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Session 97PD
Update on Provider Contracting

Track: Health

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Summary: The managed care environment has become more liberal and the provider marketplace has become more competitive. Panelists explore the nature of changes in provider (hospital and physician) contracts relative to HMO, PPO and other negotiated contracts. Attendees join the panel discussing discounts and reimbursement levels, managed care restrictions, reimbursement provision exceptions for large claims and capitation and other risk arrangements.

MR. OSCAR M. LUCAS: We have with us today Pat Gilligan, Dave Axene, and my name is Oscar Lucas. We're going to do a presentation with three different viewpoints on provider contracting. Pat's going to talk from the provider viewpoint, I'm going to talk about it from the payer viewpoint and then Dave's going to talk about health care affordability and its impact on provider contracting, or provider contracting's impact on health care affordability.

So let me start with an introduction to Pat, and then I'll go second, and then Dave's going to go last.

Pat Gilligan is a member of the Academy and an Associate of the Society. Since 1994 he has worked for Partners HealthCare here in Boston. Prior to that, Pat was Peat Marwick. Pat spends most of his time working on providing contracting

issues and payer analysis, and he's a graduate of the College of the Holy Cross here in Massachusetts.

MR. PATRICK F. GILLIGAN: I was at a session this morning and an actuary was talking about the fact that he doesn't like going to his physician, because his physician feels that he represents the insurance industry and didn't really have a very good view of actuaries. I can tell you after working for about 5,000 or 6,000 physicians for the last eight years, they don't view me much different than anyone from the outside, and you may get a little flavor of that as I go through this.

But I would say that I am in a nontraditional role for an actuary. Having worked for a provider, I never thought that I would be there for this amount of time. So the purpose of today was for me to share some of that experience and what we're doing there.

I thought we would do five things: First, just in terms of context, I will try to give people an overview of who Partners is, assuming that most of you are not from this market. But I think that a lot of the things that have happened at Partners over the last six or eight years have happened in many other parts of the country, as well.

I wanted to give you an overview of the marketplace—not only in terms of providers, but also in terms of the payer marketplace here, and then talk about what the contracting trends have been over that six to eight years.

Then I'll move into some of the drivers that we see in terms of contracting from the provider perspective and what we some of the challenges to be in the coming years.

A number of entities make up Partners HealthCare. Partners was formed in 1994 when Mass. General Hospital and Brigham and Women's Hospital, both Harvard teaching affiliates, decided to merge—that was the word at the time. And I would say that after eight years that they have not really merged in the traditional sense of a merger; but they are sister hospitals here in Boston, and that really was the beginning of Partners HealthCare.

Partners HealthCare was set up at the time as a parent company, and it still exists in that format, with Partners having employees such as myself in finance, HR, legal and other parent company services.

At the time that it was formed, one of the initial initiatives that the hospitals wanted to take was to build Partners Community HealthCare, Inc. (PCHI). PCHI is a primary care network. They thought this was very important at the time, to establish a primary care network as sort of the feeder system for the hospitals. The goal at the time was to establish a network of a 1,000 primary care physicians. We now have about 1,100 primary care physicians in eastern Massachusetts and more than 4,000 specialists.

What was not really viewed at the time was that we would really be building a hospital system. That was not contemplated when the Brigham and the General came together. But as they started to look around at a number of the community hospitals, a number of them were struggling in the marketplace and looking for a partner to come in and help them. So we started by taking on North Shore Medical Center, which has two hospitals north of Boston in Salem Hospital and Union Hospital. We also then brought in Newton Wellesley Hospital to the west. It was struggling at the time and looking for a partner.

Then we brought in Faulkner Hospital, which is very close to the Brigham in terms of proximity; and they formed the Brigham and Women's and Faulkner Hospital Corp. They really work in tandem with each other. And that was a very important acquisition for us, in that the Brigham was full a few years ago, and Faulkner was struggling. It gave us a good opportunity to be able to move some secondary care that was being done at Brigham and Women's and move that to Faulkner Hospital.

We also established a joint venture with Dana Farber. We have Dana Farber Partners Cancer Care, which includes all of the oncology activity at Dana Farber and Mass. General and the Brigham. We have McLean Hospital, which is a mental health institution out in Belmont, which was formerly a subsidiary of Mass. General and is now a part of Partners. We also have a number of rehab hospitals and home health companies, so it is truly an integrated delivery system, geographically covering all of eastern Massachusetts.

So, as I said, it was created in 1994. The entities are integrated entities, meaning that they are financially owned by Partners.

We also have a number of affiliates. There are different physician hospital organizations (PHOs) that can affiliate with PCHI for contracting purposes. So PCHI developed into a primary care network and also a contracting entity and a vehicle with which we could contract for all of the owned physicians as well as any of the affiliated physicians and act as one entity when we negotiated with the payers.

As is the case for most hospitals, a good chunk of the revenue is coming from Medicare and Medicaid. It could be up to 50 percent at some of our institutions. On average, it's about 36 percent. And this dynamic is going to be an important part of our commercial payer negotiations as we go forward.

Eastern Mass. Marketplace: Recent History

So let me give you an overview of what's happened in the eastern Massachusetts marketplace. I've tried to put this on a timeline, but they're very broad in terms of the years in terms of some of the things that were happening.

Payers. In going back to 1994, which was when Partners came together. There was a very consolidated payer marketplace, essentially in the managed care arena.

There were three major HMOs, and that's still the case today. Blue Cross has HMO Blue; Tufts Health Plan is a regional health plan here; and Harvard Pilgrim, which came together from two different health plans, I believe they merged in about 1995. It was the former Harvard Community Health Plan and Pilgrim Health Care. Once those two came together there were really just the three payers in terms of managed care business.

At the time, it was true HMO benefits with what I describe here as tight referral circles. Not every provider was in every network, not every hospital was in every network. And when you signed up for HMO benefits and picked your primary care physician (PCP), you would have to go where the primary care physician referred you. In fact, in your benefits booklet at the beginning of the year, you would know that if you picked Dr. Smith as your PCP you would have the list of specialists that he was going to refer you to and you would know which hospital you would go to. It was truly a HMO type benefit.

Premiums were flat at the time. This is post-Clinton health care, when we all decided that the marketplace was going to have to solve the health care problem. So premiums were flat, and they remained flat in this market until about '97 or '98, when they increased again.

Providers. In terms of the providers—and this is really what caused Mass. General and the Brigham to come together—it was a very fragmented provider market in terms of both hospitals and physicians. Given that there were only three major payers, they took full advantage of this and were able to get very good rates from both hospitals and physicians at the time.

Part of that, obviously, was because we had excess capacity. Both Mass. General and the Brigham were closing beds at that time, trying to reduce capacity. And there was also excess physician capacity.

Moving on to 1999, the payers—after being strong for so many years in a three-payer market—I think there were always concerns that some of the for-profits would come in, and it didn't seem to happen. All three of these payers are not-for-profit. We have a tradition of not-for-profit payers here in Massachusetts. And despite the fact the Cignas and the Aetnas are here, they do not have a large share of the HMO market.

Payer Woes. So all three of the payers wanted to expand into western Massachusetts, north into New Hampshire and Maine and south into Rhode Island. Harvard Pilgrim and Tufts made a very strong effort to try to do that. It was more complicated for Blue Cross, because they has sister plans in the other states; so they really weren't able to do that. As a result of that, there were huge losses at the health plans. All three of the health plans had losses, but Harvard Pilgrim and Tufts did, in particular. We did see premiums increase, but even so at this time their market share has now increased to 84 percent.

New Provider Networks. In response to the fragmentation in the provider side, we were not the only ones that were coming together to form a network.

Care Group was formed with Beth Israel Hospital and Deaconist Hospital. New England Medical Center, which is a Tufts Medical School affiliate, tried to launch its own competing network. And we really thought that there were going to be three major provider networks that would shake out in this marketplace to sort of match the three payers. But it didn't quite play out that way.

In regard to hospital closings, it's probably hospital failures. It's very hard for a hospital to actually close, but there are many hospital failures. We've had a few closings here in the state.

We've also had a very, very tight labor market, both for clinical labor and nonclinical. The economy here was very good, and it was very hard for us to recruit nurses, physicians and other professionals.

