

Benefit Insights

The Early Numbers Are In, And Consumer-Directed Health Care Looks Like a Winner

Early experience with consumer-directed health plans (CDHPs) indicates that the goals of cost-moderation and informed patient decision making are being met. Cost increases for these plans are well below those for other types of health plans and members are utilizing preventive care services and decision-making support tools.

These experiences were shared by several vendors of CDHP products, at a briefing sponsored by the Galen Institute, a research organization that focuses on health and tax policy. The briefing, "Reports from the Field about Consumer Choice Health Care," featured representatives from Aetna, Definity Health, Destiny Health, Assurant Health (formerly Fortis Health), Lumenos, and Vivius.

Greg Scandlen, director of the Galen Institute's Center for Consumer Driven Health Care, said that the vendors' experience indicates that employees are seeing value in the control that CDHPs give them over their health choices. "They aren't skimping on preventive services but are making wiser choices on discretionary expenses, reducing emergency room and outpatient visits, and using generics more often."

CDHPs aim to heighten consumer awareness of the cost and utilization of health care services through plan design, financial incentives, and health information. Though many plan designs are possible, a common arrangement pairs a health reimbursement account (HRA), set up by an employer to reimburse an employee for incurred medical expenses, with a high deductible insurance product. Plan deductibles, co-payments, and coinsurance amounts can be paid from the HRA, along with other unreimbursed health care expenses. Unused HRA amounts can roll over from year to year. CDHP members also have access to comprehensive health information to help them make wise decisions about how to spend their health care dollars.

The experience of the vendors at the briefing indicates that, contrary to assumptions that only young and healthy people would choose CDHPs, enrollees were more likely to be older and sicker. Despite such enrollment, costs were dramatically low: one

vendor reported that costs for the group of members enrolled in its CDHP product grew by 1.5%, compared with a 15.7% increase for a similarly situated, non-CDHP group. Another vendor reported an overall rate increase at renewal of 3.2% in 2004, while industry averages remain in double-digits.

How did the plans achieve such cost moderation? A look at utilization provides some of the answer. One vendor reported an overall 12% decrease in utilization of medical services (hospital, physician, lab, etc.), and a 6% decrease in pharmacy utilization. Another vendor reported that use of generic medications increased by almost 13% among CDHP members, and that overall prescription use declined by 11%, resulting in a 6.5% decrease in pharmacy costs. Use of generics increased by as much as 50% in some plans.

CDHP enrollees also made more use of preventive services. One vendor reported that CDHP members used preventive services 16% more than similarly situated, non-CDHP enrollees. Utilization of preventive services increased by as much as 60% in some plans. CDHP members also made better use of the resources offered to help them become better health care consumers, such as information Web sites, nurse hotlines, online searchable provider directories and formularies, and other decision support tools.

As noted above, the HRA-type of account offered as part of a CDHP can permit rollover of unused amounts into a subsequent year. Thus, a plan member has incentive to use his or her health care dollars frugally, and some vendors' experience indicates that this in fact is occurring: one panelist reported that more than half of CDHP members had dollars to roll over into the next year and, on average, these dollars amounted to 31% of members' accounts.

Though CDHPs are relatively new on the health plan scene, experiences such as these indicate much promise in the quest to curb health spending, while promoting and maintaining employees' health.

Welcome to Our Newsletter!

Obesity is approaching smoking as the #1 cause of death in the U.S. A report from the federal Centers for Disease Control and Prevention shows tobacco use killed 435,000 – 18.1% of all deaths in 2000. Obesity caused 400,000 deaths, 16.6% of the total. A Rand corporation study estimates in 2020 one in five health care dollars spent for people 50 to 69 could be for obesity and its complications. A study by Unum Provident, insurer, found short-term disability claims for obesity jumped tenfold in the past decade. Average annual cost per claimant: \$51,000.

Employer sponsored wellness programs addressing issues like weight management and smoking cessation are investments that can produce valuable returns. If you would like to increase your employees' productivity and lower claim costs in the long run, contact Tobias to learn more about wellness programs.

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Knowledge and Action Are Keys to Tightening the Belt on Obesity-Related Costs

Obesity is becoming an epidemic in America. According to the American Obesity Association (AOA, a Washington, D.C.-based nonprofit advocacy group) and based on figures from the Centers for Disease Control (CDC), 65% of U.S. adults are overweight, 30% are obese, and close to 5% are severely obese. These figures represent a dramatic increase from those reported a decade earlier. According to Rand, in 2000, one in 50 adults was severely obese, compared to one in 200 in 1986. "Severely obese" people have a body mass index (BMI) of 40 or higher, which translates to roughly 100 pounds or more of excess weight in an average adult male.

