



PBGH

Pacific Business
Group on Health

PBGH Member Benefit Strategies

Promoting Quality, Value and Access

February 2005

PBGH Member Companies

Aerojet
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Automobile Club of Southern California
Bank of America
Bechtel Corporation
California Public Employees' Retirement System
California State Automobile Association
ChevronTexaco Corporation
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Lowe's Companies, Inc.
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Target Corporation
The Clorox Company
Union Bank of California
University of California
Unocal
Varian, Inc.
Varian Medical Systems, Inc.
Verizon Communications
Wells Fargo & Company

About the Cover Art. Pacific Business Group on Health (PBGH) creates business solutions that put purchasers and consumers in the driver's seat on the road to achieving health care quality, value and access. PBGH seeks to make available a full dashboard of measures to support consumer choice of plan, hospital, medical group, doctor and treatment. Choices based on quality and value are "fueled" by performance information, benefit design, and provider payment and incentives.

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About the Pacific Business Group on Health

Pacific Business Group on Health (PBGH) is one of the nation's top business coalitions focused on health care. Our large purchaser members spend billions of dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents. In addition, PBGH operates PacAdvantage, a small group purchasing pool providing health coverage to the employees of over 10,000 of California's small businesses. PBGH is a respected voice in the state and national dialogue on how to improve the quality and effectiveness of health care while moderating costs. Partnering with the state's leading health plans, provider organizations, consumer groups and other stakeholders, PBGH works on many fronts to promote value-based purchasing in health care. Reflecting the vision of its member organizations, PBGH plays a leadership role in an array of health care quality initiatives that includes providing consumers with standardized comparative quality information and developing methods to assess and communicate the quality of care delivered by health plans, medical groups, physicians, and hospitals. For additional information or an electronic copy of this report, visit www.pbgh.org.

About the Foundation

Funding for the production of this report was provided by the California HealthCare Foundation (CHCF). CHCF, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information, visit us online at www.chcf.org.

Executive Summary

Purchasers of health care, regardless of size, are grappling with significant health benefit decisions to sustain comprehensive health coverage in the face of unabated premium increases and persistent gaps in quality of care. Purchasers and consumers alike must become more discriminating buyers of health care and apply more targeted approaches to drive improvement in health care delivery. This report highlights benefit design strategies that can promote access to better care for enrollees and favorably impact cost trends:

- Health plan options
- Health plan eligibility and contributions
- Provider network differentiation and selection
- Inpatient and outpatient benefit design
- Pharmacy benefit design
- Health promotion and health risk management
- Tools and incentives for consumer engagement
- Retiree benefits and education

The Pacific Business Group on Health (PBGH), representing large and small employers, has reviewed national trends and profiled its members' practices relative to these factors to create a road map for near-term tactics and long-term benefit strategies that improve health status and deliver value. PBGH members are adopting innovative approaches to benefit design with goals of moderating health care costs, improving quality and creating incentives for health improvement and consumer engagement. Some members have introduced new plans, including narrow network HMO options and products with health spending accounts and consumer tools, while others have implemented more incremental design changes. One of the important values of membership in the Pacific Business Group on Health is the lessons purchasers learn and apply from sharing strategies with other leading employers to help serve as a catalyst for advancing health care quality and accountability. This report seeks to share some of those lessons and experiences more broadly.

The choice of specific benefit design tactics by particular purchasers is influenced by an array of factors: workforce composition, geographic concentration or dispersion, and prioritization of other health, welfare and compensation initiatives. While most of the PBGH members have national strategies as reflected in this report, all recognize that California has unique market dynamics. In particular, California continues to have far greater penetration of HMOs, which are supported by a robust group of well-organized and integrated medical groups. At the same time, hospital consolidation in Northern California and thin networks in rural areas represent serious challenges for provider network design.

Health Plan Options

PBGH members are setting specific “breakthrough” performance-based selection criteria and requiring relative quality and cost reporting. These expectations build on accreditation and performance data (member experience/clinical HEDIS measures), as well as Requests for Proposals or Requests for Information (including the national eValue8 model) to support health plan selection. These new parameters are shaping employers’ relationships with health plans in terms of the type, number and duration of partnerships pursued. PBGH members continue to offer a mix of plan offerings (HMO, PPO/POS) and are adopting emerging plan models (narrow networks and plans with health spending accounts). A range of complementary options at various price points is allowing employers to meet the needs of their diverse workforces, while employees have a wider range of options. Added value can be achieved by purchasers’ efforts to hold health plans accountable for employees’ health improvement, engagement and provider options. Finally, to ensure health plans are compensated fairly and rewarded for outcomes improvements, some PBGH members are integrating sophisticated risk-assessment and risk-adjustment models into contracting.

Health Plan Eligibility and Contributions

The determination of eligibility criteria and premium contributions represents a key component of purchasers’ benefit design processes. Both elements must be structured to sustain accessibility to plan products for employees, dependents and retirees; as well as to create incentives for enrollees to join high-value plans based on strong performance across risk-adjusted costs, member satisfaction, clinical outcomes, measurement and reporting. Many employers are addressing premium contributions as an opportunity to engage their employees to demand value. While the majority of employers, including about half of PBGH’s members, opt for a percentage contribution to create consistency across geographic markets and to engage employees based on a range of performance information, this strategy reduces cost differentials between plans relative to employee contributions. Increasingly, PBGH members have adopted a contribution that is

based on the highest-value plan and makes transparent cost differentials across plans. This strategy results in employees bearing the full cost difference when using more expensive, low-value plans. Additional contribution strategies being utilized to achieve accessibility and affordability include adjustments based on: employees’ salary levels, number of dependents and employment status (active, early retiree, retired beneficiary).

Provider Network Differentiation and Selection

Given documented variance in provider costs and quality, employers are exploring new ways to structure provider networks and to support employees’ provider selection. Research shows a premium reduction of up to 17 percent can be achieved when contracted networks use high-performing, efficient providers. Nationally, research shows more than half of major employers have adopted multi-tier hospital and physician networks with more than another 30 percent who are considering a select or narrow network strategy. In California, hospital consolidation and mixed delivery models have hampered product availability and adoption of this network strategy. However, CalPERS, the largest purchaser of health care in the state and a PBGH member, was able to influence provider contracting practices to create a highly profiled tiered hospital strategy. Similarly, PBGH members like Lowe’s Companies, Inc., Pitney Bowes, Union Bank of California and Wells Fargo & Company have contracted select provider networks to curb costs and promote quality. The use of interactive consumer tools to inform provider selection decisions is increasing. The PBGH-developed Health Plan Chooser and other provider choice tools are increasingly being used by employers nationwide to engage consumers.

Inpatient and Outpatient Benefit Design

Employers are seeking to influence optimal provider selection and service utilization through new inpatient and outpatient benefit designs. There is significant concern about potential unintended consequences on access and avoidance of necessary care with increases in hospital admission copayments, coinsurance for outpatient diagnostics and tiered primary care/specialist

physician office copays. Purchasers are focusing on conducting analysis to ensure that patients obtain recommended and timely care.

Pharmacy Benefit Design

Extensive attention has been focused on pharmacy benefits based on the percentage of rising health care costs attributable to prescription drug trend. PBGH, along with its members, has pursued numerous avenues to moderate costs and reinforce therapeutic compliance. Examples of benefit tactics include: mandatory generics or step-therapy, replacement of copays with coinsurance, reduced out-of-pocket costs for chronic illness medications obtained via the mail, and information sharing about treatment alternatives. The use of increased copay structures by prescription drug tiers has slowed pharmacy cost trends. However, research has clearly shown that some cost sharing, particularly among the chronically ill, can actually deter care access and therapeutic compliance, and ultimately increase medical costs associated with managing an acute exacerbation of a chronic condition. PBGH members are actively looking at how their pharmacy design does not have such unintended consequences. In light of cost and care issues related to pharmacy benefit design, employers are also requiring disclosure of formulary practices (drug selection, substitution, etc.) and rebate incentives.

Health Promotion and Health Risk Management

With 15 percent of employees accounting for 75 percent of health care dollars, health risk reduction and chronic care management have become central to achieving breakthroughs in health care quality improvement and cost trend reduction. Increasingly, employers are investing in the promise of having both financial and employee quality of life returns from wellness promotion and disease management programs. Fifty percent of PBGH members currently host a Health Risk Appraisal for employees. Employers are also holding health care plans accountable for reporting information on disease management programs and measuring their impact. Several PBGH members currently purchase disease management services in one of the following ways: buy-up through a health plan, contracting with a

standalone disease management vendor, or outsourcing to a pharmacy benefit manager.

Tools and Incentives for Consumer Engagement

Consumer engagement must be at the core of any value purchasing and benefit design strategy. Employers not only hold plans and providers accountable for performance in this way, but also are making direct investments to support their members. Through tools and incentives, consumers can become more actively engaged in recognizing and pursuing value from their health benefits plan. PBGH members are active adopters of treatment option support and plan chooser tools. Employers have implemented a variety of tools, such as Health Plan Choosers, that assist members in enrolling in a plan whose attributes are best suited for the member. Yet, employees are challenged with a deficit of reliable, comparable performance information across PPO plans to which they can direct employees for informed, engaged decision-making.

Retiree Benefits and Education

Purchasers seek to apply learnings from benefit strategies for the under 65 population to retiree programs, including education and consumer engagement, access to coverage, and care advocacy. At the same time, the Centers for Medicare & Medicaid Services is piloting a number of reforms initially launched through commercial health insurance programs, including pay for performance, disease management, and public reporting of provider performance. Employers are actively engaged in understanding the implications of the Medicare Modernization Act and Part D Prescription Drug coverage.

The shared experience of large purchasers is an important frame of reference for innovation, especially as purchasers in parallel promote broader research on the impact of benefit design incentives and potential unintended consequences of increased cost-sharing. The following Summary of High-Value Purchaser Strategies highlights some key markers along road to implementing a benefit design that improves health status and delivers long-term trend moderation. The information in this report will hopefully catalyze additional efforts to promote value and quality improvement in health care.

Summary of High-Value Purchaser Strategies

The report is organized into eight areas that highlight purchaser strategies to promote quality, value and access.

1. Health Plan Options

- Use of explicit criteria (e.g. cost-effectiveness, quality, provider access and system capabilities, etc.) to select and offer “high-value” plans
- Design of plans with complementary features that represent diverse and affordable options (e.g., mix of PPO, HMO, CDHP and narrow network products) and actions to mitigate risk selection in plan choice
- Use of risk-adjusted plan payments to reward efficiency and recognize population health status to assure fair compensation of plans that manage higher risk populations

2. Health Plan Eligibility and Premium Contribution

- Use of a contribution strategy that integrates financial incentives or quality information to encourage employee selection of a high-value plan determined by performance benchmarking or risk assessment
- Use of coverage rules and contribution strategy to assure access to coverage among active employees, dependents, early retirees and retirees, such as adjusting premium contributions by employee income

3. Provider Network Differentiation and Selection

- Promote pay for performance and the provision of consumer tools that differentiate provider performance
- Use of plan options that promote selection “high performing” providers through narrow networks, tiered networks, and/or centers of excellence

- Inform employees’ choice of doctors and hospitals via standardized measurement and public reporting of provider performance

4. Inpatient and Outpatient Benefit Design

- Understand impact of changes, including unintended consequences, to enrollee share of costs in copayments or coinsurance
- Adopt benefit design incentives for optimal resource utilization, selection of optimal treatments based on efficacy and value, and understanding of health care costs, including but not limited to discretionary services
- Use benefit design incentives for optimal provider selection

5. Pharmacy Benefit Design

- Understand impact of changes to enrollee share of costs through changes in copayments or coinsurance
- Design of formulary and prescription drug benefit to support selection of treatments based on efficacy and value
- Encourage compliance with maintenance programs for chronic illness and continuously monitor for any unintended consequences of cost-sharing
- Encourage value-based purchasing by employees (e.g. use of generic drugs, mail order, and/or step therapy)

