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LARGE EMPLOYER NEEDS -- INVOLVEMENT IN HEALTH BENEFITS PROGRAMS

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Panelists: ALBERT M. CASSESE*
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GEORGE SEPLAK***
Recorder: JOSEPH W. MICHEL

Employer representatives will offer their perceptions on:

- o Participation in alternative delivery systems: Preferred Provider Organizations (PPOs) Health Maintenance Organizations (HMOs), etc.
- o Direct contracting with medical providers (hospitals, physicians, etc.)
- o Participation in coalitions
- o Employer demands for data
- o Employer selection criteria for health carriers (insurance companies, HMOs, PPOs, etc.)

MR. WILLIAM R. WELLNITZ: Our panelists for this session truly know the needs of the large employer health benefits market, because they're part of it. We have three gentlemen here today representing three major corporations in the United States.

* Mr. Cassese, not a member of the Society, is Director of Corporate Benefits for American Can Corporation.

** Mr. Driscoll, not a member of the Society, is Division Manager of Benefits Administration of American Telephone & Telegraph in New York City.

*** Mr. Seplak, not a member of the Society, recently retired from the position of Corporate Director -- Compensation, Benefits, and Personnel of Kaiser Steel Corporation.

OPEN FORUM

First we'll hear from Al Cassese, Director of Corporate Benefits for American Can Corporation (ACC), Greenwich, Connecticut. Al has spent his entire career in the area of employee benefits and the last five years with American Can.

MR. ALBERT M. CASSESE: I'll start with a couple of brief notes about American Can. It's headquartered in Greenwich, Connecticut, just north of New York City. We have just short of 30,000 employees; we used to have as many as 50,000 employees. Sales are approximately $4 billion a year, and we're involved in three major industries.

Let's start with some data from 1982 so you can get a sense of what was happening. In 1981 health care costs were rising more rapidly that the overall CPI, or about 15%. They increased another 12% in 1982. The increase in the medical CPI was about three times that of the regular CPI, roughly 11% versus about 3.9% during 1982. The daily cost of hospital room and board rose 20% in that one year. In that same year, American Can had total benefits costs, for active employees, of $164 million. Over 50% of this was for health care. Paid claims per active employee were rising at 14% per annum. You can see why we thought that it was important to pay some attention to health care costs. It's obvious from those statistics that we could not just keep going on with business as usual.

Here's a pictorial representation of what I'm talking about (Exhibit 1). The top line indicates the current projected rise in health care costs if American Can didn't do anything to change current trends. The bottom line is a rough estimate of what we thought we could do by making changes and the area between the lines is what we consider to be the savings from taking some action. In 1982, our health care costs were $85 million a year for active employees and the projected costs were increasing by as much as 15% to 18% a year. That's the top line.

A modest drop of only one percentage point in the rise in health care costs would have saved over $18 million for our company over a five year period. With a drop of 10% we could have saved $8 million in 1983 alone and $172 million over the five year period from 1983 to 1987. A more realistic savings is in the middle; a 3% to 4% decrease in health care costs would have meant

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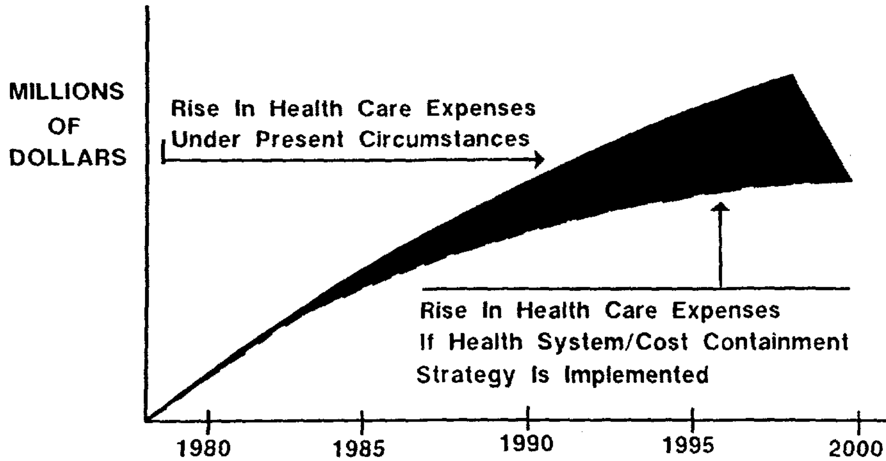

- 1982 Total Estimated ACC Health Care Expenses $85.0MM
- Projected Annual Increase 15% - 18%

that American Can could save $60 million to $70 million over the five-year period. You can be assured those numbers got some management attention, and management agreed with us that we needed to do something. The important question was, what were we going to do and how were we going to do it?

We began with three goals. The first was to lower the rate at which health costs increased. Next, we wanted to maintain the quality of medical care for our employees. Our chairman was very strong on this point. He did not want a reduction in either the level of services or the quality. And our third goal was to keep a high level of employee satisfaction. Many of you may know that American Can was one of the pioneer companies in flexible benefits programs in 1979.

We spent a considerable amount of money, time and effort building the plan to the point where it was very well received by employees, and we did not want to sacrifice our rating for the sake of cost controls.

