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Session 51PD
Self-Funding of Health Benefit Programs

Track: Health

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Summary: This session covers current topics of interest to self-funded health benefit programs. Topics to be covered include carve-out of pharmacy of self-funded programs, participation in employer coalitions for pooling of risk and negotiating favorable terms with providers and administrators, stop-loss insurance market developments and current assessment and other current developments for self-funded programs.

MR. E. JAY COLDWELL: I work on self-funded programs all the time. I work for Wausau Benefits. We're a medical third-party administrator (TPA), so we don't have any insurance. We do traditional TPA types of things. When I started my actuarial career, I never thought I'd end up with a TPA, but I find the self-funding world interesting. A lot of innovation is driven through self-funding, and in the past couple of years we've seen the rise in consumer-driven health care that's been primarily self-funded innovation. We've seen high-performance networks driven mostly by

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

self-funded employers, one of the directions of the future. A few years ago we had the leap-frog measures and the leap-frog group, which were driven by large self-funded employers, so I find it a fun place to be.

In addition to that, most people are covered by a self-funded program. That's where the money comes from. They're the people paying the bills, and they see a real drag on earnings. Some of the larger employers are ready to get out. They're saying, "Let the government take it over." Ford Motor Company is one of them. Other than all these innovations, what are the opportunities for us to impact the issues that self-funded employers have every day and make their lives better? The innovations are the bleeding edge of a few people, and consumer-driven health care even for all the talk has impacted only 1 percent of the market at most so far today.

Here are the three areas that we're going to talk about this morning: employer coalition involvement and whether it is working toward smart purchasing; pharmacy transparency and where the money is—there's money all over the place in pharmacy, of course, and we'll talk about transparency in that area; and finally the global view of the stop-loss market, what's happening and what's coming up.

Let me introduce our esteemed panel. We'll start with Tim Bowers. He's a respiratory therapist by training, has an M.B.A. and is the founder and CEO of Bowers & Associates. He works with decision support, has a large database and does healthcare management for a large group of people.

Rich Wipperfurth is vice president of sales for Innoviant, an up-and-coming pharmacy benefit manager (PBM) with a different value proposition than the big guys. His responsibilities include management distribution to the TPAs.

Greg Demars is with Allianz Life. He's the product actuary for the healthcare risk management area dealing with employer stop-loss and other provider access.

We'll have Tim start because he has to catch a plane. We'll have an opportunity for questions for Tim when he's done, and then we'll follow up with the other two speakers.

MR. TIMOTHY J. BOWERS: I don't know whether you read this morning in the *Wall Street Journal* and *USA Today* that CalPERS has taken some action, so we'll see what happens relative to exclusion of providers. I'm going to talk about employers and then go through a case study that is leading to what CalPERS is doing.

First of all, let's discuss working with coalitions. That's what I've done for approximately 20 years. They all have different agendas, and sometimes they're scattering, but it is a proposition where your skill set can help to bring those people together to become effective purchasers. There are some basics that one has to apply to coalitions. They are governance and control issues.

These are my tests as I begin to work with various groups. Do they have a corporate structure? Is that in place, or are they just a buying group? Are there articles and bylaws? Do we have senior leadership of the groups? In other words, are we dealing with the CEOs and senior VPs, or are we down at a director level or benefits manager level? It has to be senior leadership. You have to have that drive.

The membership rules as reflected in the articles and bylaws have to be set, and as the purchasers begin to move forward, they have to follow those rules. There has to be investment. There has to be skin in the game. They can't be an association. The core activities, whether they're contracting, purchasing or data analysis, have to be part of the rules that are established and the contracts that are established. As I begin to evaluate coalitions, I look at their articles and bylaws, what the investments are and whether the contracts reflect what the group is about. If there is inconsistency, it means the group is probably not going to be effective. Information is key, and the measurement system is key. Those have to be in place, and you have to have some third-party validation of that.

Finally, you have to deal with the "boss on the board" issue in these coalitions. Most of my clients are not only CEOs of the self-funded company, but they happen to also be on the board of a local hospital. There is a conflict of interest that has to be dealt with upfront. Rules of engagement, investment, articles and bylaws and a measurement system help you to deal with the boss on the board because that can confound the issue. If a company doesn't meet these criteria, from my perspective, it's an association, and we walk away from that client. You can't credibly purchase without having these types of rules in place.

I'm going to drill down a little bit on the measurement and management system. It has to integrate both pharmacy and medical claims and the plan in the network data, so it cannot be something where you simply purchase a state database. It must be a plan where you can get at the cost drivers as well as some of the quality drivers. When we talk about quality, it's claims-based quality level information. Regarding standards and the data feeds that are coming in, what are the standards? How does the claim get moved into the database? How do you interact with the TPA and the insurer? Those standards need to be published as part of the request for proposal (RFP).

The data that come out are analytic quality. What we mean by that is we're looking at rates. We're looking at rates that are comparable. Whether or not you're comparing the classifications or if you're purchasing a Milliman, it has to be comparable. We have to have apples and apples. If we have apples and oranges, we have a fruit salad, and that causes problems in purchasing.

In regard to third-party benchmarking, the manager can provide some benchmarking, but the third party has to be the benchmarked activity. There has to

be an objective review of what the data are telling you. If there is no objective review, it's an internal control issue, so the measurement system has to have that.

Let's discuss the tools. We use them interactively, but the data have to be moved out to a variety of people quickly and accessibly. Management systems have to be driven by that measurement system—measure to manage and manage to measure—so you can do vendor management and selection, provider contracting and intragroup comparison. By the way, when coalitions come together, that's one of the things that they do. They compare themselves to each other. That's an important part of the measurement system. These are the principles.

The final one is a risk issue: pool purchasing not risk. These are self-insured groups. They're responsible for the payment of the claim, and that payment of the claim will drive their decisions. The credibility of the purchasing activity whether you're buying a vendor service or a contract means you can pool for that purpose, but you can't pool the risk.

Credibility has two components. You're probably used to a size and length of time, but community influence is important. That's where that boss on the board becomes important because a small group that is influential can leverage better purchasing than a big group. Testing the community influence or the credibility is important. Again, the claim payment is the responsibility of the employer.

Those are the three activities. One is you have to have the governance in place. The second is you have to have a measurement system, and that drives the management system. The third one is don't pool risks; pool purchasing.

Let's go on to a case study. You've seen Chart 1 before. This is the rate of medical inflation. In the early 1990s, as we had both the Clinton plan and the rollout of managed care, the rates of inflation went down. All of a sudden, we had the Balance Budget Act (BBA) and also the Food and Drug Administration (FDA) came into place in late '97 as far as its advertisement. The rate of inflation also took off. During the '90s, as employers enjoyed the fruits of this declining rate of increase, or actually a decrease, the providers began to consolidate. They consolidated and consolidated. When '97 came, there were rules and regulation changes. Costs began to increase. In 2001, at about the 11.2 percent area, we started hearing a lot of screams from employers.

I'm going to get into the case study of a coalition located in southeastern Wisconsin, approximately 90 miles north of Chicago and approximately 30 miles south of Milwaukee, along Lake Michigan. They're also funded employers, and the group size is approximately 55,000 individuals. They have individual member contracts with each one of the employers. The rules are established, and the bylaws are attached to the member contract. They collectively purchase decision support services, managed care, TPA services and pharmacy benefit services. That's what they collectively purchase, and they own their own focused network. There are lingo

terms out there regarding high performance, but this is basically a community-based network. They rent the other networks, but it happens that 80 percent of the cost is right there in that community.