6. Health Promotion/Health Risk Management

- Understand impact of promoting wellness and health promotion programs, including use of Health Risk Assessments and member tools
- Use incentives to promote “active” participation in chronic care management and risk reduction
- Use of credible measures of direct and indirect ROI (via direct research or contractual requirements of plan/vendor) for targeted disease management and health promotion programs to build business case for sustained investment in such programs over the long-term

7. Consumer Engagement: Tools and Incentives

- Use consumer engagement tools, resources and information to support employees’ value-based decision-making (e.g., provider selection, prescription drug use, etc.)
- Apply principles of preference-sensitive decision making relative to plans, providers, and treatments
- “Activation” of consumers through education of members about the cost of services and the total value of health benefits

8. Retiree Benefits

- Use education and consumer engagement to encourage value-based decision-making
- Provide tools to help employees understand retiree benefits costs and engage in retirement planning
- Support the Centers for Medicare & Medicaid Services’ use provider measurement, pay for performance, and public reporting to advance provider performance accountability

Overview and Context for Purchaser Action

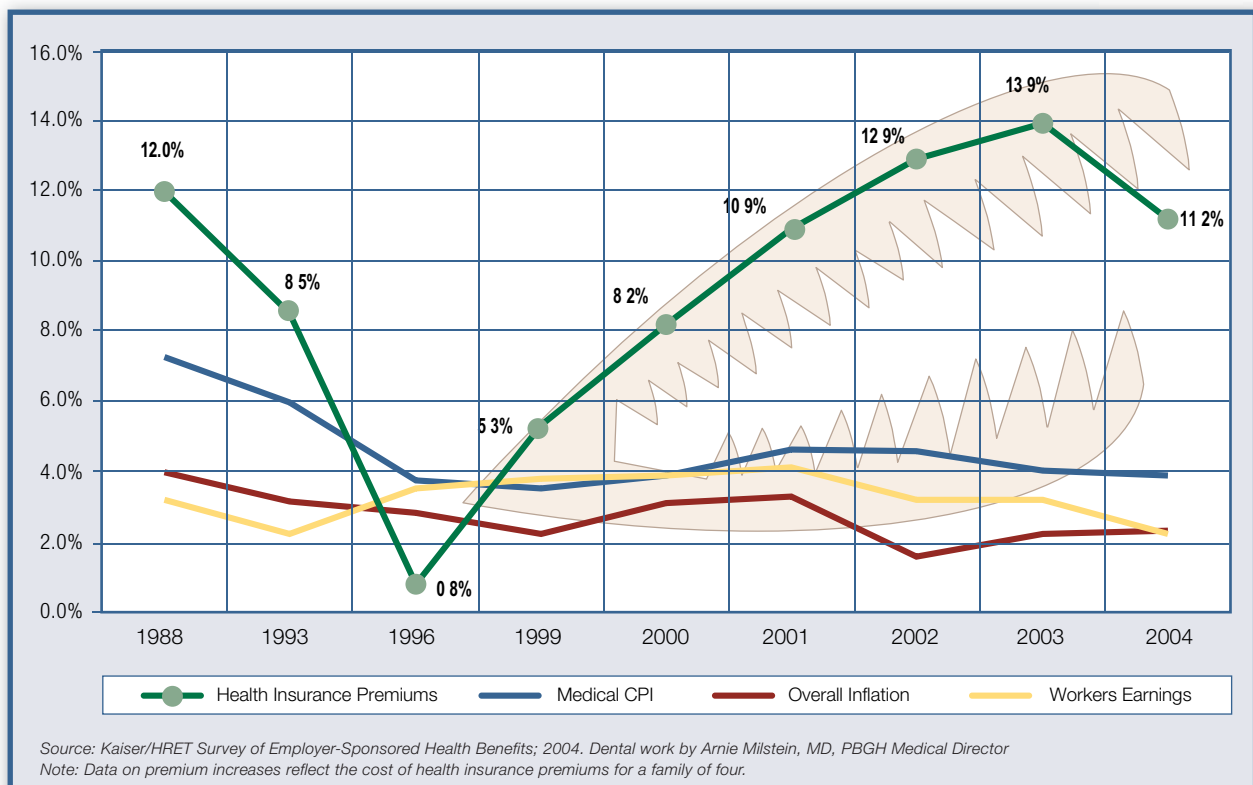
Health care costs are skyrocketing, while quality gaps abound. The Institute of Medicine has shed light on problems of inconsistent quality, unjustified practice variation, and at times, downright harmful delivery of medical services. Taken together, the high cost, double-digit trends of years past, and quality and efficiency shortfalls underscore a huge value disconnect for employers, as evidenced by a number of national employer surveys.¹ The reaction of many small employers has been to drop or limit coverage. The Pacific Business Group on Health (PBGH) and many larger employers recognize parallel tracks to curb health care costs and advance quality by: (1) using collective and strategic purchasing leverage to address the overriding system problems that result in high costs and compromised quality, (2) engaging consumers to demand quality through use of better information linked to financial incentives, and (3)

rewarding higher value plans and providers with volume and differential payment.

Sophisticated purchasers agree that “breakthroughs” are necessary for real change to occur. Health plans that implement breakthrough competencies such as effective health promotion/risk management and use of cost-effective providers can save up to 28 percent of premium.² Consumer tools linked to health savings accounts hold the promise of consumer engagement, but trend reduction and quality improvement cannot be achieved without changing how performance is measured and how providers are paid. While breakthroughs must ultimately be made by health plans, the delivery system and providers, benefits architecture must foster that change.

Purchasers are both exploring new self-funded plan options and challenging their insured plan partners to

FIGURE 1. Health Insurance Premiums are Consuming Workers' Earnings



innovate. With HMO penetration in California at 52 percent, employers recognize the value of coordinated, high quality care delivered through managed systems. However, there is significant interest in harnessing greater value for both insured and self-funded plans by using higher performing physicians and hospitals. New product designs have been stymied by cultural and contractual hurdles, administrative complexity, and lack of data and provider performance transparency. Nevertheless, progress is being made with expansion of tiered and narrow network products that seek greater provider and consumer engagement. Examples include: PacifiCare's Health Credits program and Narrow Network, Health Net's commitment to treatment option and shared decision-making support, Kaiser's expansion of Web-based tools to support consumer engagement and behavior change, and Blue Shield's collaboration with PBGH's innovative efforts to make headway in physician-level measurement. Adoption of such products will spur refinement and continued innovation.

A significant and growing portion of premium increases is unfunded relative to what employers are typically budgeting. Medical trend far exceeds other inflation indicators and is eating away at workers' wage increases (**Figure 1**). Whether public or private, large or small, purchasers are more directly sharing cost increases with employees through changes in plan contributions, copayments or benefits. The statistics are a concern for all stakeholders:

- On average in 2004, California workers experienced a 13 percent increase in contributions towards premiums.³
- Nationally, the projected 2005 premium trend of 13 percent is being reduced by over 3 percent (to 9.6 percent), not by changing the underlying cost drivers, but largely through cost-shifting to employees and reducing benefits.⁴
- In order to make up for rising health-care costs, 29 percent of organizations in one survey reported a likely decrease in other employee benefits.⁵
- The estimated number of Americans with employer-sponsored health benefits fell from 67 percent to 63 percent between 2001 and 2003.⁶

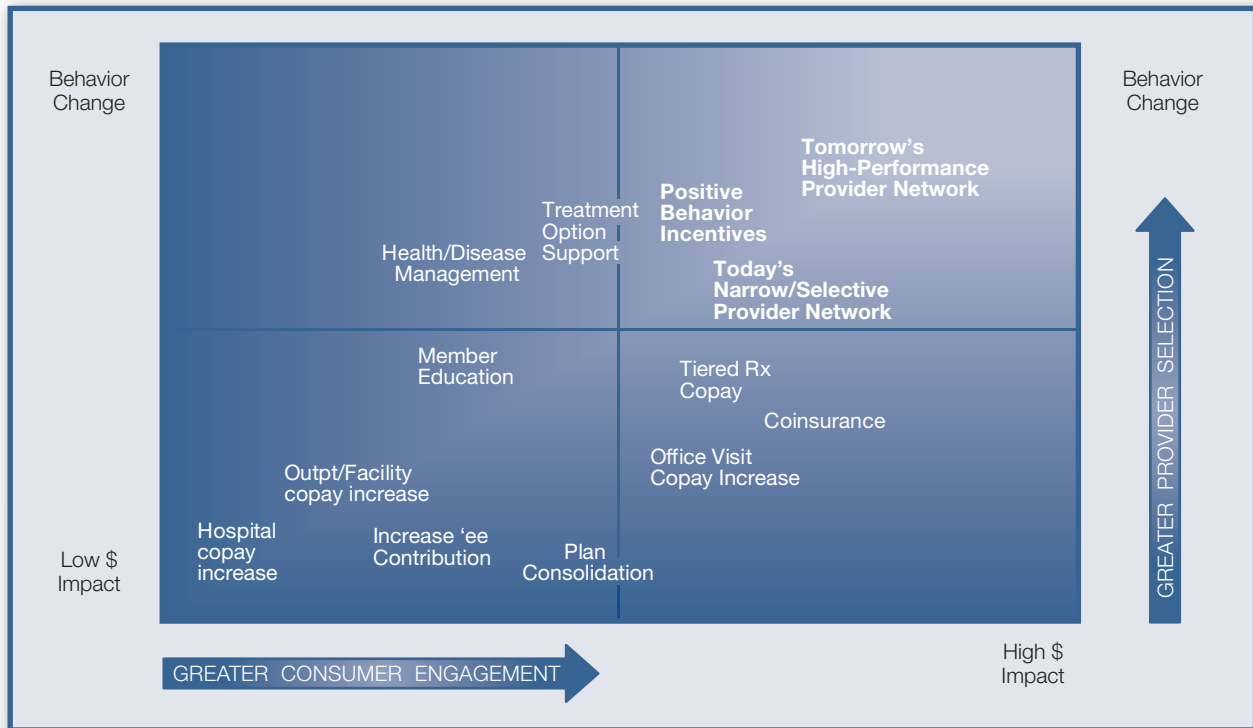
Thoughtful cost-sharing is more than cost shifting and demand management. It considers the potential allocation of costs between healthy and sicker employees, and the extent to which cost-sharing encourages employees to get the right care at the right time. When cost-sharing is utilization-based (e.g. increased copayments and coinsurance) higher-frequency users of services pay more. Employers are interested in aligning incentives for healthy behavior changes, which also positively impact productivity in the workplace. At the same time, many are concerned about implications of benefit changes on disadvantaged sectors of employees, whether because of health status or income level. Incremental cost-shifting within traditional benefit designs has provided limited financial relief. Moreover, incentives must be aligned to influence provider performance and improvements in the overall delivery of care. Indeed, there is growing concern about adverse consequences of increased cost-shifting such as avoidance of necessary care and non-compliance in medication management. Likewise, when low-wage earners are faced with higher premium contributions and/or increased service cost-sharing, the dangers of waived coverage or underutilization of both preventative and necessary care are even more pronounced.

A strategic approach to benefits architecture must address both the economic and behavioral rationale for cost-sharing. Thoughtful cost-sharing can be one element of an approach to engaging employees to be value-based consumers of health care by encouraging risk reduction, choice of high quality and efficient providers, and choice of treatments based on efficacy. Comparative information supplied in user-friendly interactive tools is essential to value-based decision making. Consumer selection of high-performing providers promotes quality and enhances the likelihood of favorable health outcomes, and in turn rewards those providers with volume. There are gaps today in relative provider performance information, consumer tools, and providers' systematic use of empirically-based knowledge. The collective action of PBGH members as thought leaders in this area is closing the gap for all purchasers by more progressively engaging consumers, and leveraging health plans and providers to demon-

strate increased accountability. **Figure 2** provides examples of actions individual employers have taken and are considering for the future, and displays graphically the relative impact that such actions may have in moderating cost or inducing behavior change that can improve quality and lower cost over the long term.

