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TRENDS IN GROUP MEDICAL PRODUCT DESIGN

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- Cost sharing and cost containment features
- Underwriting considerations
- Rating considerations
- Monitoring and evaluating effectiveness

MR. PAUL R. FLEISCHACKER: Our first panelist this morning is Matt B. Jones, Jr. from John Hancock. Matt is the Vice President of Group Operations and is responsible for the actuarial, underwriting and servicing areas for John Hancock's largest group cases.

MR. MATT B. JONES JR: Not many years ago, a panel discussion at a Society meeting on the subject of "Trends in Group Medical Product Design" would have included discussion of cafeteria plans or flexible benefits, group legal, dental, vision, hearing aids, auto and homeowner's employee benefits, and perhaps some new cost-efficient funding vehicles like ASO or Mini-Prem. How quickly the mood has changed. Now, most group medical product design changes are being done to achieve cost containment - to reduce the rate of escalation in the ever-increasing bill America's employers pay for the medical care of their employees' families.

The figures are well known to all of you. As a nation, we now spend over 10% of Gross National Product (GNP) on medical care. Twenty years ago it was under 6%. Medical care has consistently outpaced general inflation over this period but only in the recent recession did the need to control the costs of present benefits take precedence over the desire to add new, or liberalize existing, benefit plans.

You may have seen the New York Times' article in March, describing Chrysler Corporation's board-level committee which meets monthly to discuss the company's health-cost problem. Certainly these are board-level questions in many companies today. Chrysler's committee consists of its chairman, Lee Iacocca, a past president of Ford; Doug Fraser, past president of the UAW; and Joe Califano, Secretary of H.E.W. under President Carter. In the article, Mr. Iacocca is quoted as saying "Fraser, Califano and I know where all the skeletons are buried. We created the problem in the first place." That may be a bit of an exaggeration - there aren't

any providers or insurers represented on the committee. But certainly the UAW and the auto companies did have a pattern, over 40 years, of ever-improving health benefits. Walter Reuther, UAW president in the 50's and 60's, demanded a "ticket to worry-free recovery" for his workers. This ticket grew to lifetime coverage, fully company paid, so that now, according to Mr. Fraser, the UAW coverage is second only to that for the United States Congress. Mr. Iacocca says the companies went along because "we were rich and fat and sloppy and lazy. The costs weren't so great then, and so long as I was making a ton of money, it didn't matter to me." Recent press articles about executive bonuses and first quarter results in the auto industry also suggest a ton of money, but health benefit rollbacks, not improvements, are expected on the bargaining table this fall.

My remarks this morning will be aimed at what some large employers are doing in the cost containment arena. For these employers, cost containment activity can run the gamut from benefit plan design, to promoting the utilization of preferred and avoidance of unpreferred providers, to lobbying for legislative changes to control costs or jawboning providers in the community, to educating employees toward wellness, to providing certain screening and preventive programs in-house.

No one program or approach to cost containment can work for all employers. Medical benefits, like all fringes, are an integral part of the overall compensation package with which the employer attracts and retains employees. The approaches used in achieving cost containment in a fast growing high-tech company will differ greatly from the approaches in the more mature smokestack industries. Union bargaining contracts may preclude unilateral employer actions for represented employees, but programs for salaried employees are no longer automatically as good as, or a little better than, those for represented co-workers. The cardinal rule of employee benefits, "Never take anything away," is obsolete.

Whatever the approaches chosen by a particular employer, the objective is to reduce, or to reduce the rate of increase in, the employer's costs for medical care of the employees' families. Employers know as well as any actuary that to reduce costs you must reduce the amount of service used, or reduce the cost of each unit of service, or pass the bill on to someone else. The first two - controlling frequency and unit costs - are truly cost containment. The third is really cost-shifting, but in the employer's eyes it is just as cost effective as cost containment, and perhaps more so. In fact, cost-shifting to employers from providers, government programs, and from other employers has contributed significantly to the employers' medical benefit cost spiral.

At this point, I'd like to review a number of cost

containment programs we've developed with and for some of our largest group customers. It's still too soon to know how effective these programs are. We expect success, but it may never be possible to assign any savings to a particular element of a cost containment program.

On January 1 of this year, the Ford Motor Company instituted a new comprehensive major medical coverage applicable to active and retired salaried employees. This replaced the previous first-dollar coverage equal to the UAW coverage plus a supplemental major medical. The new plan has a $200 calendar year deductible with 80/20 coinsurance until the out-of-pocket expenses reach $750, at which point the plan pays 100%.

Within the overall framework of the comprehensive plan, some types of services are subjected to different coinsurance rates or maximum benefit limits designed to increase the employee's cost awareness and shift more of the cost to the employee in those benefit areas thought most subject to abuse by the patients or providers. Certainly, the most immediate cost impact of this change is a shift of the early dollars of medical expense to the employee, but the deductible and coinsurance may also make the employee a more cost-conscious consumer of medical services and thus lead to improved utilization and unit costs.

The imposition of this plan on a salaried work force that had experienced several years of layoffs, eliminated bonuses, reduced vacations and other cutbacks could not be done without substantial employee reaction. Such a plan change could also have enormous repercussions in the community, as providers, accustomed to the old first-dollar coverage, would now be faced with billing patients. There was fear that the lack of full payment could jeopardize the hospital discounts available through Blue Cross in several major states. To reduce these shocks, a so-called "Advance Payment Arrangement" was incorporated into the plan. Under this provision, the plan administrator pays to the provider the full amount of covered charges, including any deductible or coinsurance amounts that are the responsibility of the employee. The plan administrator then bills the employee. Under the Advance Payment Arrangement, each employee has a limited line of credit with a bank. Like a Master Charge or Visa account, the balance may be paid in full without finance charge each month, or payment can be in monthly installments. On delinquent accounts, the company has recourse to payroll or pension deduction.

The primary purpose of the Advance Payment Arrangement feature was, of course, to improve employee acceptance of the new program. Preserving the existing hospital discounts was crucial. It also serves to enforce the employee coinsurance since the provider cannot inflate his charges and forgive the

employee share.

Clearly this was a take-away from salaried employees. Ford's cost for the plan was reduced and hence the employee cost for the various HMO alternative plans increased. Not surprisingly, the enrollment in HMOs by salaried people increased dramatically - coincident with the new comprehensive plan.

The comprehensive plan will certainly be a bargaining issue with the UAW in the fall. The union has generally cooperated in experimental programs to limit costs by controlling when and where employees are treated. Second surgical opinion programs, capitation dental plans, and specialty PPOs are in place on a pilot basis in several areas. But the union adamantly resists cost-shifting to the employee as an acceptable form of employer cost contaiment.

