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Session 31PD
Defining "Best-In-Market" Health Opportunities

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Moderator: DALE H. YAMAMOTO
Panelists: MINDY S. KAIREY†
Recorder: DALE H. YAMAMOTO

Summary: Health and benefit professionals recognize that health care delivery systems are specific to local markets. The best plans in each market outperform the average by 15–20%. An evolution to best-in-market is clearly underway. Panelists discuss the employers' perspective of defining their strategies to identify these opportunities.

Mr. Dale H. Yamamoto: This presentation is not from the perspective of one firm's idea of what best-in-market is because both Mindy and myself have worked with different firms. One of the things that we, hopefully, have captured are some of the unique things that a lot of consulting firms are talking to their clients about as far as defining what a best-in-market health plan really means and how they should go about trying to get employees to migrate to those kinds of plans, if that's one of their goals that they see as far as delivery of health care to their employees.

Mindy Kairey is not an actuary, but Mindy and I work for Hewitt Associates. We both joined the firm about the same time, about six years ago, and Mindy has probably worked on most of our larger clients that have tried to focus and define what we mean by best-in-market and delivery of health care programs in the country. Mindy has a pretty varied background. She got her master's degree and originally worked for Blue Cross, then worked for another competitor called Mercer—I guess a few of you may have heard of that firm—and joined us. Mindy and I have both worked on similar clients, taking two different routes. For Mindy, it's trying to define what a best-in-market or a good health care plan is more from the perspective of the quality, the plan performance perspective, and my view has

†Ms. Kairey, not a member of the sponsoring organizations, is an Associate at Hewitt Associates LLP in Lincolnshire, IL.

Note: The charts referred to in the text can be found at the end of the manuscript.

been more identifying what the best-in-market is from a financial perspective. That's the division of the presentation we're going to have today.

One of the things that would actually be helpful is knowing what are employers' perspectives of health care? I know a lot of consultants would probably identify with that question a little bit better than people from insurance companies. I'm not sure which one to pick on first, whether or not you're a health actuary coming from an insurance company environment or a consulting firm. Anyone who's from a consulting firm, has that consulting firm perspective. Do you mind raising your hands just so we get that kind of perspective? About one quarter is from the consulting side and another three-quarters from the insurance company side. Anyone from a consulting firm, when we start talking about the employer perspective, I'm sure you've probably seen it all, heard it all, and talked about it all in the past, so, bear with us.

Ms. Mindy S. Kairey: We're going to spend a little bit more than one-third to one-half of our time just really setting the stage so that we can all be on the same page in terms of best-in-market, plan selection, and best-in-market pricing. We thought it would be helpful to begin with what we're seeing from a large employer perspective—what our mutual clients really are concerned about. And then we'll move more into some live examples that we've had experience in working with and share some different examples of how other employers have defined best-in-market, evaluated plans from a best-in-market perspective, and put incentives in to migrate employees to those best plans, and detail some of the results that they've achieved with that.

When we talk about a large employer, from our perspective, we're talking about employers who have more than 5,000 employees. Some of the examples that we're going to get into today tend to be employers who have even more than 15,000–20,000 employees who are moving more quickly into the area that we're going to be talking about today.

In the past, the benefit managers, or sometimes the human resources (HR) people, whom we're dealing with have had a more secure position, I would say, than they might have today—more secure in the sense that when they reported to senior management they were able to get by by saying that they couldn't determine the value of the health care that they were providing. They always were able to say that it's not like measuring widgets, that the whole health care industry is very different. What we are certainly seeing now is that benefit managers and HR people are required to quantify the value and to determine the ROI. There are a significant amount of dollars, clearly, that are being spent on health care, but, in addition to that trend, what we're also seeing is a market that has received an incredible

amount of attention recently, and the variability that exists with health care is tremendous.

The other trend that we're seeing that puts a significant amount of pressure on our contacts at clients is the trend to outsource. In an effort to provide more security to their own positions there's more of a need to send a message up about the value that they're delivering for their dollar. All of us, and particularly all of you, are very focused on the quantitative value and the financial value, but from an employer perspective and a senior management perspective, some of what they're most concerned about is the noise level or the value that an employee perceives from the health plans that they're being offered. As some of these companies get into a very competitive situation in terms of acquisitions and mergers, benefits that are not on the table are the ones that receive attention, or benefits that are provided and health plans that are provided can cause a problem for employees. What we have seen more often than not is that employee satisfaction results don't necessarily validate what employers think. If employers had to guess what their employee satisfaction would be, it would be substantially lower than what it would actually be if they had a quantifiable survey. So, what they need to do is minimize that noise level and understand how they're performing.

From a senior management perspective, and probably because of the recency of the *Fortune* 100 best employers results coming out, we're hearing a lot of employers talking about this when they state what their goals are from an HR perspective. What are they really after? A lot of times we'll hear some very generic things that most clients are saying, which is that they want to optimize employee satisfaction and reduce their cost, but what we're also hearing more recently is employers saying, from an HR perspective, "I want to be on that *Fortune* 100 list. I want my name to appear on that cover." And when you start really evaluating, and we've had the luxury of being very close to those survey results, what makes employers able to be on that list is not what health plans they're providing. It's certainly not how much money they're saving from a health plan perspective. But it is definitely the value that they're providing.

And if you look at the benefits being provided by companies on the list, it's not health plan benefits, but luxury services, concierge services, and how they treat employees. It's a much broader perspective, and that's what our contacts, even benefit managers, are saying how they want to spend their time. They'd like to be spending their time on more strategic issues and less time on managing their health plans, which they're currently doing. When we look at companies that actually appeared on this *Fortune* list and what their ROI was from a stockholder perspective, those companies outperform other companies.

