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HEALTH CARE MANAGEMENT

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- o Who is the health care manager?
- o How is health care management evaluated?
- o Ethical considerations
- o Malpractice liability
- o Data systems support

DR. ROGER S. TAYLOR: I was asked to speak to you today on who the health care manager is in a managed health care system and to explore the ethical issues in managed care. First, it's important to ask, "What is managed health care?" This is not an easy thing to answer. I think the Health Insurance Association of America (HIAA) is now struggling with a definition of managed care. The Group Health Association of America hasn't really come up with a definition, and my own department is struggling with a definition for our public.

Managed health care has a number of elements worth reviewing. First, there is a whole element of benefit design related to managed health care which allows the patients, the individual beneficiaries, to manage their own health care decisions.

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Coverage level, deductibles, coinsurance, copayments, limitations and exclusions are all elements of this self-management of health care which have been around for many years. Second and more recently, indemnity plans have introduced additional cost containment elements such as prior authorization, second surgical opinions, catastrophic case management, and psychiatric review. These cost containment elements really introduce the next level of managed care. This third level is assistance in helping the individual make informed, managed care decisions and, at the same time, adding some structures to allow physicians to manage care a little bit more. The Preferred Provider Organizations (PPOs) that have developed are structured to channel patients to the more efficient or discounted providers. They have also introduced more elements to assist both the individual patient and the doctor making managed care decisions. In terms of managed care structures, Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) provide the maximum structure for managed care. In an HMO, there are incentives for both patients and physicians to manage health care decisions more efficiently and effectively.

In this last context of the managed care issues I need to ask, "Who really is the health care manager today?" I view this as a multiple choice question, and I'll give some possible answers.

The first answer would be the patients or the beneficiaries, because they select their own lifestyle, they choose when to see the doctor, who to see, their health benefit level, and their use level of the health benefits, etc. They also decide what compliance level to have with the doctor's advice, with wellness programs, etc.

Another possible health care manager is the employer or the group sponsor. They influence the management of health care by their decisions on who is eligible for coverage, the types and level of benefits that they offer, the level of employer and group underwriting of the program, and the level of health care management they desire in those programs.

The third possibility is the physician or health care provider himself. The physician really selects the availability and accessibility of his services, the direct medical care provided, the recommendations made, where patients are referred, follow-up on preventive needs, follow-up on abnormal results, etc.

HEALTH CARE MANAGEMENT

The physician is a prime suspect for being the health care manager in today's environment.

A fourth possibility for the health care manager is the underwriter, or the managed health care system itself. They design benefit package options which provide coverage for some things under certain conditions but not for others. They provide systems to approve payment according to selected benefit packages. Those systems might include retrospective or prospective reviews or concurrent reviews. They design systems to help providers be cost effective. Those systems might include the prior authorization, the outpatient surgery list, and the other elements in managed care. They design systems for sharing the underwriting risk with incentives for providers such as capitation and withholds. Therefore, in the multiple choices of who the health care manager is, the system itself becomes a suspect answer.

The conclusion that I have come to is that the health care manager is both the patient/beneficiary and the physician. The patient clearly makes his own health care decisions, his lifestyle decisions, and his coverage choices. To some extent we've almost pretended that the patient isn't still the most critical manager of the health care system. I think this is an unfortunate byproduct of our exuberance in advertising HMOs over the last 10 or 15 years. However, the patient is still very much a manager. The other manager is the physician. He's clearly a manager as well, making individual decisions on the care provided, and he is making referrals and recommendations.

My position is that the health care system, the underwriter of the coverage, is not a health care manager. This is despite the fact that in the last twenty years, increasing inroads have been made in the management aspects of health care. I say this because the health care insurer basically sets up systems whereby coverage levels are determined. They provide assistance to the patient and the provider in being cost effective; but they should not be making actual health care decisions on an individual basis. They sometimes do make individual coverage decisions prospectively, but do not make actual health care delivery decisions. This doesn't mean that the health care insurer or the systems are not responsible to the individual in some way. They need to take responsibility to ensure that the systems have no systematic bias against quality. The system should be designed so that the community standard of care is met. There is a

social responsibility here, to build a system that monitors, identifies, and corrects any systematic quality problems. The system is not, should not become, and should not consider itself as the actual manager of the care.

Moving towards the questions of ethics, I think it's important to explore some risk and incentive arrangements that managed care systems have developed. They do pass off risk or incentive to those that are most in control of cost decisions. This is a goal of the managed care systems. The other role of risk and incentive arrangements is to reward providers for keeping the patient well and for being cost effective.

The risk arrangement should get the provider's attention. To some extent, I think the sole purpose of most risk and incentive arrangements is to ensure that the provider pays attention to the costs associated with his care decisions. It assures the discounts and makes our cost more predictable and also selectively rewards and punishes based on performance. This is in opposition to large across-the-board discounts as a cost-cutting mechanism. It allows us to be very selective in how we reward or punish. The tendency is to automatically weed out the high utilizing physicians who aren't happy with their reimbursement and who tend to leave the plans.

A risk and incentive system is not always utilization based. It allows the use of quality indicators. The more adept we become at using quality indicators, the better we'll be at using them in incentive arrangements. This will permit incentives to be measured against quality indicators and thus to reward quality.

