

REFORMING HEALTH CARE IN AMERICA

Michael Barton

INTRODUCTION

Health Care costs are expected to top \$4 Trillion by the year 2010. This will represent about 20% of the nation's GNP.¹ Already employer-sponsored health-insurance costs comprise one quarter of all non-wage compensation (surpassing leave and vacation benefits as the #1 fringe expense). It is estimated about \$4/hour of wages goes to pay for health insurance costs.²

There is a "Health Care Crisis" in America. The purpose of this paper is to further examine this issue and the impact rising health care costs have on employer delivered benefits in the American workforce. This paper will attempt to answer the tough questions on everyone's minds:

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- What is the future of health care delivery in America?
- Should Health Care be "Nationalized"?
- Will medical inflation continue to climb at a "double digit" pace?
- What can be done to combat rising health care costs?
- What will health insurance products look like in the next five years?
- Will Consumer Directed Health Care (CDHC) models save the industry?
- What impact does escalating medical insurance costs have on other employer sponsored benefits like dental, Life and Disability?

In order to answer these questions (and others), a systematic review of the role each stake holder plays in the delivery of health care is necessary. We will examine the behavior of the:

1. Provider Community

2. Employer
3. Patient
4. Insurers
5. Government

By revealing the complex issues that face each of these constituents, as well as the dynamics between them, we hope to shed light on the core issue areas in the American health care delivery system. Once we have properly diagnosed the problem, we will concentrate on the prescription for treatment.

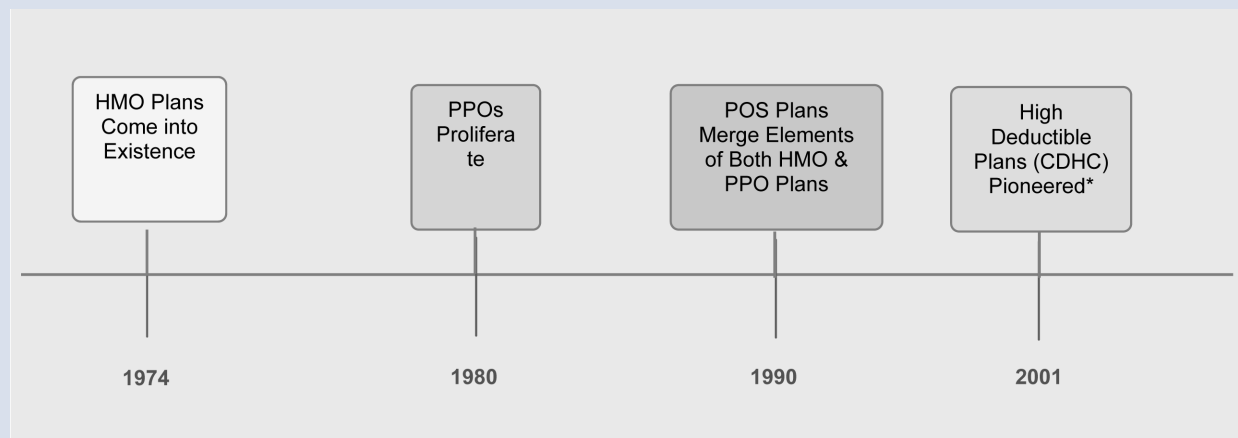
The authors of this paper believe a solution to the health care crisis in America exists. Although an overwhelming, and therefore daunting project, this paper lays out the steps necessary to correct a health care delivery system that is severely flawed in terms of cost structure, administrative burden and clinical outcome.

SECTION ONE: MANAGED CARE—A HISTORY LESSON

To grasp where we are going, we need to understand where we have been. At its core, insurance is a mechanism whereby the healthy

EXHIBIT 1

Timeline of Managed Care Health Trends



★ 20% of Mid Market Employers to Deploy CDHC.

subsidize the cost of the sick. In this way, risk is spread evenly among a population—usually an employer group. Health insurance is beset by two very large problems; 1) the cost to insure, and 2) annual price inflation. The Insurer space has been attempting to combat both issues since the mid 70's with varied success.

Managed Care as we know it today has its origin's the first HMO's that were created in Minnesota in 1974. These plans were classic "multi-specialty" groups that formed companies to accept "capitation" from insurers as a fixed form of payment for care delivered within the practice. Insurers gravitated to this method of payment since it transformed a variable claims cost to a fixed expense. Employers purchased HMO's because they promised lower premium's (since costs were capped) and robust preventative benefits.

The idea soon spread across the country and variations of the capitation model proliferated. Group models, Independent Practice Associations (IPA's), Staff models (owned clinics), and Physician Hospital Organizations (PHO's) came into existence over the next

twenty years. For a period of time both unit cost and medical inflation were reduced largely due to the advent of provider risk sharing known as capitation.

With providers on the hook for the cost of health care delivery, "Managed Care" revolution was underway. Unfortunately the provider community under valued the cost of the services provided and one of three things happened: 1) care was reduced, 2) capitations were increased, or 3) providers stopped accepting capitation as reimbursement and reverted back to "fee for service" models.

Many of the horror stories attributed to Managed Care can be traced back to this period. Provider's inability to manage costs and public out cry against "pre-paid" medicine caused the demise of risk-based medicine. Instead, product development evolved into hybrid products which introduced elements of managed care combined with fee for service reimbursement methods.

Preferred Provider Organizations (PPO) and Point of Service (POS) plans were a response to consumer demand to provide competitive

price points, but allow plan design flexibility. Later, in the early 90's, this resulted in the birth of Open Access plans which obviated the need for participants to obtain a referral from a Primary Care Physician (PCP) in order to see a specialist.

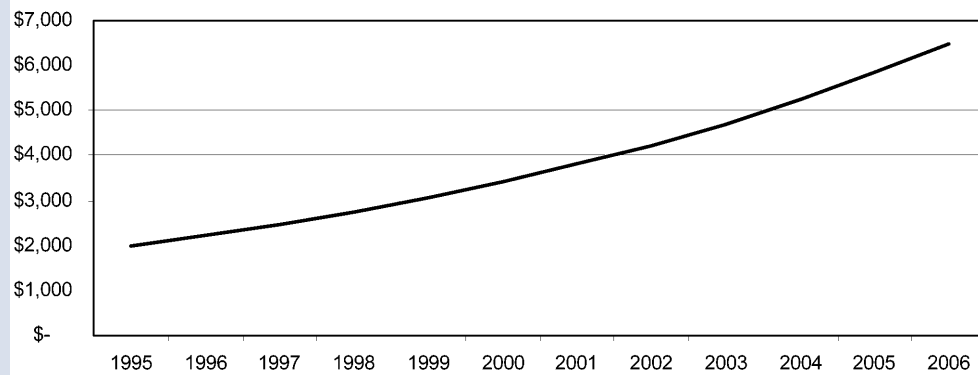
So what have we learned from this? Americans want flexible products that allow them to make decisions about their health care needs unencumbered by the insurer's regulations. We also learned that this form of health care delivery was not effective at controlling costs.

