

Reducing Healthcare Costs

for Employers

Employee Benefits Series

THOMPSON

June 30, 2010 | Vol. 1, No. 12

Inadequate Specialty-drug Management Proves Costly to Employers

If you haven't looked at your company's costs for specialty drugs lately, you're probably paying too much for them. That's because specialty drugs are often being paid for under an employer's medical benefit program, not its pharmacy benefit.

Unlike traditional drugs, specialty drugs are infused, injectable, oral or inhaled drugs that treat rare or complex diseases and conditions, such as enzyme replacement, hepatitis and multiple sclerosis. They often are administered by a health care professional in a health care setting, which increases their cost. Some can be self-administered by the patient.

Formerly just a fraction of the drugs available, they are increasingly common. Specialty drug spending increased 19.5 percent in 2009, translating to \$111.10 per member per year in average costs. It is expected that specialty pharmacy spending will represent more than 37 percent of total drug expenditures by 2020, and 44 percent by 2030, according to the

See *Specialty Drugs*, p. 6

IRS Expands Guidance on Tax Credit For Small-business Health Coverage

Small businesses that offer health insurance to workers might qualify for a significant tax credit under the Patient Protection and Affordable Care Act (PPACA), provided they pay attention to details outlined in the recent IRS Notice 2010-44.

"The tax credit possibly could make a substantial difference for some employers," says Cynthia Van Bogaert, a partner at Boardman Law Firm in Madison, Wis.

"Small employers often face disadvantages and an uphill battle to find competitive health care," Bogaert notes. "This is an extra oar to pull ahead in a bad economy."

Employers could save tens of thousands of dollars depending on their health insurance premiums, their reductions and their state's average premium for the small group market.

Obtaining the credit won't be simple or easy, however. And the amount an employer might receive varies according to whether the employer is

See *Tax Credit*, p. 2

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for-profit or not-for-profit, the state in which it is located and several other factors.

“If an eligible small business does not offer coverage, the tax credit may not be enough to get them into the game, so to speak,” says Arthur A. Marrapese, a partner with Hodgson Russ in Buffalo, N.Y. “[I]t will not completely eliminate all costs the employer would incur,” he adds. These costs include new compliance and administrative costs.

The rules are complex, so business owners likely will need to consult a tax expert and financial advisor before proceeding.

The credit is available to employers that have fully insured group health plans. The tax credit applies only to the portion of premiums that employers pay. And the credit-eligible health insurance premium expenses are capped at the premium payments the employer would have made if each employee was enrolled in a plan that has premium costs equal to the average premium in the small group market in the employer’s state. These average premiums are determined by the U.S. Department of Health and Human Services (HHS).

Also, the amount of health insurance premium expenses an employer may deduct as an ordinary business expense is reduced by the amount of the credit.

For tax-exempt employers, the maximum credit is 25 percent of credit-eligible premium expenses, and in the case of for-profit employers, the maximum credit is

35 percent. These maximum credits rise in phase II of the tax credit, which begins after 2013, to 35 percent for tax-exempt employers and 50 percent when employers are for profit.

A first step for employers is to calculate their total full time equivalents (FTEs).

The full credit is reserved for employers that have up to 10 FTE employees with average wages of up to \$25,000. Up to \$50,000 in average wages and up to 24 FTEs, employers receive a discounted credit, Bogaert says.

Employers might qualify for tax credit if they have 25 or more FTE employees, if some of those employees include the company’s owner or the owner’s family. Premiums paid for these individuals might not qualify for the tax credit.

“You don’t count a full proprietor or partner or more than 2 percent S-corporation shareholder or 5 percent owner when you determine how many employees you have for the credit,” Bogaert says. “Also, there’s an exclusion for many family members of these people.”

Employers also will need to be meticulous in following the tax credit’s rules regarding part time and seasonal employees when calculating FTEs.

