



Rising Health Care Costs

By Liz Tascio
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It's no surprise: National surveys and data point to another double-digit increase in health care costs for employers in 2008. But changes in the health care industry have also made it possible for companies to rein in soaring costs, and a few emerging trends acted on now may mean immediate and significant savings in the long run.

Health care in the United States is quickly trending away from traditional coverage and toward a more consumer-driven system, said Frank J. Aiosa, a partner in Chernoff Diamond & Co., a benefits consulting firm, and it's not too early to evaluate whether your company would benefit from making the change.

"In the next two or three years, there won't be 100 percent plans anymore," Aiosa said. "For the most part, the trend will be to move co-insurance in network."

Aiosa and Chuck Healy, Chernoff Diamond's director of business development, explained to the Human Resources Roundtable in October how an evaluation of your current health plan, an exploration of other benefit plans, and a shift to focus on employee wellness can not only save money on health care costs, but make the health care system work more efficiently, and make the workplace healthier and more productive for everyone.

What's causing the jump?

What's driving up health care costs in America? It's a question with multiple answers, Aiosa said. Among them: rising obesity, expensive state mandates, popularity of biotech drugs, consolidation of insurers, and an increase in defensive medicine.

"When you go to the doctor or the emergency room, for my neck issue, for example, did they ask me to get an X-ray and an MRI at the same time? Or did they do one test first to see if that worked and then the next test?" Aiosa said. "The insurance system we have today pays for it. It's inherent in our system to have over-utilization of our plans. In a consumer-driven plan, the employee will think about those things."

If you have an insured plan, you're subject to state mandates, which in New Jersey includes a new law regarding coverage for in vitro fertilization, which raised premiums 3 to 5 percent.

Biotech drugs, made from living organisms, have been very effective but very expensive, and pharmaceutical ads mean they're often requested by name, Aiosa said. In a traditional plan, a consumer doesn't know that the brand-name biotech drug for which they pay a co-pay actually costs thousands of dollars a month. There's no incentive for consumers to ask for a generic or an alternative medication, Aiosa said.

The benefits of consumerism

If you switch to a consumer-driven plan – a high deductible health plan – people think in terms of cost, Aiosa said.

For example, on a traditional prescription drug plan, a consumer might pay \$10 for a generic, \$20 for a brand, and \$35 for a non-preferred brand. Aiosa's family is on a high-deductible health plan. His daughter recently got a prescription for skin cream, but when she got to the pharmacy, the 4 oz. tube rang up for \$250.

“She did the consumer thing and she said, ‘I don’t want it,’” Aiosa said. “So they changed it to a generic, and it was \$40. That’s consumerism.”

Switching to a high-deductible plan

Introducing a qualified high-deductible health plan with a health savings account attached can save money immediately and provide real benefit to employees, Aiosa said.

“The health savings account – it’s portable, it’s yours,” Aiosa said. “There’s no ‘use it or lose it.’ You put a dollar in it, and it’s your dollar.”

It’s also the employee’s responsibility. Whereas the employer is the fiduciary of a flexible spending account, and has to be sure the money is used only for qualifying purchases, the employer isn’t required to monitor HSAs.

An HSA works like an IRA or a 401(k). Money goes in untaxed by the federal government – some states, including New Jersey, do tax contributions – it earns interest, and can be withdrawn to pay for a qualified medical expenses at any time. It can be withdrawn for any reason after age 65 without penalty. Some companies use it as a retirement savings vehicle for employees who earn too much to participate in the 401(k). Employees declare their contributions at tax time on Form 8889.

One of Chernoff Diamond clients, a small private equity firm in New Jersey, achieved a 54.5 percent savings by switching to a high-deductible health plan with HSA. The company had about 25 employees, all on a very rich Aetna plan at a cost of \$236,000, and was facing a renewal increase of 17.6 percent. By switching to an HDHP, the company immediately saved \$151,000.

The employer then fully funded each employee’s health savings account, and will fully fund them again in 2008. By next February, each employee will have \$11,000 in an HSA. That will cost the company \$85,000 a year, for a final savings of \$66,000 a year.

“It works,” Aiosa said. “In this model, it’s easy. There’s no way any employee is ever going to field the deductible.”

Potential drawbacks to the HDHP

It’s possible employees whose companies don’t fund the HSA might skip out on necessary health care because they can’t afford the deductible.

