Reducing Healthcare Costs for Employers

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# Alternative Risk Transfers and Captive Cells Improve Cost-Control Capabilities

Third-party administrators, health insurers and self-insured employers have found a model that controls health care and stop-loss coverage costs: alternative risk transfer (ART) programs and captives. Experts say these could be a huge benefit to small and medium-sized employers because they can lower the costs of self-insuring and make them more predictable.

Insurers have used ARTs for decades, but their move into group health coverage didn't happen until the early 2000s, says Dick Goff, managing member of The Taft Companies in Towson, Md.

In 2000, the U.S. Department of Labor (DOL) changed policy under the Employee Retirement Income Security Act of 1974 (ERISA) to allow companies to use their own captive insurance subsidiaries to reinsure employee benefits.

**See *Alternative-Risk*, p. 4**

# Assessment of VBD Vendor Performance Improves Cost Reduction

More employers are considering adding elements of value based design (VBD) programs, which build incentives into program benefit design and premium structure to encourage healthy behavior and reduce health care costs. But employers and their brokers, understandably not as familiar with VBD as with more traditional health insurance programs, may not know what to ask a plan/vendor regarding its VBD performance and capabilities.

The Washington, D.C.-based National Business Coalition on Health (NBCH) developed a list of questions to help evaluate vendor's VBD programs. The question list is part of the NBCH's VBD purchaser guide.

For instance, employers would want to make sure that the plan that claims it can provide VBD can administer rewards, such as discounts for gyms; track behavior and tie it to an employee's premium share; and integrate claims data, according to Dennis White, NBCH senior vice president of the NBCH. Since VBD also encourages the use of high value services, like preventive care, and high performance providers that reduce waste, the list of questions also includes asking potential vendors how

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**_VBD Vendor_ (continued from p. 1)**

they cost-effectively improve and maintain employees' health. The employer can then compare plans and make a better-informed selection.

"Some plans only pay claims. They don't own a provider network and don't have pay-for-performance programs, so they're not measuring provider performance. And you need a unified data set to track if something bad is about to happen [to an employee]. A missed pharmacy fill is the best predictor that something is about to go wrong. It's best for a doctor to track that but if not, then a plan has to do that," says White.

### Questions to Ask Value-based Design Vendors

The question list for VBD is a summary of a larger request for information (RFI) with more detailed questions on NBCH's eValu8 RFI tool, a web-based tool that collects information regarding plans and is used to assess plan abilities and performance in general, not just VBD. The entire eValu8 tool, which comprises more than 350 questions (of which VBD are just a few) is more likely to be used by larger employers or employer coalitions, says White.

Questions include:

1) Please describe the plan's view of VBD's effectiveness to improve the health status of covered lives and reduce purchaser costs.

2) Please describe what specific steps the plan will take to help a purchaser decide if VBD will be a beneficial strategy to pursue with regard to its health coverage.

3) Based on the plan's experience, describe what criteria it uses to evaluate if a purchaser will benefit from VBD.

4) Describe in detail the plan's capabilities to assist a purchaser in evaluating VBD as a health plan option by:

   a) aggregating medical and pharmacy claims data, mining the data for VBD opportunities and modeling the impact of VBD plan options.

   b) including other data, such as long-term and short-term disability claims, and personal health assessment survey results, in the claims aggregation and analysis process described in 4a, above.

   c) providing the purchaser with a comprehensive assessment of the results of the data analysis described in 4 a and b above, and helping the provider interpret the results of the analysis.

