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Session 77PD
What's Happening Outside of Consumer-Driven Health Plans (CDHPs)?

Track: Health

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Summary: Consumer-driven health plans are receiving a great deal of publicity these days. However, enrollment in CDHPs represents just a fraction of the commercial insured population. This session brings attendees up to date on developments and plan designs in more traditional health plan products, both employer-sponsored and individual. Topics to be discussed include emerging trends in health plan benefit design, where we go when deductibles and copayments get too high, and limited benefit plans. Attendees attain a greater understanding of various benefit options and plan design changes, as well as how these plan designs impact utilization.

MR. JOHN GOVERNALE: Consumer-driven health plans are emerging as new plans with the aim to slow growth in medical costs by providing participants with educational resources, decision-making tools and financial incentives. The hope is to make more efficient health-care decisions. However, we're not going to be talking about that. These have been slow to emerge. They're just emerging now. The data is limited and inconclusive. What we're going to be talking about is what's happening outside of consumer-driven health plans.

I'm president of Actuarial Health Solutions. . On the panel are Steve Kaczmarek, Greg Russell and Ed Schneider. Each of us share similar backgrounds. My background is in product development, rating and underwriting, reserving, provider contracting, forecasting and budgeting. Greg is executive director of actuarial services for Anthem Blue Cross and Blue Shield in Denver. His primary

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responsibilities include product pricing, provider contracting analysis, financial forecasting, reserving, utilization management analyses and actuarial systems applications. Steve is a consulting actuary with Milliman USA in Connecticut. His experience is as a product development actuary where he has been responsible for developing medical benefit plans, pricing and underwriting of those plans. Steve also served as business financial officer for Cigna's managed care products. He has also authored articles, including "Risk and Adverse Selection: Determining Profit Loads When Setting Large Group Premium Rates." Ed Schneider is consulting actuary with Reden & Anders in their Atlanta office. Ed has been consulting for the past ten years. His clients are primarily provider groups and start-up HMOs. Prior to joining the consulting world, Ed was the chief financial officer of a start-up HMO in Baltimore and a group actuary for a major Blue Cross/Blue Shield plan.

Greg is going to start out. He'll be talking about some plan design and benefit designs. Steve will pick up on some underwriting and operational issues, and then Ed is going to follow up with data reports, information, and what you do with that information and how you make it meaningful

MR. GREG THOMAS RUSSELL: I thought I'd start out with some general marketplace product trend discussion topics here. What I'm going to do is share my experiences that I've had with Anthem over the last few years in the Colorado and Nevada regions where I do my work.

The first topic is some things we're seeing. The first thing we've noticed is that there are more frequent plan introductions than we've seen in the past from competitors. This just means that the frequency at which product lines are refreshed and updated seems to be occurring at a little more rapid rate than we've seen in the past, either on an annual or semi-annual basis as opposed to maybe once every two or three years. We, of course, have followed suit. To a great degree, that has been to try to address the rising cost of care trends and affordability issues, so that we could have products that people could actually afford to purchase. We've also seen in the market the easing of restrictions on our HMO plans in terms of prior authorizations, referrals and things of that sort. We've also noticed PPO plans gaining in popularity. I'm sure many of you have seen that. We've also noticed cost-shifting to employees,in terms of higher out-of-pocket expenses, high-deductible plans or even just higher copay plans on the HMO side. In a recent study we looked at, employee contributions are now running upward of 20 percent or more on the cost side for employee share for the premiums. In my statements there's a disclaimer because I'm sure whatever it is I say here, there will be somebody in a region somewhere where it's not happening or it's different. In many cases health care is a local phenomenon, so there might be some things I say here that you're not actually observing yourself.

As far as plan design features, the PPO plan design is sort of "back to the future," in that we've gone to the high-deductible plans. In plain PPOs, we see $1,000 deductibles, $1,500 deductibles and 80/20 co-insurance types of things. One thing

we notice is that it's been very difficult for us to get away from offering benefit plans, either HMO or PPO, without an office visit copay. It just seems to be a feature that everybody has latched on to. It's not popular in the market to offer plans without it. As far as the cost-sharing of MRIs, CAT scans, and other high-end radiological services, on our HMO product line we had a zero copay for this type of benefit for a long time. We've moved that copay up to $100 for these high-end radiological services for a higher cost share, which we didn't feel was unreasonable when they're charging $1,000 or more for the service. From the utilization standpoint, we did have a good dent in the utilization trends for those services. Prior to that, we were running maybe 20 or 25 percent utilization trends for those types of services, and now we're down to maybe 5 or 6 percent on utilization. It hasn't gone negative, but at least we've got our arms around it a little bit more. As far as cost-sharing for emergency room (ER) services, there has been some bumping up in copays and so that's been very beneficial for us. We actually saw utilization trends over the past couple of years run about negative 8 percent. That's over two years, so that's roughly 4 percent a year. We were able to get some changes in behavior in terms of directing members to urgent care centers or to their primary care physicians (PCPs) and staying out of the ER, which has helped us keep our costs down.

