

Cost Management Strategies for Multiemployer Health Funds During Sustained Economic Downturns

As the nation awaits national health care reform, trustees of multiemployer health funds are facing immediate and longer term challenges related to the still distressed economy. Utilization patterns may change in some ways that increase costs in the short term and in other ways that compromise participants' health over time. As expenditures rise and continued low levels of employment lead to reductions in overall contributions, health funds may be depleted. This *NewsLetter* discusses steps that trustees can take now to ensure that plan costs stay within budgets by looking carefully at cost sharing, plan design and vendor performance.

LESSONS ABOUT UTILIZATION FROM PREVIOUS RECESSIONS

In tough times, managing health care costs continues to be important. Increases in unemployment during recessions are typically accompanied by dramatic drops in the consumer price index (CPI), but health care plan costs do not always decrease by comparable amounts.¹ Moreover,

utilization may change during downturns. Actuaries and underwriters have long understood that spending on health care, unlike other forms of insurance, can be dependent on factors not strictly related to health issues, such as consumer and provider behavior, in addition to anticipated claims fluctuation and other factors. In tough times, these influences become more pronounced.

A seemingly logical assumption is that use of health care services, like other services, declines dramatically in a recession as consumers cut back on their spending. However, experience has shown that might not be the case. In fact, increases in health expenditures remain significantly higher than increases in the CPI, even during recessions.²

When individuals are worried about the security of their jobs or losing eligibility for health benefits, they may increase some forms of utilization of their health benefits (*e.g.*, by scheduling major dental work or elective surgery³). Design changes adopted by many plan sponsors over the past 10 years, such as substantial patient copayments, higher coinsurance levels and larger annual deductibles, may go a long way toward discouraging overutilization

IN THIS ISSUE:

- > Lessons about Utilization from Previous Recessions
- > Plan Management Strategies in a Recession
- > Vendor Management in an Unstable Marketplace
- > Individual Wellness and Health Management Promotion
- > Conclusion

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The Segal Company is pleased to announce that Serena G. Simons has joined Segal as Senior Vice President and National Compliance Retirement Practice Leader. Ms. Simons is an employee benefits attorney with over 20 years of experience. A graduate of the University of North Carolina and Duke University School of Law, she has worked with several leading Washington, DC law firms. Serena is currently the Chair of the Employee Benefits Committee of the DC Bar Section of Taxation and a member of the Section's Steering Committee. Ms. Simons has been recognized in *The Best Lawyers in America* for employee benefits. She can be reached at 202.833.6472 or ssimons@segalco.com

¹ This conclusion is based on The Segal Company's review of data from the Bureau of Labor Statistics and the Center for Medicare & Medicaid Services, supplemented with data from the annual *Segal Health Plan Cost Trend Survey*. An online supplement to this *NewsLetter*, which presents the data in a table, is available on the following page of Segal's Web site: <http://www.segalco.com/publications/newsletters/sept2009supp.pdf>

² To see the data supporting this assertion, refer to the online supplement to this *NewsLetter* mentioned in footnote 1.

³ For example, see a March 13, 2009 *New York Times* article, "Bad Economy Leads Patients to Put Off Surgery, or Rush It" (<http://www.nytimes.com/2009/03/14/us/14surgery.html>) and a November 6, 2008 *New York Times* article, "Hospitals See Drop in Paying Patients" (<http://www.nytimes.com/2008/11/07/business/07hospital.html>).

of benefits. Current cost-sharing levels for both employment-based plans and Medicare may dampen the natural tendency to seek unnecessary medical services.

However, health funds with comprehensive medical plan designs may be at risk for unanticipated surges in per capita claim costs if participants anticipate they may lose coverage. This may also come from enrollment spikes in continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), as well as an increased utilization of elective procedures during periods of reduced employment.

Perhaps not as intuitive is another pattern related to recessions that plan sponsors need to watch for: *underutilization* of certain services.

When family finances are squeezed, individuals may delay important preventive care. According to a 2009 poll conducted by the Kaiser Family Foundation, many Americans are cutting back on health care because it is unaffordable. See the accompanying graph.

Such behavior may lead to greater health care costs over time to the extent that there is an underutilization of preventive procedures and key health care treatments. This can result in volatile or even catastrophic future claim costs attributable to increased complications from untreated chronic conditions.

