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# EFFECTIVE MANAGED CARE DESIGN

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o This session will concentrate on developing effective managed care programs within a health insurance benefit package. The panelists will discuss how to determine which health care expense areas to attack and how to measure the success of the program design. The session will include discussion of key expense areas like prescription drug programs and treatment of mental health and substance abuse.

MS. MARIANNE GELLATLY BRACKEY: Our panel includes Howard Atkinson from The Wyatt Company and Jean Wodarczyk from Coopers and Lybrand. Howard is from Wyatt's Washington D.C. office and Jean is from Coopers and Lybrand's Chicago office. I am Marianne Brackey from Hewitt Associates in Lincolnshire, Illinois.

We have seen very rapid changes in the last few years in the delivery of health care benefits. This morning we are focusing on managed care. There are currently many different definitions of managed care; Howard and Jean will cover the different types of managed care and define their terminology.

Hewitt Associates recently surveyed 20 employers out of the top Fortune 100 on their plans for implementing managed care. The survey participants had different definitions of managed care, ranging from something as simple as "utilization review" or "second surgical opinion," to much more comprehensive approaches. The most comprehensive approach today phases out all prior HMOs and indemnity plans and establishes a single program that is managed by a single carrier -- a "point-of-service PPO" or "open-ended HMO" arrangement.

This approach includes significant financial incentives for employees to use the PPO/HMO network of health care providers. For example, if employees go out of the network for care, they typically have very high deductibles and copayments. If employees use the preferred network of providers, they may have no or low cost sharing.

Out of the survey companies, only 20% actually had anything close to the open-ended HMO model. But another 30% were interested in that kind of model, indicating that employers will consider a radical change to their benefit program if they believe it will help them control their costs.

Some survey participants were concerned about quality and employee-relations issues related to the open-ended HMO model. For example, it can be difficult to find a network that covers all of a major employer's locations. A primary concern is that there may not be high-quality networks in every location.

Another concern is lack of continuity. Some carriers have set up joint ventures with HMOs or have bought HMOs, in order to quickly establish a national network. One major carrier bought a group of HMOs and is now selling half of them. Other carriers find that providers are dropping out of networks, reducing the ability to meet demand for care. However, it is clear that many employers will seriously consider the comprehensive managed care model, in spite of the hurdles.

Legislative proposals for mandated health care benefits could also give some impetus to preferred provider networks. The Kennedy proposal, for example, includes provisions that would contribute toward growth in preferred provider networks. Many employers believe that the level of benefits in the Kennedy bill (with a $250 deductible and a $3,000 family out-of-pocket limit) is relatively high for a mandated level. However, one provision in the Kennedy bill requires employers to offer those specific benefit levels only through preferred provider arrangements. A lower level of benefits could be applied to employees who do not choose to use preferred providers.

The panel will discuss the various managed care alternatives as well as ways to evaluate their effectiveness.

Howard Atkinson started out with Blue Cross of Western Pennsylvania and then moved to Blue Cross/Blue Shield of Michigan where he spent a number of years working on financial reporting, pricing, and experience rating for medical benefits. He provided actuarial support for the development of a state-wide PPO in Michigan for Blue Cross/Blue Shield. At Wyatt, he is consulting on medical benefits and working on the valuation of welfare benefit plans. He does medical plan modeling and carrier rate negotiations. Howard will be focusing on elements of managed care programs ranging from precertification programs for hospitalization to contract health care services. He will also comment on wellness programs.

MR. HOWARD ATKINSON, JR.:

**CONTRACT HEALTH CARE**

This part of the managed care presentation addresses one of the more dynamic aspects of the contemporary health care delivery system. For lack of a more concise name for this niche of the health care service industry, I will refer to it as Contract Health Care.

Employers now have hundreds of organizations that have been developed to address specialized areas of the evolving health care delivery system. For purposes of covering the various employer options, I have divided these health services into three categories:

1. There are the specialized health care delivery alternatives that serve as alternatives to the inpatient acute care hospital setting. These alternatives include: extended care facilities such as skilled nursing facilities; long term care nursing facilities; home health care; ambulatory surgical centers whose growth has been phenomenal; birthing centers; and hospice care.

2. There are managed care programs that support the health care delivery alternatives and usually require major modifications to the way physicians practice.

3. There are the programs that affect the need for health care. These include: wellness/preventive care programs; employee assistance programs; employee education and communication programs.

A major portion of health care expenditures, approximately 50%, are related to hospitalization. Data from the American Hospital Association indicate a shift in the utilization of hospital services and hospital cost trends since the beginning of 1983. Hospital admissions have declined sharply and lengths-of-stay have declined as well. It is interesting that the cost per patient day has continued to rise as rapidly after 1983 as before. Thus, it can be summarized that the majority of hospital cost abatement occurred because of declining utilization.

It can also be shown that hospitals are not necessarily foregoing revenue as a result of decreased utilization. As hospitals relationships with insurance carriers, hospital services are becoming more unbundled. Some of the new profit service centers are hospital based and others are new corporations in direct competition with the acute hospital community.

