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ASSESSMENT OF HEALTH CARE COST MANAGEMENT PROGRAMS

WHAT HAS RECENT EXPERIENCE TAUGHT US?

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This session will focus on recent experience of programs designed to contain health care costs.

MR. WILLIAM J. HEMBREE: What about assessment of cost containment activities? What have we learned about our efforts to get health care costs under control? Is it working? Is it being measured?

The assessment step is probably the most neglected, yet probably one of the most important efforts to get health care costs under control as employers.

When assessing the effectiveness of cost management programs, we are measuring. We are measuring whether something worked and the extent to which it did for whatever reason. We can measure the effectiveness of cost containment activity by looking at the cost of our medical care plan. Unfortunately, for a long time that was about as far as we went. Looking at utilization is also a helpful measure because you can look at the utilization of a medical care plan in terms of the number of hospital days, number of admissions, average length of stay and number of surgeries by thousands of population; you then get a better picture of the utilization in your plan. You can compare results with predictions with good utilization data.

Diagnostic specific data can help us implement a health improvement, prevention, or wellness program because it allows us to know where we are going or where we have been.

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When employers look at the indirect costs of the same illnesses that are creating direct medical care costs, they get a big surprise by adding up the short-term absenteeism, long-term disability costs, premature death costs, and productivity loss. These indirect costs can be as high as direct medical costs. Nationally, the four hundred billion dollars that we are spending on direct medical costs may be costing us a trillion dollars a year.

Certainly we want to measure the change in demographics. Is our cost containment program effective or are the results affected by the males leaving, the females entering, or the shift in demographics that resulted in change.

An article in Business Insurance stated that John Hancock saved 200 million dollars; Aetna saved 935 million dollars; and Blue Cross/Blue Shield saved 6 billion dollars. That must mean that Aetna is about four and a half times better than John Hancock and that Blue Cross/Blue Shield is at least six or seven times better than Aetna. Unfortunately, this is not the case, but what is the reader of that article left with? More precise reporting is needed.

Several things are important in measuring or assessing data:

1. Problem Identification: We need data that allows us to know whether we have got a problem or not. We need to know whether the average length of stay between the date of admission and the actual date of the procedure is longer than necessary.

2. Identifying Opportunities: If we have certain providers that are more cost effective than others, it may behoove us to think about including them in preferred provider organizations (PPO) arrangements.

3. Decision Support: Senior management people need data. They are quantitatively oriented and they feel more comfortable if they can be assured that there is measurement or assessment in place that allows them to know the bottom line.

4. Monitoring Changes and Trends: Concurrent utilization review is going to run out of steam fast. It is effective today because there is a lot of fat in the system. But when it runs out of steam we don't want to keep pumping money into it, we want to go on to what is the next more effective method. These trends should be monitored.

There has been a recent trend toward expressing savings from a specific step in dollars divided by the total of paid claims, instead of premium with no adjustments to reserves. It's just a pure clean number which we compare to data from others who use the same administrator, who are within our geographic area, and who are across the United States. We do a national survey of the fifteen hundred

largest companies, and the following are some of the savings levels that we have been able to report out of the survey.

We take how many dollars were saved and divide it by total paid claims and look at the average of that. It's crude but it is the wheel versus walking in terms of the technology. You are the best experts in coming up with what can be a good standardized way of measuring the effectiveness of health care cost containment activities and I encourage you to take on that challenge. One of the pitfalls in our efforts to measure has been insufficient awareness and insufficient interest. Today, senior management people are interested in assessing the effectiveness of cost control efforts.

A company has to be careful about overexpectations for data capabilities. Data only identify problems. Then it is important to carefully think through what is going to be done to get the problem under control.

Developing data, particularly if it is not in a good state, is expensive. That carrier or administrator may want big money to put together the right kind of data. Sometimes the expenditure is worthwhile.

It is surprising how inaccurate and incomplete the data are that an employer sees. We have seen male hysterectomies and amputations that take place four times on the same leg. Insufficient comparison norms, privacy, and confidentiality are absolutely important challenges that we have to consider.

