The Health Care Challenges Ahead for a Changing Workforce and a Changing America

by Michael J. Critelli

I want to thank you for giving me the opportunity to present a point of view about a challenge that we all face: how to deliver good health affordably to all of our citizens. As a CEO of a large business, I face a particular set of problems in delivering good health to our employees and their dependents. Many of my observations that follow, however, will apply to the broader health challenge.

You may notice that I have defined the issue differently from many who talk about health care: the challenge is delivering "health." "Health care" is a means to maintain and restore health, not a goal in itself. Thus when you start with health, as opposed to health care, as the goal then a much broader set of challenges and opportunities present themselves.

Statement of the Problem

Let's start with the state of "health" in America. Clearly, we all feel that the current health delivery system is broken and the results are unsatisfactory. As a society, we spend substantially more of our gross domestic product on health maintenance and care than any other country. This industry now approaches close to $1.6 trillion and it is growing by 12 to 14 percent per year. Yet, we have some of the world's worst health conditions. We are 42nd in life expectancy behind most of the industrialized world and some of the second world; our infant mortality rates are twice as high as the lowest country; and, we have a higher incidence of obesity, and certain chronic diseases such as HIV/AIDS, diabetes, heart disease and cancer than other countries which spend considerably less than us.

At the same time, because of our exceptionally high spending and our exceptionally high health care inflation rate, we have 44 million uninsured Americans, and that number is increasing daily. From an employer's standpoint, the uncontrollable and unpredictable increases in health care costs are a major factor in reducing the number of employees hired, in causing employers to discontinue both retiree and active medical coverage, and driving employers to move operations from high labor cost areas within the United States to lower labor cost areas within and outside of the country.

We also have an increasing discrepancy between consumer desires for unlimited choice of physicians, low cost coverage, and unlimited care, and the realities of providing affordable health care coverage. We also have a demographic time bomb with an aging population and significant government employee retiree medical obligations that are not appropriately being accounted for as they mount. Worse yet, it appears to be far easier for elected officials to avoid facing up to some of the painful choices Americans will need to make to bring health care costs under control and improve the state of our health.

As a CEO of a large employer, we clearly cannot solve all of the problems I have identified, but I will give you a roadmap for how we have historically outperformed the average and how we plan to pursue these principles in the future. Over the last six years our health care costs have increased an average of 6.6 percent versus other organizations that we benchmark against, which have seen their average costs rise 9.1 percent. This is against a backdrop where significant growth in our business services sector, whose primary product today is labor, has increased our exposure to health care issues.

Eight Principles of our Health Management and Health Care Program

Principle 1: Good health and health care management requires a partnership among patients – as consumers; providers; and payers – employers and health plans

It should be self-evident that, to tackle runaway health care costs and to maximize patient health, everyone involved in the process should be aligned to achieve the same goals. Yet too much of the health care system is designed to put the burden of health care cost containment on providers and payers.

Every individual consumer of health care needs to share in the burden of maximizing health and reducing health care costs. What are some of the things we have done to achieve that partnership?

- We've had our employees take ownership of their own health – giving them the information and tools for managing their lifestyle and purchasing decisions. There are clear linkages between healthy lifestyles and reduced health care costs. Nutrition, fitness, and avoidance of destructive lifestyle behaviors all reduce health care usage and costs. We feel education is important to enable our employees to adopt healthier lifestyles and to be better health care consumers. As a result, we created Health Care University, featuring a curriculum of health education initiatives and healthy lifestyle programs where employees earn benefit credits upon completion. These earned credits ultimately reduce their out-of-pocket costs for benefit coverage. Through the Health Care U system for instance, non-smokers receive credits for maintaining a healthy lifestyle, and those completing a course on cardiovascular health receive credits as well. We expanded Health Care U to dependents through eHealth portals.

- We have aggressively promoted healthy eating, starting with the food we make available at the workplace, and the nutritional counseling we provide to help employees and their dependents both within and outside the workplace. We also provide subsidized on-site fitness facilities and discounts for use of external fitness centers, in areas where we have no on-site facilities.
- Immunizations and other preventive procedures are critical to our partnership strategy. We provide flu shots, mammograms, osteoporosis screening, cholesterol screenings and other well-established diagnostic tools for employees and retirees in certain areas. We encourage expectant mothers to enroll in pre-natal care classes and provide advice and services to reduce the incidence of birth-related problems. We also provide well-baby and well-child care at low co-pays as a regular part of all our health care plans – covering both in-network and out-of-network providers.
- The majority of preventive benefits are offered to employees either free or at reduced costs, which is consistent with the priority we place on partnering with the employee on preventive care.
- Employees and their families share in the cost of the overall program both in terms of premiums and payments at point of service. In recent years, we have particularly focused on increasing the contributions for diagnostic tests such as MRI’s and cat scans, where it is not as visible

to employees what they are paying, and where costs are increasing significantly faster than other health care services.