The results that you're about to see are from a survey that we did a couple of months ago with our largest clients, the most senior-level people from an HR perspective from our client organizations. What we asked them is, how heavily are you weighting a variety of different cost factors when you're evaluating your health plan performance and your health benefit results? What they said from a financial perspective was that they're looking at total cost. We have some clients, and I'm sure some of you are aware of them, who are concerned with employee costs. That wasn't showing up here so much. They're very concerned with their portion of the cost, and how they can control that or minimize that as much as possible. We've had experience in distributing the survey for a few years now, and purchasing efficiency was one of the things that we wouldn't see there two or three years ago. That's again getting back to the value equation and the value that they're getting from their dollar. So, total cost is certainly the focus, followed by employer costs.

But when you start looking at some other factors beyond cost—we know that cost is important and it's never going to go away—what are some of the other things that they consider when they're defining value from their health plans? Employee satisfaction is certainly the focus that we're seeing today. But what's interesting I think from a health plan perspective is that clinical quality showing up here at 15%. In the past, it received more focus from benefit managers, but what we've seen over time is that number has declined. Because they believe that other measures are in place, such as the Health Employer Effectiveness Data Information Set (HEDIS) or National Committee for Quality Assurance (NCQA) accreditation. We have evidence that supports the fact that some employers think it's not being measured effectively, so their focus has turned to employee satisfaction as the end-all.

When they're evaluating their results, what's the comparator that they're looking at to determine how they're doing? They certainly look at year-to-year comparisons. Measuring everything on an annual basis and having a standardized process in place has become a key for them, but they're also looking at industry competitors and labor market competitors. What's going on in my particular labor market, particularly when I get to some of my smaller locations and I need to figure out what to do in Raleigh versus what to do in Chicago? The *Fortune* 500 used to be a standard for a lot of this particular employer base that we're referencing, but now this has become less important because other measures have surfaced. We can talk about all sorts of employee issues, but when you really get down to what is going to make an employee satisfied, and what's going to reduce the noise level, particularly when you're transitioning a delivery system—and what I mean by that is if you've gone from an indemnity plan to point-of-service (POS) or if you've gone from POS to an HMO—is whether his or her doctor is in the health plan. Once you get beyond that, there is a whole series of things related mostly to member services. And what we've seen from employee satisfaction results is that employee

satisfaction isn't necessarily reduced if employees have a problem or if they're disgruntled about something. It becomes significantly reduced, and it's almost the number one driver of employee satisfaction, if they have a problem that is not resolved in a timely fashion.

So, when employers and our contacts sit back and say, "All right, what are all the issues that are going on? Where's all the noise coming from? What's going to influence my discussion at the end of the year when I get to go up to senior management and say what the value is that I'm delivering?" Or, conversely, on any given day of the week, any week of any month, when somebody in senior management picks up the paper and reads some story in the media, and that phone call comes down about the recent acquisition of name-the-health-plan or the employee satisfaction results or the top ten health plans that are listed, these are all the concerns that they have to deal with on a day-to-day basis.

What we see as a trend are several different things. One is they're putting a standardized process in place to measure health plan performance so that they can address those questions in more of a proactive fashion. Second, they're recognizing that health care is a very local process, so they're starting to move more and more towards very localized, specialized plan options. Instead of having the company plan, the national POS plan, or the national PPO, it's becoming more regionalized and very market specific.

To make those local decisions and what we call best-in-market plan selection and best-in-market value pricing, they're relying on the information from the standardized measurement process. There's a whole variety of factors that they might look at in evaluating health plans, and there's a whole variety of places where they can get this information. We've already shown you evidence of what a senior HR executive considers his or her top priorities. We know it's employee satisfaction and total cost, but then when you start drilling down a little bit more, each employer weights these factors a little bit differently. If you attend our workshop, Session 73WS (not available online) tomorrow, we will show you how separate employers can weight some of these elements differently, how the weighting of these diverse factors—in addition to the measurement of what these factors are—can be different, how a health plan produces results vis-a-vis these different factors, and how we can create a very simple methodology and model so that employers can easily identify those best-in-market plans.

We've talked a lot about the triggers of measurement. I think a lot of people are aware of HEDIS, NCQA, and the other measurement sources, but what I think is troubling or very confusing certainly for our employers is all of the different types of measurement that exist out there. We have health plans that are doing a lot of their

own measurement, and employee satisfaction is certainly one of them. Consulting firms are guilty as well of trying to develop different measurement tools. The challenge for all of us is developing some sort of process that, by and large, the majority of the industry agrees with so that we can compare results from one health plan across different sources of measurement.

I mentioned variability in results. One of the sources of measurement that we rely on is the Hewitt Health Value Initiative. What that is all about is providing a standardized measurement tool that focuses very much on financial efficiency and plan performance; that is, their operating capabilities. What we do for employers and for health plans is provide them information that plots, not just their health plan in a given marketplace, but all health plans. Right now we have 2,000 health plans in the database and about 300 employers, so we think the results are fairly credible. Chart 1 is an example of a Chicago market. These are all health plans in the Chicago market, and this is actually live data. What we do is plot HMOs, POS plans, and PPOs. The indemnity plans appear in a detailed data table. What you're seeing here is financial efficiency going along the bottom and plan performance going along the top. Again, this graphs all plans and all product types in the Chicago market, and what you see is the variability that exists.

