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Session 149OF
Employers' Tools for Coping with Large Rate Increases

Track: Health

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Panelists: EDWARD C. CYMERYS
JAMES F. SANFT
BLAKE ZENGER†

Summary: The effectiveness of managed care seems to have significantly diminished over the past few years, which has lead to significant cost increases for employers and their employees. Panelists discuss the tools available for coping with these changes, such as improved information on specific providers (relative costs, charges and efficiency); analysis of the value of managed care administrative fees; The Leapfrog Group and other data quality initiatives; and plan design changes.

MR. JEFFREY T. GAVLICK: The question is: Is it good news or bad news for managed care rate increases? Well, it's bad news. Figure 1 shows the Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans, and this is how things have been: This is not trend, these are cost increases for employers. As you can see, back in the 1990s, employers did a lot of shifting to managed care. "Shifting" was a true silver bullet back then. Well, "shift" happened, and we don't have that silver bullet in our gun any more. We're hoping, today, to find a silver bullet or two in the presentations that follow.

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†Mr. Blake Zenger, not a member of the sponsoring organizations, is senior consultant at Mercer Human Resource Consulting in Boston, Mass.

Figure 1

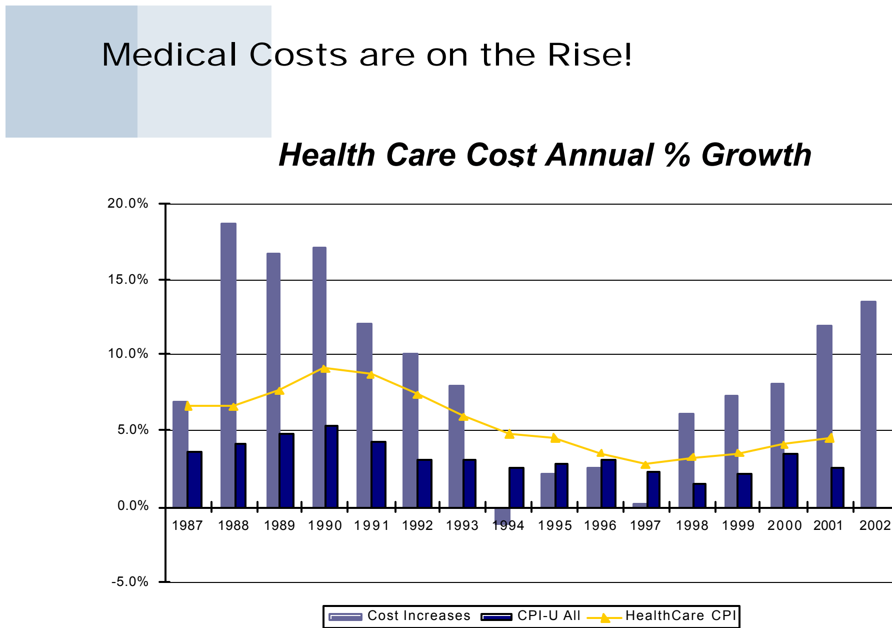
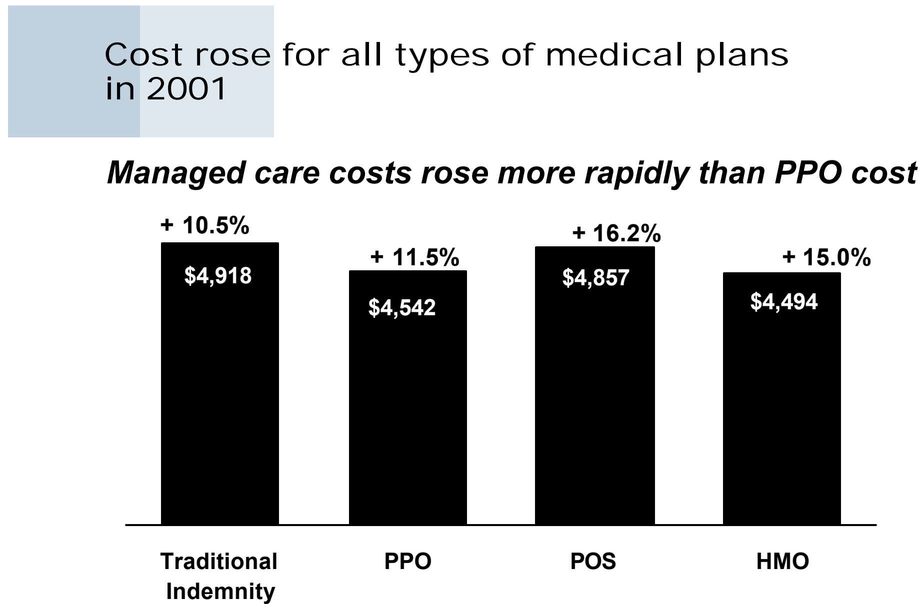


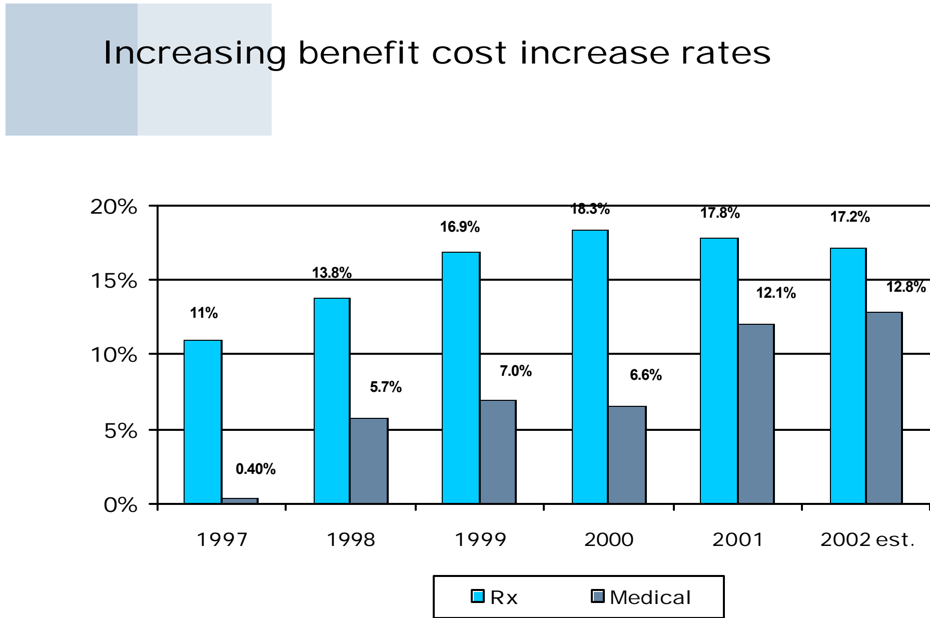
Figure 2 shows that managed care costs (i.e., point of service and HMO) advanced a little more rapidly than PPO costs. They're actually catching up to the traditional indemnity and PPO in costs. Figure 3 illustrates a break out over the last few years by Rx vs. Medical.

Figure 2



This is all from the Mercer/Foster Higgins National Survey. You can also see in Figure 3 that the increase in rates has been very high for Rx, but medical is certainly catching up.

Figure 3



Source: Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans

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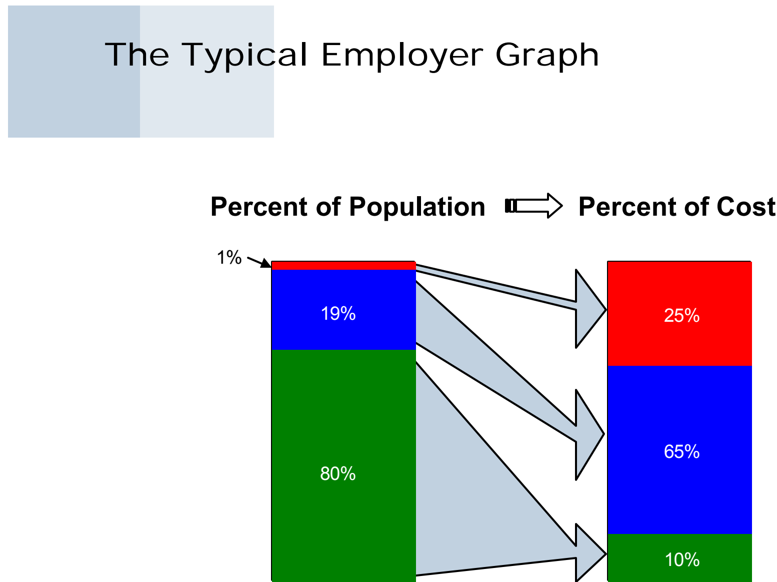
Here is another thought that we wanted to put in your mind: Take a look at Figure 4. This is what we call the typical employer graph. Notice that 80 percent of the employees generate 10 percent of the claims, nineteen percent generate 65 percent of claims, one percent generate 25 percent of your claims. A lot of what we talk about in this session will focus on this top 20 percent of employees rather than the bottom 80 percent; there is just not enough money there to spend a lot of time on it.