There has been continued rapid growth in home health care as an alternative to acute hospitalization. Medical technology increases the number of medical services that can be provided in the home, major insurance carriers have developed home health care riders that cover specific benefits for services rendered in the home, either following, or in lieu of hospital confinement. The purpose is to provide an incentive for early discharge from the hospital or to avoid confinement entirely.

Benefit levels may vary significantly, primarily due to legislative state mandates. An example of a standard home health care rider contains the following provisions:

- The person must be under the care of a physician who submits a home health care plan for the patient's care and treatment to the carrier or to the hospital coordinator.

- The services and supplies used must be ordered by a physician and furnished by a state licensed home health care agency.

- The physician must certify that in the absence of home health care, inpatient confinement would be necessary.

The idea of providing health care in the home environment is simple, but in effect is not so. Obviously, when substituting home care for hospital care, savings of benefit dollars are realized. However, that is not the sole objective of the majority of health care purchasers. There are objectives to:

- Reorient the health care "consumer" -- employer and employee alike to alternative methods of treatment, and

- Demonstrate that home health care is not only for the incapacitated senior citizens, but also for the "junior" citizen with short-term medical problems.

Skilled Nursing Facilities and Intermediate or Custodial Care Facilities are often referred to as Extended Care Facilities. These facilities have increased bed capacity by close to 19% annually since 1965. With the population living longer and the cost of hospitalization becoming more and more unaffordable to our

senior population, skilled nursing facilities are another cost effective alternative to the acute hospital care setting. Consequently, the 60% of third party payors currently financing nursing home care will undoubtedly increase.

Long-term care coverage is different from extended care coverage, which many employer group health plans currently provide. Typically, coverage is provided for posthospital recuperative care in a skilled nursing or intermediate care facility. The intensity of services in these settings is greater than in convalescent or custodial "long-term" care facilities where treatment for chronic conditions is usually excluded.

Private health insurance paid less than 1% of the 38.1 billion dollars spent on nursing home care in 1986, but the private sector appears to be moving more aggressively into the long-term care insurance market. However, the lack of relevant data on long-term care utilization by individuals in general and insured individuals in particular, severely hampers the development of a product that will adequately meet employers' needs.

While the focus of the national debate is on financing long-term care, it has been suggested that more attention be given to the availability and quality of the range of services that comprise the entire extended care continuum.

Another cost-effective alternative to acute hospitalizations that is growing in utilization is birthing centers. Now that many commercial insurers are waiving the deductible and/or coinsurance for birthing center use, it is estimated that over 12,000 low-risk births take place in these centers every year and the number is growing. Maternity patients are increasingly being directed to birthing centers for low-risk deliveries and postpartum newborn care.

Over the past ten years, hospice care has become an increasingly available choice in the United States for patients with terminal illness. Today, according to the National Hospice Organization, there are approximately 1,690 hospices currently in operation in all 50 states. In 1987, these hospices provided treatment to approximately 160,000 patients. The patient population is expected to increase to over 180,000 by 1989.

One common misunderstanding is that hospices are places where people go to die. A hospice is not a facility. It is a program designed to minimize the emotional trauma associated with terminal illness. Both the terminally ill patient and the family are beneficiaries of the hospice program.

The absence of room, board and ancillary charges defines the greatest potential for cost containment. For a terminally ill patient during the last six months of life, these charges alone could exceed $70,000 if services were provided in the acute hospital setting.

Another area of potential savings involving hospice programs is realized from the elimination of unnecessary services. Since cure is not the objective, surgeries, further diagnostic tests, some prescription drugs, and other treatment programs may be limited.

In designing a hospice benefit, some safeguards should be built into the plan design that include:

o Limiting the annual benefit per family to a specified amount.

- o Providing reimbursement on a coinsurance basis.
- o Limiting the benefit to those plan beneficiaries receiving the specified diagnosis from their physician.
- o Specifying which hospices qualify as legitimate health care delivery sites for purposes of plan reimbursement.

Maximum dollar limits on total expenses, too, can be self-defeating. The combination of a basic hospice benefit and a major medical back-up -- just as with other services -- is a good way to handle this problem.

The simple rule of thumb in designing the hospice benefit is that coverage must be at least comparable to the parts of the plan, especially where inpatient care is involved. For example, coverage of services must be comprehensive. Hospice inpatient care must also be covered so that when it is needed, it is used. Otherwise, a patient will end up in a traditional acute setting at high cost to the payor.

But, the most dramatic growth in alternative health care delivery has been the ambulatory walk-in centers. As federal and state governments, and more recently commercial insurers have applied restrictive reimbursements to acute care hospitals, ambulatory medical centers offer an alternative to health care providers as a method for practicing with very little, or no, reimbursement restrictions.