Medical inflation has increased at a pace in excess of 10% per year since 1995. The "cost issue" has been around for over a decade. Debates, and subsequent product development, have attempted to answer the markets frustration with no success.

At the heart of the matter are our competing interests as consumers. We want low priced insurance, but the ability to access health care on our terms—not the insurers. The result has been unparalleled medical inflation. Health care insurance costs have doubled since 1995 and we are fast approaching a point where employers can no longer afford to cover the cost.

EXHIBIT 2

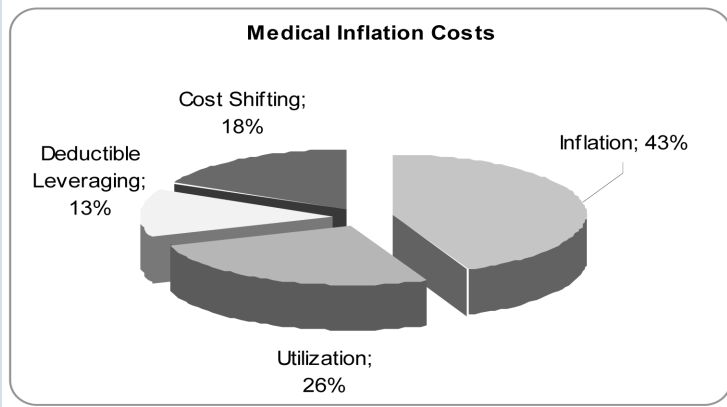
Employer Cost to Cover an Employee Per Year



In 1995, the average cost per employee per year was \$2,000. In 2006, the average cost per employee per year will be approximately \$6,500. Over 11 years, the average increase of health care inflation has increased at a rate three times faster than the national CPI.

EXHIBIT 3

Medical Inflation Costs



our best efforts medical inflation (i.e., trend) continues to rise at an alarming rate.

Trend is made up of several key ingredients:

- Unit Costs
- Volume Increases
- Aging Population
- New Technology
- Advances in Pharmacology

Unit Costs

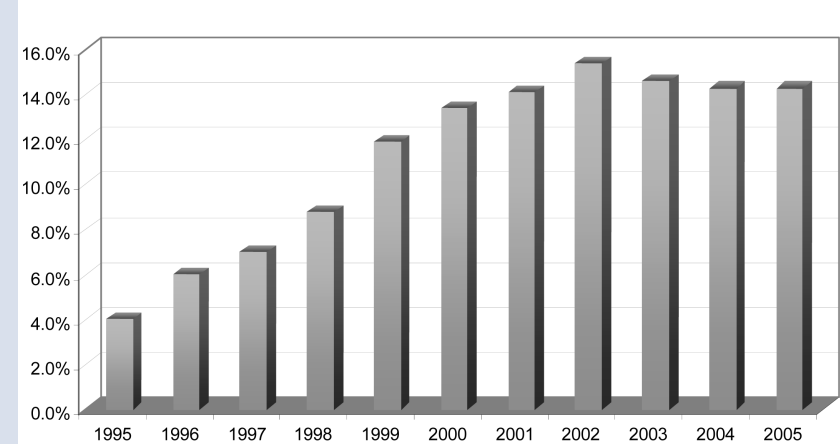
In most cases providers are reimbursed on a fee for service basis. Many contracts are negotiated as “evergreen” or perpetual. The practice, however, is that fee schedules are negotiated annually. This is particularly true with facility charges.

Hospital contracts are typically crafted on a “per diem” basis. In other words, a maximum cost per day. This contract insulates both insurer and employer from the cost associated with catastrophic illnesses. Unfortunately, however, the per diem reverts to a discount off “billed charges” in the event the total “billed” amounts exceed a pre-determined threshold.

The disparity in the contracted savings amount in the two examples illustrates both what works,

EXHIBIT 4

Medical Trend



SECTION TWO: MEDICAL INFLATION EXPLAINED

So what can we do to slow this thing called medical inflation or “trend”? To answer this question we need to first define what trend

is? Quite simply, trend is the pace at which our health care costs escalate. Pin pointing the components of medical inflation is a tricky task. Combating them is tougher still. As the chart below depicts, despite

EXHIBIT 5

Example #1 - Appendectomy

Per Diem - \$1,500
 Length of stay - 3 days
 Charged Per Diem - \$4,500
 Billed amount - \$12,750
 Stop Loss Threshold - 1st Dollar/
 \$50,000 (30% discount off billed
 amount. Not applicable since the total
 "billed" amount was < \$50,000)
 Actual "Paid" Amount - \$4,500
 Savings - \$8,250 (or, 65%)

Example #2 - Heart Failure

Per Diem - \$1,500
 Length of stay - 12 days
 Charged Per Diem - \$18,000
 Billed amount - \$64,500
 Stop Loss Threshold - 1st Dollar/
 \$50,000 (30% discount off billed
 amount.)
 Actual "Paid" Amount - \$45,150
 Savings - \$19,350 (or, 30%)

and what doesn't in hospital contract reimbursement methodology. Per diem contracts which shift the risk of service to the provider (a la capitation) limit the insurer/ employer liability. However, beyond the stop loss threshold, a percentage discount off "billed charges" dictates the price. In this example, medical inflation—in the form of "billed charges" occurs despite the insurers best efforts to negotiate employer friendly contracts.

Volume Increases

An unintended impact of managed care contracting has been the increase in the volume of services performed (or, at least billed). Simply put, providers run businesses

too. If you can't impact rate per service, volume increases are a good way to make up revenue. The number of tests performed, and the complexity of the standard "office visit" has increased dramatically in the last five years. Most of this is an attempt by providers to recoup dollars lost at the negotiating table with insurers. Some element can also be attributed to "defensive practice patterns". We will address this specific issue more thoroughly in Section 6: Government Intervention.

Aging Population

Two root causes have played a dramatic role; 1) Baby Boomers are now entering retirement age, and 2) people are living longer than ever before. The combined effect has had a dramatic impact on the American economy. The largest demographic group in America is getting older. With that, comes increased medical expense. Each of us has witnessed the impact the Baby Boomers are having on Medicare and Social Security. The economic impact is staggering. Combine this with the fact that we are living—and working—longer than ever before and the effect on employer sponsored health plans is obvious.