Tactics in the lower left quadrant have limited impact on consumer behavior and cost savings. Tactics in the upper right quadrant combine greater differentiation in provider selection and broader support for treatment option choice and behavior change.

FIGURE 2. Optimizing Value through Benefit Design



¹ Hewitt Associates, 2004 Future Health Care Expectations Survey; <http://was4.hewitt.com/hewitt/resource/spkrsconf/subspkrsconf/teleconferences/tapes/10-08-03.pdf>; <http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2005/01-10-05.htm>

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National Business Group on Health, various member survey responses, 2003-2004

² Arnold Milstein, MD, Improving the Value of Health Benefit Plans Through Consumer-Driven Health Care, Mercer HR Consulting, 2002.

³ California Health Care Foundation and Health Research and Educational Trust: California Employer Health Benefits Survey 2004; <http://www.chcf.org/documents/insurance/HRETEmployerBenefits2004.pdf>

⁴ 2004 Mercer Human Resource Benefit Survey, cited in Wall Street Journal, August 27, 2004.

⁵ 2004 Society for Human Resource Management Survey of 375 members.

⁶ Center for Studying Health System Change, Tracking Report No. 9, August 2004; <http://www.hschange.org/CONTENT/694/694.pdf>

Health Plan Options

High-Value Purchaser Strategies:

- Use of explicit criteria (e.g. cost-effectiveness, quality, provider access and system capabilities, etc.) to select and offer “high value” plans
- Design of plans with complementary features that represent diverse and affordable options (e.g., mix of PPO, HMO, CDHP and narrow network products) and actions to mitigate risk selection in plan choice
- Use of risk-adjusted plan payments to reward efficiency and recognize population health status to assure fair compensation of plans that manage higher risk populations

Purchasers rely on their health plans to be partners in considering strategic approaches to benefit designs that support both consumer and provider engagement. Whether self-funded or insured, employers view health plans as their agents in administering a benefit design and managing the provider network. The choice of carrier serves as a foundation for designing the range of health plan options.

Figure 3 below displays the array of products and provider-differentiated plan options available from a selection of California and national carriers.

FIGURE 3. The Health Plan Product Landscape

		Payer								
		Aetna	Blue Cross	Blue Shield	CIGNA	Health Net	Kaiser	Lumenos	Pacifi-Care	United
Product	PPO	PPO	PPO	PPO	PPO	PPO	Sub-Contractor		PPO	PPO
	CDHP	Health Fund	Power Hlt Fund		Care Gain	In Devt		CDHP	Signature Freedom	Definity (Formerly iPlan)
	HMO	HMO/EPO	Basic HMO	Basic HMO	HMO/EPO	HMO/EPO	Basic HMO		Basic HMO	EPO
	Hospital		Centers of Excellence	Tiered Hospital	Centers of Excellence	Tiered Hospital			Tiered Hospital	Centers of Excellence
	Medical Group		Value Network			High-Perf Network			Signature Value Advantage	
	Physician (Limited Geographic Markets)	Aexcel			CIGNA Care Network					Choice Plus

Health Plan Offerings

All PBGH members use common metrics such as accreditation, CAHPS member experience (Consumer Assessment of Health Plans Survey), and clinical performance results (HEDIS) as part of their health plan evaluation and selection criteria. In addition, PBGH members augment their review of health plans with RFPs and RFIs. PBGH supports the use of a common RFI tool, eValue8, to assess health plans' health improvement programs, provider management and consumer support services. Developed in collaboration with the National Business Coalition on Health, the eValue8 RFI enables multiple employer coalitions and national employers to communicate common performance expectations and benchmark plan performance.

Purchasers are redefining their relationship with their health plan partners by more explicitly communicating selection criteria, committing to longer-term partnerships, and requiring public reporting of outcomes, costs and quality. Many PBGH members have a large percentage of their California population enrolled in HMOs, even as HMO enrollment has decreased outside of California. Large multi-state employers often select a primary national carrier for a self-funded product, along with offering regional HMO carriers. In response to the lack of demonstrable value differentiation among some plans and limited differences in network composition, some employers have also consolidated health plan offerings. In creating larger risk pools, the purchaser can reduce administrative burden, provide consistent support services across a population, better measure population-specific outcomes, and stabilize the risk mix from annual migration and variability.

Some employers have adopted a regional strategy where carriers for all products are selected based on relative performance criteria. The criteria used by some purchasers include algorithms to rate and benchmark plans to support "buy" decisions. Taken to the next level, a few purchasers use such performance data to design their benefits architecture such that the contribution strategy favors a high-performing plan; or the cost-sharing components may encourage employees to select the higher value/lower cost plan (See Member Profile on Wells Fargo & Company).

Risk Assessment and Risk Adjustment

Some PBGH members are also implementing more sophisticated risk adjustment mechanisms with their contracting plans. When the health status of a population is measured consistently and experience trended over time, purchasers can potentially reward plans for demonstrating improved health outcomes. To help sustain a balanced risk mix and to provide fair compensation to plans that may experience adverse selection, employer premium contributions or payments to a health plan could be adjusted to reflect unavoidable morbidity, geographic coverage, and payor mix of its constituent providers.

Verizon Communications uses a contribution strategy that recognizes and promotes enrollment in a benchmark plan that is designated based on quality performance and price. More recently, Verizon tested a risk adjustment process that modifies a health plan's net premium based on enrollment, using DxCG as a risk assessment tool to analyze pharmacy claims. In a California pilot, Verizon obtained plan renewal bids on their entire population and subsequently adjusted the premiums based on actual enrollment.

The PBGH Negotiating Alliance (a subset of PBGH members that negotiate together based on a standardized HMO benefit plan and standardized performance metrics) uses a rating adjustment model that recognizes disease burden, demographic composition (age, gender, tier and active/early retiree status), and geographic distribution. Employers offering a common health plan are risk-adjusted based on their enrolled population. This analysis supports assessment of plan efficiency and adoption of value-based contribution strategies.

Consumer-Directed Health Plans

Currently, one-fourth of PBGH members offer a consumer-directed health plan (CDHP), but more importantly, most health plans have expanded health improvement and self-management tools in all their products. Many HMOs and PPOs have embraced consumerism and invested significant resources to augment information tools for members. Employers

that have insisted elements of consumer support be incorporated in all health plans believe those options add value by aligning financial incentives with member use of health information.

CDHP options typically include an employer-funded health reimbursement account offered in conjunction with a deductible plan. Plan designs include first dollar coverage for preventative services – often provided in addition to the Health Reimbursement Account. After the funds in the Health Reimbursement Account are exhausted, the employee is responsible for out-of-pocket costs until the deductible is reached. The differential between the Health Reimbursement Account and deductible varies, as do coinsurance levels and covered services. Proponents assert that enrollees are motivated to use information tools and provider choice tools because the Health Reimbursement Account is “owned” by the consumer. At the same time, there are concerns that quality and cost transparency is currently insufficient for consumers to make informed choices and that some will avoid necessary care. Services are coordinated with the employee’s Flexible Spending Account (FSA), but unlike an FSA, a surplus in the Health Reimbursement Account funds can be rolled over for use in subsequent years, and unlike a Health Savings Account, the Health Reimbursement Account funds are not portable.

Among PBGH members, the most frequently used carrier is Definity Health (recently acquired by United Health Care), with additional offerings from Lumenos, Aetna Health Fund, Blue Cross, and Uniprise iPlan. In most cases, these programs are offered as an option among PPO/POS and HMO plans, and are designed with an actuarial value similar to the PPO/POS options. One employer implemented a full replacement CDHP as their sole self-funded option. Several employers have implemented high- and low-option CDHPs with variable Health Reimbursement Accounts to provide greater choice for their enrollees.

Early results based on renewal rates reported by several carriers indicate that cost trends were moderated, use of generic drugs increased, and use of discretionary services fell. However, it should be noted that CDHP benefit levels may vary significantly across market

PBGH Member Profile #1

Wells Fargo & Company Engaging Consumers through Plan Choices and Tools

Wells Fargo offers a diverse set of plan options, including nationally a self-funded POS with Uniprise and a consumer-driven option through Definity Health. Behavioral health and prescription drug benefits are outsourced to specialty vendors. In California, Wells Fargo also offers several HMO options, including Kaiser and PacifiCare – both its traditional HMO and its Value Network HMO. After assessing plan performance, geographic and provider overlap, and relative value, Wells Fargo eliminated a third HMO option in 2003. In designing a dual option HMO that included a narrow provider network at a more competitive premium, it was critical to Wells Fargo that quality data was used in addition to efficiency.

As part of its value-purchasing strategy, Wells Fargo evaluates risk and plan efficiency by adjusting health plan premiums to reflect age, sex, and family mix of population served. Then it calibrates the premium against the illness burden of the population, which assures that plans that effectively treat sicker populations are positioned to gain new enrollment through the premium contribution incentive. Wells Fargo will pay its maximum contribution for the most efficient plan in a geographic region after risk adjustment. Costs for less efficient plan options in excess of that dollar amount are borne by the participant. If participants choose a plan that is not as efficient, given the population it is managing, the enrollee will pay the entire differential from the highest value plan.

In addition to financial incentives, Wells Fargo provides consumer tools to help Team Members (employees) make value-based decisions in selecting from the health plan options. Using a customized version of the PBGH Plan Chooser, team members have access to comparative data on plan and out-of-pocket costs (tailored to an individual’s rating of their health status and frequency of health care usage), plan rules, quality and member experience information, and key health plan attributes. To support health improvement and consumer engagement, Wells Fargo also offers an array of tools including health content information and an Internet-based health risk appraisal.

Considerations for Implementation

- Potential use of a data warehouse
- Collaboration with health plan partners to support program administration and data exchange
- Internet connectivity and access for decentralized worksites

segments, and as a relatively new plan offering for most employers, the impact of risk selection that occurs with any new plan choice has not been adequately measured over multiple years.⁷

PBGH continues to monitor the progress of such products against elements defined and described in a 2003 report "Breakthrough Plan Competencies Evaluation". Developed in collaboration with CDHPs, HMOs and PPOs, this set of "Breakthrough Competencies"⁸ are high-yield interventions designed to have a major long-term impact on health management and risk reduction, consumer engagement, provider selection and payment incentives.

High Deductible PPOs and HSAs

Several PBGH members have expanded their PPO offerings to include lower cost options with higher deductibles. Some are considering "choice" products that allow members to design their own plan with customized inpatient, outpatient and pharmacy coinsurance levels. Interest in high deductible PPO options is growing as a result of recent Medicare reform legislation that included substantial new provisions for Health Savings Accounts (HSA). In one national survey, nearly three-quarters of respondents indicate that it is either very likely (19 percent) or somewhat likely (54 percent) that they will offer a high deductible health plan with an HSA option in the next two years.⁹

One issue expressed by PBGH members is that such products not function solely as a tax vehicle, and that the qualifying health plan needs to integrate services to support member health improvement, consumer engagement and provider selection. While consumer-directed health plan designs often provide first-dollar

coverage for preventative services or allocate a portion of the Health Reimbursement Account to routine physicals and well-child care, there is concern about how less structured, high deductible plans may influence compliance with routine preventative screenings and access to care.

A recent Watson Wyatt survey suggests that most workers are unfamiliar with HSAs.¹⁰ Upon receiving an explanation of HSAs, most individuals like features such as control of funds, reduced premium, and tax benefits, but dislike the risk of significant out-of-pocket costs for prescription drugs and deductibles. Notably, healthier participants appeared to place more importance on premiums rather than deductibles, while less healthy respondents placed more importance on deductibles. In considering the addition of an HSA-compatible high deductible plan, purchasers must be fully aware of the potential adverse selection that could occur, resulting in risk segmentation by plan type.