Another substantial cost containment activity was undertaken by Ford as the layoffs of both hourly and salaried people exploded in 1981 and 1982. Under their plans, both hourly and salaried people had medical benefits continued when they retired or were laid off. Hence, layoffs or early retirement did not achieve any savings in medical plan costs, and under the then standard coordination of benefit (COB) rules, the Ford plan would be the primary payer even for the former employee covered by a new employer or as a dependent under a spouse's coverage. Because of the COB provision that the plan which has covered the employee the longer time pays first, Ford was still primary payer for their retired president Lee Iacocca although he was the very active chairman of Chrysler. There were many thousands of other former employees undoubtedly working elsewhere, or with currently employed spouses, and changing this inequity in the COB provisions became a high priority.

Allies were sought out among the other industries. Carriers were enlisted to spearhead the desired change. Insurance commissioners were encouraged to support a change. The NAIC appointed a special committee to consider the issue. The HIAA, working with the NAIC, endorsed a modification which makes present employers primary over prior employers while protecting the employee against conflicting COB provisions. This is now the NAIC standard. A few states have adopted this new provision. In Michigan, the governor signed that state's first COB legislation just last Friday, making this provision the required standard for that state.

This is but one example of employers' cost containment efforts in the regulatory/legislative arena. Chapter 372, the Massachusetts hospital cost control legislation of 1982, would not have been possible without enormous employer support and active lobbying. There are undoubtedly comparable efforts in nearly every state.

Let me now turn to some activities of another large John Hancock account - this one in a booming high-tech industry. Competition for qualified employees is keen, the fringe benefits are an important feature in attracting those employees. Nevertheless, the need to contain the costs of programs is no less real. I'd characterize the efforts here to be more toward containing utilization and price and less toward cost-shifting.

In my experience, this employer is perhaps the primary example of an analytical approach to cost containment. Before costs could be controlled, more knowledge was needed of what made up the total medical care bill. No longer was aggregate claim data adequate. Why was the cost of hospital coverage increasing? Were some hospitals better than others? Are all those confinements necessary? What can we learn from geographical differences? In other words, let's understand the problem before we correct it. This led to an enormous expansion of John Hancock's claim statistical reporting capabilities. The increased costs of data capture and processing were seen as a small investment given the enormous savings potential. To be credible in the provider community, the data review would have to involve non-carrier, non-employer, medical experts as well.

Working with a consultant group of physicians, and the John Hancock data base, a detailed study was done of 157,000 hospital claims representing 23,000 admissions and 134,000 outpatient visits over a three year period. This data represented nearly 125,000 patient days of hospital confinement. Using an audit technique on a sample of these claims, a registered nurse was asked to make appropriateness judgments according to some pre-established criteria, both as to the admission and as to each day of the hospital stay.

The study concluded that 23% of the hospital days were inappropriate. Thirty percent of the admissions, including those for surgery that should have been performed on an ambulatory basis, were inappropriate. Eleven percent of admissions were inappropriate even excluding the ambulatory surgery cases.

As might be expected for a young workforce, the study also showed maternity was the leading cause of hospitalization, and moreover the admission rate for deliveries had risen substantially over the three years. While interesting, this probably is not an area where cost containment efforts would be either desirable or effective. A striking finding of the analysis was that the average length of stay for maternity in the Northeast was 5.5 days - 72% higher than in the Southwest region, which meant that even after adjustment for differences in the medical Consumer Price Index between regions, a maternity admission in Massachusetts costs $561

more than one in Arizona.

A comparison between eight hospitals in eastern Massachusetts showed wide variations in the proportion of unnecessary admissions and days, suggesting that at least three of the hospitals should be considered as unpreferred providers.

Finally, the trend over the three years showed somewhat of a leveling off in the rate of increase in expense per confinement and per employee per year in Massachusetts, but a rather alarming increasing trend in these indicators in the Southwest region of the country.

Having identified these areas for action - what could be done to achieve some savings? To address the inappropriate admissions and days, a universal pre-admission review program has been instituted using the Eastern Massachusetts PSRO. In the first three months of operation, the approved days of stay are 15% below the days requested by the attending physician - a savings of better than 20 to 1 on the cost of the reviews. The maternity length of stay problem is being addressed through employer educational efforts about the merits of short hospital stays. The pre-admission review program is also focusing obstetrician attention on the unnecessary extra days.

The sharp differences in experience among the eight hospitals were shared directly with the providers. At a meeting of administrators from the eight hospitals, the comparative data were shown with an objective of getting a commitment for corrective action. These initial contacts were relatively low key, but having noted this employer's active participation in the development of Chapter 372 in Massachusetts, few hospitals would consider the message as an idle threat. While this one employer may not account for a substantial portion of each hospital's admissions, it is recognized as a trend setter in how other employers may deal with local area hospitals. This identifiable difference in the efficiency of providers suggests there may be real savings available through PPOs.

HMOs have for years, purportedly, demonstrated the savings achievable through efficiency. However, some employers are beginning to question whether HMOs are in fact cost containment devices. If the employer must pay the average cost of his plan to an HMO his younger and healthier employees elect under a dual choice provision, any efficiency savings go not to the employer, but to the employee in the form of richer benefits, or to employees of others through the community rating mechanism common among HMOs. A program that saves somebody else's costs is not cost containment to me.

Under a PPO, the savings achievable through use of efficient

providers can accrue to the plan and, under the control of the plan, can be shared with employees in whatever way best promotes desirable utilization patterns.

John Hancock is currently developing medical PPO programs in eastern Massachusetts and southeastern Michigan. We expect to be operational this fall. A dental PPO capability will be available this month. There are also a number of highly specialized PPOs that some of our customers are using.

A final major area of employer efforts toward containing costs is truly aimed at lower utilization through prevention or early intervention. Many employers have in-house programs for smoking cessation, weight control, dealing with stress, and other subjects geared toward promoting employee wellness. Programs for regular blood pressure checks can lead to early identification and less costly management of several medical conditions. On site exercise or locker room facilities are more and more common as a response to increasing employee awareness and more wellness-oriented life styles.

I've mentioned but a few specific activities of some large employers which I think are indicative of the widely differing activities being undertaken by many. No one activity is appropriate in every setting, and activities appropriate today will need modifications for tomorrow.

It is imminently feasible to change health care utilization practices so as to produce net savings for a corporation without diminishing the quality or care, but it isn't necessarily easy. What works for Ford in Cleveland may not work for the XYZ company in California. There are examples of success but far more examples of failure. Medicare on the national level, Medicaid at the state level, and corporations on the local level have tried dozens of different cost control activities over the last two decades, and still the percentage of GNP devoted to health has nearly doubled. Health care economist Uwe Reinhardt of Princeton University thinks it's sensible to expect health to consume 14% of GNP by the year 2000.

Cost containment efforts now have the visibility and the priority they didn't enjoy before. The need has never been greater. It behooves all of us to consider all alternatives carefully, to experiment with the promising ones, and to be prepared to lose a few in the process.