Commercial insurance carriers and employers, recognizing ambulatory medical centers as a viable alternative to hospitalization, began modifying health care plan designs several years ago to accommodate their cost management objectives. As a consequence, in recent years, the shift away from inpatient settings to outpatient surgery has been dramatic. Utilization of ambulatory surgery has increased at a rate of 5% to 7% per year since 1984. At the same time, hospital inpatient utilization has dropped about 5% per year.

There's a lesson to be learned here on how sensitive the economics can be to a rapidly changing industry. Over the past couple of years, there have been studies published that show ambulatory health care may not be the premier cost containment tool it once was perceived to be. In the early 1980s, many procedures were often done on an inpatient basis, and moving them to an outpatient setting represented a substantial cost containment opportunity. As a result, many employers adopted plan designs with incentives to encourage a shift to outpatient care. A common approach was to waive the deductible and coinsurance payment for outpatient surgery, a sensible move at the time, since paying 100% of a smaller bill still saved money.

Corporations reevaluating plan designs adopted three to five years ago are finding that outpatient incentives, used as a cost containment tool of the time, are no longer necessary and may actually increase benefit costs. The average hospital expenditures for outpatient care are increasing at more than double the rate of inpatient care. In one particular case, an insurance carrier experienced an 11% annual rate of increase for inpatient care, compared to a 28.9% rate of increase for outpatient care. In addition, the carrier, Aetna, has found examples where outpatient surgery has actually cost more than the same procedure done on an inpatient basis.

This situation regarding outpatient care underscores the role economics play in health care delivery, and also emphasizes the need to continually review cost management strategies for corporate clients.

Up to this point, I have been sharing with you alternatives to the acute care hospital that are available to employers. The second portion of this section of the presentation will address contract health care services employers have available, in conjunction with alternatives to acute hospitalization, to assist in their health cost management efforts.

Probably the oldest, most effective, and most popular alternative in this category of services is utilization review. Utilization review is designed to identify and eliminate hospital days and services that have no professionally recognized medical necessity. In addition to controlling hospitalization, it is a means for monitoring and measuring the quality of patient care.

A comprehensive utilization review program is one that does the following:

- o provides for preadmission, concurrent, and retrospective review;
- o is based on professionally recognized medical/surgical criteria;
- o works with the attending physician in all cases;
- o offers the patients and providers an appeal mechanism; and
- o one that has effective incentive/disincentives and provides for effective intervention and provider feedback, is the most effective form of health care cost containment (assuming plan design does not change).

Psychiatric utilization review, as opposed to medical/surgical, is a bit more delicate. Mental health presents special problems to designers of utilization review mechanisms because the benefits from treatment are more difficult to measure. The development of refined, objective review criteria has not been as effective for mental health services as it has for medical/surgical services. In the past, psychiatric utilization review tended to be retrospective in nature, based upon analysis of claims largely by nonmental health professionals. This approach too often resulted in arbitrary denials or approvals. As a consequence, psychiatric case management is becoming a more specialized service made available through organizations with more appropriate resources. In addition, improved methods of data analysis are helping to formulate standards for preadmission and concurrent review of the necessity of hospitalization and the appropriateness of alternative treatments for psychiatric disorders.

According to a survey conducted by the National Institute of Mental Health, nearly one in five Americans suffer from some form of mental health disorder. It has been demonstrated that even though psychiatric admissions account for only 5 to 8% of an employers' acute hospitalizations, these mental health care admissions oftentimes account for up to 30% of the employer's entire health care bill. However, the dilemma for most employers when confronting the notion of reducing these benefits is that it can be less expensive to send a worker for treatment than to hire and train a new employee.

Another program that is a popular component of a proactive approach to contain health care costs is the implementation of a second surgical opinion program.

Second surgical opinion programs gained popularity in the mid-70s when several Blue Cross/Blue Shield plans implemented pilot programs, and now almost every health care purchaser has this option available.

In designing a benefit plan that incorporates these support services, it is important to note that a separate utilization review program and a second surgical opinion program can be redundant. If an insurer has a utilization review program that addresses not only the necessity of admission during preadmission review process, but the necessity of the elective procedure itself, the value of a second surgical opinion becomes questionable. Preadmission testing should be addressed routinely during the preadmission review process.

One cannot understate the important role preadmission review can play in an employer's effort to manage health care expenditures; to provide for quality of care delivered; and, ensure that all health cost management programs are fully utilized. For example, besides addressing the issue of medical necessity, a review coordinator can route the review for mental health care to another organization better qualified to address the issues. It is also during the pre-admission review process that patients that will require extended lengths of stay or a greater intensity of services can be identified and referred to a case management specialist where alternatives to hospitalization can be further explored. An example of this is the case manager initializing discharge planning early in the hospital stay and preparing for treatment in the home via a home health care agency. Mail-order drugs could be sent for and exceptions in insurance coverages could be addressed with the carriers. It is very worthwhile to identify utilization review organizations that can provide these expanded services.

