A Healthcare Dilemma: How Companies are held Captive by poor plan design

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The ongoing healthcare dilemma in the US might for once be heading for a cure. At minimum it looks as if we may be able to provide some viable solutions to rein in an endlessly demanding monster. HMO's in the 90's served to put downward pressure on the ever-increasing costs associated with health coverage. But ice on a wound can only reduce so much of the swelling. Our best efforts have failed us and in many ways contributed to the creation of our "malfunctioning medical machinery".

In the 1950's the total cost of medical care accounted for approximately 4.5% of our Gross Domestic Product. As of 2000, annual corporate contributions exceeded $400 billion in premiums alone (Caplan, Health Benefits). And the monster is still not satiated. Today health care costs are approaching $2 trillion, representing over 15% of our GDP (Kaiser). According to Towers Perrin's *Health Care Cost Survey*, as of 2007 employers are paying close to 60% more on health care costs than they were five years ago. We outstrip any developed country (as a percentage of our GDP) in the world and lack any discernable defense to these costs.

Distribution of Average Spending Per Person, 2004	
Age (in years)	Average Spending Per Person
<5	$1,245
5-17	$1,108
18-24	$1,282
25-44	$2,277
45-64	$4,647
>64	$8,647
Sex	
Male	$2,836
Female	$3,715

Notes: Includes individuals without any spending in 2004.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2004.

We're all fed up. Harvard Professor Regina Herzlinger likens health care to a lose-lose proposition for businesses and employees alike. The former pay too much for too little and the later question the quality and depth of care they receive despite ever increasing out-of-pocket expenditures (Consumers). However, out-of-pocket expenditures may be where the cure rests.

Raymond J. Keating, chief economist for the Small Business Survival Committee, argues that the problem stems from the fact that Americans are essentially over-insured to a large extent because 3rd party payers shield consumers from the real cost of doing business. Pick almost any year in the 1990's and an audit will reveal that most Americans spent more of their own money on entertainment and apparel than they did on healthcare. Up until recently, out of pocket expenses have actually been steadily declining since the 1950's. According to data from the Health Care Financing Administration and the U.S. Census Bureau, out-of-pocket expenditures have fallen from 56% in 1950 to 17% in 1998. This mirrors an opposite trend according to the same source, which has seen government's third-party payer role grow from 14% in 1929 to 46% by 1998 (Keating).

Keating would argue that this is the source of our problem. That's not to say that insurance is not needed, but that 1st dollar coverage for matters outside of catastrophic coverage leads to an "over-insured" populace which has little incentive to make judicious medical care decisions. Regina Herzlinger couldn't agree more, "Consumers can be expected to affect health care costs only when they pay for them out of their own pockets" (Herzlinger, 262).

> *"When a third party-whether an employer provided health plan or the government – picks up the tab for reasonable and predictable health care spending, demand is driven up, and consumers and health care providers possess few, if any, incentives to be concerned about costs."* *Raymond J Keating*

We ultimately have been forced to ask who the consumer really is. Is it the corporation buying the plan from Blue Cross/Blue Shield or the patient demanding the newest and often-times costliest anti-biotic? Perhaps we should acknowledge that yes indeed, side-airbags are certainly utilitarian, but it's still essential that we all buckle up and drive safely.

The equivalent of this is showing up in the health-care arena in a movement entitled C*onsumer Driven Healthcare*. By shifting the burden of cost, choice and decision making directly into the hands of employees, competition can take its rightful hold of the market and encourage providers to compete on the basis of quality, convenience and price. "The consumer-controlled approach essentially relies on the fact that the public can control health care costs better than a government or managed care organization because the public will shop for health care more carefully and effectively than any surrogate acting on their behalf" (Herzlinger, 260).

This has led to a trend in the marketplace to replace "defined benefits" with "defined contributions". Instead of paying for a specified benefit, the employer advances a fixed amount of money to the employee, a.k.a. "the consumer" in this instance, to cover benefits that they have in part or whole selected.

An early example of this, prevalent in the 90's, involved the use of cafeteria plans. A flexible spending account would allow employees to contribute pre-tax earnings into an account which could be used to cover health care costs not currently covered by traditional insurance plans such as lasik eye surgery or certain types of dental work. The drawback was that if one did not use all of the predicted out-of-pocket expenditures for a given year, they lost that money.

