HEALTH issues
LECTURE SERIES

the future uncovered

Face the Challenges of the Uninsured

Tuesday, April 2, 2002
7:45 a.m. to 4:00 p.m.
University of North Florida Conference Center
Jacksonville, Florida

Join distinguished health care professionals at this groundbreaking seminar and explore how the issues of the uninsured affect our community.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

A G E N D A

7:45 a.m. – 8:30 a.m.	Registration	UNF Conference Center Foyer
8:30a.m.	Introduction	Susan Dentzer, Health Correspondent *The NewsHour*
8:40 a.m.	Welcome	Pamela S. Chally, Dean College of Health, University of North Florida
8:45 a.m.	Setting the Stage	Lynda Keever, Publisher *Florida Trend*
9:15 a.m.	Report of Employee Benefit Research Institute	Paul Fronstin, Director
10:15 a.m.	Break	Foyer
10:45 a.m.	Perspectives Panel/Q&A	Moderated by Susan Dentzer
	Agency for Health Care Administration	Rhonda M. Medows, Secretary
	Center for Practical Health Reform	Brian Klepper, Executive Director
	Communication Health Action Information Network	Karen Woodall, Policy Coordinator
	Florida Chamber of Commerce	Mark Wilson, Senior Vice President
	Florida Medical Association	H. Frank Farmer, Jr., President
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1:45 p.m.	Introduction	Michael Cascone, Jr., Chairman/President/CEO Blue Cross and Blue Shield of Florida
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4. Paul Fronstin

Paul Fronstin, Ph.D., is a senior research associate with the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan organization located in the nation's capital and committed to original public policy research and education on economic security and employee benefits. He also is director of the Institute's Health Security and Quality Research Program. Dr. Fronstin earned his bachelor of science degree in economics from SUNY Binghamton and his doctor of philosophy degree in economics from the University of Miami. **www.ebri.org 202-775-6352**

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Tuesday, April 2, 2002 • Jacksonville, Florida

REGISTRATION FORM

Please Print

Contact Name: Susan B. Towler Company: The Blue Foundation for a Healthy Florida

Address: [Redacted]

City: Jacksonville State: FL Zip: 32246

Phone: [Redacted] Fax: [Redacted] mail: [Redacted]

Make checks payable to: First Coast Healthcare Executives and mail to: P.O. Box 2891, Jacksonville, FL 32203-2891. Registration forms must be received by March 25th. Thank you for your participation.

$75. Check will be brought to event.

For Registration Information
Contact: Cheryl West
904-359-0981

For Conference Information
Contact: Stephanie Edwards
904-905-4411

Partners:

First Coast Healthcare Executives

Deborah Haug, President

Lori Bilello, Program Chair

Healthcare Financial Management Association

University of North Florida College of Health

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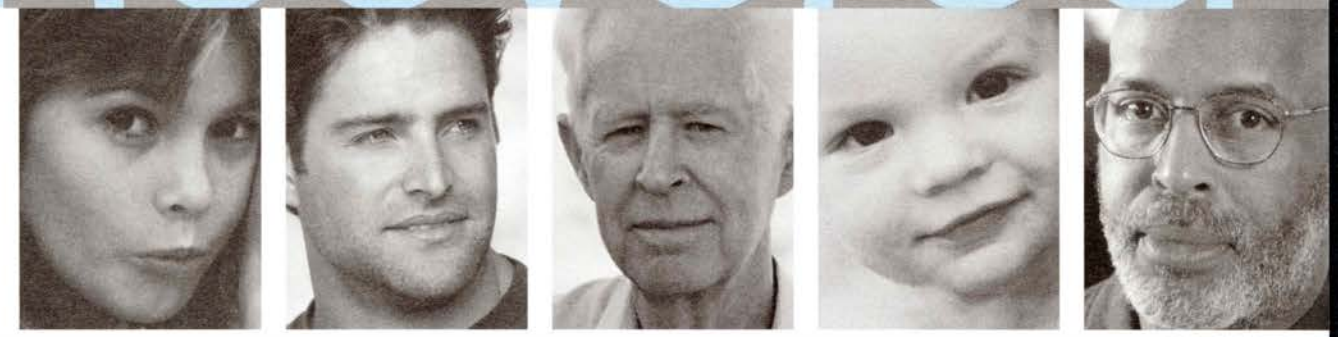

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University of North Florida College of Health

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C.H.A.I.N.

Linking Floridians Who Care

C.H.A.I.N., the Communications Health Action Information Network, is a two-year-old initiative comprised of coalitions, organizations and individuals dedicated to meeting the health and human service needs of all Floridians by forging strategic partnerships to improve access to healthcare, childcare, medical insurance and other services.

C.H.A.I.N. has played a pivotal role in Florida on a variety of health, social service and economic justice concerns. By working together with public policy makers and community leaders, C.H.A.I.N. bridges the gap between service providers, constituents and policy makers by strengthening Florida's communities. Some examples include:

- Assuming a leadership role in the achievement of marked changes in the Florida KidCare Program
- Promoting healthcare access by eliminating transportation barriers, increasing insurance access, targeting environmental health risks, identifying barriers to care, and documenting migrant/immigrant health concerns
- Promoting access to childcare, prescription drugs and flood relief through local and statewide campaigns and community involvement
- Addressing transportation barriers for low income and disabled residents
- Conducting leadership development and training programs
- Convening public education forums on state fiscal and budgetary issues
- Creating the Union of the Uninsured to facilitate collective action through empowerment of those most affected by the existing structure of the healthcare system

C.H.A.I.N.'S POLICY PRIORITIES

★ To expand health insurance coverage to Florida's working families and immigrants

★ To remove enrollment barriers such as the local match in Florida's KidCare Program

★ To include all children in KidCare, regardless of immigration status

★ To improve access to mental health services through insurance "parity"

★ To increase funding and improve staffing for long-term care

★ To create a meaningful patient's bill of rights

★ To eliminate waiting lists for subsidized childcare for working families

Yet there is still so much to do, and we need your help! Become a member of this dynamic statewide coalition dedicated to strengthening Florida's communities.

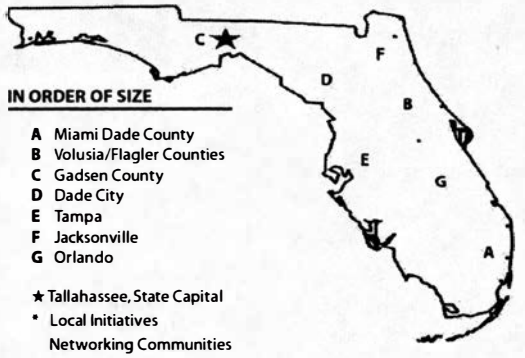
HERE'S WHAT FELLOW MEMBERS HAVE SAID ABOUT C.H.A.I.N. AND ITS ORGANIZING WORK:

"In the time that I have been involved in this program, I realized that there are people in the community that care about their neighbors and fellowman. Maybe my own little grain of sand might make a difference." **Rafael Miralrio**

"CHAIN has made me and the other students in Into the Streets, a community service group, aware of the many of the health issues confronting Floridians today." **Sue Carroway**, student, Stetson University

"Our community faces many challenges and organizations like the Human Services Coalition are even more needed if we are to achieve our mutual goal of serving the needs of the entire community." **Louis F. Powell, Jr.**, Senior Vice President, Bank of America

FLORIDA CHAIN – REGIONAL LINC'S*
APRIL 2001



IN ORDER OF SIZE

A Miami Dade County
B Volusia/Flagler Counties
C Gadsen County
D Dade City
E Tampa
F Jacksonville
G Orlando

★ Tallahassee, State Capital
* Local Initiatives Networking Communities

BECOME A MEMBER

Take Action
Get Reaction
Join C.H.A.I.N.

Membership is free.

As a C.H.A.I.N. member you will:

★ Receive weekly alerts with the latest information on federal, state and local health and human services, a list of upcoming conferences, initiatives, resources and job opportunities

★ Have the opportunity to post information for other C.H.A.I.N. members to access

★ Have access to a network of concerned Floridians ready to take action on issues of common concern.

For more information on becoming a regional LINC, or to become a C.H.A.I.N. member, please call 305-576-5001 ext. 20, send a fax to 305-576-1718 or e-mail us at hsc@hscdade.org.

Please fax the following form to 305-576-1718 or mail to: Human Services Coalition of Dade County, 260 NE 17 Terrace, Suite 200, Miami, Florida, 33132. This information will be directed to one of our six regional representatives.

Name: _____

Organization: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____

Business Phone: _____ **Fax:** _____

E-mail: _____

The Center for Practical Health Reform

A Consensus-Based, Principled Approach To Save American Health Care

FOR PATIENTS, EMPLOYERS, CLINICIANS, PROVIDER ORGANIZATIONS, HEALTH PLANS AND POLICY MAKERS

Why A New Health Care Reform Effort?

Look closely at current health care reform proposals. Two points jump out. First, they nearly always work to the advantage of the sponsoring group and at the expense of others. Second, the proposals primarily tweak details of health care finance – where the money comes from, the eligibility criteria for receiving benefits and what's covered. But health care's deeper problems are generally ignored.

Health care is a great complex machine, lurching forward without a unified plan. We're all at the wheel, trying to steer in different directions. We see but don't address the most critical issues. A large and growing number of Americans can't afford adequate care. Physicians and other providers often show little regard for current best practice, so we get wild variations in quality and cost for similar conditions. The health plan industry maintains outdated coverage, risk and medical management models, and appears unable to control areas of cost growth that should be manageable. Consumers remain isolated from the financial consequences of their lifestyle choices and their demands for unlimited services. None of these groups is accountable for the parts they play.

Many experts think political gridlock makes it impossible to fix the system. Americans spend one dollar of every seven on health care, which is so lucrative and distributed among so many competing interests that the system can't be realigned without sacrificing someone's sacred cow. The tremendous money buys influence – more than 1,000 health care political action committees now lobby Congress – and fuels constant tugs-of-war for ever-larger slices of an ever-growing pie. This same influence also blocks most meaningful reform.

So the system is stalemated. The conduct of doctors, hospitals, drug companies, ancillary providers and health plans remains fundamentally unchanged. Costs spiral upward. Quality remains uneven. The people who pay the bills are increasingly exasperated. Patients are mostly pawns. Special interests dig in. And we drift closer and closer to the precipice.

We might be there. Health costs have crossed a threshold of affordability for many employers and employees, threatening a dramatic spike in the number of the uninsured. If that happens, the impacts could ripple through health care and the economy at large, precipitating failure within key industry sectors. Congress would be pressured to deploy a national health system. American health care as we know it would change.

Confronting these issues, a broad-based group of business and health care professionals has developed and agreed on principles to change the system. Just as important, we developed an approach to effect national change.

Sensible, fairly comprehensive but not fancy, the principles are a work in progress. We not sure yet that they're either correct or complete. They must

Principles

Coverage & Organizational Structure

1. Assure Essential Care For All Americans.
2. Assure Opportunities For Choice Through Supplemental Care.
3. Maintain An Accountable Private Sector Health Care System, With Incentives for Performance and Innovation.

Information & Quality

4. Promote Compatible Information Technologies That Permit Secure, Private Information Sharing Throughout Health Care.
5. Adopt, Publish, Update and Promote Evidence-Based Practice Improvement Processes.
6. Promote Continuity and Coordination of Care.