The Players Today

Payer Rationalization. So, moving onto today, Harvard Pilgrim actually went into receivership as a result of its expansion into New Hampshire. The state put them into receivership in 2000. That's just an example of the pressure that we feel as providers—being downstream in terms of the revenue stream in health care.

When Harvard Pilgrim went into receivership, the state attorney general said that the providers would continue to provide care to all Harvard Pilgrim members, and we were not guaranteed payment for that. In the end, providers did take somewhat of a haircut in terms of their accounts receivable, but it was pretty quickly restored, and they did get back to their regular payment rates.

That forced both Harvard and Tufts to really retrench and come back to their core business here in Massachusetts. They needed to restore their profitability and get their reserves back up. Premiums were continuing to increase.

Now, every provider is in every network, every network has every provider, and referrals circles have essentially gone away. And from my perspective, we call HMOs 'indemnity in drag'. You can't really tell the difference between HMO, PPO and indemnity. Everyone's in every network; there are no referral circles. So while you still need the PCP to refer, if you want to go to a certain specialist, there's really no problem doing that. And the big three have maintained their share at about 81 percent.

Provider Successes, Failures. At the same time, the providers are pretty much at capacity. The Brigham and the General have been full for the last several years. From a bed perspective they've been relatively full. Physician practices are full.

The community hospitals are not full from a bed perspective, but they are at capacity in terms of a nursing perspective. Because of the high nursing shortage that we have here, they are often not able to take on additional business.

Some of the provider networks have not been as successful. Care Group has struggled here in the market. Some of their hospitals are looking to get out of that network. New England Medical Center Network did not take off. They did end up affiliating with some hospitals down in Rhode Island, and they recently broke off that relationship, as well.

With health care here, we don't tend to cross state lines very well, whether it's providers or payers. That's because of the regulatory environment and just our mindset. You know, Lahey Clinic had merged with Hitchcock Clinic up in New Hampshire about four or five years ago, and that also failed at working across state lines.

So that's the history of the marketplace over the time that I've been in Partners. Now, I just want to get into the trends in terms of contracting from our perspective.

A Little Background on Trends

When I started in 1994, we needed the networks because the payers were pushing very hard on providers to take the financial risk. They thought that capitation was coming this way; it was very strong in California at the time. Pretty much everyone thought that it was going to come here and would be here to stay.

So we concentrated then on coming up with a network and a formula to take on this risk. We did not focus all that much on hospital fees and we did not focus much on physician fees. Again, there was excess capacity at the time. We didn't think we had any leverage to increase the rates at that time, so the focus was on risk contracting.

But there were many flaws in terms of the risk contracting. It was what we now call here a budgeted capitation. And what I mean by that is, when we took capitation, we did not get the premium dollar paid to us on a monthly basis. We had a paper budget that was established on a per-member, per-month (PMPM) basis; it was handed to us for each one of our members. But, again, it was on paper, then they paid us fee for service throughout the term of the contract. So as we provided a visit or a discharge, the fee would rack up against the budget.

At the end of the year we'd look at what budget we were given on a PMPM basis and what we actually spent. And if there was a surplus there—that is, actual was less than budget—then the payer would pay that surplus to us. If we exceeded it, then we had to pay that back to the payer.

At the time we were focused on getting the highest percent of premium that we could; and in the end we did very, very poorly on those contracts for a number of reasons. But I would say that the largest one was that, essentially, the providers really did not have the will to take this risk. We got in early, because we thought it was coming. We knew we weren't ready for it, but we thought we may have been able to prepare better than some others if we got in early. But in the end, the market has sort of pushed back against that, and we're going the other way.

The other difficulty was that we negotiated a budget from the payers, and we'd get an overall budget on a PMPM basis. But we had a very disparate network in terms of who was affiliated with us.

We had the Academic Medical Centers and those physicians, who had one mentality. Many of those physicians are part-time physicians, in that they have research and teaching responsibilities. And they have very sick panels as well. We also had very small community PCPs—small practices with eight, 10 and 12 physicians—who were probably better able to focus on the risk, but were not in a position to financially take on that risk. So we did a lot of work on internal funds flow distribution and internal reinsurance pools, both specific and aggregate, to try to protect the providers.

So by 1999 we were getting a little bit more sophisticated around this. One of the other reasons that we got into the risk contracting was to get the data from the payer.

As a provider we don't have all the claims data that matches up for our members. We only have the information that we provide, so it's very important that we got that got that information from the payers. And based on that, we did negotiate some more favorable contracts. We understood the risks a little bit better, but, at the same time, we were looking for alternatives.

We also developed some internal health status adjustment tools. We used the DXCG health status adjuster. And while we could not get the payers to look at our population versus the rest of their network, we did use the tool internally and decided to distribute funds internally.

Just by way of example, I would say on average that the panels at Mass. General and the Brigham had a health status around 17 to 18 percent higher than our community practices, so there was a real difference there in terms of the overall severity of the patient population.

By this time, the hospitals were not doing as well and the doctors were getting busier. We were more focused on their fees and were looking to negotiate increases in both the hospital and physician fees, as well.

Performance-based Contracts
So where are we today?

For the most part, we are trying to get out of budget-based risk contracts, in which we are at risk for all services—inpatient, outpatient, physician and pharmacy and we've moved to what we now refer to as performance-based contracting, or pay-for-performance.

The idea is that we're trying to figure out certain places in which we can affect the overall utilization and be helpful to the payer and ultimately, the employer. But it's for things that we feel we can control, and we're not taking risks for things that we can't control, which is where we got in trouble in the overall risk.

We're also concerned about overall changes in benefit products and are trying to include wording in our contracts that states that the payers need to talk to us as they change those benefits. As higher deductibles come out, as tier copays come out, we want to be able to work collaboratively with the payers around those kinds of things.

What Is It? In terms of pay-for-performance, there are a number of things that we agree to do with health plans around pay-for-performance items.

They may be quality measures, looking at some of the Leapfrog measures for hospitals. For physicians, we have made guarantees around certain health plan employer and data information set (HEDIS) criteria that we would improve the HEDIS scores for our patients within the health plan. Eye tests for diabetes is one. All of these come with a number of data, health status and even benefit complications, so you really have to work through each one of these.

The eye test, for example, is one that you want to make sure is a covered benefit within the health plan and not in the eye plan. Inhaler usage is something that we've agreed on. Again, the efficacy is very clear, but it's not always true that the pediatrician is looking and prescribing the inhaler for the pediatric patient.

On efficiencies we have mostly around inpatient days per thousand and pharmacy, because we have robust programs in those areas. But we are now exploring other areas, including lab, radiology and emergency room.

Be Part of the Solution. We've moved away from this global risk and looking at pay-for-performance. The idea is to have focused areas in which we can help the payer because we want to be part of the solution for health care and not just part of the problem.

But at the same time, we are much more focused on our hospital fees and our physician fees. The hospitals are feeling squeezed now more than ever, because they are at capacity. They were able to survive before, while they did price on the

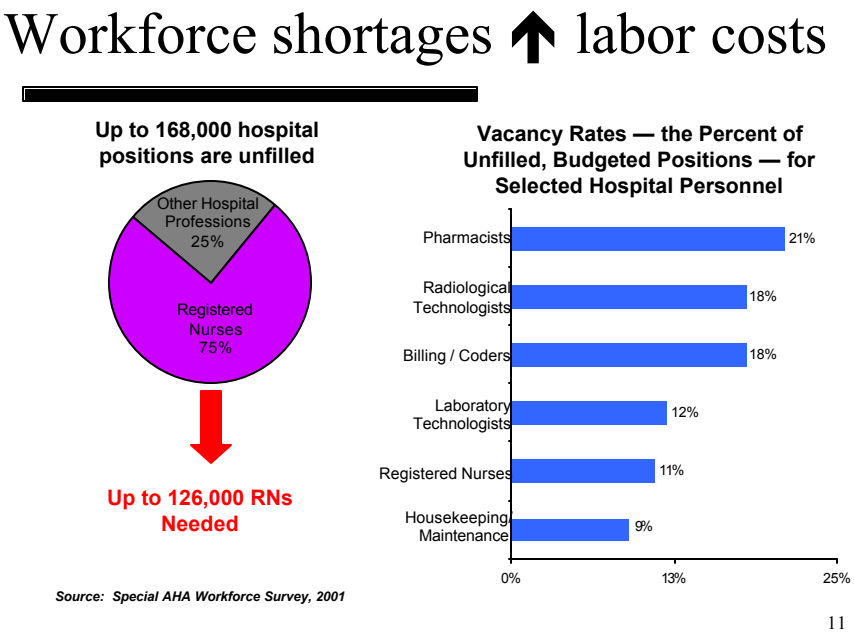
margin because they had to grow out of their problems. So they weren't getting huge increases in rates from the payers, but they were adding volume, and that allowed them to survive.

