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POINT-OF-SERVICE PLANS -- WHERE ARE WE NOW?

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Panelists: EDWARD C. CYMERYS
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Recorder: STEVEN N. WANDER

- Overview of current enrollment statistics/trends
- In-network and out-of-network utilization patterns
- Trends in benefit design
- Employer/benefit consultant demands
- Employee/employer satisfaction

MR. ANDREW H. HILES: We are going to talk about some of the things that are new with regard to point-of-service plans from several, different perspectives: the employer's perspective, the carrier or network manager's perspective, the HMO's perspective, and the consultants' and employees' perspectives. Dennis Lee, vice president of Wachovia Banks, located in Winston-Salem, North Carolina, will talk about Wachovia's experience in going to a point-of-service (POS) managed care program effective January 1, 1992. Ed Cymerys, Vice President of Finance and Risk Management for Aetna, will talk about Aetna's role in the process. We will discuss a case study where Dennis Lee will represent the employer, Ed Cymerys will represent the insurance company or network manager, and I will represent Towers Perrin, the consultant.

Let's talk very briefly about some employer trends. We have seen recently that employers are becoming much more demanding of intermediaries and providers, and we see this in a variety of ways. One of the ways is requiring multi-year performance guarantees, and those performance guarantees can take several different forms.

Typically, however, we divide them into claims-cost risk-sharing where the provider guarantees that claims will not exceed a particular trend for one, two, or sometimes even three years into the future. Also, we see an enhanced type of performance standard, not the old payment of claims accuracy or financial accuracy, but something much more comprehensive. This includes provider relations and account management teams getting I.D. cards out on time. It is a much broader version of performance guarantees than what we saw four or five years ago when the focus was really on claim payment and claim payment accuracy. We have seen our clients show interest in hold-harmless-type language so that the network managers become responsible for network management. If one of the providers does something outside the scope, or practices bad medicine, we do not think it is really the employer's obligation. We think it is the responsibility of the network manager. Not very many of the carriers were interested in this three or four years ago, but now most of the major national carriers have come to the table willing to negotiate hold-harmless language for their managed care clients.

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Another interesting trend we have seen with employers is the carving out of specialty services from the general medical plan, and these typically are in the areas of prescription drugs, mental health, substance abuse, and other high-cost diagnoses in which it does not make sense to go to a network-based program. For a lot of our clients who tend to be national in scope, there is not a network everywhere that happens to have employees. It makes sense to focus on some other areas where you do not necessarily have to have a full-blown network available.

Carriers seem to be retrenching a little bit in evaluating their current network sites for long-term viability. We have not seen carriers with unbridled enthusiasm in terms of entering new markets. Often they tend to be responding to one of their larger clients who is requesting they move in that direction, because they happen to have a concentration of employees in that location. We also have seen carriers becoming more and more interested in forming alliances with independent networks to expand coverage. I think very few of the national managed care providers now think that they can have a comprehensive network in every location in the United States. Thus, they are looking to hook up with regional vendors to try and create a broader network.

We also have seen some changes on the HMO side of the house. HMOs have been increasing in profitability, and their control over medical trends seems to be improving. Also, some of the HMOs have shown an interest in offering a broader array of products, including point-of-service and indemnity plans, as well as self-funded HMO plans. We call them HMO look-alike products.

What are consultants doing these days? It seems to me there is a broader dissemination of managed care expertise in the major firms. Most of the major firms are hiring specialists and clinicians. People who never considered working on our side of the fence now work for Towers Perrin, Mercer and all of the other firms. We also have seen a lot of consultants moving among firms. If, four or five years ago, there was a critical mass in one firm, the other firms realized that was the place to be, and they tried to swipe some of those folks away.

Projects have become streamlined. I am not sure this necessarily implies that fees will be coming down. In some cases they do; in some cases they do not; however, we do see a lot of smaller employers getting involved these days. A number of the major consulting firms, and the smaller ones as well, have figured out how to do projects fairly well. After three or four years, we can offer flexible benefit services to smaller organizations with smaller budgets.

We also have noticed over the past couple of years that we tend to agree more with the carriers and network managers on the arithmetic. When we are trying to project future claims costs for negotiating a performance standards contract or a risk-sharing type contract, we are no longer on the opposite side of the carriers. As a larger base of experience develops, everyone has become more comfortable with how some of the factors may differ and the correct way to calculate these factors. How efficient is a network in Columbia, South Carolina versus one in Atlanta or New York City? There is a common methodology developing to come up with the answer.

Towers Perrin has done several surveys of employee responses to managed care programs, point-of-service, and others. One of the interesting things we have learned is that the initial resistance to managed care programs tends to dissipate quickly. With an effective communications program, employees are comfortable with managed care after the first year or two. Once employees become accustomed to the concept of using their primary care physician or going to a staff model HMO, they are likely to be as satisfied as they were before managed care was introduced, in the days when they were in an unmanaged or lightly managed indemnity program.

Dennis Lee will share his experience of going to a managed care program.

MR. DENNIS LEE: Wachovia Corporation is a commercial bank holding company with dual headquarters in Winston-Salem, North Carolina, and Atlanta, Georgia. The three banking entities that make up Wachovia Corporation are Wachovia Bank of North Carolina, Wachovia Bank of Georgia, which was formerly the First National Bank of Atlanta, and South Carolina National Bank in Columbia, South Carolina. Our current asset size is $33.6 billion, which places us in the top 25 largest bank holding companies in the United States.

In 1990, the employee benefits committee of Wachovia Corporation set out to develop a strategy to address the ever-escalating cost of health care for our company. We felt we could not do this on our own, so we sought consulting help. As is typical of our organization, we interviewed six different consulting firms and reviewed proposals from the different firms before making our final selection to go with Towers Perrin. Upon that selection, Towers Perrin organized several meetings and helped us develop a series of objectives to meet the needs that we had identified in our initial health care discussions.

