

# Health & Benefits Perspective

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In this *Perspective*, we identify some of the PPACA provisions that affect employer-sponsored health strategies designed to change behaviors and, as a result, improve quality and control cost.

## Health care reform and total health management: Strategic opportunities to manage cost and compliance

With the recent passage of the Patient Protection and Affordable Care Act (PPACA), many employers are asking critical questions about their current strategies. While health care reform primarily emerged as insurance reform, there are significant implications for health plan program design and incentives. Many employers are concerned about how these insurance reforms will affect their programs and are asking:

- What are the new challenges in terms of controlling cost?
- Will any aspect of our current health management strategy need to change?
- Will the reforms provide me with more or less flexibility to influence behavior?
- How can health-management strategies help me comply with the law yet avoid paying an excise tax for having high-cost coverage?

Several provisions of PPACA will increase access to health care by expanding eligibility, by making coverage more affordable and by establishing coverage standards. Key provisions that have a direct or indirect impact on employer expense are as follows:

- Employers may be covering more participants due to expanding eligibility for older children, defining full-time employees as working 30 or more hours per week, automatically enrolling employees, and limiting waiting periods to 90 days.
- Individuals will have to elect coverage or pay a penalty.
- More low-income individuals, including employees, will be eligible for Medicaid.



- Some low-income workers may be eligible for federal subsidies if the cost of their employer coverage exceeds a fixed percentage of their household income.
- Plans will have to pay 100% of preventive care, remove pre-existing-condition limitations, eliminate lifetime maximums and eliminate most annual maximums.
- Plans must pay for 60% or more of covered cost.

These expansions have a positive impact by reducing the uninsured population and uncompensated care expense. However, employers will bear the financial risk of the expanded eligibility and benefits and the increased cost shifting from government-sponsored plans. A recent Mercer survey indicated that employers are concerned about these new expenses, but that their biggest concern is the 40% excise tax on high-cost plans that comes into play in 2018. How can employers avoid that tax when faced with benefit mandates and the potential for high consumption of health care services?

### Using THM as a framework

In recent years, total health management (THM) approaches that combine wellness, behavioral health, preventive care, and disease and case management with disability management and consumerism have become powerful tools, used by many employers to provide quality care, drive down costs and increase employee productivity. Successful programs often result in lower claim costs, improved health status, reduced absence and disability expenses, and higher employee productivity. Mercer's 2009 Health Care Survey indicates that employers with comprehensive THM programs achieve on average a 2% lower annual health premium trend than those employers with limited or no programs.

#### How can THM help employers address the challenges of health reform?

##### *Finding the best quality provider*

One aspect of the new law removes barriers to health care. Participants will be allowed to designate primary care physicians or pediatricians rather than having one assigned by the health plan. Participants will not be required to get prior authorizations or referrals for OB/GYN services. These changes set a direction for more freedom of choice, a movement favored by many provider groups. The risk to employers is that utilization could increase as participants search for the right diagnosis or treatment, or use a provider that does not provide consistent, high-quality outcomes.

As barriers to care are removed, directing employees to high-quality, cost-effective health care providers assumes greater importance. Most employers have used centers of excellence for medical transplant cases. This approach is being extended to other conditions through tiered or "high performance" networks, "medical homes" or new condition-specific centers of excellence. Mercer is helping some very large employers strike direct relationships with premier centers of excellence for high-cost, high-risk surgeries, such as joint replacement, cardiac care and spinal procedures. This channeling approach has also been successfully employed for individuals with chronic and/or high-cost conditions requiring significant

coordination of care from a medical home. Cost savings from these approaches derive from reducing the risk of medical complications by using providers that have demonstrated best outcomes, thus improving the overall coordination of care, accelerating the return of patients to full functionality and reducing absenteeism.

#### ***Managing compliance risk through CDHP and value-based design***

Employers have to find a “sweet spot” within their plans, making them compliant with design requirements without triggering the excise tax. Consumer directed health plans (CDHPs) coupled with employer-funded health accounts remain one of the most powerful levers available to achieve that cost target and to encourage employees to think about their use of health care services. To ease into a single CDHP plan design model, some employers offer employees a choice between a CDHP and an actuarially equivalent PPO plan. Outcome studies on CDHPs show lower cost trends without an adverse affect on health status.

Some employers are concerned that CDHPs’ high deductibles may inadvertently penalize employees with chronic conditions by discouraging compliance with much-needed care regimens. But account funding and value-based design approaches can mitigate this risk. Employers may choose to waive charges for certain evidence-based treatment options and provide incentives for patients who choose effective care. This area of innovation has been expanding over the past few years to include more targeted strategies. For example, rather than providing a preferred medication without any cost sharing, some employers are using temporary incentives to get participants to switch from high-cost drugs to ones that are lower in cost yet are equally or more effective. These change-management strategies increasingly incorporate employee assistance programs and behavioral health components, both of which affect overall program compliance and success.

