Riding the Health Care Roller Coaster

Large claims are the latest spike in costs to jeopardize a Florida multiple-employer health plan. See how the group's leadership intends to ride out the current crisis.

By Mark Weinstein and W. David Heron

Nine Florida higher education institutions that banded together in early 2003 to form a multiple-employer health plan have had a wild ride. Using numerous consultants for guidance, the institutions set up the Independent Colleges and Universities Benefits Association (ICUBA) and positioned it as the umbrella organization under which to run the self-funded employee health insurance program. Unfortunately, the schools quickly experienced financial difficulty resulting in more than $9 million in assessments required by the state insurance office to fund the program.

The torturous recovery from this early setback resulted in the loss of one institution from the plan and the total redesign of the health care package after only one year of operation. What brought the plan back from its roller-coaster plunge was the move from a traditional, open-ended, preferred provider organization (PPO) model to the current health reimbursement arrangement (HRA)-based, consumer-directed plan. The revised plan offers a traditional PPO option plus two high-deductible choices, with employer-provided HRA contributions to help offset the deductibles. The timely application of this change brought the program back to a level track, transforming early losses of more than $3 million to a capital surplus of approximately the same amount.

Our previous article, in the July-August 2006 issue of Business Officer ("Battling Health Care Costs: Round II." at www.nacubo.org/x8301.xml), describes
ICUBA’s recovery from the first-year financial train wreck, at which time we reported a $5.6 million loss for the year ending March 31, 2004.

The following actions allowed us to achieve that turnaround:

- Adopting high-deductible health plans (HDHP).
- Negotiating better provider discount rates through Blue Cross and Blue Shield of Florida (BCBSFL).
- Designing a benefit plan that promotes prevention and encourages all beneficiaries to seek care at low out-of-pocket cost.
- Using an HRA that steers employees to HDHPs.

Since the recovery of the plan throughout 2004 and 2005, two additional institutions have joined the consortium, and a third school enrolled on Jan. 1, 2008.

From a fledgling organization with little experience and low expectations, ICUBA has grown to become a seasoned juggernaut in the Florida marketplace, representing more than 6,900 employees and more than 11,200 lives.

As we approach the future, however, we are facing another organization-threatening challenge.

**Large Claims Could Pose Fatal Risk**

While ICUBA has been able to keep insurance premium increases flat over the past five years, premium amounts increased by about 15 percent for year six. ICUBA’s 2008 plan year that ends on March 31, 2009 (see Figure 1 for a summary of monthly premium charges since the plan’s inception). This increase is caused by two events: (1) the growth in the rate of “large claims,” which we define as an amount paid on behalf of any one medical—prescription drug plan beneficiary that costs ICUBA more than $50,000 in any fiscal year, and (2) general medical insurance trends that relate to aging population, improved and more widespread medical technology, inflation factors, and lack of compliance with evidence-based protocols. With no new discounts and little remaining migration to HDHPs, which already cover more than 10,000 people, we are left with no tools with which to mitigate the costs of large claims in addition to the average 8 percent premium increase already being driven by these general trends.

Since little more can be done about general trends, we’ve focused on larger claims as an area where we might achieve the most improvement. Despite the cost reductions realized by earlier plan modifications, the rate of large claims is on the rise. During the first three years of the plan, large claims averaged 4.4 per thousand insured. In the past two years, that number jumped to 7.5 per thousand (see Figure 2, which shows recent dramatic increases in large claims). While the size of each large claim has remained rather constant due to the strong BCBSFL provider discounts (which we explained in our 2006 article), clearly we are experiencing more large claims overall.

The impact of the higher numbers is dramatic. Those additional three-thousand beneficiaries translate to at least a 7 percent increase in premiums that ICUBA must charge on top of the 8 percent caused by general trends. Should the higher number of claims persist, the estimated 7 percent annual increase in premiums would become permanent.

Such a spike in claims is what keeps benefit plan administrators—like the management staff at ICUBA—up at night. Clearly, in order for our health care plan to remain viable, large claims must be kept to a minimum. We predict that for each additional large claim per thousand, ICUBA needs to raise premiums by about 2 percent. Put another way, every 10 new large claims represent a payout of about $820,000 (assuming that each claim averages $82,000)—or about 2 percent of ICUBA’s total annual plan premium of $43 million.