Normally, in American industry, when you ask employees the question, "What do you think of your benefit plan?", somewhere in the neighborhood of 50% of them will respond that they think it's good to excellent. At American Can, 85% believe it is good to excellent. We wanted to keep the rating as high as we could. Obviously, these three goals were not necessarily going in the same direction, so we did somewhat of a balancing act to keep all three of them in front of us.

We selected four strategies for attacking the problem. The most important one was changing benefit design. This was where we felt we could make the biggest impact. Some of the things we did were: switching from a first dollar coverage plan to a comprehensive plan; increasing deductibles and co-payments; installing various controls on the utilization of health care dollars, including restrictions on emergency room use; encouraging out-patient instead of in-patient care and testing, hospital pre-certification programs, second opinions and so forth. The list is long. American Can has tried most if not all of them over the last three to four years.

The second most important thing we thought we could do was look at plan administration. Here we're talking about asking carriers to rebid for American Can's business. We thought some healthy competition would make a difference and it actually did. We wanted much tighter controls on eligibility for our benefit dollars. An audit found we were paying money to employees who had left the company, one, two and sometimes three months before they had undergone the various medical procedures.

Right now, when there are two working spouses in a family the primary paying company is the one that has the male spouse when dependents submit claims. At American Can at least two thirds of our employees covered by the flexible benefits plan were males, so there was something not quite random about the males' employer being the primary paying company. Some states are beginning to adopt what is called the birthday rule, and we think we'll be in a better position with it. The rule says that the birthday of the spouse which falls earlier in the year determines the health plan which will be the primary payer for dependents. I'm hoping our situation will be better than it is with males being primary.

A third area of strategy was to look at some longer term actions which would provide results not so much in the next one, two or three years, but more in the next five or ten years. We are talking about health promotion, health risk appraisals and education of employees. It's very difficult to measure the impact of programs like these, but our instincts are telling us they've got to have a positive value. American Can runs health fairs for its employees. Many of our businesses publish regular news letters on how to be a smart consumer of benefits. Video is becoming active in our company. We show films to employees because we think they learn more from films than from the written word. We run smoking clinics and weight loss clinics. We have employee assistance plans. You name it, American Can has got it some place in the company, and we think it's going to have a pretty dramatic long term effect.

Our fourth strategy was to become involved externally. By that I mean involvement in some business coalitions which could put pressure on legislatures, hospitals, doctors and other health care providers to maintain quality care while holding down costs. This was a key area from which we could watch the

quality of the care being offered while we were tinkering with how the dollars were spent. We think we have had some success in this area.

These are overall corporate strategies and because this is a session on large corporations, I thought I'd show you why, in a large corporation, it's not quite as simple as choosing these four strategies or, in the case of trying to lower health care costs, using one or two or three different techniques. American Can is a large, decentralized and diversified company. Choosing strategies and techniques depends a lot on which business and which sector of our companies you're talking about. Our company is divided into four sectors for benefits: financial services, packaging hourly organized, packaging salaried/corporate staff and specialty retailing. Let's look at each one of the sectors of our company.

First of all, half of our profits are coming from an organization we call Financial Services. American Can owns eight insurance companies, a mutual fund company and a mortgage origination company. These operations account for 17% of the health care dollars we're spending. This sector has relatively young, relatively high turn over employees and is less labor intensive than some of our other businesses. The challenge has been to ensure that the benefits being offered are adequate. These are small to mid-size financial services companies. They are in the process of upgrading their benefits, and our challenge is to make sure they don't upgrade them by putting in the same bad design features we had in some of our other plans.

Our packaging sector, including metal cans and performance plastics, represents more than half of the benefits cost and therefore was our major concern. There were union contracts in force, and there was little opportunity to change the design of benefits for these unionized employees. However, the unions were willing to look into such things as decreasing utilization of benefits without changing the design of the plans.

The part of the company's benefit program, that is probably best known is that for our salaried work force in the packaging sector along with our corporate staff. That's the flexible benefits program. It's the most sophisticated area of the company in terms of benefits design, and we've been changing the design

of those benefits over the last few years with cost containment in mind. Our thrust was to continue to make design changes and do some things with utilization patterns, along with some wellness programs.

Our specialty retailing sector, which represents only 8% of the total cost of health care, has very young, very high employee-turnover businesses. This sector has the advantage of having its headquarters and a number of its operations in the city of Minneapolis, which tends to be very liberal on the subject of cost containment and an excellent place for controlling the cost of health care.

There aren't many similarities between any of the businesses or sectors of the company, so controlling costs for us is a very diverse, very decentralized issue.

Now I would like to go into more detail on each of these sectors. In the Financial Services sector, we had $10 million a year in costs and about 7,300 employees. These various sectors average per-capita claims costs were $1,320 a year. What have they done over the last few years? They are generally small to medium size companies and are quite progressive in their thinking. They have some excellent plan design features compared to our union contracts. Health risk appraisals have been implemented in every unit. That means that 7,000 people have filled out a questionnaire geared towards showing them the three, four or five key areas in their lifestyle that are most contributing to their poor health and their shortened lives. If you've not taken a health risk appraisal, I suggest you do. It will tell you how many years of your life you are losing by smoking, how many years of your life you're going to lose by not wearing your seatbelt and a whole list of life styles that are not very difficult to change and if you change them, maybe you'll live to 85 instead of 74.