MR. JOHN MAHDER: Benefit changes have a role in cost containment. We see everything from a "shotgun approach," which is to raise the deductible and lower the plan's coinsurance for everybody, to provisions that focus on perceived specific problems such as incentives to encourage ambulatory surgery and penalties for nonemergency use of the hospital emergency rooms.

Both of these approaches can be effective in reducing employer costs, but the former basically shifts costs to the employee unless there is some utilization deduction at the same time. The primary focus of many of the changes is to reduce the hospital utilization costs. As more care is shifting to the ambulatory arena, we have to be careful that we don't use up our inpatient savings in forms of excessive abuses on the ambulatory side of the house. An examination of our 1983 and 1984 claims showed that the deductible and coinsurance changes in the aggregate did not significantly change the employee's share of the cost of claims. These 1983 costs were 18.8 percent of covered expenses. In 1984 they increased to 19.8 percent, roughly a 5 percent increase. These figures are for the under sixty-five population. We see that same trend in employee cost sharing in both our small and large cases. When we look at individual companies that made changes in deductibles and coinsurance, we note that often the employee's share will increase by 5 percent or more.

Recent experience has convinced the employers, especially large employers, that they have to take a direct hand in cost containment. They can change benefits in the form of direct take-aways in deductibles and copayment provisions as well as give incentives and penalties to modify the utilization toward more cost effective incentives. Some of the employers are promoting good health through fitness programs and with health education materials. They use their health care services wisely by providing a telephone toll-free access to trained health care nurses to help them understand what's happening.

Employer coalitions are active in collecting and pooling data and a variety of other activities including going out and talking to providers about what they find in this pooled data source.

Recently the action in the health maintenance organization (HMO) and the third party administrator (TPA) arena has mushroomed significantly in a large part due to the employer initiatives. Employers and the government pay the bulk of the provider charges, and they want more control of both the volume of services and the amount of charges for those services.

Measuring the savings from the cost containment initiatives with any degree of accuracy is not easy. There are so many external factors that influence costs. Assume for the moment identical changes made in 1981 and in 1983 to control hospital utilization costs. The 1982 and 1984 results both showed utilization increases of 5 percent. Would we conclude that both of these initiatives were equally successful or equally unsuccessful? The answer is no, because there were markedly different results in the aggregate in the years 1982 and 1984.

Employers are becoming increasingly sophisticated and demanding concerning obtaining data on the cause of their health care costs. Hard copy reports that contain a lot of data but not much useful information are no longer adequate if they ever were. Employers are looking for data beyond their own claims experience. They are looking for data from their carrier's business, from coalitions, from public data sources as well as information that various consultants have accumulated.

Employers need their data to be timely and flexible. Computers or terminals in the employer's office are then necessary. We are talking about larger employers where access to their data and analysis on-line will mean something with the volumes they have. No matter how much data you have on each claim transaction, however, you will never have enough. The National Uniform Billing Committee has recently authorized adding coding for the admitting diagnosis on the UB-82 Form. It is doubtful that everybody is ready to capture this.

Offering employees a choice of health care benefits might be a good idea under a flexible benefit program and can direct benefits where they are needed and appreciated, but cost containment in terms of total utilization of resources is another matter.

It is likely that competition among the health care providers will be a significant factor in future costs and cost containment. Preferred provider arrangements (PPAs) and the HMOs can be effective. But, beware of preferred provider arrangements where we are talking only about a discount of a price.

Hospital admissions in days per one thousand are down 6 percent. The data for the last quarter would suggest that the drop is not as sharp.

Surgical procedures per one thousand are up slightly in total and down somewhat on the inpatient side, which corresponds to what we see in the hospitals. But the ambulatory surgery continues in its upward escalation and frequency. Charges increased roughly 10 percent. Hospital charges are a smaller percentage of the medical expenses in 1984. This is a reversal of a trend where historically hospital costs have been an increasing portion of total costs.

