

BENEFIT

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Companies Join Coalition To Minimize Prescription Drug Costs

Hoping to get a better handle on their prescription drug expenditures, more than 30 large employers have joined Rx Collaborative, a coalition organized by HR consultancy Towers Perrin to reduce employer drug costs through bulk purchasing and greater price transparency.

Billed as the first transparent pharmacy benefit manager (PBM) pricing model and the largest employer coalition of its kind, Towers Perrin said the Rx Collaborative will allow members to save up to 10% on their drug spending in the first year, and will deliver significant additional savings in subsequent years. Medco Health Solutions has been selected as PBM for the group. Under the terms of the group's agreement with Medco, member

companies will pay the PBM a flat monthly fee for each employee in the program, and a fee for each prescription dispensed by mail.

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The companies making up the coalition include ING Americas, Eastman Chemical, Mattel, and Unocal. Currently, the group's member businesses spend a combined \$800 million a year on prescription drugs, according to Towers Perrin.

In addition to offering Rx Collaborative members greater economies of scale and improved price transparency, Medco has agreed to pass on to members all drug manufacturer rebates and discounts, and to provide companies with complete information about its purchasing activities. This will enable members to better monitor expenditures, and ensure that they and their employees are getting the best possible price on their medications, Towers Perrin said.



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“Prescription drug costs have grown significantly over the past five years,” observed David Guilmette, managing director of Tower Perrin’s HR Services business. “Moreover, actual manufacturing costs, discounts and other aspects of drug pricing have been largely invisible to employers, making it extremely difficult for employers to effectively manage their drug benefit programs.”

However, Guilmette added, “by banding together and building from a clear picture of actual costs, employers can better manage their programs collaboratively with PBMs, working on utilization management, disease management, formulary development and other efforts that will have a sustainable, long-term impact on overall costs and quality. Working together with all the cards face-up on the table, employers can change the PBM business model and better manage their programs collaboratively with PBMs.”

Consumer-Directed Health Care On The Rise, But May Carry Risks

With medical insurance premiums rising rapidly, many American employers are asking their workers to bear a greater share of the cost of their health care coverage. As a means of reducing premium costs for the company and the employee, some employers are also adding to their benefits package a consumer-directed health plan, generally in the form of a high-deductible policy coupled with a tax-advantaged savings account.

But several recently published studies have cautioned that shifting health care costs and decision-making to consumers may do little to arrest the overall rise in health care costs in the United States, and could even add to the financial problems of individuals and employers.

Employer interest in HSAs and other consumer-directed options appears to be growing. In a 2004 survey of more than 3,000 employer health plan sponsors, Mercer Human Resource Consulting found that increasing numbers of larger companies are offering a consumer-directed health plan (CDHP) as an option to employees. Of the companies with 500 or more employees, 4% said they currently offered a CDHP, 14% said they were likely to offer one in 2005, and 26% expected to include a CDHP in their benefits package by 2006. Smaller companies, which typically offer fewer benefits choices to employees, were much less likely to be considering a CDHP, the survey showed.

To better assess the outlook for CDHPs, Mercer also studied data from 88 companies that offered the plans to employees in 2004. The average cost for CDHP coverage, researchers found, was \$5,233 per employee, compared with \$6,095 for PPO coverage—a difference of nearly 17%. Most of the plans used were Health Reimbursement Accounts (HRAs), but more than a quarter of sponsors said they planned to start offering the HSA, which first became available at the start of 2004, in addition to, or instead of, HRAs.

To encourage enrollment in CDHPs, employers typically waived or reduced employee contributions to the consumer-directed plans, while maintaining higher employee contribution levels for their managed care plans. But because of the higher deductibles associated with CDHPs, many employees were wary of signing up for the plans, researchers concluded. On average, 16% of employees at companies that offered a choice of plans selected a CDHP in 2004, the study found.

“Employees won’t sign up for a CDHP unless they have a good sense of its value relative to a standard medical plan,” said Ray Herschman, a consultant in Mercer’s Cleveland office. “You need good communication and education materials to help them understand how

the plans work and what services are offered them.”

Herschman described the 2004 CDHP enrollment rate as “good, considering the typically slow rate of adoption with such a new concept.” Overall, Mercer said the data suggest that employer experience with the early CDHPs has been positive.

But a survey by the California HealthCare Foundation (CHCF) indicated that many employers are uncertain about whether shifting medical costs and decision-making to employees will reduce their expenditures and improve the health of their workers.

The survey of 301 California employers found that a majority of respondents feel their health care costs are more under control today than they were a couple of years ago. Asked about the positive effects of cost-sharing, 76% of employers agreed that it forces consumers to spend more wisely on health care, and 70% said it reduces unnecessary doctors’ visits and prescriptions.