As we look at these risk and incentive arrangements, much like when we looked at the risk and incentive arrangements in the fee-for-service sector, we have a responsibility to make sure that medically inappropriate undertreatment, or inappropriate care, or delayed care is not rewarded. This is a critical component that can't be lost as we talk of risk and incentives. All contracts with providers having risk or incentive arrangements should have clear quality assurance arrangements, and also have control over any incentive distributions to doctors. They must first go through a quality review and have the potential to be modified. In other words, the incentive distribution to a doctor should be cut if there is a clear indication of a quality problem. Risk and incentive

arrangements are designed to do a number of things that are appropriate, but must be balanced by maintaining quality.

Ethical considerations are the next topic which arises in discussions of risk and incentives. Ethics is a study of human conduct; it is a study of philosophy. Ethics is not a list of what we should or shouldn't do. There isn't an 11th commandment that says, "Thou shall not incentivise." There is no rule about what's right or wrong here. When considered as a study and applied to managed care, ethics gives a number of perspectives. One is a social or a community perspective. One view is the individual decision perspective. There is a theological perspective of what God said is right or isn't right. There is also a historical perspective. There are all kinds of classification systems for ethics.

When we apply these ethics to managed care, it's important to consider both the community and the individual viewpoint. To some extent, many of the ethical concerns that have developed in managed care are simply a resurgence of this more fundamental conflict. This could be considered a dichotomy between concern for the welfare of the individual versus the community and the role of society in its legal system and structure in general, as opposed to the role of the physician with his individual patient making a health care decision.

It has almost become axiomatic in our time that the goal of health care is to serve the individual and not the community per se; yet, while we professionals in health care like to say that, in society we have taken actions that speak quite differently. We have quarantining of patients with communicable diseases, we use a triage for trauma victims. We have allocation of intensive care unit (ICU) and neonatal beds, we limit our public health care system's budget, we design limited benefit plans, etc. We allow a large percentage of our population to go uninsured, and we implement Diagnosis Related Group (DRG) systems that convert individuals into members of groups or classes. I think an ethical discussion on managed care must first acknowledge that community welfare is, has been, and must always be considered when treating a patient. Society in its legal system has responsibility to speak for the social or community needs, and that will affect individual health care decisions.

Another ethical dilemma is that the physician is an allocator of resources. In managed care, this is a critical issue. Much discussion is heard about how

managed care is "forcing physicians to abandon the traditional stance of patient advocacy in favor of participation in rationing schemes." It is almost a war cry. This confuses the issue because it implies the physicians have not been involved in rationing in the past which is really not the case. Physicians traditionally have and should retain the responsibility to decide when care is given to a patient. That decision involves allocation of resources, whether it's use of hospital beds, when the physician has office hours, whether an elderly patient really needs an ICU bed, or whether an uninsured patient is well enough to be transferred to a county hospital. These are all types of allocation and rationing decisions. Rationing itself is not so much the ethical issue, but rather the form that rationing could take and the fear that rationing under new environments of medical management could take medical practice decisions away from the patient and the doctor, and place them with organizations separate from the doctor and the patient. In other words, rationing is not viewed so much as remaining within the control of the patient and his physicians.

This leads to the concept of the physician as gatekeeper. The idea of a gatekeeper arises out of the need for a doctor who is closest to the patient to coordinate care for that patient, to provide a single, reliable source of preventive care, support, and help, and to make sure that duplication of services and inappropriate utilization of resources doesn't occur. In the interest of the patient and efficiency, this is a fine goal. It improves the quality of care when done appropriately. It does add pressure to the doctor to be in this role, but allocation decisions must be made. The doctor's office is the place that allocation decisions are best made.

One may ask if the incentives themselves cause an ethical problem. The honest answer has to be yes. Incentives do cause conflict of interest. They have in the past with fee-for-service, and they do currently with capitation. The question is not just conflict of interest but rather is a question of building systems to make sure these conflicts don't affect quality adversely. After this type of analysis of ethics in managed care, you can almost in frustration say, "What is ethical, what does God want, what does the community want, what do individuals want?" It's important to remember that managed care is not an externally imposed limit in an otherwise peaceful, all's well relationship between doctors, patients, and third party payors, who are just advocates or agents of the patient. Rather, it's the result of some very real needs of patients, of

third party payors or their agents, and of the doctors. The roots and goals of managed care are good for both the individual and society.

In terms of the future of managed care and ethics, we must acknowledge that the question is not whether managed care and rationing of resources will prevail, but rather how it will prevail. For physicians, it means accepting that care management decisions in medical care can no longer be made in the same ways as in the past, but will involve structures. We can't afford to avoid the structure, but we must make sure that physicians, not just payors, are an integral part of the structure making managed care decisions. We must deal with the difficult issues of how medical care will be practiced in the future. These include quality of care issues dealing with access, process, outcome, the need for preventive care, supportive care, and also some of the other less glamorous forms of care, especially in our aging population. We must focus on a reallocation of resources from the less responsible areas of care where there is less yield to the areas of health care that can provide efficiently for the care of all. This reallocation of resources, if properly done, could save enough money to perhaps indefinitely stave off any economically necessitated rationing. I think our focus should be on reallocation rather than the rationing of resources. This new balance of power, if managed carefully, can better meet the needs of both individuals and society, and provide the structure that can responsibly deal with ethical dilemmas as they continue to arise.