The squares in Chart 1 happen to be HMOs. Where you want to be is up in that upper right-hand quadrant. From a very, very simple perspective, when employers gets a graph like this, it allows them to question why they have a certain plan if that plan is not performing well from a plan performance perspective or a financial efficiency perspective. If they have several plans, it's a tool that could be used as an elimination. We wouldn't advise employers to look at this and think they absolutely should have that plan up there because this tool is designed to be directional and as a starting point.

The stars in Chart 1 show the average scores that are plotted for all employers who participate with those health plans. The stars recognize a particular employer's result vis-a-vis the average, so it would want its star to be in the far right-hand side. The line actually represents the distance from that plot point to the average; therefore, an employer would want its star to be as far to the right as possible. This is the variability that exists in a given marketplace. The graph on the right side of Chart 1 shows a major carrier and all of its HMO products across the country. What we would like to see is a national carrier that has a great majority of its plans in the far upper-right corner, but we don't necessarily see that. HMOs are probably the most similar. When you start looking at POS plans or PPOs that's where the disparity really jumps out at you. It's these types of results and a lack of a standardized process that is moving more and more employers to develop a best-in-market approach.

When we start looking at how they will define best-in-market and how they will weight different factors, Chart 2 is actually an example of some contracting criteria. They're able to weight different factors such as clinical quality and employee satisfaction. Does the health plan have a Medicare risk HMO available? Is it filed and approved? What's the NCQA status? What's the financial efficiency? Then they are able to drill down even further. They can even press on to financial efficiency—say a particular factor is, what should be driving their selection from a financial efficiency perspective? The bottom graphs in Chart 2 are just showing the variability in some employee satisfaction results, followed by their total cost results.

Here are some examples of what two different employers might choose to do that's very different than what they're doing today. Employer A in one location might have an Aetna POS and a Kaiser HMO. In a very different location it might use a different carrier—Blue Cross for their POS instead of Aetna, as a example, and have a very different HMO. That's one way that employer might choose to go. Employer B, and this is a strategy that we've seen now for several different clients, might put in competing POS networks in a given location. In addition to that, it might give employees multiple HMO options. Here the decision is focused on getting to that major employee dissatisfier of "is my doctor in the network?" If that is the ultimate concern for an employee, that takes that question out of the equation for the Employer B example because then the decision becomes more a focus on what the benefit level is. How much is the plan paying? How much do I have to contribute from a premium perspective?

That's an overview of how employers are making some decisions. What we'd like to talk now about is how employers are actually taking that information, assuming that there is some sort of measurement vehicle in place, and getting to that Employer A versus Employer B.

Mr. Yamamoto: Given that an employer has gone through the trouble of actually figuring out what is the best-in-market health plan in all of the different locations that it has employees, how does it get employees to join those plans? There are a lot of different ways employers can do that. The two that I'm going to focus on is communicating to them and letting them know which plan is the best plan. There are different ways to get that message across, but a key influencer is trying to figure out where employees are going to move. A lot of them will be very cost sensitive, but still they listen to the employers about what they think the best health plan is. I know some of them don't necessarily listen when you say the best health plan out there is an HMO. There's always that side message that they're concerned that I'm being sent there purely because it's the cheapest plan that my employer offers. I don't think that's necessarily true, and it's something that a lot of the

communication is trying to get across. I read in the paper an article that was buried in the back. I don't know if anyone read this. It was talking about HMOs and the fact that Kaiser is actually the first health plan to say it is not going to cover Viagra. That made the news, and it'll be interesting to see how many different employees decide not to take Kaiser just because they don't offer Viagra coverage. And I think there was something on managing prescription drugs today.

Scorecards also get a lot of notice amongst our clients and move people into the different programs. Buying guides are another one. Another is formal education. And I'm also going to talk about contribution strategies and how to price to meet the objectives of the employer's health plan strategies, and also talk a little bit about the complications it does create.

A lot of our clients today are trying to do a lot of different things with one communications package that's going out to their employees. It may be that they're targeting certain market segments and saying these are the types of health plans and these are the types of things that we want you to do so that you stay healthy. We do see a lot of communication to retirees and the elderly population about what is really a good health plan for them, and that's something that's going on in a lot of the sessions today. In particular, when we take a look at the new Medicare Plus Choice option, a communication strategy is to let retirees know exactly which one of these options is going to be best for them and get them to join the plan that probably best suits their health style or their health care needs.

From a lot of the satisfaction surveys that we do—it's just a survey that's sent out to a broad number of employees just to get their ideas and feedback—we ask employees if they are satisfied with the health plan that they're in. What would they like to change? What's driving the satisfaction of the health plans themselves? Two key things drive their satisfaction. One is the out-of-pocket cost directly from their paychecks, or employee contributions. The other one is the out-of-pocket costs that they have when they go to see a doctor.

Cost really is a driver, and that leads us to a lot of the other discussions that we'll have with our clients. That is an indirect way to communicate to them that some of these plans make some sense. So, coupled with something like a buying guide that will give employees an easy-to-read communication on what a quality health care plan is by whatever definition employers might come up with—because a lot of them come up with some different ideas of what they would like to deliver and let their employees know about the health plans—they try to give some good, clear, objective measures in a *Consumer Reports*-type guide to health care. It's not full of all that technical jargon about immunization rates, although sometimes that is what employers will try to deliver to the employees, but even if they do, it's in an easy-to-

read, graphical kind of format so they can really understand and compare the different health plans.