EXHIBIT 6

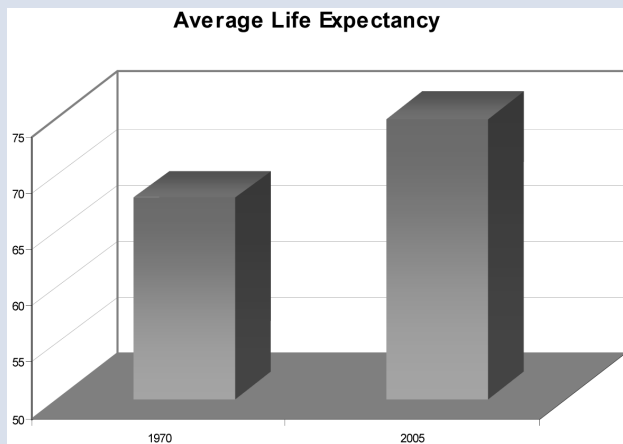
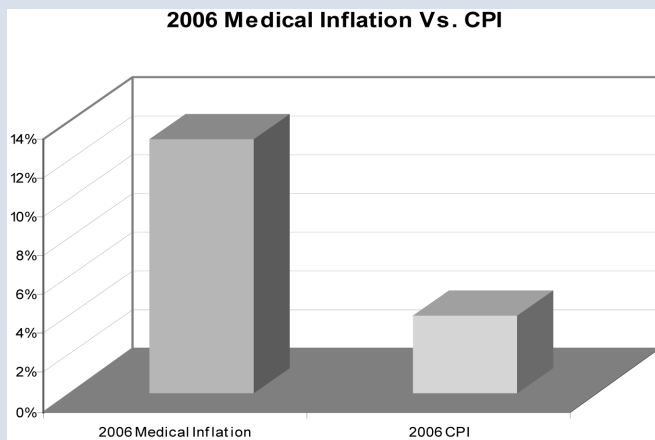


EXHIBIT 7



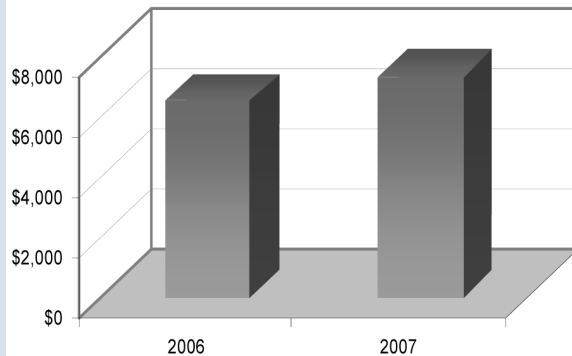
New Technology/Practice Alternatives

Three years ago a Positron Emission Transmission (PET) scan was a rarity. Now PET scans, CAT scans and MRI's are a fundamental component of the diagnosis and treatment of internal disorders. An x-ray that once cost \$75 has been replaced by an MRI costing in excess of \$500. Evidence suggests that only one tenth of one percent of MRI's reveal a condition that requires treatment. The appropriate use of these new tools may lead to early identification and more effective treatment plans. The hope is clinical improvements

EXHIBIT 8**Five Lifestyle Drugs & Cost per Script**

Botox	(per vile)	\$550.00
Clarinet	(1 month supply)	\$ 60.00
Viagra	(25mg/8 pills)	\$ 83.16
Caverject	(20mg/6 vials)	\$178.44
Edex	(20mg/6 vials)	\$141.45
Muse	(500mg/6 suppositories)	\$139.94

medical inflation—Trend. If we are to build a model that can better manage escalating costs, we must first know what we can actually impact. We cannot, for example, change the fact we have an aging population. Try as we might we cannot make people younger.

EXHIBIT 9**The Average Cost per Employee**

will more than offset increased technology costs when utilized only when needed.

Pharmacology

Restless leg disease? Public Anxiety Disorder? Two years ago we didn't even recognize these as legitimate disorders. Now there is a drug treatment therapy for these and many, many more. In 1998 pharmacy costs represented 10% of your health insurance costs. In 2006 prescription plans make up 18% of your premium. By 2008 the number is estimated to be 22% (based on drugs currently going through FDA approval).

Unlike the promise that new technology brings (improved clinical outcomes), pharmacology has focused on "life style" related treatments. As such, while they might improve your life, they have little to do with reducing the cost of care.

In summary, it is important to understand the factors affecting

We can, however, examine the types of contracts that reimburse providers fairly, but at the same time, create more predictable cost structures. We can choose not to cover drugs that while nice, are certainly not necessary. While step therapies and pill splitting programs have had a positive impact on drug costs, these steps have not been well received by consumers who see this as an unwanted intervention by the insurer.

The fact that medical trend outpaces CPI places a tremendous burden on employers. Employer revenues/margins cannot keep up with escalating health insurance costs. This erodes profitability. Many employers report that they can no longer afford to provide health insurance to their employees. As such, it is "mission critical" for America to slow medical inflation to a rate consistent with CPI.

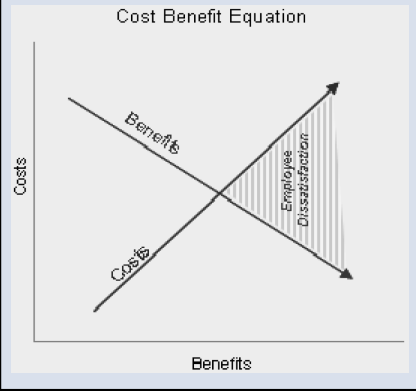
SECTION THREE: THE INSURANCE LANDSCAPE TODAY: WHAT WORKS AND WHAT DOESN'T?

The average cost/employee/year is expected to surpass \$6,500 in 2006. With employers picking up an average 70% of this cost, everyone is looking for ways to reduce liability. Moreover, through the 1st quarter 2006 medical trend is still hovering around 13% projecting 2007 costs at a whopping \$7,345/employee/year.

To combat this employers have tried a variety of methods:

- Cut employer contributions (down 2% from 2005)
- Decrease benefits (down 5% from 2005)
- Reduce/eliminate employer subsidies for non-medical benefits
- Deploy "core buy up" approaches
- Introduce wellness programs
- Vendor based Disease Management programs
- Examine Consumer Directed Health Care (CDHC)
- Employee communication campaigns designed to help consumers make better health care decisions (with benefit incentives)

In many cases employers have adopted a multi-faceted approach utilizing many of the methods described above. Employers can only cut benefits and increase employee deductions so much before the value of the plan degrades to a point where the fringe benefits are no longer a recruitment and retention tool. Moreover, as the benefit/cost equation diminishes, adverse selection increases on the medical insurance.

