

what's working

cost-containment efforts
paying off



*Ken Stuart
Administrator and
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San Diego Electrical Health
and Welfare Trust*

Over the past three years, the San Diego Electrical Health and Welfare Trust's hourly cost to fund its main health plan has declined by .5%. Over the last ten years, the trust's cost has increased an average of 3.8% annually—about a third of the national health care cost trend. In addition, the average monthly claims cost per employee has declined for three years. All of this has occurred with no reduction in benefits.

"We've made ten to 15 plan changes in just the past three years to contain costs," said Ken Stuart, administrator and chief financial officer of the trust, whose health and welfare plan covers about 5,000 lives in San Diego County, California. Among the most important changes are:

- Participants are steered to the highest quality providers by using tiered physician networks.
- A service contract gives participants the ability to seek expert validation of a diagnosis and/or treatment plan. An incentive encourages use of this service.
- The disease management (DM) program has been strengthened with incentives and a biometric monitoring component.
- About two years ago, a dependent verification program was rolled out.
- Looking for fraud, waste and abuse, a third-party vendor screens claims that have already been screened by an insurance company that had approved payment. The third-party screening occurs before claims are paid. This has generated further savings of 2-3%.

The theory behind the first two changes is "let's get it right from the beginning—first, by seeking out higher quality providers and second, by making sure somebody is checking what the patient is being told," Stuart said. "Our goal is for our participants to receive optimal medical outcomes at the most reasonable price, which benefits both the patients and the plan."

San Diego County has only two major health systems. The fund, working with the California Coalition of Employee Benefit Plan Sponsors, identified which system delivers higher quality care with better outcomes. For an office visit at the preferred health system, a participant's copay is just \$10. The copay for all other preferred provider organization (PPO) providers in the county is \$30. Within six months after instituting the differential, utilization of the featured provider was 40% higher.

"We know that if we can get people to the right doctor, we're halfway there," Stuart said. "And, if they end up going to a hospital in that health system, there is an expectation of higher quality, more appropriate treatment and a better outcome. There really isn't a lot of magic generating substantial savings in

this manner. It takes a willingness on the part of the trustees to make aggressive plan design changes and then sufficiently educating the participants so they make informed decisions as a means of best utilizing their benefits.”

The fund is in its second year of using a second-opinion service that uses nationally recognized physicians who collaborate with a participant's doctor(s) to review all medical records as a single case in order to come up with a correct diagnosis or what is believed to be the best plan of treatment. In the service's experience over more than 20 years, diagnoses change about 20% of the time; about 60% of the time a treatment plan changes. In fact, the service has found that 38% of recommended surgeries are unnecessary. In another 18% of cases where surgery is indicated, the most optimal procedure was not going to be performed. Stuart cited the case of a fund participant who was scheduled for spinal fusion surgery. The service's physicians recommended a less invasive surgery that was very successful and saved the fund about \$100,000. Over the first 18 months, savings on two cases alone covered the cost of the program for two years. Stuart added that “looking beyond the cases where a diagnosis or treatment plan is changed, there have been participants who have expressed their appreciation for being reassured a diagnosis and/or treatment is correct.”

Now, in the second year of the program, when a participant completes the consultation process the fund waives or refunds the participant's calendar-year \$250 deductible.

Disease Management

This January, biometric monitoring was added to the fund's DM program. Participants who are enrolled and engaged in the DM program are now connected via telephone to home monitors so health care professionals can detect patterns that may call for a medical intervention. The DM vendor also monitors whether a person is adhering to a prescription drug regimen. The in-home biometric testing costs the fund \$700 monthly. Alerts also identify gaps in

care and notify the participant and physician when necessary.

“The fund expects extensive savings due to early intervention and/or total prevention of what likely would be substantive and expensive medical episodes,” Stuart said.

