



BENEFIT *Advisor*

In This Issue

In this eighth issue of the McGrawWentworth Benefit Advisor for 2005, we provide our annual examination of trends in health plan cost and management. The good news for most employers is that health care cost increases are cooling. These reductions are primarily as a result of cost shifting measures that organizations have taken over the last several years.

This Advisor will discuss the current status of health plan cost drivers and tactics employers can consider to reduce their increases to meet their budget targets.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“Trends”

At first glance the news from Mercer’s *National Survey of Employee Sponsored Benefit Plans* seems promising. Not since 1999 has the annual percentage increase in cost of employer-provided health plans been so small. The increase was only 7.5%. Employers, perhaps optimistically, are expecting the increases for 2006 to be even smaller.

Does this mean your annual review of the employee medical plan will be, for once, a manageable experience? Probably not. The increases reflect the expected increase after the employer had already made changes to reduce health plan costs. The survey results simply show that employers are becoming more aggressive in their tactics to rein in medical plan costs.

This *Benefits Advisor* discusses the trends affecting employer-sponsored medical benefits. While plan cost increases are slowing down, many problems in the health care system still exist. Consumerism continues to be a hot topic among plan sponsors as a way to involve an employee meaningfully in controlling health plan costs.

This *Advisor* discusses these issues and other trends gaining traction in managing health plan costs.

Medical Plan Costs Still an Issue

With health plan cost increasing on average 7.5%, the annual cost of medical benefits is still substantial. For 2004 average PPO plan cost was \$6,095 for each employee. Even with a slower rate of increase, employers need to take action to control this sizable expense.

Factors that contribute to rising health care costs include:

- **Health of the General Population:** The health of the population as a whole and, more important, the health of your employees and their dependents have a significant impact on your health plan cost.
- **Average Age:** The workforce in the United States is aging. It is well-documented that the older the individual, the higher the annual medical expenses. Health care cost rises significantly between the ages of 45 and 69.

In general, employers are limited in the steps they can take to control an aging



population. Understanding your organization's demographics will help determine whether your plan needs to be concerned with higher cost as a result of older workers. These rising costs affect organizations with higher average ages and low turnover rates.

- **Obesity is Still a Problem:** A statistical error caused the Centers for Disease Control and Prevention to overstate the impact obesity may have on the nation in the coming years. Last year, the major story was that obesity would overtake smoking as the most prevalent, preventable cause of death within the next two years. The estimated number of deaths attributed to obesity fell when the error was corrected.

However, this correction doesn't mean obesity is any less of a concern for health plans. Health plan costs for overweight and obese individuals are higher. A Centers for Disease Control and Prevention study revealed



health care expenses for overweight and obese people were on average 37% higher than expenses for people of normal weight.

The impact of obesity on overall health is pervasive. Obesity contributes to the development and severity of high blood pressure, diabetes, and many other chronic conditions. Nationally, the overweight and obesity rates have been on the rise annually since the '70s. This gradual increase means a

higher percentage of your employees will move into the overweight or obese category every year,

and that increase will affect your health plan cost.

- **Chronic Conditions Increase Cost:** Chronic conditions are moderate to severe medical conditions that require continuing treatment. Diabetes, high cholesterol and many back problems are often chronic conditions. Treatment for chronic conditions can be costly. Often cost and health care claims indicate how well a patient follows

the prescribed treatment plan. Costs for patients who follow prescribed treatment plans can be a third of the costs for patients who do not follow treatment plans.

Health does not operate in a void and poor management of one condition can create other medical conditions. For example, when diabetes is not properly managed, diabetics are at a greater risk for coronary artery disease, hypertension, kidney problems, blindness, limb amputations, and other complications. A diabetic that follows the treatment regime, making dietary changes, taking medication regularly and engaging in regular exercise is less likely to have complications.

Treatment for chronic conditions accounts for almost 80% of medical expenses in the United States.

- **Pharmacy Arena is a Mixed Bag:** Prescription drug expenses have been a front page story for the last five years. Pharmacy benefits are one area where employers have been aggressively managing costs.

Rising prescription drug costs continue to outpace rising physician and hospital costs but the rate of increase has been gradually decreasing over the last two years. The good news on the pharmacy side is

NOTABLE THOUGHTS

**REAL GENEROSITY TOWARDS THE FUTURE LIES
IN GIVING ALL TO THE PRESENT.**

ALBERT CAMUS

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changes in the marketplace are bringing drug costs down. The loss of FDA approval for the blockbuster medications Vioxx and Bextra and concerns about long term health effects of these types of medications has reduced the use of COX II inhibitors. In addition, many of the brand name medications on top 10 usage lists will soon lose patent protection.