MR. EUGENE D. HILL: I'd like to talk about what health care management is, what the liabilities of health care management are, and what specific data support systems are required. My general thesis looks something like this: "Managed health care is a systematic response to the perverse economic incentives in small area variations in provider practice."

Managed health care is presently inconsistent in its structure and application in this country. It is realistic to assume that only incremental accomplishments rather than radical change will be realized. Finally, we have seen the full shift from a provider-driven to a payor-driven system in health care benefits.

Specifically, I think managed health care is composed of six major items -- provider contracting, a utilization management system, quality assurance, claims adjudication, a member services function, and benefit design.

Provider contracting looks at establishing some sort of payment mechanism. I believe that a discounted fee schedule is the best approach. I would recommend that fee schedules should be closely analyzed; we have seen some that are not discounted and some which are even grossly off the usual and customary level. This type of analysis will effect the ability of the managed care organization to meet its economic goals.

We incorporate a balance billing waiver on all contracts similar to what most Blue Cross Blue Shield plans have done. We require compliance with our quality assurance, utilization management, claims adjudication, and grievance sharing procedures. We always incorporate a risk and reward sharing, ranging from a pure discounted fee-for-service schedule with some sort of bonus or incentive pay based on utilization, all the way through full risk capitation arrangements. They, of course, vary with the license under which the managed health care product is offered. An HMO has considerably greater regulatory flexibility than a PPO or an EPO, and the regulatory situations also vary by state.

With regard to utilization management, I like to divide it into five categories: prior authorization, second opinion, concurrent and retrospective review, discharge planning, and case management. You will notice that I've omitted the word *surgical* from second opinion; quite often we've found that surgical second opinions tend to reinforce the primary doctor's diagnosis. However, if you use a nonsurgeon to evaluate a potential surgery, it may be possible to achieve conservative medical management and significantly increase savings. We use concurrent and retrospective reviews. Concurrent review is exactly what it sounds like, where you send in some type of provider to review the care while it's being provided as opposed to retrospective review, which acts as an audit of what has been accomplished after the fact. We make extensive use of discharge planning. This is an area where I see very substantial savings through the use of home health care, early discharge to skilled nursing facilities, use of hospices, etc. Then there is case management. I believe that the gatekeeper, which is really primary care case management, is an effective system. I think there needs to be a mechanism for catastrophic case management, because although the incidence is not great, the costs in terms of their effect on the medical loss ratio is significant. I would also add psychiatric case management; I believe this has emerged as a unique area in its own right.

In terms of quality assurance, I think there are really four areas, provider credentialing, clinical protocols, quality audits and claims adjudication:

Provider credentialing is absolutely critical. People should not be allowed into the system to provide care in a managed environment who do not have proper credentials.

The use of clinical protocols is very important, and I believe we're beginning to see an emerging national consensus on what the appropriate standard of care is for various diagnoses. We need to utilize those standards because as John Wenberg and his colleagues at Dartmouth had found, there is substantial variation in practice patterns. For example, in two communities they studied, the ratio of hysterectomies varied by a factor or ten. The bad news is that no one knows what the appropriate rate should be. In summary, there are huge standard deviations in the incidence of various surgical procedures and the incidence of hospitalization within the United States. We need a system where there are clinical protocols for the management of various diagnoses.

Quality audits are needed. These include review of surgeries, hospitalizations, and outpatient care. The outpatient care audit area is probably the least sophisticated at the present. A quality assurance program also needs to incorporate an education component.

Claims adjudication is relatively straightforward. You figure out who's eligible, what's covered, whether the procedure was medically necessary, and whether the procedure was coded properly. We have experienced Current Procedural Terminology (CPT) creep and Diagnostic Related Group (DRG) creep. Loosely defined this is the escalation of severity coding to achieve a greater reimbursement for a less intense procedure. This is occurring both inadvertently through pure ignorance and also through blatant manipulation and virtually every other extreme in between. Finally, the allowable charge should be reviewed. We have noticed a marked increase in the number of "by report" procedures. The subspecialists are billing by report as a way of escaping from a defined relative conversion factor when a relative value system is used.

We believe that member services is a unique function of managed health care and can provide significant benefits. It does three things.

1. It provides benefit interpretation. This has helped us by avoiding retrospective denial through prospective interpretation.

2. It is a mechanism of provider referral. It directs subscribers to contracting providers and assists them in obtaining health care and access to providers where they have little or no knowledge about providers.

3. Finally, we operate a grievance procedure. This is essentially an informal mechanism for settling a complaint with a provider or a payor. We believe the grievance procedure has substantial benefit by reducing punitive damage awards.

There are three aspects of benefit design. First, covered services must be defined. We believe preventive health care should be covered, particularly childhood immunizations. These are probably the best investments available in terms of the cost benefit ratio. Outpatient surgery is a mixed blessing. For example, corneal transplants which used to be done on an inpatient basis have now been shifted almost entirely to an outpatient basis at a substantially increased cost. Home health care can be a useful benefit if carefully regulated. If the home health care provider arrives at the patient's home with a mini-van full of durable medical equipment, the expenses may be greater than treating the patient in an inpatient setting. Second, financial incentives need to be provided to encourage the subscribers to access care through a provider panel who has contracted with you. Finally, there should be financial penalties in terms of denied payment for care provided without a basic medical necessity, and there should be penalties for the failure to obtain prior authorization where required.

