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WORKING WITH HEALTH CARE COALITIONS

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Recorder: JEANNIE M. WODARCZYK

- How can insurance carriers and health care coalitions work together?
- What data are coalitions requesting from health carriers?
- How are health carriers responding to these requests?
- Implications for health carriers (e.g., organizational, management information systems, etc.)

MR. CHARLES J. SHERFEY: Andrea Castell will be speaking on health care coalitions expectations. We then have a response from Bill Rosenberg on insurers' ability to meet coalitions' expectations and a response from Jim Hilferty on hospitals' ability to meet coalitions' expectations. Joe Rosmann will give us the consultant's viewpoint.

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*** Mr. Rosenberg, not a member of the Society, is director of analysis and development for Health Care Resource and Cost Management for Metropolitan Life in New York, New York.

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Andrea Castell is executive director of Health Care Purchasers' Association of Puget Sound. This is a coalition which represents public and private employers. She has been executive director of a professional review organization. She has worked for a professional standards review organization, served on the Seattle University faculty, the Department of Health Information Services. She has served as a consultant at the National Institute of Health and the Rand Corporation. She has a degree in nursing and an MBA from Seattle University.

Bill Rosenberg is director of analysis and development for Health Care Resource and Cost Management for Metropolitan Life. Previously he has worked and directed the Certificate of Needs program in Rhode Island. Bill's duties at Metropolitan include health care statistical reporting and analysis and development of new health cost management products. Bill has degrees from Harvard and Michigan.

Jim Hilferty is administrative director of Sequoia Hospital. He has served as director of marketing at Mission Services Corporation, an integrated health care provider. He has had the director of marketing and other positions at Bendix Forest Products Corporation. He has also worked with the American Plywood Association and Corning Glass. His duties at Sequoia Hospital include strategic planning, HMO and PPO contracting, joint ventures, market and program development. Jim has degrees from Hofstra and an MBA from Columbia.

Joe Rosmann is consulting principal with A. S. Hansen. He has served as assistant director and director of programs for the voluntary effort to control health care costs. He has been a manager of employee relations and training at the American Hospital Association, and manager of wage and salary administration at the University of Chicago. Currently, Joe's duties at Hansen include responsibility for Hansen's consulting services on health care cost containment strategies and programs, responsibility for relationships with coalitions, and coalitions' relationships with individual employers. Joe has a degree from Immaculate Conception. He has done graduate work at Iowa and has an MBA from the University of Chicago.

MS. ANDREA B. CASTELL: My particular task in all of this is to tell you a little about coalitions, what they are, and what their expectations are. I'd

like to start by telling you that Puget Sound is up in the Seattle area, in Washington state. When I look at states, we're kind of isolated from other parts of the country. We've only got about 4,300,000 people in the entire state; 1,700,000 of those individuals live in that Seattle strip. However, Seattle is probably the right place to be for medical care. It serves as a health care center for the Pacific Northwest, for Alaska, for Idaho, for Montana, and for a lot of Pacific rim country. So, in a sense, health care is a service that we export. It makes money for the area. We also have a lot of health care technology in the area in terms of company physio control, so being a business group on health in an area where health care is a primary industry, makes it an interesting phenomenon.

Oftentimes, physicians are categorized as the group that tends to drive the cost of health care up the highest. Someone showed me a get well card that said "Get well. Your doctor doesn't need anything else." When we started to do a little analysis of what drives up health care costs in our area, we found that you probably could sit down and put it into a formula. Health care care cost equals the sum of the number of units times the price times the intensity plus the administrative expense plus profit. And those are all the things you want to start factoring in. We found that sometimes physicians aren't very good at factoring in administrative expense or profit until the end of the year when they realize that their expenses exceed what they took in. But a lot of our hospitals have managed to still operate in the black even with the DRG payments. So, in other words, you can't always look to the physician, even though that's the individual ordering care and services to be the controller of price. You have to take a look at that equation just as well.

There are basically three health care megatrends that we see as a business group on health. One of them happens to be supply reorganization. We definitely have a situation now in most parts of the country where the supply exceeds the demand. We have expanded problem definitions to deal with. No one has really addressed the area of long-term care of the retiree and of the cost that care is going to produce for the employer community. We also have to look at buyer determination action, a more complicated way of saying that, for the first time, people who are actually paying for the services (the employer, whether it's the public or private sector employer) are actually starting to

look at what they're paying for, and they're taking some very specific action. Things are going to get worse. For a long time people have been saying, "That's okay. We're going to get rid of some of the supply, because some of the hospitals will close." We have seen in our state only one hospital close of our 129, and we have a continuing supply of health care providers, not just physicians, but ancillary providers as well. So until we have some ability to stem that supply, there are going to be a number of things taking place to adjust the demand side. So things will probably get worse before they get better.

What are health care coalitions and why do they exist? Basically, health care coalitions started out as business groups on health, and there are approximately 155 plus throughout the country. They started out because employers were taking a look at statistics which said that it's going to be very difficult to compete, not just with other industries but with businesses in other parts of the world if, as in the state of Pennsylvania, 8% of our earnings are going to health-related expenses, and we're spending an average of $1,700 per worker. That doesn't make you feel competitive in a world economy. So that's one of the reasons we started to see the growth of coalitions. You'll hear them called business groups on health, forums, and committees for affordable health care. While business is the most frequently-reported business group in all 155 coalitions, about 95.7% have a majority of business members. Only 12 of these coalitions, or 8.5% are composed of business representatives only. We fall in that minority. The particular coalition I represent is all employer, public and private sector employers. Operational coalitions are in 39 states. California has the most with 11. Ohio has the second most with 10. There are 6 in New York.

Bill Rosenberg, from Metropolitan, told me that he felt coalitions were basically underfunded. When I went to look at the statistics about what the coalitions took in in cash revenues, their budgets ranged from $500 to $1,000,300. The median is about $75,000, and the mean about $145,000. So to operate a very high-powered business group on health, that isn't a lot of money, especially for the expectations of those business groups on health. Ninety-five of these 155 coalitions are involved with data activities; 88 have data committees; and 77 have access to a data base. Clearly, data and

information are the most important objective of most coalitions, although liability reform and dealing with unsponsored care comes a close second. The coalition movement basically started because the cost of employee benefits accounted for upward of 7% of total payroll costs, and employers felt that they needed to have some influence on the organization and delivery of health care services. They felt that the organization and delivery hadn't been commensurate with the financial responsibility of close to $100 billion.

We started our particular group in March of 1982. It started with 23 senior executives of major corporations in the Puget Sound area, including Weyerhauser, Pacific Bell, Pacific Car and Foundry, the Boeing Company, and the City of Seattle. We were looking at some very concerned and strong employers. Now our particular part of the country doesn't have a long average length of stay. On the average it's about 6.2 days. We spend about $2700 for an average patient stay. We've got 29 hospitals in the area, about a little over 5,000 beds. Those are set-up beds. Our smallest hospital in the area is 21 beds, the largest about 626 beds. We have a definite oversupply of beds and an oversupply of physicians.

