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TRENDS IN GROUP MEDICAL PRODUCT DESIGN

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Introduction

The purpose of an Open Forum is to obtain a broad discussion of the topic being considered. This forum will include brief presentations by the panelists, addressing various aspects of the subject, but will allow about 2/3 of the total time for questions and discussion from the audience.

Our objective in distributing these discussion notes in advance is to stimulate your thinking about what is happening in this area. They might also serve as a reference in your preparation for the session as you consider your own experience and current plans in this regard. They are most definitely not intended to limit the scope of discussion, either as to questions to the panel or discussion between members of the audience. We hope that the session will be of interest and value to all who attend. Those factors will be directly related to the degree of audience participation.

General

Cost containment has emerged as a major topic in the continuing concern with, and debate over, health care costs. The primary reason for this is, of course, the prominence of health care costs in the overall economy (10.5% of GNP for 1983), along with continued rates of inflation in this sector in excess of those in the general economy.

This has resulted in pressure on insurers to expand on their traditional role of paying benefits in accordance with standard contracts. They are being asked to develop new contracts and products which address the concerns over the level of health care costs. Our role as actuaries is to assist in this process by identifying areas of potential value, estimating these values, and monitoring results. We also will need to be involved in the communication of these ideas with marketing and underwriting staffs. The balance of these notes includes questions on

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this topic which might provide a basis for dialogue.

Cost Sharing and Cost Containment Features

1. What is your experience with the current attitude of the marketplace regarding such benefit features?

2. What features have been most acceptable to groups?

3. To what extent are carriers moving to make such features standard in their health contracts?

4. How does the acceptability of such arrangements vary with the size and type of group?

5. How realistic are the expectations of groups with regard to potential savings associated with such features?

6. What are the implications of a possible tax cap on health benefits on the need for such arrangements?

7. To what extent are companies participating in the development of new forms of reimbursement or delivery, e.g., DRG's, PPO's?

8. How are such activities proceeding? How will success be measured and demonstrated?

9. Are products being developed to encourage healthier lifestyles?

Underwriting and Rating Considerations

1. How have changes in product design affected underwriting practices?

2. How have changes in demographic composition, mandated benefits, or other considerations affected underwriting practices?

3. To what extent has competitiveness been enhanced by new products? What products are most competitive? How does this vary by market segment?

4. What sources of data are used in reflecting cost containment features in new products or allowing credit in existing products?

5. What consideration has been given to deterioration of the traditional group risk due to competition by alternate delivery programs? How can this be handled most effectively?

6. Can the expected effects of changes in deductibles, copayments, or other contract provisions be observed in subsequent utilization patterns? How long does it take to emerge?

7. How are carriers responding to the growing interest in flexible benefit programs? What methods are being used to control the potential anti-selection associated with such programs?

Monitoring and Evaluating Effectiveness

1. What are companies doing to track the value of changes in benefit design?

2. What targets do groups have in terms of expected savings? How effectively can carriers demonstrate these savings to the groups?

3. How critical is the effectiveness of cost containment or other features to the profitability of various market segments?

4. How much risk transfer (back to the group or individual) is represented by such programs? To what extent does this leverage the carrier's remaining risk?

MR. JAMES R. TYLER: Good Morning. I'm Jim Tyler of Milliman & Robertson, Inc. Bob Dymowski is acutely, but we believe not seriously, ill and I will be moderating as well as recording our session on trends in group medical product design this morning. As indicated in the discussion notes, which were distributed in advance of the meeting, the objective of an open forum is to encourage broad discussion of the topic being considered by all participants in the forum. While the other panelists and I have prepared some initial remarks, which we hope will be useful in stimulating your own thoughts, the major portion of the time available for our forum is reserved for your discussion with us and with other members of the audience. There is probably more activity underway with regard to group medical product design at this time than at any other time in the history of group medical care products. We are all anxious to hear about the ideas which you have been pursuing or other comments or suggestions which you may have about some of the ideas which you hear discussed today.

Before we begin the program, I would like to remind you to use the microphones which are located in the room whenever you wish to speak. For the convenience of the audience and for the record, please state your name and business affiliation. If you wish to have your remarks included as part of the record of this session, please provide three copies of them to me as soon as possible following the meeting.