See Tax Credit, p. 7

Reducing Healthcare Costs for Employers

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Reducing Healthcare Costs for Employers (ISSN 978-1-933807-87-4) is published twice a month by Thompson Publishing Group, Inc., 805 15th St. NW, 3rd Floor, Washington, DC 20005.

POSTMASTER: Send address changes to: *Reducing Healthcare Costs for Employers*, Thompson Publishing Group, Inc., 5201 W. Kennedy Blvd., Ste. 215, Tampa, FL 33609-1823. Please allow four to six weeks for all address changes.

For subscription service, call 800 677-3789. For editorial information, call 202 872-4000. Please allow four to six weeks for all address changes.

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Sample Tax Credit Calculation

How substantial is the new tax credit provided to small employers under the health care reform law?

One analysis suggests this could save employers more than \$20,000. Thompson Publishing Group, publisher of *Reducing Healthcare Costs for Employers*, asked the law firm Proskauer Rose to provide a credit calculation based on this scenario:

For the 2010 taxable year, an employer that has 12 full time equivalents (FTEs) and average wages of \$30,000, is paying \$96,000 in health insurance premiums for those employees. This amount does not exceed the average premium for the small group market in the employer’s state and meets all requirements for the credit.

Based on the initial amount of credit before any reduction: the employer multiplies 35 percent by \$96,000 to arrive at the amount of \$33,600.

There is a credit reduction for FTEs in excess of 10, so the \$33,600 is multiplied by 2/15 to equal \$4,480. The credit reduction for average annual wages in excess of \$25,000 is \$33,600 multiplied by 20 percent for \$6,720. This results in a total credit reduction of \$4,580 plus \$6,720 for a sum of \$11,200. The total 2010 tax credit is \$33,600 minus \$11,200 for a total of \$22,400. 

Improve Wellness Program Marketing To Reap Bigger Financial Benefits

Numerous recent studies have shown how employer-sponsored wellness programs can save companies thousands of dollars in medical costs. But these savings only occur if employees actually use the programs and make desired behavior changes.

For instance, a worksite smoking cessation program could help employees stop smoking and prevent lung disease and future high-cost medical bills. But is it a waste of resources if only one or two people show up to the meetings.

Some employers have devised strategies for increasing wellness program participation and worker behavior changes, using a variety of tactics from contests and challenges to building excitement through word-of-mouth campaigns.

Here are some of the successful strategies they've used:

Build interest, momentum: One city government slyly used word-of-mouth marketing and a sign-up waiting line and list to build momentum for a weight loss program. "We advertised this as a special deal, making it sound like an exclusive club for employees," says Rick French, director of human resource services for Garland, Texas.

"I said, 'Are you tired of being tired? Are you overweight and would you like to drop a few pounds? Are you tired of taking those prescription medicines for cholesterol and diabetes?'" French says. "If your answer is 'Yes,' then the city will let the first 30 people who sign up see a medical professional for weight loss."

This marketing pitch was made in conjunction with advertising of a health fair. Employees who were interested in the weight-loss program were directed to wait in line to fill out an application. More than 200 employees were waiting in line for the 30 slots available in the pilot weight loss program, French recalls.

"Those people who weren't chosen in the pilot weight-loss program put pressure on us to hold a second program," he says.

"They'd say, 'I saw Mary, and she lost 10 pounds in two weeks,' so the whole thing snowballed."

Invent games with prizes: Another strategy is to turn wellness events into games with prizes for winners.

See *Wellness Program*, p. 4

Wellness Strategies That Cost Little or Nothing to Implement

Employers can begin onsite wellness programs on a shoestring budget, experts say.

Some strategies might require grant-writing, while others can be initiated by using available community resources.

The first step toward finding affordable wellness options is to work with a local chamber of commerce, university, rural development board or hospital. For instance, a state university foundation provided grant funding in collaboration with public hospitals and the local health department to pay for wellness initiatives at local employers' worksites.

