drug treatment and informs

THERE IS EVIDENCE THAT MANY SERVICES ARE OVERUSED, INEFFECTIVE, NOT PROPERLY ADHERED TO, AND AVOIDABLE.

the patient’s physician, the physician will be better able to manage and monitor the patient’s condition.

- Use education and financial incentives to encourage employees with weight problems and poor eating habits to change their diets and exercise more. Health care costs tend to be higher for obese individuals, and there is a strong link between obesity and expensive, chronic conditions such as heart disease and diabetes. A major study sponsored by the American Diabetes Association showed that patients with Type II diabetes were able to control their blood sugar levels through diet and exercise at levels equal to or better than those patients taking oral diabetes medications. Plan sponsors should consider providing some level of coverage for appropriate weight reduction programs.

- Reduce the frequency of costly claims and services that may be useless or no better than non-invasive treatment options by requiring patients to pay a greater share of the cost of these questionable treatments. For example, a major teaching hospital conducted a study on patients with arthritis in their knees. Patients who were anesthetized but did not undergo surgery (placebo surgery) had similar outcomes to patients who underwent arthroscopic surgery. In another instance of wasteful and potentially harmful care, one-third of the 150 million outpatient prescriptions for antibiotics written each year in the United States are unnecessary, according to the Centers for Disease Control and Prevention. By providing employees with easy-to-read information about the success of competing treatments (e.g., surgery, rest, and pharmaceutical therapy) and requiring patients to pay for a reasonable portion of the cost of treatment, health plans may see a reduction in the use of questionable treatments. Call the account manager and/or medical director of your health plan(s) and ask them what they are doing in this area and how they plan to expand their efforts.

Delve Into Data

Plan sponsors can identify savings opportunities by reviewing vendor contracts and competitive information and by drawing comparisons to industry benchmarks. A detailed claims analysis is the most important task a plan sponsor can undertake to ensure that its health care cost management activity will target the source(s) of its particular problem area(s). This will enable the plan sponsor to develop targeted plan design changes and patient management services that address critical areas in need of cost management.

Before making final decisions about significant changes in coverage, however, employers may want to survey employees to determine what aspects of the plan they most appreciate and what features they would like to see changed. 🌟