There are other health care services that employers routinely provide their employees such as vision, dental care, and prescription drugs. These services, too, are now entering the alternative delivery models that managed care encompasses. Particularly, vision and dental care delivery lend themselves to the PPO or Exclusive Provider Organization (EPO) benefit plan design.

Prescription drug utilization by employees may only average 7% of an employer's health care costs, but it is the largest out-of-pocket, direct health care expenditure employees realize. Besides prescription drugs being paid for through straight indemnity plans, the prescription card services -- many times they follow a capitated EPO delivery model -- and the mail-order prescription services offer employees convenience and limited or reduced out-of pocket expenditures and employers, a more manageable and predictable expense.

Mail-order prescription services are growing rapidly, expecting to corner as high as 10% of the 28.5 billion dollar prescription drug industry. With the increased competition in the mail-order business, the attraction to employers has also increased.

Since mail-order is particularly attractive to employers' retiree population -- that high maintenance drug population -- and, most vendors do not charge an administrative fee, but rather a dispensing fee, the value in terms of convenience and employee satisfaction can be immense. In addition, these mail-order and card service prescription programs, in most cases, can easily be incorporated into existing benefit plan designs.

Other programs an employer can turn to that have a more intangible effect on the health care expense bottom line, but have proven to be effective in managing

health care costs, are wellness or preventive health programs, Employee Assistance Programs (EAPs) and Employee Education Programs. All programs that address that intangible "quality of life" issue.

In most cases, EAPs being the exception, these programs, while well intended, have showed little hard data to support their cost reduction claims and are slow in obtaining any significant degree of acceptance. There have been no widely recognized, conclusive cost/benefit studies to prove the value of many prevention programs.

Though the inclusion of a preventive care program is pretty much a subjective decision on the part of an employer, there is a program that I found to be inexpensive and helpful in preventive care. There are a few organizations that offer on-site health evaluation services. These services range from a written employee questionnaire to a comprehensive physical exam, including blood tests. Results of the questionnaire and exams are reported via computer printout and in many cases reveal some conditions that motivate the employee to seek medical attention or implement a change in behavior.

These tests run from a few dollars per employee to a few hundred, but I've always found that employees find them useful and employers consider them inexpensive and well worth the short period of time and minimal effort required.

There are many other areas we could explore in the health care service industry. New services and programs are constantly being made available to employers as this evolution in health care continues. This marketplace is now more complex requiring an increased level of sophistication for all participants.

Managing health care costs is a long-term undertaking and cannot be addressed effectively with quick-fix efforts. A combination of programs designed to compliment one another for an extended period of time, supported by employee and provider education efforts, is the most effective means to managing the increasing costs of health care.

MS. BRACKEY: Jean Wodarczyk was with A.S. Hansen in the Chicago area prior to joining Coopers and Lybrand. She consults on health care benefits, including the development of direct contract arrangements with large employers and measuring the financial values of those arrangements. She is on the Education and Examination Committee for the Society of Actuaries and is on the Risk Classification Committee for the American Academy of Actuaries. Jean is also the President-Elect of the Chicago Actuarial Association.

MS. JEAN M. WODARCZYK: I work for Coopers and Lybrand in Chicago. A good deal of our work out of that office is with some very large employers who are interested in managed care from the global perspective. They are doing a good deal of direct contracting with providers, including hospitals and doctors in alternative settings. In some locations where they do not have a sufficient population base to contract directly, these employers are looking at what carriers have and trying to evaluate the value of these arrangements. These situations are constantly changing, so my talk will come from that perspective.

I would like to comment on what managed care is and what employers perceive that managed care is. I will spend a little time on the inventory method (my terminology for what I have seen some vendors come to the employers with)

trying to document savings, and then I will talk about a data analysis approach that we are using.

First, what is cost containment? Generally, U.S. employers have been looking at it from a bottom-line perspective. Cost containment means saving dollars and managed care means cost containment. I have recently seen a different perspective from foreign employers. We have seen some large companies be purchased by the British. Another company we are working with has been purchased by the Japanese. They are taking a little different look. They are interested in saving dollars, to be sure, but they are looking at managed care from a social experiment perspective as well. They see our health care cost escalation, how it is managed or not managed, as the case may be, and they are saying, "This is out of hand. We are going to show these U.S. companies how to do it." So, in many cases they are taking a look at this as a social experiment.

The U.S. employers and the managers that are handling it, however, are looking at it from a cost savings perspective. When we get into this, the question is what is cost savings -- is it short-term or is it long-term? Not unlike our politicians, most employers are looking at it from the short-term perspective. Will it improve my bottom line today? We will let future managements worry about the bottom line tomorrow. This gets into what are you attacking? What kind of savings are you trying to attain? If you are looking at the short-term, you are interested in the basic health care costs. What does it cost to provide services this year, next year, maybe the year after? But, that is about it.

What does it cost me to incent my employees to use these services? What does it cost to administer this kind of program? And, if you are looking at the long-term, then you might get into some of these ancillary things. Am I going to save any money in worker's compensation if I put in a wellness program? Or, will I save on illness days if I have some physicals, do some blood testing, and do some of the things that were addressed earlier? But, generally, I see employers looking at short-term incentives.

