

*A new health plan model invites plan sponsors to shift to a high-performance health plan that emphasizes quality and also contains costs. The model identifies individuals who are high users of care and actively intervenes in their treatment to ensure each patient receives high-quality, appropriate care for their condition from high-quality providers. Managing people, rather than diseases, makes the model work, as studies have shown. Sponsors must invest in tools and administrative support processes to measure financial, quality, clinical and behavioral data; modify plan design to support desired behaviors; guide participants to high-quality facilities by procedure; lower barriers to appropriate care; and educate participants and the community about the new plan model.*

# A Fresh Approach to Managing the Cost of Health Coverage: The Link Between Quality and Cost

by **David Blumenstein**

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It's time for a fresh approach to a persistent challenge: managing increases in the high cost of health coverage. For the last eight years increases in health insurance premiums have consistently outpaced increases in workers' earnings and overall inflation. Figure 1 illustrates the pattern through 2004. In 2006, although trend rates for medical plans are forecast to decline for the third consecutive year, they are still expected to be three to four times the rate of general inflation.<sup>1</sup>

This status quo is unsustainable. One need only look to the headlines to know that spending on health care for both active workers and retirees is so high that it is endangering the survival of many organizations, both large and small. Some argue that as health care spending takes an ever-increasing portion of our gross domestic product, it is hurting our global competitiveness.

The strain of paying for the ever-increasing cost of health coverage is particularly acute for multiemployer health and welfare funds. Health inflation is outstripping contribution increases. Wage increases have been limited for years by competitive con-

ditions in many industries. Health and welfare funds cannot turn to companion pension funds for assistance in the form of contribution diversions, as they did in the early 1990s, because those funds are also under serious financial pressure. Compounding the challenge of paying for health coverage is the coming retirement of the baby boom generation, which will be financed by smaller succeeding generations of workers.

What can plan sponsors do? This article makes a case for a new health plan model that invites plan sponsors to shift how they define a high-performing health plan, placing an emphasis on quality. Core components of the new health plan model include identifying individuals who are high users of care and actively intervening in their treatment to ensure they receive all appropriate care for their conditions, and guiding participants to high-quality providers.

### Flaws in the Current Health Plan Model

The current health plan model focuses almost exclusively on managing the price

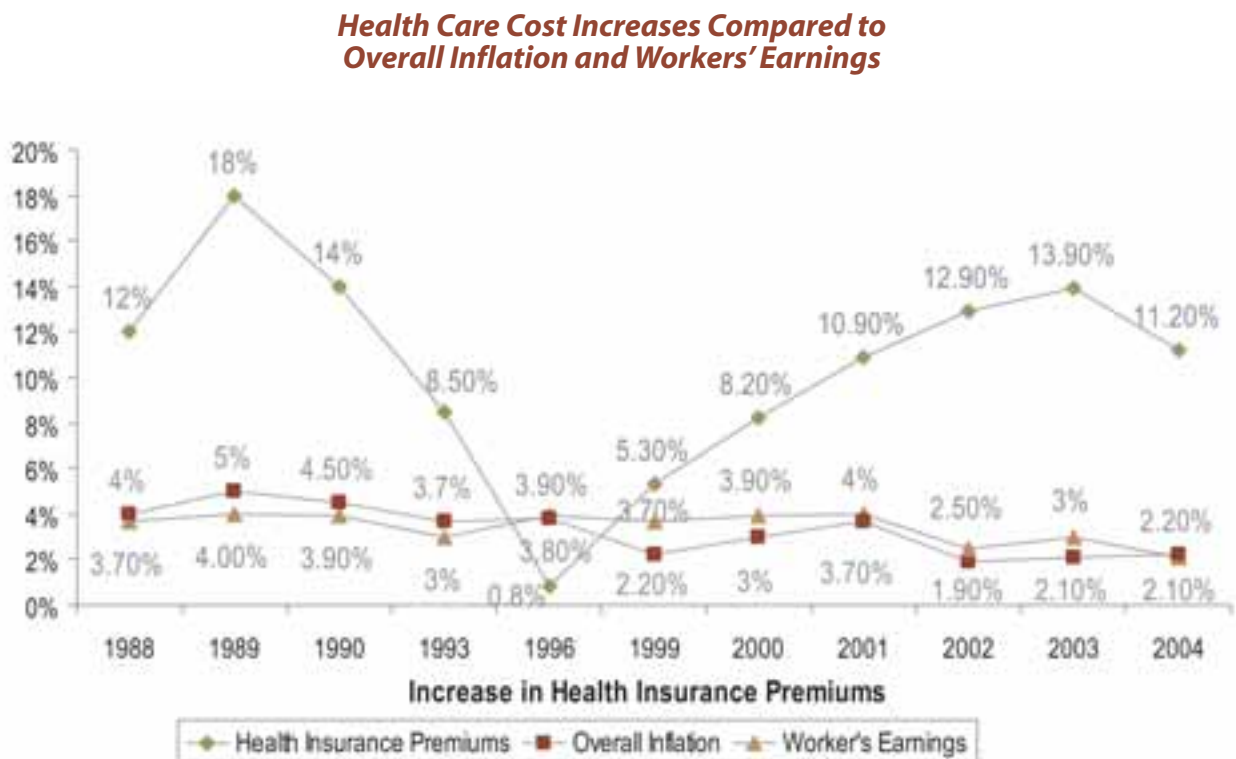
of health care through discounts and providing access to health services through physician and hospital networks. When the current model fails to manage costs, plan sponsors face a limited—and painful—array of choices: cost shifting to plan participants, eligibility restrictions and benefit reductions.

