Benchmarking

Gaining Perspective During Healthcare Reform

by Brett Sesker, HIA, FLMI, ALCH & Amy Stefka, MBA, HIA

Benchmarks are crucial to any ongoing benefit plan improvement process. They enable executives and human resource staff to compare their plans against those offered by their competitors.

In today's environment of rising costs and dynamic labor markets, employers must possess knowledge about their company, their employees and the marketplace in order to make informed and confident benefit plan decisions. High turnover rates and wasted financial resources can be devastating for any business, but comprehensive benefit benchmark data can help companies determine the level of benefits that other employers are offering and allow them to continue to attract and retain valuable employees. Comparing one organization's performance against another's will enable businesses to identify areas that may require attention, while also generating new ideas to stay ahead of the competition.

A critical component of any benchmark report is the credibility of the data involved in the analysis. SilverStone Group continues to be named one of the largest and most successful benefit specialists in the region and country (Sources: *Business Insurance*: "100 Largest Brokers of U.S. Business;" *Business Insurance*: "Largest U.S. Benefits Specialists;" *Omaha Book of Lists*: "Largest Omaha Independent Insurance Agencies and Brokerages"), which provides the critical mass necessary to put together key data points that are relevant to executives and human resources.

We are pleased to announce a summary of the first publicly published SilverStone Group "Healthcare Benefits Benchmark Report" in this edition of *SilverLink*. Normally reserved for clients, this important data has been released to all employers to help them determine where they stand in key areas of their benefits program. This article will provide a snapshot of significant data from the actual report, including detailed information from clients with 100 or more employees enrolled in their medical programs.

Implications of healthcare reform

Employers continually ask about the impact of healthcare reform and whether firms are remaining grandfathered or non-grandfathered under the Patient Protection and Affordable Care Act (PPACA) guidelines since its inception in late 2010. Of those firms that have renewed in 2011 and are subject to healthcare reform, 59% have remained grandfathered, while 41% have moved to non-grandfathered status. Only 2.4% of companies have added a new plan option for employees that would not be considered grandfathered, such as a Consumer Driven Health Plan (CDHP).

Plan design – traditional vs. CDHP

SilverStone Group tracks plan design features separately for traditional plans and CDHPs. Traditional plans include Preferred Provider Organization plans (PPOs), Health Maintenance Organization plans (HMOs) and Point of Service plans (POSs) with traditional deductibles and copay structures. CDHPs include high deductible health plans that allow members to use Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). The following paragraphs will break down the plan design characteristics for both categories.

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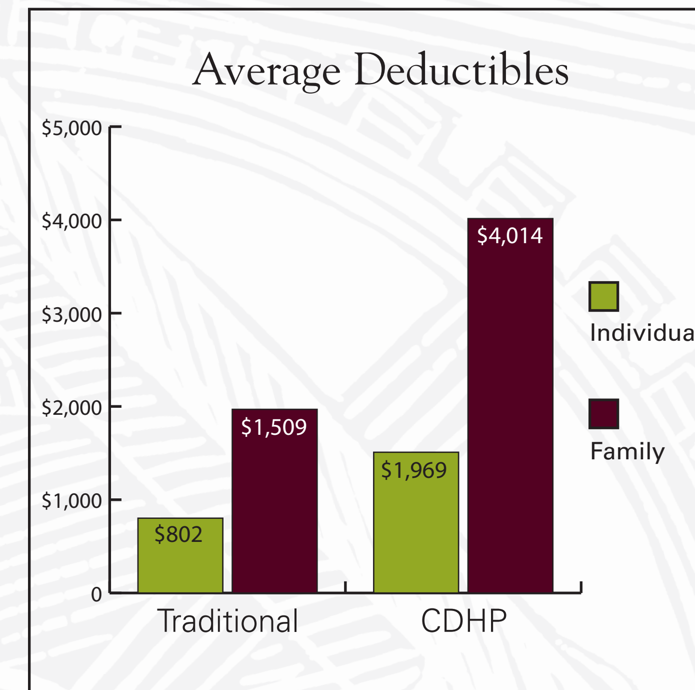
Deductibles