I have defined liability in two areas. There is provider liability and there is system liability in terms of utilization management. The case law in this area is scant. There is one case currently at the appellate level. This is the Wickline case which occurred in California. The case involved a Medicaid (MediCal, as referred to in California) recipient. Basically, the patient had a fairly adverse circumstance on discharge from the hospital, ultimately had her leg amputated and claimed it was the result of early discharge. She sued both the Professional Review Organization (PRO) (the group in California under contract to administer the utilization management for the MediCal system) and the providers, the

doctors themselves. The result was initially determined in favor of the patient, but was overturned on appeal. The significance of the Wickline case is that while in this particular case, the third party payor and the utilization management system were not liable, in the future, third party payors may be liable.

Now if payors and providers are going to be liable, what can you as a managed health care organization do to reduce your liability? Focusing on the provider, you can certainly be sure their credentials are appropriate. We take extensive applications on each of the physicians and nonphysician practitioners who work in our systems. We require that they obtain malpractice insurance. We require that they comply with our utilization management protocols, we require that they actively participate in peer review and quality assurance, and we require that they participate in our grievance procedures.

In terms of the utilization management systems, there are a number of approaches that a managed health care system can use. First, you can hire a professional staff; there is no substitute for having quality doctors and registered nurses. Second, you can buy insurance to protect yourself against the claims. As recently as six months ago, there was only one company in the country issuing such coverage and if any of you have tried to obtain Errors and Omissions (E&O) coverage lately, I can tell you that exclusions and limitations on the liability policy that I carry for utilization management are about as extreme as my Directors & Officers (D&O) coverage. Third, you can make extensive use of clinical protocols where they are available, fourth, you can do quality assurance, fifth, have grievance procedures, and sixth, provider education is also a critical component.

Simple feedback is what's lacking in many managed health care systems. All systems must be applied in a uniform and consistent manner. This is not happening in most places. I strongly believe this is an area where protection is needed.

Finally, there are basic risk management principles. In any system, there are going to be errors, both of commission and of omission. By managing the mistakes up front and aggressively, I think exposure can be reduced.

PANEL DISCUSSION

I am now going to turn to the topic of data systems. I have divided them into four categories: *clinical, financial, administrative, and marketing.* I can assure you that today there is no perfect system available; and I have looked as hard as anyone can at what is commercially available. I have rarely seen adequate systems. I characterize data systems as the ability to track, to trap, to use, and to teach.

The clinical systems may be placed into four categories. The first category is diagnosis classification. Unfortunately, there are very few systems that can be applied prospectively, rather than retrospectively, to classify a particular illness or injury. For example, the ICD-9CM coding that occurs upon discharge is of little value when doing concurrent review, because these are diagnoses that are designated upon discharge. The DRGs are also based on the ICD-9 CM. To attempt prospective care adjustments, a diagnostic classification system that can be applied based on symptoms rather than to a diagnosis obtained after substantial workup is needed. I think this type of system will emerge as an important component of managed care over the next few years.

The next two categories we need to look at are frequency and intensity of service. Finally, the fourth category is at quality. Quality is almost as nebulous as the diagnostic classification. Quality can be reflected in both process and outcome, and these are not well defined today.

With respect to financial systems, at a minimum, a general ledger system, an accounts payable system, an accounts receivable system, a claims system, and a utilization management system are needed. The biggest systems' problem is to interrelate the systems. The ability to cross reference data is needed; I have seen few systems that can do this.

In administrative data support systems, three things are of particular importance. They are cost, productivity, and quality. Measuring administrative quality is easier. Measures such as claim turnaround time, the error rate on audit of claims, and member satisfaction with the benefit interpretation may be used.

In marketing systems, there are four areas to consider. A data support system that can help identify the target market is important. A data support system

that can identify a particular product independently is needed. This permits, for example, calculation of individual loss ratios by product. The data system should help analyze relative price position in the market, and finally a data support system to help evaluate success of promotional campaigns is desirable.

Our company, which has very limited resources, does little promotion of our products. We spend our money to recruit and very little on advertisement on television, radio, billboards, and in magazines. However, some managed care organizations are spending millions of dollars on advertisement. It is difficult to measure the benefit of advertising expenditures.

Finally, I would like to present an example of putting these concepts into practice. The example is outpatient prescription drugs. I'm going to provide some considerations about dealing with benefit design, provider contracting, claims adjudication, utilization management, quality assurance, and member services as they particularly impact outpatient prescription drugs. This is simply an example of how comprehensive managed health care is in its approach to individual benefit design issues.

With regard to benefit design, we limit our prescription drug coverage to generic equivalents. We also impose very strict quantity limitations. We include industry typical exclusions and limitations about noneffective drugs and drugs that are only approved for experimental usage, etc. We provide financial incentives for the prescribing provider and for the subscriber to obtain a prescription from a contracted provider.