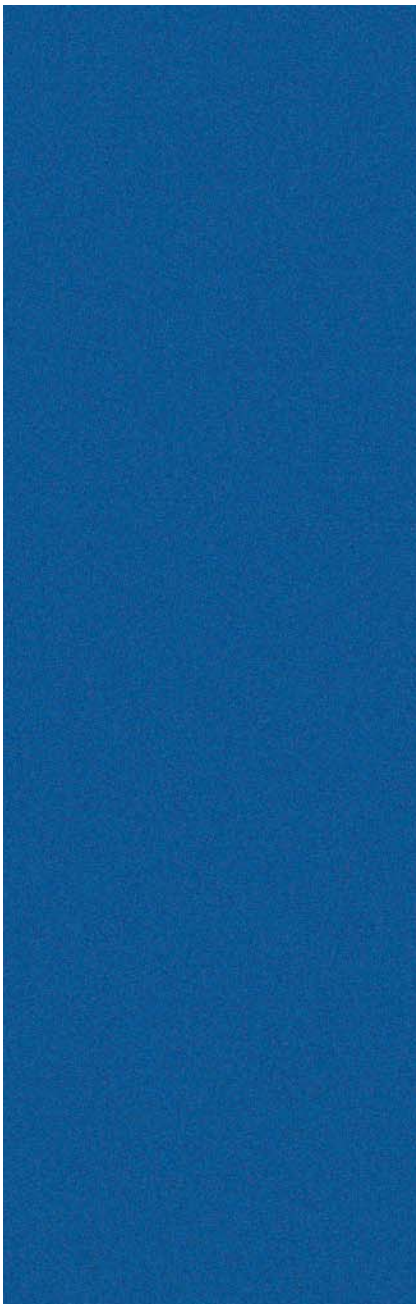
#### ***Paving the way for real behavior change with incentives***

In addition, employers will have more opportunity to improve wellness and preventive care for employees. For example, some employers provide incentives to employees who consume health care responsibly. Provisions in the reform law will increase allowable incentives from 20% to 30% of the cost of coverage for improved health status, and the new law requires that certain preventive services be covered with no cost sharing.

#### ***Is it time to tweet?***

Young adults comprise a major portion of the uninsured population. They may not have access to coverage. Or they don’t purchase it because they think they are healthy. Part of this population group will become covered due to the requirement that employers cover dependents to age 26.

Employers should begin planning how best to deliver benefits to this population and should analyze the cost impact of covering these individuals on their plans’ bottom line. Part of that planning should include how to effectively communicate plan benefits to this population. For example, some employers believe that messaging will be more effective if delivered through new communication channels, such as social media sites. Thus, while Mercer emphasizes a communications strategy as critical to driving change, we now recommend a more segmented approach using emerging channels.





### ***Aligning health care vendors***

Health plans face heightened scrutiny with respect to the accuracy of their rates, the percentage of total cost paid for claims and even their executive compensation. The most intense scrutiny will be focused on fully insured plans because they need to meet a minimum medical loss ratio (MLR) of 80% to 85%, depending on group size. Among the uncertainties at this time:

- Will regulations dictate what services must be provided as part of the core plan and designate which ones will be counted against MLR?
- Will health management expenses, for example, be counted against the MLR or be factored outside the limit?
- If there are carve-out vendors involved, do all their expenses have to be aggregated against the MLR?

The risk to employers is that fully insured plans may have less incentive to invest in care management, coaching, new engagement tools and other services that threaten the allowed MLR and their profitability.

The constraints placed on self-funded and fully insured plans and their vendors limit the levers available to employers that are trying to hold overall costs down. Close oversight of carriers and independent vendors providing care management services becomes essential in this environment, to ensure optimal performance and to understand the true return on investment (ROI).

### ***High-cost claim management – More important than ever***

The removal of lifetime and annual limits exposes employers to new risks for participants with catastrophic expenses and end-of-life care. Understanding this population and the emotional challenges they face in making decisions about treatment options will become more important. Quality of care for high-cost claimants also affects disability costs, which can also be substantial. Vendors differ in their ability to effectively identify and manage these multiyear cases, and many employers are now starting to seek out best-in-class providers.

### ***Finding the real ROI***

Employers will have to stay vigilant to ensure that they are getting the best ROI from their health plans, including any carve-out plans. Vendors face new levels of challenges in trying to manage cost for new dependents, for individuals who had been excluded due to pre-existing conditions, and for those who previously met their lifetime or annual limits. It will be necessary to ensure that there is common understanding about the impact of these changes on future medical trends for active and retired employees. The scope of services provided by vendors, the targeted interventions they provide and the performance metrics all need to be evaluated. For example, revising performance guarantees around clearly defined goals for participation, engagement and outcomes will be essential. Employers will have to evaluate the real impact of care management programs regularly and rigorously, as the true impact of reform unfolds.



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### **Taking action**

Compliance with health insurance reform will have a long-term impact on employer cost in terms of expanded access, plan design mandates and indirect cost shifting. Employers should begin to evaluate the value of a THM strategy that encompasses plan design, incentives, care management, employee engagement and vendor management. Mercer recommends that employers consider the following strategies to continue to provide high-quality care in a cost-effective way:

- **Diagnosis:** Use a robust diagnostic tool, such as Mercer's HERO Scorecard, to understand the current status of your THM program and identify gaps and cost-saving opportunities.
- **Integration:** Ensure that you are getting the best bang for the benefit buck by integrating program design, performance, oversight and data across all medical and disability vendors.
- **CDHPs:** In combination with employer-funded savings accounts, CDHPs can make employees smarter health care consumers. When designing health plans, consider combining CDHPs and value-based design approaches that can positively change employee behavior and provide a greater focus on wellness and prevention.
- **Quality and cost transparency:** Provide high-performance networks or consider centers of excellence models to provide quality and cost-effective care to employees.
- **Effective communication:** With new participants in the health care program, leverage segmented communication approaches and new media outlets.
- **Measurement:** Measure and understand the true ROI of programs in place.
- **Vendor oversight:** Evaluate vendors, particularly their ability to identify and manage high-cost claimants.