



BENEFIT *Advisor*

In This Issue

In this sixth issue of the McGraw Wentworth Benefit Advisor for 2009, we discuss health plan trends. In these difficult times, it is imperative organizations tightly manage their health plan costs.

Many factors influence health care cost increases. With the poor economy, cost increases are likely to be exacerbated by increased utilization due to job uncertainty and the government funding of COBRA. Employers will have to manage plans diligently to keep costs in check for 2010.

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 McGraw Wentworth website at www.mcgrawwentworth.com.

“Health Plan Trends”

In the last year, Michigan employers have been faced with a severe economic situation. No one can remember economic conditions ever being quite like they are today. Michigan leads the nation in unemployment. Chrysler, GM, and a number of auto suppliers have filed for bankruptcy recently. Michigan had been fairly isolated in its economic distress until the third quarter of 2008 when the banking industry collapse affected the entire country.



employers began using the TrendBenders™ cost control strategies. This year TrendBenders™ offered wellness and consumer driven health plans more frequently than the survey base as a whole.

Planning for 2010 will be a challenge for all employers. The issues below will likely figure into 2010 planning, but it will be hard to determine their exact impact on cost.

McGraw Wentworth’s *Mid-Market Group Benefits Survey* shows Southeast Michigan employers managed to hold health plan cost increases to an average of 5% for 2009. West Michigan employers held health plan cost increases to an average of 5% as well. While these single digit increases are low compared with past increases, PPO plan costs were just under \$5,000 annually for single coverage and just about \$13,500 for family coverage.

This year’s survey also shows employers significantly changed their plan designs, eligibility management, wellness programs and employee contributions to keep cost increases in check. TrendBenders™ managed to keep average cost increases to 2% or less for 2008 and 2009. In 2009, many

- The difficult economy will continue to plague our auto industry.
- The Obama administration will tackle health care reform this year.
- Employers will need to comply with the Mental Health Parity Act.
- Health care claims will tend to increase – most likely because employees faced with uncertain employment conditions will take care of health concerns while they still have health insurance.
- More former employees will elect COBRA because the government is subsidizing a portion of COBRA premiums.

- Health care providers may increase their fees when they renegotiate their contracts with health plans and PPO networks. As unemployment increases across the country, health care providers will have to treat more charity cases and may seek higher reimbursement amounts from privately insured patients to cover that extra burden.

Employers are starting to change the cost-sharing elements of all health plans. The rich benefits that were typical in Michigan are becoming less common as Michigan moves closer to national benchmarks. For 2010, employers will need to use a host of strategies to control health plan cost. If the economic landscape for Michigan does not improve this year, many employers will need to continue making changes to keep health plan costs flat.

This *Advisor* compares our mid-Michigan survey data with Mercer's 2008 *National Survey of Employer-Sponsored Health Plans* to analyze trends, both locally and nationally.

In addition, we will discuss:

- The issues affecting health care and the cost of that care in this country.
- The strategies to control health plan costs.

Issues Affecting Health Care and Cost in This Country

All of the Presidential candidates discussed health care issues during their campaigns last year. Health care was the hottest issue until the economic downturn pushed health care reform to the back burner. However, health care reform will be back in the spotlight soon. President Obama has vowed to tackle this issue in 2009.

The one thing President Obama's first 100 days in office has shown employers is that this President will likely take action.