We try to contract with national pharmacy chains. We prefer national chains because they tend to be more sophisticated. They have personnel who can execute a contract and can provide wide geographic coverage. For example, we contract with K-Mart. K-Mart operates a large chain of pharmacies and discount retailers in the Western United States. They view their pharmacies as a loss leader. They want people to come into their stores. K-Mart tells its customers that a prescription refill will take 15 minutes at minimum. Their surveys indicate a customer will buy three or four nonprescription items if he comes into their store to obtain his prescription. They are very favorable in their pharmacy discounting. We use a recommended formula, developed together with our physicians. The formula gives the prescription drug provider an estimate of

what prescription drugs they can be expected to provide, it helps with inventory control, and it allows the managed health care provider to restrict the contracted providers to drugs that are proven effective. It also allows restriction to generic substitutes when possible. We give the pharmacy a provider and a member list on a monthly basis, typically using an electronic tape. The average price we currently pay is 90% of the average wholesale price, plus a $2.50 dispensing fee. I believe this represents a 20 to 25% discount from what commercial carriers are reimbursing on a claims paid basis.

For claims adjudication, we use a third party administrator. As a small insurance carrier, it was impractical on cost basis to develop a data processing system that would keep current with all of the different dosages, and the way that the drugs come packaged, etc. Instead, we contracted with an entity that specializes in this and all claims are submitted to them electronically by our contracted pharmacies. This saves a tremendous amount of expense and time in claims adjudication. The people who specialize as third party administrators of outpatient prescription drugs can provide the carrier with valuable data.

In terms of utilization management, we monitor the frequency of prescriptions by ambulatory visit. This allows identification of the utilization rate on a provider specific basis. We also track drug use by age, by sex, by diagnosis, and by the unit cost per scrip. Finally, we monitor the pharmacies for formulary compliance. At the moment, we don't require that they comply with the formulary. We issue a recommended formula, and eventually tend to make the formula a requirement. This is another area where change will be on an incremental rather than a radical basis.

Finally, there are quality assurance and member services. Extensive use of provider education is desirable as quality assurance. The education can be as simple as a monthly newsletter, or as extensive as a topical presentation offered in a seminar format. We do quality audits; the third party administrator helps us with the audits. We review drug/drug interactions. We can do this on a patient specific basis because of the detail available in the database. It is surprising how many patients are regularly taking incompatible drugs prescribed by different providers. Most of the time, hopefully, they are merely ineffective, but occasionally they can be quite harmful. Our final emphasis is on member education. The intention is to move the members towards managing their own

lifestyle in a healthy way, because we believe that this is a good, long-term investment.

MS. GLORIA MCGHEE: My perspective is that of a consultant dealing with carriers and employers who are approaching managed care from the viewpoint of single, dual, and triple options. My comments relate to a schematic diagram of a health premium program (see Exhibit 1). The diagram indicates that managed health care can be used in any type of medical benefits or insurance coverage. The diagram demonstrates how the patient flows through the health care system, and how the risk bearer (either the insurance carrier or other claims payor) can use evaluation, reporting and other controls to bring about managed health care.

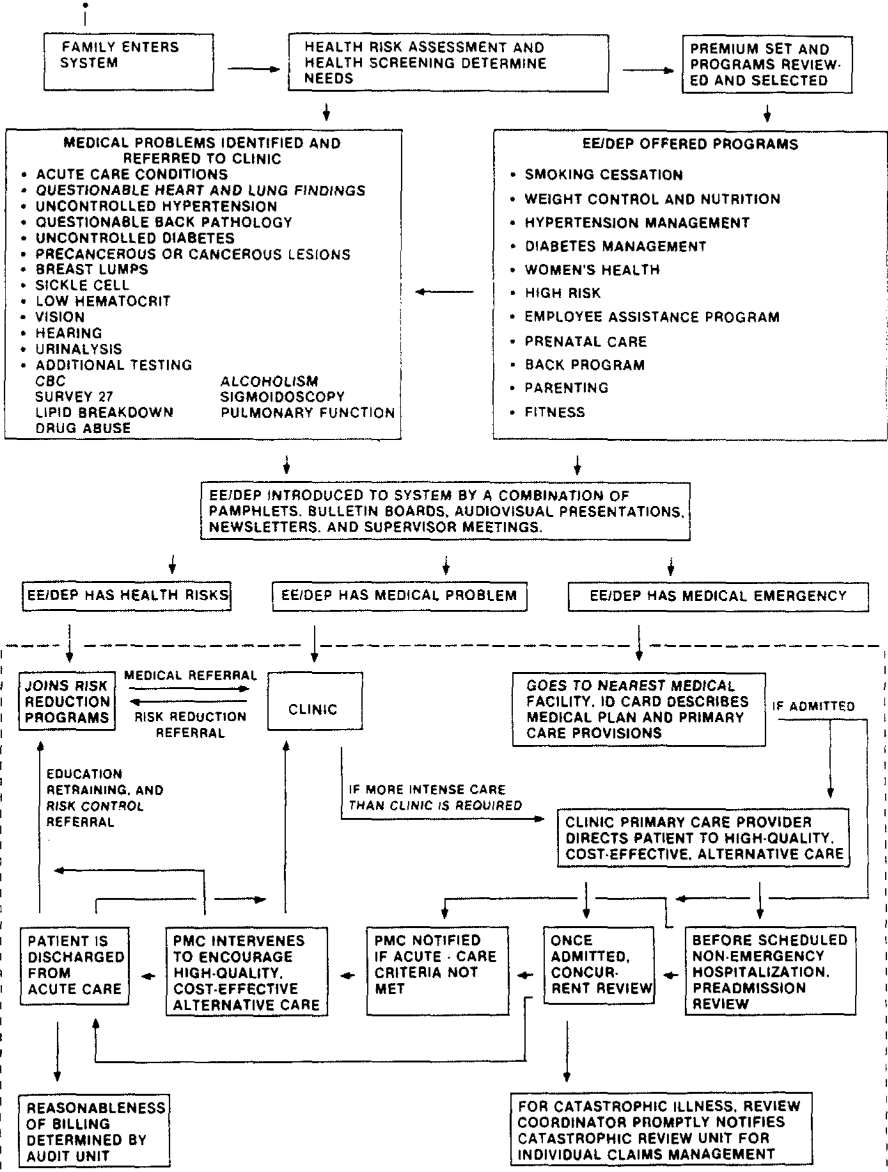
Everyone has the responsibility to manage health care. When a person makes a decision about his health, I like to feed information into a computer to know the impact of that decision. The person must first decide what benefit design he wants. You can help them to make an educated decision. For example, if they won't accept much responsibility for their health, then they may wish to join a health maintenance organization. If they won't accept full responsibility for their health and would like some choice along with some price breaks and incentives, then a preferred provider arrangement may be the best solution. An indemnity plan is obvious when the person prefers retaining complete choice. Of course, this person gets few price incentives.