But we have some real wants. When you're working with health care coalitions, once you find out what they are like in your area, who they are composed of, and realize that you've now got a forum, then you've got an opportunity to do some things together. You've got some new players, and they are the employers. Chances are they're in the business of cutting down trees and building airplanes. They're not in the health care business. They want to get involved at this point. They have a new interest with their payroll costs going up, with worrying about whether they're going to have an increase in payroll taxes to fund this uncompensated care problem.

The coalition issues are going to change as you see coalitions mature. You can see the issues now deal directly with employers, with cost, and with insurance. They will be dealing more with the community. They will be dealing with quality. They will be dealing with issues of the uninsured. The more the employer has to pay, not only for the benefits of his employee, but to assume a more direct burden for the community, the more the employer is going to start

moving from what is specifically his or her business to what's going on in the community in general.

There are other issues to address as well. We're going to be looking at community, social, and policy needs; at quality; at wellness; and at medical education. Do we still need to have all the medical schools? Do we need to continue to produce the number of providers? You can do a lot with hospital beds and change services, but if you continually produce direct providers of care, you've still got that oversupply. So we're taking a look at continuing medical education and continuing education for a number of other practitioners. Those are issues that we're going to be looking at in the long-term as well. In some parts of the country, rural health is a tremendous issue. Do we allow a hospital 120 miles from the nearest suburban metropolitan area to stay in business with its 20 beds, or do we say everybody should get in a helicopter and come in to the city, and use that rural facility as in infirmary only? Those get to be tremendous issues when you start moving to the western part of the country, and you've got a lot of geography and a lot of space. Try to ferret out some of those issues when you're dealing with Alaska and the Anchorage Coalition; it gets to be pretty interesting.

This is something I feel very strongly about: There is more to pricing than a good sharp pencil. Oftentimes as employers, we're besieged with data, lots of numbers, and an individual whipping out a pencil and saying, "Let's get down to business." We're saying, "Wait a minute! You've got data; what we want is information. We're managers. We make our decisions from the information that you give us, and we know there's data behind it, but don't just give us three feet of computer printouts. Could you possibly distill it and put it on a page and a half?" That's the thing the providers are going to start to hear over and over and over again. You need to have superb data analysis capabilities. It's not enough to tell an employer any longer that you need to have a wellness program. You need to have a health promotion program. Somewhere along the line, someone has to say, "Gee, you've got a wellness program here, and a lot of people going in the hospital for low back pain. How come nobody's put together a program on the healthy happy back?" So you start blending your program. That's an example of taking data and presenting it in an information

format. When we sit down to take a look at prices or costs, we want somebody to do some analysis for us.

Health care is supposed to be a service industry, but it's really an information industry. You can't provide good service or good care, unless you have some information. You can't take care of someone unless you know what they need. The entire health care industry really depends on good information -- not just data. Basically when someone asks what a coalition wants," I say "We'd love to have information, to know a little about quality, and it would be great if we could have efficiency." Now why do you need six people standing around a nursing station writing on a medical record? Who's sick, the patient or the medical record? Can this basically operations type health care industry slim itself down to be very efficient?

More than just information, quality, and efficiency is a desire on the part of the business community and employers, whether in public or private sector, for some consistency -- consistent data. We want to reach a comfort level in making management decisions with that information. If insurance carrier A defines maternity one way, and insurance carrier B includes all of the codes for termination of a pregnancy that might be the same codes as a normal delivery, we need to know that. We need to know that there's going to be a difference in the numbers, a difference in the type of conditions that are covered in the particular array of data or information. So we're looking for consistency. We like to know that an inpatient day means the same thing in hospital A, hospital B and hospital, C. So there's a real desire for consistency. We'd like to have consistent quality, and one of things that we in the business community hear most often is you can't measure quality because it's never going to be consistent. I don't know if that's true any longer. I think there are a number of indexes that would allow providers of care to definitely array patients in categories so you'd know that if some patients fell in category zero, they were less sick than those who fell in category four. We want consistent utilization management, and I think that's very important when you start to measure the success of utilization systems.

A number of the health maintenance organizations that we're involved with have primary care gate keepers -- no preadmission program. How do we know that the

50 to 250 primary care family practitioner or internist gate keeper types are using the same standards for utilization management? And are those guidelines any better than a preadmission program? We're looking for consistency, and that's going to be a question and a request you are going to hear from every single one of the 155 coalitions. Do know that the issue of quality is the one we will ask about the most, because everyone is shadow pricing, and we've got a difference of maybe only $20 a day in daily room rates. One of the first lines of demarcation we are going to ask is "Who's got the sicker patient? How can we measure quality? What's the morbidity rate? What's the mortality rate?" But also we want to know if you're a cancer center with a high mortality rate, whether you have a hospice to where people might go to die, so we don't give you a black eye when you don't need one.

There are some questions for the future. We want to know if we're going to end this managing of health care, and I'm going to talk about managing with a small "m," not with a capital "M," because we might have in time managed fee for service environments and not just HMOs and PPOs. Are we going to have something happen to the physician-patient relationships? Will the physician at some point cease to be that patient's advocate? Will cost containment adversely affect quality? As employers we're concerned about that. We have something to deal with called "employee relations," and we want to make sure that we have truly chosen health care modalities for employees and dependents, whether in the public or private sector, that are good quality care. Sometimes you might have to pay a little bit more for that. Those are things that we're looking at from an employer's standpoint, and those are things you'll hear from the employers as members of coalitions in that round table or collective effort.

One reason a lot of employers have joined coalitions is to have some direct dialogues with those providers of care -- to sit down at a table with the major providers of care in the area, with the insurance carriers and with the management consultants. If you were to bring everybody to a table and say, "Look, we need to manage the health care resources in our area, and it might not mean the setting up of a formalized managed system; everybody's going to have to give up a little bit." The management consultant can't keep the employer from discussions with insurance carriers. Insurance carriers can't keep the hospital from

discussions with the employer. So you need to give a little bit on the turf. I always liked this Greek proverb because it's so applicable to everyone, "When the ship misses the harbor, it is seldom the harbor's fault." I think that that's a good lesson for all of us. We have to know where we're going, and we have to have some guidelines or we're not going to be able to find those guidelines or find where we're going until we have some dialogue with each other.

MR. WILLIAM H. ROSENBERG: I'm going to talk about the relationship between health care coalitions and health insurance carriers. I talked to Andrea briefly before coming here, and I had no idea that we would see things in such a similar manner. Since statistical reporting and analysis are part of my responsibilities at Metropolitan, I tend to have a biased view that information is at the heart of the relationship between carriers and coalitions, and I am pleased that maybe it's not just a bias.