Rising Costs. Now, we're seeing rising costs, both in terms of labor and other costs. And from the federal government we're seeing a reduction in payments, or at least a reduction in increases. The Balanced Budget Act of 1997 has really kicked in in terms of Medicare payments, which has affected both the teaching hospitals and the community hospitals. The recent changes in the resource-based relative value schedule (RBRVS) system have resulted in a 5.5 percent decrease in rates for physicians this year. Without legislation, by the end of this year, they'll see another four percent to five percent decrease next year.

Shortages. In terms of the shortages that we're seeing, the economy has changed a lot here in Massachusetts.

As far as nonclinical labor, that market has changed a lot and we are able to bring in those people. But there are still significant shortages in nurses as well as technicians and other clinical providers. This is an area in which we're trying to look very long-term and are trying to come up with some solutions to educate and provide programs for this. This is not just a local issue. This is an issue that I think providers are facing across the country (Figure 1).

Figure 1



A couple of examples: There are about 125,000 vacant nursing positions across the country, and different regions are trying to compete for that. We're finding it

very difficult, especially based on the cost of living here, to recruit nurses, and we are seeing huge increases in nursing salaries from year-to-year.

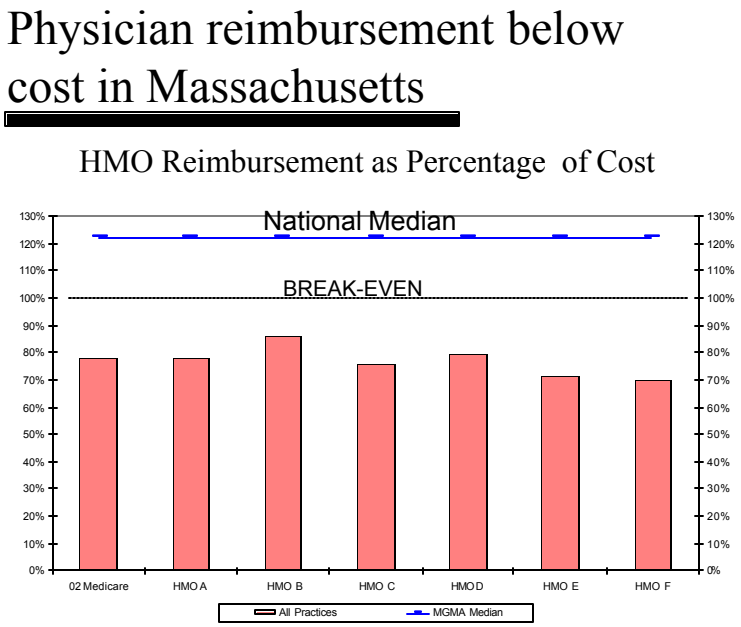
As for radiology technicians, there have been huge increases in radiology utilization and availability of imaging. There's going to be a constant demand for those techs over the next several years.

For the first time, we're actually having trouble recruiting physicians for certain specialties, as well. The Brigham and the General has always been able to recruit and fill their residency programs, but that has gotten much more competitive. Certainly, there are work and life issues in terms of the physicians, and physicians are avoiding certain specialties such as cardiothoracic surgery. There may be a decrease in the rate, but with the increase of the baby boomers, we are expecting to see increased activity there over the next 10 years, but we're having trouble recruiting people.

For seasoned physicians, it's gotten very aggressive in terms of physicians being recruited to different marketplaces that we have to compete with. In terms of anesthesiologists and some other critical positions, if they're not filled, then you just can't provide the service.

Physician Costs. We're actually looking at physician costs for the first time, and this is something that the physicians really didn't look at (Figure 2). Many of the physicians may be owned by a hospital and salaried. Some of them are on their own. And many of the ones that were on their own actually did make money in their risk contract. They didn't worry about negotiating the fee schedules, because they managed their patient population and then they had a surplus at the end of the year. Now, those contracts have gone away and, all of a sudden, the fee schedule is very important.

Figure 2

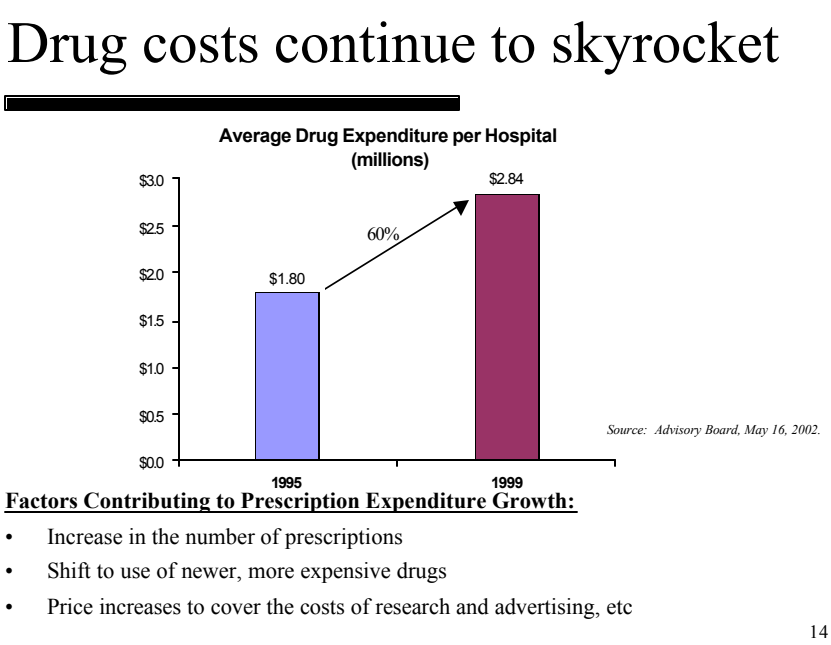


We don't have any payer here paying us above our physician costs. We are looking at it on a relative value unit (RVU) basis, and we will be looking to negotiate these fees in the future.

You should know that in this marketplace, most of the health plans have one fee schedule that they dictate, and that's the fee schedule by which the providers get paid. So we will be looking at those fee schedules and trying to get them adjusted accordingly in our next round of negotiations.

Drug Costs. The drug costs you all know and hear about in the press everyday, but this is something in terms of within the hospital, that we're looking at (Figure 3).

Figure 3

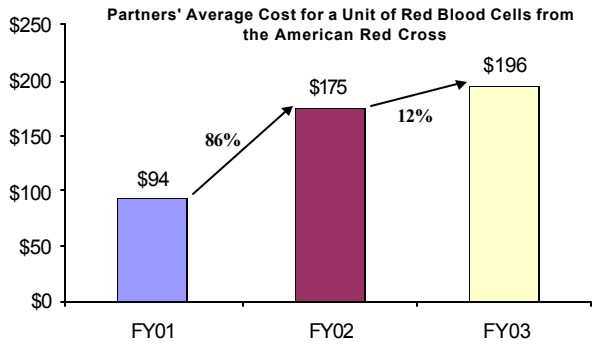


We're actually trying to look at the hospital costs similar to the way a health plan looks at their costs, and hospitals hadn't been doing this for a long time. I mean, in a health plan, they're going to look at their inpatient medical and surgical and all their actuarial service categories. The hospitals weren't doing that. And we are doing that now to look at what our fixed costs—our space costs, labor, etc.—and really trying to find out what the drivers are of our cost increases so that we can negotiate those going forward. We've had a 60 percent increase over five years in terms of our drug costs.

Blood Costs. Blood is another example: there have been huge increases in terms of blood, whether we buy it from the bank or whether patients come in and donate at our own facilities (Figure 4). Either way, the cost has gone up because of new technologies, use for blood because of new patient safety regulations and just overall shortages nationwide.

