

Benefit Design Critical to Protecting Out-of-pocket Costs for Employees

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Abstract

In the past few years, employers have struggled with finding the optimal approach to healthcare benefit cost sharing. Recently, a leading actuarial firm analyzed employer out-of-pocket (OOP) data and the financial impact of OOP expenses on employers and employees. Findings were shared with a group of leading employers who meet periodically to discuss innovative benefit design strategies. Attendees viewed models that showed what effects various copayment and coinsurance amounts would have on employer and employee costs. Many attendees were intrigued with results that indicated increasing OOP costs for the sickest employees would do little to lower overall benefit costs.

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Effective benefit programs are crucial for employers if they are to recruit and retain valuable employees. Typical employer strategies to manage costs and employee usage include copayments and coinsurance. In today's era of benefit cost sharing, the most seriously ill employees often incur the highest out-of-pocket (OOP) expenses. A leading actuarial firm recently analyzed employee benefit claims data and presented findings to a group of the nation's top employee benefit executives. This analysis demonstrated that excessive employee OOP payments do little to reduce an employer's overall healthcare costs. The undue burden that OOP expenses place on the sickest employees can actually increase benefit costs if it results in the employee's nonadherence with treatment regimens and, consequently, additional comorbid conditions. The benefit executives learned about new proprietary tools available to help them model effective benefit design strategies. Armed with these tools and working in partnership with managed care, employers will be better able to determine the most effective benefit design for their employees and their organizations.

Setting the Stage for a Discussion About Biotechnology and Benefit Design

Human resource and employee benefit leaders face mounting challenges as they try to control benefit costs. They must address a range of issues, including rising expenses, uncertainty over potential government policy changes, concerns about how to safeguard employees' health, and resource management. New prescription drugs on the market may offer solutions, but they also create challenges. These medications are sometimes costly but may enable skilled workers to stay on the job longer; they increase productivity and decrease absenteeism. Many of the more promising medications are biotech drugs, so-called because they derive from biotechnology. Managed care executives have long recognized the potential of biotech drugs to improve therapeutic outcomes and control overall benefit costs.

Employers often struggle to develop benefit programs that work the best for their companies and employees and help retain and recruit valuable workers. One of the major challenges employers face in determining which benefit design strategy is best is an insufficient amount of current data. This is particularly true regarding biotech

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drugs, for which only a few years of data regarding use and cost exist in many therapeutic areas.

To address ongoing challenges in healthcare benefit design and discuss critical issues that employers face, Integrated Therapeutics Institute, LLC (ITI), a national consulting firm specializing in healthcare data analysis and communications for employers and pharmaceutical companies, convened several of the nation's top employers. The participants are not merely representatives of large organizations; they are the thought leaders behind some of the nation's most innovative benefit design programs. Individuals attending the 2-day Employer Summit include **Robert Berglund**, vice president of employee benefits and insurance, Boyd Gaming Corporation; **Raymond J. Brusca**, vice president of benefits, Black & Decker Corporation; **Louise Probst, RN, MBA**, executive director, St. Louis Area Business Health Coalition; **Gerald Richerson**, human resource manager, Southern Company Services; **Michelle Martin**, director of health and welfare benefits, CBS; **Julie G. Tatum, GBA**, director of health and welfare benefits, Clear Channel Communications; **Robert C. Wald**, director of benefits, Smurfit-Stone Container Corporation; **J. Brooks Watt, MD**, director of corporate medical services, Gillette—a Procter & Gamble Company; **Kenneth D. Wells, MD**, corporate medical director, El Paso Corporation; **Lynn Zonakis, BSN**, director of health strategy and resources, Delta Air Lines, Inc; and **Robert D. Moroni**, moderator and consultant (former director of healthcare plans at General Motors Corporation).

Presenters included **Frank Kopenski, ASA, MAAA**, associate actuary for Milliman, Inc, and **Grant D. Lawless, MD, RPh**, executive director for corporate accounts at Amgen Inc.