Economists have all held for a long time that one of the causes of market failure in health care is a lack of information in the individual medical care by cell transaction. After all, doctors like other professionals, are distinguished by their information expertise.

Because doctors have medical knowledge, they play a role in not only the supply side of health care but also in the demand side. That's one of Andrea's questions for the future -- can the primary gatekeeper serve that role and also be an advocate for the patient? Doctors as agents for their patients strongly influence many demand decisions -- for example, admitting to the hospital, referring to specialists, prescribing drugs, or ordering diagnostic tests and procedures.

The fact that patients rely on doctors for much of their demand decision making will continue to be a structural failure of health markets. Adding to this anomaly is the historical but changing limited role of price in demand decision making. I say it's changing, because I seldom now hear the old adage "my hospitalization costs nothing; insurance pays for it."

I'd like to examine the relationship between coalitions and carriers within the context of this larger role of information in health care. I would submit that the goals of access to quality care at a reasonable cost can best be met by attacking the demand side's information disadvantage. Further, the complexity of health care markets, and therefore, the difficulty of achieving these goals, requires sophistication beyond that present or achievable among individual buyers of health care. In this sense, I would characterize the relationship between carriers and coalitions as one that goes beyond data collector and data collector user. As the physician serves as an agent for individual health care buyers, so may carriers or others serve as agents for aggregations of buyers such as coalitions.

I'd like to outline three components of this evolving role: analysis, network negotiation and management, and utilization review. I am sure that you are all well aware of the increasing frequency with which coalition members request data from carriers. It's eminently reasonable for coalitions to demand data, whether it be to advocate positions on legislation, to uncover problems, or to design strategies for solving these problems. Claims data bases represent unique data resources. No other source of demand data matches the potential of claims for timely and useful information. I say potential because claims data are by-products of transaction systems. As by-products, claims data are extremely inexpensive to collect. The marginal costs of adding data elements to a claims file is minuscule when compared to the costs of sample data collected by the National Center for Health Statistics, for example.

The problem is that claims data are not equivalent to the information demanded by coalitions. I agree with Andrea on this score. Coalitions are not primarily interested in analyzing the way claims are submitted and paid. They want to know how providers provide and patients utilize health care services, and at what price. Thus, one implication of coalitions' demands for data is that carriers need to rethink their commitment to the fundamentals:

1. What data should be collected, even if they are not essential to paying a claim? Second and third diagnoses, for example, are critical, as is audit of the quality of the data. For example, is it important to know where the doctor's check was sent or where the patient saw the doctor?

2. How should the data be stored to permit speedy retrieval? How many years of data should be on disk to permit timely low-cost retrieval of data for one set of zip codes?

Of course, these commitments require significant resources. In essence the ability to meet one group customer's needs requires that the capability exists for all, and most group customers are not demanding this kind of information. In addition, pure data capabilities alone are insufficient.

A second and perhaps more critical implication of coalitions' demand for data is the need for expertise to translate the data into information and intelligence. Because coalitions typically comprise employers with multiple carriers, data consistency is a major frustration. Even the standard use of UB82s may not result in consistent hospital data tapes, because of differing claims processing storage and retrieval environments. This problem pales by comparison to other than hospital data.

Data which are presented in clearly defined useful formats descriptive of health care utilization and costs are "information." Information presented in the right format at the right time to decision makers can be "intelligence."

An example of intelligence is the role of information in network negotiation and management. Presumably, coalitions as aggregations of demand, seek to influence health care delivery and costs in their communities. Influence can be enhanced with intelligence. Hospitals will not respond to strategies supported by old inaccurate non-case mix-adjusted data or information.

On the other hand, current intelligence provides the sophisticated buyer negotiator with a quantum leap in his or her bargaining position. Price and efficiency intelligence about competing hospitals and patient migration can make the difference. The oversupply of doctors and hospital beds make health care a buyers' market, and maximum leverage will accrue to informed buyers.

The emergence of a demand for intelligent buying strategies implies a need for carriers to recruit a new kind of talent. Whether coalitions establish networks themselves or not, carriers must be able to match or exceed their

customers' expertise. Coalitions require the same health economists and planners, epidemiologists, medical professionals, and hospital administrators who now work for the coalition.

One area where all of these types of expertise come together is in utilization review. Utilization review, whether preadmission, second opinion, or case management, is the provision of information to the doctor-patient by cell transaction. It is a way for transferring aggregate intelligence and sophistication to the individual level.

As claims systems evolve to health care management systems, the historical separation of health care financing and health care delivery is blurring. This has profound implications with respect to the conflicting goals of access, quality, and cost containment.

Physicians and their patients have the ultimate responsibility for the course of care. Utilization review programs which add new information -- for example, programs that help the patient ask the right questions -- must be carefully designed to add the intelligence without interference.

Hence, carriers which conduct utilization review programs must meet performance standards not unlike that for claim offices: efficiency, service, professionalism.

Utilization review telephone stations must be properly staffed. "X"% of calls must be answered within twenty seconds. "Y"% of reviews must be complete within 24 hours, and so on. To do this and for the programs to work, there are a lot of other components other than efficiency. Obviously, the multiple disciplines of health care must be integrated with traditional group carrier claims and administration functions.

I would like to close by sharing with you one area that I believe is on the "cutting edge" of all of this -- ambulatory care. As hospital cost containment proves more and more successful, a greater share of health care expense will move to the outpatient or ambulatory area. We have seen some customers' claim

dollars change from 65% in-hospital to less than 50% in-hospital just in the last few years.

To extend utilization review to ambulatory care, two key technical problems have to be overcome -- establishment of norms and the costs of review.

Dr. Donald C. Harrington of Pioneer, California, worked with panels of national experts in each medical speciality to create what he calls "patterns of treatment" which are norms for ambulatory doctors' visits, lab tests, and other diagnostic procedures.

EXHIBIT 1

PATTERNS OF TREATMENT*

PATTERN:

"Diseases of the Upper Gastrointenstinal Tract"

CPT-4 Code	Procedure Description	Maximum Per Month	Times Per Quarter	Done Per Year
90030-90050	Office Visit	2	4	6
80002-80019	Chem Panel	1	1	1

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Exhibit 1 is a simple example of a pattern of treatment for diseases of the upper gastrointestinal tract. The maximum frequencies for brief or limited office visits are two per month, four per quarter, and six per year. For a chemistry panel, the maximum would be one per year. The CPT4 codes in the bottom row are automated multipanel tests. Ostensibly, the full panel would only be required once, and the individual test would only be indicated in the course of treatment.

