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Health

Balancing for Success 2004: The Top Ten Issues Facing the Managed Health Care Industry

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Introduction

IN A TREND THAT HAS BEEN GATHERING MOMENTUM FOR THE PAST FEW YEARS, COST CONTINUES TO BE THE DOMINANT ISSUE FACING THE MANAGED HEALTH CARE INDUSTRY, AND THE HEALTH SECTOR OVERALL.

While cost is not the only issue present among the top ten, its pervasiveness means that all other issues, trends, challenges and opportunities can only be understood in the context of cost.

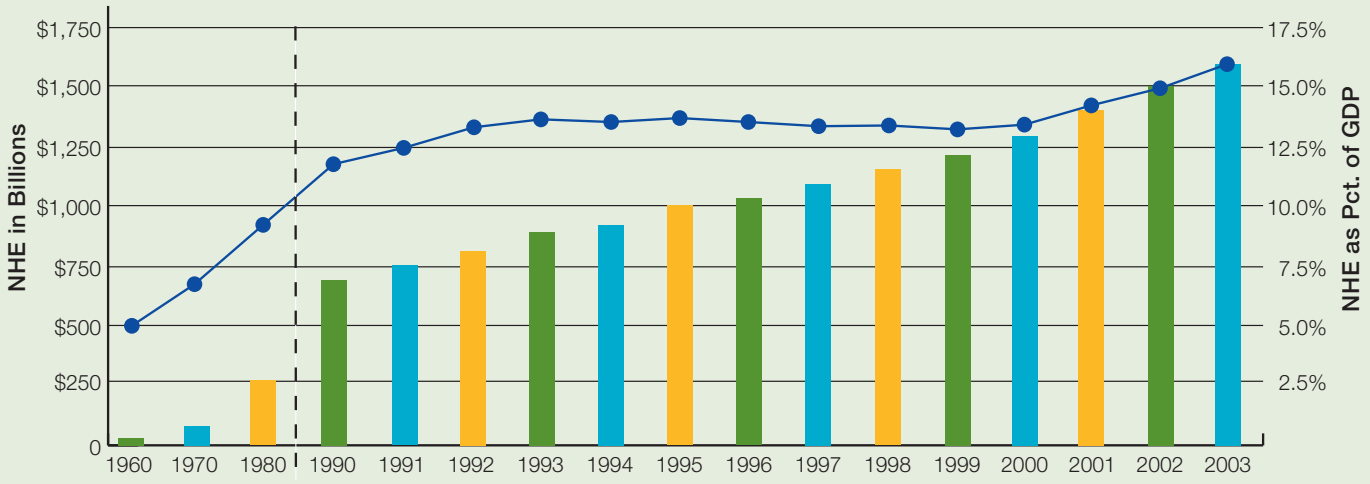
Perspectives were gained from interviews Capgemini conducted in late 2003 and early 2004 with executives of many of the nation's leading health insurance, Blue Cross Blue Shield, and managed health care organizations. Through the course of our conversations, certain issues emerged as consistent and interrelated themes:

1. **Affordability**
2. **The Uninsured**
3. **Medical Cost Inflation**
4. **Medical Management**
5. **Hospital Systems**
6. **Provider Reimbursement**
7. **Administrative Costs and Operational Efficiencies**
8. **The Health Care Consumer**
9. **Liability**
10. **The Government**

This paper explores the complex issues and challenges health plans are navigating—as well as Capgemini's insights into helping our clients weather the storm and set new strategies for safe passage.

Affordability

EXHIBIT 1: National Health Expenditures and Their Share of Gross Domestic Product, 1960-2003

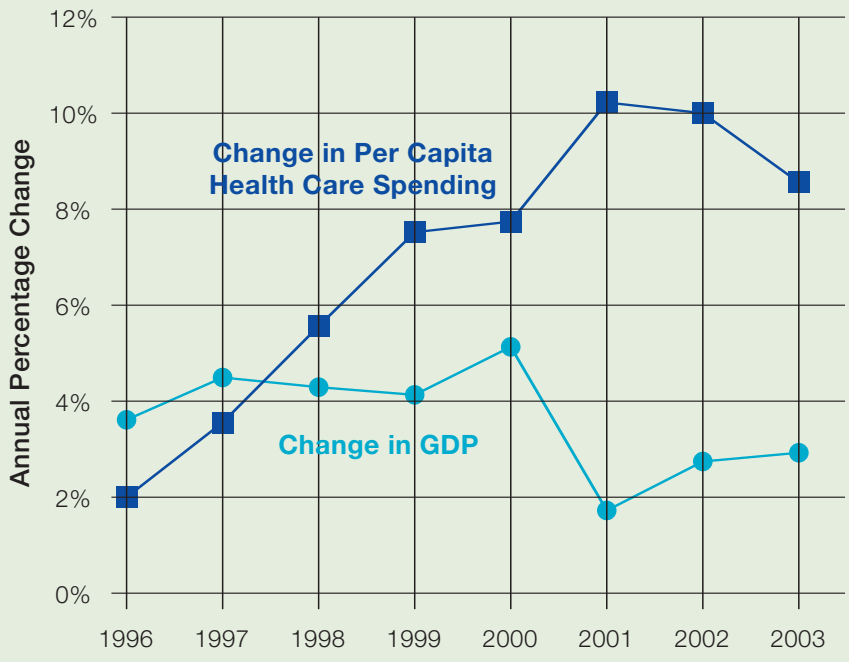


Source: Centers for Medicaid and Medicare Services (CMS), Office of the Actuary

1. Affordability

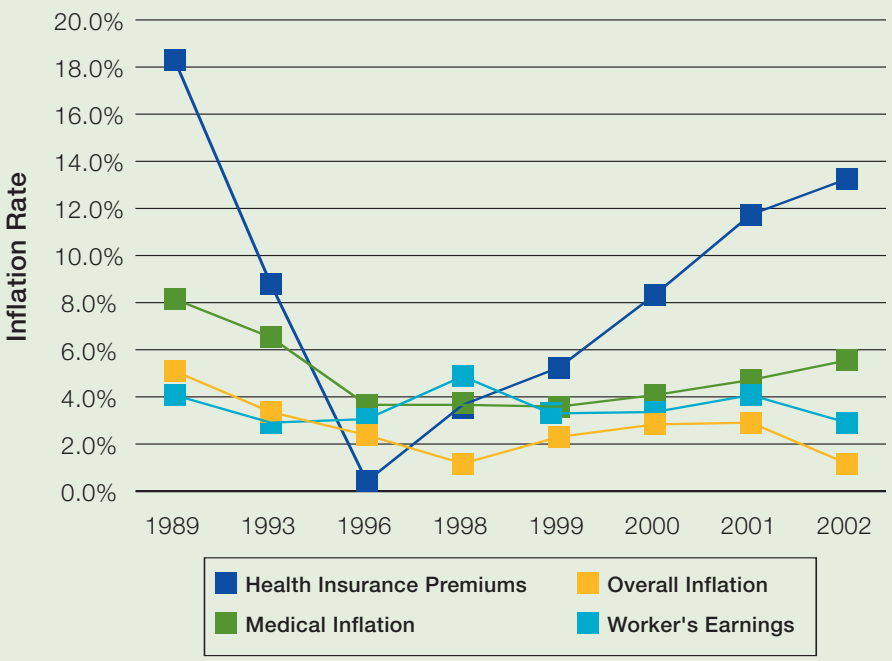
Just as in past years, affordability remains at the top of the list of issues concerning executives in the industry. Declining affordability is the direct result of rising costs, but is also affected by the economic environment in general. As illustrated in *Exhibit 1*, the total spend in health care is now in excess of $1.7 trillion. It is more than 15% of the gross domestic product (GDP) .As the graph illustrates, health care costs have always risen (even while commercial premium costs remained stable in the early 1990s). The booming economy of the early and mid-1990s helped to hold it at slightly more than 13.1% of GDP. But now, costs are escalating at a furious rate. At the same time, we have experienced economic slowing. Even though we are seeing some early downward movement of health care cost inflation as well as a modest improvement in the overall GDP, as shown in *Exhibit 2*, there remains a wide gap between the two.