⁷ Consumer-Driven Health Care: Beyond Rhetoric With Research And Experience A Special Supplement To HSR, Health Services Research, Vol. 39, No. 4, Part II August 2004.; <http://www.hcfo.net/cyberseminar/0904/hsr.pdf>

⁸ Accessed at <http://www.pbgh.org/news/eletters/documents/BreakthroughPlanCompetenciesReport.pdf>

⁹ "US Employers See a Role for New Health Savings Accounts in Their Benefit Programs, April 27, 2004 Press Release, Mercer HR Consulting; <http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1135645>

¹⁰ "Consumer Awareness of Health Savings Accounts (HSAs), Watson Wyatt Research Brief, <http://www.watsonwyatt.com/research/deliverpdf.asp?catalog=ONL016&cid=x.pdf>

Health Plan Eligibility and Premium Contribution

High-Value Purchaser Strategies:

- Use of a contribution strategy that integrates financial incentives or quality information to encourage employee selection of a high-value plan determined by performance benchmarking or risk assessment
- Use of coverage rules and contribution strategy to assure access to coverage among active employees, dependents, early retirees and retirees, such as adjusting premium contributions by employee income

In conjunction with plan selection process, employers construct an eligibility and contribution strategy to foster employee plan selection. When considering the basic parameters of such a strategy, employers necessarily consider corporate culture, basic demographics, employee turnover and common industry practice. Purchasers seek to balance providing equitable access to different plan products based on employee preference, while creating incentives for members to choose high-value plans.

Eligibility

For PBGH members, benefits eligibility is most commonly set at 30 to 90 days of employment; organizations with populations that have higher turnover tend to have longer eligibility waiting periods that may extend to six months of employment. Benefit coverage is also offered to part-time employees, typically once workers meet a threshold of 20 hours per week.

Contribution Strategy

Most PBGH members pay between 70 to 90 percent of premium for individuals, with the majority at 75 to 80 percent of premium. Despite experiencing significant premium increases over the last several years, PBGH employers have made relatively modest changes to premium contributions. While employees' proportion of cost-sharing has increased, it has not kept up with the double-digit increases associated with health care overall.

Adjusting employee premium contributions is about more than just cost-sharing. It can be a means of engaging employees to act like consumers; demanding value (a function of cost and quality) and making value-based decisions. To do so, some employers are adopting fixed (and in some cases, risk-adjusted) contributions relative to the price of a "value plan" as opposed to the more traditional "percentage share."¹¹ Roughly half of PBGH members offer a fixed dollar

contribution. For these purchasers, employees bear the full cost difference for the perceived value of a more expensive plan. In most cases, the employers' contribution is based on the lowest cost plan, thereby strengthening the impact of cost differentials.

By altering contributions to encourage employees' selection of "high value" plans, employers seek to reward value with volume, while at the same time lowering direct costs to the employer. High value plans have a lower cost on a risk-adjusted basis, perform well on clinical outcome and process measures (e.g. HEDIS), report better consumer experience (e.g. CAHPS), and promote value networks through measurement, rewarding performance (e.g. active participation in IHA's Pay for Performance initiative in which seven California plans reward providers using common metrics), and public reporting (e.g., NCQA Quality Compass and Leapfrog). Employees who choose a "lower value" plan will incur significantly higher costs because the employer's contribution favors the value plan with the employee paying the entire cost difference.

In contrast, the vast majority of employers generally, and about half of PBGH members, still contribute a percentage of premium, thereby reducing the cost differential among various plan options for employees. Two major reasons cited by employers to retain a contribution based on percentage of premium include the desire for consistency among national plan offerings and to engage members in using health plan quality and performance information (rather than cost only). Additionally, geographic differences may be considered for mitigating the cost differences across plans choices, as HMOs typically are not available in rural areas.

Contributions for Dependent Coverage

Consistent with national trends, some PBGH members have significantly increased employee contributions for dependent coverage. To minimize the number of enrollees maintaining dual coverage, some employers provide an offset or direct payment to members who waive dependent coverage. Others require an additional payment from members that elect to maintain

PBGH Member Profile #2

University of California

Salary-Based Contribution Strategy

In 2004, the University of California implemented a contribution strategy stratified by salary bands, with the goal of maintaining affordable access to coverage for all employees, particularly those with incomes below \$40,000 per year. This strategy is also linked to UC's efforts to risk-adjust contributions, which not only supports migration to the high-value plan(s), but also helps the University to maintain diverse health plan choices.

The chart below summarizes the approximate employee contribution required for family coverage for 2004 and displays the percentage of income that this represents as being paid by employees in each salary band.

		Approximate Employee Contribution Required			
		Rates for Family Coverage			
		<\$40K	\$40-\$80K & retirees	\$80-\$120K	\$120K +
HMO	Monthly	\$36	\$86	\$141	\$187
	%	1.3%	1.8%	1.8%	1.5%
POS	Monthly	\$172	\$215	\$274	\$320
	%	6.3%	4.5%	3.5%	2.6%

University of California also customized PBGH's Health Plan Chooser (originally introduced in 2003) to support members' choice of health plan with premium cost, point-of-service out-of-pocket costs, quality and member experience information, and preferences about provider and specialty care access.

Considerations for Implementation

- Review of current employee salary stratification by carrier
- Engagement of key constituents/business units and communications strategy
- Annual indexing of salary bands
- "Cliff" effect if salary is at borderline of threshold: a salary increase would be diminished by the increased contribution for health benefits
- Payroll system compatibility

dual coverage. Charging a surcharge to dependents who enroll when they have coverage elsewhere provides a disincentive to dependents with alternative coverage options but does not penalize dependents with no alternative options.

Nearly all PBGH members use a three-tier (single, two-party, family) or four-tier (EE, EE+Spouse, EE+Child, EE+Family) structure for determining contribution strategies. This structure allows for passing through the relative cost differential for dependent coverage. National surveys suggest a movement away from two-tier (single, family) coverage towards increasing the number of eligibility tiers or charging for each specific dependent thereby assessing a larger contribution for large families.

Means-Based Contribution

Employers are looking at how plan contribution strategies can best assure that employees maintain their health insurance. Some employers are adjusting the required contribution not only by the health plans' cost and value, but also by the employee's income. Nationally, 18 percent of employers report use of pay-based contribution strategies; 22 percent are considering adoption at a future date.¹² By using "salary bands", employers pay a higher percentage of the premium for lower income employees. Multiple PBGH members link contribution to salary (or are planning to implement) and other employers are considering adoption of the strategy¹³ (See Member Profile on University of California).

Risk Adjusted Contribution

Several PBGH members risk-adjust contribution based on the illness burden or demographic composition of each plan to encourage enrollment into the plan(s) that demonstrate higher value. The risk adjustment does not affect premium to the plan, but the reduced contribution encourages migration into in the high-value plan. (See Member Profile on Wells Fargo & Company)

Eligibility and Contribution for Early Retirees

Increasingly, PBGH members and large employers generally are increasing the relative contribution required of early retiree beneficiaries compared to active employees. These increases reflect both the significant cost differential in an early retiree population compared to actives and the desire to offset the magnitude of premium increases for current employees. This may be reflected in demographically adjusted contributions or employee status. In some cases, employers make no contribution to premium, but allow access of early retirees to the organization's group-rated premium. Eligibility rules for early retirees vary considerably and are often linked to date of hire and number of years worked. Some companies do not allow for reinstatement of coverage after an early retiree has opted out. In consideration of the possibility that some early retirees have dual coverage, one employer is allowing re-enrollment upon termination of the alternate coverage.

Eligibility and Contribution for Retirees

Most PBGH members and large employers generally are significantly increasing the relative contribution required from retiree beneficiaries relative to active employees. For many employers, the magnitude of the retiree premium increases significantly exceeds that of pre-65 coverage. Retiree contributions have increased also as a result of dollar caps on the portion of the premium paid by the employer. In recent years, many employers have also eliminated future retiree coverage for new hires. One employer recently introduced new limits on retiree coverage, but by adjusting their future liability, the employer could reallocate budgeted resources to increase contributions for active employees. Employers are broadly evaluating their Retiree benefit strategies with the advent of the Medicare Modernization Act.

¹¹ In traditional percentage of contribution sharing, an employee pays a constant percentage of premium, e.g. 20%. When this is the case, employees bear 20% of the increased cost of a lower value plan and may not be aware of the full price differential.

¹² Hewitt Associates, 2004 Future Health Care Expectations Survey

¹³ On a recent NGBH employer survey, 23 percent of responding employers report consideration of salary bands when calculating contributions

Provider Network Differentiation and Selection

High-Value Purchaser Strategies:

- Use of plan options that promote selection “high performing” providers through narrow networks, tiered networks, and/or centers of excellence
- Promote pay for performance and the provision of consumer tools that differentiate provider performance
- Inform employees’ choice of doctors and hospitals via standardized measurement and public reporting of provider performance

There is growing recognition that the choice of providers – hospital, medical group, and physician – has a significant impact on both quality and cost of health care. Research supporting the PBGH Breakthrough Plan Competencies¹⁴ suggests premium reduction up to 17 percent for effective selection of high-performing and efficient providers. Refining a network to emphasize high-performing, efficient providers can be done via “tiering” or “narrowing”¹⁵ the network. Employers also cite member access and satisfaction as important considerations to implementing tiered or narrow provider networks.

Several findings from the recent 2004 Hewitt Survey on Health Care Expectations confirm interest among large employers in using provider network design strategies to support value purchasing (**Figure 4**). There is clearly growing interest in tiered and narrow networks, and greater adoption of hospital vs. physician network products.

Tiered and Narrow Hospital Networks

PBGH member adoption of tiered and narrow network designs is constrained by product availability, which is limited by both the lack of publicly reported hospital performance metrics and hospital

FIGURE 4. Network Design Strategy

% Adopting in 2004 or Considering a Future Date		
Hospital	60%	Introduction of a multi-tier network that provides access to all hospitals, but greater employee cost sharing for less cost-efficient facilities
	37%	Introduction of a select or narrow network plan that only covers care at the most cost-efficient hospitals
Physician	56%	Introduction of a multi-tier network that provides access to all physicians with lower employee cost sharing for more cost-efficient physicians
	32%	Introduction of a select or narrow network that only covers care provided by the most cost-efficient physicians

Source: Hewitt 2004 Survey

consolidation. However, purchaser demand for health plan accountability in managing hospital costs and interest in narrow network options will hopefully continue to advance product development. Several California plans use Leapfrog data and information from initiatives to improve public reporting (coronary artery bypass graft surgery and maternity care). PBGH has also helped advance a set of national standards for hospital quality measurement. In 2002, PBGH supported the analysis of a wide range of clinical performance measures, a number of which were subsequently endorsed by the National Quality Forum. Currently, PBGH is providing technical advisory support to a new California-based initiative to promote standardization of hospital quality measurement and is supporting health plan efforts to refine cost rankings from unit price to episode-based measures of longitudinal efficiency.

The consolidation of hospital systems, particularly in Northern California has also been cited by health plans as an obstacle to the expansion and adoption of such products. The negotiating leverage of such systems has forestalled plan efforts to differentiate networks. Blue Shield of California and PacifiCare were among the plans that launched tiered hospital network products based on relative cost differences. The paucity of quality metrics has also limited early growth in these two- and three-tier products, although Blue Shield moved its entire block of small group business (including PBGH's small employer purchasing pool, PacAdvantage) into this program. As an important bellwether for employer purchasing strategies, the recent decision by CalPERS to implement a narrow hospital network for its HMO plan may accelerate adoption of this strategy (See Member Profile on CalPERS).

While many PBGH members are considering explicit tiered or narrow-network products, the PPO and POS plan designs offered by virtually all large employers have such characteristics inherently embedded in their design. The degree to which value-based considerations are applied to the designation of providers as "in-network," represents the degree to which the networks are based on "value-selection." Purchasers are increasingly seeking just such explicit demonstration of network selection from their health plans.