To assure the availability of quality health care at an affordable price for all Wachovia employees, we felt it paramount to continue to put the focus on quality and less emphasis on cost, although cost was certainly a very important issue. The second objective was to maximize the value, perceived and real, of all benefits, including family-life or work-life issues. I believe it is important from our standpoint to address the perceived value of benefits. Oftentimes, working in the employee benefits area, I find people do not really have an appreciation for what they have, because they have nothing to measure against. Basically, there is a feeling among employees that benefits are an entitlement, and not a form of compensation. Until you can give them a sense of comparison, they really do not realize the value of the various benefit programs that they have. This was interwoven into our overall approach to addressing the health care issue. We wanted to provide the same plan for all Wachovia employees. We wanted to continue to be committed to the family unit; provide financial equity to all participants in the plan; design a plan that specifically addressed cost and quality of care issues concerning obstetrics, mental health, and prescription drugs. We wanted to achieve a predictable trend factor that was below area and industry norms. We wanted to include wellness and preventive care programs to encourage healthy lifestyles among our employee population and to educate our senior management employees on various health care issues. Last, but certainly not least, in terms of importance, is be sure to communicate all benefit plans to the employees effectively.

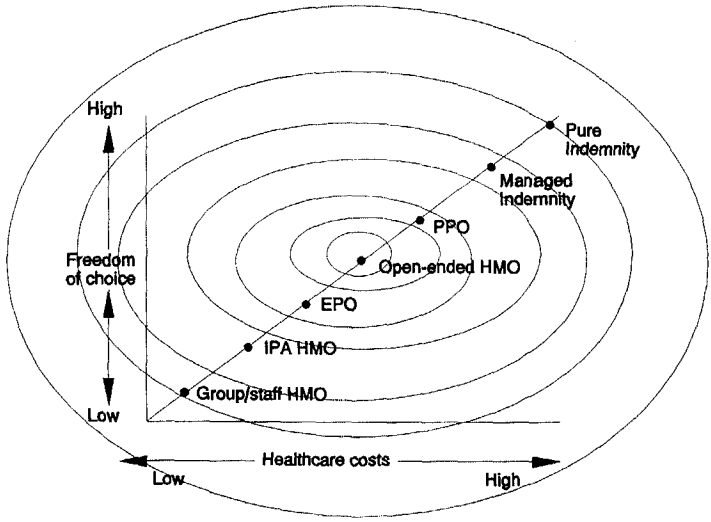
Our experience will not necessarily be identical to that of other companies who have gone into a managed care environment. First, you have to understand that in 1987 Wachovia Corporation as it is today did not exist. In 1986, Wachovia Bank of North Carolina and Wachovia Bank of Georgia merged to form what was then called First Wachovia Corporation. The two institutions were very different in terms of their benefit programs for employees. For instance, Wachovia Bank of North Carolina had a very generous benefit program. They paid the full cost of health care for the employee. They paid about 75-80% of the cost of insuring employees' dependents and had a very low deductible. It was a traditional indemnity plan. On the other hand, First Atlanta Corporation was more in the area of what we call managed indemnity. As a part of their plan, they had utilization review, concurrent review, and discharge planning. They had a higher cost-sharing ratio (about 40/60) among employees, and they also had HMOs available to employees in the Atlanta area. We had two institutions similar in their line of business, similar in their approach to selling banking services, but very different in their philosophies about benefits. The first hurdle to overcome was a common program that would enable us to merge the benefit programs of the two companies.

In 1991, we acquired South Carolina National Bank and, once again, had to go through a similar process of assimilation. South Carolina National was also a company that was at the end of the spectrum that we would call pure indemnity. They had no utilization review, no concurrent review, just a pure indemnity plan. Chart 1 shows the relationship between the freedom of choice among people who select their health care plan coverage and the health care cost. It is obvious from the illustration that the greater the level of choice among individuals to choose providers or to choose services, the less control you have over the cost of those services. The more restricted that freedom, the more control you have over the cost.

As you are probably aware, at the high-freedom/high-cost end of the spectrum is your pure indemnity plan where individuals have absolute freedom to choose their provider and to seek services when they want them from whom they want them. A classic case is the emergency room. An individual may have a pain in the evening and go to the emergency room instead of waiting until the next morning and calling the family physician. This produces very high-cost services for fairly minor ailments, in most cases. The other end of the spectrum is a group or staff model HMO where the HMO actually hires a staff of physicians to work in their own facilities. They can deliver care at the most economical price, although some would question whether it is the highest quality and the most appropriate care. One of the arguments we will continue to hear is that managed care means denial of care. In some cases you can make an argument that perhaps the way you manage care and manage cost is by denying care when it is necessary.

On the other hand, we prefer to believe that if you truly manage care with the intention that the individual gets the right care in the right increments at the highest quality on the front-end, you will avoid the additional costs coming back to you on the back-end. Having to treat a person a second and third time because of improper care on the front-end can be very costly.

CHART 1
Wachovia Considered a Continuum of Delivery Approaches



Note: Positions on the continuum are illustrative.

In 1987, Wachovia was really at about three different points along this continuum. On the high-end, as I mentioned, Wachovia Bank of North Carolina was in a pure indemnity environment; First National Bank of Atlanta was a combination of managed indemnity, plus both a staff model HMO, PruCare of Atlanta, and an individual practice association (IPA) model HMO, HealthAmerica. We had employees strung out over three different health care options in the Atlanta location. When we merged the two institutions we decided to introduce a flexible benefits plan; in the process we gave individuals a choice of two different indemnity plans and, in some cases, HMOs. We also began the process of educating the employees in our North Carolina market about the important features of utilization review, discharge planning, etc.

One of our efforts has been to move down the continuum and get more of our employees into a managed care environment. It has been a successful effort on our part. I will share some of the statistics with you in a few moments. After we selected Towers Perrin, and they helped us develop our stated objectives for the design of a health care program, we started looking for a carrier, a third-party administrator and a network manager. This process began by accepting proposals from several different insurance companies. We reviewed proposals from Aetna, CIGNA, Metropolitan, Provident, Prudential, and The Travelers. We made the decision to go with Aetna.

We were looking for a financially integrated, point-of-service HMO, and indemnity coverage. In every place possible, we wanted to give our employees three different health care options: a pure HMO, a point-of-service plan, and a traditional indemnity

plan. There was one caveat: the traditional indemnity plan would be more of a catastrophic plan with a high deductible and moderate premium, but a plan that would definitely cause someone to think long and hard about choosing the indemnity plan, as opposed to gravitating toward the managed care options. We met with the various carriers, and we made our decision to go with Aetna. We began the process of developing the program. The target implementation date for our managed care roll-out was January 1, 1992. We allowed ourselves about 12-18 months to actually develop the networks, get the systems in place, and communicate this to the employees.

