

RECORD OF SOCIETY OF ACTUARIES 1988 VOL. 14 NO. 1

MANAGED CARE AND COST CONTAINMENT

Moderator: DAVID V. AXENE
Panelists: RICHARD L. DOYLE*
LINDSAY RESNICK**
Recorder: DAVID V. AXENE

- o Methods of managing care (e.g., preadmission certification, large case management, on-site concurrent review, etc.)
- o What methods have been most effective?
- o Experience to date under managed care products
- o Are savings being generated?
- o Employer acceptance of managed care products
- o Provider acceptance of managed care products
- o What will future managed care programs look like?

MR. DAVID V. AXENE: Dr. Doyle will discuss cost containment and managed health care from both a physician's point of view and an HMO or PPO point of view. Lindsay Resnick will present the carrier's point of view. I will close off with a few comments on what opportunities might be in store in the future.

Calendar year 1987 was one of the worst on record for health care carriers. I'm sure that most of your managements are reeling from the financial results of 1987. Companies, still experiencing losses, are desperately hoping for a quick turn around. I presume that is why this room is as full as it is. You are trying to find another tool to help you figure out how to solve the health care financing problem.

The health care industry has repetitively experienced economic cycles. If you go back and plot financial results over the past thirty or forty years, you'll find that the industry goes through about a five- to six-year cycle. Carriers make money for three years or so and then lose money for three years or so. This cycle has been repeated over and over. The industry is in the down cycle right now.

If you go back two cycles into the late 1970s right after ERISA, the big trend was toward self-funding. Carriers tried to reduce retention levels and tried to cut expenses. Groups were moving toward self-funding. A common response during that down cycle was "Why don't we create ASO products and minimum premium products?" and "What can we do to cut our administrative expenses?" Major corporations were looking for ways to save money. They focused on 10% of the health care dollar, not the 90% (i.e., claims). Self-funding helped a

* Dr. Doyle, not a member of the Society, is a Consultant in La Jolla, California.

** Mr. Resnick, not a member of the Society, is Senior Vice President of Celtic Life Insurance Company in Chicago, Illinois.

PANEL DISCUSSION

little, but it didn't do much. It didn't have the potential to do much. As we moved into the last cycle in 1981-1982, PPOs were more popular, and HMOs were becoming even more popular. The industry introduced some "pseudo-cost containment" programs. These programs willingly accepted accolades of achieving success, but unfortunately for them and the industry the cycle was just getting better. Far too often we were giving credit to all the new programs. Retrospectively it is clear a lot of the results were due to the improving cycle, not some of the cost containment efforts.

Now we are in the down cycle again. Again we are looking for an improved solution. Some of us working in the managed care area believe that during this cycle the industry will learn its lesson once and for all. With the growth in the HMO industry, if the industry doesn't learn its lesson this time, the managed care industry probably will teach a much more painful lesson in the coming cycles. This session will be very important for those who are trying to find out more about managed care. How do we really manage the health care system? Can we manage the health care system? How do you really accomplish health care management and cost containment?

What we are going to try to do in this discussion may be a little controversial, perhaps trying to spur on your interest. If your company doesn't figure out how to do something to control health care, your organization may not have enough assets to continue its existence, especially if other companies figure out how to control health care.

My biggest concern is that most of our attempts to control health costs also generate adverse selection in greater quantities than we ever experienced before. Today's health care cost management is not as easy as it would have been ten years ago before the significant effects of adverse selection emerged. When you look at cost containment and health care management, you are going to have to understand and manage adverse selection while you are doing it. Controlling where the healthy people seek services, and trying to put the sick ones in the most highly controlled environment are some reasonable objectives. Until we get a good handle on adverse selection, we won't get a good handle on health care cost management.

The former governor of Colorado, Governor Lamm, recently spoke to a group of obstetricians. Recently, I was talking to a group of physicians who had been to this meeting and they encouraged me to read his remarks. There are some things that relate to health care cost containment.

He describes the Ten Commandments of Health Care. The first commandment is "Man cannot live by health care alone." I think that right now we often think that as long as we have the best high tech health care in the country we can still maintain some kind of cost containment.

The second commandment is "Honor thy doctor and thy hospital, but also honor thy sewage disposal plant worker and public health nurse." There are a lot of things we can do in cost containment that have nothing or very little to do with the actual health care industry. For example, public health departments have significantly controlled the cost of certain bacterial diseases.

The third commandment is "Love thy neighbor, but don't bankrupt America by giving to your neighbor all of the medicine that is technologically available." He believes in rationing, which not everybody wants to accept. He suggests that

MANAGED CARE AND COST CONTAINMENT

we will have to ration health care. Perhaps there is some advice there we should listen to.

The fourth commandment is "Thou shalt spend thy health money where it will buy the most health care." Right now that is not often an issue.

The fifth commandment is "Thou shalt not 'overdoctor' society and be sure not to 'overlawyer' society either."

The sixth commandment is "Thou shalt not kill nor shalt thou strive officiously to keep alive." In other words, we need to take a good look at some of these heroic medicine things that right now we believe are in the name of good positive ethics.

"Honor thy mother and father, but also honor thy children." His biggest concern is what are we doing to our future generations. If we do not figure out how to contain health care costs, what is in store for our children and grandchildren? I think that everybody (i.e., our publics, our groups, our governments, our employers, etc.) is concerned about the cost of health care. As actuaries, we are probably as equipped as anybody to understand and control the cost of health care. We have the right training to do a lot of this, but why aren't we doing it? Maybe we need some guests to show us how.

I will use that to introduce our first speaker. Dr. Doyle's curriculum vitae (CV) is so long that we could take the rest of the session to go through it, but I'll highlight a few things that impressed me.

First of all, he's an M.D. He thinks the health care system has some serious problems. Most recently he was the Medical Director for Travelers Health Network and also worked with Travelers Insurance Company's PPO and Patient Advocate programs. Currently he's in private consulting and has been associated with some consulting companies. He is a practicing consultant with utilization management and quality assurance programs.

DR. RICHARD L. DOYLE: Understanding the medical perspective on how cost containment can be achieved by managed care requires a brief definition of some terms. Managed care is health care carried out under review and/or contracts for the purpose of cost containment. It involves parties other than patients, physicians, and payers. It may involve risk management, typically reinsurance. Some options can be construed as cost management. Finally, the role of the medical director or medical management is specifically and uniquely care management, which I would define as what happens when formal health care is sought.

In managed care the payer can delegate management, that is, take actions which are expected to have the indirect effect of changing the way other people behave. These actions contain the payer's financial liability, but have no direct effect in containing the costs themselves. They are risk sharing or passing increased amounts of incurred costs to beneficiaries in the form of increased deductibles, coinsurance, copayments or penalties with the expectation that patients will seek more cost-effective care. This latter expectation is undercut, however, by the relatively small amounts of money involved, by the prevalence of dual coverage, and by out-of-pocket maximums.

The second delegated management action is risk transfer which contains the funds available to providers with the expectation that they will reduce the costs

PANEL DISCUSSION

of care, because of reversed incentives. Examples would include prospective payments, including salaries, capitation, Diagnostic Related Groups (DRGs), or risk pools. This reversal of incentives, of course, has been criticized by providers as possibly jeopardizing the quality of care provided, but there's no conclusive demonstration in the aggregate, as opposed to isolated anecdotes, that it truly occurs.