Our panelists today include Gilbert M. Reich, Executive Vice President of The Equitable Life Assurance Society. Gil will be speaking to us about a survey recently commissioned by The Equitable, entitled "Options for Controlling Costs", and the implications on benefit design which can be drawn from the survey results. We also have Carl Ricciardelli, Vice President and Actuary of Health Care Service Corporation of Chicago, Illinois, who will describe some of the cost containment activities which the Illinois Blue Cross/Blue Shield Plan has undertaken. We expected to have David W. Reynolds, Vice President, Human Resources of Georgia-Pacific, to describe some of Georgia-Pacific's experience with regard to its own employee benefit programs and some of the cost containment activities which the company has recently undertaken. Dave was called out of town. He is being replaced on our panel by Dan Hawkes, an Associate in the Atlanta office of William M. Mercer. Dan has responsibility for Georgia-Pacific and other large accounts.

My own remarks this morning have two purposes. The first of these is to establish a background for our discussion this morning by describing my view of the current environment of the group medical care business. The second purpose is to describe the kinds of responses to this environment which I see developing, and the need for consideration of adequate underwriting and monitoring of these products. My perspective is that of a consulting actuary who specializes in group health consulting for carriers, in particular for Blue Cross and Blue Shield plans.

The first characteristic of the current environment is that while the rates of medical care inflation have continued to decline for most categories of benefits, they are still high relative to the overall rate of inflation. There will be further discussion by the other panelists.

Another significant aspect of the current environment is the degree of competition which is present between providers, particularly hospitals and physicians. I have seen a number of references to declining utilization of hospital facilities and a number of hospitals have been forced to reduce staff or discontinue the provision of certain types of care. Physicians, too, have become increasingly aware of their need to maintain an adequate patient base in order to realize satisfactory income levels from their practices. Thus, both hospitals and physicians have shown considerable willingness to negotiate payment levels for their service in return for opportunities to maintain or increase market share in their service areas. Competition among providers is an important new aspect in the environment.

A final consideration with regard to the environment is the continuing recognition of the effects of changing demographics on the workforce, and the need for employee benefits. This has led to some reconsideration of the traditional coordination of benefits provisions, particularly when an increasing number of employees are covered under self-funded contracts which might not include such provisions, and the introduction of various forms of flexible benefit programs ranging from full cafeteria plans to flexible spending accounts with standard benefit programs. The increase in interest in such programs has further accelerated the interest of the federal government in the possibility of obtaining additional revenue by limiting the current favorable tax treatment of group medical care products provided by employers.

The first of the product responses which have been developed to address the concerns by the current environment fall into the category of redesigning traditional products. We have observed a significant shift away from full first-dollar coverage and the combination of basic medical care benefits plus supplemental major medical toward the comprehensive major medical design. The new comprehensive products, in many cases, incorporate higher deductibles as employers finally recognize that the popular $100 deductible no longer makes economic sense. Copayments and limitations on out-of-pocket maximum benefits associated with such programs have also been increased in many cases. Other aspects of product design have included variations in deductible or copayment levels in order to create additional incentives for non-hospital versus hospital treatment.

A second type of response has been the incorporation of various cost containment options into traditional contracts. This will also be addressed further by Carl in particular.

A third type of response has been an increased emphasis on the use of alternate delivery systems, such as HMO's and PPO's. After a fairly slow start in most areas of the country, HMO enrollment in many areas has been increasing rapidly. This growth has benefited from improvement in the relative level of HMO costs, as compared to traditional programs. Despite the broader range of services typically provided by HMO's, the cost of such programs often compare favorably to traditional programs due to the higher rate of increase in traditional cost in recent years and to differences in the underlying experience levels between traditional and HMO programs. Preferred provider organizations, or PPO's, differ from HMO's in that the providers do not participate directly in the risks of the program. Instead, they agree to provide services at negotiated reimbursement levels in return for the endorsement of the sponsoring organization and expected increases in patient loads.