Accountability

7. Publicly Disclose Quality Information on Professionals, Institutions and Procedures. Phased-in data release, protection of organizational improvement efforts, and accountability for the acuity levels of medical conditions.
8. Publicly Disclose Risk-Adjusted Pricing Information for Patients.
9. Promote Individual Awareness Of and Responsibility For Choices Affecting Health Care.
10. Reduce Medical-Legal Liability Through Practice Standards and Greater Accountability Throughout the Care System.

be validated and possibly revised by more people. But basically, they say this. **If we want to keep the health system we've come to enjoy, every group — patients, doctors, hospitals, insurance companies — must embrace disciplines that hold us accountable for our choices.**

The Center for Practical Health Reform (CPHR) has three broad objectives. First, we must validate and refine the principles with more discussion. Next, we must identify the operational and financial implications of the principles. And third, if appropriate, we'll advocate to translate the principles into adjustments in policy.

We're recruiting people with a common understanding of health care's deeper problems and the conviction that we can set things right. By uniting and acting methodically, perhaps together we can streamline American health care and make a better system. Equally importantly, maybe we can avert a meltdown of the system and the chaos it would wreak on America.

Approach

CPHR is different than many change agencies because it is **multi-constituency, non-partisan** and **action-oriented**. We believe the only way to achieve balanced, meaningful reform is to work closely with consumers, business, providers and payors, to formulate approaches acceptable to them all. We also believe there are **two parts to any reform effort: content (what change is needed)** and **action (how you make it happen)**. Our focus is on the latter as much as the former.

As a first step, we'll refine the principles by convening more Round Tables around the country. In other words, we seek national consensus on the rules that can guide reform. In turn, this can create bottom-up political pressure for change.

A second activity will coordinate an effort to identify the financial and operational implications of the principles. If feasible, a third activity would support a national effort to translate the principles into changes in policy.

Comments

The Center for Practical Health Reform is doing what needs to be done by forming consensus, a pathway to get the US to universal health coverage. While the nation is crying for health reform, the Center holds great promise for defining the right way. *Harris Berman, MD, CEO, Tufts Health Plan*

The Center's principals are compelling. Its assessment of the current system's shortcomings, and their proposed solutions, are on the mark.
David Kelsey, Director, National Accounts, Premera Blue Cross

Everyone agrees the health system needs reform. And everyone has opinions about how it should be reformed. But until now few have been willing to invest the resources necessary to create some basic elements of reform and test them. It is inspiring that this is the 'guts' of your project.
Robert Christenson, The Minnesota Health Care Round Table

It is a monumental task, but yours is the "practical" & sensible direction for our society to take. *Alan Cudney, Premier Healthcare Informatics*

Your efforts are at the core of what we need to accomplish in the next generation of health care. *George Halvorson, CEO, HealthPartners*

There are half a dozen efforts to get new conversations started about health care reform. This seems the most practical and original.
Ed O'Neil, Ph.D., University of California, San Francisco

The Center's **National Advisory Panelists** and **Senior Advisors** are not theorists, but practitioners, involved with health care every day — from business, hospitals, physician practices, health plans and professional groups. These individuals agreed that a bottom-up effort to fix health care is essential, and generously offered to serve.

Harris Berman, MD, Tufts Health Plan, Boston

John Burns, MD, Ft. Lauderdale

Becky Cherney, Central Florida Health Care Coalition, Orlando

John Erb, Deloitte & Touche, LLC, NYC

Karen Feinstein, Pittsburgh Regional Healthcare Initiative, Pittsburgh

Norbert Goldfield, MD, 3M, Wallingford

Jim Hotchkiss, HealthPrime, Atlanta

Stanley Hupfeld, Integris Health, OKC

Randy Kammer, BCBS Florida, Jacksonville

Ralph Kimmich, Southwest Airlines, Dallas

Catherine LaPenta, Dupont-Dow Elastomers, Wilmington, DE

Gregg Lehman, PhD, National Business Coalition on Health, DC

Anne Llewelyn, RN.C., PRIME, Ft. Lauderdale

George Lundberg, MD, Medscape, NYC

Scott Miller, Centura Health System, Denver

Edward O'Neil, PhD, Univ. of Cal., SF

Philip Smith, MD, Cerner, Inc., Kansas City

Joseph Spiak, Bank of America, Charlotte

Kate Sullivan, US Chamber of Commerce, DC

Special Advisors

J. Brooks Brown, MD, Founder & Chairman, Brooks Health System, Jacksonville

Pat Hays, Founder, Sutter Health & Former CEO, BCBS Association, Chicago

Alan Hicks, Founder, VHA, Dallas

Phil Nudelman, Founder & Former CEO, Group Health Coop of Puget Sound, Seattle.

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CommunitiesInCharge - *Jacksonville*

Financing and Delivering Health Care to the Uninsured

Communities In Charge – Jacksonville is a coordinated community effort to increase health care access for the low-income working uninsured in Duval County. Recognizing that federal and state fiscal constraints make it imperative to address the needs of the uninsured at the community level, this coalition of agencies, organizations and providers formed in 2000 to address the issue.

JaxCare is the community-based strategy being developed by the *Communities In Charge – Jacksonville* coalition to achieve that goal. The strategy has three components:

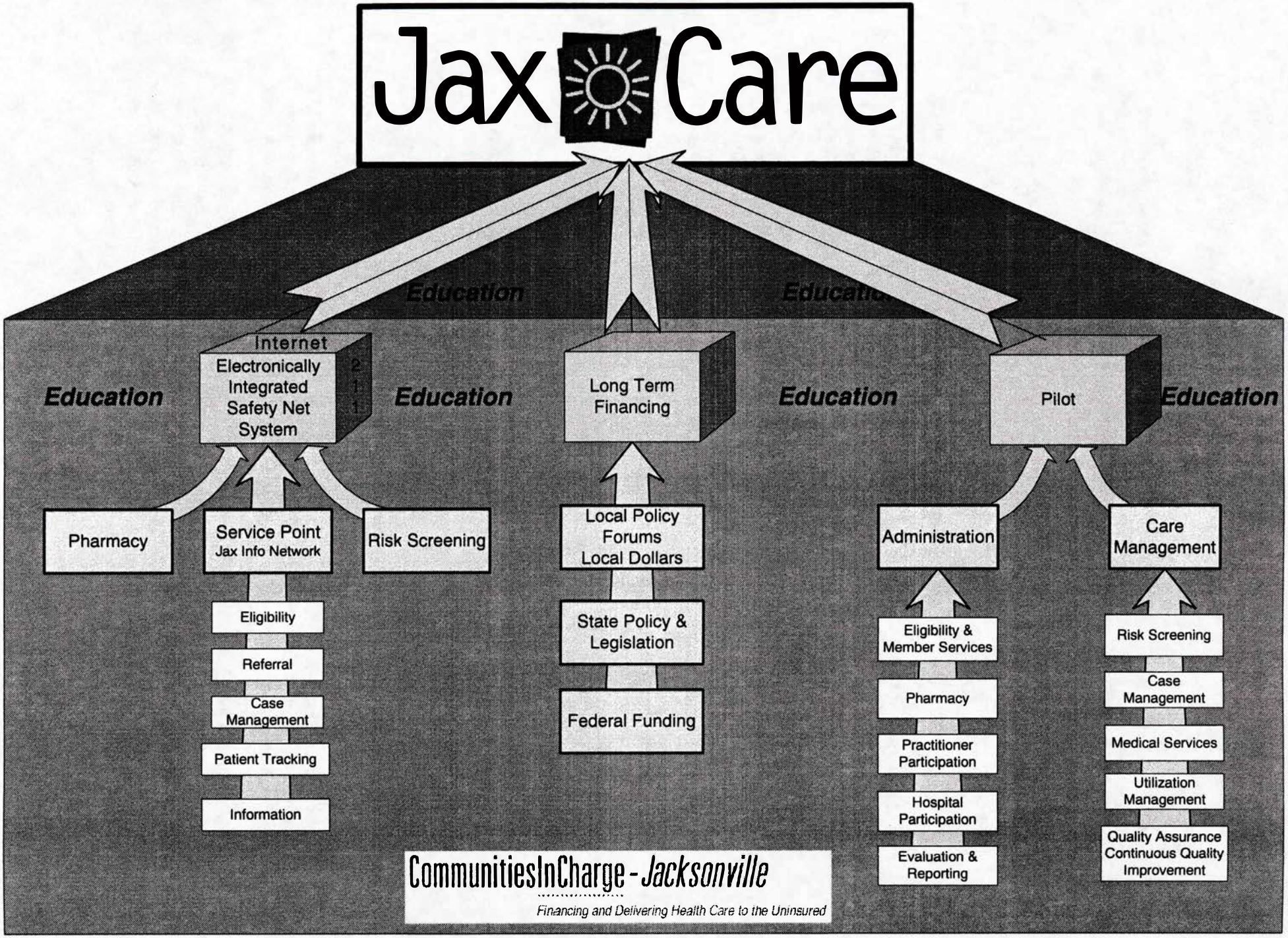
- **Financing Access to Care:** To define strategies appropriate for Jacksonville, *Communities In Charge* in partnership with the Jessie Ball duPont Fund, is convening local policymakers, stakeholders and professional colleagues with national and state experts for discussions about the local challenge of financing and delivering uninsured health care. The Jacksonville Community Forums on Health Care and the Uninsured offer policymakers an opportunity to engage in informed discussion and issue analysis in a neutral setting where information and resource sharing can take place. From this process, a strategic plan will be developed and a critical path structured for its execution.

- **Delivering Care:** With the goal of a county-wide comprehensive managed care program for the uninsured emphasizing primary care and prevention, *Communities In Charge* is launching a demonstration program in 2002. The success of the demonstration is dependent upon the donated services of community physicians and other providers until long-term funding is obtained. Three hospital systems, multiple physicians and ancillary providers have agreed to participate in the demonstration program, which is being launched this spring.

- **Maximizing Efficient Use of Existing Resources:** Building on the current Internet-based system used in Jacksonville by United Way's First Call, *Communities In Charge* is electronically networking the healthcare safety net providers with the social service providers in the community. This system will include:
  - On-line eligibility screening for all safety net programs in the county
  - An electronically shared community-wide case management system
  - A risk screening tool to identify chronic conditions
  - A link to pharmacy information for enrolled clients
  - Enhanced referral and information look-up
  - A data repository for patient and program information,
  - Statistical tracking and reporting capabilities

Communities In Charge is supported by a grant from the Robert Wood Johnson Foundation, local matching dollars and a Community Access Program (CAP) grant from the U.S. Health Resources Services Administration. Please contact us at 904-244-9270 for additional information.

Coalition partners include the City of Jacksonville, Shands Jacksonville, Baptist Medical Center, Brooks Rehabilitation Center, Memorial Hospital, St. Luke's/Mayo, St.Vincent's Health System, Duval County Medical Society, Health Planning Council of Northeast Florida, Jacksonville Chamber of Commerce, United Way of Northeast Florida, Duval County Health Department, Blue Cross Blue Shield of Florida and multiple providers including Jacksonville's Federally Qualified Health Centers (Sulzbacher Center for the Homeless & West Jacksonville Community Health Center).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Eligibility & Member Services
Pharmacy
Practitioner Participation
Hospital Participation
Evaluation & Reporting
Risk Screening
Case Management
Medical Services
Utilization Management
Quality Assurance
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CommunitiesInCharge - Jacksonville
Financing and Delivering Health Care to the Uninsured

kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION

February 2002

THE UNINSURED AND THEIR ACCESS TO HEALTH CARE

While two-thirds of Americans receive health insurance coverage through their employers and nearly all the elderly are covered through Medicare, millions of Americans lack health insurance either because their employer does not offer it or they cannot afford to pay for it. Medicaid and the State Children's Health Insurance Program (CHIP) play an important role by covering millions of low-income people, especially children. However, limits to these public programs and gaps in employer coverage leave over 38 million Americans uninsured — creating substantial barriers to obtaining timely and appropriate health care.

