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Apply Medical Data Tools to Manage Cost and Improve Care

by Jerry Reeves

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Administrators and trustees of employee benefit plans are beset with the daunting challenges of very high medical cost increases and low worker salary increases. For most of the past 15 years, the annual cost trends for health insurance premiums have been more than three times higher than the increases in worker salaries. Access to affordable health insurance has become a primary reason to join a union. Aggressive tactics are required to survive and thrive in this era of high expectations and poor delivery of health care. Fortunately, using enhanced information tools combined with incentives to change behaviors offers hope to overcome the present chaos in health care. Following is a review of the impacts from applying medical data tools to manage cost and improve care in our health and welfare trust serving 50,000 hotel and restaurant employees and their 70,000 family members in Las Vegas.

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Apply Medical Data Tools to Manage Cost

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Sources of Cost

We use medical data analysis tools to evaluate cost drivers. Our health costs are primarily driven by payments to participating physicians (31%) and hospitals (23%) and for drug costs (20%). Only 6% of patient visits to the local University Hospital emergency department are for true emergencies. More than half are for urgent conditions that could be safely handled in extended-hours urgent care clinics, and more than one-third would be more appropriately handled in a doctor's office. The conditions leading to hospitalizations following emergency room visits are primarily heart disease and lung disease, followed by digestive disorders and infections.

Many visits to doctor offices could be handled well by phone or e-mail if payment incentives were properly aligned. Only 37% of visits are for new symptoms. The two most prevalent conditions managed at doctor office visits are colds and lower back pain. About 30% of doctor visits are for a routine check of chronic problems such as arthritis or high blood pressure, and 6% are during flare-ups of chronic conditions. Most of the rest of the visits are devoted to the worried well.

We collate information about physician practice patterns and display payments in episode treatment groups. Variations in cost for physician care are determined not only by price per unit of

service, but more dramatically by the number of units of service per episode of care. For instance, a bronchitis episode might include payments for the physician's professional services, a chest x-ray and blood tests, antibiotics and perhaps for hospitalization. Such episode treatment groups have been widely tested and validated and are commonly used for physician profiling.

The table shows examples of payments we made to physicians in four specialties for episodes common in their practices. Physicians in each specialty were arrayed by average cost per episode when they treated at least ten such episodes. Outcomes of treating these episodes were similar except for the dramatic differences in cost. The most expensive internists and family practitioners were more than seven times as expensive as the least expensive peer in their specialty. Cardiologists generated more cost for managing chest pain patients than internists. The most expensive cardiologist generated \$1,000 more cost per chest pain patient than the lowest cost cardiologist. And the most expensive orthopedist generated \$7,000 more cost on average per knee surgery than his least expensive competitor.

After considerable deliberation and consultation regarding the overall needs of our participants, our PPO health plan found it could not afford about 3% of the providers in its network of 800 providers. Cost trends for PPO physician services had increased by 4.2%, respectively, during the year preceding our decision to discontinue contracts with these 55 providers. During the year following the

network changes, PPO physician costs increased only 0.2%. We believe extra savings and performance improvements were realized through ripple effects on other providers in the network. For instance, our annual hospital cost trend decreased from +3.9% just before the intervention to +1.4% in the following year.

Communities may develop widely disparate health care patterns over time. For instance, our region generates higher medical costs for Medicare beneficiaries in the last six months of life than about 70% of other regions. The highest cost regions generate 113% higher-than-average rates of inpatient visits and 52% higher use of hospitals and specialists for similar patients with similar conditions (Fisher et al. 2003). However, access to care and measures of quality are no better, and measures of prevention are worse. More dollars did not buy more quality.

Other factors subject to data analysis tools that worsen medical costs include labor and professional shortages, waste, fraud, new technologies and new drugs. When misaligned payment incentives reward being busy (more doctor visits) rather than better outcomes (diabetes and blood pressure in control), it can be helpful to report performance comparisons and provide incentives related to performance results. Sophisticated information analysis and reporting tools are now available to display important sources of avoidable variance from expectations. Root cause analysis of the variations and sustained corrective actions can yield significant savings and improved outcomes.