Referring to the first line of the diagram, a family enters the system. The system provides awareness of health risk and their current lifestyle through health screening and risk assessment programs. Then, the family can join risk reduction programs when appropriate. At this point, there is opportunity to set premiums and to discuss the patient's responsibilities.

Moving downward on the diagram, the family enters a stage where medical problems are identified, patients are referred to clinics based on health screening results, and health programs are offered.

The next stage is employee education. It may be accomplished by a combination of pamphlets, bulletin boards, supervisor meetings, etc. When the health assessment and education are completed, the family has identified the health risks present in their lifestyle and early controllable diseases have been identified.

EXHIBIT 1



Now, when the patient visits a physician, the physician no longer has total responsibility for making the right health care decision.

As the insured moves through the enrollment process, three paths occur. First is the person who is not ill but has some health risk. These people would join a risk reduction program. I prefer a program which is not provided by the physician, per se, but is provided by health care providers working with a physician, or by an employer with an advisory physician. Second, some people will be assessed with an acute health care problem. They would be directed to a primary care gatekeeper physician. Finally, some people may have acute illnesses and need immediate hospitalization.

Health risk assessment is the first opportunity for capturing data. There is reliable information to predict the results of being overweight, lack of exercise, poor sleep habits, poor diet, and uncontrolled hypertension. There is also data which correlates the effects of hypertension or a prior heart attack on a person's future health. Education and other services will prevent some of the illnesses that are going to occur.

Next, as the patient moves through the illness delivery system (making a distinction between health care delivery and illness care delivery), there is opportunity to have screening mechanisms on the claims that come in. Precertification, concurrent review, and case management are all opportunities to offer physicians alternatives to hospitalization.

Frequently, one of the mistakes that we make from a risk bearing side is that we only use the labels that are popular today. For example, there is one set of coverage, one type of precertification, concurrent review, and a given set of case management. Those controls may not work for a patient with special needs. Clear language that offers the opportunity for a patient or a physician to request that an alternative benefit be covered is desirable. The system should permit identification of inappropriate coverage, when it is being used because it is the only coverage, so that an alternative may be offered.

A great deal of data is gathered at the point of discharge. This is another opportunity to assess the patient and see if there is any unmanaged care. My opinion is that the risk bearer is responsible for identifying and encouraging

correction of unmanaged care. We have a complex system today; because it is complex, neither the patient nor the physician always has the support needed to maximize the benefits of managed care. Therefore, a support system is needed that collects data and is sufficient to indicate the need for intervention at the point a problem arises. This permits correction of the problem before it becomes a large hospital bill or a 30-day hospital stay, when the only alternative is to battle out the bill over the telephone with the physician.

My approach is more of a loss prevention program, early identification, monitoring to see that what you expect to occur is occurring and if not, why it is not. This is what I believe is managed health care. We've covered the items that are administratively related and related from an HMO point of view. I think you can take this schematic diagram, put it in a form of benefit design of services, and do the analysis from an indemnity point of view, a PPO point of view, or an HMO point of view.

MR. LYLE: Mr. Hill, you had talked about the concept of going through a very detailed data analysis procedure and periodically you have had something such as DRG creep. What do you do at that point?

MR. HILL: Is everybody familiar with the concept of DRG creep? Is that a well-known phenomenon? A good example of the DRG creep is that the difference in the federal Medicare payment for hypertension with renal failure and renal failure with hypertension is approximately $4,000 on a per stay basis. This is a radical shift in dollars and cents as a result of the coding procedure. Assume that all hospitals now have a marvelous thing called the "DRG grouper" which will pick the most lucrative reimbursement justifiable. It is also important not to assume that the professional review organizations overseeing or auditing the coding of the DRG data are either competent or consistent. My first recommendation is trust no one, and do the review yourself.

