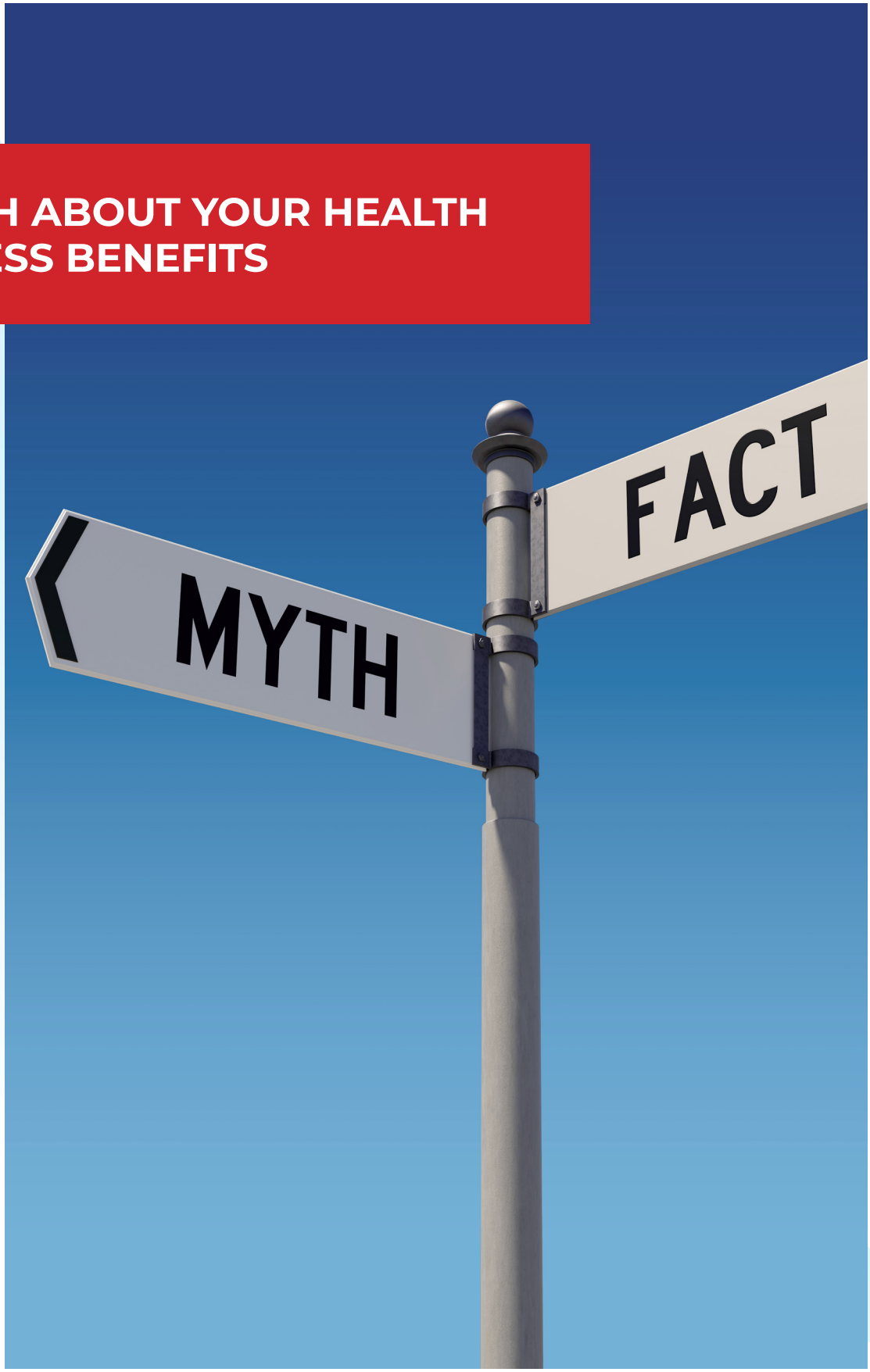
MYTHBUSTERS

THE TRUTH ABOUT YOUR HEALTH & WELLNESS BENEFITS

As you compare costs, consider plan designs, and weigh the value of your existing benefits, dig into the data and metrics.



There are metrics buried under a mountain of myths about health benefits. Those numbers we overlook or brush aside—or simply don't know about—could provide the game-changing information required to make informed strategic benefit decisions, plan design changes, manage utilization and expenses, and improve health outcomes.

Case in point: Since the onset of Covid-19 in the U.S., we've seen a sharp increase in drug overdoses. More individuals faced economic and mental health hardships which accelerated the use of substances. This problem, along with other mental health conditions, takes a toll in the workplace. And from a benefits cost perspective, causes utilization spikes, inflates expenses, and requires additional support resources that everyone pays.

That is just one example of a metric buried in the mountain of data when employers review health and wellness benefit offerings. And there are many more, we'd like you to know about. It goes back to the truth that information is power. When multiple layers and views of your metrics and data are available, you are one step closer to providing employees with high-quality, affordable care that can measurably improve their health.