The first generation of managed care programs was basically cost shifting. Raise the deductibles, change the coinsurance. It will save us money right away and then perhaps it will stop some utilization. Perhaps it did. But we saw some step functions and then inflation took off and we were back on the same roller coaster we were on before.

Then we got into some second generation managed care. We saw some preadmission testing and controlling weekend admissions. The whole focus here was to control utilization.

Now we are moving into third generation cost containment. We see risk sharing arrangements. We see some fee negotiation. I am seeing employers contract for case rates and they thereby say that they do not care about utilization any longer. They have a case rate that controls how much they pay for any one thing. It is up to the hospital to handle the utilization. We see some large case management. Centers of excellence are on the horizon, telephone hot-lines, some wellness programs, and review of alternative settings.

When we get into these fee negotiations, we see a lot more in the way of claim audits. In other words, after we have negotiated for all of this, who is going to check to make sure that it actually got paid the way it said it was going to

be paid, and that we are actually saving the money we thought we were going to be saving?

The first financial analysis approach that I saw coming out of carriers and vendors of these managed care arrangements was an inventory method. Here is an example of something that was delivered to one of our large clients early in 1988 to discuss what happened to their managed care program. This came from a carrier in the Midwest. The employer was spending about $24 million in this particular area of the country. We see that the carrier told them that there were 48 chemical dependency and 79 psychiatric cases reviewed for a total program savings of $116,604. These savings were achieved through disallowance of a full 542 medically unnecessary inpatient days. For all cases with resolution days of January through June of 1987, 49% of the days reviewed for psychiatric and chemical dependency cases were disallowed. What the carrier report does not tell you is what happened to those cases. They did not vanish. How were these people handled?

Chemical dependency was another area they analyzed. Total days disallowed were 353 for almost one full year of inpatient days. Hospital savings on 32 resolved cases totalled $37,282 with physician savings reaching $2,182. Even if all of this was validated, $2,000 was not particularly phenomenal, given the $24 million overall that this employer is spending. The analysis goes on with nervous and mental disorders, and attributes this roughly $71,000 savings on the hospital side and $6,000 on the physician side. The problem is the reporting does not tell us what happened to the people. It is not outcome related. Do these people still have chemical dependency problems? Did they move to an outpatient setting? Did it cost money at the outpatient setting? If so, how much? It leaves all of these questions unanswered.

This same employer also received another report from the carrier that outlined some of the other managed care arrangements that were in place. The purpose appears to be to justify the activity that took place during the year. You can see that we have preadmission certification requests for the fourth quarter and year-to-date. We can see how many were requested, and we see how many preoperative days were eliminated -- two of them over the course of the year. We see how many admissions were denied as inpatient, but we do not see what happened to those denied inpatient days. We see continued stay certification requests.

Of those requested, all of them were approved. That makes me suspicious of their approval methodology. We often then wonder how the original days were established. Some of the carriers or vendors will establish the expected days right at the beginning, based on what the physician asked for. You ask for X days, we give you X days. And, then anything off that we save. Whenever I see that all of the continued stays were approved, we start to look at that kind of thing.

And we get into concurrent reviews and see how many days we have saved there. You can see the bottom line savings of this program was $70,600 for the entire calendar year. It does not tell us how much those alternatives cost or what we are paying for this program.

Another interesting thing that I have seen is that a mechanical savings report can generate savings if the patient dies in the hospital in fewer days than were approved for the stay.

From the vendor's perspective, there are some definite advantages to the inventory approach. It is nice and simple to explain. It is definitely determinable. You can count the days that were approved. We can count the days that were not approved, attribute a value to that, and tell the employer that you saved something. Some of these analyses are decent; some of them are not. Just because it says so on the report, does not mean that it actually saved you anything, and it does not follow the outcome of the patient through the entire process.

What I would like to talk about next is the data analysis approach whereby we are looking at the entire program from an overall view for the entire cost period. It is important to have a comprehensive picture, both of inpatient services and outpatient services, physician services, and so on. And, to take a look at the bottom line impact of all of the dollars being spent.

You need to start out taking a look at who is using the services? Why are the services being used? And who is providing the services? When you do that, you have to ask yourself, what are the problems that we see with this particular employer's health care costs? What more must we know about those costs? And what can we do to reduce them?

The purpose of the analysis is to select efficient providers and to select quality providers. Most often we end up negotiating rates, be that with a carrier or a direct contractor. With very large employers, we find they have quite a bit of clout and we can negotiate rates.

To begin with, we need to take a look at who is using the services? Which employees are using the services? Is it by location? What is the age/sex distribution? What do the claimants look like? Are they the employees, the spouses, the children? And what are the wage categories? Is it union, nonunion? Why are the services being used? What are the medical conditions that we are seeing?