To apply these norms, which have been created for every diagnosis, to claims, the second technical problem -- the cost of review -- must be overcome. Hospital review is easily cost-justified. The cost of review is very small when compared to the costs of a hospitalization, but for ambulatory care, it would not be unreasonable for the cost of a medical professional reviewing a claim to be higher than the cost of the claim itself.

EXHIBIT 2

Incoming Claim	Normal Claim Processing	Claim Appropriate for Payment	Patterns of Treatment	Pass	Claims Paid
	. . . Valid ICD-9 Code . . . Valid CPT-4 Code . . . Consistent with Plan Provisions		Fail Review		

The flow chart in Exhibit 2 shows the transformation of a claim payment system into health care management information system. To follow the chart, an incoming claim must first be processed normally with the addition of valid a ICD-9 diagnosis and a CPT-4 procedure code. These codes are rarely used codes by most carriers today for ambulatory care. If the claim meets the standard criteria for payment through normal claim processing, a two-step utilization review process can begin. First, the claim under consideration is electronically linked with all claims and history for the past twelve months for that patient and that doctor. Remember there are one-month, quarterly, and annual patterns of treatment. The temporal pattern in claim history is then compared electronically to the normative patterns of treatment. If the utilization evidence by that comparison is statistically aberrant, the computer will indicate that. If there is no statistical problem, the claim will pass the pattern and go off to the right of the chart and be paid.

It is very important to note that "statistical" problems are just that. The process I have described thus far takes maximum advantage of what computers do well, but that is not enough.

The claims which "fail" to pass statistically must be reviewed by medical professionals. In essence, the patterns of treatment are a sophisticated sampling method. This overcomes the cost of review problem because only those claims which have a high degree of probability of being excessive are reviewed. The reviewers then collect additional information by phone or from claim history to validate the statistical results. A non-recorded application or the use of ambulatory care in lieu of hospitalization could "explain" apparent aberrance.

There are many potential applications of this technology and many questions. This review process can be used for provider preference, that is how to select efficient doctors, and for utilization review. But at least with respect to the latter, it is important to note that, in contrast to hospital utilization review, the service in question has already been delivered.

As employers individually or in coalitions advance in the era of managed health care, they and their carriers will have to grapple with the obvious issues surrounding this and other similar technologies. We will all need to draw the line between financing and delivery of medical care.

MR. JAMES P. HILFERTY: Let me give you some background about Sequoia Hospital and about the health care coalition called the American Electronics Association Committee (AEA) on Health Care. Sequoia's located about 25 miles south of San Francisco. It is a 438-bed, full-service community hospital. We're considered a fairly high-tech hospital. We're also fortunately one of the low-cost hospitals in our area.

We have a reputation truly for high-quality, very warm patient care and for high employee morale. For example, we've never in the 35- or 40-year history of the hospital had an employee strike, and in an industry where moving from hospital to hospital is sort of taken for granted, our average employee has been with us for about 8 1/2 years. People at Sequoia know their jobs well, work hard, and like working there.

About 20 miles south of us is a place called Silicon Valley. You've probably heard of it. Silicon Valley is the home of a lot of computer and electronics companies like Apple Computer, Hewlett Packard, Lockheed Missiles and Space. The companies in Silicon Valley have a really excellent trade association.

A few years ago, the AEA convened a committee on health care. The Committee studied and developed a great deal of information about health care delivery in the San Francisco area. At the end of its study, the Committee commissioned the A. S. Hansen company to do a feasibility study to determine whether Hansen could put together a system to contract directly from the corporations to hospitals and doctors. Hansen completed the study and did, in fact, develop a

direct contracting system, and the SHOP program was born. SHOP, incidentally, stands for Shared Health Option Program.

My own estimate of the AEA list of objectives from the hospital's point of view would be:

1. Purchasing leverage

2. Quality assurance

3. Risk sharing

4. Management information

5. Product development

I think that the first objective pretty naturally is that the employers wanted to use their purchasing leverage to reduce their health care costs. Closely tied to that, and I think very important to employers, is the second point -- a desire to get the highest quality care by contracting primarily with the high-quality hospitals in the area. The third objective is financial risk sharing. I think this objective was designed to give both the hospitals and the employers the major stake in working together, something that they had really no history for. If you share risk, chances are you're going to work together. And the last two objectives are to develop a data base, which the previous two speakers talked about a bit, and then working together to develop more targeted, more cost-effective health care. And when I say more targeted, I mean health care programs that fit the special needs of the individual employers. For example, some of the companies that we've worked with see substance abuse, alcoholism and cocaine as a real danger to their employees. Another company with an older employee population may be more interested in cardiovascular programs for prevention of things like stress that have an impact on cardiovascular disease. To repeat, though, the essence of the SHOP program is that the individual companies chose what they feel are the most desirable hospitals and physicians and contract directly with them for health care delivery.

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I think honestly the idea of negotiating and contracting directly with corporations was so new to hospitals that it came as sort of a shock. I want to tell you, though, that our experience, after a great deal of trepidation when we first heard about it, in working with employers has been extremely positive. More than that, it's been exciting, and it's been fun. Perhaps the most important factor in the entire experience has been communication.

Our first contact came with the people from A. S. Hansen, the consultants that the AEA had used. Hansen has been the coordinator between the corporations and the health care providers throughout in the SHOP program, which is still ongoing. I'm not here to do a commercial for the Hansen company, but I do want to say, in my opinion, that the entire process was helped tremendously by the work that Hansen did, and honestly, it was more than just the work. The two people who started the program and have worked with us initially, Joe Rosmann and Kathy Schroer, really made it interesting, exciting, and above all, very friendly. This first started out with the feeling among most providers which was, "What's going to happen? Are these going to be barracudas in here tearing apart what we've spent three decades putting together, a culture, quality care, and so forth?" I really feel that the job that the people from Hansen did in personalizing and making everyone both from the corporate side and the hospital side comfortable was tremendous.

Well, after the initial meeting with Hansen, the entire AEA committee came to the hospital for a visit. To my knowledge, our hospital had never before met with Employer Health Care Coalition, any coalition, or, in fact, any employer, except on a casual basis. Well, wonder of wonders, hospital people loved it, and the corporate people loved it. Our people found the AEA committee members very knowledgeable about the specifics of health care. That gave them a lot of confidence, and more than that, they were really concerned about the quality of care, not just the price. Again, that gave them more confidence. Now to give you a sense of how successful the first meeting was. It was supposed to go until 5PM. We finally were getting the last of us out the door at 7PM. The mood was very positive, and in fact, one member of the committee liked the visit so much that she came back a few weeks later and had her knee operated on. You can't ask for more than that!

