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Medical Plan Costs for a Hospital's Own Employees Rising in 2011; Hospitals Finding Creative New Strategies

National and regional benchmarking confirm that costs are rising. In its tri-state area survey, Cammack LaRhette provides laser-focused detail on the cost drivers and true benchmarks.

Now in its sixth year, the Cammack LaRhette tri-state area hospital medical and prescription drug benefit survey has grown from 11 to 33 hospitals, representing over 100,000 employees. The survey encompasses the New York Metropolitan area and includes select hospitals in Connecticut and New Jersey. While surveys abound in the benefits world, Cammack's singular feature is its narrow focus and detail. Cammack LaRhette staff verifies the self-reported data, provided by plan administrators, with source data from vendors' claim feeds and data warehouses. This process ensures utmost accuracy and meaningful results. Additionally, the survey gathers data not traditionally found in other benefit surveys, like the effects on survey participants of mergers and closings of area hospitals.

The survey has enjoyed a high level of repeat participation year after year, which helps clarify trends over time. At the request of the health care institutions, it has also expanded to include more hospitals over a wider geography, with meaningful slices of data based on size and location. Participants include large hospital systems, acute care facilities, teaching hospitals, and specialty care and community hospitals, ranging in size from under 1000 employees to over 15000. The Cammack LaRhette survey is unique, in that it drills down to several levels of detail, by including various cost and utilization metrics, benefit design and funding. Metrics include:

- Administration expenses
- Claims expenses
- Financing
- Reinsurance
- Demographics
- Utilization
- Cost sharing
- Plan design
- Domestic, in and out-of-network claim levels

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The findings

Note that detailed findings are only available to hospitals who participate in the survey. This description represents a broad overview of findings.

The survey's findings reflect the changing landscape and regulatory environment for hospitals, which, unlike other employers, must meet the challenges of health care reform both as provider and employer. Sweeping changes have affected the healthcare space and in response, many hospitals surveyed are contemplating mergers, partnerships and business changes, as fee-for-service pricing models are replaced by other structures. Nearly all survey participants agree that the much-anticipated ACO regulations fall short of creating a path to the next phase of healthcare's transformation. The recent ACO Final Rule will continue to influence how hospitals ultimately react to the evolving landscape.

Healthcare reform dominated discussion in 2010; however, with most provisions taking effect in 2011, the financial impact over a full 12 months is not yet discernable. Nearly 50% of hospitals indicated they would likely make plan changes that would result in loss of grandfathered status, causing them to bear the full brunt of all healthcare reform's mandates. A combination of the weak economy and healthcare reform has increased dependent enrollment under the age 26 rule in some hospitals, and increased spousal enrollment due to job losses. Spouses tend to cost an average of 1.2 times the employee's cost, and expanding contract size in general will drive costs up in the future.

Hospitals with under 1000 enrolled employees experienced the largest increases, from the highest at 17.5% to the lowest at 2.5%. On the whole, costs rose about 7%. The survey observed that the median total medical and Rx plan expenses, inclusive of administrative fees, have increased from the 2010 median of $11,210 per year to $11,989 per year.

Employee cost sharing among medical plans has also grown significantly, while growth in employee cost sharing among Rx plans has been much more modest.

Plan design and utilization

The PPO, offered by 73% of surveyed hospitals, continues to be the most prevalent plan offering. Among those, 79% provide a second option plan, with 30% offering a PPO/EPO combination. Both inpatient and outpatient utilization is down from last year, while emergency room visits are up by 15%. Specialty drug utilization is similar to last year's, but the percent of plan dollars spent on specialty drugs is increasing. Most plans incent their members to use the domestic facilities with low cost sharing.