Figure 4



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We will look at three perspectives on this topic: the advisor, the carrier and the employer. First, we'll have Blake Zenger, who is a colleague of mine in the Boston office of Mercer Human Resource Consulting. He is a consultant—and, thus, the advisor. Blake does have the distinction of not being an actuary. When you meet him, you'll find that he does a lot of work with data and provides a lot of advice based on data, so he certainly speaks our language. After Blake, we'll move to the carrier perspective, which will come from Edward Cymerys of PacifiCare Health Systems in California. Finally we'll get the employer perspective from James Sanft. I hope that with these perspectives, we will get a broad look at the kinds of things employers are doing to stem the tide of these rate increases.

If you have questions, you are welcome to ask them at any time. With that, I'll turn it over to Blake.

MR. BLAKE ZENGER: Thanks, Jeff. One thing that we at Mercer try to do when we work with large employers is to put ourselves inside the heads of benefits managers. So as we go through the materials that I've prepared, I'm going to try to get you to think about some of the challenges that are being faced by benefits managers right now.

As you could see by some of the materials that Jeff used, as well as some of the slides we're going to look through, this is a very challenging time for benefits managers. They are getting asked questions from chief executive officers (CEOs) and chief financial officers (CFOs) that they've never been asked before. In fact,

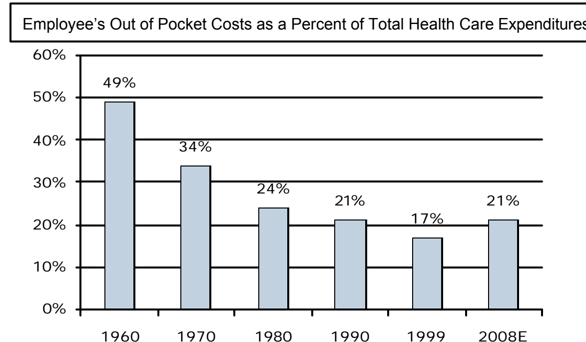
traditionally CFOs have not played a major role in the design and specifics of setting up benefit plans. But from our experience, we're seeing that CFOs are playing a much more active role in doing that, and they're asking some pretty tough questions that benefits managers haven't been used to answering in the past (Figure 5).

Figure 5

What CEOs/CFOs Are Asking Benefits Managers to Do

- Keep health care costs level
- Preferably decrease them
- Employees need to assume more of the expense

To accomplish this, "business as usual" will not work



Source: HCFA, Morgan Stanley Dean Whitter Estimates

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As you look across the landscape that benefits managers face now, there are some of the old culprits that have been out there for a long time. Namely, Medicare and Medicaid reimbursements continue to decline, and pressure is being put on private payers to make up the difference for an aging population and increasing prescription drug costs. But you have some new ones that haven't been around in the past, especially in the weak economy that we face, and some significant increases in costs that we haven't seen for a while.

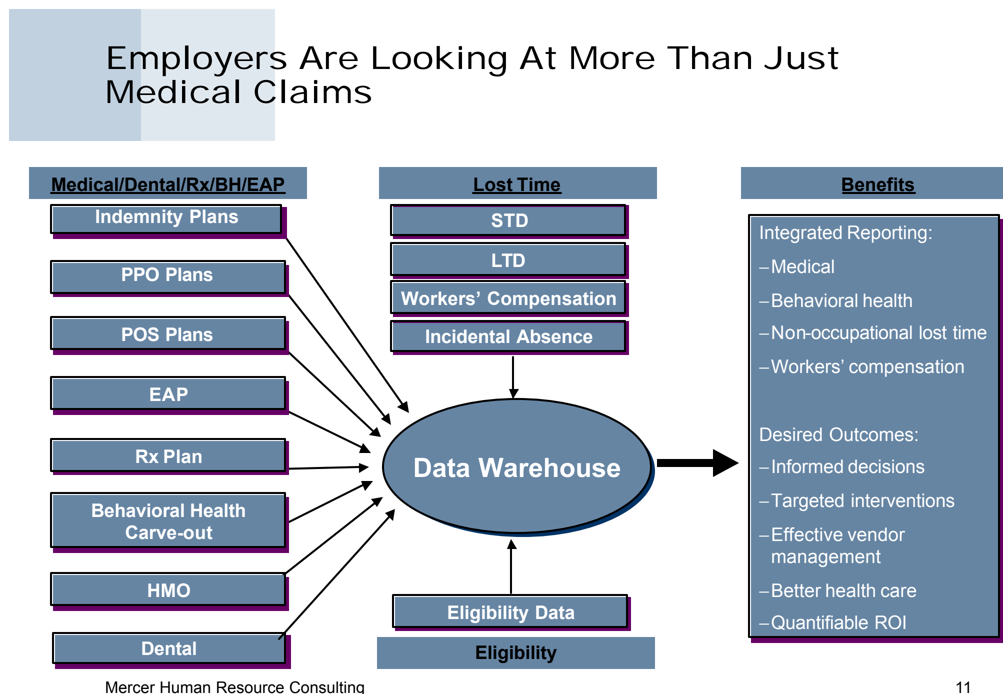
The other directions that we seem to be going—and we're going to talk quite a bit about this—are toward engaging employees more in making health care decisions and consumers playing a greater role in the benefits area. That is a great concept. However, we don't have a lot of good information about the quality of care that is being provided. So benefits managers are challenged not only by the pressure to increase the percentage of the cost being picked up by employees, but also by not having adequate information to help employees make those sorts of decisions.

Going back to the involvement of CFOs, they are accustomed to getting a lot of detailed information about what drives costs with respect to the more traditional aspects of the business. So if the CFO of a manufacturing organization approaches

the manufacturing executives, those executives can typically tell the CFO very clearly the costs of supplies and labor. Those sorts of questions are now getting leveled at benefits managers, who are having a very difficult time providing answers. One of the key messages that I'd like you to take away is that employers are beginning to use new tools—based on detailed claims data—to get underneath their trends. This allows them to tell a CFO, for example, that the 18 percent trend that they're seeing this year is made up of a two percent change in demographics; eight percent from people just going to the doctor more often; five percent from the underlying increase in health care costs; and the rest is due to catastrophic claims experience. These are questions that most benefits managers have not been able to answer in the past. In addition, with the availability of data today, you can make comparisons to relevant benchmarks. You can get some context for your own claims experience and look at some of the underlying issues that are specific to your population as an employer instead of the population as a whole.

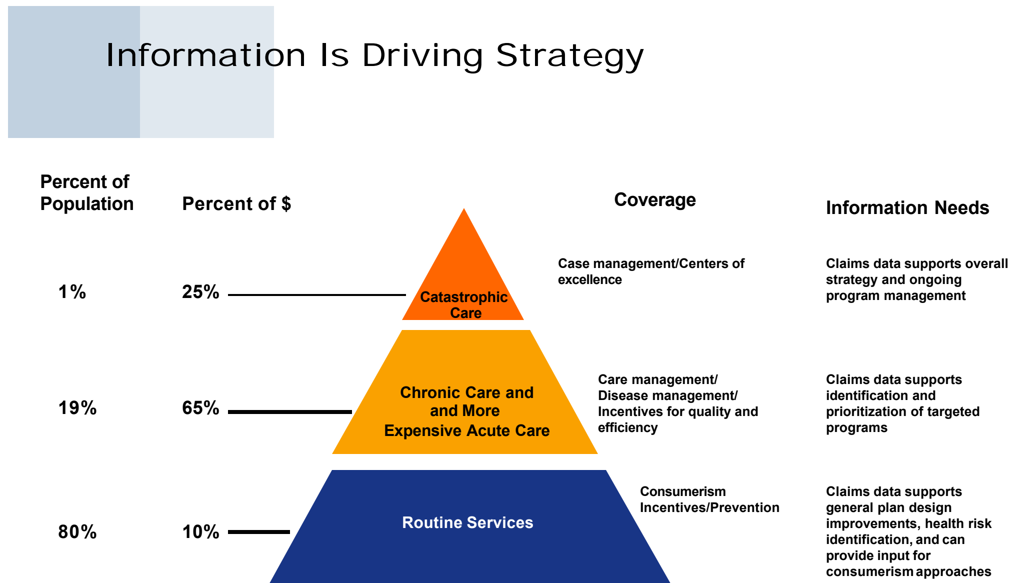
Back to this concept of tools—one of the tools being created by large employers is a database that houses a variety of data. Figure 6 exhibits how these data are not just medical claims any more. The data warehouse links medical claims with prescription drug information too. Also, an emerging area is the ability to pull in lost-time and absence data, such as short-term or long-term disability, and to look at the full range of costs impacting your employee population.