Looking at large claims from this perspective demonstrates the financial risk to ICUBA, as a self-funded, medical—prescription drug insurance pool. Managing for the reduction of large claims is demanding; and, if we don’t get it right,
ICUBA could get hit with a deluge of claims. That means higher premiums, which could result in our plan no longer being a viable, competitive option for current or future member employers.

Gaining Insight by Analyzing Claims
The ICUBA Board had been enjoying its health plan’s positive trends from mid-2004 until the third quarter of 2006. It was then that the rate of large claims increased significantly. The spike to 7.5 claims per thousand was an increase of 70 percent over the average increase of the prior three years.

Since that time, we’ve spent many hours trying to understand the increase and considering how to mitigate the problem. Initially, some members wondered why a premium increase hadn’t been applied to premiums paid to ICUBA from April 2007 to March 2008. Because that did not happen, the increase for April 2008 through March 2009 represents a much higher percentage than one that would have resulted from an incremental increase along the way. It would seem, however, that board members concerned that we did not hit the mark on setting premiums last year are being too harsh. Looking back at the process, at the time that April 2007 rates were set, the large-claim rate had increased for only the five months ending November 2006. The rate for the previous 39 months (ending June 30, 2006) had remained at 4.4 per 1,000, and the significant increase in premiums was not something the ICUBA Board was interested in pursuing. (At that point, the large-claim rate was high for only 5 of the prior 44 months.)

Our new reality is that ICUBA employers must continue to raise premiums as long as the large claims remain high or rise even more. Our job is to figure out how to stabilize large claims.

The board started the process by reviewing claims data. Not surprisingly, a number of the claimants had recurring cancers or chronic conditions requiring ongoing and expensive treatment. In any given year, other people became part of the large-claim group, such as transplant beneficiaries, cardiovascular patients, those with musculoskeletal problems for which one-time surgery might be required, and premature babies who required long-term care.

Understanding the source of the large claims, we saw clearly that the prevention and mitigation of these claims would be the most difficult component of plan administration. For ICUBA to continue to grow and be successful, we knew that we must work with our member employers to adopt a strategy to prevent the occurrence and prevalence of large claims. In order to hone in on this strategy we identified the following trends:

- Almost all large-claim cases were from patients who did not seek proper evidence-based care earlier in the same year that the large claims were incurred.
- Overall, 40 percent of all insured people did not access any medical care services, including low-cost preventive services.
- Fifty-five percent of all insured people were not receiving preventive services recommended by the U.S. Preventive Services Task Force, such as physicals, mammograms, colorectal and prostate screenings, lipid panels, and glucose testing.

Initial Ideas
Accordingly, the board adopted a more aggressive approach to the large-claim problem. The approach featured three strategies:

Managing for the reduction of large claims is demanding; and, if we don't get it right, ICUBA could get hit with a deluge of claims.
1. Initiate a disease management program to promote better care for people with chronic conditions. We attempted to minimize variation from best practices by using a shared decision-making model that includes health plan nurses and patients and encourages patient access to services. We identify patients eligible for the program by using predictive modeling systems to prioritize those patients with the best chance for improvement through engagement. This program is available 24 hours a day to provide unbiased, evidence-based information in multiple formats and languages. In addition to the five core conditions (coronary artery disease, diabetes, congestive heart failure, asthma, and chronic obstructive lung disease), more than 30 other conditions are supported. About one in seven people that we insure participates in a disease management program, and about a third of these people are participating in more than one program. We have evidence of positive outcomes from program participation.

However, we are unconvinced that a disease management program that relies on telephonic interaction can be as effective as an on-site version. We are currently evaluating such models, while realizing that, with more than 20 work-site locations—some servicing very few employees and families—it will be difficult to make such services available equitably to all people insured.

