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# PURCHASER'S PERSPECTIVE ON HEALTH CARE

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| Panelists: | JAMES W. CATO* |
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| Recorder: | ROBERT H. DOBSON |

- o An employer representative and broker will discuss their views on the current health care marketplace.

MR. MARVIN H. GREENE: Our panelists are not actuaries, but they do have a lot of experience in employee benefits. Mr. Ned Strain is Employee Benefits Department Manager at Thilman & Filippini in Chicago. He has an MBA from the University of Chicago and he sits on the governing council of the International Foundation of Employee Benefits. He has been a consultant in the employee benefits field for over 21 years.

Mr. James W. Cato is the director of employee benefits at A. O. Smith Corporation in Milwaukee. A. O. Smith is a diversified international company listed among the *Fortune* 500 largest industrial firms. A. O. Smith has about 12,000 active employees worldwide and about 6,000 retirees. Of its 10,000 U.S. employees, approximately 7,500 of them are unionized.

Our agenda today is broken down into three components: Mr. Strain will start by talking about what cost containment means to a consultant in the employee benefits area. Mr. Cato will then give a case study about current cost containment activities at A. O. Smith and what the major employer today is looking for in this area. Then both panelists are going to give a few comments at the end

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on a number of system interventions such as utilization review, large case management, HMOs, etc. They will give their feelings on how these approaches are working out -- are they really cost containment?

Before we start, I would like to point out that this is not a technical session. The session is intended to point out how cost containment efforts are implemented and perceived in the real world. I would like to emphasize, however, that cost containment remains a very hot topic. For example, in 1986, A. O. Smith's medical care expenditures were $28 million and their after-tax profit was $29 million. Management at A. O. Smith, as well as other major employers, view health care as an area that can be managed and perhaps even achieve a reduction in cost.

MR. NED STRAIN: The topic, as you are aware, is the purchaser's perspective on health care. One of the real problems is who is the purchaser? You normally think of the person that gets the services as being the purchaser, but what we are aware of, obviously in our industry, is that it is the employer. The employer, in trying to put the employee into the purchaser's position, is probably facing one of the biggest challenges that has been faced. With the purchaser being the employer, his perspective is probably one of confusion. There are many claims on the part of the providers and on the part of the vendors. It is very difficult, to look at all the techniques, all the mechanisms, all the different services that are available, and determine what is going to work for your group as an employer.

Many times I will be working with a client and the client will say, "My one objective is to reduce costs." If that is the only objective that the employer has, he can drop the plan. When I have said that before, sometimes the employer will say, "No I can't do that." That gets into the rest of the objectives. We don't want to lose sight of the fact that an employer has a plan obviously for a reason other than to save money. We are going to take those other objectives and set them aside for the time being and focus on what is a very hot issue, and that is cost containment in health care from the purchaser's perspective, the purchaser being the employer.

The group benefit dollar that the employer pays is broken into two categories: administration and claims. The important thing to remember is, in most large

groups, the administration accounts for about 10% of that dollar. Claims are the other 90%. Remember what we the insurance industry, the providers, the consultants, and the brokers have done. We have taken the employer on kind of a spiral winding path. We started out about 10 years ago talking about alternate funding. This would fix his problems. The funding alternatives that we presented attacked either claim reserve charges or credits for them, they attacked premium taxes on the state level, and they enhanced or at least restructured the employer cash flow.

The other place to look on the administrative side of that dollar is obviously at the fees for claims adjudication: all the things that are tied in with the claims services, whether it be a Third Party Administrator (TPA) or an insurance company under an Administrative Services Only (ASO) arrangement, the accuracy, the timeliness of the claims, the type of reporting that is provided. As you can see, this list under administration is certainly not complete, but you will see that what we are going to be building is a structure to put the various cost containment techniques and mechanisms into, so we have a way of identifying them.

With administration also comes direct claims filing, another mechanism for saving the employer some money. Coordination of benefits falls into this area. It has been estimated that in 1998 some 80% of the workers will be in two income households. Coordination of benefits is going to play a very important role. I am sure you are aware of all that is on the horizon with the birthday issue, including the various approaches to coordination of benefits recognizing the primary and secondary carriers, deductibles and coinsurance. All these things have to be brought into play.

Eligibility is another very important area for the employer. If you look at it to tie in with coordination of benefits, it makes some sense for the employer to keep information on eligibility. When I first started in the business, I was working with a meat packer. I was their consultant for their benefits program. They had a large group of non-English speaking people that worked there, and they were wondering way back then why their claims were so high. It seemed like they were getting an awful lot of dependent claims. What they found out was the employees felt that the entire magic of the plan was in that ID card. If someone in the neighborhood got sick, they would hand them the ID card. The

person in the neighborhood that was sick would go to the hospital, not be able to speak English, and show them the card. They had the card, and they got service. The employer paid for it. So eligibility is important.

Subrogation is an area that Mr. Cato will touch on briefly. It is often overlooked in plan design and yet, when you look at the settlements that are out there in our society right now with the law cases that are awarding a lot of money, it makes some sense to focus in on this area.

