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# The Balancing Act: Medical Plan Cost Control Programs & Member (dis) Satisfaction

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Given the steady upward trend of healthcare costs, plan sponsors continue to face the challenge of offering plans that are both cost effective and market competitive relative to industry/community benchmarks. Plans make changes to try to impact trend and improve outcomes. Plans communicate new programs at open enrollment and through other media. Despite our concerted efforts, I still get the sense that most members (including my own family at times) just want their medical plans to pay their claims. Because of this all too common reality, we are seeing a rising tide of member dissatisfaction. This dissatisfaction leads me to ask; do our members understand the benefits of and need for our current programs before we attempt to add new ones like wellness and disease management? How do we design plans and programs that seek to control costs and direct care to the best potential outcomes without creating barriers to receiving recommended care? The following three examples happen on a daily basis and can be prevented through a re-prioritization of member education and revisiting plan design strategy.

**Utilization Review & Prior Authorization**

As more medical procedures are available for multiple conditions and indications, we are seeing an increase in member and provider dissatisfaction with reviews for medical necessity, particularly around experimental and investigational treatments. This classic cost control program which seeks to confirm that proposed treatment meets the standards of nationally set criteria is the first place where cost and outcome management strategies collide with the member's expectation that the plan will cover the care their physician recommends to improve their health. Are we (re)educating members as to why these programs are in place? Where was this covered in your last open enrollment presentation and is it highlighted in your benefit summaries? Have you reconsidered your strategy around whether or not your plan recommends, requires, or requires utilization review with a financial penalty, for example?

**Specialty Pharmacy Programs & Formulary Management**

Given that specialty medications will be the primary trend drivers in pharmacy spend over the next 5+ years, many employers are trying to get in front of this risk and to manage their cost exposure. Many of our pharmacy benefit manager partners are recommending mandatory specialty programs that combine prior authorization and a single source approach to managing this risk. In many instances, specialty medications are being prescribed for alternative indications (not FDA

approved or not on the label) and being denied. In other situations, members are dissatisfied with the manner in which they have to access these medications for very serious medical conditions (mail order, next day delivery). Secondly, as many drugs are becoming generic and other brand drugs are competing against other medications proven to be more effective and less expensive, members are being told that their medication is no longer covered on the formulary. Despite the significant amount of research and consideration by the pharmacy benefit manager and our directive to them to manage costs and our clients' formularies, there continues to be a good amount of plan and member resistance. Are we covering the cost and savings benefits of these programs and the importance of formulary management when we cover the co-pays at open enrollment and on our benefit summaries?

**Isn't My Diagnostic Procedure Preventive?**

Even before Health Care Reform, most of our plans had a benefit differential where plans paid more for what the industry calls "preventive" care. From a health risk management prioritization perspective, this is problematic and from a member's perspective, it doesn't make intuitive sense. Members with chronic or acute conditions who need to adhere to recommended care guidelines (doctor's visits, lab and diagnostic tests set by nationally recognized experts like the American Diabetes Association) represent a greater financial risk to a self-funded plan. While it is important to keep our healthy members healthy, isn't it more important to keep our sick members from getting sicker? Next, as more and more medium size groups are implementing or managing a disease management program, members are shaking their heads as they review plan benefits. "The nurse is telling me to get my recommended care for my diabetes, but the care I need is too expensive for me to get, particularly if I have multiple conditions and when compared to what is considered 'preventive'." Isn't my recommended care ***preventing*** further illness? We need to give consideration to our plan design structures and how they complement our health promotion initiatives. Is there continuity between our programs and our plan designs?

**Final Thoughts**

As more plans consider health promotion programs like wellness or disease management, we need to make sure that we work on the foundational plan management programs that our members engage in on a daily basis. If our members do not have an understanding for how these programs work and why they are important, they will not be receptive to additional programs that we offer to manage their health. We may not have gained their trust and partnership in the management of their health. We need utilization review and specialty pharmacy programs, for example, to free up the dollars to remove the barriers for our members to receive recommended care. We need to re-energize our combined efforts around employee education and consumerism to maintain and build upon existing programs and by doing so, set-up new programs for success.

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