Figure 4

Unit blood costs have increased 108% in past two years



Increases due to improved technology, patient safety regulations, and nationwide shortages

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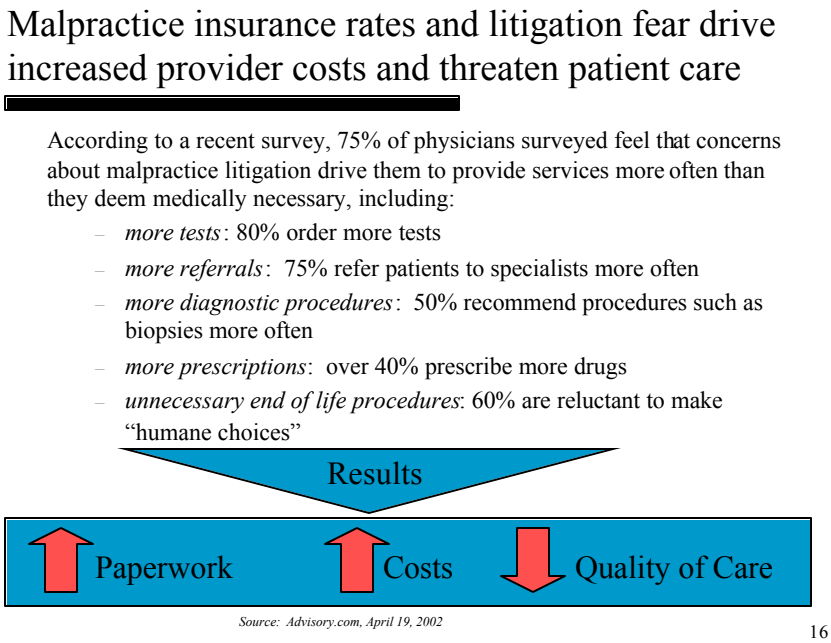
Malpractice. Medical malpractice is another issue for providers.

I've never heard a physician say in public that they think that they're doing more tests because of fears about medical malpractice, but you can see the statistics here when they are asked (Figure 5). I do ask them behind closed doors, and they do feel that there is excess utilization for this reason.

Figure 5



That could be another way of describing our failure in terms of taking budgeted capitation or budgeted risk. If you asked a provider when they were working on a day-to-day basis what gave them sweaty palms, it was more the issue of medical malpractice than it was the fact that they were on a risk budget from the health plan and just didn't focus on it.

Prognosis: Not So Good

So, going forward, we see a lot of inflationary pressure, both in terms of our physician fees and our hospitals.

We know that our payer partners don't have the same view. They're looking at medical CPI in the range of four percent or five percent. When we take our nursing and other labor costs and we look at new technology and those things, we're looking at inflationary increases for us on a unit basis of around eight percent.

Finally, let's just to go back to the government payers. While the commercial payers would say that this is not their problem, we know that Medicare and Medicaid are not going to give us eight percent over the next several years; they're going to give us more like two percent. So if we're to stay in the same position that we are, the only place that we could get that is from the commercial payers.

So if we're seeing increases in the eight-percent range, and if you spread that or allocate, and the commercial payers make up the government payers, we're really looking at more like 10 or 11 percent. This is not the perspective of the payers at this point. So with that, I will turn it over to Oscar.

MR. LUCAS: My name's Oscar Lucas. I'm with Premera Blue Cross in Mountlake Terrace, Wash. I joined Premera about a year-and-a-half ago as director of corporate actuarial, and about six months ago I was asked to take over what we call our health care economics areas.

Before that, I was with Milliman and Robertson's Seattle office, and I was a health care management consultant there.

I'd like to give you a little overview of Premera, just so you can understand who we are and the market that we're in, and talk a little bit about the provider expectations and member, or customer, expectations. The point here is that there's kind of a dichotomy there, or a division. They're not exactly headed in the same direction.

We'll look at provider reimbursement. What makes that up? How does that fit in with overall health care cost trends?

The last thing I want to talk is about some of the things that we've started doing to manage provider reimbursement trends at Premera.

Premera has about 1.4 million members. About 1.1 million of those are in Washington state, where we're known as Premera Blue Cross. We have a Blue Cross license. Our friends at Regence have the Blue Shield license. In Alaska, we are Blue Cross/Blue Shield of Alaska with about 200,000 people. And then we have a small company we started a few years ago down in Oregon called LifeWise of Oregon, where Regence has the Blue Cross and Blue Shield license; so it's not a Blues plan. We also have some LifeWise members in Washington. In 2003 we plan to enter the Arizona market.

Basically we sell group and individual PPO, point-of-service (POS) and indemnity. Primarily, it's group PPO. We have moved away from HMO, and we contract with about 120 hospitals and in excess of 15,000 physicians and then a number of ancillary providers.

Issues in the Northwest

Some of the issues that we see in the Northwest markets:

Utilization Shift. We see continued utilization shift in terms of hospitals, utilization shifting from inpatient to outpatient. In 2000, we for the first time saw hospital bed days per thousand start to go back up, and that's a trend that has continued.

Alliances. There's some consolidation or joining of hospitals. I wouldn't say necessarily it's consolidation as much as it is just alliances between hospitals. And it seems like anytime we sign a contract, everyone else in their alliance seems to know about that contract in short order.

Capacity Issues. As elsewhere in the country, we're seeing a lot of capacity issues in the hospitals. As a result, some of the hospitals seem to be less willing to give us good discounts.

Charge-based Reimbursement. There's also a push toward charge-based reimbursement. Especially in Washington State, we do a lot of case-rate and per-diem reimbursement, and there's a strong push on the provider side toward charge-based reimbursement.

More Charge Master Updates. Historically, a lot of hospitals would not do annual updates of their charge master. That is a thing of the past. Everyone is updating their charge masters at least annually. There's an awareness by the hospitals of the bottom line impact and the issues of cost shifting.

ASCs on the Rise. Ambulatory surgical centers (ASCs) also have taken off in the Northwest. There's a shift from outpatient to physician-owned ASCs.

Pressure From Doctors. On the professional side, we're seeing a lot of increased pressure from hospital-based physicians, either in terms of refusing to negotiate with us or contract with us, because they know they're going to get paid at the higher rate if it's a preferred hospital. To a lesser extent, that applies to non-hospital-based physicians.

Some of the expectations of providers that we hear in feedback from them in negotiations is that they're looking for prompt payment of claims. There's been a strong pushback against claim edits.

They don't want us to hassle them, and they are looking for incentive programs. This seems to apply, especially as we've moved away from risk-based reimbursement or risk programs with the doctors. They're now looking for some way to improve that revenue stream, so there are a lot of requests to at least discuss incentive programs.

Rate Increases. And then in terms of rate increases, we're seeing—at a hospital on a unit cost that is case mix-adjusted and normalized from year-to-year— eight percent to 12 percent. Occasionally, we get requests for higher, in the 20 percent to 40 percent range. We did recently have one hospital in the Seattle area that asked for 55 percent. After we modeled it out, it was 55 percent. We went back to them and said we thought that was a little on the high side—perhaps they could look at it again and consider the way that we modeled it. They did and came back at 33 percent. So we're still negotiating that one.

On the professional side—our nonhospital-based doctors—we're seeing four percent to eight percent, a lot of five percent and six percent. And then, as I mentioned, hospital-based is often higher than that.

Expectations
Customer expectations is an area in which we start going a little bit the opposite direction in some areas.

They're looking for high-quality care and access to broad, stable networks—they don't want you having some doctors in one year and not the next.