MR. JAMES C. CHARLING: I'm to cover the trends in product design for the medium-size employers categorized as about 100 to 1,000 employees. A lot of what I'm going to say is exactly the same type of things Matt has said but they take on a little different perspective as the employer size

decreases. One of the characteristics is that some of the needs may fall a little more heavily on the insurer or the administrator, simply because the resources and the understanding of the smaller employer may not be quite at the level of the larger employer.

I have no detailed studies or surveys to report on. My day-to-day responsibilities are in the Underwriting area, so I'll talk from the standpoint of what I see.

I'd like to start from the vantage point of a benefit manager. A lot of what's going on in product design relates to the concepts that are now in his lap. Let's talk about some of those. First, we're all well aware of what medical costs have done over the last 10 years. They have reached a point where they now receive the attention of key individuals within a company, creating the pressure back upon the benefit manager. The problems that we're dealing with are fairly complex in nature, so the expectation being placed on the benefit manager now is a bit appalling.

Perhaps for the first time in recent history, the benefit manager is being asked to actively manage the plan. The days seem to be gone when plan changes are all improvements. The active management of a plan in that environment was just not that great, but if you are trying to set up a strategy to do some cutbacks, cost sharing changes, and things like that, the active management increases considerably. Now, there is increasing pressure, primarily financial, for plan reductions to be made. Whether these reductions are relative or absolute depends on your perspective. With the backdrop of the changes in yesteryear, where there were primarily increases, these are definitely reductions.

At the same time plan changes are being made, there is also a very strong-felt need to put a plan into place that is more dynamic, that can function well in the future. This, again, is a concept that I'm not sure has been dealt with much over time. I think many of us are aware of plans in our own companies and employers that we deal with that have sat in place with very little change for long periods of time. I think that day is gone. We certainly hear talk about indexed deductibles and things like that, but I don't know that I have ever seen what I would consider a purely indexed deductible written into a plan. I have certainly seen it written into the practice of companies.

Up to this point, I've really referred to cut, cut, cut. However, the benefit manager must still keep in mind that one of his roles is to provide the employee benefits and have employee recognition of these benefits. Without that, the dollars being spent for these programs in no way gain the

proper degree of importance with the employees.

With the pressure for plan adjustments, there is an enhanced communication need being placed on the benefit manager. The new benefit designs must be communicated very clearly with the employees. Most of the designs that we are seeing today do have some real thinking behind them in terms of effects and in terms of why they're going into place. Some of them are attempting to come off the solid statistical analytical base that Matt referred to. Some of them are coming straight out of the trade press - "I know I saw it and read it. It sounded great so let's do it" - so that the level of thinking ranges all the way from grabbing on to whatever is there to some real analytical work. However, the employees must understand what's going on to keep them from viewing the changes as merely cutting away at their compensation program. In fact, some of the items that are viewed as cutting benefits are really, truly employee benefits. An example that I would include is a plan change that encourages outpatient surgeries (surgery to be done in the same day type of environment) and allows people to understand that it is really and truly an option that they have - I would agree that that benefits them. There is a certain mentality, particularly in the size of employers we are dealing with, that the only way to get surgery paid is to go into the hospital, and I don't think employees really want to do that. So if your plan design changes and the communication that goes with them help employees realize their option, there is a gain. You may be using a disincentive plan or something like that to get there, which means a dollar cost, but still there are gains to be talked about.

In the area of communication, employers are also being asked to communicate with providers. Certainly in the upper end of the size group we're talking about, we feel that the provider of the health care dollar is the employer. The result we are getting is increased requests to talk to providers as a party with our customer. We tend to stay away from talking to the provider by ourself because we don't really think, at least on a given plan basis, that we are providing the dollars for benefits; that money is just flowing through. As a result, any actions that are to be taken by the employer in terms of plan design, etc., that affect the provider community should be communicated with that community to the extent possible.

Since the eye of scrutiny is on the benefit manager, he's also being asked to tighten the administration of the plan. Gone are the days when he tells the administrator or the insurer not to bother with the coordination effort or not to screen for usual and customary. Again, the communication needs with the employees may be substantial.

In addition to close scrutiny being placed on the benefit plan of today, there is also increased discussion about

wellness programs and other long term concepts. Matt referred to this. I think a change is occuring here away from a certain mentality historically that equated these things with the Tenneco plan or the Kimberly Clark approach. I don't know how many of you have seen the Wellness at the Work Site film, which was produced by HIAA, but it shows examples of smaller employers doing what they can do to have wellness programs at their level. In the size of groups I'm talking about, these programs may well fall on the benefit manager.

Within all of the plan design change possibilities, there are several pressures. First, there is a tremendous amount of press in the various publications about the different programs and the different methods that other companies are taking. Likewise, there are alternate financing systems such as HMOs and PPOs for the benefit manager to evaluate and consider. There is a broad agent, broker, consultant world that is suggesting various design changes. Also, there is the insurer or administrator who probably has an idea or two of his own as to what makes sense and what can be administered. The benefit manager is, therefore, torn by all of the various new concepts that are being suggested.

In this light, the benefit manager is looking to the insurer or administrator for help in all these areas. At this stage, one of the most important assistances we can provide is help in sorting out the various topics of cost containment. If you just throw them all in one big basket and try to figure out which way to go when, I think we would all be appalled by that. However, we can say, "Let's start setting some objectives and let's take on some things that may have an immediate effect on yearly costs, Mr. Employer. At the same time let's do some things over here that you don't expect a nickel back on tomorrow, but, over the long haul, are the right kinds of things to do."

Certainly, the employer is looking for tighter administration of the program. To the extent possible, the benefit manager is looking to the insurer to monitor the results of plan changes. Data, information, analysis, and recommended actions are also being demanded. The days are gone when the claim payor enters only sufficient information to pay the claim. In fact, many days it seems like the claim processor has become a data collector as opposed to a claim processor. Employers are looking to insurers for communication material. Also, many employers are looking to insurers to be involved with the provider community in helping to communicate the employer's needs and concerns. They are looking for data for employer coalition impact. As you can see, the roles of benefit managers, and us along with them, are really broadening.

Let's talk briefly about the medical benefit designs that we

are seeing. You're certainly well aware of these but let me mention them since there is a fair number of different approaches that are being taken.

Plan design is definitely gravitating toward the comprehensive medical approach. Deductibles are either increasing, or they are becoming special purpose deductibles, such as inpatient hospital and emergency hospital outpatient deductibles. We are seeing indexing discussions and again some indexing actions on a year to year ad hoc decision basis. The sharing of the medical bill by the employee is increasing. A common belief in plan design is that increased sharing by the employee will communicate a message that will help make the individual purchaser of medical services a better consumer. I hope this is true, but we're also asking people to ask questions where most haven't for a long time. This topic is a bit foreign to the purchaser and to the provider of medical services, but it is becoming increasingly common.