As mentioned above, the introduction of flexible benefit programs has also been a response to this environment. These will be discussed in detail in another forum to be presented later today, and I will therefore not go into a lot of detail about them at this time. A common aspect of all of these responses is what they represent in terms of risk transfer between either the employer and the employee, in the case of restructuring of traditional programs, or between the employer and provider, in the case of alternative delivery systems. Employers' recent experience with high rates of medical care inflation have left them very reluctant to continue to bear this risk. The limitation of risks associated with defined benefit pension plans has led to the movement to replace such benefits with defined contribution plans. It seems reasonable to assume that this trend will continue to be observed with regard to the provision of group medical care benefits as well.

How do we respond, as actuaries, to the questions raised by the environment and these product design responses? Our traditional approach has been to review past experience and to develop estimates based on projecting this past experience into the future. The effect of such new product designs, however, is to make the future significantly different from the past. This is something that we need to consider in our evaluation of possible cost reductions or changes in utilization associated with such product revisions.

The increased frequency of dual choice options and the introduction of flexible benefit programs raises the issue of individual selection which traditional group underwriting rules have sought to limit. I believe that we need to develop models which can illustrate the potential effect of such selection on individual groups or blocks of business in order to develop appropriate rating strategies.

Our first panelist is Gil Reich, Executive Vice President of The Equitable. He came up through the sales side of The Equitable Group Operation, and may possibly have some "actuarial" jokes which none of us have heard before. His current responsibilities include directing the sales, service, administrative and financial undertaking of Group

Operations, which services the large group market.

MR. GILBERT M. REICH: Good morning, ladies and gentlemen. It's a pleasure to participate in your program this morning.

Although the title of your forum is "Trends In Medical Care Benefits", Jim Tyler was kind enough to suggest that I key my remarks to the healthcare survey which The Equitable commissioned the Louis Harris Organization to conduct, and which was publicly released last October.

I'm pleased to respond to Jim's suggestion because we at The Equitable Group Operations believe the survey was the first step in focusing attention on the need to develop a consensus on the new directions required in the healthcare industry. It is also helpful in developing the kinds of healthcare cost containment practices those of us who are third party administrators should be advocating to the industry and to our clients.

If we fail to take this type of initiative, I have no doubt we will soon summarize "Trends In Medical Care Benefits" in one sentence. Less is less. With that introduction, let me tell you about the survey.

In commissioning the Harris Group, we charged them to do their best to make the report fair, balanced and comprehensive. Their report, entitled The Equitable Healthcare Survey: Options for Controlling Costs, was everything we asked for: it was also surprising.

I won't test your endurance by covering every aspect of the survey today. To do so could easily put me in the position of the man described by Samuel Johnson when he said:

> "He talks like a watch which ticks away minutes
> but never strikes the hour".

Rather, I will follow Dr. Johnson's admonition and simply try to tease your curiosity with selected highlights and hopefully encourage your careful study of the survey itself.

A good place to start is with overall views of the healthcare system. The American public is far from satisfied. Only 21% of all adult Americans believe that the system works pretty well and only minor changes are necessary. Fifty percent, including majorities of hospital administrators, corporate benefit officers and union leaders, believe that while there are some good things in the system, fundamental changes are needed. And, this I think is surprising, a quarter think that the system has so much wrong with it that we need to completely rebuild it. Imagine, 25% of Americans say junk the system and start anew.

When asked how satisfied they were with the availability and quality of healthcare, 70% or more said they were generally satisfied. And 86% of all adult Americans said they and their families had been able to obtain all the medical services which they needed in the previous 12 months.

The cost of the care was quite another matter. Majorities of Americans, varying from 51 to 63 percent, believe that the costs of prescription

drugs, doctors' visits, hospitalization, lab tests and x-rays, on the whole, are unreasonable. Indeed, of the American families who reported that on at least one occasion, and possibly more, they failed to obtain needed medical help, the cause most frequently referred to was the high cost of the care.

I recall reading somewhere of a doctor who said:

> "We doctors are never as good as our patients say we are when we cure them. And
> We are never as bad as they say when they get our bill."

Some of that I'm sure gets factored into a survey of this sort. But, even generously discounting all the data accumulated, I think you'll find it is clear that public concern about the cost of healthcare is very great. Especially when the data is viewed in the context of the assertion that only 16% of all adult Americans have ever, at any point in their life, selected a doctor because his or her fees were lower than those of another doctor.