"We worked with three communities on worksite wellness for pretty small employers," says Kevin Jacobson, rural communities program manager for the Wisconsin Office of Rural Health in Madison.

"We provided the funding and general management assistance for the wellness programs, and the sites came up with ideas," Jacobson adds.

Here are some of the programs they initiated at no cost to employers:

- onsite cooking programs in which a dietitian offered healthy cooking and shopping tips;
- a fitness expert demonstrated workout routines that employees could do at home;
- smoking cessation and stress management seminars, lasting 30 minutes; and
- walking programs, typically free or very inexpensive, depending on how much a worksite might spend on posters and getting the word out to employees.

The City of Garland (Texas) decided to promote walking among staff and had the local police department identify a safe one-mile walking trail, says Rick French, director of human resource services for the city.

The city employer also invites its third-party administrator and local physicians to come to the worksite and provide health education in the form of brown bag lunches. "We talk to doctors about doing these brown bag lunch sessions as a community give-back," French says. "I don't pay a penny for any of it." 🏠

Wellness Program (continued from p. 3)

One motor technology company kicked off a wellness campaign with a walk/run contest around its main building. Employees would pick up a card from a 52-card deck on each lap around the building with the goal of building a good poker hand, says Liz Lund, business development manager for Black River Memorial Hospital in Black River Falls, Wis.

The employee with the winning hand of poker won a free weekend at a summer resort. Lund helped the employer develop the program and found it a vacation prize that was purchased at a discounted rate. Runner-up prizes included three-month trial memberships at a local gym.

Of the company's 250 employees, about 50 participated in the walk/run, and most of them did at least four or five laps.

The employees responded positively to the exercise game event. And it also gave wellness experts a captive audience for discussing body weight, fat risk areas and how to read nutrition labels.

Create a “reality TV” contest: “The most productive wellness program and the highest participation rate we’ve seen is where you have a challenge,” says Eric Tischendorf, an occupational health coordinator and wellness specialist at Langlade Hospital in Antigo, Wis.

Competition can result in behavior change, as the reality TV show “The Biggest Loser” clearly demonstrates. Following the popular program’s lead, some employers have created their own “biggest loser” contests for weight loss challenges or exercise dares.

Lund worked with an electric plant that held a body fat reduction challenge among workers. The person who lost the biggest percentage of body fat would win the contest. The wellness competition included having staff listen to dietitians and other health experts about safe and effective weight loss strategies.

In one town, employers had small teams of workers band together in a walking contest where the goal was to walk 15 miles each week, says Kevin Jacobson, rural communities program manager for the Wisconsin Office of Rural Health in Madison. The team that walked the most each week would receive water bottles and health-related prizes.

“The contests contributed to the wellness programs’ success and kept people interested in a positive way,” Jacobson notes.

Other employers have used competitions to convince employees to keep from gaining extra weight over the holidays. Called a “Holiday Challenge,” the companies can run these programs without hiring wellness counselors. All they need is to have a committee that reports ideas to the company’s chief executive officer, Tischendorf says.

A Holiday Challenge would have weekly weigh-ins between Thanksgiving’s Day and New Year’s Day. There would be small incentives and rewards each week, or a big prize could be given at the end of the competition, he explains.

“Each team that maintains or loses weight at the weigh-in could receive a coupon to a local grocery store or win an iPod® or receive a massage,” he says.

Give financial incentives: Some wellness programs lack any sort of marketing glamour potential, so employers will need to align employee incentives with their health plan goals.

For instance, if an employer wants to reduce smoking among staff then the best strategy might be raise the health insurance premium for people who continue to smoke and take no actions toward quitting, Tischendorf suggests.

Since this strategy typically is a shock to employees when first introduced, some companies will begin with a small behavior change goal first. They might keep insurance premium rates the same for workers who smoke but who are willing to attend smoking cessation classes. Then the next year, the goal would be to quit smoking altogether in order to avoid the premium increase.

“So employees who are smokers would pay 20 percent more the next year if they don’t stop smoking,” Tischendorf says.

