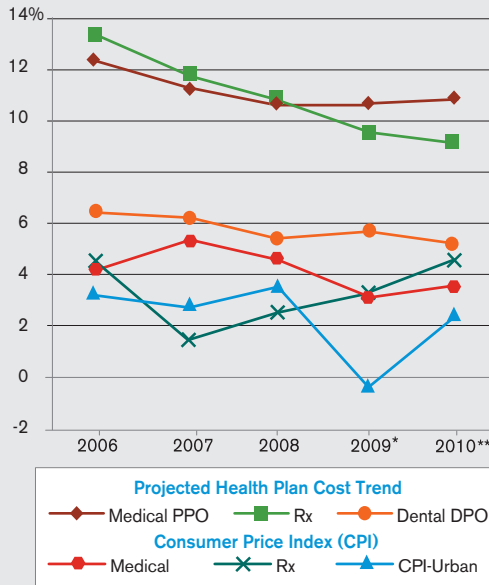


TREND AND CPI

In 2010, health plan cost trend will remain relatively flat but is still higher than general inflation.



* 2010 CPI data is for February.

** In 2010, prescription drug carve-out data was captured for retail and mail order delivery channels combined.

Sources: 2010 Segal Health Plan Cost Trend Survey (<http://www.segalco.com/publications/surveysandstudies/2010trendsreport.pdf>) and Bureau of Labor Statistics for CPI (<http://www.bls.gov/cpi/>)

Trend is the forecasted change in claims cost determined by insurance carriers, managed care organizations (MCOs), pharmacy benefits managers (PBMs) and third party administrators (TPAs). Trend can be influenced by a variety of factors including price inflation, the leveraging effect of copayments, cost shifting and utilization. The **CPI** is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The CPI is often used as an economic indicator.

NATIONAL HEALTH CARE REFORM LAW

President Obama signed into law both the Patient Protection and Affordable Care Act (PPACA – Public Law 111-148) and the Health Care and Education Reconciliation Act (HCERA). The HCERA (also known as the “budget reconciliation bill”) contains a package of significant changes to the PPACA. Together these two laws will go into the history books as the new health care reform legislation. These are the most important laws affecting multiemployer health plans since the passage of ERISA in 1974. Information on the laws can be found on The Segal Company’s Web page Stat! Health Care Reform Weekly.¹ To help plan sponsors understand the practical implications of national health care reform, Segal will conduct webinars and will release publications focusing on various aspects of law

COMPLIANCE NEWS

Three federal agencies jointly released interim final regulations implementing provisions of the Mental Health Parity and Addiction Equity Act of 2008. The new rules will require extensive testing of plan mental health and substance use disorder benefits against medical benefits to assure that the plan does not have a more restrictive financial requirement or treatment limit than the predominant level in medical/surgical benefits. The new regulations require quantitative testing of six inpatient and outpatient benefit categories, including emergency care and prescription drugs. The rules also prohibit separate deductibles, and require review of behavioral health management programs. The regulations will apply to collectively bargained plans for plan years beginning on or after the later of either July 1, 2010, or the date of the termination of last collective bargaining agreement ratified before October 3, 2008.²

NOTEWORTHY NEW RESEARCH

Increasing cost sharing for ambulatory care among elderly patients may have adverse health consequences and may increase total spending on health care. A study found plans that nearly doubled copayments for primary and specialty care had fewer annual outpatient visits, more annual inpatient days, and a higher proportion of hospitalized enrollees compared with plans that did not change copayments.³

WHAT MULTIEMPLOYER HEALTH FUNDS ARE DOING TO MANAGE COSTS: SELECTED STRATEGIES

Conduct an Average Wholesale Price (AWP) cost-neutrality analysis of the plan’s current PBM. In response to the price “rollback” of AWP values in First Databank and Medispan databases effective September 26, 2009,⁴ PBMs have been including language in client contracts suggesting various calculations intended to produce cost-neutral drug plan costs after the reduction in AWP costs. Plan sponsors should consider performing this analysis in order to validate PBM changes to contractual pricing guarantees and assure that cost neutrality has been attained.

Implement strategies to manage radiology services.

Plan sponsors may want to consider creating prior authorization and utilization review (UR) on all radiology services, particularly advanced imaging, ordered by physicians. A prior-authorization and UR program on advanced imaging may be able to produce savings in a range of 10 to 25 percent. For example, one plan design strategy would be for plan sponsors to require prior authorization for a pre-determined list of diagnostic outpatient imaging services. Those participants that do not obtain prior authorization will incur higher cost sharing (e.g., \$100 copay in addition to standard benefits).

Reduce copayments for specific drug therapies. Recent experience has shown that reducing member drug copayments for key therapies (e.g., cardiovascular, asthma) can improve drug compliance rates and lead to less need for expensive medical care. For example, a number of clients have reduced member out-of-pocket costs for prescription drug therapies that treat diseases such as hypertension, high cholesterol and diabetes.

VENDOR MARKETPLACE

UnitedHealthcare, a large health insurer, and Continuum Health Partners, a New York City based hospital system, have reached an agreement regarding their contract dispute. The organizations negotiated compromises on insurance rates for hospitals and on a proposed rule that would require hospitals to notify the insurance company within 24 hours of a patient’s admission or incur a financial penalty.

¹ See the following Web page: <http://www.segalco.com/publications-and-resources/stat/>

² See Segal’s Bulletin, “MHPAEA Regulations Released”: <http://www.segalco.com/publications/bulletins/march2010MHPAEAregs.pdf>

³ See “Increased Ambulatory Care Copayments and Hospitalizations among the Elderly” in *The New England Journal of Medicine*: <http://content.nejm.org/cgi/reprint/362/4/320.pdf>

⁴ For background, see this 2009 Segal Bulletin: <http://www.segalco.com/publications/bulletins/july09AWP.pdf>



For information about the strategies above or any of the developments discussed on this page, contact your Segal benefits consultant, or send an e-mail to info@segalco.com