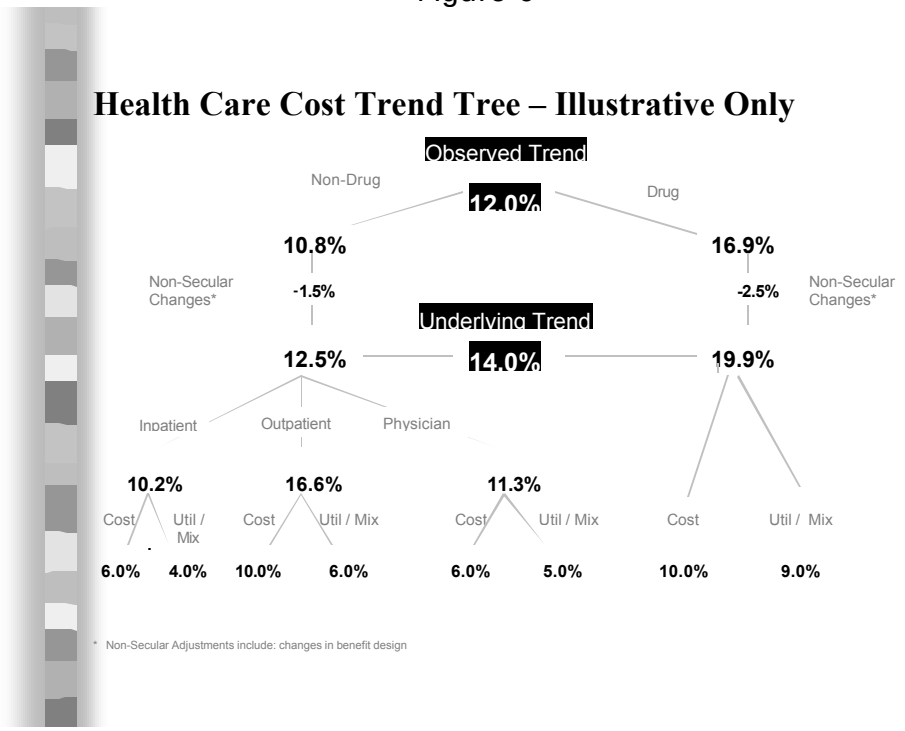
They look for nonrestrictive care management and affordability. And from what we're hearing back, affordability to them means premium trends under 10 percent. Now, perhaps expectations is not the right word there—perhaps desire or what they think they can afford—but I think they realize most of our rate increases right now are in the 15 percent range to groups.

So there is a dichotomy. From one side, our customers are expecting us to hold things down and would like to return to the days of the single-digit rate increases. On the provider side, there's a real need for increased reimbursement, so the expectations are not necessarily consistent here.

One thing that we try to do when we're working with our providers is to help them understand that the provider cost trend is only one component of the premium trend. Other components include mix of services and the intensity of those services, as well as administration and margins. What we're seeing is that success requires trying to balance or manage the components of trend.

The Trend Tree
We've started using what we call a trend tree (Figure 6). It's something that we picked up from the Blue Cross/Blue Shield Association to illustrate trend, and we found it's a helpful tool when we're working with providers to help them understand that unit cost is only one piece of the overall trend.

Figure 6



As an insurer, we insure a number of the hospitals and the physician groups that contract with us. Of course, they always want to know why they're getting a 15 percent to 20 percent rate increase, but we only seem able to pay them six percent or eight percent more. So this is one of the tools that we use to try to explain that.

What we look at are the major components of the health care dollar, the PMPM trend, and we split that out between unit cost, utilization and mix trend. And then roll that up in what we call underlying trend or a secular trend. Basically, what would the trend be if you didn't change the mix of the group of insureds or the benefits?

And then you have the observed trend. That would take into consideration benefit buy downs—what do we really expect to observe in per member, per month health care costs? This doesn't show the administration component, but it's just a tool that we've used. And the numbers in here are illustrative. They're not unreasonable for what we're seeing, but they are illustrative.

Addressing Trend Management

The last thing that I'd like to go through with you a little bit is what are we trying to or how are we trying to address management of the provider reimbursement trend?

First of all, we acknowledge that it's real, because we try to work closely with our provider partners. They have real issues, as Pat has pointed out, that they're to

work through. So it's not an issue of trying to see how we can get away with paying the least amount to our providers.

There are five things that we've done in the last, I guess, six months since I've been over in health care economics, and I'll go through these in a little bit of detail.

Management Tools
For provider reimbursement, we've put in a budget process.

Some of you may be surprised that we're just now doing this, but we've looked at the providers' preferred reimbursement methods.

We've looked at the provider renewal process for efficiency.

This past year, we started developing tiered provider networks.

Also, for 2003, we're starting to do the pay-for-performance or at least enhance the pay-for-performance arrangements that we have.

Historically, actuarial and finance have done a top-down development of provider budget for each year and said to our network development people, "Here's what you've got to work with for the year." In this year's build-up for budget health care economics, which I'm in charge of, I said, "Let's build up from the bottom and take all of our providers—hospital, inpatient, outpatient, ASCs, physicians—and look by region at what we think we're going to have to pay in terms of increases over the next three years and then take a fixed market basket of dollars and roll that up and see how that compares with what actuarial finances is telling us the budget's going to be.

Not surprisingly, when you involve your network development people in this type of a project, it tends to roll up higher than what actuarial and finance would like it to be for the next three years. So we put together this budget and a strategy of how we would get there. And then we had to go through a reconciliation process with actuarial and finance. And there were some—for the lack of a better word—horse trading, and we did compromise. Basically we had to go back to the network people and say, "OK, if you were really aggressive out there,"—which is not what they wanted to hear—"what do you really think you could get?" We then rolled that up and worked with actuarial and finance to come to an agreement on what we would use for the next three years.

So the next step was to develop some budget monitoring tools so that each month we can sit down and go through the renewals for the month and say, "OK, if we actually go out and deliver these and sell at this rate to our providers, what does that do to our year-to-date budget, our monthly budget and your annual budget?" So we had a way to monitor what was happening and forecast the impact of specific changes at the provider level.

Part of that is a checkbook or savings account, whereby the network development people, if they save money in a provider contract, can move that forward and hold it to another provider and use it later. Or, if they can come up with a convincing argument that for a provider that's renewing later in the year, that they're going to bring it in lower than budget, then we can let them use that for that purpose.

Preferred Reimbursement Methods

The next step or the next tool that we put together was a discussion about preferred reimbursement methodologies. This starts out with the premise that not all methodologies for reimbursing providers are created equal.

So we came up with an evaluation tool. A lot of this was not so much that I already knew what I wanted the answer to be for some of these reimbursement methods, but there was a need to work with the provider network people who do the contracting to help them understand why one reimbursement method might be more desirable than another.

We created a list of 10 desirable characteristics of a reimbursement methodology and then went through and assigned a point value, so the total points for all 10 added up to 100. You can go through and evaluate for, say, hospital inpatient, the different reimbursement methodologies that are available to us, rate them zero to 100 percent on each of those characteristics, and then score and rank the preferred methodologies.

One thing that I guess I should have anticipated was when I sat down with Health Care Excel (HCE), which is a consulting firm, and we put our values together, things like "The reimbursement method promotes cost efficiency or promotes quality of care," ranked real high. When I had the network development people go through and assign points where they thought things should fit, things like "Simplicity of method" and "Provider acceptance" ranked really high.

Once we came up with the preferred methods for our three-year budget, we put together a strategy for the reimbursement method that we wanted to go with on a provider-by-provider basis, with the understanding that with bigger providers or smaller providers, the methodology may vary.

Provider Renewal Process

The third thing that we did was to replace what I would refer to as an ad hoc renewal environment with a calendar-driven process.

Again, this may be something that everyone else in the world does, but at Premera, we waited until a provider sent you a notice that they were canceling their contract with you and then jumped through lots of hoops and did a fire drill to put together a renewal package for the provider network staff.

And what we tried to do here was replace that with a calendar-driven process, which meant that we're going to look at every contract every year.

We had a lot of what were called 'evergreen contracts'. And the question always comes up, "Now, who are the evergreens for?" Because it was OK when there were a lot of providers that didn't change their chargemasters very often. And with real low stop losses and annual changes of chargemasters, maybe it's not that great of a deal to have an evergreen contract under those circumstances.

So we put together a calendar-driven process. We redid the workflow and tried to make it as efficient as we could. We built a calendar that had monitoring tools built in and standards of performance for how long it took to do each step of the process. Then we came up with a standard renewal package.

Each region and each director seemed to have their own renewal package that they wanted us to use, so we said, "We're going to take the best from each package, and that's what we're going to use. And if you've got a better idea, feel free to submit it to us, and we'll review it and maybe change."

Renewal Formula. We also came up with a provider renewal rate formula.

Historically, when I went over there, one of the things that baffled me was how we came up with what we thought the renewal rate increase ought to be. It basically came down to, "This provider has some really good negotiators, and they really beat up on us every year, so we're going to give them eight percent. Whereas, Provider B, is not very good at negotiating, so we think we can get five or six percent from them." We've replaced that and also come up with what we call an escalation process, whereby each month we look at the renewals between health care delivery systems and health care economics. If we can't come to an agreement on keeping it within the budget, then there's a process for escalating that up through management.