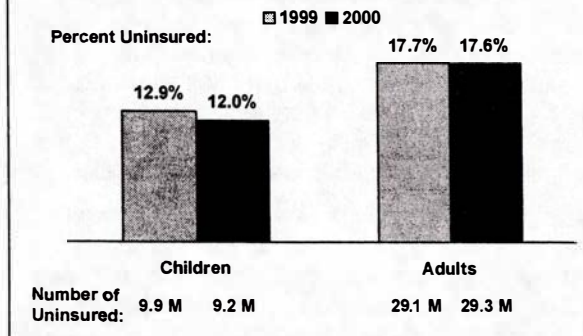
HOW MANY ARE UNINSURED?

In 2000, 38.4 million Americans, or 16% of the total nonelderly population, were uninsured. The number of uninsured grew steadily throughout the 1990s until 1999, when modest increases in employer coverage due to the robust economy, coupled with expansion and improved enrollment in public coverage, led to the first decline in the number of uninsured in over a decade.

Changes in children's coverage accounted for another small decline in the number of uninsured between 1999 and 2000—decreasing the number of uninsured children from 9.9 million to 9.2 million—while the number of uninsured adults grew slightly (Figure 1). The largest gain in coverage occurred among near-poor children (those with family incomes between 100% and 199% of the poverty level), where coverage was expanded through Medicaid and CHIP.

Figure 1

Uninsured Rate for Children and Adults, 1999-2000



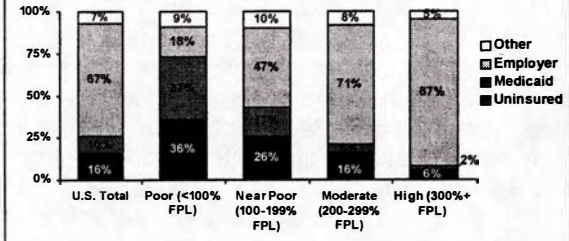
SOURCE: Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, analysis of March 2000 and 2001 Current Population Survey.

WHO ARE THE UNINSURED?

Low-income Americans (those who earn less than 200% of the federal poverty level, or $27,476 for a family of three in 2000) run the highest risk of being uninsured. Over a third of the poor and a quarter of the near-poor lack health coverage (Figure 2). The poor and the near-poor comprise nearly two-thirds (64%) of the uninsured population (Figure 3).

Figure 2

Health Insurance Coverage by Poverty Level, 2000

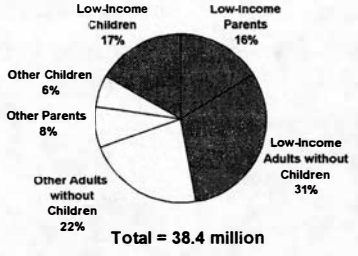


Note: The federal poverty level was $13,738 for a family of three in 2000.
SOURCE: Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001 Current Population Survey, 2001.

Four out of five (83%) of the uninsured are in working families—72% live in households with a full-time worker and 11% with a part-time worker. Low-wage workers are at greater risk of being uninsured, as are unskilled laborers, service workers, and those employed in small businesses.

Figure 3

The Nonelderly Uninsured by Age and Income Groups, 2000



Note: Low-income is defined as below 200% FPL.
SOURCE: Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001 Current Population Survey, 2001.

There are disproportionately more adults than children among the uninsured, as coverage under Medicaid and CHIP primarily assists children. Over 60% of uninsured adults have incomes less than 200% of the poverty level.

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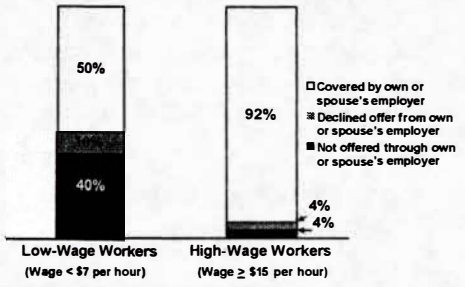
WWW.KFF.ORG

WHY ARE SO MANY AMERICANS UNINSURED?

The expense of insurance makes private coverage unavailable to many Americans, particularly low-wage workers. They are far less likely than higher wage workers to be offered insurance as a benefit, either through their own job or a spouse's job (Figure 4). Individually purchased insurance is often not a viable option, as these plans typically charge very high premiums or offer limited benefits.

Figure 4

Access to Employer-Based Coverage for Low and High Wage Families, 1998



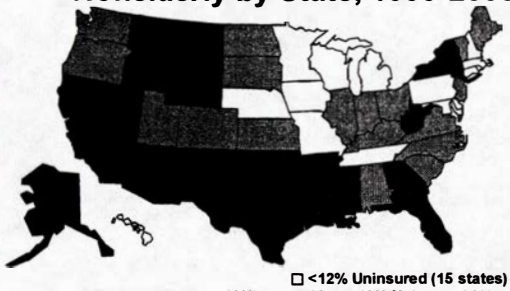
Note: Workers categorized by highest hourly wage in family.
SOURCE: B. Garrett, unpublished analysis based on Garrett, Nichols, and Greenman, 2001.

Medicaid fills in gaps in coverage for 40 million low-income Americans; however, coverage for adults is very limited. Nonelderly adults must meet stringent income eligibility standards, and even the poorest are generally ineligible if they do not have children. Parents may qualify for Medicaid, but their income eligibility levels are set much lower than children's. In addition, neither Medicaid nor CHIP has reached its full enrollment potential, leaving many eligible children still uninsured.

Uninsured rates vary widely across states largely due to differences in industries and employer-sponsored coverage, the share of families who live on low incomes, and the scope of state Medicaid programs. Nearly a four-fold difference exists between the state with the lowest (Rhode Island, 7%) and highest (New Mexico, 27%) uninsured rates (Figure 5).

Figure 5

Uninsured Rates Among the Nonelderly by State, 1999-2000



SOURCE: Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, analysis of 2 year-pooled data from March 2000 and 2001 Current Population Survey, 2002.

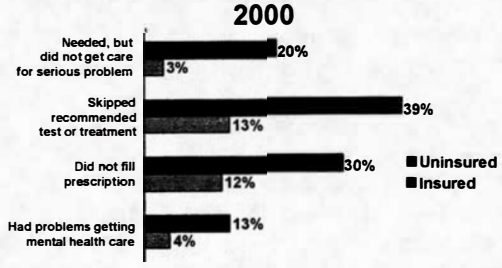
WHAT DIFFERENCE DOES HEALTH INSURANCE MAKE?

Health insurance affects access to health care as well as the financial well-being of families. Nearly 40% of uninsured adults and 25% of uninsured children have no regular source of health care. Coupled with a fear of high medical bills, many delay or forgo needed care (Figure 6).

- Uninsured children are 70% more likely than insured children not to have received medical care for common conditions such as ear infections, and 30% less likely to receive medical attention when they are injured.
- Nearly 40% of uninsured adults skipped a recommended medical test or treatment, and 20% say they needed but did not get care for a serious problem in the past year.

Figure 6

Percent of Nonelderly Adults with Barriers to Care by Insurance Status, 2000



SOURCE: *The NewsHour with Jim Lehrer*/the Kaiser Family Foundation National Survey on the Uninsured, 2000

- Both uninsured adults and children are less likely to receive preventive care. Uninsured adults are over 30% less likely than insured adults to have had a check-up in the past year. Similarly, a third of uninsured children did not see a doctor in the past year.

Delaying or not receiving treatment can lead to more serious illness and avoidable health problems, which ultimately makes a difference in how healthy people are.

- The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes.
- The uninsured with various forms of cancer are more likely to be diagnosed with late-stage cancer. Death rates for uninsured women with breast cancer are significantly higher compared to women with insurance.
- In addition to health consequences, the financial impact of being uninsured can be substantial: few uninsured say they have received health services for free or at reduced charge, and nearly 30% of uninsured adults say that medical bills had a major impact on their families' lives.

Charitable physicians and the safety net of community clinics and public hospitals do not substitute for health insurance. Lack of coverage clearly matters for the millions of uninsured Americans—affecting job decisions, financial security, access to care, and health status.

For more information on the uninsured, see "Health Insurance Coverage in America: 2000 Data Update," publication #4007. For additional free copies of this fact sheet (#1420-03) call (800) 656-4533.

The Kaiser Commission on Medicaid and the Uninsured was established by the Henry J. Kaiser Family Foundation to function as a policy institute and forum for analyzing health care coverage, financing and access for the low-income population and assessing options for reform. The Kaiser Family Foundation is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

BlueCross BlueShield Association

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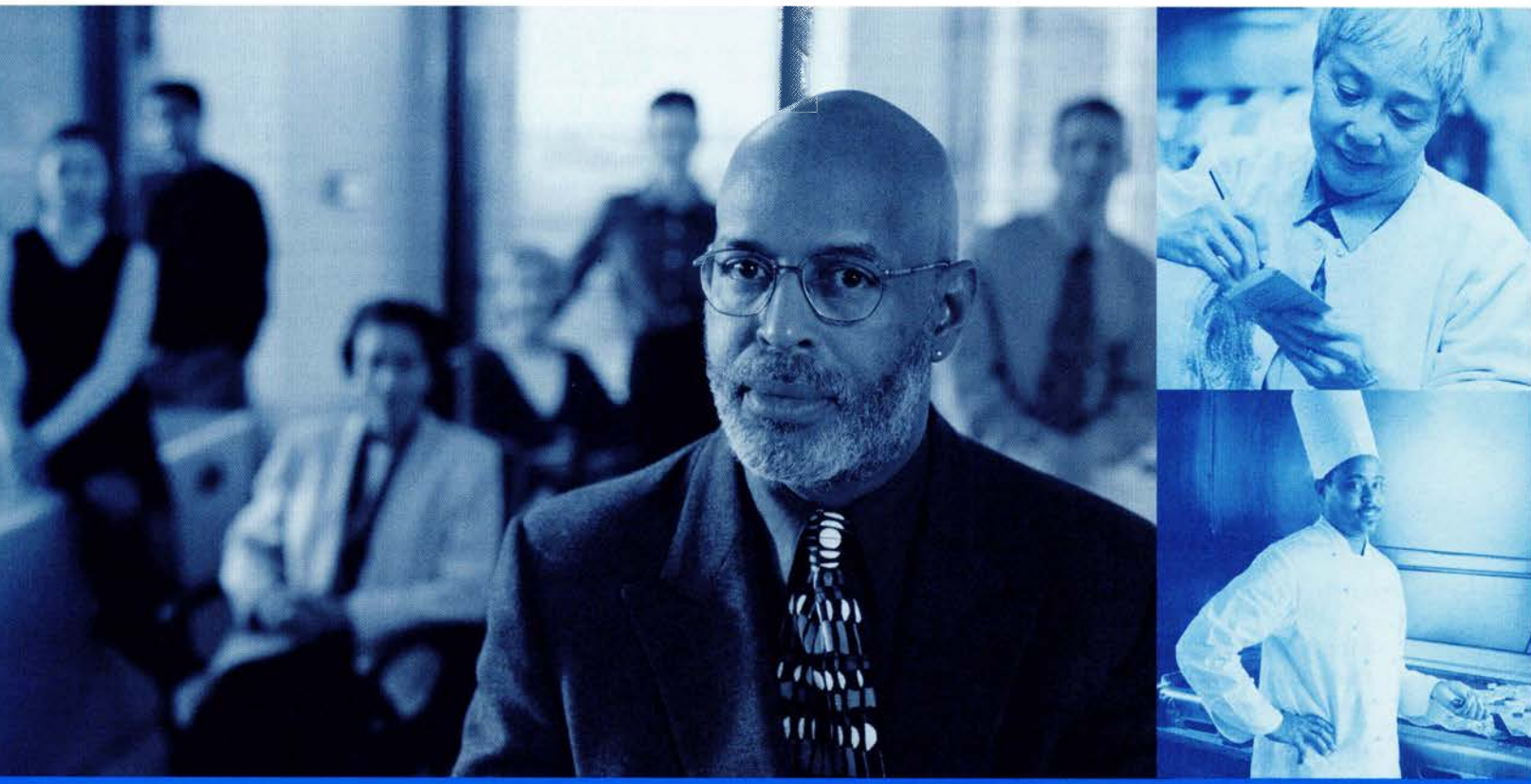
Fast Facts About Small Businesses and Health Insurance



What Small Businesses Need to Know About Health Insurance

Public Issues

A Blue Cross and Blue Shield Association Continuing Public Issues Initiative

The Tax Advantages of Employer Coverage

The federal tax code encourages businesses of all sizes to provide health benefits to their employees.