5) Describe in detail the plan's capabilities to implement and administer a VBD plan that:

   a) waives or reduces copayments/coinsurance for specific prescription drugs;

   b) waives or reduces copayments/coinsurance for preventive office visits;

   c) waives or reduces copayments/coinsurance for preventive services, such as annual colonoscopy for people over 60 years of age;

   d) waives or reduces deductibles linked to completion of health risk assessments;

   e) waives or reduces deductibles linked to participation in disease management programs;

   f) waives or reduces deductibles linked to participation in wellness programs, such as weight loss or smoking cessation;

   g) waives or reduces drug copayments/coinsurance for individuals with specific diagnoses;

   h) waives or reduces copayments/coinsurance for specific service received by individuals with specific diagnoses, such as lab tests for patients with diabetes;

   i) waives copayments/coinsurance by selecting a high value treatment modality or provider;

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**Reducing Healthcare Costs for Employers**

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# Financial Incentive Use Becoming More Sophisticated, Rewards Tougher to Earn

Employers use financial rewards to motivate their employees to participate in wellness programs and improve their health — and ultimately lower health costs. But in search of strategies to increase employee participation, employers are making it harder for employees to earn those financial incentives.

### Employers Tweak Rewards Programs

Financial incentives are strongly linked to higher rates of member participating in health risk appraisals, biometric screenings, health coaching, weight management, disease management and smoking cessation programs.

Employers are going further by tweaking financial incentive programs to: (1) change what will be incentivized (health risk assessment and weight loss are on the rise); and (2) make the reward contingent on actual employee progress in a health indicator.

In a survey on purchasing value in health care published by Towers Watson and the National Business Group on Health, employers reported toughening their requirements on employees before paying out that financial reward. For example, more than one-third of employers (37 percent) that offered incentives only did so to members who met employer requirements to complete a health engagement activity, such as actually reducing body mass index or successfully completing a smoking cessation program. Another 23 percent plan to do so in 2011. Almost one third (29 percent) of surveyed employers reward only members who participate in multiple health activities, and that number is expected to almost double in 2011.

"There's a lot of buzz on incentives based on participating and outcomes, not just [completing] a health risk assessment," says Bruce Kelley, senior consultant with Towers Watson in Minneapolis.

### Financial Incentives Legally Clouded

Employers offering rewards or penalties to influence employee behavior need to comply with applicable laws — and those laws conflict at some points. "You have to look at them all. What's okay under one law may not necessarily be okay under another law," warns Heinen.

Many employers structure their incentive/wellness programs to comply with HIPAA, prohibits a group health plan from discriminating against individuals for having a disability or medical condition. "[HIPAA is] the clearest standard at this point," says attorney Joseph Lynett, regional coordinator for disability leave and health management at Jackson Lewis in White Plains, N.Y.

Under HIPAA (enforced by the U.S. Department of Health and Human Services), employers can offer rewards, but limited to no more than 20 percent of the cost of employee plan coverage (which will rise to 30 percent in 2014, courtesy of health reform). They also must offer a reasonable alternative for people who can't meet the reward requirement and allowing individuals the ability to qualify for the reward every year.

Certain state laws bar discrimination against employees for lawful activities while off-duty. Employers should tailor financial incentive programs to comply with them.

Unfortunately, HIPAA is not the only law affecting financial incentives. The American with Disabilities Act (ADA) bars wellness programs that make disability-related inquiries or require medical examinations unless the wellness program is voluntary. The Genetic Information Nondiscrimination Act (GINA) prohibits group health plans from adjusting premiums or contribution amounts based on genetic information and bars collecting genetic information or asking employees to take a genetic test. (Employees can provide the information if it's voluntary and there's no reward or penalty attached.)

But the Equal Employment Opportunity Commission (EEOC), which enforces both GINA and the ADA, has not yet defined what constitutes a "voluntary" wellness program or voluntary provision of genetic information. "A monetary incentive can render a program involuntary. The EEOC hasn't given a definitive answer," warns Lynett.

While the EEOC still hasn't taken a formal position on what is "voluntary," the agency did publish an informal opinion letter in October 2009 saying that requiring employees to complete a health risk assessment (HRA) in order to be reimbursed for health expenses violated the ADA because it wasn't voluntary and asked many disability-related questions.