To take this point one step further - how many of you have faced the decision to give up your fully free choice of physician to obtain the higher reimbursements available under a PPO or an HMO? I assume you found this decision a bit cumbersome, and you're not alone.

Benefit plans are now incorporating same day surgery and second opinion surgery programs. Yesteryear, people shuddered at the mere thought of telling a doctor that they were going to get a second opinion, and I think they still do to some degree. It creates a confrontation situation. I think we need to stay away from the confrontation kinds of things.

There is continuous discussion as to whether incentive approaches or disincentive approaches make more sense. Likewise, in the second opinion surgery area, there is an equal amount of discussion about whether the second opinion has to confirm the first opinion. I think we see a fair amount of requests for incentive designs and I think essentially what some of the requestors are telling us is, "I'm going to spend more than I would have otherwise, but at least I've created a differentiation." Certainly, from my perspective, you have the risk of getting too much of a good thing. You get the incentive too good and all of a sudden there are too many services being used.

Likewise, you've got the risk of putting a program in place and not changing it. A key example of this is the same day surgery list. If you do it on the incentive basis, you may want to put on that list surgeries that can be done in the outpatient setting but are not now routinely done so. As medical technology improves, some of those procedures will become very commonplace in the outpatient setting. If you

don't change that list, all of a sudden you are paying your outpatient incentive for things that are commonly done in that setting. And so again we have dynamic design - changing these things, adjustment, modifying.

We're also seeing a fair amount of interest in weekend admission disincentives, outpatient testing, and generic drug plan design. With some of these things, I think, at least at this point with a smaller employer, we're struggling with administrative problems. This also is true in some of the data areas. The employer wants the five digit ICD code on claims, but they don't come to us from the provider. Mechanically we can capture it, we can summarize it, but if it is not provided, the question becomes, "Are you willing to pay me twice as much as a claims administrator just to chase down more detailed data?"

From an administrative standpoint we have referred to tighter COB investigation and more detailed data gathering. Alternative medical care is one idea that is intriguing. I don't know how many of your companies are involved in it. In the LTD world we have been working with rehabilitation efforts. In certain types of long term medical treatment, perhaps we can use some of that same expertise to work with the patient, the employer, our providers, and ourselves toward an alternate, less costly approach, but one just as satisfying from the patient standpoint. We're doing this now. It's like rehabilitation; you work long and hard and then there are one, two, three, four, or five cases that come your way which have a big dollar savings associated with them. These tend to be the comatose type patient, the long term maintenance type patient, where there may be a way to provide that maintenance in a less costly setting.

Certainly from an administration standpoint, we are dealing with employee level information versus case or plan level information. We're getting a lot of discussion of salary based deductibles and things like that. From a group administration standpoint, that essentially means having that plan defined down at the employee level; we no longer can work with just a case level plan description. That may necessitate a major change in systems. I think a lot of administration was done on the basis of determining whether an employee had dependent coverage and certifying the dependent at the time of claim. Now we are talking about name, date of birth, and all the details on the dependents. The other side of this is that we are asking the employer for more input. Certainly we have no other way to produce all this information about the employees. There is one place it comes from, and that is the employer. Sometimes in the size group I'm talking about, employers want the information, but when you say what has to come in so the facts can come out, they say they can't do that. The same is true on some of the

detailed reporting at claim time.

Another area of sharing that is being explored to a greater extent is the need and level for employee contributions. I believe that the employer that has required employee contributions in the past is in a much better position to make many of the desired plan changes. Somehow the issue of whether you want everybody to pay or whether you want the users to pay can get a conclusion fairly quickly. I would rather have the users pay, and you can get agreement on that much quicker than you can get an agreement on a plan reduction. But they are essentially the same issue.

One final area that continues to somehow be mixed into the cost containment discussion of medical product design is the self-funding of medical programs, particularly for the smaller employers. Somehow, someway, this is supposed to produce real cost containment gains to the employer if they utilize a self-funded approach as compared to a conventionally insured approach. I'm not quite sure how, but it does get mixed in with cost containment.

I would categorize this marketplace that we're dealing with as very much struggling in its attempts to find the proper plan design. Employers have reached a point where they are not only struggling in the conference room, but they are willing to put some of these designs into place and then watch how they work. The role of the benefit design in this regard is not to cure all of the problems, but rather to communicate a message to the employees that is consistent with the message that the management of these companies needs to communicate. That message is, very simply, that the medical plan costs of the company must be reduced, or at least the rate of increase must be slowed down. The plans and communications that are being made to accomplish this are a bit cumbersome for all parties to deal with. By all parties, I mean the employer, the employees, the consultants, the insurer or administrator, and the providers. Nevertheless, there is no choice now, we are all dealing with these changes because the time is right. We are learning as we go.

We look at what we did yesterday and it seems rather trivial in terms of what we're doing today. I'm sure the same will hold when we look back tomorrow on what we're doing today. Nevertheless, we are seeing this continual searching for alternative approaches to providing the employee group with medical benefits. In the size cases I'm talking about, the insurer and the administrator are very much right in the middle of it, perhaps a little more as an advisor than in the larger case market. It's fun, exciting, and frustrating, but it's happening and we're all trying to work with it the best we can.

MR. RICHARD NIEMIEC *: I'd like to subtitle this talk, "What's been going on at Blue Cross/Blue Shield for the last five years and why didn't we do it sooner." I will be describing today some of the cost containment and cost sharing approaches that we have developed at Blue Cross and Blue Shield of Minnesota, as well as my observations about similar features which have been developed by other carriers and HMOs in Minnesota. The Minneapolis-St. Paul Twin Cities Area has been a hot bed of HMO activity for the past 10 years. In the 1980's the "competitive approach" has evolved after various regulatory approaches, including certificate of need, appeared to be ineffective in the 1970's. A local citizen's group which specializes in shaping public policy and a business/labor coalition formed through the initiative of Minnesota Medical Association have been active participants.

The exploding cost of medical care is as much of a problem in Minnesota as it is in the rest of the country despite some of the pioneering activity that I mentioned above. Blue Cross and Blue Shield is no different than any other carrier - we respond to the expressed wishes of our customers, and the employer groups are demanding action to contain costs! Although we have been involved in many cost containment activities for years, it has not been until the last four years that this employer support for stringent cost containment has crystallized. The support of employers, labor, and providers has allowed us to initiate the programs which I will be describing shortly.

First, let me describe some of the more traditional cost containment programs which Blue Cross and Blue Shield has used for many years.

1. Our Coordination of Benefits program has been administratively sound and has demonstrated savings exceeding 16% for many years.

2. Our Usual and Customary (U and C) program has been in operation for over 15 years and has registered savings at the rate of about 4% for many years. It depends, as most Blue Cross and Blue Shield U and C programs do, on our participating agreements with physicians and other allied providers. Our subscribers are held harmless if they use participating professionals. In recent years we have limited the increase in the customary levels to ensure that they are kept in line with the increase in overall inflation.