Today defined contributions have gotten much savvier. In 1996, as part of the Health Insurance Portability and Accountability Act, tax-free *Medical Savings Accounts* were introduced on a trial basis to ease the high insurance premiums many small business owners and self-employed individuals had to contend with. Having passed the test, MSA's are here to stay in the form of *Health Savings Accounts.* An HSA provides a tax saving vehicle by which individuals and companies can set aside dollars to pay for out-of-pocket medical expenses. The dollars remain with the account holder and grow tax free until age 65 at which time the account holder can withdraw funds for non-medically related purposes (a taxable event).

Health Reimbursement Arrangements are another tool, currently under-utilized in the small group market. HRA's are funded solely by the employer and combine the best features of an HSA and a flexible spending account. Tax free funds can be utilized to pay out-of-pocket expenses or even to purchase health insurance if the employer wants to give the employee complete control and autonomy over their healthcare. This is an attractive feature to a healthy "40 something year-old" employee that would like to purchase long-term care coverage instead of a policy that focuses on heavy primary care utilization. Like the HSA, any unused funds can roll-over and can be used to cover non-traditional expenditures such as physical therapy or alternative medicine (according to the Summary Plan Description). Employers can pick up the interest earned on these accounts. HRA's are most effectively structured when attached to a traditional HDHP plan which kicks in after an HRA account has been drained and the deductible has been met. This serves as an incentive to avoid over utilization and to shop around for the cheapest service and prescriptions.

> *Former JAMA Editor, Dr. George Lundberg, argues that insurance has grown beyond its usefulness when it attempts to cover care beyond catastrophic coverage or even perhaps established preventive services. "In a world without coverage for routine care, practitioners would compete for patients on the basis of their expertise as well as on the quality of their services. Costs of care would moderate and satisfaction with care would increase" (125).*

What do CDHP's mean in practice? Can it actually save your company money without gutting the benefit levels provided to your employees?

XYZ Company (name has been changed to protect privacy) is a larger sized firm for a fully insured health plan with 124 employees covered and have some health problems. This firm's current health broker was from a respected and well established multi-line agency covering the full range of employee benefits and commercial insurance. The agent had over 30 years of experience in the insurance industry. This company's renewal had come in at +24.1%. The broker's solution was to stay the course and accept the increase. His reasoning flowed out of the fact this company was having trouble with group participation requirements, they were under the 75% of eligible employees rule and 50% of total full time employee requirement. If they moved to a new insurance carrier they would have

to entice more employees onto the group plan. The employer felt he could not raise the company's contribution level to get more employees into the plan. They took the 24% increase to keep a plan in place (the current carrier didn't audit the plan to se if they were meeting participation requirements).

No Plan Changes: Just kept health plan in place.

XYZ Company Current Plan Renewal:

*Out-of-Pocket includes Ded.	In-Network	Out-of-Network
Lifetime Maximum:	$5,000,000	
Coinsurance:	90%	70%
Calendar Year Deductible:		
Per Individual	$250	$500
Per Family	$500	$1000
Per Confinement	n/a	n/a
Out-of-Pocket Max:*		
Individual	$1500+co-pays	$3,000
Family	$3000+co-pays	$6,000
Hospital Charges:		
Inpatient	10% after Ded.	30% after Ded.
Outpatient	10% after Ded.	30% after Ded.
Emergency Room	10% after Ded.	30% after Ded..
Office Visits:		
Physician Charges	$25 Co-pay	30% after Ded.
Preventive Care	$25 Co-pay	30% after Ded.
Lab & X-Ray	100% after co-pay	30% after Ded.
Mental/Nervous:		
Inpatient	40% after Ded.	50% after Ded.
Calendar year max.	10 days: 3 admissions/lifetime	
Outpatient	40% after Ded.	50% after Ded.
Calendar year max.	12 visits: 25/lifetime	
Prescription Drugs:		
Tier 1	$10	
Tier 2	$20	
Tier 3	$35	
Rates:	Current	Renewal
Employee Only 87	$277.51	$344.39
Employee + spouse 11	$595.17	$738.61
Employee + child(ren) 11	$507.21	$629.45
Employee + Family 15	$907.12	$1125.73
Total Monthly Premium:	**$49,876.35**	**$61,896.51**
Total Monthly Change ($):	**$12,020.19**	
Total Admin + Est. Claims:	**N/A**	
Total Annual Premium:	**$598,516.20**	**$742,758.12**
Total Annual Change ($):	**$144,241.92**	
Total Annual Change (%):	**24.10%**	

Sage gives this solution a grade of D. We can do better!