While there is widespread dissatisfaction with the high costs in general, there is very little consensus of their cause.

Slightly more than 40% of the American people blame the "increasing cost of the same service", classical inflation, as the cause for higher costs. Of this group, one-third blame the use of new and more expensive treatment and equipment. People using more services than they used to are not acknowledged as a major cause of escalating expenditures by the American public.

When the different groups interviewed were asked to rate ten different possible causes contributing to the rise in healthcare spending, they rated in descending importance:

- Expensive new equipment and technology,
- The tendency of doctors to order more tests than necessary,
- The growth of malpractice suits,
- Lack of competitive pricing among doctors, hospitals and nursing homes,
- Unnecessary hospitalization for minor ailments,
- Increased availability of government programs like Medicare and Medicaid,
- Fraud and abuse by providers,
- Aging of the population,
- Longer than necessary stays in hospitals, and
- Increased availability of employer-provided health insurance.

Perhaps what these views and rating tell us more than anything else is that the public has become more knowledgeable and more sophisticated than it was even a few years ago. Then, very few people gave much thought to increased spending as being related to new technology. This increased knowledge and level of sophistication suggests that the public will be more demanding of the leadership -- be it from the government, industry, labor or the healthcare system itself -- in their approach to and solution of this crisis of cost.

The survey tells us that most people regard as unacceptable the government's proposal to make the top-end of the more expensive health insurance premiums taxable benefits. Not because of the tax, however, but because it is viewed as being ineffective. In the public view, there is nothing an individual can do in the way of reduced utilization to avoid paying the tax. A majority of Americans also disfavor shifting costs from Medicare patients to other patients. Again, because it does nothing to address the basic problem.

Perhaps the most surprising aspect of the survey was, when specific initiatives were suggested, the high correlation between a program's acceptability and its perceived effectiveness. Programs perceived to be effective were likely also to be acceptable. In fact, those interviewed were not asked if they favored or opposed programs -- merely, were the programs acceptable or not, and if acceptable, to what degree: very, somewhat, or not very acceptable.

Consider these results:

- 65% of the public said it would be very or somewhat acceptable to require employees to pay part of their own health insurance premiums;
- Over 50% find it acceptable to increase deductibles and co-insurance levels;
- Mandatory second opinions for non-emergency surgery are overwhelmingly acceptable;
- 63% of Americans are willing to accept a system that uses nurse-practitioners, mid-wives and physicians' assistants;
- Over 80% of the public find it acceptable to have a system that encourages people to have tests and minor surgery done in out-patient facilities rather than hospitals;
- 70% of Americans would be willing to accept a system which requires patients to select doctors from a list of doctors who would provide basic medical care for a predetermined fee;
- And, finally, 76% of the public find DRG's (diagnosis related groups) acceptable. This system, in which fixed fees are paid to doctors and hospitals for treating patients with particular types of diagnoses, is <u>not</u> viewed by the public as government control of prices.

My report to you would not be complete if I did not state that the views of the American public, as I have reported them, are not universally accepted by all segments of the system. Medical society leaders are the least willing to accept, or even recognize as effective, changes that are likely to adversely affect the financial incentives for their profession, and they believe that only minor changes are needed in the overall system to improve it.

The fact that the Harris Organization surveyed medical society leaders rather than practicing physicians is a criticism of the survey, which The Equitable accepted as valid. It was suggested by many that the views of those doctors who practice medicine might differ from those who practice politics. So we went back to the Harris Organization and asked them to conduct a complementary study of practicing physicians.

The field work for this study, completed in January and February, consisted of 500 interviews with a representative cross section of physicians. The results of the interviews are being tabulated and we expect to publish them in early June. Based on the few highlights that I can share with you today, this study will be a blockbuster.

Our early study showed that 2/3 of the physician leaders believed that the American healthcare system worked well. Less than half of the practicing physicians believe it works well and, as said earlier, only 21% of the American people think it's working pretty well.

This increasing negative perception as you descend the service ladder from provider leaders, to provider, to consumer is exacerbated by the fact that there is no consensus among practicing physicians with regard to priorities for change in the nation's healthcare system.