A case example involves a plan change in 1981, where the employees were offered a choice - keep your current plan of rich benefits or enroll in a new cost containment program with a lower employee contribution. Cost containment in this instance equated with a higher deductible and more employee payment for coinsurance. About one third signed up for the new cost containment plan. The claims costs per member on the cost containment plan were about 35 percent below those of the old plan, which went up. The benefit differences in the deductible and coinsurance would have only accounted for about 15 percent of that difference. The age and the sex composition of the groups were just about the same. By putting the cost for the combined plans together, they were in line with what we would have expected. We probably had employee selection taking place and not much in the way of cost containment. By 1984 the old plan was phased out.

Another case involves a large national corporation with multiple divisions that introduced a cost containment plan at the beginning of 1984. The deductibles were up sharply. The employee copayments were increased. Incentives and penalties were added to encourage ambulatory care and to discourage unnecessary surgery. Employee choice was not a factor. But, all the divisions did not adopt the cost containment plan in 1984. The net result for the corporation as a whole was that claims cost per employee in 1984 decreased primarily due to lower hospital utilization. Most of the divisions that did not change to the cost containment plan showed cost increases as expected. But, there were examples among both those that did and did not change that were contrary to expectations.

Both of these cases involved significant deductible and coinsurance changes. We had one case where an employer made two rather simple changes. Listed surgical procedures would be paid at 100 percent with no deductible if performed outside of the hospital and no room and board benefits would be paid for Saturday and Sunday nonemergency admissions unless surgery was performed on the following day. Now the limited experience to date indicates that the percentage of surgery on an inpatient basis for the listed procedures was down significantly. The total admissions on the case dropped. The Saturday and Sunday

admissions remained about constant. The average length of stay on the Saturday and Sunday admissions dropped about a day and a half as compared to the period before this feature was effective. So it appears that the surgery requirement on the next day may have had an impact on the length of stay.

Finally, we pulled a few cases at random where there were no significant plan changes recently and we looked at the experience. The hospital utilization didn't change much. Surgical utilization increased primarily due to ambulatory care. In general, the total claims cost increased about the same but probably a little more than we expected on the book of business as a whole.

MR.MICHAEL J. WHELAN: CIBA-GEIGY is a chemical pharmaceutical company and a wholly-owned subsidiary of a Swiss corporation with locations throughout the U.S. Our sales are approximately 2.2 billion dollars. We have ten thousand salaried employees and three thousand union employees. The union employees are basically covered by Blue Cross/Blue Shield. However, I am addressing the salaried plan. We have been self-funded since 1982 and have been paying our claims since 1974.

The average annual increase in medical and dental costs was 28.9 percent for 1980-82. The average annual increase in those costs was 10.5 percent for 1983-84. 1984 would have been approximately 5 percent higher if we had added to our reserves as we did in 1983. In 1984, we put no money into reserves because we were overreserved in our 501 (c)(9) trust.

In 1981, we set up a strategic health care task force because of those rising costs. Our initial decision was that additional cost-sharing for employees or cost-shifting to employees was not enough. The basic theme was cost effective quality health care. We emphasized wellness and did not change the benefit plans that much. We encouraged alternative delivery systems like HMOs and ambulatory surgery. We gave a bonus for using ambulatory surgery and we covered childhood immunizations up to a capped amount which was in line with our preventive emphasis. We also increased our dental coverage. We cover preventive services at 100 percent, ordinary dental work at 80 percent, and prosthodontic at 50 percent. We said we would not pay for hospital admissions more than twenty-four hours before surgery. Preadmission testing was covered 100 percent. We increased our home health care and hospice care. We encouraged second surgical opinions for all surgery. We penalized people who didn't get second surgical opinions for fourteen selected procedures. Our basic emphasis was on health promotion, health awareness, risk assessment, risk reduction, fitness and excercise, employee health management, disability management, and employee assistance programs. We covered birthing centers at 100 percent. We got rid of the coordination of benefits (COB) credit bank and eliminated the deductible carryover benefit. We covered emergency treatment in doctor's offices and free standing clinics or emergency centers at 100 percent. We eliminated the three dollar supplement for private hospital rooms. We no longer covered excess surgical charges beyond the reasonable and customary through major medical. We said

we will cover the reasonable and customary charges and 10 percent above if medically justified. Then we added routine new born care. Our basic aim was long term; we were educating employees and families on how to be healthy and to lead a healthy lifestyle.