The historical trend is -1 percent between '90 and '98, and then the rate of increase took off. It's basically equal to what everybody else saw from '99 to '02. It might be a little bit higher.

FROM THE FLOOR: Does that trend include utilization?

MR. BOWERS: Yes, it's full trend. It's medical and drug.

I thought what I would do is now is give you a snapshot of the delivery system. We had a number of independent hospitals. They were independent and not affiliated with one system in '90 (see Chart 2). In '03, there are two systems (see Chart 3). The green system is a group called Aurora Health Care, which is becoming a national poster child for integrated delivery systems, and the other group is the Wheaton Franciscan Health System based out of Wheaton, Ill. Those are the two that have gobbled up the provider system. In addition to acquiring the hospital facilities, they've also acquired a number of physician practices.

What happened to us between '90 and '03 is the market changed. This is what we're dealing with in this locale. I could probably pick any community, at least that we operate in, and it's much the same. We have the free-market fish pond with a big muskie eating everything up. What's happened to us is that as the reimbursement in Medicare changes hit, now we have local monopolies or a regional oligopoly. This is what's happened.

According to a *Milwaukee Journal Sentinel* article based on Mercer, the medical costs are 55 percent above the Midwest average. Part of that is because benefit plans haven't moved, and we understand that, but another part of it is structural in that we have few suppliers that are vertically integrated. Providers have consolidated and have formed local oligopolies and monopolies. We've run from multiple insurers down to three insurance companies. Soon we'll be faced with, "Which electric company do you want to buy from?" It is one of the critical issues. Structural price problems and cost problems within the system are so great that two of the local congressmen asked the governmental accounting office to come in and do a study, and those data are supposed to be out in '04. I bet, given the information that I just saw in the *Wall Street Journal* and *USA Today*, that locally in California they're dealing with the same thing.

What are employers doing? This is what a number of us are wrestling with, and functionally this is how they're beginning to view consumer health. A number of them are asking whether it's an affirmation for higher deductibles and whether we shouldn't just be straight with people.

The situation is they had good success through the '90s. Some of that is because the markets were successful. Some of that was because there were multiple providers, and they hadn't consolidated. Some of it was markets that they enjoyed, and some of it was because of the purchasing decisions.

In about '99, as we started seeing this, they had a consolidation of the providers, and we started seeing the rate of increase go up to about what the national average is. There wasn't any fungible or additional benefit for being part of the coalition. This is another aspect of groups that people talk about, and it's well-documented, at least in the psychological data. It's called positive disintegration. It's when people get together and say, "What are we doing here? Is this providing any additional value?"

When you ask that question, you correct the course, and that could be that you split or that could be that you form another group, but there is a point of positive disintegration. It's natural. It occurs in every group and probably every organization. Remember we had a measurement system, and it was validated by third parties. When you hit that point, you start asking what is driving the costs. What are the cost drivers? Inpatient costs are approximately 30 percent of the pie, but outpatient facility costs are approximately 32 percent.

What do we mean by outpatient facility costs? Medicare changed its regulation and allowed for integrated health systems. When one of its physicians saw a patient in its facilities, it could charge not only the professional fee but also a facility fee. What's happened in that cost inflation—remember that 13 percent—is that this wedge has grown immensely for this active group, so outpatient facility is a huge wedge of our costs.

The factors in the provider pricing are driven mostly by new technology and medical devices. Chart 4 comes from PricewaterhouseCoopers. By the way, I'm a recovering hospital administrator, and one of the courses that we took was, "If I build it, they will come." The bricks and mortar in this facility are immense. Within southeastern Wisconsin as a whole, it's approximately $4 billion in annual medical facility structures getting put in the ground. There's not a lot of population growth. In this market share, half are fish because it's Lake Michigan. The other half are people. You have to have some volume to cover this increasing fixed cost, but they're driving medical devices. They're investing in them to create competitive advantage with that other hospital system. It's warfare that is completely unregulated.

Drilling down a little bit more, this gets into some of the opportunities that we have. Chart 5 is a medical claim, and it shows you what good data have and also where we have some challenges. This came from two bills. This came from a Health Care Financing Administration (HCFA) 1500 bill, which is an outpatient facility bill, and a HCFA Uniform Bill (UB). The bottom line came from a UB 92. Before the regulation, this visit, which included an observation room charge, a visit for a low intensity and an injection, would have cost this group $189 on a charge basis. This is not

discounted. Because of the regulatory change, with the integrated system, there was another charge on top of it, and we have a 60 percent increase. There is an increase in costs because of the billing practices of the providers.

Chart 6 shows a duplicate claim, and it tests the TPA because it's the same individual, but one is coming through on a 1500 claim and another bill is coming through on a UB 92. Never the twain shall meet because of auto-adjudication, and all of a sudden we're paying 60 percent more. That's one of the pushbacks that's beginning to happen with these groups: what's fair, what's reasonable, and, by the way, I'm not interested in duplicate charges. It's going to test TPAs because that type of demanding activity means that you have to make some investments in unbundling and duplicate software. We could go on and on in this, but we're beginning to see the cost shift occur because of the integration of physicians and hospitals.

What have the coalition actions been? The biggest issue is that if you attack things on a unit price basis, you might lose because you want to look at total cost. We use episode treatment groups, which is one of the ways to look at both all medical claims and all pharmacy claims. A number of insurers do that. You need to look at the total cost of that care on a total payment basis, and then you need to look at the unit cost drivers.

Apply a health employer (effectiveness) data information set (HEDIS) to this to determine whether or not there's any quality or disquality basis. You can use HEDIS claims-based variables. There are 15 or 16 HEDIS claims-based data variables, and they're good as far as looking to see whether there's any disquality aspect.

Manage the vendor. In this case what this means is the vendor is that community-based provider. What do you do with it? You say, "We're not going to pay this anymore." "Fees get lumped together." "You're going to get cut out." "We're going to apply a per-provider deductible or co-pay." Or you say all of them. That's what happens. Those are strategies for active vendor management. With a TPA tighten up the administrative role. It's a coalition action that's coming off of this positive disintegration whereby you can't put up with the cost anymore, so you find out what's driving the cost and then attack those cost drivers.

Benchmarking is important for a couple of reasons. One is you have to find out whether or not it's plan-driven or truly cost-driver-driven, and benchmarking is a way to get at that plan effect. The analysis of medical and drugs is moving more toward transparent pricing. Population health is important, but it's more important whether or not somebody is taking a proactive stance in what we call defined prevention or whether or not the benefit plan is driving some utilization or driving equivocal services, isolated signs and symptoms, which is one of those larger disease categories.

We started talking about risk groups. They are episode risk groups (ERGs). Some people call it predictive modeling. ERGs are the peer-reviewed model, what's going on currently and what's going on in the future, how that can drive better disease management, and whether there is some application back into the stop-loss market to take out unrealistic fluctuations and trend. The issue is that's a two-edged sword. Sometimes risk increases, and sometimes risk decreases, so you have to be prepared for that. The data are what the data are, so employers have to deal with it.