EXHIBIT 10**EXHIBIT 11****Other Statistics (2000 Prevalence Data)****Smoking**

- Smoking is the leading preventable cause of death in the U.S.^{3&4}
- Each pack of cigarette sold in the U.S. costs the nation an estimated \$7.18 in medical care costs and lost productivity.³
- Smoking costs the nation \$150 billion each year in health costs and lost productivity.⁶
- Employers can save \$1,100 a year for every employee who stops smoking.⁷

Obesity

- Americans spend \$33 billion a year on weight loss products.⁵
- The percentage of overweight children has doubled since the '70s.^{3&5}
- Nearly 2/3 of all Americans are overweight or obese.¹
- Obesity-related costs in the U.S. total approximately \$100 billion a year.³
- Obese individuals spend 36% more on health care services, and 77% more on medications than individuals with normal weight.⁵

Other

- Diabetics cost American business 35% more than non-diabetics.^{6&7}
- For every employee who reduces their cholesterol levels from 240 to 190, employers save an average of \$1,200 per year.⁷

Simply put, young/healthy employees will waive due to the high cost of insurance leaving a progres-

sively sicker insured population. The result is an exponentially higher cost/person insured—the classic death spiral.

So what works? What doesn't? Most industry experts believe American's need to take greater responsibility for their own well being. As such, whether you are tinkering with plan design, contributions or adopting a CDHC model—a balanced health insurance strategy will most likely take advantage of new ideas in the Wellness and Disease Management fields. The balance of this section is dedicated to identifying strategies that have worked for other employer groups to improve the health and well being of their insured population.

Wellness

There is an increasing belief that a healthy, happy workforce is essential to employer prosperity and that workplace wellness can not only transform corporate culture, but improve lives.

Much of the Health Care crisis can be traced back to the American Lifestyle which is characterized by fast pace, fast food, lack of exercise and prodigious amounts of stress.

2000 Prevalence Data shows that of Americans³:

- 40% are physically inactive
- 23% smoke
- 22% have heart disease
- 19.8% are obese

In response to these incredible statistics, employers have deployed a variety of programs. They range from employee incentives to fill out Health Risk Assessments, to comprehensive programs involving on-site biometric testing and health coaches with continuous follow-up to enforce behavior modification.

What makes a wellness program successful depends on the company, its culture and its employees. Below are some of the key factors that universally contribute to making a program successful:⁸

- Executive buy in and commitment to the success of the program
- Ongoing Communication—print, on-line, and face-to-face mediums to address the major drivers behind rising health care costs
- Plan Designs which incorporate incentives for employees to adopt healthier lifestyles whether it by a premium discount, reimbursement for costs of gym memberships, weight loss programs, smoking cessation programs, etc.
- Promote healthy eating by taking an aggressive approach with the company cafeteria and vending machines by offering healthy choices versus high fat, high calorie foods

To impact cost the industry needs to focus both on supply (service/costs) and demand (how much care we utilize). There has been increased emphasis on wellness within the last 2-3 years by organizations of all sizes. The focus is on identifying the specific health related behaviors of an organization's employee population. Once identified, the idea is to provide employees with the information, tools and resources needed to help them to make behavior changes that impact health care costs.

Wellness Programs incentives have progressed from gift certificates or small giveaways encouraging participation, into programs providing significant cost reim-

bursenments or premium discounts for those employees who meet health standards or participate in a wellness program. The belief is that through wellness education, information, and decision support tools, wellness programs will help people to adopt healthy habits and consume health care services more efficiently and effectively.

Some of the nation's largest employers have made headline news with their tactics which have extended beyond what has traditionally been the "norm."

More and more companies are focusing on smokers because of the large impact they have on health care costs and productivity losses. The concern is that they may start focusing on other behaviors that they feel contribute to higher health care costs as well, such as rock climbing, eating Hershey bars, etc. The biggest question among some employees is "Is this going to lead to something else?"

Legal Implications

The now famous Wal-Mart internal memo, which recommended wooing younger and presumably healthier workers as well as discouraging unhealthy job applicants by including physical activity in all jobs, has been the target of compliance issues. Critics argue their strategies are either blatantly illegal or aggressive within the legal "grey" area.

While intuitive, it is very difficult to show a direct cost savings as a result of implementing a wellness program. In addition, many of these programs are new, being implemented in the past year or two. However, those employers that have implemented some sort of program have seen lower than industry trend renewals.

Company Wellness Case Studies

Black & Decker – the nation's largest manufacturer of power tools and accessories found that its blue collar workers (representing 40% of the 10,000 U.S. based workforce) had higher rates of obesity. Through analysis they found the obesity was also related to employees on long-term disability leave as a result of back pain, hip, knee and ankle problems. To encourage healthier lifestyles they adopted several strategies:

Ongoing Communication Campaign—to address the major drivers of rising health care costs and highlight the benefits of regular exercise and smoking cessation

Developing a Wellness Fund to reimburse employees and dependents up to \$350 to defray the cost of gym memberships, home exercise equipment, nutritional counseling, smoking cessation and other similar programs. Incorporating health food choices within their cafeteria offerings from seven types of sausages and fried fatback to one regular sausage and one with turkey, as well as one heart-healthy entrée and side dish.

Although it has been difficult to directly tie these initiatives to a specific savings, Black & Decker has seen medical cost increases held down to the low single digits.⁸

Weyco – a Michigan based health benefits management company, has targeted smokers as a way to reduce health care costs. After announcing a tobacco-free policy in Sept. 2003, Weyco began to test employees for smoking in 2005. Four of its 200 employees chose not to take the test and were forced to leave the company. There is currently a law suit underway against Weyco.^{9&10}

Scotts Miracle-Gro Co. – with 5,300 U.S. workers, imple-

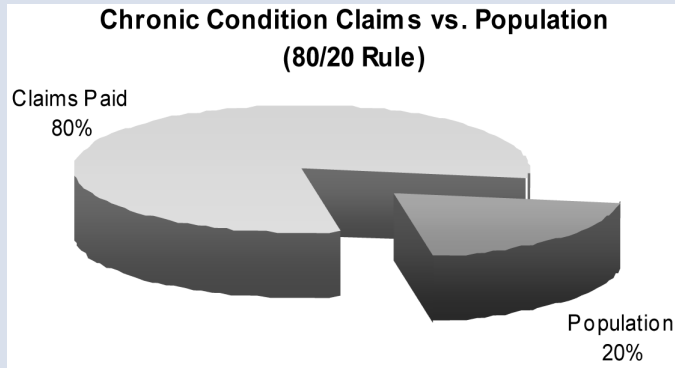
mented a broad wellness program that includes a \$5million fitness gym and health clinic that opened last November at the company's headquarters. Employees on the medical plan have free access at the health clinic to a physician, nurse practitioners, diet and fitness experts and a pharmacy with generic drugs. In return for these conveniences, every year employees must take an online health risk assessment (HRA). A "health coach" then contacts employees and arranges a treatment program for any health issues that are identified through the HRA. If employees don't take the HRA or participate in the program, they pay \$40 extra a month in health care costs. Scotts is adding an additional step to their program this year (Oct. 2006) by randomly testing for tobacco usage by their employees in states where it is legal. Those found to be smoking will be fired. In states where it is not legal, the employees on the company medical plan could see their health care premiums substantially higher.^{9&10}