We allowed each one of the health plans to give us something like a 150-page description of their plans. It's something that they write themselves for the employees that explains from their perspective why they would want to join that health plan. Instead of seeing the individualized marketing material directly from the health plan, it's all uniformly packaged into one, little thing, so an employee could look at the three different health plans offered and get the message from the employer as well as from the health plan helps to make their decision.

The fourth thing that employers want to do is educate their employees as being consumers of health care right now. You're not given a smorgasbord of different things that you have a right to join. It's pick the best health plan that fits your lifestyle and your family needs. To encourage migration to health plans that the employers feel makes the best sense for them we have, for lack of a better term, value pricing. Value pricing is trying to define employee contributions to meet the migration strategies of employers and to achieve the goals of getting employees into the health plans that are best for them. This is just one piece in the whole equation to get employees into those health plans.

What are the variables that they might take into account when they try to figure out what the employee contributions have gone beyond, just looking at the premium costs or the budget rates for the year? It's taking a look at things like financial efficiency. Strip away the fact that Plan A costs $120 per employee per month for a single versus Plan B that costs $130 a month. Don't focus on those kinds of literal cost differences because there are some things that get in the way with a real cost comparison between two different plans, simple things like whether or not Plan A has a $10 copay versus a $15 copay in Plan B. One of the things that they'll take a look at is making adjustments to the actual premium cost and explaining that to employees so they understand all the different criteria and factors that go into pricing the health care plan and have a better understanding of exactly which plan to join. They don't just look at the difference between $120 and $130 and come to the conclusion that $120 is cheaper. A lot of them go to some great extents to even model the differences in health plan designs relative to the contributions and give that to the employees.

The second variable is geographic variances. There's definitely a different cost in Chicago and Honolulu, for example, or even in Maui versus North Carolina or Montana. But traditionally employers viewed a lot of these different alternative pricing strategies by saying their cost on a national basis for their indemnity plan, POS plan, or whatever was a self-funded plan on a national basis, was one cost.

They didn't care that it cost more in Los Angeles, Florida, Chicago, or anyplace else versus Montana and North Carolina. They compared that cost to the local health plan in that area. So, I think we're coming to the realization that we need to change that. A lot of this was done ten years ago, so it isn't really new. What is new is marrying all these different strategies. We, as actuaries, have probably been doing that for the last 10–15 years, along with more of the softer side of evaluating what a health plan is and what a valuable and best-in-market health plan is. That's taking a look at some of the qualitative plan performance, which is the third variable. A lot of the HEDIS information being collected right now through NCQA would classify as being a qualitative kind of plan performance. It's looking at immunization rates and some really hard data to try to distinguish what's a better health plan from one to another.

The fourth variable is taking a look at employee satisfaction surveys and identifying health plans that employees are more satisfied in, making not only the communication effort to let employees understand that Plan A is appreciated a lot more by your fellow employees, but including that as a variable in how you price the plan too. So, if employees are more satisfied with Plan A, I'm going to subsidize Plan A with more money than I would Plan B because it has a lower employee satisfaction rating.

The fifth variable is plan operational effectiveness. These are some measures that aren't necessarily collected through an NCQA measure, but they may be collected by some other surveys that are being done. We have our own survey. A lot of consulting firms have their own surveys of health plans through requests-for-information kinds of things. But just the fact that HMO A can deliver identification cards within three days after someone applies versus Plan B taking some two months is a source of satisfaction or dissatisfaction with employees. It's a potential measure that you can include within the whole pricing structure. The sixth variable is using some outside credentialing organizations. Use the fact that one plan is NCQA accredited on a full basis versus a temporary accreditation. Use some of the things that are outside of somebody's purview to judge whether or not a plan is good or bad.

Among the key pricing objectives, one would be to get employees to migrate into the "high-value" plans. High value is really in the eye of the beholder, but one of the things that Mindy mentioned that we're going to talk about tomorrow in our workshop is a computer model we've put together. It's something that we're using with our clients to help answer the question, what's important to you? You can get all these different factors together and come up with an answer and do it more objectively than just having a bunch of people sitting in a room trying to figure out intuitively what feels the best. This is the next step into objectively trying to figure

out what truly is the best health plan. How do we get people to join those health plans? The pricing will not migrate the employees into those health plans, but it's going to reinforce a lot of the communication messages that have been relayed to them already through those buyer's guides or other means of communication.

The hope is that through all of these processes, the pricing, and the communication, we get an overall improvement in the programs, and the health plans that are delivered to the employees, reduce overall costs, and potentially help us leverage the position and the negotiation with those of you who are from insurance plans or health plans, because one of the things that we're doing with this whole value-pricing process is trying to identify the highest value plan. If you're not a high-value plan, we're not going to subsidize you as much, and that forces you, as the representatives of the health plan, to try to improve any kind of measure that's being used right now by that employer to select that best-value health plan. Because the employer's going to subsidize the best valued health plan at a higher rate, it would naturally improve migration into your plans too.

There are a lot of different ways we can try to define what that employer subsidy is, but I classified them into two different strategies: a one-dimensional strategy versus a two-dimensional strategy. We can probably, given that we're a roomful of actuaries, come up with a quadruple-dimensional strategy, too, using all that abstract algebra. But I'm not going to be doing that because I didn't do very well in abstract algebra. For a one-dimensional strategy, we'll take all of the pricing criteria that we've talked about, anything that employers feels is really important to them, and put them into one measure. It's a linear measure where you just come up with scores for all the different criteria and weight them according to what the employer feels strongest about. All you do is line them up and start dividing all the different health plans into different buckets and define a strategy—a percentage or a dollar amount that they're going to subsidize for each one of these different groupings. I'll have some real-life examples later on.

