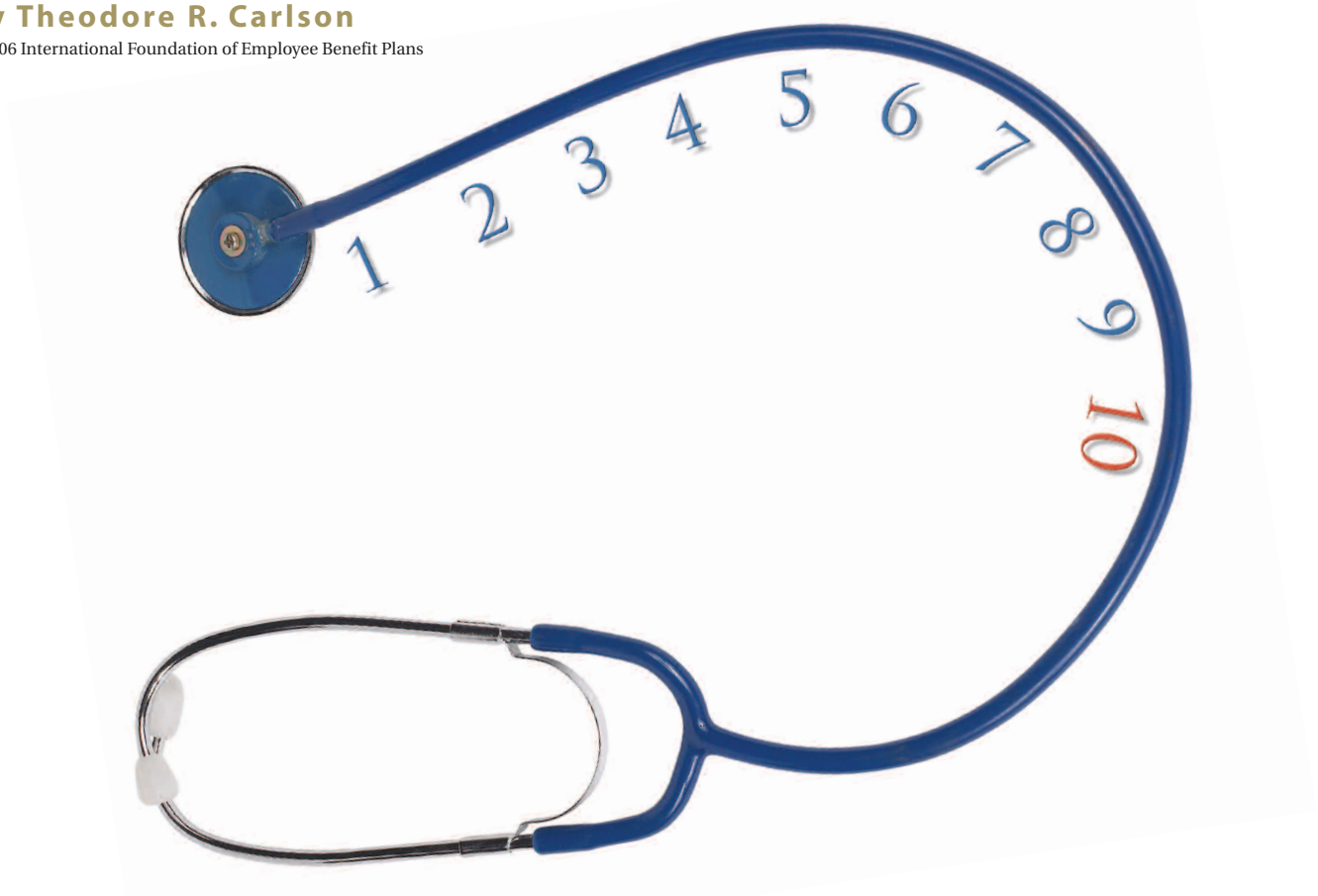
Health plan sponsors face different cost drivers now than they did ten years ago. Both the health care and the insurance industries have changed fundamentally. The federal government has increased insurance company risk exposure through various laws, and additional state-mandated benefits are also a concern. Plan sponsors need to focus on the cost dynamics within their own plans to reduce health care costs. Ten strategies help plan sponsors achieve this goal.