EXHIBIT 2: Economic Weakness Coupled with Soaring Health Costs



Source: Center for Studying Health System Change; Milliman USA Health Cost Index
U.S Department of Commerce, Bureau of Economic Analysis

EXHIBIT 3: Health Insurance Costs Eat Up Potential Wage Increases



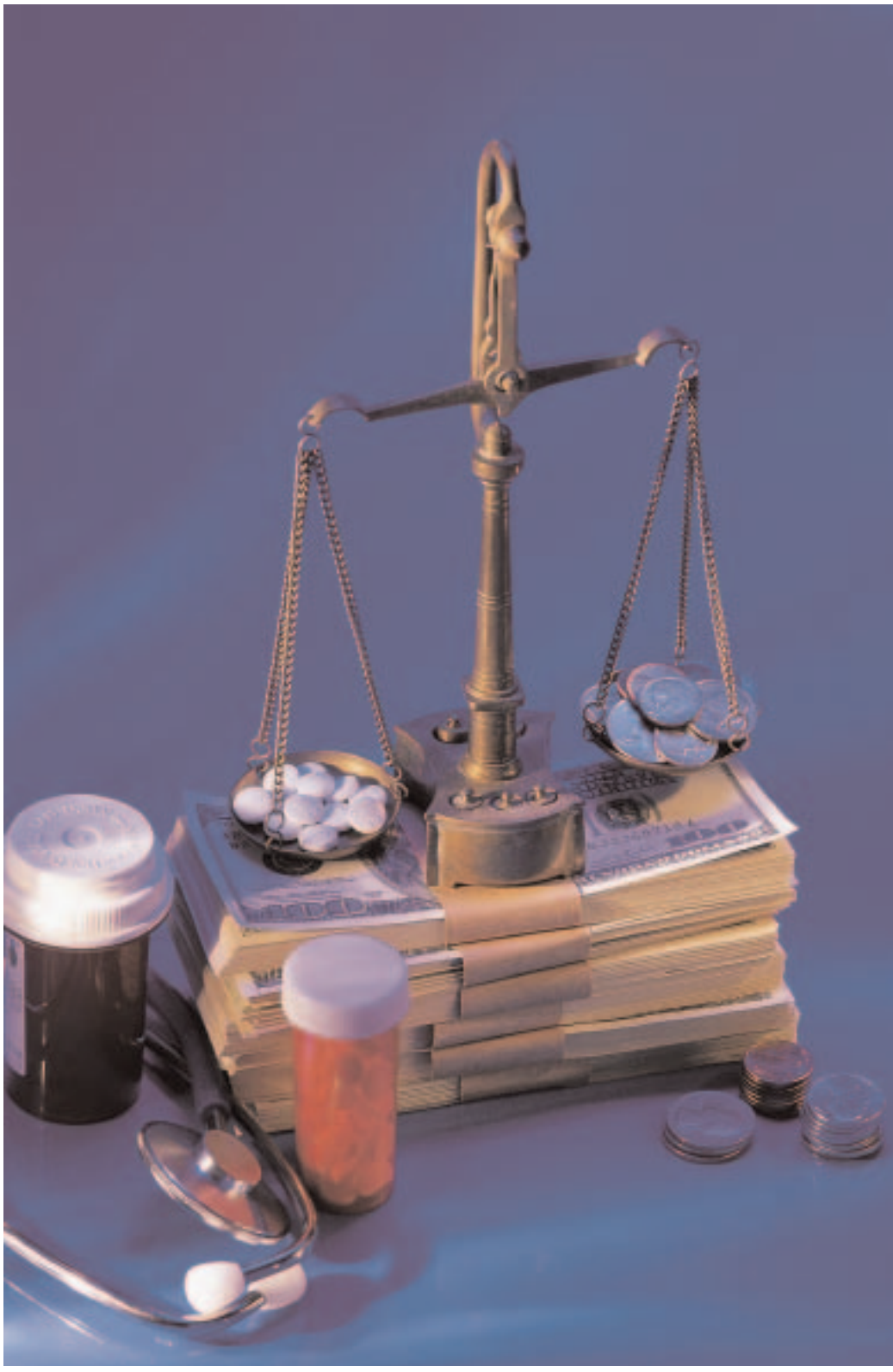
Source: Kaiser Family Foundation/Bureau of Labor Statistics
U.S Department of Labor

Exhibit 3 demonstrates the effect of rising health insurance premium costs on wages. Companies have only so much money available for employee benefits overall, including wages, health insurance and other benefits. When health insurance costs show significant inflation, there is simply less money available for all other employee benefits, the primary one being wages.

The problem of affordability is felt both by consumers and by businesses that provide coverage for their employees. Employers' responses vary, depending on their size and financial strength. Large employers have asked their employee benefits consulting firms to negotiate with health insurers and managed care organizations (MCOs) more aggressively than ever. Large employers still absorb most of the cost increases, but are increasingly passing on some of those costs to employees in the form of higher deductibles and copays or coinsurance, as well as larger payroll deductions. Some large and medium sized employers are also experimenting with so-call Consumer Directed Health Plans (CDHPs), which are discussed below.

Small employers are feeling the greatest pain. As the CEO of a major Blue Cross/Blue Shield plan stated: "Our biggest competitor is not another health plan — it's no insurance at all." In other words, small employers are dropping coverage altogether when it becomes unaffordable. The problem of affordability becomes even worse when jobs are lost, hiring is slow, and new jobs that are created are often lacking in health insurance benefits.