The current health plan model is flawed in other ways. It does not manage and reimburse based on the delivery of health care quality, treatment outcomes and patient safety. Moreover, there are few, if any, incentives for efficiency and medically appropriate utilization. Plan participants are expected to navigate the health care system themselves with too little information about physicians, hospitals and medical best practices.

As important as the flaws are the solutions—or lack of solutions—being promoted by both the private sector and our country's leadership. The ideas of group responsibility and *risk pooling* (i.e., covering a large group for unpredictable events in order to lower the financial risk for

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Figure 1



Source: Kaiser Family Foundation 2004 Annual Survey.

### *Aspects of the U.S. Health Care System: The Good, the Bad and the Ugly*

The following eye-opening statistics put U.S. health care spending in perspective: The United States now spends more on health care than on automobiles. U.S. spending on health care per capita exceeds China's per capita spending on everything. Despite the expense, there is much to applaud about the U.S. health care system. The care it delivers is among the most advanced in the world and, in some cases, is the most advanced. In fact, the cost of care in the United States is being driven less by pure inflation than by the consumption of increasingly sophisticated care. Ever-improving, sophisticated medical technology makes all of the following possible: more accurate diagnosis, better treatments and less invasive procedures. New specialty drugs are being genetically engineered to target and treat specific diseases.

Reassuringly, the rate of growth in health care spending in the United States is similar to that of other industrialized countries. However, our national per capita spending on health care is more than double the industrialized world's median: \$5,267 compared to \$2,193 in 2002, according to data published this year by the Organisation for Economic Co-operation and Development (OECD).

Unfortunately, high per capita spending does not ensure uniformly good news about the U.S. health care system. The bad news includes the fact that, compared to other industrialized countries, Americans go to the doctor less often; are less satisfied with health care received; have lower life expectancy; have lower-than-average childhood immunization rates; and have a much higher infant mortality rate.

There is an ugly aspect to the U.S. health system. Despite spending more than other industrialized countries on health care, the United States is the only industrialized nation without some kind of national insurance. Consequently, there are 45 million uninsured Americans. Half of these people owe money to hospitals and 33% of the uninsured are being pursued by collection agencies. Unpaid medical bills are the leading cause of bankruptcy in the United States. The death rate for the uninsured is 25% higher than for those who have insurance.

Such incomplete or poor-quality care drives costs: Preventable adverse drug events in hospitals alone cost \$2 billion per year. The annual tally for all medical errors is \$37 billion. It has been estimated that improving quality and efficiency could reduce annual health care spending in the United States (\$1.7 trillion in 2004) by 15-30%.

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everyone in the group) are under attack. In addition, there appears to be no serious discussion of true national health care reform, despite the fact that the imperfections of the current health care system, briefly discussed in the above exhibit, seem to underscore the need. This makes it even more crucial for plan sponsors to have workable strategies at their disposal to deal with the skyrocketing cost of health care.