2. Adopt a strategy to encourage use of low-cost prevention benefits so that employees and their families find medical problems early, when they are best treated. To encourage early and effective treatment, there is no deductible on any ICUBA health insurance plan for physician office visits, outpatient mental health visits, physical and occupational therapies, prescription drugs, or emergency care services. To promote use of prevention benefits, all services recommended by the U.S. Preventive Services Task Force are provided at no out-of-pocket cost to the patient. In addition, the plan offers free employee assistance and advocacy services; care coordination; and health newsletter that addresses health concerns.

To monitor and treat patients, care coordinators include caregivers and physicians in helping patients and families understand diagnoses, treatment options, and the patient's responsibility in the process. We anticipate that patients will be able to manage their treatment benefits much more effectively through participating in the care coordination process.

We also recognized that adding more employers with younger, healthier populations would be a way to reduce the large-claim rate. However, the reality of ICUBA is that our participant population, being in higher education, is generally older than that of other industries—and older employees are less likely to leave their

ICUBA must continue to work on the underlying causes of large claims by focusing on prevention and mitigation.

3. Work with BCBSFL care coordinators to engage as many patients as possible with claims totaling more than $25,000. For the first six months (April 1, 2008, through Sept. 30, 2008) of the current plan year, we engaged 55 of the 66 people with claims of more than $25,000, and 26 of the 28 people with claims of more than $30,000. Almost all of these people experienced one or more of the following: cancer, cardiovascular disease, musculoskeletal problems, transplant needs, or premature deliveries. Employers and spouses ages 45–64 have accounted for about 37 percent of ICUBA enrollment and 55 percent of claims cost. As a result, ICUBA is now focusing on recruiting private education employers in the primary and secondary education market that may have a more favorable age demographic.

The board also explored the possibility of shifting its large-claim population to a third party. However, further research determined that it would cost at least 10 percent more per year—or about $4 million—to do that. In other words, continuing to self-fund the risk made more sense than shifting the program to a fully insured basis.

In the end, ICUBA and the employers that comprise it are in the unique position to provide the best employee health insurance benefits possible—better on a group basis than employees would receive in the
marketplace by themselves. However, it's clear that ICUBA is best able to provide health insurance benefits for those who incur claims totaling less than $50,000 per year. We are not well prepared to deal with the extreme difficulty of assuming the responsibilities associated with insured individuals who have catastrophic claims in any given year. The quality of care and assumption of financial responsibility for large cases is too great for an organization the size of ICUBA to effectively handle.

Fortunately, President Barack Obama's health care proposal supports the ICUBA employer-based model by making investments in health information technology, prevention, and care coordination. Further, its proposal creates low-cost regional insurance pools that cover 75 percent of the risk associated with catastrophic claims, as long as the employer commits to prevention and care coordination services. Of course, we welcome the implementation of this pool.

Additional Complications

Some members of the ICUBA Board, whose institutions have experienced a low percentage of large claims, have voiced concern about raising premium rates. After all, the HDHP at their particular schools register loss ratios below 100 percent, which means they are still contributing more premiums to ICUBA than claims paid, administrative load, and other expenses associated with providing employee benefits.

In response, ICUBA management noted that, even for employers with low rates of large claims, the lower rate will only continue if the employer over time adopts a strategy to control the large claims that will inevitably increase as the insurance pool ages. When that happens, PPO premiums will become more expensive, and that increase will find its way into the high-deductible plans as more people with large claims move to the HDHP because of the significantly lower premium.

In the end, ICUBA must continue to work on the underlying causes of large claims by focusing on prevention and mitigation. While we do that, we have convinced these particular employers that they have the best long-term opportunity to manage their large claims by collaborating with ICUBA.

Other Approaches to Large-Claims Risk

Although consumer-directed health care continues to be an important component of ICUBA's success, we have seen that in itself it is not quite enough. ICUBA must also continue to pursue value-based integrated plan design strategies. That is, ICUBA must evaluate activities not only with regard to their financial impact in the current year, but with a focus on their long-term value. For example, free mammograms and colonoscopies may cost more in the current year yet actually save more if early detection or preventive treatment means that dozens of people avoid expensive cancer treatments later on.