The San Diego fund sends all its claims data to a DM vendor, which flags anyone with a reported diagnosis of one or more of five chronic conditions: asthma, coronary artery disease, diabetes, chronic obstructive pulmonary disease and heart failure. A new musculoskeletal program is being added. Incentives are used to encourage participants to use the DM program. Unlike many health plan sponsors, the San Diego fund offers the DM program on an opt-out basis, which Stuart believes accounts for a 70% participation rate versus 25% to 30% participation in opt-in programs. For participants enrolled and engaged in the DM program, all medications relating to the chronic condition or conditions now have a copay that is the lower of \$5 or 5% of the discounted cost.

“We started the DM program about five years ago and are seeing a return on investment of \$3.50 to \$4 for every \$1 spent,” Stuart said. “That's money that goes to the bottom line for the fund. It means employers have to contribute less, which in turn saves members' jobs.”

Dependent Audit

Stuart said that for a nominal investment, the fund recently conducted a dependent verification and ended up disenrolling between 30 and 40 people who weren't eligible to receive benefits. Each of these persons represented up to \$2 million in potential medical claims liability along with dental and vision claim exposure.

“Federal government statistics suggest a savings of between \$2,000 and \$5,000 a year for every dependent we disenroll who isn't really a dependent,” Stuart said. “And the word got out that we were checking.”

He thinks that given the unlimited liabilities imposed by the Affordable Care Act, the fund may save even more.



The board of trustees of the San Diego Electrical Health and Welfare Trust.

Claims Prescreened

There is a rule of thumb that 3% to 6% of total claims are paid to providers not entitled to them. The San Diego fund hired a third-party entity to prescreen all claims—after the insurance carrier screens them and indicates which claims should be paid.

“We still find a good number of claims should not be paid in accordance with nationally standardized code edits and application of usual, reasonable and customary pricing criteria,” Stuart said. “For our first nine months, the fund realized savings of 2% to 3% of total claims, which suggests that plan sponsors need to know that only properly billed claims are being paid by their insurance carrier or claims administrator.” Because the fund pays the vendor a fixed percentage of validated savings, there is no direct cost to identify such extensive savings.

The fund also paid for a transactional audit of prescription drug claims from January 2010 through June 2011 to verify proper payments in accordance with its pharmacy benefits management agreement. It used the results to negotiate a new contract to include more favorable language and pricing. The audit cost \$12,500; the savings have been more than double that, Stuart said.

Provider Quality

Locally, the California Coalition of Employee Benefit Plan Sponsors—in which the trust fund is active—is working on

a medical appropriateness program to identify the best local providers and give purchasers more clout. Stuart, the immediate past chair of the California Health Care Coalition (CHCC) board of directors, is a big proponent of putting more information about providers in the hands of purchasers to help them make plan design changes that will steer participants to the most highly recognized providers. He represents CHCC on the board of CHART, founded and led by Dr. R. Adams Dudley from the University of California San Francisco. CHART is striving to make hospital quality performance data more available to health care purchasers and consumers.

Stuart noted that the San Diego Electrical Health and Welfare Trust continues to have challenges—particularly in getting participants to take responsibility for their own health and wellness. For example, only 5% of eligible participants take advantage of the free annual routine physical exam the fund provides. And there still are the 30% of people with targeted chronic conditions who do not respond to or opt out of the DM program. The fund knows there is a 19% difference in average costs between people in the program and eligible people who don't participate.

Stuart thinks improving a health plan starts with trustees gathering as much information as possible from their plan's professionals to identify any and all programs and plan design concepts that may reduce costs without reducing benefits. Trustees need to be willing to invest plan assets in programs and plan design features that make use of high-quality providers so participants achieve the best medical outcomes at reasonable cost.

“It is important to keep in mind that when health plans and health systems negotiate their now mostly proprietary bilateral contracts, what is really being decided is how much their mutual purchaser clients are going to pay for services,” he said. “Therefore, purchasers must control their own destiny by maximizing their collective voice and making it clear to their health plans and/or local health systems that they are going to reward only those that deliver the best opportunity to achieve true value.” ■

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