# WHITE PAPER . . . Lowering Your Medical Rates by 10 to 20%

by Allan Checkoway
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## Note the following headlines:

→ Double digit medical insurance rate increases continue in 2011

→ # of obese adults doubled- between 1980 to 2000

→ Incidence of diabetes in 6 years (1997 to 2003) increased 41%

→ Dupont wellness study: "excess" illness costs $2,463/ee/yr

→ Wellness & the importa of benign discriminati

Lowering Your Medical Rates by 10 to 20% . . . Is it possible? Absolutely! Without risk? Yes. Double digit medical rate increases are expected to continue into 2012. Under the "rule of 72", it'll cost over $1,000/month in 7 years to insure a single employee under a traditional HMO program. CFO's are asking "where's that money going to come from?"

Employers ask every year at renewal time "when will it end?" *Today* is my answer but first, let's consider some relevant data. A recent study identified that **36** percent of insured employees and dependents have **minimal claims** (limited to physician visits and RX copays). Another **56** percent have claims up to **$500** in a calendar year, while only **14** percent have claims exceeding **$500**.

One medical insurer recently reported 80 percent of their claims in dollar amounts come from less than 10 percent of their insureds'. Therefore, we can assume there's an 80% probability that most employers (and their employees) are overpaying for their medical coverage. Employers end up subsidizing 20% of their higher claim employees by overpaying on 80% of their healthy employees.

HMO's tend to pool their rates for "cross sections" of employee groups, setting average prices. Those "cross sections" are dependent upon age, family status, zip code, SIC code (industry grouping), male/female ratios, all in incremental age groups. Unfortunately, such pricing doesn't allow for better than average claims/loss ratios on more favorable groups.

Within the same zip code area, let's say we have one company with well educated high earning professionals, most utilizing their health club memberships. Their cafeteria only offers healthy, low calorie lunches. Another group around the corner pays similar premium rates although there are numerous smokers, some overweight and several heavy weekend drinkers. They have similar premium rates as insurers have to spread premium equally amongst <u>all</u> groups with no method to recover any extra premium being paid by healthier groups.

### THE HIGH CONCENTRATION OF U.S. HEALTH CARE EXPENDITURES

Since we are experiencing substantial increases in the cost of healthcare, with no end n sight, it is translating to double digit medical insurance rate increases. Let's consider why this has occurred and, more importantly, is there anything we can do about it?

We know that actual spending of healthcare dollars is distributed unevenly across individuals, different segments of the population, specific diseases, & payers. Analysis of health care spending shows that five percent of the population accounts for almost half (49 percent) of total health care expenses. The 15 most expensive health conditions account for 44 percent of total health care expenses. Patients with multiple chronic conditions cost up to seven times as much as patients with only one chronic condition. This translate into
health care expenses in the United States rising from $1,106 per person in 1980 ($255 billion overall) to $6,280 per person in 2004 ($1.9 trillion overall).

### THE DIABETES EPIDEMIC - OBESITY A MAJOR FACTOR

"Diabetes affects tens of millions of people in the United States and costs about $174 billion each year in medical expenditures - <u>more than any other health condition</u>." Even worse, diabetes is the sixth leading cause of death in the United States. "Increasing evidence is showing that obesity and type 2 diabetes are inextricably linked, and rising obesity rates are fueling the growing type 2 diabetes epidemic."

We know that excess weight exacerbates health problems like high blood pressure and abnormal cholesterol levels in diabetes patients, often leading to heart disease and kidney failure, among other problems. Meanwhile, weight loss, even a modest amount, has been found to help people with diabetes achieve and sustain blood glucose control and live healthier, longer and more active lives.