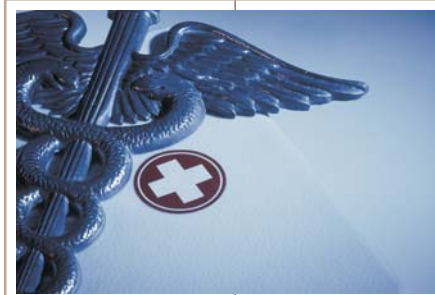
Fixing our ailing health care system will not be an easy task. If this problem had been easy to fix, it would have been fixed by now. In order to reform health care, the legislation needs to consider the following underlying issues:

- **General Health:** Many health care claims are the result of poor overall health. In much of the discussion relating to health reform, improving the general health of this country is often overlooked. Elected officials do not want to alienate their constituents by implying they may be partly responsible for health care cost increases. Unfortunately, even though it is not a pleasant subject, the public shares some responsibility for our increasing health care costs. For that reason, health care reform should focus some effort on improving health. The following factors influence an employee's health:

- **Age:** Our population is aging. The oldest baby boomers will be eligible for Medicare soon. We will continue to see more and more people enrolling in Medicare and the government will be pushing hard to keep costs under control by pressuring health care providers to accept deeper discounts for Medicare patients.

Since Ponce de Leon never found the fountain of youth, there is not much we can do to stop aging. However, managing health throughout life can help offset some of the health costs typically associated with aging. In addition, teaching people to manage their health as they age will help minimize complications.

- **Chronic Medical Conditions:** According to the Centers for Disease Control and Prevention (CDC), almost half of all Americans live with a chronic disease. For one in ten Americans, the chronic disease is disabling. Even with these grim statistics, adult Americans receive



recommended preventive, acute, and chronic care only about 55% of the time which drastically reduces treatment effectiveness. Chronic conditions include common ailments such as high blood pressure, high cholesterol, diabetes, asthma and so on. These conditions require medication management and lifestyle changes.

Many patients don't take their medications as recommended and don't make lifestyle changes. Also, they often don't get the advice and follow up they need from their primary care physicians. Physicians unfortunately

are pressed for time and sometimes don't take the extra few minutes to make sure patients understand their instructions. Any effective health care reform must include properly managing health.

- **Lifestyle Choices:** Our choices every day affect our overall health. What we choose to eat, our physical activity, how we handle stress, if we have a drink with dinner, all of these decisions over time have an effect on our overall health. It is estimated that 50% of all health problems are related to poor behavior choices. Because of the increased focus on employee health, people are beginning to recognize the relationship between their lifestyle choices and their well being. Recognizing this relationship is only the first step. The next step is to change poor habits.



- **Provider Issues:** Any effective health care reform needs to consider the problems facing health care providers in this country. Being a health care provider is not an easy proposition today. Providers must provide excellent care while they make health care a profitable business. Health care payers, including our federal government, continue to negotiate lower or flat fees for services. This means providers must use their time

efficiently; they may not always give patients all the time they need.

Providers also face the threat of malpractice suits. Patient expectations are very high and health plan providers react to those expectations. Thus to avoid any potential malpractice issue, many health care providers test for all possible options instead of only the most likely ones.

Another problem is the current payment process. In our health care system providers are paid for the volume, not the quality, of service. Physicians, therefore, may simply try to treat more patients rather than try to treat more patients well. For example, physicians may prescribe insulin for a diabetic patient,

but fail to recommend annual eye and foot exams. Many proposed health care reforms

now involve quality. Physicians can prevent complications when they have the time to make sure their patients get the care they need.

Quality is essential to any health care reform. Every year Dartmouth studies show a good percentage of the health care received in this country is unnecessary and in many cases even harmful. Americans want more health care, but they really don't understand that unnecessary care can be harmful to their health. They also are unaware that many

treatments doctors recommend have not been proven to be effective.

It is hard to believe how little most Americans understand about health care. Their primary concern is simply whether or not their health plan will cover a recommended treatment. Rarely are they concerned about whether or not a recommended treatment will be effective. In fact, the government and health plans require very little reporting of outcomes. When outcome data is collected, it is rarely published. The government has now begun to establish quality measures and require outcome reporting. However, this information has yet to be published in an understandable format that encourages patients to consider outcome data.

The government may reform health care in a number of ways:

- Implement quality of care programs and outcome reporting.
- Provide affordable health care options for the uninsured.
- Revisit the tax-favored status of employer-provided health plan coverage.