Tiered Networks

We also looked at tiered provider networks and have our first generation of a tiered network out there.

Right now this is in the Washington market only. We are going to put this into Oregon. Alaska's kind of a different state from everywhere else, and I'm not sure how successful tiered networks will be up there. For example, in Fairbanks, there's one hospital and it's 400 miles from any other hospital. By the way, for some reason, they can get away with contracting very favorably with us. We basically pay around 98 percent of charges.

This is part of the new product that we're calling Dimensions. The things that we looked at in assigning providers to tiers were reimbursement level and how efficient they are.

In terms of efficiency we looked at episode treatment groups (ETGs), as well as length of stay, efficiency and degree of health care management as kind of rough dividers. Historically, we have kept quality measures on our larger providers.

Last is kind of a market reality. There are some hospitals that you simply aren't going to put in your lower tier, so that certainly figured into the decision.

This process was done actually in a different area of the company, so health care economics takes responsibility for that in 2003, and we start renewing these and looking at some refinements to that process.

Pay For Performance

Finally, we have had some pay-for-performance, but we're working to enhance that. I think there are a lot of the same things that Pat mentioned, but we've got basically network strategy factors that are going to go into that, such as: What do we want the network size to be? How much cost differential do we want by tier? What is our competitive position with other plans? What is the budget? And then on provider specifics, there is the efficiency of the provider, the quality of care that they provide and what is their market presence.

In conclusion, I'm not finding a silver bullet out there. I'd like to tell you that I did, but it's really not out there, that I know of.

This is really a balancing act between provider and customer expectations. We're trying to approach this by managing the components of trend rather than by trying to come up with a magic formula.

So with that, I'm going to turn this over to Dave Axene. Dave's an FSA, a member of the Academy. In 2001 he joined the firm of Ernst & Young as a partner, and he is the national director for financial analysis and assessment. Before joining Ernst & Young, Dave was with the consulting company formerly known as Milliman and Robertson as a principal and health care management consultant. Dave's a frequent speaker at industry meetings. He's an author of a number of published articles and co-developer of the Health Care Management Guidelines that Milliman puts out.

Dave's a graduate of Seattle Pacific University and also, I believe, has an MS from the University of Washington.

MR. DAVID V. AXENE: I'm looking forward to talking today a little bit about a strategic look at provider contracting.

There are four things I'd like to talk about today: Our challenging environment; a new concept called health care affordability, which you may not have thought about before or you just haven't talked about it; some strategies involving patient involvement, sort of along the lines of tiering; and then maybe some next steps.

You may not have noticed, but our economy is sluggish right now. It hasn't been the best of times.

Health cost increases—we've had our double digits come back. It's no longer just a drug problem. A year or so ago we talked about the drug problem. In fact, I think it was at the last annual meeting that I talked at a session about the drug problem. It's no longer a drug problem; it's an everything problem.

We are getting significant provider demands. We're getting new technology that's coming on faster and more intensely than ever. And we have our malpractice crisis returning one more time.

We have some legislative challenges that we haven't seen in as much intensity, what I call the reverse sentinel effect of the Patient Bill of Rights. We have the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its impact on health costs.

Last week I was speaking with a group of hospital CFOs—and I'm not quoting Pat, because he wasn't there—and I asked them in this meeting, "How many of you think that HIPAA is going to contribute a major part to your health care cost in the near future?" And not one of them raised their hands. I wasn't sure if they'd read the regulations or they were hoping for a permanent extension, but HIPAA has a significant impact, both on the provider side and also on the payer side.

Let's talk about affordability. We've all talked about health care costs, and I'm going to warn you that it's hard to move from a world defined by costs into one defined by affordability. And you're going to get confused; I've been confused.

A group of us within Ernst & Young spent the past four or five months developing a major effort on this whole issue of health care affordability, and it's just about to be released. I thought I would be able to give you final, approved documents that you could have today, but I don't. It's unfortunately perhaps more controversial than we had all thought it would be. It seems pretty straightforward to some of us, but not to others.

Nuts and Bolts of Affordability

What is health care affordability? First of all, if you live in a community, and you've recently tried to buy a house or you've read your newspaper, you might have heard about housing affordability. In San Diego, where I have the privilege of living right now, the recent newspaper, right around the time we were starting this back in the May or June timeframe, said that less than 20 percent of the people in San Diego County can afford the average house. OK, that's rather shocking. You'd say that you don't want to move to San Diego in the near future unless you have a lot of money to buy a house.

On the other hand, in health care, we've often talked about the cost. We've often talked about the health care costs as a percent of gross domestic product (GDP), which is a form of affordability measure. But we really don't talk about affordability. I'm going to try to brainwash you to start thinking about that, because it helps answer some new questions.

Definition. Basically, we're talking about *the ability to pay for health care without significant sacrifice*. It goes beyond the concerns over cost and basically refers to how much money is there to pay for it.

Why would there be a concern now? Well, since September 11, post-Enron, post-WorldCom, post-whatever else is zapping us in the economy, we have a significantly smaller bucket of money to pay for health care. And you can start thinking about what this really means. We defined an index as "a ratio of health care costs to available income." So it's basically a ratio of cost to income. Or, out of the money we have to spend, what portion of it is going to the cost of health care?

Indexing. We looked at three separate types of indices. One was employer indices—what does the employer have to spend? We looked at the employee indices to see what the employee had to spend. We also looked at the government—what portion of their monies are spent on their health care programs for Medicaid and Medicare, etc.? We even combined the employer and the employee to talk about a private index.

Figure 8 summarizes in the far right-hand column, where there are headings. The combined column has been sorted from lowest affordability to the highest. You'll notice that it goes from 65 percent in Delaware to 169 percent in West Virginia. Low numbers refer to very affordable, so low index means high affordability or low unaffordability.

Figure 8

Role of Health Care Affordability – cont

Table 1: HCAI Indices					
			Private		
State	Employer	Employee	Payer	Govt	Combined
U.S. Total	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Delaware	0.82	0.71	0.77	0.42	0.65
Colorado	0.94	0.80	0.87	0.60	0.78
Nevada	1.04	0.67	0.86	0.69	0.80
New Jersey	0.97	0.73	0.85	0.73	0.81
Hawaii	0.94	0.71	0.83	0.83	0.83
Minnesota	1.07	0.84	0.95	0.60	0.83
Virginia	0.91	0.86	0.89	0.77	0.85
Washington	0.95	0.92	0.94	0.71	0.86
California	0.88	0.91	0.90	0.83	0.87
Alaska	0.90	0.79	0.85	0.95	0.88
Georgia	0.90	1.06	0.98	0.70	0.88
Wyoming	1.04	0.83	0.93	0.77	0.88
Connecticut	0.87	0.98	0.93	0.85	0.90
Illinois	1.03	1.01	1.02	0.71	0.91
Massachuetts	0.86	0.93	0.90	0.94	0.91
Michigan	1.29	0.64	0.97	0.83	0.92
Oregon	0.93	0.92	0.93	0.93	0.93
Ohio	1.09	0.75	0.92	1.00	0.95
Utah	1.05	1.09	1.07	0.72	0.95
Idaho	1.05	1.08	1.06	0.75	0.96
Maryland	1.15	0.77	0.96	0.96	0.96
Arizona	0.93	1.04	0.98	0.97	0.98
Iowa	1.06	0.89	0.97	0.99	0.98
Nebraska	1.04	1.02	1.03	0.90	0.98
Missouri	1.08	0.84	0.96	1.05	0.99
Kansas	1.11	1.01	1.06	0.88	1.00
Rhode Island	1.06	0.78	0.92	1.23	1.02
Indiana	1.17	0.87	1.02	1.05	1.03
New Hampshire	0.98	1.10	1.04	1.05	1.04
Wisconsin	1.32	0.92	1.12	0.89	1.04
Texas	0.97	1.32	1.15	0.90	1.06
New York	0.87	0.95	0.91	1.37	1.07
Pennsylvania	1.10	0.78	0.94	1.33	1.07
North Carolina	0.91	1.18	1.05	1.18	1.09
New Mexico	0.82	1.31	1.06	1.22	1.12
Oklahoma	1.20	1.24	1.22	0.92	1.12
Vermont	1.36	1.02	1.19	1.07	1.15
Arkansas	1.12	1.32	1.22	1.07	1.17
Tennessee	0.99	1.24	1.12	1.33	1.19
Florida	0.98	1.26	1.12	1.41	1.22
Kentucky	1.10	0.99	1.04	1.60	1.23
Montana	1.42	1.25	1.33	1.20	1.29
South Carolina	1.10	1.23	1.17	1.57	1.30
Maine	1.27	1.16	1.22	1.57	1.33
Alabama	1.04	1.35	1.19	1.67	1.35
Mississippi	1.25	1.53	1.39	1.90	1.56
Louisiana	0.97	1.70	1.34	2.26	1.64
West Virginia	1.05	1.70	1.37	2.32	1.69

Source: 2002 E&Y Health Care Affordability Index

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In other words, we argued on this for a long time, "Do we want a high number to be good or a low number to be good?" We finally concluded after arguing on this for several days that we were going to call a low number good, because low number good means low cost, too, and it just made more sense. The number one criticism of our PR firm and also the early press is that, "Oh, it should be the other way around," and we argued with them. We'll just see who wins. Who knows?