Annual claim costs per employee including actives and retirees are distorted because HMO people are included for dental coverage and not medical coverage. Annual claim costs were $1,508 per employee in 1981; $1,832 in 1982; $1,859 in 1983, and $1,904 in 1984.

Utilization rates were 642 days per 1,000. That is about average, but compared to HMOs, it's awful.

The preadmission testing cost in our "Taking Care" program was $34,638. Any savings is dubious. If a day had been spent in the hospital, it would have cost $157,000, but we have no way of determining if a person would have gone into the hospital one day. In 1984, we spent $14,413 on the home health and hospice care. This is a questionable figure. If the days had been spent in the hospital, they would have cost $66,300, a possible savings of $52,000.

By eliminating hospitalization more than twenty-four hours before surgery, we saved $62,400. COB savings of $2,516,000 were approximately 13 percent of paid claims. Savings in excess surgical fees were $23,390, where they were more than 10 percent above reasonable and customary.

Hospital discounts amount to $34,476. The total cost of installing our Taking Care program in 1983 was $569,000. Expenditures and savings are summarized in the chart at the end of this article. In 1984, we spent $466,000. The only savings we could ever attribute to it, outside of improved health is $450,000 for 8900 in-house employee treatments. The cost of these in-house treatments was $112,500.

In regard to HMOs, we spent $600,000 in 1983 and $970,000 in 1984. We have great difficulty getting records from the HMO on our healthy people. It may be adverse selection. The people who are buying the HMOs might be a great advantage to have in our plan, but we have no way of telling.

MR. ROBERT COMEAU: Mr. Whelan, you took away the three-month carry over, the October, November, December, of covered expenses toward the deductible. What was the reaction of your people to that?

MR. WHELAN: Of all changes, the strongest reaction we got was to changes in the coordination of benefits - the deductible and the excess surgical fee not being covered by major medical. Actually, people were more concerned about the COB credit bank than they were about the carry over of the deductibles.

MR. COMEAU: On your coordination of benefits, are you coordinating with what your plan pays or will you still allow the employee to receive up to 100 percent of the expenses?

MR. WHELAN: We are aiming to get a nonduplication coordination of benefits scheme in by July. We are still doing 100 percent.

MR. KEVIN RUSSELL: Regarding the penalty for not obtaining a second opinion on those fourteen selected procedures, what has been your experience? Do employees get the second opinion or do they accept the penalties?

MR. WHELAN: People obtain second opinions but are annoyed with it. We have no way of telling if anybody declined to get surgery because of a second surgical opinion.

MR. RUSSELL: Do you keep any numbers on what percentage of those second opinions are nonconfirming?

MR. WHELAN: We have a study going on now.

FROM THE FLOOR: In California we see a lot of advertisements by chiropractors that they will accept whatever the insurance company will pay. Of course, that lends itself to a lot of abuse. Have any companies taken steps to offset this?

MR. MAHDER: We have determined what the prevailing fees are for the care in the area and have limited covered expenses to that amount. We then applied the deductibles and coinsurance in figuring our benefit.

MR. WHELAN: We cover chiropractic the same way we do a medical doctor. Last week I went to the eye doctor, and after my visit, I decided this whole area is a losing battle. He asked me if my insurance covered this visit. When I said no, he asked if I would be covered if the visit had been for an emergency. When I said yes, he started to suggest calling the visit an emergency. When I said that part of my responsibility in my job is health care cost containment, he got a sheepish look on his face. He is an honest, nice man, but willing to lie so that I can get covered by my insurance. Every employee faces this and most employees would be idiots not to say let him put whatever he wants on the bill. It is very discouraging.