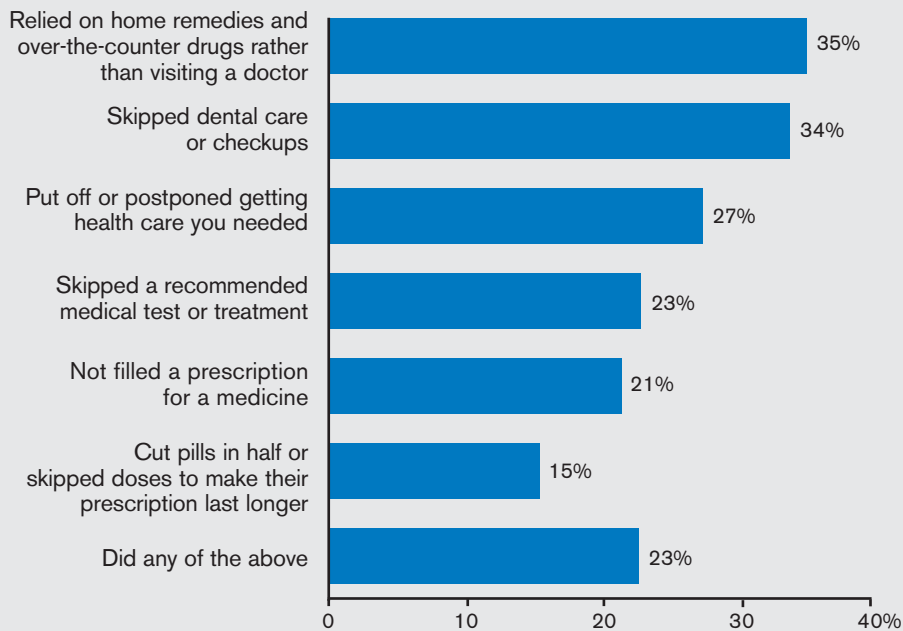
Finally, as patients may be trying to cut back on their health expenditures, plan sponsors need to be aware that

providers have the ability to influence both the *supply* and the *demand* for services. Various studies by the Dartmouth Institute for Health Policy & Clinical Practice have found regional differences in the number of tests ordered and procedures performed that the researchers attribute to the number of physicians in an area and available resources, rather than to underlying health conditions.⁴

To mitigate increased, unnecessary health care utilization, while encouraging the use of proven preventive procedures, trustees may want to develop specific strategies to control costs. These strategies can be designed to address the key areas of cost management: plan management, vendor management and individual health management.

Consequences of Health Care Costs

In the past 12 months, have you or another family member living in your household done each of the following because of the cost, or not?



Source: "Key Findings: Kaiser Health Tracking Poll — February 2009", (#7866) The Henry J. Kaiser Family Foundation, February 2009. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

PLAN MANAGEMENT STRATEGIES IN A RECESSION

In addition to keeping health inflation in check, plan sponsors should consider the following strategies for managing their health care costs:

➤ *Monitor participant use of health-care services via data mining.*

While increasing cost-sharing with participants through higher copayments and deductibles is sometimes seen as an easy way to rein in costs, too much cost-shifting could have the unintended consequence of forcing participants to avoid needed preventive services. Another way to approach cost-sharing is through the use of data-mining tools to hone in on the specific areas of utilization that are driving plan costs. Armed

⁴ For example, this year, the Dartmouth Atlas Project examined Medicare spending data and concluded that state differences "are largely due to discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other resources — and a payment system that rewards growth and higher utilization." A press release is available on the following page of the project's Web page: http://www.dartmouthatlas.org/press/NEJM_Release_RWJF_022609.pdf

with specific data to identify the diseases and treatments that are driving up costs, trustees are better able to develop ways to address those cost factors.⁵

➤ **Manage health plan rolls.**

Eligibility audits can ensure that the plan is paying only for participants and dependents who are eligible to receive benefits. One Segal client that conducted an eligibility audit in 2008 discovered that approximately 8.5 percent of dependents covered by the plan were not eligible for benefits. Positive enrollments (*i.e.*, requiring documentation of dependent status) is another approach many funds take to manage health plan eligibility rolls.

➤ **Review eligibility provisions.**

During periods of economic downturn, welfare funds are experiencing added financial pressure as participants who are not working remain eligible for benefits through regular eligibility cycles or hour banks. Many trustees have had to take a hard look at eligibility requirements and tighten eligibility rules — even though it is likely that an individual's ability to pay for extended eligibility is even more difficult during times of unemployment.

➤ **Check reserve levels.** Many health funds faced significant escalations in health care costs over the past decade and are only now reestablishing adequate reserve levels. As a result of the current economic stresses that health and welfare funds are facing, reserve policies and levels play a vital role in maintaining a fund's long-term viability and stability. Reserve levels should be regularly reviewed to ascertain

the effect of potential utilization increases and volatile market and employment conditions. Trustees should periodically review reserve policies to ensure that the fund can meet the financial challenges that are likely to arise during an economic downturn.⁶

➤ **Reexamine Appropriateness of Current Cost-Sharing.** In today's challenging economy, trustees may find it necessary to modify their plans' cost-sharing provisions. If that course of action is required, trustees should seek to minimize disruption to participants, to maximize the impact *and* to promote appropriate patient behavior.