Second, coding on all charts with the hospital expenditures greater than $5,000 should be reviewed. We currently challenge about one in ten classifications. The reason that we collect the DRG data is an observation of increasing desire on the part of the hospitals to contract on a DRG basis rather than a per diem, a discounted per diem, or a discounted charge basis. We collect the data and check the coding. When we find cases that appear to be inappropriately coded,

we review the medical records of the hospital and ask them to justify the coding used.

DR. TAYLOR: One important consideration in the DRG creep phenomenon is that the UB82 doesn't provide the data necessary to accurately access the DRG used. There is increasing interest on the part of some third party payors, including ourselves, to consider the access to the abstract. This allows systems to include the data needed to review quality indicators. An industry wide standard would ultimately be desirable.

MR. GREGORY W. PARKER: Please address the issue of inadequate data systems. Is the inadequacy because most people trying to participate in managed care don't understand fully what they need, or is it due to expense considerations? Could you elaborate on the lack of adequate management systems?

MR. HILL: Both of the reasons suggested are correct. We are in a transitional evolutionary phase right now. By going through the evolution of attempting to design and install our own systems, I became aware that we didn't know enough about what is desirable during the design phase, therefore the design is quite difficult. The measures of both quality and effectiveness of medical care are not sufficiently defined to be useful. Most of the systems which exist today have been constructed without reference to a managed care environment. Most of the large insurance carriers, for example, have huge mainframe computers. The programming required to integrate a clinical database with a financial database is prohibitively expensive. It is essential to have clean data and be able to integrate the utilization data with claims data in order to adjudicate claims and to give feedback to your providers about their performance.

DR. TAYLOR: The systems I have seen which are somewhat adequate have grown out of the managed care experience rather than the more traditional indemnity experience. They are small systems intended for use on micro computers. Those systems have fairly stringent requirements for their use. When a membership base expands to even 50,000 or 70,000, a whole new piece of hardware will be needed and the current software becomes inadequate. The systems are set up for traditional HMO models and not for doing any cost or utilization analysis. When response to the changing environment is needed, these systems are too rigid and limited in the membership level which they can

support to be worth changing. There are some small systems which claim to be able to integrate data, but when applied to the growing business, they become difficult to work with.

MS. MCGHEE: I have not seen any adequate systems. I usually do my own system designs which take six months to a year. The largest problem arises with identifying the level of detail which is needed during the design phase.

MR. JAY BOEKHOFF: My question concerns quality assurance when the community standards of quality vary. The variance implies difficulty for large organizations dealing in multiple communities. Are the community standards a by-product of the fact that quality assurance is not currently measurable by objective standards? As procedures to objectively measure quality develop, I believe we will move from community standards toward a more national standard.

DR. TAYLOR: There is an amazing amount of variation in practice pattern by community. The ratio of hysterectomies might vary as much as by a factor of 10 from one community to the next. However, in national offices we are far from stating that the rate of hysterectomies in a certain circumstance is a particular number, and any variation more than 50% of the standard deviation is due to bad care. This is because we are not sure what the correct standard should be and because we are unable to measure at the needed detail level on a national scale. We are not able to measure the clinical variations from one DRG group which consider quite a few variables. We are all aware that the DRG grouping is not a perfect system. We don't know how many variables we would have to record to determine a national standard.

The next issue is that managed care is a local phenomenon. The focus of managed health care is really the relationship and the activities between a doctor, their patient, other health care providers, their patients, etc. We can build systems to help support this and make it efficient. We should be able to develop some national standards to help identify when someone is several standard deviations from the norm. We can't make a qualitative statement about whether that's good care without doing a full chart review of the case and having physicians in that community make the assessment. Even as a national company, I feel managed care needs local medical directors and local physician committees.

MS. GRACE L. MALLOY: I am interested in long-term care in the context of managed care.

MS. MCGHEE: Managed health care should be a mechanism to keep people out of long-term care facilities, intervening to promote independence. For example, consider an accountant who has had a stroke. The traditional treatment would be to place him in a rehabilitation facility. Suppose the accountant has a short-term memory deficit. Now, the accountant who can use both arms and legs as a result of the rehabilitation treatment, but can't make change and tell time, may end up in long-term care. If the same money is used towards a cognitive re-training program, in six to eight weeks the accountant might return to work. This type of alternative approach is managed care.

DR. TAYLOR: Even after appropriate resource reallocation, there is still a need for long-term care for the patient who truly needs skilled nursing care. In many locations there are limited bed capabilities for skilled nursing. Where bed capabilities do exist, there is an intermediate level of care that perhaps the administrator of the facility would prefer not to use his nursing time on. There are also patients who are difficult to place in intermediate to long-term care facilities because their needs are higher than traditional skilled nursing. There is also the whole category that doesn't technically require skilled nursing care. This is the area of society that is least addressed. Pricing this type of care and avoiding adverse selection in benefit design is a very real problem. There is the very basic question of why families save money, and what rights they have to use that money at their own discretion as opposed to taking care of these kinds of needs.

MR. HILL: The long-term care system in this country can be categorized as inadequate. The inadequacy is compounded by the lack of both a management system and adequate insurance. Many people are trying to devise a mechanism for convincing the market that there is a need for a long-term care product, a product to adequately cover their needs which is still affordable.

MR. ROY GOLDMAN: Please comment on plans which require preadmission and concurrent review and plans which do utilization audits. Are these measures really managed care or are they simply cost saving mechanisms?