**See *Financial Incentive*, p. 7**

## *Alternative Risk* (continued from p. 1)

### Reform Created Reasons for ART

ART captives can reduce the uncertainty and decrease costs over the long term by having a group of self-insured employers share catastrophic risk. One employer might have a high-cost year when an employee's baby is born prematurely, but the employer's stop-loss rates won't spike up because the group shares in the risk. The next year, another employer will have an employee needing a kidney transplant, but again the group will share this risk. ART captives can drive down health costs by actively managing risk through provider discounts and driving provider competition, Goff says.

Health plans using ARTs are helping self-funded plans manage risk without resorting to pre-existing condition exclusions, recently outlawed by health reform.

Health reform will help to hasten the trend because TPAs, insurers and employers will want to form their own captives before 2012 when the states start forming health insurance exchanges.

"They'll want to keep the federal government out and keep control of their own destiny," Goff says. "By utilization of captives in the ART world, we have association health plans, and we've done it in lieu of the government."

Employers, TPAs and insurers use captives for both normal and catastrophic claims coverage. The traditional stop-loss insurance market has been shrinking, and small employer groups can't take on self-insurance risk without a funded pool arrangement, Goff says.

"You'll begin to see homogenous groups coming together to form a captive, and the captive will enter into a partnership with traditional group health carriers," he adds.

Employee Benefit Management Services, Inc. (EBMS), a TPA in Billings, Mont., created a captive for stop-loss coverage in 2002 because stop-loss premium increases were causing some clients to switch from self-funded to insured, says Rod Kastelitz, vice president of sales and marketing.

### Responding to S-L Premium Volatility

Traditional stop-loss coverage has specific and aggregate coverage. Specific coverage for individual losses poses a major problem for smaller self-insured plans.

For instance, self-insured employers could find their stop-loss coverage cancelled if they had a high-claims year or if the stop-loss company had a particularly bad year and went out of business. Or the reinsurer would raise rates through lasering; that is, putting high deductibles on sick individuals with high claims. This transference of risk to the employer created a huge amount of cost uncertainty from year to year.

An employer that had no high-cost claims for a decade could find that after one bad year, its stop-loss premium increases dramatically.

The ART captive might not be the least expensive stop-loss coverage in the first year, but over a period of years when the increases prove to be small and predictable, it likely will be a less costly alternative, experts say.

The Taft Companies is working with a large employee benefit agency to form an incorporated self-captive with cells for small employer groups covering two to 50 lives, as well as a cell for medium sized employer groups, and even cells for large employers that have 1,000 covered lives on up.

"All of that risk will be pooled," Goff says. "Then we're going to form a catastrophe cell which will take a layer of reinsurance risk for cancer, premature babies, etc."

Here's how it works: A small employer with 25 covered lives will go through an underwriting process, just as they would when buying group health insurance. They'll select from a menu of plan designs that all contain some risk management protocols, including some sort of wellness package.

There is a pre-loss part to the plan design that focuses on wellness and other strategies for improving employees' health and reducing costs, and the post-loss part that includes utilization review, an organ transplant network and other features.

"There will be a formal contractual system that the insured employer must follow, and if they don't follow it, they won't be renewed or accepted into the group," Goff says. "They will dictate what the wellness plan is, how it's accessed and monitored, how drugs are delivered and even who the TPA is."

The key is the employer will need to follow the risk management protocol or risk losing the coverage.

"We're taking the best of the best from within the traditional health care market and improving it or contracting for their services," Goff explains. "The insurance company isn't the one driving the cart, it's the captive that is."

*Case Study*

# Successful Stop-loss Captive Stabilizes Employer Costs

Billings, Mont.-based Employee Benefit Management Services, Inc. (EBMS) opened as a third-party administrator (TPA) in 1980, and two decades later the company saw that its self-funding services business was being threatened by a hardening of the stop-loss market.

The market was upside-down with stop-loss insurers closing and consolidating, and contracts and underwriting changing dramatically, says Rod Kastelitz, EBMS' vice president of sales and marketing.