Another item in the administrative aspect are risk charges. I think that there are many employers, many purchasers of health care through an insurance mechanism, that are not aware of the fact that they really should take a look at what the trigger points are in their program or what the pooling points are and determine what's right for them. Add that additional element into the decision matrix.

Well, we took the employer through the administrative aspects of a plan design and plan funding and we gave him a very cost efficient mechanism for funding and delivering health care benefits to his employees. About five years after we did that, the employer came back to us and said, "I'm real tickled you got me on a minimum premium with a drag and a retro and I just love it. It's real slick and we've got our claims adjudication expenses down to 4.2% of what would have been an equivalent premium and this is real neat, but my costs are still out-of-sight." We met that with, "Well, Mr. Employer, it's still your problem and we are not going to really address the issue, but we are going to talk about sharing those costs with someone else." We came up with a lot of cost transfer techniques. Employee contributions are obvious. When you tie in the idea of the two-income households, it makes some sense even for a paternalistic employer to require a dependent coverage contribution. If nothing else, it will force the thought of where best to have the dependents covered, under the spouse's employer or with your own plan.

Deductibles and coinsurance on the face are simple cost transfer mechanisms. Sometimes you look at an employee group and you recognize that the employer is tapped out. Witness the A. O. Smith situation where the cost of the medical plan was almost equal to the corporation's after-tax profit. Maximums also shift cost, because you realize that the dollar after that has to be paid somewhere.

You haven't changed the nature of the claim, you haven't changed the frequency of the claim, nor the severity, so a maximum serves for cost transfer purposes. Preexisting condition limitations are the same idea, you are not changing the claims, you are simply transferring the cost.

Other limits would not necessarily be dollar limits, but limits on where service can be received or who can provide it. If you are not going to provide service for chiropractors and somebody goes to a chiropractor, you have simply transferred the cost. The cost transfer mechanisms, although somewhat acceptable to employees, don't really attack the problem, do they?

We haven't done anything about either the frequency of claims or the severity of claims. Let's take frequency first. The concept here is preventing the claim from starting. Now the deductible and other cost transfer techniques do have some impact in this area. In addition to transferring the deductible and coinsurance cost to the employee, the side benefit of it, if you will, is it may cause the employee to think twice prior to seeking care. Often we almost encourage the employee to at any time seek whatever care he feels is right at that moment. We have done nothing about educating them. The deductibles and the coinsurance serve the beginning, the ground layer, if you will, the foundation of that purpose of education. We are at that point asking the employee to stop and think before he starts the claim. As you are aware, with an admission to the hospital, even if it is just an emergency room visit, there is no such thing anymore as a small hospital claim. This may be advantageous. The important thing to realize is that there is a burden on the employer to educate the employee as to what the alternatives are and what his choices are.

Straining and including preemployment physicals is an area that has been found by some to be most effective. Honeywell did a study on their own employee group and found that 8% of their employees produced 78% of their total health care claims cost. What price would the employer be willing to pay to screen out or identify that 8% before claims happen? You know we always banter about the 20/80 number. No matter what you are looking at, 20% produces 80% of the result, 20% of your salesmen produce 80% of the sales. We have made the assumption that that holds true for medical care. But I think the Honeywell example, especially in today's incredible high technology medical care delivery system world, is probably more realistic.

Second opinion surgery, if you think about it in this context, is really to reduce the frequency of claims. As with many of the techniques, and especially when we get into the severity reduction techniques (Mr. Cato will point this out when he talks about the A. O. Smith experience), you are going to find that you have to be very careful in evaluating not only the potential savings from these techniques, but the cost of administering them. We are working with a client where on the surface it appears that they had a huge number of hysterectomies. Compared to an average data base, they did. However, when we delved into it and adjusted their experience on an age and sex basis, we found out that they were below what would have been anticipated for that particular group as far as hysterectomies. To include hysterectomy on a second opinion surgical listing would simply add the price of a second opinion to each and every hysterectomy.

Another thing that we are seeing here with the second opinions is that instead of making the list mandatory, some of the utilization vendors are saying activate the program, activate the utilization review every time you are going to have a surgery and we will make the determination of whether or not a second opinion is needed.

Wellness and other lifestyle effect programs are the last in this list of frequency reduction techniques. I think that that is where the future lies. The problem is to get the benefits manager to believe that there is going to be a pay-off in this area. They will come back with all sorts of excuses and rationale like, "Yeah, I can put in a jogging program, but only healthy people jog so who am I reaching with it?" I think you should focus on a couple of the big pay-off items, such as smoking and the whole stress and hypertension area. If you can get some programs working in those areas, and they need not be expensive, you will see some effect.

There is another problem to look for. We have some clients who are considering putting in the full physical facilities (the health club type approach). You have to be very careful on how that is presented to the employees, because what you may be doing is simply reaching the people that already belong to health clubs, who will just drop their private membership and start using your facilities. You may not be reaching the group you are trying to reach.

This list is not all inclusive, but if you look at the cost of a group plan and the components it's broken down into, this gives you some pegs to hang any ideas on. When you look at a cost containment technique, you have got to figure out what it is designed to do.