This strategy should be coupled with education about why the employer wants workers to quit smoking, including information about lung diseases and an emphasis on how the employer cares about their employees’ health, he adds. 🏠

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Performance Management Software Gives Plans Ability to Limit Health Costs

A relatively new way to reduce health care costs is to integrate and mine health care data to identify costly risks so that action can be taken to reduce them.

Using information technology (IT), employers can link to claims data, run programs and reports, and employees can see their data. Employers finally have something to use to manage health care, explains Henry Cha, president of Healthcare Interactive.

Fully insured employers often lack access to claims data, and even self-insured plans that have data, need analytic and predictive modeling tools need to visualize and manage health trends, Cha says.

Dashboard Displays Forecast Data

A data dashboard — sometimes called a scorecard — is a software system that extracts selected data from an employer or plan's other health information systems, integrates them as needed, and displays them in table format, usually with graphs and text so readers can track their performance.

The dashboard shows up on an individuals' desktop, laptop or phone, and data is refreshed on a pre-programmed schedule. Dashboards are usable by the particular department directly involved in compliance, billing, revenue or sales, for example — but also by company executives who need to view reports and understand trends.

The metrics on a dashboard are specific and measurable toward a numeric target. When metrics dip below target levels, the employer or plan can take corrective action. Many data dashboards use the traffic-light colors of green, amber and red to flag the status of areas being measured, giving the viewer a quick sense of issues or trends that may signal that further action is needed, according to Gerry Blass, a consultant in Colts Neck, N.J.

Since the data reports in real time, employers/plans can make plan-design or wellness-program changes more quickly. For example, an employer can test if a change in copayments affected members' use of their health benefits. "After one month, you can switch it. You don't have to wait until the reporting period is done," says Cha.

The dashboard enables viewers to drill or scroll down and pull up more specific information on the data being measured, and can be programmed so that different people receive different reports on the same data. For instance, a company's CEO or CFO may only need a

10,000-foot snapshot of health care cost trends; the administrator of the health plan or human resources director may want much closer detail about plan utilization.

Dashboard Informs Top Management

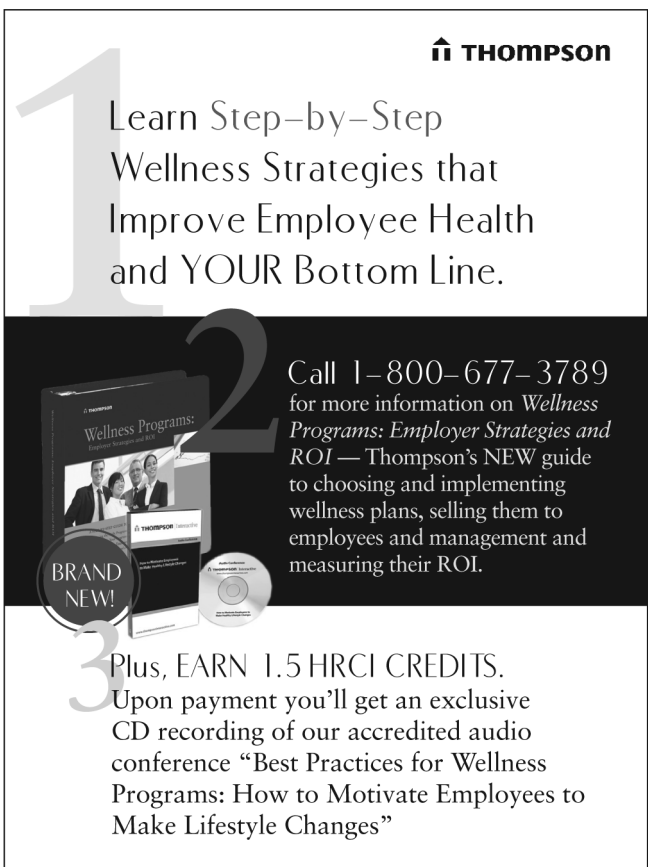
Healthcare Interactive's dashboard can flag frequency of particular procedures, how many members in a plan are being treated for diabetes, and whether offering a \$75 gift card was sufficient incentive for a member to switch from a brand name to a generic drug.

