

Benefit Insights

Health and Productivity Practices Have Payback for Business

If long-term cost management is the goal, measures that shift a portion of current health care costs to employees seem to fall short. Though increasing employee cost sharing through adjustments in premiums, copayments and coinsurance can bring an employer a temporary respite from steep health plan cost increases, more employers are looking for a long-term strategy, and eyeing health and productivity initiatives as part of the solution.

This long-term view recognizes that the true cost of benefits programs, including health care, consists of more than the out-of-pocket benefits payments alone. Though perhaps hard to quantify, the lost productivity resulting from employee health issues—whether the employee is absent or not—are very real. Research from the Integrated Benefits Institute added calculations of lost productivity to medical benefits payments to estimate that, of the whole, 71% is lost productivity from absence, 19% is workers' compensation and group health medical payments, and 10% is wage replacement.

When viewed this way, it's apparent that an approach that focuses on the cost of health benefits alone, and attempts to lower these costs through reducing or discouraging utilization, can be shortsighted. A longer-term view sees appropriate, timely medical treatment as an investment in employee health, and seeks to implement programs and initiatives designed to help workers remain healthy and productive.

According to the 2005/2006 Staying@Work Survey from Watson Wyatt and the National Business Group on Health, 41% of surveyed employers already incorporate health and productivity initiatives into their overall health care planning, and 32% planned to do so within the coming year. Data from the survey revealed some of the most common health and productivity practices—

Practice	Offered in 2005/2006	Offered in 2003
Employee Assistance Program	94%	88%
Return-to-Work Program	81%	56%
Health Promotion Program	75%	56%
Health Risk Appraisals	72%	N/A
Work/Family Balance	71%	44%
Paid Time Off Banks	40%	36%
Personal Health Coach	40%	N/A

Employers that implemented a greater number of health and productivity practices were better able to achieve the desired outcomes. For example, 57% of the companies with 20 or more health and productivity practices reported a better employee understanding of health improvement, compared with 9% of the companies that had fewer than 10 practices in place. Also, employers with 20 or more practices in place were twice as likely to say that this strategy had worked to increase employee satisfaction with the benefits program.

Importantly, employers that took a broad view of how different benefits worked together by integrating various programs reported reduced lost time, improved health and lower costs. A separate survey from the Integrated Benefits Institute found that, over the next five years, 85% of employers want to link health and group medical data to employee absence, disability, lost productivity and company financial performance.

Health and productivity initiatives complement the consumer-directed health care model, which increasingly is making its way into employee benefits programs. With employees being asked to assume a greater responsibility for health care decisions, now is an opportune time to consider health and productivity initiatives.

Benefit Strategies, Inc. is pleased to present our quarterly newsletter which contains important information on current and/or emerging employee benefit topics. Ultimately, our goal is to provide you relevant benefit information that will enable your organization to fulfill both its financial and benefit objectives now and into the future. As always, we welcome your thoughts and suggestions. We appreciate your confidence in us and thank you for allowing us to serve your organization.



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Delivering results, not promises.™

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Population Health Management Requires Knowing Your Health Plan's Cost Drivers

Any employer with a health plan has seen evidence that a small percentage of the covered employee population accounts for a very large percentage of the plan costs. For example, an employer could realistically find that 20% of their employees account for 80% of health plan costs, but this ratio varies from employer to employer and year to year.

Disease, health management and wellness programs that are based on specific, identifiable health conditions found

in the employer's workforce can vastly improve the overall productivity of the workforce. These plans, which seek to improve diagnosis, adherence to treatment regimens, and follow-up care can also result in cost savings to the employer's health care program.

An analysis by Buck Consultants of a particular employee health plan population highlights the types of inappropriate

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Prescription Drugs Are Largest Slice of Out-of-Pocket Spending Pie

For the average person with medical expenses, nearly half of their out-of-pocket costs go towards paying for prescription drugs, according to an analysis of health care spending by the Kaiser Family Foundation. This is true for people with both very high and very low overall health care spending, and even for spending levels in-between. For the average non-elderly person with private health insurance (as compared to all health care spenders), prescription drugs account for 35% of total out-of-pocket spending.

Overall, according to the analysis, about 20% of health care costs are paid out-of-pocket by individuals. However, the average person who has health care expenses pays about 35% out of pocket. The difference between the two figures, the analysis explains, stems from the fact that health care spending is not evenly distributed across the population. A small percentage of people account for most health care spending, and for these high spenders the out-of-pocket share represents a lower-than-average portion of overall health care spending (probably because they are more likely to have reached the out-of-pocket maximums under their plans, while those with few expenses still are making payments toward the deductible). The following figures illustrate this point:

Health Care Spending of Non-elderly Persons with Private Insurance

Percentile of Health Care Spending	Average OOP Payments	Average Share Paid OOP
Top 1%	\$ 2,467	6%
2%-5%	\$ 2,017	15%
5%-10%	\$ 1,574	22%
10%-20%	\$ 1,208	29%
Lowest 80%	\$ 261	37%

As noted above, prescription drugs account for the largest portion of the average individual's total out-of-pocket spend-

ing for health care. Total out-of-pocket spending breaks down as follows:

Distribution of Overall OOP Health Care Spending

Type of Expense	Average Person with HC Expenses	Non-elderly with Private Insurance
Rx	43%	35%
Office-Based	26%	31%
Dental	17%	20%
Vision	7%	8%
ER	2%	2%
Outpatient	2%	2%
Hospital	1%	1%

The study also examined different types of health care expenses, and analyzed, for each expense, what share was paid out-of-pocket:

Average % Paid OOP For Various Health Care Expenses

Type of Expense	Average Person with HC Expenses	Non-elderly with Private Insurance
Vision	74%	76%
Rx	54%	51%
Dental	41%	37%
Office-Based	26%	28%
Home Care	17%	21%
ER	14%	14%
Outpatient	11%	13%
Hospital	5%	4%

Survey data such as this can be useful for employers when considering making changes to the out-of-pocket payments required under the health plan, such as co-payments, co-insurance and deductibles.