When we do this, we start out with an employer and we say we need to take a look at these things. We need to take a look at the kinds of diagnoses that you are having with your employees. What are the preventable illnesses? What are the conditions that are not normally hospitalized? Does this vary by geographic region? What are the potential outpatient surgical cases? You have to be very careful; as was mentioned today, we find more and more that surgeries being performed on an outpatient basis cost more than they might on an inpatient basis. We need to know what that potential is and the way they are being served. What potential unnecessary surgeries are there? We take a look on a variety of cuts of the population.

Then we look at who is providing the services. Which hospitals are being used? Which physicians are being used? What are the kinds of special services? What is the climate in this location? How are people choosing these different providers? If Hospital A is really inexpensive, but no one is going to Hospital A, and Hospital A is going to give you a 20% discount, it does not matter because chances are your employees have decided that this hospital is not a quality hospital.

We look at the patterns of use -- days of care per thousand, the discharge rate per thousand, average length of stay, and try to establish an expected. Expected is a touchy issue. Different employers have different perspectives of

what their expected might be like. We like to work with them -- sometimes it is based on a comparable company in their area. Sometimes it is a fuzzy, "You tell us what it is." Sometimes they have some definite ideas of what their target objectives are, based on what their current experience is. But, we do like to develop an expected so that we can track whether or not we have achieved the results we are trying to achieve.

How much do the services cost -- average charges, room and board and ancillary? As we see that more and more states are controlling the costs of some of some of these providers and people are focusing on room and board costs, we see that those remain fairly flat, because those tend to be published. The ancillary costs take off like crazy.

And, finally, what are the patterns of use, comparing actual to expected?

These are two employers in the California area that we worked with. I normalized the discharges and have set them both to have 1,026 discharges, but the proportions are actual experience. In Company A, their largest number of cases is in the circulatory system area. They have a problem with neoplasms. With this profile, the employer needs to concentrate on what it costs to handle circulatory system problems, if he is looking for services. He has a relatively older employee base and we are seeing some of those diseases that are more common to the older employees. Company B has most of their cases under pregnancy and childbirth. So, Company B needs to be focusing on those kinds of situations.

So if Company A and Company B both negotiated the same set of rates from the same carrier or hospital, they may impact these companies very differently based on the expected kinds of cases that they might have. The point here is that you need to know yourself as an employer, know what your expected costs are coming from before you get involved in negotiated arrangements.

One of the other things we like to do is take a look at the providers. Once we know what the employer's profile is, we spend quite a bit of time reviewing the financial situation of the provider. The employer hopes to look at the hospital situation so we know just what it is that they are capable of providing. The hospital is a voluntary hospital, not a teaching hospital. We can look at a Medicare Intensity Index. That is a published index which gives us a clue as to the severity level of the cases being served at that hospital.

We look at how much money is being spent by Medicare recipients, how much is being spent by Medicaid recipients, how much uncompensated care is that provider trying to carry on its back, and then what is left from the private pay? Then, how does that client shape up compared with that provider? Is it a big player in that provider's services or is it small time, so they will not care to negotiate?

We take a look at how their mark-ups are running. We know if they give us a 30% discount and they're already losing 20% a year, that relationship is not going to last very long.

We try to look on a department-by-department basis. When we look at cost to charge ratios, we often see that medical supplies and charges to patients are where hospitals are making most of their money. We also see that there are some significant loss leaders as well.

So we get a feel for what the financial situation is at the provider. Where are they getting their money from? How are they able to cope with the situation? How might they best address the employer's needs?

We also look at a DRG analysis of the hospitals. In one case, the hospital's proposed rates were equivalent to roughly a 47% discount when we ran their expected cases through the charges. This told me this hospital really did not know what kinds of cases it was expecting to get from this employer.

And then the question becomes do you want to take advantage of this or do you want to have a long-term relationship?

So to conclude, I'd just like to say in this data analysis approach you need to look at the employer profile specifically. You need to know the providers inside-out. You need to evaluate the plan design, the cost of incentives, what you are doing to motivate your employees, what it is costing you, and develop expected measures.

In return, you get a better bottom-line analysis of what you expect to happen in the next year than if you just take a piecemeal look at what second opinion surgery is going to do or what a utilization review vendor is going to do. Disadvantages are that it requires much complex analysis, takes time, and requires demographic data that are very difficult to get.

MS. BRACKEY: We will take general questions now. We have had some material on design and cost issues. You may want to focus your questions on issues we have not yet covered today.

MR. DALE C. GRIFFIN: I would like to know your comments on the problem of outpatient and ambulatory services having their costs increase much more rapidly than inpatient. First, the implication is that they are overpriced now. Do you think that is true? Or were they underpriced to begin with? And if they are overpriced, have you seen movements already toward competition that will take care of that problem? Do HMOs have a big financial advantage here?

MR. ATKINSON: I think actual costs of outpatient services today are somewhat overpriced. This is an area where employers have not been able to quantify and manage the costs. Consultants are exploring with employers the idea of looking at outpatient costs. In the future, I think there really will be a deflation of the total costs.