The area where we are seeing the most activity is in severity reduction. By that I mean the claim has started, and you haven't stopped it through the freqency reduction. What do you do now? Let's start with utilization review. This is obviously a very important area. What do we mean by utilization review? It started out as simply an analysis of utilization. Primarily it was after discharge. After discharge is still important to give you a look at what your group is doing to give you a basis for developing an action plan. It is not a proactive stance, if you will, to simply look at what has happened afterwards. So utilization review today takes on both a concurrent and preadmission aspect. The preadmission certification programs are important. They have squeezed a substantial amount of fat out of the system. In this day and age, what we are advising our clients to do is even if they don't believe in it, even if they don't really want to trouble the employee, even if they don't want to get involved in the doctor/patient relationship or whatever other excuse they are using to stay away from preadmission certification, they need it as a strictly defensive measure.

There are two hospitals in Chicago where, when a patient is admitted, if there is not an awareness of a utilization review program, the file is stamped in about 40 point type "no UR." Now why do you suppose they do this? They are obviously looking for the areas where some of the shifting that needs to be done (from the Medicare patients and from the patients that have UR) can go. Strictly from a defensive standpoint, I think it is also important that if you look at the statistics, you get about a 90% success rate through the sentinel effect with the physicians. So even if you are not going to do any negotiating with them or jawboning, simply putting the physician on notice that somebody is counting the days and watching his technique, will achieve substantial results.

Concurrent review is important, but very difficult to work with; it is very difficult to get access to the records, and very difficult to get acceptance. There are some utilization review firms that do have the capacity to provide concurrent

review. The question then becomes monitoring the cost efficiency of it. If it can be done, it should definitely be considered.

Managed care is another big issue. There is a lot of smoke out there with managed care. Managed care takes on all sorts of different aspects or techniques depending on who is selling it, who is buying it, and how it is being marketed. Some companies are marketing a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), and an indemnity program, or a triple option program and calling that managed care. It may or may not be. Simply giving employees choices doesn't mean it's managed care. Why is managed care such an important item? Why is it well received? Why is it even being demanded in many cases by the employer? If you look at where the employer was a couple of years ago, we were telling him through things like preadmission certification and second opinion surgery that he had to spend a lot of time and money educating his employees on how to access the medical care delivery system. It got to the point where some of the employers were saying, "Oh, I see. All I have to do is put in enough payroll stuffers, put enough notices on the bulletin boards, have enough training courses, and show enough audio-visuals, and at some point in time when the doctor says to the employee *laminectomy*, the employee Pavlovian light will trigger, "Let's see, laminectomy backsurgery, backsurgery second opinion, second opinion wallet, wallet card 800 number, make the telephone call." The employers are saying, "That's ridiculous. When they take a bathroom break, I've got to retrain them before they can go back to work on the lathe. I can't get them to that level of sophistication and knowledge." One employer said, "Furthermore, I don't do it in any other area of their life. When they are looking at their car to decide whether to buy a new car or keep it for another year, I don't get involved in that decision. When they figure out how they are going to fund their children's education, I don't get involved in that decision. When they decide whether to buy or rent a home, and they decide to buy, I turn them loose nude and naked into that whole mortgage market without any help. They can figure those things out. Why is it my responsibility to do everything in the medical care area for them?"

That is what managed care is all about. One form of it that I think we will probably see as the most acceptable involves the patient advocate type of arrangement, where the education comes at the time of need. The employee calls and explains the problem. The options are then given to the employee. The

PPO arrangement is explained, the HMO arrangement is explained, the indemnity approach is explained, and the courses of treatment are explained.

The problem is one of liability. Is this practicing medicine over the telephone? Many utilization review firms have taken the stance, "No, we can't get into that area." But that ultimately is where it is going to end up. There has to be a patient advocate who is medically knowledgable and who can work with the patient and make the patient feel more comfortable. If you think about it, isn't that one of the reasons why the employer has a plan: to reach some level of satisfaction and comfort with the employee. It's got to be at the time the plan is working -- at claim time.

Prescription mail plans are an area where dollars can be saved. When you break down your claims data and find out how many dollars are spent on drug therapy over a period of time, you will find that substantial savings can be made in that area.

Next are employee audits of hospital bills. Remember back about four years ago, even in Chicago, there was a retailer who was saying that they had come up with this fantastic program to cut costs. It involved giving the patient $.50 (in fact, I think it was $.25), for each dollar of mistake that the employee found on the hospital bill. Well, the problem, if you think about it, is that you have got to identify the bill before it's corrected. So you are really processing the claim twice. It rests on the employee to argue with the hospital. I think the biggest value is not a cost containment value, but to get the employee to recognize what huge component of that health care dollar is tied up on hospitalization. That is part of the educational process.

Coming up next then is preadmission testing. Obviously this saves hospital days. A patient advocate, a managed care program or a good utilization review program will bring this to the physician's attention and he will utilize it.

