



## STRATEGIES TO HELP YOU MAKE THE BEST HEALTH CARE DECISIONS FOR YOUR COMPANY

Health care costs are increasing at an average rate of 15% annually. Unfortunately, a solution to this problem is more elusive. The changes that employer's have made to their benefits plans have not produced the reduction in costs hoped for. Obviously more aggressive strategies and better consumer decisions will need to be made to drive cost efficiency and quality of care.

The first step to tackling this problem is to develop a strategy in six key areas: cost sharing; dependent elections; plan selection; provider selection; prescriptions; and disease management.

**Cost Sharing.** Employee contributions are estimated to increase 18% in 2003 and out-of-pocket costs are expected to increase 23%. However, these increases are not proportionate to the overall increase in health care costs. In the last five years, health care costs have increased 50% while out-of-pocket expenses have increased less than 20%. It is suggested that employers look at not only the amount of cost sharing their employees do, but rather they design their cost sharing to encourage wise consumer behavior and cost efficiency. Out-of-pocket expenses are a key element in cost sharing and an even larger element in terms of influencing purchasing decisions.

**Dependent Elections:** They can account for a major portion of an employer's health coverage costs. Employers generally want their dependents and spouses who do not have coverage available elsewhere to enroll in their plan. Do employers want dependents and spouses who do have other coverage available to them to enroll? If an employer offers a plan that is better or has lower family rates than the spouse's employer's plan, the company that is covering the spouse is essentially subsidizing the medical costs of the other employer. These subsidies can account for as much as 10% to 20% of an employer's cost. Other options to consider are changing eligibility requirements for dependent students and increasing contribution levels for dependents instead of employees. An audit of the current plan members is also recommended to ensure there aren't any dependents still enrolled that are no longer eligible. Ineligible dependents can add up to 5% of an employer's medical costs.

**Plan Selection:** Employers should be evaluating various aspects of their plans to ensure that the plans are the most cost effective and that employees are happy with them. There are a number of benchmarking techniques that employers can use to evaluate plan rates, including rates that are adjusted demographically. Employers may also review the discounts that different plans get from the providers and hospitals in their network.

**Influence Choice:** A lot can be gained from analyzing the provider choices being made by plan participants. Recent estimates show that over 50% of the increase in health care costs are attributable to hospital care. Migrating employees seeking care to the most efficient hospitals could potentially lower costs. The first step employers should take is to access data on their own providers and compare them with other providers in the area in terms of both cost and quality. The opportunity for employers lies in identifying who the most cost-efficient quality providers are and then creating plan designs that will encourage employees to select those providers for their care.

**Prescription Drugs:** The prescription drug benefit is the most widely utilized health benefit and can significantly impact overall health cost. There are some strategies that can help consumers take a much stronger ownership in managing their conditions, not only from a wellness perspective, but also from a financial one. One new approach is reference-based pricing, or therapeutic mac. This system disposes of the formulary approach for a lot of the brand name drugs, and identifies an employer's level of coverage within certain therapeutically equivalent treatments. Provided with the right decision support tools, this approach allows employees to drive their own care, knowing what their condition is, what their targeted outcome is, and what the price tags are that are associated with the different conditions. HRA's are increasingly playing a role in managing pharmacy benefits. HRA's can be applied specifically to managing pharmacy benefits, where employers would provide first-dollar funding to cover a portion of an employee's deductible before a coinsurance plan kicks in.

**Disease Management:** Individuals with chronic conditions drive about 60% to 80% of health care costs, in terms of costs to a health plan. In addition, many chronic conditions are precursors to acute episodes that can result in high-dollar claims. Most employers have not effectively engaged the small percentage of the participants that are driving such a large percentage of the costs into appropriate management programs. Employers need to review available claims information and have their disease management providers do a targeted analysis to determine where the cost drivers are. Once the population is profiled, employers should address how they can engage the at-risk or high-cost groups. The key to the success of a disease management program is communication so that potential participants understand the benefits of the programs. Other keys to success are convenience of access to program resources and employer-driven incentives to encourage the behaviors they are trying to drive. Some possible incentives include: reducing the out-of-pocket maximums for individuals who hit their cap but who participate in conditioned management programs; co-pay coupons for prescription drugs; or providing testing supplies for diabetics who participate in the program.

# AB1401, CALIFORNIA COBRA

Effective 9/1/03

**NOTE: As of this writing, there are numerous ambiguities in this law. The information below represents an interpretation of this legislation as of December 2002. We hope there will be clarification on many provisions prior to the enactment date of September 1, 2003 but this is not a certainty.**

## COBRA Coverage

Individuals who begin receiving COBRA coverage on or after January 1, 2003 will be eligible for additional COBRA coverage periods in some cases. Every group contract entered into, amended, or renewed before September 1, 2003, shall be subject to the provisions of this section. This applies only to health plans and not dental-only or vision-only plans. The benefit provisions begin on September 1, 2003.

## Employers with less than 20 employees – not subject to Federal COBRA

Employers would be required to provide Cal-COBRA coverage for a 36-month period for all Qualified Beneficiaries (including the employee) after a Qualifying Event unless:

1. An individual fails to make a premium payment;
2. CAL-COBRA requirements no longer apply to the individual;
3. An employer (or successor employer) no longer provides any health coverage;
4. A Qualified Beneficiary moves out of a plan's service area; or
5. A Qualified Beneficiary commits fraud or deception in the use of plan services.

## Employers with more than 20 employees – subject to Federal COBRA

Employers would be required to offer Cal-COBRA coverage to individuals that would have lost coverage after 18 months (or 29 months in the event of a Disability Determination). The total coverage period for Federal COBRA and Cal-COBRA will not exceed 36 months from the date of the original Qualifying Event.

Of special interest, a period of Cal-COBRA coverage applicable after the exhaustion of Federal COBRA coverage will have two significant differences from the Federal COBRA plan:

1. State-standardized rates, similar to the rate scheme already in place for small group plans in California will be the maximum permissible charge for coverage. Thus, it appears that employees receiving special Cal-COBRA coverage extensions will not be paying the premium charged to the employer for coverage provided under the normal COBRA plan.
2. The benefit program will be one of two plans filed with the state by the insurance carrier. Therefore the plan may also have different benefits. The insurance carriers are commissioned with the responsibility of providing plan matrixes for eligible individuals.
3. Coverage extension does not apply to non-core coverages – such as stand alone dental or vision plans.

Insurance carriers are required to offer two plans for selection. This means that a Qualified Beneficiary eligible for extended coverage will have another enrollment period and will be able to make a selection between the two plans offered. AB1401 requires the insurance carrier to provide notification to the Qualified Beneficiary plan participants at the time of loss of coverage under the Federal plan – which will include a plan matrix and applicable rates. In procedures identical to those currently in place for small employer groups in California, the insurance carrier will handle the notification and enrollment.

Violations would be punishable as a misdemeanor criminal offense.

## COBRA Notices

The COBRA Qualifying Event notice must be amended to include information on the Cal-COBRA coverage extensions available to large groups and the provision of a 36-month coverage period for all Qualified Beneficiaries of small employer groups.

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