No change to office visit co-pays or Rx co-pays.

No Plan Changes: Just kept health plan in place.

Their solution was risky. Insurance companies reserve the right to audit clients. If a large claim occurred and it was found that they weren't compliant with participation requirements in their contract, their employee's claim could be denied and their group health plan cancelled. If the employee's health condition was severe and ongoing, they would be declined by any other insurance carrier they would seek coverage with. The net-net of this solution was that the company was forced to absorb a 24.1% premium increase and was left out of compliance. All that can be said was that it was the lesser of two evils, they at least had a plan.

Let's ask a rhetorical question. If 80% of employees in America spend under $2,000 in total medical expenses in a given year, is a plan that only charges this employee 20% of total claims up to that amount, a good plan? It means 80% of employees would be capped at $400 in out of pocket medical expenses, if they spent the full $2,000. This is substantially better coverage for most of the employees that have a health plan through their work.

What are the cost savings to the employer on our suggested plan design changes? The savings over the renewal, factoring in higher than normal utilization (+15% over trend) was estimated at $192,956. That's over $1,556/employee in cost savings with a superior benefit. This is a 26% decrease over the renewal rate, which by the way is this company's new reality. Last year's premiums are last year's premiums.

A better approach is giving this employee a better benefit. Under their

XYZ Company Proposed Plan Renewal:

Table 1: HRA EXMPLE **Out-of-Pocket includes Ded.*	**Proposed Plan** **In-Network**	**Out-of-Network**
Lifetime Maximum:	$5,000,000	
Coinsurance:	90%	70%
Calendar Year Deductible:		
Per Individual	$250	$500
Per Family	$500	$1000
Per Confinement		
*Out-of-Pocket Max:**		
Individual	$1500+co-pays	$3,000
Family	$3000+co-pays	$6,000
Hospital Charges:		
Inpatient	10% after Ded.	30% after Ded.
Outpatient	10% after Ded.	30% after Ded.
Emergency Room	10% after Ded.	30% after Ded.
Office Visits:		
Physician Charges	$25 co-pay	30% after Ded.
Preventive Care	$25 co-pay	30% after Ded.
Lab & X-Ray	100% after $25 co-pay	30% after Ded.
Mental/Nervous:		
Inpatient	40% after Ded.	50% after Ded.
Calendar year max.	10 days: 3 admissions/lifetime	
Outpatient	40% after Ded.	50% after Ded.
Calendar year max.	12 visits: 25/lifetime	
Prescription Drugs:		
Tier 1	$10	
Tier 2	$20	
Tier 3	$35	
Rates:	Proposed vs. Renewal	
Employee Only 87	$344.39	
Employee + spouse 11	$738.61	
Employee + child(ren) 11	$629.45	
Employee + Family 15	$1125.73	
Total Monthly Premium:	**$61,896.54**	
Total Monthly Change ($):	**$12,020.19**	
Total Admin + Est. Claims:	**N/A**	
Total Annual Premium:	**$742,758.12**	
Total Annual Change ($):	**$144,241.92**	
Total Annual Change (%):	**24.1%**	

current plan the employee faced $1,500 of deductible and co-insurance risk plus any and all co-pays. When one factors in the Rx co-pay exposure this can be a lot of money over and above the deductibles and co-insurance. If an employee or family member was on two $20 Rx's and two $35 Rx's, that's $110/month in co-pays or $1,320/year in additional medical expenses, none of which count against the $1,500 single/$3,000 family deductible/co-insurance out of pocket maximums. Our plan would have capped the single out of pocket exposure at $2,000/single and $4,000/family. These out of pocket maximums would include all office visits and Rx's.