Ten Practical Strategies to Reduce Health Care Costs

by Theodore R. Carlson



In the 1990s health care cost increases were moderate as managed care succeeded in controlling cost. However, the new millennium has brought a different set of circumstances, the result of fundamental changes in both the health care and insurance industries. The strategy of letting competitive market forces provide solutions to rising health care costs is being replaced. Plan sponsors are now focusing on internal cost drivers to reduce cost.

When managed care was first introduced, providers were loosely organized and vulnerable to targeted negotiations. These negotiations either excluded providers from managed care networks or extracted discounts. Today these same provider communities are much better organized against such tactics. In most geographic areas only a couple of organizations negotiate on behalf of all facilities. As a result, managed care companies have been forced to accept what the providers offer or not have an adequate network to offer their customer base.[1]

The insurance industry has consolidated as well. Twenty years ago, more than 50 insurance companies offered health insurance. Today the number nationally is down to a handful—a much smaller universe to tap when seeking competitive bids. These remaining carriers have become more focused on maintaining their

profits. Health care stocks now trade at a 10% premium to market.[2] As a result, insurance companies have become more conservative in the risks they are willing to insure. This makes it difficult to obtain cost savings quotes.

Compounding this issue is the fact that the federal government has increased insurance company risk exposure with laws ranging from the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)[3] (extending coverage to nonworkers after termination) to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[4] (reducing the impact of preexisting waiting periods). State governments have provided similar concerns with a broad range of initiatives requiring the provision of additional benefits (state-mandated benefits) or extending coverage on fully insured plans.[5]

So what are plan sponsors to do? The answer: Focus on the cost dynamics within their own plans to minimize cost. Following are strategies to achieve this goal.

1. Get Value From Your Professional Benefits Advisor

It is not about how much your benefits advisor is paid. Instead, it is about the value they provide for what they are paid. Your benefits advisor has a tremendous influence on the strategies pursued and the results achieved. It is critical that they provide objective and unbiased advice if you are to maximize savings.

The first step in determining value is to understand how much advisors are paid and who pays them. This amount should be verified independently or through your Form 5500. In addition, you should request disclosure of any marketing fees, incentives or awards/prizes they are provided. Most organizations are much more willing to disclose this information since the New York attorney general's lawsuits on contingent commissions.[6]

Once the amount is identified, balance it against the services provided. If payment is made as a percentage of premium, has the level of service increased as premiums increase? If not, are there additional services that can be provided, such as automated electronic eligibility, Web site design and/or maintenance, access to a call center or identifying direct provider contracting opportunities?

In the final analysis, it is the responsibility of the plan sponsor to extract value from the arrangement with the benefits advisor, just as it is the employer's responsibility to extract value from the work of its employees.

2. Understand the Law and Use It to Your Advantage

Section 125 of the Internal Revenue Code provides opportunities for the federal government to share in the expense of your group health benefit program. By allowing participants to pay medical expenses and premiums before tax, the government provides tax savings. At a minimum, every plan should have a Section 125 premium-only plan (POP), where participants pay their premiums before federal and Federal Insurance Contributions Act (FICA) tax. (Plan sponsors save the FICA tax.) As deductibles and out-of-pocket amounts increase, *flexible spending accounts (FSAs)* can be used to shift some of the benefit reductions to the government by using pretax dollars.

Recent changes in the law allow plan sponsors even more latitude in designing their plans. *Health reimbursement accounts (HRAs)*[7] allow plan sponsors to create individual accounts that the employer funds and the employee uses to pay medical expenses. While HRAs eliminate the problem FSAs have in that the money on deposit has to be used by the end of the year (or 90 days later if allowed for by the plan),[8] only employer contributions are allowed. In addition, like FSAs, the employer is responsible for managing the plan.