Two things that we took into consideration as we made our selection were the access and the coverage potential of the various insurance companies. It is important to remember that, in Atlanta, we had already introduced HMOs; since the time of the merger we had used Partners of Atlanta as an HMO, which was owned by Aetna. In addition, we had, during that time, introduced HMOs to North Carolina, and Partners of North Carolina was an HMO in the Piedmont triad area (Winston-Salem, Greensboro, and High Point, North Carolina), affiliated with Aetna. Admittedly, one of the things in Aetna's favor was that they could meet all of our other requirements. They already had a foothold in Winston-Salem and Atlanta, because we had a large number of our employees in those networks. They were able to come across and meet us on other areas that were of extreme importance to us. We were very pleased to select Aetna to be our partner as we moved forward.

Of course, quality of care was very important to us. One of the things that impressed us about Aetna's program was their credentialling process for their physicians -- not only the credentialling up front, but the recredentialling process they went through on an annual and, in some cases, biannual basis. Utilization performance was important also. We wanted to be able to measure the effectiveness of the enrollment in the managed care options, both the point-of-service plan and the HMO. We wanted to look at them in the aggregate, as well as on an individual basis, to help us compare pricing and risk.

We were looking for a commitment to Wachovia. One of the things we talked about virtually every day was partnership; this had to be a partnership. We had to work through our differences and come to a consensus on what the critical issues were. We had to lock hands and march forward to accomplish the objectives we had set for ourselves.

Aetna was able to offer simplicity. Our employees had been through a lot of change in the few years since the merger, and we wanted to offer a program in which they could make a very simple transition. Centralization of claims processing and member services -- sort of one-stop-shopping -- was important to Wachovia. One of the things at Wachovia we are most proud of is a concept called personal banker. Every customer of the bank is assigned a personal banker; that personal banker coordinates all banking services for that customer. If you have a question about a loan, opening an account, lines of credit, or anything of this nature, you go to the personal banker, and that individual coordinates your services.

We wanted that same concept to come through in our health care plan. We wanted employees to be able to call one place and have everything that they needed to have

done coordinated through that particular location. Aetna was willing to do this. They set up a separate member services unit just for Wachovia employees. They gave us a single telephone number that employees could call, not only with questions about claims, but also questions about providers, the network, special services, utilization review, etc. Aetna was able to give us a single source, if you will, for all this information, which made it much easier to communicate to our employees.

In addition, we wanted risk sharing. We wanted an arrangement set up so that, if claims exceeded a certain level, Aetna would share in those additional costs. On the other hand, we had an arrangement that, if claims were to fall below a certain level, we would be willing to share in the savings. We have sort of a risk savings/sharing arrangement.

We also wanted performance guarantees on the front-end regarding implementation. Aetna put on the table some fairly substantial financial penalties if they did not meet certain deadlines in terms of implementation. These performance guarantees included network development. They committed to have certain networks developed, and up and running by certain dates; if they did not meet the deadline, there was a financial penalty involved. They also committed to have claims turnaround. They committed to have 95% of all claims turned around in 14 days from the date they arrived at the claim center. Again, financial penalties were on the table if they did not live up to that.

Aetna does a survey for us of a sample of individuals who submit claims or call into member services with problems or questions about health care. Individuals are sent a survey form, and they are to respond to it. They are asked if the individual they contacted was helpful, responsive, and courteous. Did they help you get your problem solved? There is a whole list of questions. Aetna committed that we would have a 95% positive response from employees on the services provided through its member services area. These were the types of things that Aetna committed to deliver, and they were willing to put some financial might behind them.

We asked Aetna to do future network expansion commitments. Initially, we started out with a three-year plan. In year one, we wanted a commitment that we would have deliverable networks in Atlanta, Charlotte, Winston-Salem, Greensboro, High Point, and Dallas. We do have a small lockbox operation in Dallas, and it seemed like a natural extension to use the Aetna Partner's plan in Dallas as an HMO option in that particular location. Dallas may seem a little strange. It is not one of our higher population areas, but we have said that, if we can drop an HMO in a location without creating a lot of turmoil, we will do it. We would rather have people in a managed care environment than a pure indemnity environment, and Dallas was a natural for this.

In year two we wanted to extend the networks into the Raleigh, Durham, Chapel Hill, North Carolina area and the Columbia, Greenville and Spartanburg, South Carolina area. In year three, which is the year that we are currently in, we are looking into expanding the network to Savannah, Georgia; Charleston, South Carolina; Augusta, Georgia; and, Macon, Georgia. So far everything has gone well. We have been able to meet all the deadlines and get the networks up and running. The response from the employees has been very positive as well.

Another thing we looked for from Aetna was account management structure. We wanted our accounts set up in such a way that we could look at our claims experience not only by plan but by state. We wanted to be able to monitor what type of cost savings we were getting in each of our state locations to compare them somewhat against one another. This required Aetna to do a few things differently in their accounting system that they were not accustomed to doing. They were willing to meet our needs and expectations. Also, we wanted comprehensive, understandable reports. This is an area again where Aetna has, for the most part, met our expectations. Where they have not, they continue to work on developing reports that will help us; we are novices in the area of understanding what is going on within our health care plan.

One of the more difficult things from an employee benefits perspective is to take reams and reams of information about diagnoses, treatment patterns, and cost, boil them down to manageable numbers which we can take to an executive management group, and say, "Here's what's going on in our health care plan. Here are our top five diagnoses. This is where the money is being spent. Here are some actions that we can take to help address this particular problem." So, we looked for reporting capability from Aetna.

We looked for flexibility. The key was that we wanted a couple of items that were somewhat out of the ordinary. We wanted a fully integrated managed mental health/substance abuse program that incorporated our existing employee assistance program (EAP). When Aetna first came to the table, they indicated that they would like to have us use Health Affairs International, their managed mental health/substance abuse utilization review (UR) group, to manage our mental health program. We responded that we have EAPs in our three locations, and we have been using them for three to four years. Our employees are comfortable with them and have confidence in them. We would like to integrate our EAP into the managed mental health care program so that a referral from the EAP will be treated the same as a referral from the primary care physician.