One of the popular plan design features we've also seen in the market, and we've done these as well, is the per day copay feature on inpatient admissions with HMOs, typically with a three- or four-day cap on the copay amounts. The caps are maybe $1,500 or $2,000 for an inpatient admission. Another popular plan design feature is a copay differential between PCPs and specialists. We did those as well. From a plan-paid per-month-per-member (PMPM) basis, we're roughly at a 0 percent trend on that, mostly due to the higher cost-sharing with the specialists in terms of keeping the costs down for the premiums. Our actual utilization trends are still continuing to trend upward, but at a much slower pace than we'd seen before. Getting these copay differentials in was beneficial. I'll mention that it was a challenge for us from a systems perspective to actually put those in place. Not everybody's claim systems were easily capable of putting those things in place. We did get it done, but there was quite a bit of work to do that.

My last observation on the HMO side is just that these plans are becoming less popular now. Just speaking for my own state in Colorado, we've lost probably 15 percent of the membership in the state in the last couple of years. We've definitely seen a shift away from that. One reason is that we've lost the cost advantage over PPO plans. If you put a high-deductible PPO plan in the market and you have a lot of cost-sharing to the members, you're definitely going to get some cost reductions on premium rates for that. In addition, from a contracting perspective with the providers, in many circumstances we're losing the beneficial cost differential on our per diems and on a case-rate basis for PPO versus HMO. We're getting some blurring on the contracting side too. Finally, the HMO is less popular now because it's an HMO. HMOs have gotten bad press over time with those types of plans. The perspective on the employer side is simply that the promise was that an HMO would

help restrict cost and improve quality, and I think it probably accomplished that for a great portion of the 1990s. Now we're getting to a point where we've squeezed out a lot of the excesses and there's not a lot left to move there.

On the prescription drug benefit side, everybody knows that trends have been very strong over the past few years, although we did see some easing of those trends in 2003 with a higher generic mix, some over-the-counter gains and some brand patent expirations. There are a number of benefit design features that we've either seen or done ourselves in the market to help dampen the drug trends, including putting in three- or four-tier drug copay types of plans (generic, formulary brand, non-formulary brand and high-cost self-injectables). We've also tried higher copays and increased spread in copays between the tiers with some success. Currently our most popular copay set for prescription drugs is the 10/30/50, with the 30 percent cost share on the high-cost self-injectables, and that's been beneficial for us in the market. We have that in both Nevada and Colorado. It has also helped us drive up our generic use of prescriptions to about 50 percent, so it's been beneficial to get that bigger spread in our copay differentials between brand and generic. In some cases, we're seeing carriers that had these copays in place now putting deductibles in front of those, which is not something we've tried ourselves yet, but it's out there.

Some carriers are going back to prescription drugs as part of the base medical benefit, using co-insurance instead of copays, or either placing drugs or adding drugs to their pre-authorization list to control utilization of some of the higher-cost drugs out in the market. In terms of all the things I have mentioned, the plan design goals are simply to increase the use of generics and increase member out-of-pocket expense in order to control the premium rates on the benefit plans. We do see some problems with member compliance on the prescription drug plans because their out-of-pocket expenses are too high, so that's something that needs to be considered and thought through when we design our benefit plans. It's kind of an access and quality issue. That's another component in addition to cost.

Now I want to talk about benefit buy-downs, which is simply the act of an employer purchasing a less costly benefit plan. We looked at some different surveys in terms of the activity on benefit buy-downs, roughly 30 to 40 percent of employer groups in the market across the United States have purchased less expensive plan designs. When they have done so, the average reduction, in 2003, has been roughly 5 percent. If you multiply the percentages, you're approximately at a point-and-a-half to two points overall in trend, although in Colorado and Nevada we've seen buy-down trends stronger than this. The 30 percent and 40 percent is pretty accurate for us as well, but we're stronger than the 5 percent on the buy-downs, maybe in the neighborhood of closer to 8 percent to 10 percent for us on the buy-down activity. Employers are definitely looking for places to go for cheaper plan designs.

