TOP 10

Health Insurance Cost Management Strategies

BY PATRICK HARADEN

Health insurance costs for employees and retirees continue to consume a larger portion of municipal budgets each year. Although we have accepted the reality that health care costs will not go down anytime soon on their own, there are a number of cost management strategies that municipalities can implement to both reduce costs and slow the rate of increase. The cost savings from these approaches can be seen and realized in the annual budget process as well as in a reduction in Other Post-Employment Benefit (OPEB) liabilities.

Years ago, issuing an RFP for health plans every two years or so and having the carriers bid against each other was a somewhat effective way to reduce costs. With the advent of municipal health reform and the Affordable Care Act, there are now more restrictions on plan designs, coverages, rating methodologies, and the definition of savings, which make the biennial RFP approach less impactful.

In light of today's environment, the following is on overview of ten techniques that can and should be evaluated to control health insurance costs. One should note that most of these strategies would require bargaining with the appropriate unions and/or Public Employee Committee (PEC) for them to be implemented.

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1. Limited Networks

With this strategy, the exact same plan design (copays/deductibles) is offered as current, but only within a limited provider network. The providers in the network are selected by the insurance carrier based on cost, quality and outcomes. The goal of this strategy is to offer a network that can provide a wide range of medical services with a similar quality and patient experience at a lower cost. Savings is generated because premiums (or claims in a self-insured plan) are lower in these arrangements.

2. Tiered Networks

Rather than limiting access to certain providers, all providers in the carrier's network are made available, but they are "tiered," meaning a different copay amount would apply depending on which tier the provider is in. Providers are tiered by cost, quality and outcomes measures, and the "best" providers (low cost, high quality) are usually Tier 1, with the lowest copay. Savings is generated as members pay substantially more out of pocket if they see a more costly or lower quality provider. There is also a "utilization" savings as some members will be steered to providers in lower tiers, which is a lower cost to the plan.

3. Plan Design Changes

Changing plan design elements (e.g., copayments, deductibles, out-of-pocket maximums) generates savings for the plan. As members pay more for a service, they either reduce unnecessary services or visits, or begin to shop for lower-cost services. The biggest "bang for the buck" is increasing the deductible amounts. Under the 2011 municipal health insurance reform law, municipalities can propose plan design changes up to the Group Insurance Commission benchmark plan, which remains Tufts Navigator for active/non-Medicare retirees and UniCare Indemnity for Medicare retirees. Current deductibles in the GIC benchmark plans are $300 for individuals, $600 for a two-person family, and $900 for a family of three or more. Plan design changes above these limits are allowed if an agreement can be reached with employees.

4. Pharmacy Benefit

Pharmacy costs are now the biggest driver of health care cost increases. The costs of certain name brand medications and the increasing cost of generic drugs are contributing to this growing problem. One cost control method is to "carve out" pharmacy from the medical plan. This involves using a separate vendor to manage the pharmacy benefit. There can be a fourth or fifth tier of cost sharing (in addition to the standard three-tier generic/brand/non-preferred system in place) as well as a separate specialty drug pharmacy. Savings is generated by better pricing, contract language, rebate sharing, utilization controls, and step therapies.

5. Telemedicine

This strategy provides coverage and either a lower copay or no copay for certain office visits that are done telephonically or through a FaceTime or Skype application. Savings is generated because the plan cost for these visits is less than for an in-person visit.

6. Plan Audits

A plan and claims audit should be part of the strategy for any community that is self-insured or part of a purchasing group. Every two years, a claim audit vendor should be used to ensure that the health plans are paying claims correctly—per the plan document, only for eligible members, without duplicate payments, and collecting from any third parties that are responsible (e.g., auto, workers' compensation, Medicare, etc.). Savings is generated from recovered payments. This audit strategy is separate from the eligibility audit that is required to be performed every two years, and also different from a Retiree Drug Subsidy (RDS) reopening audit to determine if any additional RDS money is available. All of these should be part of a comprehensive audit strategy.

7. Employer Group Waiver Plan

Many municipalities have a traditional Medex plan to cover Medicare retirees. These plans are eligible for a Retiree Drug Subsidy that is paid to the municipality either quarterly or annually. An alternative Medicare plan is an Employer Group Waiver Plan (EGWP or "egg whip"). An EGWP is the same Medex plan and plan design, but the rates are reduced because the plan is no longer subsidy-eligible. The amount of the rate reduction is usually more than the amount of the subsidy, and the reduction in rates can also reduce the municipality's OPEB liability.