The main purposes of the meeting were to highlight primary cost drivers in national healthcare and correct some myths that inadvertently influence the development of many employee benefit programs.

Analyzing Employee Benefit Programs

Participants acknowledged that employers must frequently deal with uncertainties surrounding rising healthcare benefit costs and their ramifications. Employees are too often forced to make critical financial and personal decisions related to their healthcare benefits—benefits provided to improve

health outcomes and productivity. In extreme cases, employees who could not afford their company's high premiums opted to have Medicaid cover their children. If trends such as wage compression continue and annual raises fail to keep pace with premium increases, many more workers will face ongoing hardships.

Although cost is likely the overriding consideration influencing an employee's use of available benefits, other factors may include lack of knowledge regarding the value of a specific therapy, forgetfulness, and apathy. "When we analyze utilization data, we should recognize that not only can it show healthcare resources that are being used, it can also highlight covered benefits that are not being accessed that should be," explained Raymond Brusca, vice president of benefits at Black & Decker Corporation. "One third of our female employees and dependents aged 35 and older are not getting an annual mammogram or Pap smear. I want them to spend that money, because, in the end, it will create a healthier employee and reduce costs."

Robert Berglund, vice president of employee benefits and insurance at Boyd Gaming Corporation, echoed Mr Brusca's concern about unused benefits: "The good news is 60% of employees are not using their healthcare benefits. The bad news is 60% are not using their benefits." Several participants noted that although ensuring appropriate benefit use was challenging, another important element to consider was employee demographics. "We now have an entire generation of employees that has grown up with copayments, and these employees are often insulated from the true cost of medical care," expressed Dr Kenneth Wells, a corporate medical director for El Paso Corporation.

The important topic of copayments versus coinsurance was of great interest to participants because these are widely used by employers to influence benefit use. Participants noted that a growing number of employers are reverting to coinsurance, but they also indicated that copayments would likely remain a tactic for many companies. Benefit plans began implementing copayments in the 1990s to provide members with a simpler—and often less expensive—option. Copayments were also a simpler option for employers and plan sponsors, particularly when used with tiers. "Copayments simply work as a mechanism for utilization in many drug

categories today,” explained Dr J. Brooks Watt, medical director, Gillette—a Procter & Gamble Company. “Copayments are simple to understand and implement. Because of those features, copayments are a tempting strategy for high-cost prescription drugs.”

Coinsurance gained popularity in the 1970s and 1980s, and today, many employers view it as “old-style.” Coinsurance requires employees to pay a percentage of the actual cost of the healthcare services provided. While this approach to cost sharing is viewed as outdated, interest in coinsurance has been renewed because of the perception that it helps employees better understand actual healthcare costs and ensures more equitable division of costs between employers and employees.

Seriously Ill Patients Bearing the Financial Burden

Following a discussion about the realities of benefits, copayments, and coinsurance, moderator Mr Moroni led participants through some critical research that had been collected and analyzed by Milliman, Inc, a premier global consulting and actuarial firm. While there were considerable data highlighted at the meeting, participants agreed that one of the most compelling facts they wanted to share with colleagues and peers was that although the severely ill represent only 1% of the population, they account for 22.3% of all healthcare costs; chronically ill patients make up 5% of the population, yet are responsible for 46.6% of healthcare costs.¹

Not surprisingly, these 2 categories of patients bear a significant portion of OOP costs. The Milliman, Inc data showed that, on average, OOP spending by severely ill patients exceeds \$2000 per member per year just for prescription drugs. This figure has greater significance viewed against the backdrop of the average income of chronically ill and severely ill employees. According to the *Statistical Abstract of the United States: 2004*, the most severely ill employees have average annual incomes of \$48,000, and under some popular benefit designs, they accrue more than \$3500 in OOP expenses—more than 7.5% of their gross family income. Many employers do not truly understand the financial impact OOP costs can have on employees and unknowingly place this burden on the most seriously ill.¹

Hospital and Medical Expenses: Key Drivers of Healthcare Spending

While most employers have no desire to overburden their sickest employees, they also do not want to saddle other employees with disproportionate financial obligations, nor do they want to spend an excessive amount of the organization’s limited resources on healthcare benefits. By digging deeper into their own healthcare utilization data, employers can better understand the true culprits behind high benefit costs and acquire the knowledge needed to design more effective benefit strategies.