In addition to all the buy-down activity, you're also seeing the added frequency of benefit plan design changes in the market. With all this activity in plan design, in

the product portfolios that a carrier would actually offer himself, the number of benefit plans in some cases is increasing. In addition to that, you’re also getting more price points and a bigger spread from your high-end to low-end pricing in the market, maybe in some cases ratios of more than two to one from your highest- to your lowest-cost benefit plans, depending on your product type. I'm probably preaching to the choir with this, but as new products are introduced, make sure you retire your older benefit plan designs and get your groups moved off of those to help yourself administratively. Otherwise you end up with a couple of hundred plan designs that you have at least one member on, and that can be burdensome from an operational perspective.

We've seen some things in the market recently that we thought were unique features or ideas. I’m not entirely convinced of the wisdom of all these, but these are things we have seen in the market. We're seeing high-deductible plans but they have 0 percent co-insurance, which means you go through a deductible and then it’s 100 percent coverage. I’m a little skeptical of that one because it takes the member out of the equation for cost-sharing once you get to the deductible side. I worry about that one from a utilization perspective. There are prenatal visits with one global copay. This is on the HMO side of the business for covering that. That’s actually something we did as well. We were having prenatal visits where each time the member went to the physician, the member was paying their copay of $10 or $15. We decided to just roll it into one copay for the whole sequence of visits. We thought it would be better administratively. We're also seeing consistency in plan design. What I mean by that is having carriers going through their product portfolios and making sure that the details of the benefit features of the plans that they actively market, if they’re in both HMO and PPO indemnity product lines, are synced up, where it makes sense to do so, for operational efficiency. For example, what's your maximum durable medical equipment (DME) benefit? What’s your maximum number of visits for physical therapy? These are some basic things to make it easier on yourself from an operations standpoint.

We're seeing limitations on high-cost benefits. An example of this is the surgical treatment for obesity, gastric bypass surgery, in terms of increasing cost-sharing for that. In Colorado we’ve seen a significant spike in this type of surgery, to the tune of maybe a 200 percent increase over the past year-and-a-half or so. That was very dramatic for us. We have since instituted "centers of excellence" by identifying only certain facilities to do those types of procedures. We've negotiated a rate we feel is reasonable for the service and determined if the facility is providing the right amount of quality for that as well. We’ve noticed in the market the isolating of these high-cost services that are having spectacular trend rates and we are making adjustments in your plan designs for that.

The last item is reduced network plans. What I mean by this is, for example, on an HMO plan design, deciding to contract with a local market and you have maybe half of the hospitals and a subset of your physicians in it. You’re trying to leverage a smaller network for some better reimbursement rates, so plan designs are a little

bit less expensive than you would have had otherwise if you had offered a broad network. Those are some things that we're seeing come back to the market. Actually, we've even had a couple of hospital systems approach us and say that they'd like to do this with us.

There are some consequences of all the changes we've talked about. Affordability is still an issue, in spite of our efforts to address it through our product design changes. The dent on our cost-of-care trends is maybe a point-and-a half or two percent. We've put a lot of things in our product design changes. Affordability hasn't gotten any better particularly, so although the plan design changes were probably well-intended and in most cases for the best, it's still an issue. Out-of-pocket expenses for some employees are becoming cost prohibitive. I think it's somewhat alarming that insurers will sell a $1,000-deductible benefit plan to an employer. In some cases, you have employees that are on the lower end of the spectrum in terms of what they're actually paid in wages, and a $1,000 deductible can be a barrier to these employees getting health-care services at all, simply because the cost-sharing is too great in some circumstances. While somebody actually has insurance, it can still present a challenge in getting the right care at the right time in the right setting for that.

Simply make sure that the focus still stays on the basics of unit cost and utilization of services. Try to manage those well, as opposed to simply trying to address affordability through plan design changes, although that's a component of the equation.

In terms of other consequences,we've got more products and rates on the market, since we've put new plans out there as well, so that's a wider array for carriers to manage and for employers to manage through making benefit decisions. Another consequence, and I say this one almost facetiously, is that the departments of insurance (DOIs) are busier. There are more product and rate filings, so they've got more to do than they've had before. Lastly, I heard at some other sessions this week about provider complaints regarding being able to collect on the member's cost share, so in some cases providers are turning to collection agencies to get the deductibles and co-insurances back on these high-cost deductible plans.

MR. GOVERNALE: Steve is going to take up some underwriting operational issues.

MR. STEPHEN J. KACZMAREK: I'd like to think that a lot of people are here because they realize this is an important topic. In February you may have seen a news release that CDHPs have topped 1 million members. That *is* a milestone, but there are 160 million other members in our other plan designs, so obviously this is a very important topic for all of us.