Figure 6



Previously, Jeff talked about placing a significant emphasis on managing one percent of your population that drives 25 percent of your costs. This is true, but I've actually modified this figure a bit and stated that the primary focus of many benefits managers at this point is trying to get to the 19 percent of their population that drives the 65 percent of costs (Figure 7).

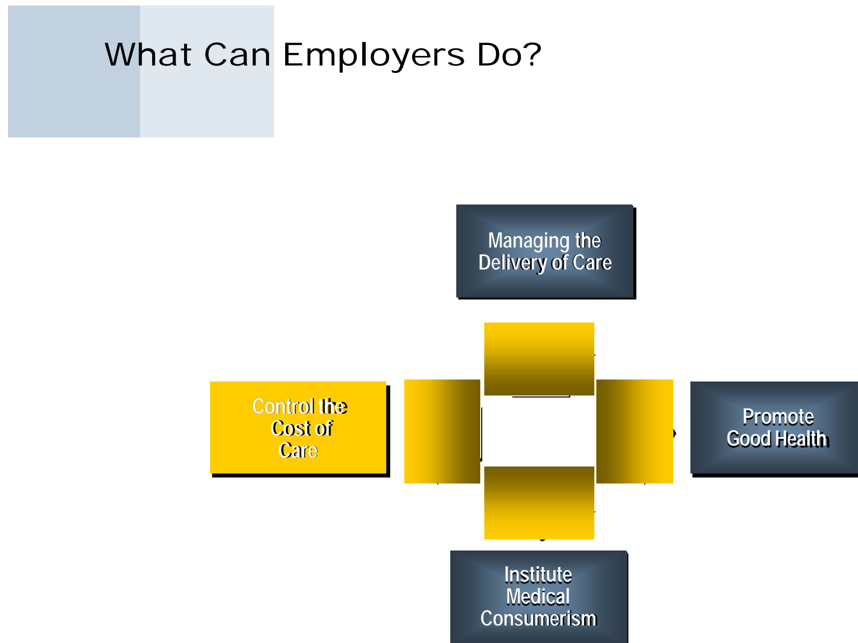
Figure 7



Some things can be done to manage catastrophic experience through case management, and, clearly, there are opportunities for savings there. But one of the things I'll talk about later in my presentation is examining your data to identify the risks of your population and the specific clinical issues that may call for some programs to be implemented, like disease management programs—another area that benefits managers are looking at more closely now. This group at the bottom, the 80 percent, as shown in the slide, presents opportunities to manage the risks of your population by using data to understand the risks of that population and to keep them from moving into the next level up in this figure—the chronic and more expensive acute-care level.

Now, let's look at some other specific tools, which I've broken into four categories (Figure 8).

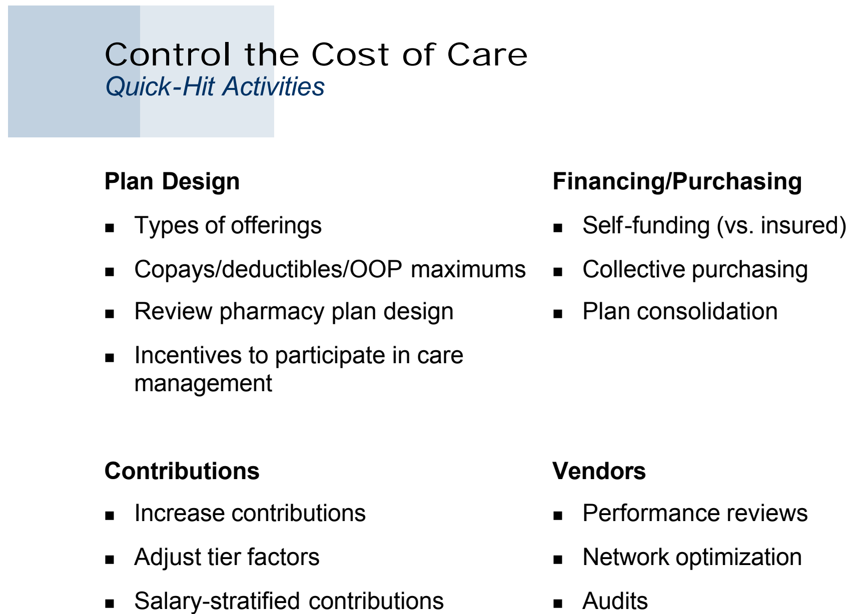
Figure 8



Some of these tend to float around a bit, but I am going to use this as a framework on the models as we're talking about them.

First, quick hit activities (Figure 9): These are things that I'm not going to spend a lot of time on, because I think they're all very familiar to the people in the group. There are a lot of efforts being made in this area right now. The plan design changes, which most employers are requesting this year, typically have some pretty large cost-shifting components to them—such as higher co-pays, higher deductibles, office-visit co-pays of $20 and inpatient hospital co-pays that are rising into the $250 range—as well as other aspects of increasing contributions and efforts to maximize the performance of networks so that you get more people going in-network and taking advantage of the discounts.

Figure 9



Some benefits managers are relying more on benefit plans audits to make sure that benefit plans are paying claims correctly. All of these are some of the quick hit things that we all know and use a lot right now. I want to focus more time on some other areas. In managing the delivery of care, there are many topics that we could talk about. I have picked two. The first topic is high-performance networks, as you can see in Figure 10. Ed will talk more about this, so I will not spend a lot of time on it.

Figure 10

- High performance network development uses data to identify and qualify the most efficient providers
  - Episode treatment groups
  - Providers are compared to each other
  - Inefficient specialists can use over 40% more resources
- Medical care can be shifted to the most efficient providers by:
  - Benefit plan design modifications
  - Physician partnerships
  - Limited networks

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My take on high-performance networks is this: Line up all doctors that meet a certain quality threshold, rate them from low to high based on their efficiency, and then identify those doctors who are the most efficient. Employees are then encouraged to use these low-cost or more efficient providers. There are some significant savings opportunities in these sorts of tiered network approaches. It is one of the areas gaining a lot of traction, and some of the large national health plans are beginning to set up tiered networks or networks within a network.

Figure 11 outlines patient safety. The Institute of Medicine in 1999 published a study that has gotten a lot of play in the media. It says that 98,000 Americans die every year from preventable medical errors, making errors the leading cause of death in hospitals. Bob Galvin at General Electric made an interesting observation about this. He said that if you put activities that Americans do into three categories—pretty safe, fairly safe and very risky—going to the hospital actually falls into the risky category, and that is based on one fatality per thousand encounters, which puts it on par with mountain climbing.

Figure 11

The Leapfrog Group
Patient Safety

- IOM estimates that up to 98,000 Americans die every year from preventable medical errors
- Leapfrog Group
  - Consortium of more than 100 Fortune 500 companies
  - Base their purchase of health care on principles encouraging patient safety measures
- Leapfrog's Mission: Providing information to help consumers made more informed health care choices
- Initial Leaps in Patient Safety
  - Computer Physician Order Entry (CPOE)
  - Evidence-Based Hospital Referrals (Refer patients needing complex medical procedures to hospitals who have demonstrated the ability to perform these procedures)
  - ICU Physician Staffing - Staff ICUs with physicians who have credentials in critical care medicine

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A group has emerged called The Leapfrog Group, which is a consortium of large employers that have banded together to push the agenda of patient safety forward. They have committed to make health care purchasing decisions in a way that recognizes some of these patient safety issues and identifies to their employees the most reliable and highest quality providers. Three main areas they've chosen have encountered a lot of criticism because they aren't necessarily based on long-term clinical studies or clinical trials. Instead, these are based on the best judgment of this group of members in the consortium.