This required a lot of work, but it was a successful venture. We brought individuals together from Aetna, from Health Affairs International, from our two EAPs and from our employee benefits section. We developed an arrangement whereby employees can go either to their primary care physician or to the EAP; a referral from either will get them into the network at full benefits. In addition, we added a penalty that the benefits are reduced to a 50% level if you bypass the EAP or your primary care physician and go for mental health/substance abuse treatment. Thus, there is a financial disincentive in the plan, but there also is the incentive of being able to go to an EAP, as well as a primary care physician.

We had a mail order prescription drug program in place; Aetna agreed to let us continue to use that particular program, as opposed to switching over to a comparable program Aetna had. Again, the least amount of change there is for employees, the more desirable. Employees were accustomed to using Baxter Health Care for their prescription drugs. They were confident in that company, they had good results and we had good feedback. We figured why upset the apple cart. Again, Aetna was willing to be flexible.

Our last concern was a Wachovia-designed prenatal care program that began in 1989. Aetna has a prenatal care program; however, there were some subtle differences in the way ours was working and the way theirs was designed. They agreed to adopt our particular program and manage it on our behalf. Once again, flexibility on Aetna's behalf was extremely important.

As a result of our discussions with Aetna and the work that we did with Towers Perrin, we came up with a plan design we refer to as managed flex. In what we refer to as our managed care sites, we replaced our former traditional indemnity plan, which was a $400 individual deductible plan, with a point-of-service plan. We no longer offered the indemnity plan. In our managed care sites, we offered three plan options: a pure HMO, a point-of-service plan, and a catastrophic-type indemnity plan.

The low-option indemnity plan is available in all locations. In sites where we do not have a managed care option, like Asheville, North Carolina, employees have a choice of two indemnity plan options -- a low-deductible option and a high-deductible option. As we try to expand our managed care program into those locations, we will probably reel in that low-deductible indemnity plan option and encourage people to move in the direction of either the HMO or the point-of-service plan.

The results have been very favorable, and we have really been pleased with where we are. We would like to be in better shape in terms of penetration, but, given the massive change we have undergone with our employees, we feel we are moving in the right direction. The trend is certainly favorable.

In 1992, managed care was available to over 70% of the Wachovia employee population. In those sites where managed care was offered, 60% of the employees enrolled in a managed care option. I prefer to look at that a little differently than just saying 60% of those who had managed care available to them enrolled. I like to take out those individuals who chose not to participate in any health care plan; in most of our locations we have somewhere in the neighborhood of 10-15% of employees who will actually opt out of health care coverage. They have spouses that are employed and are covered under the spouses' plans. In the flex plan, obviously, they have the choice of being in the medical plan or not.

In the case where we look at only those employees who selected a health care option in a managed care site, we have a 70% penetration. This will vary from location to location. Just to give you an example, in the Piedmont-triad area, we have 75% penetration of all employees who participate in the flex plan. Of the employees who elected a health care option, 82% are enrolled in either the HMO or the point-of-service plan. In Atlanta, we have 62% penetration. If you look at only those who selected a health care option, it is 70%. In the Greenville-Spartanburg area, we have about 26% of the employees enrolled in a managed care point-of-service plan, if you look at all eligible employees. If you exclude from that group those who did not elect health care coverage, we have about 30% penetration.

If you look at locations like Atlanta, Winston-Salem, Greensboro, High Point, and Charlotte, where HMOs had been present before, even though they may have been different HMOs, the vast majority of people who are enrolled in a managed care

option are enrolled in a pure HMO. They have gotten over the hurdle; they are accustomed to using network providers, and they are comfortable with an HMO.

In those locations where managed care is being introduced for the first time (Columbia, Greenville, Spartanburg), there is a higher enrollment in the point-of-service plan and a lower enrollment in the HMO. This is expected, in my mind, because the point-of-service plan really is more of a transition plan than it is the final plan that you want to have in place.

Given a choice, I would rather have all of my employees in a traditional HMO than in a point-of-service plan or an indemnity plan. If you remember back on the health care cost containment continuum, the more control you exert over the accessibility of physicians, and the more control you exert over utilization, the more control you can exert over the price of that care to the individual. We see the point-of-service plan as a transition plan to help people get accustomed to the idea of using a panel of physicians or a network of providers, while still having the element of choice; they can go outside the network and still receive health care services, albeit at a lower reimbursement rate. Again, we are pleased with the enrollment we have had to date in our managed care options, and we are beginning to see some very positive trends develop.

Preliminary 1992 financial results show that our per-employee costs are up 10-13% over 1991 costs. This is particularly pleasing to us because in the previous years, 1987-91, we were seeing an annual increase somewhere in the neighborhood of 20-22%. We feel that managed care has definitely had an impact on Wachovia's health care plan; our employees have gotten accustomed to the idea of going to a panel of providers and getting their services coordinated by a primary care physician. In 1993, we hope to see even more favorable results than we saw in 1992.

We went back to the beginning when we first rolled this program out. We projected what our health care costs would be over the next five years if we did nothing, if we left everything exactly as it is. We applied the historical trend factor for our plan to the next five years. Using that as a benchmark, we compared our 1992 actual results to what we had predicted had we not gone in the direction of managed care. We saved $4.5 million in one year, and that represents about a 10-15% savings; our claims costs for 1992 were at $38 million. Therefore, we feel that managed care has definitely paid some dividends for Wachovia.

What are the next steps? We want to focus on utilization results. Why are employees continuing to select the low option, catastrophic indemnity plan in locations where managed care is available? This is particularly interesting in Atlanta, Georgia, where we have about 60% of the employees enrolled in the HMO or the point-of-service plan. There is about a 15% opt-out rate, and another 25% are in the basic plan. The basic plan has an $800 individual deductible with a $2,400 stop-loss limit. We are curious why that many people would continue to opt for a traditional indemnity plan when these other two options are available.

