

# Benefit Insights

## Research Confirms Promise of Consumer-Driven Health Plans

Though consumer-driven health care plans (CDHPs) are becoming more widespread, many employers are taking a wait-and-see approach toward implementation. In a survey conducted in late 2005 among members of the International Society of Certified Employee Benefit Specialists, about one-third of employers that had not yet implemented a CDHP said they thought the consumer-driven concept was too new and wanted to wait and see other employers' results before going forward.

Companies taking this approach might be interested in the results of a study by McKinsey & Company, a management consulting firm, of consumer-driven health plan participants. Though other studies of CDHP experience have been done, this one was unique in that it examined plans in which the CDHP was the only health benefit offering.

According to the results, CDHPs are "delivering on their promise to increase consumer engagement and reduce utilization." The responses of the CDHP participants indicated that they made more careful, value-conscious health care utilization decisions, and that they had a heightened level of engagement in their overall health and wellness.

Five key findings emerged from the study, according to the published report:

- CDHP participants appear to be more value-conscious. For example, although they were twice as likely to report not seeking care for conditions they perceived as less serious, they were no more likely than traditional plan participants to put off treatment for what they thought were serious conditions. Those who had sought treatment (non-pharmaceutical) in the past year were three times more likely to have selected a less intensive (and less expensive) set-

ting, such as an urgent care center rather than an emergency room.

- CDHP participants were as likely or more likely to receive preventive care, and were 20% more willing to take part in company-sponsored wellness programs. They also were more likely than participants in a traditional health plan to say they pursued preventive treatment—such as an annual physical—because it was important for their long-term health or because it would save them money in the long run; traditional plan participants more frequently said they had annual physicals because these services were covered by their health plan.
- Companies in the study reported lower health care costs, even when including costs that had been shifted to employees. Part of the reason for this may be that individuals with chronic conditions who were in a CDHP were 20% more likely than those with traditional insurance to say that they carefully followed their treatment regimens. Also, CDHP participants were nearly twice as likely to discuss less expensive treatment alternatives with their doctor or pharmacist.
- Less than half of CDHP participants said they were as satisfied with their current plan as they had been with their previous plan, a result that did not vary by health status but which did vary widely among companies, suggesting that how a company helps employees transition from traditional to consumer-driven care—and its attendant decision-making responsibilities—is critical to success.
- CDHP participants seem to be more open to their new plans when they perceive factors other than cost-shifting

*continued on page 2*



We are pleased to present to you Lambert & Carney's Employee Benefits newsletter. This newsletter is designed to give you timely and important information regarding employee benefits, government regulations, new products, and other areas of interest to employers and their employees. We value you, your employees, and your business and continue to strive to provide you with the very best products and service available.

Please contact Paul Lambert or Sean Carney at (800) 357-1840 if you have any questions.

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## **Employers Must Provide Electronic Medicare Part D Disclosure Notice to CMS**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new prescription drug program to Medicare and created two employer disclosure requirements. Medicare Part D is a voluntary program that provides outpatient prescription drug coverage to eligible individuals. Because some individuals who are eligible for Part D also might be eligible for prescription drug coverage from an employer-sponsored health plan—these individuals are entitled to receive a Notice of Creditable Coverage (or, if appropriate, Notice of Non-Creditable Coverage), which explains how this other coverage compares to Medicare Part D. This information is important because individuals who decline Medicare Part D when first eligible are assessed a penalty if they later decide to enroll, unless they have had creditable coverage in the meantime.

In addition to providing the appropriate notice to individuals who are eligible for Medicare Part D, *affected employers must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the prescription drug coverage they provide is creditable by March 31, 2006.* Disclosure is provided through an electronic Disclosure Notice form that is available on the CMS Web site (<http://www.cms.hhs.gov/apps/ccdisclosure/default.asp>). This electronic form is the only option for providing the required notice. In January we prepared guidance for our clients to help them comply with this requirement.

Most employers—even those that do not offer any type of prescription drug coverage to retirees—are affected by the Disclosure Notice requirement, because it is required if the employer plan provides prescription drug coverage to any Medicare-eligible individuals (for example, active employees over age 65 and spouses or other dependents who are Medicare-eligible for any reason, including age, disability or end-stage renal disease). Disclosure is required whether an employer plan is primary or secondary to Medicare.