This churning of discontent by provider and consumer should be a strong warning signal to all of us who are vitally interested in the free healthcare market and our concern is increased when we learn from our new study that:

> "A majority of physicians believe that the third-party payment system, as it exists today, is a major contributor to increased healthcare spending".

Why should this concern us? Well, if we were investors with a substantial interest in a real estate development, our level of concern would be at the breaking point if we learned that most people thought the neighborhood where we placed the development was unacceptable, and the specific houses we built were a large part of the problem. In this real estate situation the ingredients for bankruptcy are present. In our real situation, bankruptcy may be a consideration for us as insurers or TPA's, but the collapse of the voluntary healthcare system is a real concern for providers and consumers alike.

What I'm saying is the survey defined the scope and depth of a problem that touches every aspect of the system. It's not their problem. It's <u>our</u> problem. It's the problem of third party administrators, doctors, hospitals, corporate America, consumers - even the Society of Actuaries.

Having given you the bad news, let me give you some good news. All is not lost. The surveys suggest a number of practices which will be acceptable to all interested parties and also suggest that a policy consensus can be achieved. The necessary ingredients are leadership and hard work and you, as members of one of the most prestigious professions involved in the process, can supply both.

Employers, hospitals, and doctors need to understand the economic dynamics of healthcare. Corporations need help in analyzing their costs, understanding the dimensions of their problem, and understanding the implications, short- as well as long-range, of benefit modifications.

This clearly is within the scope of your professional pursuits. What works for one company may be only minimally effective - or not even practical - for another. You must help employers weigh potential savings against employee acceptance: and assign priorities to benefit changes based on cost-effectiveness and feasibility of implementation. And, your professional recommendations must be delivered in a way that busy executives can quickly understand, accept and implement.

The Equitable has made a significant step in this direction with the development of a healthcare cost management-plan design evaluator. This is a process of measuring an employer's benefit plan effectiveness on specific cost management features. It identifies target areas for change, and provides customized action plans geared to the employer's specific needs. If any of you are interested in looking at the program, I'll be happy to send you some material on it, if you write to me in New York.

On the issue of developing policy consensus, the survey identifies the need and suggests a number of areas that can help us achieve it. Last October I suggested, as a means toward this end, the formation of a healthcare cost management institute and, on behalf of The Equitable, offered to supply $1,000,000 in seed money.

The Equitable continues to work to move the institute from concept to reality. Progress has been slow but we expect to see it established. Through it all components of the healthcare system can cooperate in developing mutually satisfactory solutions to mutually disagreeable problems.

A concept currently in vogue is managing turnarounds. Most writers on the subject believe the effort begins with recognizing the need for a turnaround. If the two surveys do nothing else but crystalize this reality for everyone, (the need for a turnaround), they will have been more than worth the effort.

If we then turn to the second phase, harnessing our collective talents, interests and hard work (and here the actuarial profession should have a significant role), one day, soon, all of us who are interested in continuing and improving the voluntary healthcare system can say that we cared, and we participated proudly in the ancient dictum,

Physician heal thyself.

MR. TYLER: Our next panelist is Carl Ricciardelli, who has 25 years of experience in life and health benefits, both joint and individual. He worked for 2 life companies and 1 consulting firm before taking his current position as Vice President and Chief Actuary with Health Care Service Corp., the BC/BS plan in Illinois.

MR. CARL RICCIARDELLI: The topic of our open forum today is "Trends in Group Medical Product Design". With the exception of flexible benefit experiments, most of the recent group medical product design consists of the development of cost containment features. One can hardly pick up the National Underwriter, or Business Insurance, or any of the trade or business papers without an article, and usually a major one, on some aspect of the containment of medical care costs.

What I would like to do this morning, is to provide a kind of historical and conceptual framework for these emerging programs.

First, the whole issue of the containment of costs arises because, in recent years, we've seen medical care cost increases outpace the overall CPI by a factor of about 2. The magnitude of these cost increases can be understood if one regards the provision of medical care as a business. And, therefore, subject to the economic law of supply and demand.

On the demand side, we've seen an unprecedented and apparently insatiable demand for more care. Some of the precipitating factors include the triggering effects of programs such as Medicare and Medicaid, and a strong sense of entitlement that appears to have pervaded the medical care cost demand picture. Further, partly as a result of emerging technology, we see increased emphasis on the pricelessness of human life.