We want to take a look at plan selection, go to the employees and find out what motivates them to choose one plan over another. We want to continue to do surveys on employee satisfaction with the network. We want to explore new

managed care sites. I mentioned previously that, in 1993, we will be looking at locations like Savannah, Augusta and Macon, Georgia, and Charleston, South Carolina. Augusta, Georgia is approximately 50 miles from Columbia, South Carolina. There is an opportunity there, if we get a network established in Augusta – they can blend together. We could have a standard-metropolitan statistical-area-type network around that particular location. The same thing is true for the Savannah/Charleston area. Savannah and Charleston are about 70 miles apart. There is an opportunity to build those two networks towards a common center point. We are trying to explore new managed care sites and update Aetna reports. There are some things we found we did not get out of the reports that we feel we should have asked for. We have gone back to Aetna, and they have been very cooperative in helping us get that information.

In closing, I would say that the experience has been an interesting one. As I mentioned earlier, our experience has not been identical to that of any other company. One of the things that stands out in my mind is that we introduced HMOs in several of our locations where we had a large concentration of employees. We did not really see the impact of the point-of-service plan in those locations like we thought we would. We did not need a transition. People had already made their mind up that they were willing to go with the managed care environment, and they gravitated toward the HMO. I believe we also confirmed that, if you are introducing managed care for the first time in a location where people have not been exposed to it before, the point-of-service plan provides a very attractive bridge for individuals who are skeptical about using managed care networks, using a select panel of physicians and a primary care physician. Also, if they feel they need a specialist and do not want to go through their primary care physician, they can go outside the network. They will still get some coverage. It will not be as good as if they used network providers, but it is a taste of what managed care is all about.

As we go forward, we will be watching the migration of employees from the point-of-service plan to the HMO. We believe the satisfaction level will be such that those individuals who try point-of-service for a while will decide to go straight into the HMO, get the high level of benefits with the lower co-payment and the broader coverages.

MR. EDWARD C. CYMERYS: I am going to give an insurance company perspective on several of the things that Dennis Lee already described. I am going to break down the description into three categories: the preliminary meeting that Wachovia held to describe the program they wanted to implement, the team that we had to assemble to respond to those needs, and then the request for proposal (RFP) process itself. Basically some of the actions that came out of this process will somewhat validate the trends that Andy mentioned on the carrier side of things.

Dennis ran the initial meeting with Aetna. This was a critical meeting for us because we really wanted to understand what Wachovia was looking for. Wachovia's strategy and commitment to managed care was clearly stated, and they were willing to use their leverage as a major employer in their community to help get managed care going. To put this in perspective, we all come from different parts of the country. There was an article in *USA Today* that identified areas of the country that are most and least receptive to managed care. Wachovia is planted right in the middle of some of those areas that were identified as the least receptive to managed

care. This can somewhat underscore what he was up against -- both with his employees and the provider community.

During the preliminary meeting, Wachovia said they wanted a carrier as a partner to manage their claim costs, to manage their provider networks, and to be responsive to their program as it evolved. Dennis described it as a hand-in-hand attempt to implement this program, again recognizing that the community was not a hotbed of managed care.

At the meeting, it was clear that Wachovia was looking for a managed care focus. From our perspective, it was clear we had to assemble a team that had that focus. We included a senior medical director from Aetna; an account manager who would service the account after the sale, carry through the commitments that were made up front, through implementation and as an ongoing service; an installation manager that could be accountable for meeting all the installation deadlines; a sales support staff to, again, help the process of responding to the RFP and making sure that it happened; and local medical management representatives who were going to be involved with the program on an ongoing basis and act as network liaisons because, again, they had a number of sites that were in different situations. A few years earlier, in responding to an RFP for a company like Wachovia, the medical director and network management staff would have been missing from the list of people that now, with managed care, are crucial members of the team.

The RFP was an interview. We found Towers Perrin's RFP to be very thorough; it was very detailed as far as the location of the employees. It allowed us to do a careful analysis of how well we could service those members in our networks and contained a detailed mapping of where our providers were compared with the employees. The RFP also detailed the list of things that Wachovia asked of Aetna and allowed us to respond to all of the details.

The network match showed that the program they wanted to implement was going to cover roughly 70% of their employees, and that included Winston-Salem, which was really an affiliated HMO. Carriers obviously have to try to expand their geographic coverage by forming these affiliations with HMOs in locations where they do not have a presence. The alliance has to be strong enough so that, if a customer like Wachovia is looking for a point-of-service plan, they will be willing to work with us and live up to the same kind of commitments we have to live up to on performance.

Andy and Dennis indicated some of the performance guarantee areas that were requested: claim processing turnaround time and accuracy, satisfactory account management services, I.D. cards and provider directories, delivery, and data analysis and reporting. The requested performance guarantees also dealt with member satisfaction. A satisfactory appeal process system for members is a key in managing the liability that is present in some of these systems. There needs to be an avenue for members who are not satisfied or are unhappy with the care, so they can be heard without having to go into the court system. They also asked for an in-network usage performance guarantee to ensure that the networks are accessible and user friendly so that people will take advantage of them. In the area of provider education, they wanted to make sure the providers were being educated on the program so that,

when the members go to the provider's office, there is an understanding of the program.

Our focus has been to have a very open relationship with Wachovia as we move forward, to put a high priority on committing to things that we are confident we can deliver, and to make sure that we deliver on those commitments. We focused on a joint strategy to cover some other areas and to close the coverage gaps.

Wachovia has been supportive of using quality providers and a joint effort to educate members; as far as the commitment to quality providers, there is credentialling. Many times you get into a situation where you are introducing managed care in an area where it is fairly new, and the members are new to managed care. People have a list of their specialists or doctors they want to include in the networks. It is critical that, in a system like this, you focus on the natural referral patterns of the physicians; have primary care physicians and specialists that really understand managed care and are willing to work with you to make it happen. They also must cooperate with the credentialling process and the quality measurement that needs to happen.

Try to look at this in the context of the legislative actions that you have heard about in many of the other sessions. The direction that Wachovia has moved is very consistent with what is described as the managed competition model. They put an emphasis on medical management, a program that really focuses on lowering claim costs and eliminating unnecessary utilization. Also, part of the managed competition direction is for employers to use their leverage with providers and focus through a carrier or accountable health plan to help get the providers on board with managed care. They can manage those providers to optimize the quality and minimize the cost of the program, and then develop a partnership with the carrier and the employer focusing on the members' health, or getting them healthy if they are ill.