Key personnel meetings are basically CEO to CEO. That's where it is, and you have to feed the data to them. What's happened to date since the group started is that, by taking in some action based upon some solid metrics, it has become stronger. It's grown and reestablished its rules for engagement. The trend is down to about 5.5, so 15 months into it is not a long time, but it's better. They're beginning to wrestle with it. There's still a lot of opportunity, but that's what the coalition has done.

Moving forward, we've positioned locally in these high-performance networks the theme that affordable health care is vital for the sustainable community. That's the high bar. If this community that these employers are in is going to exist, we must have affordable health care. The other issue that's beginning to rise in Wisconsin and nationally is who profits from nonprofit. These are nonprofit organizations that don't have a lot of public scrutiny and accountability, and the structural problems are great. The Feds are beginning to look at it, and I think states are going to begin to look at it, so that's an important issue.

One of our next steps is actionable data. We want more and better data and more transparent data. We're looking at defined prevention and integrating. When I talk health risk assessments, they could be the combination of a solid SF-36 or some well-defined scrubbed risk assessment together with some ERGs and then coaching: "People, are you going to the right provider?"

Create plan and network incentives to steer quality providers. That's more of a reach because at least our legal counsels have pushed back a little bit on what the definition of quality is and who should define that because of the medical malpractice risk. We're taking an approach of informed choice, but then putting in either plan-specific or network-specific rate differentials.

One of the keys to success is group leadership. You have to have some effective management, and it's going to be credible information. That's such a critical role that you just keep refining it and defining it.

This all takes time. We've been doing it for a long time. We've gone through ups and downs. I would say that the successes here are that groups go through positive disintegrations, and if we continue to get hired, that's good. You can go through a positive disintegration and get outplaced, but it's a slow process. It's going to be

driven by the affordability issue, and it's going to be driven by boiling the frog as by the data and the actionable data.

FROM THE FLOOR: If there are truly monopolies, how can all of the data information in the world matter when that person has only one choice?

MR. BOWERS: The interesting thing is that that group within the community comprises both public sector and private sector employees. The things that scare providers are rate review and capital expenditure review, and those terms in those leadership meetings come up.

The other issue is when the integrated health system CEO of the nonprofit is earning $3 million a year. That's where the utility of public sector employers comes in because things have to be much more open, and you can begin to engage that. Is that a threat? You bet it is. Does that mean that you're going to get short-term price concession? It's going to be tough. Where you have oligopolies, that combined with plan-specific and provider-specific deductibles and co-pays that drive share gets their attention. Is it a lot of money? No, but it's more defined rates, and that's how you work it. It's a tough role, but you have to work it that way.

MR. KEVIN DOLSKY: My question is you commented that there are three carriers left in the marketplace or something like that. Please expand on the idea of why self-funded employers getting together can do a better job than the self-funded employer of going to one of the big three carriers or whatever you have left and saying, "You guys have market share. Why don't you do this?" Could you comment on why self-funded companies should get together?

MR. BOWERS: I think that John Wennberg at Dartmouth has written a book on health care being a local phenomenon. It's a small-area analysis. Coalitions that are focused in communities are more effective than large carriers because of a couple of reasons. The first is that they're part of the community. The second is that if they have some size in some of the named employers, they will do better with those local providers if they have the information and management system.

What happens on a regional basis is that the larger carriers are probably going to do better. They're going to be the wraparound, if you will. One of the rules of engagement is if you're an employer that wants everybody in and the best possible deal from all providers, your choice is probably going to be a larger carrier, and you're not going to be part of the coalition. You're out. Go shop on your own. If you're focused on that community, you're going to do better than that larger carrier. That's what happens. It's a focusing of the power of the group and the power of the data to deal with the local providers. That's what my experience is.

MR. RANDY A. GOMEZ: Yesterday I went to a session that dealt with an issue somewhat similar to this one, but they were talking about incentives to doctors and

education to employees and making the employees have more control with more information available to them. I don't think I heard that today.

MR. BOWERS: Our experience is people need help navigating the system, and people view their provider through their benefit plan. When you're driving incentives, price is a tough thing to do on the provider side, but an effective way to do this is focus community networks, changing your co-pays within the plan on a provider-specific basis or on the deductibles and then providing some type of a nurse advocate that helps them through the maze. Provide a coach. Those are the three things that we see working.

The other stuff is a lot of theory, but people are buying plans and understand those pocketbook issues, so you have to hit them with where the understandable pocketbook issue is, which is the co-pay or the deductible, and if provider X is more than provider Y, and you can't get anything out of him, put in a higher co-pay or deductible in that provider. People understand simple things. If they have quality problems, if they have coordination problems, that's the role of good case management. Keep it simple. Don't overcomplicate it.

MR. GOMEZ: I have one more question. Can you talk about the TPA that's being hired to do the work? Is it that each employer has its own TPA, or do you have one coalition TPA?

MR. BOWERS: It varies. In certain circumstances the group has gotten together and said, "By virtue of the fact of our purchasing, what we want to do is issue specifications and bid out TPA pharmacy benefit services." Some do that. Some employers choose not to do that but still have to standardize their data. They all come to that conclusion, by the way. They all want to purchase. When you start purchasing, the question is whether you can get better service and a better value proposition from a single provider. Some start with multiples, and others start with one. Both have been successful if you have the data standards and the administrative standards in place.

MR. LAWRENCE MITCHELL: I want to pick up on this last comment. If I have multiple TPAs and have multiple data information coming into some source for somebody to read, who is reading it?

MR. BOWERS: There are standardized decisions for databases, rules that have been established. We have those. There are a number of firms that have those types of elements.

MR. MITCHELL: What I'm asking is: Has the coalition then decided that one entity will read and interpret? Is it an overall decision?

MR. BOWERS: Not necessarily interpret. Standardized data warehouses are there, but they may have an interpretation to another firm. They may do that.

MR. MITCHELL: I understand that there may be data warehousing, but if there's a coalition of 10 companies, are there, perhaps, three interpreters?

MR. BOWERS: There's one interpreter—independent.

Remember, these are self-insured employers. Plan designs are the purview of that employer. To the extent that the rules of engagement are that certain plan design parameters need to be changed to steer to providers, the people would implement that, and you would establish general rules. Maybe you want to have steerage equal to 20 percent benefit value differential. We keep it that broad, and then the employers have the ability to put in any plan design that they want.

FROM THE FLOOR: Taking those last two questions to the back end where there's one TPA, how about purchasing their stop-loss on the self-funded 10 individuals?

MR. BOWERS: One of the principles that we have had is pool purchasing, not risk, and we haven't attacked the reinsurance side at this stage. We're beginning to think that there may be some value in that in opening up the contracts a little bit with potential bidding reinsurers, looking at the reinsurer as a mechanism to drive or steer to more defined pricing providers whether or not they're transplant or other types of care. We're in that process but have not done a lot of group purchasing of reinsurance. We have not attacked that yet.

MR. RICH WIPPERFURTH: I am the vice president of sales for Innoviant. We are a PBM company that is attacking the marketplace in a bit of a different way. We offer the same types of programs that other PBMs do, but we do it in a transparent basis, which means that we spend a lot of time probably doing what you do. We explain the rates and services that are available for self-funded employers and help them to understand how to do an apples-to-apples comparison, to borrow a phrase from Tim, and so we understand what they're negotiating for. In today's marketplace, PBM rates are complex, and the reality is that trying to create an apples-to-apples comparison that you can understand and get a self-funded employer to understand can be difficult.