On the supply side, providers have not only expanded to meet the developing demand. But, by advances in medical technology, have served to stimulate that demand even more.

And so, the medical care cost spiral and the construction of hospitals and other facilities over the last several years. And, as in other industries at other times, the momentum of these changes drives costs beyond the willingness or ability of consumers to pay. And facilities are over built.

So, it's no wonder that we are now in the condition of having a good percentage of our hospital beds empty. We face room and board costs today that seem incredible ten years ago. And there continue to be geographic misallocations of medical practitioners.

We've come full circle. The consumer wants lower costs; and the providers need to compete with one another for patients.

The provision of medical care does obey the law of supply and demand. Against this background, the recent and continued emphasis on developing effective cost containment programs can be viewed as attempts to change the behavior of providers as well as consumers. So, it would be helpful in our review of cost containment programs to classify them as supply side or demand side programs.

Another natural categorization of these programs relates to the way that costs are measured. Total costs for a benefit program are a product of utilization rates and unit costs. Some of the current and emerging cost containment programs direct themselves at utilization, where others aim at unit costs. And some programs attempt to influence both utilization and unit costs.

Once we have programs broken down into supply side and demand side, and those which attempt to influence utilization as opposed to unit costs, third-party payors are left with a number of additional activities.

First, almost all of the standard and emerging cost containment programs will involve additional administrative or other expenses. And such processing normally involves some delay in the payment of claims. Further, if these programs are to be provided in any volume, automated systems changes need to be defined, designed, and installed to handle that volume.

This additional increment to our cost of doing business needs to be passed on to the group account.

Secondly, we have the savings that would accrue to a group account upon the effective implementation and operation of a cost containment program. Specific savings levels incident to the application of particular programs are difficult to come by. Even if they were available from the operations of other insurers, one can never be sure that their application in your company will result in the same level of savings. What we've done at Blue Cross/Blue Shield of Illinois is institute these programs for certain accounts on a pilot basis, measure the results, and then project the savings results to other plans based on utilization patterns, demographics, and geography.

And, as insurers become more comfortable with predicting savings, we may be asked to guarantee those savings. So that, in developing estimates of savings, we may wish to develop so-called average savings levels - usually expressed as a percentage of total claims - and more modest guaranteed savings levels.

And the final item we need to be concerned with is the ability to demonstrate the favorable results of these programs. If we are to retain any credibility with our group accounts, we need to reach agreement, in advance, on the methods by which we will measure savings, and have an adequate data base and reporting structure so as to satisfy those agreements.

In this latter connection, an important distinction needs to be made. There are some cost containment programs which - by their very nature - are designed to change behaviors for <u>all</u> consumers or for <u>all</u> providers. The savings from these programs may not be readily determinable on a group-specific basis. But they must be imputed in some way in an account-specific savings report. And the methods for doing so - as we pointed out earlier - need to be agreed upon up front.

Of course, the bread and butter cost containment programs are those that lend themselves directly to account-specific demonstration of savings.

At this point I would like to review a number of the cost containment programs that we've developed at Blue Cross/Blue Shield of Illinois and give you some data as to the categories these programs fall into and the approximate costs for administering the program and the expected savings.

First, we have the mandatory additional surgical opinion program (MASOP). This program requires an additional opinion whenever surgery is recommended for thirteen elective, non-emergency surgical procedures. If a second opinion is not obtained, hospital benefits are reduced to 50% of the otherwise eligible charges. And, that reduction - those dollars - are not eligible for major medical and do not apply to any out-of-pocket expense limit.

This program is clearly a demand side program that attempts to change behavior with respect to both utilization and unit costs. Results can be tabulated on an account-specific basis. In order to do so, one needs to tabulate the extra costs of second opinions, as well as the costs of alternative care, and set these against the estimated costs of the standard care.

Our initial estimate of the administrative costs for this program is about $1.00 per contract per year, and we estimate savings - on a full benefit program - to be about 4/10% of claims.