- **Employees pay no tax whatsoever on the amount their employer spends buying or subsidizing their health benefits. This saves workers hundreds of dollars – and in some cases thousands of dollars – in taxes each year.**
- **Companies can arrange to have employees' share of premiums deducted from gross pay so the workers pay no income tax on it. This puts more cash in their paychecks.**
- **Employers can deduct the entire cost of the health insurance as a business expense, reducing business' gross income, saving on taxes and offsetting a significant part of the costs of this essential benefit.**
- **On the other hand, employees who purchase health insurance on their own can deduct none of those premiums – zero – unless they have steep medical bills.**
- **Self-employed workers can deduct 60 percent of their premiums, and by 2003 they will be able to deduct 100 percent. Only 12 percent of the uninsured are self-employed.**

How much does health insurance cost?

Businesses of all sizes – even the smallest – qualify for group rates. Insurance is almost always less expensive for employers to purchase than for employees to buy on their own.

Remember: workers, as a group, are healthier than those who are not working. Group insurance spreads the costs of those with major medical bills across the larger pool of workers. Premiums cover both the routine care that most of us get and the expensive treatments that we need when seriously ill.

In almost every health plan, a small number of patients runs up a large share of the medical bills (It's not always the same people). Spreading those costs among the sick and the healthy in the group holds down premiums. The average premium contribution that employees paid in 1999 to insure themselves was $35 per month or $420 for the year.

Coverage for an entire family was four times as expensive: $145 a month or $1,740 a year. But remember: those premiums can be deducted directly from gross pay so that the employee pays no income taxes on them.

For small and mid-size employers, the average cost of providing health benefits was $189 per month per employee, or $2,268 a year. And the actual cost is less, because they can deduct all of it as a business expense.

What Small Businesses Know – and Don't Know – About Buying Health Insurance for Their Employees

- **Most Americans get health insurance through their jobs. Almost 100 million workers – 3 in every 4 – are covered by health insurance provided at work. When you add in their families, nearly two-thirds of everyone under 65 – some 155 million Americans – enjoy health coverage through the workplace.**
- **For every person covered by Medicare, Medicaid or other government health plans, there are nearly three people with private coverage, and most of that insurance is tied to their jobs or the jobs of their spouses or parents.**
- **But not every worker is covered by health insurance. Surprisingly, a large majority of the 42.5 million Americans without health insurance are workers and their families.**
- **Sixty percent of the uninsured live in families headed by someone working full-time, 12 months a year.**
- **The smaller the business, the less likely it is to offer health benefits to workers. Sixty percent of uninsured workers are employed by small firms.**

But that's not the whole story.

- **Many small businesses do furnish health insurance – even those that pay modest wages.**
- **Two-thirds of all those who work in businesses with fewer than 10 employees have health insurance, and most get it through their jobs.**

And here's the biggest surprise of all:

- **Many small employers are in the dark about the tax advantages of offering health insurance to their workers.**
- **Fifty-seven percent of small employers surveyed in Spring 2000 did not know that they could deduct 100 percent of the costs of providing employee health insurance.**
- **They didn't understand that health insurance costs come right off the top of gross income like salaries and other business expenses.**

Many small business owners operate under other misconceptions.

- **They think that if their workers buy health insurance on their own, they get a tax break. But that is not the case. Only the self-employed can deduct health insurance costs (unless your medical bills are so steep that they consume at least 7.5 percent of your income).**
- **And despite laws that the U.S. Congress and state legislatures have passed to make health insurance more affordable, many employers don't know about statutes that protect the rights of small businesses in the health insurance market.**
- **Most small business owners were unaware that it is against the law for insurers to deny them group coverage because of their particular workers' health.**

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) limits insurers' ability to exclude those with pre-existing health conditions and makes it easier for people to stay insured when they change jobs.

It requires insurers that offer small-group coverage to accept any employer group of 2 to 50 employees. And it gives employers the option to renew their group coverage, unless they fail to pay the premiums or for certain other reasons.

Insurers – and employers who sponsor their own health plans – cannot consider employees' health in deciding whether to enroll them or determining their individual contributions.

There's a lot of confusion about this among small businesses.

- **Only 35 percent of small business owners knew that there were limits on what insurers can charge employers with sick workers versus those with healthier workers.**
- **Half of the employers surveyed cited cost as the major reason they did not offer coverage.**
- **Most small business owners had an accurate idea of what providing health insurance would cost them. The average small or mid-sized business paid $189 per employee per month in 1999.**
- **A sizable number thought their employees couldn't afford health insurance even if the business offered it. Some take solace that their workers were already covered on spouses' plans.**
- **Almost a quarter said they were unwilling or unable to share any of the costs. But a third were willing to pay a portion. The rest were not sure what they could afford.**

Given the importance of health and health care in everyone's life, this is not a decision that employers take lightly, no matter what the size of their payroll.

- **Nearly a third of the businesses had made inquiries in the past two years with a broker, health plan or purchasing alliance about buying coverage for their workers.**
- **Almost 3 in 10 of the small businesses said they were likely to start offering health benefits in the next two years. Seventy percent said this was unlikely.**
- **Most said that getting extra help from the government would increase the odds of their offering a health plan.**

The decision to provide health benefits isn't based just on paternalism or a sense of duty. Most businesses find that it makes sense for them – dollars and cents.

- **Businesses that provide health coverage report that it helps them recruit and retain workers, boosts productivity and reduces time lost to sickness or absenteeism.**
- **Firms that don't offer health benefits believe that has only a small impact on their ability to attract and keep good workers.**
- **But 9 percent of small businesses with no health insurance reported high employee turnover, three times higher than the firms with health insurance.**

While some employers figure their workers would rather have the money in their paychecks than in benefits, businesses without health insurance tend to pay lower wages, too.

- **At almost half the firms without health insurance, a majority of workers make less than $15,000 a year. Only 12 percent of the businesses that provide health insurance had that many low-wage employees.**
- **The businesses without health insurance tend to have more part-timers, more female employees, more young workers and more minority employees.**

A Portrait of the Uninsured

If you're 65 or older in the United States, you get health insurance through Medicare. It covers 99 percent of people in this age group, as well as 5 million disabled workers and those with kidney failure at younger ages.

If you're poor, you can get Medicaid, the federal-state plan for those with low incomes, especially families with children.

Medicare alone covers 39 million Americans, and Medicaid covers 32 million (some people have both). Now there is a third major government plan, the State Children's Health Insurance Program, which covers 2 million children and is rapidly growing. And 7 in 10 Americans have private insurance.

And that leaves 42.5 million Americans – 15.5 percent of the entire population, and 17.4 percent of those under age 65 – without health insurance.

Who are they?

- **Ten million are children under 18. One child in seven is uninsured.**
- **Twenty-five million are workers, most holding down full-time, year-round jobs.**
- **Eight million are adults with no jobs.**
- **More than 10 million are living in poverty, but 32 million are from working class or middle-class families.**
- **Most of the uninsured are white (52 percent), but minorities are more likely than whites to lack health coverage. Thirty-three percent of Hispanics and 21 percent of African-Americans are uninsured, compared with 14 percent of whites.**
- **Young adults ages are the most likely to be uninsured. Almost 30 percent of those age 18 to 24 and nearly a quarter of those 25 to 34 lack coverage.**
- **Roughly 15 percent of adults ages 35 to 64 are uninsured.**
- **Low-income families are most at risk of being uninsured.**
- **The risks are also greater for workers in small firms, and those who work part-time.**
- **34 percent of those who work for companies with fewer than 10 employees are uninsured. By contrast, only 12 percent of those working for companies with 500-plus employees are uninsured.**

Doesn't Medicaid Cover the Poor?

Medicaid provides extensive protection for millions of Americans, but it covers only 2 in 5 of those living in poverty.

Every pregnant woman and every child in families below the poverty line are supposed to qualify for Medicaid. But in most states, adults without children are not eligible for Medicaid, no matter how low their income (unless they are disabled).

In 32 states, an adult who works full time at a minimum wage job makes too much ($10,700 a year) to qualify for Medicaid.

While 15.5 percent of Americans were uninsured in 1999, there are wide variances from state to state in how many adults and children went without health coverage. (Thanks to Medicare, only 422,000 elderly people were uninsured).

Rhode Island boasted the lowest rate: 6.9 percent. Five other states – Minnesota, Iowa, Missouri, Connecticut and Pennsylvania – had rates of less than 10 percent.

In six states – Arizona, California, Louisiana, Nevada, New Mexico and Texas – more than 20 percent of residents lacked health insurance.

Gaining and Losing Health Insurance

Thanks to growth in private insurance coverage, the number of Americans without health insurance fell by 1.7 million from 1998 to 1999. That was the first time in 12 years that this problem has gotten better instead of worse.

While the Census Bureau estimated that 42.5 million people went without health insurance for the whole year, most people who become uninsured do not stay that way. People usually are eager to obtain coverage, even if it means switching jobs.

Some people move in and out of coverage, usually as they get a job or lose one. Others are offered health insurance at work, but turn it down.

- **Two-thirds of those who become uninsured stay that way for less than a year, and 40 percent go less than six months with no health insurance.**
- **Someone living in poverty ($13,650 for a family of three in 1998) is four times more likely to be uninsured than those in families making 300 percent of the poverty level ($40,950).**
- **But almost 3 in 10 of the uninsured earn more than $40,000 a year. One in 12 lives in a household with income above $75,000.**

New Ground Rules on the Insurance Markets

While the employment-based health insurance system in the United States is voluntary, Congress and the states impose ground rules on the group insurance market, including provisions aimed at spreading out the costs and keeping premiums affordable.

If you and your family have always been insured, a health plan cannot refuse to cover you for a heart problem, asthma or any other chronic or pre-existing medical condition.

If you had a break in insurance coverage of 63 days or longer, when you sign up for a new plan, the insurer can make you wait 12 months before paying for treatment of the pre-existing condition. After that, it must cover the condition the same as any other illness.

The bottom line: It pays to be insured and stay insured.

But not everybody gets that opportunity, and some workers who are offered health insurance don't take it, often because of the expense.