Again, if managed competition moves further along, Wachovia would not be that far from having set up their own accountable health plan that would meet a lot of the guidelines that are floating around.

MR. MARTIN E. STAEHLIN: What statistics do you have on why the trend line was lower than you expected? You said it was 10-13%. I am particularly interested in the in-network versus the out-of-network components; you actually tied some of those savings to the people that were using the networks as you constructed them.

MR. LEE: Right now, we do not have the final statistics for 1992 utilization where we can see the in-network versus out-of-network usage. In talking with our claims processing office in Macon, they say that the in-network usage is very high. We had very little out-of-network usage among those individuals who have chosen to go into either the point-of-service plan or the HMO. I attribute it basically to the discounts, quite frankly, that we are getting through some of the providers and the hospitals. I also think that just the utilization is down; that the care is, in fact, being managed more carefully than it has been in the past when people had the freedom to go to whom they pleased and at what time they pleased.

MR. HILES: There are some other aspects to that savings number to which we need to be sensitive. In the past, the HMO relationships Wachovia had were capitated-type

arrangements where Wachovia paid a premium and did not participate in the financial experience. We thought that cost us some money. The 1993 savings number we have identified is in an environment where the HMOs are self-insured with everybody else. So, to the extent that we were giving away some dollars in that insured HMO-type arrangement, I think we have saved some dollars there as well. The savings number might even be a little more favorable than it appears on the surface because a point-of-service plan, where many of our high-option indemnity people gravitated to, is getting a much greater benefit value than the managed plan. We are saving money, and we are giving a better benefit to employees.

MR. STAEHLIN: How often from either a consultant or an Aetna perspective would you analyze the trend line that Dennis is looking for? If you are saying he is waiting for a year, does he have to wait another year to see 1993 or are you going to do a quarterly update?

MR. HILES: We like to do that every time the client pays us to do it; we would do it daily if they asked us to.

MR. LEE: We knew the first year that everything was new. We wanted to wait to get the first year's numbers and look at them in the aggregate. We discussed using a quarterly review once we get past the first year. We have not completed the 1992 numbers yet. Our objective is to move to a quarterly review to really watch what is going on within the networks.

MR. HILES: We are in a position now to take a hard look at what happened during 1992, and, as indicated, the reports have just become available where we can assess how utilization really did change over the past 12 months.

MR. JONATHAN M. NEMETH: In your discussion, you were talking about active employees. If you provide coverage to your retirees and if the network covers these people, are there any unique problems or things that come out in this analysis?

MR. LEE: Our retirees are basically offered the same health care options as our active employees. In 1990, we went to a defined-dollar plan for our retirees. All retirees who are eligible for health care (the only thing they have to do to be eligible for health care is to meet the minimum age of 55 and have 10 or more years of service), have the same health care options as our active employees. They receive a benefit allowance that is a function of a $50 benefit factor multiplied by their years of service; that allowance can be applied against the cost of the health care option they elect. There are no serious problems with it, other than many of our retirees want to stay in the HMO. They travel a lot, living in North Carolina in the summer and Florida in the winter. HMOs are just not real accommodating when you are receiving medical service outside of the service area. That has created a problem.

Once the retirees reach age 65 and become eligible for Medicare, we take the HMO option away from them because the HMOs just really do not work very well with Medicare. It is very difficult to coordinate claims payments with the Medicare system. Let's just take an individual that retires at age 60. We determine their benefit allowance. We give them the choice of plans, and they make a choice. We offset the premium by their benefit allowance, and they can stay in that plan until

they reach age 65. If they chose an HMO, we let them choose again once they reach age 65. If they chose one of the other plans, point-of-service or indemnity plan, then they are locked into that plan for the rest of their retirement with the caveat that they can always choose down. We will let them choose down to a lower level of coverage, if they want to.

MR. NEMETH: So, your post-65 retirees are covered under the point-of-service plan?

MR. LEE: Yes, that is correct; and they like it. The retirees have responded very positively to being allowed to continue in that plan.

MR. HARRY L. SUTTON, JR.: As I understand it, the only HMOs you offer are Partners National Health Plan HMOs, or do you still have some of the old ones?

MR. LEE: We do not have any of the old ones. We have the Partners National Health Plan in Winston-Salem and Atlanta, and Aetna has built Exclusive Provider Organizations (EPOs) for us in Charlotte, Raleigh-Durham, Chapel Hill, Greenville, Spartanburg, and Columbia. In fact, we are in the process of trying to move the Partners of Atlanta HMO to more of an EPO-type environment.

MR. SUTTON: There is a lot of discussion about claims processing, and there was a mention of EPOs. Two of them are still fixed-price HMOs, but you are thinking of changing them to EPOs?

MR. LEE: That is correct. I will admit to you that the difficulty we are going to have is the Partners HMO in North Carolina -- it is an HMO owned by the physicians and the major hospital in Winston-Salem. It has all the doctors locked up, and it is going to take a little bit more clout than just us, I think, to pry enough physicians loose to build a network that can compete against that particular one.

MR. SUTTON: Andy, in looking at the fees for the other HMOs versus the two Partners National Health Plan HMOs, and then the estimated cost of the networks, did you think that the other HMOs did not reflect the age/sex composition of the group very well? Did they indicate whether they used community rating by class? You felt that you were able to get a lower cost by switching to an EPO, or a POS, than you would have had just paying a pure capitation rate.

MR. HILES: Yes. We did not actually go through the arithmetic on that. The incumbent carrier for Wachovia prior to Aetna was Provident. Provident had actually gone through the exercise of doing a look-back study for a lot of those employees. I know there are some fundamental problems with look-back studies, but it is an indicator of how these folks would have performed in a self-insured environment. They went through that exercise and determined it would be financially advantageous to bring those people into a self-insured environment.

MR. SUTTON: A lot of the employees have been offered a straight HMO or a POS plan. Did the POS plan come out more expensive or less expensive than the HMO?