Employers that contract with a Part D plan to provide prescription drug coverage (or that contract directly with Medicare as a Part D plan) are exempt from the disclosure requirement. Also, an employer that does provide prescrip-

tion drug coverage to retirees, and that has been approved for the Retiree Drug Subsidy, does not need to file the Disclosure Notice with CMS with respect to the retirees for whom the employer is claiming the subsidy.

The Disclosure Notice must be submitted to CMS annually. The initial Disclosure Notice must be provided by March 31, 2006, for plan years that end in 2006. For 2007 and later plan years, disclosure must be provided within 60 days after the beginning of the plan year. Also, a Disclosure Notice must be submitted within 30 days after a prescription drug plan's termination, and within 30 days after any changes that affect the creditable coverage status of the plan.

The information required by the Disclosure Notice includes the following—

- Identifying information about the entity filling out the form, including employer name, EIN, address and telephone number.
- Period of time covered by the Disclosure Notice.
- Number of benefits options offered to Medicare-eligible individuals.
- Creditable coverage status of the benefits options offered.
- Estimated number of Medicare Part D-eligible individuals who are expected to be covered under the benefits options as of the beginning of the plan year, and an estimated number of the individuals expected to be covered under a retiree health plan.
- Latest date on which the Notice of Creditable Coverage (or Notice of Non-Creditable Coverage) was provided to eligible individuals.

The CMS Web site ([www.cms.hhs.gov/creditablecoverage](http://www.cms.hhs.gov/creditablecoverage)) provides guidance on this and other questions about Medicare Part D.

Contact **Lambert & Carney** if you need any assistance complying with this disclosure requirement.

### ***continued from page 1...Research Confirms Promise of Consumer-Driven Health Plans***

as driving a company's decision to make the switch to a consumer-driven plan.

Research such as this can contribute to the decision-making process as an employer considers adding—or

switching to—a CDHP.

**Lambert & Carney Benefits Group** has helped several of its clients adopt CDHP alternatives. These clients have been able to see real savings in their health care plans.

## Realizing the Cost Savings Available from Generic Drugs

Like health care costs overall, the rate of spending increases for prescription drugs has slowed; however, it still remains one of the fastest growing pieces of health care spending. From 2002 to 2003, for example, national prescription drug spending increased 11%, lower than the 20% increase in 1999 and the 15% increase in 2002, but higher than the 2002-2003 increases for physician services (9%) or hospital care (7%), according to an analysis from the Kaiser Family Foundation.

Several factors are driving the increases in prescription drug spending. Utilization is on the rise, due to the development of new drug therapies, increased substitution of drug therapies for more invasive treatments, and an aging population. According to the same Kaiser Family Foundation analysis, 61% of the population under age 65 had a prescription drug expense in 2002, as did 91% of the population age 65 and older. In the decade 1994-2004, the number of prescriptions purchased increased 68%, compared to the 12% growth in the U.S. population. Also, from 1994-2004, when the average annual inflation rate was 2.5%, retail prices for prescription drugs increased an average of 8.3% a year.

Appropriate prescription drug therapies are critical to health care treatment—or good health maintenance—for countless individuals. However, cost concerns cannot be ignored. Generic drugs can offer the same results as their brand name counterparts, for a more affordable price. The challenge health plans face is encouraging their members to make wider use of available, appropriate generic substitutes.

What exactly is the savings to be had from generics? This will vary from drug to drug, but estimates put the cost of a generic drug as anywhere from 30-80% less than the cost of the brand name counterpart. According to a statement from the National Association of Chain Drug Stores made to a congressional subcommittee, in 2004, the average price of a brand name drug was \$96.01, while the average price of a generic drug was \$28.74. Not only are generics priced more moderately, their cost increases average less than those for

brand name drugs, according to a study from the General Accounting office. In that study, the average retail price of 50 examined brand name drugs increased three times as much as the average retail price for 46 examined generics.

The fact that generic drugs cost less may be one reason people have the impression that generics are not of as high quality as brand name drugs. Overcoming this misconception through education and communications can help to increase utilization of generics. Such communications should work to inform plan members that a generic drug has the same active ingredient as its brand name counterpart, but that it costs less because generic drug makers do not have the research, development and advertising costs associated with brand name drugs.

