Alliance Learning Circles ™

EXECUTIVE SUMMARY

MAXIMIZING THE LEVERAGE OF YOUR SELF-FUNDED BENEFIT PLAN

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Pulling the right "levers" in designing and administering self-funded health plans can help employers maximize their benefits. Three experts in self-funding offered advice for gaining leverage at The Alliance Learning Circle event held Feb. 17 in Madison.

Tailoring Your Plan

Catherine Knuth, consulting actuary – health practice at the Milwaukee office of Milliman, an independent actuarial and consulting firm, said self-funding is attractive to many employers because it offers them more levers to pull. Self-funding gives employers more flexibility in plan design and provider networks, in part because they are under the jurisdiction of federal Employment Retirement Income Security Act (ERISA) laws and so are exempt from state mandates (see box at bottom right).

Knuth noted that self-funding offers greater control to employers in five areas:

1. **Benefit design**: Employers can tailor benefits to their industry, their employees and their goals. For example, a factory might want to cover blood testing for lead levels. Employers can also create exceptions and amendments to address special situations, such as covering additional physical therapy sessions to help an employee return to work.
2. **Provider network**: "The provider network is hugely important to a benefit plan," Knuth said. Considerations include the structure of the contract and how it impacts unit costs or discounts. The ability to use reimbursement levels to create incentives for provider quality and efficiency is valuable. Costs can vary significantly by network and by market, so it is essential to understand how each specific employer's utilization would be re-priced as part of the network selection process.

Four Factors

Cheryl DeMars, CEO of The Alliance, said that four factors typically motivate employers to adopt a self-funded employee health benefit plan:

- Achieving flexibility and control.
- Paying only for what employees need, rather than unnecessary costs related to insurance company profits or mandated benefits.
- Acting on a strong belief in the value of wellness and health promotion.
- Capturing return on investment (ROI) on the company's employee health spending.

Mandate Exemptions

Self-funded benefit plans are exempt from state insurance mandates. Each mandate typically comprises less than 1 percent of the cost of benefits for fully insured plans, but those costs add up.

In Wisconsin, self-funded employers are exempt from:

- 31 benefits mandates, ranging from AIDS/HIV testing to home health.
- Six provider mandates, including chiropractors, licensed health professionals and optometrists.
- Seven covered person mandates, ranging from grandchildren to continuation of coverage through age 27 for dependents.

3. **Claims processing and customer service**: The self-funding plan administrator should offer a combination of benefits flexibility, a provider network interface, a history of strong performance and good customer service. Equally important, they should provide information to help the employer bridge the gap between having claims data and knowing what to do with it. Tools that allow employers to benchmark their performance against peers are valuable. Fees are always a factor.
4. **Cost and utilization management**: Self-funded health plans can benefit from utilization management, pre-authorization, case management and disease management. Knuth advised employers to learn more about the qualifications of the individuals hired to work with their employees and dependents, the fee structure, and return on investment (ROI)/performance guarantees.
5. **Wellness programs**: A comprehensive approach aims to improve employees' overall health, not just the employer's bottom line. This approach often combines benefit design, wellness programs and utilization management to achieve a long-term decrease in health plan costs, increased employee productivity, reduced absenteeism and improved morale. Careful implementation is critical to overcome employee resistance, achieve ROI, comply with Health Insurance Portability and Accountability Act (HIPAA) regulations and avoid shifting costs to employees.

Examining Four Key Levers

Scott Weltz, consulting actuary – health practice, also with Milliman's Milwaukee office, examined sample health claims and spending patterns to delve deeper into four levers that help employers impact health costs.

The first key lever is the provider network selected by the self-funded employer. Within these networks, the greatest savings are typically achieved through provider discounts negotiated with hospitals, physicians and other medical providers.

"This is a volume game," Weltz noted. The average discount can vary 30 percent among different networks, meaning for example, that a self-funded employer with an annual health plan spend of $3.5 million could save as much as $1.4 million simply by changing provider networks.

Employers should review discounts carefully when selecting a network, since the variation in discounts provided for a specific health provider and the mix of charges can have a significant impact on costs. Weltz said simply comparing average discounts for a network will not necessarily lead to the lowest total spend. Understanding how an employer's own book of business would fare is essential to accurately compare networks. Examining hospital inpatient, hospital outpatient and professional claims can provide a good indicator of costs. When data is available, episodic groupers can reveal which providers deliver appropriate levels of care. For example, an episodic grouper can identify providers that order a high number of tests for every patient.

The second lever, plan design, examines how often employees and dependents use specific types of services and then adapts the plan to steer them toward the best options. Weltz recommended a holistic approach that combines utilization, case and disease management programs along with wellness programs. That allows employers to provide incentives like waiving copays or deductibles for employees with targeted conditions such as diabetes. Employers can benchmark key metrics and follow trends by service categories and disease states.

Stop Loss Coverage and Care Management

Weltz cited stop-loss coverage as the third lever because it dampens the effect of claims volatility, especially for small employers who are more vulnerable to the negative impact of a few catastrophic claims. Simulation models can help employers target the right level of stop-loss coverage based on size and risk tolerance.

Care management and wellness programs comprise the fourth lever. Weltz noted that while these programs often have a positive impact, it can be difficult to prove short-term ROI. In some cases, short-term costs may even increase if a disease management program persuades patients to fill prescriptions and visit physicians. Savings result after three to five years through reduced hospital and emergency room visits.