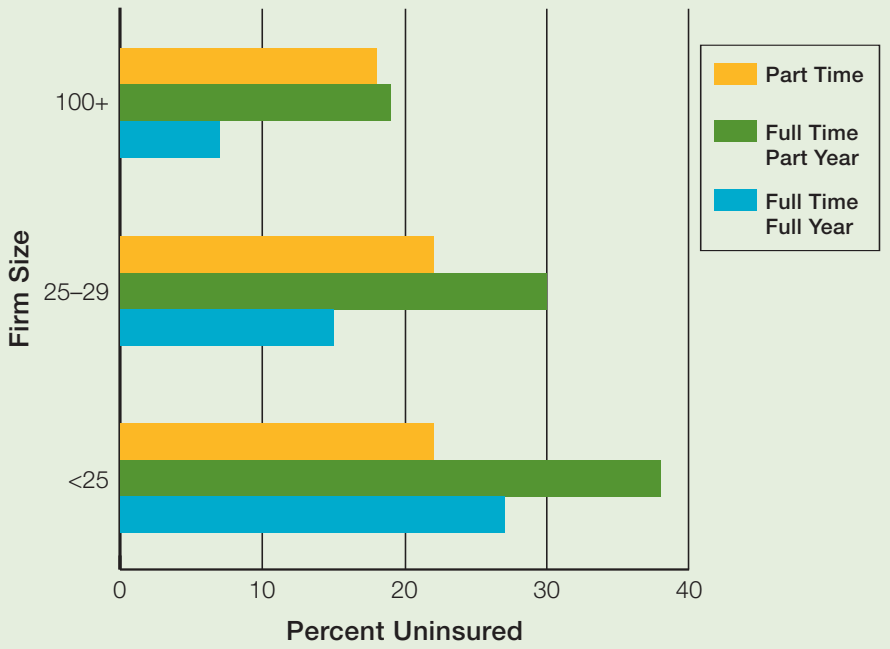
Even as costs continue to rise across the country, there are some pockets of slower increases in medical costs. In 2003 and 2004, medical inflation in the mid-Atlantic was reported by MCOs to be in the high single digits. In other parts of the country, rates have held steady, and a few plans have even provided a small rate reduction or premium "holiday" due to slowing medical cost trends. To support evidence of a slow down in medical cost inflation, the Office of the Actuary of the Center for Medicare and Medicaid Services (CMS) projects growth in spending in 2003 will be 7.8%, down from 9.3% in 2002.[1] The reasons for this moderating trend have not become apparent and it is far too soon to know if this represents a long or even medium term trend, so underwriters remain cautious when creating rates; however, some modest relief may lie ahead. It is not unreasonable to expect that the moderation will continue, at least for the short term and health plans continue to apply new medical management techniques, particularly advanced disease management as well as modifying benefits design, both of which are discussed in this document.



[1] Health Spending Projections Through 2013, *Health Affairs* Web Exclusive, February 11, 2004.

The Uninsured

EXHIBIT 4: Uninsured Rates Among Workers by Firm Size and Work Status, 2000



Source: Kaiser Commission on Medicaid and the Uninsured. Health Insurance Coverage in America, February 2002.

2. The Uninsured

The number of Americans without health insurance continues to rise. In 2002, over 41 million Americans were without health insurance, and by 2003 that number had risen to 43.6 million. Not all of the uninsured are unemployed, however. As illustrated in *Exhibit 4*, workers in small firms in particular are at risk of not having health insurance, and the current rapid rise in insurance premiums is going to accelerate this trend. Add to this the reaction of states attempting to control Medicaid costs by reducing the number of people eligible, and the pool of uninsured rises even faster.

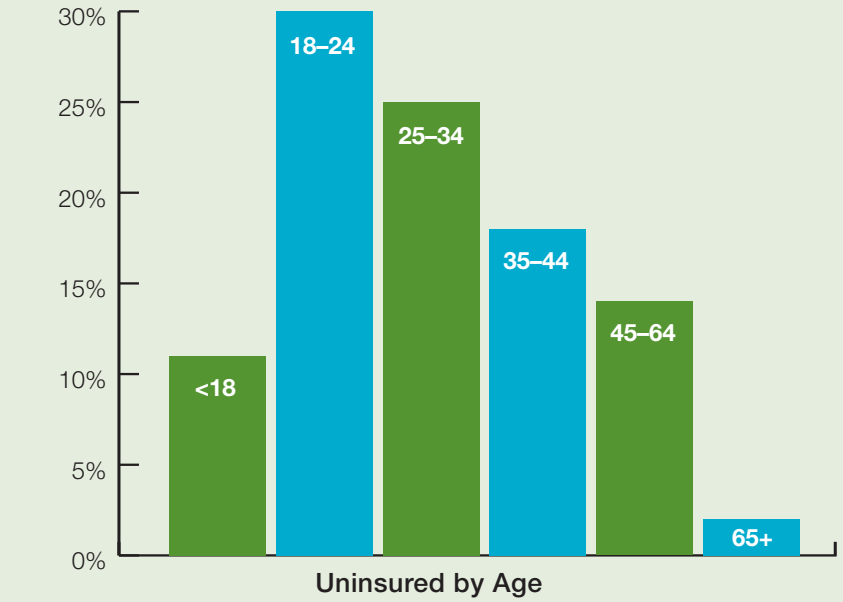
The problem of the uninsured has a direct impact on the cost of health coverage through its effect on the risk pool. *Exhibit 5* demonstrates that the majority of the uninsured are young and presumably healthier (based on the general concept that as one ages, medical problems are more likely to arise and persist). Since employment usually follows the LIFO (last in, first out) principle, this also means that the

work force tends to be somewhat older and presumably less healthy. The net effect is to further accelerate the cost of health insurance for workers who have it.

Of those who lose their jobs, only one in five purchases insurance through their COBRA benefits. This is not surprising, since according to a 2002 Robert Wood Johnson Foundation report, the average cost of COBRA family coverage was $600 per month, while the average unemployment benefit was only $939 per month. The cost of COBRA coverage has risen since then.

Every executive in the managed care industry considers the problem of the uninsured to be highly significant. There is broad support for the concept of universal coverage within the industry, though how such coverage would best be achieved produces various opinions.

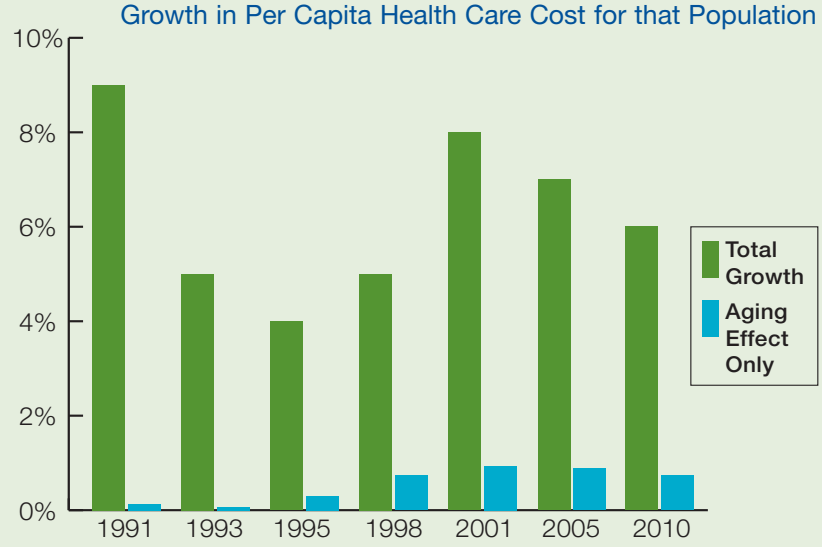
EXHIBIT 5: Weakness in Employment Levels and Health Cost Inflation Have a Negative Effect on the Risk Pool



Source: U.S. Census Bureau, September 2003.

Medical Cost Inflation

EXHIBIT 6: Effect of Aging of Non-Medicare Population on the Annual Growth in Per Capita Health Care Cost for that Population



Source: Brandle C. Strunk and Paul B. Ginsburg, center for Studying Health Systems Change, Data Bulletin No. 23, September 2002, Figure 1.

