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Health Benefits 101:
University of Kentucky Case Study

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Health Benefits 101: The University of Kentucky's Effort to Improve Lives, Control Costs and Offer a Sustainable Benefits Package

BY JOEY PAYNE

A few years ago, the University of Kentucky found itself faced with unsustainable trends in retiree health care costs, as well as the rising cost of health care in general. This article provides an overview of the decisions made by the University of Kentucky to effect positive change in its health benefits for employees, retirees and their family members. These changes resulted in the creation of targeted health intervention programs, increased benefits and services for some individuals, preservation of retiree health care benefits and mitigation of overall costs to the university.

Introduction

When Lee T. Todd Jr. became president of the University of Kentucky on July 1, 2001, it was a critical time for employees, retirees and the university as it related to health benefits offerings. President Todd established a task force to examine the health benefits issues for active employees and appointed Health Management Services Professor Tom Samuel as "czar" for health benefits. After the task force made its recommendations, Professor Samuel worked with leaders in human resources on implementing a schedule of change. Some of the key tenets of the recommendations included increasing the university contribution (subsidy) for employees with spouse and dependent coverage; introducing "consumerism" into the health plan benefits design; working with the top-ranked College of Pharmacy on the rising cost of prescription drugs; and integrating the university's wellness program with the health plan.

While the health plan for active employees was undergoing change, an even tougher issue was being discussed on the retiree health benefits side of the equation: a committee established by Interim Vice President for Fiscal Affairs Jack Blanton was in the process of reviewing the university's costs for Other Post Employment Benefits (OPEB) under Governmental Accounting Standards Board (GASB) 45. The committee consisted of financial, HR and retiree representatives. The committee made recommendations to the administration on how to alter retiree health benefits in order to maintain reasonable benefits while also making them sustainable. However, the recommendation was rejected by the campus community due to the perceived lack of campus-wide involvement and disbelief that the funding problem truly existed since none of the university's benchmark institutions were having public discussions on the topic.

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Eighteen months later, a new committee was established and former KPMG Accounting Professor and Associate Dean of the Gatton College of Business and Economics Mike Tearney was named chair of the committee. This committee consisted of retirees and faculty members from accounting, agriculture, economics, law and health care, as well as staff members from across campus. The first step of the process was to determine if a funding problem truly existed. After reviewing the OPEB liability figures, the committee determined a problem did indeed exist and that the "do nothing" approach would require the university to dramatically increase its annual funding of retiree health benefits.

The following discussion outlines the university's innovations, the decisions made and the savings realized by applying "best practices" to the management of employee health benefits. These best practices and innovations, from designing new health benefits programs to tapping into valuable existing resources, have brought human resource leaders from around the country and the world to the University of Kentucky to review and study its strategies and programs.

Improving Lives

The University of Kentucky (UK) has approximately 28,000 health plan members. This figure includes employees, retirees and family members. All health plan participants fall somewhere on a continuum of health, ranging from very healthy to chronically ill (see Figure 1). The university's health plan works closely with its health and wellness program and the UK PharmacistCARE program to deliver telephonic lifestyle case management programs and disease management programs. Lifestyle case management includes the Behavior Health Improvement Plan (BeH.I.P) and Weight Loss Matters, an on-campus weight loss program. BeH.I.P addresses depression, stress, smoking, weight loss, pre-diabetes, sedentary lifestyle and high blood pressure. Weight Loss Matters focuses on what and how to eat rather than how to diet and encourages long-term behavior change. Participants can self-enroll or be directed to the programs by their physicians or health counselors provided through the Healthtrac Rewards Program.

Health & Wellness

Healthtrac Rewards is a tiered-incentive offered through the university's health and wellness program. Employees, retirees and their adult family members can earn up to $15 per month ($180 per year) by taking a health assessment several times throughout the year, agreeing to talk to a personal health coach and logging on to a Web site and recording exercise and healthy behaviors on a monthly basis. UK boasts over 9,000 participants in Healthtrac Rewards. These programs are popular with both employees and retirees and have helped create a culture of personal health awareness and responsibility at the university.

