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Hospitals and Health Systems:

An Inside Look at Employee Health Plan Strategies To Control Costs and Provide Access to Healthcare

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Highlights

Because of their dual role as benefit plan sponsor and provider of healthcare services, hospitals face a unique set of challenges when deciding how to offer medical and pharmacy benefits to their employees. Our research into hospital and health system benefit plan strategies has led us to several key findings:

1. Benefit plan costs for hospitals and health systems average 6 percent higher than other self-funded employers, primarily because:

   a. Hospitals employ more women, employees older than 40 and employees with chronic conditions than other self-funded businesses, which are sectors of the population that use the healthcare system more frequently than other groups.

   b. Some health plan design strategies selected to increase hospital revenue also resulted in higher employee benefit costs.

2. Hospitals and health systems generally use one of five distinct benefit plan design strategies when offering a self-funded PPO to their employees.

3. Using a health system's domestic network of providers can nearly double hospital revenue per employee, as compared to outsourcing the network to a commercial PPO that contracts with all of the health system's providers.

4. Despite their higher benefit plan costs, hospitals and health systems manage utilization with better compliance with preventive testing and disease management, and with an average length of stay that is 28 percent lower than other self-funded employers.

Background

CoreSource administers employee benefits for more than 700 self-funded employers across the United States. We used data from August 2007 to August 2009 from 65 hospital and health system clients to identify and compare benefit plan strategies, characteristics and utilization. The number of employees at these health facilities ranged from fewer than 100 to nearly 25,000, for an average employee population size of 1,400.

Purpose of the Study

Managing the financial performance of a hospital or health system requires balancing the need to grow patient volume and revenue with the need to control labor costs. Health systems, as payers on employer benefit plans, also need to balance their role as a key medical partner to physicians and other healthcare providers affiliated with the health system.

In order to pair the right benefit strategy with the right hospital or health system, we conducted an in-depth analysis to help better understand how hospitals choose strategies, why they choose them, and how they could reduce benefit costs.

The Study Focused on Three Key Areas:

Section 1: What benefit plan designs do hospitals and health systems use to address the dual role they face as a healthcare provider while also being the employer and payer?

Section 2: How can a hospital or health system determine the appropriate benefit plan strategy given its individual objectives?

Section 3: How do health benefit plan costs and utilization for hospitals' and health systems' members differ from other self-funded employers?

Section 1:

Benefit Plan Strategies Used by Hospitals

To build a health plan to meet their employee benefit needs and budgets, hospitals and health systems generally use one of five core design strategies, which are heavily defined by the value placed on promoting use of their domestic networks. The strategies below are listed from most aggressive to least aggressive in promoting the use of a domestic network:

- Domestic Preferred: Hospitals use this strategy to motivate employees and members to use the health system's own hospitals, clinics and other medical services to achieve the highest level of domestic network use possible.
- Direct Contracting: Hospitals maximize domestic network usage by contracting directly with affiliated physicians, local referral sources and other providers to fill any gaps in medical services, such as specialty cancer, neurosurgery or burn treatment, not provided by the health system.
- Financial Performance: Hospitals seek to motivate high domestic network use to drive higher health system revenue.
- Domestic Option: Allows employees and members to use the domestic network or other providers with a commercial PPO network with similar benefit coverage levels. Domestic network use depends on the reputation and services available from the hospital or health system.
- Outsource PPO: With this strategy, hospitals do not offer a direct domestic network but allow the market to set the hospital's reimbursement rates by outsourcing it to a commercial provider network.

The percentage of CoreSource hospital and health system clients that use each strategy, the traits of each strategy and incentives are shown in the following chart.