How many people here have seen the Academy's public policy monograph on CDHPs? For those of you who haven't, it's readily available. If you go to the very last page or the end of the one section, it basically says that there's no definitive

proof that CDHPs are causing any change in utilization patterns of consumers. It's a somewhat interesting finding for all the fanfare that it's getting. Eventually they may take off. We may want to go back to history to notice that in 1973 when the HMO Act was passed, it took 15 or 20 years for managed care to really come to the forefront. I would assert that a couple of forces will make CDHPs eventually become important sooner, things like medical trending as high as it is and also technology, which is just increasing the rate of change. Despite all that, we're going to focus on all the other products that we have to deal with.

The first point is that companies cannot be reactionary to the changes occurring around them. They have to put in place a process to evaluate what's happening and what their competitors are doing, and they have to be prepared to take all that information in and develop courses of action. Not only is it important for risk selection on insured blocks of business, although that is of paramount importance for many insurers, it's also important because these changes that we're talking about will impact medical cost outcomes. Sure those medical cost outcomes are important for insured business, but the rest of your customers who may have self-funded plans are going to care about those cost outcomes as well.

What is it that companies should be evaluating whenever they look at these changes? I have four categories: what's covered and what's excluded, cost sharing, medical management process and effectiveness, and funding options. Let's touch upon each of those.

So what is covered? A number of years ago, health plans started pulling infertility treatment from coverage. Why? The cost treatments themselves were somewhat expensive, but they were able to deal with that by putting lifetime maximums in place, maybe $10,000 for infertility treatment. They were concerned with something else. What was it? It was the adverse selection that comes from it. What happens? The infertility treatments lead to multiple births, multiple births lead to preemies, preemies lead to shock claims and shock claims ruin your experience. Let's talk about morbid obesity. The cost of the procedure itself is not that expensive as of a year or so ago. I think it's less than a dollar PMPM, actually quite a bit less. That may be going up because it's becoming much higher utilized, but the average morbidly obese person has average morbidity costs that are seven to eight times that of an average member. The issue here is that if you're the last carrier standing offering coverage for a condition that everyone else has eliminated, you're stuck holding the bag. That's especially true, not just in a multiple choice offering, but in almost any situation, because of the number of working spouses. The bottom line is that almost everyone will have coverage from more than one health plan.

I'm just going to highlight two quick things about cost-sharing. These two things are important because they will drive decision-making at the point of enrollment. If you're a high drug utilizer and you have a low copay plan available, you're going to take it. It's obvious to the person who's doing that comparison. Also, mental health

and substance abuse (MHSA) is an issue because the comorbidity is involved.

Let’s move on to medical management. I’ll give credit where credit is due. Some of my information comes from a presentation I saw by a medical director from Tufts Health Plan. He pointed out that there’s a spectrum of medical management that goes beyond how we typically think of this. Start off thinking about case management. Case management might impact one percent of a population. That’s very intense and it’s very focused on some high-cost drivers. As you move down from that, you also want to think about and evaluate the way that disease management is working. Disease management might impact 10 percent of a group. Move further down the spectrum and look at lifestyle intervention. This is a term that I started using, but it gets at those conditions that will lead to some of those other conditions that will be part of disease management. The theory is that if you can intervene and make changes in that person’s lifestyle, you’ll prevent them from actually getting a condition that needs disease management. Then you work your way down to the last section of the spectrum, which is keeping the healthy healthy. That’s how he was viewing it, and I think it’s a fairly logical way of assessing what’s out there and thinking through that spectrum and how it impacts your product portfolio.

I’m going to take a little bit of a different take on funding and not talk about administrative services only (ASO) versus insured versus experience rated. Rather, I want to talk about some of the issues we see emerging here and how these plan design changes could be impacting this. The first example is that an HMO is approached, and they are asked to quote, fully insured, on an account that’s also going to offer a PPO product. The PPO product is self-insured, there’s no experience available and there’s no information on the contribution strategy. How many people have seen that? There are a fair number of you, but not everyone. I know of at least two companies that have bled badly because of that approach—one of them to the tune of about $25 million, another one probably only $3 or $4 million. But on a percentage basis, both of those had a very significant impact on the profitability of earnings for those two organizations. That approach is happening because you have people who are going to game the system a little bit and figure out a way to save some money. I would also point out that in this particular example, both organizations violated their own internal policies to allow that to happen. So as we talk about benefit parities, changes in our products and how the products work, I think it’s important that we focus on our own internal policies and the processes that we go through to make sure that bad things like that don’t happen.