#### **Shattering Prevalent Health Care Myths**

The way plan sponsors have adapted to the current health care system is based on several myths about quality and cost. It is important to understand the reality that is masked by these myths because this knowledge enables plan sponsors to de-

sign and employ strategies to better manage cost and care.

**Myth: Providers deliver high-quality health care.** Consider the following sobering statistic from the Institute of Medicine, which shows that providers are all too human: 225,000 people die in the United States each year due to "preventable hospital and pharmaceutical drug errors."<sup>2</sup> (To put that large figure in context, it is exactly half the number of people who die annually from *all* cancer-related causes and about one-third of the number of people who die from heart-related conditions. It is the equivalent of 25 people dying *every hour of every day* of the year.)

**Myth: Like many other products and services, higher cost health care means higher quality health care.** Data proves that there is not necessarily a connection

between cost and quality. Both low-cost and high-cost providers deliver high-quality care, and there is evidence that high-quality care will oftentimes be less expensive. See Table I for an enlightening comparison of risk-adjusted data for angioplasties at six hospitals in the Washington, D.C. area. The data reveals that the hospital with the lowest average charges for this procedure (Hospital B) performed the procedure with the second highest frequency, had the lowest average length of stay and had the lowest mortality rate (equal to that of one other hospital).

**Myth: There is little variation among providers in terms of the quality of care they provide.** In fact, like the cost of health services, quality varies widely. Complication and mortality rates differ. Moreover, a 2003 Rand Corporation study

### Sample Variations in Costs and Quality for Angioplasty at Six Hospitals in the Washington, D.C. Area

Table I

	Volume	Mortality Rate	Complication Index	Average Hospital Charges	Length of Stay (days)
Hospital A	1,351	Less than 1%	184*	\$29,854	3.1
Hospital B	930	Less than 1%	110	12,441	2.6
Area Average	320	1.03%	100	37,941	3.1
Hospital C	205	1.32%	123	36,297	3.7
Hospital D	151	2.27%*	125	42,122	3.2
Hospital E	145	1.80%	41*	25,677	3.2
Hospital F	101	1.62%	171*	29,428	3.1

\*Statistically significant.  
Source: HealthShare Technology.

on the quality of U.S. health care found that Americans receive only 55% of care recommended by their own doctor or best practices. Table II presents data from that study on the percentage of recommended care received by condition.

**Myth: The solution to managing high health care costs lies in controlling administration costs and vendor fees.** Although controlling the cost of plan administration and managing vendor fees are important components of managing cost and can continue to yield incremental savings, there are opportunities for deeper savings. Estimates are that improving quality and efficiency could reduce health care spending by 15-30%.

**Myth: Encouraging plan participants to become educated “consumers” of health care services—by increasing cost sharing, creating individual health accounts and/or introducing consumer-directed health plans—will be enough to manage health care costs.** The logic behind this “consumerism” approach is that requiring people to spend their own money first will encourage them to act more responsibly and become smarter consumers of health care. Although no one seriously disagrees that a more informed participant is a good thing, the major flaw in this logic is the fact that a relatively small percentage of any health plan’s population is responsible for the vast majority of health care spending. A 2003 study by the Kaiser Foundation Health Plan found that 30% of the population is responsible for 90% of the health

care costs and that 1% is responsible for 30% of all health care expenditures.<sup>3</sup> The people who are spending the dollars in our system are not just spending a few hundred dollars per year. They are individuals with a single medical condition or, more likely, multiple medical conditions for which serious care is needed. The question is: Are they receiving the care they need and is the care they receive high quality?