- **Five out of six workers say their employer offers a health plan to some or all workers. (Often, part-time or temporary employees are ineligible).**
- **Three-quarters said they were offered coverage at work, and a sizeable majority takes up that offer.**
- **Still, fewer than two-thirds of employees participate in their own employer's health plan.**
- **The number of workers declining coverage has grown from 1 in 9 a decade ago to 1 in 6 today.**
- **Almost 14 million workers declined coverage in 1997. Nearly 3 million felt they couldn't afford it.**
- **Some turn it down because they are covered under a spouse's policy. Others were gambling that neither they nor their family members would get seriously ill or have an accident.**

That's a difficult bet to lose.

Health insurance is not inexpensive. But if you've ever landed in the hospital or endured a serious illness, you know it is a relief to have coverage, especially for your children.

BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

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BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Blue Plan Initiatives

Keeping Healthcare Affordable

March 2002

Product Design

Pharmacy Cost Management

Disease/Care Management

Administrative Costs

Education and Communication

Evidence-based Medicine

Healthcare Cost Campaign

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Introduction

One of the most significant challenges facing businesses and consumers today is the rising cost of healthcare. Many businesses, confronted with these cost increases, are either offering reduced coverage to their employees or shifting more of the costs to them. In extreme cases, some businesses are questioning whether they can continue to offer healthcare insurance to their employees.

Blue Cross and Blue Shield Plans, committed to providing access to affordable healthcare have undertaken numerous initiatives to address rising healthcare costs.

This report describes those initiatives grouped in six key areas:

- Product design
- Pharmacy cost management
- Disease/care management
- Administrative costs
- Education and communication
- Evidence-based medicine

Specific examples are provided to illustrate these initiatives.
For more information, contact Gary Verdon at gary.verdon@bcbsa.com or Neepa Patel at neepa.patel@wro.bcbsa.com.

Area #1: **Innovative products** that address the rising costs of healthcare.

Blue Cross and Blue Shield Plans are addressing rising healthcare costs by developing innovative insurance products. These products act to mitigate rising costs in several ways:

- Reducing the high costs often associated with providing healthcare to the uninsured
- Providing choices that allow consumers to select healthcare that best matches their needs
- Enabling consumers to take active roles in matching the healthcare they receive with the associated costs

This section reviews four types of coverage designs being offered by Blue Cross and Blue Shield Plans to address rising healthcare costs while continuing to provide access to quality care.

Low Cost Products to Maximize Access

Several Blue Cross and Blue Shield Plans have developed insurance products targeted at those consumers who do not have employer-based insurance available to them. These low cost products allow more people access to preventive care and screenings, which help to keep health problems from becoming severe and requiring expensive treatments.

Blue Cross and Blue Shield of Louisiana

Launch Date:	August 2001
Product Type:	PPO, Indemnity
Target:	Uninsured
Enrollment to date:	100+ businesses

In August 2001, Blue Cross and Blue Shield of Louisiana launched a more affordable group product for business owners. Nearly one-fourth of Louisiana's small businesses do not offer health insurance benefits to their employees.

trueBlue, a fully comprehensive group health insurance plan, allows small business owners to realize premium savings of up to 45 percent over other, more traditional Blue Cross and Blue Shield of Louisiana PPO plans. This product is available in both PPO and traditional indemnity plans, and offers a variety of deductibles and out-of-pocket maximums.

The trueBlue plan features a benefit design that makes premiums less expensive for employers by allowing members to share more of their first-dollar healthcare coverage. The plan is based on two benefit categories: (1) hospital/inpatient and outpatient services and (2) prescription drugs. Members are responsible for two separate deductibles, one for each benefit category. Once the deductible is met under each category, the cost of healthcare is shared on a coinsurance basis, usually 80/20, until the out-of-pocket maximum is met. Then the plan pays 100 percent of the allowable charges for covered services. A second option is also available, which includes three deductible categories: (1) inpatient services, (2) outpatient services and (3) prescription drugs.

There has been strong interest in this product and more than 100 businesses have purchased the product to date.

Blue Cross and Blue Shield of Montana

Launch Date: Summer 2000
Product Type: Indemnity
Target: Uninsured

Montana has a large uninsured population, nearly 19 percent, in a population just greater than 900,000. Most employers in Montana are small businesses, a significant portion of which do not provide any healthcare benefits for their employees. A combination of low wages and increasing healthcare costs makes the cost of health insurance high, and often unattainable, for the average worker and his/her family.

Blue Cross and Blue Shield of Montana developed the BlueCare product with significant discounts from physicians and hospitals in order to achieve a more affordable premium. BCBSM worked with the provider community to promote understanding of the benefits of accepting discounted rates versus no payment from uninsured patients. The Plan worked closely with three hospital partners and several multi-specialty medical groups to develop a more affordable health insurance product.

The insurance commissioner encouraged the effort in the development of this product and upon filing the benefit plan with the commissioner's office, approval was expeditious.

Cost savings to the consumer for the BlueCare product premiums are approximately 50 percent compared to a regular indemnity product.

Flexible Options Products

Blue Cross and Blue Shield Plans are offering employers flexible option products, including defined contribution plans, that enable employees to make informed decisions on their healthcare coverage and the related costs. Employees can choose a lower premium with correspondingly higher deductibles and co-pays associated with the coverage, or vice versa based on their willingness to share in the cost.

Blue Cross Blue Shield of Massachusetts

Launch Date:	January 2002
Product Type:	PPO, HMO, POS
Target:	Groups of 100+
Enrollment to date:	1,000 members (in first month)

Blue Cross Blue Shield of Massachusetts launched several product initiatives in January 2002 to create new options for customers who want to be more involved with their healthcare decision-making.

One of these is an initial offering in the category of "defined contribution" or "consumer self-directed" plans and is known as Tri-Blue. Tri-Blue is a triple option plan which enables employers to offer employees a choice of three plans with varying price, product and benefit coverage; one low, one medium and one high. Price is influenced by the deductible and co-pay levels chosen. The employer chooses the three plans to offer from 12 standard plans that are arrayed as low, medium or high. The employer may target their contribution to one of the low, medium or high levels; Blue Cross Blue Shield of Massachusetts recommends that employers target to the medium level and allow employees to buy up or buy down to meet their needs. Tri-Blue is available to employers with over 100 employees on an insured and self-funded basis. The potential cost savings from the product offering will depend on the employer specific situation, the products selected and the contribution strategy.

Blue Cross of California

Launch Date: April 2001
Target: Small groups

In April 2001, Blue Cross of California began offering Flexscape, a defined contribution product for the small group market. This product is geared toward employer groups with 2-50 employees and is designed to help employers better manage their healthcare costs while offering employees more choice. Flexscape allows the employer to contribute a fixed amount of money per employee for healthcare coverage. Employers can contribute at three different levels – $80 per employee per month, $100 per employee per month, or greater than $100 per employee per month. Employers then choose from among Blue Cross of California's current small group products, and provide a selection of products for their employees with varying levels of cost. Employees use an online decision tool called EmployeeElect Plus to help decide on the most appropriate product. They can use pre-tax dollars to pay for the remaining premium cost or for non-covered benefits.

Regence Blue Cross Blue Shield

Launch Date:	November 2000
Product Type:	PPO, POS and HMO
Target:	Small groups (26–250)
Enrollment to date:	2,200

Regence Blue Cross Blue Shield has partnered with MyHealthBank to provide a defined contribution tool for employers. This product provides Internet-based, self-directed healthcare options for employees, giving them more control and flexibility, while providing more financial stability for employers.

In this model, employers determine a selection of insurance products for their employees. Employers can choose from a number of Regence's products including PPO, POS, and HMO products. Next, the employer provides a defined contribution for each employee. The employee uses the MyHealthBank website to compare the health plan choices and enroll in the most appropriate plan based on their budget and healthcare needs. Depending on the product's price, the employee may have some money left over. Remaining money is deposited into a health bank called the Health Freedom Account. The money in this account is pre-tax and can be used toward non-covered healthcare expenses or out-of-pocket costs, or can be rolled over for the next year.

Products Offering Tiers of Provider Networks

Another type of product being offered by Blue Cross and Blue Shield Plans provides consumers with a way to factor the cost of care into their choices of physicians and/or hospitals. These products present several levels of provider networks each with a different cost. Tiers can be created based on several criteria: provider classifications, such as community hospitals versus academic medical centers; comparative overall cost of treatment adjusted for severity and other factors: or reimbursement rates and geographical access.

This variance in cost to the consumer can be delivered in one of two ways. First, the employer contributes a fixed amount to the monthly premium and the employees' monthly payroll deduction will be lesser for lower level tiers and correspondingly more for higher level tiers. Alternatively, the monthly payroll deduction might be the same across the tiers, but the dollar coverage for services may be fixed and the consumer would be responsible for the incrementally higher cost for services at higher tiered hospitals.

By providing the necessary information and including the member in the cost decision, members are encouraged to make careful choices about the level of resources they choose to access.

Premera Blue Cross

Launch Date:	June 2002
Product Type:	Flexible forms of EPO and PPO
Target:	Group, followed by individual

Premera Blue Cross is addressing rising healthcare costs by building a tiered network of doctors. The tiers consist of three groups:

- group of physicians who accept the Plan's standard payment, or whose measured efficiency compares favorably to a regional average;
- group who opts for higher payments; and
- group who does not contract directly with Premera Blue Cross.

The first group of physicians will be part of every insurance policy offered. This tier is designed to be a fully adequate network. Doctors whose reimbursement levels fall into the higher categories described above, will be in the second and third tiers.

These groups or tiers can be mixed and matched in a variety of insurance plans – with varying prices and out-of-pocket costs. The option is offered to employers beginning in 2002.

Employers and members are able to choose from varying networks and see how their costs will differ, based on their choices. Premera Blue Cross's tiered networks enable physicians, employers and consumers to make more informed decisions about the cost and quality of healthcare, while maintaining choice.

Blue Shield of California

Launch Date:	January 2002
Product Type:	PPO, HMO (except Medicare HMO), POS
Target:	Small and Mid-sized Groups (<300) and Individual and Family Plans
Enrollment to date:	Applies to all members (except Medicare)

Healthcare costs associated with hospitals have risen dramatically and some hospitals are significantly more expensive than others. Blue Shield of California (BSC) has introduced a "network choice" program that gives consumers a choice to limit the costs of their own healthcare while enabling Blue Shield to provide members with a broad network of hospitals and curb potential premium increases.

The network choice program categorizes hospitals as "choice" or "affiliated" based upon their cost. More than 80 percent of BSC's hospitals are in the choice category. Members who receive services at a choice hospital will not be charged additional co-payments or coinsurance, while those who receive non-emergency services at an affiliated hospital will pay a higher co-payment or coinsurance.

To be launched in April 2002 with small and mid-sized groups (< 300) and individual and family plan members, the program will eventually expand to include large groups. Medicare members are not included in the program and emergency services will not trigger the higher co-payments.

High Deductible Products

Blue Cross and Blue Shield Plans offer a variety of products with high deductibles. This group of products addresses rising healthcare costs by enabling consumers to influence their healthcare decision-making. The consumer pays for all healthcare until the deductible is reached. Upon reaching that threshold, additional healthcare costs are covered by the Plan with a co-pay for the consumer. The monthly premiums are lower for these products, therefore, employers may cover all of the premium costs for these products and not require employees to make any monthly contributions. In fact, some of these products also include medical savings accounts (MSAs). In these cases, employers contribute to the MSAs which employees use to offset their healthcare costs below the deductible.