Most Employers Need to Provide Medicare Part D Creditable Coverage Notices

Though most employers do not provide prescription drug benefits for their retirees, most nonetheless are impacted by a particular provision of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)—namely, the requirement that individuals who are eligible for Medicare prescription drug coverage be notified as to whether they have creditable coverage under their employer’s plan.

The MMA created Medicare Part D—a voluntary program for which eligible individuals who choose to enroll pay a premium for outpatient prescription drug coverage. The Notice of Creditable Coverage is required in order to help individuals who are eligible for Part D decide whether to enroll for Part D coverage. Individuals eligible for Part D who decline enrollment when first eligible will be assessed a penalty if they later decide to enroll, unless they have had “creditable coverage” in the meantime. The late enrollment penalty is in the form of a higher premium, which will be applied for the duration of the individual’s enrollment in Medicare Part D. The late enrollment penalty applies to Part D individuals who go without creditable coverage for any continuous period of 63 days or longer after the end of their initial Part D enrollment period.

The reason the Notice of Creditable Coverage affects most employers is that it is required if the employer plan that provides prescription drug benefits covers any Medicare-eligible individuals. For example, if an active employee medical plan with prescription drug benefits covers any spouses who are Medicare-eligible for any reason—age, disability or end-stage renal disease—the notice is required. Furthermore, the notice is required whether the employer’s plan is primary or secondary to Medicare. (For employers that do provide prescription drug coverage to retirees, the notice is not required if that coverage is directly through a Medicare Part D plan.)

The notice must disclose whether the prescription drug coverage under the employer’s plan is “creditable.” Essentially, coverage is creditable if it is at least as good as the coverage under the standard Medicare Part D plan. “At least as good as” means that the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D coverage. Guidance from the Centers for Medicare and Medicaid Services (CMS) indicates that this determination measures whether the expected amount of paid claims under the employer’s prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

Actual attestation of equivalence by an actuary is required only if the employer offers—and intends to continue to offer—prescription drug coverage to retirees and is seeking the subsidy available under the MMA for doing so. Employers that are not seeking this subsidy—i.e., most employers—can apply a design-based comparison to determine whether their prescription drug coverage is creditable. According to CMS guidance, prescription drug coverage is considered creditable if it—



1. Provides coverage for brand and generic medications;
2. Provides reasonable access to retail providers and, optionally, for mail-order;
3. Is designed to pay on average at least 60% of participants’ prescription drug expenses; and
4. Has no annual benefit maximum or a maximum that is at least \$25,000 (or an actuarial expectation that the amount payable by the plan in 2006 will be at least \$2,000 per Medicare-eligible individual). However, if the prescription drug coverage is integrated with other health benefits, the integrated health plan must have an annual deductible not greater than \$250; no annual benefit maximum or a maximum of at least \$25,000; and a lifetime maximum of at least \$1 million.

The notice must state whether or not the prescription drug coverage is creditable; the meaning of creditable coverage; and why creditable coverage is important, including the penalties an individual can be subject to if he or she does not have creditable coverage and declines enrollment in Medicare Part D within the required time period. Additionally, if the coverage is non-creditable, the notice must explain the time period during which the individual can enroll in Medicare Part D. The CMS also recommends additional items for the notice. CMS has model notices and model language that can be used for employers that choose to prepare their own notices. An employer can arrange for a third-party vendor to provide the notice on its behalf.

The Notice of Creditable Coverage is required prior to the Medicare Part D election period, which starts November 15. It must be provided on an annual basis, upon beneficiary request, and at certain other times. Employers need to review these requirements to ensure that they are meeting the Medicare Part D Notice of Creditable Coverage requirements.

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utilization that can needlessly drive up health plan costs. In the studied employee group, 60% of diabetics and 91% of covered employees with high cholesterol were not receiving adequate follow-up care. Both of these conditions can lead to serious, costly complications if not effectively managed: diabetes can lead to kidney, heart and vascular disease as well as blindness; high cholesterol can increase one's risk of heart disease. The analysis included claims for an individual with chronic low back pain, who in a search for relief visited several providers, with the result that duplicative MRIs were performed every few months.

The conditions described above—diabetes, high cholesterol, low back pain—are not unique or rare, but are ones found in any employer's workforce. The utilization issues uncovered in the analysis probably are not uncommon, either.

Because effective population health management requires an understanding of exactly what drives a health plan's costs, data analysis is an initial, critical step. This can identify the subset of the overall population with particular conditions that may be appropriate for disease management programs. The health plan vendor should be able to mine data in a way that complies with privacy standards while providing actionable, useful information.

Health risk appraisals or assessments are another tool to identify areas where the implementation of disease-specific education and care management programs, or behavior-specific wellness programs (such as for weight management or smoking cessation) could make an impact. Through such appraisals health plan members self-identify any current conditions and provide information on their health and lifestyle. Not only can this data help an employer assess whether implementation of any disease- or behavior-specific programs might be worthwhile; it can facilitate outreach to individuals most in need of such intervention. Again, a health plan vendor should be able to assist with the overall process and with a cost/benefit analysis of any initiatives that seem like a good fit for the workforce.

Identification and involvement of individuals and groups with chronic or high-cost conditions, or with risk factors that can lead to development of such conditions, can result in timely and more appropriate utilization patterns. This, in turn, can ensure that health plan dollars are put to best use, and that fewer employees shift into the higher-cost category of health care spenders. Look to your health plan vendor or benefits professional to assist you in population health management.



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