Disease Management

The medical carrier community has led the charge in promoting disease management programs on a wide-spread basis. Carriers have adopted prospective outreach programs to improve health care outcomes for specific disease states. The promise is to reduce future need for medical resources and thus curtail health care costs. Insurers estimate 15%–20% of the population has long term chronic medical conditions. These account for 80% of all claims paid. Primary diseases targeted:

- Asthma
- Diabetes
- Congestive Heart Failure

EXHIBIT 12



- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Hypertension
- Depression (as a co-morbidity)

Identification of these diseases can be through:

- Claims payment
- Utilization Review
- Case Management triggers
- Self-referral
- Health Risk Assessments (if integrated with DM Program)
- PBM data (if integrated with DM Program)
- Predictive Modeling

Traditionally these programs have been passive and more case management oriented. More recently, emphasis has focused on reaching out to middle and high risk individuals with assignment of “Health Coaches” to develop individualized care plans.

Aetna, for example, is heavily invested in Disease Management developing a “Disease-Specific Risk Stratification Model” to identify members with chronic diseases who are at increased risk of a potential large claim within the next 12 months. An outreach will

be made to these members to more education and support in managing their disease.

As employers become more sophisticated in their approach to both Wellness and Disease Management they will integrate programs into single a continuum of care. Elaine Mischler, M.D., Chief Medical Officer, Avidyn states:

“Integration is cutting edge. Disease Management can be very effective for those with a chronic condition, but if we can get ahead of the curse and work on the people who are yet to have a claim—those 30% to 35% preventable and modifiable conditions—we can slow down the pipeline of people flowing into chronic conditions.”

So what is in it for the employer who promotes disease management programs? Carriers are reporting between 5%-10% in claim cost reductions. But, over what period of time will the return on investment accrue? How are savings measured? The devil is in the details and often times the “real” savings numbers are harder to get at. Nevertheless, we can all intuitively agree that disease management programs are an important building block in a balanced health care plan.

This section has focused on “What employers can do to help

control costs.” Clearly helping employees choose healthier life styles and managing chronic diseases states will have the long range impact of reducing the cost of care. But what else can an employer do? Employers can choose to deploy more aggressive forms of insurance that engage the consumer in the purchase and management of their own health care. In the next section we will expose the latest thinking in health insurance product development.

SECTION FOUR: HEALTH INSURANCE PRODUCTS—CDHC EXAMINED

In 2006 20% of the Nation’s employers with greater than 200 employees will deploy some element of a Consumer Directed Health Care (CDHC) approach.¹¹ By 2007 that number is expected to double. Why? Because employers are searching for the “silver bullet” to stave off high premiums coupled with double digit inflation. This begs two questions:

- Why do employers believe CDHC is their salvation? and
- Will it work?

CDHC plans have been around since 2001. Only recently has their adoption rate begun to climb. Why were employers reticent about deploying these plans? Was it the fear of early adoption (and concerns about the “bugs” in the program)? Were employers simply not ready to give up their benefits in favor of high deductibles and massive cost shifting? Or, have we heard this story before when we were told HMO’s, then POS plans, were the future of health care delivery?

Probably some combination of “all of the above” is the real answer. At least for the next few

EXHIBIT 13

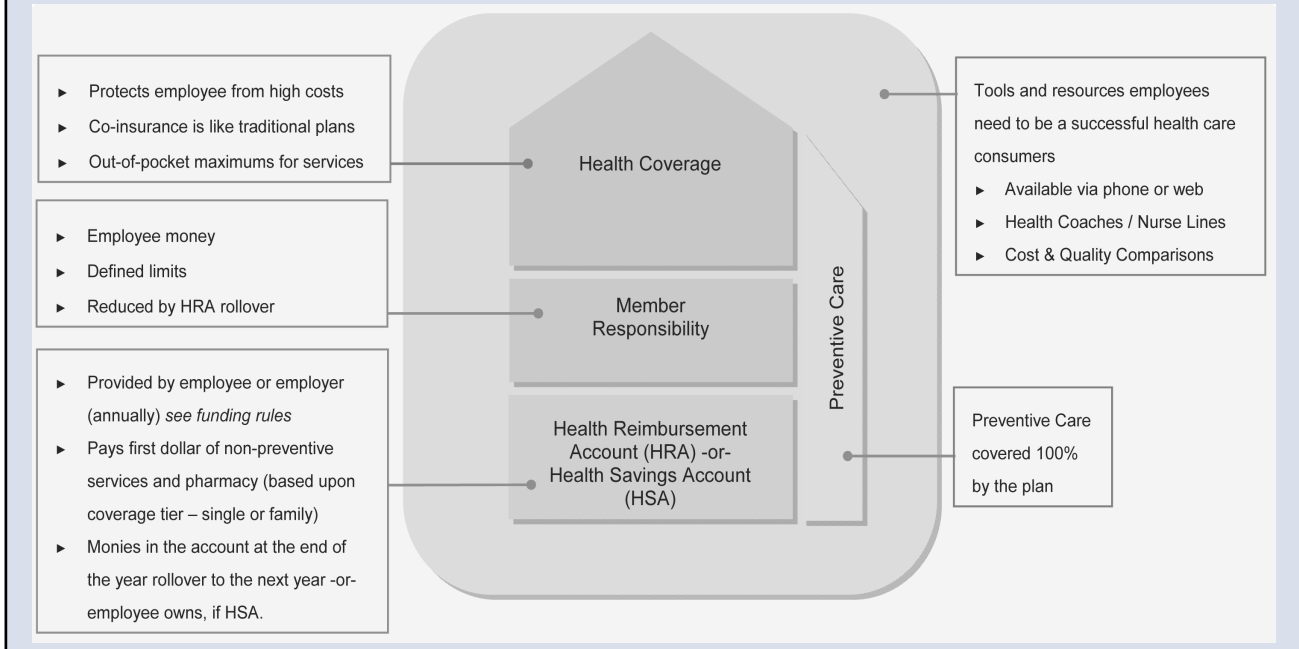
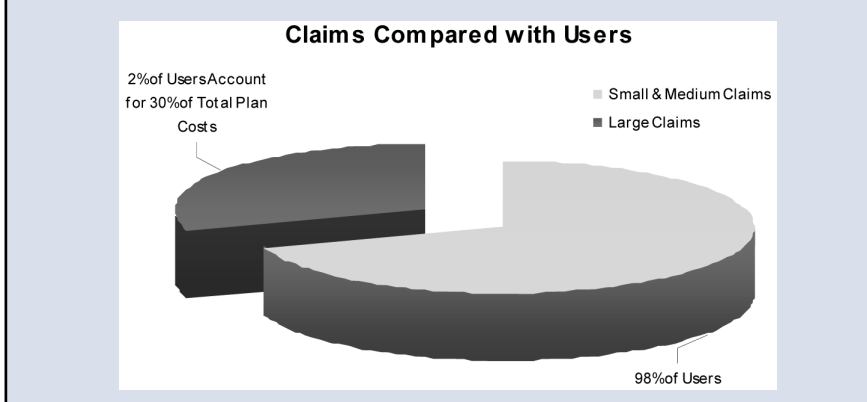


EXHIBIT 14



years, however, it appears CHDC models are going to be a part of the health insurance landscape. In its current form, it is unlikely that CDHC is the “solution” we all crave. There is, however, promise in the notion of “consumerism” that the product is founded on.