Employers are waiting to see how health care reform bills will affect employer-provided health coverage.

Strategies to Control Health Plan Cost

This year it seems all employers are trying to keep health plan costs in check. Successful employers have adopted strategies ranging from spousal limitations to increased cost sharing. With the poor economy, we expected fewer wellness initiatives; surprisingly, however, wellness investments increased.

Employers need to shift more of the cost and accountability to their employees. Employers can control health care costs only when employees become part of the solution. Employees really need to partner with the health plan in order to manage cost effectively in the long term.

Employers should consider the following strategies to control costs in 2010:

- Plan Design Changes
- Consumer-Driven Health Plan Options
- Wellness and Disease Management Strategies
- Eligibility Strategies
- Contribution Strategies
- Quality and Value Options

In a difficult economy, employers focus on short-term strategies that deliver reliable results to meet their budgets. They need to balance those short-term, verifiable savings options with long-term employee health and well being options where cost savings may be less definable.

Plan Design Changes

The McGraw Wentworth *Mid-Market Group Benefits Survey* showed an unprecedented number of employers made plan design changes in 2009.

PPO Plans

This year the median PPO deductibles increased to \$300 single and \$600 family. The coinsurance also increased: plan participants now pay 15% of eligible expenses in-network and 30% out-of-network. The out-of-pocket maximum increased this year to \$1,200 single and \$2,500 family. The emergency room copay increased to \$75. In the six years McGraw Wentworth has conducted the *Mid-Market Group Benefits Sur-*

vey, we have never seen this level of change in plan design. Several of our local plans are now inching much closer to matching national benchmarks.

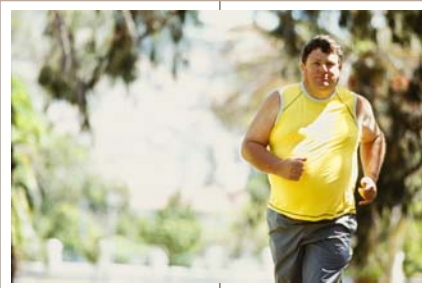
Employers may need to continue to modify plans to keep PPO costs in check. If your plan can re-involve cost in the decision-making process, your employees will make more informed choices. Your organization may want to consider strategies such as split copays for primary care and specialist visits or adding additional copays for expensive imaging services. These additional potential costs will compel participants to ask whether the service is necessary and whether less expensive options exist. Although some Michigan health plan vendors do not currently offer these provisions, they are beginning to consider them, so these options may be available in the next few years.

HMO Plans

HMOs have also seen change this year, but not quite as dramatic as PPO plans. The office visit copay stayed flat at \$15 and only 15% of employers charged different copays for primary care doctor visits and specialty office visits. Nationally, the office visit copay was \$20 and almost half of plans charged a separate copay for primary care and specialty visits. Southeast Michigan has seen a distinct move away from 100% coinsurance that is typical in HMO plans. Only 72% of plans still have 100% coinsurance in the HMO, the other 28% require employees to share some percentage of the cost. In Southeast Michigan just over 20% of all employers have a plan deductible or inpatient hospital copay. Na-

tionally, 61% charge an inpatient copay. HMO plans also saw emergency room copays increase to \$75.

HMO plans are now requiring more employee cost-sharing. Changes in the HMO marketplace are influencing this increase. Five years ago, many of these HMO cost-sharing options were not available locally. Today, most HMOs have cost-sharing options employers can add to their plans. Nationally, employers are also interested in introducing consumerism into the HMO plans. Many HMO plans have moved away from the pri-



mary care physician gatekeeper approach to allow a more open access network or at least direct access to a few different specialists in their network. Without the physician

guiding all care, employers want to reintroduce some level of cost-sharing so employees will make wiser health care decisions.