FROM THE FLOOR: I am with a small company, and we write ten to fifty life groups. We installed an inside limit on several therapeutic procedures, the last one being chiropractors. Twenty dollars a visit is the most we will pay for a total of six hundred dollars. We thought we might have some trouble with the state insurance departments but we filed with them and got by.

MR. EARL HOFFMAN: Northwestern National Life has a mandatory second surgical opinion plan that we offer to our groups. Based on our limited experience, our nonconfirmation rate is running between 10 and 15 percent.

MR. ANDERSON: Mr. Hembree, do you have any figures for cost savings due to improved attendance and productivity? So far the cost savings seem to be expressed in terms of dollars that we didn't have to spend because of medical procedures, and yet you mentioned that there

are other important factors and it would be good if we could quantify them.

MR. HEMBREE: They do need to be quantified. I don't know of any data that answers your question. There are a number of companies, who are into extensive research on their own population to determine what the cost effectiveness is of productivity improvement and absenteeism reduction that comes out of the fitness programs.

FROM THE FLOOR: Mr. Whelan, because your firm is involved in the pharmaceutical business, do your employees have any discount on drugs or prescriptions?

MR. WHELAN: The people in the pharmaceutical division do but nobody else does, which causes great unrest. We do not encourage a generic drug program as part of our Taking Care program.

MS. STEPHNE BEHREND: Mr. Mahder, did you say that the number of days per one-thousand has gone down by 6 percent in the hospital?

MR. MAHDER: That is what our data shows, 1984 compared to 1983.

MS. BEHREND: Is that basically without any plan changes?

MR. MAHDER: There have been some deductible, coinsurance plan changes. The figures I gave indicate that the employee's share increased from roughly 19 to 20 percent. The reduction in utilization is independent of that kind of a change. Whether it is due to the implementation of the diagnostic related group ((DRG) reimbursement or whether the economy is picking up, we really don't know.

MS. BEHREND: Does your experience include actives and retirees, and was it just the medicare DRG impact?

MR. MAHDER: No. This is the experience on our active employees and their dependents.

MR. ANTHONY J. HOUGHTON: We had a PPO program priced in St. Louis, where they would pay 100 percent of the physician's charge with a cap at 80 percent of the ninetieth percentile. For the ninetieth percentile this particular procedure was $750, and they would pay the doctor's full charge as long as it was $600 or less. If it was more than $600, they would pay $600 (80 percent of $750). The cost savings based on our looking at the percentiles was 6 percent, so it was not dramatic. It cut only 10 percent of the doctors 20 percent unless their charges were smaller amounts. We now have quite a few HMOs in that area all of which have either preadmission certification or protocols as to which type of procedures will be done on an inpatient basis, which ones will be done ambulatory, what are normal lengths of stay, which ones will have the surgery done without staying the night before, and so on. We also have quite a few programs other than HMOs, which are starting to have preadmission certification, where the medical practice on the whole community is suddenly being impacted. If the doctor who does a lot of hernia operations knows that for children under fourteen

and for certain people he has to operate on an ambulatory basis unless there is medical indication he will soon be doing it that way for all his patients. Those are the things that for the last eighteen or nineteen months have caused a lot of reductions in the possible utilization.

MR. STEVEN M. PUTTERMAN: Doctors basically prescribe what's covered in the plan. In one way that is admirable, we do not like to have a financial hardship put upon us in order to get our health care covered. But I am wondering if some of the restrictions that are in plans nowadays, which are there to prevent abuses, perhaps need some revision or a second look, for example, home health care. Any comments on how to control the use of these types of facilities (a) as far as preventing abuse by people that don't necessarily need them, or (b) specifically directing patients to these alternate facilities.

MR. HEMBREE: Let's say there is a three-day hospitalization requirement before being able to have extended care. You look at the data for the people who are in the extended care facility, you find an average length of stay of about 3.001 days. This tells us that we have got something that is designed to try to keep the hospitalization from occurring but is creating a hospitalization unintentionally.

