Needed Prescription for Reduced Health Care Costs

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To combat ever-increasing health care costs, an innovative tool, which can be utilized by employers offering medical benefits, is a wellness program. The results are win-win for both employee and employer. The employee gains education and an improved lifestyle while maintaining access to quality care, while the Employer enjoys cost-efficient or even *avoided* claims.

THE PROBLEM: INCREASING HEALTH CARE COSTS

A January 2002 survey found that the average health premium per employee increased 12.2 percent in 2001 with a projected 13.6 percent increase in 2002.[1] Rapidly escalating health care costs in a sputtering economy is a heavy burden to bear for employers offering medical benefits. There are several factors that contribute to the avalanche of health care costs, as follows.

Technology

Research, cutting-edge procedures, tools and medications all cost money—lots of it. Recent estimates report that new medical technologies cost the health care industry an annual average of $40 billion.[2] A plethora of new drugs have hit the market. These drugs are costly to research, pro-

duce, and consume for both insurers and patients. They have done much to enhance both the quality and quantity of life. For instance, the class of medications called beta-blockers have decreased mortality in coronary heart disease patients by approximately 30 percent.[3] New machines with astounding capabilities have been created, such as three-dimensional MRIs, which may replace invasive diagnostic cardiac catheterization. New medical tools are developed daily. One such tool is the new drug-eluting Cypher stent (at an approximate cost of $3,000), which can replace traditional stents (at a cost of approximately $300) in interventional cardiology. It is amazing how far technology has advanced and there is promise of even more future discoveries. Technology costs money, and the recipients of that technology are the ones paying for it.

Aging American Population

The number of people aged 65 and older is expected to double over the next 30 years, increasing from 34 million in 1999 to 69 million in the year 2030.[4] When Social Security commenced in the 1935, less than half the population lived beyond age 65. Currently life expectancy is an average of age 77, and actuarial tables are changing constantly.[5] Because elderly individuals tend to use more health-care resources, including technology-based treatments and multiple prescription drugs, elderly care expenditures will continue to escalate as nearly 80 million baby-boomers reach retirement in the near future.

Government Legislation

The US government has been a major culprit in increasing health care costs. With attempts to both shift costs to the private sector and protect American citizens, the government has fostered increased legislation, such as COBRA and HIPPA. Employees who elect COBRA typically incur costs at least 50 percent greater than active employees. For example, the added COBRA costs associated with a 10 percent reduction in staff can produce an additional 10 to 15 percent increase in overall health benefit costs per active employee for as long as 18 months.[6] The overall cost of HIPAA compliance has even been estimated to exceed Y2K compliance costs. HIPAA requires new record-keeping methods to protect privacy, and has added billions of dollars in new expenses for hospitals and insurers nationwide. Legislation can also have the side effect of breeding litigation. Hence, a multitude of additional and costly lawsuits ensue,[7] placing additional financial strain on businesses.

American Culture

American cultural values help explain growing health demands. People in the United States have much faith in the market, and its ascendancy in medicine has received much hype in recent years. Armed with a mil-

lion-dollar health care card, Americans are active in seeking out the best resources available for themselves and their loved ones. Americans value and demand choice, they believe strongly in technological progress and aggressively seek out what seems new and better[8] . . . but they don't want to pay for it. So far, they have had a measure of success.

Obesity, cigarette smoking, and stress are unhealthy lifestyles that have piled on additional costs in the American health care system.

Obesity

The subjective prevalence of obesity (obtained by self-report) in the United States increased from 19.8 percent in 2000 to 20.9 percent 2001.[9] However, the measured prevalence is substantially higher (30.5 percent) based upon data collected for NHANES between 1999 and 2000.[10] The health risk of being obese is extreme, and almost one third of Americans are flirting with the risk of coronary heart disease, osteoarthritis, sleep apnea, diabetes, and various cancers. Obesity also increases the risk of various back injuries, which are a significant cost to the industry. Being obese is a lifestyle that, when addressed successfully, can significantly lower health care costs while increasing patient health, productivity, and job attendance.

Cigarette Smoking

Smoking is the number one cause of preventable death, and the leading cause of lung cancer, emphysema, and pulmonary-obstructive disease. It has been linked to cancers of the mouth, throat, esophagus, bladder, pancreas, cervix, and kidney. Half of all smokers die as a direct result of smoking. It is estimated that more than 400,000 deaths result annually as a consequence of cigarette smoking.[11] The most important causes of mortality include atherosclerotic vascular disease, cancer, and chronic obstructive pulmonary disease (COPD).[12] Despite these health risks, about 25 percent of the American population smoke cigarettes. Smokers also generate 31 percent higher claims than non-smokers.