After my first meeting with the health care committee, we were asked essentially to make a sales presentation to the American Electronics Association. Again, a totally unique experience for a hospital. Most of you know, I don't think in the past it's been considered appropriate for hospitals to basically sell their features and their benefits. So, in some ways, it was a great opportunity for us. We talked about the fact that we do have the lowest cost per discharge in the county, and that we provide an extremely broad range of services. So that, if you contract with us, we can handle most of the services for employees in our area. We have one of the most complete heart programs in the state; we have a really high-quality medical staff; and so forth. Affirmation came from the way that the company reacted to our presentation. In all of the meetings with the companies, they played back to us that they understood and appreciated the value of what the hospital had built over the years in terms of quality programs, cost-effectiveness. This was a big surprise to us. The thing they cared most about was the caring atmosphere at Sequoia, because a lot of us feel that is catching to sick people. You can, in fact, sort of catch health. And there is no greater affirmation than to be chosen by these companies for their preferred hospital network, and that, thankfully, has happened several times very recently.

Let me just say simply that through the SHOP program we, in fact because we are a good and a low-cost provider, have been able to increase our market penetration. That's very important and necessary during a time when the whole industry is shrinking.

Our hospital has barely signed the first direct contracts with employers, and already we find ourselves looking for innovations in terms of improving services, ways to get the price down, or even promoting directly to employers or employees and get a larger share of their business. I think that that is an extremely healthy sign for the future of our organization. When you begin to innovate around the needs of your clients or your customers, you begin to insure your future.

In a nutshell, our attitude is that direct contracting with employer coalitions offers hospitals an extraordinary opportunity to communicate with corporations about their health care needs and together to develop programs that precisely

fit those needs. I think that the hospitals that do that well are the hospitals that are going to survive and succeed in an industry that is going through a shake-out. Some hospitals are going to be able to take that kind of communication and innovate, come up with a better value, not in other words, just a lower priced day in the hospital, but also perhaps ways to minimize days in the hospitals. After all, the value that employers are seeking is healthy people, not just lower hospital costs.

As hospitals and employers work together to develop programs, hospitals will have a whole new set of opportunities. I think that you'll start to see the smarter hospitals improve the kinds of services that they offer, the availability of those services, and the way that they communicate with employers about those services. We mentioned the price of those services. In the past, one of the key questions that you had to ask of the hospital trying to innovate was, "Well, is it covered by insurance?" The key question now will be, "Can we prove to the employer that this will be cost-effective?" We have worked with the employer to develop the program, now can we prove to the employer that the program is going to be cost-effective? That establishes a whole new set of ground rules for innovation, and in my opinion, a much better set.

I think that direct contracting will help hospitals avoid a lot of perils. Let me mention just one. If too large a portion of a hospital's business is tied to a few HMOs and PPOs, those organizations can start to dictate reimbursement rates, contract terms, even what services you're going to offer. In a situation like that, hospitals are very much at risk. You basically have someone else dictating the configuration of your organization. Working with employers, on the other hand, gives hospitals a much more diversified revenue base and more control in the marketplace.

There isn't a long history of employers and hospitals working together, and not every hospital is going to make the adjustments needed to develop that relationship. For the hospitals that can adapt, I think the potential rewards are great. The really longterm success of any organization, yours and mine, is its ability to communicate with customers, to figure out their needs, and to build the business around those needs. The hospitals that make that effort to

work with employers will have more control of their own destiny, their survival and their success.

MR. JOSEPH H. ROSMANN: My remarks are more general in nature coming more from the perspective of a sociological and an economic view of what's going on in health care around the issue of coalitions. If you look at the fundamental developments taking place in the health care industry, I think the common theme that you find occurring on all sides of the industry -- providers, insurers, and employers/patients or employees -- is consolidation. On the supply side, the fact of excess supply is leading to recognition of the fact that methods have to be looked at to increase the efficiency of the delivery of care. That means, tightening up, cutting out costs, figuring out where duplication can be eliminated. Coalitions have been going on in the supply side of the health industry for 35 or 40 years now.

The birth of the multi-hospital systems all the way back in the 1950s and the late 1940s is the earliest example of coalitions on the supply side. There's also an example of a coalition on the purchaser's side that goes back even farther than the hospital coalitions, and that is the old Blue Cross plans of the 1930s which were nothing more than a collection of individuals to consolidate purchasing power both for insurance and for the purchase of health care.

With the advent of what I would call traditional insurance now the coalition concept, at least on the purchaser's side, went by the way. We had, in essence, throughout the 1950s and 1960s and the early 1970s the crowning of the idea of individualized insurance and individualized purchasing of health care, and the individualized delivery of health care through the traditional fee-for-service health care system. Everybody on the purchaser's side, the insurer's side, and the provider's side are now trying to figure out how to move away from this highly individualized nature of the health care marketplace to a more consolidated marketplace. The hospital industry really took off aggressively with this in the late 1970s and the early 1880s with the very rapid expansion of coalitions among hospitals. We now have a tremendous consolidation going on on the part of the hospital industry. It's starting to happen among insurance companies driven by the need to be more competitive in the newest activity going on in health care, which is purchasing health care.

WORKING WITH HEALTH CARE COALITIONS

I would guess that quite a few of you come from companies which have in the last year or two decided to become involved in shared purchasing arrangements among insurance companies to help bring about the development of contract medicine, getting away from fee-for-service to service-for-price. The real issues are where are the coalitions going on the true purchaser's side, namely the organizations that Andrea talked about among employers, and what are the implications of that for insurance companies and also to some extent for providers of health care?

There's an axiom that we all learned way back in an early economics course that once a true marketplace happens, the people who drive that marketplace are the purchasers. Sellers can offer and offer and offer, but if there is nobody buying, the market's never going to develop.

On the assumption that health care is working in the direction of becoming an increasingly more efficient market, I would suggest that there are many reasons why we should believe that employer coalitions have a strong future before them. The implications for insurance companies are fairly traumatic. Jim Hilferty mentioned the idea that hospitals really liked working directly with employers. For the first time they were finally able to talk to their real customer or at least get much more close to their final customer, the patient, than they ever have been able to do before. To the extent that employers are able to overcome some of the concerns that keep them from working still more closely together, I believe that we are going to see more and more consolidation of purchasing occurring in health care. This will be done on a highly localized or regional basis.

The sharing of data is just the first step in helping to accomplish that. In the course of sharing the data, employers begin to also identify that their's is a better deal that they all individually can take advantage of. Pretty quickly, however, we find out that that takes a lot of time and that it also may require more expertise than the employers have. The next step that we see increasingly happening is for employers to figure out how they can consolidate that cost and time on their part to still get a better deal for themselves while maintaining flexibility.

We see coalitions which have reached that point, then asking themselves two basic questions: Can they be purchasers directly themselves and go through the effort that that takes, or do they have to utilize services of some outside entity which does a lot of the upfront screening and invests to establish the control mechanisms to make the marketplace work more efficiently on the provider's side? So we see coalitions looking at two possible alternatives, engaging the services of insurance companies or other third parties which have made the investment in gathering data and negotiationg contracts upfront, or alternatively, instead of using a middle person or middle man organization for that role, doing it themselves.