PBGH Member Profile #3

CalPERS

Hospital Selection for Value

In a 2002-2003 strategic planning process, CalPERS adopted a set of goals that included improving value by focusing greater competition and accountability at the provider level, including measures aimed at:

- Selecting providers based on performance;
- Holding those providers more accountable;
- Moving more CalPERS care to higher performing and higher quality providers; and
- Enabling and supporting individual members in the understanding and use of quality, effectiveness, and pricing information

With premium increases in excess of 50 percent over the last three years and major budget constraints from a looming statewide fiscal crisis, CalPERS implemented bold measures in 2004 to offset impending health premium increases. Working with Blue Shield, its primary network HMO, to analyze hospital cost patterns and available quality performance information, CalPERS elected to offer a narrow hospital network that was projected to save \$36 million in 2005 and \$50 million in 2006.

CalPERS approved a plan to eliminate 38 hospitals statewide, 13 of which were Sutter Health facilities. This served to offset the projected HMO premium increases. Since the initial decision, ten facilities have been added back to the network because they were willing to meet the established criteria. Four other hospitals were reinstated at the request of the Department of Managed Health Care.

Quality indicators used to rank the hospitals included:

- Leapfrog participation
- Meeting thresholds for select Leapfrog volume measures
- Participation and above average performance in the PEP-C member experience with inpatient care survey
- JCAHO accreditation level
- Participation in the California Perinatal Quality of Care Consortium

Considerations for Implementation

- Network disruption and geographic access analysis
- Availability of providers through alternative health plans
- Engagement of key constituents
- Communications strategy

Tiered and Narrow Physician Group Networks

An increasing portion of PBGH members have contracted for select provider networks as a means of moderating cost and promoting quality. The PacifiCare Narrow Network product has been adopted by a number of PBGH members. Additional companies in the PBGH Negotiating Alliance are considering this plan option, and have also evaluated the Health Net Premier Network program. One impediment to adoption noted by many members is the limited geographic areas in which such products are available. Among PBGH members, the narrow network product has been offered as a side-by-side option, although some companies are considering a full replacement approach. Additional considerations include introduction of benefit design differences to create a pricing incentive for migration and some members' belief that enrollees are more likely to be engaged in making medical group than hospital-based selections because of the greater immediacy of physician choice.

As the differentiation of provider groups is refined through the expansion of quality metrics, uptake may increase. In addition to the PBGH Consumer Assessment Survey results on member experience with provider groups, medical group-level HEDIS-based clinical performance metrics was publicly reported for the first time in 2004 as a result of the California Pay for Performance Initiative.

Tiered Physician Networks

National PPOs (e.g., Uniprise Choice/Choice Plus and Aetna Aexcel) have begun to offer product designs with different coinsurance levels based on provider cost and efficiency. Large purchasers have collaborated with Aetna to inform the design of the Aexcel product, offered in a limited number of markets, which differentiates specialty physicians based on efficiency for episodes of care, and for a limited set of quality metrics.

Education about Hospital Options

PBGH employers are ahead of the curve in employee education about hospital selection, due in part to PBGH's

leadership with HealthScope, Coronary Artery Bypass Graft Surgery (CABG) outcomes research, and Leapfrog, all of which are accessible by virtually all Californians, available through most health plans, and specifically promoted by a number of PBGH employers. A limited number of employers offer a direct link to data on www.Leapfroggroup.org, but the majority of members make this information available via HealthScope or their plans' Web sites. Two-thirds of PBGH members encourage health plans to promote Leapfrog metrics via performance guarantees or RFP renewal inquiries.

All major California network HMO plans and national carriers provide enrollees with performance information about hospitals, working with subcontracted vendors such as HealthShare and Subimo. These vendors rank hospital performance based on a wide range of publicly available data, including hospital claims data reported by the Office of Statewide Health Planning and Development (OSHPD), self-reported information on implementation of Leapfrog Patient Safety initiatives, and data on CABG outcomes.

One current limitation of these data is that most do not include hospital cost efficiency information to guide a member's selection of a higher-value facility. Additionally, each vendor may use different algorithms to determine hospital rating, resulting in different rankings for the same service. PBGH conducted an assessment of hospital choice tools this year and is providing direct feedback to vendors and plans on opportunities to enhance the consumer interface and to expand the underlying quality metrics to better differentiate hospitals.

While public data on a full range of clinical outcomes remains limited, there is significant interest by purchasers and plans to support increased awareness and use of such sources of information to guide the selection of a hospital. Unocal is one employer that has created a Web-based HR portal that includes hospital performance information from HealthGrades. The information is available directly to employees and retirees, without having to access a particular health plan's Web site.

¹⁴ Improving the Value of Health Benefit Plans through Consumer Driven Healthcare, Mercer HR Consulting, 2002.

¹⁵ A "tiered" network is one where copays and coinsurance differs based on the tier to which the provider is assigned. A "narrow" network does not allow covered access to providers outside the network.

Inpatient/Outpatient Benefit Design

High-Value Purchaser Strategies:

- Understand impact of changes, including unintended consequences to enrollee share of costs in copayments or coinsurance
- Adopt benefit design incentives for optimal resource utilization, selection of optimal treatments based on efficacy and value, and understanding of health care costs, including but not limited to discretionary services
- Use benefit design incentives for optimal provider selection

As escalating health care costs have continued, employers have adopted incremental changes to cost-sharing at the point of service for inpatient and ambulatory care. At the same time, there is significant concern about unintended consequences of increased out-of-pocket costs, including avoidance of necessary care and non-compliance in medication management, which in turn could actually increase total medical costs. While employers seek to avoid imposing financial barriers to enrollees accessing needed care, they also want to make the true cost of health care more transparent. In a recent survey of large firms, 57 percent of respondents indicated they are somewhat or very likely to increase prescription drug copayments, 57 percent are likely to increase deductibles and 53 percent are likely to increase cost sharing for office visits.¹⁶ In California, where significant enrollment remains in HMOs, the copayment structure has served to shield consumers from experiencing the relative cost increases for various types of services, as well as obscure the relative cost of common office visits, diagnostic laboratory tests or MRIs.

Inpatient Hospital Services

Hospital admission copayments are on the rise as purchasers target the fastest growing component of overall medical trend. A number of PBGH members indicate increased use of coinsurance for hospital services. Adoption of a per admission or per day copayment was also reported, with the latter accompanied by a per admission cap, and with the sum of all costs contributing to the out-of-pocket maximum.

Outpatient Hospital Services

For the last two years, the rate of outpatient hospital cost increases has been the fastest growing component of overall medical trend.¹⁷ Some plans have introduced benefit design options that include a coinsurance for hospital-based diagnostic services, including laboratory and radiology. In some cases,

advanced diagnostic imaging is differentiated from routine and/or preventive services.

Physician Services

Most employers report making incremental adjustments to office visit copays over the last several years. Reflecting the benefit design used by a majority of participants, the PBGH Negotiating Alliance increased its "model plan" office visit copayment from \$15 to \$20 for 2005. Additionally, there has been growing interest in using differential primary care physician and specialty office visit copayments. Thus far, this approach has been more commonly used in PPO than HMO plans. Current combinations vary, including \$20 PCP/\$25 specialist, \$15 PCP/\$25 specialist and \$20 PCP/\$30 specialist. For plans with different coinsurance levels for primary versus specialty care, the typical differential is 10 percent.

National surveys report growing interest in adoption of coinsurance-based coverage for office visits, an interest being acted on by PBGH members in 2005. Key goals are to make costs more transparent and to create a savings incentive to choose high performance providers where such networks are available. A coinsurance structure also allows the purchaser to establish a benefit structure that is automatically indexed to medical trend, and thereby avoid annual or bi-annual office copayment

FIGURE 5. Types of Cost Sharing Currently In Use

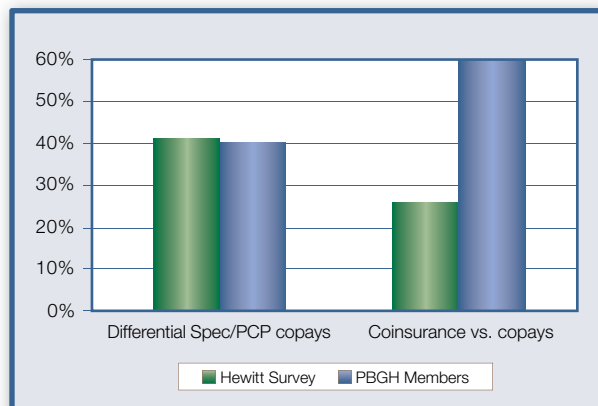


FIGURE 6. Copays, Deductibles and Out-of-Pocket Maximums

Employee Out-of-Pocket Costs	2002	2003
PPO in-network deductible of \$1,000 or more (% of employers)	20%	34%
PPO in-network individual out-of-pocket maximum (median)	\$1,500	\$2,000
HMO hospital deductible required (% of employers)	15%	50%
HMO office visit copayment of \$20 or more (% of employers)	22%	33%

Source: Mercer 2004 Survey

adjustments. The prevalence of managed care contracts in California whereby medical groups subcapitate primary care services may be a barrier to adoption. **Figure 5** illustrates PBGH member adoption of coinsurance among all products (including PPO).

There has been growing interest in pricing differentials for primary care and specialty services, but limited uptake. One impediment to adoption among HMO offerings is the lack of consistency in the plan designs for which carriers have received regulatory approval. Such a design is not offered by Kaiser, whose integrated model does not support a primary/specialty care differential. Another barrier is the lack of consistent options available outside of California, which is problematic for national employers seeking to implement a common benefit design. Lastly, due to the prevalence of capitated provider group arrangements in California, the actuarial value of such a benefit design change might not be fully realized.

Understanding Design that Promotes Better Care and Access

PBGH and its members are acting on their need to better understand the implications of cost-sharing by reviewing existing evidence that supports consumers getting access to the right care at the right time. The goal is to use the best available evidence to support quality-based benefit designs.

¹⁶ California Health Care Foundation and Health Research and Educational Trust: California Employer Health Benefits Survey 2004. ; <http://www.chcf.org/documents/insurance/HRETEmployerBenefits2004.pdf>

¹⁷ Center for Health System Change, Tracking Health Care Costs, Data Bulletin #27, June 2004.

Pharmacy Benefit Design

High-Value Purchaser Strategies:

- Understand impact of changes to enrollee share of costs through changes in copayments or coinsurance
- Design of formulary and prescription drug benefit to support selection of treatments based on efficacy and value
- Encourage compliance with maintenance programs for chronic illness and continuously monitor for any unintended consequences of cost-sharing
- Encourage value-based purchasing by employees (e.g. use of generic drugs, mail order, and/or step therapy).

Prescription drugs have received significant attention for benefit design changes over the last several years because pharmacy has represented a large component of medical trend. There has been recent moderation as a result of aggressive formulary management, key drugs going off-patent accompanied by generic alternatives, and financial incentives. Nonetheless, pharmaceutical costs continue to far outstrip inflation and employers are particularly concerned about the financial impact of new specialty drugs. Advances in pharmacy benefit design are due in part to the discrete nature of pharmaceuticals, which allows differentiation based on cost and efficacy. Additionally, the tendency to carve-out services and the systems capacity of PBMs has resulted in improved data access for improved trend and utilization analysis.

Prescription Drug Benefit Design

Benefit design has been a major focus among PBGH employers, who have undertaken a wide variety of initiatives to promote cost management and promote compliance. The availability of information resources and drug pricing data has enabled some of these targeted actions, which include:

- Mandatory generics
- Mandatory step-therapy requiring enrollees to try more cost-effective drugs before allowing the use of expensive brands
- Replacement of copayments with coinsurance tiers
- Reduced out-of-pocket costs for chronic illness maintenance drugs obtained via mail order
- Provision of information about treatment alternatives and drug substitution options
- Implementation of a drug debit card to facilitate coordination with FSA accounts
- Policies supporting utilization management, e.g. substitution and authorization of select drugs

PBGH Member Profile #4

Pitney Bowes

A Prescription for Change

To implement a population-based health improvement strategy, Pitney Bowes evaluated its overall disease burden and identified targeted opportunities to improve health status and reduce risk. Existing programs include wellness promotion and preventive care via an on-site medical clinic, education tools through "Health University" and financial incentives to complete a health risk appraisal. Pitney Bowes revised its prescription drug benefit with the goal of improving compliance with medication management of chronic illness.