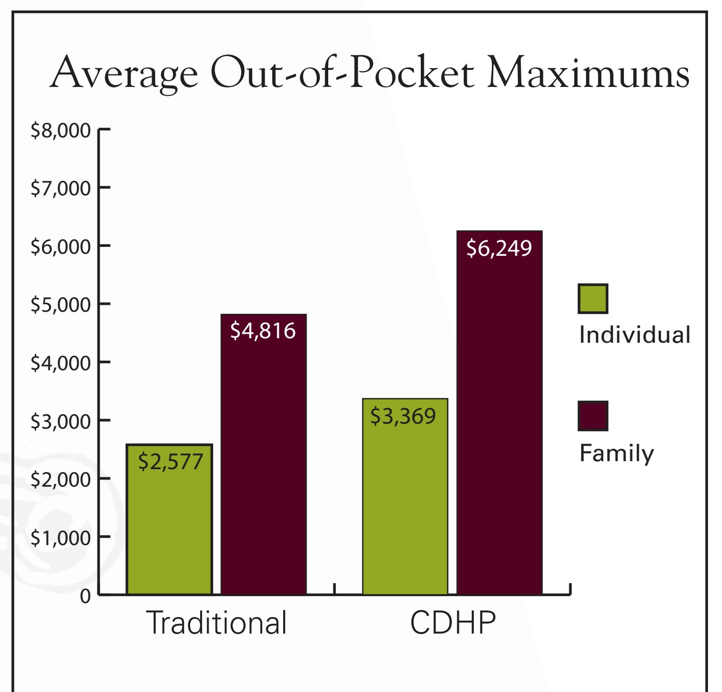
Traditional plan deductibles have increased by nearly 15% for individuals and 12% for families since 2009. Many employers have shifted toward higher deductible options to keep premiums at a minimum. CDHPs have seen a modest decrease (-2%) in average individual deductibles and just a slight increase (3%) for families. These numbers reflect the fact that as employers begin to offer these types of plans, they tend to start on the lower end of the deductible spectrum.



Out-of-pocket

The increase in out-of-pocket maximums since 2009 for traditional plans has been more gradual for individuals and families (8% and 4%, respectively). This is partly due to the fact that increasing a deductible has a much bigger impact on premiums, with "first dollar" cost shifting to employees for services such as hospital visits.

On the CDHP side, the increase since 2009 has also been slight (5% for both individuals and families), though many plans are adding coinsurance after the deductible has been met, which makes it appear as though they are increasing at a faster rate. The illustration in the next column outlines the averages in 2011.

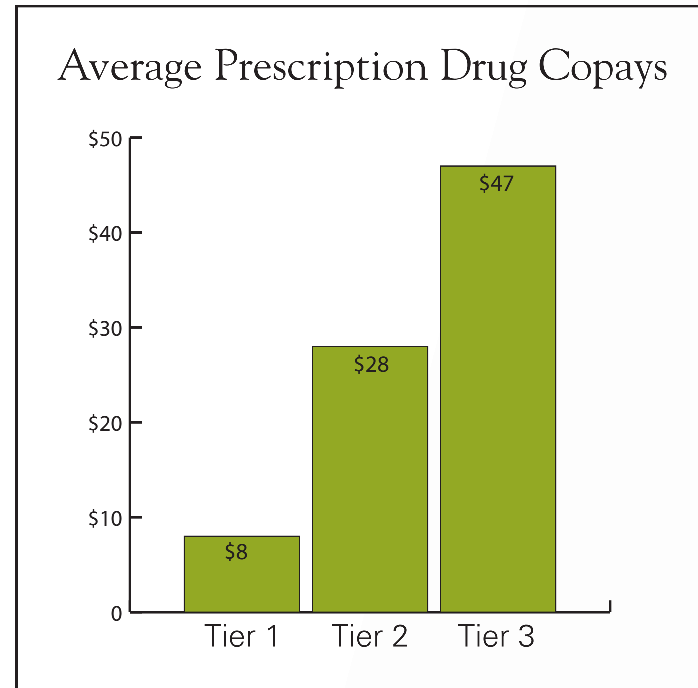


Prescription drugs

Prescription drug copay structures have changed dramatically in the past decade. Almost all Midwest employers have moved away from a 2-tier generic and name brand structure to a 3 or even 4-tier structure. While the standard 3-tier structure has been a popular option, the addition of a 4th tier provides for specialty medications and is becoming more commonplace, as these drugs have a price tag that can add up to thousands of dollars per month. When implementing a new structure, it is important to avoid excessive cost-sharing when setting the copay dollar amount for the following reasons:

1. As stated, specialty medications are extremely expensive and having the consumer pay an additional $50 – $75 will not have a substantial impact on the amount paid for the claim.
2. In many cases, it is essential for medication adherence to prevent members from incurring more costly claims (such as hospital admissions). If the copay is set too high, there is a greater risk that the member will choose to discontinue using their medications to save on costs, which could possibly lead to larger claims down the road.

While Tier 1 (generic) and Tier 2 copays have remained relatively stable over the past few years, Tier 3 copays have experienced an increase of 9% since 2009 because more employers have been encouraging the use of lower-cost generic alternatives. The figure below outlines the 2011 average copays:



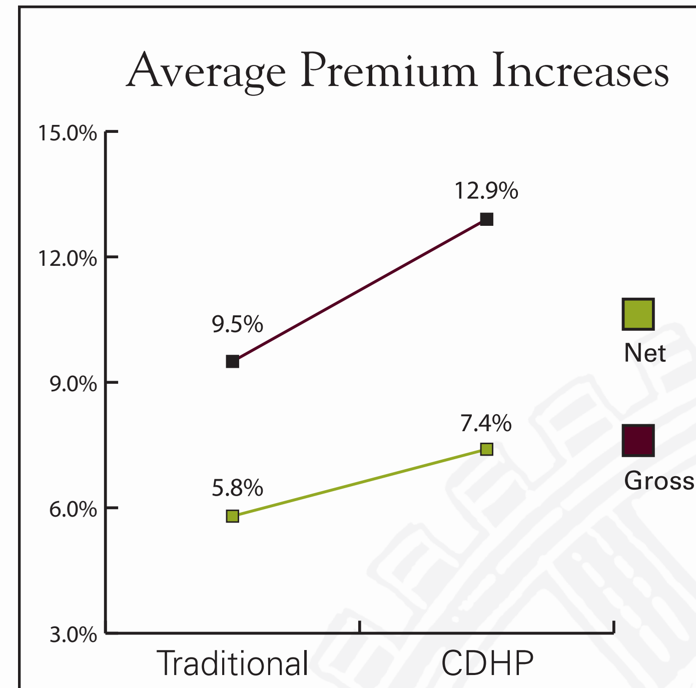
Preventive and routine care

With the rise in wellness program initiatives, preventive and routine care is beginning to be covered at 100% by benefit plans. Annual dollar maximums, such as $300 or $500 per member, have been standard within the structure. Traditional plans typically have a lower annual maximum averaging around $411, while CDHPs average $790.

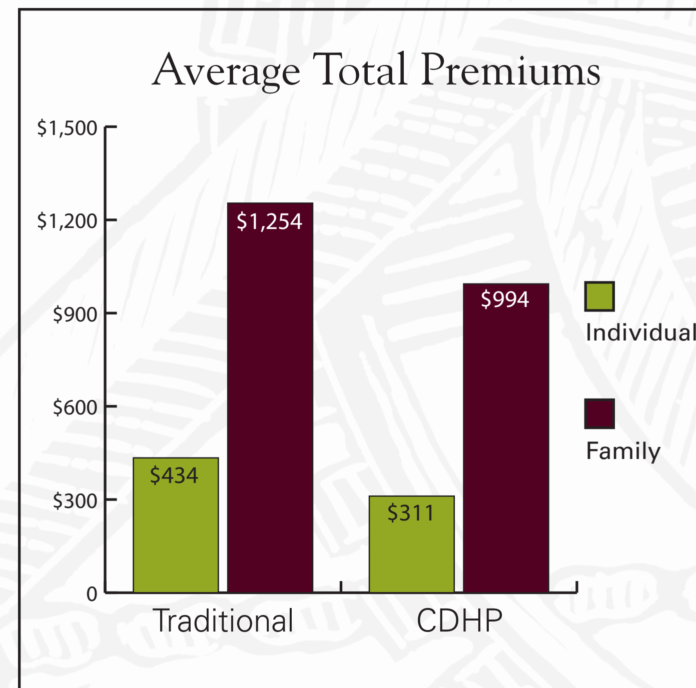
Following the passage of healthcare reform, some employers were mandated to remove any annual dollar maximum that was in place if they lost grandfather status under the new law. Among SilverStone Group's clients, 57% of those with traditional plans and 78% of those with CDHPs have an "unlimited" routine care maximum.

Premiums and cost sharing

Premium increases have slowed, but not as much as employers would like. SilverStone Group's unique approach to benchmarking data shows both a "gross" and a "net" increase in premiums:



The chart above illustrates how making plan design changes (which often create more out-of-pocket costs for the members) can skew the results. On average, employers shift 4% of costs back to employees by increasing deductibles, out-of-pocket maximums, copays and other benefits each year. The following chart outlines the average total premiums for 2011:



Employers continue to contribute 5 – 10% more toward the premiums for individual coverage than for family coverage. To add to that, firms are providing incentives for their employees to opt for CDHPs by contributing approximately 3 – 5% more toward those premiums than those of traditional plans.

What should you offer?

Many companies have found that offering employees a choice in benefits ultimately creates a much happier workforce. While it is still standard for companies to offer only one plan, there has been a 3 – 5% increase in those offering a dual choice or a 3-plan option. It has also become more common to offer a CDHP alongside a traditional plan, a trend which has grown by 3 – 6% since 2009.

Among SilverStone Group's clients who have 100+ employees, 71% have a self-funded plan. The preference for selecting this plan is due to the savings on premium taxes and the flexibility with plan design, as well as the potential to reap savings when claims are running well. As healthcare reform guidelines continue to roll out, we anticipate an increase in smaller employers (less than 100 employees) looking at self-funding as an option to avoid some of the regulations that will be imposed on the fully insured market, which could ultimately cause premium increases for that arena.

In addition to different plan options, it is important to consider the benefits of implementing a wellness program. Employers see it as a way to help curb rising medical costs while also providing additional benefits to their employees. Nearly 40% of firms are offering a "formal" wellness program, which may include a biometric screening, health risk assessment or ongoing activities for participating employees throughout the year. Moreover, 67% are offering incentives such as premium reductions or contributions to HSAs to reward employee participation.

New law, new plan

Newly instated laws and regulations resulting from healthcare reform have forced firms to take responsibility for implementing numerous changes and absorbing their costs. Reviewing plan design strategies employed by SilverStone Group clients will arm you with information to help maintain a competitive benefits package and enable you to recruit and retain quality employees.

Contact Brett Sesker or Amy Stefka at
bsesker@ssgi.com | astefka@ssgi.com