I have two other quick examples. I’ll call them "creative" solutions. A large employer takes 40 of its sickest employees, puts them in a subsidiary and gets a small group quote to cover those sick employees. How many people have seen that? I see a few hands, but not quite as many. Here's another "creative" approach to dealing with this. A company moves to a much higher cost-sharing plan. Maybe they go from a $250 per confinement copay to a $1,000 per confinement copay. But on the back side, the employer reimburses the person who has been admitted

to the hospital $750 out of company funds to cover that. Has anyone seen that? (There are a few more hands.) These are things that are happening. I would argue that, as we look at the continued pressure that employers are facing because of rising health-care costs and all the changes that we're going through trying to stay ahead of all this, if we take our eye off the ball for just a second on how we underwrite and the policies that we use, those things will continue to happen and "creative" solutions will continue to come about.

Profit load is something that we as actuaries are skilled at doing and have spent a lot of time thinking about. However, in practice, I'm not sure that I see this happening a lot. Are we really varying our profit loads to reflect the nature of the risk? For example, we talked earlier about the ability to cut out coverage and to do things to limit the volatility of claims costs, whether it be from a lifetime or annual maximum, or limitations on coverage for certain conditions. Whenever we do that, shouldn't there be an associated adjustment with the profit load because the volatility is different? Many insurers will do the volatility associated with account size. How about the reliability and completeness of information? How much better do you feel about the predictability of claims for an account that you've received all the information that your underwriter has asked for, compared to an account where there's missing information? How many insurers have the intestinal fortitude to insist upon a higher profit load for that account that has greater risk?

As far as underwriting systems, new technologies are creating many more opportunities for us. I'm going to give you an example of one in a minute. The other thing I want to point out is the implementation of predictive modeling. At an earlier session, it seemed like a lot of the companies represented there have already implemented predictive modeling approaches. At least a few of those have implemented the following approach. We're going to use our traditional underwriting along with predictive modeling. We'll blend the two together, but we're also going to monitor the results so that retrospectively we can come back and compare which one was a better predictor of the overall claims costs. It seems like a logical approach.

The multiple-choice offering is that example I mentioned a minute ago. Most people here are probably familiar with gold choice products. It's an HMO offered beside a PPO. Most people would agree that there's a certain level of selection, both positive and negative, associated with that product. The HMO experience is probably running a little better than if it were a stand-alone HMO product. The PPO experience will probably run a little worse. Yet very few companies are able to track those mixtures to know how much of their HMO book experience, which they use as the basis for developing manual rates, has what level of selection embedded in it. If you think about it, your experience is impacted dramatically by those large groups and the database that you have for claims experience, yet you're going to use that experience to develop manual rates and use those manual rates on an insured basis to issue quotes. It seems like a lot of us may have a certain level of underbidding going on whenever we use HMO manual rates to quote on a total replacement

basis, and we may be overstating that claims cost for PPOs. As we get the questions, I'll be curious to see what your reaction is to that, but I would assert that a lot of insurance companies are in that position today. I am just pointing out that as we see these changes, we're going to see a wider differential between the high and the low plan. I think that's a point Greg made earlier.

I want to mention the use of new consumer resources. There's a lot of cost and quality information that's out there, and it's viewed as being very positive to provide that type of information for consumers that are using CDHPs. I've yet to hear a good argument why the same information shouldn't be made available for someone who uses a PPO or an HMO. It would seem that that would be useful information for everyone. As far as stored value cards, some of you may have read this week that there's more definitive ruling out on how HRAs and HSAs and FSAs are all integrated together, but all those combinations of programs and of coverage could be very confusing and difficult to manage for the average consumer. Stored value cards, like the Benicard or any of those other companies that are cropping up, have the capability of putting together an administratively simple solution for consumers. I would challenge all of us to find ways of using that type of technology to make life a little simpler for the customers that we serve, the end users, the consumers.

Finally, let's talk about enrollment decision support tools. Because we're offering more choices (and these choices can be very confusing for us, let alone for people who don't do this on a day-to-day basis), enrollment decision support tools are becoming more popular. Cigna this week had a press release that through CareGain they're offering a calculator to show how the cost of a CDHP compares to another product. United Healthcare is considering offering something. . These things are going to help consumers understand how the products work and do some sort of comparison between those two.

MR. EDGAR W. SCHNEIDER, JR.: The title of this session is fairly open-ended. I took advantage of that flexibility to define the topic I want to talk about. That topic is what people commonly refer to as "dashboard reports."

Over the past decade, most carriers have come to recognize the importance of capturing data. The collection of such data in data warehouses and the tools used to extract that data have proliferated. We've had two earlier sessions on data warehousing and hot technology topics. So we've got the data, and we've got the data warehouse, but our clients are now asking us, "What the heck do we do with this data? What should we be looking at? At what level of detail should we be looking?". Over the past few years, Reden & Anders has been engaged by clients to come in and look at their executive management reporting package and comment. Again, I'm going to refer to that executive management report package as the "dashboard report" or "report card."