Although health care cost reductions are not currently apparent, recent research has indicated that Healthtrac Rewards participants, all of whom self-selected into the program, were of higher past cost versus non-participants, indicating a greater potential for cost reduction and health improvement in the future. As is common when initially unhealthy employees enroll in health improvement programs, these participants pursued more preventive care than non-participants, which may contribute to the non-reduction of health care costs. However, Healthtrac Rewards participants who agreed to talk to a personal health coach had lower average costs than those who did not talk to a health coach, suggesting that a greater commitment to and involvement in the program is correlated with desirable outcomes.

Thirteen hundred individuals participate in BeH.I.P., the university's telephonic lifestyle case management programs, and Weight Loss Matters has enrolled approximately 150 participants. These programs have seen positive results in the reduction of targeted health risks and also have received national recognition. In 2005, the university received Honorable Mention for the C. Everett Koop National Health Award — an award that highlights employer programs that positively influence personal health habits and encourage cost-effective use of health care services.

PharmacistCARE

The PharmacistCARE program offers educational programs to participants with diabetes and/or cardiovascular disease. The program is nationally recognized and has won several awards and received honors including American Diabetes Association Recognized Program status; Pinnacle Award (the American Pharmacists Association's highest honor for excellence in patient care); recognition by Senator Mitch McConnell in the Congressional Record; designation as a University of Kentucky Commonwealth Collaborative; and the Innovative Pharmacy Practice Award from Kentucky Pharmacists Association.

Over the past four years, patients with diabetes who have participated in the diabetes education programs have improved their clinical indicators and lowered diabetes-related medical costs compared to non-participants. While reaching approximately 350 patients with diabetes, the program is seeking further participant incentives from the health plan to entice the remaining 800 patients with diabetes in the health plan to join the program. The cardiovascular program was introduced during 2006-07 and continues to see an increase in the number of participants each month. At present, there are approximately 50 participants enrolled in the program.

Financial Impact

Health care expenditures for active patients in the DiabetesCARE program were compared to a control group of diabetes patients within UK HMO over a 24-month period. The total health care expenditures for both groups increased at an equivalent rate; however, the pattern of utilization shifted during the intervention year for the patients enrolled in DiabetesCARE. The control group experienced a decline in ambulatory and drug utilization that was followed by a considerable increase in spending on inpatient and emergency center services. The DiabetesCARE patients increased their use of medications and ambulatory care during the intervention year but significantly decreased utilization of inpatient and emergency center services compared to the control group.

Clinical Outcomes

The best method to track control of diabetes is the A1C test which shows the average blood sugar level over the past two or three months. Lower A1C levels indicate patients in the DiabetesCARE program showed a significant improvement in glycemic control. Those in the higher baseline A1C levels had the greater reduction in A1C levels. In addition, all components of the cholesterol panel as well as blood pressure readings improved in participants.

Chronic Care Disease Management

Participants with chronic diseases (coronary heart failure, coronary artery disease, end stage renal disease, etc.) are offered chronic care disease management programs coordinated through the university's third-party administrator. These programs are offered on an opt-in basis and have been used to mitigate the costs associated with "large claim" cases. Although return on investment is difficult to calculate since many of these "events" happen before participants enter the programs, we do know the number of excessive large claim cases ($250,000+ annually) have been reduced from more than five cases per year before 2001-02 to two to three cases each year since.

Silver Sneakers

Medicare eligible retirees are eligible to participate in the Silver Sneakers program by enrolling in the Private Fee for Service Medicare Advantage Plan offered by the university. Silver Sneakers provides Medicare-eligible health plan members access to gym memberships and fitness programs.

All of the above mentioned programs are UK's attempt to address long-term medical expenses. An investment now in these programs is expected to prevent or lower future medical claims.

Controlling Costs

In the late 1990s and early 2000s, health plan premiums for active employees had been increasing at double-digit rates. Historically, the university's contribution strategy for active employees was to pay toward the cost of a "single plan" for the employee, but no more for employees whose plan choice included spouses and dependents. Some employees' annual salary increases were marginalized by annual health plan premium increases if they elected coverage greater than single coverage.