3. Our Utilization Review programs are designed to routinely review the quantity of health care services provided to our

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subscribers. We analyze our claims data to identify any inconsistent practice patterns or excessive utilization. We also review claims for unduly complicated, obsolete, experimental, or cosmetic procedures.

4. Our Fraud and Abuse program identifies instances where providers deliberately attempt to defraud us by requesting payments for services not performed, charging inconsistently among patients, and providing non-medically necessary services. If legal recourse is appropriate, we initiate it. We work cooperatively with local medical and professional societies and state licensing authorities to ensure that the services in question are within the scope of licensure. The newer cost containment and cost sharing programs which I will be describing seek to shift risk to employees and providers. They also seek to contain costs and eliminate inappropriate or unnecessary services. Employers, labor, providers, consultants, and subscribers all have taken an active part in designing, implementing, and evaluating these programs. We have had a long-standing commitment to advisory committees composed of members of these groups. We are beginning to see changes in behavior on the part of both providers and subscribers.

The cost containment programs which we began in the early 1980's are Effective Care '81, designed to reduce utilization in the chemical dependency and mental health areas, Mandatory Second Opinion, Outpatient Surgery, and Private Review, a hospital pre-authorization and concurrent review program conducted by the Foundation for Health Care Evaluation, which is a peer review organization of physicians. I will later describe our AWARE program which is a preferred provider type of approach. AWARE, which became operational in early 1983, evolved from some of the earlier cost containment and usual and customary programs. I will close my remarks by briefly describing the experiences we have had with our comprehensive major medical product, which was introduced by us in 1977.

1. Effective Care '81 attempts to deal with the extremely high utilization of psychiatric and alcohol and drug dependency treatment in Minnesota. During the early to mid-1970's, the Minnesota Legislature mandated some of the most comprehensive mental health and chemical dependency minimum benefits in the country. By 1981 we had observed a doubling since 1976 of the expenditures for our subscribers in these two areas. A great majority of the care was provided in inpatient facilities despite the fact that Minnesota has an extensive network of qualified outpatient facilities.

Effective Care '81 was developed in close cooperation with the psychiatric and chemical dependency professional groups. We developed a set of criteria to determine when mental health and chemical dependency inpatient care is needed. We

have received requests for this criteria from many parts of the country.

We have maintained a high participation level with mental health and chemical dependency facilities. We have required them to demonstrate the necessity of treating patients as inpatients and to establish a formal plan of treatment which addresses the needed length of stay. The program is retrospective in nature and incorporates a three-level appeal process. The program has been widely accepted by our employers and subscribers. It is not optional but rather is in place for all Blue Cross and Blue Shield of Minnesota subscribers. The evaluation of the first year of the program indicated that we denied approximately 11% of the inpatient days as medically unnecessary. The subscriber was held harmless for all of these denials. In addition to these explicit savings, we believe there was a large sentinel effect in which the facilities established outpatient and shorter inpatient treatment plans. Evaluation of the second full year of the program will be completed soon; we expect similarly impressive savings. Twenty-eight day stays for chemical dependency treatment which, not coincidentally, matched the minimum benefit used to be typical. That is no longer the case for our subscribers due, we feel, to Effective Care '81.

2. The Mandatory Second Opinion Program was developed in 1982 after much research into other second opinion programs around the country. In the past our experience had been limited to a totally ineffective, group-specific voluntary program. Our mandatory program, which is similar to programs described earlier, requires subscribers to seek a second surgical opinion to verify the medical necessity of certain specified surgical procedures. If they do not, benefits will be reduced to 50 percent or totally denied, depending on the desire of the groups. The second opinion, of course, is a paid-in-full benefit to the subscriber. We have selected a network of physicians throughout Minnesota to perform the second opinions. I must admit that the network is somewhat sparse in the less populated rural areas, and that is somewhat of a problem. The referral to the second physician is handled by a toll-free telephone network. If the subscriber wishes a third opinion to help make the decision on surgery, that also is a paid in full benefit. The program is optional to groups, and we have approximately 110,000 members enrolled in it.

We have not completed the evaluation of the first year, but expect to track the number of calls, number of referrals for second opinions, cost of consultations, number of surgeries performed and not performed, and the estimated savings from the surgeries not performed. We will develop the above statistics by specific procedures. We are collecting data from the consultation claims of the second opinion doctor so

that we can correlate this data with the actual surgical claims experience. Evaluation will be on both a group-specific and corporate basis.

3. The Outpatient Surgery Program is based on a list of 25 surgical procedures that can usually be safely performed on an ambulatory basis. We used, as a starting point, the 1981 list developed by the Foundation for Health Care Evaluation, the local physician peer review organization which I described above. We modified the Foundation's list based on our own claims utilization and medical review judgement. For groups which select this program, their subscribers must obtain pre-authorization approval for inpatient hospitalization for these twenty-five procedures. If hospitalization is recommended by the subscriber's physician, telephone inquiry is required to determine if hospitalization meets our criteria. If we deny pre-authorization or if the subscriber fails to notify us before hospitalization, inpatient benefits will be reduced to 50 percent or totally denied, again based on the employer's option.

The outpatient surgery program will be evaluated by tracking the percentage of procedures done and dollars spent on an inpatient and outpatient basis. We developed baseline data prior to implementing the program so we will have corporate as well as group-specific data to share with our groups. I agree with Jim's comments about employees' acceptance of outpatient surgery and second opinion. If the employee understands the need, they will be much more apt to accept it. We have also seen that unions don't always see second opinion and outpatient surgery as a take-away.

4. Private Review was made available largely at the request of some of our large employer groups. As I mentioned, it is administered by the Foundation for Health Care Evaluation and requires pre-authorization of all elective hospital stays and uses on-site concurrent review. It is a non-delegated review conducted by Foundation employees, which is in contrast to an earlier 1978 delegated review program which produced spectacularly inconsequential savings. We collect a $12 annual administrative fee which is remitted to the Foundation. This additional cost to the group with no savings guarantee is one of the drawbacks to employers. An additional problem is that there is no way to enforce physician compliance.

This program has attracted approximately 50,000 members in mostly large employer groups. In my opinion, the results of the program have been mixed. While undoubtedly there are savings, the Foundation has not had a comprehensive data base to perform the evaluation.

As I mentioned previously, the metropolitan Twin Cities area has been embracing the "competitive approach" for several

years. In addition to the continuing promotion of HMOs by major corporations, the PPO approach has attracted much interest beginning several years ago. Many individual hospitals have considered it, networks of doctors have formed to offer PPOs, and several major hospital chains also began serious investigation of PPOs. Blue Cross and Blue Shield actually began developing the AWARE program before PPOs became a hot item. We have not had a hospital differential since 1977. When we approached hospitals four years ago about a cost-justifiable differential, many of the lower cost ones essentially told us that they were only interested in reimbursement schemes which rewarded efficiency.