3. Medical Cost Inflation

The overall problem of affordability is simply a manifestation of medical cost inflation. Even with the moderation of trend that appeared in 2003 in a few parts of the nation, medical cost inflation remains substantially above overall inflation and indeed continues to outstrip overall growth in the GDP. The other component of cost — administrative costs — is far smaller in comparison (though still important). The reasons for medical cost inflation are far different now than they were during the last spike in medical costs. In the late 1970s through the mid 1980s, overutilization was a primary cause of rapidly rising costs. Managed health care brought this under some measure of control and we did see a relative lowering of medical cost inflation. Overutilization still occurs, but to a much smaller degree than in decades past.

There are many reasons for medical cost inflation. The usual suspects are: rising costs for institutional care (both inpatient and outpatient), the rising costs and uses of pharmaceuticals, regulations and benefits mandates, continued widespread variations of medical practice, litigation and the threat of litigation, and a variety of other reasons. Certainly the ability of hospital systems to negotiate from a position of strength has led to higher reimbursement. It is also commonly believed that the aging of the population is a major contributor, but some researchers have questioned this, as demonstrated in *Exhibit 6*. What there is no question about is that a small percentage of patients account for the vast majority of costs, as seen in *Exhibit 7*.

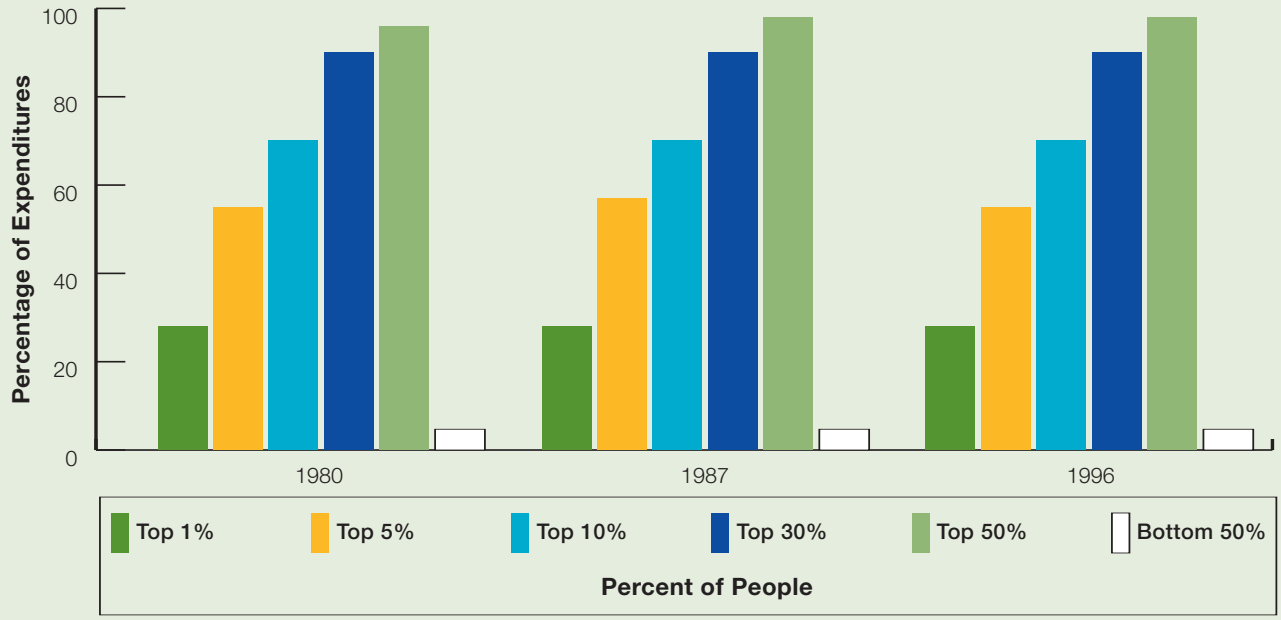
There are new suspects as well. First among these is the development of new technology. As medical devices get smaller and smaller, and become more easily implantable, their use skyrockets. Examples of such devices include implantable cardiac defibrillators and cochlear implants. Drug-eluting vascular stents are another example of an important new implantable technology that is even more widely used. Such new technologies are usually available

from only one or two sources, and therefore their costs are very high. This problem becomes exacerbated if Medicare does not reimburse a hospital for the true cost, and the hospital must therefore cost-shift to the private sector.

Genomics are just now on the horizon of pushing up medical costs. Existing genomic testing such as that used to determine preferred therapy in certain types of breast cancer are now being used more frequently than in even the recent past, and screening for drug efficacy by genetic typing is just around the corner. Since patent law in the U.S. allows the patenting of genetic markers, such testing is subject to fees to the patent holder. Related to this is the development of new biologic agents, which have yet to be factored into the cost mix.

In the 1980s when overutilization was clearly identified as a prime cause of cost inflation, there was considerable belief that costs could be brought under control. And by and large they were. In the new millennium, such hope does not presently exist. There are no clear and simple reasons for cost inflation. There are no villains. For this reason, most analysts do not see an easy answer to rising medical costs, even with the possible slow-down in cost inflation seen in some parts of the country this year.

EXHIBIT 7: Health Spending Remains Highly Concentrated on a Small Percentage of People



Source: Berk, Mark and Alan Monheit, The Concentration of Health Care Expenditures, Revisited," Health Affairs *March/April 2001.*

Medical Management

4. Medical Management

Medical management continues to evolve away from acute, episode-based interventions and towards advanced disease or care management, or population health management approaches. This involves the use of predictive modeling techniques to identify "at risk" patients who are about to incur large claims. Technology enables prioritized outreach to these people to prevent complications. The effect is to reduce the amount of inpatient and acute care, while increasing the amount of outpatient care, office care, non-physician based interventions, and drug utilization.

Due to financial pressures, MCOs have been looking to create a short-term return on investment (ROI). Organizations that are adopting the most comprehensive approach — which goes way beyond diabetes, heart disease, and asthma to include acid-related stomach disorders, low back pain, osteoporosis, fibromyalgia, incontinence, and irritable bowel syndrome — are generating a 3:1 return on their investment, and reducing their medical expenses by 2-3 percent. *Exhibit 8* provides data from one such organization.

At the same time that advanced disease management (DM) is showing improved results in cost, quality and member satisfaction, physicians are beginning to push back. One major complaint is that of being called by multiple DM vendors during the day. They see a lack of coordination as well as an increase in "hassle." Some physicians are demanding that the MCOs pay them the money that would otherwise be paid to the DM vendor, arguing that it is the physician that manages the disease. Many MCOs respond by trying to work with single DM vendors for all or most clinical conditions, thereby reducing the number of calls to both patients and physicians. Most DM vendors do work with community physicians. However, given the results of advanced DM programs, it is unlikely that MCOs will choose to stop using them in favor of simply paying physicians more money.