We have good penetration by HMOs in the large city locations of the business units within this sector. Two of the units, Associated Madison and American Capital, have adopted some flexibility in medical plans, by giving their employees a choice in their medical options. There are hospital pre-certification programs in virtually every unit throughout that sector.

Specialty retailing represents only $5 million of the costs, 8% of the total. There are about 5,800 employees working in primarily two units, Fingerhut and Musicland. The most important number is the $820 annual cost per capita. Compare that to the sector with $1,320. There's a very big difference.

These units have several accomplishments. Fingerhut has very high employee assistance plan utilization statistics. American Can is running an average of about 4% of the eligible employees using an Employee Assistance Plan (EAPs), while Fingerhut is up near 8% or 9%. Either these units have a lot more problems in their employee work force, or they have figured out how to use the plan better than the rest of the company. Because these units are in Minneapolis, they can negotiate with some hospitals for discounts, and with Preferred Provider Organizations, have added incentives for out-patient surgery and very cost effective plan design features.

Musicland's business has not been doing well. It is working hard to improve earnings so its effort is somewhat different. It's keeping its reserves in-house, which gives it a couple of extra bucks a year. Musicland is certifying claims in house to save some of the money it would otherwise pay an outsider. Coordination of benefits is being tightened up; that's an area where you don't have to change your benefits design to squeeze some dollars out. Because Musicland is in Minneapolis, there is a very strong HMO penetration at its headquarters.

Next is the tough nut to crack, our packaging hourly employees, all 15,000 of them. They spend $1,630 per capita on health care cost compared to $820 in the specialty retail organization. There is little movement in the union contract area. We have not been able to negotiate changes in the benefits plans, so all accomplishments tend to be on the softer side. For example, unions were willing to run hospital pre-certification concurrent review programs. They were willing to have union company committees work on health care cost containment. They like the idea of expanding employee communications to keep the cost of health care down and they like implementing EAPs. We do think, over the long term, some of those features are going to work. Unfortunately, we cannot change plan design in this part of the organization.

The last sector, which has the flexible benefits population, had $13 million in cost and a fairly high per capita expense of $1,565. Here's the area where our flexible benefits plan gives us the opportunity to do something with design changes and changing employee consumption patterns, not very easy to do in more traditional benefits plans. For example, over the last five years we have doubled the number of employees each year who have participated in HMOs. Four years ago we only had 1% of our employees from this flex plan in an HMO. In 1986, the number is as high as 23%. We are paying fixed dollars to an HMO which, hopefully, is cost-effective when it delivers the services and we've no upside risk for the high-cost employees who may incur some very high costs in any particular year. We've also been able to lower carrier fees and have much tighter administration now than we did when we started.

When we changed carriers, the first carrier we had, and still have, for our hourly packaging employees was fairly liberal in its interpretation of our plan and in the way it paid claims. The carrier we have now happens to be at the opposite extreme, very conservative, very tight administration. That sounds good up front; that's what we paid for. We saved something in the neighborhood of $2 million a year on retainer fees to the carrier, and we think we've got better administration and better data. Unfortunately, we did not anticipate just how conservative this carrier would be. Our employees were told there was going to be no change in the benefits plan at all the year that we changed from one carrier to the other. When they looked at how their claims were being paid, it seemed to them that there were lots of changes in the benefits plan. This happened because the second carrier was now reading the plan the way it was originally written, while the first carrier had gotten fairly lazy and liberal in its interpretation. It made a big difference to us. We did not fully anticipate the reaction of our employees. We've had the new carrier for a year and a half, and I'm still not sure we're totally recovered from the change.

We have hospital preauthorization programs, higher deductibles than we used to, on-going wellness programs, and we've shifted consumption patterns. In our flexible benefits plan there are four levels of choice in medical options. The first one we call core, and the remainders are A 1, A 2, and A 3. Core is not

a bargain basement plan, but it is not a rich plan either. Our A 3 plan is virtually full coverage. In 1987 we might eliminate it.

Some of the things we've been able to do over the years by placing price tags on employees ability to buy levels of medical care have changed consumption patterns dramatically. In our core plan for example, which is the lowest level of medical coverage and costs nothing to employees, we had 4% of the employees covered four years ago. Now 20% are in the core plan. In A 3, the richest medical option, we used to have 64% of our employees. We're now down to about 20%. How did we accomplish this? We've changed consumption patterns by pricing those options the way we did, and we're very happy with the results.

The most difficult part is to quantify what this all means. Some of these numbers are quite sketchy, some of them come from parts of American Can versus the total company, but they are indications, so let me share them with you.

Lower retention fees to our carrier saved American Can about $2 million a year. In our domestic metal business, even though it is highly unionized, the actual claims were $5 million below the budgeted claims for 1985.