Outpatient treatment is an area that about five or six years ago really caught on. If you can keep them out of the hospital and have them treated on an outpatient basis, you are going to save money. But what has happened? If you look at your claims data, you are going to find that an x-ray, same hospital, same x-ray, in all too many situations costs twice as much as an outpatient than

as an inpatient. So the hospital is still going to get its money. Now the problem is that this is an area where there is a lot of fat now and it can be attacked, but very few utilization review firms have any data or are willing to get into the outpatient area.

I think it's important that if you are looking at utilization review firms, you first of all figure out what you want them to do. Are you talking about frequencies, severity or cost transfer? What aspect of that dollar do you want them to work on? Then, make sure that their objectives are in line with your objectives and that they can perform.

Alternatives to acute care are probably another important future area. This varies so much by region, but there we are talking about home health care, birthing centers, hospice, and extended care. If you will, it ties in a little bit with the Employee Assistance Program (EAP) approach. To make something like this work, you have to know what other facilities and what alternatives are available in your community. This again can be tied together with managed care. A managed care vendor that is familiar with those facilities can direct the patients (your employees) to those alternatives and manage the discharge. When you think about it, you can have an awful lot of different entities working with you as an employer on your medical plan.

Claims adjudication is not the end of it, if you think about really getting in and educating your employees, making sure that they do take the appropriate steps. Out of that comes the need for the benefits manager to be aware of and create an environment where these different entities can talk to each other.

Discharge planning obviously doesn't help unless somebody lets the discharge planning operation know that there is someone in the hospital. The same with rehabilitation. The claims aspect and the managed care all have to work together. One of the things to watch for here is not to let each of these groups do their own data collection, because then you are going to get several sets of data -- data from the PPO, data from the HMO (if you can get it), and data from the claims adjudicator under the indemnity portion. It's all going to be different data, so you need one single source.

Alternate delivery systems are the last item on the list. This includes HMOs and PPOs and again, it varies so much by region. I am very much involved in Chicago with the Certified Employee Benefits Specialists (CEBS) group and we put on what we called an HMO/PPO shootout last fall. The representatives from the HMOs and PPOs kept trying to get the employers and the benefits managers to focus on quality. The alternate delivery systems are ready to talk about quality, but I don't see the demand yet on the part of the employer (the buyer) to buy on the basis of quality.

One of the real problems we are going to see in the next few years is the definition of what quality is, how it is measured, how it is translated into dollars. Now you are starting to see in the literature from many of the HMOs an attempt to define quality on their own terms. Maybe out of that an accepted definition will grow, but I don't see anyone yet measuring outcomes. I don't see anyone yet measuring episodic costs for care. We are a long way from what's really going to be meaningful to the purchaser.

I hope that you see that what we are trying to do here is give you a structure. When the employer looks at cost containment, he has got to determine what it's going to do to reduce his costs. This is, again, certainly not all inclusive, but the structure has worked for us as we work with employers.

MR. GREENE: I am certain this is not anything new to a lot of people, but how it gets implemented is an important step. An employer is often faced with many choices of what to do with cost containment. Mr. Cato is going to explain to us how A. O. Smith attacked the issue and what they wanted to focus on, why they prioritized the actions they took and what practical situations caused them not to take a specific action that they otherwise might have wanted to do.

MR. JAMES W. CATO: What I want to do is discuss some information that we have put together as it relates to the cost involved in health care at A. O. Smith Corporation. We have been concerned about our health care costs for a long time, but we didn't have the appropriate data to be able to properly analyze that cost. We went to our carrier to try to get that data only to find great difficulty in getting it. When we looked at episodes, we found that the last episode in a year was representing all episodes that had occurred during the year, if there was more than one. So they were just putting it in as a

single episode. What we finally did after working with them for some long period of time was decide that they didn't have the ability to be able to analyze the data in depth to the degree that would make sense to us. We searched the marketplace to find that there were a number of firms that had some capabilities that we could utilize in helping us to analyze the data. The thing that I was concerned about was taking the shotgun approach as opposed to the rifle approach.

Mr. Strain indicated that there are many cost containment, if you please, opportunities there. Which is the right one, which is the one that should be implemented in your plan, for your employees, and your type of environment that would work, that would help control costs? We thought that the first thing we had to do was analyze our costs and determine where the problems lay.

I think we all recognize that a health care plan to many employers is a way to say to employees, "Here is a great plan." Each plan over time has evolved, many times as the result of negotiation. It has been put together little piece on top of little piece on top of little piece that appears to be very insignificant over the years of negotiating with unions (and we are a very heavily unionized organization). As you sit down at the table, the negotiator at the other side of the table has several objectives in mind, but one of them is to wind up with a contract that is livable both by the company and by the union. Sometimes little pieces get slipped in that don't appear to be significant at the moment that you negotiate it, but over time you have built a package that is really difficult to live with now because it is not cost effective. Those are some of the problems we experienced with the many unions that we have dealt with.