### WAISTLINES EXPAND INTO A WORKPLACE ISSUE

"Among U.S. adults aged 18-79 years, the incidence of diagnosed diabetes increased 41% from 1997 to 2003". "And obesity is a major factor in this recent increase of newly diagnosed diabetes." Medical News TODAY

"Weight loss, even a modest amount; has been found to help people with diabetes achieve and sustain blood glucose control and live healthier, longer and more active lives." "Percentage of adults classified as obese doubled from 1980

to 2000 to 31 percent of the population." "Employers pay heavily for obesity's spread. Obesity accounted for 27 percent of the rise in medical costs from 1987 to 2001." New York Times 6/23/2008

**DIFFERENT GROUPS WITHIN A GROUP**

Employers have historically purchased coverage for their employees based on the perceived needs of an entire group, without regard for employee "segments". For example, in one 40 person group, we identified there were 14 that were in their 20's with 12 in their 40's, the other 14 were all 50ish. A 25 year old male rarely goes to his doctor so he doesn't need "1st dollar" coverage. Conversely, the 45 year old married couple with 2 children in the emergency room every other month needs more comprehensive coverage. Point being, we can have two or three groups within the same group from a needs perspective. The all important question we ask is, how do we satisfy the needs of each group at the same time?

**DOUBLE DIGIT RATE INCREASES**

Up to this point in time, how have employers generally been dealing with double digit rate increases? The "norm" has been to utilize higher copay plans to diminish the impact of say a 12 percent renewal increase. If there's no hospital copay currently, the employer utilizes a $250/in hospital copay to reduce the 12 percent to 4 percent. If there's already a $ $250 hospital copay, then the next move might have been to increase the hospital copay from $250 to $500.

How long can this continue and WHEN DOES IT END? The problem with this approach is that eventually we end up with no place to go. Sooner or later we need to "dig in our heels" and create a business plan to better manage our healthcare dollars.

**THE NEW "GENERATION" OF SELF FUNDING**

Given that 71 percent of employers with 2500+ employees are already self funding, are their any self funding options for smaller companies? Yes, dependent on several factors. You need to ask, are you dissatisfied with double digit rate increases, suspecting your employees are not heavy utilizers of medical care? Are you willing to accept some risk in exchange for the potential of saving premium dollars? Are your employees generally healthy and not an "older" group? Is your company profitable, or on the road to profitability, possibly in a growth mode? These are just some of the questions that you'll need to answer before taking on the risks, and potential rewards, of self funding.

It's important to note that employers are now becoming more proactive in controlling skyrocketing medical insurance rates with formalized wellness programs. The Dupont Corporation recently discovered that "excess" illness (employees not taking care of themselves) was costing them $2,463 per healthy employee annually!!

You may well be an excellent prospect for self funding, especially the "new generation" self funding that is tied directly to a wellness program. More than 81 percent of U.S. businesses with 50+ employees already utilize some form of wellness program. The most common types focus on exercise and health club memberships, weight management/nutrition, smoking cessation, stress and disease management. Many of these wellness programs are promoted by the insurers themselves. Yet, we need to look beyond traditional wellness programs towards the "new generation" of wellness programs tied directly to a self funding program. But, more on that on another day as this WHITE PAPER is on cutting medical premiums 10 to 20% in "general terms".

There's no "one size fits all". Many of our readers are not in a position to risk self funding due to the size of their business or just the inherent financial risks themselves. At this point in time, is there any way the smaller employer can create a business plan to better manage their healthcare costs TODAY and in future years? YES.

**HIGH DEDUCTIBLE PLANS**

Seek out an insurer who offers a menu of high deductible ($1,000 and more) medical plans. We then can replicate the risk-sharing of self funding with this "new breed" of high deductible medical plans. At the same time, we can fund the deductible via a *Personal Spending Account* via a Third Party Administrator (TPA). The deductible ($1,000, $2,000 up to $5,000) is administered by a TPA that reimburses each employee for their deductible amounts partly or in full.

**Caution!**

We want to add a cautionary note relative to the "new breed" of high deductible medical plans packaged with a *Personal Spending Account*. As much confidence as you might have in your insurer, you're also placing your trust in a TPA as they'll be interfacing with your employees. Since the "new breed" program is a departure from your employees comfort zone, make sure you're dealing with a highly regarded Third Party Administrator.

**THE BOTTOM LINE**

Comparing the cost of a high deductible program with a traditional $250 hospital copay plan can save upwards of 15 to 30% in premium contribution. That savings is more than adequate to fund the "shortfall" created by the deductible. The key to the "new generation" concept is that the deductible is funded with the employer's savings through the *Personal Spending Account,* making high deductible plans beneficial for both employers and their employees.

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