MR. MAHDER: Effective work in the preferred provider arrangements can be of help. Concentrate on finding providers who are cost and quality conscious rather than putting restrictions into the plan to control that kind of abuse.

MR. WHELAN: We got rid of the three-day requirement, but we require a physician to say that extended home care is necessary.

MR. PUTTERMAN: Everybody believes in medical necessity and it makes sense, but let's see how we administer it. Has there been any thought to concentrating on specific diagnostic categories that by their certain characteristics would benefit from focused plan design or attention?

MR. HEMBREE: Plans have been designed to try to be the answer to all kinds of situations rather than trying to be specific or placed on a functional basis. We won't continue to pay for medical care in this country in the way that we have historically paid for it.

MR. MARTIN STEMPEL: What has been the experience with alcohol and drug programs?

MR. MAHDER: In our claims coding there is provision made for reporting treatment in connection with alcoholism and drug abuse. We do not see much claims experience coded this way because the providers' reports shield their patients. Also the benefit provisions under the plan will pay more if they don't have any indication of alcoholism or drug abuse.

MR. STEMPEL: What has been the experience with just pure and simple hospital bill audit?

MR. WHELAN: We audit anything over $5,000, and we save on every audit. We are going to start an employee-audit program and pay back 50 percent of anything our employees discover.

MR. MAHDER: On the audit of the bill by the carrier, our numbers showed something like 2.2 million dollars. That averages out roughly $500 net per audit.

MR. HEMBREE: Our survey showed a savings of 1.2 percent of paid claims. Until you are less than zero on doing hospital bill audits, you are ahead. One of the good things that comes out of this is that it creates a sentinel effect within the hospital community.

MR. STEMPEL: Don't you get that back on the other end though, isn't that cost-shifting?

MR. HEMBREE: It could be. It is a system problem. In the future, we may pay on the basis of episode of care.

MR. WHELAN: We had a man in the hospital with a $800 bill for Desinex. Desinex is that powder for athlete's foot. His disease had absolutely nothing to do with Desinex. We questioned the hospital and they said it was a mistake. Another case for a premature baby had staggering bills. We told the hospital because the bill was over X dollars, we were going to audit records. Before anybody went out to look at the records, they sent us a check for $100,000.

MR. HEMBREE: That's cost containment of the highest order.

MR. DALE TERRY*: AmeriCare Health Corporation operates a string of individual practice association (IPA) HMOs in the western states for profit. In our first contract round of negotiations with hospitals we came up with per diem rates at selected facilities. One thing we left on the table though was outpatient surgery. We haven't necessarily had a problem with utilization, but we have had a problem with price. We then went to an individual rate for up to about three hundred outpatient procedures and would not like to have to repeat that every year as it expands out to five or six hundred. Is there any experience with collapsing those procedures down to four or ten categories that might be used then in contracting in the outpatient surgery area?

MR. HEMBREE: Not very many employers have directly contracted for outpatient surgery services. The hospitals do not like to lose inpatient hospitalizations and if the outpatient surgi-centers raise their costs too much then the hospitals start looking very competitive in their outpatient section. Sometimes the patients would rather be down the hall from high intensity backup than be down the street from it. So if costs were comparable, the hospital might come out ahead. It may be a competitive solution more than anything else.

* Mr. Terry, not a member of the Society, is employed by American Health Corporation

MR. TERRY: We plan to break down our contracting into four areas in operations under a general and a local anesthetic. One hour of operating time would be the cut off so that we would come up with cost categories for under an hour and over an hour for both kinds of anesthesia. We could then see if our facilities conform to those costs.

MR. HEMBREE: That is a good idea, but be careful about quality, and don't let them give people general anesthetic if it can be done by local. That deteriorates the quality of care and increases the risk to the patient.

