

Controlling Your Business's Health Care Costs: **6 Things You Can Do Now**

Businesses can't afford to count on health care reform to provide relief from escalating health care costs.



Introduction

In the midst of what economists are now calling the Great Recession, health care costs have continued to increase dramatically. A recent study by PricewaterhouseCoopers' (PwC) Health Research Institute suggests that the trend of rising costs will continue. PwC projects that employer health care costs will increase by 9 percent in 2011¹. The projected rate of growth is down 0.5 percent from 2010. However, employers are once again faced with increases that far outpace inflation, wage increases, and revenue growth. The largest and fastest growing components of these costs continue to be physician fees and hospital costs (82 percent increase from 2000 to 2009), and prescription drugs (104 percent increase from 2000 to 2009). By comparison, insurance administrative costs increased at a slower rate for the same time period, and actually declined 2.52 percent during the past six years².

While the new health care reform law³ passed in March 2010 expands access to health insurance coverage, most analysts agree that the new law contains only modest provisions to address the trend of rising costs.

To predict what the future holds for health care costs, some point to the state of Massachusetts, which passed a health care reform law in 2006 very similar to the new federal law. Like the federal law, Massachusetts reform expands access to health care and requires most individuals to purchase health insurance. Even though the

Efforts to control costs will continue

to rely on the efforts of all stakeholders—employers, employees, providers, insurers, and health insurance agents/brokers.

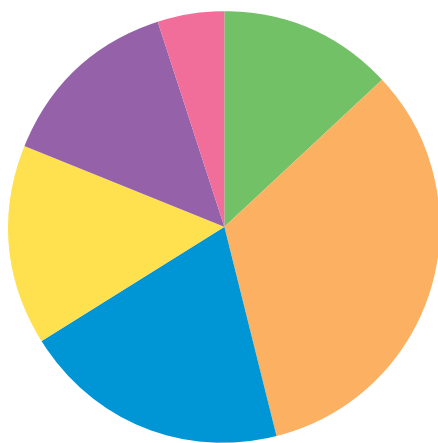


portion of the population with health insurance coverage has increased to more than 95 percent, health care costs have continued to rise, and state regulatory bodies have become embroiled in contentious disagreements with insurers over rate filings the state deems excessive. Insurers, on the other hand, say the proposed rate hikes reflect well-documented increases in medical costs. Viewed from any angle, this type of disagreement threatens the long term stability of the health care delivery system, and stands as a troubling harbinger for the national efforts to implement reform.

If the national trend follows what's happening in Massachusetts, and many experts think it will, businesses can't afford to count on health care reform to provide relief from escalating health care costs. Controlling costs will continue to require the efforts of all stakeholders—employers, employees, providers, payors, and your health insurance agent/broker. This guide offers six proven tactics you can employ in whole or in part, as you develop your health care reform era cost-control strategy.

87% of health care premiums

pay for physician and hospital services, prescription drugs, and other medical services.



- Physician Services (33%)
- Inpatient Costs (20%)
- Outpatient Costs (15%)
- Prescription Drugs (14%)
- Other (13%)
- Other Medical Services (5%)

1 Focused Provider Networks

On average, 87 cents of each health insurance dollar is spent on physician services, inpatient/outpatient services, prescription drugs and other medical services⁴. Thus, the pricing discounts health insurers are able to negotiate with health care providers for medical services is a critical factor in the calculation of health insurance premium. An insurer improves its negotiating position when it is able, through benefit design, to steer patients to a particular provider. Health care providers will often offer deeper discounts to an insurer in exchange for the promise of higher patient volume. The benefits of steerage can be seen most clearly when comparing traditional PPO and HMO plans.

Traditional preferred provider or PPO plans typically offer access to the broadest choice of health care providers, making them popular with employers interested in giving employees the widest possible choice of doctors and hospitals. Conversely, an HMO (Health Maintenance Organization) plan provides access to a strictly defined set of providers, often from a single health care delivery network. In many instances, the administrative component of the HMO is actually owned in whole or in part by the doctors and hospitals of the health care delivery network. The rationale for choosing an HMO over a PPO is economic; while the HMO limits choice of doctors, it can provide significant premium savings to the employer versus a traditional PPO.

Choosing an HMO versus a traditional PPO will continue to be an effective way for some employers to control their health care costs. In fact, WPS Health Insurance offers an HMO option, Arise Health Plan, in 20 counties across northeast and north central Wisconsin. However, the relative lack of provider choice intrinsic to an HMO

With a focused network plan such as *Patient Choice*, **employers can realize double-digit savings** in comparison to a traditional PPO.



plan can limit the viability of this solution for some employers.

Today, some employers are finding middle ground with an arrangement that offers the premium savings of an HMO, while providing employees a broader choice of doctors and hospitals.

One such plan available in southeastern Wisconsin is *Patient Choice* from WPS Health Insurance.

