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Benefit Cost Management in the New Millennium

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The new millennium will bring new challenges to managing employee benefit plans. *Costs are going up. The provider community is consolidating. COBRA and HIPPA have added cost and complexity. Employers expect strategic partnering and a high degree of flexibility while reducing benefit managers' budgets and staffs. This article provides specific strategies and tactics for managing benefit costs in this new era.*

Over the last several years, health and welfare benefit plans have enjoyed modest cost increases due to deep discounts negotiated by managed care. During the period 1994 – 1997, annual cost increases never exceeded 2.5% and actually fell by more than 1% in 1994.[1] However, moderate increases and the ability to buy competitively priced fully insured HMO benefits may be a thing of the past. Reasons for this change include:

1. Mandated state benefits have increased 25 fold between 1970 & 1996, increasing the cost for fully insured plans.[2] Self-insured plans have seen the ERISA preemption veil pierced in New York [3] with other states looking to duplicate New York's success. And federal laws such as COBRA and HIPAA have impacted costs for both insured and self-insured plans.

2. HMO consolidations are reducing competition in many markets. In Texas, Aetna would have controlled 64% of the Houston HMO market if it had not been required to sell the NYLCare HMO business.[4]

3.The provider community has reorganized itself through mergers and acquisitions, which will translate into higher prices.[5] In addition, physicians are pushing to join unions to take advantage of the collective bargaining process.

Against this back drop of higher costs, benefit

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managers are expected to be strategic business partners. As such, they are expected to treat employees as customers and shift from a professional bureaucracy to a highly automated operation supporting organizational goals and objectives. The focus of this article is to provide benefit managers with alternatives for managing escalating benefit costs in this new era.

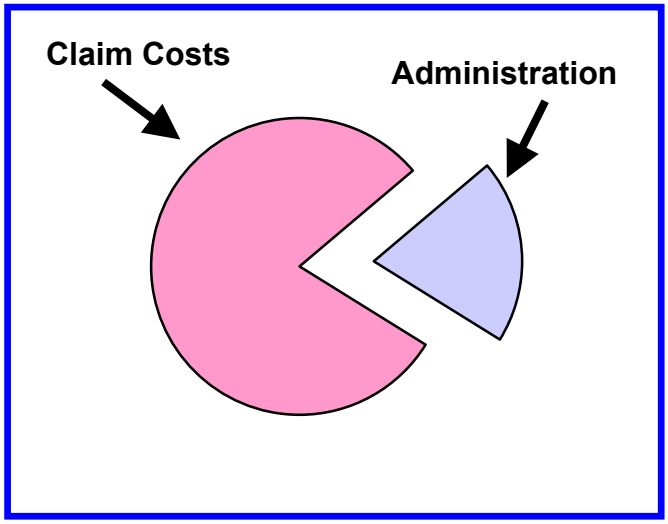
Where to Focus

Benefit plan costs can be divided into administrative and claim costs. *Administrative* costs comprise 15% to 20% (See Fig. 1) of total costs and include insurance, broker/consulting expense, managed care fees and claim administrative expense (whether from a Third Party Administrator or insurance company). Historically, administrative costs have been put under a microscope since they are easy to identify and competitive bids can be placed on a spread sheet and compared.

The *claim* cost component represents 80% - 85% of plan cost. While having many times the potential for cost savings, they are more difficult to manage. It is this second component that provides the greatest cost savings opportunities.

Claim cost management has 3 areas of potential cost control; 1) risk aspects of the group, 2) claim payment accuracy and 3) managed care effectiveness.

Figure 1



Risk Aspects

The dictionary defines "risk" as the probability of loss to the insurer. It is from this definition we will focus on those characteristics within the group, which have a higher probability for generating loses. Or from another perspective, which characteristics if eliminated, would lower aggregate benefit cost.

Three dimensions of this issue are; 1) claim cost anomalies, 2) turnover considerations and 3) actuarial characteristics of the group.