Blue Cross and Blue Shield of Minnesota

Launch Date:	January 2002 & April 2002
Product Type:	MSA
Target:	Individual, small groups
Enrollment to date:	Small group: first month enrollment is 60+ groups, project 600 groups in year 1. Individual: With April 2002 launch, 1,500 individual accounts by the end of 2003.

Blue Cross and Blue Shield of Minnesota is offering several products with high deductibles, including a group of products designed to work with medical savings accounts (MSA). A qualified MSA product was introduced in late 2001 to small employers and an individual product will be available in April of 2002. Additionally, the Plan is currently developing a high deductible product with a personal savings account for large groups.

The qualified MSA plans for small groups and individuals offer deductible levels for singles of $1,650, $2,100, and $2,500. Family rates are approximately twice as much. The large group products may have any number of deductible levels.

These products address rising healthcare costs in two ways. First, as discussed previously, these high deductible products educate consumers on the costs of healthcare and enable them to make active decisions about the healthcare that they receive. Second, the flexibility of the design contributes to their affordability, which helps reduce the number of uninsured and the related cost pressures of the uninsured on the healthcare system.

Blue Cross and Blue Shield of Minnesota, *continued*

The premium for MSA Blue is 22 percent lower than Blue Cross and Blue Shield of Minnesota's highest deductible comprehensive medical management plan. At the same time, because the savings accounts are federally qualified, the employer's contribution is tax-deductible. Combined, the high deductible plan and tax preferred status should result in substantial overall savings for group and individual purchasers.

In addition, the savings accounts currently (as of February 2002) earn 4.5 percent interest for the member.

Blue Cross of Idaho

Launch Date:	October 2000
Product Type:	PPO
Target:	Individual and small groups

Blue Cross of Idaho has developed a high deductible health insurance plan that is compatible with a federally qualified Medical Savings Account (MSA). MSA Blue℠ PPO utilizes Blue Cross of Idaho's statewide PPO network and is currently available in the individual and small group markets. Blue Cross of Idaho endorses a local MSA administrator to coordinate the MSA portion of the package. Unused dollars are invested in the MSA on a tax-deferred basis and roll over from year to year.

The MSA component of this product promotes the member's involvement in making choices and decisions on how to spend their healthcare dollars. The product was launched in October 2000, and has experienced steady growth in enrollment.

Area #2: Programs aimed at moderating cost increases of **pharmaceuticals**.

The rapidly rising cost of pharmaceuticals is one of the most significant challenges facing the healthcare industry. Blue Cross and Blue Shield Plans have, and continue to seek ways to limit the high cost increases associated with prescription drugs. Many consumers, particularly the elderly, cannot afford the medications they need to stay well. This further exacerbates the problem by placing them at risk for more serious, and more costly, medical conditions and accompanying treatments.

Many Blue Cross and Blue Shield Plans have three-tier prescription drug benefits in place which provide optimum cost coverage for less expensive alternatives. Consumers bear more of the cost when they or their providers choose a more expensive drug if there are less costly, equally effective options available. The identification of less expensive alternatives allows the Blue Cross and Blue Shield Plans to play a key role in the moderation of rising pharmaceutical costs.

Additionally, because providers are largely responsible for the decisions about pharmaceuticals, physician education on the use of generics is a key area of focus for the Plans.

Plans have also in-sourced pharmacy benefit management functions in order to gain more control over their pharmacy costs.

Benefit Design

Blue Cross and Blue Shield Plans have developed innovative pharmacy benefit designs to both lower utilization and encourage cost effective choices by shifting some of the costs to the members. These benefit designs include 3-tier drug benefits with high co-pays, customized formularies, tiered co-insurance and reference pricing.

Blue Cross Blue Shield of Hawaii

Launch Date:	Mid-1999
Target:	All groups
Enrollment to date:	234,000
Initiative:	Reference Pricing Drug Benefit

Blue Cross Blue Shield of Hawaii developed a new reference pricing drug benefit designed to encourage members to make cost effective choices and manage their rising pharmacy costs.

It is a modified 3-tier drug benefit:

- **Tier 1** — Generics ($5 co-pay)
- **Tier 2** — Preferred Brands ($10 co-pay)
- **Tier 3** — Other Brands ($15 co-pay + the difference between the non-preferred brand price and the average price of the drugs in Tiers 1 and 2 for the therapeutic class)

Blue Cross Blue Shield of Hawaii conducted a broad marketing and education campaign to all constituencies to ensure employers, members, pharmacies and providers understood the new design. This benefit design has been well received and offers members choice because every drug is covered on a tier.

This benefit design was launched in mid-1999 and has approximately 50 percent of the Plan's commercial membership currently enrolled. Blue Cross Blue Shield of Hawaii has lowered their pharmacy costs from a projected $33 per member per month in 2000 to $25 per member per month and estimate overall savings of 14 percent.

In-Sourcing Pharmacy Benefit Management Functions

Blue Cross and Blue Shield Plans have in-sourced various pharmacy benefit management (PBM) functions in order to gain more control over pharmacy costs. Many Plans have significant market share in their markets and are able to negotiate the same or better deals with the pharmacy networks and drug manufacturers for rebates as their PBMs. Many have found that it is helpful to have formulary and clinical management together and that being able to integrate pharmacy data with hospital and physician claims data enables better pharmacy management.

Blue Shield of California

Launch Date: 1997
Initiative: In-sourced Pharmacy Benefit Management

Blue Shield of California provides all pharmacy benefit management functions internally with the exception of claims processing and mail order. In addition, they have benefit designs with closed formulary and 3-tier co-payment benefits. Significant savings have been realized from in-sourcing formulary management and contracting with manufacturers for rebates/discounts. They are able to maximize their rebates as they can drive market share of drugs through their benefit designs, with the goal of contracting for clinically equivalent lower-cost drugs.

Blue Shield of California in-sourced contracting and formulary management in 1996. With internal costs of less then $500,000 annually for these functions, they have been able to save an estimated 2 percent of drug costs, approximately $10 million annually on a $500 million drug budget. Additional reductions of drug trend have been achieved with benefit design changes and internal benefit management. These savings are passed on to the consumer through reduced premium increases.

Area #3: **Disease and care management** programs that seek to improve health and control costs.

The disease and care management programs implemented by Blue Cross and Blue Shield Plans help members and providers monitor and maintain treatments associated with chronic diseases such as asthma and diabetes. These programs help to control healthcare costs through the avoidance of more costly medical intervention necessitated by a lack of preventive care.

Additionally, through monitoring of utilization reports, the Plans can help providers better manage at-risk patients.

Providing physicians and members with proactive health solutions.

These programs focus on education that helps members better understand their conditions and the treatments necessary for managing their diseases. This effort assists physicians and encourages members to be more proactive in their own care.

Blue Cross and Blue Shield Plans/National Diabetes Collaborative

Launch Date: Spring 2001
Initiative: Collaborative disease management program

The National Diabetes Collaborative (NDC) is a multi-focused initiative involving approximately 20 BCBS Plans that began in Spring of 2001. Currently there are four initiatives in various stages of implementation:

- **Administrative Data Analysis** — Create data collection methods to examine diabetic care indicators, utilization, and cost using administrative data in the PPO population.
- **Baselining/HEDIS Outcomes Evaluation in Disease Management** — Collect information on how Plans follow ADA guidelines, implement DM interventions, and use HEDIS measures, and develop a consensus Blue diabetes care guideline.
- **ROI in Diabetes Disease Management** — Develop a consensus data model on efficacious and cost effective disease management programs.
- **Physician Performance Measurement** — Examine the unique issues associated with measuring physician performance in open access systems and document Plan practices.

Blue Cross and Blue Shield of Missouri

Launch Date:	April 1997
Target:	Physicians and at-risk members
Participants to date:	6,000
Initiative:	Asthma, high-risk maternity and diabetes disease management

Blue Cross and Blue Shield of Missouri assists physicians and members with educational materials on asthma, high-risk maternity and diabetes, and information to help them coordinate members' care.

For those members who have participated in the asthma program, both clinical and utilization outcomes have improved significantly. During a four-year period, Blue Cross and Blue Shield of Missouri has seen emergency visits decrease from more than 25 visits, to about 10 visits per 1000 members in the asthma program. During the same period, members not in the program saw asthma-related emergency room visits increase from about 17 to 19 visits per 1000 members. And as expected, the medical costs for people in the program decreased while costs for people not in the program remained unchanged. Costs for members with asthma in the program were down about 50 percent while it remained stable for members with asthma not in the program. From 1996 through 2000, asthma-related costs decreased from $63 per member per month to $37 per member per month for members with asthma, exclusive of pharmacy costs. This translates to a $1.2 million asthma-related medical cost reduction in 1999-2000. Total program costs for 1999-2000 were $170,000.

Another successful program launched five years ago for pregnant members in the company's Alliance PPO and BlueCHOICE HMO is the RightSteps program, which uses a combination of maternity case management and educational materials to help members and their physicians manage maternity care. Members who participate in the program deliver fewer low birth weight babies than would be expected. Among low birth weight infants that were born to RightSteps members, these low birth weight babies had fewer complications and lower first year medical costs than their non-RightSteps, low birth weight counterparts. Savings due to fewer babies and infants with medical complications are equal to three times what was invested in the program.

Blue Cross and Blue Shield of Missouri *(continued)*

Maternity costs in 2000 for RightSteps participants were slightly higher than for the non-RightSteps cohort - $14,113 vs. $13,441 per member. However, infant medical costs (from date of birth through first birthday) were much lower for infants whose mothers were RightSteps participants ($355 per member per month) than for infants of non-RightSteps mothers ($621 per member per month). This represents a $350,000 cost savings.

In August 2001, Blue Cross and Blue Shield of Missouri began offering a comprehensive program to PPO and HMO members with diabetes. Of about 444,000 members initially eligible for this program, the company estimates that about 11,000 members have diabetes. These members and their physicians will have access to educational materials on managing diabetes. The members also will have the support of a team of registered dieticians associated with the TakeCharge Diabetes Program.

Blue Cross and Blue Shield of Kansas City

Launch Date:	2000
Target:	Physicians and at-risk members
Initiative:	Asthma, chronic obstructive pulmonary disease, diabetes and congestive heart failure disease management

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"Healthy Companion: Working Together for Better Health" is Blue Cross and Blue Shield of Kansas City's umbrella program for four disease state management initiatives. The targeted diseases are asthma, chronic obstructive pulmonary disease, diabetes and congestive heart failure. Rolled out on a staggered basis in 2000, the programs provide both members and providers with education and support for disease management.

The Healthy Companion programs aim to provide proactive, preventive interventions that focus on health management and truly provide for patient empowerment and responsibility for care of their health. The program uses an "engagement" rather than enrollment format. This means that all members identified with a disease are considered "in" the program and will have intervention unless they actively opt out.

For members, interventions are focused primarily on education about standards of care and self-management of their disease(s). They are supported with educational mailings, assessment and educational calls from disease-specific case managers. The frequency of calls is based on risk stratification (higher risk, more frequent calls/contacts).

The program has many elements for providers including: evidence-based guidelines that outline standards of care, chart reviews with reports about how their own panel of members meet the standards of care, aggregate outcomes for the health plan on standards of care, a provider 800# number, web-based support for program interventions and a quarterly newsletter that highlights different standards of care throughout the year. Annual outcome reports are shared with providers and include utilization measures, quality of life measures for those who are part of the program, process measures about the activity in the program, and satisfaction measures for both members and providers.

Outcomes available to date from the first full year of the program have been very positive. Quality of life measures for those who are part of the program have seen significant improvement. Member-reported utilization has shown significant decreases. Member satisfaction is very high and ranges from 82-89 percent overall satisfaction, depending on the disease program. Participation in the programs has been good, with only 5-8 percent of members opting out of the programs.