I would like to emphasize, however, that none of these delegated actions directly contain the costs at all, which are defined by the volume and true cost of each activity. The payer can also take direct management actions to contain costs which you can see here. Financial management can be retrospective, such as the review or audit of bills to determine proper payment. More typically though, it is prospectively obtaining contracts for price discounts before the provision of services. Health related actions, other than the public health measures lauded by Governor Lamm, would be such things carried out directly by a payer (i.e., as a health promotion program or a health education program, including the use of the health care system). The goal would be both short- and long-term improvement in health and the prudent use of health care resources.

Finally we come to care management, defined as changing what happens when health care services are sought. The features of this include utilization control, quality assurance, the use of alternative providers, and the direction of patients to efficient providers. Before discussing in some detail the scope, the methods, and the results of care management, I would like to place it in context with what I call "the four Ps of managed care."

The *purpose* of managed care is cost containment with the provision of quality health care. The *perspective* of managed care is the achievement of short-term cost savings and quality rather than long-term health maintenance. The reason for this is obvious; people move around, change jobs, and change coverage. Therefore, the people involved with managed care products and managed care businesses cannot take the perspective of what's really going to happen twenty or thirty years from now. A third is the *paradox* of managed care which is that of marketability and manageability which are in contrast. What is most marketable, namely a large, accessible, stable product, is what is least manageable, and what is most manageable, a limited set of committed providers, may be least marketable. Fourth, the *problem* for managed care is the existence of fee for service under which fluctuations in volume and service mix have a dramatic impact on costs.

The scope of care management can and should be all the professional actions which cause health care costs. Obviously individual payers may choose to focus on less than all professional actions, either by the type of service such as hospitalization or by cost thresholds. An HMO with full risk would typically have a comprehensive approach. PPOs and managed indemnity would typically do less, thus the PPO and managed indemnity would typically concentrate on inpatient care, whereas an HMO would extend its care management to outpatient care as well.

For inpatient care, management looks first at the occupancy of the hospital, namely the medical necessity of admissions and days of care. If hospital contracting is on a DRG or per case basis, a review of the days of care is usually unnecessary and omitted. The next thing looked at is the level of care in a

MANAGED CARE AND COST CONTAINMENT

facility, namely the medical necessity of special care units or the appropriateness of specialized rehabilitation or skilled nursing facilities. Third would be ancillary services, namely the medical necessity particularly of expensive or repetitively applied services. Fourth, concurrent care, namely the medical necessity of multiple physicians providing care at the same time to the same patient. Fifth, the quality of care as judged by events which constitute adverse outcomes (i.e., processes which subject patients to unwarranted risks and patient dissatisfaction).

For outpatient care, management looks first at the category of the provider. Is the patient's clinical problem addressed by a specialist physician or multiple specialist physicians in conjunction with a primary care physician or by a single primary care physician alone or by a nonphysician provider such as a nurse practitioner or a psychologist? Secondly, management looks at the location of care. Is the care in a physician's office or is it in a physician's operating room, surgery center, emergency room, urgent care center, hospital outpatient facility, or ancillary center? Third, management looks at the necessity of surgery. This is an expensive treatment modality even in an outpatient setting. Is it necessary? Fourth, management looks at the necessity of various medical services. This would include the frequency of office revisits, the frequency of periodic health exams, prolonged treatment programs such as cancer programs, chiropractic care, the extent of workups during emergency room and urgent care visits, expensive diagnostic technology, ancillary services by physicians or others, and prescription patterns. Fifth, management looks at creative billing practices. In response to fee limits, particularly by government but also by other payers, physicians have learned and adopted practices, including charging for services historically not charged for, or bundling billing into more lucrative components and upcoding by the basic descriptor or modifier and last, of course, quality of care. Are adverse end points the results of errors of commission or omission? For inpatient care, the errors might likely be those of omission. So what performance standards, what protocols, what algorithms define expected processes? Again, what is the level of patient satisfaction?

Now I have taken the time to enumerate all these ways in which health care costs might break out to emphasize three points. First, fee-for-service reimbursement is the problem. Second, illustrate the challenge and potential for care management. Third, most importantly, demonstrate the futility of attempting to achieve long-term cost containment by indefinitely reviewing uncooperative providers. Thus, the opportunity for managed care, beyond the achievement of price concessions, is to identify and categorize efficient quality patterns of care, to exclude providers who are neither intrinsically efficient nor fast learners, and to channel beneficiaries to those who provide efficiency and quality.

I'm going to talk next about the various methods of care management more or less in a sequence starting from the most focused to the most broadly applied. So the most selective is what is called case management or large case management or catastrophic case management. This is not synonymous with care management, but is a term of art based on the insurance observation that 3% of the beneficiaries cause 40% of the costs. These are the patients who may benefit most from case management. These patients include those with one-shot catastrophes such as prematurity, trauma, or stroke and those with more chronic conditions such as cancer, AIDS, or neurologic degenerations. At present the wildly escalating costs of mental health care have caused many to emphasize psychiatric case management as distinct from traditional medical case management. Most psychiatric admissions are extremely prolonged and expensive. Historically

PANEL DISCUSSION

in insurance the case management function was invoked when a cost threshold was exceeded or when specific diagnoses were seen. Case management concentrates on assuring coordinated care and expedient hospital discharge when feasible. It also offered out-of-contract coverage for services which might reduce the costs by moving care to a nonaccrual home setting even when traditional utilization review (UR) principles would justify hospitalization.

In its best expressions, case management has arranged patient transfer for the enhancement of quality as well. The limitation of case management in its traditional insurance role was late notification of cases and the nonlocal nature of the carrier-based nurses. Now standardized hospital UR review programs provide better case finding than earlier notification with the result that the case management function is used more often. In addition, expanded demand has led to increased local resources in most communities. Despite the characteristic insurance function of authorizing out-of-contract coverage, PPOs and HMOs need to approach these kinds of cases in the same way, namely an early, aggressive intervention to achieve an economical, long-term treatment plan.

The next most frequent approach is that of the second opinion program for proposed surgery. Small area variations and differential surgery rates make the case for this method. To be cost-effective, however, it requires the second opinion be rendered by a selected panel, including nonsurgeons, and it should have waiver criteria allowing the omission of this extra consultation cost in a significant percentage of cases. While 3% of cases in a group health population will be suitable for case management or second opinions, up to 10% may be hospitalized. A hospital review program is intrinsic to PPOs and HMOs and is obviously increasingly prevalent in insurance.

Hospital UR may be generalized on all cases or focused on suspected or identified problems. The first step in hospital review is preadmission authorization based on the proposed reason for admission; a determination of surgical necessity, perhaps including a second opinion; an outpatient procedures list; and the assignment of an expected or authorized length of stay. Approximately half of the admissions, including obstetrics, should have this kind of review. The second step, involving the other half, is admission review of unscheduled admissions. The typical indemnity review program is available for review five days a week during working hours. Some are extended to 12- or even 16-hour-a-day coverage. Fewer are operational on weekends, thus up to a third of admissions may avoid admission review. Comprehensive admission control as practiced by the most efficient HMOs requires 24-hour, 7-day-a-week availability, not only of the care manager, but also of alternative resources such as a home care contractor.