Under *Patient Choice*, health care services are delivered by multiple regional Care Systems—fully integrated health care delivery systems consisting of physicians, specialists, hospitals, and outpatient clinics. The employer funds coverage to the most cost-effective Care System and employees can buy up to access higher cost Care Systems. The annual Care System selection process creates competition among providers that can help control costs and improve the quality of care.

With a focused network plan such as *Patient Choice*, employers can realize double-digit savings in comparison to a traditional PPO, and still address employee needs for a broader selection of providers. WPS also offers other focused network solutions in most major markets in Wisconsin.

The fundamental objective of VBBD is to incent the use of **proven, high-value clinical services** through insurance benefit design.



2 Value-Based Benefit Design

Value-based benefit design (VBBD), also known as value-based insurance design, is a relatively new concept in the health insurance industry. According to the University of Michigan Center for Value-Based Insurance Design, the core principles of this concept are:

- *Value equals the clinical benefit for the money spent.*
- *Value-based benefit packages adjust patients' out-of-pocket costs for health services based on an assessment of the clinical benefit to the individual patient, based on population studies.*
- *Thus, the more clinically beneficial the therapy for the patient, the lower that patient's cost share will be. Higher cost sharing will apply to interventions with little or no proven benefit.*

In short, the fundamental objective of VBBD is to incent the use of proven, high-value clinical services through insurance benefit design. Individuals pay less out-of-pocket for clinically valuable treatments, and doctors may receive higher reimbursement or bonuses when they provide these services. Ineffective or marginally effective services are subject to higher out-of-pocket costs.

Incentives can include reduced or \$0 copays for certain prescription drugs used to manage potentially high-cost diseases, free cancer screenings, free or reduced-cost wellness services, and bonuses for providers who meet certain standards of care.

Many large employers—such as Wells Fargo, Lowes, and here in Wisconsin, Madison College—have successfully implemented VBBD and are seeing real benefits. These include improved

compliance with medications, medical cost offsets, and reductions in absenteeism and disability costs⁵.

WPS Health Insurance offers a VBBD plan for both small and large groups in northeast Wisconsin. The *WPS Value Incentive Plan* targets potentially high-cost conditions with a variety of incentives including reduced copays on high-value medications, free health risk appraisals, reduced copays at convenient care clinics, and pay-for-performance bonuses for doctors who meet certain clinical performance standards.

Motivating employees to make positive lifestyle changes—even small ones—can **significantly reduce your health care costs over the long term.**



3 Reduction of Modifiable Risk Factors

According to the Centers for Disease Control and Prevention (CDC), more than 75 percent of health care spending pays for diseases that are preventable⁶. If you can successfully motivate your employees to make lifestyle changes necessary to reduce or eliminate risk factors, studies have shown that you can reduce health care costs over the long term.

On average, for every 100 people in Wisconsin⁷:

- 65.6 may be overweight or obese
- 35.8 have high cholesterol
- 31.8 use alcohol excessively
- 27.7 have high blood pressure
- 22 don't exercise
- 18.8 smoke
- 9.9 have cardiovascular disease
- 9.8 have asthma
- 8.2 have diabetes

Some people may have more than one risk factor.

Additionally, 2007 Department of Health and Human Services data shows that for every 100 employees, an average of 44 suffer from stress or stress-related issues.

Three of the most prominent risk factors that correlate with high health care costs are obesity, smoking, and stress. WPS analysis of

the correlation of Body Mass Index (BMI) measurements over 30 (30 or higher in an adult is considered obese) and health care costs have shown a 38 percent increase in costs. Other studies have shown similar or even higher costs. Motivating employees with these lifestyle habits and conditions to make changes—even small ones—can significantly reduce your health care costs over the long term.

Wellness Council of America (WELCOA), an organization dedicated to worksite wellness programs, has identified seven best practices for employers to follow when creating a comprehensive, effective wellness program. WPS Wellness programs, available for both small and large groups, closely follow the recommendations and structure recommended by WELCOA, with an emphasis on reducing the highest impact and most modifiable risk factors and lifestyle choices.

Most adults spend more of their waking hours at work than anywhere else. That makes worksites a prime venue for promoting healthful habits. The bottom line is that reduced health risks equal lower health plan costs. By implementing a proven strategy to improve employee health, you are making an investment in your most valuable resource—your workers.

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the right drug,
in the right dosage,
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4 Comprehensive Prescription Drug Management

The 2010 Milliman Medical Index indicates that 17 percent of the increase in pharmacy spending in 2009 was due to an increase in drug use; the remaining 83 percent was due to “average unit cost increases³.” In other words, the growing use and per-prescription cost of medications continues to be an important driver of overall health care costs, accounting for 14 cents of every dollar spent⁴.

A comprehensive prescription drug management program that focuses on getting your employees the right drug, in the right dosage, at the right time, is critical to getting these costs under control. The pharmaceutical industry continues its concerted offensive to protect the profits of their brand name drugs, employing a variety of tactics including changing the chemical characteristics of drugs, their dose and dosage forms, and lawsuits against generic manufacturers. All of these efforts are intended to delay or otherwise foil the introduction of lower cost generic equivalents. In this environment, an effective prescription drug management program must include clinical and administrative mechanisms that maximize generic drug utilization when appropriate. These mechanisms include automatic generic substitution and step therapy, which drives use of the most cost-effective drugs first before more expensive brand drugs are dispensed.