For employers that are doing it themselves, there are two models developing. You have the model of the American Electronics Association. It is a collection of individual companies sharing data, sharing a substantial portion of the negotiation process, coordinating between themselves and providers on the required management mechanisms, but still individually choosing the providers with which they wish to work, and individually negotiating the price. The other model that is beginning to develop in several communities takes what has happened in the Silicon Valley a step further. Companies are deciding to give up some of their individual flexibility in return for still greater clout and still lower development and management costs, namely creating true shared purchasing organizations or co-ops. This is in many ways going back exactly to what Blue Cross started in the late 1920s and early 1930s, namely one plan for all, with perhaps some individual tailoring of "products" that the company can take advantage of for its employees.

To our knowledge, there are four communities now around the country where these true co-ops have developed, Columbus, Georgia, a group of companies in San Diego, a group of companies in Rockford, Illinois, and a group of companies in Northeastern Illinois in the far northern suburbs of Chicago. This organization's name is the Lake Country Health Care Coalition.

The implications of these co-ops are really major for those of you who are with insurance companies. The co-op no longer has a need for your organization. Some of these co-ops are even going so far as beginning to think about setting up risk pools which they can then use as a basis for underwriting the risk for

small employers who join the co-op. It's even possible that some of these co-ops may go so far as deciding to administer all of their own claims.

Perhaps one of the fundamental factors driving this kind of direction is the concept of regionalization. Most of us never go any further for health care than 15 or 20 miles from our homes at the most. Fifteen or twenty miles is just about the radius of the typical metropolitan area in the United States, 40 miles across in diameter, 20 miles in radius. Health care providers have already recognized the economic advantages of regionalization. In many communities of 20 miles radius or more, the hospitals are already consolidating into provider groups of maybe 3 or 4 or 5. The HMOs, many of which were started by entrepreneurial provider-oriented individuals, are also consolidating in part because employers are now starting to think about forcing consolidation.

The major planning activities going on in the health care area among the majority of Fortune 500 companies is how to begin to consolidate all of these HMO contracts that we have, and that is forcing in part the consolidation of HMOs. At the same time the providers which are not in HMOs recognize that in order to become more efficient they also have to consolidate. I think what we have here is kind of a fundamental change going on in the health industry which is getting away from national marketing concepts, getting away from national control, coming down to local control, local consolidation on both the supplier side and the provider side. The unknown is: are there enough economies to be realized on the employer's side in retaining the involvement of national organizations primarily for administrative efficiencies?

Running marketing programs on a nationwide basis is extremely costly, as any of the large national insurance companies know. More regionalized marketing activities can be far lower cost and much more efficient. Also, given the fact that so many health care providers are going to try to overcome the efforts of consolidation because it runs counter to what we professionals really like to do, namely your own thing. Any more consolidated marketing activities will always have to be sufficiently flexible to counter the latest new thing that smaller organizations can accomplish, albeit on a much more localized geographic basis.

There are many reasons to suggest that coalitions, particularly on the purchaser's side, are going to become more and more important. They may potentially eliminate the role of insurance companies unless insurance companies can figure out ways to work very cooperatively with coalitions rather than trying to control what the coalitions are wanting to do for themselves. If this were primarily an employer group, I would make a different set of conclusions.

MR. SHERFEY: Andrea, the Health Care Purchasers Association of Puget Sound is an association of employers, both public and private, I understand, and there are other coalitions around the country that include providers and, in some cases, unions. I am wondering if you could comment for us on the advantages and disadvantages of including or excluding providers and unions in the group.

MS. CASTELL: The clear advantages of including providers and unions are twofold. If everybody is at the table, you don't need to repeat what you're doing. The other advantage is clearly revenue. The insurance carriers have a great deal of money that they put into other coalitions, as do providers and labor unions. When you're totally dealing with employers, you've already cut out three-quarters of the people you can enlist for membership, so first of all you're repeating everything twice, and second, you're limiting your revenue base. That's the down side. The up side is that people are of a definite mind set, and you can get consensus much more quickly.

Taking your position to the state legislature is a little bit easier: deciding how you're going to operate, what data elements you want, what particular programs you want to put on. It's a lot easier to marshal 40 different employers together than it is to marshal 40 employers, 10 insurance carriers, 23 hospitals, and maybe 15 management consultants. So you're consolidating. I've talked with some of the other coalitions that are a mixture of business, provider, and carrier, and they say they quickly have to separate business from everyone else and deal with that entity. It doesn't matter if you have everybody coming to the same table, you quickly move somebody else down to one side.

MR. HILFERTY: Joe, could you see these co-ops and coalitions moving into the provider field, in other words, buying hospitals?

MR. ROSMANN: No

MS. ANDREA FESHBACH: Mr. Rosenberg spoke about the need to accumulate and save more data because of the needs of coalitions, and he also said that sometimes if one major group client wants certain information it then becomes available to everybody. Who pays for the additional costs in retrieving and saving information?

MR. ROSENBERG: That's a good question. I view our claims operation as one big data collection engine for my interests. The claims auditors don't look at it quite that way. They look at it as a highly competitive commodity business that places a great emphasis on getting the cost of paying a claim down. Right now the costs of collecting the additional data are part of the costs of paying the claims that are charged to the customers in a normal routine of business. One of the things that's been fortunate for Metropolitan in a way is that the new use of electronic adjudication to improve the productivity of claims payment has enabled us to capture more data without necessarily causing the cost of paying a claim to go up. In fact, it's been going down. The problem of retrieval of data and reporting is one that's increasingly being identified as a value added service and charged for accordingly. The problem there, as I indicated, is that there is a tendency to charge the users, or at least, when you look at the costs, to aggregate the costs of this enterprise on the outputs of the process, which are the reports. The customers who use the reports may be a target for charging, when, in fact, the customers who never asked for a lick of data are having an advantage for having it kept, and having the capacity to produce. So it's an interesting internal problem. I think that fortunately the demand for data, the reports, the analysis, is growing so rapidly that these allocation issues will be somewhat moot, and it will more be something that our customers appreciate as they shop around.

MR. HILFERTY: You've all obviously invested a lot in your data systems. Have you sold some of those systems to other insurers or other entities to recover some of your costs, or do you plan to do so?

MR. ROSENBERG: We haven't, and I'm not aware of any plans, but things that were true a year ago are not true anymore. Our subsidiary, Corporate

Health Strategies, which some of you may have heard of, sells its services to Metropolitan customers and other corporations, and I think that, the expertise is what employers want, and they'll get it. They'll buy it wherever it's available.