EXHIBIT 8: Population-Based, Advanced Disease Management

IMPROVED HEALTH	COST SAVINGS	MEMBER SATISFACTION
• Significant improvement in diabetics' Hemoglobin A1c levels. • A 14% decrease in the overall rate of hospital admissions. • 18% reduction in emergency room visits.	• Average savings in excess of $41 per program member per month. • ROI of at least $2.90 for every dollar invested. • Projected 2% to 3% reduction in total commercial health care spend rate for fully insured business.	• >95% of eligible members participating in the program. • 90% of chronic members and 74% of impact condition members were very or somewhat satisfied with the program. • 84% of core, chronic disease members and 64% of impact condition members report they had more control of their health. • 57% say the program helps them communicate better with their doctor.

Source: BCBSMN and American Healthways; September 2003.

Hospital Systems

5. Hospital Systems

Substantial regional consolidation has provided many health systems with an exceptionally strong negotiating position. This is not because hospitals are taking an unwarranted profit, however. They are under their own pressures, especially in hiring clinical personnel. The nursing shortage is the most problematic, but other clinical positions such as imaging technicians, pharmacists, and many others are also experiencing shortages. That means that hospitals must pay top dollar to attract such personnel. In addition to personnel costs, hospitals need to constantly keep equipment updated, deal with physical plant costs, and invest in new technologies. Add to this what many see as an impending hospital bed shortage, and it is highly unlikely that institutional costs are going to go down.

A pesky side note issue for MCOs and for community hospitals is the emergence of single-specialty hospitals. These hospitals focused on a single specialty with a high number of associated procedures. Cardiac care, orthopedics, and ear-nose-throat are examples. Full service hospitals claim that single-specialty hospitals "skim off" the most lucrative patients, including patients who are at low risk of complications, leaving the full service hospital to service those patients who are at higher medical risk and who are less profitable. MCOs worry that single-specialty hospitals, since they usually have physician equity, provide an economic incentive to physicians to overutilize. The recent Medicare Reform Act provided for an 18 month moratorium to study such hospitals, but the outcome after that is uncertain.

Managed care organizations see the need to create less of an adversarial and more of a "partnership" relationship with providers, but not through capitation or risk-based joint ventures, since those approaches have not been successful. Instead, payers and providers in some markets are beginning to collaborate to mutually improve their operational performance. They seek to establish more efficient linkages for eligibility, enrollment, denial management, registration and scheduling processes to reduce time and administrative costs. For example, by working together, they can eliminate rework from resubmissions, and reduce bad debts resulting from inaccurate eligibility, coordination of benefits (COB) or claims information.

Provider Reimbursement

6. Provider Reimbursement

Now that global capitation has significantly diminished in popularity and simple physician capitation is no longer increasing (and even decreasing in use), health plans are searching for ways to tie reimbursement to performance. In other words, create a new value-based reimbursement system.

Basing reimbursement on cost control is still a goal, but is no longer occupying center ground. Executives are now talking about trying to create value-based reimbursement to promote adherence to evidence-based clinical practice (both for physicians and for hospitals), and to focus on quality outcomes and patient safety. Several experimental reimbursement systems have been put into place in recent years, but it is too early to know if they are having any impact. In most cases however, the funding for such programs comes from improved medical cost control. One executive in the industry described the goal as "keeping base increases to mid single digits, while creating sufficient surplus to pay incentives above that."

Administrative Costs and Operational Efficiencies

7. Administrative Costs and Operational Efficiencies

Although administrative costs in health plans make up between 9% and 15% of the total costs, all health plans are actively seeking ways to reduce that amount. There are two primary ways to do so: increasing efficiencies and increased growth. The latter strategy simply means increasing the membership base so as to increase the leverage of support systems and personnel; i.e., increase the denominator more than the numerator. The former strategy involves changing business processes and often requires changes in information technology (IT), or at least how IT is used.

The goal of business process redesign in health plans is to reduce the number of transactions that require human intervention, and to reduce the amount of paper used overall. This means increasing the use of self-service by providers and members through the Internet as well as other means such as direct electronic connections and interactive voice response systems. As an overall goal, health plans want to move almost all routine provider-payor transactions to an electronic format, a goal that underlies the Health Insurance Portability and Accountability Act (HIPAA) rules on transactions and code sets.

The deadline for healthcare organizations to comply with the privacy and transactions and code sets requirements of the HIPAA regulations was October 16, 2003. However, Medicare gave itself an extension and allowed providers to continue to submit in the old format. Commercial health plans put contingency plans into place and likewise continued to accept non-conforming transactions. Likewise for all 42 Blue Cross Blue Shield plans. Some industry analysts estimate that fewer than 50% of providers have achieved true compliance with transactions and code sets. It is unclear when enforcement of the transactions and code set rules under HIPAA will take place.

Outsourcing has begun to take hold in this industry. There are two main types of outsourcing: IT only, and business process outsourcing. In the first case, the cost and management of the data center or the entire IT function may be outsourced to a company that specializes in IT, thereby allowing the health plan to cap its IT costs as well as to improve its reserve position under statutory accounting principals.[2] Business process outsourcing focuses on highly repetitive activities that require human intervention — key entry, for example. Such processes may be outsourced in the U.S. to a low-cost part of the country, or may be outsourced offshore. For example, one company images paper claims, and then provides access to the images to personnel in India to key enter them into the company's claims systems. The claim is then adjudicated in the U.S., but theoretically does not need to be.

One specific administrative issue raised in several plans is the need for a more functional identification (ID) card. In many cases, this is characterized as a "smart card." In other cases, a simpler swipe card is being contemplated. In all cases, the goal is to provide physicians and other providers with the electronic ability to do eligibility checking, ascertain the need to collect a deductible at the time of service, submit claims, and other routine business functions. As consumer directed health plans become more prevalent, the ability to such cards to interface with health reimbursement accounts becomes important.

[2] Under statutory accounting principals (SAP), unlike generally accepting accounting principals (GAAP), the value of I.T., buildings and other non-liquid assets cannot be used (other than a small percentage) to count towards financial reserves.