Claim Cost Anomalies

Claim cost anomalies represent claim payments that, when compared to a standard, are excessive. Comparisons can be made to data from other benefit plans or from the plans own historical experience. In either situation, the goal is to identify claim cost patterns that are significantly impacting benefit plan cost.

An example could be identifying alcoholism costs as higher than those for similar groups. Other examples could include inappropriate use of emergency rooms or a high level of asthmatic or diabetic hospital admissions (both conditions can be cost effectively managed when patients properly manage their health). The goal is to identify anomalies and then implement corrective action to control these costs.

Historically, finding comparative data was difficult. This will be much less of a problem in the future, since many organizations are now reporting data under the Health Plan Employer Data and Information Set (HEDIS). The challenge for the future will shift from too little information, to a situation where benefit managers can get lost in the details of evaluating too much data.

Turnover Considerations

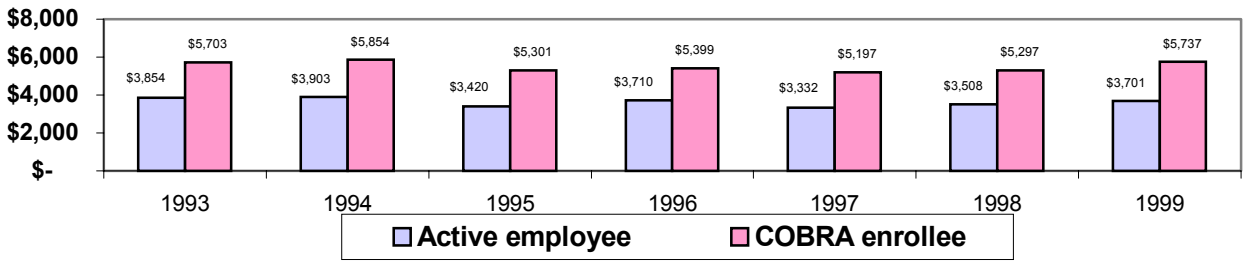
The second risk factor is looking at the employer's turnover ratio. COBRA has

event that there is a divorce, coverage can be extended up to 36 months. And if a former employee is found to be totally extended to 29 months.[6] This issue is important because it forces the employer to provide coverage to former employees and their dependents after termination. Figure 2[7] demonstrates how claim costs for COBRA enrollees exceeded active employee costs during the period 1993 through 1999.

Employers need to monitor their turnover in relation to new employee's initial eligibility for health insurance to proactively identify areas of potential loss. Further complicating this problem is HIPAA which requires employers credit employees with credible coverage toward pre-existing condition waiting periods.[8] The result, individuals with poorer health can quickly impact employer costs – and continue to impact costs after termination.

Turnover statistics need to be evaluated to determine if employees are leaving after initially becoming eligible for coverage. It is not sufficient to track only COBRA expenses, since these expenses will only identify the problem after the fact. Instead, it is necessary to proactively monitor turnover ratios since a low COBRA expense factor could have more to do with an employer's good luck than sound fiscal plan management. Lengthening initial benefit eligibility periods while paying the former employer's COBRA rates to eliminate recruiting difficulties may be a simple solution to this problem.

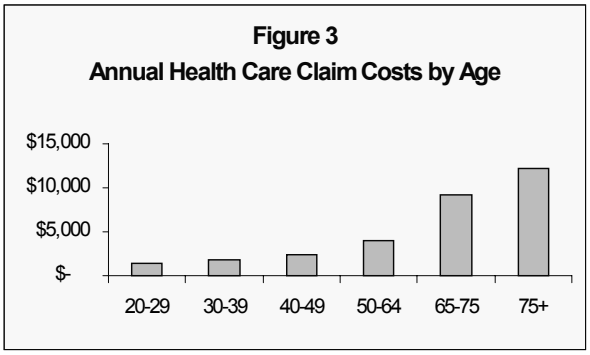
Figure 2
Employer's Experience with Adverse Selection
Under COBRA 1993 -1999



Actuarial Characteristics

The third risk factor are the actual demographics (age, sex, marital status, etc.) of the group. These characteristics represent the type of individual being covered. For example, young groups will have high maternity claims while older groups will typically have more heart disease. Identifying these characteristics early provides the benefit manager the opportunity to seek out cost effective educational or intervention programs.