The first action taken was to implement a larger subsidy for spouse and dependent coverage. The university's benchmarks were subsidizing spouse and dependent coverage in the 90 percent range (now falling toward 80 percent). UK's contribution for a single plan when applied to a family policy was approximately 33 percent of the premium. Over a three-year period with increased funding, the university's contribution for family coverage has increased to approximately 62 percent. This infusion of recurring money into the health plan in the form of a subsidy for spouse and dependent coverage helped stabilize the number of employees and family members enrolled in the health plan and made coverage more affordable for the average university employee.

With more participants enrolled in the health plan, the goal was to introduce them to health care "consumerism." Consumerism is the current strategy in health benefits, replacing HMOs and managed care from the 1990s. When reviewing the past capabilities of managed care, consultants indicated that maximum efficiency has been reached. It is now up to the patient/health plan participant to make wise choices to help control medical spending within an organization. Medical spending continues to increase nationally, often resulting in unaffordable health benefits for many U.S. citizens.

UK's entry into consumerism came in the form of offering a consumer-directed health plan known as Health First and by adding coinsurance to the prescription drug program. Health First has not been as successful as other plans since it has a high deductible (common in consumer-directed health plans) and a higher monthly premium than other plans offered by the university. The UK HMO, which requires Lexington-area participants to use UK HealthCare for medical services, remains the most popular choice for employees (65 percent participation) and pre-Medicare retirees due to the low monthly premium.

The most significant cost savings has been realized through efforts to better manage the university's prescription drug benefit program. Prior to the 2003-04 fiscal year, HR entered into an agreement with the UK College of Pharmacy to provide services for health plan participants. These services consist of two pharmacists working full-time in the employee benefits office, managing the prescription drug benefit and offering copay counseling services. Other groups of pharmacists offer disease management services for patients with diabetes and cardiovascular disease and also offer database aggregation services.

During the 2003-04 fiscal year, HR staff made sweeping changes in the management of prescription drugs. The first change was related to the "carving out" of the prescription drug benefit. HR now contracts directly with a pharmacy benefit manager (PBM) instead of a third-party administrator or health insurance carrier that contracts with a PBM. This arrangement allows the university to receive rebates directly from the PBM based on prescription usage and to have more control of the plan design and formulary.

During benefits open enrollment in the spring of 2003, UK introduced coinsurance (paying a percentage of the actual drug cost versus a flat copay amount) for prescription drugs as a form of consumerism. Under the previous plan design featuring flat dollar copays ($8, $20, $40), participants paid on average approximately 30 percent of the overall cost of the prescription. The purpose of the new Rx plan design was to engage the participant in the process. The hope was that a participant would not just accept the highest cost "brand" medication being dispensed, but would check to see if it was a preferred brand or if a low-cost generic medication was available. Initially the out-of-pocket cost of medication was more expensive for some participants, causing them to contact HR with complaints. However, with the introduction of copay counseling services, participants with concerns about increased prescription costs were directed to the two pharmacists working in the employee benefits office.

These pharmacists review the participant's medications, offer information on the medications, check for drug-to-drug interactions and make recommendations for alternative medications that can lower the cost for the participant. Recommendations can be made to switch to a preferred brand from a non-preferred brand or to switch to a generic choice. Some drugs do not have a generic alternative, but there may be other drugs in the same "therapeutic class" that have cheaper alternatives. Recommendations for prescription changes are forwarded by the participant or pharmacist to the participant's prescribing physician for consideration. The vast majority of time, the physician is willing to make the switch. When medications are affordable, patients/participants are more likely to purchase them and take them as directed, which in turn improves compliance, thereby reducing more potential costly health complications.