There are four objectives for this presentation. One objective is to define what an executive management dashboard report is. The second objective is to discuss the

reporting process that is involved with the dashboard report. The third is to identify common problems we encountered in reviewing carriers' reporting processes. The fourth is to find some best practices.

The dashboard report is not per se a paper document; it is a process. The purpose of the report is to allow management to monitor key performance metrics over time. I’m going to focus on two of those terms. One is "monitor." The focus and format of the report should be on monitoring versus analyzing key issues. As I will discuss later, the analysis is a separate component of the process. The second major term is "over time." Looking at a metric at a point in time, be it days per thousand or any other metric, is meaningless. You need to look at what the level is, what the level changes are over time. You still have allowed variability in any metric you define, and you need to look at the overall pattern versus one point in time.

What’s the role of the dashboard report? What does management want to accomplish by having people develop and give them monthly dashboard reports? There are basically three things we've identified. Is the client doing a better job in this area than it did last month or last year? Is our inpatient utilization up and down? Are we paying claims quicker? Are we paying them more accurately? One of our major things is comparing current performance against historical. Second, are your actual results tracking budgeted or targeted expectations? The third is to allow the client to compare itself against competitors or national benchmarks. Again, this is the monitoring component. I’ll add one more. It allows management to identify emerging opportunities or potential problems.

Going back to the dashboard report being a reporting process, we defined three phases of the process. The first phase is measuring and monitoring of the key performance metrics, and it needs to be done consistently and it needs to be done over time. The second phase is when you do see a deviation from what’s expected or a deviation you do not like, you need to analyze it. You need to peel the onion and dig down deeper. The third phase is once you’ve developed a positive or negative deviation, you need to address it through strategies—take advantage of it or resolve it.

There are some common issues and problems we’ve encountered, such as the lack of agreement on the role of the dashboard report within the company. Is it basically a monitoring tool, an analytic tool or a process? Generally, carriers that try to define it as an analytic process or as an analytic tool end up with dashboard reports that are so voluminous that the monitoring function is severely diluted. It’s not allowing management to focus on what they need to be focusing.
Who is responsible to understand the reason for the impact of changes in the metrics being monitored? This is the proverbial corporate function of pointing your finger to another area. Say you want to look at an uptake in inpatient utilization, who is responsible for figuring out the reason for that? Is it the medical management area? Is it the actuarial area? Many times these problems span across

functional areas. You need to figure out who's going to take the lead in resolving aberrations you see in monitoring your key metrics. As another example, the provider relations area is getting a lot of complaints about providers not being paid, being paid slowly and being paid incorrectly. Whose problem is that? Is it provider relations? Is it claims? Is it IT? One of the things that needs to be defined is who's responsible for the metrics and understanding changes in the metrics.

Another problem is failure to define important metrics that indicate if the organization is achieving its mission. You would think most companies have an annual budget and business plan. You would think that most of those should be included as one of the metrics. To give you an example, we see a lot of clients that have very ambitious plans for disease management. They've allocated a lot of resources, be it people or money, to the disease management area, but they don't monitor the results, so they don't know if their investment of time and resources is paying off or not.

The next issue we've talked about briefly is the confusion of the monitoring and analytic functions of reporting. One of the clients we visited had a dashboard report in excess of fifty pages. On each page he had three items and it was all in small print. At that stage, it gets filed with everything else. It was so voluminous that it lost any effectiveness. No one has time to go through fifty pages each month to try to figure out what the trends are.

Let's move on to some of the areas for best practices. The first one is that this is a process that needs to be disciplined. It needs to be looked at monthly and monitored over time. It is not necessarily a process that once implemented will generate immediate results. It's a process, and for it to be effective you have to be disciplined and do it over time consistently. The definition of the metrics should be straightforward. I'll give you an example on that. One of our clients is having problems coming up with its dashboard report because the medical management area wanted to define emergency rooms to be actual paid or denied emergency room visits. That holds up the whole process of getting the key metrics defined. They finally decided they were going to go with paid emergency room visits per thousand. If the medical management area wanted to look at the denied, that's fine, but on the denied side, you don't have a benchmark to measure yourself on and it's too detailed to get involved with. It was more of an analytic versus a monitoring function.

The categories we traditionally see addressed are what you would expect and what you see in most clients' business plans: financial, membership, operations and clinical. One of the things we talked about earlier is if you do see changes away from target, positive or negative, somebody needs to be accountable for understanding why these changes are occurring and then take advantage of them or resolve them. The metrics themselves are not useful without a supportive management process. Benchmarks are useful—how you're comparing against your competitors in a variety of areas but the lack of external benchmarks by itself does

not mean that the metric is not good. Again, compare your current experience against historical experience to see if you're doing better, be it C or B or other measures for which you cannot get valid benchmarks. The last one is simplicity. If you can put it in graphs, it's a lot easier to understand by senior management. They don't necessarily take a lot of time to look at reports, so if you put them in graphic form that eases the understanding of such reports.