Another recent change allows sponsors to introduce high-deductible plans (minimum deductible of $1,000 single and $2,000 family) which, if designed properly, allow the employee to open a *health savings account (HSA)*.[9] Contributions up to the amount of the deductible are tax-free and can be made by either the employee or the employer. These accounts function much like a medical IRA with the employees responsible for establishing accounts, making qualified withdrawals and accounting for withdrawals on their 1040 tax forms. One drawback is that unlike an HRA where the employer creates a notational account and funds the expense when reimbursement is sought, HSA de-

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Managing Benefits Plans,
June 2006, pp. 1, 11-13.
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Table

Health Accounts Compared

	Flexible Spending Account (FSA)	Health Reimbursement Account (HRA)	Health Savings Account (HSA)
Eligibility	Employees whose employers make available and participate	Employees whose employers make available	Employees with high-deductible plans (HDHPs)
Health insurance requirement	None	None unless plan design requires	Qualified high-deductible plan
Contributions	Employer, employee or both	Employer only	Employer, employee or both
Annual contribution limits	None legally required but plan may set limit	Employer sets limit	Lesser of 100% of deductible or amount established by law
Qualifying expenses	IRC §213(d) expenses, no health premium expenses	IRC §213(d) expenses, unlimited premium expenses subject to plan design	IRC §213(d) expenses, limited health premium expenses
Responsibility for appropriateness of reimbursements	Employer and plan administrator	Employer and plan administrator	Employee
Nonqualified withdrawals	Not allowed	Not allowed	Yes, but taxable plus 10% penalty. No penalty after age 65, death or disability.
Rollover of unused funds	Not allowed	Allowed, but plan can establish limits	Unused funds roll over until used.
Nonforfeitable	No, but limited COBRA rights	No, but COBRA rights apply.	Yes, and fully portable
Employee contributions pretax	Yes	No	Yes
Contribution limits	Determined by employer	Determined by employer	Determined by law
Reimbursement of most medical expenses tax-free	Yes	Yes	Yes
Health insurance premiums paid out of account	No	COBRA	Yes, if 65 and/or collecting unemployment insurance
Account owner	Employer	Employer	Employee

posits require a cash outlay because employees own the accounts. In addition, unlike HRAs where unused funds are generally forfeited upon termination, employees take the HSA account balance with them.

The above table compares many of the features of FSAs, HRAs and HSAs, which can be the cornerstone of many cost-savings strategies.

3. Introduce Consumerism

One of the problems with how we fund health care in the United States is that most participants have no idea what medical care really costs. We have insulated participants from the true cost to the point that many equate the cost of a doctor's visit with the copay. This would be similar to paying 20% of the retail cost for your clothes. Eventually, you come to believe that the cost is the discounted amount instead of the full price.

Consumerism makes people aware of the cost by having them share in the cost (usually on a tax-advantaged basis) to encourage participants to be better shoppers. The goal is to have participants shop health care for both quality and price. However, to accomplish this strategy plan sponsors must make quality and price information available so that participants can shop and compare. While this information exists only in a limited manner today, progress is being made in accumulating and distributing it.[10]

Consumerism is about changing behavior patterns so that participants make better and more cost-effective decisions. Consumerism should include:

- Benefit designs that give participants a vested interest in seeking out high-quality, lower-cost services (including alternatives)
- Access to information so they can shop and compare price and quality
- Strategies to keep participants engaged (HRAS or HSAs that provide account ownership).

4. Change Benefits

The benefit design of the plan must support the fundamental goals of the plan

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sponsor. Following are general benefit considerations that should be taken into account in addition to broader design issues such as introducing consumerism.

- Copays should include a percentage of the total charge so the participant is aware of the true cost.
- Deductibles and out-of-pocket limitations should be periodically adjusted to keep up with inflation. Regular adjustment keeps the participant aware of increasing costs.
- Plug any leaks in coverage. Avoid rewarding participants for doing the wrong thing. Design deductibles, copays and incentives so they align with your overall strategy.
- Have a strategy for biotechnology drugs, where the cost per patient can range from $6,000 to $350,000+ per year.[11]

5. Increase Managed Care Discounts

Managed care discounts are diminishing. However, if you shop your plan wisely, you can maximize the discounts available (this is where benefit advisors can help). Look at your savings reports regularly and question what is going on. Shop your plan and see if the discounts available are better with the competition. Hospital daily charge masters are similar to what hotels use; we just do not have hotels.com to obtain lower prices for us (yet).