Most employers and health plans use pricing strategies to make generic alternatives more attractive. A study from pharmacy benefit manager Express-Scripts examined the difference between the copayments charged for a generic versus brand name drug and how the size of the difference affected utilization of generics. According to this study, the generic fill rate steadily increased as the copayment differential increased, and this occurred without a decrease in overall utilization. For every \$10 difference in generic versus preferred brand copayment, a plan can expect an increase in its generic fill rate of three to four percentage points.

The study also found that plans that use step therapy (a requirement that a lower cost drug be tried before a higher-priced alternative is covered) had, on average, a 2.7 percentage point increase in their generic fill rate. It also concluded that plans with three copayment tiers had a greater affect on the generic fill rate than plans with non-tiered or two-tier coinsurance.

As more and more well-known brand name drugs come off patent and generic substitutes become available, health plans have the opportunity to realize significant cost savings, if members utilize the generic alternative.

### **continued from page 4...Periodic Review Helps Ensure Value of 401(k) Plan**

correctly? The same question should be asked of loans and withdrawals, and distribution requests.

- Self-service features—A decade or more of advances in telephone, and then Internet, capabilities have removed much of the paperwork from 401(k) plans. Today's 401(k) plan participant usually can perform many tasks (such as changing investment elections) and get information (what's my account balance?) without taking the time of plan administrative staff. Are the self-service features available to your employees user-friendly and easily accessible? Do they in fact help empower employees to get the most from the plan?
- Customer service—Even with extensive self-service features, employees still at times may need human

assistance. How readily does your vendor make this available? Are the hours generous enough to accommodate your employees? Are the customer service reps knowledgeable and courteous?

- Employee participation—Are participation rates where you'd like them to be? Any of the above factors can be affect employee participation, in a positive or negative way. Additionally, the quality and adequacy of plan communication materials can drive participation.

A 401(k) plan is one of the most important benefits an employer can make available to its employees. A thorough, periodic review of the plan is important to ensure that this significant benefit operates as efficiently and effectively as possible, both for the plan sponsor and for employees.

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## **Periodic Review Helps Ensure Value of 401(k) Plan**

With employees being responsible for most of the decision-making involved in a 401(k) plan, it can be easy for an employer to let the plan run itself, once set up. However, it's important not to lapse into such a routine. Though the day-to-day "management" of the plan rests with participants, a 401(k) plan sponsor cannot put a plan in place and then fade into the background. A plan sponsor has the fiduciary responsibility to ensure that the plan operates in the best interests of plan participants. Administrative processes, investment offerings, investment managers, and compliance processes should be reviewed periodically to make sure that all fiduciary obligations are being fulfilled.

In addition to the fiduciary issues, periodic plan review makes good business sense. Over time, an organization's goals and needs can change; employee demographics can shift; technologies will evolve; and the investment climate can change. All of these events, and others, might make plan revisions appropriate.

Several aspects of a 401(k) plan should be part of a thorough, periodic review:

- Cost—What is the plan costing participants, and you, the plan sponsor? Participants pay their share of plan costs through reductions in the investment return credited to their accounts. Plan sponsors need to examine the extent

of this reduction, and understand the fees that are being charged. High expense ratios can eat away at the growth of participants' accounts. The employer should also examine the plan costs that it shoulders—legal compliance fees, consulting costs, staff expenses, cost of communications—and determine whether they are reasonable.

- Investment offerings/Investment performance—Do the available investment options offer plan participants an appropriate array of choices from the risk/return spectrum? Are the choices a good fit for your employees? How does performance measure against benchmarks or similar investment options offered by different vendors?
- Administration/Compliance—From the employer's perspective, is the plan running the way you had expected? How much human resources/benefits staff time is devoted to administrative issues and oversight? If the responsibility for compliance matters (e.g., nondiscrimination testing, annual filings) has been outsourced, is the vendor completing these tasks in a timely and correct manner?
- Administration (from the employee's perspective)—Are employees' contribution elections/changes and investment elections/changes being processed promptly and

*continued on page 3*



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