The next step is concurrent length of stay review, although as I stated earlier, if the payment is under DRGs it may not be necessary to do that. The gold standard for concurrent review is daily on-site review of all patients, although clinical circumstances may make this unnecessary.

Retrospective review is one of two types: one, doing your usual review on patients who were missed earlier, and two, reviewing patterns or data to identify excessive unnecessary admissions or lengths of stay.

The final step, which must follow this second aspect of retrospective review, is feedback to physicians and the evaluation of physicians for retention in an alternative delivery system based on their performance on hospitalized patients.

MANAGED CARE AND COST CONTAINMENT

At this time no more than 10% of enrollees will have received care management. Many more patients receive physician services and ancillary services, which I will consider together.

In discussing the management of physician care I will pass over the issue of contract fees as a cost containment technique by saying it is not powerful for savings because the lower-fee physicians can raise their charges to the maximum payable. Bill denying or adjusting payment as part of a data or profile based analysis of costs results in the selective retention of cost-effective physicians. PPOs do very little management of physician care, so most of this next section will be about HMOs.

The first step to be considered is the possibility of replacing primary physician services with those of less expensive professionals. This is most achievable in staff or group model HMOs, less so in Individual Practice Associations (IPAs) and PPOs. In the former staff model type or group, the issue will arise when there appears to be a need to add more physicians and the question we can come up with is "Can we make better use of a nurse practitioner?" It is also desirable to contract with nonphysician substitutes for specialists such as psychologists, social workers, and optometrists.

The next technique for control of physician cost is a primary physician relationship. This is not typical in PPOs and nonexistent in indemnity. IPAs generally recognize the operational advantage of having a relatively large panel of members for each primary care physician, namely a relatively small number of primary care physicians. However, IPAs generally compromise on this for marketability to have the most accessible network and to get the existing indemnity patients of those particular physicians. A staff or group model will be imbued with concepts of productivity of the primary care physician with respect to panel size, visits per day, and referral rates. Low referral rates without adverse outcomes mean the primary physician is resolving the clinical problem. It serves no purpose to have a primary physician gatekeeper if he overrefers due to limited skills, interest, or commitment. There should be a policy definition of primary physician responsibilities and an evaluation of their fulfillment in conjunction with a review of referral rates and referral cases.

Particularly expensive referrals, ancillary usage, or nonparticipating referrals may require authorization by a medical director. Ambulatory care must be reviewed specifically by inspection of outpatient charts. Selective inspections of certain physicians must occur based on physician profiles, data-based variances, or exceptional billing or encounter patterns. Selective inspections should also focus on frequent or expensive diagnoses and on services whose frequency varies from the actuarial projections. In addition, random audits of each primary care physician should occur annually. In a PPO, providers receiving the most funds should have charts audited. Physician profile data need to illustrate both outpatient and inpatient performance in comparison to peers with respect to frequency of events and total costs. It also needs to look at specific components of care and costs, adequate management information, and unit price by service.

In summary, management information system data should identify a matrix of suspect physicians and suspect services. In addition to feedback, there needs to be medical evaluation of these variances, determination of their causes, re-education or enhancement of controls, and selective retention of those physicians who perform.

PANEL DISCUSSION

Another approach to physician care management is the initial selection of participating physicians; again one may contrast the approach of PPOs and IPAs with urgent recruitment needs to the more deliberate interview and selection process of staff and group model situations where collegiality and commitment to organizational goals are considered, as well as professional expertise. Physician selection could be based on previous data or review of samples of care as well as interviews.

The results of care management initiatives are least well known for ambulatory physician and ancillary costs. Bill audits of selected hospital bills reputedly save 5-7% of charges which would be exceeded by the savings from discount or risk transfer contracting. It is still worthwhile on large bills if the contract payment is a discount from charges or if there is some kind of outlie or compensation as part of the reimbursement.

Case management offers a relatively large return, perhaps saving tens of thousands of dollars in particular cases. Estimates show \$5 to \$15 savings per \$1 spent on this relatively inexpensive method. To achieve the payoff you must have early notification and you need to be working on psychiatric cases as well as medical cases. Some of the vaunted savings from second opinions on some of the highest stated nonconfirmation rates are misleading because some programs have claimed credit for moving certain surgeries to an outpatient setting as a result of the consultation. These results can be obtained more cheaply by a traditional UR program.

Second opinion programs based on the random selection of another surgical specialist for the opinion typically have very low nonconfirmation rates of the order of 1-3%, which coupled with the performance of surgery with at least some coverage in half of the nonconfirmed cases results in no savings as a result of the process.

On the other hand, a Boston group has reported as high as 75-80% diversion of coronary bypasses through their consultations. Now that is a substantial savings. The average experience is nowhere near this high. However, with a panel selected for prudence, nonconfirmation rates in excess of 10% might occur. Nonconfirmation rates at 6% or greater will result in savings from the program. Consultation costs can be reduced by the application of waiver criteria, which should avoid consults in at least 25% of instances.

Hospital utilization, even under review, has extremely variable outcomes. Unmanaged experience in group health may exceed 600 days per thousand with admissions over 100. Efficient HMOs may be under 200 days. Last year the Office of Prepaid Health Plans found that profitable plans average under 320 days per thousand. This obviously varies from region to region and market to market, while unprofitable plans average 368 days per thousand. The Group Health Association of America data bank reports that staff model HMOs average 60 admissions per thousand, group models 70, and IPAs 80. Now if you are going to have a length of stay at something like 4 and you're at 80 admissions, you are really bumping up against the 320 which is the threshold for profitability. I would not say that the numbers I've got up there are state of the art. The state of the art may be lower than that, but the objectives are ambitious and reasonable goals. In developing rates and so forth, you may project a higher number, but I think that is deliverable in any system which does not have adverse selection and has good management of the care.

MANAGED CARE AND COST CONTAINMENT

There are regional and experience rating type differences in PPOs and managed indemnity utilization levels. But effective review programs have achieved 30-40% reductions in days, and in instances days down to the mid-200s. These methods have addressed hospital costs.

Ambulatory and physician costs have been much less subjected to care management. A physician visit frequency under two per member per year is achieved only with substantial nurse practitioner substitution. Three visits would be favorable, and four are average, perhaps a little high. More common ambulatory care controls include cost management strategies such as capitation or discounts. Despite this, ambulatory cost overruns are common both in IPA and PPO settings.

I believe the reason can be seen in a brief budgetary analysis. Managed indemnity will often spend \$1.50 per subscriber per month or even more for a hospital UR package, a telephone UR, a second opinion, and case management. While this can be done more cheaply locally, it does equate to about \$0.75 per member per month purely for hospital controls which address half the delivery system cost.

Managed ambulatory care costs at double this investment would be proportionate, but probably inadequate, because of the greater frequency and diversity of clinical events. However, let's take \$1.50 per member per month for a comprehensive control program. How many start up, break even in 20,000-member HMOs, and spend \$30,000 a month on care management? How many 50,000-member HMOs are spending \$75,000 a month on care management and still lose money? How can PPOs compete on cost containment with less money?