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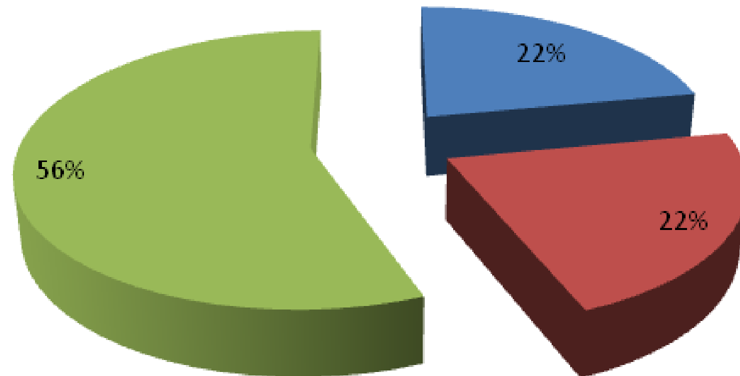
Percentage of self insured hospitals in survey with and without stop loss



Outlook and strategy

Health care costs will unquestionably continue to rise, and the current economic and regulatory environment will ratchet up pressure on hospitals as never before. In addition, data has shown that hospital workers are more likely to use their health benefits, because they are more adept than employees in other industries at engaging the healthcare system. Recent publicity, however, around higher costs for health benefits for those in the health care industry may be a bit misleading. The cost has to be measured against like packages – and we frequently find that hospitals' benefit programs are richer than other employers.

Despite these pressures, hospitals must be leaders in promoting health, reducing costs, and decreasing utilization in their own health plans, while increasing efficiencies and quality in the delivery of care. This juxtaposition of factors is challenging, in the light of frequently competing initiatives. Furthermore, various stake holders (employers, insurers and regulators) who look to hospitals to manage the health and costs of patients, will want to know how well they have done in managing the health and costs of their own employee population.

Population Health Management

A hospital has more impact on its population's health and health care cost than any other employer does. In the recent report from the American Hospital Association, "Hospitals and Care Systems of the Future" , economic futurist Ian Morrison predicts that, as the payment incentives shift, health care providers will undergo a classic modification in their core models for business

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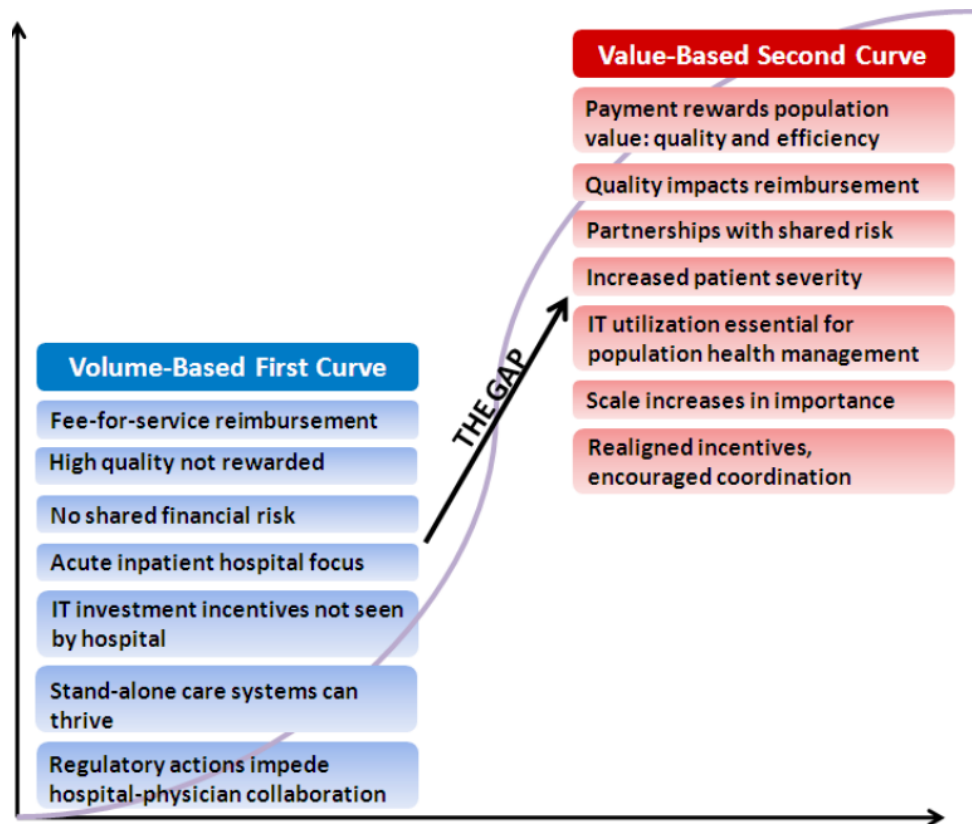
and service delivery. He refers to the current environment of volume-based service delivery (associated with fee-for-service payment models) as the first curve. He describes the second curve as the future model under payment reform, based on bundled or global payment and/or incentive models, i.e., value-based service delivery. Hospitals will have to move from the first curve to the second curve to succeed in the future. The figure below depicts the current and future states.