Pharmaceutical spending remains the fastest growing component of an employee healthcare benefit plan and continues to receive considerably more attention than other components of healthcare spending. It is important for employers to recognize how other factors affect their overall benefit costs. In reality, medical and hospital services account for the majority of an employer’s benefit expenses.

According to the Milliman, Inc research, severely ill employees (categorized as the top 2.5% of benefit utilizers according to the Milliman, Inc data) typically incurred annual treatment costs in excess of \$60,000 for hospitalization and medical care. The sickest employees were consistently responsible for 20% of prescription drug spending, including biotech, generic, and branded medications. Biotech drugs only constituted ~6.6% of the total benefit expenses for the top 2.5% cluster of severely ill patients.¹ The study authors highlight this fact not to minimize the expense of biotech drugs, which is clearly significant, but rather to ensure that employers clearly recognize the effect other benefit elements have on total costs. This type of data could be useful in employers’ efforts to develop more comprehensive, balanced, and fair approaches to managing benefit costs.

The Milliman, Inc data also showed that many seriously and chronically ill patients have multiple conditions, such as concomitant high blood pressure and diabetes, which affects costs. Recent managed care data have shown that employees who have 3 concomitant chronic conditions (eg, diabetes, asthma, and hypertension) may incur cumulative healthcare costs equivalent to those incurred by cancer patients.¹

What do the current cost of benefits and the prevalence of disease mean to employers? It means that some of their most valuable employees will

develop severe or chronic illnesses and comorbidities in the prime of their careers and are at risk of being burdened with excessive OOP costs. These OOP costs can take a huge toll economically on individuals and their families and might result in reduced adherence to medication regimens, which, in turn, could lead to greater costs long-term. It is unfortunate that many traditional approaches to benefit design are potentially harmful to employees and their family members suffering from chronic or severe illnesses.

Incorporating Biotech Therapies in Benefit Design Goals

Today's employers are accustomed to controlling healthcare costs through utilization management, copayments, and common managed care tactics. These efforts often cannot change the behavior of people who are severely ill, specifically those using biotech therapies. "Those employees need those drugs and often have little to no choice in alternative therapy," stated Lynn Zonakis, BSN, director of health strategy and resources at Delta Air Lines, Inc.

Because of the potential value of biotech therapies, as well as their surrounding complexities, attendees recommended that their industry colleagues return to a company's basic, underlying goals in designing a benefits program. While specific goals will vary between organizations, an effective benefit program should generally aim to transfer a fair share of costs to members; preserve reasonable OOP costs and access to care; manage healthcare resource use and clarify discretionary treatment versus real therapeutic advances; and shift to generic medications and preferred brands when available, provided they offer equivalent therapeutic outcomes.

Participants in the Employer Summit have recognized the value of biotech medications and the need for effective benefit design for years. Some had already developed or were in the process of implementing innovative approaches to benefit design.

How to Categorize Biotech Drugs

How to classify biotech drugs has been a concern for employers. Traditionally, physicians have administered biotech drugs to patients, specifically for cancer, rheumatoid arthritis, and multiple sclerosis. This is why most health plans classify biotech therapies under the medical benefit. This strategy is beginning

to change as pharmacy benefit managers (PBMs) become more involved with managing biotech drugs. In 2005, specialty pharmacy providers or PBMs managed ~20% of biotech medications. Heavy marketing of PBM services to employers could soon increase that percentage significantly.²

Pharmacy managers believe they can do better in negotiating lower costs and providing greater oversight using the National Drug Code (NDC) billing system. The NDC system supplies detailed information about the type, amount, and frequency of drugs administered. Most participants at the Employer Summit had considered or were considering moving biotech medications under pharmacy management.