MS. WODARCZYK: I think that without a doubt the outpatient costs are overpriced. Hospitals are striving to maintain their bottom line. So, when we focused on inpatient costs only, it should have been obvious that they were going to increase the outpatient cost if we did not watch that. There is still a lot of fat in hospitals; and while they claim that there is not, we should be able to get those outpatient costs down. My recommendation to most employers is to contract for outpatient costs at the same time as inpatient costs. I don't like to see them contract on a discount basis because all you see is an increase of 30% and then a discount of 10% and you are worse off than before. We have to get hospitals to agree with employers that a particular kind of service, regardless of whether it is inpatient or outpatient, should cost a certain amount.

MS. JOAN P. OGDEN: What are you seeing with regard to the move of surgery into physician office surgical suites?

MS. WODARCZYK: I have seen it. The biggest thing, of course, is the cataract surgery that moved into suites. The problem there is that surgeons do not like to reduce the cost of the service involved so they often charge as much as they might have had this been the complex surgery that it used to be. We are seeing Medicare catch on to that, and expect to see some changes in how doctors are being compensated for those kind of services.

Yes, there is more of that; and there is a battle between the doctors and the hospitals as to who gets the money for it. Hospitals have traditionally tried to attract doctors to serve in the hospital, and now the doctors are direct competitors with the hospitals. It creates quite an interesting political situation.

MR. CHARLES J. PAYDOS: It is interesting that both our panel members represent consulting firms. The insurance industry has gone through a bad period the last couple of years. And as a result of that, a number of group insurers have gotten out of the business. Also HMOs have had a fairly tough time with a number of them going out of business as well. My impression is that many large employers are not at all satisfied with their own managed health care effort either. In the context of that, what do you have to say about all these managed care techniques? Do you think that they will do the job for the country?

MS. WODARCZYK: About 25% of my time is also spent working with some of the carriers who have managed care programs in place that are not working very well. Some of these programs were ill planned and ill designed. They did not know what they were purchasing. The management and philosophy of the organizations they purchased did not fit their own. They just bought something to solve the problem and sold it to employers. The employers grew disenchanted and did not save any money. I do not think we did our homework, measuring who it was that we were contracting with and what it was we were getting. We were more interested in having something that covered the entire network . . . to have every hospital, to have something in every location, and we did not do it very well. I think if it had been done properly, we would be seeing some impact. I think the reason that employers are not working with carriers is because they are disenchanted with what the carriers have done. They have felt that until the carriers can get their act together we will have to do it ourselves.

They do not want to be in the business of insurance, but these are big dollars and they cannot afford to let the big dollars go out the window until the carrier gets their act together.

I think there is a lot of opportunity for carriers should they get things under control.

Can managed care work? It can work. We can do a much better job than we are doing without managed services.

MS. OGDEN: A number of my clients had prescription card service benefits for their employees with relatively low copayments, for example, $5 or $7.50. In recent analysis, I have been discovering that the employees are using these most effectively. They are purchasing prescriptions for $5 or $7.50 and selling them on the street for considerable amount of gain. What can be done to manage utilization of prescriptions?

MR. ATKINSON: Under that kind of environment, that is a difficult one. Most mail order and prescription card services are interested in getting out a quantity that will not cost them as much as it would to have someone come back every other day or every month. There is a trade-off idea of volume selling versus selling at the appropriate mark-up. I am not sure how you get at that one.

MS. WODARCZYK: I would like to make one comment about the projections that managed care does not result in very much savings. That is true, unless you have guts to do something about the utilization. Frankly, we have not had the guts to do something about it. Anybody who looks at national statistics can see that in the southeast, there is an incredible use of hysterectomies for birth control use. We have managed care programs in there, yet no one is willing to say, "No, this will not be done." Our society is not comfortable yet with telling people how their medical care should be handled. A utilization review program is no good unless you are really ready to review and do something about it.

MR. D. DALE HYERS: I want to echo what you have just said because what we have found is that the insurance carriers are apathetic. There is a lot that the insurance company can do and tremendous savings are available from it. Now, let me add to your problems. I always like to look out and see what is the next thing coming after we have skinned this bear. If you look at managed care today, you are only looking at managed care A. There is managed care B coming down the road. Take a look at the delivery of medical care and the fact that we have gone from the general practitioners to specialists. We are going to have to go to another level of managed care where we are not just managing in terms of costs, but managing doctors as well. Today, one doctor prescribes a medicine. The patient takes the medicine and goes to another specialist who prescribes another medicine that counteracts the first one. The first doctor then increases his until we have poisoned the patient with medicine. That is just a very small example of new level of managed care which we are going to face before the end of this century. We are going to have to have specialists in medicine. And I do not know what we are going to call this person, but he is going to have to be some sort of medical coordinator just from the standpoint of medicine and not from cost. We are going to have work carefully with them or we will have some very serious problems and the insurance industry is going to face it on both the cost and medical care.