Integrated program of health management products and services

Several Blue Cross and Blue Shield Plans are offering their members services for Integrated Condition Management and Shared Decision Support through an outside business partner. These products and services enable healthcare organizations to reach and engage their members with a collaborative, shared decision-making model of healthcare management. The desired outcomes of the initiative are to improve the appropriateness of medical care, increase patient satisfaction and control overall costs.

Blue Cross and Blue Shield of North Carolina

Launch Date:	1998 & 2000 (Health Dialog)
Target:	At-risk members
Participants:	BCBSNC anticipates contacting approximately 47,000 members in 2002 alone who are candidates for one of the health management programs.
Initiative:	Integrated population health management program, including case management and shared decision-making components.

In 2000, Blue Cross and Blue Shield of North Carolina began offering a set of Health Dialog's products to their managed care populations. North Carolina's high-risk population is offered coaching and decision-support services for their chronic disease conditions. The Health Coach is an experienced registered nurse with whom a member can share their concerns, 24 hours a day, 7 days a week. The patient can either phone the Health Coach directly or request a callback. In addition to the health coaching program, the general managed care population has access to the services for minor medical condition symptom management and nurse triage.

From 1998 through 2000, BCBSNC's integrated population health management programs documented significant cost savings. Such savings are computed into future premiums, to help moderate medical cost increases.

Blue Cross and Blue Shield of Michigan

Launch Date:	1999
Target:	Informed consumers and at-risk members
Participants to date:	1.5 million members
Initiative:	Integrated Care Management Program

Blue Cross and Blue Shield of Michigan, beginning in early 1999, began expanding current care management programs, offering new care management services and enhancing access to health and wellness information to their members. The purpose of these efforts is to educate and empower patients to take a more active role in their own healthcare – resulting in an improvement in the quality of care and health status. Over the past two years, the Plan has enhanced and integrated these multiple programs, resulting in a fully integrated program that guides members into intervention levels that more effectively address their health needs. These program levels are:

- **Guided self-management:** provides members with health education, symptom management and shared decision-making services, including videotapes, self-help handbooks and audio tapes. Partnering with Health Dialog, Inc., BCBS of Michigan incorporates a "reach and engage" strategy through which members are encouraged to contact the Plan for help with specific conditions, and are offered assistance from a nurse "health coach", helping members to self-manage their conditions and, along with their providers, make informed decisions on the treatment options that are best for them.

- **PersonalPath.com website** (through a partnership with PersonalPath Systems, Inc.) – available to the entire membership – provides personally-relevant health and treatment information, products, and services that empower consumers to make informed health care decisions for themselves and their families. PersonalPath.com allows all users – sick, well, and those providing care for others – to take a more active, better-informed role in managing their health care needs. While Blue Cross and Blue Shield of Michigan makes the site available state-wide, members can receive an added level of personalized content from PersonalPath.com's unique technology platform, which uses de-identified member health care information to deliver only the most individually-relevant information and services to the user. To date, more than 110,000 Michigan members have registered as users of the website.

Blue Cross and Blue Shield of Michigan, *continued*

- **Integrated case and disease management:** provides telephone-based management to members with high cost or high risk chronic and acute conditions, as well as those who may be at risk for future complications as a result of their conditions. As a part of the partnership with Health Dialog, BCBS of Michigan has developed and applied predictive modeling techniques and statistical methodologies to proactively identify members at risk for chronic conditions and high health care costs. Nurses aid members and providers with coordination of services, moving them from one level of care to another as needed, and management of their disease in accordance with established clinical guidelines.

- **Complex case management:** provides on-site and telephone-based management to the sickest members of the population, addressing their serious, often terminal, illnesses.

Through partnership with PersonalPath Systems, Inc.'s Franklin Health program, these services are provided to complement the Plan's existing case and disease management programs and address the portion of the population that accounts for over 30 percent of the medical claims cost to the Plan. Franklin Health's studies have shown that treatment in the complex case management programs can reduce claims costs by as much as 25-30 percent.

As the integrated approach to care management grows, BCBS of Michigan believes there are opportunities to increase the use of effective treatments, while reducing the use of those that are marginally effective. More informed health care consumers make better – and less costly – health care decisions.

Area #4: Addressing and reducing **administrative costs** through the use of innovative technological solutions.

Blue Cross and Blue Shield Plans are implementing systems that reduce administrative costs, not only internally, but also for providers and members.

Many Blue Plans encourage providers to file claims electronically which saves time and money for both the providers and the Plans. Claims can be filed more quickly and accurately and require less follow-up when standardized.

By addressing the resources required for handling functions such as claims payment and enrollment, Plans are able to significantly reduce administrative costs.

By enabling members to access automated information about common or simple questions, Plans are able to significantly reduce the costs required to service these requests and to better focus on more complex issues.

Blue Cross and Blue Shield of South Carolina

Launch Date:	2000
Target:	Physicians and members
Initiative:	Easy access to member information

Blue Cross and Blue Shield of South Carolina has Internet-enabled both member and physician self-service functions in order to provide faster, more convenient service to two of their most important constituent bases.

Many of the customer service inquiries from both members and physicians that traditionally came into the Plan through its call centers, can now be transacted via the Internet product, My Insurance Manager. This capability allows both members and physicians to be more productive by allowing them to conduct inquiries at their convenience using a secure Web application. Information is available 24 hours a day, 7 days a week, expanding the time frame from traditional customer service hours, and eliminating wait time on the phone for members and providers.

The functionality currently available to members and physicians in My Insurance Manager over the Internet includes: ID card request, eligibility, benefit booklet, deductible/out-of-pocket status, claim submission, claim status, explanation of benefits statements, referral submission and referral/authorization status, other health insurance status, primary care physician change, bill status, and customer service inquiries. The Web site, www.SouthCarolinaBlues.com, also features a searchable provider directory.

Blue Cross and Blue Shield of Illinois

Launch Date:	2001
Target:	Physicians
Initiative:	Real-time claim resolution

Blue Cross and Blue Shield of Illinois has partnered with RealMed to implement a real-time claim resolution system. This system connects the Plan to physician offices and enables real-time claims processing via the Internet. This system positively impacts costs from a labor, mail and customer service perspective.

Physicians are motivated to sign-on to the program by knowing that their claims will be processed immediately versus the 30 to 40 days required by traditional payment systems.

As of November 2001, Blue Cross and Blue Shield of Illinois had signed agreements covering 1,116 doctors and, in that month, 51,000 claims were completed electronically. In January 2002, over 22,000 claims were processed electronically.

Area #5: **Educating** stakeholders on issues that affect the rising costs of healthcare.

Blue Cross and Blue Shield Plans are providing educational resources to their members and other stakeholders. This information is delivered to members through Plan direct contacts. Additionally, Blue Plans are reaching out to wider audiences through the incorporation of these messages into Plan public and community relations programs. These resources focus on two key areas:

- Providing information on the reasons for rising costs allowing consumers to make better decisions about managing their healthcare options

- Educating consumers on better health management and increased safety thereby helping reduce the need for costly medical treatments due to accidents or other preventable conditions

Promoting Understanding of the Causes of Rising Healthcare Costs

Several Plans have developed materials designed to inform members, business leaders and legislators about the reasons for rising costs. These materials address not only the reasons, but also provide information about healthcare options that help to lower costs.

More informed stakeholders are better able to make appropriate decisions and to influence those factors that are driving healthcare costs.

Independence Blue Cross

Launch Date:	Fall 2001
Target:	Brokers and employers
Initiative:	Providing information that enables business decision makers to make more educated decisions about health insurance

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Independence Blue Cross has distributed a brochure to brokers and employers entitled The Challenge of Rising Healthcare Costs. The brochure provides background information and education on why costs are skyrocketing, addressing topics such as: the aging population, technological advances, prescription drugs, the impact of legislation, and litigation and malpractice costs. By providing information on the reasons behind rising healthcare costs, Independence Blue Cross seeks to work cooperatively with their stakeholders toward the common goal of access to quality healthcare that is also affordable.

Blue Cross and Blue Shield of Vermont

Launch Date: 2000
Target: Members, general public
Initiative: Providing prescription drug information via a public symposium

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Given prescription drug cost increases of more than 20 percent in most group health benefit programs and the significant challenges these increases pose for group purchasing, Blue Cross and Blue Shield of Vermont organized, sponsored and hosted a major public symposium in the fall of 2000 on the high cost of prescription drugs.

This symposium meeting featured a number of prominent local and national experts discussing the forces that are driving high prescription drug costs, as well as possible strategies to control drug expenses. It was videotaped and aired throughout the fall on local cable television stations across Vermont.

BlueCross of Northeastern Pennsylvania

Launch Date: Fourth Quarter 2000
Target: Members, general public, business decision makers
Solutions: Providing information via an integrated communications campaign

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In the fourth quarter of 2000, BlueCross of Northeastern Pennsylvania launched an integrated communications campaign to help key constituents understand major issues impacting the costs of healthcare including: healthcare cost drivers, the complexities of the regulatory atmosphere, and the decline in reimbursement rates.

A proactive educational approach was employed through the use of press releases and five full-page newspaper advertorials. Supporting the media initiatives were: a series of editorial board meetings with local newspapers in targeted areas; customer and business roundtables throughout the Plan's coverage area; one-to-one employer meetings; and member meetings.

BlueCross BlueShield of the Rochester Area, BlueCross Blue Shield of Central New York, and BlueCross BlueShield of Utica-Watertown

Launch Date:	Summer 2001
Target:	Members, general public, business decision makers
Audience to date:	900,000+
Initiative:	Integrated campaign that provides information on-line, in print and in presentations

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These three Blue Cross Blue Shield Plans, owned by Excellus, Inc. – independently, collectively and through the New York State Conference of Blue Cross and Blue Shield Plans – have ongoing efforts directed at educating the public and other stakeholders on the rising costs of health care. The Plans actively call for greater collaboration among stakeholders. They act to promote evidence-based medicine and regional centers of excellence, along with system-based solutions that enhance quality and contain costs. Additionally, the Plans and the Conference are also continually working with business groups and others to fight against mandates.

Some specific efforts include:

- Health Policy Reports developed to educate key business leaders and stakeholders about health care issues and trends. Reports to date include a detailed analysis of what drives health coverage premiums in Upstate New York, a report on coverage for experimental treatments through clinical trials, and a report on the uninsured and rates in upstate New York communities. The reports are promoted by news release and in mailings to community and business leaders.

- Newspaper inserts in the Sunday editions of major daily newspapers describing the key areas of health-care costs.

- A monthly TV report in Utica, New York on healthcare issues.

- The New York State Conference of Blue Cross and Blue Shield Plans website (http://www.nysblues.org) which provides factual information on public policy issues. Updated materials on this site are promoted to reporters and via e-mail notifications to community and business leaders.

- A presentation by the CEO of Excellus to New York State's largest business lobbying group on what businesses can do.

- A presentation by the COO of Excellus to business leaders in Syracuse.
- Presentations by BCBS management to local business and community leaders about the major drivers of premium increases, trends, and actions to reduce the rate of increase.

Additionally, the Plans convene stakeholders – providers, business, and government – to discuss potential initiatives to address rising healthcare costs, e.g. capacity management. These meetings educate stakeholders on the drivers of rising healthcare costs and identify potential obstacles for initiatives designed to address rising costs.