Physicians as Cost Drivers

Specialty	Condition	Low	Average	High
Family Practice	Otitis media	\$ 46	\$ 109 (+137%)	\$ 412 (+796%)
	Bronchitis	\$ 89	\$ 150 (+ 69%)	\$ 771 (+766%)
Internal Medicine	UTI	\$ 81	\$ 140 (+ 73%)	\$ 778 (+860%)
	Angina	\$ 86	\$ 297 (+245%)	\$ 743 (+764%)
Cardiology	Angina	\$ 241	\$ 611 (+154%)	\$1,389 (+476%)
Orthopedics	Knee surgery	\$2,727	\$4,473 (+ 64%)	\$9,383 (+244%)

Table

More than 80% of the costs of health coverage are due to medical conditions and characteristics of patients. Less than 20% of the costs are subject to administrative improvements. Shifting more health costs to participants may help engage patients in making value-based health purchasing decisions. But to achieve sustained reduction of health cost trends, these health service users must understand their health risks and be committed to healthier lifestyle choices and preventing complications of their diseases.

We implemented Web-based health information tools for our participants and their care support teams. Participants who complete our health risk appraisals learn whether their body is older or younger than they thought and receive guidance on the specific steps they can take to achieve a younger health age. Many actions under their own control can reduce their risk of heart disease, diabetes, lung disease and cancer. Tips to avoid injury, reduce stress, reduce fractures, reduce pain and deliver a healthy baby are disseminated online, by phone, by mail and through personal visits. Surveys, interviews and data analysis help identify patients with barriers to good care. These include transportation limitations, cultural expectations, limited health literacy, poverty and disabilities. We are developing targeted programs to meet the most pressing needs of our population. Online tools and directories help members choose top-performing physicians who speak their native language and have convenient locations and office hours.

Organize Information Sources

There are many sources of information available to health plans. Valuable data buried in medical, mental health, laboratory and dental claims are often overlooked. Early in developing information tools it is important to choose actionable important data elements, clean up double entries, test data validity, choose proper case mix adjusters and implement unique identifiers of physicians and patients. Even in a PPO health plan with free choice of providers, it is possible to link patients to particular physicians. The behavior of the patients reflected in medical claims can indicate who the patient believes is her doctor. Perhaps more than 50% of the evaluation and management

visits in a year were to a particular physician. Or more than 30% of the costs of an episode of care were incurred by an ordering physician.

Combining laboratory test results and pharmacy claims with cost-and-use information in medical service claims adds the ability to determine whether patients diagnosed with disease are filling recommended prescriptions and improving control of their chronic illness. Our health risk appraisals and on-site health screens substantially enhance the ability to create personal health records and health protection checklists for the patient and her caregivers.

Use Information Tools to Improve Provider Performance

The essence of applying information tools to manage health care cost is comparing case mix-adjusted measures of cost per unit and number of units of service with benchmark measures in similar populations. A variety of public and private sources publish charges, payments and utilization patterns of physician, hospital and pharmacy services in various regions of the country. Physician patterns of care may be displayed by episode type, specialty, practice size and payer type. Hospital patterns may be displayed by admission rate, length of stay, readmission rate, risk-adjusted mortality and risk-adjusted complication rates. Pharmacy patterns may show percent generics, cost per prescription and prescriptions per 100 doctor visits. Newer information tools display gaps in care—missed opportunities to deliver needed medical services. Often the reports display observed occurrences compared to expected occurrences. They may report both with and without severe outlier cases.

The information is only helpful if it is shared with owners of the processes of care—physicians and patients. Transparency generates accountability. When the comparisons are risk adjusted and specific behaviors contributing to the differences are identified, physicians often implement changes that bring themselves more in line with their peers. The volume and intensity of performance changes are proportional to the market clout of the requesting party (health plan,

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HEALTH CARE — ADDITIONAL Resources

Article Briefs

Abstract Health Information Technology Widely Praised, Slowly Adopted

Health information technology, utilizing electronic medical records, electronic prescribing, regional medical information networks, computerized physician order entry and physician use of handheld devices, has the potential to reduce medical costs for employers and improve health care quality. It can cut costs, reduce errors and simplify implementation of disease management programs. However, since the benefits are more immediate for insurers and employers, health IT has not been embraced by doctors. Thus the adoption of health IT looks to be inevitable, but far from immediate.