AWARE uses five major hospital inpatient categories - medical, surgical, obstetrical, psychiatric, and chemical dependency. Unusual cases are included in 24 specialty categories such as heart surgery, hemodialysis and kidney transplants. We rank historical statistics on total charge per day and charge per case. We found a cost difference factor of 2 or 3 times between hospitals for similar cases. An AWARE hospital agrees to accept a negotiated per diem which does not exceed the hospital's historical charges adjusted for inflation or the 55th percentile for all charges, also adjusted for inflation, whichever is less. Thus, payment maximums are slightly above the community average and establish a reasonable limit for Blue Cross and Blue Shield's payment. The payments to the hospitals are adjusted for subscriber liabilities such as deductibles and co-insurance. Each hospital has also agreed to a negotiated length of stay for each of the categories. If the average length of stay decreases for a hospital, Blue Cross and Blue Shield agrees to pay the hospital 50 percent of the savings. On the other hand, if the average length of stay increases, the hospital agrees to pay us back 50 percent of the additional reimbursement.

The hospitals responded well to the new challenges of AWARE. They generally liked the broader AWARE categories (as opposed to the 467 DRG categories) and they responded positively to the average length of stay incentives when we began discussing the concept with them in 1982. Periodic interim payment reimbursement is also included in the program. The program became operational on April 1, 1983. Twenty of the 27 Twin Cities Hospitals agreed to be part of the AWARE program on that date. During the first contract year which ended at the end of 1983, actually a nine month period, we estimate that $9.2 million was saved for our groups and subscribers. Of that savings $3.4 million was attributed to the length of stay incentives. Half of that was returned to the hospitals, resulting in a net savings of $7.5 million. We believe that our challenge to the hospitals through AWARE made them more efficient.

For 1984, all Twin Cities hospitals have chosen to

participate in the AWARE program. We are considering expanding the program to cover outpatient services and outstate hospitals in 1985.

Historically, Blue Cross and Blue Shield has had a strong working relationship with physicians and other health care professionals in Minnesota. We felt that physicians hold the key to controlling hospital utilization and wanted to include them directly in the AWARE program. We extended AWARE participation to all physicians and most allied professionals in Minnesota. Currently participating professionals automatically became AWARE unless they resigned. Many physicians recognized the competition they were facing for patients and joined. Through this offer, our participation percentage jumped from the high 60's to the low 80's.

AWARE professionals must notify the subscriber that a referral or admission is made to a non-AWARE physician or hospital and that the subscriber may be liable for additional costs. AWARE physicians and podiatrists agree to obtain preadmission authorization for all inpatient admissions except emergency, obstetrical, psychiatric, and chemical dependency. We utilize the local physician peer review organization, the Foundation for Health Care Evaluation, to administer pre-authorization in the Twin Cities Area. They also conduct concurrent review on 20% of the cases to monitor quality of services. Outside the Twin Cities metropolitan area, physicians are currently only required to pre-authorize 25 designated procedures. However, Blue Cross and Blue Shield plans to require pre-authorization later in 1984 for all admissions other than the exceptions mentioned above. You can see how AWARE has encompassed some of the aspects of outpatient surgery and the private review program.

AWARE professionals continue to be paid at usual and customary where the customary is set at 85th percentile with an annual inflationary cap. Non-AWARE professionals are paid up to the 55th percentile with the subscriber being liable for balances above that amount. While there are some savings attributed to the lower pricing for non-AWARE professionals, the major portion of our projected savings are expected to come from the pre-authorization portion of the program.

In announcing the AWARE program in March of 1983, our president, Andy Czajkowski, stated that he felt that AWARE was a most significant change in the fee-for-service reimbursement philosophy in over 25 years. We feel that AWARE has met this expectation. Initially, we give rate savings of 7% for groups that take the hospital portion of AWARE. For groups that take the physician portion there is an additional 3% rate savings. Almost 220,000 members belong to AWARE including the State of Minnesota group and many other large employers. Labor has become one of our biggest supporters of AWARE. AWARE has become the only direct sales

individual product which we market. (This individual product, incidentally, also includes a nonsmoking discount, which is scaled by age.) I see all of the above evolving into a very conscious case management approach - still in the fee-for-service setting, but with limited choice.

Let me turn now to comprehensive major medical. Blue Cross and Blue Shield has emphasized comprehensive major medical (CMM) products since 1977. We have long felt that this type of benefit structure forces the subscribers to be more conscientious about their utilization of health care services. While the deductible is an important aspect of CMM, it may be the co-insurance feature (which we usually set at 20%) which is the most effective way to control utilization. I'm sure that all of you have followed with interest the Rand Corporation studies on the impact of cost sharing. There are, of course, many other studies of CMM benefit structures around the country. I will confine my remarks to some of the conclusions that we have reached about our products. CMM is the only direct sales individual product which we offer and the dominant offering in the small group area. It has, however, had little penetration in our larger group market.

In light of the high level of medical charges, we do not feel that a $100 to $150 deductible is particularly effective in controlling utilization. In our individual products, we have seen a movement from 71% of the contracts in 1979 being $150 deductible to only 22% by the end of 1983. Our $300 and $500 deductibles moved from 24% in 1979 to 66% by the end of 1983. Our $1,000 or more deductibles changed from 5% to 12%. This migration to the higher deductibles was primarily composed of the lower utilizing subscribers.

In the group area we have seen less movement. The $200 or less deductibles moved from 89% in 1979 to 63% by the end of 1983. The $250 to $500 deductibles changed from 10% in 1979 to 30% in 1983. The $600 or more deductibles changed from 10% in 1979 to 7% in 1983. That is probably the result of a mix problem. In the group area, we have seen the higher utilizing groups, especially those with ongoing medical cases, moving to the higher deductibles so that their rate increases are smaller. The compounding factor which troubles us with this type of business is the funding of the front end deductible by many employers which, of course, destroys the cost sharing incentive for subscribers to control utilization. We are not sure how often this occurs but we have reason to believe that it happens more often than we would like.

On the whole, our CMM product continues to show promise as a cost containment approach but, as I mentioned above, there are many unanswered questions and some troubling aspects. We, like most other carriers, are continuing to study

experience and modify benefits and marketing approaches to better meet our objectives.

This concludes my prepared remarks but I would like to add one more comment about something which happened yesterday. We had a press conference yesterday, with good press coverage, where we announced the first year results of our AWARE program. We think that it is a very significant program and all of us feel good about it. We also decided to reannounce for the fifth time our organ transplant coverage. We have been besieged with phone calls from reporters about it and it has been reported in one form or another accurately and inaccurately over the last couple of months. The transplant announcement was a tag-on to the end of the press conference. Virtually all of the questions we received at the press conference were on organ transplants. I picked up the paper today as I was coming out of the airport. We received front page coverage, "Blue Cross to Cover Organ Transplants." There was no mention of the AWARE program. I think that illustrates some of the difficulty we have communicating these cost containment programs, even the effective ones, to the public.