That said, what we thought we'd do is talk a little bit about what's happening in the market, what's driving cost, what some of the strategies might be to attack some of the cost, what some of the cost drivers are and how to attack some of the cost drivers. The overview again is the state of the industry.

One of the things that's important to understand is precisely how we have gotten to where we are. The state of the industry is unique, and what's happening in the industry right now is it's a bit of back to the future. Several years ago, pharmacy rates were loaded completely into an administrative fee, and everything else was a pure pass-through, so if you went to the Walgreen's pharmacy, CVS or Rite-Aid, whatever the contracted rate was at that specific pharmacy was passed to the

employee at the point of sale. What industrious and intelligent PBMs did was begin to take that administrative fee and build it into margin that they would apply at the point of sale.

If you were evaluating PBMs, the administrative rate for one PBM might look dramatically different from another PBM that began to understand how to put margin and take that administrative rate and make it smaller by putting margin into the rate applied at the pharmacy. The basis for evaluation was difficult to get a handle on. Where it used to say $4 per employer per month, now it said $1 per employer per month, and it was difficult to truly understand what the differences were.

The other opportunities that we can discuss today are what is happening in the marketplace and what some of the drivers are. Brand medications are a primary driver of cost in pharmacy as are now specialty injectables. That's what's happening there. We'll also discuss some of the long-term strategies for managing cost.

Here's an interesting story. I was in front of a customer yesterday, a relatively large customer in Chicago, that was being serviced by a large carrier. After 40 pages of analysis on a PowerPoint presentation that it delivered, its overall recommendation was to just increase markets and increase your membership. The challenge is that PBMs haven't exactly endeared themselves to the organizations that are trying to help manage cost. PBMs can provide some of the consulting services and work that organizations need to evaluate pharmacy. Historically, that hasn't been happening.

What's happening in the state of the industry? In short, we've seen double-digit trend year after year. When I sold PBM services 10 years ago, I said many of the same things that I say today. Utilization is because of direct-to-consumer advertising. It's also because of the aging population. New therapies have come out. Many years ago, SmithKline Beecham came out with a product called Tagamet. It was its first billion dollar product that drove its stock through the roof.

If you think about what's happening now, there are new products for things like rheumatoid arthritis called Enbrel. If you looked at the top 10 by cost of most groups' pharmacy utilization, Enbrel would be sitting there. The market dynamics are relatively similar. The trend for pharmacy is supposed to continue to increase at double digits; however it's supposed to decrease in actual numbers. While the trend last year was near 17 percent or 18 percent, this year it's projected to be closer to 15 percent or 16 percent.

Drug spend is also increasing dramatically. What we're seeing from an '02 Towers Perrin study is that 16 percent of the total health-care costs for actives are rated pharmacy, and for retirees it's 35 percent. These statistics are continuing to grow, and by individual case there's a lot of variability, but generally these numbers hold true.

The interesting thing is that today, in '03, pharmacy cost is approximately $168 billion. By '10, it's projected to be nearly $310 billion. If you watch the stock of some of the publicly traded PBMs, you can also notice the trend line of this stock looks remarkably similar to the ingredient cost. PBMs are under a tremendous amount of scrutiny right now. You could open up almost any paper, and there would be some information about a PBM regarding implementation or integration fees that they have paid in exchange for business or grant money that they had received. Ultimately, employer groups, their consultants and their brokers are beginning to wonder where the money is. Can we please understand exactly what the administrative expense is relative to the pharmacy? We know that on the medical side, it's 10 percent to 12 percent. What is it on pharmacy? PBMs have historically not been able to give that type of information. They continue to drag their feet when asked, and so the primary result is James Sheehan of the federal government and Eliot Spitzer, who's just been going after the investment community, are now setting their sights on PBMs. If you're a smart broker or a consultant, one of the first things that you do to generate some goodwill with your employers is take pharmacy out to bid because it's amazing how PBMs can always tighten their rates if they need to.

What does the environment look like today? Essentially, in this circle (Chart 7) entitled "Defining the environment," that's where the money's being spent. The physician and the patient are in that circle. The physician and the patient get together to spend the money. The physician has more information than the patient, although, because of the FDA rules that Tim was talking about, we now have a lot of information, too. The physician, who's being detailed by pharmaceutical representatives and who has a sample closet full of branded medications, prescribes the product to the patient, and the patient brings that medication to the pharmacist, who then transcribes that into a claim. The claim is then paid by the payer in a self-funded environment. That circle represents the majority of the $168 billion spent on pharmacy.

There are two entities that circle around that circle that want to have influence. One of them is the pharmaceutical manufacturers and the other is the payer, the employer in concert with the PBM. In '01, the World Series sponsors were Paxil and Budweiser. If you look at Sesame Street, the sponsors are Zithromax and, I believe, Cheerios. Pharmaceutical manufacturers are amazingly adept at creating brand. That's what they do. They're good at it. Frankly, the products that they're branding to us are necessary and good products.

The challenges and the behavior that they're generating also generate a tremendous amount of dollars, so pharmaceutical manufacturers have decided to earmark the people who have the influence over where the dollars are spent. In '01, they spent approximately $2.4 billion communicating with us and approximately $10 billion communicating with physicians. They also spent dollars communicating with PBMs, and those dollars spent communicating with PBMs were in the form of administrative fees. Administrative fees are typically a percentage of the cost of the

products that are being dispensed. You can imagine if a high-cost brand medication is the medication that's being dispensed by the PBM, the PBM makes more because it's getting a percentage of that ingredient cost versus a product that might be less expensive. I'll give you an example of that later.

In '03, the statistics are interesting in that the FDA has had an impact. Pharmaceutical manufacturers still spend about $10 billion communicating with doctors, but now they spend $10 billion communicating to us.

FROM THE FLOOR: When you refer to that as an administrative fee, is that what we call in the marketplace a rebate?

MR. WIPPERFURTH: No, it's called a rebate administrative fee. Pharmaceutical manufacturers provide a rebate to a PBM. In that rebate is something called a rebate administrative fee. Rebate administrative fees are interesting tools. Essentially, if you're a pharmaceutical salesperson, you want data from a PBM because the PBM data tell you which physicians prescribed which products. If you're the sales representative for Cialis or Levitra, you want to know which physician prescribes that product because if the dividend equivalent amount (DEA) number on the claim file comes through as a doctor in your territory, you get paid. They're invested in creating these contractual relationships between PBMs and their pharmaceutical manufacturers.

It's not a bad thing. It's an appropriate thing, but to get the data from the PBM, a payment goes through, and the payment is the administrative fee that sits on top of the rebate. The payment comes in in bulk, but the rebate administrative fee comes off the top of the rebate. The rebate that gets represented to the employers is not truly 100 percent of the payment that was generated by that claim. It's this payment that has James Sheehan and others and a lot of employers and some coalitions wondering how much that is exactly because if you're the federal government, and you're generating revenue from the PBM based on your claims volume, that's a reduction in the discount that you've been promised. If they can prove that there's been a reduction in the discount promised, that may have an impact on their most-favored-nation pricing, and no one will negotiate. If you're a PBM, you don't want too much scrutiny on your rebate administrative fee.