“This is supposed to reduce unnecessary care, waste in the system,” Aiosa said. “The bigger issue is when someone says, ‘\$4,000 deductible? I’m not taking my kid to the doctor.’”

Preventive care on these plans is usually free, Aiosa said. “A well-woman visit, child immunizations, all of that should be free. Make it easy for them to go.”

Implementing an HDHP costs the employer very little, outside of educating employees about the new plan and how to use it. An employer can offer it to a certain class of employee or to the whole company. However, if the employer funds one group’s HSAs, all employees on the plan have to be funded the same amount, no matter where they work or what they do.

The plan is subject to risks associated with anti-selection, something Aiosa called “the death spiral.”

“What happens is the healthier people join that (HDHP) plan,” Aiosa said. “The sicker risks get left with the rest of the plans, and over time, the spread continues, and the plan defeats itself. The premium can’t support all the claims on this one plan. So the idea of beating anti-selection issues, or the death spiral, is to financially integrate the plans.”

‘The least expensive claim’

“The least expensive claim here is the claim that you don’t have to pay at all,” said Chuck Healy, Chernoff Diamond’s director of business development. It’s worth it for most companies to implement a wellness program that keeps employees from getting sick or injured in the first place.

“One of the biggest trends in this country is we are becoming sicker and sicker and sicker, as a population, though obesity,” Healy said. “What’s the result of that? Higher costs. More absenteeism. It’s having a direct impact on productivity, sick days, the bottom line of your business.”

The Centers for Disease Control began surveying American obesity in 1990. That year, 10 states reported that 10 percent of their populations were obese. By 2006, only four states could say that fewer than 24 percent of their population was obese. Twenty-two states said at least 25 percent of the population was obese; two of those states reported their rate was at least 30 percent.

“So this is what we’re facing,” Healy said. “How can we help our employees, and how can we help our businesses and our bottom lines?”

The key to a wellness program, particularly one that focuses on a better work-life balance, is to have support from management at the highest level, Aiosa said.

“It’s difficult,” Aiosa said. “You try to implement (a wellness plan) and you get, ‘What’s the return on investment?’ That’s what the financial officers want to know.”

The good news is that large companies that did implement wellness plans years ago have seen measurable results, Healy said.

Wellness: How to start

Start with a health risk assessment, in which employees report – to a third party vendor, if that’s what’s most comfortable – their behaviors and habits. Once you have an idea of your population’s health, you can offer a wellness plan that fits the company’s needs and budget.

New York state offers a free quit-smoking program. Vendors can tailor programs to fit companies of all sizes. You can also implement a voluntary program where employees pay as they go, such as exercise classes on campus.

To encourage participation, you can try a carrot or stick approach, and reward or penalize employees, Aiosa said.

“Scotts Miracle-Gro, they wield a very big stick,” Healy said. The company invested millions in a wellness program, including a 12-month smoking cessation program. Employees were told that if they didn’t quit by the end of the program, they’d be fired.

That’s working its way through the court, Healy said.

Mini-med and alternative drug plans

There are other ways to drive down drug costs, Aiosa said. For example, make generics more appealing by dramatically lowering the co-pay, Aiosa said.

“It doesn’t have to be a consumer-driven health plan, it just has to create the thought,” he said. “If you create a \$50 spread in co-pays, maybe that’s all you have to do.”

Some companies have begun mandatory generic substitutions; the consumer pays the difference for the brand. A consumer already using a brand can be invited to ask his doctor if the generic will work for him; if the answer is yes, the drug plan can offer a free three-month supply as an incentive.

For companies with many hourly, low-wage, uninsured employees, a mini-med plan can offer real benefit at low cost. Employees pay about two to three hours of wages per week for the plan, and in return get a certain number of office visits and prescriptions per year. Benefits are capped at \$100,000, which employers should explain beforehand. Adding this plan may even reduce turnover, Aiosa said.

Conclusion

To help employees make sense of any new or current benefits, see if your advisor or carrier provides an online informational service, toll-free numbers, or claim concierge services, Aiosa said. When evaluating your broker or adviser, review fees and negotiate them down to industry standards.

Start assessing your health benefits as soon as possible, even January 2, Aiosa said. Work with your advisors, and meet at least quarterly to review claims and utilization of the plan. Know which drugs are most frequently prescribed and why. Determine whether your plan is performing to your carrier’s norms, and if not, why not. Do some research on every carrier, every solution, and every funding mechanism.

“Consider them all,” Aiosa said. “There could be an anomaly you could take advantage of.”

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