Compared against last year's premiums, we estimated we could have lowered their costs for benefits by -8.1%, not a +24.1% increase. This would be a savings of $48,713.52 over last year, roughly a $393/employee less expensive than a year ago with an improved benefit.

How did our plan design actually perform for the year compared to staying the course offered by the current broker? Our plan came in $232,698 (this was a savings to the employer of $1,877/employee). Even though this was a prestigious broker and firm, we question the benefit they provided this client. This broker and firm did not present a single CDHP model for consideration.

We have gone through two annual renewals with this firm since they switched to our plan design. The first renewal was +9.1% and the second came in at +9.3%. Both of these renewals were within trend for the last two years. Yet this group was less than healthy. The year before the 24.1% increase, their renewal was +31% (also factored into this first year on the plan was the fact that the insurance carrier was buying the business). Much of the usage was in the arena of Rx claims. Plans with co-pays for prescriptions tend to get higher than normal renewals. This was this group's experience. When Rx's are made part of a higher deductible there is less effect on loss ratios, hence a better renewal rate. This burden of first dollar costs isn't simply passed onto the employee, as you can see in our plan design, all covered medical expenses, including Rx and office visits, count against the employee's out of pocket. Employees on traditional PPO & HMO plans don't know what their maximum out of pocket liabilities will be because they don't know how many Rx's they might be

Key Facts:

- ✓ In 2005, the U.S. spent $2 trillion on health care, which is 16 percent of GDP and $6,697 per person.
- ✓ Health care costs have grown on average 2.5 percentage points faster than U.S. gross domestic product since 1970.
- ✓ Almost half of health care spending is used to treat just 5 percent of the population.
- ✓ Prescription drug spending is 10 percent of the total health spending, but contributes to 14 percent of the growth in spending.
- ✓ While about 26 percent of the poor spent more than 10 percent of their income on health in 1996, the number increased to 33 percent by 2003.
- ✓ Many policy experts believe new technologies and the spread of existing ones account for a large portion of medical spending and its growth.

Source: Kaiser Family Foundation, *Health Care Costs, A Primer, August 2007.*

prescribed (my personal record was an employee who was on 19 meds, 17 of which were taken daily). On our plan designs, if you stay in net-work, you can know what your out of pocket limits are.

Total employee exposure is capped at $2,000 for singles.

Enhanced Sage Plan Renewal:

Table 1: HRA EXMPLE **Out-of-Pocket includes Ded.*	**Sage Plan** In-Network	Out-of-Network
Lifetime Maximum:	$5,000,000	
Coinsurance:	70%	60%
Calendar Year Deductible:		
Per Individual	$2,000	
Per Family	$4,000	
Per Confinement	n/a	
*Out-of-Pocket Max:**		
Individual	$5,000	$7,500
Family	$10,000	$15,000
Hospital Charges:		
Inpatient	70% after Ded.	60% after Ded.
Outpatient	70% after Ded.	60% after Ded.
Emergency Room	70% after Ded.	60% after Ded.
Office Visits:		
Physician Charges	70% after Ded.	60% after Ded.
Preventive Care	70% after Ded.	60% after Ded.
Lab & X-Ray	70% after Ded.	60% after Ded.
Mental/Nervous:		
Inpatient	Subject to Ded.	
Calendar year max.	$2500 per year max.	
Outpatient	$10,000 lifetime max.	
Calendar year max.		
Prescription Drugs:	Subject to Ded	
Tier 1		
Tier 2		
Tier 3	.	
Rates:	Proposed vs. Renewal	
Employee Only 87	$209.14	
Employee + spouse 11	$456.12	
Employee + child(ren) 11	$336.29	
Employee + Family 15	$617.99	
Total Monthly Premium:	**$36,181.54**	
Total Monthly Change ($):	**($25,715.00)**	
Total Admin + Actual Claims:	**$75,882**	
Total Annual Premium:	**$510,060.48**	
Total Annual Change ($):	**($232,698.00)**	
Total Annual Change (%):	**-26%**	

Our plan is simple!

Our plan provides further tax savings via an FSA for known medical expenses

Over $232,000 in savings!