Another of our cost containment programs is mandatory outpatient surgery - what we refer to as MOPS. Under this plan, sixty-five non-emergency surgical procedures are identified. Full coverage is provided if these procedures are performed on an outpatient basis. If the surgery is performed as inpatient without supporting medical documentation, as opposed to the previous program which reduced benefits by 50%, both hospital and surgical portions of such claims will be denied. Also, the denied charges are not considered eligible charges for major medical and do not apply to the out-of-pocket expense limit.

This program is a demand side program attempting to effect unit costs primarily, and utilization to some degree. The results lend themselves to account-specific tabulation. We estimate our costs of handling this program to be between $5.00 and $7.00 per insured per year, and we expect savings on the order of 3% of total claims for a full benefit package.

Our preadmission review program is similar to the mandatory outpatient surgery program in that the same sixty-five selected surgical procedures form the base. However, in this case, a review of the appropriateness of intended care is made prior to the services being rendered. As with mandatory outpatient surgery, if our preadmission review does not support a necessity for inpatient admission, or if the review was not sought prior to admission, the hospital and surgical portions of the claim are denied.

This again is a demand side program affecting both utilization and costs, and lends itself to tabulation of savings on an account-specific basis. Our estimated costs of handling such a program are approximately $5.00 per subscriber per year, and savings are estimated to approximate 7% of total

claims. This is one of the big ones.

One of the programs that does not lend itself to account-specific savings determinations is our uniform periodic payment program. As you may know, Blue Cross/Blue Shield of Illinois has contracts with virtually all hospitals in the state. Of those hospitals, the ones participating in this program receive weekly payments from us which approximate the reimbursement for services that will be rendered to our subscribers during a typical week. In return for such upfront payments, participating hospitals must administer a concurrent utilization review program for all Blue Cross cases.

This is a supply side program designed to change provider behavior with respect to utilization. Because it's a program that applies to all Blue Cross subscribers, it is very difficult to assign savings effects on an account-specific basis. The costs of operating the program are built into our basic retentions and we have seen positive effects from this program as well as others in tracking hospital days per thousand over time.

I'd like to mention one final item and that relates to the reporting of savings and - in general - reporting that can help tailor programs that effectively modify behavior for specific groups. A few years ago we developed PROBE, which stands for Performance Reporting of Blue Cross Experience.

PROBE 1 relates to hospital utilization, while PROBE 2 non-development deals with physician claims. Under PROBE 2, utilization data is accumulated and developed by hospital, type of service, diagnosis, age bracket, incidence, and admission and discharge day.

The typical statistics report would include average length of stay, cost per case, cost per day, cost per diagnosis, frequencies, total admissions, and so forth. This type of data can be developed for any group of roughly 1,000 or more lives.

MR. TYLER: Our next speaker is Dan Hawkes, who has extensive experience in the area of fringe benefits. His background includes 9 years with the Metropolitan Life's Group & Pension Division. He worked both in underwriting and in Group Sales. He currently consults for the Atlanta office of William M. Mercer, primarily for large corporate employers.

MR. DANIEL R. HAWKES:

Introduction

Medical care claim payment expenses are more than dollars on a ledger sheet. Their characteristics and composition reflect both the wastefulness of current consumption and the potential for future cost savings. Therefore, utilization data analysis should be used to:

- reveal specific areas of cost waste and abuse;
- identify which (or which combination) of several potential actions would deal directly with revealed problem areas; and

- monitor the results of subsequent aggregate intervention action.

Specific Problem Areas

The fallacy behind most utilization study reports is that they tell you the non-specific obvious. That is, they indicate in broad generalities:

- that some types of surgery occur with a frequency which breaches national norms; and

- that length of hospital stays or frequency of admissions are excessive as compared to some standards.

As a result, specific action options are neither apparent nor guided by the data. Neither is the likely impact of actions preventing the actual forecast of results in advance.

Specific Results

(A) "Convenience admissions" is a term often used to describe entry into an acute care hospital at a time dictated by patient or physician preference rather than by a necessary treatment schedule.

Often, traditional study reports concentrate only on weekend admissions. Their narrative commentaries merely suggest that a problem exists and that "something" must be done about it.