Betting that longer-term moderation of cost trend could be attained by improving the health status of their population, Pitney Bowes lowered the cost for drugs commonly prescribed for selected chronic illness to a 10% coinsurance. Reduced cost-sharing for select maintenance medications led to increased compliance with drug regimens. The results were dramatic: a 6% reduction in costs per diabetic and a 15% reduction per asthmatic for overall savings of more than \$1 million per year. Key drivers were the reduction in emergency room visits and hospital admissions. Total drug spend moderated as increased utilization of maintenance medications was offset by reduced costs for "rescue" drugs used to treat more severe illnesses and complications that previously might arise from non-compliance.

Not only did the change in cost-sharing lead to more patients getting the right care at the right time - it actually saved money in the total cost of care for diabetics and asthmatics.

2004 Prescription Drug Plan Design

	Basic		Extra Rx	
	Retail	Mail Order	Retail	Mail Order
Deductible	none	none	none	none
Tier 1	10% coinsurance	2X Retail coinsurance	10% coinsurance	2X Retail coinsurance
Tier 2	30% coinsurance	2X Retail coinsurance	25% coinsurance	2X Retail coinsurance
Tier 3	50% coinsurance	2X Retail coinsurance	35% coinsurance	2X Retail coinsurance
Coinsurance Limit	Mail Only		Retail/Mail Combined	
	EE	\$1,500	EE	\$1,000
	EE+1	\$3,000	EE+1	\$2,000
	EE+Family	\$4,500	EE+Family	\$3,000

Considerations for Implementation

- Use of claims analysis and predictive modeling tools to identify targeted interventions
- Use of a PBM or health plan capable of administering a customized formulary and cost-sharing design
- Communications strategy

Impact of Cost-Sharing

Employers are increasingly assessing how changes in cost-sharing promote patients getting the right care at the right time, versus having unintended consequences of discouraging needed care (see Member Profile on Pitney Bowes). While increases in tiered prescription drug copayments have helped offset recent pharmacy trends, an unintended consequence may be reduced access to needed medications for individuals with chronic illness. Recent studies have shown that dramatic increases in copayments may discourage some beneficiaries from complying with maintenance drug regimens, while more gradual adjustments have less impact; furthermore, changes in utilization can vary based on drug class.¹⁸

Use of Pharmacy Benefit Managers (PBM)

Many employers use a PBM to manage the prescription drug benefit – both directly with a carve-out relationship and through health plans that subcontract with PBMs. Employers using PBMs value the direct support for benefit design planning, drug utilization analysis, trend analysis and data reporting. Additionally, offering a self-funded program enables an employer to align benefits – both cost structure and formulary composition – across all plan products. A more limited number of employers carve out prescription drugs from their insured HMO plans, with concerns expressed by others about potential data integrity and care coordination gaps that could result from such actions.

An emerging issue is increased transparency in drug substitution practices and valuation of rebates and how those rebates are passed through to the plan sponsor. Nationally, legal action by several states has led to greater disclosure about formulary development practices and drug substitution. Two members participate in a PBGH-sponsored group purchasing arrangement that includes transparency in the retail component whereby retail discounts pass through to the plan sponsor; adoption of a transparent structure for rebates is under consideration.

Member Education

Employers have also invested efforts to educate members about generic use and relative cost of medications. In one national survey, 25 percent of respondents indicated current use of a PBM's Web site to make available information on drug pricing and lower-cost treatment, with 52 percent considering for a future date. Sixty-two percent of respondents would consider requiring PBMs to provide EOBs that list drug pricing information.¹⁹

Drug Efficacy

Community-based efforts to support research and education on drug efficacy may also provide additional tools for health plans and employers. In California, health plans have also collaborated to promote generic substitution through financial rewards (discount coupons) and education. There is growing interest in use of benefit designs that promote use of cost-effective and efficacious options.

¹⁸ Pharmacy Benefits and the Use of Drugs by the Chronically Ill. JAMA, May 19, 2004-Vol 291, No. 19

¹⁹ 2004 Hewitt Survey on Health Care Expectations: Future Strategy and Direction

Health Promotion and Health Risk Management

High-Value Purchaser Strategies:

- Understand impact of promoting wellness and health promotion programs, including use of Health Risk Assessments and member tools
- Use incentives to promote “active” participation in chronic care management and risk reduction
- Use of credible measures of direct and indirect ROI (via direct research or contractual requirements of plan/vendor) for targeted disease management and health promotion programs to build business case for sustained investment in such programs over the long-term

One-third of adults are living with at least one chronic condition. Fifteen percent of employees account for 78 percent of health care dollars. Add to that the cost of associated productivity loss,²⁰ and employers’ interest in keeping employees well is understandable. Present day employers walk a tight rope of how to appropriately intervene into personal health issues versus picking up the tab for poor health status left unchecked. Increasingly, they are investing in the promise of both financial and employee quality of life returns from wellness promotion and disease management programs.

Health Risk Appraisals

Health risk reduction and chronic care management are central to achieving breakthroughs in health care quality improvement and cost trend reduction. Large purchasers view health and disease management programs as important tools for moderating health care cost and ensuring their enrollees receive appropriate care. To this end, they are complementing their consumer engagement strategies around cost-sharing with efforts to engage consumers in improving their health. Fifty percent of the PBGH members currently host a Health Risk Appraisal (HRA) for employees. There are various degrees of HRA intervention, ranging from the lowest “touch” (making them available for voluntary completion) to a more intensive involvement (offering incentives and/or integrating data with plan or disease management program data to identify high risk individuals).

Incentives

Incentives for participation in HRAs and/or disease management can be financial or non-monetary. Some employers design incentives to reinforce their benefit plan design, e.g. reducing/eliminating copayments for maintenance drugs, mail order drugs, or compliance with

step therapy protocol. Blue Shield of California and PacificCare offer Web-based health promotion programs that recognize participants through points acquisition, which are then converted to specific rewards. Although incentives for participation in disease management are not widely used today (see **Figure 8**, less than 10 percent of PBGH members report use of incentives for disease management), the trend is growing. Examples among PBGH members include:

- DirecTV (formerly Hughes Electronics) offers a \$300 reduction to employee premium contribution if a member completes an HRA and complies with any recommendation to participate in a disease management program (See Member Profile on DirecTV).
- Pitney Bowes offers a \$150 contribution to a member's Health Care Savings Account upon completion of an HRA and its education program, Health Care University.

- Stanford University is launching a new program to incent employees to complete an HRA and participate in health coaching (See Member Profile on Stanford University in Consumer Engagement Section)

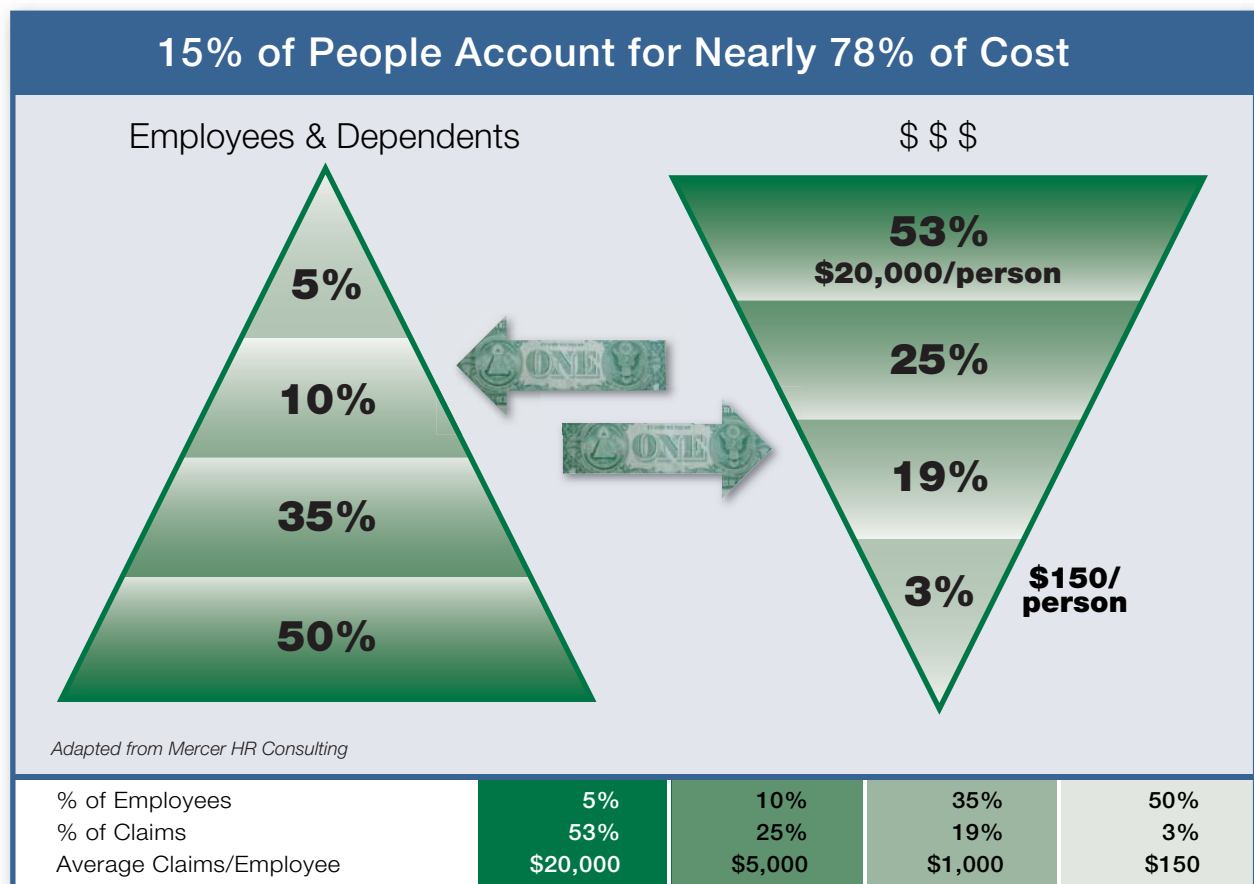
Using Data to Develop a Disease Management Strategy

Consistent with national survey results, about a third of PBGH members report using HRA, pharmacy, claims, and/or other data to inform a disease management strategy.

Evaluating Health Plan Disease Management Services

Purchasers seek to assure that their health plan partners and subcontracted health management vendors are accountable for delivering coordinated services across the continuum of care. Inceas-

FIGURE 7. Small Percent of Individuals Drive Total Cost



PBGH Member Profile #5

DIRECTV

Managing Health and Wellness to Improve Productivity

Recognizing significant costs associated with medical claims and productivity loss combined (estimated at \$7,000 per employee per year medical and \$21,000 per employee per year in medical-related productivity losses), PBGH member DIRECTV implemented a wellness initiative (WorkWell) and disease management for diabetes, asthma, back pain, and congestive heart failure.

Incentives for employee participation are compelling. Employees save up to \$300 on annual premiums, \$250 on preventive services annually, and an initial gift certificate received at time of Health Risk Appraisal completion. To receive the incentives, employees must practice healthy behaviors that meet a wellness goal or must participate in a risk-reduction program.

DIRECTV has worked with its carrier partner and multiple vendors to achieve its health management objectives. After data revealed a higher proportion of at-risk individuals at their call center (higher medical costs and absenteeism 26 percent higher than other sites), DIRECTV designed a site-specific program for this worksite in collaboration with disease management vendor CorSolutions. The program used self-assessment and data analysis to identify at-risk employees, who were incented to participate in targeted disease management. Doctors in the community were identified and involved in the program through outreach for return-to-work collaboration and shared incentives that include a pay for performance component.