Copay counseling currently saves UK approximately $4.6 million per year (see the calculation below). Prior to implementing coinsurance, the university's generic fill rate (percentage of drugs purchased in the generic form) was 42 percent. Over the past four-and-a-half years, the generic fill rate has increased to 69 percent. The university's PBM indicates that for every 1 percent increase in generic medication usage, the pharmacy spend is decreased by 1.01 percent. For fiscal year 2006-07, the university spent approximately $17 million on prescription drugs.

Increase in UK generic use = 27%

27% x 1.01% savings factor = 27.27%

Amount spent on Rx in 2006-07 = $17 million

Annual savings: 27.27% x $17 million = $4,635,900

See Figure 2 for details related to the increase in generic fill rates and the various programs initiated. As the generic fill rate has increased, the average cost per prescription has continued to decrease, resulting in the participant continuing to pay approximately 30 percent of the overall cost of the prescription. Both the participant and the plan benefit financially when the participant is engaged in the process.

UK health plan premiums have remained stable over the past several years due to a variety of plan strategies: copay counseling, plan design changes, lifestyle case management and disease management programs. During the past five years, large national employers have had medical trend above 9 percent while the university has realized an actual trend during this same period in the 6 percent range.

Sustainable Retiree Health Benefits

Prior to the implementation of GASB 45, the university expense for retiree medical care was approximately $7.3 million for fiscal year 2004-05. UK's annual cost in fiscal year 2007-08 under GASB 45 would have been $30.5 million, a four-fold increase. A committee established by Executive Vice President for Finance and Administration Frank Butler and chaired by retired professor Mike Tearney determined that the annual funding requirements were not affordable. Changes needed to be made not only for the short term to make retiree medical benefits affordable in 2007-08 when GASB 45 was scheduled to go into effect, but also for the long term in order to be sustainable for the future. Working with a consulting firm, the committee implemented several changes in retiree health benefits in order to reduce the cost of the program while maintaining the benefits for this constituency.

Employees Hired After January 1, 2006

One decision, which was made fairly quickly, was to eliminate the employer subsidy for employees hired after January 1, 2006. Employees hired after January 1, 2006, have access to the group medical plan and group rates when they meet retirement eligibility, but do not receive a premium subsidy from the university. Although simplest

to execute, since current employees and retirees were not affected, the reduction in the annual funding was not significant enough and did not solve the impending problem. The impact of this change will be realized over time by limiting the growth in the liability; however, further cost reductions were needed.

Medicare-Eligible Retirees (age 65 and older)

UK funds 90 percent of the monthly premium for Medicare-eligible retirees. Current Medicare-eligible retirees continue to pay their Medicare Part B premium to Medicare and pay $25 or 10 percent of the monthly health plan premium, whichever is greater, to the university (10 percent of the monthly premium is expected to be greater than $25 in the next few years). This change protects retirees from larger future rate increases within a given year, but makes it clear that as premium costs increase, retirees will pay more as well.

Pre-Medicare Retirees (under age 65)

The fundamental change in UK's retiree health benefits plan has been in the area of pre-age 65 (pre-Medicare) coverage. Prior to the change, pre-65 retirees participated in the same health plans and paid the same premiums as active employees. However, the university subsidizes only single coverage for these pre-65 retirees. GASB 45 requires institutions to record the liability for the "implicit subsidy" for pre-65 coverage. This subsidy is realized when pre-65 retirees (usually older than the average employee population) are combined with the active employee population to determine monthly premiums for coverage. In health plans, there is a strong correlation between age and medical claims, meaning the older an individual is, the more medical claims that person typically incurs. When pre-65 retiree medical claims are established separately from active employees, the costs are often close to 50 percent or more than premiums for active employees. GASB 45 requires employers to recognize this expense as a part of the annual OPEB liability if they do not establish "true pre-65 retiree rates."

Employees and Retirees Eligible to Retire as of July 1, 2007

Although the university increased the monthly premium charges for pre-65 coverage, it increased the employer contribution or subsidy for employees who were eligible to retire as of July 1, 2007. Employees and current pre-65 retirees in this group pay 10 percent of the monthly premium (benchmarked to the UK HMO), with the university picking up 90 percent of the monthly premium. A significant cost increase has been realized by retirees who elect spouse coverage, since they are now paying a higher monthly premium but are not receiving a subsidy from UK for spouse or dependent coverage.