### Defining a High-Performing Health Plan: Managing Costs and Managing Health

Knowing the truth about the U.S. health care system gives plan sponsors a new perspective on what a “high-performing” health plan means. The current financial and administrative measurements of a

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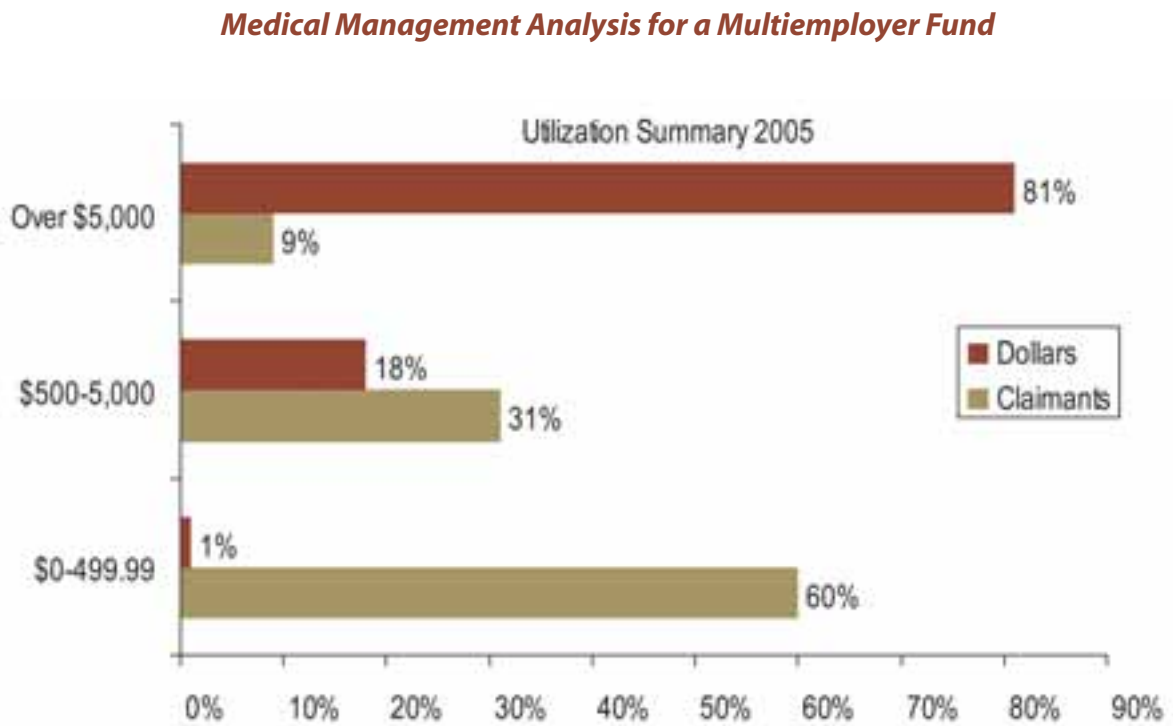
Table II

### Percentage of Recommended Care Received by Condition

Low back pain . . . . .	68.5%
Coronary artery disease . . . . .	68.0
Hypertension . . . . .	64.7
Depression . . . . .	57.7
Orthopedic conditions . . . . .	57.2
Colorectal cancer . . . . .	53.9
Asthma . . . . .	53.5
Benign prostatic hyperplasia . . . . .	53.0
Hyperlipidemia . . . . .	48.6
Diabetes mellitus . . . . .	45.4
Headaches . . . . .	45.2
Urinary tract infection . . . . .	40.7
Hip fracture . . . . .	22.8
Alcohol dependence . . . . .	10.5

Source: Elizabeth McGlynn et al., “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, Vol. 348:2635-2645, June 26, 2003 (No. 26).

Figure 2



Source: InforMed.

plan's health—the adequacy of reserves, the competitiveness of discount arrangements and fees with service providers, and the efficiency with which it is run—remain important, but plan sponsors should also be looking at additional performance measurements and asking themselves related questions:

- *Quality care:* Are we delivering quality care?
- *Clinical care:* Are participants receiving the clinical care they need?
- *Participant behavior:* Are participants actively engaged in managing their own health?

The new health plan model focuses on managing health, as well as managing costs. To manage health, plan sponsors should devote their efforts to achieving the following goals:

- Organizing targeted interventions for high-risk participants and at-risk participants (i.e., those who have asymptomatic illness or disease)
- Guiding those who need care to high-performance, high-quality providers, especially for elective procedures driving a large percentage of plan cost.

The new health plan model emphasizes the care that individual participants receive.

It links quality and cost because managing people, rather than diseases, lowers costs, and studies have shown that using high-quality providers can lower costs.