MR. LEE: In a preliminary review of those claims, we show that the HMO is actually performing better than the POS plan, but it has not been analyzed as closely as it needs to be.

MR. IRWIN J. STRICKER: In 1992, probably most companies had a decrease in trend regardless of the type of plan that was being sold. What was your experience with your indemnity block of business?

MR. LEE: Just the indemnity piece was up about 19%.

MR. STRICKER: In 1992?

MR. LEE: Yes, sir.

MS. ALICE ROSENBLATT: If you are offering both a straight HMO and a point-of-service plan, isn't it the same network; is the in-network benefit identical? How are you structuring the employee contribution to avoid adverse selection? Are you experience-rating the whole thing together?

MR. LEE: Again, the options are offered under a flex plan. In our plan, all employees get what we call choice dollars. They get flex credits; that is the company contribution towards the cost of the plan that they will elect. From a company-financing standpoint, we are giving everyone the same amount of dollars to spend on health care. It then becomes their choice as to how much they want to pay out of their own pocket to choose a particular option. The point-of-service plan and the HMO do use the same network of providers.

There are some subtle differences in the design of the plan. For instance, in the HMO, the employee pays a $10 co-payment for an office visit. Under the point-of-service plan, they pay a $15 co-payment per office visit. There is no deductible for a hospital admission under the HMO, but, under the point-of-service plan, there is a $400 deductible per-hospital admission. Clearly, the HMO option is the most valuable plan, in my mind. If you are going to use health care services, you come out better under the HMO than you do under any of the other plans. Again, the reason that we offer the point-of-service plan is really to get people to try it -- to get people to try using a plan that has panels of physicians. I'll relate an example we often see with a husband, a wife, and two children. The husband's and wife's physicians are network physicians, but the pediatrician is not; or the OB-GYN is in the network, but the primary care physician is not. They do not want to give up their relationship with the OB-GYN or the pediatrician. However, they still want to take advantage of the opportunities available under a point-of-service or an HMO-type plan. The point-of-service plan offers a middle ground. If the POS works, then maybe you would think again about going into the HMO environment and changing pediatricians or OB-GYNs. Again, it is more of a bridge/transition from a pure indemnity environment where the employee has the absolute freedom of choice to an environment where there is less freedom of choice.

MR. HILES: We really wrestled with the employee contribution issue when we were setting the price tags for the plans back in the middle part of 1991. There were a couple of reasons that led us to making the HMOs more expensive than the

point-of-service plan. The HMOs provide a slightly better benefit than the point-of-service plan. In the past, the HMOs had been the most expensive plans. We thought it made sense based on benefit value and inertia to keep the same cost relationship. As it turns out, we had an increase in HMO enrollment; we did not have a reduction. We were pleased with the way things turned out, which does not mean it is perfect. Actually, we are in the process of rethinking that strategy and making the HMOs the most attractive offer, at least in terms of employee contributions, to try and encourage more enrollment in those fixed panel programs.

MR. LEE: Let me mention one other thing. There is a pricing differential built into our flex program as well that we do not like to talk about. It is the hidden subsidy for dependent coverage. This hidden subsidy is consistent across all of the benefit plan options. I'll clarify what I said earlier about what the company pays towards the cost of health care. We give individuals flex credits they can apply towards the cost of health care. In addition, we have modified the actual published premium by a hidden subsidy to keep the cost of covering spouse/dependent children at a lower level than it probably should be.

MR. HILES: Those who have not set price tags for flex plans can have prices in which there is a flat credit for all employees which creates this impression of equity; then you hide the subsidy for dependent coverage in the price tags. The alternative is to have the level of credits vary by the level of coverage the employee selects. If someone is getting employee-only coverage, they get 1,000 credits; if they get employee plus one, they get 1,500 credits; and if they pick employee plus two or more, they receive 2,000 credits.

MS. ROSENBLATT: Are the premiums being experience-rated together so that, after you have a year of experience and you might be getting some adverse selection, how are you determining the premiums, the cross-subsidies between the plans?

MR. HILES: Whenever we price a flexible benefits plan we try to price all the plans together. In fact, there are subsidies going back and forth. We at Towers Perrin call this technique incremental pricing.

MS. ROSENBLATT: Are you maintaining what I would call actuarial differentials between the plans based on benefit differentials?

MR. HILES: Yes.

MR. SUTTON: Did the number of people in the low-option indemnity plan drop when you did this plan or did they stay about the same? You still looked at it as an objective to find out why they kept it.

MR. LEE: In a location like Atlanta the employees previously had an option of an indemnity plan with a $400 deductible, an indemnity plan with an $800 deductible, and an HMO. We replaced the indemnity plan with the $400 deductible with the point-of-service plan. As a result, we had some migration of the people covered in the $400 deductible indemnity plan to the basic plan; and some of them went to the HMO. We really want to talk to these people and find out what motivated them to make their choice.

MR. HILES: What we are looking at for people who take high deductible indemnity coverage is that they have done this because they are low-paid employees and cannot afford high-option coverage, or they are high-paid employees, and can afford the out-of-pocket limit; they would rather go ahead and pay a little extra in terms of out-of-pocket to have freedom of choice. Those are the people we are really interested in. We do not want to have these people who can afford better coverage taking the unmanaged plan.

MR. SUTTON: My guess would be, having looked at flex plans, that the cost of your indemnity plan is extremely low, the people that opt into it are low utilizers.

MR. HILES: That certainly has been the case for Wachovia historically.

MR. SUTTON: So, you have the problem of actuarially adjusting that and charging higher than the actual cost.

MR. LEE: We do have that and you are right. The premium for the basic plan ($800 deductible) is the lowest in terms of fixed cost. If an individual feels he is going to utilize the plan quite a bit, the $800 deductible is somewhat scary to your lower-paid employees. I might be surprised when we actually do the analysis, but there are three things I think we will find. Banks are not the highest paying companies in the world. We have a number of people who say I just cannot afford to pay the premiums to be in an HMO or a point-of-service plan. I will take my chances and pay the lower premium. You are going to have the people, mentioned earlier, that say I have got enough money to self-insure the first $800-2,400 of out-of-pocket expense. I will pay the low premium and use the money elsewhere.