The best-in-market in this situation is going to be defined as potentially the lowest or the highest score that any one of the health plans would have received. So, for the other plans, their price or their actual subsidy would be driven off that best-in-market kind of strategy. It could be a percentage of premium that the employers are willing to pay. It could be a fixed dollar amount that's being adjusted with all of these factors.

For a two-dimensional strategy, compare the financial measures that you come up with, after any kind of adjustments that you want to make for it because of plan designs or geographic differences, to some other kind of measure. It could be plan performance. It could be one of the qualitative measures. It could be a

combination of a lot of the different features. Next, put together a matrix that defines the employee contribution pricing. I've seen some matrices that other health actuaries in our firm have created, as well as some that have been put together by f health actuaries from other consulting firms, so I know people are doing that. These things can get pretty complicated, so I'm going to try to simplify them.

Here is a one-dimensional illustration that we developed for a real-life client through a lot of different means. We just didn't sit down and say we're going to weight financial efficiency 50%, plan performance 30%, and employee satisfaction 20%. It can take weeks and months just to generate those three simple numbers because, besides identifying what those percentages are, we have to figure out what's really important to that particular employer in delivery of health care to its employees. When you look at the result, it looks awfully simple, but it really does take a long time to make some decisions, unless we have somebody who wants to get through this process fast. In that case, we could probably do it in half a day.

What our client did was weight all the plans based on these criteria and came up with three separate tiers or groupings of pricing that it considered exceptional, standard, and poor based on measures of exactly what that was. We scored each one of the health plans from a financial efficiency perspective, and for the client the financial efficiency took into account what the cost of the plans were, whether it was budget rates for the year for self-funded plans or premiums for the fully insured plans. We made some pretty simple adjustments to that for the standard demographic differences between the different health plans, and the geographic differences. This particular client offered four different POS plans nationally and about 200 different HMOs throughout the country, so we couldn't afford to go to all of the HMOs and say we wanted all of their encounter and claims data so we could do a sophisticated risk adjustment. We decided to do something very simple, and for the most part it gets to what they're trying to uncover with the differences in financial cost without going through the more theoretical claims-intensive kind of analysis.

The second piece is plan performance. Plan performance for the client was a measurement of a lot of the different features, again based primarily on information that we're getting from health plans through a standard request for information (RFI) process. It also did an employee satisfaction survey to identify which health plan, from the employee's perspective, is the best health plan in the market right now. We added all those numbers up using the weights. Even though we said the 50%, 30%, and 20% weights, when you really get down to the total possible scores, those really aren't the weights because there's some internal weighting with how these programs are scored in the first place.

Subsequently, the client came up with all the different total value scores in every single market area throughout the country where they had employees. It came up with four plans labeled a Tier 2 plan. They were standard plans. One plan was in Tier 1. It had a score of over 175, which was the exceptionally good plan. I think 150–175 was going to be in the standard tier, and anything below 145–150 was going to be in the lower tier, Tier 3. Then the client came up with a set of employee contributions that, absent this change in strategy, would have been uniform for all the different plans: $15, $30, and $50 for single, employee plus one, and family coverages. With the move to the three tiers, you get some dramatically different results. By the way, the $15, $30, and $50 were pretty consistent from what they had the year before. I think there might have been about a 5% increase in the overall cost. But, as shown in Table 1, you can see some pretty dramatic differences in what employees in Philadelphia now have to pay out-of-pocket to join each one of these plans.

For the standard plans it's still the same $15, $30, and $50, but the plan that happened to be in the Tier 1 area, has now been cut in half to $8, $15, and $25. The plan that ended up with a very low score ended up with substantially higher costs: $47, $93, and $155. If I were the employee who happened to be in HMO 6, I'd really have to like that HMO to stay with that plan, given that now my contributions are going from what was about $13 last year to triple that at $47. So, it really is a driver. The client got a lot of people to migrate out of what it deemed as being not only the financially inefficient plans but also the poor performing plans. By the end of 1998, the client felt it saved about $8 million in the overall scheme of things. It thought this was a success, and anticipates further movement because this is going to be tweaked even further.

TABLE 1
"ONE-DIMENSIONAL" ILLUSTRATION
PRICING CONSIDERATIONS

Pennsylvania—Philadelphia Market

	1999 Monthly Contributions[1]			1999 Monthly Contributions[2]		
HMO Name	EE	EE+1	EE+ Family	EE	EE+1	EE+ Family
HMO 1	$15	$30	$50	$15	$30	$50
HMO 2	15	30	50	8	15	25
HMO 3	15	30	50	15	30	50
HMO 4	15	30	50	15	30	50
HMO 5	15	30	50	15	30	50
HMO 6	15	30	50	47	93	155
Enrollment Weighted	15	30	50	15	30	50

[1] Set uniform employee contribution
[2] Applying value pricing

Chart 3 is a two-dimensional example. Again, this is for a specific client in the market, although the exact market escapes me right now. This is the same chart that Mindy showed earlier that had financial efficiency along the x-axis and plan performance along the y-axis. The further you are on the right-hand side, the more financially efficient you are. That means lower cost for the employee. For plan performance, the higher you are, the better quality health plan you have. What we've done is just divide the quadrant into these four different pieces, and say that for anyone whose health plan ends up in the first quadrant, we're going to give them the highest subsidy from an employer perspective. Anyone in the fourth quadrant, we'll give the lowest. We will make some decisions on what's more valuable between 2 and 3—financial performance or plan performance—and we may have different percentages in 2 versus 3, depending on what that particular employer's emphasis is.