Cost containment involves managing the plan, a good plan, a plan that is perceived by the employees to be a good plan, a fair plan, one that renders quality care. You can identify what quality of care is, because I don't know how to do that. It means so many different things to so many different people. We could spend the rest of the session getting your definitions and they would all probably be different. In my opinion, quality care is high if the receiver of the service is happy with it and satisfied with the physician, the facility and the service that is being rendered. I think you have to say that is quality care. It may not be quality to me, it may not be quality to you, but it is kind of like Ford and Chevrolet. If they are in a comparable price range, which is better,

which is quality to you? I don't have the answer to the quality piece. I think it is perceived in our employee population.

We are looking to give that employee a plan that has some perceived quality, a good plan that is at a reasonable cost to the employer, one that he can afford. We've given them, after we have developed that plan, a blank check and said, "Now you go out and you find the provider." That provider happens to be the physician who controls the dollars that are being spent in that plan by the decisions that he makes. As an employer, we have not had a part in it. We want to take a part in it, we want to become part of the shopping and help make some of the decisions that we have left entirely up to the employee, mostly up to the physician.

We started a study. We looked at all of our locations and we carved up our data by age, sex, location, active employee, retired employee. I am just going to mention a few of the pieces that we looked at.

Location A has the largest segment of employees and retirees that we are covering under our health care program. We saw that from 1983 to 1986, our health care costs in that location went up about 33% compared to all other locations going up around 20%. We asked ourselves why. We also saw that from 1985 to 1986 in that location A, our health care costs went up almost 12%. With all other locations, they went up only 1.2%.

I am going to concentrate on location A where we offer a traditional ASO indemnity plan, or whatever you want to call it, and three HMOs. One of the HMOs is an ASO arrangement and the other two are fully insured arrangements. The cost with the traditional ASO plan, in 1986, is running about $3,200 per employee. With the ASO HMO that we have, it is running about $2,600, and for the other two fully insured arrangements, $2,400 and about $2,300. Now the first thought that comes to your mind certainly is that you have adverse selection in the plan. We don't deny that. We do have some adverse selection in the plan.

Next, we cut that population into groups of employees. We looked at the various groups of employees as to salaried exempt, nonexempt salaried employees, union salaried employees, hourly nonunion, union hourly, salaried retired and hourly

retired. We see some startling things as far as segments or pockets of people are concerned. When looking at the salaried retirees, we see some increases of 10.7% from 1985 to 1986. Of the hourly, we see 25% increases. We also looked at the hourly population diagnostic groups. We went down pretty deep looking at some of these diagnostic groups and comparing them. We looked at about 1,800 episodes; we looked at about 13,000 hospital days with an average length of stay of about 7.4. Total medical expenses for location A, looking now only at the traditional plan and the HMO that we have as an ASO arrangement, is about $8,300,000 with about $4,600 average charge per episode.

The next thing that we looked at was in-hospital utilization. When we looked at the episodes per 1,000, they were not too bad. In the traditional plan, we have 113, and in the HMO, we have 93. We measured the norm, which we called the North Central norm, which covers seven states bordering in and around the Wisconsin area. That norm is running about 112. We didn't feel too bad when we looked at that. Then we looked at the days per 1,000. It kind of jumped out at us. We see 918 days per thousand in the traditional plan versus 485 in the HMO and about 605 in the North Central norm.

So we identified some problems and they began to shape out as being excess hospital utilization: length of stay, inappropriate admissions for short hospital stays, inappropriate inpatient surgery, premature surgical admission, and hospital price per case. We looked at them and found some real problems. Some of the types of problems we found were in psych and substance abuse and in the circulatory system.

When we put the dollars together as to what we thought were excess charges, we looked again at the $8.3 million. A large segment of that we identified as being excess. Excess average length of stay generated a huge bucket of money. The excess price also was a big hunk of the dollars that we identified. Actually, we looked at the cases and looked at the charges and did some tests to arrive at what we thought were realistic, real dollars that are measurable. In this case, we are looking at room and board charges and services that were rendered as it related to the case, that were unnecessary as viewed by our experts.

We looked at hospital confinements in excess of 30 days. This really jumped out at us. In one case, we had a length of stay of 300 days with an expected length of stay of 15 days, or 285 days. That's a weird case. You say, "How can that happen?" Simply because we don't have in place a mechanism to get involved in the case until we get the bill in hand. Then we become aware of it. Some of the other items that jump out at you are unbelievable, but they are factual.

Inappropriate admissions was another situation that we looked at. We had total admissions of about 5,000 and we felt that after looking at all those cases, there were about 185 of them that were inappropriate admissions. There were about 277 inappropriate hospital days in those cases and about a quarter of a million dollars just plain room and board charges that were in those cases.

For inappropriate inpatient surgery, we discovered we had about 150 cases there that were inpatient, the majority of which should have been outpatient. We were looking at about 551 excess hospital days and about $200,000 excess room and board charges. Inappropriate inpatient surgery was at 627 cases, but again $250,000 was what we felt were inappropriate charges.

For premature surgical admissions, we saw 286 excess days costing $50,000.

We looked at many other things, but I am giving you a little flavor of what we are confronted with in this location as far as what I call runaway health care that we are not controlling.