In summary, from the perspective of cost containment, staff and group HMOs are most favorably modeled with fewer physicians, fewer specialists, more compatible and powerful incentives, and an organizational orientation. IPAs and PPOs need more intense care management as well as cost and risk management. As this evolves however, IPAs and PPOs, while allocating increased resources to this, may find that the management resources become excessive. They will find that the greatest return on investment and the most friction-free satisfaction will be in remodeling their delivery systems to retain only those providers with demonstrably efficient patterns of care. The needs of managed care have been stated most succinctly by one of our twentieth century philosophers and scholars in this brief stanza which could serve as a model for managed care systems.

"Every gambler knows that the key to survivin' is to know what to throw away and to know what to keep." Kenny Rogers

In conclusion, I think this is the power of managed care systems and alternative delivery systems. They do have the opportunity to contract with the people who turn out to be the most efficient people for cost containment. I do not mean to imply that the care management needs to be a very blunt, initial triage system separating out large sets of providers. I do think that the power and effectiveness of a managed care system is causing change among providers. It would be significantly enhanced if they could state to those providers up front, "It is very unlikely that you are all going to get to the promised land with us. We are going to retain and march on with those who perform efficiently."

MR. AXENE: Our second speaker is Lindsay Resnick. He is a Senior Vice President of Product Management with Celtic Life. Before joining Celtic Life he

PANEL DISCUSSION

was with the BC/BS National Association and was a manager of hospital payment programs and cost containment activities. Prior to this he was with the Massachusetts Department of Public Health in the office of Health Planning. I met Lindsay through my activities with the Health Section Council. Lindsay is going to be presenting the insurance company industry point of view.

MR. LINDSAY RESNICK: As a nonactuary in this group, the first thing I would like to do is put a caveat on my presentation. I will attempt to walk through some hopefully logical thinking of a product strategy when looking at managed care for an insurance company. The caveat I will put on top of that is that some of this is geared to Celtic's marketplace, which is the one to fifteen small group marketplace. A lot of the criteria I have laid out in looking at products in the managed care product spectrum is applicable to all size groups. But in small groups, clearly there are some unique characteristics. The purchaser or final customer is generally much more unsophisticated than the employee benefit manager you are dealing with in large groups.

It is a very price-driven marketplace. The agent/producer has a much larger role in this end of the market. From a carrier perspective it is a marketplace filled with both good competitors and with bad competitors that come in for a quick hit and leave the marketplace. It is a very volatile marketplace, and it is one that requires a lot of specialization.

I will look very briefly at some of the environmental characteristics that need to be considered and are considered when shaping a managed care strategy for a carrier.

First, we will look at where our industry is going. We're in a transition, we're no longer just an insurance company, we're really an insurance health care company. We're in the health care business. We're going to walk through the managed care product spectrum to help identify for you some of the options that are available, some of the advantages and disadvantages.

Clearly, there is a whole variety of what I have termed "health policy concerns" that are putting pressure on us as we're developing these products. A lot of them I don't need to talk about: health care expenditures and inflation, issues around the uninsured, AIDS, technology, long-term care, government regulations, things like the Kennedy bill, and the whole overall issue of measuring quality health care. A lot of these topics are dealt with throughout this meeting. We will be discussing the uninsured and the underinsured which I'm sure will be devoted to Senator Kennedy's proposal and some of the new proposals that have come up. I think it is going to be extremely interesting to see this meeting next year after the November elections to see what is on our plate for government regulations. AIDS is on the agenda this year. These clearly are the issues that are putting pressure on us.

The key players, clearly the hospitals, are in the survival game right now. Profits are down, inpatient use is down, and costs are up. Technology has a lot of impact on this. There are fewer patients, but sicker patients. There is no question that utilization management on the hospital side has been effective. It's moved care to the outpatient side. I think we are now feeling the ramifications of that. Outpatient use is up, costs are up. We've seen a switch from inpatient to outpatient care. Hospitals are looking to recoup the losses that they are incurring on the inpatient use and we are seeing charges for outpatient procedures that match a one-night stay in the hospital. Much more complex

MANAGED CARE AND COST CONTAINMENT

treatments are being done on the outpatient basis and we have had a lack of effective utilization controls on the outpatient basis.

From a physician's perspective, things don't look all that bad. Earnings are up, utilization is up, and the costs are up as well (i.e., malpractice insurance). As practitioners have moved from solo practice to group practices, one of the benefits they have enjoyed is more sophisticated billing techniques. They now have someone to manage their practice. For years this has plagued them as a major problem. Consumers are demanding more services and there has been a lack of effective utilization controls on the physician population.

From the consumer perspective, health care is a right. To the consumer, health care is a blind item. They don't know what they are buying. The physician is telling them what they need to have. They have a lot of difficulty measuring quality. How long did I wait in the waiting room is one way to measure quality. Did I have the right tests? Is it the right x-ray? I have no idea as a consumer. Consumers have a natural tendency to demand more health care services (i.e., looking for that miracle), but the formula has changed. We are now involved in managing risk through managed care. We've made the transition. A lot of companies have a lot of difficulty making the transition. Many haven't made all the steps, but we are really dealing with the health care business. We are no longer dealing with the simple insurance formula. We are a health care company.

One problem that has been created is who are we? We've become very difficult to define. Compare my company with Kaiser, MaxiCare, Travelers, and U.S. HealthCare. The lines of definition are clearly not there anymore. There are a lot of common functions. Everybody is involved in administration and claims processing, underwriting, and high tech information systems. That applies to a Kaiser, as well as a Celtic, as well as U.S. HealthCare.

Selecting and managing risk, we're meeting each other head to head in the marketplace, and we're all involved in utilization management. The difference, however, is the move that the HMOs and some of the more sophisticated managed care systems have made in either owning hospitals and employing physicians, sharing risk through selected provider contract arrangements, and requiring insurance to lock into providers. These are some of the lines that still exist in separating ourselves.

I would like to move along to look at a managed care product and put together for you a product spectrum that takes you from a pure managed care fee-for-service system to the other end of the spectrum, the HMO/PPO type of alternative. In looking at these options, it is important to keep in mind a set of criteria.

The first is an obvious one in that it is profit margins. Where does this fit into both a short-range strategy and a long-range strategy for the corporation?

Market attractiveness. What's the ease of selling the product? Is it going to be a competitive product that the sales force, the agent, is going to be interested in selling? From an employer's standpoint, what is the benefit? What is the price going to be as far as the long-term effect on his premium? From the employee's, how easy is it to be involved in the managed care system? Is it just me making a phone call, do I have to memorize a list of providers that I can go

PANEL DISCUSSION

to and that I can't go to? There is a whole variety of market attractiveness criteria that needs to be considered.

Administrative interface. What is this going to mean as far as costs to the company in revamping administrative systems, claims systems, customer service, etc.?

Communication. How difficult is it going to be to communicate these programs? The problem has been they all have rules. If you have a published 800 number, or if your benefits are penalized, the other end is being locked into using a certain set of providers. How hard is that going to be to communicate? What is control from your standpoint? What is the carrier of control? Are you going to have someone else out there as a third party conducting your utilization management or is this going to be an in-house capability? That element of control has a tremendous impact on the reliability for you to price the product. Is XYZ utilization management company doing the UR, is it in-house controlled and a known entity that interfaces into your claims system? These are two different products.