Most of the time, clients give the same subsidy to 2 and 3 because there isn't any strong indication from employers that they want to weight financial efficiency more than plan performance. Some of that is more cost-efficient. We usually try to weight those two the same. As an example of pricing with that kind of strategy, this particular client subsidized the program at 95% for anyone who ended up in quadrant 1. Anyone who ended up in quadrants 2 or 3, are being subsidized at 90%. In quadrant 4, they're being subsidized at 85%. So, the client chose to make the distinction between all the different quadrants based on what the programs actually cost. Another way to devise the price is to use more of an incremental price difference. Plans actually define what the dollar amount of the employer's

subsidy is going to be, so that the employer's subsidy in quadrant 1 might be $100 a month. Quadrants 2 and 3 might be $90 a month. And quadrant 4 might be $80 a month. Define it in dollar terms, and employees have to pick up any difference in those costs.

Another way to take a look at the two-dimensional pricing is to divide the plans up into quadrants, and start making diagonal lines to try to figure out which ones are financially efficient, high-performing plans. In Chart 4, I'm going to give anyone too far left of this diagonal line the highest subsidy. People in between the diagonal lines will get the middle subsidy. And people in quadrant 4 will get the lowest subsidy from the employer. You can slice and dice this whole puzzle, but those are a couple ways that we might do that.

Whenever we start talking about this value pricing issue and devising employee contributions a different way than they've done in the past, you always run across some transitional issues, such as what to do with employees who get a huge jump in employee contributions. They don't want a riot on their hands at the plants. That happens every single time that we adopt one of these programs. Frankly, a lot of times when they look at the jumps in employee contributions from the old method to this value pricing method, it scares HR managers enough that they don't want anything to do with this. So, even though we've gone through a two- or three-month discussion and gotten their buy-in that this is probably the best thing to do based on what they're trying to do with their health programs, when the dollar amounts are calculated, they get scared and actually drop the whole program. For the ones who are brave enough to go ahead, we'll start developing a way to ease them into these kinds of different pricing strategies. Maybe what they're trying to do is ultimately get to a 90%, 80%, 70% kind of pricing structure. We gradually get them there by starting out with 95%, 90%, 85% or even less, depending on where their contributions currently are. We also minimize the contribution increase for an individual employee. We go through the exercise to try to figure out who's going to be hurt by this strategy to make sure that they're not hurt.

Table 2 shows another client that has been doing value pricing for awhile, and it's interesting to note that even though it's had the same criteria and weightings for defining how each one of the different health plans end up in each one of the different tiers from year to year, from 1997 to 1998, you can get a sense of where the health plans ended up from one year to the next with the same consistent definition of a Tier 1, 2, and 3 health plan. You get a lot of plans going from Tier 1—out of the 66 that were in there in 1997, 45 stayed in Tier 1. We actually had 18 move to Tier 2 and another 3 that moved to Tier 3, so you get some dramatic jumps, even from year to year, even though you have the same definition.

TABLE 2
"VALUE PRICING"
MIGRATION FROM 1997 TO 1998

1997 Tier Grouping	1998 Tier Grouping			
	Tier 1	Tier 2	Tier 3	Total
Tier 1	45	18	3	66
Tier 2	50	18	8	76
Tier 3	11	3	24	38
Total	106	39	35	180

That's another issue that you have to wrestle with employers, recognizing the fact that depending on what you're using for data to place plans into each one of these different tiers, it can potentially drive employee contributions wildly from year to year. This particular client let the numbers fall where they may so that if you had a Tier 1 health plan one year and it moved to Tier 3 the next year, it didn't care. "That's how we decided to measure the particular health plan. That's how we're going to subsidize those health plans." So, those employees, even though they didn't change their plan, can see some pretty significant changes in their employee contributions, either up or down.

Value pricing is not for everyone. It does produce some divergent results potentially from year to year, even beyond that transition year. It also produces an added communication challenge because it's not that straightforward to explain exactly how you came up with those employee contribution numbers in the first place. To convey that to employees in a simple enough language that they can understand makes it a big challenge, but a lot of our clients are doing that. It's more difficult to administer because you have a whole bunch of different sets of employee contributions in each one of the different areas. Even though they may have an HR system already set up to handle different employee contributions by work location, even within work location it may have some different subsets of how to set the employee contributions, so it really does add to the administration of health plans significantly.

One of the things I think it does produce is a more equitable—and I guess equity is also in the eye of the beholder—employee contribution level. I think it's a step toward getting there, and by a particular employer's definition, a high-value plan does enhance migration into these plans. You do see movement of employees into the plans that are deemed as being the high-value plans slowly through the employee contribution strategies. I believe that's it.

From the Floor: In evaluating the quality of some of these programs, has anyone put any value on the cost of the employee downtime for managed care? From that, I mean looking at it as a manager of employees, not as a health care consultant. But

as a manager of employees, some of my employees who are in managed care programs are taking time off from the job because of less flexibility in appointments, extra visits to the gatekeeper, or time on the phone arguing for approvals, and that's costing me money as an employer. How do I evaluate that and factor it in relation to the cost I'm saving by paying that network provider less premium?

Mr. Yamamoto: Anybody from a health plan want to take that question?

Ms. Kairey: I think that's an excellent point. If you really look at it from employers' perspectives, the two issues that they're really trying to achieve ultimately are: (1) is my employee's health status actually improving as a result of the health plan that they're participating in? and (2) the issue of absenteeism, lost time, and decreased productivity, which has become more of an issue and more of a concern for many of our clients. I think that what they struggle with is the ability to measure it, and for a lot of employers, the only way to actually do that is if somehow or another they have integrated databases able to track a person through a whole series of episodes of care. And, quite honestly, most employers are not able to do that. I think it's quite encouraging, that employers will start talking about that issue of lost time, and you get into a very philosophical debate, but the truth of the matter is that when push really comes to shove on that, they are not able to track it and quantify it.