8. Health Savings Accounts/ High-Deductible Health Plans

This alternative uses a High-Deductible Health Plan (current minimums are $1,300 single/$2,600 family) along with a Health Savings Account. These HDHP/HSA plans have the lowest premium cost, as they are designed so that all non-preventive services (including prescription drugs) are subject to the deductible. The HSA component is an account that is owned by the employee used to fund the expenses that are subject to the deductible. Unlike a Flexible Spending Account (FSA), in which any money not spent is forfeited, money left in an HSA rolls over to the next year. Savings is generated from the lower premiums and the "consumerism" impact caused when members pay for all non-preventive services up to the deductible amount. Individual employee and spouse education is suggested for this approach, as these plans function differently from traditional plans in a few other areas as well.

9. Incentives

The use of dollar incentives for members is also an effective cost-management strategy. There are a few incentive programs that municipalities could use.

• Members who use tools to choose lower-cost, high-quality providers could share in the savings or receive a flat dollar amount/gift card.

• Members can receive "credits" to use against their contributions if they complete certain wellness or screening activities.

• Employees could be given a dollar amount to "opt out" of coverage.

10. Health Reimbursement Arrangements

A Health Reimbursement Arrangement (HRA) can be used in conjunction with a lower-premium plan that has higher copayments and/or deductibles. The HRA helps limit members' out-of-pocket expenses by reimbursing certain amounts in excess of a certain dollar amount, or for certain copayments required under the underlying plan. Typically, the premium reduction is worth more than the maximum actual costs of the reimbursements. (Some health plans limit the amount of an HRA used with their plan.) A separate insurance policy can also be used in place of the HRA to protect member out-of-pocket expenses.

There are other health care cost management strategies that can be considered, such as different contribution percentages for different tiers of coverage (single/family), spousal or dependent surcharges to contributions, or offering alternative plan designs. These types of strategies, however, may require changes to Chapter 32B or related regulations for them to be implemented.

The rules, regulations, and laws regarding employee benefits in Massachusetts are numerous and complex, and under constant change. A strong employee benefit strategy should also include advice and input from legal and labor counsel, as well as each municipality's employee benefits consultant.

Affordable Care Act Considerations

In addition to the annual budgetary and OPEB liability pressures that necessitate having a health care cost management strategy in place, the Affordable Care Act provides two other compelling reasons.

First, there is an "affordability" requirement for municipalities offering coverage to full-time employees. In general, the lowest cost (to the employee) for single coverage in a plan for which the employee is eligible can be no more than 9.66 percent (in 2016) of the employee W-2 wages (Box 1) under one of the safe harbors allowed by the IRS. The employee does not need to enroll in that coverage, and there is no affordability requirement on family or non-single coverage. For example, if the W-2 (Box 1) for the lowest-paid, full-time employee (annually) is $21,000, then the employer must offer a plan that has a monthly cost of $169.05 or less ($21,000 divided by 12, times .0966). The penalty for noncompliance with the affordability provision is $3,000 per year for each employee for whom the plan is unaffordable, but only if that employee goes to the Marketplace and receives subsidized coverage.

The second ACA cost consideration is the so-called Cadillac tax. The implementation of the tax has been delayed from 2018 until 2020, but no other aspects have been changed, although there are several proposals to do so. The Cadillac tax provision of the ACA was the federal government's way to regulate health care cost indirectly—a tax on higher-cost health insurance plans rather than federal cost controls on doctors, hospitals and pharmaceutical companies. The tax operates as an "excess" tax. If the total cost of the plan (plus other costs, such as FSA, HRA, HSA, etc.) is greater than $10,200 for single and $27,500 for non-single coverage, there is a 40 percent tax on the excess over these amounts. (These amounts may be adjusted based on a formula tying to the federal employees benefit plan, thereafter adjusted for inflation.) Regulations are still not final on the calculations, or who is responsible for paying (submitting) the tax, or how contribution percentages would apply. (For example, is the "rate" the rate plus the tax, or is the tax added after the contribution percentage?) The best strategy for the Cadillac tax is to avoid it, and make sure that any contracts that extend beyond 2020 address the issue.

– Patrick Haraden