MR. ATKINSON: Recently I attended a luncheon where Dr. Paul Elwood, who is the founder of the HMO movement, talked about the next generation of cost management. That is basically where he is coming from as well. He entitles it "Outcomes management." So I guess the person is an outcomes manager. The idea is to look at treatment by a physician to determine whether the recommended procedures are in fact the best way to go. No one has really done that. No one has actually quantified and looked at procedures and said, "OK, if you have two choices, A and B (drug A and drug B, in your example) which one is better? Doctors are free to make those decisions right now. There is no determination of which is the most effective treatment. Data collection is the way to begin the outcomes-management process and the next wave of cost management.

FROM THE FLOOR: I have a comment and a related question. The comment is an appreciation for your view of the long-term. What happens to a patient just because there is a cost savings in a particular case. A carrier in my state has a $5,000 maximum outpatient psychiatric benefit. In a serious situation, you can hit that maximum quickly. The carrier is concerned about raising the maximum because of all the other problems that they have. They are not really willing to

raise that outpatient maximum without some data to say that it will not increase costs significantly. Do you have any such data?

MR. ATKINSON: I might say that $5,000 is in the range of common practice. I see most insurance carriers offering $5,000 to $10,000 on mental and nervous outpatient care. The big problem right now is limiting unnecessary utilization, not necessary utilization -- how to assure that utilization is appropriate utilization.

FROM THE FLOOR: This is just a thought to chew on with respect to what seems to be the next big opportunity for cost savings. On the one hand there seems to be widely disparate rates of utilization by location, for different types of procedures. It seems that health care is a local kind of product; it is the face-to-face interaction on behalf of the subscriber or the insured with the physician that will produce the greatest level of savings. Do you think it is a view from the national level or from the local level that will bring the next level of savings?

MS. WODARCZYK: Health care is local at this point, although we are seeing Medicare turn this into a national base somewhat. Many large employers are taking a look at, for the first time, what is happening in their different locations and they are asking the question, "Why is it different?" They are looking for providers that do provide services in the most efficient manner and then selecting those providers. I think we will see, slowly but surely, some national practice patterns or some national practice requirements of doctors as we go forward.

MR. WILLIAM R. LANE: Compliments of our federal government, Section 89 now makes a benefit plan discriminatory if the benefits are not definitely determinable. Do you see a problem with case management or with utilization review where patients cannot tell ahead of time what the benefits are going to be because they do not have the expertise to determine if it is medically necessary according to the rules? Perhaps the whole program is not definitely determinable according a federal law and therefore, is discriminatory.

MS. WODARCZYK: How about a Section 89 seminar after this?

Section 89 is one of the bigger problems that we will have to face. Maybe that will be covered in Thursday's sessions.

MR. SCOTT R. SIEMON: You mentioned third-generation cost management fee negotiations. I assume you are talking about with the MD or the doctor. How many employers do you see doing this and how are they doing it?

MS. WODARCZYK: We see that as a second step for large employers. The first thing they do is contract with the hospitals. Then they move in the second or third year to contract with the doctors for services. I would like to see them contract on a capitation basis, but that does not happen all the time. Sometimes they contract on a discount basis because of the political climate of the area.

MR. SIEMON: I am wondering if anyone is doing it at a point of claim or precertification . . . certifying a hospital stay or a surgery and trying to get into a negotiation phase at that point?

MS. WODARCZYK: I have not seen that happen.

MR. DAVID WILLIAM DICKSON: I want to get into a little bit of theory for the future. What I hear being said is that the best way to handle utilization is to have some type of a selective contracting, and that traditional indemnity insurance probably is not viable long-term. Everybody sooner or later is going have to have some type of preferred provider or HMO . . . some type of selection where you have a panel where you say these physicians have either been negotiated with or they are more efficient than other physicians or hospitals. If, as good actuaries, we all come up with the same criteria for determining which hospitals are the most efficient, then we are all going to be using the same physicians and we are all going to be using the same hospitals. We are going to push somebody out of business. I think one of the key economic points of being able to selectively contract is that you have to have an oversupply of hospital beds, of physicians, of specialists. Theoretically, at some point, we will probably be rid of that oversupply and we would all be using the same people. Does that bring us back to point zero where we really will not be able to negotiate any longer, and at that point we are all back on the same footing again? There is no set of preferred providers, and so forth.

MS. WODARCZYK: I think that the premise that all the actuaries would use the same criteria is amusing. I do not know if they would agree on anything. But, yes, there is an oversupply. The supply and demand scale on health care is out of whack totally. I think we have a long way to go before that will happen.

MS. BRACKEY: If we have built the incentives to discourage inefficient providers and also established the controls to ensure that people are not getting improper care, we will have accomplished a great deal. But we have not done that yet.

MR. ATKINSON: While we are theorizing, long term we do not know how the practice of medicine is going to change with technological advances, etc. So, I am not so certain that we will be back to ground zero again.