From a business strategy standpoint, if a managed care product is going out with an offensive strategy, is it something that is going to be unique in the marketplace, make a splash, or is it going to be a defensive one (i.e., I'm going to have a PPO because everybody else has a PPO)?

Finally, and most important, outcome evaluation. What tools and what rules have been set up for you to be able to measure the outcome of this program?

Looking at the options that are available, I started first with what I will term managed care fee for service. The objective is to maintain a high-performance utilization management program that first of all, has the ability to affect clinical outcomes, and second of all, will maintain the physician/patient relationship without interfering with that and without subverting the physician responsibility for care for that patient. Within this there are a series of next generation utilization management techniques which I'll deal with later.

The advantage of this is that it exists today. A recent study says 70-80% of employers out there have been exposed to this or have this in their plans. This is in place. It maintains the freedom of provider choice to the insureds, and it eliminates the need for provider contracts. This often shows up as a disadvantage; it has limited investment. It provides or puts in place correctly for the insured the opportunity to have a system. It's a benefit to them, it helps them select and buy right in the health care market. It is available to all insureds, it's not just something that involves a set of hospitals in the Los Angeles area, or the Chicago area, or the Tampa area; it is something that can be put in place as a nationwide program relatively quickly, and it keeps utilization management state of the art if the right program is in place.

The disadvantage is clearly that savings are based only on utilization management techniques; it does not incorporate the price advantage achieved through provider contracting. Without question, the effectiveness of the program weakens as competitors catch up or as competitors stay ahead with utilization management.

I think it's important to look at some basic program characteristics for the utilization management. Again, there are clearly a number of external

MANAGED CARE AND COST CONTAINMENT

environmental players that need to be taken into consideration. As a carrier, the ability to control the process and measure the outcome is critical. For the producer agent, it has to be a product that he can take to his client and compete with the HMOs and PPOs that are out there in the market. For employers, the price advantage and the effect on the overall benefit package is important. For the employees, it is important to have a nonbureaucratic, nonintrusive type of program. For the medical community, there needs to be a program based on sound clinical practices that is nonintrusive for them to deal with. This probably is not going to be possible because they are going to look at any of this as intrusive. I have seen a number of programs that say if you don't comply with the rules set up in the utilization management program you get a 20% penalty or a 50% penalty in some instances, but the penalties are never invoked. Unless invoked, I don't feel that you are ever going to be able to achieve the results the program has set out to achieve.

From an internal aspect there are some critical components of these programs. The first is clinical integrity. It has to be a program founded in a clinical philosophy. This means the involvement of professionals, be it nurses or physicians. One of the things we have done is introduce a social worker into the program. The program is administered by RNs and a management staff for the case management component. There's a social worker who runs the program. There are medical directors, an associate medical director, and a handful of clinical specialists -- physician specialists who are able to deal with just OB cases or just pediatrics.

Clearly utilization management, as managed care is, is a growing industry and what we're doing right today is not necessarily going to be right three years from now or even next month. These programs need to be established in a base that encourages refinements and program enhancements and experiments. This clearly makes your job as evaluators and pricers of these programs frustrating. Programs are constantly changing, the rules are not staying the same, it is very difficult. On the other hand, this is the only way to start doing some targeted and focused UR.

Accountability for professional judgment from a legal standpoint is important. Clearly documentation and accountability for the encounters that take place are important. Administrative interface is also important, especially the other aspects of administering the business (i.e., customer service, claims, underwriting and pricing, and outcome evaluation). What are we going to use to go back and see if the program has been effective? What reports are we getting, diagnosis or specific reports, length of stay? What kind of standards are we holding it up against? Is there another set of claims experience inhouse that we can use that is not under the managed care to measure against the managed care program assessing for adverse selection, etc.?

I've mentioned high-performance utilization management. The basic components are a precertification program, concurrent review, retrospective review (particularly in the case to maintain quality assurance for the program), and catastrophic case management. What we're looking at as the next generation utilization management system involves outpatient review. Outpatient review is critical as far as integrating into the next generation of these programs. Targeted services are psych and substance abuse, maternity, special care units, criteria and management of ICU care, burn units, etc. We are beginning to take catastrophic case management and bring that down to some back injuries, backpain, and say, what do we need to case manage those and help discharge clients and

PANEL DISCUSSION

get those people out of the hospital and get them into home health? Home health, health education, pharmaceutical reviews, and management are others.

The next component is the managed care fee for service that begins to target certain vendor arrangements. This builds on the managed care fee for service and begins to introduce price advantages for high-dollar, high-savings services. Whether it be a national agreement with a home health supplier with catastrophic case management or terms with drug companies to target some high-payback, high-dollar savings, it builds on the managed care fee for service. You get price advantage for some of the high-dollar services. It moves away from some of the problems of the UR services that attempt to negotiate on a case-by-case basis price, whether it be over the phone or whatever. The disadvantage, again, is that it introduces price advantage, but it is only a partial solution. Low market penetration in a particular area may inhibit the ability to ever fulfill this. The up-front investment could be substantial. Where a national vendor or a regional vendor relationship isn't available, we need to go out and start contracting with 25 home health agencies.

Moving along the product spectrum brings us to the traditional PPOs in certain regions or around the country.

From my perspective, there is continual market pressure in the small-group market. I would say "market pressure" in the terms of sales departments rather than employers banging down the door to have this. But the sales people clearly feel the need for PPO products.

What this does on a managed-care basis is that it introduces price advantage as something that can be done quickly. The up-front investment is not all that great if you go the route of leasing. Clearly, some others have put substantial sums of money into establishing these networks. The delegated utilization management, if that's the route you go by assigning utilization management to the PPO, may in fact be more effective than what you have in house. Then again, it may not. The PPO market now allows the choice of a variety of vendors. The disadvantages as far as I can see show limited success. Foster & Higgins put out a survey recently stating the differences in what employers have seen as a decrease in claim costs. I think for PPO products it's 6.9%. For a straight managed-care, fee for service it was 5.7%. Not a great difference!

The price differential gained through the negotiated contracts may not be enough for start-up costs, benefit enhancements, access fees, etc., to offset what I need to get a profitable product out there. Keeping the utilization management component rather than delegating it to the PPO may be a problem. You may want to keep it, but the PPO may not want to give it up. On the other hand, it is becoming more common to just buy into a contracting agreement. Payments for network access other than on a per-employee basis may be difficult. It's something I have tried to stay away from.

Finally, on the left end of the spectrum would be what I would call the dual option. That is combining the managed-care, fee-for-service product with an Exclusive Provider Organization type of product or an HMO either by design or possibly by a simple tandem marketing agreement. This would be where you enter into the market with an HMO partner. Traditionally to date from my market perspective, HMOs have stayed away from the under 15 and under 10 market. The advantage for us is that it is a unique opportunity for innovation in small groups. It's a defensive strategy and a fight further and further into

MANAGED CARE AND COST CONTAINMENT

a market; we'll be there and we'll be ready. It's an offensive strategy because I haven't seen a lot of examples of it, particularly in a small-group marketplace. You certainly get strong utilization management and, in places like California, entering at this stage of the game is certainly a better response, probably, than a PPO product.