Let's look at five healthcare myths you should stop believing.

Myth #1:

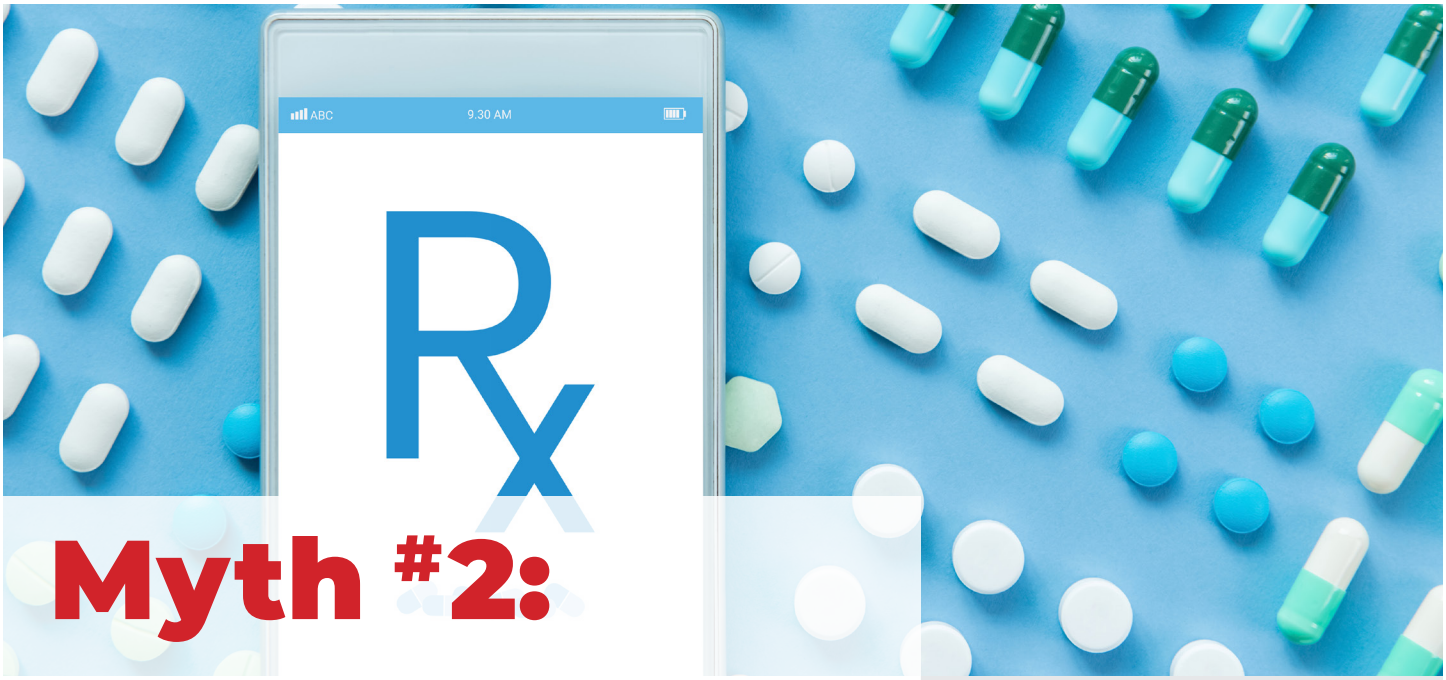
Discounts are the Best Way to Evaluate Plan Costs

Not even close. Too often, employers compare plan costs or measure the value of a network by looking at provider discounts. But an organization's claims are never the same year over year. Which means old data is being used to estimate future costs. Provider contracts are renegotiated, and the information is not immediately available for spreadsheeting. In addition, the process does not consider the savings achieved through bundling services. Next, the base charge rate, before discount, is unknown.

A provider discount is the difference between the charge rate for a health care service and the contractually determined reimbursement rate. If Carrier One obtains an average discount of 31 percent, while Carrier Two obtains a 35 percent discount for the same service from the same provider, it does not mean Carrier Two is paying less for the service. Because the provider's base charge to Carrier One and Carrier Two can be different, the true value of the discount is unknown. Which makes comparing plans or networks based simply on provider discounts impossible, and benefit plans less sustainable.

Take-Away Tip

Evaluate total cost of care for your covered population. It's the amount paid for all care, and utilization patterns. Where the focus has been on achieving a deeper discount, change the story. If you can keep people healthier and prevent them from needing care for an illness, your organization and members will save significantly more than they will with a discount. Focus on how the medical plan will help nudge your population towards better overall health and well-being, and accessing appropriate care at the right time, avoiding more expensive and potentially less effective levels of care. Understand that discounts off an unknown price vs. the bottom-line cost is a deceiving way to evaluate a plan's costs.



Myth #2:

Generic Prescriptions Are Always Cheaper

A name-brand prescription medication must cost more than the generic, right? With generics typically priced 80 to 85 percent less than the brand names, employers have long educated employees to use generic prescription drugs when available.