In summary, for the dashboard reports to be effective, focus on your key performance criteria and objectives. If you get too much detail in there, you've lost the focus. Review the key performance criteria monthly and over time. Again, if you look at it piecemeal and you monitor it piecemeal and you don't have enough of an experience period over which to measure performance, you're not going to come up with any meaningful results. You need to be consistently defined. The variances need to be analyzed. The key is that you look at the dashboard report as a leading indicator of potential opportunities or problems. Once you've identified an opportunity or problem, action plans need to be developed to deal with the variances. Again, the variations we've seen out there with these companies are amazing with the amount of data they have, but there's another step in the process of defining what I do with the data and what I should be looking at.

MR. GOVERNALE: Greg, one of the points that you raised on prescription drugs is going to a four tier, actually a high-cost self-injectable portion as the fourth tier, possibly with a 30 percent cost share. Are you seeing where these self-injectables or the injectable drugs are actually going through the prescription drug or the Pharmacy Benefit Manager (PBM) portion of the product, as opposed to not being in the PBM portion and more on the medical plan side?

MR. RUSSELL: There are probably a couple of things to say on that topic. One is that we don't see that much utilization on that particular tier at this point. It's more of a pre-emptive type of a benefit change. These are things we're anticipating coming in the future. Second, as your question sort of implies, it's not the easiest thing in the world to administer. In some cases you're getting self-injectables administered in a physician's office and trying to sort that out from something where the people have actually purchased the injectable and they do that themselves through a pharmacy. The circumstances where it runs through a pharmacy is treated on the fourth tier, and if it's happening in a physician's office in most cases it's not.

MR. GOVERNALE: On your prenatal visits to go to one global, let's say that a plan has a $10 copay. What might be the one-time global copay for a plan of that nature?

MR. RUSSELL: Locally, it was a $200 copay, but that was with an average office visit copay of about $20.

MR. GOVERNALE: So roughly ten visits?

MR. RUSSELL: Yes. We tried to make it cost neutral.

FROM THE FLOOR: I have two questions or comments. The description of the session mentioned topics for limited benefit plans. I’m not sure what that term means and hopefully one of you can comment on that. The other question is, where do we go when deductibles and copayments get too high?

MR. KACZMAREK: I believe it was three years ago that there was an attempt to offer very limited benefits in the marketplace. It had a relatively high deductible, and then it had a piece of coverage that took you up to about $10,000 in annual maximum coverage. It was written by one of the major insurance companies. It received some attention in the press. After about six months of not selling anywhere, it was pulled off. That might be one form of the limited benefit coverage that may have been referred to. We didn’t touch upon it because I’m not sure that there’s a market for it. What we’re seeing instead is the high-deductible plans, partnered with or without a health savings account (HSA). The high-deductible plans are becoming a bit more popular. As an example of that, the Blues in the Carolinas have a very significant book of business at PPO deductible plans of $1,000 and larger. I think there are some other regional pockets where those high-deductible plans are becoming more common. The interesting thing about the Carolinas is if you look at the nature of the employers down there, they tend to be smaller employers in some of the major industries or textiles, so it kind of fits with the environment that those plans are designed to meet.

MR. RUSSELL: In terms of the question of how high is too high for a high-deductible plan, I’m not sure I have a simple answer for that. What I'm about to say I haven’t actually seen in the market yet, but I’ve heard some discussion of it. Employers with a broad range of salaries for your employees, where maybe the ones that are lower on the scale are going to be challenged by a $1,000-deductible-or-higher type of a plan, were actually designed benefit plans where the deductible amount is actually scaled to the salary, not perfectly, but if you make between this amount and that amount, then your deductible is $500 and so on. I haven’t seen anyone roll that out yet.

MR. GOVERNALE: If anybody actually does his or her taxes and looks at following his or her Scheduled A, the government is expecting us to spend 7.5 percent of our adjusted gross income before we start getting deductibility for those expenses. If any employer out there wanted to look at something like that, where do they target it? If you’re looking at something where it’s a function of compensation, do you target it at two percent five percent 7.5 percent or at 10 percent? If you have employees that are making $40,000 and they target it at 10 percent, it’s a $4,000 deductible. Ouch. Those employees are going to be complaining to their employer, "What are you doing to me? We used to have a $250 deductible plan, and now it’s up to $4,000." That’s a real pinch. Even if it were at five percent, you’re going to cut it down to $2,000? Cut it to 2.5 percent, down to $1,000? Unfortunately, I think a very pervasive mentality in this country is, "Don’t touch my health benefits. I

don't want to pay a lot of money for them." People have no idea what the cost of those benefits are.