Our plan design is simple. The employee pays 20% of the first $2,000 of all medical expenses. They pay the next $5,333 at 30%. After this, all medical services are covered at 100%. This limits their exposure to $2,000 total. If an employee knows they are going to go through this much, we adopt the program so that these costs can be paid with pre-tax dollars through an FSA.

If an employee were taking four meds like we discussed earlier ($1,320/year of co-pays) and had $400 of office visit and testing costs to monitor these Rx's. Their out of pocket would be $1,720. Our plan would be $1,000 (20% of first $2,000 and 30% of next $2,000. This is the estimated total of all Rx and office visits.). Many employees don't run their Rx co-pays through an FSA, so when taking into account an employee in a 25% marginal tax bracket, this traditional PPO plan would consume $2,293.33 of their income. By running their $1,000 of out-of-pocket costs through our FSA program, Uncle Sam would give them a $250 tax break, thus reducing their $1,000 of medical expenses to $750. The net-net is dropping income loss from $2,293.33 to $750. This takes plan design change and employee education, but it is well worth the effort when you examine the results.

> *"On average we save employer groups between a $1000 and $3000 per employee per year while improving the overall benefit package 90% of the time."* *Ron Dobervich, Chief Consultant, Sage Benefit Group, Inc.*

Why did we pick this example? Because it is representative of companies of 50-200 covered employees on their health plan that are fully insured. One study shows that 91% of companies with more than 200 employees on their health plan, are partially self-funded, so this group is in the sweet part of the fully insured market. In my market research less than 1% of brokers have implemented an HRA based plan design. Of those that have, most use the TPA services of the insurance carrier, which limits plan design creativity (and might I add cost savings). This is the street. Most brokers don't sell or recommend these types of plans. Why don't they learn them? Most of the time we are lowering premium costs by going to the high deductible by 30-50%. This means a commission cut to brokers by 30-50% (state variations apply). Yes the broker needs to work harder and smarter to do these new plans and make less money than selling the old traditional HMO and PPO type of plans.

> *Fully insured, partially self-funded and self insured plans differ in the details administratively but the actuarial assumptions and savings are synonymous with this sample case.*

Current plans cover up real costs associated via co-pays. Our plan designs expose them. We implemented a similar plan design in a company whose employees were taking the most "advertised" method of treatment. The real cost of a popular medication more than one employee was taking ran $160 per month – hidden of course by their $45 Rx co-pay. Many didn't realize that the former medication they were taking before the "advertised" one came out was available over-the-counter. This medication was just as effective in treating their condition as their prescription yet significantly

cheaper. Switching to a 30% out-of-pocket cost to the employee – many opted to pay 30% of $20 vs. 30% of $160. Knowledge and education are key to taming claims costs and improving worker health.

So what can a business do when evaluating their current health benefit package?

- Use a broker who has years of experience in implementing CDHP's or encourage your current broker to work with a consultant that understands the nuances associated with FSAs, HSAs and HRAs – all of which make up the CDHP package.
- Use an independent TPA – one that is not tied to the carrier. This should save dollars and provides greater program flexibility and ease of transition should you desire to change carriers in the future.
- If you currently have a high deductible policy in place and are not realizing the premium discounts you'd like to see, consider moving to a higher deductible (without office visit and Rx co-pays).
- The preferred high deductible insurance plan is one that has had all co-pays for office visits and prescriptions stripped out. These services account for approximately 60% of medical expenditures and are the largest contributors to overutilization.
- Many carriers offer HDHP's that provide 100% coverage of preventive health benefits – these plans are still HSA qualified and do encourage good behavior.
- The more an employee contributes to health insurance premiums the better an HSA option becomes. The more an employer contributes to the health insurance premiums the more advantageous an HRA becomes.
- Employee education is key. Look for a broker/consultant that can routinely provide tools and resources to assist with your employee's needs to understand how to save money and find value in the CDHP landscape.
- Consider adding a Wellness Program to your benefits package. Whether participatory or standard based – an incentive based, actuarial derived plan provides proven cost savings and a happier, healthier employee population. CDHP's provide the most flexibility when implementing a wellness program.

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