Prescription Drug Plan Options

This year we have seen very little change in prescription drug benefit programs. The copays stayed flat both locally and nationally. Locally, two-tier programs are most popular, but just barely. More employers are moving to three-tier arrangements. Nationally, three-tier arrangements dominate the market. The slow move locally to a three-tier copay arrangement is not too much of a shock. The one area employers have made changes in throughout the last five years has been pharmacy benefits. Pharmacy benefit options are a key interest of employers for 2010.

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Employers can consider a variety of options to control drug costs. Any strategy that encourages employees to use generic rather than brand name drugs should help employers. It is estimated for each 1% increase in the use of generics, a health plan can save 1% to 2% in health plan costs. In the next five years, a number of popular brand name drugs—such as Ambien CR, Lipitor, and Prevacid—will have generic equivalents. In addition, ExpressScripts' *2008 Drug Trend Report* indicates that in many drug classes, not enough employees have switched to generics. Some of the biggest gaps between actual generic fill rates and potential generic fill rates are found with oral contraceptives, gastrointestinal medications, antihistamines, antidepressants and hypnotics.

Employers can encourage employees to use generics in a number of ways. First, the plan can require employees to use only generics. This plan provision simply states the health plan will cover only generic medications if a generic is available. Second, the plan can significantly increase the difference in copay for brand name drugs. According to our survey, most plans have a \$30 difference between generic and brand name copays with a two-tier drug copay. The difference drops to \$20 between tiers when a three-tier program is adopted. Step therapy also encourages employees to use generics. This regimen requires a plan participant to use the least expensive drug first; if that drug is not effective, the participant may then turn to a more expensive option.

Consumer-Driven Health Plan (CDHP) Options

Nationally, large employers (500+ employees) saw an increase from 14% to 20% in the number of employers offering a CDHP. The increase was not so dramatic locally; we moved from 16% of employers offering a CDHP to 19%. A quarter of our TrendBenders™ offer a CDHP. CDHPs are growing at a steady rate. Just a few years ago, these plans were either touted as the silver bullet to solve all that ailed our health care system or criticized because they were seen as a vehicle to significantly shift cost to plan participants. The slow and steady growth of these plans over time indicates that they are here to stay and have become a workable option to help control health plan cost.

Over time, enrollment in these plans has steadily increased as well. We see more and more employees choosing CDHPs. Some of the enrollment increase is due to the plan structure, and some is probably because employees are gradually beginning to accept these plans.

The national CDHP strategy is different from the local approach. Although all plan designs are similar in deductible and out-of-pocket costs, how accounts are offered and funded differs dramatically. Nationally, over the last three years:

- Health Savings Accounts (HSAs) just this year became more popular than Health Reimbursement Arrangements as the account paired with a CDHP.



- Over the last three years, more employers have contributed to HSAs. In 2006, 57% of employers contributed, and by 2008, that figure rose to 71%.
- Employee contributions for CDHP, the cost to elect the plan, were slightly less than the PPO plans, but only slightly.

Locally, the strategy seems to be the direct opposite of the national mindset:

- HSAs have always been the more popular account choice in Michigan.
- Over the last three years, the number of employers contributing to HSAs has steadily decreased. In 2007, 90% of employers contributed to employee HSAs. In 2009, only 53% of employers contributed.
- Employee CDHP contributions, the cost to elect the plan, have remained low.

Both nationally and locally, the strategy is to encourage employees to set aside funds in their HSAs. Nationally, employers encourage employees by placing some funds in their accounts. Locally, the approach is to charge less for coverage and allow employees to redirect their savings into their HSAs.

Wellness and Disease Management Strategies

In these tough times, all employers are struggling to make ends meet. Surprisingly, our mid-market survey shows an increase in the number of organizations choosing to offer comprehensive wellness plans.

For most organizations, a comprehensive wellness plan involves an investment. The programs usually include a Health Risk Assessment with biometric screening, health coaching and a variety of features designed to improve health and increase physical activity. Despite the investment necessary, the number of comprehensive wellness programs offered increased by 5%; about one fifth of all employers offer these programs. Within TrendBender™ organizations, the number increased by 8% and just over a quarter of TrendBenders™ offer these programs.