Safeguards that protect employees from incompatible drug combinations and adverse drug events that can result in catastrophic medical costs are important elements of a cost saving prescription drug program; as are mail order, online consumer tools, and 24/7 telephone access to pharmacists and clinical specialists who have

a deep understanding of specific drug classes used to treat chronic conditions. For employers with self-funded health plans, securing a prescription drug plan predicated on transparent pricing and guaranteed rebates can add up to substantial annual savings. That can dramatically impact overall health plan administrative cost.

The rapidly growing use of specialty drugs is exacerbating already skyrocketing prescription drug costs. Specialty drugs (sometimes referred to as biologic or biotech drugs) are high-cost prescription drugs used to treat complex or rare medical conditions. Specialty drugs represent the fast-growing category of prescription drugs costs, with an average cost of \$2,000 per treatment and an annual prescription cost for many specialty drugs that can exceed \$100,000⁹. Needless to say, it's crucial for your insurer or pharmacy benefits manager to have a rigorous program in place that tightly manages appropriate use, purchase channels and administration of these medications.

An HSA-qualified plan can give your employees **more choices and greater control** over their health care decisions.



5 HSA-Qualified High-Deductible Health Plans

HSA-qualified high-deductible health plans (HSA/HDHP) have continued to be an important component of an overall cost control strategy since their introduction in January 2004. HSA/HDHP enrollment topped 8 million in the group health insurance market as of January 2010, up from 6.2 million the prior year, with average individual deductibles of \$2,329 in the small group segment and \$2,203 in the large group segment¹⁰. This growth, while impressive, represents only 6.5 percent of the total private health insurance enrollment in Wisconsin¹⁰.

An HSA-qualified plan can give your employees more choices and greater control over their health care decisions. Traditional health plans can insulate employees from the true cost of care. Richer benefit designs with low deductibles and copays can create the perception that health care is inexpensive. With few incentives for judicious utilization of health care services the result is predictable: increased and sometimes inappropriate use of health care and higher-than-necessary costs.

HSA-qualified high-deductible health plans can change the way employees interact with the health care system. Studies have shown people covered by an HSA/HDHP are more likely to ask about the cost of a visit to the doctor prior to making an appointment (26.2 percent vs. 16.1 percent) and more likely to inquire about lower cost alternatives for recommended treatments (32.9 percent vs. 25.2 percent)¹¹.

Employees own their HSAs and have full control over how these tax-favored funds are used to pay for qualified medical expenses.

At the end of the year, any unspent money simply rolls over for future medical expenses and continues to accrue interest. This added level of engagement and responsibility teaches employees about the true cost of health care and provides a material incentive to stay healthy and make prudent use of the health care system.

A multi-choice plan package keeps employer costs low and predictable, but allows employees to **choose a plan that works best for them.**



6 Multi-Choice Plan Packages

While HSA/HDHPs have proven to be an effective cost control tool, the implementation of these plans in a workplace accustomed to richer benefit plans can present a challenge. A poorly planned rollout of this type of plan or wholesale replacement of a traditional health plan with an HSA/HDHP can be viewed by employees as a “takeaway,” sometimes causing negative workplace dynamics.

A multi-choice plan package provides the key benefit of allowing the employer to offer one or more HSA/HDHP options alongside more traditional plan options. The employer funds a base plan, typically the lowest cost option, and employees can “buy up” to the richer benefit. The employer books the savings and achieves more predictable annual costs, and employees are granted meaningful choices, while becoming more engaged as consumers in the health care purchasing process.

An example of a multi-choice plan package is *ConsumerSelect* from WPS Health Insurance. Groups of all sizes can offer up to four plan options. There’s no extra cost to create a package with multiple WPS plans and the employer enjoys single-carrier ease of enrollment and administration.

Controlling health

care costs is our
common interest.

Conclusion

Experts predict that the health care costs trend will continue into the foreseeable future. The 2010 Milliman Medical Index contains the following ominous observation:

While underlying cost drivers as yet remain relatively unchanged, there are some changes that will have a predictable effect on cost. The immediate changes, such as increasing dependent coverage up to age 26 and elimination of lifetime and annual benefit maximums, will cause a direct shift in costs from employees to employers.

This guide presents some practical tactics businesses can employ as part of a health care cost control strategy, but it is intended only as a starting point. In the emerging health care reform era, the health insurance agent/broker is likely to become an even more important resource for employers as they attempt to navigate this new and uncertain terrain.

The next few years will be challenging for all stakeholders in the health care system, and controlling health care costs will continue to be a common interest shared by all.

About WPS Health Insurance

WPS Health Insurance is Wisconsin's leading not-for-profit insurer and has provided competitively priced, high-quality health coverage to businesses and individuals statewide since 1946. To find out how WPS can help your business control health care costs, **contact your local agent, or call 1-866-297-4977.**



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