First, encourage physicians to enter their prescriptions via computer or a PDA. Everyone has received a prescription with lousy handwriting that makes it seem amazing that you actually got the right drug from the pharmacist. Second is a list of seven procedures recommended by the consortium that are more complex. The consortium members are trying to get their employees to go to providers that have demonstrated higher quality. Specifically, they encourage employees to go to hospitals that have crossed some volume threshold, so they're not getting heart care done at a community hospital that has only done something once before. Instead, they would go to a teaching hospital that has a lot of experience doing these sorts of procedures. A third approach involves benefits managers encouraging their employees to go to hospitals where they have the properly credentialed physicians on staff in the ICU department, for example. All of these areas I've mentioned have been shown through research to offer many opportunities for improving patient safety.

Figures 12 and 13 exhibit analyses of the cost of chronic health conditions. Promoting good health gets back to what I mentioned before about trying to use the claims data to address issues that are specific to your population. This means examining your claims data and comparing it to benchmarks to see, for example, if your group's experience with heart disease is above or below where it should be, and then looking at the trend. Is the trend for that particular cost going up or down? Are there disease management programs in the marketplace to address some of these? There is also a lot of debate right now over the return on investment of some of the existing disease management programs.

Figure 12

Managing Delivery/Promoting Good Health

Analyze high cost chronic conditions

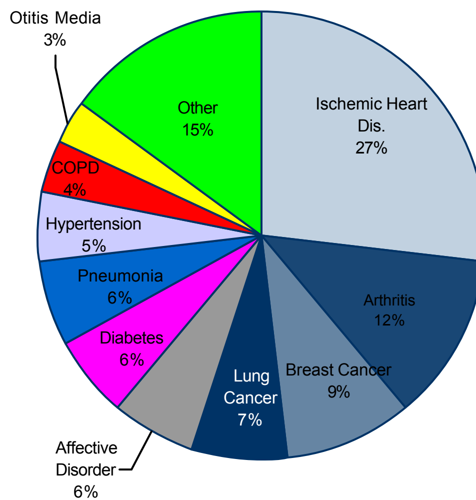

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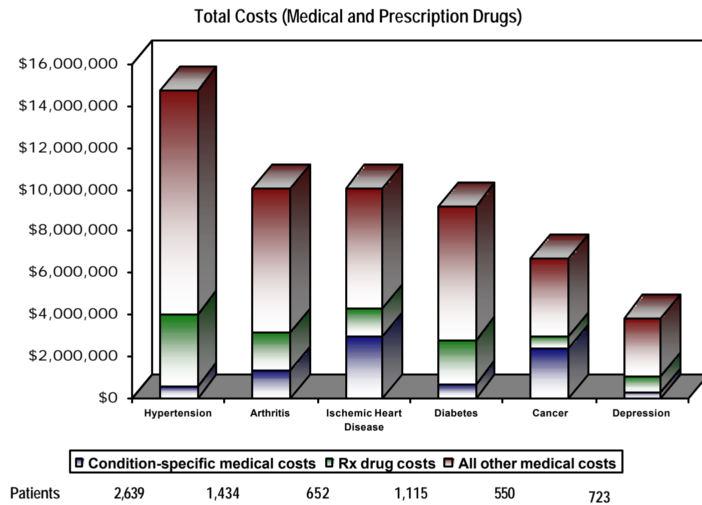
Figure 13

Promoting Good Health/Managing Delivery
Quantify the full cost of chronic illnesses



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Some of the best known of these disease management providers are starting to offer performance guarantees—some fairly significant—where they're putting fees at risk. This is one of the key indicators that shows this is something that will really take off in the near future. Once that happens, in my mind, it means this has become an area where there will be a lot of employers moving in the direction of implementing disease management programs.

Let's get back to this idea of obtaining the full picture of your experience—not only look at the cost to treat heart disease, but also the medical costs as outlined in Figure 14, for example. You also need to be able to pull in, on a person-specific basis or a person-centric basis, the prescription drug experience and then all the other costs of treating that individual. For example, if you look at ischemic heart disease and the medical costs for those people with the disease, it's a significant amount of money. But we then pull in their prescription drug costs and all of the other costs for treating those individuals, it's more than double.

Figure 14

Disease Management
It's Not Just the Direct Medical Cost

	Average Per Capita Health Cost	Percent of Workers with Condition Missing Workdays	Estimated Work Loss Costs (in billions)	Total Costs for Persons with Condition (in billions)
Asthma	$2,779	20%	$3.4	$31.2
Cardiac disease	$10,823	37%	$3.8	$42.4
Diabetes	$5,646	10%	$3.5	$57.6
Mood disorders	$4,328	18%	$11.5	$66.4
Hypertension	$4,073	8%	$11.5	$121.8

Source: Druss, Marcus, et.al., Health Affairs, Nov/Dec 2001

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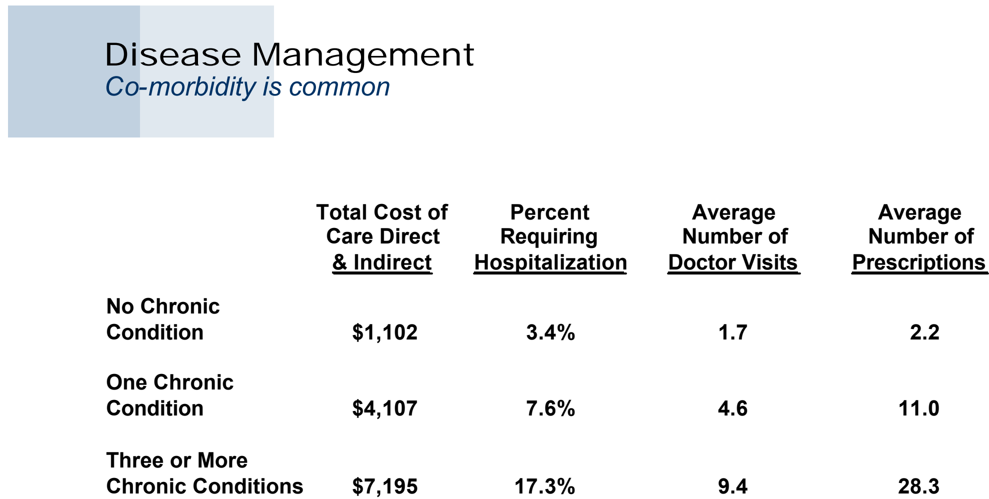
This brings up the issue of co-morbidities. Patients that have, for example, ischemic heart disease tend to have other co-morbid conditions. Disease management programs often will treat not only the particular condition, but also a lot of the co-morbid conditions on a person-specific basis (Figure 15).

Figure 15



Disease Management

Co-morbidity is common

	Total Cost of Care Direct & Indirect	Percent Requiring Hospitalization	Average Number of Doctor Visits	Average Number of Prescriptions
No Chronic Condition	$1,102	3.4%	1.7	2.2
One Chronic Condition	$4,107	7.6%	4.6	11.0
Three or More Chronic Conditions	$7,195	17.3%	9.4	28.3