One of the keys to successful wellness programs is participation. Employees need to participate in order to get any benefit from a wellness plan.

To encourage participation, employers often offer employees some sort of incentive, such as prizes, cash, or reduced health plan contributions. Forty-nine percent of employers in



Southeast Michigan offer incentives. Those employers also achieve an average participation rate of 76% to 99%. The fifty one percent of employers that do not offer any incentives achieve only a 10% to 25% participation rate. Other wellness surveys show the same results; incentives boost participation.

While most employers tie incentives only to participation, some tie the incentive to achieving a certain health goal. One common program that ties incentives to health goals is Blue Care Network's Healthy Blue Living product. In this product, participants that make lifestyle changes to improve their health receive a higher level of benefits than those

who will not commit to improving health.

Another approach employers take to tie health goals to incentives is adding a smoker surcharge. Smoker surcharges have received a significant amount of press in recent years, and this year we have seen a 5% increase in employers adding these surcharges; 8% of employers now have surcharges. The national benchmark is just 6%. Locally, the median amount of the surcharge was \$30.

Smoking will continue to be a health issue that draws attention in Michigan. Recently the tax on cigarettes increased dramatically to fund expansions in the Children's Health Insurance Program (CHIP). In addition, the November 2010 ballot may

propose a ban on workplace smoking. The workplace smoking ban has been proposed in Michigan many times, but it has always been defeated in the legislature. According to the

Centers for Disease Control, only about 20% of the population smokes; therefore, the smoking ban may pass in a popular vote.

Fortunately, wellness programs remain a strong strategy in light of Michigan's economic struggles. Employees, now more than ever, need to handle stress well and make good nutrition and exercise decisions.

Eligibility Strategies

Eligibility strategies are the administrative practices necessary to make sure only eligible dependents remain on the plan.

Limiting coverage for spouses is a popular strategy in Michigan. One type of limit is the spousal restriction. With a spousal restriction, your plan will cover spouses only if they do not have other coverage available. Spouses with coverage available through their employers would simply not be eligible for coverage. In 2009, 11% of employers in Southeast Michigan had a spousal restriction. Only 3% of employers nationally adopt this restriction.

Spousal surcharges are also becoming more popular. A spousal surcharge allows spouses with coverage available through another employer to enroll in your plan; however, they need to pay an additional premium. Spousal surcharges increased by 5% in 2009, with 12% of employers offering them. The median surcharge amount assessed was \$100 a month. Nationally, 5% of employers charge spousal surcharges.

Spousal limitations are more popular in Michigan than they are nationally. Initially, they allowed employers to maintain rich benefit plans and still keep a handle on cost by eliminating spouses covered by another plan or by adding the additional surcharge. As employers shift more benefit costs to employees, it will be interesting to see whether spousal limitations remain a popular cost control strategy.

Another common eligibility strategy is the dependent audit. Thirty five percent of survey participants conducted a dependent audit in the last two years. These audits help employers confirm that a dependent is still eligible under the plan. If a dependent is not eligible, the coverage ceases. Employers can either do the audit in-house or outsource it.

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Our survey indicates 80% of employers chose to do the audit in-house and 20% hired an external vendor. Dependent audits are effective; they have helped employers remove an average of 4% of dependents from coverage. For that reason, employers continue to express interest in monitoring eligibility and plan to use dependent audits to help control costs.

Contribution Strategies

Employers continue to list “increase employee contributions for coverage” as a top cost control strategy. Every year, the dollar amount of employee contributions does increase. However, the employee’s percentage of health care premiums has been relatively flat for the last several years. Southeast Michigan employees tend to contribute less for their family coverage than national employees. Thus Southeast Michigan employers may have some room to consider increasing employee contributions for family coverage.