MR. ALLEN R. ELSTEIN: We're not a company that deals in health care, but I do some personal work that deals in that area. I noticed that as a philosophical kind of reaction, we're seeing a lot of dialogue between hospitals and various employer type coalitions. We're seeing a lot of medical care cost by statistics. Two groups that are not particularly involved at the moment are physicians and employees, and I'll give you two examples. Physicians have complained to me that they're caught between a rock and a hard place, if they discharge the patient early or if an Emergency Room physician might not admit the patient, then they're satisfying the hospital constraints. However, the Melvin Bellis of the world have told them that they are certainly subject to suit. This has caused a lot of stress on the part of physicians who are not part of your process. Employees or Medicare Patients have pointed out to me on any number of occasions that the patients feel that they are a part of what is called Medicare dumping or employee dumping where the patients don't really feel they're ready to be out of the hospital, but their so-called former advocate, the physician, is booting them out, or there is talk that the hospital's going to lose money on you, or the PRO (peer review organization) won't allow it. If we're talking about quality in medical care, I guess my question is, "Why is it that the private words of physicians or the employees or the Medicare patients seem to be sort of cries in the wilderness?" These people don't seem to be included in this process, and do you really think that you're improving health care when we're using statistical averages, and we all as actuaries know that variances are what really count? The average number of days in the week may be seven, but the average appendectomy may not take 7 days. I'd like to get some reactions.

MR. ROSENBERG: I agree with some of the concerns that you have, and I have them too. I'm kind of interested to hear what Andrea says about them. Health care is an enormous industry, and it's an enormously complex industry. Even a medium-sized hospital like we are is a very complex undertaking. One of the things we have talked about is that we put over $1 million a year into

uncompensated care, and we really need to do that for the Melvin Bellis of the world, whether they really exist or not. The reality is, if you lose money long enough, you don't get to serve anybody because you're gone. So I think, if you trailed all the numbers, you'd find that essentially Medicare and business are picking up that uncompensated care. I'm kind of talking around this issue. I think there's no good answer. It's a very complex issue. It's something that concerns us because quality of care we feel is what we're all about. We think that's the product we have almost a religious feeling about. You know, that's why we're there, and if we can't do that, we probably should be doing something else. At the same time, the realities are that people want lesser cost care. Again, I think there's no good answer. I came into the hospital field from industry, Bendix Corporation and Corning Glass, and I had real definite ideas about how it should be done, and how inefficient it was. Well, four years of reality have changed my mind about that. Having a really good friend in the hospital definitely changed my mind. I mean as long as it's somebody else, it's easy to be cost-conscious. When it's you or somebody you love, you get real interested in the quality of care.

MS. CASTELL: The same things have been said whenever health care has been managed. In the Seattle market, we're looking at a very interesting phenomenon. We don't know what's happening, and I think it might have to do with choice. We have 17 managed care systems. They have less than 10% of the market, in fact, only about 6% of the market. One of them has been there approximately 40 years. We have 8 others coming into the market because the actuaries in the area say there's under 6% penetration, and the conclusion is to move into this market. We have people who have average incomes of about $12,400 a year, and, I think in the Ohio area had looked to us like $9,300. Most of the people are college-educated, and the most important thing to them is the ability to chose, the ability to make that determination themselves, so they don't like to be told to go to certain places. That may cause some concerns about service, and some misperceptions about quality.

I don't ever like to compare what's going on in the Medicare program with what's going on in private industry. The private employer, whether it's a municipality or whether it's a Fortune 500 company, has unions, and it has employee relations concerns that it tends to look at. So, in all good faith, an

employer might enter into an HMO arrangement having been convinced sometimes by another group of people that this is an advantageous cost-effective way of doing it, and that X number of doctors have signed up. Employees are starting to get smarter now, because we're learning that we know what company A just did. Company A went out and signed up 1500 doctors who got a piece of paper in their office, and the doctors just automatically signed it thinking they were going to get additional patients. You know, we're learning that that doesn't work right now. So we have a number of employers saying, "We're not offering five HMOs. We're going to offer the one that's the best or the two that are best, and maybe some preferred arrangements." But don't try to lump what's going on with the Medicare population with what's happening with business. That's dealing with a federal program, and those programs are run differently. They are not as client-sensitive, and I have said that probably once a year for the last 10 years, and usually have someone in the audience from HCFA who writes a letter to my board chairman. That's why a lot of companies are looking to dealing with their retiree benefits including the Medicare program themselves. A benefit package is part of compensation, and that's how an employer deals with it. If funding health care in your retirement is something someone gives you, the employer wants a little bit more control, so I think you're going to see a lot of rethinking and reworking.

MR. ROSMANN: I think it's a very important question, and it gets back in some ways to some of the sociological issues that I was alluding to before. The typical physician these days will tell you that they don't want to be subject to the next gimmick that comes down the road and that they want to control the way they provide care to their patients. If there was one aspect of our experience in the Silicon Valley that really confirmed for me why our approach might make some sense it would be the opportunity for dialogue that was created that will be maintained between employers and physicians and their hospitals. The physicians throughout the Valley have begun to organize themselves into physician groups, not always totally around their hospital, but closely linked to their hospitals so that they and the hospitals can work together to talk about common concerns, quality, management decisions to control the way in which care is provided on a day-to-day basis, and data. On the employer's side, the things that were so important to them, Jim mentioned, is the issue of quality. They don't want to be on the losing end of the Melvin Bellis either.

That group of companies decided that the only way it could really address this issue in tandem with the providers with whom it is working is through a common data base that collects the right kinds of information that both providers and employers can look at together and provides a mechanism through which doctors can talk to employers with their hospitals.

MR. SHERFEY: I think one thing this points out is there are different kinds of employers, and some are very concerned about the quality of care issues, and others are not.

MR. ALLAN GOLD: Joe, at the end of your talk you indicated that you might be telling us something else if we were an employer group. I was wondering what that might be.

MR. ROSMANN: You've got to really work hard to figure out how to work with the employer to meet its needs for flexibility. I would have been giving a stronger message primarily of "get together and solve your common problems" rather than responding to somebody else's definition of what those problems are. The nation's insurance companies have decided on their definition of how the marketplace should work and are marching long and hard down that road. It may well be that employers may be telling you increasingly that some of the things are great, like the data, the patient communication support to make these contract mechanisms work, but not the dictating of who their preferred providers should be. The employers want the freedom to choose with whom they contract. That will be done increasingly on a local community basis of the purchasers agreeing among themselves what the best deals are for them and what best will meet the needs of the community. I see increasingly employers not looking at health care buying decisions as strictly the best price. They are also addressing all those broader community issues of Andrea's group. They are aware of indigent care and long-term care issues and want to work with the providers that are moving in those kinds of directions.