Source: Anderson & Knickman., Health Affairs, Nov/Dec 2001

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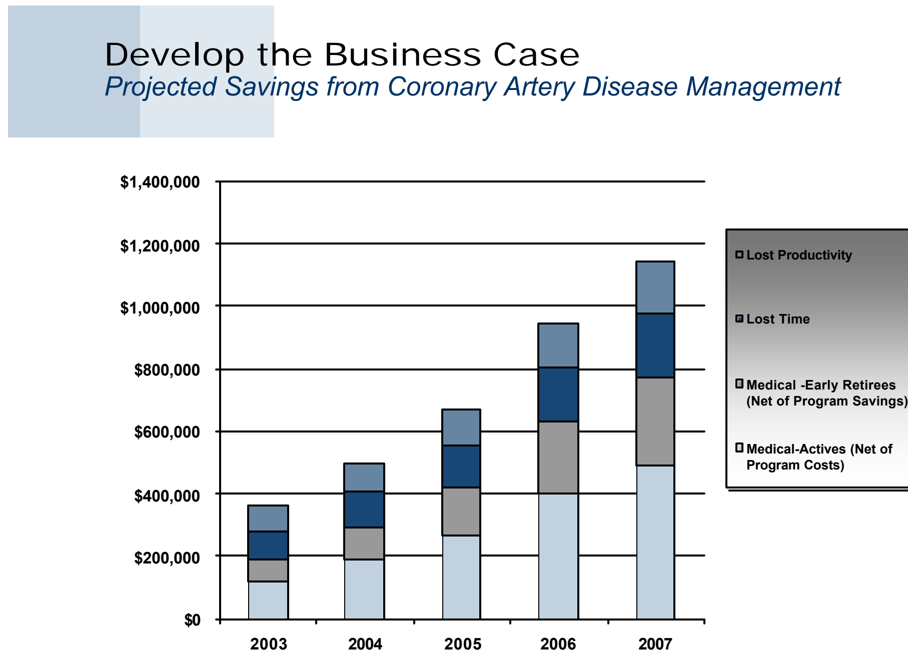
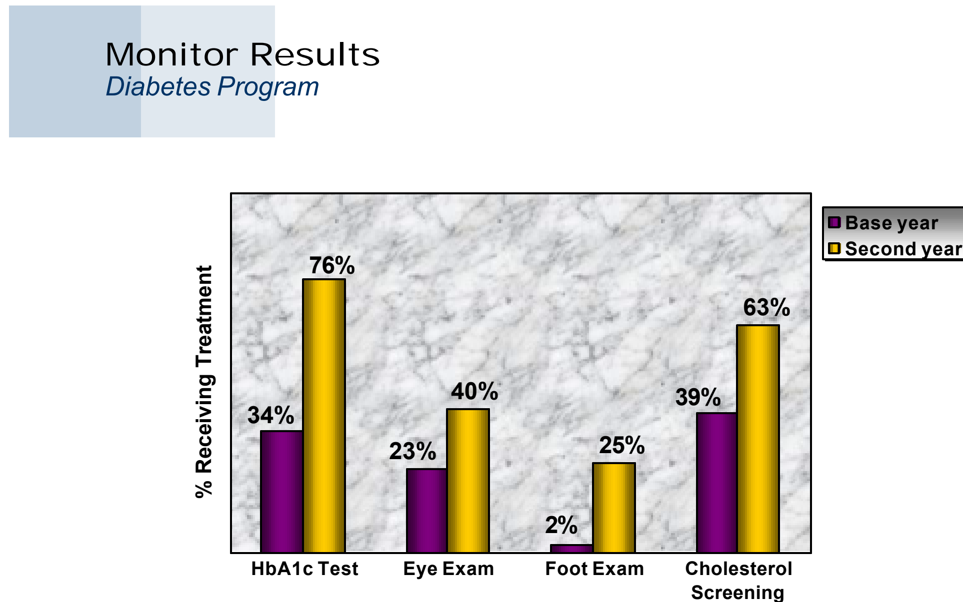
Then you take this even one step further—this concept of having all of the data available to you to make these sorts of decisions. Look at lost work time, both direct costs from wage replacements and short-term disability programs and then loss of productivity costs—to the extent that you can make some estimates about what those are. The story becomes pretty compelling. Benefits managers are starting to take this data back to the CFO and the CEO to make a business case for implementing these sorts of programs. They do cost money, but with the data available, you can make a pretty strong business case for these sorts of programs. It's another tool being used at this point by benefits managers in controlling the high-cost trends (Figure 16).

Figure 16



With the data comes the ability to monitor results. This enables you to look not only at specific measures, like whether the diabetics in your population are getting the proper tests when they enter into these sorts of programs, but also to make some return on investment calculations and provide these to your CFO. See, for example, Figure 17, which shows how you can monitor the results of a diabetes program.

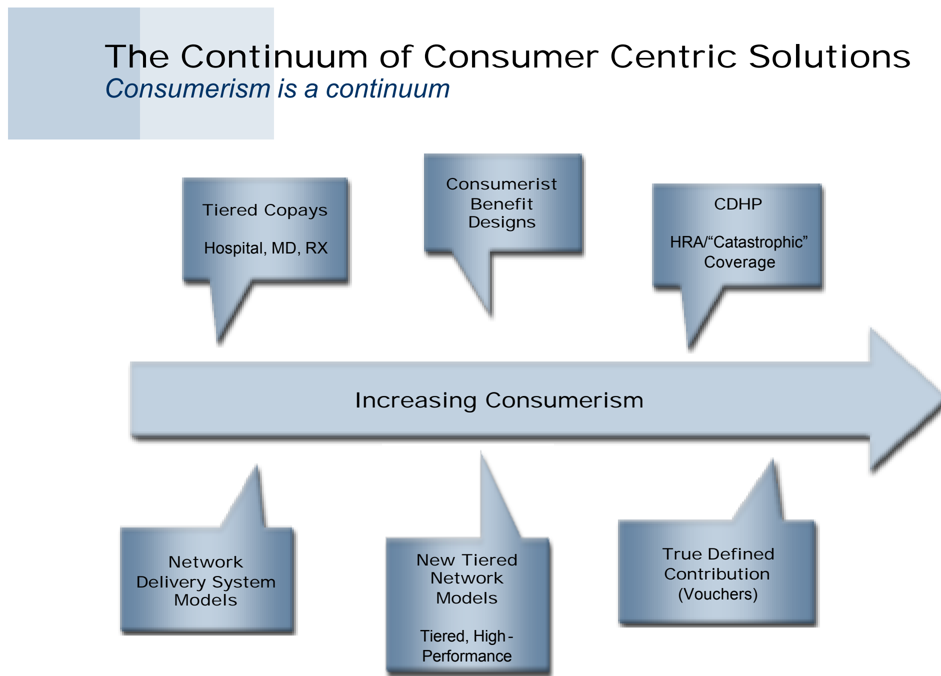
Figure 17



Promoting consumer accountability: Let me make it clear, the topic of consumerism means a lot more than just the consumer-directed health plans that we're all hearing a lot about right now. This is a continuum ranging from providing basic information to employees via the Internet about how they should approach doctors (i.e., the questions to ask them) to a voucher approach, which would be similar to a defined-contribution approach on the retirement side. Clearly, the emphasis now is on consumer-directed health plans. I'll give you a little bit of the consultant's perspective, as an advisor to employee benefits managers.

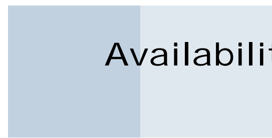
What we're seeing is a struggle to get good quality information about health care. It is the key that is missing in a lot of these consumer approaches. It's like having a consumer report where you have a list of the products, for example, televisions available for purchase, but without any information about the repair history. You don't even have any information about the features, so the data available to consumers—to actual patients that are going to see the doctor—is very limited at this point. It's just in its infancy as far as the data available to provide to consumers about their care (Figure 18).

Figure 18



To the same point, if you look down through this list of percentages in Figure 19 of people that have all of the information they need to make good health care decisions, it's starting to reach about 50 percent on some issues—like how to communicate with your doctor. There is some good information on the Internet that employers are providing to their employees on some of those issues. But when it comes time to evaluate the quality of doctors it is very little if you look at the 18 percent number there.

Figure 19



Availability of Information

Percentage Having "All the Information Needed" to Make Good Health Care Decision

Type of Information	Total
How to choose doctors	42%
How to choose a health plan	43%
The range of services covered	33%
How different types of plans work	34%
How to evaluate the quality of doctors covered by the plan	18%
When it's necessary to go to a specialist	30%
How to seek assistance with specific illnesses and health conditions	28%
How to take responsibility in decisions that affect your health care	35%
How to communicate better with your doctor	51%
How to evaluate the quality of health care provided by doctors	30%

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There are a couple of points from Mercer's perspective on consumer-directed health plans. This is an emerging area, and one of the things we have found is that of all of the different decisions that benefits managers are making these days, it is most important that they get help from people like you that are in this room. Some of the tricks of the underlying actuarial assumptions about consumer-directed health plans are critical for benefits managers to fully understand before they implement some of these programs. Understanding some of the issues around risk selection, which exist with consumer-directed health plans, as well as understanding what you lose in the way of discounts by some of the approaches to this—especially dot-com approaches.