A unique aspect of this issue is found as employers recruit (retain) older workers. "Eighty-eight percent of today's jobs are knowledge based[9]" making it possible for workers to continue to work beyond normal retirement age. Since Social Security now requires most employers to be primary for all full time employees regardless of age[10], benefit costs can quickly add thousands of dollars to the compensation equation for older workers. A $15,000 clerical position can end up costing the employer many times that amount in benefit costs as older workers are employed (or the current workforce ages). Figure 3 demonstrates the correlation between age and annual health care claim costs.[11]



Another dimension of this issue is the fact that employment relationships are no longer static. Demographic shifts in the employee population resulting from recruiting strategy changes can alter cost projections. In some cases younger workers will replace older workers (such as in many Midwest manufacturing facilities where older workers are entering retirement age in large numbers[12]). In other situations, older workers will be recruited to fill positions in a tight labor market. In either situation, the ability to forecast future costs predicated on demographic shifts in the employee population will be necessary.

Payment Accuracy

Accuracy of claim payments is critical. Total plan costs represent benefits paid plus administrative costs. If claims are overpaid by 5%, then plan costs are inflated by that amount. Three areas to focus on are; 1) eligibility, 2) claim audits and 3) administration of specific cost saving provisions.

Eligibility

Eligibility files are the gatekeeper for the claim payment system. Once a claim passes the eligibility filter, the only remaining question is the amount to be paid. Considering many plans have million dollar maximums, the possibility exists for an ineligible person to generate a substantial over payment. Reviewing the accuracy of eligibility lists on a monthly basis will continue to be important.

Eligibility list accuracy takes on a new emphasis as many plans have or will move to a paperless exchange of eligibility with vendors utilizing automated enrollment software. The accuracy of transactions processed needs to be verified since the information on these magnetic mediums may either 1) not be processed correctly or 2) not be accurate. Both the accuracy of the information and how that information is processed needs to be verified.

Claim payment audits

The organization hired to pay claims can have a tremendous impact on plan costs. This claim payer will draft checks drawn on a corporate account or charge claims to the employer's experience. In either situation, complex claim paying software is used. This software utilizes multiple co-insurance levels (in area, out of area, etc.) driven by a constantly changing managed care provider database. Correct payments become the conclusion of successfully blending this complex software with a low paid claim examiner who is usually between the ages of 18 and 35.

These claim examiners have to accurately select the proper managed care network in addition to accurately handling traditional eligibility, benefit category and data entry functions. They are subject to the same performance issues as other employees and are often under pressure to increase productivity. Yet their accuracy has a direct financial impact on benefit plan costs. It makes sense to evaluate the accuracy of these payments given the nature of the workforce and the complexity of the systems. Randomly selecting claims and then manually repricing them will provide the plan with a measure of claim payment accuracy.

Another benefit of auditing claim payment accuracy is to confirm that the payments being made follow the plan document. Communication is difficult at best, but the complexities involved in describing when to pay, at what level to pay and who to pay has become even more complicated due to managed care. Benefit payment modules in the claim paying software must determine the correct level of payment for thousands of procedures while taking into consideration managed care discount arrangements and any special plan provisions.

The audit function takes on even greater importance as providers electronically file

claims. These electronically filed claims are input directly into the payers system for adjudication and payment. While this process eliminates data entry errors by the claim payer, it also creates the potential for claim over payments on a larger scale.

Administration of specific cost savings provisions of the plan

There are several cost savings provisions routinely built into benefit plans that if properly managed and executed, will provide additional savings. Two of these are coordination of benefits and subrogation.

Both need to be monitored to determine whether they are yielding maximum results. Reviewing savings reports in comparison to similar groups will identify additional savings opportunities. With the dramatic changes the workforce has experienced over the last 20 years (both husband and wives working) coordination of benefit issues regarding who is to pay first are common. Thousands of dollars can be lost if the claim payer is not aggressively investigating current claims and constantly obtaining information for future claims.

expenses paid out currently in anticipation of future recoveries three to five years later, the plan needs to ensure that all monies due are collected. Procedures should identify subrogation claims initially, require completed subrogation agreement forms be obtained and then track these claims over the years until settled.