The classification of biotech drugs generated considerable commentary among attendees, and participants agreed on one point, in particular: Biotech medications are vital to a strong, effective, and competitive benefit design. "Biotech drugs are why we have insurance—to keep our people alive and functional," stated Michelle Martin, coauthor of this article and director of health and welfare benefits at CBS. "If our employees have to take these medications, we don't want to make them cost-prohibitive to our people or to our company." Ms Martin noted that CBS recently had moved a portion of its biotech drug benefit to the pharmacy plan to take advantage of deeper discounts. She observed that moving benefits for biotech drugs from medical to pharmacy resulted in savings for the company, but CBS employees' copayment for a particular biotech medication increased from \$15 to \$50. Ms Martin said that CBS never intended to increase OOP expenses to such an extent and therefore decided to waive copayments for this particular drug for 1 year.

New Modeling Tools Show Optimal Benefit Design

A critical section of the Employer Summit involved an in-depth discussion on benefit design led by Mr Kopenski, who offered his insights into benefit design strategies that could prove useful regardless of how an employer classifies biotech benefits. Milliman, Inc has developed an innovative proprietary model that can help employers better determine the effects cost-sharing measures have on OOP expenses for employees, including those with chronic or severe illnesses, while highlighting the

employer's true potential savings. This predictive tool provides employers with various copayment and coinsurance outputs that can influence employee behavior. The model answers these questions: What happens as employers change copayment amounts for generic, preferred, and nonpreferred medications? What happens if the benefit changes to a full coinsurance design, without any limits? How can a company alter coinsurance design to help employees who have chronic and severe illnesses without increasing employer costs? One Milliman, Inc scenario demonstrated that for a specific prescription categorized under the medical benefit, employees paid ~\$285 annually, but when that prescription was reallocated to the pharmacy benefit, employee costs increased to \$904 per year.

The main finding of the Milliman, Inc report was that higher copayments and coinsurance place an undue burden on the severely ill, often limiting their access to necessary treatments, without reducing employer premium costs. Many severely ill patients do not have therapeutic alternatives and have no option to select less costly treatments to control their OOP obligations.³

The Milliman, Inc data also illustrated that shifting costs to the severely ill was of questionable value because it was unlikely to provide significant cost savings. One model used a standard pharmacy benefit of 20% coinsurance with no OOP limits; the employer's annual medical and administrative costs totaled \$2396, and OOP expenses for the average employee were \$176 per year, whereas the sickest employees paid \$3324. A growing number of healthcare leaders believe that employees' medication adherence level greatly decreases once their OOP expenses exceed \$1000; using this standard model, a severely ill employee's OOP was almost triple the recommended level. Most notably, none of the models indicated that increasing OOP expenses for the sickest employees significantly reduced employer costs.

The Milliman, Inc model illustrated what would happen to employer and OOP costs when adjusting the benefit design. A significant finding of the Milliman, Inc data was that even when behaviors such as employee medication adherence did not change, varying the benefit design could increase or decrease costs. Under the model, moving to a 20% coinsurance benefit with no OOP limit increased cost sharing for employees in the highest 1% of benefit uti-

lization to a surprising \$17,595—clearly excessive for the average employee. Revising the benefit to a tier-4 benefit employing a 25% coinsurance rate for tier-4 drugs increased employee cost sharing to \$5202, an amount still too high for the average employee. While some employers might believe that such cost-sharing measures save money for their companies and reduce costs for average employees, the model showed this was not the case. The employer's total cost remained at \$2396 under the 20% and tier-4 coinsurance design models, although both placed an excessive financial burden on the sickest patients, who have few or no therapeutic alternatives.