PANEL DISCUSSION

DR. TAYLOR: This is a critical differentiation of the role of the managed care system. My feeling is that the prior authorization systems, the concurrent review systems, etc., that help make an initial decision for the patient and the provider as to whether something will be a covered benefit, are doing exactly that. They are making a benefit decision. It's not really different than deciding not to cover alcohol and drug rehabilitation in your benefit program. The managed care preauthorization process is trying to decide whether the coverage applies in a particular case. Categorically, it's a different kind of activity than a coverage or a benefit interpretation issue. In implementation, it's more difficult than just denying coverage. When a retrospective denial process or even a concurrent process exists where you might be telling the provider and the patient a service is no longer covered, there is a notification requirement to the patient. Mechanisms are needed to protect the patient from getting billed retrospectively for things obtained in good faith while following the rules of the managed care system. This is where provisions are needed for balance billing waiver and hold harmless from billing for unnecessary denied services that the doctor provided. Many contracts with providers have a provision that they can't bill the patient for denied service unless the patient was initially told by the provider that that service is unlikely to be covered. The medical care decision is a separate issue and whether it is going to be covered is an important issue for both patient and doctor.

MR. GOLDMAN: The question is whether the patient has an option when told that only five days in the hospital will be covered but he may need to stay seven.

DR. TAYLOR: I think the truth is that the patient has the same options as the patient who has no insurance. The traditional concept of indemnity insurance is to indemnify the patient against unusual or excessive cost for medical care. After medically necessary, you're saying to them, "We are indemnifying you for excessive costs, but this cost is not necessary; therefore you have the choice of paying for it yourself or leaving."

MR. LYLE: You seem to be drawing a distinction between comfortable medical care and quality medical care, defining medical necessity as including use of the least costly setting for care. Including convenience items and comfort items in the limitations and the exclusions as not being medically necessary is important.

MR. CLAYTON A. CARDINAL: For the different levels of review (concurrent review, preauthorization, case management), as a function of the total cost for a program, could you site the various cost and benefit offsets? For example, you must know what a concurrent review costs, even though the benefit offset is less tangible.

MR. HILL: Our company has a corporate medical director and a corporate staff of registered nurses involved in both quality assurance and utilization review. On the local level we have registered nursing staff and a local medical director on a part-time basis. I spend 1 1/2% of my premium dollars on the pure utilization management function exclusive of claims adjudication.

MS. MCGHEE: The cost of utilization review is related to the degree of utilization management desired. For example, is your goal just to eliminate gross abuse? Alternatively, if your goal is a level of 300 bed days per 1,000, more staff and expense will be involved.

DR. TAYLOR: We have probably five million covered lives who have indemnity coverage with prior authorization. We operate this from a single national site with an 800 phone number. Different parts of the country and different employers have different levels of enforcement. The patient may use it in some plans and get the same coverage as if they didn't use it. In other plans, the patient might pay an additional 20% coinsurance, etc. At the Equitable (pre-EQUICORE), we believed there was about a 4 to 1 ratio of savings by having the program versus the cost of the program. This varies significantly by employer. I've now stopped saying 4 to 1 because that number originated in communities where the Blues and commercial patients were using 900 bed days per thousand. The spill over effect of managed care on DRGs is dropping nonmanaged communities down to the rate of 600-700 days per thousand, meaning that a weak national prior authorization program can no longer produce this kind of cost savings. The more invasive prior authorization and management procedures that are locally based are more expensive. They use concurrent reviews sending people into the hospitals to look at the chart as opposed to "continued stay review," such as calling on the telephone from a national office to check a hospital stay. It's more expensive and hopefully the cost benefit ratio is greater.

PANEL DISCUSSION

MS. DEBRA SNODGRASS MCCHANE: What do you do about the social admissions? For example, the elderly woman with two broken arms who lives alone, or an ill child with an illiterate parent who can't administer medicine correctly. Is there a cost effective way to deal with that type of situation?

MS. MCGHEE: The child is a case management issue. The first issue is coverage of social problems. If you did not intend coverage, then the decision is a coverage issue. The care that that person needs is a social problem, but you may not be able to solve that particular problem as you are looking at that claim.

There are going to be social issues that you cannot address for coverage and you must choose ahead of time what you are going to cover. There are alternatives. For example, if you cover hospitalization and the child is a diabetic, and because he didn't have proper family support is admitted for a diabetic complication, that admission shouldn't have occurred. You must provide the alternative coverage the child needs to correct the uncontrolled medical problem.

DR. TAYLOR: In a managed care environment, you're more able to make an educated decision about trading off benefits than in an indemnity environment. For example, the indemnity plan might make the decision that home health care is not a covered benefit in the situation of the elderly woman, forcing the patient to stay in the hospital. A managed care environment can make the trade-off decision to pay for home health, even if home health coverage has been exceeded, rather than pay for a hospital day. Benefit decisions are more individualized. Even in the indemnity world there is a realization, especially in catastrophic care, that flexibility is needed. EQUICORE was an industry leader in starting a catastrophic case management program. When we identified a catastrophic diagnosis, we set up a special office to help the patient make cost effective decisions and we approved noncovered alternatives because they are cost effective. Managed care can do this better.