But if you take a look at this, we'll pick Kansas, because it's a 1.0. Kansas has a 1.1 on the employer side and a 1.01 on the employee side. What that means is the average employer in Kansas pays a little bit more than average as a percent of its revenues. The employee pays just a bit more than average. And the total private side is a 1.06, meaning somewhere between 1.01 and 1.11. And then the 88 means that the government pays a smaller proportion of health care costs than some other states.

Those of you who have studied how public programs work know that there are some givers and some takers. The Southeast is famous for taking, because they don't have the tax revenue to support a lot of the national programs. On the other hand, some of the more successful business states end up paying a greater portion of other people's programs. But you can see that there's a wide divergence.

Now, if we look at this chart what you'll see is that about 25 percent of the states are below 90 percent (Figure 9). And if you look at those above 110 percent and add that up, it's about a quarter or more of the states that are above 110 percent.

Figure 9

Role of Health Care Affordability – cont

- Health care affordability varies considerably from one region to another

Range	State Distribution	% Distribution
< 0.80	2	4.10%
0.80 - 0.89	10	20.80%
0.90 - .99	13	27.10%
1.00	1	2.10%
1.01 – 1.10	8	16.70%
1.11 – 1.20	5	10.40%
1.210 - 1.30	4	8.30%
1.31 – 1.40	2	4.10%
1.41 – 1.50	0	0.00%
> 1.50	3	6.30%
Total	48	100.00%

Source: 2002 E&Y Health Care Affordability Index

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One thing that we concluded in looking at this is that a plus or minus 10 percent margin probably is in the acceptable or tolerable range. If you're beyond 10 percent of the average, that outlier is causing significant grief to providers in the low affordability index area—the very affordable states; or, if you're above 110 percent, we're finding that that is creating significant health care affordability problems in those states.

So you basically have 12 states that are on the very affordable side, but you have 14 states or so that are on the very unaffordable side.

Well, it's just an average. We're not saying 100 percent is the right answer. But if you go around and talk to the stakeholders in the marketplace, you'll hear Pat saying, "We're enough money." You'll hear Oscar saying, "It's costing too much." You'll hear the employees saying, "I can no longer afford the new payments. I'm getting out of my health care program."

So I am suggesting that a 100 percent, or the 1.0 here, is not a healthy situation. It's already a stressed situation, but you can see the deviation that you have around that 1.0.

Fourteen states face serious affordability issues today, and these are presented in worsening affordability—New Mexico, Oklahoma, Vermont, Arkansas, and you can see the rest of the list out to West Virginia. Those are the least affordable states. Those are the states that have a crisis today—a very serious crisis.

Now for the good news: If you project health care costs, which is the numerator, and project that using best-estimate financial forecasts for the next five years; and do the same on the denominator, which is basically the money we have to spend for that, 47 out of the 48 states we studied (we couldn't get data from the two Dakotas) reach an unaffordable level.

What that says, in terms of today's dollars, is that everybody except Delaware—and frankly, I think Delaware's a fluke, because of some unusual Washington, D.C.-area stuff—gets to a point of unacceptable affordability in the next five years. It's very frightening.

Now, if you look at the most affordable states, the good states—Delaware, Colorado, Nevada, New Jersey, Hawaii, Minnesota, Virginia, Washington, yes, California and Alaska—California has some of the highest health care costs in the country, but it's the 12th most affordable state in the country, even though its costs are high. This comes back to the transformation from cost to affordability. It's not what you might expect, so when you're dealing in those markets, health care is actually in a good situation right now, even though it has very, very high costs.

Who's Driving This Bus?

Well, once we studied this, we wanted to find out what the drivers are. What are the impacts of this?

Now, the numerator is cost; so, obviously, anything impacting cost might be a driver. The denominator is income. For the employer, we actually used gross state product by state, because that was the best measure we could find to help us understand what the total revenues were. For the employees we used income. And for the government we used total taxes—state, local and federal taxes.

And if I recall right—I don't have the exact report in front of me—around 15.7 percent I think it was of the government's tax base goes to health care. I think it was around 5.5 percent or 6 percent of the total gross income of corporate America went to health care. Notice that their profit is a lot less than that right now. And then on the employee side, I think it was around 2.5 percent or 3 percent of the employee's income was spent on health care.

So in trying to understand each of these, we did a comparison looking for correlations.

There was a very strong correlation to inpatient utilization. Again, we're just looking at it by state. We just wanted to do something basic, by state, to see if we could understand this. And those of you who remember your probability and statistics material will know that when it goes to 1.0, that's a really strong correlation; and when it's at zero it's not so good. If it's negative 1.0, it's still very good; it just went in the other direction. So that's my primer or refresher course for you on statistics.

It turns out that on inpatient utilization, it was a fairly strong correlation of about 0.37. What that says is as utilization of hospital services goes up—bed base per thousand increases—we end up, most of the time, having an affordability problem in that state. The states with the best bed base per thousand, the most efficient systems, in fact had more favorable affordability. Some of you will say that's obvious. Well, it's not so obvious when you do the ratio—what happens to income.

It appears that the states that had more affordable health care also had more affordable, or more efficient, inpatient utilization, which then permitted some of those funds to be used for services other than health care, which possibly strengthened the economy. So there were some other factors going on.

Now, I've spent the past 30 years of my life working in the managed care field; so obviously, I wanted to demonstrate that managed care penetration was a good thing. Well, it's a minus 0.19. It's not as strong as even inpatient utilization, which is not surprising, if you think about it.

Among managed care organizations, there are some that know what they're doing, and there are some that don't know what they're doing. And so if you looked at the effectiveness of the managed care organization, it would look much better on this correlation. But, yes, there was a slight tendency to have more favorable affordability as you become more effective with your managed care program.

There was a much stronger correlation with provider supply, which says that when there's an oversupply of providers, it drives up the unaffordability of care. We talk about big networks; we talk about small networks. I think Pat said that they are in every network. It's clear that even on a statewide average that when you have an oversupply of providers, it drives up the unaffordability or the unacceptability of the cost.

We took a look at average hospital size. For example, if you have a bunch of big hospitals, is it better than if you have a bunch of small ones? Well, there was a slightly negative correlation there, suggesting that if you have bigger-than-average hospitals, you're going to have more affordable care. This is somewhat obvious because of the spreading of fixed costs over more patients.

There was a fairly strong negative correlation to the strength of the local economy, which basically says, that when you have a strong local economy, you end up with more affordable health care. An indirect way to push this is to encourage the economy in your local community. Lo and behold, there will be more money to spend; as a result, it will be more affordable.

If you go back to the table, you'll see that some are high and some are low. If you look at the employee, the employer and the government columns, some are high and some are low. But we wanted to find out if there was any marker that suggested that any one of those three indices more matched the total than the other. The strongest correlation we found in the whole study was with government funding.

It turns out that if you clearly understand what the government's doing on a state basis, it is almost as good as looking at all of the three sectors, which I thought was very important.

Almost as good as the government one is what employees pay. For those of you from health plans, how much your employer clients transfer to the employees dictates affordability. A lot of us in that sector have basically let the employer do whatever they want. I think that this is an area in which more strategy influenced in that marketplace.

What's the Upshot for Contracting?

OK, this is a session on contracting; so why does this matter?