An increasingly sedentary lifestyle and workplace, fast foods, along with super-sized meal portions all have played a role in making us a fat—and unhealthy—nation.

Obesity is associated with more than 30 medical conditions, according to the AOA. Research from Rand found that obesity is linked to higher rates of expensive, chronic health conditions than smoking, heavy drinking, and poverty. Diabetes, hypertension, heart disease, osteoarthritis, and depression are among the chronic illnesses linked to obesity. As a result of the connection between obesity and chronic conditions, obese individuals spend more than the general population on health services and medications: 36% more for health care services and 77% more for medications, according to Rand.



With obesity and health care costs trending up, the implications for employers are staggering. According to a release by the Washington Business Group on Health (WBGH), businesses lose more than \$12 billion each year due to the byproducts of obesity: higher utilization of health care, lowered productivity, increased absenteeism, and higher disability insurance premiums.

In June 2003, the WBGH launched the Institute on the Costs and Health Effects of Obesity. The Institute will serve as a resource for businesses on obesity-related issues and as a source of strategies for decreasing the incidence of obesity. The Institute's first product is an Employer Toolkit, which highlights successful work-based healthy weight management programs and strategies.



Another project that identifies actions employers can take to promote healthy weight management comes from a Roundtable of the Kaiser Permanente Institute for Health Policy. Sponsored by several organizations with ties to business and health policy and research, the Roundtable was the culmination of an effort between Kaiser Permanente and the CDC to develop a broad-based approach to the public health crisis of obesity. The Roundtable developed suggested policies and actions for communities, the health care system, schools, and the workplace.

The group's priority recommendation for employers and health plans involved the development of a HEDIS measure for body mass index. HEDIS (Health Plan Employer Data and Information Set) measures, crafted by the National Committee for Quality Assurance, provide employers with information about health plan performance. According to the recommendation, employers could use a HEDIS BMI measure to choose health plans that offer weight management services, tools, and resources. Then, health plans could use the measure to encourage contracted providers to more thoroughly integrate BMI and weight management into the health care services they provide.

Other Roundtable recommendations for employers include making health risk appraisals available to employees, along with plans of action for those at risk; facilitating programs such as Weight Watchers at Work; and encouraging employees to enroll in health plans that offer comprehensive approaches to weight management.

Examples of other simple steps employers and plans can take to encourage behaviors aimed at controlling the obesity trend line include: stocking vending machines with bottled water and healthy snack foods; negotiating employee group discounts with local gyms; communicating that health care flexible spending accounts can be used for physician-recommended weight-loss programs prescribed for a diagnosed disease (including obesity); and providing employees with access or negotiated discounts to personal and online weight management programs and/or nutritional counseling.

What approach is right will depend on a business' employees, budget, and philosophy. At minimum, employers should become familiar with the facts and figures on obesity and its impact on the workplace, and communicate this information to employees.

Integrating Management of Disability Programs Fosters Return to Work, Cost Savings

Although the rising cost of health care has grabbed headlines, the cost of employee absences has garnered less attention. Yet, the costs to employers when employees miss work—whether caused by sick days, disability leave, workers’ compensation, or other approved leave—are substantial: temporary workers, overtime, lost productivity, and dissatisfied customers. Furthermore, employee absences stemming from illness or injury may be associated with substantial medical costs. UnumProvident, a provider of income protection insurance, estimates that the 10% of the work force filing occupational or non-occupational disability claims accounts for 55% of a company’s medical costs.

The aging of the work force and an increasing number of claims for “new” types of disabilities will push the cost of employee absences even higher. Repetitive strain injuries (such as carpal tunnel syndrome) are a byproduct of today’s technology-laden workplace, while hectic and overloaded lifestyles contribute to chronic fatigue, depression and other stress-related illnesses. Clearly, it is in an employer’s financial interest to find ways to better manage disability-related absences. One approach that has shown promise is integrated disability management.

The goal of an integrated disability management (IDM) program is to manage all employee absences—regardless of cause—in a way that results in the employee returning to appropriate work as soon as possible. IDM can be as simple as combining the processes for a company’s STD and LTD programs, or it can entail integration of all absence/leave programs (sick days, STD, LTD, workers’ compensation), along with the medical plan. The processes and services that come under a common umbrella in an IDM program can include claims reporting, administration and analysis; case management; rehabilitation and return-to-work services; and the point-of-contact for inquiries.