Stress

There is no doubt that stress is a factor in many health problems. It can complicate conditions like high blood pressure, heart disease, migraine headaches, and sleep disorders. According to the Express Scripts 2001 Drug Trend Report, antidepressants are the second most used therapy class. This report also states that the September 11 terrorist attacks led to a rapid escalation in the numbers of prescriptions for anxiety medications across the nation.[13]

Having placed such heavy financial burdens upon the insurance industry, American citizens have reached the point where they may have to dip into their own pockets to pay part of the costs, and they are all screaming "foul!" But what can be done?

Traditional Methods of Cost Reduction

Employers have utilized cost-shifting methods by increasing co-payments, deductibles, and coinsurance, as well as increasing employee premium contributions. Additionally, employers are trying to cut costs by either reducing or eliminating benefits. As an example of this frustration, the Target Company has reportedly dropped paid vacation and health care benefits entirely for part-time employees.[14] Wal-Mart makes new hourly workers wait six months to be eligible for benefits, and then offers plans with deductibles that range as high as $1,000—triple the norm.[15] According to surveys, many more companies in the United States expect to follow suit.

Other additional avenues of cost management are negotiation for higher discounts, utilization review, and case management. Wal-Mart has been using a team of six people to scour every state for the lowest-cost networks of doctors and hospitals.[16] Not every employer has the resources to accomplish such a task.

Yet, all these methods have failed to *permanently* make a dent in the overall problem of increasing health care costs. The balloon has already been squeezed as tightly as possible. Many employers feel overwhelmed by the intensifying demands being placed upon them. There seems to be no escape. Insurance companies have instituted utilization review, tried point of service arrangements, network discounts, disease management, standalone discounted prescription drug cards, and anything else that is attractive and sells. Due to privacy issues, employers are unable to obtain adequate reporting and claims information in order to manage generally the second- or third-highest expense they have: health insurance.

THE PRESCRIPTION

What can be done to heal this situation? The solution involves a combination of employer assistance (such as wellness programs) and employee/consumer responsibility (consumer strategies).

Medical Association recently revealed that at least 25 cents of every health care dollar is spent on the treatment of diseases or disabilities that result from potentially changeable lifestyle behaviors.[17] Dr. John Schaeffer, shareholder at North Ohio Heart Center in Elyria, Ohio, has speculated that unhealthful lifestyle habits may comprise as much as 40 percent of claims dollars. It is obvious that there is something that can be done to significantly reduce health care costs, simply by a concentrated attack on this very area. Voluntary wellness programs with incentives to join may be a solution. Once launched, the wellness program will identify those at risk via health screening. The targeted group will then need assistance in taking corrective measures, which often involves difficult behavioral changes.

Wellness Programs

The wellness program focuses on the fact that those who choose *not* to correct fixable problems are those who will most likely cost the plan the most. For those who do participate, HIPAA laws specifically allow for a decreased premium contribution to be charged.[18] To be a bona-fide member of the program, the employee must submit to the screening and if/when directed to an appropriate class/program, will have to reasonable attempts to complete it.

The incentive to join the wellness program can be approached from a positive standpoint (*i.e.*, a credit towards the employee's medical premium contribution) or a negative one (*i.e.*, a direct penalty charge or an additional premium contribution for non-participation).[19] If a claim is a result of a behavioral pattern, logically, the employee should be required to pay more. Businesses that promote wellness among their health plan members may realize a four to one return on their investment, according to Dr. Jeffery Burnich.[20]

Further incentives involve recognition, contests, or other rewards to help reinforce the task. A concentrated program targeting each risk component lasting four to eight weeks with a final evaluation to measure results is sufficient. Structured programs are necessary. With the busy American lifestyle, one more thing to do is usually not at the top of the list. Motivation to make health a priority is enhanced if employees are educated on simple ways to take corrective measures and make good health choices throughout the day.

Generally, a wellness program begins with a health screening to identify those with lifestyle situations that need attention. The screening consists of blood tests, height and weight check, blood pressure, and family history. The tests are taken by a health organization that can maintain and organize the data collected and ensure confidentially. If disease management is available through a preferred provider organization (PPO), third-party administrator (TPA), or insurance company, it will serve to supplement the screening for identification purposes.

According to their test results, employees should be directed into the appropriate mandatory target program(s) such as:

- Stress management. Utilize an Employee Assistance Program.

- Weight management. Offer weight loss programs such as Weight Watchers and physician monitoring.

- Physical fitness. Offer exercise classes to teach employees how to stay fit in realistic ways.

- Nutrition. A dietician can help educate employees how to buy and prepare healthful food.

- Medical self-care. Provide a 24-hour nurse hot-line to make valuable information available to insureds, answer their questions regarding health and care, and cut down emergency room costs and misuse.