The Health Care Consumer

8. The Health Care Consumer

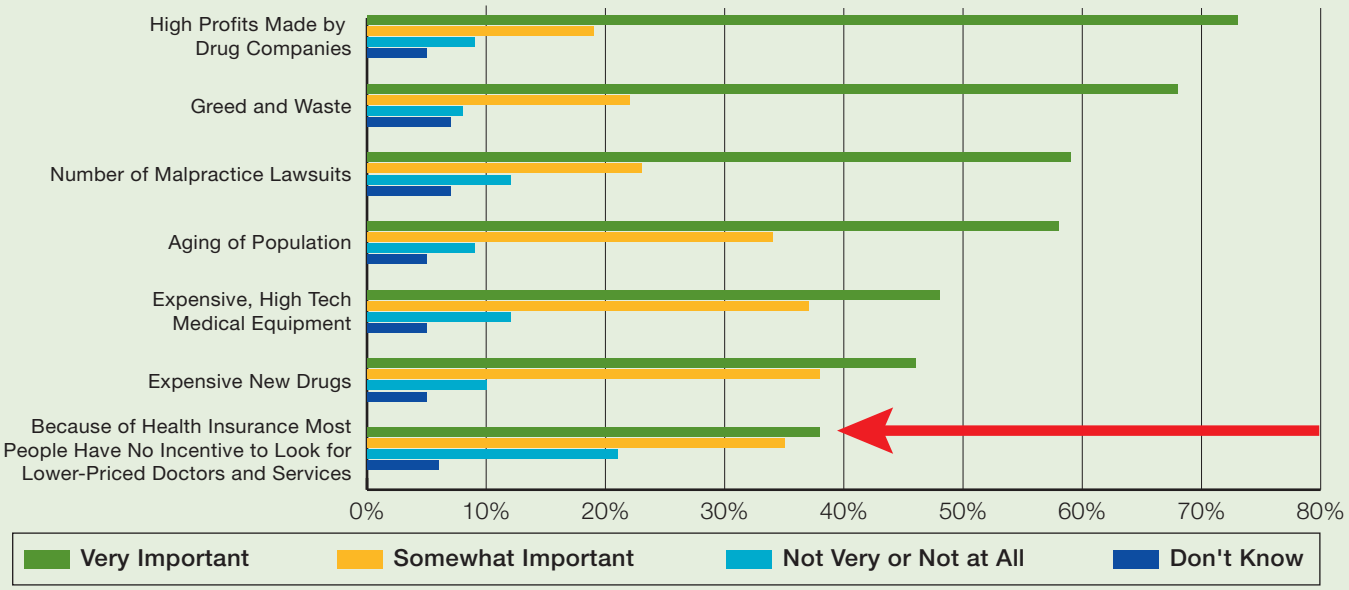
As health plans have moved away from "traditional" managed health care and towards new approaches in medical management, benefits design has also changed. The primary reasons espoused for changes in benefits design are to: (1) reengage consumers regarding the cost of health care, (2) get consumers to change their own behavior, and (3) attenuate premium price increases.

The first two reasons are based on the belief that consumers have been too disconnected for too long from the actual cost of the health care that they are asking (or even demanding) to have. Because of this disconnect, demand rises since there is little economic consequence. Executives in the health plans and provider systems, as well as many physicians, subscribe to this belief. Consumers do not necessarily agree, as evidenced by a poll taken in 2002 by the Kaiser Family Foundation, National Public Radio and the Kennedy School of Government (see *Exhibit 9*).

Consumer directed health plans (CDHPs) at this point share certain attributes:

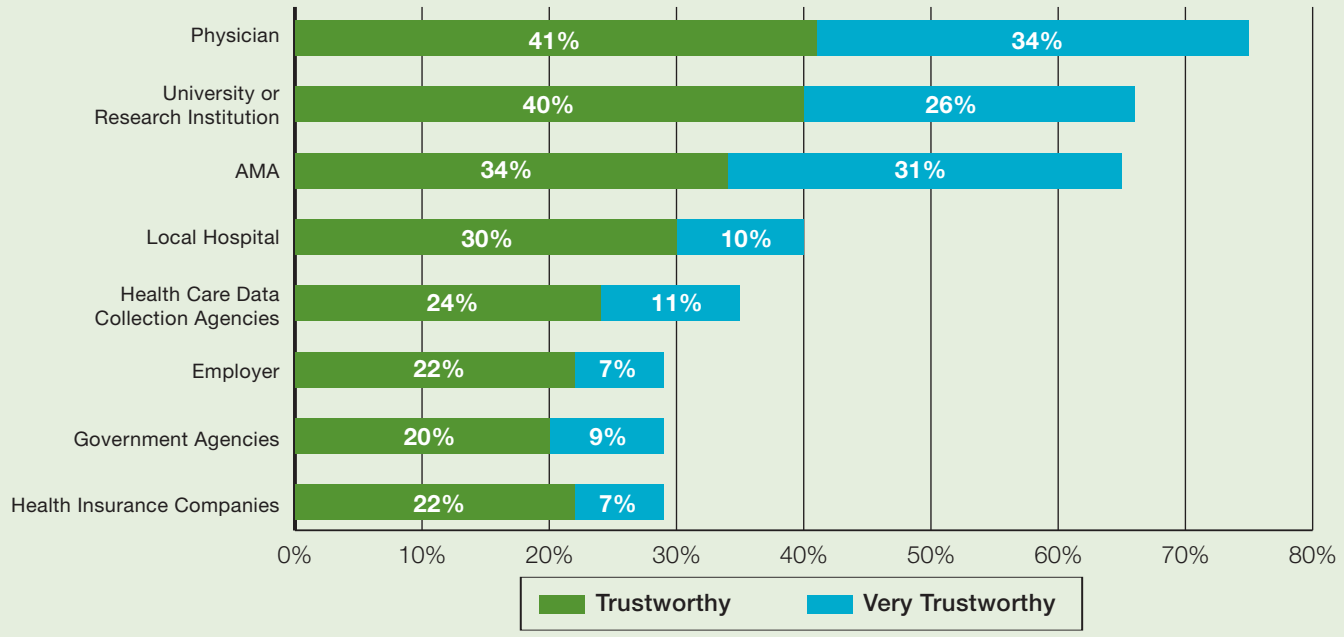
- The presence of a health reimbursement account (HRA) that is funded on a pre-tax basis with unused funds being able to roll from year to year
- A gap or "bridge" amount between the amount of funds in the HRA and when a catastrophic type health insurance policy comes in

EXHIBIT 9: Why People Think Health Care Costs Are Rising



Source: NPR/Kaiser Family Foundation/Kennedy School of Government Health Care Survey, May 2002.

EXHIBIT 10: Current Ratings of Trustworthiness of Information Sources



Source: VHA, Inc. Health Care 2001: A Strategic Assessment of the Health Care Environment in the U.S.

- Access to preventive services outside of the HRA arrangement (this is not universal in CDHPs however)
- Linkage to a preferred provider organization (PPO) to provide some level of fee discounting to consumers
- Information to allow consumers to make informed decisions about health care.

