Delving into Health Costs

How employers and employees are finding health cost savings through education

Employers — and subsequently, their employees — are becoming more savvy about the decisions involved in choosing and administering a health plan, often a business's second- or third-biggest cost of operations. Just as safety initiatives can help reduce property and casualty insurance premiums, health insurance savings can often be achieved through self funding, says Mike Debo, senior sales and renewal executive at HealthLink/RCBA.

"By instituting wellness programs and encouraging routine physicals and post-condition care for not only employees but for covered dependents, employers can reduce premium and claims costs while increasing productivity," Debo says. "Instituting wellness programs, encouraging routine physicals and promoting post-condition care are especially beneficial to self-funded groups as they see the savings in the form of fewer claims spent, which can reduce reinsurance costs."

What is driving employers to be more involved with their health plans?

For many employers, the No. 1 reason they are becoming more involved is that they have no other option. They may have already maxed out what they can do from a plan design perspective with greater participant out-of-pocket costs. In addition, fully insured employers are constantly getting rate increases, but over the years, often no one has been able to fully explain the increases.

What are some tools an involved and educated employer can use to lower health costs?

An employer's decisions are only as good as its information. That is why many business owners move into self-funding, where there is greater reporting about their group and its claims, whether medical or pharmacological.

One of the first tools businesses use is to have participant biometric testing, which provides the employer with information on how many people in the group have high cholesterol, hypertension, weight or smoking issues. From that — combined with reporting and claims — employers can create wellness programs and condition management programs. Wellness programs eventually save money from a claims perspective, but it might take a year or two to absorb the initial cost of testing.

With a year's worth of information from claims and wellness programs, businesses can begin to change their plan design to address health conditions, utilization patterns or provide unique coverage for their plan participants. For instance, a business may find its participants are frequently visiting chiropractors because of their job type. With that information, they can look at not only how many visits they are allowing for chiropractors and the cost but also institute a condition management program strictly for back injury care.

Then, they can look at pharmacy claims. Are participants using generics as often as they can, brand names as necessary or mail order whenever possible? What does the employer need to do regarding the pharmacy benefit to not only ensure that people get the drugs they need but also to make it cost effective for the group?

By changing the plan design and addressing the specific needs of a group, employers often find they don't need a particular program, such as condition management or a 24-hour nurse line, further cutting costs.

How can employers overcome initial resistance to wellness programs and other initiatives?

Most people aren't going to participate in biometric testing, a smoking cessation program, a weight loss program or a condition management program unless there are cost differentials to participants in the form of incentives or disincentives. Plan participants often think such programs are an invasion of privacy or that they require too much of a time commitment, but when there is a 10 to 30 percent difference in premium costs, they get involved.

How can employers communicate to employees the true costs of health care?

One of the easiest ways is to use a plan with no co-pays, where everything goes toward deductible/coinsurance, so that participants understand how getting an X-ray at an outpatient facility versus a hospital can mean the difference between a bill of $700 or one of $1,800.

Reporting is extremely important because it provides the knowledge to make wise decisions. Communication is equally important, whether via traditional posters and payroll stuffers or new technology smartphones, emails and blast texting.

To be effective, the communication must address how to get the most out of plan benefits and programs while avoiding unnecessary costs to the participant and the group.

How do self-funded plans give employers so much more control of their health program?

Employers have full control, outside of federal mandates, to do what is best for plan participants and plan costs. For example, if an employer has a population with an average age of 45 and people taking off work for elderly parents going into nursing homes or going to the doctor frequently, the employer can bring in a vendor to work with employees on how to make decisions about their parents. This takes pressure off employees. They show up to work more regularly and are more committed to the company because of the service their employer provided.

With self-funding, it's at least a three-year commitment of time and effort to cut costs and provide better benefits for employees. The employer has to sit down on a quarterly to semi-annual basis to go through reports and have someone scrutinizing claims. Employers with healthy groups may stay fully insured because they think there is no risk involved, but the risk is that they pay $2 million for something that costs $1.5 million. With self funding, employers have a program that they are in charge of, a program better suited for them and for their plan participants