Leah Carlson.

Employee Benefit News,
December 2004, pp. 41, 46.
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employer, payer coalition) and the perceived importance to the requestor. If the requestor's beneficiaries comprise less than 10% of that physician's practice, and the message is conveyed only as a routine mailing, it is unlikely to significantly influence the doctor's behavior. On the other hand, if the requestor represents a coalition of large employers and health payers whose participants comprise more than 25% of the doctor's practice and the performance report card is timely, delivered in person and associated with financial rewards for better performance (or penalties for poor performance), the doctor's behavior is more likely to change in response to the feedback.

Involve Patients and Physicians

The Institute of Medicine, Rand Corporation, National Committee for Quality Assurance (NCQA), Center for Medicare and Medicaid Services (CMS), Leap Frog, National Quality Forum, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and others have taken steps to address the woeful gaps in care and patient safety prevalent in hospitals and doctors offices. Between 30% and 60% of patients with heart disease, diabetes, pneumonia, decubitus ulcers and cancer do not receive care that medical evidence shows they should be receiving. After more than 25 years focused on doctors, hospitals and health plans, the quality movement has not substantially eliminated quality gaps. We must focus on directly helping patients make informed and timely health decisions for themselves. Doctors advise; supporters advocate; but the patient decides what treatment he or she will seek and accept.

Information tools on the Internet are becoming ubiquitous for every imaginable decision. And consumers are seeking answers to their health questions for themselves and their loved ones more and more frequently. About 70% of Americans use Internet. The adoption rate of the Internet has been much more rapid than the adoption rates of telephones and television.

Most people self-diagnose frequently—whether it's a decision that a headache is not a brain tumor and a cough is not lung cancer, or a decision that Junior's runny nose does not require an immediate trip to the hospital. For up to 40% of doctor visits, and for more than 100 common

medical conditions, self-care is the treatment of choice. There are now more than 600 potent medications available over the counter, previously available by prescription only. Patients who self-diagnose and self-treat have much higher success rates than in the past.

Unfortunately, the rushed physician encounters so prevalent today do not satisfy the needs of patients. In a recent study of 1,000 doctor visits leading to 3,500 clinical decisions, patients were provided adequate information to make informed decisions about their choices less than 10% of the time on average. Another study showed that more than 50% of the medical information provided by doctors during medical visits is forgotten instantly. Therefore, patients require comprehensive health information and support in addition to any advice they receive from busy physicians in order to close care gaps and prevent avoidable complications.

On average, Americans receive more than 250 attempts to get their attention to make some decision daily. These might be advertisements on TV or radio, ads in newspapers and fliers, phone calls, e-mail spam, infomercials, etc. It is unreasonable to believe that four brief doctor visits a year would substantially influence patients' health care decisions. More than 99% of their health decisions are made between doctor visits. Multiple touches by mail, phone, flier, e-mail and personal contacts are likely necessary to effect behavior change.

The information is most helpful when it is available during those fleeting teachable moments—when a life circumstance has focused the person on making an important health decision. At that moment, the patient needs credible, understandable guidance relevant to the needs at hand.

We have implemented a suite of online health decision support tools developed by practicing physicians certified in 20 specialties. These personalized tools on the fund's Web site guide the participant through questions about their symptom or concern to most likely answers about "what might I have and what should I do?"

Family members, trusted friends, health educators, care navigators, health coaches and health professionals can access these tools through our Web site to assist members. We provide answers to questions

about finding a medical home, covered services, health plan copays, participant eligibility, health risks, explanations of conditions and treatment options, whether new treatments have been proven safe and effective, community resources for cancer victims, comparisons of costs of various treatment options, and many other relevant and helpful health information items. Helpers and professionals can print relevant handouts from the Web site and patients may access these directly.

These information tools are available with staff helpers at our customer service center and will soon be available in our health promotion center and participating physician offices. The layperson natural helpers, health coaches, health educators and caregivers access the Web-based tools to provide medically sound information on prevention and early care while they offer psychological support and practical coping tips. They encourage self-education, personal responsibility and assertiveness. The physician retains the responsibility to listen carefully to the patient, then to assess the patient and recommend best treatments.