Significantly, in the new health plan model, everyone has a new role. The plan sponsor acts as a facilitator, providing new tools and information, as well as a financier. Participants must be active and informed consumers of health care services, rather than passive recipients of care. Providers are less dominant in directing care and must become more accountable caregivers. Managed care organizations become case managers and advocates, instead of overseers and gatekeepers.

In addition, administration and quality measurements are different in the new health plan model. Administration is integrated rather than disconnected. Quality measurements are made at the individual level rather than the network level.

### Intervening in the Health Care of Selected Participants

As a first step to pursuing the new health plan model, plan sponsors may want to use *health-risk profiling*, which measures the health of the plan popula-

tion and divides the population into various “buckets”: healthy, at-risk and living with disease. A more important tool is *predictive modeling*, which identifies *individual high-risk* and high-cost users within a population in advance of the expenditures by looking at historical patterns of utilization. These are the participants who are driving a high percentage of cost and will benefit from targeted, clinical intervention. The fact that half of the growth in health care spending is for conditions like asthma, obesity and diabetes' underscores the need for managing these chronic conditions.

Figure 2 shows a medical management analysis for a multiemployer health and welfare fund in the Midwest, which reveals that 9% of claimants in 2005 had more than \$5,000 in claims in 2005. The data in Table III shows gaps in the care that these individuals should be receiving.

Targeted, clinical intervention through personal health advocacy programs typically uses nurse coordinators, who assist the primary care physicians and patients in order to achieve financial, clinical and behavioral improvements. They help educate and monitor patients who have chronic conditions. They promote com-

**Health Risk Profiling:  
Evidence-Based Medicine Indicators and Protocols for Diabetes Mellitus:  
Analysis of a Multiemployer Fund**

<b>CARE PATTERN</b>	<b>Not Compliant</b>	<b>Compliant</b>	<b>Total</b>	<b>Percentage Compliant</b>
Patient taking insulin with evidence of self-monitoring blood glucose testing	28	0	28	0%
Patient that had a physician assessment in last six reported months	92	86	178	48
Patient that had a triglyceride test in last 12 reported months	97	80	177	45
Patient that had an LDL cholesterol in last 12 reported months	95	82	177	46
Patient that had an HDL cholesterol test in last 12 reported months	93	84	177	47
<b>DISEASE MANAGEMENT</b>				
Patient that had an annual screening test for diabetic nephropathy	141	29	170	17
Patient that had an annual screening test for diabetic retinopathy	159	16	175	9
Patient that had at least two hemoglobin A1C tests in last 12 reported months	124	52	176	30
Patient with a diagnosis of diabetic nephropathy, proteinuria or chronic renal failure that are prescribed an ACE-inhibitor or angiotensin receptor antagonist	3	0	3	0
<b>MEDICATION ADHERENCE</b>				
Patient compliant with prescribed ACE-inhibitor (minimum compliance 70%)	7	44	51	86
Patient compliant with prescribed angiotensin receptor antagonist (minimum compliance 70%)	5	14	19	74
Patient compliant with prescribed biguanide (e.g. metformin) (minimum compliance 70%)	11	47	58	81
Patient compliant with prescribed sulfonylurea (e.g., glipizide, glyburide, glimepiride) (minimum compliance 70%)	10	32	42	76
Patient compliant with prescribed thiazolidinedione (e.g. pioglitazone, rosiglitazone) (minimum compliance 70%)	2	18	20	90
<b>TOTAL UNIQUE PATIENTS</b>	175	148	325	46

Source: InforMed//Ingenix EBM Connect.

pliance with recommended treatment plans that follow accepted physician-supported, evidence-based clinical care guidelines. Managing compliance issues proactively results in reduced inpatient stays, reduced acute and trauma situations and better health.

When an individual is predicted as a high-cost user, he or she usually has a num-

ber of medical issues and disease states (sometimes called comorbidities). Progress is measured against an integrated treatment plan developed for each individual based on the entire person and his or her comorbidities, not on an individual's progress with a particular disease to the exclusion of the other medical issues that person is facing.