If you think about it, the PBMs live in this netherworld where the pharmaceutical manufacturer is paying them dollars based on the product prescribed. The more expensive the product, the more the rebate administrative fee while the payer is paying the PBM company to reduce cost. Now you have this issue where your formulary management team is getting together. Your physicians have said, "These five proton pump inhibitors work for stomach upset. They're all relatively equal. They include Nexium, Aciphex, Protonix, Prilosec and even Prilosec's over-the-counter (OTC) product. We've determined that they're all relatively clinically appropriate, and now we're going to give this group of products to our business group."

Historically, the business group thought a lot like this, and this is typical in the industry. The business group would say, "All right. They're all clinically equal. Which product gives us our best rebate?" If you're a PBM, and the only piece that you're at risk for is a rebate, Nexium is an outstanding product. It's a great product, is heavily advertised, has a decent market share and offers a big rebate. The challenge is how to find a PBM that asks a different question. What's the lowest net cost? What's the cost of the product less the rebate? What's the lowest-net-cost product? Now that PBM is thinking more like the payer that's at risk. In that type of a scenario, Protonics, at $100 a pill, versus Nexium's $135 a pill less its 25 percent rebate versus Nexium's 30 percent rebate, offers approximately $25 a month in savings while giving a similar side effect profile and excellent clinical results.

The challenge is how to identify organizations that are aligned in their philosophies with the payer. When you align yourself, and this doesn't necessarily mean that you shouldn't take the rebate administrative fee, you should know what it is so you know what you're negotiating for as an employer. If you don't take the rebate administrative fee, though, or if you explain to an employer what it is, you now are able to share those dollars with the employer. The employer knows what it's negotiating for when it's negotiating its pharmacy rates, and the payer and the PBM are in goal alignment.

Our strategy is to reduce your relevant costs. Let's take that message and drive it inside this circle. We can talk to the patient. You can communicate through pharmaceutical manufacturers or with the doctors. We can communicate ourselves with the doctors, and we can communicate with pharmacists via formularies and online messaging. The marketplace is shifting. About a year ago, when we were out talking about our message, which is similar to this, nobody cared, frankly. People thought it was great in theory. The word "interesting" was used, which is a death knell in any presentation. We began to see proposals that would come through requesting transparent pricing, and one or two players in the market did this. Recently, the state of South Dakota decided, and wrote this into a house bill, you have to be able to be transparent to work in the state. The market is definitely shifting. Eleven PBMs stepped up to the plate to offer it. None of the big guys did, interestingly enough, so the market is changing.

The other strategy if you're truly focused on cost is identifying what the primary cost drivers are. If you think about what trend is, trend is the average cost per prescription dispensed multiplied by the total number of prescriptions that are dispensed. If your kid's sick, and you need a prescription, it's unlikely that your behavior is going to change so much that you don't get the prescription. If the kid has an ear infection, the physician will tell you there's not much you can do about it, but he'll give you a prescription and you can get it filled. You're going to get it filled. The reality is that PBMs have limited impact on the number of prescriptions that are dispensed.

The opportunity is to impact the average wholesale price (AWP) or the total price of the products that are dispensed. The AWP goes up annually. If you think about Nexium, the cost of Nexium, Protonics and others goes up between 10 percent and 13 percent annually. The primary reason it's going up is because the marketplace is shifting. The competitive nature of an individual therapeutic category shifts. The other reality is that pharmaceutical manufacturers' pipelines are drying up.

If you think about where they're moving right now, it's bioinjectables. If you read the *Wall Street Journal*, it has that strip in the middle where it talks about mergers and acquisitions, and you frequently read about a biotech that's been snapped up by a big pharma. That's primarily because big pharma doesn't have the pipeline it used to and sees these biotechs as a way to drive market share in an area that either it works in or doesn't work in. The strategy then for pharma is if Prevacid is the number-one proton pump inhibitor, and we know we have major market share, we can move the price up because we don't have anything behind it. There's nothing coming behind it to take up that slack. One of the major reasons AWP is increasing is because pipelines are drying up.

Increases in member utilization are amazing. The average person takes eight prescriptions a year. That's just the average person. If you're a retiree, you can take anywhere from 12 to 24 prescriptions a year. Utilization is generally increasing. The other reality is we're an aging population overall, and there are new therapies. I talked about rheumatoid arthritis and Enbrel. It's an incredibly expensive product, but if you have rheumatoid arthritis, you're going to work now. You were missing work before. These are appropriate therapies. The challenge is they're incredibly expensive. These new therapies are offering us new medical solutions for people who historically had none.

Tim talked about outdated benefit design. Nowhere is this truer than in pharmacy. We're seeing a tremendous shift from flat co-pays to coinsurance to give insurers an opportunity to demonstrate the true cost of the product. We're seeing a remarkable shift toward low coinsurance levels on generics because generics represent such an amazing value. What coinsurance allows you to do is not have to change identification cards repeatedly. You are providing people with an opportunity to understand the cost of the product that's been dispensed. We're also seeing co-pays and deductibles being put in place on pharmacy. What that does is offset some risk.

We talked a little bit about the manufacturer shift in niche markets. Manufacturers are looking at biotechs as a way to drive market share. If you own a market on a specific product, you can generate a tremendous amount of revenue. The other reality is that the formulary that's being put together by individual PBM companies goes a long way toward trying to control some of these major cost drivers. If you prefer Nexium on your formulary, I can guarantee you that your costs are going to be higher than the PBM that prefers Protonix or even Prilosec's OTC. Looking and paying attention to what's on the formulary is a painful evaluation, but lots of people are willing to do it.

Specialty pharmacy is something you're going to hear again and again. This is where PBMs are beginning to focus primarily because these are new products that are gaining in utilization, but if you think about it, specialty pharmacy drugs as a percentage of total utilization are generally 1 percent or less of total utilization, but they are more than 13 percent of total costs. In our book of business it's under 0.5 percent, and it's 11 percent of our total costs.

These are engineered medications. They're not derivatives of a coca leaf. These are DNA-based products that have been genetically engineered by scientists that not only provide relief from symptomology but may solve the issue. They treat the condition. The average cost of a brand medication that you buy at Walgreen's or Joe's Pharmacy is roughly between $90 and $100 per 30 days of therapy. The cost of these specialty injectables on average is $1,200 per 30 days of therapy. If you're a 500-employee self-funded group and have a hemophiliac or somebody who needs to take growth hormone, it's a challenge to manage your costs. We'll talk about what some of the opportunities are for management.

The other thing, and this plays well into the integration that we talked about between TPAs and PBMs, is they did a study with 56 oncologists and found that when they were able to take these specialty injectables and run them through on the medical side, they were marking up these $1,200 products an average of 37 percent. If you can take these products and drive them through pharmacy, you're getting a reduction in the AWP of an average of 14 percent. We're talking about a more than 50 percent reduction in cost. If you can move that product from medical to pharmacy, you can generate tremendous savings. We'll talk more about that, too.