Leveraging these complementary approaches to accomplish more patient understanding, appropriate self-care and prevention is reported to return more than \$3 for each dollar invested in the outreach programs.

In addition to multiple touches to engage patients, we use data to develop specific actions and to-do lists for patients and doctors. We use claims data to identify care registries for physicians—lists of their Culinary Fund patients with diabetes, for instance. We then generate lists of high-priority expectations (such as blood tests, eye exams and blood pressure treatments) that our claims information suggests have not been completed. We send these notices to both the patients (consider talking with your doctor about these) and physicians (your patient may soon ask you whether this service has been done recently). Studies have shown that those who receive the clinical reminders (diabetes, heart disease, lung disease, breast cancer, heartburn) are statistically much more likely to accomplish the treatment, at a net savings of \$1.3 million per year for a plan with 100,000 participants. The return on investment is more than \$4 for each \$1 spent.

Mail reminders directly to physicians

only about specific medical care gaps such as the apparent need to prescribe specific blood pressure, cholesterol, diabetes and heart failure medicines also result in statistically significant increases in adherence to nationally recommended treatment guidelines. The return on investment in the first year is about \$1.50 for each \$1 spent on the program. Sustained outreach programs to physicians and patients to improve adherence to treatment guidelines and modify lifestyle choices like smoking, sedentary behaviors, overeating, social isolation, seat belt use and substance abuse can substantially decrease health cost trends and help ensure ongoing affordable health insurance coverage.

Focus on Pharmacy

Pharmacy costs represent our third most expensive source of health costs behind physicians and hospitals. Substantial savings are available through increasing the proportion of prescriptions filled with generic drugs. There are more than 1,300 effective generic drugs available to treat more than 90% of the prevalent medical conditions. Many blockbuster drugs are no longer protected by patents and are available over the counter (Prilosec, Claritin, Naprosyn) or as generic drugs (Mevacor, beta blockers, ACE inhibitors, oral diabetes drugs, blood pressure drugs, pain medicines, antibiotics). On average, each generic prescription costs about \$55 less than the average cost for brand-name drugs.

We have combined several interventions to engage our physicians and plan participants in preferentially using generic drugs. They can access direct comparisons of brand-name drugs and the generic alternatives on our Web site by clicking on the drug currently prescribed, the dosage strength and the condition being treated. The current drug is explained including its cost, followed by descriptions of generic alternatives and their lower costs. This can be printed for further discussion and consideration.

As with most interventions, we believe more people will engage if there are incentives. We implemented a three-tier formulary in June 2003. At retail pharmacies the copay is \$5 for generic drugs, \$13 for preferred brand drugs and \$28 for nonpreferred brand drugs. Then we

opened a free pharmacy for members in October 2003. They can fill prescriptions for 250 generic drugs at our main campus with no out-of-pocket expense.

In June 2004 our coalition of 22 large employers and health trusts rolled out a generics campaign at worksites and through radio, newspaper and billboard ads. We also visited our busiest doctor offices, showing them their prescribing patterns compared to their peers and a listing of the specific generic alternatives available that could still achieve their desired outcome and save their patients substantial out-of-pocket expenses. Our annual pharmacy cost trend decreased from 10% the year before to 1% the year after beginning these interventions. Savings the first month after starting the three-tier formulary was \$154,000.

In November 2004, the savings was \$699,000 compared to the baseline month. Generic prescribing increased from 39% before the interventions to 53% after the interventions. In 15 months, we saved approximately \$8 million, even though prescriptions filled per member per month increased by 8% and patients were filling more of their cardiac drug prescriptions.

When we review our total medical cost trends, we see that they decreased from 5.8% annual increase in the year before to 3.7% annual increase after adding more health information interventions. We

continue to enhance and adjust programs according to need and opportunity.

Summary

Increased use of medical data and health information outreach programs create significant change in how clinicians practice, hospitals operate and patients navigate through our complex, fragmented health care system. Early results indicate health care cost trends decrease and care improves.

Perhaps the most daunting challenge to prevailing illness and complications is getting participants' attention and building their confidence that they can improve their health. Information tools, frequent touches and relevant incentives are engaging more and more of our participants in sustained care improvement interventions.

B&C

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