Many employers are concerned that increasing employee contributions may make coverage unaffordable for their low income workers. In organizations with a wide range of low income workers and higher income workers, increased contributions are a real concern. One strategy employers are considering in this case is income-based contributions. Employees with lower incomes will pay less to participate in the health plan and employees with higher incomes will pay more. The theory is that a higher income employee can afford to pay more for coverage.

This strategy can be a challenge for employers and has not really taken off locally. Only 5% of employers in Michigan base contributions on income. Nationally, 13% of employers adopt this approach.

Employers interested in tying contributions to income should consider the following:

- *Distribution of employees across the various income levels.* Most employers set contribution strategies to achieve a net cost result. Your organization needs to set contribution amounts based on the number of employees at each income level. If most of your employees are at the lowest income level and you decrease contributions for all your low income employees, employees at higher income levels will have to pay substantially more to make up for the fact most of your employees are paying less.
- *Potential payroll vendor limitations when it comes to employee contributions.* If your organization sets up:

1. 4 separate contribution levels based on income
2. 3 different plan types
3. 3 coverage tiers, single couple and family

You would have to administer 36 different contribution options based on income, plan elected and participants covered. You would need to explain and administer this complicated structure properly.

Increasing employee contributions remains a top cost control strategy for employers. However, in 2009, employers increased their employees’ share of costs for using the plan,

but did not drastically increase employees’ share of the premiums to purchase coverage.

Quality and Value-Based Options

With health care reform back on the front burner, all kinds of strategies are being discussed to help improve the health care system. Some of the discussions are even centering on quality and potentially value-based designs.

One of the hot quality topics being discussed is the concept of a patient-centered medical home. In fact, Blue Cross Blue Shield of Michigan is launching the largest commitment to the

medical home by an insurance carrier to date. The goal of a patient centered medical home is to provide comprehensive health care to patients across the entire health care system. It sounds

like an HMO, but it is a different approach that focuses on quality. The Blue Cross Blue Shield model has identified in-network providers that provide quality care. Those physicians tend to make sure their patients get all recommended tests. What’s more, they follow up to ensure the patient continues the treatment. Quality is one measure to determine whether a physician’s group will be considered a medical home. Other measures include certain onsite capabilities and a commitment to move toward electronic medical records.



Because quality care reduces costs and complications, the Blues will also pay medical home providers more. Certain aspects of the medical home are not yet clear, however. For example, the Blues have not explained the process they will use to communicate which providers are considered medical homes.

It will be interesting to see whether this strategy works in the long term. If patients get appropriate care and learn to manage their health properly, we will likely see more of these medical homes in the coming years.

Value-based insurance designs are similar to the medical home concept. Their primary goal is to make sure employees get the care they need. Most value-based designs center on pharmacy benefits. The thought is that a handful of prescriptions have been proven effective when treating a host of conditions like blood pressure, high cholesterol, asthma and diabetes. When



patients fail to take these medications, they develop costly complications. Value-based plan designs remove financial barriers from patients getting these essential prescriptions. They typically offer them for free or at a very low cost.

Locally, only a small percentage of employers are using a value-based plan design. More employers have expressed interest, but certain vendors in the local area cannot administer these plan designs. Nationally, 19% of employers have added some type of evidence-based cost feature. The most common approach is to reduce the employee's share of the cost for effective medications like those used to treat asthma and diabetes.

Health plans will likely offer more options to help control cost and improve quality than they have in recent years. Threats of health care reform will only accelerate the process.

Concluding Thoughts

The economy is affecting most employers in Michigan and many across the country. While controlling health plan costs has always been a struggle, in today's economy, it is a stark necessity. Employers were successful in keeping costs in check last year, but 2010 may be even more brutal. Most employers will be happy if they can just keep costs flat.

In 2009, we have seen more change in plan design than we have seen in the last six years of conducting our *Mid-Market Group Benefits Survey*. Unfortunately, next year's survey may show even more change. Employers will need to look at a variety of strategies to control cost in 2010.

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

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