"One of our [clients] who had been self-funded for many years heard from their carrier that they would have a triple-digit rate increase to their stop-loss premiums," Kastelitz says. "We stepped back and said, 'There's got to be a better way to do this.'"

EBMS' owners decided to capitalize their own risk pool, contracting with an insurer to be a front carrier. The insurer is paid for policies, ratings and state licenses, but assumes none of the risk.

"In turn, they basically allow us to do all of the functions they'd do administratively," Kastelitz says. "We issue policies, collect premiums and pay all the money that needs to be paid out."

The stop-loss captive, formed in 2002, was called Stop-Loss Insurance Services.

The goal was to offer self-insured employer clients an alternative to the uncertain annual costs of the traditional stop-loss market. There would be no individual loss risk, no lasering, and no huge rate increases for employers because the group would share all risk for high medical claims. The captive was run lean with as few expenses as possible, Kastelitz says.

Rates for EBMS' captive have increased each year, but at a lower rate than the market as a whole, he notes.

"And we lessen those increases because we're sharing profits back with clients," he adds. The captive gives self-insured employers an incentive to keeping their high-end medical costs down because they receive 80 percent of any profits the captive makes, Kastelitz says. Twenty percent of the profits stay in the program for future growth. "We have a very loyal following because they can share in the profits," Kastelitz says.

Captives, like the one formed by EBMS, will eliminate individual group underwriting because they rely on a pool of employers to keep overall costs more stable.

"This program has helped our clients stay self insured because their stop-loss coverage now is predictable from year to year."

After eight years, the captive has $12 million in annualized premiums, 23 employer clients, and about 31,000 covered lives.

"The program has been profitable every year," Kastelitz says. "About 25 percent of our business uses this specialty niche product, and 75 percent of our clients use outside stop-loss carriers, so this is not for everybody."

### Plans Buy Into Premium Stability

The captive doesn't offer the lowest initial prices, but over time self-insured employers will stabilize their stop-loss premiums and likely save money.

For instance, under traditional stop-loss coverage, an employer might have a $50,000 deductible. But the stop-loss insurer finds that one person in the group has a chronic disease. This triggers lasering by the stop-loss company, which is when the insurer raises the deductible for one particular plan member — say, in this example — to $200,000.

So if the individual's medical expenses reach $200,000, it means the self-insured employer now has an additional $150,000 in expenses on top of stop-loss premiums, Kastelitz explains.

"So they could be running along with good years and then have one bad year, such as a premature baby, and their [costs] might double," he says.

"Most of our clients participating in [captives] are the same types of clients who are doing innovative things on their own," Kastelitz says.

# Early Retiree Reinsurance Program Deadline Changes

Employers no longer have to worry about being the first to enroll in the new Early Retiree Reinsurance Program (ERRP), according to a recent government notice about how the $5 billion federal fund will be distributed.

HHS recently clarified some points about the ERRP, which began June 1, 2010, and is part of the Patient Protection and Affordable Care Act (Pub. L. 111-148). It continues through Dec. 31, 2013 or until funding runs out.

The update reflecting this changes is posted at http://www.hhs.gov/ociio/Documents/application_faq.html**.** Also, HHS says applications can be submitted through the U.S. Postal Service. More information about ERRP is at http://www.hhs.gov/ociio/regulations.

"Initially, we thought the application had to be submitted on a first-come, first-serve basis, but HHS now says it's the actual claims requests that have to be in first," says Gary B. Kushner, president and chief executive officer of Kushner & Co. in Portage, Mich.

Employers need to apply to be part of the program, but their applications will be accepted at any time during the program's lifespan.

"Once you're approved for the program there is a process where you submit eligible claims, and it's as you submit the claims — not as you submit the application — that it's based on first-come, first-served," Kushner says.

The HHS clarification on June 30, 2010, takes away some of the pressure for quickly applying to the program, but it's still advisable to make this a priority for the second half of 2010, Kushner says.