It is an area in which there is a lot of energy and emphasis now. Some of the large national vendors are building these sorts of approaches. With those national vendors will come strength in the discounts that they're able to provide employers. But this issue of selection bias still exists. So these are plans that I think are not going away, but clearly they're going to need the help of people that are really smart regarding actuarial assumptions underlying the decisions.

MR. GAVLICK: Blake, a comment and a question: With regard to the consumer-directed health plans, I understand that we did ask some questions in the survey referenced earlier. Because some of the large employers or first employers were out there a year or two ago, we will start to get information, at least on participation and so forth, on some plans that are implemented in 2000. I have a question for you: It's a very data-intensive approach that you take. With the HIPAA

privacy rules that are coming up, what is the implication of that, and is that going to interrupt your ability to get the information you need?

MR. ZENGER: That issue is obviously coming up a lot right now because of some of the deadlines—some have passed and some are approaching—on HIPAA issues. To the extent that large employers are using an outside vendor to do these sorts of data-warehousing approaches, the data vendors can do all of the necessary securing of the protected health information that's required. Employers that actually have access to the databases themselves don't have access to any of the protected health information. The social security numbers are encrypted. All of the linking of the prescription drug and the medical claims is done ahead of time, so there's no need to have access to social security numbers. But it is a concern, especially when you start to pull in some of the short-term and long-term disability data. It's an area that is still being discussed with the legislation that exists out there at this point.

MR. EDWARD C. CYMERYS: I'm an actuary. I've spent about two-thirds of my career on the West Coast, and before that, I was a New Englander. So I have a bit of a balanced perspective, although the California view will come through. I think Blake did a good job of laying out some of the things I'll flesh out a little more. The program notes say the effectiveness of managed care seems to be significantly diminished over the past few years, which has led to significant cost increases for employers and their employees. I think Jeff actually rewrote that because it was a lot harsher to the managed care plans the way it was originally teed up. I used the perfect storm theme to illustrate that there have been a lot of forces that have come together.

During this meeting, people heard about member demand, low cost sharing plan designs, which have persisted, combined with what's gone on in the provider side—provider organization failures and hospital system mergers. I think in an earlier session there was a discussion about provider contracts, and it started out with a description of the Boston area hospital systems that have come together. With regard to Medicare and Medicaid, the funding has been squeezed and the prospects for rate increases are pretty pessimistic. Some of the earlier slides touched on chronic illness cost escalation and the gap in information needed to make decisions.

Member demand and co-pays mask provider cost differences—I think health plan members generally don't know the cost of an office visit, or whatever procedure or drug they might have had recently, but they do know how much their co-pay is. For one of the moderators from an earlier session, who is in a defined-contribution plan, drug costs were top of mind. Because of the masking of these costs, employers generally demand broader networks. We are asked what is the process to add providers with both HMO and PPO products. Employers all have additional providers that they think should be added to the network. It's a mindset in the business that they're not thinking about what it is going to cost to add providers or whether they fit all the criteria of the networks. Then there is a gap in information

about the health care decisions—who are the most efficient and effective providers and then, for members, what actions would help manage specific health conditions. The disease management programs are really education programs for members.

On the provider side, a number of states have been hit with organized physician group turmoil. Texas and California have been two states where there were a lot of organized groups that took capitation risk. A bigger factor was insurance departments pushing some of the prompt pay rules. In other words, if an insurance company has a requirement to pay claims within a certain time period, the insurance department held the insurance companies accountable for any delegation of that responsibility out to the providers. Actuaries understand that if you haven't funded your incurred but not reported claims (IBNR) and unexpectedly , you have to accelerate your claim payment, it spells disaster. Some of the groups could have avoided this if they had been a little more disciplined. For tax purposes, sometimes groups are paying out the reserves that they have at the end of the year. If in early January they are required to speed up their claim payment, it just creates a disaster and it did create a cash flow disaster in those states.

Hospital systems have merged and strategically tried to target areas where they could effectively eliminate competition. The Tenent hospital system is an example that has been steadily announcing higher and higher earnings publicly. In their calls to investors, they have talked about how they've gained leverage with carriers and now can demand much higher payments. Medicare has really been squeezing the providers. I think again out West where there's a high penetration of M + C plans, the funding increase is at two to six percent, but the cost trends are still in the high teens. Payments decreased to the physicians on the Medicare fee schedules, and that further causes some cost shifting. The costs for chronic illness—with new technologies and drugs—have been extraordinarily high.

The old reaction that I think employers had was, if they didn't like the rate increase, they bid their plan or eliminated a carrier. I think CalPERS is a good example. CalPERS is in California, obviously. They are very large, with 1.2 million members: 350,000 in PPO, 500,000 in network-model HMOs and 350,000 in staff-model HMOs. They have consolidated the network HMOs and, for the 2003 plan year, they were unhappy with the rate increases they got. Initially, they were planning to keep all three plans, and they put out a bid that was essentially lowest-bidder-take-all. They pulled the trigger on that and eliminated the other plans, consolidating to one, but it really didn't save them any significant amount of money on their increase. A system that large ended up agreeing to what will amount to a 26-plus percent year-over-year increase. I think other large plans are finding that, too. From the carrier perspective, just buying this membership is not enough. There has to be some reasonable margin in the rates for us to be able to do business.
The reaction of the carriers, the managed care companies, to these cost increases has been to manage the delivery of health care and promote good health. Hospital tiering and narrow networks have been a big piece of this effort. I characterize it a little bit differently than Blake, based on what our initial steps have been. Blake recommended that the providers that reach a certain quality threshold should be

rated by cost. We've taken a little different approach. We have said that cost is still critical. So providers have to reach certain cost thresholds. Then they're graded on quality, and that information is pushed out to our customers. The same approach is used for the physician organizations and individual physicians. Now, because of bankruptcies, solvency thresholds are much more critical for capitated providers. We're ending up with a tiering based on the quality and cost matrix. We are also trying to come up with a narrow network that is scoring high in quality and provides competitive cost also.

We are also in the process of pushing out the data on this integrated value equation of cost and quality. The total system cost includes the groups that are practicing around at specific hospitals, the pharmacy costs and the hospital costs. Looking at these components together is the usual approach for HMOs that had either a global capitation or other capitation arrangements. We're used to looking at all of the providers that are involved with managing a member on a coordinated basis to evaluate the total systems cost. Also, I'll touch on a number of quality measures for physician organizations, physician groups and then hospital quality.

Again, total system cost equals the provider, hospital and pharmacy costs. A number of the hospital quality measures are driven by Leapfrog initiatives such as making sure they're participating, including some of the measures (e.g., computerized order forms, ICU staffing and patient satisfaction measures). There are a few measures related to heart procedures, as Blake touched on. These measure whether the providers have adequate volume so that they're doing the procedures enough. The number of complications they've had from these procedures are also reported.

The physician measures include a lot of preventive services measures: screening, immunization, testing and a variety of measures along those lines.

MR. GAVLICK: Ed, how are providers reacting to some of these network activities that are going on?

MR. CYMERYS: The providers have, not surprisingly, had a mixed reaction. First, they want to see their scores before they agree to participate. There has been some segment of the provider community that wants to measure themselves and publish that information to control the "spin" of the story. They want to be the one taking out the ads, publicizing some result that they have achieved and putting some spin on it. We have had extreme reactions from some hospitals that said if you publish our data, we're going to cancel our contract—even before they saw any of the numbers. So, they couldn't really argue that they thought it was unfair, but they know from looking at this information that they're going to score very unfavorably, maybe on cost compared to similar quality or whatever. Although I would say the majority of the providers have been very cooperative, like the idea and want to be measured against their peers. They know that will lead to system-wide improvement and they have been very proactive and supportive in the process. So, it's a bit of a mixed bag. I think as more information gets out to the public, is

validated in terms of accuracy and we start to develop a little bit of a history, that more people will get on board. PacifiCare was involved in what we call our "quality index" early, which published a fairly objective quality report card on our physician groups. We've been doing that for years now. Initially there was the same kind of noise around it, but people have gotten on board. It has had a significant impact on getting people to give us the information so that they can be fairly judged, and people are used to seeing the trends of how things are changing over time.