From the Floor: When you get into value pricing where you're bringing in more than demographics or plan design, how did you deal with the HMO regulations on that? And how did you address that issue with your client?

Mr. Yamamoto: The way I address the HMO contribution issue is to compare what the employee contribution is for a particular HMO against the self-funded plan so that we're not discriminating between the two and just focusing on those two kinds of issues. Generally, with most of our clients, the HMO contribution is actually a lot lower than the self-funded plans. So, you're not running against the issue of seeing different employee contributions from that HMO to the self-funded plans. I guess the way I've interpreted and read the regulations and all kinds of interpretations afterwards, too, is that the HCFA is being pretty lenient about how it determines whether or not an employer is discriminating against an HMO in setting its contributions. Given that latitude, we have not had a problem in coming up with these kinds of objective measures, but one of the things that we do look at is the bottom line. After we get the contributions done, with all these different, objective measures that we've done, we have to make sure we're abiding by the HMO contribution there too.

Mr. Daniel R. Plante: Many of the clients we work with use best-in-market type approaches to eliminate plans that are not providing enough value. Dale, you indicated that there's a lot of jumping from year to year in how a health care provider's best-in-market or value measure can change. What protections do you put in place to prevent the elimination of a plan that may one year look like it's not best-in-market and yet be best-in-market in subsequent years? In other words, do you keep it in place even though it has a rough time in one particular year?

Mr. Yamamoto: I don't think we're necessarily eliminating plans because of poor performance from any one of our measures in one year. Generally, our clients are looking at a series of results over more than one year. If we see a plan being one of the Tier 3 plans for three years in a row, it's going to see declining enrollment, because that's going to happen. Eventually, if you have a plan that's always in the lowest subsidized tiering area, generally the employee contributions are going to be higher for those plans, and at some point in time, an employer is going to have to make a decision whether or not to freeze enrollment or completely eliminate that plan. So, you're right. In the past, low performers were great candidates for either freezing enrollment or terminating them altogether. This kind of measure actually helps in that kind of communication to employees, because they can understand the fact that this health plan has been a low performer this whole time. I've had to pay more money just because maybe I like the doctor in that plan, but at least they've been communicating from year to year that I'm paying more money for this plan because it does score low. So, they're not going to be surprised if they're paying that extra cash, and after the third or fourth year, all of a sudden it's not offered anymore. I think it does present a clearer message to them about some of the decisions that are being made by the benefits manager. It just doesn't come as a surprise. In the past, we've eliminated plans, and employees called in pretty upset that they'd lost access to their provider, and they had to go through the process and change the plans again. At least this gives them some advance warning. From that perspective, I think it's actually better to have that kind of pricing strategy and communication to the employees.

Ms. Kairey: I second that because the trend that we're seeing is not so much the elimination of plans but employers taking more of an effort to say it has not been worth it. The noise that we're hearing from employees when we eliminate a plan is not worth it, recognizing that total cost and particularly the employer cost is what's important to us. We're just going to allow as many plan options as we want out there, or as employees want out there, but there's a threshold to what the employer will pay, and then the employees pick up the difference if they are so inclined.

From the Floor: At one point in time the industry was pushing towards single carrier approaches across the country. Now it seems we're moving to best-in-

market with multiple HMOs and multiple POS plans in each location. To the same extent that the industry went too far one way, I think what I've heard you say about halfway through the presentation is going too far the other way. If we're encouraging employers to keep all the POS plans and all the HMO plans and letting them preserve their market shares, I don't think we're sending the right message to the market in terms of efficiency, volume, economy of scale, and rewarding the really effective, better-managed providers for what they're doing.

Mr. Yamamoto: I assume that was a rhetorical question.

From the Floor: I'm saying that especially because of the comment you made towards the end of your presentation about several employers, in effect, keeping multiple POS plans and keeping multiple HMOs.

Mr. Yamamoto: No, I agree. I'll let Mindy speak for herself. But I agree. I think there is a balance between how many different POS plans or different plans are being offered to employees. A lot of employers have potentially outsourced their administration of health plans and said, "I have XYZ company taking care of this. I'm going to pay the same amount of money no matter how many health plans I have, so I'm going to go for the best-in-market." We may have some of those, but I do agree. I think you do potentially lose some economies of scale if you do that to a big extent. There's a balancing that goes on to make sure that you're not throwing the baby out with bath water. With something like this there is that potential of getting too hung up on trying to find "the best of all worlds," which is the best plan in every single market that you have employees. You have to balance that against what's feasible from a financial perspective and an administrative perspective. If you're losing money because you have 14 different POS plans scattered around the country, it doesn't make sense.