MR. MARK D. NEWTON: How does the patient treatment data that you collect get translated into new patient treatment norms? I have two parts I'd like you to think about. Does the fact that you only review abnormal cases tend to ratchet up the treatment norms that you set anew? Or, will collecting only

data that your co-op uses for treatment norms, excluding the treatment data that fee-for-service or traditional insurance arrangements could pick up and take, tend to drive down norms -- the fact that you're only using co-op data, and that you're not using data from anywhere else?

MS. CASTELL: I'll address it from an employer's standpoint. For as long as I have been in health care, which almost borders on a quarter of a century now, everybody has always created a column for us which says "national norms." I always say, "Forget it. I want four columns. I want you to give me the nation. I want the region, and I want you to give me the middle group that we're in, like our co-op or our HMO, and I want you to give me mine, as an employer." We're starting to ask for that. We just don't want one line. We want to look at three or four lines of comparison, so no matter how it's translated, that's just a benchmark, it's just a checkpoint, and it's not an absolute.

That means something else was wrong. They're just little benchmarks, so how the data comes in and how it's interpreted to us as employers are just benchmarks. The only thing that we don't want is just one column. We're going to ask you for four or five sets of norms or comparative checkpoints.

MR. ROSENBERG: If I could comment on what Andrea has said and also respond to the first question, as a data person I hear Andrea's plea, which I agree with. I also immediately observed that that means four times the amount of processing in generating the report, and therefore, some more expense. Data are expensive. That's part of the reason why I asked her what the budgets were of these coalitions. An average budget of $75,000 is not enough to pay for a good one-year study of a half dozen employers. I guess we could argue on that.

As far as the question about the ambulatory norms which does focus on aberrance, I think your point is well taken that looking at ambulatory care is kind of like crossing the Rubicon. It just hasn't been done before. The data available nationally, national household interview surveys, or the national ambulatory medical care surveys, are not adequate to do that sort of analysis, because they're sample data. They're, as I mentioned, very expensive to collect. So I'm trying to characterize ambulatory utilization review as a new

technology. The starting place, I think, stems from what we observed in looking at variations in hospital practice. The work done in the early 1970s by Jack Winberg and others, which identified extremely large variations in medical practice with respect to surgical procedures across small areas, implies to me that those similar variations exist with respect to ambulatory care. The data we've seen in the first 9 months of this year, in which we've had this ability at Metropolitan, support that. The emphasis is that the average person is 40 times more likely to see a doctor in the doctor's office than that person is to go in the hospital. Doctors who have been comfortable with utilization review in the hospital for all of these years are not accustomed to having what goes on behind the curtain in their office questioned. Given that and given the need to be sensitive to the doctors, I think the most pragmatic approach is to look at the gross aberrances first, and they are gross. The norms will be refined over time. They'll be refined by panels of professional experts, and they'll be refined empirically. That's going to take quite a lot of time and effort. In the short run, if we are crossing the Rubicon, it seems to me that it makes sense to go to the mat, if you will, when you know you're going to win. Therefore, the emphasis on the gross aberrance is practical, at least.

MS. CATHERINE D. LYN*: I understand that the aim of your investigations is to minimize the cost of health care. Have you found if there's an element of costs due to fraudulent claims and if there is, how is this tackled?

MR. ROSENBERG: One of the areas I did not address in my remarks about this ambulatory utilization review program is what you do when you identify a claim that is aberrant, and the service has already been rendered. One of the side effects of our program is that we have identified instances of fraud, and quite efficiently identified them. The normal procedures would come into play. I'm not a claims expert, but there are, I think, long-spread or long-standing methods of properly dealing with fraud. The other area is that, as more and more insurance companies contract with doctors for preferred arrangements, it almost goes without saying that fraud is a reason to terminate the contract. It's another form of provider risk sharing. Providers are putting their market

* Ms. Lyn, not a member of the Society, is with R. Watson and Sons in Kingston, Jamaica.

share at risk by being on the list or not being on the list. I think dealing with fraud is the same as it always has been, but the tools for identifying it earlier are much better now.

MS. CASTELL: Actually if we could modify it a little bit to define kind of fraud, it would be helpful. There is something that we're looking at with the help of Bill's system which might help us design a better benefit plan. We are getting somebody to do a large education session for our employers in early December 1986 on mental health benefits. A number of employer members said, "We've got to start talking about this area because we have employees and their dependents complaining about the fact that we've only got $500 worth of coverage for the year for mental health outpatient, and the employees are seeing a doctor for a medication refill and it's costing them $80. They're fast using up their claim." Isn't that fraud? Well, no it really isn't fraudulent, and it isn't fraudulent if someone charges you $80 for a 20-minute hour. It's just that we haven't as employers done a very good job of defining that benefit. If we had a system, an outpatient ambulatory monitoring system, like this, we could begin to pick that up and say, "How frequently is this happening. Is it only happening with certain providers?" We didn't know that all mental health providers were charging the same thing, or isn't it interesting that we thought MDs charged more than everybody else? It's just the reverse. It's the outpatient ambulatory systems that we're looking to more for that type of overview aggregate information. While it doesn't truly border on fraud, it's something we're not comfortable with, because it uses up scarce resources. It will help to define benefit plans better. That becomes a very attractive feature for us in the ambulatory area.

MS. JAN P. O'SULLIVAN: I was wondering if any of you have seen any data indications that wellness programs are working, or are coalitions focusing on this, or are they too busy worrying about doctors and hospitals, and things like that, with their limited budgets?

MS. CASTELL: We looked at wellness programs, but we had a group in the area that was really into it. We said, "Okay, fine, if you want to do wellness and health promotion. We certainly, in the long-run, want to look at some cost benefits of this, but more importantly, we want those programs tied into the

health care needs. Don't try to sell us a healthy happy heart program when everybody's got low-back pain." Those are the types of connections that we want. We want somebody to take a look at our health care utilization for both inpatient and outpatient and to start tying that to wellness programs, and health promotion programs. If the major diagnostic category is diseases and disorders of the digestive system, and you have an awful lot of outpatient visits for flu, an awful lot of hospitalizations for nausea and vomiting, wouldn't it be sensible some time in October to have a whole wellness program on taking care of yourself when you've got the flu and taking care of your family? Nobody's really done that for employers. Start tying those things together and start pulling out the programs to meet employee needs.

MR. HILFERTY: I'd like to say just one thing about that. The hospital industry is kind of noted for fads which become real visible, and then they pass on. A few years ago wellness went through and made a ripple, and passed on, and we find it coming back. I think one of the things we're getting from this direct contact with employers is that they're really looking for healthy employees. That's what hospitals are there for, to get you back onto the street and healthy, so we see a real resurgence and a real opportunity in the wellness field. If any of you are interested, Lockheed has done a lot of work on wellness and, in fact, has statistically tracked it and found it to be very cost-effective from Lockheed's point of view.