In my experience, Atlanta has been a rather unique market. There is an extremely large number of specialists and a very small number of general and family practitioners. We have a number of employees whose cardiologist is their family physician, and they are not willing to change. Thus, they go into the basic plan, they continue to see their cardiologist when they have indigestion or something of that nature, and they pay cardiologist fees. This is indigenous to the Atlanta market; there really is not a sufficient number of primary care physicians.

MR. SUTTON: Previously, we were looking at nationalized health insurance or mandated benefits for everyone, and you said you had about 5% or 10% of the people not taking anything, particularly those employees with the ability to get coverage from some other source. I do not believe an employer should permit any employee, forgetting the dependent aspect, to be without health coverage, even a catastrophic coverage. I dislike flex for that one reason; if you offer them a lot of money, and they want the money, they opt out. If they have coverage through somebody else, then you are shifting the cost to the other employer, but I do not like the idea of people being allowed to opt out from a basic plan, or at least a catastrophic plan.

MR. LEE: We ask individuals who opt out to show us evidence that they are insured under another plan. If a person opts out, we take back one-half of the credits we had provided to them for health care. If they choose benefits that allow them to have extra credits left over, the remaining credits cannot be converted to cash. They

have to be deposited in one of the spending accounts. So, there are some disincentives to just opting out. You do not get an increase in your take-home pay if you opt out of health care.

MR. HILES: Employers throughout the Southeast really vary their approach to allowing opt-outs. There are some employers that do not take a particularly paternalistic attitude toward their employees, and they allow them to opt out even without evidence. We have other employers that force their employees to take coverage whether they need it or not. Companies like Wachovia tend to fall somewhere in the middle; they will allow their employees to opt out. They will give them a reduced number of credits, and they will require some form of evidence -- a signed document or group certificate number.

MR. LEE: If the federal government is going to mandate employers to provide health care to employees, they also need to mandate employees to take the health care that is provided to them.

MR. HILES: I agree with that.

MR. LEE: Let's let the gate swing both ways.

MR. STEELE R. STEWART: How extensive is the network? If you had fewer physicians in the network in one area, did you notice there was less participation in the point-of-service or HMO plan? Was there any consistency?

MR. LEE: In places like Winston-Salem, we have a very good physician network. Forsyth Memorial Hospital is probably one of the best hospitals in the State of North Carolina. It also is one of the lowest-cost hospitals in the state. When they compare their rates against the other hospitals in the state, they always rank in the very low tiers. They are very good, very inexpensive and have a very good panel of providers that practice out of Forsyth Memorial. So, in Winston-Salem, it is easy for employees to choose the HMO because the best hospital and the best providers are in that particular network.

In Atlanta, it depends on where you live. If you live on the Northeast side of town, you have Northside Hospital and Piedmont Hospital, which are very good, well-recognized hospitals. We have very high penetration there. There have been some problems with some of the hospitals on the southwest/southeast side of Atlanta. They are getting their act together, but there have been some published reports about the quality of care being delivered. The number of physicians that want to practice at those hospitals is fairly low. As a result, you have much lower penetration there.

In an area like Greenville/Spartanburg, South Carolina, where they really are not very supportive of the idea of managed care, you do not have very good penetration there because you just do not have a sufficient number of providers. You usually fall out with pediatricians. In those locations, the adult's physician might be in the network, but there is not a pediatrician within a reasonable distance. The result is people do not join the network.

MR. HILES: Before most of our clients will go into a network location, we will assess whether or not we think it is a good-quality network. We rarely, if ever, will rely, solely on the word of the network manager that it is a good quality network. We try to help the client make those decisions; we also do an analysis to try and assess the quality of the network to see if it is a place where we should stay with a network-only choice.

MR. CYMERYS: From a carrier perspective, good access to the network is really critical for our success. If your members are ending up outside of your network, you lose control of what is going on; particularly if somebody ends up in an institution. Procedures may be performed on that member that may not be in the best setting. This is an area we have really focused on nationally.

MR. SUTTON: Andy mentioned a hold-harmless agreement. It sounded like you were holding harmless against accidents of medical malpractice or poor-quality care. Did I misunderstand? If it was correct, is that part of this agreement? Would the providers forgive the expense or pay for the repair or the damage?

MR. HILES: What we are really trying to do is hold the network managers responsible for all the things that they say they are going to do; they are going to select providers who are board certified. The hold-harmless agreement is really focused on those things, as opposed to the actual practice of medicine.

MR. LEE: We want to be sure that the employee cannot hold the plan sponsor responsible for a poor decision made by a physician within the network. We feel that Aetna has addressed this through their credentialling process.

MR. SUTTON: So, essentially you are trying to prevent the employer from being sued for recommending a lesser quality physician in a network.

MR. LEE: True.

MR. HILES: Yes, that is right. A hold-harmless agreement certainly is no guarantee that it will not happen. It is just one more way to protect the employer.

MR. LEE: Our network in Charlotte was tested about three months ago. There is a lot of activity going on in Charlotte with respect to managed care. There was a physician panel in our network family practice group. They were purchased by a clinic which has a large physician practice in the Charlotte area. Aetna had negotiated with the clinic early on in the process; the clinic had indicated they were not interested in joining the network. Some time later they came back to Aetna indicating they would like to get into the network. However, they wanted us to take all of their physicians, specialists included. We said that we had a complete network; we did not need additional specialists. The network was complete, and we felt satisfied with it.

Well, the clinic brought pressure to bear on this physician group, and they disenrolled all of our employees. It affected about 500 employees whose primary care physicians all of a sudden dropped out of the network. We have had very little backlash from that. Our employees were confident enough in the network, and the panel of

other physicians was good enough that they basically selected primary care physicians in other practices. There was very little fallout from this.

One of the things that is so important in this whole process is communication. You just cannot communicate enough with employees about what is going on in the medical care area, what are some of the things that are driving up the cost of care, and what you, as the plan sponsor, are attempting to do to help them have access to quality, affordable health care. We have really tried to do a good job of communicating with our employees. We still have a long way to go, but, for the most part, I think they now understand the dynamics of what is going on in the health care system and why it is important for us to go out there and try to exert some pressure on the system to make it more friendly to the people who are receiving the services.