The not so good news in pharmacy is many specialty medications, almost custom designed to treat specific medical conditions, are being developed and approved. These medications are usually injectible and often very expensive. Employers will need to determine whether their plans should cover these treatments and the most cost effective way to pay for them.

- **Provider Practice Patterns and Effectiveness:** One of the hot topics being discussed across the country is the quality of care and its overall impact on costs. Provider practice patterns and effectiveness do affect cost. Providers that establish relationships with their patients and encourage appropriate follow up care and preventive screenings are generally more effective.

Provider practice patterns and quality of care are being analyzed to determine whether steering patients to quality providers will decrease health care costs.

- **Medicare Part D:** Medicare Part D will affect employer cost. Employers will benefit directly if they sponsor a retiree health plan. But even

if an employer does not sponsor a retiree plan, Medicare Part D will probably impact the pharmacy marketplace on a whole. The potential impact could occur in many areas. Vendors will bid aggressively for the opportunity to become a PDP sponsor. If vendors lose revenue as a result of aggressive Medicare discounting, they may seek to increase profits in the private sector. Medicare requires Prescription Drug Plan contracts to be transparent, and CMS can also audit plan results. Because of these requirements, pharmacy benefit managers may offer more transparency, and may be more willing to participate in plan audits.

As an employer, you have little control over several cost drivers, for example, aging employees or the Medicare Part D effect on your discount arrangements with your pharmacy benefit manager. However, you can certainly decrease some costs by focusing on improving your employees' health or helping them manage their chronic conditions.

Although employees are getting the message regarding the rising cost of health care, taking accountability for those rising costs is another matter. Employees do not want to consider the impact their own lifestyle decisions have on their health care costs. To reduce health plan costs, continue to help your

employees understand the impact lifestyle has on health and help them break poor habits.

Trends also show employees' don't realize health plan costs affect overall profits. In a 2004 Towers Perrin survey, 43% of employees *disagreed* with the statement "Rising health care costs impact my employer's ability to succeed as a business."

Employees need to understand that the health plan in many cases is a significant expense and rising costs do impact business profitability. The case with GM has been well documented in Southeastern Michigan. GM needs to add \$1,500 to the purchase price of each vehicle just to cover health care costs.

This year employers are looking at a wide range of strategies to help manage health care costs. Some organizations are jumping on the consumer driven health plan bandwagon and implementing high deductible health plan options. Other organizations are focusing their efforts on improving health and effectively managing chronic conditions. Other organizations are focusing on eligibility and contribution strategies to drive enrollment into the most cost effective plans and reduce the number of individuals covered by their plan.

How Are Employers Managing Costs?

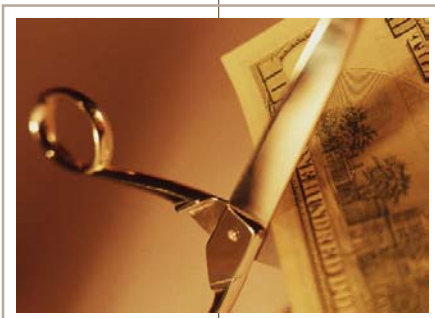
Hewitt recently released the results of its 2005 *Health Care Expectations: Future Strategy and Direction Survey*.



The results offer a glimpse into the strategies organizations are considering or implementing in an attempt to manage health care cost.

The Hewitt study indicates employers were expecting a 12% increase in health plan cost for 2005, but could only absorb an 8% increase. Organizations are evaluating a host of options to reduce the trend to the manageable 8%. The findings indicate:

- Interest in consumer driven health plans continues to grow. In the Hewitt survey, employers indicated they expected consumer driven arrangements to be less expensive than PPO and HMO plans.
- The survey indicates during the last five years employer costs have increased over 76% and employee plan cost has doubled. Employers say they have reached the point where their employees understand containing health care cost is a shared problem. Employers are interested in giving their employees the tools they need to better manage their health care decisions.
- The study shows a marked increase in the use of condition management programs. Condition management programs include disease management programs and wellness initiatives. In 2005, 83% of companies indicated they offer some type of condition management program which is a 10% increase from 2004. Programs



addressing weight management are very popular with 56% of organizations offering specific weight management initiatives.