As someone who is working with self-funded employers to help them identify what the method to truly identify cost is, I look at how the goals are aligned between the organization and the PBM it has been working with. What do its goals look like versus those of the employers? If the PBM is unwilling to provide you information about where the revenue comes from, and if it can't literally break down the revenue on a per-claim basis, you should begin to question why that is. On a $100 drug, a 1 percent differential between what I've contracted at the pharmacy and what I've resold to an employer is worth approximately $0.50 a claim. If your PBM can't tell you that, you may want to inquire further. What type of rebate revenue does it generate? Is there a rebate administrative fee? Are there grant dollars associated with the claims that my client generates? What type of generic rate is there?

If you think about where PBMs make their money, the number-one moneymaker for PBMs is mail generic claims. Number two is retail generic claims. Number three is mail brand. Number four is retail brand. Do you know what the margin is?

When I went back to a client of mine I hadn't seen for a long time, I asked him what he thought his rates were. He could tell me specifically his adjudication fee is zero. His brand rate is AWP less 15 percent and his rebates are $2.40. I knew that most of the revenue that the PBM was generating was on generics, and I asked him what his generic rate was. He didn't know, which is why most of our revenue is on generics. The real challenge is understanding what the rates are. Can you evaluate that for your customer? If you're pushing generics as a benefit design, are you also getting a good deal on the discount side? If you're not, you're working against yourself.

The concern is that if you think about this tired metaphor of the iceberg, we spend all of our time negotiating above the waterline: dispensing fees, discounts, rebates, AWP discounts and adjudication fees that represent between 3 percent and 7 percent of the total cost. If you think about how the formulary is put together and whether or not this group is truly aligned to move to the lowest-net-cost product, now you're talking about real savings. That's the actual cost of the product. If you want a big rebate, I can guarantee you a big rebate, but I also can guarantee you that I'm going to raise your ingredient cost. It's like buying a car: the best rebates are on the most expensive cars.

We talked a little bit about transparency. The real objectives are: Can I understand what your rates are and can I have unrestricted access to how you process claims and what those discounts are? Can I come and look at the contracts you have with pharmacies and pharmaceutical manufacturers? There are some PBMs that will let you do that. There are also a lot that won't. Make sure that they have a full suite of clinical tools. Can they tell you that they can give you a program and can measure its outcome? Do they offer OTC coverage? Why? Can they demonstrate what the new per-unit cost is of Prilosec OTC versus Nexium or Protonix?

There's a $2-per-unit cost, which is essentially a day's worth of therapy difference. Can they apply that type of a program? Are they willing to apply that type of a program? Can they measure that type of a program? Do those programs come with fees? Most of them do, but some don't. It's a big difference. We worked with a client yesterday with 7,000 people total. That prior authorization (PA) fee was more than $180,000 annually.

There are opportunities. OTC is a big opportunity in two major cost-driving categories. There are also a lot of drugs coming off of patent soon, and even though legislation (Waxman-Hatch Act) is allowing pharmas to be creative about what they now patent, there's still a number of drugs coming off patent. Prozac is coming off of patent. Selective serotonin re-uptake inhibitors (SSRIs) are probably in the top three of every single group that we represent in this room for spend. Prozac coming off of patent represents an amazing opportunity for us. People are becoming more familiar with what the cost of the medications is. Play on that. Does the PBM offer material that can promote generics? Does it have material that will promote its formulary? Can it offer a four-tier formulary if you're looking in that direction?

I like Tim's comment. It's the KISS rule: keep it simple stupid. People can understand generics. It's a tremendous deal. Make it a good deal for them. Our own benefit is a 10 percent generic, 25 percent brand, 25 percent plus 15 percent brand nonformulary. Our average brand member share is under $2, but our brand utilization is over 50 percent. For every 1 percent that you can move generic utilization north, you save $0.40 per month per member (PMPM). It's a huge opportunity.

People are also becoming more familiar with the fact that they're probably going to run into an editor, too, at the pharmacy that's going to have an impact on the claim that they've received. There's some temperance for that. More employers, 86 percent, are applying clinical programs to the point of sale that are either clinically based or cost-based, and that's growing.

Regarding reform in pharmaceutical marketing practices, fewer and fewer organizations are getting unrestricted access to doctors.

What are the challenges? One is closing the gap between payers, prescribers and patients. While patients are learning more about prescription costs, you still ask the average person what a brand medication costs, and it's $10 to $20. Looking at coinsurance is a huge opportunity. Encouraging the employer to communicate about its benefit design is also important.

Many expensive drugs are about to hit the market soon. Depending on who you ask, there are between 500 and 700 biological agents and specialty injectables that are about to hit the market soon, so it's going to be important for a PBM to demonstrate what the actual costs are of these new expensive medications. Look for PBMs that can break out those high-cost injectables and tell you what those costs are specifically; otherwise they'll skew your trend to the point where it will be difficult to identify what the actual trend of pharmacy is.

People have also gotten much smarter about which plans they choose, so making sure that you don't incent a group to go to a plan that will ultimately lead to ruin is important as well. Occasionally, we'll run into groups that have a rich plan—the bronze, silver and gold strategy—and they'll end up with everybody in one prescription plan when they've been thinking more about the medical side. Wrapping pharmacy and the overall strategy is important. Even though it's 16 percent to 30 percent of the total cost, the trend on pharmacy continues to grow in double digits.

Just for fun next time you're talking to a PBM, ask whether it can stand up on the board and tell you how much it's earning on a per-claim basis. Ask whether it can tell you what its maximum allowable cost (MAC) list looks like and how many drugs hit its MAC list. It's incredibly complex. Most employers don't understand how much they spend on a per-claim basis. If I asked a group of employers how much they've

spent, and I've done this before, people's hands start raising as I drop down from $7. At about $1 people start to raise their hands on a per-claim basis. That's about how much we spend. The average PBM makes between $3 and $7 on every prescription generated. Does your employer know how much it's paying? What is it negotiating for?

Strategies include plan designs that encourage the use of appropriate therapy, but also lowest-net-cost therapy. Have regular communications with patients to help them to be better with their physicians. If you get your drug, you go to the pharmacist and ask, "Is there a medication that's generic for this drug?" The pharmacist will say, "No way." If you ask that question at the physician's office, they might say, "There are 10." If you get a Nexium prescription, go to the pharmacy and ask, "Is there a generic?" There's not. You can ask at the doctor's office, "Is there a generic for the condition that I have?" There are multiple for proton pump inhibitors. That type of behavior change can have a huge impact.

Finally, be aggressive about understanding the pharmacy benefit environment. We believe that it's a PBM's job to tell you how it operates and makes money. In summary, costs are going to increase. Employers have a huge impact on what's going to ultimately happen, and the biologics are going to drive costs. It's up to us to work together to help to educate the employers and their employees.

MR. GREGORY G. DEMARS: I work with Allianz Life. I've been with the company for 12 years, and nine of those years have been in the healthcare side. The past six focused on stop-loss, HMO reinsurance, provider access and medical access. I'm in a division called healthcare risk management, and we focus on access of loss medical products.

Today, I'm going to give an update on the stop-loss insurance marketplace. I make no claim to be an expert in this field. It's such a huge dynamic market with so many different players that it's difficult to keep your arms around everything. The players included in this marketplace are brokers, healthcare providers, care managers, carriers, employers and health plan administrators, to name a few. I plan to hit on three perspectives: the carrier, the employer and the administrator.