Benefit Plan Strategies

	Domestic Preferred	Direct Contracting	Financial Performance	Domestic Option	Outsource PPO
Percentage of Health Systems	*17%*	*22%*	*19%*	*22%*	*20%*
Network Strategy (Provider Rates)	• Domestic fees are 10% to 30% lower than commercial PPO • Average 15% higher savings rate than commercial PPO • 45% to 70% of domestic network utilization	• Domestic fees are 5% to 40% lower than commercial PPO • Average 10% higher savings rate than commercial PPO • Direct contracting to access gaps in tertiary services • 45% to 80% of domestic network utilization	• 10% to 30% higher domestic fees than commercial PPO • Average 17.5% lower saving rate than commercial PPO • Higher domestic network use drives higher benefit costs • 30% to 60% domestic network utilization	• 5% to 40% higher domestic fees than commercial PPO • Average 17.5% lower saving rate than commercial PPO • Use of domestic network depends on size of system • 35% to 65% domestic network utilization	• Outsource network benefit to allow market to set fees • No domestic network offered • 20% to 40% domestic network utilization
Benefit Plan Incentives	• 3-tier benefit plan • Domestic incentive: + 95% coverage + 10% higher benefit • 20% higher overall in-network benefit vs. non-network • Manage care for total population to control costs	• 2-tier benefit plan • + 85% coverage for domestic & other PPO networks • <10% higher overall in-network benefit vs. non-network • Prior approval program to manage overall usage of services	• 3-tier benefit plan • Domestic incentive: + 90% coverage + 13% higher domestic benefit • 20% higher overall in-network benefit • Open access to care – less utilization review	• 2-tier benefit plan • + 85% covered at domestic and PPO networks • <10% higher overall in-network benefit vs. non-network • Traditional care management used	• 2-tier benefit plan • 10% lower total benefit coverage than other strategies • 0% to 19% higher overall in-network benefit • Prior approval program to manage overall usage of services

Section 2:

How Hospitals Determine the Right Benefit Plan Strategy

To design an employee health plan for an individual hospital or health system, a number of factors must be considered, including financial objectives, local market dynamics, the culture of the employment market and organization, and optimal plan components. These important factors and other decision criteria, such as the aggressiveness of a hospital's domestic network incentive, can help determine the best benefit strategy for a hospital or health system.

Other Questions to Consider

1. Do employee health plans generate revenue or incur costs to be managed?

Hospitals and health systems offering a domestic network can decide how much they will pay themselves for the health services provided to members of the employee benefit plan. Some health systems want their health plan members to use the domestic network to generate revenue for the hospital. The Financial Performance and Domestic Option strategies increase revenue by reimbursing the domestic network between 5 percent to 40 percent more than a commercial PPO network. The Domestic Preferred and Direct Contracting strategies view the benefit plan as a cost, seek to control their employee healthcare costs and encourage use of the domestic network to control costs by reimbursing the domestic network 10 percent to 40 percent less than the commercial PPO network.

Why pay retail?
Some health systems charge their members retail, or the full cost for services without any negotiated savings, when using the domestic network because the higher employee benefit costs result in higher Medicare and Medicaid reimbursements. Hospitals using this approach are more dependent on Medicare and Medicaid to generate a net margin. Medicare revenue averages 36 percent of total patient revenue for hospitals using a retail approach as compared to 30 percent for other hospitals in the study. This approach is used more often by rural hospitals where personnel costs have a bigger impact on the hospital's total costs. Personnel costs for rural hospitals account for 54 percent of total operating costs, as compared with hospitals in urban areas where personnel costs account for 49 percent of total operating costs.

How do health systems manage care?
Health benefit plan costs need to be managed or employee contributions will become unaffordable, and fewer employees will choose to participate. Health systems using the Domestic Preferred and Direct Contracting strategies to keep employee benefit costs down experienced lower utilization of inpatient hospital, emergency room, physician office visits and other medical services. Lower utilization may be due to using care management programs or more efficient practice patterns of the domestic network providers. The result is health benefit plan costs that are 4 percent to 8 percent lower for hospitals managing the benefit plan costs, relative to hospitals employing the "retail" approach that reimburses the health system at above-market levels. Health systems outsourcing the network to a commercial PPO had health benefit plan costs that are 13 percent lower than the other plan strategies, with much of this difference resulting from the lower cost, rural geographic areas where these hospitals are located.

2. How can hospitals motivate use of the domestic network?

Hospitals use the benefit plan design to offer financial incentives to encourage members to use domestic network providers and other providers in the commercial PPO network. PPO benefit plans include a benefit plan coverage differential, which is the difference in a member's out-of-pocket costs expressed as a percent of total payments to the network hospital or physician as compared to when they use a healthcare provider not in the network.

Health systems may provide a benefit coverage differential by offering:

- A single-tier plan with a limited difference (10 percent or less) in benefit coverage level when using domestic or commercial network providers as compared with non-network providers. Domestic provider usage may be higher due to the convenient access to care for employees.
- A two-tier plan providing network benefit coverage for domestic and proprietary network providers, which is 20 percent higher or more than the benefit coverage level for non-network providers.
- A three-tier plan providing the highest benefit coverage level for domestic network providers, and lower coverage levels for commercial network providers and non-network providers. This approach creates a clear financial incentive for members to use domestic network providers.