Mr Kopenski brought everyone's attention to what was perhaps one of the most significant statistical analyses of the day: "By using a 20% coinsurance benefit with a \$1000 OOP limit, employer costs remain the same, average employee costs remain basically the same, and you are able to limit the expenses of your most severely ill employees." As one attendee noted, "This really highlights that you don't have to beat up on your sickest employees to save money."

Medical directors and nurses participating in the program were especially interested in the OOP data. "We know that OOP costs impact adherence," Ms Zonakis stated. "Anything that helps to limit the burden of expenses on the severe and chronically ill can end up encouraging persistence and compliance and will end up not only improving therapeutic outcomes but also help control costs for employers over the long run."

Participants noted that under many of the models, costs might change even when behaviors did not. The group believed strongly in finding ways to educate employees and change behaviors. "As a company, we believe that when you change plan design you have to also change behavior," said Mr Gerald Richerson, human resources manager at Southern Company Services. "In order to have truly effective benefit programs, we must find ways to educate our employees on the value of their healthcare benefit and the role they must play in managing their costs, as well as those of their employer."

Employers also believed that it is vital for any benefit offering biotech medications to provide education and support for employees about their respective diseases and treatment therapies. "We believe case management is an important part of our benefit offering

to employees,” noted Ms Julie Tatum, director of health and welfare benefits at Clear Channel Communications. “Our PBM will be looking at whether or not prescriptions are filled and refilled with follow-up to both patients and physicians. We think this will really help with compliance and create better outcomes for our employees and our company.”

Conclusion

Participants in the Employer Summit stated that the most important lessons gleaned from the presentation were recognizing where healthcare benefit dollars are spent and realizing the importance of tailoring benefit design for employees who suffer from chronic or severe illnesses. Fewer than 5 of 100 people are responsible for half of an employer’s healthcare spending, and those employees tend to stay on the job longer than 5 years.³ Since these employees are likely to remain employed, it is in an employer’s best interest to provide optimal benefits.

Participants agreed that copayments and coinsurance have constructive roles in improving cost sharing and controlling overutilization. They also felt, however, that employers must carefully consider the effects these measures have on individual employees and balance this with critical therapy needs and the potential long-term consequences of hampering access to therapy.

One strategy participants recommended adhering to when designing benefit plans was the principle “the devil is in the details,” because averages can be misleading. This is especially true when incorporating copayments or coinsurance into benefit models. Executives must consider the following:

- What are the long-term effects of this decision?
- Is this the complete picture for individual employees, specifically those already burdened with severe or chronic illness?
- Will this benefit design help the organization retain employees and reduce turnover?
- Will this benefit design address absenteeism and presenteeism?
- How will the benefit design affect productivity and morale?
- Will the benefit design lower total premium costs?

For employers to answer these questions and aid them in making decisions, they must collaborate with their PBMs and managed care providers to

establish employee profiles. This will enable employers to understand employees’ unique circumstances and avoid tendencies to implement a quick fix using carve-outs and discounting programs that focus on one therapeutic area, such as biotech medications.

The rising cost of biotech drugs as a component of the overall pharmacy benefit is of continuing concern to benefits administrators, and more importantly, company executives. While participants did not want to minimize the impact biotech drug costs have on benefit decisions, they cautioned against taking a simplistic approach, such as increasing copayments for biotech drugs or decreasing access to them. They emphasized the need to take a more balanced approach to benefit design and examine all factors that influence costs—including hospital and medical expenditures—and felt that the results would be well worth the effort.

Employers who ask the right questions and implement benefit designs based on data and employee needs ultimately will manage costs better and create a strong workforce. This strategic approach will make such employers more competitive in today’s increasingly global marketplace while ensuring that they do not overburden valued employees with high benefit costs.

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