An integrated strategy benefits from all components and elements of the health plan working in concert. For example, the pharmacy benefit manager who works closely with medical carriers and behavioral health providers helps ensure that a holistic program gives an individual with diabetes the medical, pharmaceutical, and behavioral support he or she requires to most effectively and most economically accomplish total overall health.

ICUBA has been employing such an integrated plan for about as long as the consumer-directed health care model has been in place. Plan participants receive free wellness benefits, $25 incentives to complete health risk appraisals, no deductibles applied to the pharmacy benefit or ambulatory care treatments—and free behavioral health visits are included in the Employee Assistance Program.

More, however, needs to follow. For example, the board is considering additional monetary relief for large-claim participants who take advantage of the integrated program, free on-site physician visits to encourage compliance with medical protocol, free pharmaceuticals for patients following verifiable best-practice treatments for diseases like diabetes, and no-cost behavioral health visits for patients on psychotropic drugs. The board believes that these are the right programs to implement because of the challenges regarding the way ICUBA generally incurs health care expenditures. Here are the related facts:

- Forty percent of health care costs can be affected by the behavior of the patient.
- Patients receive correct treatment in the physician's office only about 54 percent of the time.
- More than 30 percent of health care costs actually lead to no improvement in quality outcome.

Nearly 9 in 10 people with Type 2 diabetes can prevent or delay onset with a combination of diet, exercise, and drug therapy.

At the same time, we recognize that part of integrating a somewhat disjointed medical care treatment program is to facilitate vendor partners working together. We are making progress on this front by having no less-frequent than quarterly vendor partner meetings that include ICUBA's medical carrier, pharmacy benefits manager, behavioral health provider, stop-loss carrier, and others. As important as getting all the vendor partners in the same room to operate as an integrated team are the services of a database warehouse vendor partner that we've retained. The idea is to bring all the health plan data together to assist in decision making. The database is to be used to demonstrate or identify the following: (1) work sites where health improvement is necessary, so that work-site programs reflect specific needs identified; (2) work sites where people are getting healthier, so that we can determine how we can replicate the success; and (3) ways various work locations are using prevention benefits, so that we can tailor communication to improve benefit use.

To provide benefits in a patient-centric fashion, it is important for all providers of service (medical, drug, and behavioral) to work together, using the aggregate database to share information on how to improve services to the patient. By working together, our vendor partners have been able to collaborate to accomplish several improvements in delivery of benefits to employees and families.
- Increase generic drug use from 54 percent last year to about 59 percent currently. This equals a savings of about $9 per insured person per prescription per month. We were able to achieve this milestone by engaging physicians in prescribing generic drugs, sending consumers information as to how they can save money by buying generics, making sure that all providers of service understand the economic incentive for patients using generic drugs, and requiring patients to deliberately rule out use of a particular generic drug before the brand-name drug is dispensed.
- Create the ICUBA Cares program to improve health services such that employees and families are more engaged as consumers and patients. This program is designed to provide broad access to services, encourage (or provide incentives for) early access to services, educate patients to make the best choices of service providers, enhance quality through following evidence-based medical protocol, and achieve a sense of real value in how health care services are accessed. Currently the vendor partners are working on better diabetes treatment that affects 4 percent of the people covered by ICUBA who also consume 15 percent of total costs. Efforts include bringing together the medical, prescription drug, and behavioral health providers to better treat people with diabetes.
- Conduct health fairs at all employer work locations to give service providers face time with employees and families. This allows vendor partners to directly engage with plan participants and to encourage access to services provided. These health fairs have allowed us to triage employees and families based on risk factors identified through health risk appraisals and biometric screenings. Many employees have been reached this way when other vehicles for interaction have failed. Several employees with high blood pressure or high blood glucose were sent to physician offices right on the spot.

At this point, we cannot predict the overall effectiveness of our cost-containment efforts—or what, when, or how new health care policies might affect the cost-benefit dynamics of the ICUBA health plan. What we do know is that we’ve taken this roller-coaster ride before and survived to take another run. We’re hoping that the right combination of planning and circumstance will let us avoid another precipitous plunge.

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