Future Retirees

Another group who will experience a significant cost increase in the short-run is employees hired before January 1, 2006, but who were not eligible to retire as of July 1, 2007. This group of employees will receive the university subsidy for pre-65 coverage based on their age and years of service at retirement. UK will pay between 20 percent and 85 percent of the premium until the retiree becomes eligible for Medicare (usually at age 65). Once the retiree becomes eligible for Medicare, the university will pay 90 percent of the premium.

Working With Medicare

In recent years, Medicare has enhanced its program to offer more services to beneficiaries (Medicare Part D and Medicare Advantage plans) while offering subsidies to employers to entice them to continue offering retiree health benefits so as not to totally shift the cost to the government. Medicare Part D offers individuals the ability to purchase prescription drug coverage. Additionally, it offers employers a variety of subsidy options if they continue offering prescription drug coverage for Medicare-eligible retirees.

Initially, the university took advantage of the "28 percent subsidy" in 2006. This was the best option at the time since it required little or no change to the employer's benefit offering. In 2007 however, UK switched to Medicare's Employer Prescription Drug Plan (PDP) option. This option requires the university to follow Medicare's guidelines more stringently and offered the highest level of subsidy to the university. Under GASB 45, the university has the ability to recognize the subsidy received under the Medicare Employer PDP, which reduces the GASB liability and expense. Dollars received under the 28 percent subsidy from Medicare are not eligible to be recognized under GASB 45.

On the medical side, Medicare began offering Medicare Advantage plans as a result of the Medicare Modernization Act of 2003. In the Lexington area, the first plans offered were PPO plans where only certain providers participated. The network was limited under this plan, and the university chose to remain under the Medicare "carve-out" option where Medicare is the primary health coverage for retirees, and the university's plan is more of a supplement and pays secondary. For 2007, UK chose the Private Fee for Service (PFFS) plan, which is a fully-insured plan. This plan offers Medicare beneficiaries the ability to utilize any provider who accepts Medicare, and services are paid for by the retiree with copays. This plan limits the out-of-pocket expense to the retiree for large catastrophic procedures (e.g. surgery). Retirees continue to pay Medicare Part B premiums to Medicare, and Medicare provides health insurance companies a monthly "capitated" payment for anticipated services for each participant enrolled in their plans.