Consumerism can simply be defined as, “the engagement of the patient in the purchase and management of his/her treatment”. CDHC models encourage this behavior through the use of high deductibles which shift the cost of

care squarely on the patient’s shoulders. Gone are the days of co-pays which insulate the patient from the true cost of health care. More recently, Personal Care Accounts (PCA’s) have been offered to CDHC participants as a way to defray high deductibles with either Health Reimbursement Accounts (HRA’s) or Health Savings Accounts (HSA’s).

CDHC’s architects will tell you the intent of the model is to shift the Nation’s benefits mentality from one of entitlement to engagement. When patients

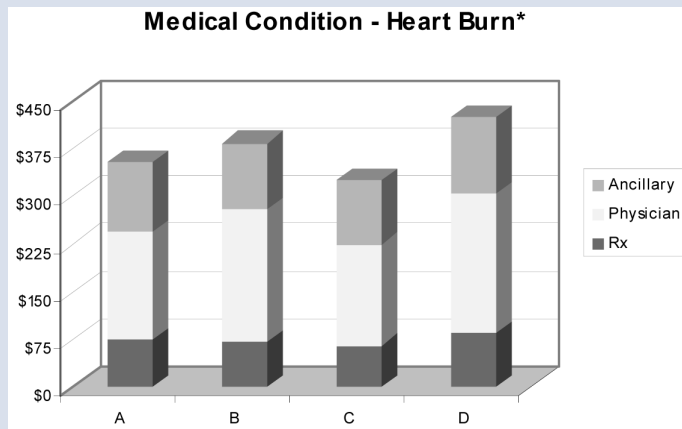
reach the point when they are “shopping” for health care in the same way we do for any other retail product, consumerism is achieved. Moreover, as we shop for health care, providers will become more sensitive to the competitive market pressure that Managed Care has shielded them from for decades.

The impact on “unit cost” and “volume” based trend should be measurable. The promise of CDHC can be summarized as:

- Immediate insurance cost relief due to benefit reductions
- Utilization reduction since patients will not seek “unnecessary” care
- Slowing of trend because providers will be subject to traditional market forces (thus holding down price)

The practice of CDHC is not nearly that simple. Early studies of large CDHC populations show mixed results. First, many employers offer a CDHC plan

EXHIBIT 15



along side a traditional PPO/POS plan. In this scenario CDHC plans “select” the better risk in the group as younger/healthy individuals gravitate to the lowest “out-of-paycheck” deduction. Where this is the case, we would expect CDHC plans to perform better than market. This does not represent an improvement in delivery model, however, but rather culling of the better risk into one product vs. another.

This is the second time in the last twenty years this historical anomaly has occurred. It first happened in the late 80’s when insurers realized they could “skim” healthier risks with low cost HMO’s and boost short term profits. Many of the same factors are at work today as CDHC sponsors look to validate their plan results. A truer prediction of CDHC performance can be found where CDHC plans are offered “sole source.”

Unfortunately there are few credible examples of sole source CDHC offerings. As adoption rates grow for CDHC, so will the number of sole source CDHC deployments. It will be interesting to track their results—beyond the first year benefit cost reduction—to measure

the impact on both consumer utilization and provider trend.

As a result, a healthy skepticism still exists regarding whether or not CDHC plans will save the industry. Experts point out that nearly 30% of every employer’s health care costs are derived from large claimants (about 2% of users). Other than a simple benefit reduction, CDHC plans will have no impact on a large claimant. People in life or death situations do not “shop” for health care bargains (and when they do, it is to upgrade, not reduce care).

Also, the practice of “purchasing” care is still nebulous at best. The cost of health-care services are not posted with “price tags” like other consumer items are therefore frequently unknown to the patient. Without knowing the price, how can we “shop” for care?

When you are in your doctor’s office and he checks off four cpt-4 codes, do you understand what you have just purchased? Were you, the patient, aware of alternative treatment patterns? Probably not.

Again, the concept of consumerism is entirely reasonable. The practice of consumerism in today’s health care delivery system is problematic since we do not have to

the tools to make effective treatment purchases. Improvement needs to be made in the way providers post and bill services if we as consumers are to have a legitimate say in the buying decision. We will discuss this notion in Section 6: Government Intervention.

SECTION FIVE: PRACTICING THE GOLD STANDARD OF HEALTHCARE—REDUCING PROVIDER PRACTICE VARIATION

You only have a 50% chance of getting the right care at your first physician office visit.¹² Ever wonder why they call it a physician practice? Much of the “practice” of medicine is not learned in schools, but rather through “on the job training”. So how do we help physician’s become better, more efficient doctors? And if we can do this, will it result in decreased costs?

Most experts believe the answer is yes. As much as 40% of the care rendered in America is unnecessary.¹² Much of the waste is attributed to physician inexperience which produces wide variation in provider treatment plans—for the same disorder! More still is due to defensive practice patterns of physicians leery of malpractice suits.

Prevailing opinion argues the best way to reduce cost is improve the quality of care. As such, some of the nation’s largest health care insurers have invested enormous resources in the measurement and reporting of clinical practice patterns. The intent was initially to identify abusers in the provider community. The process, however, has evolved—with the help of practicing physicians—to the search for the “Gold Standard” of health care.

EXHIBIT 16

Provider Name: Jones, Frank, M.D.
Specialty(ies): Cardiology
Address: 151 Farmington Avenue, Hartford, CT 06156
Phone Number(s): (860) 273-xxxx

Cardiologist	Clinical Performance	Efficiency Measures	Aexcel Status
Frank Jones, M.D.	Met all measures	★★★★☆	Designated *

* For more information on clinical performance, efficiency measures, criteria used and the designation process, visit our [Frequently Asked Questions](#) page for more information.

Efficiency Rating for Designated Providers

★★★★☆	Average	★★★★☆	Better than most
★★★☆☆	Better than average	★★★★★	Among the

Note: Data provided to members is at a summary level.