The software involves senior managers of a company in the management of their health benefits program. "[It] allows the plan administrator [and C-suite leaders] to have insight in how the benefits plan actually operates: the trends, exposures and losses [they need in order to] head off huge costs," he explains.

"The typical CEO/CFO doesn't see the health plan as their territory, but it should be. This shouldn't be siloed in HR," says George Pantos, Esq., executive director of the Healthcare Performance Management Institute. "The data provides decision support, so then you can

See *Software*, p. 8

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Specialty Drugs (continued from p. 1)

TriZetto Group. While specialty drugs originally concentrated on oncology and rare diseases, they are now more focused in the treatment of more common diseases such as diabetes and asthma.

“About 30 to 50 percent of the new drugs coming [to market] are [specialty] drugs. We’re moving away from traditional oral based therapies,” explains Marty Mattei, associate vice president of Pharmacy Products and Services for TriZetto, in Greenwood Village, Colo.

However, specialty drugs are much more expensive than traditional drugs. For example, traditional therapy for hepatitis or multiple sclerosis is about \$100 per month; specialty drug therapy for these conditions is \$500 to \$5,000 per month, says Mattei.

“These specialty drugs are amazing. But [since] it costs up to \$300,000 per year for one patient, it can be impactful to a payer,” notes Steve Russek, a vice president with Accredo Health Group, a subsidiary of Medco, in Franklin Lakes, N.J.

Move Out of Physicians’ Offices

Unfortunately, employers are unknowingly paying more for specialty drugs than they need to because 30 percent to 70 percent of these drugs are administered in physicians’ offices and reimbursed under the medical benefit, not the pharmacy benefit, warns Russek, who says specialty drugs cost 19 percent more as a result of being paid through the medical benefit.

Physician-administered specialty drugs are more expensive because physicians bill insurers for them as if they were a medical procedure. The physician obtains the drugs, marks them up by 5 percent or 6 percent, then charges an administration fee. Further, drugs are discounted more deeply under the pharmacy benefit and are subject to stricter pharmacy utilization management. And medical claims are not as automated as pharmacy claims and are still often submitted on paper, says Mattei. “There’s a pharmacy silo and a medical management silo, with little communication and interaction between them,” he adds.

Physicians are inclined to offer specialty drugs to patients in their offices, or even to prescribe a specialty rather than a traditional drug to capture additional revenue. Finally, “there’s a financial incentive on a physician to provide the drug rather than write the prescription,” says Russek.

What’s more, when these drugs are administered in a health care setting such as a physician’s office, they are billed under J codes, not the typical pharmacy NDC

codes, which are more specific, so it’s harder to track utilization and actual costs for these drugs. “Medical claims systems are designed for medical claims, not pharmacy claims. You don’t know what drug was dispensed, how much, if it was brand name or generic, or its strength,” says Ritu Malhotra, PharmD, with the Segal Company in Chicago.

Physician-administered specialty drugs are more expensive because physicians bill insurers for them as if they were a medical procedure.

A patient may also pay a different copayment for the same specialty drug, depending on whether it’s paid for under the pharmacy or the medical benefit. Russek has seen patients getting physician-administered specialty drugs hit their deductibles faster, which means that employers/plan sponsors are picking up the tab sooner.

What’s worse, sometimes specialty drugs are covered under both benefits, but that goes undetected because the two benefits don’t talk to each other. As a result, the employer/plan sponsor pays for a drug when it didn’t intend to. For instance, sometimes pharmacy utilization management will deny payment for growth hormone, so the patient obtains it through his physician’s office, and the medical utilization management okays the expense, says Russek. Or if the pharmacy utilization management program has a rule that it will pay for only two cycles for infertility specialty drugs, once the patient uses up this coverage, she moves over to the medical benefit for additional treatment cycles, and the employer is none the wiser.

