



## BRINGING DOWN THE COST OF HEALTHCARE MARKETPLACE INITIATIVES TO HELP CONTROL MEDICAL INFLATION

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*HEALTHCARE COSTS CONTINUE TO ESCALATE AT RATES THAT OUTPACE GENERAL INFLATION, AND IF LEFT UNCHECKED, WILL BECOME AN ECONOMIC BURDEN TO INDIVIDUAL CONSUMERS, BUSINESSES AND OUR NATION. THIS EDITION OF **INSIGHTS** WILL SUMMARIZE A SELECTION OF MARKETPLACE INITIATIVES AND AFFORDABLE CARE ACT (ACA) PROGRAMS BEING DISCUSSED AND IMPLEMENTED IN AN ATTEMPT TO HELP MITIGATE THE RISING COST OF HEALTHCARE. THESE CONCEPTS, MANY OF WHICH ARE NOT NEW, ARE NONETHELESS ATTRACTING RENEWED ATTENTION AND WILL ADD ACRONYMS AND TERMINOLOGY TO OUR COLLECTIVE HEALTHCARE VOCABULARY.*

### VALUE-BASED MEDICAL MODELS

Simply stated the goal of a “value-based” medical model is to provide the plan and consumer the most “bang for the buck”. This model encourages consumers to actively participate in maintaining a healthy lifestyle, proactively manage chronic disease and use providers that demonstrate high quality patient care.

Examples of “value-based” plan designs include:

- ◆ Reducing or eliminating copayments for certain drugs that help manage chronic diseases such as high cholesterol, hypertension, and diabetes as it’s less costly to manage the illness than to pay for expensive care when maintenance is neglected.
- ◆ Assessing additional charges for “overused” or “preferred” services and procedures when a less costly alternative is available. For example, a member may be charged an additional copayment for an MRI when an x-ray could be just as effective.
- ◆ Encouraging preventive care in a cost effective manner. Under the ACA, non-grandfathered plans must provide many (in-network) preventive services with no cost sharing requirements to plan members. The regulatory agencies announced that guidelines

will be drafted to permit plans to utilize value-based designs to provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care. For example, a plan could charge for a preventive service (such as a colorectal screening) performed in an in-network outpatient hospital setting when a less costly alternative such as an ambulatory surgical center is available.

### REDESIGNING PRESCRIPTION DRUG PLANS

In addition to reducing or eliminating copayments for certain chronic care prescriptions, other techniques being utilized to help control prescription drug costs are:

- ◆ Replacing a “tiered” copayment design with a deductible and coinsurance strategy. It’s not uncommon to waive the deductible for generic drug purchases in this type of arrangement.
- ◆ Applying an additional coinsurance or copayment amount after a certain dollar threshold of spending has been reached. Some designs limit this to retail and/or brand name drug purchases to encourage the use of generic and lower-cost alternatives.
- ◆ “Step therapy”, that requires the use of a lower cost medication before a more costly (and sometimes newer) drug is prescribed, is a more commonplace approach and many prescription drug plans now require this feature.

### ACCOUNTABLE CARE ORGANIZATIONS

An Accountable Care Organization (ACO) is basically a network of doctors and hospitals established to manage and coordinate patient care in a cost-effective manner. ACOs that can demonstrate cost effective high quality patient care would receive financial rewards. You may be thinking that this sounds a lot like a Health Maintenance Organization (HMO), and you are not alone in that sentiment. However, some differences are generally as follows:

- ◆ An ACO patient would not be required to stay in-network or designate a primary care physician.

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- ◆ An ACO may be established as a fee-for-service arrangement. HMOs are generally “capitated” arrangements whereby a provider is paid a monthly fee based on plan enrollment.
- ◆ No referrals are required to see a specialist.
- ◆ Evidence-based guidelines and quality measurement standards (on which financial rewards will be based) are utilized to ensure quality patient outcomes.

The ACA includes guidelines for ACO establishment, initially to help control Medicare costs. Beginning January 2012, a Medicare ACO that agrees to manage the healthcare needs for at least 5,000 Medicare beneficiaries for a period of no less than 3 years will be eligible to receive financial rewards for favorable results. The ACO must have systems in place to report on quality and cost measures.

The ACO concept is not without its share of controversy. Critics cite the potential for abuse exists when networks become large enough to control market share and pricing strategies. The provider community contends they should not be held accountable (and lose financial rewards) when patients seek care outside the ACO and hamper efforts to control care and manage costs.

Medicare ACO program details are expected sometime this year. It's believed the ACO medical model will become more prevalent in the broader marketplace if ACOs can help to bring Medicare spending under control.

## GAP, WRAP OR BRIDGE INSURANCE

Call it what you will. This supplemental benefit basically pays the out-of-pocket costs in High Deductible Health Plans (HDHP) which can be as much as \$5,950 (single) and \$11,900 (family) in a 2011. These supplemental plans can be designed in a variety of ways and may be offered as a voluntary or employer benefit. Critics claim that adding this “filler” benefit detracts from the essence of consumer-directed plans, insulates the individual from the true cost of healthcare and encourages excess utilization.

## WELLNESS PROGRAMS

Workplace wellness programs have been around for years and come in many different forms. Typically more prevalent with larger employers, these programs run the gamut from gym memberships, lifestyle coaches, and smoking cessation tools to disease management programs, health risk assessments, financial rewards for

meeting certain biometrics and creating an employee contribution strategy to reward healthy behavior (i.e. charging lower contributions for non-tobacco usage).

Many insurance carriers will offer plan sponsors financial incentives to incorporate wellness tools into the benefits package. Generally more common with larger employers, incentives to smaller plans are now becoming more prevalent. Plan sponsors should explore these potential cost-saving options.

The ACA also encourages workplace wellness efforts. Grants will be available for small businesses (100 employees or less) meeting certain criteria who do not currently have a wellness program in place. By 2012, HHS must create employer-sponsored wellness program reporting requirements and the Centers for Disease Control must survey employers about wellness program efforts in order to develop recommended best practices.

## SUMMARY

There is no simple solution or magic elixir to fix what ails the nation's costly healthcare system. The growing needs and populations covered under subsidized entitlement programs such as Medicare, Medicaid and ACA will continue to exert upward cost pressure on our entire healthcare system. In response, look for the marketplace to explore new options and implement innovative programs as we search for solutions to help make affordable quality healthcare a reality for all of us.

## ADDITIONAL INFORMATION

For specific questions concerning information contained in this *Insights*, please contact your Chernoff Diamond consultant.

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