Blue Cross and Blue Shield of Minnesota

Target:	Members, providers, employers and legislators
Initiative:	Providing information and resources on the use of health care services and better health management

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Blue Cross and Blue Shield of Minnesota focuses on educating all of their stakeholders on the optimal use of healthcare services, while attempting to improve health outcomes.

Their efforts include:

- Helping employers understand how their employees use healthcare services, how to structure their health plan to meet company needs and how to address rising costs through cost-sharing measures.
- Health Behavior Assessments and Individual Health Modification Reports for employees
- Cost trends kit for agents and media that explains and illustrates the real drivers of healthcare costs.
- Care enhancement programs for heart disease, diabetes and more than a dozen chronic conditions with the potential to save more than $2 for every dollar invested. (To be launched mid 2002) Also have disease management programs for 14 rare diseases.
- Identifying and supporting community-based solutions to health problems
- MinnesotaDecides, an initiative to engage Minnesotans in healthcare reform
- MinnesotaActs, a grassroots program to help Minnesota communities tackle teen tobacco use
- Health-focused community grants of nearly $1.4 million have been awarded
- Care enhancement, including regular interaction with nurses, for 16 common conditions and 14 rare diseases. These programs help people stay healthier with their conditions, which in turn, lead to fewer emergency room visits and hospital stays.

BlueCross BlueShield of Tennessee

Launch Date: October 2001
Target: Members, general public
Initiative: White papers on pharmacy costs and health plan affordability.

In October 2001, BlueCross BlueShield of Tennessee released a white paper report entitled *Rx for Pharmacy Costs in Tennessee*. This paper takes an in-depth look at the reasons behind escalating prescription drug costs and the impact on consumers and the healthcare industry. Because Tennessee leads the nation in per capita prescription drug use, the report highlights specific information on healthcare trends, demographics, and policies throughout the state.

The goal of this report is to provide members and the general public with the information they need to put drug companies' advertising into perspective and understand the choices and control that they have over their healthcare costs.

In early 2002, BlueCross BlueShield of Tennessee released its second white paper, entitled *Health Plan Affordability in Tennessee* that addresses the conditions and concerns that drive rising health plan rates.

Specifically, the paper examines the broader issue of increasing health insurance cost. This paper seeks to describe the major factors impacting the increase in health premiums at BlueCross BlueShield of Tennessee by outlining the drivers and conditions that affect health plan affordability.

Providing Information on Health and Safety

Reducing the occurrence of accidents and promoting good health habits help reduce costs by avoiding the need for expensive treatments. Blue Plans are working to educate consumers on how to stay healthy and safe.

Blue Cross and Blue Shield of Alabama

Launch Date:	1998 & 2000
Target:	Members, general public
Initiative:	Information on health and safety

Blue Cross and Blue Shield of Alabama's program focuses on educating members and the general public about the prevention of common accidents, for example wearing bicycle safety helmets and using seat belts. Launched in 1998, this program/campaign is titled "BeCareful BeSafe." BCBS of Alabama has partnered with the state of Alabama on several projects to promote safety, including four-color posters for Alabama public schools.

This program was developed in response to the increasing loss of life and serious injury to Alabama's population, especially its children, due to the lack of use of seat belts, child safety seats and appropriate cycling safety helmets.

The BeCareful BeSafe initiative has had a strong response from the marketplace. Members request copies of the messages and seem to find this theme engaging and easy to remember.

The Jefferson County Department of Public Health awarded Blue Cross and Blue Shield of Alabama's BeCareful BeSafe campaign with its highest Public Service award in 2000. The Alabama Department of Public Safety reports that seat belt usage is at an all-time high in Alabama.

"For Your Health" is a web-based and print campaign that targets the general public. This campaign, which began in 2000, emphasizes patient/customer responsibility in the healthcare cost equation; it also stresses the importance of good communication between doctors and patients. Many of the more than 140 topics address the health and safety needs of children, appealing to parents and caregivers to raise a healthy and safety conscious generation.

Public and Community Relations programs

Blue Cross and Blue Shield Plans are delivering messages about the rising costs of healthcare via the many community outreach programs with which they are involved. Plans use these programs to inform the general public on both the causes of rising costs, as well as to provide information and access on health management issues like screenings and prevention.

Blue Cross and Blue Shield of Florida

Launch Date:	Fall 2001
Target:	Members, medically under-served Floridians
Audience to date:	Statewide general public
Initiative:	Screenings and wellness programs

Through various community relations programs, Blue Cross and Blue Shield of Florida provides caring solutions and affordable healthcare choices by providing screenings and wellness information to help prevent catastrophic illnesses.

The wellness programs work to combat rising costs by encouraging healthy behaviors that help prevent serious health problems. The screenings provide access to detection services that seek to identify health problems early, before they become catastrophic.

Early detection and treatment of breast cancer is a major focus in this area. Among the activities focused on this disease by the Plan are:

- A donation of $300,000 for a mobile mammography vehicle in Jacksonville
- Breast cancer education materials delivered through sponsorship of the Koman Race for the Cure

Additionally, Blue Cross and Blue Shield of Florida strengthened its commitment to the community in 2001 with the establishment of a separate philanthropic foundation, The Blue Foundation for a Healthy Florida. The Blue Foundation's purpose is to support programs that promote the health and well-being of the uninsured and underserved. Providing access to medically under-served residents impacts healthcare costs through the prevention and/or early detection of otherwise catastrophic conditions.

The Blue Foundation awarded $925,000 in 2001 to sixteen non-profit organizations across the state of Florida for such diverse programs as educating older adults about prescription drugs, to training physicians on women's heart disease symptoms, to improving the lives of adolescents with diabetes.

Anthem Blue Cross and Blue Shield

Launch Date:	1998
Target:	Female members, ages 35-60
Initiative:	Education and screenings for women's health issues

In 1998 and 1999, Anthem Blue Cross and Blue Shield Plans in Indiana, Ohio and Kentucky launched a program called Anthem's Healthy Woman. The program, which targets women between the ages of 35 and 60, provides information on prevention and management of illnesses, as well as education about treatment options.

The program kicked off with a five-city tour of health events featuring information booths, a nationally known speaker and a panel of local health experts who responded to questions from the audience. Attendance at the events, which were heavily promoted to bring awareness to women's health issues and the resources available to them, was by invitation only. Additionally, Anthem's Healthy Woman program also included a component offered to the general public. In collaboration with Kroger Food Stores and Procter & Gamble, thousands of women were reached through a month-long program offering on-site mammograms and health information materials in stores.

After evaluating the program's effectiveness over a two-year period, it was determined that providing high-profile speakers and information materials were good things to do but there were additional ways to involve women more closely in the care of their health. In 2000, Anthem repositioned Anthem's Healthy Woman as a worksite wellness program. Preventive health screenings and health education materials are offered at the worksite, or in the case of broker events, at a site convenient to most participants. Women get personalized health risk assessments from licensed practitioners and have the opportunity to talk over their individual results with Anthem's Healthy Woman's medical director. The program also includes a healthy lunch and well-known speakers.

In 2001, in evaluations completed after the events, women said that they were more likely to improve their diets and perform self-breast exams as a result of the activities and screenings offered. By a large majority, they also said that they were more likely to start exercising as a result of learning more about heart health. These screenings identified attendees that had several risk factors for heart disease, including high levels of cholesterol and high blood sugar. In the case of a recent Kentucky event, a majority of the women were found to have high cholesterol and high blood sugar.

By targeting women at work, Anthem can maximize its ability to deliver messages that speak to the importance of maintaining a healthy lifestyle.

Area #6: Supporting **Evidence-based Medicine** through TEC and RxIntelligence.

Systemwide, Blue Cross and Blue Shield Plans are committed to addressing the issues that affect rising healthcare costs. Some of the initiatives designed to impact these issues are developed through the Blue Cross and Blue Shield Association for use by all of the Blue Plans.

Two significant initiatives are the Technology Evaluation Center and RxIntelligence.

BCBSA is a strong supporter of evidence-based medicine in a number of national settings: in partnership with national medical specialty organizations, as an important resource to federal agencies, and as an advocate of medically necessary care that embraces the concept of evidence-based medicine. This payer leadership role is valued by employers seeking effective care for their employees.

Technology Evaluation Center

Launch Date:	1985
Target:	Providers, health plans, large employers
Initiative:	Promote evidence-based medicine through assessments of medical technologies

Blue Cross and Blue Shield Plans are leaders in promoting evidence-based medicine for their members. Blue Cross and Blue Shield Association lends support to promoting effective care on behalf of BCBS Plans through the Technology Evaluation Center (TEC).

TEC is a nationally recognized and respected program that assesses complex medical technologies and procedures. These evidence-based TEC Assessments are crucial guides to help Plans make important clinically based business decisions about effective care and coverage.

Evidence-based medicine is an extraordinary demonstration of effective cost management. The learning from evidence-based assessments of medical technologies enables medical practitioners to utilize the limited resources available to them on treatments they know will work.

TEC Assessments and evidence reports provide the foundation on which organizations – such as physician specialty societies – develop clinical practice guidelines, as well as tools and strategies for improving the quality of health care services. TEC Assessments provide objective information to those who deliver and manage medical care. They are based on clinical and scientific evidence and evaluate whether a technology improves health outcomes, such as length of life, quality of life and ability to function. TEC assessments are not recommendations for coverage decisions by health insurance companies.

An average of 20 to 25 assessments are published per year, providing health care decision-makers with timely, rigorous and credible information on clinical effectiveness. Since 1985, TEC has completed more than 300 assessments.

Recently, TEC expanded its scope to help consumers make informed choices about their care. Summary, consumer-friendly TEC Assessments as well as the full TEC Assessments are now available to the general public. Through bcbs.com, and in partnership with national organizations such as Coalition of Cancer Cooperative Groups, Blue Cross and Blue Shield Association is helping our members make informed choices in a time of need.

Through the Agency for Healthcare Research and Quality (AHRQ), the federal government has designated TEC as one of a limited number of Evidence-Based Practice Centers. As an Evidence-Based Practice Center, TEC provides analyses of complex clinical issues at the government's request.

RxIntelligence

Launch Date:	2001
Target:	Providers, health plans, large employers
Initiative:	Promote evidence-based medicine through assessments of pharmaceutical efficacy and costs

An independent, non-profit organization founded by the Blue Cross and Blue Shield Association in 2001, RxIntelligence is dedicated to finding reasonable answers to questions about prescription medications.

RxIntelligence gathers, reviews and disseminates information to subscribers and is designed to aid in evaluating new medicines and comparing the effectiveness of existing and new drugs.

Research done through RxIntelligence provides information on the safety and efficacy of new drugs recently approved or approaching final Food and Drug Administration (FDA) approval.

The research findings impact rising costs through the analysis of drugs in the same class to determine if they are interchangeable, and how costs and outcomes compare. The findings also compare different therapeutic alternatives for a defined episode and determine the cost and clinical outcomes for a defined episode, the functional status of the patient at the end of an episode and the measurement of the patient's acceptance/appropriateness of treatment.

RxIntelligence's evidence-based drug evaluation program is committed to:

- Promoting the delivery of rational medical care with more predictably consistent outcomes
- Evaluating the efficacy and possible risks of new and existing pharmaceuticals
- Offering a credible source of information for medical policy and decisions
- Validating the uniqueness of new drugs and the therapeutic interchangeability of existing drugs
- Evaluating the impact and appropriateness of off-label usage
- Helping physicians and consumers make decisions about drugs

The RxIntelligence board of directors includes representatives of Blue Cross and Blue Shield Association, American Academy of Family Physicians, Ingersoll-Rand Company, International Union UAW and Kaiser Permanente of Southern California.

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