MR. FLEISCHACKER: I'd like to address a question to Jim Charling, but really it applies to all three panelists. You mentioned the fact that the communication to the employee is an extremely important part of the total process of cost containment, cost sharing, and making the employees aware of how they can make effective use of their program. To what extent does your company actively assist the employers in developing these communications programs, particularly the smaller and medium-sized employers?

MR. CHARLING: Let me just list four or five things that we do, and I think we all realize that if we are at the 1000 employee end of the 100 - 1000 employee range, our involvement might be a little different than if it's at the 100 employee end of that range. We certainly are involved in drafting CEO letters to the employees describing what is going on, providing material for in-house organs, talking about what and why the changes are, payroll stuffers, and employee work site posters. We may be involved in employee meetings, but probably not at the lower size end. A lot of this depends on geography and how spread out the work force is. Especially at the lower size end, we have certain package plans. We have or just about have a film strip available to use in employee meetings to describe the pieces of the plan. So far, at least, they have been well received.

MR. NIEMIEC: I agree with Jim's comments. I wish we were doing more communication work, even though we have several people in the marketing area that really work on it full time. Whenever we are invited in by an employer, we

definitely take advantage of the opportunity. Something has happened in the last year in our area that has helped to open up the door more. That is this wellness approach - exercise programs, stress reduction, and things like that. We've seen more acceptance of the cost containment program, to at least be able to explain it to people, if we tie it in with the wellness program. People like to feel good about themselves, and when they do start to feel good about themselves, then I think they take more interest in their health care coverage. In the Twin Cities area, where the HMOs have about a 30% penetration, the thing that people really like about the HMO is the fact that they don't have to submit claims. I think that the traditional fee for service coverage, ours included, is complicated. I think people go into it conditioned to think it's complicated, and that's why it's difficult to open the door. There have to be some teasers, besides the more traditional explanations of what is going on.

MR. JONES: I'll just add one thought to that. I agree with what both the others have said about communication materials. I think, particularly, wellness is a key. We've developed a product called Wellness Works Wonders, which is designed to help the employer establish the wellness programs within his own company and which includes a lot of communication materials.

MR. LANCE MALKIND: On the topic of alternative care arrangements, we frequently must go beyond contractual provisions. An article in the Dallas Times Herald last January discussed the problem of children trapped in pediatric intensive care units (ICU). One reason some of these children are trapped is that insurance companies would rather pay $1,500 per day to keep the child in the ICU rather than $200 for home health care, which might not be provided for in the contract. I wrote to one of the physicians quoted in that article and suggested that when this situation comes about, the provider should make an effort to contact the insurance company (going to the CEO if necessary, and not stopping at the level of the Claims Manager) to attempt to work out an alternative care arrangement. Insurance Companies are not always altruistic, but if we have a chance to save money and ease a considerable amount of anguish by going extra-contractual, we will usually do it. Someone must be responsible for taking the initiative.

MR. NIEMIEC: We've taken that approach and our utilization review people have the option now to deviate from plan benefits and to pay for alternative care.

MR. KERRY A. KRANTZ: I'd like to ask a question to Mr. Jones about the Age Discrimination in Employment Act (ADEA). I read the Society study note recently which described the ADEA as applying to active employees between the ages of 65 and 69. I was a little confused about why that might apply to Lee Iacocca as a retired employee.

MR. JONES: I didn't mean to suggest that the coverage was because of ADEA. The automotive company coverage provides that even an employee on layoff or in retirement is still covered under the plan and is entitled to benefits. It was the COB provision where, in the determination of the order of payment, the rule said that the plan that had covered the individual longer pays first. Lee Iacocca's Ford coverage did not terminate with his retirement. So Ford paid before Chrysler. It was strictly a COB problem.

MR. KRANTZ: There are two ways, I would assume, of reimbursement right now. One is cost-based and the other is charge-based. My assertion is that charge-based customers will be taking a lot of cost-shifting from the cost-based customers. I'm wondering if the trend is going rather rapidly to the cost-based reimbursement method.

MR. JONES: First, I'd have to agree that the trend is enormous. I happen to serve on a Health Insurance Association of America (HIAA) committee that is probably responsible for the big numbers that have been published. We see the cost shift from Medicare and Medicaid increasing to something like $9 billion. I'm not sure that I feel the trend will be toward cost-based reimbursement, however. I think the trend, which the HIAA would like to see, will be to all-payer equality, whether it be cost-based or charged-based.

MR. RICHARD B. SIEBEN: I have three questions. First, to Dick Niemiec, how many length of stay categories do you have?

MR. NIEMIEC: Just the five major categories.

MR. SIEBEN: You don't subdivide?

MR. NIEMIEC: No, because the rest of them are unusual cases.

MR. SIEBEN: Have you or has anybody else tracked the migration of out-of-pocket limits in your contracts? You talked about the deductibles, but have you got information or data on out-of-pocket limits over a similar period?

MR. NIEMIEC: I don't have it right at hand. I don't think there has been a great deal of increase in the out-of-pocket limits.

MR. SIEBEN: Where do you see your typical limit?

MR. NIEMIEC: In the group business, probably $2,500.

MR. CHARLING: I would certainly agree. We see customers very quickly wanting to talk about and wanting to make moves on

the deductible. But the companion change in the out-of-pocket limit that needs to occur if the coinsurance is to do anything gets totally blown all out of proportion.

MR. SIEBEN: I'm dismayed that $1,000 and $1,500 are still typical out-of-pocket limits, whereas the earlier major medical contracts twenty years ago paid 75% of the first $10,000, so that there was a $2,500 out-of-pocket limit.

Have you had anything going on cost containment that's been effective in the explosive cost of prenatal or neonatal care?

MR. CHARLING: All I hear my claims people say is that this is the current big ticket item. And I certainly haven't picked up from those conversations any inroads on alternative ways to handle it.

MR. NIEMIEC: We have the mechanism, but I don't know how often we've used it.

MR. FLEISCHACKER: I have one comment regarding Mr. Sieben's question on the increase in out-of-pocket limits. On the small group side, the multiple employer trusts, we've seen a definite upward shift in the out-of-pocket limit, which is going up to a $5,000 out-of-pocket limit from the $1,500 or $2,000 limits of a year or so back.

MR. IRWIN J. STRICKER: I have a question to Dick Niemiec on the program of reimbursing hospitals for the reduction in the average length of stay. Was the analysis standardized to take into account changing types of disabilities? Was there a comparison of your results with any nonparticipating group to see whether similar reductions were being achieved there as well?

MR. NIEMIEC: No. That is something we should grasp, but we didn't feel that that would seriously distort our analysis.