**Directing Participants  
to High-Quality Care  
for High-Cost Procedures**

A number of federal government and private sector resources are available to help plan sponsors assess the quality of

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Table IV

### Cost Analysis by Quality Ranking of Chicago-Area Hospitals for Cardiac Catheterization

Quality Quartile Rank	Top Hospitals	Cost
1st	Hospital A	\$22,997
2nd	Hospital B	18,956
2nd	Hospital C	19,608
2nd	Hospital D	15,270
2nd	Hospital E	30,925
3rd	Hospital F	27,445
3rd	Hospital G	23,558
4th	Hospital H	30,872
4th	Hospital I	28,895
Average of all hospitals above		\$24,281
Average of top three hospitals		\$20,520
Difference between top three hospitals and all hospitals above		-15.5%
Difference between top three hospitals and most expensive hospital		-33.6%

Source: HealthShare Technology's database.

health care providers. The Hospital Quality Initiative (HQI) of the Centers for Medicare & Medicare Services (CMS) is one source of publicly available information. The HQI Web page ([www.cms.hhs.gov/quality/hospital/](http://www.cms.hhs.gov/quality/hospital/)) links to the Hospital Quality Alliance's Web site for comparing information on hospital quality: [www.HospitalCompare.hhs.gov](http://www.HospitalCompare.hhs.gov). Plans can also purchase or subscribe to proprietary databases offered by several vendors. For sample comparisons, see the data presented in Tables I and IV.

Information about the quality of individual physicians is not as comprehensive as information about the quality of hospitals. Online resources include the following Web sites: [ama-assn.org](http://ama-assn.org), [docinfo.org](http://docinfo.org) and [abms.org](http://abms.org). In addition, in October 2005, CMS announced an initiative for physicians to report evidence-based, consensus quality measures: the Physician Voluntary Reporting Program.

### Supporting Elements of the New Health Plan Model

In addition to guiding participants to high-performance, high-quality providers

and organizing targeted interventions for high-risk and at-risk participants, the success of this new health plan model also depends upon the following:

**Modifying plan designs to support desired behavior.** Instead of offering tiered networks, plans should direct participants to high-quality physicians and facilities by procedure. Barriers to receiving appropriate care should be lowered. Plans may also want to reward participants for complying with care guidelines. Plans may also want to add pay-for-performance features to physicians and facility reimbursement rewards to high-quality providers for following guidelines and/or improving outcomes.

**Explaining the new approach to participants and providers to obtain their support.** Plan sponsors have an opportunity to shift the way that participants and the provider community think about health care. Participant communications might explain that the plan is their health care advocate and guide through the health care system; the plan will ensure they receive the safest and highest quality health care; the plan aims to strengthen the patient/provider relationship; the plan emphasizes quality over price because the plan spon-

sors believe high-quality care helps manage the cost of health coverage. Providing access to information can empower participants—and physicians—and engage them in playing an active role in individual health management.

### Conclusion

The value of the new health plan model is not merely theoretical. Many plan sponsors in both the private and public sectors—significantly, including Medicare—are already experimenting with cost-management techniques that emphasize quality and are seeing significant returns of two to three times their investment. In the short term, plan sponsors' greatest opportunities to reduce costs are undertaking targeted individual interventions for frequent users of health services and guiding those who need health care to high-quality providers.

Plan sponsors that want to adopt this new health plan model—a high-performing health plan—will need to invest in tools and administrative support processes to help manage the quality of care and total health of the participants. Data is key. Plans must measure financial, quality, clinical and behavioral data. In addition, it is important to modify plan designs to support desired behaviors, guide participants to high-quality facilities by procedure and lower barriers to appropriate care. Communication plays a crucial role in building needed support. Plan sponsors, participants and the community need to be educated about the new health plan model.

**B&C**

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### Endnotes

1. See The Segal Company's 2006 *Segal Health Plan Cost Trend Survey*, available on the following Web page: [www.segalco.com/publications/surveysandstudies/2006trendsurvey.pdf](http://www.segalco.com/publications/surveysandstudies/2006trendsurvey.pdf).

2. Institute of Medicine, *Crossing the Quality Chasm*; and Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the

United States," *New England Journal of Medicine*, Vol. 348:2635-264,5 June 26, 2003 (No. 26).

3. Kaiser Foundation Health Plan, Inc., Task Force on the Future of Health Insurance, November 2003.

4. Roger Lowenstein, "The Quality Cure?" *New York Times Magazine* (March 13, 2005).



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