From a carrier side, I'll go through January '04 and what we saw, as well as what some of our competitors saw; recent underwriting trends and product trends; state assessments, which a lot of you are probably familiar with, but I'll walk through that; and medical management and disease management crediting lists that we're seeing on the stop-loss side.

I'll start with the January '04 stop-loss marketplace assessment. By several accounts, it's a soft market. Competition is extremely high. Closing ratios are extremely low. Why is that? What's causing this cycle in our market? One reason is recent profits. Some survey information shows that '01 and '02 were profitable years for that marketplace. Coming off of that, we're seeing competitive rating

action from many of the different carriers. ASO carriers are also delving into the medical market, which they hadn't in the past, so those groups in the 200 to 1,000 life range are now stepping into that market, creating more capacity and more competition from that perspective.

Across the board you have aggressive ratings. Some are questionable, irresponsible and unjustifiable in our eyes. Not that Allianz probably doesn't have a few of its own irresponsible rates out there, but, for example, we'll have a block of a dozen accounts with a producer that we've had for four years, a nice stable book of business, and we hope in January '04 to get the leverage trend and to continue that relationship. But we'll see carriers come in and rate 20 percent beneath our existing rate, much less getting the leverage trend component on the existing block. You always have some of that. We're seeing more of it right now with our competition.

According to the aggressive rating validated via the barroom napkin survey at some recent conferences (and Tillinghast does a rate increase survey every year, which will be coming out), I think for '03 the rate increase was in the 14 percent range. Discussions that we've had recently indicate it's been in an 8 percent to 15 percent range. On a same-to-same basis, if you have a base trend of 10 percent, you're going to get yourself into the 20+ percent range on a leverage trend basis, so you can just see the competitiveness and the aggressiveness out there, which in this soft market leads to the question of how long that will maintain. Obviously, carriers and writers of this business can't maintain that for long, so it'll be interesting to see in nine to 12 months what changes are on the capacity side.
This environment may be a challenge, especially, I would guess, for the managing general underwriter (MGU) marketplace as that competition ramps up and margins thin. It will be interesting to see. It often breeds some innovation in trying to overcome and differentiate yourself among other carriers. The MGU market has been challenged in the past and has always come through, so I expect that again. Those that have the strong relationships with their carriers will certainly rise up and work through that.

Generally, persistency is up. Again, it's the carriers and the writers of this business stepping up and doing everything they need to do to try to maintain that book. That's somewhat tied to the rate increase activity that we're seeing being aggressive. From my perspective, the cycle on the fully insured side seems to be fairly moderated. I think Tim brought up that in certain markets, you have only three material writers. I think with respect to this product line, you still see upward of a dozen pens in a given area. I think that capacity issue is leading to some of the irrational cycles that we still have on the stop-loss side. The capacity has been fairly steady. I have read there are 25 carriers and 75 MGUs, and that's been fairly steady over the past year, but it will be interesting to see how that changes in light of the current marketplace.

Regarding underwriting and product trends, we've seen a lot of rate caps in the marketplace since January. Most of them have come since the January season,

when I think production was low and some people were coming out with different alternatives to the marketplace to differentiate with these innovations and changes. The disclosure requirements are tightening up equally if not more so to make up for any give there has been on the product or on the rate side. Disclosure has been a real challenge. Some of our TPA partners have commented often that disclosure is killing them and that they feel they have a group locked down into a proposal. At the last minute or at the effective date, another disclosure is required, and they have to walk away.

Lasering continues. Lasering, for those of you not a part of this marketplace, is the practice of setting a higher attachment point on a high-risk individual with an employer group to avoid the risk charge that's out there. This continues, and it's common not only on new cases but on renewal as well. When something pops up for a client, the carriers or the writers of this business are stepping in with a laser. Of course, the market's a bit segmented on the approach that it takes here. There's a segment of the market that utilizes lasering quite a bit on the renewal side as well, and then there's another segment of the market that takes a preferred approach that recognizes you're going to have some of those claims.

Ideally, with an employer, you're able to offer an appropriate rate to begin with. Certainly you'll have some swings as you go, but not what you see with some of the writers of this business that will have the low rate the first year and then when something pops up, they're lasering, so the relationship between the employer group and that entity is done at that point. Ideally, these employer groups will see the value in passing on the extreme cut-throat low rate for the underwriting approach that several carriers do that is not lasering again on renewal, but taking some of those hits as you would expect throughout the life or throughout the durations of an employer group's risk.

We are seeing lower corridors on aggregates as well as focused product initiatives on employer groups coming from HMO plans that probably don't have the experience to share and bring those people an alternative, which often comes in the form of a two-year type of arrangement.

Concerning state assessments, generally it's states trying to fund their health risk pools for people who are unable to get coverage through private insurance. Essentially, it's a tax on employer groups funneled through fully insured carriers or stop-loss carriers. Currently, there are 32 states with these and 175,000 lives covered, but every week I hear of a new state bringing this up and discussing this as an option to bring in more revenue to cover its high-risk pool. The funding is collected on either a percent-of-premium or a per-cap basis. The percent-of–premium basis is fairly easy for the stop-loss market to deal with. It's similar to a premium tax of sorts.

A percent of cap is a bit of a challenge. We've had a situation, which is alleviated now, but in Colorado, the assessment was $26 per day per member (PDPM) PE per

year. When you tack that on or have that be a part of your stop-loss risk and have an employer group with a $400,000 or $500,000 attachment point, you're going to have an assessment that's 40 percent of your risk premium. There's a huge challenge on the per-cap side. The tactics and the viewpoints are certainly different among the self-funded marketplace, the stop-loss marketplace and the employer-insured marketplace. I think the employer-insured marketplace would prefer the per-cap method because it is such a challenge on the stop-loss side.

The stop-loss market, from my perspective, is not opposed to an effort to try to develop some of this funding to expand insurance coverage, but it's a question of whether we can put forth an assessment that's structured in a way that is prospective, equitable, across a broader base and over a pool that's managed effectively.

Some of the issues with assessments are the retrospective calculations and how they're developed. The assessment will come out and will be on groups that you may already have effective, meaning your ability to account for that and charge for that is impossible, so you're having to make a guess or a call on what that assessment might be. You have the issue of offsets. If you are a company that has a broad range of products in a given state, you may be able to offset the per-cap, so managing that is a bit of a challenge. Some states have the offsets, and some don't.

Another issue is large employers that don't buy any stop-loss insurance, and they're totally self-funded. There's a spectrum of the marketplace that doesn't have any contribution to these high-risk pools because they're not paying it through the stop-loss carrier and they're not paying it through a fully insured carrier. As a result, there are gaps in some of the approaches here. I think a lot of us in this room have backgrounds in eligibility, plan design, medical management and structuring of these types of pools. Hopefully some of us would be involved in some of the assessment development to make it more equitable and more appropriate.

Next, I'm going to briefly touch on medical management and disease management credits as employer groups and TPAs have delved into creating new disease management programs. Often when they're in our office, TPAs bring up how great and how awesome their disease management programs and their medical management programs are. Of course, they'll walk through the one anecdotal case of a transplant patient where they did save 30 percent by moving that patient to a network and expect the next thing out of my mouth to be, "Well, let's just put 30 percent discount across all of your rates."

