Bending the Trend

Emerging cost drivers and the leveraging effect of medical trend on self-funded health plans.

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One of the first things taught in Economics 101 are the diminishing effects inflationary trend has on the value of a dollar. Nowhere can this be better illustrated than in the rising cost of health care in the U.S. Few industry segments are as vulnerable to these diminishing effects as self-funded health plans, which happen to be the most effective and frequently used form of alternative risk transfer. Even with the widespread familiarity of self-funding, the leveraging effect that medical trend has on self-funded plans is often overlooked.

For the past decade, the cost of health care in the U.S. has been increasing at an average annual rate of nearly 10%, a trend rate steeper than most other U.S. economic segments. The rate of medical trend is expected to decrease in 2016 however; it will still significantly outpace general economic inflation. The estimated per capita annual spend for health care for 2015 is approximately $12,500 for 2015 and projected to increase to $13,750 in 2016. It is important to note this is the average cost of health care and not the cost of health care insurance. The cost of insurance, what most employers are more concerned with, is a direct reflection of the expected costs charged for health care. The only way to make health insurance more affordable is to make health care itself more affordable.

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Why it's happening (a few things that you probably didn't realize):
There are a number of elements that drive inflationary trend relative to medical insurance. The root problems of health care pricing are much too complex to breakdown in this discussion and most of us, particularly those that self-fund their health plan, are already familiar with the more obvious cost drivers of health care. In addition to a trend of large claims getting larger, it's now time to introduce a new round of cost drivers that self-insureds need to prepare for.

■ ***New specialty drugs and therapies***
Specialty drug approvals have surpassed traditional drugs over the past five years. This trend is expected to continue for some time as the FDA approval pipeline is full with new therapies for cancer, rheumatic diseases, hematology and a number of other conditions. A new drug treatment for Hepatitis C is estimated to have added a half percentage point to total employer medical cost increases and one-fifth percentage point to total medical costs in 2014. A recent Express Scripts report concluded that total national prescription drug spending increased 13.1% in 2014.

■ ***Unlimited lifetime maximums***

One of the by-products of the Affordable Care Act (ACA) is the mandate for unlimited individual benefits. Prior to January 1, 2014, health plans could limit a participant's maximum lifetime benefit to $1 million. The ACA gradually increased that limit to $1 million annually and ultimately to an unlimited lifetime maximum. The new unlimited maximum has expanded the procedure coding and billing ability of healthcare providers. For some it has become an open checkbook. Many treatments, therapies and procedures that used to cap out at well less than $1 million are now regularly exceeding that threshold.

■ ***Cyber security for private health information***

The U.S. Department of Health and Human Services reported that more than 90 healthcare providers experienced significant data breaches in 2014 and large data breaches of Anthem and Humana earlier this year were well publicized. Stolen health records are considered much more valuable than credit card data and are being aggressively targeted. Some of these breaches have resulted in multimillion dollar settlements and significant government fines. The added cost of enhanced cyber security and liability insurance for medical providers, as well as insurers, will contribute significantly toward increases in health care costs.

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And why it affects self-funded plans

■ ***Leveraged Trend***

Stop-loss carriers increase the risk charge for employers with lower specific deductibles. Since a lower specific deductible transfers more risk to the insurer, the corresponding risk charge becomes a greater portion of the specific premium charged to compensate for the increased coverage. Lower specific deductibles are also more susceptible to the adverse effects of inflationary forces.

Leveraged Trend is the effect of first-dollar medical inflation, which, as mentioned earlier, can average anywhere from 6%-10% per year, on stop-loss claims. A simple illustration: assume an employer with a self-insured health plan has stop loss coverage with a $50,000 specific deductible. Incurring a $100,000 claim in 2014, the employer would receive a $50,000 reimbursement from the stop loss carrier.

In 2015, assuming a 10% medical trend, that same medical claim would be valued at $110,000 and the employer would receive a $60,000 reimbursement from the stop loss coverage.

Even though the claim had only increased by 10% from the previous year, the stop-loss reimbursement increased by 20%. This is sometimes referred to as Deductible Erosion and exemplifies the increased (leveraged) effects that inflationary trend has on self-insured plans. Assuming there are no significant changes or adjustments to the benefit plan or specific deductible from one year to the next, the stop-loss carrier would need to seek an increase to premiums to compensate for their increased risk exposure or the insured's decrease in exposure.

What can be done to "bend the trend"

Because of their ability to preempt many ACA and individual state benefit mandates, self-funded plans maintain the greatest administrative control and latitude over plan design. The following are emerging plan design techniques being implemented to offset the effects of inflationary medical trend.

■ *Prudent cost sharing*

Another provision of ACA is the looming "Cadillac tax" which, beginning in 2018, will impose a 40% non-deductible tax on the value of employer-paid benefits exceeding a maximum threshold. This will spur more cost shifting to employees as a way to reduce the value of benefits provided to employees. Most of the shifting will be in the form of higher out-of-pocket maximums and greater use of High Deductible Health Plans (HDHP). Participants of the plans will assume a greater portion of the financial responsibility which will help foster better consumerism. Improved consumerism will be achieved as long as the out-of-pocket maximum is not set to a point that it discourages the plan participants from seeking needed or timely treatment.

■ ***Implement Referenced Based Pricing schedules***

Reference Based Pricing (RBP) is a benefit design in which the health plans define the maximum amount it will cover for a particular health care service. RBP provides a more defined fee structure as provider reimbursements are tied to a specific reference point for the procedure or service. This can either be Medicare Plus, the Medicare reimbursement point as a base plus a defined margin (e.g., Medicare plus 50%) or a defined benefit schedule. This scheduled approach specifically defines the maximum dollar amount assigned by the benefit plan for each treatment or procedure. This would allow the benefit plan to isolate and contain specific "cost-drivers" within a benefit plan.

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■ ***Alternative treatment venues***

Many progressive benefit plans are encouraging employees to seek lower-cost alternatives to traditional treatment and care. "Medical Tourism" in which the benefit plan will pay for employees and even a spouse or partner to travel to other lower cost locations, including different countries, for qualitatively comparable treatment is gaining in popularity. The cost for an orthopaedic procedure, such as a hip replacement in a top-tier facility in Mexico or Panama, will be a fraction of the cost for comparable treatment in the U.S. The benefit plan can cover travel, accommodations and treatment and still pay much less than the U.S. treatment cost.

■ ***Virtual care and telemedicine***

New technology allows hospitals and physicians to consult and remotely monitor patients. This is especially effective for those with chronic conditions. Remote (virtual) observation is timelier and less expensive than office visits. Congress recently added several Medicare payment codes for telemedicine and also designated $26 million in funding for telemedicine programs for rural communities. Increased use of telemedicine is expected to save billions of dollars across the U.S. healthcare system over the next two decades.

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The list continues to grow. Increased cost sharing fosters better consumerism. More efficient plan design, alternative treatment venues and greater use of technology can empower a self-insured health plan to shave costs and "Bend the Trend" of medical inflation in their favor.

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