“The more sophisticated patient is getting more benefit than one following the rules. Many of them understand how to move back and forth [from benefit to benefit],” says Russek.

Members face a health and safety issue when they obtain specialty (or other) drugs from more than one benefit program, since there’s no coordination between the two, and drug interaction problems may not be caught. For instance, if a patient fills a prescription for treatment of his psoriasis via the pharmacy benefit, and then obtains an infusion from his doctor for arthritis, the patient won’t know that those two drugs should not be used together. “Since the infused drug isn’t under pharmacy management, an alert won’t show up the way it would at the local pharmacy,” says Russek.

See *Specialty Drugs*, p. 7

Tax Credit (continued from p. 2)

Employers must pay at least 50 percent of the health care premium, and the premiums must be uniform, to qualify for the subsidy. In other words, employers that pay 50 percent of the premium for their rank and file workers, but 100 percent of premiums for their management employees would not qualify, Bogaert explains.

For 2010, this lack of uniformity is less of an issue because an exception is made so long as all employees receive at least 50 percent of their premium paid by the employer. But if employers that pay different percentages of premium costs depending on employees' job or status continue the practice in 2011, they'll lose their tax credit.

Further, employers that apply have to follow nondiscrimination rules, meaning they have to have more uniformity in design, Bogaert says.

The health reform law allows businesses to maintain their current health plan designs as a grandfathered plan. But if employers wish to obtain the tax credit, they must


make a plan design change and lose their grandfathered plan status, she adds.

"If you keep your grandfather plan status and keep variation in premiums then you'll give up a tax credit in 2011, but you'd be able to keep your health plan design," Bogaert says.

All new health plans will be subject to nondiscrimination rules that are going to be applied to all insured plans that do not have grandfather plan status, effective for plan years that begin on or after Sept. 23, 2010.

For-profit employers should watch for detailed instructions from the IRS on applying for the tax credit.

Also, another issue to watch out for involves controlled groups, Bogaert says. If an employer has a subsidiary and between the two different entities there are 40 FTEs, then they are not permitted to apply for the tax credit for both of these entities, she says.

"You have to aggregate employees under the same controlled group," she says. "If you have a parent company and subsidiary that is 80-percent owned, then they'll be combined." 

Specialty Drugs (continued from p. 6)

"These are the hidden costs of specialty drugs. The employer loses control and it's very impactful financially. This is a very common problem," warns Russek.

Note that while this directly impacts self-funded employers, it also affects fully insured employers, which may face higher premiums because of increased utilization and costs, says Russek.

Plan Sponsors Can Rein In Costs

Employers/plan sponsors can plug this leakage, experts say. "They first need to recognize they have an average of 50 percent of drugs being paid for under the medical benefit, and look at the utilization and cost data for specialty drugs under both benefits," says Russek. "Sometimes clients are surprised these are covered under the medical benefit [at all]," he adds.


Once employers/plan sponsors gain an understanding of the type and extent of the problem with their member population, they need to better manage the utilization of these drugs. One way to do so is to modify pharmacy and medical management benefit design to ensure that some or all specialty drugs become reimbursable only through the pharmacy benefit. For instance, specialty drugs for hemophilia, immune globulin and rheumatoid arthritis cover about 40 percent of the specialty drugs can be moved to the pharmacy benefit to save employers money quickly, says Russek. He also suggests that

growth hormone be locked out from medical management and moved exclusively to pharmacy.

Another step employers/plan sponsors can take is to extend to their pharmacy benefit managers (PBMs) the authority to apply pharmacy utilization management to both pharmacy and medical management data, says Malhotra. Some PBMs are now offering this service, she adds.