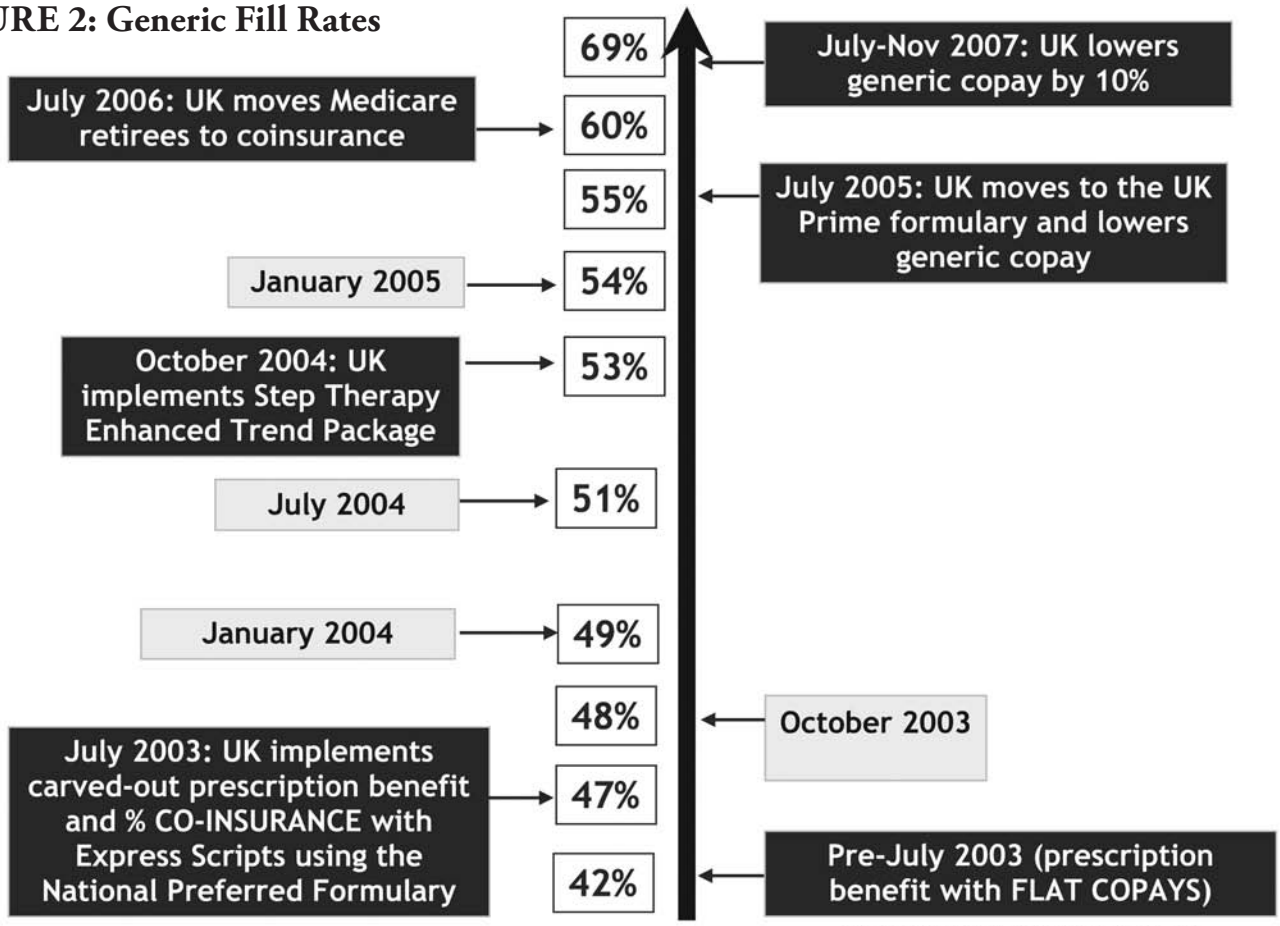
The aforementioned changes in retiree health benefits along with the programs offered though Medicare have enabled UK to reduce its fiscal year 2007-08 OPEB liability under GASB 45 from $30.5 million to $13.6 million. In spite of significant savings, the university was required to add approximately $5 million of recurring funds to the 2007-08 fiscal year budget to fully fund the OPEB liability under GASB 45. Programs and subsidies available through Medicare are dynamic and will need to be evaluated annually to position the university to take full advantage of available options and to make changes when existing options are eliminated. Changes in benefit design, employee eligibility and Medicare programs have made UK's retiree health benefits sustainable for long into the future.

Conclusion

The University of Kentucky has taken several steps to help its employees improve their health. Healthy employees impact the university's bottom line on several fronts, from increased productivity to less absence from work to decreased health care costs and much more. UK's health and wellness programs, including diabetes education and management, cash incentives for healthy living, weight loss management, behavioral health programs and chronic disease management, provide employees with educational services and the support they need to succeed. Engaging employees in the prescription drug buying process with the utilization of coinsurance and consultations with UK pharmacists continues to keep the trend on the Rx benefit in line. And after a thorough review of retiree health benefits and adjustments to pre-65 plan design, along with the implementation of Medicare Advantage and Medicare PDP plans, UK has made its retiree health benefits sustainable for the future. The University of Kentucky's very real problem of spiraling, out-of-control health care costs was not solved overnight, but with a lot of research, creativity, hard work and patience, very real solutions were able to be implemented, and the university is leaps and bounds above where it was just seven short years ago.

FIGURE 1

FIGURE 2: Generic Fill Rates



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