FROM THE FLOOR: If I heard you correctly, you said you either have or are introducing a fourth tier that would have up to a 30 percent copay to members on injectables through retail or that they pick up on their own. Do you feel that you have, as a plan, better cost control of drugs supplied through the retailer, the PBM if you will, versus through the physician's office? Would you comment on your strategy? How do you as a plan determine whether that medication is a medical or a retail drug, in terms of where it falls in the benefit?

MR. RUSSELL: I'll answer the second question first. At this point, it falls where the drug is administered. If the physician is doing that in his office, it's going to fall on the medical side regardless. If it's through a pharmacy, then it's going to be on the pharmacy benefit. Do we have better controls over the costs through our pharmacy network relative to a physician's office? Yes.

MR. HOBSON D. CARROLL: My first comment has to do with the focus that was taken in the first presentation on the trends as they affect the premium cost to the employer. I think to some extent we contribute to a major problem in the country. You see these headlines that say, "Employers try to get control of their health care costs" or somebody "was given by a consultant a benefit plan that's going to really control their costs." What they really mean by that is *their* cost, not the *total* cost. Consultants go to an employer and say, "You've changed the benefit plan this way, so this is going to be the impact on your cost." Why not show them the *total* cost, the *total* expected cost of the plan, including everything—the contributions, who's paying the contributions, who's paying the out-of-pocket, the expected total cost, here's your piece, here's the other piece, this is what you're not paying, and how the cost shifting is affecting their employees. I don't think most employers have any idea, in real numbers, of the limited share sometimes that the employer is paying, especially in self-funded plans, but in a lot of the insured plans, too. Often the employer is paying a minority of the total cost. I think we contribute sometimes when we focus on the premium cost.

The second comment is that—I think "limited benefit plan" is a horrible term, but I guess it's the most accurate one. Everybody wants these deductibles going up, up, up. Why? They want to try to get the costs down. Well, why not bring the thing down from the top? While I recognize what's insurance and what's financing, the way our country has decided to do this because of the tax system and everything like that, is just do dollar-swapping at the low end. But for a lot of people who don't make $50,000 a year—or maybe they do and they still can't—that $1,000 deductible might as well be a catastrophic claim. Ask them, "Would you rather have a doctor copay plan to take care of the ear infections for the kids and stuff like that, or do you want to be protected for a heart transplant?" I think they'd choose the former, but we don't offer them that. I think we need some product development. We ought to be encouraging the look at limited benefit plans. Maybe two percent of

claims are in excess of $10,000 in a year, and so we bias the whole system toward taking care of that $50,000, $100,000, or $200,000 claim. I think we have the responsibility to seriously think about impacting that under-insured population by offering more coarse metal plans than gold, silver or platinum.

MR. KACZMAREK: The only quick reaction to that might be that there was a good session earlier at this meeting that talked about the Leapfrog Group initiatives, which are designed to squeeze waste out of the health-care system in general. I agree that that's a good focus to try and look for greater efficiency. Think about the amount of data that's available and how poorly that data is used today. Different courses of treatments are used to treat the same condition or ailment, and there are very few comprehensive studies done to see which of those courses of treatments is the most cost-effective or has the best quality outcome. HIPAA is going to make it even more difficult, but there are some limited trials being conducted in closed systems to try and get at some of that. We're grossly under-utilizing the ability that we have collectively as a nation to squeeze waste out. As far as your other comment about looking at the total cost and how much is shared by the employees, I don't think I agree with that one. My experiences have been that the benefit managers for large companies want to know what percentage of premium their employees are paying and how much cost-sharing is embedded in the plan. They take those two pieces, add them together and get to what the relative cost-sharing is between the employer and the employees. That's my experience with the larger employers.

MR. DAVID P. MAMUSCIA: I want to follow up on Ed's comments by asking, how many are using data warehouse services, or companies that supply data? A few. It's a great way to get your arms around the metrics and data of your clients, but the only caution I would raise is that it sets expectations very, very high. Everybody figures that now that we have the data, we'll figure out what's really going on. My observation is that you never seem to get to a conclusion. There are a lot of random events in the data that are not explainable other than the fact that they're random events. If you choose to do that with your clients, and again, I'm not against it by any stretch of the imagination, but as Ed pointed out, be very careful in what you choose as your measurements and know your client very well before you forge ahead with your reports. Otherwise, you spend your whole life running data.