Managed Care Effectiveness

Managed care discounts will continue to represent significant savings for employers. Certifying that anticipated savings are obtained and competitive will continue to be a challenge. But at least two other issues need to be evaluated in relation to the effectiveness of a managed care plan. They are overall quality as it impacts organizational goals and objectives and provider accessibility.

The new millennium will require benefit managers to look beyond the simple cost comparison grid and evaluate managed care plans relative to their success in helping the organization achieve specific goals and objectives. While many evaluations will be organization specific, one universal measurement will be comparing the number of sick days utilized under each of the managed care plans. The goal, to identify managed care networks, which generate the fewest sick days by keeping employees healthy at the lowest unit cost (premium).

The second issue is determining if the managed care network originally selected continues to serve the needs of the current employee population. Managed care networks change over time and employee demographics change as well. Providers drop out, networks consolidate and employer locations expand or close. The original reason for selecting a managed care network may no longer exist. Periodic re-evaluation will prevent the employer from sponsoring a network that no longer serves the needs of the employee population.

Conclusion

Managing benefit plans in the new millennium will be even more challenging than during the 1990s. Compounding this challenge is the fact that many benefit managers will need to perform in an environment where resources continue to be reduced and senior management expectations continue to rise.

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[1] Jerry Geisel, "Health Cost Jump May Start Trend", Business Insurance, January 25, 1999, pg. 1

[2] Jensen, Ph.D., Gail A. and Morrisey, Ph.D., Michael A., "Mandated Benefit Laws and Employer Sponsored Health Insurance", Health Insurance Association of America, January, 1999, page i.

[3] On April 26, 1995, the Supreme Court upheld hospital surcharges imposed by New York law. The court saw the law's indirect economic effect on employee benefits as too attenuated to support a finding of congressional intention to preempt ERISA. New York Blue Cross V Travelers Insurance, U.S. 131 L.Ed. 2d695.

[4] Houston Business Journal, Vol. 30, No.5, June 25 – July 1, "AETNA Agrees to Divest NYLCare". June 22/PR Newswire – The Medical Association of Georgia released their analysis that in Atlanta, 83% of the HMO market is controlled by 4 payers, AETNA – 27%, Blue Cross Blue Shield – 24%, CIGNA – 18% and Kaiser – 14%.

[5] Glen Melnick, et al, "Market Power and Hospital Pricing: Are Non Profits Different", health Affairs, May/June 1999. Study determined that after 1986, all hospitals, regardless of ownership type (for profit, private non-profit, or government) raised their prices in response to a merger.

[6] The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer continued health care coverage to employees and dependents who are loosing coverage under the employer plan.

[7] Stephen A. Hugh, COBRA Costs Remain High, But Fewer Become Eligible for Coverage, Employee Benefit Plan Review, September 1999, table on page 24

[8] Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employers to credit newly covered employees with credit toward the preexisting waiting period (if any) for all prior coverage documented by a Certificate of Credible coverage and which does not have a break in coverage of 63 days or more.

[9] Joanne Wojcik, Business Insurance, Aging Workforce Likely to Raise Costs, Nov. 166, 1998, page 12, - Comments made by Dr. G Krsitin Crosby during a presentation to the 17th annual ISCEBS Benefits Symposium held Nov. 1-4, 1998 in Seattle, Washington.

[10] The Deficit Reduction Act of 1984 (DEFRA) made employer plans primary for actively at work employees and their dependents who were 65 or older. Previously employer plans could be secondary to Medicare for employees over age 70.

[11] The National Data Book, U.S. Dept. of Commerce, Economics and Statistics Administration, Issued October, 1997, Exhibit 4, Health Costs Rise With an Aging Workforce, page 17

[12] The Wall Street Journal, July 13, 1999, Plants Face Challenge as Boomers Retire, page 1, The Outlook