The OutSource PPO strategy does not include a domestic network option, but each of the four other strategies can deliver domestic network usage of more than 70 percent in some cases. An analysis showed the difference in benefit plan coverage explained 30 percent of the difference in domestic network usage between health systems, while higher combined network benefit coverage (for both domestic and commercial network providers) explained the other 70 percent of the difference. Health systems with the highest domestic network usage had benefit plan coverage that was 4 percent to 9 percent higher than similar health systems. Higher network benefit coverage is often used with the retail reimbursement approach to limit members' out-of-pocket costs to amounts similar to what they would pay if the health system used commercial network reimbursement levels.

3. Should a hospital provide access to care by direct contracting or outsourcing?

The scope of healthcare services available through the domestic network is an important consideration in determining the appropriate benefit plan strategy and financial incentives for members. Our analysis of the local market for each hospital analyzed for the study showed that hospitals were more likely to offer significant incentives for members to use the domestic network when:

- The hospital is part of a larger health system. (Health systems electing to use the Domestic Preferred and Direct Contracting strategies had, on average, more than 500 beds and 2,000 employees in their local market area.)
- The hospital offers a broad range of tertiary medical services, such as specialty cancer, neurosurgery or burn treatment, through the domestic network. (Approximately 80 percent of hospitals and health systems offering most of the medical services needed through the domestic network offered significant financial incentives in their plan. Meanwhile, 83 percent of the primary care and rural hospitals use one of the three less aggressive strategies to motivate use of the domestic network because the domestic network does not offer tertiary medical services.)

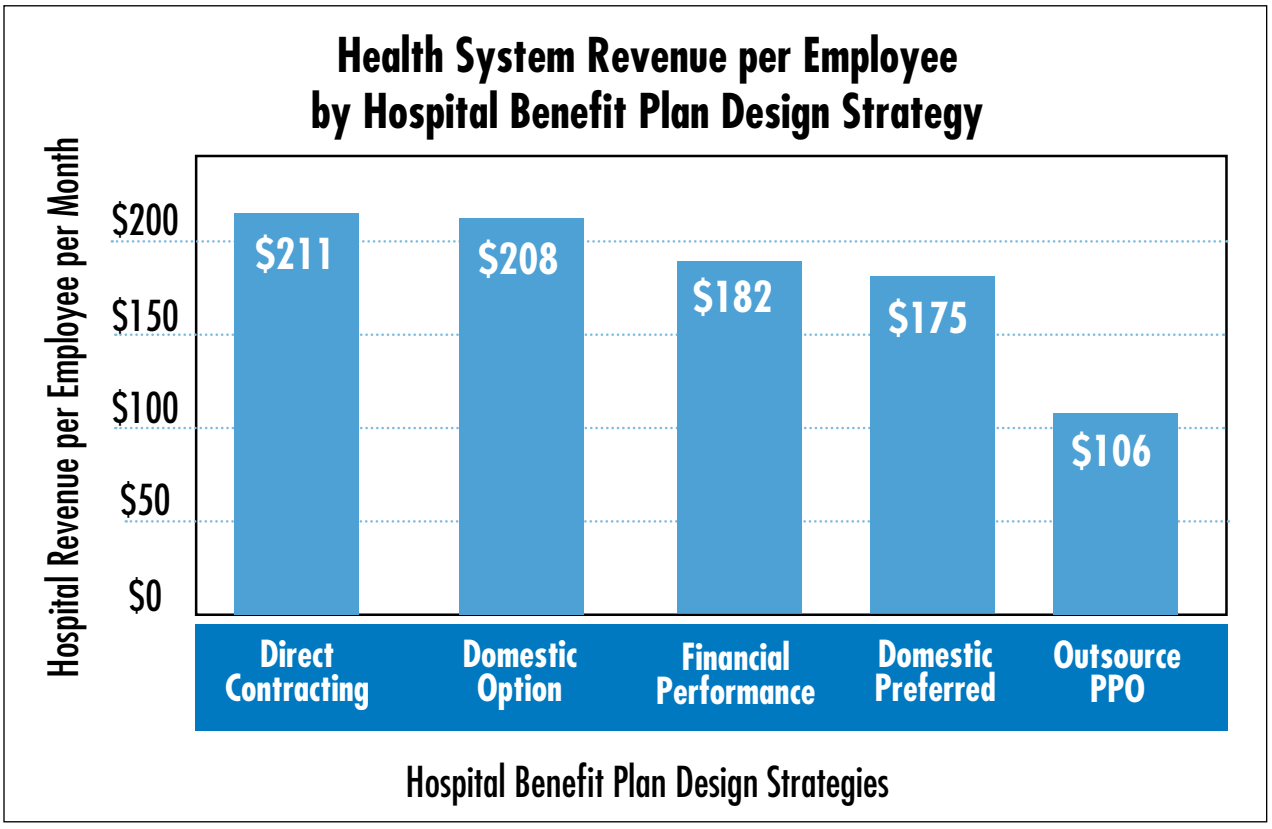
With all the strategies, overall network utilization (combined domestic and commercial networks) of 75 percent to 99 percent was achieved by selecting a commercial PPO to maximize access to care and negotiated savings.