CHART 1
PERFORMANCE VARIABILITY

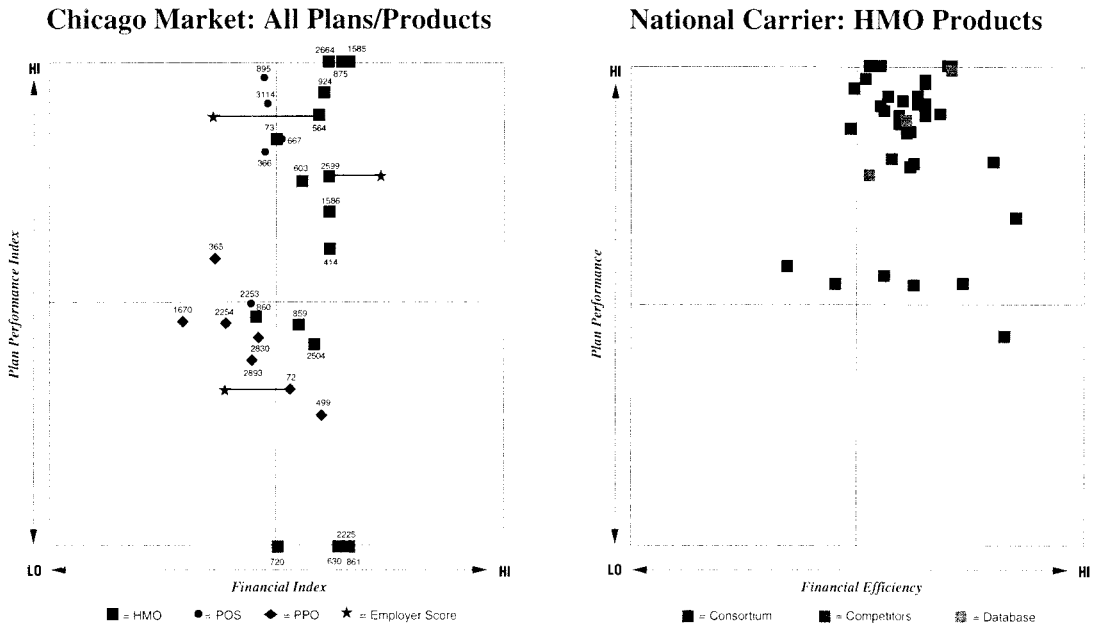
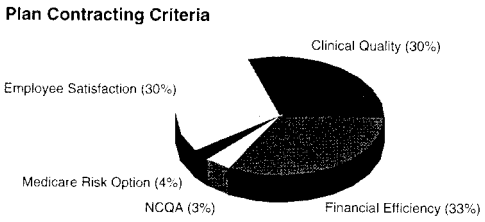
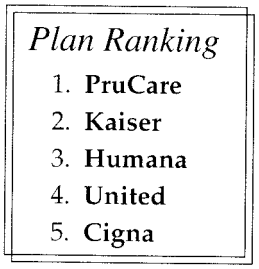
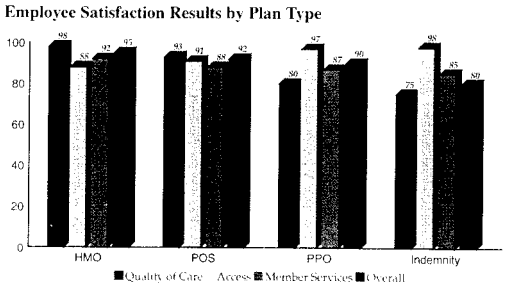


CHART 2
CHOOSING BEST-IN-MARKET PLANS







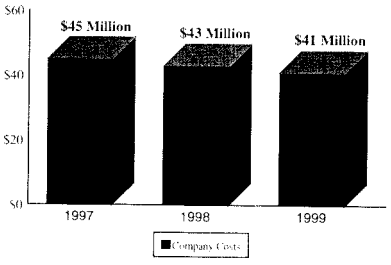


CHART 3
"TWO-DIMENSIONAL" PRICING

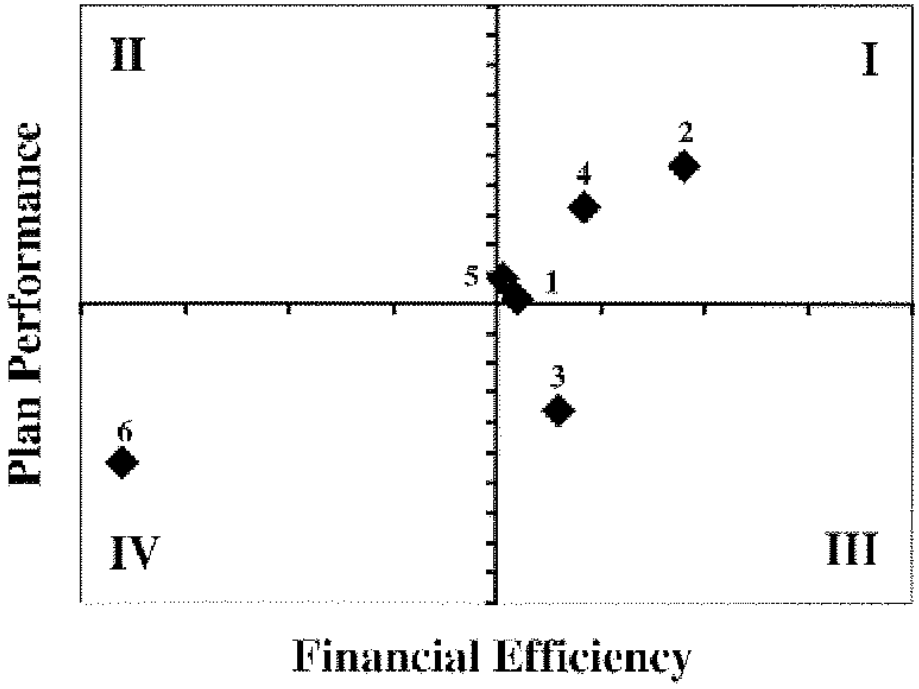


CHART 4
"TWO-DIMENSIONAL" PRICING