MR. DAVID V. AXENE: Both Minneapolis and Massachusetts, where you have achieved significant cost savings, have relatively inefficient delivery systems where the bed days and the cost of other items are quite high compared to the nationwide average. I was wondering if you have any examples where you have tried a program in a more efficient delivery system, to see the magnitude of savings that you have been able to get there.

MR. JONES: I'm not aware of them if we do. I am only aware of those two particular programs. I agree with you that it is easier to get spectacular savings when you're in a spectacular area.

MR. AXENE: You were talking about the Advance Payment Arrangement where you were actually paying the providers the deductibles and co-payments. Have you tried to tie that into any kind of flexible benefits or some of these other flexible spending accounts?

MR. JONES: We had an order to do that but the IRS got in the way. We expect sometime early in 1985 we will put in a program that does precisely that. We will automatically pay the deductibles and coinsurance and take it out of a flexible spending account.

MR. ROBERT A. HALL: We have had many larger employers in particular indicate very strongly that they want to change the COB provision to reduce the secondary benefit payment. At this point, we essentially have agreed to do that for larger employers who want to put the COB provision on a maintenance of benefits approach. I wonder how many other companies are doing that type of thing, because it is clearly a cost saving to the employer. Admittedly it's cost shifting, but, from my perspective, it's not an unreasonable thing to ask the employee to go to a maintenance of benefit type of COB provision.

The maintenance of benefits approach really doesn't impact on the primary carrier at all. The secondary carrier looks at what has been paid by the primary carrier and if the secondary carrier's program would pay somewhat more, then the secondary carrier pays the difference. If the secondary carrier would pay less than the primary carrier has already paid, the secondary carrier doesn't pay anything.

MR. JONES: The HIAA committee approved changes in the model COB legislation within the last month or six weeks. There was a number of changes. The new provision would allow precisely this maintenance of benefit approach. I think there is a great deal of interest in it. The new provision also would allow flexibility in the coordination level, the point at which you start cutting the employee back. Instead of having it be 100%, it could be any other amount down to 80%. There are even COB proposals that would address the cafeteria benefits issue if the employee were eligible for a plan and elected not to take it; coordination could be done as if he had taken it. I think there is an enormous amount of interest on the part of employers that are sick of paying the claims for other employers' employees because the other employers were smart enough to put in a big deductible or a high contribution to persuade all the claims to go somewhere else. This particularly happens in school committees.

MR. CHARLING: Just one more comment. We believe that the deductibles and the coinsurance and those kinds of things are really going to help make a change, yet we still allow plans to coordinate to 100%. That effectively does away with all that design that we spent all our time putting in. I agree that we are seeing the interest and I think that the HIAA recommendations are going to start making these changes happen on some sort of orderly basis, as opposed to each of us striking out on our own.

MR. JAMES J. CONNORS: Mr. Jones, you mentioned a massive statistical analysis that you did - a processing system using data beyond your own claim files. Was this a joint effort with some other organization or did you buy data?

MR. JONES: It was really an effort dictated by the policyholder. He retained another organization using our data. So it was a cooperative effort. We had to select the data. We did not have to create any.

MR. CONNORS: So the policyholder provided the other source?

MR. JONES: The policyholder obtained the other source and paid the bill. I think there is experience with some of our other policyholders that suggests more and more the large employer may be going to other than the insurer or claim processor for some of the analysis of his data. There are a number of consultants that are springing up and are willing to do this and seem to be enjoying full time employment.

MR. WILLIAM SONNLEITNER: Has anybody seen cold hard evidence of what you save by second surgical opinions, or does somebody have evidence that you don't save?

MR. JONES: I guess you're suggesting that the evidence is sparse, and I think I agree with you. Years ago, we had some very decisive evidence that we saved many thousands of dollars, provided we stopped counting soon - that is, don't look at what happened with postponed surgeries and things of that nature. Some plans that we have going on an experimental basis with one policyholder in the Chicago area suggest maybe 5% or 6% saving, but again I don't know how to address the question of the surgery that may not have been done today because the patient elected some drug therapy instead, but still might have to be done tomorrow.

MR. SONNLEITNER: I think you're suggesting that the savings are illusive.

MR. JONES: That may well be true.

MR. NIEMIEC: We agree. When we were developing our second

opinion program, we had a hard time finding data. Some of the savings that were given for second opinion we thought were simply crazy. I think we are going to have a rather hard time pinning down the savings from our plan.

MR. CHARLING: Whatever little historical data we have on it is largely based on voluntary second opinion as opposed to today's version, which is certainly much more mandatory. We have a general feeling that second opinions may well be perceived as having a much greater cost savings than there really are. It may be the single item in the cost containment arena that is blown well out of proportion.

The data question has been raised several times. I assume you are all seeing customers wanting some kind of normative data. What are you using for this? Where do you find the bench marks? How much actuarial credibility theory do you have to throw aside in order to find any bench marks?

MR. SCOTT S. THORNTON: One of the problems that we see in the cost containment area is how to quantify the actual savings from a specific program. I know, in our experience, we implemented several cost containment measures, but it is hard, or maybe we have neglected the analysis after the change was implemented, to see whether they even worked. Are there any suggestions you would have on techniques to quantify the results?

MR. JONES: Other than paying a claim under two plans I don't know of any.

MR. NIEMIEC: When we first started talking about second opinion, actually after it had been in for awhile, a doctor, one of our board members, came to us and suggested that we set up a control group and an experimental group. And we said, that's fine - we'll try to do it if we can find willing employers, but when employers hear about the program they want to do it. That's the problem with these cost containment programs - they've got pizzazz, you put them in, and maybe you never know how well they work out. I think it's a big problem, and you may spend a lot of administrative dollars in the meantime.

MR. CHARLING: I think we are going to have a real problem trying to get employers to understand that you've put something in yet you can't tell them what it did. Many of us believe that it's doing the right kinds of things, even if we can't quantify everything.

MR. JONES: We tried to quantify some of the savings. We do have a requirement at claim payment time that the claim approver go through a cost containment screening to record savings. You can record the amount you think you

didn't have to pay under coordination of benefits. Maybe you can record the fees you didn't have to pay because no surgery was performed, but I suspect that those are not statistically very valid figures. It is nice, however, to have something that comes out of the computer that says, "Look what we saved."

MR. NIEMIEC: For a long time we've pumped out a report for virtually any sized group that wants it, whether it's valid or not. We report everything that we can capture on their claims file and spend a lot of time on those "what if" type of situations. The groups seem to like it, but I don't know how much it changes their decisions.

MR. CHARLING: We certainly do that on COB savings, usual and customary savings, hospital audit savings, and the like. But in the second opinion and outpatient surgery programs, a key part of the savings may be the sentinel effect. Then, a whole different measure is involved.

MR. JONES: In a program such as a mail order alternative to a prescription drug program, you can actually measure savings, but it's not a very big item to start with, so the savings are not very impressive. There are impressive savings under the plan, but the item may be such a small part of the employer's program that it is not very noticeable.