Hospitals are more likely to contract directly when they have:

- A limited number of tertiary care medical centers available in the market;
- Established referral patterns with affiliated providers or other long-term relationships;
- Little difficulty recruiting needed professional staff; and
- No plans to develop or expand the services available through the health system.

Our analysis of hospital and health system revenue PEPM suggests offering financial incentives to use the domestic option, such as those offered through the Domestic Preferred and Financial Performance strategies, does not result in higher health system revenue than if they contract directly for services as in the Direct Contracting and Domestic Option strategies.

The following chart estimates health system revenue PEPM for all five strategies. The range of hospital revenue PEPM can be more than $100, depending on the strategy used. At the high end, Direct Contracting brings in an average of $211 PEPM, while the Outsource PPO strategy offers revenue of $106 PEPM at the low end. (Revenue for the Direct Contracting strategy may be overstated because the estimate includes revenue for affiliated providers who may not be owned by the health system.)



Cost Management Strategies

Traditional cost management strategies can be more effective for health systems than they have been for other self-funded employers. These strategies include:

- Hospital review: Despite an 18 percent higher admission rate, health systems' average length of stay is 28 percent lower than other self-funded employers.
- Pharmacy benefit management: Health system employees participate in generic drug and mail-order pharmacy programs at higher rates than employees of other self-funded businesses.

However, some hospitals prefer not to use traditional utilization management approaches because of the potential negative perception it can create with employees and affiliated physicians trying to comply with the requirements.

Section 3:

Health Costs and Utilization: Hospitals vs. Other Self-Funded Employers

Our analysis also looked at what is driving the higher benefit plan costs at hospitals and health systems as compared with other self-funded employers. Some of the difference is explained by the benefit plan strategies that health systems use to increase hospital revenue by incurring higher employee benefit plan costs. Our analysis indicates hospital benefit plan costs are higher primarily because of higher utilization of healthcare services – including more hospital admissions, physician office visits and prescription drug use due to the demographic profile of members of hospital employee health plans.

The following chart shows benefit plan costs, a demographic profile and member utilization for hospitals and other self-funded employers.

Health System Benefit Plans vs. Other Self-Funded Employers

Health Benefit Plan Metrics	Health Systems	Other Employers
Health plans costs		
• Total plan costs per member per month:	$336	$317
Medical benefit plan costs	$280	$260
Pharmacy benefit plan costs	$ 56	$ 57
Demographic profile of adult members in health plan (excluding members older than age 65):		
• Females as % of all adults enrolled	63%	50%
• Adults age 40 to 64	61%	59%
• Average members per employee	2.11	2.03
Healthcare services used per 1,000 members:		
• Inpatient hospital admissions	77	65
Medical/surgical admissions	57	51
Maternity admissions	14	10
Mental health/chem. dep. admissions	6	4
• Average length of inpatient stay	4.6	5.9
• Emergency room visits	261	197
• Physician office visits	3,420	3,165

Demographics

When compared to other self-funded employers, the analysis found, hospitals employ more women, employees older than 40 and employees with chronic conditions. These results are significant because:

- Healthcare costs for women through age 45 are 28 percent higher than men of the same age, primarily because women go to the doctor more often, CoreSource data shows.
- Healthcare costs for men and women older than 40 typically are three times higher than younger employees because adults older than 40 use healthcare services more often and have a higher incidence of chronic disease, according to CoreSource data.
- Employees with chronic disease have higher healthcare costs due to increased use of services to manage their condition(s).