Another strategy is to approach providers directly (direct contracting) for greater discounts. The additional discount could be as simple as the provider agreeing not to collect deductibles and/or coinsurance. This type of approach will require use of a third-party administrator (TPA). Large insurance companies with proprietary PPO networks will not administer a direct contract they did not negotiate. However, TPAs have the ability to administer this type of arrangement. Just make sure that the facility you negotiate with has at least the same, if not better, quality ratings compared to other providers. Health care that has to be paid for twice because of errors is much more expensive regardless of the amount of discount.

Also review the coinsurance and benefit payment level for benefits paid outside the PPO network. The plan generally receives no discount on out-of-network services. Plan design can reduce the benefit payment out of network to the provider's Medicare allowance. Or lower coinsurance on out-of-network benefits (HMOs pay zero for nonemergency services not approved by the primary care physician). If a participant chooses to go out of network, make sure the plan pays as little as possible (unless services are not available in network).

Estimates are that 50% of a plan sponsor's health care expenses are lifestyle related—the food we eat, the decisions we make regarding exercise, etc. Wellness and disease management both strive to reduce or eliminate health care expenses by changing participant behavior.

6. Change Eligibility Rules

How soon new participants are added to the plan and how soon they are removed can impact cost. Plans can delay a new participant's original effective date 90 or 120 days (provided the rule applies uniformly). If coverage is an issue in a new-hire situation, pay the new hire's COBRA premium from the former employer. The idea to remember is once a participant is added to the plan, the plan will generally have the sick participants (including dependents) for at least 18 months after they terminate.

Upon termination, self-funded plans should terminate employees the day their termination is effective. They may have a COBRA right, but the sooner the clock starts ticking, the sooner the liability can end. While there are administrative concerns with this approach, consider the impact of a large claim that could have been avoided. The goal is to provide benefits only for those who are entitled to benefits by virtue of their employment or legal qualification (such as COBRA).

Also, make sure the cost to your participant to add dependents is equal to or greater than the cost at other employers in the same labor pool. The goal is to prevent providing an incentive for your plan to cover all of the dependents in the labor pool because of a more generous plan subsidy. Additional dependent units have the potential to increase cost due to the risk of a dependent incurring expenses exceeding the participant's contribution.

7. Self-Insure

Another consideration is to move away from a fully insured arrangement to either a partially or completely self-insured approach. The advantages of self-insurance fall into several broad categories:

- Designing benefits to fit your specific situation and eliminating those required by state law
- Setting your own rates including selecting utilization factors appropriate for the group
- Eliminating margin (also known as insurance company profit) from your rates
- Freeing up claim reserves that can be reinvested into operations (usually equals 25% of one-year claim cost).

The actual savings from self-insuring will be dependent on the group itself. However, if executed properly, savings can range from 7% to 10%. These savings can be leveraged if the plan sponsor designs the benefit plan focusing on solving specifically identified problems. For example, you could negotiate a direct provider contract or reduce out-of-net work benefits to a level not offered by the insurance company.

To eliminate some of the risk of loss, self-insured plan sponsors can buy stop-loss insurance. These products come in two varieties:

1. *Specific stop loss,* which caps losses on one claimant at a specific amount, such as $100,000
2. *Aggregate stop loss,* which caps losses on the entire group at, for example, 125% of the prior year claims increased for inflation.

However, these products are different from fully insured products. They provide coverage during specific time periods, such as a calendar year. At the end of the contract period (possibly in the middle of a large claim), the plan sponsor may have to renegotiate the terms of the contract.

A word of caution with self-insurance: It has been said that with self-insurance the plan sponsor is pledging the assets of the organization to satisfy the medical claims incurred by plan participants. This

is true unless a 501(c)(9) trust is used, which further complicates the strategy and raises cost. It is imperative that the plan sponsor has an experienced and trusted advisor familiar with self-funded approaches and products.

8. Include Wellness/ Disease Management

Estimates are that 50% of a plan sponsor's health care expenses are lifestyle related—the food we eat, the decisions we make regarding exercise, etc. Wellness and disease management both strive to reduce or eliminate health care expenses by changing participant behavior. They are just different sides of the same coin, both designed to help participants make better choices.