We came up with some recommendations. They are not everything that Mr. Strain talked about. We have to realize that we live in a real world. We have seven unions at this location. We have to negotiate with each of them. One of the things that we found a long time ago in other negotiations, as we have tried to put health care cost containment and control within our programs, is that the union is willing to talk to you about managing your health care, but they are not willing to talk to you about shifting cost and that it is very important.

We looked at utilization review. Mr. Strain dwelled on that quite a bit, but our approach to utilization review is a little different from what he described. We wrap that all together in a bundle. We call that preadmission certification. We

call that continuing stay review, and ambulatory and second surgical opinion, but second surgical opinion being different from what most companies are doing. Most companies give you a list of what you have to get a second opinion for. Ours is very restricted. The employee makes the telephone call for preadmission, and gives the data that is needed. They don't get involved anymore. The call is made directly by a medical professional to the physician that is attending the case. They get the medical history and all the reports related to that case. Based on norms, they will determine whether or not a second opinion for any case is warranted. If it is, they will get back to the patient and set up a second opinion. It doesn't matter what the case is, they are first looking at the medical evidence and determining whether a second opinion is needed. I think you saw earlier that we need to get very much involved in large case management within our employee population.

Price review per case is also something that we are looking at very carefully and wrapping in to that total utilization review. We are also negotiating the price up front with the physician and with the hospital before admission to the hospital. Competitive medical purchasing is another issue. We don't have a solid, strong PPO in this location, but we are looking at developing a PPO arrangement.

We have also looked at some plan design features in trying to correct the problems that we have within this location. When we put just those few features together, we are looking in plain, simple, conservative dollars of carving somewhere between around $1 million to $2 million out of that $8.3 million. This is our best estimate on a conservative basis by just being able to manage.

Last year we started looking for vendors in the marketplace. Some of the reasons that we were looking for vendors to manage our ASO business was to be able to get to this type of data on an ongoing basis and be able to retrieve it and analyze it. We wanted a vendor that had that capability in house to be able to do that. It is very hard to find. I think there are some things on the forefront and things that are happening in the industry. There are some people that claim they have the capability, but when you really get down and look at what they have and their capability, it is questionable.

We also went into the marketplace, because, as Mr. Strain talked about, the 10% administrative and 90% claims cost. We have been squeezing administrative costs

with the ASO arrangement that we had. We thought we got all the blood out of the turnip, but we went to the market to test it. We found there was a lot more blood in the turnip, if you please. We wound up, after an 18-year relationship, making a change. Believe me, you don't want to make a change in the type of environment that we are in, where you've got 50 to 60 medical plans, all types of dental plans, all types of ASO plans, and so forth, unless it is really worthwhile. It is a major job when you deal with the number of plans that we have, the number of locations that we have, and the number of unions that we have.

We went to the marketplace and identified what the pricing was for that ASO piece. After identifying an organization that was compatible to the personality of A. O. Smith and our needs, we finally decided to make that decision. We are now into our third month. Just getting through that transition, and believe me no transition like this is 100%, I can say you will have some minor problems. Fortunately, ours have been rather minor. We're looking at covering in here somewhere between 35,000 to 40,000 lives. We had a backlog of claims from the other carrier, as you might suspect would happen. It built up and dumped and the new provider of ASO services had to catch up and pay current claims and keep an employee population, hospitals, doctors, etc., happy. They have been juggling more balls than you can imagine, more than you can juggle at one time and keep everybody happy. We've gone through it, everything is caught up, and we're running very smoothly. We are extremely happy with the change and at the same time carving out a big nugget of additional expense for a fairly long contract arrangement with the provider of that ASO service.

MR. GREENE: There is a lot of talk these days of PPOs, HMOs, and managed health care. From our point of view as consultants and from Mr. Cato's point of view as the buyer of these things, there are both positive and negative aspects. I thought we would just take a few minutes and let Mr. Strain and Mr. Cato comment on what they see as being good and bad and what their opinions are of these various types of intervention mechanisms. Perhaps we can start with the program that is making a big play these days, and that's large case management.

MR. STRAIN: I mentioned before that case management is a hot topic. The first of two aspects of it that I think the employer has to deal with are concerns. We talked a little bit about the litigious society. But there are concerns for negligence that could come back to the employer, such as breach of

contract, confidentiality, statutory violations and conformance with local laws. The other aspect, in a general nature when you are looking at case management, is when do you exercise it? What do you look for that triggers case management? We talked about Honeywell with 8% of the employees producing 78% of the claims cost. When do you kick in case management, if you will, on that 8%? Several different approaches should be considered. Again, you are going to have to determine what, as the employer, your objectives are.

If your case management is being driven by a utilization review firm, make sure that they are not only aware of your objectives, but that they have the same philosophies, and perhaps most important, that they have the ability to deliver results in the areas you have outlined as your objectives.

This again is not an all inclusive list, but these items do set some guidelines for developing when you kick in case management.

1. You can do it on a diagnosis basis. Certainly terminal or progressive diseases are going to be important to identify those.

2. Many of the programs run strictly on a claim dollar amount. We'll get involved in case management for every claim that exceeds $25,000. That may not always be the best approach and you may be depriving yourself of some savings in some areas that don't reach the point.