- Special designation in the provider directory
- Clinical performance scores posted

While intriguing, the number of specialties monitored by insurers is still quite small. As evidence based medicine gains traction across a broader section of the medical community, we can expect variations in practice patterns to diminish. Where this is the case a corresponding improvement in clinical outcomes, and reduction in treatment cost, should occur.

Humana, for example, has embarked on an aggressive program of provider “transparency” where hospital costs for 30 key diagnostic codes are accessible via the web. Patients can then compare costs, as well as, clinical performance of facilities prior to selecting the site of care.

Humana is also rolling out their version of a “high performance” network called E². Humana’s program uses clinical protocols to measure the efficiency and effectiveness of provider practice patterns. At point of launch, Humana will evaluate four primary care specialties and sixteen sub-specialties designed specifically to help physicians improve the quality of care.

As indicated, however, much of the “waste” in the health care delivery system is generated by providers who “over practice” medicine in an attempt to reduce legal liability. The provider community needs support in the form of government regulation if we expect to curtail “defensive practice patterns”. The role of government, and effective intervention techniques, is reviewed in the next section.

Clinical evidence gathered by insurers suggests there is enormous variation in provider practice patterns for the same disease state. More than can be explained by just the variable state of morbidity from patient to patient.

In an ambitious campaign, Virginia Mason Hospital in Seattle, has adopted clinical benchmark data provided by Aetna. This program has significantly reduced patient cost by focusing on evidence based medicine. The effect has been a 40% reduction in patient cost for specific episodes of care. Donald Storey, M.D.; National Medical Director—Aexcel of Aetna states:

“Insurers have the desire—and the obligation—to participate in solutions for our nation’s health care dilemma. At Aetna, we view the contribution of information on provider performance to both providers and consumers in as transparent a fashion as possible as one of the primary ways we can meet this desire, and obligation. By doing so, we contribute to all stakeholders having a greater appreciation of the high value of services being delivered and consumed in our health care delivery system.”

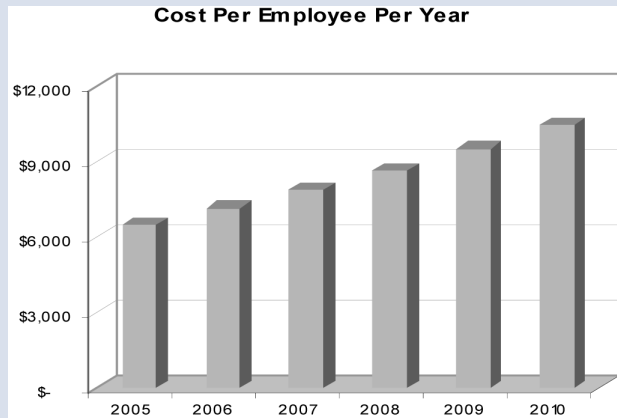
Why? Is there one right way, for example, to treat Heart Burn? In sharp contrast to traditional wisdom (where every patient, and therefore treatment, is unique) the answer in many instances may be yes! Working in concert physicians across America, carriers are using “evidence” or “fact based” medicine to identify optimal treatment protocols’.

A recent Aetna study validates this concept through the examination of common disease states, like heart burn. The Aetna study revealed wild variation in both treatment protocol and cost for the treatment of routine heart burn.

The implications for health care delivery are staggering. Through the use of clinical outcome data, carriers are in process of identifying “high performing” physicians. Performance is measured based on clinical outcomes, like complication and re-admittance rates, and tied to adherence with well defined and accepted protocols of care.

For example, in Aetna’s Aexcel Network providers practicing the “Gold Standard” of health care will receive:

EXHIBIT 19



need vs. a full battery to cover their legal liability?

California and Texas have adopted legislation limiting non-economic malpractice awards. This has resulted in reduced insurance premiums for providers and greater competition in the medical malpractice insurance space. With very little stretch of the imagination you can see where our government can have a tremendous positive impact. The basic building blocks for the reformation of America's health care delivery system already exist. We have identified them in this paper. Employer sponsored health awareness initiatives, physician treatment best Practices, innovative health insurance products and effective government intervention can be combined in an intelligent way to promote consumerism and enable the normal market forces described best by Adam Smith's "Invisible Hand".

SECTION SEVEN: WHAT'S NEXT? THE FUTURE OF EMPLOYER SPONSORED BENEFITS

Predicting future events is always a hazardous task. Some things seem self evident though. No integrated plan to solve America's health care crisis has been adopted. There are

many good ideas, programs and plans. Most of which are developed in industry specific silos.

Linking physician reimbursement to evidence based protocols, for example, is a natural step. In fact, examples already exist. Maternity "case rates" pay providers for the entire episode of care—from first visit to delivery. Diagnosis related groups (DRG's) perform the same function. These reimbursement models work. Their exists today 558 published Episodes of Care (EOC's) published Ingenix. These groupings represent all known adult care options. What if there was a clinical "best practice" for each of the 558 EOC's? What if a provider reimbursement "case rates" were created for each EOC?

Today, patients pay for each individual service rendered, not for the total treatment of a disease state (e.g., maternity). Linking physician reimbursement and clinical protocols to EOC's provides a basis for creating a common language for the treatment and purchase of health care.

Unfortunately, EOC's alone will not solve America's health care crisis. There exists no cohesive approach that address' what is a very complex and wide ranging

problem. In the absence of a clear fix several dynamics will emerge:

- CDHC will achieve an immediate, but short term, impact in the battle against rising health care costs.
- The search for the "Gold Standard" of medicine will gain traction and merge with EOC's to provide clinical guidance for physicians.
- As EOC's promulgate, care will no longer have to be rendered by the Physician. Physician Assistants (PA's) will become the "new doctor" as care is pushed down to more cost effective practitioners.
- Employers will shift employer contribution dollars from ancillary benefits to medical plans to absorb increases.
- America's "working uninsured" rate will continue to climb well in excess of 25% of the Nation's work force.
- Voluntary benefits—of all kinds—will proliferate.
- Medical inflation will continue at a pace twice as rapid as CPI.
- Carriers will launch defined contribution plans with fixed reimbursement schedules for EOC's (e.g., \$50—Office Visit, \$7,500—knee replacement, etc.).
- Government legislation will focus on further refining the tax savings and usability of Personal Care Accounts (PCA's).
- The U.S. will continue to lead the civilized world in both Health Care cost and consumption.