"We're telling clients to not drop everything to get the application in, but they also shouldn't wait too long," he says. "And as you have eligible claims, begin to submit them."

To be eligible for the program, employers need to provide health benefits for retirees who are at least 55 years and are no longer active employees. They cannot be eligible for Medicare. A retiree's spouse, surviving spouse, and health plan dependents also are eligible, regardless of age.

Also, employers must have chronic disease management programs with cost-saving measures in place.

Any actual health care claims between $15,000 and $90,000 per year can qualify for reimbursement of up to 80 percent under the program.

## *VBD Vendor* (continued from p. 2)

j) offers different copayment /co-insurance levels for different providers based on quality and cost assessments of the providers;

k) offers discounts on health/wellness-related activities (weight loss programs, health club membership, etc.);

l) offers health plan premium reductions for participating in disease management or in health risk reduction programs (smoking cessation, weight loss, etc.), and

m) offers other value-based positive incentives.

6) Describe whether each of the capabilities detailed in question 5 can be limited to enrollees with diagnoses of: (a) asthma; (b) hypertension; (c) hyperlipidemia; (d) diabetes; (e) depression; and (f) prior cardiac event.

7) Detail what consumer support programs the plan has available to provide coaching and educational support to individuals with specific chronic conditions. Indicate whether these programs are internally run services or provided by a subcontractor.

8) Detail what wellness programs the plan has available that are designed to improve the health and well-being of all individuals, including healthy and low-risk individuals. Indicate whether these programs are internally run services or provided by a subcontractor.

9) Detail what specific mechanisms the plan has in place to ensure that different parts of the plan's organization and vendors all coordinate to offer a smooth-running VBD plan.

10) How many accounts does the plan currently support that have implemented some aspect of VBD?

11) What issues have arisen in implementing a VBD plan and how did the plan address the issues.

12) Please provide the names of three accounts that have implemented a VBD plan with the plan, with at least one being available to enrollees for more than 12 months.

# Reform's Notice-of-change Rule Complicates Health Cost Control

Employers will need to give health benefit plan members more advanced notice than they have in the past when they are making changes to reduce health plan costs.

Section 2715, subpart D-4 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) lists a requirement for the new summary of material modifications (SMM) when plan changes are made. The SMM is a written notice that goes to plan participants.

The "notice of modifications" requirement reads: "If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved … that is not reflected in the most recent … summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective."

Health plans used to have 60 days after a policy change to inform all participants. Now, they have to give 60-day advance notice of the change or risk a $1,000 penalty per participant

Some experts thought the provision would not go into effect until 2012, but this is incorrect, says Gary Kushner, president and CEO of Kushner & Co. in Portage, Mich.

"The effective date of this is for plan years that begin on or after Sept. 23, 2010, but for grandfathered plans it goes back to March 2010," Kushner says. "There could be employers who are out of compliance already if they had a July 1 plan year."

What makes this provision especially difficult is employers often don't receive their renewal packages from agents, brokers and insurers 90 days in advance, which is how much time they would need to implement changes with a 60-day advance notice to plan members.

"I think employers are going to have to be very vigilant on this and push very hard on their carriers," Kushner says. "It's the same issue with third-party administrators (TPAs), so if I'm getting stop-loss quotes, I need to talk to my TPA and get those quotes much earlier than I have been."

Employers that are not able to send out the SMM 60 days before the change takes place are facing a substantial financial risk.

For example, if an employer with 100 plan members plans to change the health plan design on Jan. 1, 2011, then the notice needs to be sent out by Nov. 1, 2010. If the notice is a few weeks late, a plan member could complain to the U.S. Department of Labor (DOL) that he had not received proper advance notification, and DOL could fine the employer, Kushner says.