3. Look for a pattern of repeated hospital admissions. This opens up a whole area. It may not be a single claim, but it may be an employee or a family. Look for the families where you have repeated admissions.

4. Also, look for a pattern of outpatient therapy that runs greater than six weeks. This is often indicative of something that could involve some savings when managed.

5. Home health care by a registered nurse, if it's more than somewhere between two to four hours a day, probably needs some management.

6. Likewise for skilled nursing that runs beyond six weeks.

7. The last one is that you may become aware of the need for case management through an interim billing from the hospital. That may be your first notification that something is going on.

If you look at the criteria, you recognize again the need to manage your input. How do you get information about a claim that's being managed? That again is where good case management or a utilization review firm can be of assistance to you. Again, it takes a lot of coordination of the various service vendors that are working with you on the plan.

Now I would like to ask Mr. Cato what he looks for in something like large case management, how he prioritizes his objectives and goals, and how he determines whether or not a case management firm can deliver.

MR. CATO: We took a while in looking at a number of what you now call utilization review organizations, thoroughly searched the market, and visited their facilities. It's amazing what you see when you visit somebody that's out in the marketplace selling their wares and what they have at home to show you. It's an eye opener. If any of you ever have an opportunity to do just that, you should do it. It is an education, especially if you are working with clients such as myself that are interested in purchasing services from a utilization review organization, be it from a major insurance company or somebody that is just specializing in this area or other health care cost containment areas.

The staff is very important to us. Who is going to be on the other end of the phone talking to our employees? Are they professionals, are they clerks, what professional credentials do they hold and can they identify with the employee or the dependent of the employee that has to make that call?

We went through screening, looking at how the data was collected, how it was used and how effective it would be and what it would cost us. Price was definitely a consideration, but we were willing to vary on costs. We weren't looking for the bottom dollar, we were looking for a good quality program. We wanted something that wrapped together more than just certification to a hospital. We wanted a program that would let us negotiate with the physician as far as his charges to handle the case, or, if they identified the case to be a large case,

then the ability to be able to manage that case or tie that case into a large case management program that we or they had established.

We wanted a program that was cost effective, as opposed to a type of program that we described to you earlier that we were looking at. We felt that program was very ineffective in controlling costs with simply 365 days of full room and board without large case management or without any type of other care facilities provided. What's the alternative but to stay in the hospital? That's what was happening to us, so we were looking for a vehicle whereby we could get that case out of the most expensive environment into a good environment via the home setting, a long-term care facility or wherever, but out of that really expensive environment. It is not necessary to be there when you're in a long recuperative type of environment. Our objective was to find a deliverer that could manage those cases for us and disburse them into the proper setting to take the case to a place where the family is happy, the patient is happy, the physician is happy, but the cost of it is managed.

MR. GREENE: Mr. Cato, there are some concerns about employer liability. Did your legal department have any concerns about the couple of cases now that would indicate that the employer may be sued for improper advice?

MR. CATO: There are some concerns, and we have been looking at this now for a year. We have researched our general liability, our umbrella liability and we are still pursuing this. As a matter of fact, we will be contacting a carrier that was just identified for us. There is a great deal of concern on the part of our management as it relates to liability. We don't know totally what that means to us yet. I don't think any employer does, but we do have some concern. That's one of the reasons we were very selective in picking the utilization review firm that we did, because we wanted professional people responding in professional ways. We wanted somebody we could rely upon, depend upon, and that could stand up in court and say that this was handled in a very professional manner.

MR. GREENE: I take it that your large case management is predominantly initiated by the utilization vendor, but there are a couple of other trigger points that they may not know about, such as dollar amounts and a pattern of hospitalization. Did you do anything special about getting the data or were you just forgetting about those other trigger points?

MR. CATO: We are forgetting about them for now. We are just initiating the program and I think we have to refine it as we move forward.

MR. GREENE: One of the other things that you mentioned in your comments was about HMOs. It looked like the HMO costs were significantly lower than costs in your traditional plan. Does A. O. Smith have a strategy of moving people to HMOs or are you neutral? Do you think that they are an effective way to control costs?

MR. CATO: That's a loaded question. We, at this time, do not have a strategy. We have looked at it, we have talked about it, but we do not have a strategy of moving people into HMOs. There are some problems as we see them at this time. Milwaukee, which is the area that we are looking at, has got more HMOs than you can imagine. Many PPOs are beginning to develop and a lot of things are happening in that marketplace. Everybody, as you well know, has the best HMO and the best PPO, and the best hospital and the best everything. Trying to evaluate HMOs is very difficult. Trying to put together an HMO that services a population that we have and make that population perceive that they have got a very good package of very good quality, is very difficult. At this point, we have elected to offer three HMOs and continue with the traditional plan that we have, but we continue to evaluate whether or not we want to offer some incentive by going to an HMO fully insured arrangement provided we are sharing in the dollars that that HMO is saving.