From a health plan perspective, understanding affordability adds a new dimension to developing your contract. If you know how affordable care is, you have another set of ammunition to use in the contracting strategy. Since there is such a close tie between employee affordability and overall affordability, provider contracting can be enhanced by better understanding the employee contribution to the product or the networks that you're dealing with.

Meaningful provider involvement and maintaining affordability of health care in its region can be used in negotiating the deal. I can hear it now: "Affordability is bad in this state. We can't afford to pay you anymore, because we don't want all these uninsureds. You're going to have to give us a better deal."

On the other hand, the providers are going to say, "Look, we've been doing a good thing, we deserve more of the money." And so that will be an offsetting pushback.

In areas with less affordable care, additional pressure is possible in negotiating. And since there was such a strong tie between bed base per thousand and other characteristics of efficiency, it revitalizes the need to improve medical management. Now we're going to have to talk about it with a different label; we're going to have

to do something a little bit different, but it just makes the importance of that re-emerge.

Health Plan Action Points

So what should health plans do? They should understand affordability to better position them. Realize that pricing elasticity varies significantly by region.

Those of you who are with national plans need to understand that it's not just an issue of looking at cost by region. You need to understand affordability by region, because you may have already hit the end of the spectrum in a particular region.

I think this provides an opportunity to collaborate with stakeholders to collectively do something and perhaps eliminate the blame passing and start to develop a real solution. On the other hand, if you work with a provider, the more affordable areas provide you an opportunity to demand more reimbursement from the payers that you're dealing with, because you're in a more affordable marketplace.

In less affordability areas it's exactly the opposite. It provides you an early warning signal regarding your contracting. It may be an initiative or a catalyst to realize that you have to do something to improve something there, because you're not going to be able to meet your budgets.

I happen to spend about half my time with providers and half my time with health plans. When you talk to people such as Pat on the provider side you have to understand that they're not making this stuff up. In other words, they have real costs that are driving their needs for that. There needs to be something to improve those costs, and perhaps this will provide the signal for them to do that.

It also gives providers an opportunity to discuss health care policy issues as part of the contracting process, because we're all in this together; and unless we find a collaboratively appealing solution, we've got a serious problem.

Providers should continue to act locally, but with a more global awareness of where the system seems to be headed. I mean, if you go out and realize that in five years, according to these projections—and we did not use conservative projections to break the bank; we tried to use best-estimate economic assumptions and inflationary assumptions—by 2007, we have a very, very serious problem. If we don't collectively try to do something, we'll probably all be enjoying a government-run system.

Hospitals need to look more carefully at their forecast, their budget plans, their business plans and their capital programs. They must focus more efforts on understanding resource demands, demand management, efficiency of the operation and, frankly, getting the most out of their current operations.

Patient Involvement Strategies

I'd like to shift gears now and go over to patient involvement strategies.

One of the big problems we have, as all of you know, is that the patient thinks health care is free. There have been two emerging solutions—one has been tiered Rx pro-copays; another one is network tiering—basically trying to help the patient understand that there is somebody there writing checks and your choices impact that.

In his presentation, Oscar shared three or four different ways of caring. What we have seen is negotiated costs, quality of care, efficiency medical errors, patient satisfaction, provider profiling results, HEDIS results and medical management initiatives. We've seen all of these used in various tiering programs.

There's a lot of activity out there right now to create tiering programs, and a lot of people are trying to find out, "Do I do something simple with cost, or do I make it very complex and try to reflect lots of variables?"

Unfortunately, the hospitals predominantly don't know how to deal with this. What they say is, "We're not used to our admissions department collecting copays." And so you're talking about an administrative change in how hospitals run. Usually, the people in the admitting department know how to fill out some forms to admit you. They don't understand the idea of how to collect a copay.

Good News. There's some good news. Most of those things can be measured concretely.

Providers proactively respond to improving their rating, and they'll do whatever they can to show up on the better tier list. Many plans are taking a serious look at this, although a lot of plans are wondering why they ever got into it. It's very consistent with the consumer-driven product model, sometimes called defined contribution. —Having tiers built into that consumer-driven choice model is fine. One of my customers refers to it as network transparency. In other words, they're just talking about trying to have transparent networks so that the patient can better understand what the network costs.

Bad News. The bad news is, complexities are often significantly simplified to produce a viable product offering.

You may have the most wonderful work for the most wonderful project come out with the most wonderful answers, and somebody somewhere along the line will say, "It's too complex," and they'll come up with something really simple. Whenever you simplify something good, you usually end up messing something up at the same time.

The first approaches were poorly crafted with very strong negative public perception. There was a health plan in southern California that decided to do something on their pharmacy tiering, and infusion costs ended up where the patient

had to pay a ton on the infusion side, because of formulary issues and just the cost of that. And it only took a week or so for that to show up in the "L.A. Times," and all of a sudden, they stopped doing that. A lot of negative PR has been associated with this.

Some providers are not able to administer it. Plan designs need to be simple for members to understand and take appropriate action; and unfortunately, this complicates the plan design.

There are several keys to success on these: Identify the most important member issues before designing it. In other words, you need to understand your member population. What are they going to react to? It's very simple. It's not rocket science. But I find a lot of people going in based upon what they think the member understands or what they think the member will do, and they don't really get to know, through focus groups or whatever, what the member really wants.

From the hospital side it's real important that the card has the per-admit deductible or the per-day deductible, or copay, on the card to help the hospital admission clerk to understand what's going to happen.

I think if you avoid too much simplification, you'll have a better product. It can't be too complicated either, but don't simplify it too much or else you lose all the value of what you're doing.

I think it's very important to link it with best-practice information sharing. In other words, link it with what's happening within the tier so that people can find out how to improve their tier rating and how they can move to the more favorable tier.

I think it's important to grade on a curve, to develop the ongoing spreading of results to fit into tiers. If you go through your calculation and have everybody in tier three and nobody in tier one and tier two, if you had a three-tier system, that just didn't work. It's important to grade on the curve, to at least spread it out a bit.

I think that the small-town rural solution for hospital contracting in one-hospital towns is a very serious issue. How do you tier a one-hospital town? Do you just discount benefits so that they're really not there? What do you really do? That's an important program to understand.

And I think that you need to carefully integrate professional tiering with the institutional tiering to make sure that that makes sense. Don't just stop at the hospitals, make sure that the doctors who control that are also involved in the process.

Next Steps in Contracting

So in terms of contracting, what are some next steps?

Stay Current. Number one, stay current. There's a funny little thing showing up from Cordis, a J&J subsidiary, called the drug-coated stent. They're going to use it for angioplasty—brand new, earth-shattering technology. I suggest that the health plan understand this and go out there and start to understand that and see what impact that's going to have on contracting before it's out on the street.

Medicare's way ahead of the health plans. They've already identified two diagnosis-related groups (DRGs) for its use, even before it's been approved by the FDA. But I don't know how many of you have gone out there and modified your contracts to see what that's going to do. It's very important for you to stay current on technology.

Providers Are Your Friend. I think that you need a proactive approach to understanding the needs of the health care stakeholders in crafting an important solution. Instead of viewing the providers as an enemy or an adversary, I think everything that we've talked about, affordability and contracting of the future, we need to team a bit more on those and realize that we have a problem that if we don't fix collaboratively, our dear government will.

Understand, Then Act. Be cautious and take time to understand the issues before blindly pursuing solutions. Don't do something stupid in your tiering program. Make sure that you really understand it.

Make sure you test it out with both your provider community and your member community. You've heard the phrase, "Think globally, act locally," but health care is a local issue. You need to understand this. If you say, "It will never come to my town." Well, maybe it will. And you need to make sure that you understand that, but be aware of the global impact.

Doom and Gloom is Real. If you look at the forecast that we made on health care affordability five years from now, you need to understand that the employer piece is expected to go up 59 percent in the next five years. If they just transferred half of that increase to the employee, it more than doubles the employee cost. Consider what the government's going to be doing in reducing its costs. And Pat says it has to come out of the private community; you saw it in his presentation. Well, I don't think there's any money there. Thank you.

SANDY HERMAN: Dave, in doing the affordability index, did you try to correlate any of this against the percentage of employee population that's uninsured?

MR. AXENE: We didn't do a direct correlation to the uninsured by state; however, the costs of the uninsured are in there. So we figured that it was implicitly in there, but we did not do a correlation by state. The recent news of the 1.5 million extra uninsureds caused us to want to complete this report a little faster, though.