- As a result of the partnership principle, our key stakeholders are more closely aligned today and we encourage all parties to work together.

Principle 2: Improve Employee Access to Affordable Health Care

We are atypical among large companies in maintaining an in-house medical function with two physicians and an array of professional providers including physician assistants, nurse practitioners, and nurses. We have eight on-site medical centers in our major population facilities across the country.

These clinics are free of charge for employees and are open every workday to accommodate the demand within a particular facility. These clinics have benefited us as well as the employees for a variety of reasons:

- Employees have access to clinical care for minor illnesses and injuries without having to leave the office, without having to schedule an appointment, and without the long waiting times they experience at private care physician offices.
- We can generally give them a full course of therapy for medications at no charge to treat their acute illness.
- If their condition is more serious, we can refer them to a competent outside physician or health care facility and communicate in advance what might be needed. This facilitates easier access to higher quality care in the outside health care system as well.

- We also provide immunizations and preventive screenings through our clinics, and make them more readily accessible to employees and retirees.
- We see a number of savings. We save significantly on absenteeism. In fact, employees who are ill will come to work to use the clinic, rather than making a discretionary decision to stay home for the day to access their private care physician. Every time they come to an on-site clinic instead of going to a private physician we avoid paying our share of the co-pay. Our savings are enough to cover the cost of the on-site medical care facilities and staff. Over the last five years we have handled over 160,000 patient encounters among our Connecticut employee population alone, which has resulted in early detection of major illness as well as advice on how to get the most value from the health care system.

We believe that this principle not only applies to physical medicine but also behavioral health. We are a pioneer in providing parity for behavioral health care as evidenced by winning the NAMI award in 1998. This is embodied by the access we provide to the Employee Assistance Program, which gives eight visits to qualified behavioral health care professionals to help employees who have psychiatric and substance abuse problems. One of the major concerns all health care plan providers have is the skyrocketing cost of behavioral health care. By giving employees financially attractive access through our EAP program, we are better able to manage downstream psychiatric care costs.

Principle 3: Manage our Covered Population

As an employer of over 25,000 active and 3,500 retired employees in the U.S., and as a payer for thousands of additional covered lives, we need to insure that we make our health care program attractive enough to achieve a high degree of employee satisfaction, but not so attractive that we create an adverse selection problem. Like many other companies, we provide financial disincentives for dependents that select our plan when other coverage is available to them and conversely, provide financial incentives for employees to opt out of our plan when they can get coverage under a spouse's plan. We must grapple with the growing number of un-insured's, both directly through migration to our plan, and indirectly through cost shifting to the private sector.

Additionally, like most large companies operating in all 50 states, we are addressing the emergence of domestic partners benefits. I feel it is manageable to provide domestic partner coverage for same-gender couples as we currently do. Proposed legislative mandates will put cost pressures on employers looking to extend the benefit to opposite gender partnerships, however, with the requirement to provide full benefits, including retiree medical coverage.

Principle 4: Leverage our buying power as a major employer

Our objective is to provide our employees with high quality but affordable comprehensive health care through regional, best in class models. Therefore, we have consolidated a number of health plans and are an aggressive purchaser of health care as well as monitoring and evaluating the quality of care delivered by the health plans. Because of the skyrocketing cost of HMO coverage, we have aggressively narrowed the number of providers with which we do business, although we have not gone so far as to give employees only one choice nationwide or over a multi-state region. We have leveraged our relationships with major payers such as United Health Care, Aetna, Humana and Kaiser, to get better access to services at better costs by giving them more opportunity in more geographies.

<u>Principle 5: Anticipate and manage large case situations effectively.</u>

We recognized back in the early 1990's that we could do a great job in the vast majority of health care situations, only to have our cost containment efforts wiped out by a handful of catastrophic medical events. We began to staff up to manage large cases in a caring way, but with a recognition that there are many opportunities for covered employees and dependents to make choices that would reduce their costs and ours.

The first thing we realized is that many major health care costs arising in large cases occur at the end of a person's life. The execution of a living will and health care power of attorney provides better alignment of end stage care and the patient's intent. That is why we encourage retirees to execute these documents, for example, as part of equipping our employees and retirees to become more informed health care consumers.