It's taking that whole thing to the next level and assessing value on the disease management programs. I know there are even forums and discussions here this week on the measurement tools and how we can take steps toward those being of value. Ideally, from the high-dollar risk perspective, taking even that next step of being able to assess on a high-dollar perspective what the value of some of these

disease management programs are would be helpful because right now we have a lot of organizations sending in, and it's a wide spectrum. Some are looking good, but, on the other side, you get the summaries of our lives that are 80 to one, and I have a hard time doing anything with that except filing it in my circular file.

On the employer perspective, the rising healthcare costs make self-funding more attractive because of the standard prose with self-funding, such as the premium tax, the flexibility and benefit plan design and allowing employers to take more risks so there's less emphasis on a profit margin having to be made on it from a first-dollar risk perspective. As we see healthcare costs continuing to blow up, each one of those values only strengthens as rates climb. The market's responding with rate caps, flexible coverages and carve-outs.

Employers, as I talked about earlier, certainly are investigating an array of medical management and disease management programs. Again, many of our TPAs have come in and not only are developing the programs but are saying the sales and implementation of those programs across their books are taking off. January was a big step for them, and they expect much of their books to be taking part in their disease management programs throughout '04 and into '05.

From an employer perspective, large claim trends are significant. We heard yesterday that the provider contracting trend hospital charge masters have been going up in the range of 25 percent to 35 percent for the past several years. I threw out my quick leverage trend assessment earlier. Our leverage trend calculations capture all of that. A lot of our risks above $75,000 or $100,000 are going to be hospital risks. If their charge masters are going up that significantly, it'll be difficult to stay on top of that. Most of the networks, including PPOs and HMOs, are outlier-riddled. You see few fixed contracts in place any more. It's the exception and certainly not the norm even on the HMO side, which you may have seen a lot more of here five years ago.

Small employers are extremely rate-sensitive. Again, it's that challenge underwriting-wise from a stop-loss perspective of how their rate sensitivity might be $3,000 because of the situation they're in. Again, that $3,000 gain may mean the next year they're without a carrier. They're having to rerate, and it may be at a point where they have a person who has come down with something or they've taken on a new employee. That's the risk they're taking each time they do that.

Large employers are looking for more stability given no material rate difference, of course, although I think traditionally, and it continues, that the larger employers are looking for more stability and look to the bigger, more stable carriers for their coverage.

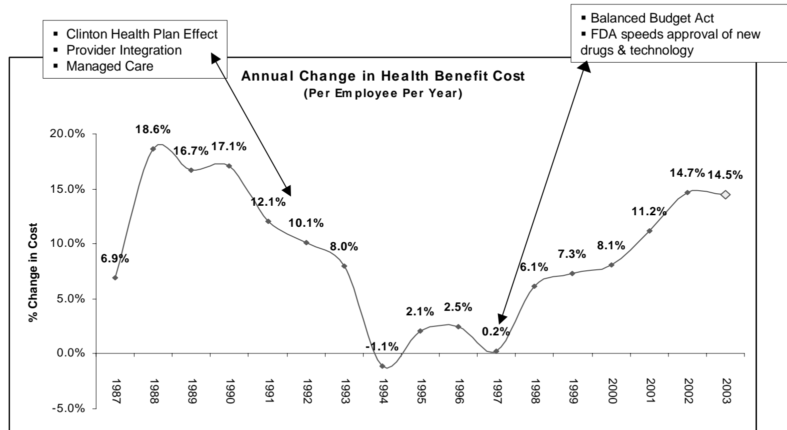
There are some health plan administrative key issues. A lot of them are testing the consumer-driven and health status adjuster (HSA) programs. Like I said, they're developing a lot of these disease management programs. Some of them that we

work with still have yet to put any of them in place. They're just now getting into developing some of these programs. It's a wide spectrum. Some have a full portfolio of programs that the employers can utilize. Some are just stepping into that realm, which leads the small independent TPAs having to divest or invest significantly in programs, but also the systems and data and regulatory issues that they have. There has been quite a bit of consolidation in this marketplace when you look at a Pfizer-type situation. There's no new entry—just consolidation from what we've seen. We will continue to watch this.

In conclusion, I have a bold statement: Change continues. I suppose every presentation that we've seen this week can probably conclude that way. I think the value of self-funding is strong, and the need for excess of loss coverage is not diminishing. From an employer perspective in the competitive market that it is on the stop-loss side, now would be the time to take a look at that because people are extremely competitive.

Chart 1

MEDICAL INFLATION



Sources: Mercer Human Resource
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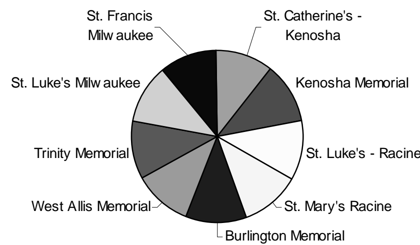
Chart 2

PROVIDERS - 1990



Source Bowers & Associates, Inc.

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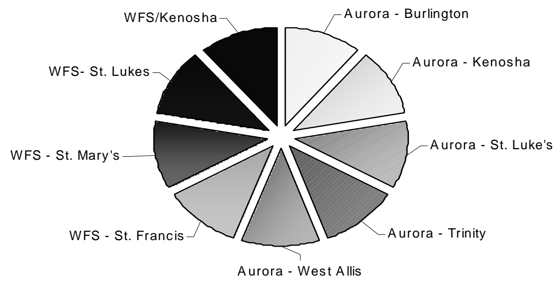
Chart 3

PROVIDERS - 2003



Source Bowers & Associates, Inc.

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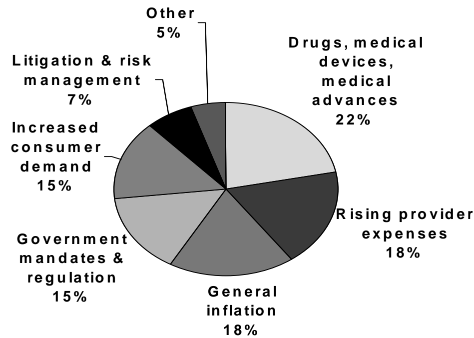
Chart 4

FACTORS DRVING PROVIDER PRICING



Source: Price Waterhouse Coopers

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Chart 5

Date of Service	AAAA
Provider	XXXX
Physician	YYYY
Provider Tax ID	ZZZZZ
Billing Type	Electronically Billed & Auto-adjudicated

Code	Description	Billed Amount	% Before
20610.LT	OBSERVATION ROOM/TREATMENT - LIMITED	$ 81	43%
99212.25	VISIT - LOW ACUITY-ESTABLISHED PATIENT	66	35%
J1030	INJECTION	42	22%
Subtotal before rule change		189	100%
20610	OBSERVATION ROOM/TREATMENT	113	60%
Total after rule change		$ 302	**160%**

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Chart 6

Date of Service	AAAA
Provider	XXXX
Physician	YYYY
Provider Tax ID	ZZZZZ
Billing Type	Electronically Billed & Auto-adjudicated

Code	Description	Billed Amount	% Before
20610.5	OBSERVATION ROOM/TREATMENT	$ 162	66%
J1030	INJECTION	84	34%
Subtotal before rule change		246	100%
20610	OBSERVATION ROOM/TREATMENT	226	92%
Total after rule change		$ 472	**192%**

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Chart 7