If we combine the per capita cost for medical, dental and preventive medicine we find, the flexible benefits program had an annual per capita cost of $1,600 in 1982 and $1,845 in 1985, which is only a 5% annual increase. The steel workers had a $2,250 per capita cost in 1982. It's now only $2,552, only a 4% rise. The expected cost increase in 1982 was something in the neighborhood of 13%, 14% or 15% a year.

EAPs are another fairly soft area in terms of measuring value. One of the common statistics throughout industry that we've seen is, for every dollar you spend on a plan of this kind, you'll save $3 in the long run on medical programs that pay claims for illnesses due to stress, psychiatric problems, alcoholism and a whole series of problems dealing with employee wellness. Our EAP counselors are outsiders. If we use the ratio of one to three we could be saving in the neighborhood of $600,000 a year on health costs.

On HMO penetration, we now have a limited exposure on 25% of the employees in the company because they're in HMOs. The data is very sketchy in specialty retailing and financial services. The company is not at the point where it can even measure some things, so data are limited in that part of the company. The most difficult thing is trying to measure the body count when you're in the middle of a revolution, and the whole medical industry is in a revolution. So we're not quite sure what we're measuring. We're not sure to what degree our plans have had this effect or whether it's just that the industry has changed and we're benefiting from it. We'd like to think we've had some effect.

So where are we going in the future? The whole area of retiree costs has not yet been addressed by most companies, and because American Can is an old line manufacturing company, we have lots of retirees. We've got to think about the cost of providing for retirees. We've got to think about how we can change plan design. I see intervention techniques in the next 3, 4, 5 years staying alive and well; prepaid care, managed care, Preferred Provider Organizations. Long term, I don't know whether these intervention techniques will last, but in the next few years, I think they're going to help us quite a bit.

An area that you can help us in is defining the data. By nature, human resource people are not data oriented. I'm not in my element when I talk about these costs. We are necessarily in an environment where measuring the impact is extremely difficult, and yet we want to manage the subject in the same way any other management issue would be managed, and that is with knowledge of what's happened in the past as well as good estimates of what's going to happen in the future. I'm not quite sure any of us can predict the future of the health care industry over the next few years.

We're going to try more wellness programs at American Can. We've got specialized techniques that we're going to be trying, including generic drug programs which are becoming fairly popular now. An interesting technique that our actuaries and one of our carriers helped us with is to charge smokers higher rates than non-smokers for life insurance, starting in 1987. We're going to provide a lot more financial incentives to have employees consume medical services in an intelligent fashion. The difficult part is trying to

measure how much incentive money we need to put into the pot in order to get a given reaction from employees. That's another challenge for actuaries.

As I see it, we're working in a very exciting time and we've got lots of initiatives going. What we need are advisors along the way. Advisors such as the insurance carriers, the medical profession and actuaries, who will help us to manage the data which I think is the key to success. If we can't measure what we're doing, we're never really going to be sure that we've had an effect. So, we do need the help of all actuaries.

We need data, more data and even more data. We have not been getting enough. It's getting better, but it's not good and I offer a challenge to all of you to go back to your companies and think about this subject. I'm sure all of you are involved in one way or another with the cost of medical care. We need your help. We need it badly. It's a critical problem for our company as well as many other companies. It's your help that's going to get us through.

MR. WELLNITZ: Next we're going to hear from George Seplak. George recently retired from the Kaiser Steel Corporation where he had been Corporate Director for Compensation, Benefits and Personnel. While George has retired, he continues to consult at Kaiser Steel on essentially on a full time basis.

MR. GEORGE SEPLAK: Not too many years ago, Kaiser Steel was under the corporate parenthood of Kaiser Industries, 84,000 employees strong; 14 companies involved in enterprises from steel manufacturing, to aluminum manufacturing, to international shipping, broadcasting and the Kaiser Foundation Health Plan. In 1976 Kaiser Industries dissolved, and Kaiser Steel became a separate and distinct company. At that time we had 16,000 employees. Now we're down to 1600 employees. By late 1983 we were no longer in the steel manufacturing business. We shut down our steel manufacturing operation. We're now involved in steel fabrication, coal mines, real estate, pulp loading and energy progeneration; we're small but mighty. We have a great potential for future profit.

Where we have not downsized is in our retirees. We now have over three retirees for every active employee. Of equal importance to the number of retirees is the level of benefits. We have 4,800 steel worker retirees. And they have the

active level of medical benefits, which consist of basic health plans, major medical, drug, dental and vision. All are fully paid for by the company.

An additional problem is that the retirees are young. With the steel worker pension plan, if you are in a shut down mode or if there is a prolonged lay off, you have open windows that provide full benefits. The rule of 65 provides that an employee with only 20 years of service, if he has age and service totalling 65, can go out with full benefits and a supplement until age 65. There are also 70-80 features that provide full early retirement benefits. So we have many retirees who are well under 50 years of age participating in all of these benefits. Also, the benefits include coverage for the surviving spouse and dependent children. If dependent children are going to school, benefits go all the way up to age 25.