Employers/plan sponsors/plans can also consider adding a software tool that connects the two benefit silos to capture specialty drug dispensing in the medical management benefit, says Mattei. For instance, TriZetto now offers a web-based hosted software application called TriZetto Pharmaceutical Utilization Management that integrates medical and pharmacy data so they can be managed together.

"It's good for all pharmaceuticals, but especially these new drugs," he notes. Mattei estimates that using such an integrated platform for these drugs provides a return on investment of 3:1 to 4:1 because of the increased automation and integration of the pharmacy data. TriZetto also offers a free analysis of an employer's/payer's potential savings. In addition, one health plan has just signed on to use TriZetto's software, says Mattei.

Fully insured employers should ask their health plan what it's doing to manage these costs. 

intervene and take actionable strategies to guide health behavior and head off costs,” he adds.

Plan members can view a dashboard that reflects their own health utilization in a Facebook-type application. The availability of this employee window is another opportunity for the employer to counsel employees about their health benefits and conditions, says Keith Lemer, president of WellNet Healthcare, which uses the HPM software for its 250 clients.

Once a high-risk member is identified, the program administrator contacts the member using the social media application to offer education and coaching, or to remind them that there’s a cash incentive if they participate in a wellness program. “This is your medical village connected to you. It brings it all together via technology,” says Pantos. The employer only sees the aggregate data and does not know which employee has which condition.


“If 2 percent of your population is high-risk and 17-18 percent is moderate-risk, and you don’t do anything,

then you will have most costs down the road. But if you identify the people with risk and have a nurse engage them [to make healthy life style choices], you can save millions by avoiding hospitalization,” says Lemer.

“With HPM software, it prevents the event from happening by using the data in real time to head off events,” says Pantos.

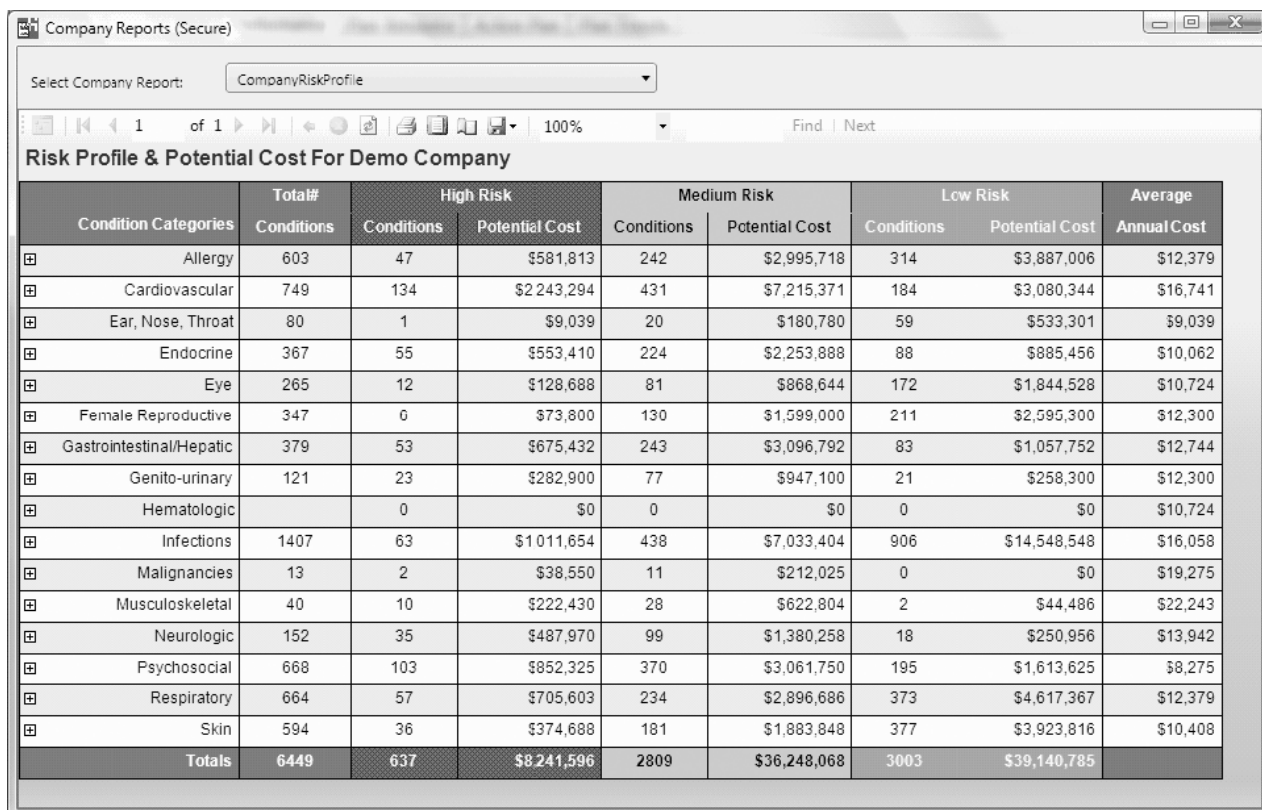
According to Pantos, this software can generate savings of 20 to 30 percent for companies. It saved a school with 500 employees nearly \$1 million in year one by informing a move from name-brand prescription drugs to generics.