A key feature of an IDM program should be a system that facilitates easy and early reporting of absences. Such a system provides a “heads up” that an employee is absent and triggers a determination of whether the absence is one that needs management to ensure proper medical treatment and a prompt return to work. For example, an employee experiencing back problems may miss a few days of work when the condition first flares up; after time and without the right treatment, the condition may worsen to the point of a lengthier absence and a STD or LTD claim. Under a traditional approach to disability claims management, the employee likely would not be contacted for intervention until some point after STD (or even LTD) benefits



have begun. By then, a disability mentality can set in. Statistics show that the longer an individual is out of work for a disability, the less likely that person is to return.

In contrast, with an integrated approach to disability management and a good absence reporting system, the absent employee would be contacted early on, the reason for the absence determined, and the back strain condition managed to ensure timely and appropriate care. The need for and feasibility of workplace adjustments would be determined, along with the possibility of the employee returning to work on a reduced schedule or in a modified position until full recovery. The result is an employee who returns to work sooner.

Studies show that employers do see savings by taking an integrated approach to disability and absence management, though the savings experienced can vary dramatically. It’s not hard to see how savings result, given that appropriate early return to work can boost employee productivity and morale and lower all costs associated with a disabling condition. A happier, healthier work force, and cost savings to employers make integrated disability management a feature to explore when adding or revamping a workplace disability benefit program.

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Next lowest (or highest) pricing to purchasers for retail trade.

Insurers that qualify as HMOs or represent other captive populations will usually achieve a pricing advantage due to special status pricing.

Ability to Move Market

The formulary is vitally important in delivering market to manufacturers. When an insurer or PBM can tell Pfizer, manufacturer of Lipitor, that all (“all” is always qualified) prescrip-

tions for cholesterol-lowering drugs will be written for Lipitor (versus Zocor or Prevacol), they are “delivering market” and creating a competitive advantage for Lipitor that Pfizer is willing to pay for through lowered pricing.

Outcome

Formularies can improve care through the careful, ongoing review of drug effectiveness results by the formulary decision makers, leading to best choices based on the latest research and use market forces to deliver lower pricing.

A Look Behind the Curtain – Inside the Drug Formulary

Your company, like most employers, probably has a prescription drug program that includes a drug formulary. You know how the formulary works with your co-pay design, incentivizing members to make cost-effective medication choices. Now, peek behind the curtain and see how the formulary works from the insurer's side.

Purpose

Insurers (and employers) use the formulary to manage costs and to improve care. When a drug company introduces a new drug that is similar to other drugs already available to treat the same disorder, they are considered to be “therapeutically equivalent” or, work in the same way to treat the disorder. Given an equal choice, the insurer might offer only the less expensive drug in its formulary, i.e., “equal quality at a better price” or require higher co-pay for the more expensive drug. In the case of Lipitor versus Pravachol, both drugs belong in a therapeutic class called “statins.” They lower cholesterol by slowing down the body’s ability to make cholesterol. Drugs in this class include atorvastatin (brand name Lipitor), fluvastatin (Lescol), lovastatin (Mevacor), pravastatin (Pravachol) and simvastatin (Zocor). Consequently, the insurer may choose to cover only one or two of these drugs, based on their ability to negotiate favorable pricing.

Drug Selection

Insurers use a pharmacy & therapeutics (P&T) committee to select formulary drugs. The committee, made up of doctors and pharmacists, reviews the medical research on drugs within therapeutic categories. Within each category, they select the drugs that are “best in class” for inclusion on the formulary. The insurer then

works to negotiate the best prices for the selected drugs.

The committee also tracks trends in side effects and outcomes of various drugs and may determine that a drug be eliminated if their ongoing research suggests that the benefits are not as real as the drug maker originally claimed.

In this way, the formulary protects plan members from drugs that are not performing as planned.

Cost

Insurers or, more frequently, sub-contracted pharmacy benefit managers (PBMs) negotiate the purchase price of drugs based on three factors: volume, “class of trade” and “ability to move market.”

Volume

Insurers negotiate better pricing based on the volume of drugs they expect to purchase – the greater the volume, the lower the price. To the extent that a formulary delivers greater volume of one drug over another, the formulary creates a volume advantage that is useful in negotiation.

Class of Trade

Drug manufacturers must follow a “class of trade” system that provides:

Lowest pricing to the federal government;

Next lowest pricing to hospitals;

Next lowest pricing to HMOs and other captive settings;

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