- Organizations are increasing efforts to force transparency. The transparency efforts are not limited to pharmacy programs. Organizations want transparency in cost and quality data. Employers are reviewing HEDIS data and Leapfrog patient safety standards to encourage quality and improve clinical outcomes.
- Contribution strategies vary. On average, employees are paying 22% of the premium cost for employee only and 26% of the cost for dependent coverage. Interestingly, the Hewitt study indicates 21% of employers will tie contributions to employee income in 2005.
- Employers are also encouraging dependents to enroll in other available health plans. Twenty four percent provide flex credits to employees whose dependents opt out of the plan. Seven percent require employees to pay additional contributions to cover a spouse eligible for another health plan. Eight percent do not allow a spouse to enroll in their plan if other health plan coverage is available.
- Prescription drug benefits have changed over the last five years. Of employers surveyed:
 - Seventy-seven percent have implemented a three-tier prescription drug copay structure.

- Forty-five percent have coinsurance applicable in some area of their prescription drug plan.
- Twenty seven percent use step therapy protocols.
- Twenty five percent require employees to use available generic drugs.
- Twenty two percent require employees to use mail order for maintenance medications.
- Sixteen percent use a reverse copay structure.

Employers are looking at many strategies to help control cost. The strategies fall into three basic categories:

- Cost-shifting or cost reduction
- Improving health status
- Improving buying habits

Cost-Shifting or Cost Reduction

Strategies to shift or reduce costs are popular with many organizations. Employers can effectively measure savings with these strategies because the plan is shifting cost to its participants. Certainly, it is easier to measure these savings than it is to measure savings from investments made to improve health or improve buying habits.

- **Plan Design Changes** – Changes to plan design include offering different plan options, increasing copays, adding deductibles and decreasing coinsurance levels. These changes can have a great financial impact. Not only do plan participants pay more of the cost, they also

tend to seek care less often. Typically, plans will see a drop in use as they increase the participant's cost at point of service.

- **Network Options:** Organizations can also investigate the network options that decrease costs. These options are expanding as vendors and carriers offer less expensive alternatives:

- **Less Restrictive HMO Options:** Employers may want to reconsider HMOs. Although employees have not embraced a gatekeeper approach to managing health care in the past, many HMOs are now offering open access products to allow employees more control in managing their health care within the HMO network.

- **Performance Based Networks:** National carriers have been launching performance based networks throughout the country. Humana has plans to launch one in Michigan this year. In some cases performance based networks are simply limited scope networks offering deeper discounts. In other cases, these networks select providers based on quality and effectiveness. Performance based networks are new to the market so there are no independent studies to support their effectiveness. In some areas of the country, these types of networks are facing legal challenges from providers.

- **Contributions** – Organizations are considering more creative contribution strategies.

Employers are looking to reduce the covered lives on their plans. Therefore, they are increasing contributions for plan coverage and specifically, increasing contributions to cover dependents on the plan. Spousal surcharges or complete exclusions when a spouse has other group health coverage available are becoming more popular.

With the popularity of consumer driven health plans growing, contribution strategies become an important factor to consider. A consumer driven health plan can become significantly more expensive than

anticipated if it is not properly priced.

Many organizations are requiring little or no contribution to elect a consumer driven health plan. With this strategy, however, your organization may add covered participants, because employees who had previously waived health plan coverage may elect coverage under a plan when the contributions are minimal.

Also, in self-funded arrangements, low utilizers will gravitate to a lower cost CDHP. Because they make very few claims under either plan, they may decide to move to a CDHP for \$300 a year rather than pay \$1,200 for a traditional plan. From an employer's standpoint, not only does the plan not save any money on claim cost for a low utilizer, but it will also lose contribution income.

Pricing benefit plans that offer a CDHP along with more comprehensive health plan options must be done carefully. If the contributions are set too low for a CDHP, the organization may lose substantial contribution revenues that will have a significant impact on net plan costs.

Improving Health Status

Plan results often confirm the general rule that 20% of the population generates 80% of the plan cost. Study after study confirms most expenses under a health plan are incurred to treat chronic health conditions. It makes sense because individuals managing chronic conditions seek care regularly.



Improving the health of plan participants and their lifestyle choices should

have a number of positive effects, including reduced absenteeism, higher productivity and reduced plan utilization:

- **Wellness Initiatives** – Wellness plans and initiatives offer programs and resources to help plan participants improve their lifestyles. Wellness plans aim to prevent disease when participants' lifestyle choices may put them at risk. The primary goal of wellness initiatives is to motivate the 30 to 40% of a plan's participants with low or moderate health risks that could benefit from structured health management programs.

Structured coaching programs would include weight loss management, smoking cessation, stress management, exercise programs, and nutritional courses.