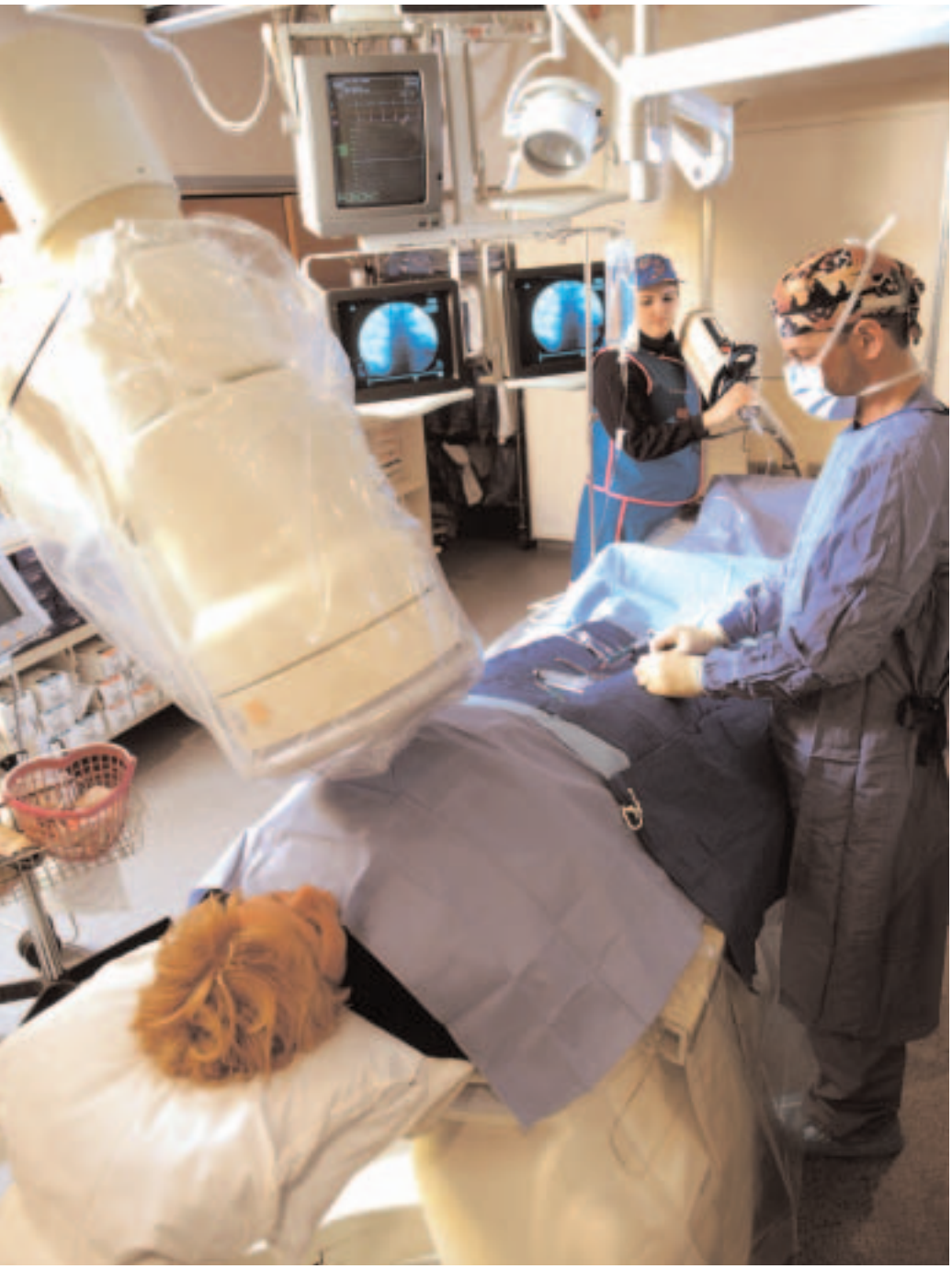
The difficulty at this time is that the amount and quality of information available to consumers is highly variable. [what do consumers need the information for?] Not all of it is useful, and there is little current evidence that consumers are using what does exist. An additional difficulty is that consumers generally do not trust health plans to the same degree that they trust providers for health information, as illustrated in *Exhibit 10*.

CDHPs have their detractors. Arguments against them include:

- Not all consumers are alike, and individuals with little discretionary income may not seek or receive all the medical care they need due to economic barriers
- Since the vast majority of health care costs are consumed by a small number of individuals (see *Exhibit 7*), CDHP designs have little or no impact on those people
- CDHPs do not appear to provide value and only function as a pure administrator.

While early reports are favorable in terms of both cost and member satisfaction, since enrollment in CDHPs remains relatively low at this time, it is not known what the ultimate impact on costs, quality or consumer satisfaction will be. There are stand-alone companies that specialize in administering CDHPs, and almost all health plans and insurers now have a CDHP option to offer. In all cases, strong actuarial and underwriting capabilities need to be present. A robust IT infrastructure is also required, as is access to information by consumers. Health plans that offer the benefit but cannot adequately administer it will quickly get into trouble.

Liability



9. Liability

Liability has always been an issue for health plan executives. The nature of liability has changed somewhat, however. In recent years, large class action lawsuits were both a threat and a drain on resources. While such lawsuits remain part of the landscape, they have begun to diminish somewhat in relation to medical malpractice lawsuits increasing. In some areas of the country, a significant number of medical malpractice lawsuits now name both the health plan and the health plan's medical director as defendants. This creates an understandably chilling effect on a health plan's or medical director's willingness to try and manage costs. The end result is the health plan passing the costs on to the consumers in the form of higher premiums.

A perverse effect of the liability problem is the hindrance on patient safety initiatives. Health plan medical executives note that hospitals and physicians are loath to document many problems with procedures for fear that such documentation will be subpoenaed and used against them. Documentation is at the heart of improving processes that will lead to increased patient safety. If it is not possible to identify systematic errors or problems that have a negative effect, then it is very difficult to rectify them.

The Government

IT IS IMPOSSIBLE IN HEALTH CARE TO AVOID THE IMPACT OF THE GOVERNMENT. AT BOTH THE STATE AND FEDERAL LEVELS, THE IMPACT OF LAWS AND REGULATIONS ARE FELT EVERY DAY.

10. The Government

For health plans that span multiple states or operate on a national basis, the problem is multiplied. Prior attempts at the federal level to pass a so-called "Patient's Bill of Rights" have wound down, though many elements of it have been incorporated in other legislation. States still pass benefits mandates, but many executives feel that this is slowing down with the increasing recognition that such mandates increase the cost of coverage, leading to higher numbers of uninsured.

HIPAA, as mentioned earlier, passed its deadline for compliance on transactions and code sets not with the predicted train wreck, but with near silence as CMS itself announced that it would not be enforcing compliance. Providers and payors continue to make efforts towards compliance, but when the country will achieve full compliance is still unknown.

HIPAA has another trick up its sleeve. Recently, the National Committee for Vital and Health Statistics (NCVHS) recommended to the Department of Health and Human Services the replacement of ICD-9-CM with ICD-10-CM and ICD-10-PCS. Since the NCVHS is one of the few official agencies under HIPAA that has the authority to make such recommendations, this is a non-trivial event. Health plans, as well as providers, will be required to expend resources coming into compliance with this new coding system if and when it is adopted. The primary cost will be in changing I.T. systems to use the new codes, but retraining of clinical personnel and claims processing personnel will also require resources. Timing remains unknown.

The Congress finally did pass a Medicare Reform Act, providing an immediate drug discount program for seniors, to be followed by drug coverage in 2006. In addition to the drug coverage program, there are actually 200 different sections, including sections on fraud and waste, and significant sections on a new model of Medicare managed care called Medicare Advantage. This is a regional PPO program, though it incorporates existing Medicare+Choice HMOs. The Congress also provided a significant

reimbursement boost for 2004 to entice plans to remain in the program as well as provide better benefits to Medicare enrollees. Plan executives believe these steps are positive, but remain wary about the long-term aspects of dealing with the federal government.

The Medicare Reform Act also contains provisions for a disease management demonstration program that is considerably larger than that put in place prior to this. This program is outside of the Medicare Advantage program and is aimed at fee for service Medicare. How and when this program will be put in place remain unknown at this time.

The Medicare Reform Act contains one other item, this one having nothing to do with Medicare. It seems that the concept of the HRA in a CDHP inspired the federal government to come up with its own variant: the Health Savings Account (HSA). While the HSA program does not replace existing Archer Medical Savings Accounts (MSAs), it might as well.

