Employee Benefits & Wellness Excellence

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The **Wrong Benefit Design Can Drive Up Chronic Disease Costs And Plan Risk**

4 essential plan features employers should consider adding to their 2022 coverage

*By George Huntley*

Employers have long been the largest health care payer in the U.S. As recently as 2019, employers provided medical insurance for 56.4 percent of all Americans – 183 million children and adults – more than Medicare, Medicaid and the Veterans Administration combined.

Employee benefits professionals, therefore, play a vital role in improving the nation’s health. This is particularly true for people living with chronic conditions like diabetes, asthma, heart disease or cancer who otherwise could not begin to cover the cost required to manage their disease, or the complications and comorbidities that often go along with it.

Despite varied and concerted efforts to bend the cost curve, health spending continues to rise, cutting deeper into bottom lines and frustrating employers and employees alike. Problems arise when plans inadvertently restrict coverage for important tools employees need to proactively manage and improve their health.

**Shifting Costs Instead of Saving**

To date, the most prevalent savings lever has been shifting costs to employees, through higher deductibles, coinsurance and copays; a higher share of premiums; and lower coverage levels. Requiring “more skin in the game” from employees is supposed to slow cost growth by encouraging more prudent health spending decisions and discouraging waste.

Unfortunately, for many employees and their families, the pendulum has now swung too far, resulting in many fully insured people rationing or forgoing care altogether. Nearly 1 in 3 U.S. families decided not to seek medical care due to cost, according to a 2020 national survey by Bankrate. Rates varied by generation, with 40 percent of millennials reporting rationing, compared to 35 percent of Gen-Xers and 24 percent of baby boomers.

In the Bankrate survey, rationing was as prevalent among families with employer-provided insurance (34 percent) as it was among the uninsured (33 percent).
According to the Kaiser Family Foundation, among insured adults in the U.S.: 34 percent say it is “very difficult” or “somewhat difficult” to afford their deductibles; 28 percent struggle with the monthly cost of health insurance; and 24 percent cannot afford their co-pays for office visits and prescription drugs.4

Costs of Rationing
Statistics like these reveal the lose-lose scenario facing far too many organizations with ineffective health plan designs: rising costs for coverage that fails to meet the needs of employees and their families.

In other words, companies are paying for benefits that drive overall costs up instead of down — from catastrophic claims due to cost-related rationing and medication nonadherence, lost productivity due to absenteeism or presenteeism, and higher turnover at a time when many businesses struggle to recruit and retain staff.

Prevention and wellness efforts will likely fail to meet expectations if employers do not first critically examine their health plan design, particularly coverage for prevention and management of chronic conditions. Fresh fruit in cafeterias, pedometers and standing desks are nice employee perks, but organizations that want to bend their cost growth curve should first ensure their health plan provides affordable access to medications, medical devices and other standards of care.

Among health care services, consumer demand elasticity — or cost sensitivity — is greater for prescription drugs than any other category, including specialist visits.5 Higher prescription drug costs correlate with higher pharmacy abandonment rates, and lower medication adherence and persistence.

In a recent study of commercially insured patients, 60 percent did not fill new prescriptions when their cost-sharing was more than $500, compared to 5 percent abandonment for prescriptions with $0 patient cost-sharing.6 The average abandonment
Prevention and wellness efforts will likely fail to meet expectations if employers do not first critically examine their health plan design, particularly coverage for prevention and management of chronic conditions.

Affordable insulin is the bedrock of diabetes management for 1 in 3 people with diabetes and Internal Revenue Service guidance allows preventive coverage for glucose management in high deductible health plans. Yet ineffective plan design and pricing distortions from the rebate system leave patients paying list prices of $300 or more per vial of insulin that has a net cost of $90 or less.

Insulin is only one piece in a mosaic of medicines, medical devices, software, supplies, services, medical nutrition therapy (MNT) and diabetes self-management education and support (DSMES) the disease demands.

Private health plans generally cover long-term diabetes complications, including amputations, blindness, end stage renal disease, heart attack and stroke. Individualized care can help prevent or delay the onset of these costly and life-limiting complications. The shift to individualized care is better for people with diabetes and their families, and wiser investment of health care dollars for payers, especially in the face of a diabetes epidemic.

Employers who have committed to Diversity, Equity and Inclusion (DEI) efforts in their workforces also should be aware of persistent health inequities in communities of color – including higher risk of diabetes and reduced access to medicines and devices. Employers can help address these inequities by ensuring their health plans cover standards of diabetes care for all employee demographics.

Obesity represents another “penny wise and pound foolish” coverage category. Obesity is a metabolic disorder affecting more than 42 percent of Americans. It is linked to higher rates of diabetes and other serious comorbidities including cardiovascular disease, stroke and osteoarthritis. Nevertheless, many health plans cover limited counseling on one hand or bariatric surgery on the other. There is precious little in between, despite the growing number of effective, and less invasive options now available.

Studies confirm between 80%-98% of dieters regain their lost weight within 3 years. Relying on
weight loss counseling as the primary strategy to fight diabetes and obesity is proven to be a losing proposition. It is time to remove the stigma from this serious, chronic metabolic disease and cover medical treatment for overweight and obesity according to standards of care.

**Finding the Win-Win**

At the end of the day, we all want to reduce costs and improve health – which also boosts employee productivity, satisfaction and retention. This can only be achieved by designing health plan coverages that invest in chronic disease management, shifting the cost curve away from the catastrophic and expensive complications.

Here are four key plan design features that employers should consider adding to their 2022 coverage:

1. Pre-deductible coverage for chronic disease management
2. Low, predictable employee cost-sharing spread throughout the plan year
3. Rebate pass-through on drugs and supplies to eliminate list price exposure
4. Treatment choice/individualized care versus "one size fits all"

There is one more critical layer required to accomplish this goal – active management of intermediaries like insurance companies and pharmacy benefit managers (PBMs). These players often operate without a lot of transparency. Close oversight is essential to eliminate perverse incentives and conflicting interests, ensuring the value of the pharmaceutical and medical device spend for both employers and employees. A win-win!

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Notes


3. Ibid.


7. Ibid.


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George Huntley is the Chief Executive Officer at Diabetes Leadership Council.

Would you like to comment?