Many organizations are offering attractive incentives to individuals to participate in wellness events. Some plans are lowering health plan contributions for those who participate and others are offering a higher level benefit plan to those who participate.

• **Disease Management Programs**

– Disease management programs target medical conditions with treatment regimes proven to reduce the severity of the disease. These programs are designed to help individuals follow a prescribed treatment plan for their condition. Proper treatment does not always mean finding the right physician, it also involves following the prescribed treatment protocol.

Disease management programs target specific conditions and employers will select the programs they need. Knowing what chronic conditions drive your plan cost is important.



Chronic conditions can vary greatly depending on age, gender, and lifestyle. Employers should find a vendor who offers programs best suited to their employees. These conditions usually can be identified through analyzing health plan and prescription claim data.

Insurance carriers have invested significantly in disease management initiatives in the last five years. Insurers who bear the risk for plan performance have a vested interest in making sure plan participants

manage their conditions properly. Many insurers have reaped significant benefits from their disease management initiatives.

Improving Buying Habits

Improving buying habits is typically associated with consumer driven health plans. The interest in consumer driven health plans has increased significantly nationwide, and it's catching on in Southeastern Michigan as well. The 2005 McGraw Wentworth Southeast Michigan Mid Market survey indicates that while only 5% of employers offered a consumer driven arrangement in 2005,

19% are considering implementing one for 2006.

Consumer driven plans are intended to improve participants' health care purchasing decisions. Consumer driven plans in many cases will significantly increase an individual's out-of-pocket cost (primarily by introducing a high deductible health plan). Studies show that employees who have to pay more out of their own pockets make fewer health care claims. Anyone who has to pay the full cost of an office visit will be less inclined to visit a physician when it is not truly necessary.

If employees have to pay more for health care, the plan needs to provide reliable tools to help them decide when to seek care and how to evaluate the quality and cost of that care. Buying health care is not like buying consumer goods. It is imperative to secure appropriate care when necessary. If a plan is to improve the buying habits of its participants, it should provide:

- Accessible tools that can help them research medical symptoms, diseases and treatment regimes.
- Accessible reference guides listing quality providers they can use if treatment is necessary.
- Accessible resources disclosing the cost of various services from different providers.
- Accessible cost information on prescription drugs and alternative therapeutic options to encourage participants to use generic drugs whenever possible.

NOTABLE THOUGHTS

**YOUR MOST UNHAPPY CUSTOMERS ARE YOUR
GREATEST SOURCE OF LEARNING.**

BILL GATES

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Although some of these comprehensive tools are not yet available, health plans recognize their importance.

Improving buying habits is important with any plan you offer your employees. Even if your plan is not a full blown consumer driven health plan, employees will need tools to make wise health care decisions and to control plan costs.

What are Employers Doing?

According to the Michigan Mid-Market Survey conducted by McGraw Wentworth in the spring of 2005, local employers are taking action. For 2005, the most prevalent cost control strategies included:

1. Increasing employee contributions
2. Increasing plan deductibles
3. Increasing prescription copays
4. Increasing office visit copays
5. Decreasing coinsurance percentages under the plan (increasing percentage of expense employee pays)
6. Auditing dependent eligibility
7. Changing carrier/TPA/health plan
8. Implementing a 3-tier prescription drug copay design



9. Requiring available generic rather than brand name drugs on prescription plans
10. Adding new PPO plan options

Benefits are big news in Southeastern Michigan as the auto companies struggle with the burden of health care costs in this difficult economy. Employers are taking action to best manage these costs.

Conclusion

All employers handle their health care plans differently. Some employers use high level benefit plans as a recruiting tool. Other organizations offer moderate plans but more competitive wages. The benefit plan you choose affects your cost. Certainly, high level benefit plans have become impossibly expensive for most organizations.

Organizations should review their own situations, cultures and opportunities to best manage cost increases. What is clear, however, is that health care plans need to be reexamined constantly to measure performance and to find opportunities for savings.

The budget planning process that was once an annual review is becoming a discussion that occurs all year long in organizations across the country.

It is also clear, this process is not easy. Medical benefits were never simple, and their complexity is increasing rapidly. Keeping up to date on trends, benchmarks and cost issues could be a full time job.

Because of this increased complexity, organizations must make time to evaluate plan options and costs properly. If you choose a consumer driven plan, be prepared to spend significant time learning the details. Your organization will also need to launch a communication campaign to help employees understand the new plan design and its impact on their health care coverage.

If you have any questions, please contact your McGraw Wentworth Account Director. **MW**

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