Again, another disadvantage is that it may be too unique. There is a high level of both agent/producer education that needs to take place, as well as employer/employee education. As you get down to that small market, you're dealing with an unsophisticated purchaser. Explaining the rules becomes very difficult and expensive. Administration can be very complex when integrating into what you have for standard products and there probably is a limited number of partners to deal with on this.

In conclusion, the most important aspects I would encourage you to consider are the basic criteria that other elements of your company will be looking at. I think that there is definitely a lot to choose from, whether it be maintaining and continually refining the basic utilization managed care, fee for service, or moving toward the HMO, there are a lot of products, and a lot of mixes that can go on between products. And there are certainly second-, third-, and fourth-generation managed care products facing us very quickly. These are not easy to integrate into the traditional insurance operations and strategies that we have all become very comfortable with and very used to. I do think that they can yield competitive advantage. Utilization management components, particularly on the hospital side, have already proved that enhancements continue as you move toward outpatient review and targeted diagnosis review. The price component will yield a competitive advantage and clearly the market attractiveness of having these products brings competitive advantage.

The big issue, however, is that we are really dealing with something that is very new -- from product to delivery systems to short time span -- and we have delivered something that is very difficult to get your hands on. The definitions have not been agreed upon, and the regulatory boundaries have not been established. We are seeing places like New Jersey allowing only one UR organization -- URL, I think it's called -- and it's a New Jersey regulatory body that is allowed to formally review care. We are going to see more of this! I think as the Kennedy legislation comes along as well as other pressures, we are going to see some new regulatory boundaries established. I don't think all of the participants have been heard from, whether they be the medical community, ourselves, and our customers, both our sales customers and our final customers, the consumers. I don't think we have heard yet what they want.

The flip side is that I think it is here to stay. I think as an industry, we are responsible to help direct the growth and help shape the refinements over the next few years and well into the 1990s. We are in the health care business and I think that it is a new concept to grab onto and I think there will be some surprising developments. I think it's here to stay.

MR. AXENE: You have heard two different perspectives, one from the HMO perspective and one that is more of a carrier's, especially small-group perspective. I am going to try to bring the two perspectives together and talk about what's in store for the future.

First of all, every health care underwriter is still searching for the best and most cost-effective method to underwrite health care benefits. The significance

PANEL DISCUSSION

of the HMO's effectiveness has been seriously clouded by adverse selection. No one has talked about that today but some of the HMO's results have been seriously questioned as HMOs have been accused of skimming and only enrolling healthy people. Although I firmly believe that adverse selection is not the main reason why HMOs have been effective, I do believe that we have to adjust the results to see what the impacts of adverse selection are so we can tell on a consistent basis.

On the other side, the ineffectiveness of indemnity carriers to effectively control the cost of health care has been reasonably accepted by most carriers. At least their actions, in failing to take more serious action, have said they are happy to take their unsatisfactory results. Unfortunately, our publics are not willing to accept that. We are faced with a serious dilemma and we are trying to determine how the best of both worlds -- the indemnity world with all of its freedom and flexibility, and the HMO world with all of its cost containment, health care management, and restrictions -- can be blended in a way to cost-effectively manage the health care system. I am convinced that an effective methodology exists today, but we have to implement it.

As might be anticipated, this method actually coordinates and combines several approaches, permitting some flexibility, which the employers and the public want, yet demanding certain prerequisites. It can be developed from either a carrier perspective or from an HMO perspective. It is being developed from both of those perspectives as I speak. It isn't a panacea. We can hope that it is a panacea. It appears to develop more hope than any other method that I've seen to date.

Before describing the approach, let's take a look at some of the basic cost-control programs we have talked about already: hospital admittance control, concurrent review, provider discounts, provider incentive/penalty programs, care and case management, and provider communication programs. Based on the current technology, the ideal system will likely include most, if not all, of these methods of control.

Most of the insured programs want complete freedom of choice with infinite flexibility. That's the whole basis of cafeteria programs that are so popular today -- employees want to choose what benefits they want! As I hinted at earlier, that seems to generate quite a bit of adverse selection. One of the big reasons managed-care system penetration has not reached 100% in any regional area is the fact that people want flexibility. They do not want to be stuffed into an HMO, into a very small group of providers, and told that they can only go there. As a reaction, they don't sign up for the HMO. Some HMOs' marketing to small groups demand 100% of the employees. But as long as we have this demand for flexibility, we'll never get 100% penetration. The system must be understandable to both the insureds and the employer. Too many of our systems today are too complex.

The product that I believe best blends all of these issues has been called by many names. I believe it is most frequently called the point-of-service multiple option. When you think of a typical swing plan, you can swing between a PPO and an indemnity plan. If you go to the participating providers, you get a good deal. If you go out of the system, you have lower benefits or higher costs. What we're seeing today is an integration of HMOs and PPOs and indemnity plans under one roof with the basic point-of-service choice of where you want to go. Those of you who are employed by HMOs are probably shuddering right now,

MANAGED CARE AND COST CONTAINMENT

trying to figure out how one could ever do this. In the carrier world you are probably concerned about how to do work with the HMOs.

Essentially, this particular product has gained popularity faster than almost any product I have ever seen. A few years ago, we started working with the traditional multiple-option product. Enrollees sign up for one of the options once a year. I still think this product is the best way to go. Unfortunately, the marketplace was addicted to the swing plan. The marketplace seems unwilling to sign up for the more restrictive product and demands a point-of-service selection. This has been the predominant experience we have found among our clients and their markets.

We need to forget about all of the acronyms we have been using. For the rest of my presentation, forget that you ever heard about an HMO. Forget that you ever heard about a PPO. Forget that you ever heard about indemnity. Let's talk about what these really are, varying levels of health care management. First of all, think of a choice for an HMO as a choice for very tight or aggressive health care management. The choice for a PPO is nothing more than a choice for moderate health care management. The choice for indemnity is a choice for no health care management. When you look at these three different product lines this way, what the public is asking for is a choice for varying degrees of health care management. All we have to do is to come up with a package that can combine all three of these to satisfy our public's needs. The quicker we dispose of our too often misunderstood and inconsistent labels, the better we will become at controlling health care costs.

It is intuitively obvious, at least to me, that the tighter the management, the more effective the results of management. I do not understand why it has taken so long for the health care sector to figure this out. It is a basic business management concept. If you do not manage your business, it's going to fall apart. And if you do manage your business, it will probably come out a little bit better. So why don't we apply "Basic Business 101" to the health care system. The marketplace currently prefers the less controlled environment. We haven't educated them very well. They don't like the tightly controlled environment because they like freedom of choice. If we could package this in such a way, and maybe lure the public into health care management, perhaps we could have a better approach. I dislike giving up the controls of an HMO as much as anybody does, because I think that it's the best way of controlling health care. But until we can package this so that the public can see the advantage of it, we will have permanent problems.

What does this product look like? How is it set up? What does it really look like? First of all, let's look at the typical carrier approach. We first of all have an indemnity product out there that let's you get anywhere you want. A few years ago, we tried to create swing plans, and essentially what you have is a narrow group of providers who call themselves PPO providers and if you go to this inner ring of providers you get better benefits than if you go to the outer ring of providers.