EXHIBIT 20

Willis Summary of Benefits

Procedure & Description	Amount Paid by Provider
Office Visit -New PI	\$ 44.00
Office Visit -New PI	\$ 83.00
Office Visit -New PI	\$ 26.00
Office Visit -New PI	\$ 122.00
Office Visit -New PI	\$ 104.00
Office Visit-estab PI	\$ 25.00
Office Visit-estab PI	\$ 26.00
Office Visit-estab PI	\$ 32.00
Office Visit-estab PI	\$ 78.00
Office Visit-estab PI	\$ 114.00
Office Consult	\$ 26.20
Office Consult	\$ 121.20
Office Consult	\$ 119.20
Office Consult	\$ 136.20

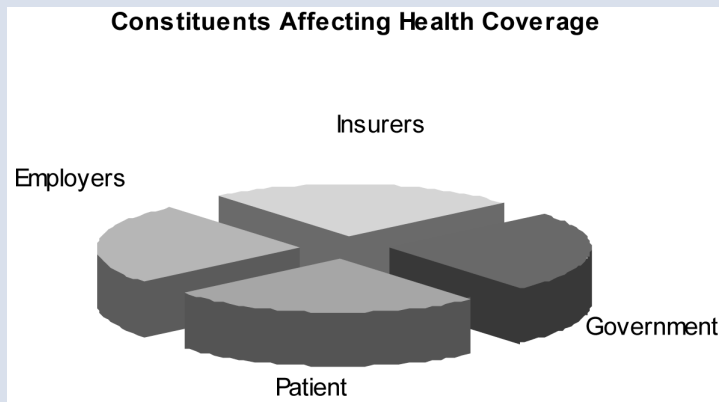
better than others. All of them are complex. All of them involve massive, fundamental changes to America's financial, legal, and health care infrastructures. This is also why they will never be adopted.

Perhaps the answer lies in identifying what works and how to improve current operations. The truth is we don't need to re-invent health care delivery. The tools already exist. With a few minor modifications America's health care system can be "tuned up" to perform on a level equal to or better than any delivery system in the World.

The basic building blocks to reducing Health Care costs are pretty simple:

- **Improve America's Health**— In Section 3 we identified numerous examples of Wellness and Disease Management employer deployed programs to improve the health and wellbeing of their employees. The key here lies in adoption and recidivism rates. Mandates or incentives must be applied to increase usage.

EXHIBIT 21



Not a pretty picture. Nevertheless, there is still reason for optimism. The advent of EOC treatment protocols marks a giant step forward in the advancement of health care delivery, as well as, its financing. Identifying more efficient protocols makes intuitive sense. Clearly, determining "best in class" treatment paths will reduce redundant service costs resulting from treatment variation/experimentation if the proper physician incentives exist—like competing for patient business.

The next logical step is identify and link together in an organized manner the other elements already existent to today's managed care environment to develop a working

plan for correcting America's health care crisis.

SECTION EIGHT: SOLVING AMERICA'S HEALTH CARE DILEMMA

The ground swell around consumerism is evident. There appears to be no turning back. But what needs to happen to turn a promising notion into sound practical application? What other elements in today's current health care delivery system show promise? How can these advances be integrated into a strategic plan that will address the Nation's health care needs?

There are numerous plans for the reformation of health care currently floating through Congress. Some are

- **Design Insurance Programs** encouraging consumerism— In Section 4 we outlined the CDHC products insurers have developed to engage patients in their health care treatment.

- **Practice Better Medicine**— Section 5 examined the use of evidence based medicine and spread through (EOC's). The carrier industry is working hard to encourage fact based medicine through high performance networks, transparency, and improved reimbursement mechanisms. The clinical result will be the creation of physician guidelines to practice more effectively and efficiently.

■ Effective Government Intervention—As stated in Section 6, regulatory devices need to be instigated which facilitate free market conditions in the health care space. Chiefly; 1) limited tort reform, and 2) legislation to simplifying billing codes and requiring providers to post costs. If our government refuses to get serious about these simple reforms, the market has little chance of “self-correction”.

The intelligent combination and coordination of these activities will lead to “quite revolution” in health care delivery. The integration of what is currently working with new ideas will result in a new age of health care where individuals both understand their treatment pattern as well as its costs. In this world, trend can be reduced to a number consistent with CPI and employers can regain focus on their core business versus managing their health insurance budget.

Why? Adam Smith predicated that people will act in their best interest’s given information necessary to make reasonable decisions. This in turn creates market pressure to compete for the consumers business—thus aligning price with demand. The American economy is founded on this simple principle. Why should the treatment of health care be any different?

Prescription for solving America’s health care dilemma.

Employers

- Adopt a benefit plan that rewards consumerism.
- Deploy incentive laden Wellness plan.

■ Make DM mandatory for eligible patients (or tie reduced benefit schedule).

■ Make benefit communication a “business imperative”.

Providers

■ Embrace and help further refine EOC’s.

■ Accept fair reimbursement for each EOC.

■ Reinvent the Physician Charge Sheet in a language lay people understand and post charges within the patients view.

Insurers

■ Use nationwide patient databases to help the provider community create/update EOC’s.

■ Build intelligent insurance programs linking benefit design and physician reimbursement to EOC’s—defined contribution style.

Government

■ Enact legislation; 1) streamlining billing procedure codes, and 2) force providers to post and publish service costs.

■ Enact legislation with “limited” tort reform with recovery caps for malpractice.

■ Review existing patent law as it applies to Drug Manufacturers ability to recoup “R&D” costs at consumer’s expense.

The steps identified in this paper will conservatively reduce health insurance costs 25% over time and relegate trend to a number consistent with CPI. Why? Because providers will pay less in malpractice premiums. Physicians will provide more appro-

priate care. Clinical outcomes will improve. Patients will have the tools to actually “shop” for health care and incentives to take better care of themselves.

In this environment medical insurance carriers become clinical data banks and stop loss companies. Providers become business owners who must compete for patients. Patients become what they should have always been—informed consumers. And, in America, the consumer is king!

I envision a world where:

- Insurance benefits include no words like—deductibles, co-insurance, copays or out-of-pocket maximums.
- Insurance benefits are described as a fixed dollar reimbursement/procedure.
- Providers post the cost/procedure.
- Provider networks are irrelevant since benefits are now defined contribution style (e.g., reimbursement/procedure).
- Reverse auctions occur where providers “compete” to perform a specialized procedure for a patient in need (a la “Lending Tree.com”).
- Employer health insurance contributions (averaging \$4,500/ee/year) are not paid to insurers, but to the employees HSA.
- Employees purchase claims administration and stop loss coverage and pay 100% of the premium based on individual election (e.g., stop loss at \$7,000, \$10,000 or \$15,000 per family per year).

The solution is before us. More importantly, the elements for ref-

EXHIBIT 22

Physician Charge

Current State

Future State

Summary of

Current State

Future State

ormation already exist in some form. These ideas/programs need simply to be integrated and deployed on a larger scale. Once accomplished, the economic balance that exists in every other industry will finally prevail in the health care space.

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