To encourage the purchase of generics, plans were created with lower patient cost-sharing for them. Most of us would choose a generic, assuming the out-of-pocket price will be less. But with many of today's prescription discounts, incentives, and rebates, brand-name medications are sometimes less expensive.

Take-Away Tip

Current policies have created deeper discounts for brand-name drugs. Look at the total cost of the prescription after all discounts and incentives are applied. Make sure your plan is encouraging cost-effective purchasing. In addition, you may want to increase your awareness of market share of popular drugs by class. Trends may be encouraging additional incentives and discounts on specific brand-name drugs. When you dig deep and analyze the data to learn the net cost of prescription drugs, you can effectively evaluate which option makes the most sense.

Myth #3:

Evaluating Network Access is Key to Receiving the Right Care

Today, employers run network disruption and access studies to ensure employees can find care when they need it. For example, that a provider is available within a set number of miles from their location. It is thought that having providers available means employees will get the right care. Actually, network access is not a key indicator of better care. Access to the right provider is more important, because not all providers deliver the same level of care. Just like in business, some providers do a better job and deliver better outcomes than others. You want to compare providers' ability to comply with evidence-based treatment standards. When selecting a plan, understand the conditions your employee population is facing. Conditions such as asthma, musculoskeletal concerns, diabetes, etc.

Next, figure the cost of treating common condition episodes during a typical 24-month period. These cost-per-episode comparisons measure how efficiently physician, inpatient and outpatient services are utilized. If health care providers overprescribe tests or fail to properly manage a condition, their per-episode costs will be high. Providers that coordinate care and successfully implement evidence-based care management protocols will have low per-episode treatment costs.

Take-Away Tip

Rather than evaluating access to an entire network, focus on the providers and whether they will address your employees' common conditions. Remember, cost variances do not guarantee better care, healthier outcomes, or increased consumer satisfaction.

Myth #4:

Changing Vendors Will Always Save You Money

Vendors compete for your business. So don't be surprised if a vendor claims it can reduce your current spend by, for example, 8 percent if you choose their plan. Dig into the numbers and find out how costs and savings are being calculated.

Is the vendor actually, saving you a percentage off spend? Is the vendor saying they will save a percentage of spend by eliminating the need, and therefore the cost of another vendor because that service is included in their offering? Are they just eliminating a service and calling it a percentage of savings? Again, understanding the data will help you determine when a vendor's offer is actually a "deal."

Take-Away Tip

When evaluating costs and savings, compare vendors and plans apples-to-apples. This is important because one estimate could include all claims data, and another could account for claims data, but minus pharmacy, or minus mental health services. Or one might include all your offices if you have multiple locations, and another might break out locations individually making it difficult to compare your options. So, back to the data: First, gain a big-picture understanding of the numbers. Then drill down and identify patterns that can help you make informed decisions. Don't jump ship on a vendor because another claims it will deliver savings. If an offer sounds too good to be true, it probably is.

Myth #5:

In-Person Care is Always Better than Virtual Care

Telehealthcare soared during the pandemic as providers ramped up virtual visit technology to safely deliver patient care. And, as people became more accustomed to virtual care, they realized the benefits—primarily, accessibility. And in the mental health space, privacy, and less stigma. Virtual care eliminates some environmental biases and can help support those struggling with mental health issues who might not otherwise seek help. As in-person care has phased in, we have choices: virtual or in-person care.

Take-Away Tip

Virtual care is efficient, effective, and convenient for follow-up appointments, mental health visits, skin issues, and continued relationships with established providers. On the other hand, some conditions warrant in-person care. If you choose telehealth, understand the pros and cons of virtual care from physicians you know and trust vs. an online telemedicine company.

Overall, preventive care visits support a better quality of life. And virtual care can promote better health and early detection. So, encouraging your people to keep appointments and take advantage of the convenience of virtual visits can improve overall outcomes.

The Bottom Line

When we understand the metrics and dig into data, we can make informed benefits decisions that save cost and best support the health of our employees and dependents health. As you review your existing health plan, take a myth-buster approach.

1. Read the fine print.
2. Review the last 24 months of utilization and expenses.
3. Understand the chronic conditions your employee population faces and recognize the variables among different offices if you have multiple locations.

The bottom line is data and metrics matter. Understanding them will allow you to identify opportunities to improve care, realize savings, and promote better health and wellness within your population.

DATA AND METRICS MATTER.

health action council

Enhancing Business. Enlightening Lives. Enriching Communities.

Health Action Council is a not-for-profit 501(c)(6) organization representing mid and large-size employers that works to improve human and economic health through thought leadership, innovative services, and collaboration. It provides value to its members by facilitating projects that improve the quality and moderate the cost of healthcare purchased by its members for their employees, dependents, and retirees.

Health Action Council also collaborates with key stakeholders health plans, physicians, hospitals and the pharmaceutical industry to improve the quality and efficiency of healthcare in the community.

LET'S KEEP THE CONVERSATION GOING!

healthactioncouncil.org | 216.328.2200