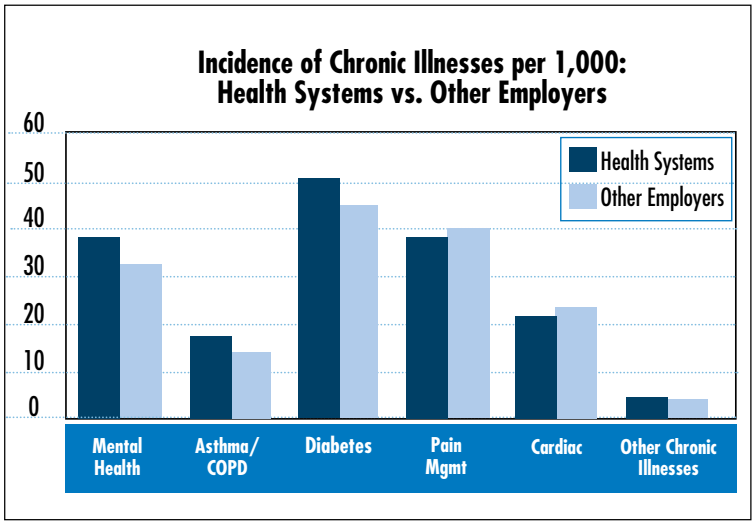
The chart below compares the incidence of specific chronic diseases among hospitals and other employers.

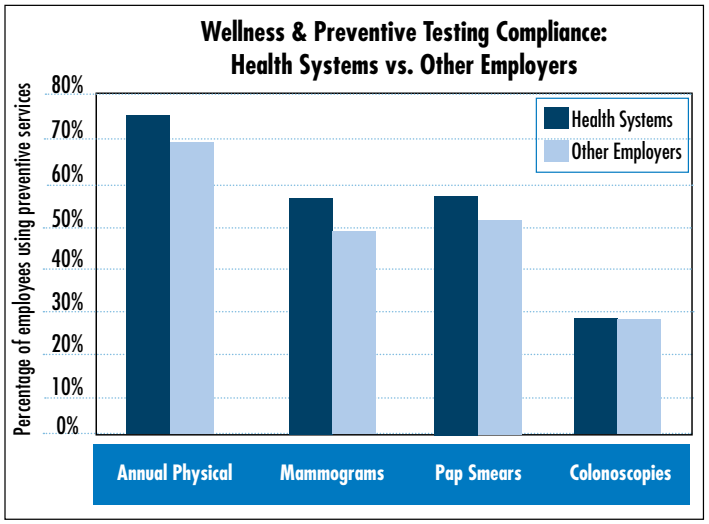
Total Population Management and Prevention

While hospital and health system employee benefit plans cover more members with chronic disease, the CoreSource analysis shows that these members are more compliant in managing their conditions than members of health plans offered by other self-funded employers. This trend represents significant cost-savings, as CoreSource client experience demonstrates that members with chronic conditions who follow recommended guidelines for treatment of their condition(s) have lower healthcare costs than noncompliant members with chronic illness.

Health system members also use preventive health services more frequently to manage health risk factors. Our claims analysis showed healthcare costs for members diagnosed with cancer were lower if the diseases were identified earlier due to preventive screenings such as mammograms, Pap smears or colonoscopies.

The chart below compares employee compliance for annual physicals and specific tests for hospitals and other self-funded businesses.





Conclusion

Hospitals and health systems face unique challenges in designing their employee health plans. They operate as both a healthcare provider and employer, with employee healthcare costs averaging 6 percent higher than other self-funded employers. This is likely due to the fact that their employee population consists of more women, people older than 40, and people with chronic conditions, all of which use healthcare services more than other groups. Another factor to consider is their inpatient admission rate, which is 18 percent higher than other self-funded employers, despite their lower rate for length of stay. To design the right group health plan for a health system given all these factors, hospital HR managers, CFOs, brokers and benefits administrators must collaborate to determine the appropriate mix of benefit plan strategy coverage.

Our analysis showed that hospitals and health systems typically use one of five distinct benefit plan designs. Depending on the plan strategy chosen, a difference of more than $100 PEPM in revenue can exist. Other factors to consider when developing a strategy include managed care requirements, financial incentives, domestic network reimbursement levels and contracting with other providers to meet hospitals' employee benefit needs, budgets and revenue expectations. It is even more critical – and complex – for health systems to monitor the cost and utilization trends of their self-funded employee benefit plans to maintain the desired balance between the competing financial objectives along with maintaining positive relationships with their employees, affiliated physicians and other healthcare providers.

Contacts

For more information on how to determine the right benefit plan strategy, visit the CoreSource hospital benefits website at **www.coresource.com/onyourside** or contact the Sales Executive in your area by calling **800.832.3332,** or e-mailing us at **inquiries@coresource.com.**

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