The corporate-wide program reaped substantial savings. Third party evaluation of the WorkWell and disease management implementation shows a return on investment of 2.7 to 1. Program participants experience less illness, less absenteeism, and less short term disability.

Considerations for Implementation

- Analysis of priority health conditions that impact medical trend
- Vendor evaluation and selection
- Employee communications strategy
- Design and budget implications of financial incentives and rewards

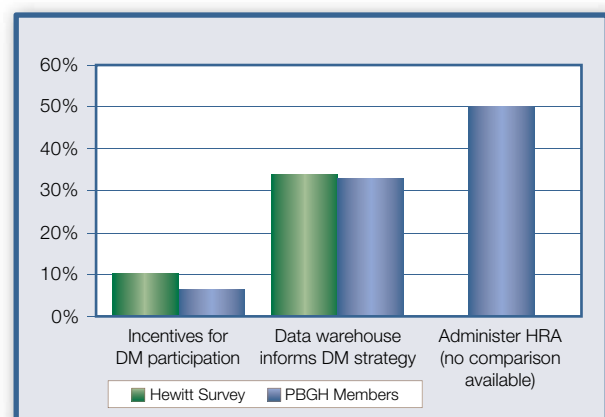
ingly, purchasers are holding plans accountable for reporting information on disease management programs and measuring impact of a program. One way PBGH impacts this area is by assessing health plan disease management services through the annual Negotiating Alliance Request for Proposal process, focusing on member, provider, and vendor interventions, community collaboration, program effectiveness and outcomes. PBGH's audit and review of health plan-based programs indicates that while plans have improved reporting of clinical outcomes, few are measuring the financial impact and quantifying its effect on premium trend.

Buy-up and Outsourced Disease Management Programs

Several PBGH members currently purchase disease management services in one of the following ways: buy-up through a health plan, contracting with a standalone disease management vendor, or outsourcing to a pharmacy benefit manager (PBM). Several PBGH survey respondents are considering some type of disease management "buy up" for 2005. In addition to the annual Negotiating Alliance RFP process, PBGH seeks to advance performance expectations for both health plan-based and vendor-based programs through the Joint Purchaser Group Disease Management Vendor Assessment Project.

Whereas historically, disease management was incorporated into the clinical services provided by health plans insured and self-funded programs, employers are recognizing a rationale for contracting directly:

FIGURE 8. Employer Focus on Disease Management



- Costs associated with chronic illness are huge. Employers may have more control over program quality and measurement when they directly contract for services.
- Health plan delivered disease management is available only for health plan enrollees, resulting in a fragmented system for an employed population with access to multiple health plans. This complicates use of data, and may result in inequitable distribution of services among employees.
- Employers may realize a greater return on investment (ROI) accessing the expertise of a specialized vendor and designing a customized product that is tailored to their unique needs and population mix.

The Disease Management Vendor Assessment assisted purchasers in developing a strategic approach to managing the health of their total population. The Assessment will identify potential best-in-class vendors and establish joint-purchasing contractual options that leverage member volume with that of other employer coalitions that are partnering on the project. This study also enhances existing knowledge and evaluation approaches for plan-based disease management services, supports the development of industry-leading performance expectations, and seeks to establish a common platform for evaluation of ROI.

Important differentiators among the vendors include:

- Infrastructure and use of predictive and behavior models to identify, monitor, and target individuals who would most benefit from a health management intervention.

- Consumer engagement and behavioral change models.
- Provider outreach and engagement.
- Coordination and integration of services across multiple carriers and vendors.
- Use of standardized metrics to evaluate clinical outcomes and members' functional status.
- Measurement of ROI, direct medical cost savings, utilization impact and effect on productivity and absenteeism.

²⁰ The combined cost of medical claims and lost productivity associated with chronic illness is now estimated at \$659 billion annually (Overman S., Living with Chronic Illness, www.dr-overman.com)

Consumer Engagement: Tools and Incentives

High-Value Purchaser Strategies:

- Use consumer engagement tools, resources and information to support employees' value-based decision-making (e.g., provider selection, prescription drug use, etc.)
- Apply principles of preference-sensitive decision making relative to plans, providers, and treatments
- “Activation” of consumers through education of members about the cost of services and the total value of health benefits

Purchasers believe that consumer engagement must be at the core of any value-purchasing and benefit design strategy. Employers not only hold plans and providers accountable for performance in this area, but are also making direct investments to support their members. Through tools and incentives, consumers can become more actively engaged in recognizing and pursuing improvements in the value of their health benefits plan. The opportunities lie in all aspects of plan management, from health improvement strategies that enable a member to better manage health risk, to network design that incents a member to seek a better performing provider or treatment. At the same time, purchasers also recognize the shortage of good evidence on how incentives and information best promote health risk management and selection of better performing providers and treatments.

Consumer Education

Nationally, consumer education is cited by many large employers as the near- and long-term solution to addressing rising health care costs. Many employers believe:

- More educated consumers will make more cost-effective health care decisions.
- Educated consumers will have a great appreciation of the actual costs of using services.
- Member education must be aligned with incentives for cost effectiveness in order to avoid the misuse of negotiating leverage by “high quality” providers.

PBGH employers have committed significant resources to promote consumer education. **Figure 9** (see page 31) shows that over 70 percent provide education on benefit costs.²¹ Communication vehicles include both regular ongoing communications and targeted newsletters upon open enrollment. Employers also integrate information across the full range of health and welfare benefits to educate members about the value of those benefits.

Consumer Plan Choice Tools

PBGH employers are active adopters of treatment option support and plan chooser tools. Benefit design arguably begins with plan choice, and helping a member enroll in a plan whose attributes are best suited for the member is an initial opportunity for engagement. Employers have adopted a variety of tools that assist members in selecting a health plan based on value. Employers have also implemented tools developed by benefits consultants as part of their HR Web portals. Some tools focus on the benefit design comparison or cost differences across options. Others distill an employee's self-identified preferences into a single recommendation. Vendors offering plan choosers include Asparity, Hewitt and WebMD. In addition, PBGH's Health Plan Chooser tool is currently in use by five members that offer a wide array of health plans: PPO, POS, Consumer-directed options and HMOs. They include California-based and national employers that use a range of contribution strategies.

By example, the PBGH Health Plan Chooser (**Figure 10**) enables consumers to self-identify their health status and likely frequency of use of health services, and projects the associated out-of-pocket costs, including the premium contribution. Integrated health plan quality and member experience information helps guide the member to make a value-based purchasing decision, and an integrated doctor directory allows the member to confirm provider availability. Using the tool, the member creates a customized report card of plan attributes and ranks these in order of preference to facilitate selecting a plan. An important goal is to make the relative weighting of these preferences transparent to the member.

Health Plan Tools

Employers also encourage use of health plan information resources and support tools by supplying direct Web links via their Intranets. Many employers rely on health plans to provide information tools and support to access services. To assess the quality of these tools and guide further discussion with plans regarding opportunities for improvement, PBGH used common criteria to evaluate the Web site resources for both California and national carriers (see box). The results were also used to inform investments by employers to

PBGH Assessment

Health Plan-Based Consumer Tools

All plans have expanded Web site capabilities for both public and member use as a central tool for consumer engagement. The majority of plan web sites are providing a broad range of health information, services, products and programs. Although some plans are enhancing their websites to include more interactive capabilities, current features often focus on providing static information and transactional functions. There were no differences in offerings between the PPO and POS products and some differences between the PPO/POS and HMO offerings (provider-only sections of the websites were not assessed).

Services Commonly Offered by All Plans

- Summary plan description information
- General health information
- Wellness/health promotion guidelines and advice
- Chronic disease information
- Provider directory information
- Drug choice options information – prescription vs. OTC, Generic vs. Brand, retail vs. mail
- Quality information on facilities (typically Health Share or Subimo)

Services Offered by Some Plans

- Health content information, customized by disease/problem or demographic segment
- Personal health record
- Shared decision-making information
- Treatment option support
- Self-care information
- Access to personal claims history and transactions

Services Offered by Few or No Plans

- Claims-based "push" personalized health information
- Cost of services or specific procedures
- Cost of service modeling tools
- Quality information on physicians
- Lifestyle behavior change resources

Considerations for Implementation

- Consistency of resources among health plans offered
- Opportunities to work with health plans to create tailored messages
- Maintaining and updating links to health plan tools, along with any limitations regarding member only vs. public access

PBGH Member Profile #6

Stanford University

Consumer Tools and Financial Incentives

Stanford University provides an array of tools and incentives to support member engagement. The University implemented the PBGH Health Plan Chooser to better equip employees to make value-based decisions. Because Stanford's contribution strategy is based on the high-value plan, i.e. all employees receive a standard contribution towards premium regardless of plan selection, the cost differential in selecting a lower-value plan is borne directly by the employees. The tool supports preference-sensitive decisions with consideration of premium and contribution costs, out-of-pocket costs based on likely utilization, plan quality, doctor availability, and plan rules. User experience metrics indicate that over 80 percent of the users found the tool helpful, and 71 percent of the survey respondents intended to switch plans.

Beginning in 2005, Stanford will be uniquely working across plans – PPO, consumer-directed, and network HMOs – to provide incentives for completion of a Health Risk Appraisal (HRA) and participation in health improvement programs. Each plan offers its own HRA. Stanford will pay all participating employees (not dependents) \$100, with incentives for Consumer Driven Health Plan enrollees rolling into the Health Reimbursement account. In addition, Stanford funds up to an additional \$150 of incentives administered through the plans for participation in an applicable health improvement program. Stanford receives aggregate data only from each plan. Because Kaiser's integrated model incorporates assessment and care management, Stanford chose not to implement the premium adjustment/incentive for Kaiser enrollees.

Considerations for Implementation

- Budgeting the incentives to reflect potential volume of participants
- Communications strategy that addresses potential privacy concerns among employees
- Collaboration with health plan partners to support program administration including the definition of health improvement programming eligible for incentive
- Facilitation of reporting requirements with each plan to best enable aggregating data across plans and program evaluation

expand the resources on their HR portals to complement plan tools.

Quality and Performance Information

Employers actively use performance information to hold their health plans accountable, but are often challenged in engaging their members to use health plan and provider quality data to inform their choices. Integrating such information into decision support tools is one approach to increasing uptake. Another option is customization of the information to meet employer and employee needs. Such branding also enables an employer to integrate diverse resources into a package of information tools for members. A number of PBGH members customize the HealthScope Web site or link directly to HealthScope to provide information on health plan, hospital and medical group quality information, along with a California physician directory.

Consumer Incentives

Nationally, employers report interest and success with using financial incentives. The Hewitt Survey responses indicate that 21 percent of employers currently offer incentives for employees that participate in wellness or other health-related initiatives, and 57 percent are considering future adoption. Additionally, while 10 percent of current employers offer incentives for at-risk individuals to participate in condition management programs and comply with recommended therapies, 61 percent are considering future adoption.²²

See the Box for an illustration of Stanford's approach; other examples among PBGH employers were discussed in the Health Promotion Section.

Consumer Support. Health plans and employers are increasingly adopting decision support tools that provide transactional information. As the science evolves around understanding behavior change and preference-sensitive care, there is growing interest in promoting use of Web-based health risk reduction and treatment option support tools that offer information tailored to individual preferences. In some cases, plans and employers are providing health promotion and management services through nurse advice or health coaching programs.

Examples of employer-based initiatives include:

- The University of California has added campus-based health advocates to assist members in resolving health care access and administrative issues.
- California State Automobile Association outsourced care advocacy services to assist retirees in navigating the health care delivery system.