Wellness programs target behavior to prevent a condition from developing (eating right, exercising, etc.). Disease management targets behavior after a medical condition has developed (controlling diabetes, asthma, etc.). Either can generate results in the right circumstances. To be effective, these programs require:

- A stable employee population with low turnover. Both programs take years to impact results, and high turnover simply means your efforts will benefit the employee's next employer.
- An integrated approach with rewards built into the benefit design to reward good behavior
- A respected advocate to keep the program focused and on track, even when business pressure mounts. Senior management has to be supportive as well.
- A culture that encourages compliance. It does little good to send participants mailers talking about proper eating habits and then provide high-fat lunches (pizza or other fast food) during meetings or hold meetings in the local bar.
- Commitment. Commitment. Commitment. Behavioral changes come slowly and cultural changes come even more slowly. These programs are about changing lifestyles, not about a quick fix.

9. Focus on Total Compensation

Viewing employee benefit cost from a total compensation perspective helps plan sponsors keep their focus. Hiring a receptionist for $20,000 who costs an equal amount to insure is not cost-effective. Combined benefit costs and salary should be evaluated for each job category within the company. If lower paid employees are using a disproportionate share of benefits, other business strategies might be more cost-effective (outsourcing, using a professional employer corporation (PEO) or use of a subcontractor).

Larger organizations sometimes get caught up in the concept that all participants need to be provided identical benefits. While nondiscrimination laws must be followed, alternative strategies (outsourcing, use of subcontractors, etc.) can help an organization achieve the same end result with lower costs.

10. Make the Pieces Fit

Each of the strategies discussed can be implemented independently. But by combining a number of strategies, savings can be geometrically increased. While an HRA has many positive virtues, implementing one independent of other changes will convert a traditional cost-sharing benefit plan design into a first-dollar plan with increased cost. By contrast, introducing consumerism with a larger deductible partially offset by an HRA contribution will provide the foundation for cost reduction. Add in a wellness program with additional HRA contributions for compliant behavior (for example, taking a health risk appraisal) and you can compound your savings. **B&C**

Endnotes

1. Reese Merle, "Hospital May End Pact with HMO," *Wall Street Journal,* August 16, 2000.
2. Johanna Bennett, "Two Health-Care Stocks Offering a Haven," *Barron's* online, June 15, 2006 at online.barrons.com/public/article/SB115038598649181289-j_pUdKXGmLFM_lWykpxgxq6fxwY_20060718.html?mod=9_0002_b_free_features.
3. COBRA requires employers with 20 or more employees to offer continued health care coverage to employees and dependents who are losing coverage under the employer plan.
4. HIPAA requires employers to credit newly covered employees toward the preexisting waiting period (if any) for all prior coverage documented by a certificate of credible coverage and that does not have a break in coverage of 63 days or more.
5. Gail A. Jensen, Ph.D., and Michael A Morrisey, Ph.D., "Mandated Benefit Laws and Employer-Sponsored Health Insurance," Health Insurance Association of America, January 1999, page i. There are currently more than 1,400 state-mandated benefits and options. Kenneth E. Thorpe and Curtis S. Florence, "Why Are Workers Uninsured? Employer-Sponsored Insurance in 1997." *Health Affairs,* March/April 1999.
6. Andrew G. Simpson, "N.Y. Attorney General Spitzer Sues Marsh Over Contingent Commissions," *Insurance Journal,* October 25, 2004.
7. IRS Notice 2002-45 and IRS Revenue Ruling 2002-41 (June 26, 2002).
8. Referred to as the "use-it-or-lose-it" rule, money not used by the end of the plan year (or 90 days thereafter for plans that have adopted the new rules) is forfeited.
9. Internal Revenue Code Section 223(d)(1).
10. Section 261 deals with administrative simplification provisions designed to improve reporting effectiveness of the health care system by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.
11. David Carver and F. Randy Vogenberg, "A Practical Approach to Addressing a Longer Term Benefits Strategy: Implications of Biotechnology Medications," *Employee Benefit Plan Review,* Volume 60, Issue 5, pages 21-23.

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