The carrier-developed plan is like the following. First, you have an indemnity product, but if you are willing to go to a narrower group of providers such as a PPO, you get better benefits. If you go to this very selective group of providers, where the ultimate level of health care cost management occurs, you have the best set of benefits. Indemnity coverage usually means no health care management. PPO means partial or modified health care management. HMO

PANEL DISCUSSION

means maximum or ultimate health care management. Preferably we can use the description rather than the label. Diagram 1 presents a graphic presentation.

Now let's look at an HMO version. The HMO already has the inner circle. We are starting to see swing plans developed where you can go outside of the HMO on certain criteria and have care provided by a wider band of providers that are less controlled. This program is the two-stage type approach. If you take a close look at Pru-Care Plus, it is basically an HMO and non-HMO choice. A third approach we're seeing is where the HMO allows you to go out to either a preferred provider group, or to any provider. Again, the HMO hopes to control members but is willing to let the patient have some choice (Diagram 2).

These two products look very similar (see Diagrams 1 and 2). Over on the carrier side we have pressure to move patients toward health care management. They create incentives and move patients toward this inner circle where you can get better benefits for more, but subject to tighter controls. In the HMO world, we see the HMOs letting people out. Hopefully, they're not letting too many out. They are attracting more people in who want to go out periodically.

Some people call it open-access HMO, others call it the opt-out plan, and still others call it point-of-service triple option. It's called so many different things that you can never tell what it is. But if you set those two circles up side by side, what you're going to see is that in a few years, you are not going to be able to tell who did it. Basically, the HMO industry, whatever that means, is going to start looking an awful lot like the insurance company industry. They are going to have similar products and it will only be a label on the product that will separate any two. Patients are motivated with incentives to choose the delivery system of most control. If they get better benefits they have to give up some of their flexibility. Patients are granted enough flexibility to be able to reconsider their choice on a condition-by-condition basis. This needs to be carefully monitored because of the adverse selection it generates, but the experience to date shows that it seems to work effectively. We have found that an annual choice rather than an everyday, condition-by-condition choice, can probably save 6-12% of rates. Currently, the market is willing to pay 6-12% to buy this product.

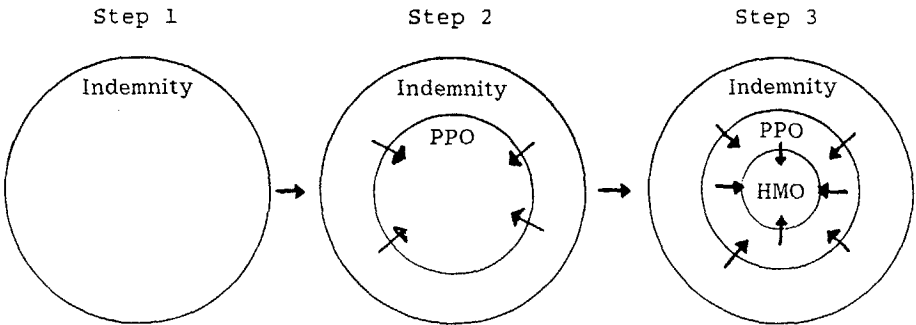
The typical carrier development uses both the two-way choice and the three-way choice. Carriers without HMOs have to make agreements with HMOs to do this. The BC/BS plans have created a national HMO network. They have all the products, the prudent buyer programs, the PPO programs. They are all set to do it. I'm just waiting for it to emerge in every plan if it hasn't yet. I've seen this developed in many different carriers, both big and small. PPOs with better discounts can be rented by carriers or HMOs. The program is centrally administered. I'm convinced that it can be managed effectively.

There is another very subtle advantage to this product which I think is probably the biggest reason why we need to consider it. It seemingly helps solve the adverse selection problem. Right now in a particular group environment you'll have one HMO bidding against one carrier, that in turn is bidding against a BC plan, which in turn is bidding against another PPO or another HMO, and you have four or five, maybe ten, companies trying to get the best business at the lowest rate. Under this scenario, somebody always loses. The losers are the guys that got adversely selected against, the winners are the guys that didn't or got favorably selected against. By putting all options under one health care umbrella, and by convincing your publics that they don't need all

MANAGED CARE AND COST CONTAINMENT

DIAGRAM 1

The Carrier-Developed, Point-Of-Service
Multiple Option Product



<u>Option</u>	<u>Control</u>	<u>Benefits</u>	<u>Provider Access</u>
Indemnity	None	Low	Unlimited
PPO	Moderate	Medium	Moderate
HMO	Intense	High	Limited

PANEL DISCUSSION

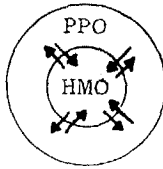
DIAGRAM 2

The HMO-Developed Point-Of-Service
Multiple Option Product

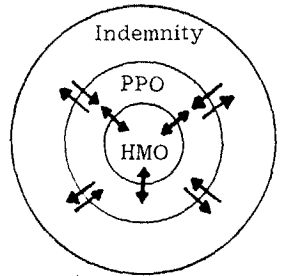
Step 1



Step 2



Step 3



MANAGED CARE AND COST CONTAINMENT

those other choices, companies can minimize adverse selection. The solution that best controls cost is one that best controls adverse selection. Although you might disagree with my perception of what may happen, I hope you'll take a serious look at my approach of characterizing different health care products by the degree of health care management, not by inaccurate labels (i.e., PPO or the HMO). Most of what we have been calling PPO is nothing more than moderately discounted fee-for-service business. I think that until we realize that, we have to manage the health care system and control it. Dr. Doyle and Lindsay told you how they have tried to control the system. It's very active management, not passive management.

For those of you who have a problem accepting Lindsay's idea of an insurance health care company, go back and take a look at the book *In Search of Excellence*. A very similar thing occurred in the book when they described Penn Central. I have used this many times in my presentations. Penn Central did not realize they were in the transportation business until it was too late. Hopefully, the health insurance community will realize that it is in the health care delivery system control business before it's too late for them. Cost containment and health care management are integral parts of this health care business, and we cannot take them too lightly.

MR. PAUL J. DONAHUE: Dr. Doyle spoke at the beginning of cost containment as a societal issue mainly containing the total of medical care costs. It seems to me that mostly throughout the rest of the discussion the focus has been on containing costs to the employer with less attention paid to transfers to individual insureds through copayment and lower levels of benefits. In the triple option do you suppose that the sum total to society can be contained as opposed to the amounts the employer contributes? When people swing out to the indemnity option they pay more, but the total in terms of cost of services provided remains the same. To show you what I think the answer to that question is, does the evidence so far show that owners of hospitals and employers of physicians have a fundamental long-term advantage in containing costs?

MR. AXENE: I personally think that the multiple option type of a product does control the total cost to society because the disincentives of using the uncontrolled options are so high that people will gradually be forced into these controlled programs. So I do think that it has a better chance of doing it than not doing it. There are still issues of bad debt, the ability to not pay, and the overall issues of Medicare/Medicaid.

MR. MARTY STAEHLIN: It's an intriguing point that you are making about solving adverse selection. I hope I'm asking this question correctly. I think it is dependent upon your price structure and the selection process that you have. One thing that I believe is that on minimum premium business you did not need the best products, you needed the best retention, the best pooling charge, the best trigger point. I didn't understand why people couldn't understand each one of them didn't need to stand on their own and be the lowest in the market; it was the whole product. So in your doughnut example there's going to be different cost discounts to have the full service, the partial, and the none, and depending upon your data as to how you're tracking who's moving around, each of these different people who have this product that includes everybody, you're still going to have different cost deltas.