The service is web-based and available for a monthly fee, removing the need to purchase programs, and making it more affordable, says Lemer.

In considering Health Performance Management or similar software employers and plan sponsors should consider: (1) asking for a demonstration or trial; (2) working with the vendor to customize the reports to company location, demographic, etc.; and (3) determining what level of involvement you want from the vendor. 

Dashboard Shows Utilization Projections

Here’s a sample snapshot of a Health Performance Management dashboard, courtesy of WellNet Health Care. The depiction below shows the low, moderate and high risks of plan members in a particular population using the red (high-risk), amber (medium-risk) and green (low-risk) traffic light colors, the number of members in each category and the corresponding costs.



Condition Categories	Total# Conditions	High Risk		Medium Risk		Low Risk		Average Annual Cost
		Conditions	Potential Cost	Conditions	Potential Cost	Conditions	Potential Cost	
Allergy	603	47	\$581,813	242	\$2,995,718	314	\$3,887,006	\$12,379
Cardiovascular	749	134	\$2,243,294	431	\$7,215,371	184	\$3,080,344	\$16,741
Ear, Nose, Throat	80	1	\$9,039	20	\$180,780	59	\$533,301	\$9,039
Endocrine	367	55	\$553,410	224	\$2,253,888	88	\$885,456	\$10,062
Eye	265	12	\$128,688	81	\$868,644	172	\$1,844,528	\$10,724
Female Reproductive	347	0	\$73,800	130	\$1,599,000	211	\$2,595,300	\$12,300
Gastrointestinal/Hepatic	379	53	\$675,432	243	\$3,096,792	83	\$1,057,752	\$12,744
Genito-urinary	121	23	\$282,900	77	\$947,100	21	\$258,300	\$12,300
Hematologic		0	\$0	0	\$0	0	\$0	\$10,724
Infections	1407	63	\$1,011,654	438	\$7,033,404	906	\$14,548,548	\$16,058
Malignancies	13	2	\$38,550	11	\$212,025	0	\$0	\$19,275
Musculoskeletal	40	10	\$222,430	28	\$622,804	2	\$44,486	\$22,243
Neurologic	152	35	\$487,970	99	\$1,380,258	18	\$250,956	\$13,942
Psychosocial	668	103	\$852,325	370	\$3,061,750	195	\$1,613,625	\$8,275
Respiratory	664	57	\$705,603	234	\$2,896,686	373	\$4,617,367	\$12,379
Skin	594	36	\$374,688	181	\$1,883,848	377	\$3,923,816	\$10,408
Totals	6449	637	\$8,241,596	2809	\$36,248,068	3003	\$39,140,785	