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VENDOR MANAGEMENT IN AN UNSTABLE MARKETPLACE

As cost components and vendor contracts become increasingly complex, it becomes even more important for trustees to confirm that their health funds are receiving market-competitive pricing and services. They can do a number of things to ensure vendors comply with their commitments:

➤ **Take advantage of competitive pricing.** Recent experience has shown that it is possible to obtain lower cost coverage, particularly for prescription drug benefits and life insurance. Health funds that have not recently sought competitive bids for providing benefits may want to

test the market, as improved pricing yields immediate savings.

➤ **Spell out expectations for managed care provider networks.** Plan sponsors may find it helpful to review vendor contracts and create performance guarantees tied to outcomes and avoidance of provider abuses. In this way, plan sponsors can make it clear to their carriers that they are expected to keep network provider price increases in line with overall inflation and to keep a close watch for possible provider abuses. For example, a growing number of plan sponsors and insurers are no longer paying for claims directly related to hospital errors.

➤ **Improve case management and health coaching services.** Plan sponsors can flag trends in non-compliance with essential preventive diagnostic and pharmaceutical therapy and have vendors intercede more aggressively to get patients to stay on appropriate therapies that avoid complications from disease.

➤ **Audit medical provider claims.** A claims audit can help identify overlap, waste and inefficiency.

When working with vendors in today's economy, another serious consideration for plan sponsors is instability of insurance companies. That topic is addressed in the text box on the next page.

INDIVIDUAL WELLNESS AND HEALTH MANAGEMENT PROMOTION

Another way plan sponsors can contain long-term costs and better serve participants is by encouraging employees to become more involved in their own health care through education and wellness promotion. Examples include the following:

➤ **Redesign benefits to promote wellness.** While wellness programs

⁵ For more information about health plan data mining, see Segal's January 2008 *NewsLetter*, “Total Health Management Strategies and Success Factors”: <http://www.segalco.com/publications/newsletters/jan2008.pdf>

⁶ For more information about reserves, see Segal's July 2003 *NewsLetter*, “Keeping Health Funds Healthy: The Importance of Reserves”: <http://www.segalco.com/publications/newsletters/july2003.pdf>

Coping with Instability in the Vendor Marketplace

The current recession has been notable for the number of insurance and financial institutions that are being downgraded, entering bankruptcy, acquired by a competitor or taken over by the federal government. In the current environment, health plan sponsors need to be aware that insurance carriers may be or become financially vulnerable.

Health benefit plan sponsors should make sure that they are placing their business with financially secure companies that will continue to meet the financial qualifications outlined in the bid process and in their contracts. Carrier ratings should be updated and reviewed periodically to verify the ongoing financial stability of the organization. Plan sponsors should be on the lookout for early signs of trouble, such as ratings downgrades from multiple rating agencies, successive downgrades, increased media scrutiny, network stability problems and participant-service problems. Plan sponsors should actively monitor their vendors' performance for both transactional processes and for customer satisfaction. In addition to the softer indicators, some key financial statistics to consider when evaluating insurers are:

- Financial strength ratings (e.g., Secure ratings from sources such as AMBest, S&P, Moody's),
- Negative ratings outlooks, and
- Rapid declines in net worth (e.g., gross changes in capital and surplus).

do not create immediate cost savings, continued emphasis on participant and dependent wellness can help to improve the overall health status of a health fund's population with the corresponding reduction in high-cost claim events over time.

- Provide incentives for participants to seek treatment from more cost effective providers, where costly specialists and treatment

"Improving the health literacy of participants through ongoing education and communications, in conjunction with promoting wellness and self-responsibility, can improve outcomes and reduce long-term health plan cost trends."

environments are not necessary or desirable. Options include development of plan incentives to use retail clinics, nurse practitioners and other, qualified health care providers, and financial disincentives to seek non-emergency care from emergency rooms and other high-cost providers.

- Invest in medical decision support tools that educate participants to be better consumers of health care. Improving the health literacy of participants through ongoing education and communications, in conjunction with promoting wellness and self-responsibility, can improve outcomes and reduce long-term health plan cost trends. Plan sponsors can play an important role in helping participants learn how to assess health information.

Recently, some vendors have begun to offer a guaranteed return on investment when these programs are implemented. For disease management initiatives, these guarantees can be a significant percentage of program fees. Additional contract language is usually needed to ensure that performance guarantees are measured and reported appropriately.

CONCLUSION

The current economy creates new challenges for health plan trustees. Those that are well prepared for the effects of bad times will be less likely to burden their participants with more health plan cost increases and benefit reductions, and will be less likely to encounter financial surprises down the road. Rigorous health plan monitoring and a willingness to apply both tried-and-true and innovative

new tactics can help health funds weather the challenges brought by the current downturn.



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