Some of the things we think we are seeing is that one of the HMOs is really saving some dollars and managing some cases very well. However, because the marketplace is bearing the higher price, they may be the lowest priced HMO in the area, but it is just marginally low. They are not fully sharing the dollars that are being saved. They are building more facilities and moving on with it. You talk to them about it and they say, "Why should we? The market bears what we are doing and we are already the best managed HMO and the cheapest HMO in the area. So why should we do anything any different?" There are some problems that we see in there, but we are continuing to look at them.

MR. GREENE: Mr. Strain and Mr. Cato, one of the areas that came across loud and clear was the question of the cost per retiree versus the cost per active employee. It was roughly twice as much. Is there a strategy, or have you

seen a strategy, of moving retirees into HMOs and/or using your large case management for the older group, or is your large case management just for your active employees?

MR. STRAIN: I'd like to participate in this. The only strategy that I have seen with the companies that I have been working with in Chicago as far as utilization of HMOs, has been in the retiree area. One of the problems, obviously, is your retiree population frequently has more geographic spread than your actives do, but where they can be localized or where there are groupings, I've seen a lot of employer interest in utilizing HMOs. One of the problems we have in Chicago, and I don't think we are all that unique, is the reluctance of the HMOs to share data. You can in some situations get an insurance carrier who also has an HMO to experience rate the two delivery systems together. In most cases, we end up dealing with hospital owned or doctor owned or proprietorship HMOs. It's very difficult to get any sort of experience rating from them, so I think the employers are thinking, "All right, how can I take advantage of this? I know that there is shadow pricing. How can I make that work to my advantage? What is my identified group of high utilizers? My high cost group?" Mr. Cato's data brought that out very well, that it is all too frequently your retirees. That's where I've seen HMO strategy utilized.

MR. GREENE: What about large case management, is that usually for actives only?

MR. STRAIN: I haven't seen much interest in the retiree area, simply because large case management, as we are looking at it today, is fairly new and I think that there are some instant payoffs with the active group. I think it takes a sophisticated employer to keep and analyze data so he knows what his needs are. Again, the instant area of the larger payoff is going to be in the active area, but I think that potentially, as we are looking into long-term care, as we are looking at people living longer, as we are looking to the medical care technology applied to keeping people alive longer, large case management may have its greatest payoff in the retiree population.

MR. CATO: The only comment I have to add to that is that shifting retirees, especially in a negotiated situation, becomes difficult. If you have negotiated a plan and then you try to shift them from that negotiated plan into something

different, you can run into problems there from a legal standpoint, especially if it is a plan that is offering benefits that are less than what you had negotiated for that retiree group.

MR. GREENE: One other thing that might bear some mention is the subrogation issue that Mr. Strain mentioned earlier. I know that you have had some experience in that area too that you might share.

MR. CATO: Let me just take a minute and share that. I joined A. O. Smith six years ago and I walked in and looked at our medical contracts and found we didn't have the right of reimbursement or subrogation clause. I was faced with a malpractice suit case by an employee in one of our locations that was running up costs well in excess of $100,000. The employee went in for what was a simple four or five day stay in the hospital for surgery and had problems. We tried to enter the case (since we paid the bill, we thought we had the right to recover it), only to find we didn't have the right to do anything. We didn't have a provision in the contract that allowed for it. I tried to put the right of recovery/ subrogation clauses in our contracts, only to run into a buzz saw with our negotiated plans, because we hadn't negotiated. Our employees really liked getting those dollars we had paid for and I didn't understand why. You talk about $100,000 in medical recovery, that really went directly into their pockets, where we had paid the bill, when there was a third party involved that should have paid the bill.

We have been successful at this point in getting such provisions in all of our plans with the exception of the location I spoke about earlier, and that's on the table being discussed currently. We have seen some big dollars go in the pocket of the employee because we were not able to intervene in the case where there was an accident or a malpractice suit or some other third party that should be paying the bill.

MR. TIMOTHY M. HARRINGTON*: Mr. Cato, have you negotiated directly with hospitals?

* Mr. Harrington, not a member of the Society, is a Member of the American Academy of Actuaries and Assistant Actuary of Blue Cross/Blue Shield of Massachusetts in Boston, Massachusetts.

MR. CATO: I don't negotiate, but in the utilization review program that we have in place, they do negotiate directly with the hospital. It's not always successful, bear that in mind, but we do negotiate with them. Some hospitals are willing to negotiate prices to cover the case. We are finding that a utilization review organization that has grown very rapidly and has strength within a community representing more than one employer, has greater negotiating strength. "I've got five maternities, hospital, that are coming in and I may be able to direct three of them to you, but I want to negotiate a price." They get pretty serious about negotiating when you start talking about two or three cases coming to them. Some just flatly say no, but our approach is to try to negotiate in all cases a fixed amount with the hospital. We will come back and relook if there is some unusual circumstances that would come up; then the hospital does have a right to come back if they can prove their worthiness, if you please. We may consider some additional funds for that particular case. We have had fairly good results with that. The physicians particularly have been very willing to negotiate. Our plan calls for payment at the 90th percentile of reasonable and customary (R&C), but we start negotiating at the 50th. If we can get anything below the 90th, we're better off than we would have been if we just got the bill. We are finding we are having a great deal of success in that area.