"Life in the Gap"

The space between the two states is referred to by Morrison as "life in the gap". Hospitals face the hurdle of how to navigate this gap without losing revenue, by shifting to value-based when the payment methodology is still anchored to fee-for-service reimbursements. The AHA report offers the example of one health system that took $400 million out of expenses while improving overall quality overall; however, the majority of the savings was realized by the insurance companies, according to a hospital executive.

On the other hand, waiting too long to make the shift will put hospitals behind the market. They jeopardize their readiness to operate in the value-based market as payment methods change, and risk financial losses under those payment methods. The transition to value-based delivery is a major

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undertaking that will completely change the way most hospitals do business. Yet hospitals can explore, experiment and learn without new financial risk, by using the self-insured employee plan. As a self-insured plan, the hospital already assumes the risk under the plan, as it strives to build the value that the new market will demand.

As we presented in our first article in this series, "The Self-insured Employee Benefit Plan as a Foundation for Risk/population Health Management," http://www.clcinc.com/pdfs/Self-Insured_Employee_Benefit_Plan_Risk_Population_Health_Management.pdf and in the June 2011 HFMA cover story by CLC client, Adventist Healthcare, "Starting a Medical Home; Better Health at Lower Cost," http://www.clcinc.com/pdfs/Starting_a_Medical_Home_Better_Health_at_Lower_Cost.pdf this strategy is proving a fruitful place to begin the transformation from volume to value-based economics.

In the November/December 2011 issue of Healthcare Executive, the feature article "Leading Toward Population Health: Key Skills Help Put the Pieces in Place" , the author states , "A senior leader's main role in leading toward population health will be to position the integrated delivery system to achieve this status for pilot population groups and to structure incentives to accomplish it. Specifically, some systems are choosing to pilot this transition with their own colleagues (employees) for three reasons. This is the group about whose health the organization cares most; it is a knowledgeable group of consumers; and most systems self-insure this populations thus assuming full risk." We posit that the population also provides access to a 360-degree view of all the health services it is currently accessing, making that data available for analysis and action.

Self-insured employers are also seeking for meaningful ways to impact the cost of health care for their organizations and their employees. In " The Road Ahead; Shaping Health Care Strategy in a Post-Reform Environment" – the 2011 16th Annual Towers Watson/National Business Group on Health; Employer Survey on Purchasing Value in Health Care , the authors note that, "Many employers are taking bold actions, and implementing new health benefit program changes to drive employee and provider accountability." How will organizations engage local health providers to achieve improved health and productivity, efficient utilization, and quality outcomes, while reining in cost? Some answers will soon emerge. Hospitals that have already managed these same objectives with their own workforces will be the partners of choice for self-insured employer groups.

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Conclusion

While our survey remains the hallmark for hospitals in assessing their own employee benefit plans, it also provides focus on the future of hospitals as providers of health care services. The hospital's own benefit plan for its employees is positioned to become the "learning lab" for the future business of healthcare providers. We look forward to the evolution of the plans and to compiling our survey in upcoming years.

Cammack LaRhette provides full service consulting in healthcare, HR, employee benefits, retirement, actuarial and communications services. We build long-term relationships, offering high touch client service that has earned us a 98% retention rate.

For more information on our healthcare practice or any of our other services please contact Frank Lonardo, Practice Leader at 1-212-227-7770 or flonardo@clcinc.com.

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i http://www.aha.org/about/org/hospitals-care-systems-future.shtml

ii Healthcare Executive, volume 26, number 6, November/December 2011; published by the American College of Healthcare Executives

iii http://www.towerswatson.com/assets/pdf/3946/TowersWatson-N-GH-2011-NA-2010-18560.pdf

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