Kaiser Steel, over the years, has taken advantage of every cost-saving device we know. We've gone from things like the tax advantage of pre-funding under a voluntary employee benefit plan association, (wherein if you have an advantageous tax year, you pre-fund the next year's benefit cost) to using minimum premium for all our insured plans. Naturally, as a Kaiser Company, we have Kaiser Foundation Health plan as an HMO. This gives us superb participation. Our hourly people participate to the tune of 85% in the HMO rather than the alternate choice insured plan. Of our salaried employees, 60% of them participate in the HMO.

In terms of Preferred Provider Organizations, we deal with California Dental Service, now Delta Dental, which uses participating dentists. Our drug plan is provided by Pharmaceutical Card System (PCS), which uses participating pharmacies, and a vision service plan which uses panel doctors or optometrists. Getting back to our 4,800 steel worker retirees, we've reached what I consider to be a remarkable understanding. This has all been done with the help of the union, the retirees, labor negotiators, actuaries, carriers and providers.

Early in 1984 we initiated discussions with the union and stated that there was a substantial legal question, in the company's view, whether it had an obligation to continue paying retirees health benefits after the shut down of the steel mill and the expiration of the company/union insurance agreement. The

company also informed the union that, regardless of the legal question, there was a serious question whether the company could continue to pay for the health benefit program without facing bankruptcy or liquidation sometime in the future. The single sum liability of our steel worker retired health plan was calculated at something like $222 million, and remember this is for a company with 1,600 active employees. The stream of payments started at $11 million and continued to the year 2043. We were looking at a very long term liability.

The union disputed the company's contention regarding our legal obligation to continue health benefit payments, but after a detailed examination of the company's financial condition by the union's financial analysts, they concluded that the company's doubts about its ability to pay were well justified. As a result, although the union did not purport to act as bargaining agent for the retirees and still did not agree with the company as to it's legal obligation to continue to pay the cost of the health benefits, the company and the union entered into discussions.

The discussions had two basic goals. One was to clarify the company's obligation to continue to pay for the retirees' health benefits, and the second goal was to establish a system which could afford the best assurance that the company could and would be able to fulfill that obligation.

On September 14, 1984, the parties signed a memorandum of understanding which they believe accomplishes those goals. The key element of the memorandum of understanding was a program of continuing coverage which offered lifetime health benefits on a modified basis to eligible retirees, spouses and, of course, their dependents. The main features of the program of continuing coverage were as follows: for the lifetime of the retiree and spouse and eligibility of the dependents, the company would continue to pay the cost and the future inflation in the cost of the basic health plan, which is a very broad and extensive hospital surgical plan. Under the same conditions, the company would continue to pay the cost of the prescription drug program for the retiree, spouse and dependents. But the program was to be modified. The deductible of $1 was increased to $3, for a 30-day supply of a medication. We also established a mail order generic drug program, which if used had no deductible. During that process we learned that 50% of all prescriptions

filled nationwide are refills. We also learned that 70% of the cost of total prescription drug purchases are related to regular maintenance medications. This is extremely important to a group of retirees.

The drug program is also dedicated to the use of generic medication unless the doctor prescribes a brand name. In 1984 numbers, 14 brand names had an average cost for 100 tablets of $13.54; 14 generic equivalents had an average cost of $3.13 and that's a savings of 77%. For example, there's a drug called Librium which retails for $24.56, its generic equivalent is called Chlordiazpoxide, and that sells for $2.85 or about 12% of the cost of the brand name.

The next thing we did, with respect to the retiree or surviving spouse over age 65, was to continue to pay the cost of the major medical for the next ten year period, January 1, 1985 to December 31, 1994. Any retiree who reaches age 65 before 1994 will have major medical through the remainder of that period, as well as his spouse and dependents if he has any.

The retiree could choose company-paid vision or dental as an alternative to the major medical. This is a sensible choice for those who participate in the Kaiser Foundation Health Plan, because the benefits are so broad there's really no need for major medical. Effective January 1, 1985 the company stopped paying for dental and vision for all and for major medical for those who were under age 65. All of these people were given an opportunity to continue dental, vision and major medical on a self-paid basis. The benefits were modified downward but still provided good protection in order to keep monthly costs realistic. The retirees also have to pay the inflation cost in the future. Somewhat over 60% chose one or more self-paid plans.

Next we offered the retirees a lump sum buyout, a single cash payment for all present and future rights to all health benefits. We offered $9,000 in cash to each retiree and spouse if they were under age 65 and $6,000 each if they were over age 65, and if there was one in each category we split it. If a retiree was over 65 and chose a lump sum, we paid him $6,000. If he had a wife under 65, we paid $9,000 for a total of $15,000. Approximately 1,300 retirees accepted the buyout, reducing the population from 4,800 to 3,500.

We found, because of the youth of these retirees, a lot of these people were working for other employers, felt no need for the medical coverage and preferred the cash instead. So, in that instance the young ages of the retirees worked in our favor. When this was presented, it was in no way presented to represent the value of those benefits. I should stress that very highly.

Then the company established a retired benefit trust. The basic purpose of the trust is to provide funds to guarantee continued coverage. If and when the trust is large enough, the company will purchase a fully paid insurance policy to provide continuous lifetime coverage. This is possible because when Kaiser Industries liquidated, in order to take care of the obligation to retiree medical benefits, we purchased benefits from two insurance companies, plus benefits from Kaiser Foundation health plan for the lifetime of those retirees.