The basic construction of an HSA product is:

- It is a commercial product (i.e., it is not a Medicare product at all),
- A high deductible insurance policy (minimum deductible is $1,000 per individual or $2,000 per family)
- Pre-tax funding of the HSA to a maximum of the amount of the deductible
- Unused HSA funds can roll from year to year
- The product cannot be combined with any other form of health insurance (i.e., it cannot be combined with any other type of health coverage)

Virtually all major health insurers are developing or are already offering an HSA product. In addition to health insurers, banks and financial institutions are looking at this as a possible entry into the health market. It is far too early to know how popular this product will ultimately be.

Conclusion

ARE WE AT THE BREAKING POINT? NOT YET. WHEN THE ECONOMY WAS ROBUST AND GROWING, THE RATE OF RISE OF HEALTH CARE COSTS CONTINUED TO RISE BUT REMAINED AT SOMEWHERE BETWEEN 13.1% AND 13.5% OF GDP — A LEVEL WE WERE COMFORTABLE MAINTAINING.

As we rise above 15% of GDP and the number of uninsured rises, the pain becomes greater but not yet unbearable. But at what point do businesses — even large ones — begin to bail out and stop providing health benefits? If health coverage premium inflation went from double digits back to single digits where it had been previously, would the system stabilize?

No managed care executive expects a massive abandonment of health benefits coverage to employees by employers, but if the problem of the uninsured begins to have a significant impact on the middle class — in other words, if a substantial number of middle class citizens lose their health insurance — then the political pressure will become unbearable.

The Opportunities for Health Plans

The resurgence in costs provides an opportunity for health plans to demonstrate value. The market place has evolved and health plans must evolve right along with it. Greater efficiencies in administration, better use of data and information, advances in care management, modifications in benefits design, advances in customer relationship management — these are all strategies that health plans must execute well. Beyond this, plans must create new approaches to deal with cost escalation, perhaps not this year or next, but in the near-term nevertheless. Achieving a goal of health cost inflation in the single digits, with administrative costs in the single digits as well is a worthy one, and achievable with sufficient vision and effort.

At the same time, health plan executives need to be highly mindful of the disparity in consumer attitudes and of the beliefs in the health care industry about the causes of health cost inflation, the role of the consumer and how much consumers are paying out-of-pocket for health care. If effectively dealt with, these clashing beliefs may help to achieve change in consumer behavior, and in the longer term perhaps even move us towards an acceptable approach to universal coverage. If not dealt with, negative public attitudes could result in even greater legislative action, to the detriment not only of the managed care industry, but to the nation as a whole.

About Capgemini Health

CAPGEMINI HEALTH IS THE GLOBAL LEADER IN PROFESSIONAL SERVICES TO THE HEALTH INDUSTRY, DELIVERING BROAD-BASED AND RESULTS-DRIVEN SOLUTIONS FOR TODAY'S BUSINESS CHALLENGES.

We are the only company with the diversity and dedicated experience and resources to address many sectors of the health industry, including hospitals and health systems, academic health centers, post acute care facilities, physician groups, managed care organizations, life sciences organizations, and health-related technology companies. Our professionals include clinicians and former industry executives, who collectively bring hundreds of years of health care experience to clients.

Gartner, Inc. recently named Capgemini the #1 Top Consultant and System Integrator, and the #1 top Outsourcer worldwide in the health provider market. Kennedy Information, Inc. also ranked Capgemini #1 in the provider, payer and life sciences categories in a recent report entitled "The Global Healthcare Consulting Marketplace." These rankings further confirm Capgemini's leadership in health care consulting.

Our clients tell us that what makes Capgemini different is the unique, collaborative way in which we help them take advantage of opportunities and solve their problems. Collaboration has long been a recognized cornerstone of our approach to business and is part of our DNA. We have now formalized this core strength into The Collaborative Business Experience — our commitment to your success.

Backed by decades of industry and service experience, the Capgemini Collaborative Business Experience will help you achieve measurably better, faster, and more sustainable results. We provide the talent and tools you need to stay ahead of the competition. The bottom line: Collaboration makes you stronger, by combining what you do best with what we do best.

Capgemini is uniquely positioned to collaborate with you. We don't just serve health organizations. We come from and represent the health industry. We commit the following capabilities to solving our clients' problems:

Top talent and unparalleled experience.

We have a team of 1600 people dedicated to the health industry worldwide. Our proven solutions are delivered by executives with real-world experience running health companies. Our staff includes former CEOs, CIOs, and COOs of hospitals and managed care organizations, as well as former executives from research-based life sciences companies, and former government decision-makers. We have more clinicians on staff than any other consultancy — including physicians, nurses, coding specialists, laboratory and radiology technicians, pharmacists, and dieticians.

Knowledge transfer and proven solutions.

Through organization-wide cost, revenue and system performance initiatives, we've achieved financial improvements ranging 5-15% for some of the largest health organizations in the country. We have a portfolio of proprietary tools to deliver proven results and speed cycle times, including advanced facilitation techniques, demonstration centers and development laboratories. At Capgemini, we have been a pioneer in developing collaborative practices such as our Accelerated Solutions Environment (ASE), which helps companies create rich strategic and technology solutions in record time.

Unbiased technology orientation.

We have a network of world-leading technology partners, including Eclipsys, IDX, Trizetto, Microsoft, Oracle, PeopleSoft, Cerner, EPIC, and Siemens. Our IT professionals have expertise in all of the major packaged systems used by the health industry. We have full

resources in place to run an IT organization, the depth and breadth to advise, consult or outsource.

Thought leadership and involvement in the industry.

Hailed by Gartner for our ability to capture "mind share" through thought leadership, Capgemini has a longstanding tradition of investing a portion of its yearly profits into Research and Development work — a commitment that helps the firm bring deep market insights and innovative solutions to its clients. In the managed care arena, our professionals authored a leading text on the industry, *The Managed Care Handbook*. In the provider market, we recently published *Innovating Clinical Care through Technology*, the first comprehensive book regarding clinical information systems. And we literally wrote the book on collaboration between health organizations, *Enabling Collaboration Between Payors and Providers*. In addition, Capgemini's professionals hold a leadership role in the health industry, including chairing HIPAA-related committees; testifying before the National Council on Vital and Health Statistics; and actively participating in a variety of industry professional associations including: AAHP, AHA, ACHE, AONE, HFMA, HIMSS, CHIME, HRDI and NCPDP.

A focus on value and results.

We can help our clients use a variety of tools that give a full picture of potential opportunities, assigning value not just to production or financial capabilities but also to the benefit of intangibles, such as improving patient safety, helping you grow/improve your service quality, technical capabilities, market share, professional resources, clinical expertise, operational productivity and reputation — all in a manner that ultimately maximizes ROI and profitability. Then we collaborate with clients to ensure that projects are well grounded and achieve the results they expect at each stage of delivery, and that it does so even when circumstances change over the course of the project.

Range of health-specific solutions

addressing the full scope of operational and technology issues, including:

- Business Strategy and Transformation,
- Clinical Transformation,
- Revenue Cycle,
- Supply Chain Management,
- Health ERP Packages, and
- Payor Services.

About Capgemini

Capgemini is one of the world's largest providers of Consulting, Technology and Outsourcing services. The company helps businesses implement growth strategies and leverage technology. The organization employs approximately 55,000 people worldwide and reported 2003 global revenues of 5.754 billion euros. More information about individual service lines, offices and research is available at www.capgemini.com.

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