Second, we recognized that when patients have choices, they might not understand all of the risks and benefits of treatment alternatives. We believe that part of the value added services of a health plan is to have robust disease and care management programs to help members through the system. (<u>Dave/Jack recommend deleting the following because they think it will be redundant: Through our large case management program, we help them select the treatment path with which they feel most comfortable,</u>

including awareness that the most aggressive treatment is not always the best. One of the interesting findings from our health care outcomes analyses is that different communities have predictably different treatment recommendations for the same or similar types of medical events. For example, comparing two demographically similar communities, the incidence of caesarian births can be dramatically different, depending on the treatment preferences of the obstetricians and hospital staffs in the communities.

Third, if patients select a treatment program, we make them aware that there are alternative, often lower cost, sites to receive that treatment. It is counterintuitive for someone not involved day-to-day in our health care system, but some localities provide equal or better care than others at a lower cost.)

Principle 6: We want our covered employees and retirees to receive care from the highest quality providers.

One critical component of my vision is to steer those we cover to the health care provider who is best in class for each type of treatment. Over time, a body of data has been created to allow for outcomes analysis at a provider or community level. This data should be shared with those we cover, and they should be able to select providers who will give them the best results, or, at a minimum, avoid providers who do not perform as well. Even if the data on provider outcomes is not available, we educate those we cover on the fact that, with respect to particular kinds of medical procedures, experience often makes a difference. Within our eHealth portal is a “Consumer Corner” where employees and their family members have access to links to external quality websites.

Principle 7: We regard HCAs and HSAs as valuable components of our health care planning.

We recognize that some of our employees cannot afford to buy the type of coverage they need. However, particularly for scheduled or anticipated medical events, they can effectively use our health care spending account as a tool to manage their out-of-pocket costs. We have provided a great deal of education and counseling on how to use the health care spending account effectively, and have benefited from the tax savings resulting from it.

We have introduced a high deductible plan coupled with a $150 seed into an HCA, which is one of our stepping-stones to more consumer involvement.

Principle 8: While retaining retiree medical coverage, we have created a plan design that minimizes its actuarial cost.

When we tried to find tools to reduce our retiree medical cost increases, we discovered that, from an actuarial standpoint, we could significantly reduce our cost by only giving credit to employment occurring at and after age 45. Thus, one of the criteria for full retiree medical benefits is to be at least 55 years old, with at least 10 years of service since the age of 45. We have found that the majority of employees do not start to focus on pension or retiree medical benefits until well into their 40’s. Thus, by not counting service occurring before age 45, we do not incur a cost for employees for whom these benefits are less important, and we avoid accruals for the vast majority of our population.

Results

Since we embarked upon this comprehensive health management program in the early 1990's, our results have been outstanding. Our total annual out-of-pocket costs were virtually flat during the entire 1990's. Over the last six years, while we have experienced significant increases in our costs, our overall trend rate of increase is one-third less than other large self-insured employers.

At the same time, our employees have continually rated our medical benefits program as one the number one employment benefit. We have also won numerous awards for innovation in health care, including the C. Everett Koop award which we won twice in 1996 and 1998 and the American Psychological Association Award in the Fall, 2002 for our support of employees through the national tragedy stemming from the events of 9/11.

Risks and Threats

I am very proud of what we have accomplished, and I am sure that many of you in the audience have pursued similar strategies. But I also want to discuss some of the threats to what we have put together. I believe strongly that we need to maintain the ERISA pre-emption for self-insured employer health care plans. If we were subject to the rules of each of the 50 states for health care plans, we could not be effective in providing quality health care at relatively low cost.

My experience with state governments is that they can be successfully lobbied by particular special interest groups either to mandate specific kinds of coverage, or to preclude certain kinds of health management programs. For example, in some states, an insured plan cannot charge smokers higher health insurance premiums because of overly broad "community rating" legislative mandates.

We also need to educate our elected officials at both the state and federal level about the heavy administrative burden they place unnecessarily on medical providers, employers, and payers.

Finally, we need to insure that elected officials do not overhaul our health care system without understanding some of the complexities of the system. For example, HIPAA produces some unintended consequences while trying to protect patient privacy. If you do not believe this, try to contact a hospital and get information about the status of a family member who may have been brought into the hospital unconscious and who is in intensive care. You will find some hospitals that will not communicate anything to you because of an overly cautious interpretation of HIPAA. Any legislation needs active input from those who have to live in the health care system every day, and those who bear its primary cost consequences.

Final Comments

I do not pretend to have the answers to our health care crisis. At the same time, I believe that much of what we have accomplished is applicable to the larger issues we face. The major message with which I leave you is that there are significant opportunities for improvement even within our dysfunctional health system. And, these opportunities can most effectively be leveraged through partnerships among patients, consumers, providers, and employer-payers.

I hope my enthusiasm for addressing this crisis is now obvious to you, and I look forward to participating in the broader public debate when the federal government finally begins to tackle the problem. Thank you for giving me the opportunity to present our story to you!