The company's initial contribution to the trust to provide funds to guarantee the future benefits was our Cushionberry Mine, which is a limestone mine with an appraised value of $15 million. The intent is to sell that mine and donate the proceeds to the trust. Additionally, the company established a profit sharing program, which basically involves a long-term commitment by the company to dedicate 20% of its annual cash earnings above $15 million to securing and paying for health care benefits for retirees.

The intent is eventually to fully insure core benefits (that is the basic health and prescription drug) by purchasing the insurance policies. If the fund is sufficient, the company, through the trust, will again start paying for major medical, dental and vision benefits. The program of continuing coverage was successfully implemented on January 1, 1985. I think it's a remarkable achievement of a concerned union and a concerned company putting partisanship aside. Our retirees were not happy to accept a reduction in benefits, but I think they understood the company's contention that its future ability to pay was certainly in jeopardy after detailed financial analysis. The company contributed substantial future profits and assets to provide guarantees.

Finally, I'd like to mention the excellent and strong support we received from our actuaries, consultants and our carriers and providers, without whose help this job would have been virtually impossible.

MR. WELLNITZ: Last we're going to hear from John Driscoll of AT&T. He's the Division Manager of Benefits and Administration. He's been with AT&T for over 25 years, with the last 10 in personnel. John's responsibilities involve policy administration in the benefits area for all of AT&T nationwide, including health, life, disability income and workers' compensation. His primary focus, of late, has been the medical cost management area.

MR. JOHN DRISCOLL: First, this is not a numbers oriented presentation and it's not very global. It's project oriented because this project is very much on our company's mind. We think it's a win win situation for the company and employees, and we've just gotten started.

Over the past several months AT&T has been unfolding a communications plan for a new health care review process that we call Health Check, which took effect April 1 for its management employees. I am the project manager for this new plan.

What my company is now doing and implementing is really a basic change in our health delivery system for management people, and we think it has very significant cost implications for many of the factors we're talking about.

Health Check represents a conversion to a managed care system, which encourages a change in behavior patterns in a positive way. We're asking our employees to form a partnership with AT&T. The company provides the framework for more quality with financial incentives, and the employees participate in the process by becoming better consumers of health care.

We did an analysis and the rising cost of medical expenses was gigantic. Al, I think you said it was about 15% a year at American Can. At AT&T it was 22% over the 1980-83 period. It's very dramatic, and we wanted to do something. I'm not going into the global strategies of the policy and administration, the coalitions and the wellness, but we did those also. I'm going to talk about this new project, which I call design and development -- how we went about our vendor selection and some savings involved. The administrative process puts a lot of emphasis on the communications program, because when we went out and did our homework and created our focus groups, we found that people said, "Tell it

like it is; you have to communicate better than you ever did before." We learned that health care review is very often perceived as a take away. So, we're very sensitive to that, and we think we have been successful. Our 800 hot-line number went in March 1, and the phones are just ringing off the hooks. People have listened and they are participating. So we think that we've gotten over that major hurdle.

We are utilizing a conglomerate of everything you've seen in dealing with health care review: pre-certification, which is an omnibus term; concurrent review or length of stay, where we expect to see our greatest savings; and discharge planning, individual case management, where we're talking about a $4 million savings. We're talking about, in the management population, 115,000 active employees who are covered and about 300,000 eligible people counting dependents. The company has 335,000 active employees and 80,000 retired, about 25% retired. In HMOs, we have only 6% participation, so we're very low on that.

In terms of dollars, the medical plan for 1986 has an estimated cost of about $800 million dollars for the total company. We're talking about some significant money, and there's money to be saved by proper utilization.

New to our plan are the three alternate settings of home health care, extended care facilities and birthing centers. Birthing centers are only in the formative stages. There are only 25 certified throughout the country. Some people are expressing interest, so we've made provisions for them.

We also have second surgical opinion. We went from a voluntary to a mandatory one. We felt voluntary second surgical opinion would double our treatments because of the cost involved and because treatment modes are very judgmental, so we put it in as mandatory. We also have financial incentives. One is that you get paid 100% if you get a second opinion, whether it's confirming or not. There is a disincentive if you don't come into the process. You get a 20% reduction of benefits subject to a maximum of $400.

Last summer we went to ten firms to bid as the third party administrator of this health care review; six independents and four insurance firms. The four

finalists were one independent and three insurance firms. We picked Intracorp, a subsidiary of CIGNA, out of Bluebell, Pennsylvania. We did that because it had two solid years in health care review with 135 branch offices. It had a competitive bid, and we got good feedback from many of the companies that it services.

Intracorp now has 2,000 clients. We're the biggest. They have Gulf and Western, Continental, Bank of America, Southland, (which is the 7-11 stores) and the City of Los Angeles. We were pleased with what Intracorp showed us in our bid. Since then we have had Intracorp in front of our medical team, which includes our corporate vice president, and put it through its paces technically on the modes and the diagnoses, the AMA standards, the routines, the exceptions, the flow and so on. It did very well. We think we've got a good vendor.