- Smoking cessation. Interventions directed towards individual smokers increase the likelihood of quitting smoking.

Smoking cessation could include advice from a health professional, individual and group counseling, and pharmacological treatment to overcome nicotine addiction. The effectiveness of nicotine replacement therapy (NRT) is about 1.5 to 2-fold higher than quitting without NRT. There is promising evidence that Bupropion may be more effective than NRT (either alone or in combination). However, its most appropriate place in the therapeutic armamentarium requires further study and consideration.[21] The American Cancer Society and Heart Association have anti-smoking campaigns, educational classes, and trained experts to inform employees.

The complexity of the law must be taken into consideration when implementing the program. For example, HIPAA does not require the person who attends the weight program to actually loose weight, or the person who attends the smoking-cessation program to actually quit smoking, but they *can* be required to continue programs indefinitely if goals are not met. However, the employer must be cautious because obesity and smoking can be considered to be a disability. Smoking is an addiction and obesity has been declared to be a disability. Should an employer discriminate against these people, they could find themselves in the middle of a lawsuit under the Americans With Disabilities Act.

The screening will often reveal a problem for which no program has been designed or is sufficient to address. In this case, there should be a referral to a physician. For example, a person who has high blood pressure should be referred to a primary care physician. When this happens, a form is provided for the doctor to complete, proving that the person has been seen and giving the doctor the opportunity to list on the form any recommendations to improve health. The form is then submitted to the wellness program administrator, who would be responsible to communicate screening results and any requirements and monitor compliance.

Consumerism

Surprisingly, there is reportedly a significant amount of "fat" in the health care system. Many health care providers who offer indifferentiated services have significantly different costs. Generally, in-hospital MRIs are

more expensive than obtaining the same procedure at a freestanding facility, as are lab services, and so on. Different hospitals may perform appendectomies, deliver babies and fix broken legs, all at significantly different

Figure 1. Case Mix Adjusted Average Hospital Stay Charges

Case Mix Adjusted Average Hospital Stay Charges
Emerald Health Network Contract Rate Per Admission

Provider	Days	Total Charges	Case Mix Rate Per Admission
A	179	$388,968	$3,642
B	421	$1,248,305	$5,180
C	306	$818,659	$5,525
D	93	$261,612	$5,865
E	185	$775,242	$5,910
F	551	$1,591,079	$6,534
G	277	$830,248	$7,907
H	677	$3,426,961	$10,264

costs. Yet each facility has excellent capacity to deal with these problems. The procedure is the same; only the cost is different. Even though Hospital A may offer a 50 percent discount, Hospital B a 40 percent discount, and Hospital C a 15 percent discount, Hospital C *may very well be the most cost effective* if the original price charged for a particular procedure is lower than the others. It should be noted that Hospital C may be just as qualified as Hospital A in the performance of the given procedure.

Some procedures *should* be directed to the facility best equipped to handle them, regardless of price charged and discounts. Procedures such as organ transplants and cancer treatment should be directed to the facility with the best reputation for treatment in the area, without compromise.

The average layperson has little ability to discern which facility to use. Therefore, the proponents of Health Reimbursement Accounts (HRAs) must be asked how the member, even though he or she will be using some of his or her own dollars to pay the bill, will know the best place to go for services. What if the member's Doctor recommends an MRI at a hospital convenient for the doctor, without regard to cost? Should the member know to take the initiative and insist on a referral to a cost-effective, freestanding clinic? The member will only know these things with the help of his employer, and the employer will only know these things with the help of its TPA, PPO, and other resources that have the ability to perform a cost study of area facilities. How does the member know, when he or she is transferred to a tertiary care center, that the MRI and other diagnostic tests he or she already had done were not transferred, and that the tests at the new facility were duplicated and unnecessary? These wasteful practices that exist with-

in the system require professional management. PPOs should limit the number of participating physicians so that they can be managed more easily. Case management personnel should become much more active in working with primary care physicians to help reduce duplications and other inefficiencies, thereby reducing costs.

What about the cost of these alternative programs? The cost of a complete wellness program is generally non-existent due to the fact that many employees will refuse to participate, especially the first time around, therefore paying 20 percent higher premium contributions. Consequently, they not only pay for the program, but also make it profitable for the employer to offer the program as well as purchase expert management of it. Furthermore, with proper direction to the least-costly facilities, the employer will obtain more direct and immediate savings that enhance the cost picture.

The *real* reward however, is a few years down the road (unfortunately difficult to prove conclusively), when "Harry" never had the heart attack he was heading for, saving the company $60,000. Perhaps cancer, liver disease, lung disease, hip replacements, and more have been avoided because of the wellness program. This is where the large savings will occur. The best way to reduce the cost of the claim is to preempt the claim and thus never incur cost for it.