Future innovations will include analysis of episodes of care. A patient will be compared against benchmarks for similar conditions and co-morbidities—so it's kind of a risk-adjusted view. Initially, we will look at those costs for measurement against benchmarks. But more importantly, provider contracts will be set up so that providers are paid on that basis. The organized physician groups have had the complaint that they have been assigned sicker patients so their capitation payment should be higher. Legitimately, they have a concern. They can't control which groups are underwritten or which patients get signed up with them. They're relying on the law of large numbers that they're going to end up with an average population.

If they start getting paid a different way, and they're being paid commensurate with the case that they're taking on, then that kind of enrollment risk or underwriting risk becomes a non-issue. Providers who specialize in a high cost procedure for a specific episode of care will be measured against a benchmark for that procedure. I think this way of looking at costs will emerge in a couple of different ways. You'll start to see historical cost information available to members who are trying to choose providers, and then contracts with providers will have specific payments for certain episodes of care.

On engaging the consumer, trying to have member cost sharing that looks below the average and looks at the relative variations in cost is starting to emerge through plan designs reflecting tiering, high cost/low cost options and those types of things. I think the greater the availability of information and incentives around participation in preventive disease management programs the more likely it is that these programs will be successful. You may be aware that the Medicare program has some pilot programs for specific disease categories, where Medicare fee-for-service beneficiaries can opt-in to a disease management program. They can then have their prescription drugs covered, as long as they agree to cooperate with the disease management program. The Centers of Medicare and Medicaid Services (CMS) is convinced that under a disease management program the overall cost will be lower. That also has been of interest to some of our large-employer customers with large retiree populations that want to understand how they can participate in some of these types of programs.

Consumer-directed plans are becoming more popular. The way PacifiCare set it up, it starts with a preventative care account that doesn't roll over. You really want to encourage people to get their preventive care. The next layer is a health savings account, which rolls over if not used so there's some incentive to use services only

when you need them. The gap between these accounts and the higher levels of coverage that kick in after that annual deductible is the member responsibility.

In summary—and then I'll hand things off here—the basic mission of managed care companies is to focus on improving clinical service and cost outcomes through provider and disease management programs and aligning incentives. Now we're adding robust consumer information, both to give some visibility to the cost and quality (i.e., variations on the provider side) and also on education and information about health care choices for members. This provides some accountability on lifestyle choices and provider selections and gets them more involved.

MR. JAMES F. SANFT: I'm vice president and chief actuary for Worker Benefit Plans of The Lutheran Church—Missouri Synod (LCMS). We cover 6,000 separate entities, anywhere from a small congregation that might be hiring a pastor and a secretary to schools. We have the largest Protestant school system in North America, universities and service organizations. In total, we have around 30,000 active workers plus their dependents. We also service retirees, and we run the full scope of the core benefits: retirement, life, disability and health. Of course, we're here to talk about health. In the plan that we call the Concordia Health Plan we have 21,000 active workers and their dependents, and we have about 4,000 retirees in our Medicare supplement product. Virtually all of our plans are self-insured, but it certainly is a key component to our health plan.

To give you an idea of the scope of our plan, in 2002 we'll pay out about $148 million in benefits: $98 million goes to medical, $22.5 million to prescription drugs, a little over $11 million to dental, $2.2 million to mental health and substance abuse and $14 million for administrative expenses including our administrative services only (ASO) fees. So certainly in terms of an insurance background, which most of you have, and the environment that I came from, these aren't very big numbers. But I think from an employer perspective, for a health plan it's a reasonably sized health plan. I also want to back up a little bit and ask where these dollars come from. Literally, they come from the $5 and $10 bills that are dropped in the Sunday morning offering plate. The funding isn't always the most secure for an employer entity, so it adds to the challenge of managing the plan.

The title of this session suggests how employers are dealing with large rate increases, and you'll see a recent history of 18 percent, 18 percent, 19.2 percent and 15 percent increases. Certainly when I think about the CalPERS number that was presented a while ago, I'm very happy. My constituency doesn't know how good these numbers are compared to the rest of the world. But at the same time, I look at the four years that I've been involved in setting rates with the health plan that's up 91 percent. I have, in effect, doubled the cost back out to our employer entity. It's a good news, bad news scenario. These are relatively low in this environment, but once you start adding that up, it gets pretty extreme.

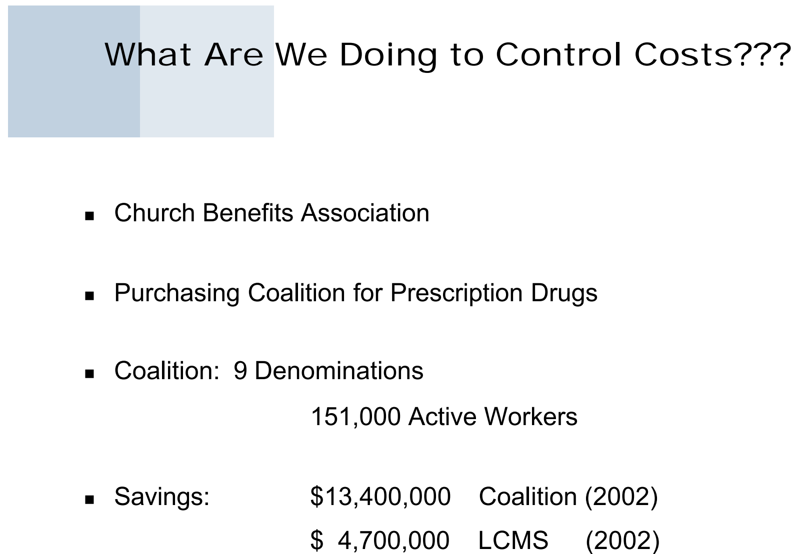
If you think back to Blake's presentation, you'll see that we are doing some of the things that he suggested. We've tweaked the copay and the coinsurance and have

tried to shift more costs over to the members. I've been driving for consolidation of our vendors. We've done a significant amount of that since 1999, which was when I first came to work with Worker Benefit Plans. I think we can see a couple real advantages of consolidating vendors, but the biggest is getting down to just a handful of vendors, then you can manage them more easily and you have more influence with them. If you only have 1,000 lives with a particular vendor, and as I'm using vendor here, I'm talking about networks: the Blue Cross network, Cigna. We don't work with PacifiCare, but I guess they would always be willing to take us in. Those would be the vendors. If you only have 1,000 lives with them, you don't get a lot of attention. But once you start putting 10,000 to 15,000 active workers in the plan, then you start seeing a little bit more attention. We have also put in some basic things. For example, we never had a lifetime maximum in our plan for in-network benefits so we're trying to get those things in there to cover the top end. Certainly, plan design and vendor management is a key.

Until recently, we were still paying a good portion of our health claims out of our own office in St. Louis. The medical had been nearly outsourced, but we still had some pockets in the country where managed care had been available for some time, but we just never moved our members to a managed care plan. Until January 1, 2002, we were doing our own dental and Medicare-supplement claim processing. We have outsourced those to vendors. We are anticipating seeing claims savings—not huge, but probably the biggest piece was closing our internal claims operation. I can't imagine what would happen if we would have had to try to become HIPAA compliant servicing the types of numbers that we're servicing. We really would have had the same costs that the carriers have in terms of systems, but without a base to pass the cost.

Figure 20 lists some solutions for controlling costs. One really exciting element for me has been working with the Church Benefits Association. We work very closely with our peers at other denominations and, in fact, formed a purchasing coalition for prescription drug benefits. There really is a lot of leverage as you get greater numbers. Within our coalition, we ended up having nine denominations participate—The LCMS, the Evangelical Lutheran Church of America, Presbyterian USA, Southern Baptist. It includes some of the big-name denominations in the United States. In total, we brought about 151,000 active workers to the coalition and across the coalition in one year. In 2002 alone, the coalition aims to save $13.4 million, and my number there on the slide for the LCMS is $4.7 million. I'm not really sure how to take that. I saved the most, is that good, or is it bad? All I'll say is that I didn't negotiate the original deal with our prior pharmacy benefit manager.