FIGURE 9. Consumer Engagement Strategies of PBGH Employers

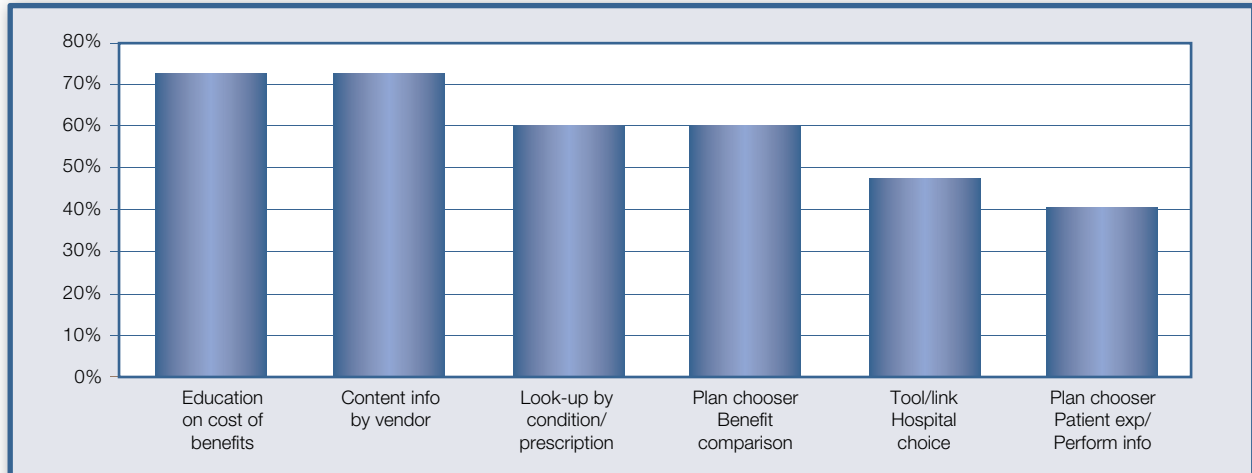


FIGURE 10. Wells Fargo's Customized HealthScope Consumer Information

Wells Fargo Medical Plan Chooser

Navigation: About You | Costs | Doctors | Quality Ratings | Features | Services | Results | ? Help | LogOut

Plan Rules & Features

Medical plans' rules and features affect which doctors you can see, whether you get care that's proven to work and if you're well informed about your treatment choices. Use this page to decide which medical plans' rules and features best fit your needs. [Read more about Medical Plan Rules and Features.](#)

Rate each plan based on how well its rules and features match your needs. **Good fit** means you can do what you want in the areas you care most about. Choose **so-so fit** if the rules or features limit your choice in a key area. **Poor fit** means you think the rules or features restrict you too much in important areas.

Tips: You may pay extra to use certain hospitals, doctors or services in some plans. See the services page for details about coverage.

Health Plan	Rate or Remove Plan	Choosing Doctors and Hospitals	Seeing a Doctor	Getting Help with Treatment Choices	Programs for People with These Medical Conditions	Plan Provides First Dollar Coverage
PacifiCare SV HMO - Northern California	Not Rated	Choose plan providers from list	Must select PCP; referral required for specialist	Nurse advice by phone	Cancer, Coronary Artery Disease, Depression, Heart Failure, Diabetes, End-of-Life & Frail Member Care, Renal Disease, Neonatal Intensive Care	Pay copays/coinsurance
WF Definity Health Plan Gold	Not Rated	Can see non-plan providers but pay more	No PCP required; can self-refer to specialist	Coaching for health problems and treatment choices. Medical care cost estimator online. Nurse advice by phone. Choose a hospital online aid	Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Heart Failure, Diabetes	Pay provider fee with Personal Care Account dollars; rollover any remainder for future years

How to use the Wells Fargo Medical Plan Chooser:

- Tell us **About You** to tailor the tool to your needs.
- See a list of your plan choices.
- Compare the plans on:
 - Costs to you
 - Doctors in the plan
 - Quality of care and service
 - Plan Rules and Features
 - Medical Services coverage
- Remove plans that aren't a good fit.
- See Results and rank plans to help you choose.

I accept the **Terms of Use** for this tool.

Start Comparing Plans Now!

²¹ PBGH members' adoption includes HMOs and PPOs. All strategies listed are exclusive of HealthScope links. Virtually all Californians have access to HealthScope thereby understating this figure's illustration of access to performance data on plans, hospitals, and medical groups.

²² Hewitt Associates, 2004 Future Health Care Expectations Survey.

Retiree Benefits

High-Value Purchaser Strategies:

- Use education and consumer engagement to encourage value-based decision-making
- Provide tools to help employees understand retiree benefits costs and engage in retirement planning
- Support the Centers for Medicare & Medicaid Services' use provider measurement, pay for performance, and public reporting to advance provider performance accountability

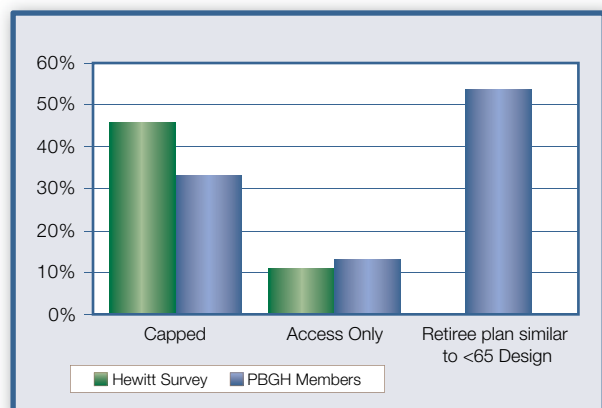
In a national survey,²³ 64 percent of CEOs reported they were “very concerned” about the cost of Retiree benefits. A number of PBGH employers have tiered strategies linked to date of hire or retirement year, and may have a “grandfather” clause for existing retirees or employees that meet specified service requirements. As employers make changes to benefits, affecting members with start dates subsequent to the policy change date, complex layers of “grandfathering” can result leading to administrative challenges and at times, confusion by beneficiaries.

Commercial programs are available to supplement Medicare Part A and B, while the non-Medicare eligible face significantly higher-priced commercial options. Often, employers will adopt an “access only” program, giving retirees access to more competitively priced group rates, but requiring a full cost contribution.

Retiree Contributions

PBGH employers' retiree programs reflect national trends with regard to capping and access-only benefits. A third of responding PBGH members have capped their contribution and several offer access-only, full cost options. Additionally, over half of responding PBGH members report that benefit design (with regard to copays and deductibles) matches that of the commercial population for the majority of their plan choices.

FIGURE 11. Limitations on Retiree Benefits



Supplemental and Medicare Advantage Coverage

The majority of PBGH members provide retiree coverage to eligible beneficiaries through supplemental coverage or a Medicare Advantage program. Enrollment has declined significantly in Medicare Advantage programs in recent years due to health plan withdrawals from higher cost geographic areas. Recent increases in Medicare Advantage payments may help reverse this trend.

Two PBGH employers, FedEx and Safeway, have partnered with AARP to provide supplemental gap coverage for retirees. The coverage is administered by AARP's Employer Account Services division, whose policies are underwritten by United Health Care. AARP's size brings the rate stability and national coverage preferred by some employers, and allows employers to make an optional defined contribution. Retirees may continue to participate in the program, even if the employer ceases its relationship.

Retiree Education and Savings

The Employee Benefit Research Institute recently reported on worker and retiree attitudes about savings and retirement.²⁴ This study indicates a significant overestimation by workers of their likelihood to: (1) work until and into retirement years, (2) maintain benefits through an employer, and (3) an underestimation of the amount of financial resources necessary to fund a comfortable retirement. With employers looking to HSAs and other vehicles for funding retirement programs, communication and education is an important aspect of any program implementation (see Member Profile on Communication with Retirees).

Medicare Reform

Employers are actively evaluating their retiree programs in light of recent legislation. The Medicare Modernization Act (MMA) of 2003 passed by Congress in November contains three key elements relevant to employers' provision of group retiree benefits:

1. The provision of Part D as a Medicare benefit may make employers' provision of a drug benefit duplicative. In order to encourage employers to maintain coverage, CMS will

PBGH Member Profile #7

ChevronTexaco & University of California

Expanding Retiree Education and Communication

Retirees and their dependents are a complicated group to communicate with. They don't have immediate access to office-based communications, they have varying levels of ability to use communications media and understand complex messages, and they are bombarded with, at times, conflicting messages about their options and products geared to the individual direct-sale marketplace. Pair that with potentially multiple levels of retiree benefits available due to grandfathered policies, and it is understandable that benefit managers sometimes spend precious time on the phone with individual members and their families, attempting to navigate the chaos. Two PBGH members are addressing the challenge head-on with their online, user-friendly information for retirees posted on publicly available websites.

Using a question and answer format, University of California hosts <http://atyourservice.ucop.edu>, a self-serve center featuring a Retirement Plan Benefit Estimator that helps employees calculate their future retirement benefit. Armed with it, and the Fortune Forecaster, employees can estimate required savings to accommodate their anticipated retiree date. Additionally, through the At Your Service portal, employees can access their retirement account balances and general investment strategy information.

ChevronTexaco maintains information at <http://hr2.chevrontexaco.com>. This indexed portal enables access to published materials, newsletters, communications, and plan descriptions all in easily printable PDF format. Additionally, an automated video clip informs users how they can, via a password-protected login, access personal benefit account information and the company's plan chooser tool. Employees also have password access to a Retiree benefits calculator that estimates pension benefits and retiree medical contribution eligibility.

Considerations for Implementation

- Variable retiree Internet access and potential need for multiple mediums
- Communications might be more encompassing than benefits alone, branching into policy and interpretation of regulations
- System support of interactive tasks, e.g. account management, update profile, etc.

provide a non-taxable employer subsidy equal to 28 percent of all expenditures between \$250 and \$5,000 per beneficiary when Part D has been waived and the employer provides an actuarially equivalent plan.

2. Enriched provider payments for Medicare Advantage plans encourage greater geographic coverage. Additionally, Medicare Advantage plans will include a drug benefit that is actuarially equivalent to Part D, or beneficiaries may enroll in Part D to complement their Medicare Advantage plan.
3. Rules allowing tax-deductible contributions to a Health Savings Account (HSA) by the employee and/or employer offers another vehicle for retirees. HSAs provide tax incentives for employees to save for medical expenses after retirement, while at the same time encouraging them to make value-based decisions when spending “their” money.

Actuaries evaluating an employer’s eligibility for the subsidy based on a program’s actuarial equivalency will consider contribution strategies and benefit levels.

Benefit Planning in Response to MMA and Part D Prescription Drug Benefits

While navigating the new terrain laid out by the MMA, employers have a number of options to consider, all of which are variations of these three approaches:

- Continued provision of an actuarially equivalent plan with receipt of the federal subsidy.
- Design of a “wrap around” benefit that enriches the Part D plan, for which no subsidy would be rewarded. Employers would likely save money compared to previously provided comprehensive coverage.

- Cessation of a retiree drug benefit altogether with recommendations to retirees to enroll in the Medicare Part D benefit.

Despite an oft-quoted New York Times article²⁵ expressing concern that employers will use MMA as an excuse to discontinue coverage, most employers anticipating a decrease of retiree benefits are not doing so in response to the MMA, but are continuing down the path of a strategy put into motion prior to Medicare reform. At least one PBGH employer is instituting a plan to augment the Part D benefit by covering the Part D mandated “gap” of \$2,850 thereby prolonging employees’ required “TROOP” (true out-of-pocket costs) before catastrophic coverage is instituted.

Large Purchasers Informing Medicare Reform

In the Medicare reform debate, PBGH successfully advocated for reforms that would begin to build into Medicare quality measurement and rewards for more efficient delivery. CMS’s adoption of provider measurement and pay-for-performance contributes significantly toward the tipping point of overall transparency and accountability. This momentum, together with the forces affecting the commercially insured population, will result in the changes necessary to assure higher quality care delivered more efficiently.

²³ Kaiser/Hewitt 2003 Survey on Retiree Health Benefits, January 2004.

²⁴ “Will Americans Ever Become Savers?” Employer Benefit Research Institute, The 14th Retirement Confidence Survey, 2004, Issue Brief 68, April 2004.

²⁵ Drug Law is Seen Leading to Cuts in Retiree Plans, New York Times, July 14, 2004.



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