IMPLEMENTATION

Admittedly, it is a rather sizeable task to implement a full-scale wellness program. Experience has been gained with a model client, North Ohio Heart Center, a group comprised of over 30 cardiologists, just as many primary care physicians, as well as technical and other staff. This client is to be commended for its innovatory spirit in the effort to control costs as well as benefit its employees. It has proceeded with recommendations and incentives for employee participation and recognizes a responsibility to be trendsetters and examples to their patients and the community.

Two years after implementation, the wellness program can be a struggle to maintain. It is important to continue to coordinate meetings, have brown-bag lunches, keep the "wellness" idea in the forefront of employees' minds through posters, newsletters, and other promotions. These are all important facets of the program. Most human resource directors who enthusiastically embark upon the program get overwhelmed, bogged down with other things, or simply do not have the ability to keep it going. Although it requires time, it is not brain surgery. In the long run, it is prudent to hire professionals who specialize in wellness programs to promote and take responsibility for all the logistics that ensure success of the program.

RESPONSIBILITIES

Each of the "players" in the game must examine its respective responsibilities and take action.

Employers

When it comes to health care, the employer is, in many circumstances, looking at its second- or third-largest line item expense. Yet, very few have managed to be pro-active about it. The employer complains about the cost, threatens to cancel the program (knowing that that cannot be done if the employers want to maintain employees), and refuses to get involved in the management of the plan. It is time to make a change.

Agents

Agents are at a crossroad where they could either make themselves obsolete, or become invaluable players in this game. Agents make phone calls, get appointments, obtain census data, shop for quotes, spreadsheet the results, and finally present it to the client so that the employer can select the best overall plan. Through the course of a year, agents take clients on a couple of golf outings, a few lunches, collect 3 to 4 percent of an ever-increasing commission and feel that they have done a good job. Yet that is not enough. The agent is in the best position to work as a liaison between the other players so as to create such programs and manage health care. It is time to create a new paradigm.

Third-Party Administrators

TPAs pay claims. As a by-product of paying those claims, they create volumes of valuable data that is often ignored or superficially blended into a few bar graphs and pie charts, without recommendations. Ironically, it is difficult for some TPAs to give total cost of a newborn's delivery (ob, hospital, sonograms, blood tests, and other components attributable to maternity), which makes it impossible to measure the efficiencies of hospitals and impairs the ability to design and develop various programs to address those concerns. They often provide questionable utilization review services and other revenue-raising devices to negotiate lower discounts and call themselves consultants. It is time to utilize the valuable information that is available.

Preferred Provider Organizations

PPOs have served their purpose. They have contracted all the physicians in the world, negotiated discounts, provided complicated contracts, shared some of the discounts with the employer while keeping some of it for themselves, then have called it a day. It is a shame that although the TPA and the PPO have valuable medical and prescription drug information that

would not only help employers keep their costs down, but also help health care facilities to operate more efficiently, this important information remains in the "uncharted waters" of their computers. It is time to do more to help manage increasing costs.

Employees

Employees are responsible for their own life and health. They need to be taught to take as much care in purchasing health care as they do for personal purchases. Many will go to great lengths in order to save a few hundred dollars on the purchase of an automobile or put themselves through amazing inconveniences to save a few dollars on airfare. The same care should be taken with health care purchases. There are decisions consumers have the freedom to make when spending their own money, and a consumer may be willing to spend more for certain conveniences or "superior" service. As with other goods and services, if consumers wants "more" or "better," then they will have to be willing to sacrifice more of their own hard-earned dollars.

SUMMARY

For a myriad of reasons, costs in the health care field are soaring. Employers are in a position to design and implement health care programs. Clients such as North Ohio Heart Center are to be commended for pioneering such a well-rounded wellness program with incentives such as discounts on premium contributions. As those who sell health care services, the agent is in a strong position to promote and create reform. Employees/consumers can do much to improve their own health and not incur claims. With employer assistance in identifying health problems via screening, and TPAs and PPOs providing appropriate disease treatment and useful reports, members can be identified and helped by professionally designed wellness programs.

The employee who does not wish to do anything to promote his or her own good health or who wishes to be comforted with the greatest level of convenience and perceived quality of health care, may do so; the employer will allow the employee to make that decision and will even be willing to SHARE in the additional cost! But, that sharing will take place through additional premium contributions to the employee who does not choose to participate in the wellness program, and through additional coinsurance if the employee chooses not to participate in the consumer program by utilizing network providers.

Health care professionals and PPOs can do much in determining which facilities to use and eliminating waste in services. Health care is an area that must be managed in the same way that inventory expenses,

accounts receivable, and accounts payable are managed. Making health care purchases wisely could save the system.

NOTES

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