Figure 20



The message is that for employers, there really is value in trying to come together. Certainly, a lot of coalitions have been formed at the regional level, but this one has spread across the entire United States, and we were able to do that successfully. In fact, now it has given us tremendous momentum to acknowledge that we've solved that one, at least temporarily anyway. Are there other things that we can do? Right now, we are working on a project to see if we can enter into a collaborative purchasing arrangement for medical benefits. We engaged a major consulting firm to get their hands around the data. They just returned the data to us, identifying some of the no-brainers that we need to dive into in the next year or so and then some things that can be more long-term development. This is another way in which collaborative efforts with other organizations are powerful, and you certainly see large employers doing that nationwide.

Another component is member education. I guess for actuaries you understand what we say right away when we're talking about a self-insured trust, but getting this concept to our membership is very difficult. I don't know about the grammar on this, but the concept of "we insure us" usually is very effective when I meet with different members of our constituency—perhaps in a room like this where I explain to them that their health care dollars are going to help the other people in the room and vice versa. That's usually pretty powerful when they start to understand. When they can understand the nature of self-insured trust, it becomes a lot more personal right away. It's then understood that we're just charging them what it takes to keep the pot filled with money.

We also need them to focus in on their responsibility as members of the plan. This brings up the whole idea of consumerism. Sure, health and wellness are important, but also how do they navigate the health care delivery system as good consumers. We know more about how to shop at Wal-Mart than how to navigate the health care system. Also looking down the road, we're not making any steps now, but it definitely is on our radar screen to be moving to the consumer-driven approach. At least maybe with some of our universities, where we have a bit more sophisticated audience and an HR department right there on site that can help us educate people.

We're also looking at our entire product portfolio and introducing a level of choice. I do understand that choice means costs go up, but we want to get enough plan designs that start to get them more actively involved in their health care decisions, for example, by reintroducing deductibles. We haven't had those in our plans for quite some time. As I said, we're going to be looking to the consumer-driven. But in essence, we're trying to get them to get a little more skin in the game, and we want to roll out choice at the employer level and then possibly at the employee level, as we get to some of our larger entities.

We're also looking at rate initiatives. I don't think our entities really understand just what health care costs. Some of our universities say they just want to go it alone. For example, they say that they met the Blue Cross agent and think they can save a ton of money if they go on their own. There will be some opportunities for us to act more like an insurer and let them get into a little bit of an experience-rated or cost-plus basis.

Demographic and occupational ratings are really interesting. As I mentioned, we allow service organizations in our plans—quite often nursing homes. The nursing homes love the deal they get because right now they can buy into our health plan at the pastor or teacher rate, but we need to educate them by explaining that these entities do in fact have higher claims cost. It's just a matter of equity to go ahead and charge them more. So we're going to be looking at some rating initiatives to try to even level out the playing field. I guess it might be the same in a typical large employer if they had a subsidiary who was driving costs a lot more for whatever reason, they may charge that entity appropriately.

The biggest thing for an actuary comes back to the same idea of data, and Blake did a great job explaining that. We've worked with Ingenix to build our own data warehouse. When I got to work with Worker Benefit Plans in 1999, we had no data. Imagine an actuary with no data. Health care costs are going up, your board members look at you and you say "I don't know," or you have to tell them what they can read in USA today or anywhere else. We were left with no way to formulate a real solid action plan. So what we've done is build the database going back to 1998 and forward and updating it on a quarterly basis. We've also asked Ingenix to conduct a baseline analysis. We have asked them to tell us where our population is, what sorts of behaviors might they have that lead to the claims. This will lead us into the whole area of demand and disease management that Blake touched on. Let's get to that 19 percent of the people who are running the 65

percent of the claims. But rather than just throw programs at our members and see what happens, let's try to use more of a data-driven approach. For me, this has really been an exciting project to get up and running and for us to be able to get our hands on it.

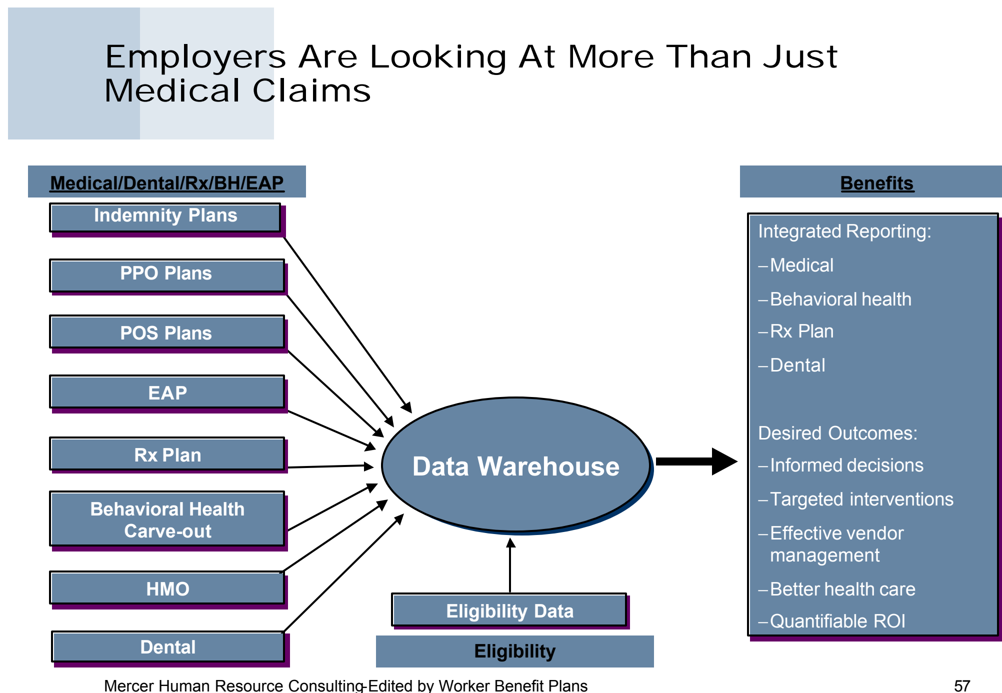
Jeff, you asked Blake about the issues of privacy and the concerns for the data. We've run into some real issues about this because we want the patient-specific data, and when we do, we say that in this capacity we're not acting as the employer, we're acting as the health plan. So for example, we instituted a $2.5 million life-time maximum. You can't institute this if you don't have the data. So we're trying to tell the vendor that we have another actuary on staff; we're doing the normal data analysis that a carrier's going to do as an administration of the benefit. A lot of us are thinking about HIPAA, but you remember HIPAA is the lowest standard in that if a state enacts tougher statutes, the state's laws follow. We're discovering that in Minnesota, they apparently have decided that they need to go above and beyond HIPAA. So we've got some real issues trying to get our data out of a vendor in Minnesota, and they're defaulting to the more stringent standard.

MR. GAVLICK: Let me ask you a question. How far along are you on this initiative? Do you have data yet? Have you made any observations or discoveries at this point, or is it too early?

MR. SANFT: We were able to get a lot of data. It's not 100 percent yet, but for example, we were able to answer some fairly straightforward questions. If the university wants to know what our claim experience has been, we can look at it on an employer-by-employer basis. But in terms of the baseline analysis, there is definitely good news and bad news. The good news is that on a demographic-adjusted basis, my claims experience is better than what the Ingenix database would indicate. The bad news is that I'm trending at a rate much higher than the rest of the world. So I'm catching up for whatever reason and, for example, we know that now at a higher level, but we don't have everything in place yet to do the drill down.

I stole Blake's figure again, but I cut out part of it. The biggest part that I really cut out was the top where it has to do with the lost time and the disability (Figure 21). Now, I'm on the disability side. That's important because we're still looking at our total cost, but lost time doesn't really mean anything to my customer base. So we really didn't incorporate that into the database, but this is a great schematic. This is exactly what we're doing—pulling in the eligibility data from our internal system and dumping in the claims data. It is an incredibly powerful tool, and in talking to Ingenix and others, large employers are doing this. No surprise to this group, data is such a key for formulating action plans going forward.

Figure 21



The comment was made earlier there's no single silver bullet. I covered a lot of things very quickly, but it's absolutely right. There is no single silver bullet. You must confront this on every front. Some steps are small. Some steps are large. Blake had his quick-hit items. Those are no-brainers; you have to get in there and do those. But for the long term, we know we need to change our member behavior. Whether that will be through education or plans that give them a financial incentive to make better decisions, I think that's really where we're going to have to stand up and use the data to drive our future steps.

MR. GAVLICK: Okay. Thank you, Jim. Thank you all.