The savings we are estimating for our management people is a net of $10 million. This is based on length of stay being reduced by one day. A $2 million saving on surgery, $2 million on out patient, and yet another $2 million on individual case management for chronic diseases or catastrophic situations is expected.

If the total company were in at this time, we're estimating about a $40 million net savings. That's about 8% of our hospital bill. In one of the earlier sessions, one of the companies, Home Life, estimated that plans it insures experience about 10% cost reduction, but we're looking for 8%. Hopefully it's realistic.

We've been telling our people that this is a professional review system. We've got a good vendor at Intracorp, and there is quality care. We told them if you think this charge is only for the cost reduction, then you should think of quality as being better not to go into the hospital than to go in the hospital, because you can get sicker in the hospital. Something like home health care is better because you are in a support system, and it's better not to have surgery than to have surgery. So, if you buy that concept, there is quality care. There is dollar advantage because you get 100% coverage of charges if you get a

second opinion whether its confirming or not. We pay for the second opinion and the third.

These are the themes we are emphasizing to our people. We've had meetings all over the country. We had a total of 400 meetings, and 19,000 people attended. We've come a long way toward acceptance of this new program. It's only for management at this time, and started April 1 with Intracorp.

Before hospitalization Intracorp looks for medical necessity, appropriateness of setting, in or out patient and length of stay. Intracorp calls the doctor and talks about the condition, the diagnosis and the tests using AMA standards. Intracorp sometimes negotiates and sometimes it simply agrees on a date. In 97% of the cases the doctor and Intracorp reach an amicable agreement on what the time of hospitalization should be. Intracorp experience shows a 17% reduction in length of stay, about one day. So depending what number you use (I use $450), that's $450 for each day saved.

The need for second opinion has to go through Intracorp's Health Check effort too. It gives the employee up to three doctors in a specialty and a claim form. Those doctors are on the referral list because they're specialized, they will be available to our people, they will process the claim form, and they have no bad record as far as Health Check is concerned.

The need for pre-admission testing and the discouragement of weekend admissions was part of our medical plan program before. That is what this third party outfit is supposed to do. It is supposed to bring some structure to all this. And during hospitalization Intracorp is in touch with the hospital. The day before discharge it calls the hospital and asks, "Is so and so getting out tomorrow?" If the answer is yes, the case is closed, and it goes to the file for seven years retention. If not, they call the doctor and ask, "What happened?" If there's a medical reason, then the stay is extended.

We are not penalizing our people if the length of stay is marginal. We're working with the statistics. This plan is very soft compared to other plans you've read about. In some plans, if the third party says you can't go in the hospital and then you go in, you get reduced benefits or no benefits. Or if

the length of stay is agreed upon and changed, there is no added benefit. Or if the second opinion is non-confirming, there is no payment by the company. Or if you don't come into the process there's a 20%, 30%, 40% benefit reduction with no cap. We have a 20% reduction with a $400 cap, so we're very soft and I think we're very positive. We've been telling our people this, and I think that's the reason for the acceptance. Statistically, I hope this is going to work.

For discharge planning, if they come out on time and they go home with no further treatment, the case is closed. But if they go into a less intensive setting, the stay is monitored by this Health Check operation. We had three cases in Bell Labs two weeks ago that went from the hospital to home health care and saved 35 days, which was a $13,000 net savings, and that's pretty encouraging. Of course, when you get these catastrophic cases where there are multiple serious situations, you can save $15,000-$20,000 per case. The post-hospital treatment includes a review of home health care and extended care through individual case management.

To employees we're saying, "Health Check provides alternate setting information and answers to general health care questions. We think that you should be active consumers of your own health care." We're pushing, "Isn't your body and your health more important than the time or material things? And we ask you to participate with the company to be more active in the decision making process. The booklet gives you tools to work with. Health Check is your structure to work with. Intracorp gives you information to give you confidence, and choices to make. It provides a requirement which almost forces you to deal with your doctor by saying, "Doc, I love you, but the company is now making me get a second opinion. I have no choice in order to get full benefits." Or "Doctor, you have to come into the process or there's not going to be any flow of insurance money." We felt basically that the doctors are like our employees; they are nice people, and they'll appreciate that we've got a good plan and that we pay on time. According to Health Check/Intracorp, things will work out.

The financial incentives are that the consultation fees, whether the second or the third opinions, are paid at 100%, and if you get them, whether confirming or not, the plan pays up to the reasonable customary amount.

At AT&T, we think that instead of having a laid-back, no incentive kind of plan which almost encourages people to go into the hospital or into the emergency room, we have a plan which encourages people to take on this partnership, be concerned about cost and realize there's no necessary correlation between cost and quality of care. There is a sentinel effect with the providers. Rising medical costs are moderating to 8% to 9%, where there used to be 10%, 15%, 20%, in part, due to this.

People are concerned about bureaucracy. It normally takes one call to Health Check to be told about the statistics. Health Check then calls the doctor once to talk about in patient versus out patient and the length of stay. Then Health Check calls the hospital the day before about the discharge date, and if it is as planned, the case is closed.

It's only when things go off plan that Health Check may bring a physician advisor in to work doctor-to-doctor, or if there is some further discussion with the doctor regarding an extended length of stay. The procedure is to call before you go into the hospital or if it's an emergency, call within two days after the fact and get a second opinion if it's on the list of required.