MR. AXENE: Are you asking if there is any long-term cost subsidization between the various options? Will the high-cost people go to one place or the

PANEL DISCUSSION

other? Essentially my answer to that is yes you have to have long-term cost subsidization. It's just like selling a high/low plan. The high gets higher and the low gets lower. You can't charge what they should be or else the whole program will go out of balance. Actuarial balance is very important on the options.

MR. STAEHLIN: Yes, but what I want to add is different health care provider companies have different ideas about how you do that and that's what is still going to make the competition a little tricky.

MR. TED L. DUNN: My company is presently spending millions of dollars on people who are doing four things. One, they are negotiating with providers setting up PPO arrangements and risk-sharing arrangements. Two, they are doing patient care services, large loss case management, and UR. Three, people are massaging the data to attempt to show what is really happening out there. Four, they are trying to explain this to our clients, the brokers, consultants, and group policy holders. I've got one other public I'm concerned with and that's my executive management and my board of directors. Is what we're doing really cost-effective? Can we really afford all of what we're doing, because we literally are spending millions of dollars a year on this.

DR. DOYLE: The components have been demonstrated to be cost-effective in generating more savings than the cost of doing them as was the thrust of my remarks. Costs tend to break out in the areas that you're not working on. Basically what I'd said was the futility of expending all those millions of dollars. If you are going to keep trying to preserve a marketable provider network which guarantees a very open access to everybody, I think that the market will resolve their preferences to open access if people price things right. It may be in conjunction with the investment that people aren't pricing things correctly. I'm not sure that all the care that needs to be provided is being provided, but I'm sure there's still a lot of fat going on. I disagree with the view that we've been cutting into bone through what's been happening yet, but it may be that the net product will involve more mammograms, more transplants, more certain other things and I don't know from a societal perspective what the right number is -- whether it's 11% or 10% or 12%; I don't think that's crucially material.

MR. RESNICK: I think, unfortunately, it's a nonanswer and it's all those things we are telling investment right now and you've got to see in three years what's come up. One of the things that I've read recently that I thought put a good handle on it was an article by a gentleman named Paul Gramaldy, who's done a lot of the initial DRG work, in the April issue of *Healthcare Financial Management*. It's called "Measuring Managed Care -- Does It Really Save Money?" He attempts to walk you through some definitions of claims experience and trade-offs on certain of the targeted things, and I'd recommend reading that to get a handle on the question. We are making an initial investment right now. One of the things that we have done is tried to focus that investment in slightly different areas than where you have. We've looked much more into catastrophic case management, utilization management of where to put your money, and we've tried to get into provider contracting when a lot of that has either settled out or when there is just some simple leasing arrangements to get at.

MR. AXENE: Most of what's been called managed health care, even though we've been spending millions of dollars, has been worthless. It's because it hasn't taken the task at hand and done it as effectively as it can be done as HMOs and other plans have demonstrated. Secondly, I think that the issue is

MANAGED CARE AND COST CONTAINMENT

the burden from adverse selection. It is a culprit out there that we have to get a handle on. We need to learn how to control and predict it. One of the areas that I know I'm spending a lot of time right now on is unraveling the adverse selection issue because it has caused most of our management headaches.

DR. DOYLE: I'd like to endorse Dave's first comment, again as Lindsay was speaking I know with his emphasis on utilization management in indemnity, I know the people he has worked with, and I'm sure that's true. But I've worked with them also, and one of the things that we do is evaluate UR programs. They range from excellent to total shams. Simply because there's some UR allegedly in the ball game, that doesn't mean that the care is appropriate as they certify it.

MR. RESNICK: That was my point, you or someone within your company, with the responsibility, has to maintain control. I'm very uncomfortable with those situations where I see it just being delegated out to some third or fourth party to conduct it and be done. This has to be someone both bringing them in from the outside but who internally knows what's going on.

MR. DALE A. RAYMAN: My question is for Dave and again in reference to your doughnut model. The concept definitely makes a lot of sense. I'm wondering though from a practical standpoint if you have HMOs which are capitated and that's one of the fundamentals of HMOs, now you've got two problems. First of all, you mentioned in reference to a prior question that there's going to be some cost utilization between the options; and second of all if you make the choice at point of service, how do you continue to capitate the doctors or price the model not knowing how many services the HMO will provide?

MR. AXENE: In all of the working applications of it, we continue to capitate primary care providers irrespective of where patients went and it works. I can talk more about showing how it works, but you have to continue the capitation in the program.

MS. NANCY F. NELSON: My question is for Dr. Doyle. You mentioned briefly the problem of overutilizing physicians which can either occur in a primary care situation where he's being paid on a discounted fee-for-service basis or on a referral basis for a capitated position. What do you do after you've identified the physician? Do you give him a chance to change his ways or how do you handle your member problems.

DR. DOYLE: I think that we wouldn't do surgery first. The first thing would be to identify the problem, but then indicate that there was a need for correction within a time frame and that if that didn't occur we couldn't go forward and there's sort of a probationary period and then a nonrenewal of the contract or termination or whatever you do.

MS. NELSON: Have you seen that implemented?

DR. DOYLE: Sure.

MS. NELSON: How is it received by the members? Frequently, the physician that provides the services is considered to be the good physician.

DR. DOYLE: Maybe so, but some of the members will drop out and stay with the doctor but that's better than red ink and some of the members will switch

PANEL DISCUSSION

and be perfectly comfortable. My point is that you need to make that play and make that identification relatively early. You don't want the guy to get hundreds and hundreds of members before you find out he's a bad guy. So that's why you need to be tracking them as soon as there's enough quantity of activity to give you some valid profiles; you need to be getting in to look at whether or not the actual services, not simply the statistics, but whether the actual services are appropriate or not. If they're not, you've just got to make the play. If you have to sacrifice some members, that's better.

MR. AXENE: My experience with that is that it's usually poorly worded physician contracts that prohibit you from doing what's needed. I have found no problem in writing letters to patients saying that based upon our peer review of Dr. Smith we have found that he delivers inefficient care. When you explain it that way, you may get a threatened lawsuit for libel from the doctor, but you still will get significant patient retention because you explained what you did and they'll respect you for it.

MR. KENNETH S. AVNER: I just didn't want you to get away with your thesis uncontested that the difference between an HMO, PPO, and a fee-for-service plan is a level advantage. It seems I do this every year, I come up and I say "But that's not what HMOs are all about and that's not what PPOs are all about." PPOs were basically, a lot of us thought, a response to an oversupply in the marketplace and UR cost containment was overlaid on that as a good way to get five or six extra points off. I would make it evident that there are certain places in the country where there is no oversupply. There are certain kinds of services where there is no oversupply and the PPO program kind of breaks down there. I don't want to go into a discussion now, I'm just saying your picture is very nice and clean, you can hit in the middle, but I'm not sure it's accurate or completely accurate.

HMOs originally, a lot of people thought, were not so much cost containment mechanisms as a different way of practicing medicine. There was a change in the way doctors would look at patients and at that whole delivery system. All I want to do is contest it.