MR. EDWARD H. FRIEND: I recently talked with an orthopedic surgeon studying frequencies of worker's compensation surgeries for lower back conditions. In Sweden and Great Britain the percentage per one thousand of patients or of workers getting laminectomies was about one fourth of what we were getting on the West Coast. Would anyone discuss the extent to which this would indicate that we have an opportunity for curtailment in surgical activities by virtue of physicians' attitudes to undertake surgical work as an economic support.

MR. MAHDER: Dr. John Winberg at Dartmouth has published a number of studies on small area variations in utilization of hospitals, particularly as it relates to surgical admissions. He finds significant variations within a state. Certain types of procedures seem to have low variations and utilization seems to be pretty well fixed; whereas in other circumstances there are five-fold, six-fold, ten-fold variations, which he attributes to just the basic practice patterns in the area, not to the prevailing conditions. We have looked at our experience in 220 geographic locations around the country for relative frequency of hospital admissions by diagnosis and also of procedure variations. Although our areas are different from Winberg's studied areas, we see the same kinds of variations and the frequency distributions. The relative frequencies vary significantly between different locations.

There are probably a number of things that can be done. The first of which is to take this information and go to the particular areas involved where the variation is substantially in excess of what you might call the norm and inform the providers. This is an approach that Dr. Winberg has used and he claims considerable success. He has watched what has happened following these discussions. These are not confrontations. We will follow-up to see whether in fact there was any change following contacts with the providers.

MR. HEMBREE: How does an employer attack that? You can find doctors keeping patients in the hospital for five or six days and then sign those doctors up with a PPA or PPO if they have any capacity left. The other side of that is going to be fraught with problems. The employer says that given this data it will pay for five or six days but not for twelve. They might try to make it stick with the employee held harmless. Not many employers in this country are quite to that point yet.

MR. WHELAN: We had a limited analysis of our 1983 experience made last year. At our plant in Alabama, hysterectomies were way out of line both compared to our own internal experience and to national experience. But hysterectomies are one of the fourteen surgical procedures that require a second surgical opinion. Alabama hospital days cost considerably less than they do other places in the country but hospital stays are considerably longer than they are in other areas of the country. We are in coalitions but the coalition's clout is limited because of antitrust problems. Part of our program is disability management. We had some disability experts come in and look at the program, and they said our records were discouraging because so many of our cases were back problems. People had an operation, went on LTD, then had a second operation, and a third operation in some cases. Laminectomy strikes me as far more dangerous than probably not doing anything about it, if you can possibly do without it.

MR. D. DALE HYERS: Once somebody knows that we have some information, if they have doubts about what they are doing, they are going to start being more careful. It is part of our responsibility if we have information that can be substantiated to use it. You can call it job owning if you wish, but there is a substantial amount that can be done with the data.

If you tell the hospital you will review a particular claim or possibly every one of twenty-five claims, that hospital will take care of probably 90 percent of the review process for you. They don't want to be discovered in an error.

MR. HEMBREE: We just haven't squeezed hard enough yet to cause the system to down size.

TAKING CARE
HEALTH IMPROVEMENT PROGRAM
1983 & 1984 COSTS AND ESTIMATED SAVINGS

TOTAL 1983 COSTS - $569,000

1984		COST	ESTIMATED SAVINGS
EMPLOYEE HEALTH MANAGEMENT	ADDITIONAL/M.D. LOWER	$112,500	
	OTHER COSTS (R.N., LAB, DRUGS)	100,000	
		$212,500	
	8900 EMPLOYEE TREATMENTS IN-HOUSE		$450,000
FITNESS PROGRAM	AVERAGE SUBSIDY $35 1084 PARTICIPANTS	$ 40,500	
OTHER PROGRAMS (SMOKING CESSATION, ETC.)	AVERAGE SUBSIDY $25 2140 PARTICIPANTS	$ 53,000	
EMPLOYEE ASSISTANCE PROGRAM	MAXIMUM SUBSIDY 657 PARTICIPANTS	$ 80,000	
HEALTH AWARENESS	PUBLICATIONS, ETC.	$ 80,000	
		$466,000	