Here is what happens if you don't come into the process: There's a 20% reduction in benefits. If you don't make the call before admission or if you don't get the second opinion, you pay 20% of hospital and/or 20% of surgeons fees up to $400, which is not included as part of the deductible or out-of-pocket maximum. There are some companies according to the literature and workshops that I've been at which have tried this voluntarily, and the project bombed. Nobody pays attention. So this is just an attention getter and it's not that damaging. Hopefully, it won't happen, because people are really going to be angry. We've blanketed the company with P.R., and with meetings and literature. It seems to be working.

One of the big themes also is the advocate. Intracorp has registered nurses you can call with a minimum of five years hospital-surgical experience, and some of them have utilization review experience. They are very helpful about treatment modalities and about tests and general health care questions. They

are advocates and are trying to protect you from unnecessary surgery or admissions.

Once they get into the process, we think people will think its a good thing. So far so good. Once they have more information, they feel better, whether or not the second opinion says, "Yes, you need surgery." If you have two opinions that say no, you may want to wait. In either case, the company pays for the second or third opinions. The more information you have, the better off your health is going to be. You will have a more intelligent relationship to your body and to the medical community. We're making it easier to get second opinions -- we're going to give you up to three doctors with numbers and the form, or you can get your own doctor, but we don't want that doctor referred to you by your doctor. The system appears to be working.

Under Health Check, you also get higher levels of reimbursement at 100%. Plus new choices in treatment settings which are the three that I mentioned. This is very important. You can call Intracorp for general health questions about different facilities available in the area, or about doctors.

We went out earlier in the year and did focus groups for management. We talked to 115 management people throughout the country in all our major lines of business. We tried to find out what was on their minds, their attitudes and knowledge about the plan. From that, we developed a communications strategy. This was not too long after divestiture. The employees still felt good about the company, not too sure where the company was going or where they were at in it, but they loved the health care benefits. That's shown up five or six years in a row on employee attitude surveys. Benefits always comes out number one.

They didn't know much about our medical plan, because who reads the summary plan description? They told us, "Whatever you do, be straight and tell it like it is, and you have to communicate better." So we came back, and with that and the homework I did, we tried to come up with our communications campaign. The theme was health care partnership. It sounds corny, but when you work through it, it's very real. People have accepted it on the surface and I'm taking silence for acceptance. We've only had three negative comments and one endorsing Health Check. We developed a network of 80 trainers who did all the

meetings across the country and they called back every day. If there are questions, they are given immediate responses or dealt with through Intracorp to fine tune on a daily basis. So I think that immediate response back to people is paying off.

We brought these 80 people in and did a one day training. I did 400 meetings and again 19,000 have been briefed. Also, we have video presentations and information packages available. There is ongoing assistance by the trainer network as well.

At the information meetings, we emphasize that you're better off four to one to show this is not a take-away. And that management is not afraid to come out and stand in front of you to talk about the old plan or the new plan. We're ready to answer and if we don't have an answer we'll get back to you with information. We emphasized and defined quality because quality, to some of our employees, sounds like it's a con job. They were suspicious, and we tried to work through that.

We talked about how savings were achieved through the length of stay and the various components of the process. We told them about doctors' reactions so they may be prepared to get a negative response. Hopefully not for second opinions, because that's been around for a long time, but perhaps with the intervention of Intracorp and Health Check on their length of stay and in-patient and out-patient decisions. Doctors are becoming more familiar with this because it is becoming a way of medical life.

We also talk about employee concerns. The video tape emphasizes all the concerns people had in the focus groups. Based on the homework I did with other companies, plan design is very critical; we designed our plan to avoid those negative criticisms. The volume we had on our 800 number in April was tremendous. The first two weeks Intracorp was averaging 23 incoming calls per nurse per day, and there are 14 nurses. Now the average is 10 to 15 calls per day. Because every call generates two more calls plus the earlier backlog, we think maybe questions have accumulated. A lot of the calls are maternity admissions, and some of them are general health questions. We think that's going to moderate, otherwise we projected the wrong way.

We've had over 1,000 hospital admissions in two weeks and we were only predicting 1,000 per month. The numbers still look good, but it's frightening. The employee feedback has been good, and I think it's been real.

For the future, I'm going to talk short term; we have to fine tune this process. We will be looking at some Dental Maintenance Organizations (DMOs) and maybe some dental PPOs. We'll be looking at some prescription drug, and mail order drug processing for retired employees. We're going to go into employee awareness and promotion. AT&T has quite a sophisticated health care promotion package in one third of our company which is not fully implemented, so we're going to try to figure out how, over maybe the next ten years, to bring health care promotion throughout the entire company. We think that's the area which will have a cost payoff over time. We have studies to show the correlation of quality of life and cost savings.

We're also going to be looking at, the cost of retiree benefits. We have 80,000 to 85,000 retirees, so it's not as critical as with some other companies. We have three different medical plans as of January 1; one for nonmanagement, one for management which includes Health Check, and one for retirees, so it does give us flexibility to do things differently.