However, more than three-quarters of the employers surveyed also expressed concern that cost-sharing causes consumers to forgo needed medical care, and has a negative impact on individuals with chronic conditions. In addition, 40% of respondents told researchers they believe cost-sharing reduces the productivity of workers.

“Employers in California and nationally are increasingly turning to cost-sharing as a way to rein in their own health care costs,” said Jill Yegian, director of the Health Insurance Program at CHCF. “Cost-sharing doesn’t reduce the total health care bill, however. In fact, health care costs continue to increase at a double-digit pace.”

Another warning about possible hazards associated with HSAs and other consumer-directed health options was sounded in a recent study by the Commonwealth Fund, which found that high-deductible health plan enrollees are more likely to have medical debts, and are

more likely to forgo medical services, than enrollees in plans with low or no deductibles.

The Commonwealth Fund’s survey of more than 4,000 adults found that around one-half of insured adults with deductibles of \$500 or more said they had medical bill problems or debts, compared with fewer than one-third of those with lower-deductible plans. The findings also indicated that individuals with high-deductible plans were more likely than those with lower deductibles to skip medical care or fail to fill a prescription.

“Health savings accounts coupled with high deductible health plans have potential pitfalls, especially for families with low incomes or individuals with chronic health conditions, who are at greater risk of accruing burdensome medical debts and facing barriers to needed care,” said Karen Davis, president of the Commonwealth Fund. “The evidence is that increased patient cost-sharing leads to underuse of appropriate care.”

A recent survey on consumer awareness of Health Savings Accounts by Watson Wyatt showed that most Americans continue to have at least some reservations about CDHPs. While a majority of the individuals surveyed said they liked HSA features such as control of funds and lower premiums, more than 50% also expressed concern about the financial risks posed by higher deductibles and prescription drug payments.

Following a detailed explanation of how HSAs work, Watson Wyatt asked 1,000 adults with health insurance about their attitudes toward the accounts. While 91% of respondents rejected plans with very low premiums and very high deductibles, 52% said they would be interested in plans with somewhat low premiums and somewhat high deductibles. But those who described their health as fair to poor showed greater interest in plans with somewhat



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high premiums and somewhat low deductibles than in higher-deductible plans, which were, in turn, favored more strongly by healthier respondents. Respondents cited “maximum out-of-pocket costs” as the factor that would influence them most when deciding whether to enroll in an HSA.

The results of the Watson Wyatt survey also suggested that most people are not interested in reducing health care visits to save money. Of those surveyed, 59% said they think their consumption of health care services would remain unchanged even if they enrolled in an HSA, and only 16% said they think they would use fewer services.

A recent Boston University report addressing the problem of escalating U.S. health care costs rejected CDHPs as an effective means of controlling spending. In their report, School of Public Health professors Alan Sager and Deborah Socolar argued that cost shifting promotes underinsurance, pushing patients to deny themselves care.

“Reducing coverage by requiring more patient payments will doubtless reduce the use of care by average Americans, and encourage patients to try to second-guess the tests and treatments that their physicians prescribe,” Sager and Socolar observed. But, they added, “there is evidence that these changes are not clinically safe, and no evidence that they cut costs overall. Non-physicians cannot readily tell whether care is needed.”

The Boston University researchers cited statistics indicating that a relatively small number of seriously ill people—roughly 10% of patients—account for more than two-thirds of all health care costs. “A huge share of patients—especially those needing the most care—will simply never be able to investigate and grapple with detailed efficacy and cost information,” they pointed out.

Instead of shifting responsibility for health care spending to consumers, Sager and Socolar argued, it is essential “to contain costs in ways that squeeze out waste, and mobilize the savings to finance high-quality care for all Americans—while paying all needed caregivers adequately.”

Employers Spent More On Benefits In 2003

American businesses remained committed to providing benefits to employees in 2003, increasing their spending over the previous year, a U.S. Chamber of Commerce survey of its members showed.

The average benefits expenditure per employee rose to \$18,358 in 2003, from \$18,000 in 2002, according to the survey of nearly 600 companies. Broken down by benefit type, employers spent an average of \$5,653 on medical insurance, \$4,932 on paid time off, and \$3,303 on retirement and savings.

On average, employee benefit costs accounted for 37.6% of payroll for the companies surveyed. The study also found that, at 40.1%, manufacturing companies spent a slightly higher percentage of payroll on benefits than other types of businesses.

The most commonly offered benefits were medical, paid holidays and vacation, and retirement plans. Health insurance was the most expensive benefit, representing an average of 11.6% of payroll among the companies surveyed.

“Employers are continuing to offer their workers a broad range of benefits in order to maintain a strong workforce despite the rising cost,” said Bruce Josten, Chamber executive vice president.



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