## *Financial Incentive* (continued from p. 3)

So what's okay under HIPAA may be unlawful under the ADA or GINA. "You have to look at all three laws separately. In this instance, an employer may be able to pass ADA muster by denying those employees who don't take the assessment from being in a richer health plan, but not denying them coverage outright, suggests Hall.

When the EEOC does take a formal position on what is "voluntary," employers may have to restructure programs or eliminate rewards because they'll now be "involuntary." "This is a classic, textbook case of the law constraining employers from doing the right thing [by helping their employees live healthier lives]," he laments.

In addition, employers need to watch for state laws that bar discrimination against employees for participating in lawful activities while off-duty, such as smoking, and tailor any financial incentive program to comply with those laws, says Lynett. So an employer may not be able to penalize employees for not successfully completing a smoking cessation program.

**Tip:** Don't forget to ask about tax treatment of incentives, since some kinds may not be tax exempt and employees would have to treat them as additional income, which could affect their popularity. To avoid legal roadblocks, have counsel review what you're planning to do about incentives.

### Strategies to Implement Financial Incentives

Employers can launch and/or fine-tune their use of financial incentives to increase employee participation and reduce health care costs. Effective approaches include:

**See *Financial Incentive*, p. 8**

## *Financial Incentive* (continued from p. 7)

1) **Determine what incentives will work best for your workforce.** "It's not one size fits all; you need to find out what fits in your culture," says Peter Hayes, CEO of consulting firm HC Solutions in Scarborough, Maine. Some workforces are more motivated by incentives tied to their benefits (such as premium reductions), while others prefer cash. Hayes' former employer Hannaford Brothers surveyed its workforce regarding incentives and discovered that many people wanted a healthy-behavior credit, which was a weekly $20 bonus as long as the employee participated in the wellness program. "We went from 30 percent participation to 90 percent participation," Hayes notes. One employer discovered that its employees valued airline miles the most, says Barry Hall, principal and global wellness research leader for Buck Consultants in Boston. There is evidence that disincentives — motivating by penalties, not rewards — are effective, but some employers don't want to send a negative message, and use cash because it's easier, says Heinen.

2) **Don't offer incentives alone**. "Incentives are a way to get people to try something, but it's not affecting long-term behavior," warns Kelley. For example, the incentives should be reinforced with a corporate culture of wellness, clear communication why the company supports these initiatives, and a consistent message. "You can't have inconsistencies. Why support weight management and then have a break room full of [pastries]?" asks Heinen.

3) **Create a strategy.** The most effective programs look at the long-term picture as well as the short term. "Don't do the program of the month," warns Hayes. For instance, one company raised the requirements from one year to the next to earn rewards. In the first year it first offered incentives just for employees to complete an HRA; the next year the employees also had to participate in a program to earn the reward.

4) **Consider the structure of the incentive to maximize its perceived value.** People often respond more to high-value or status rewards, such as exclusive trips, a TV or access to fancy seating at a sporting event rather than the equivalent in cash, which people then spend on gas or groceries, says Heinen.

5) **Maximize results without overpaying.** While in general the greater the incentive, the greater the participation, that's somewhat simplistic, warns Hall. For instance, there's no need to provide a reward of $100 if $75 will work as well. Employees are also motivated by other factors, such as interdepartmental contests and social pressure. "It's huge. People are more likely to want to do something if others are doing it," he notes. "Statistical optimism," which is the tendency of people to overestimate their chances to win, may also be helpful. "A raffle ticket may be a higher motivator than giving everyone $25," says Hall. That may also reduce the employers' overall outlay on the incentive.

6) **Emphasize today's rewards.** How to communicate the incentives and the programs will make a difference in the amount of participation, says Heinen. "Focus on short term benefits and rewards, like 'you'll feel better today and sleep better tonight.' The message 'be healthy so you can be with your grandchildren in 20 years,' isn't working as well," she points out. Employees also respond well to factoids and stories, says Hayes. They don't necessarily respond well if they perceive that incentives are being offered merely to help the employer reduce health care costs, warns Kelley.