Claims data can enable projections of wellness savings, while delivery patterns can indicate a program's potential success. Measures that can be expected to improve through these programs include the use of blood glucose testing by diabetics, compliance with prescription medications aimed at controlling high blood pressure and the number of office visits made by employees with a chronic illness.

In the future, Weltz said efforts to monitor quality would offer another lever for steering employees to high-value providers.

Tools You Can Use

The Alliance offers tools to benchmark plan performance and compare the value of providers:

- The ***Summary Plan Design (SPD) Benchmarking Tool*** can be customized to compare your company with global data.
- ***QualityCounts™ Reports*** examine variations in quality and costs among inpatient and outpatient health providers within The Alliance network.

If you have specific questions about these products contact:

Summary Plan Design (SPD):
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The Pharmaceutical Landscape

Paul Rosowski, a registered pharmacist and manager of clinical pharmacy for WEA Trust as well as a board member and chair of the Member Value Committee for WisconsinRx/National CooperativeRx, predicted that significant changes in the pharmaceutical landscape will impact prescription drug programs, which typically represent 15 to 20 percent of costs for self-funded plans.

The industry is moving away from the use of the average wholesale price (AWP) as the standard for prescription costs due to a landmark court case. There are several contenders for setting the benchmark for prescription prices, which means that self-funded plans should re-price claims when comparing pharmaceutical contracts based on the benchmark that will be used.

Changes in the generic industry also impact competition and make it more difficult to forecast spending on generics, which typically make up 17 percent of pharmaceutical spending. Brand manufacturers and generic manufacturers are developing agreements that move up the launch of generic equivalents of some drugs, while more brand manufacturers are either manufacturing generics themselves or buying generic manufacturing companies. In some cases, generic manufacturers are contesting the patents of non-generic drugs in court to move up the timetable for launching generic equivalents.

These changes can impact the savings generated by generic medicines, with the price of generic medicines that effectively treat the same condition varying from 8 cents to $1.04 per dosage in some cases. In addition, pending federal legislation is expected to impact the manufacture of "biosimilars," which are new, biologically similar versions of existing drugs.

Targeting patients and employers

Pharmaceutical companies are moving beyond their traditional promotional approaches to target patients and employers with a variety of strategies that aim to influence consumers to select specific prescription medicines.

For example, the "combination" medication Ziana® replaces two prescription medications commonly prescribed for acne. Consumers can use a $35 rebate from Ziana's manufacturer to reduce their monthly out-of-pocket cost from $50 to $15.

Meanwhile, the health plan's monthly cost increases from $47 to $263 when Ziana is used compared to generics.

"This is happening more and more often with a lot of these new drugs and combination drugs," Rosowski said.

Another factor is the increasing use of specialty medications to treat chronic or rare diseases at an annual cost that can range from $13,000 to $200,000 or more per patient. These complex medications require special handling and monitoring and are reimbursed through both pharmacy and medical channels. Specialty medications represent the fastest growing component of pharmacy spending and are expected to increase from 20 percent of spending in 2006 to 26 percent in 2010 although they are used by less than 1 percent of the patient population.

Rosowski suggested creating "dashboard" measurements to monitor the use of pharmaceutical benefits and compare them to benchmarks. Key measures to monitor include:

- Generic dispensing rate (GDR), which is calculated by dividing the total number of generic prescriptions by the total number of all prescriptions.
- Generic substitution rate (GSR), or how often generics are prescribed when they are available, which is typically expressed as a percentage.

A one percent change in either measure typically results in a 1 percent change in the total pharmaceutical spend for a health plan.

In addition, employers should analyze spending for both therapeutic class medications and specialty medications (see box at right).

Steps for analyzing spending

Therapeutic class analysis:

- Identify the top five to 10 therapeutic classes by gross cost
- Calculate cost and use metrics in each class
- Benchmark against your peers
- Determine gaps and opportunities for improvement

Specialty pharmacy analysis:

- Measure specialty medication claims in both pharmacy and medical benefits
- Calculate cost and use metrics in both areas
- Identify key cost drivers in specific therapeutic classes
- Identify specialty medications that could be accessed through a more cost-effective channel
- Identify opportunities to designate preferred specialty medications

Influencing Consumer Choices

Rosowski described how WEA Trust has created a Value Choice Drug Plan (VCDP) that offers incentives for using the right generic drugs for preventive diseases, based on the best ROI in both cost and quality of life. WEA Trust has three co-pay tiers along with a free "value tier" for high-value medications in 15 therapeutic areas, such as high blood pressure and cholesterol management. The VCDP is structured to increase co-pays for non-preferred drugs, exclude medications with limited value, and differentiate between high and low cost generic medications. WEA Trust also is developing a special medication management plan.

WEA Trust used a pilot project to explore the possibilities from promoting the benefits of switching to lower-cost drugs, in this case over-the-counter proton-pump inhibitors (PPIs) used to control "garden variety" forms of heartburn and stomach acid. The benefit design was altered to cover a 90-day supply of over-the-counter PPIs for a single co-pay.

Personalized letters, a mock prescription bottle containing a $10 bill and a copy of a Consumer Reports article on "Best Buy Drugs" were sent to 500 plan members who were using Nexium®. Fifteen percent made the switch to low-cost over-the-counter medications, saving $135,000 for WEA Trust.

The promotional project was later expanded to another 1,000 members with a 14 percent response rate that increased the total savings to $400,000.

"We're hoping to do more of these programs," Rosowski said. Like other programs aimed at helping self-funded employers monitor and manage health plans, reaching out to consumers directly provides a way to leverage expenditures to increase value.