I want to know an equal amount about any day of the week when an overnight charge was incurred for other than a medical necessity. As for weekend admissions per se, I want to know more than totals vs. any kind of standard. I want to know which were gunshot wounds, heart attacks, auto accidents and maternity deliveries as opposed to hernia repairs and cyst removals. I want to know the time delay between admission and proactive treatment. Moreover, if the length of stay and associative charges are less at a given hospital for weekend treatment than for weekday stays, I want to know that, too.

(B) As for frequency of surgery, I want to know specifics. Exactly what kinds of surgery are being performed with alarming frequency? Which surgeons in what areas are linked to the problem? Which frequency problem surgeries are among those cited in national studies as questionable or open to a non-surgical solution? Which operations lend themselves to outpatient surgery? Is there a potential link with lifestyles or work environment for the types of illnesses or types of surgeries being cited in the report?

(C) As for frequency of hospital admission or length of stays, I also want hard facts. What specific diagnoses are involved (including secondary medical problems or complications)? What hospitals and/or doctors are linked to the problem? What types of patients are involved (ie., employees, spouses, children)?

It is the answers to these and similar questions which direct activities -- not generalities compared to averages. Further, the actual costs associated with each diagnostic group treatment situation speaks to

the technicality of appropriate action.

Armed with such specifics, it is possible to shoot economically with a rifle rather than with a shotgun. It is possible to contract with Professional Review Organizations (PROs) to concurrently review those specific illnesses at those specific hospitals for which problems have been detected.

It is possible to identify which specific types of surgery at which locations require inclusion of a second surgical opinion listing.

It is possible to identify which hospitals or which physicians at the same hospital provide the most affordable care for "apples to apples" patient situations.

It is possible to determine whether or not a preadmission certification program is needed, and if so, for what illnesses, for which types of patients, and at which hospitals.

It is possible to know what specific benefit plan charges and communication/education efforts are needed at specific locations to promote or to deter certain consumption habits.

It is possible to identify preferred providers and non-preferred providers for the purpose of either attempting to influence patient traffic or as a basis for negotiating for most cost effective treatment practices.

Barriers To Data (Trash In; Trash Out)

It is a problem we all need to deal with if we are to meet the challenge of producing meaningful reports. Beyond trying to study a single group of employees which is too small for statistical accuracy, the most significant barrier to the production of meaningful reports is not necessarily with finding the expertise and technology to do DRG analysis with physician linkage. To be sure, the firms with this technology (as opposed to those who say they do) are few, but they do exist.

However, the greatest problem area lies in the quality of input data either supplied by medical care vendors or captured by your insurer or claim payment administrator.

As to the vendors, in many rural areas, the quality of information supplied to a claims office by the doctors and hospitals has much room for improvement. The snap-out carbon billing system which contains procedure coding, is helping greatly to improve the quality and accuracy of patient treatment information. Medicare will soon require DRG identifier coding for its benefit reimbursement requests, which will undoubtedly give rise to its uniform usage by hospitals. However, once that barrier is crossed, we still have a problem recording that data in our systems.

In order to have really useful data, the claims payor must code hospital claims via the International Classification of Diseases -- Ninth Addition (ICD-9-CM). Five digit coding is preferable (and should be requested).

However, even three digit coding is useful. Further, it is important that the data reflect the ICD-9 coding for both the Admission and the Discharge Diagnosis. Secondary diagnosis coding is also very important. Prior to 1983, no carrier used such a coding scheme. Using a variety of two digit cause codes was the standard industry practice.

Procedures (e.g., surgery) accompanying hospitalizations must also be coded (i.e., CPT, HIAA, or CRV). A linkage is often necessary between the original "referring" physician and the hospital confinement. Put another way, for each hospitalization the data should reflect the attending physician, the surgeon (if any) and, if possible, the family doctor or specialist who referred the case. An entire treatment capsule is thereby grouped with the diagnosis.

For outpatient treatment, the same detail coding is needed with a clear reflection of (a) the type of outpatient facility utilized and (b) the type of service rendered.

With this kind of data gathering focus, an information tool is possible which is concurrently:

- location specific;
- Diagnostic Related Groups (DRG) specific;
- physician specific;
- hospital specific (including division by emergency room and same day surgical wing); and
- links pre- and post-confinement care with hospitalization charges.