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MANAGED MENTAL HEALTH AND OTHER ANCILLARY BENEFITS

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- Substance abuse
- Prescription drugs
- Vision

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MS. JOAN M. PEARSON: I'm going to talk about managing mental-health (MH) and chemical-dependency (CD) treatment costs. CD is also known as substance abuse. The topics that we will cover are: (1) key indicators that suggest when a change in your approach to MH management makes sense, (2) differences between managing MH and managing medical, surgical, and obstetrical care, (3) options that employers have available to them in managing MHCD, (4) network-based managed MHCD, (5) continuum of care (i.e., residential treatment, partial hospitalization, and structured outpatient), and (6) performance of these programs.

Let me talk about this whole area just a bit. The companies that have been involved in managing MHCD care through network-based programs are starting to have a very significant impact on the delivery of MHCD treatment in this country, so significant that private psychiatric hospitals, which were very profitable three to four years ago, are now in Chapter 11. The occupancy rates for acute MHCD treatment are dropping precipitously.

Now let's talk a bit about inpatient care. One of the differences between MHCD and medical and surgical care is the amount of dollars spent on inpatient care. In medical-surgical, about 50% of the dollars are spent inpatient, and 50% are outpatient. In

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MHCD, 70% of the dollars are spent inpatient. In addition, a very small number of people use these services, and those who do sometimes stay a very long time. The real opportunity for saving in the MHCD arena, and that's primarily MH, is in managing the length of inpatient MH treatment and the patients who need it.

When a client has days per thousand in the 150-225 range, I know that there will be significant savings opportunities for them in managing their MHCD program. What about the norms? The admission data that we have is fairly good. We know that on average, admissions per thousand will run between five and seven. But days per thousand is driven by the plan design. There are more weird special limits in MHCD than you'll find anywhere else. You'll find maximum dollars per year, maximum days per year, and other kinds of special limits on MH that really drive the days per thousand. They don't tend to drive admissions, but they do drive days. It's also driven by the part of the country that you're in. In my part of the country, Washington, for a variety of reasons we have very limited supply, very limited demand, and very limited benefits for MH and CD. Texas, in contrast, has very high days per thousand. The climate there has created supply, which, in turn, has created demand.

In terms of these indicators, if you are an employer that has days per thousand upward of 60, or a cost that's running $125 or more per employee per year, you may want to look at whether managed MHCD care might deliver higher quality and savings to your company.

Between 4-6% of the population in a given year will use MHCD treatment, in comparison with 85% of the population that will use medical and surgical care. When you choose to manage MHCD care, you're touching fewer people.

Another interesting difference is that a very small number of people can be accountable for a very large percentage of your expenditures. A client in Silicon Valley had 31,500 people eligible for MHCD benefits; 13 of them accounted for 60% of the costs, and that's not uncommon. This means that by effectively managing these 13 people, savings can be substantial. So you're touching a very small number of lives. Also, the people who need this type of care often need case management and assistance with their psychiatric problems indefinitely. These people are very troubled, and ongoing review and case management is probably going to be part of the picture for quite some time.

Another difference is that children and adolescents are often responsible for more than half of the expenses. This is important to employers, because it means that managing MHCD often doesn't touch their employees, it touches the children of their employees.

I've talked about the percentage of MHCD that is inpatient on average. As managed care comes into being, and as clients are in their second and third years of managed MHCD programs, what you see is about half of the dollars being spent on inpatient care and half of the dollars being spent outpatient. Thirty percent may be spent for acute inpatient care, 20-30% for alternative care (anything between inpatient acute settings and office visits), and maybe 40-50% for outpatient MH as we know it. Currently, we're not doing a very good job of tracking alternative care, but that will happen very soon.

Another nice feature of managed MH is that you can offer it everywhere. This has been an issue with point-of-service managed care. What about the employees who live out of the metropolitan area? What typically happens for managed MHCD is that ad hoc arrangements are made with a local provider that is often the only one in town. The care is managed, a maximum benefit is available to the employee, and it's perceived as a network benefit everywhere. But in fact, behind the scenes, ad hoc arrangements are made, often including price negotiations and managed care. So given the small number of people who use these services, and given the availability in some of the outlying areas, it makes no sense to have a fully contracted network everywhere in the country. It's foolish to have a managed MH company contract with a hospital that's the only provider for 500 miles. They're only going to see one or two admissions per year; that just doesn't make sense. In those situations, you try to do the best you can. But it's usually not in a rural area where you're finding your high cost anyway. It's in the metropolitan areas. So you can put in the same benefit plan everywhere, which makes managing your MHCD plan much easier.

I like working in this area because very few people know how to select a provider for MHCD. If you ask a primary-care physician, a pediatrician, an internist, or a family-practice physician to make a referral for MHCD, only 5% are comfortable doing that. So even if you wanted to talk to your primary-care physician, it's very difficult to get a referral that he or she feels comfortable with. You don't talk about a psychiatrist in the same way you do a pediatrician. Thus, providing access to MH, through an up-front assessment, gets the person to a qualified therapist and is often viewed very positively by the patient. Very few people have an existing relationship with a psychiatrist, psychologist, or a social worker.

There's a wide range of opinion among well-respected psychiatrists about how to treat a given patient. You will find that the range of agreement is much narrower among most medical specialties. For example, in the area of orthopedics, there's a fair amount of agreement about how to best set a broken leg or how to deal with a variety of orthopedic problems. This is not true at all with psychiatry. One of the underlying differences is that the amount of resources that one highly esteemed psychiatrist will use to treat a patient can be 10-, 20- or 30-fold what an equally esteemed psychiatrist will require in treating that very same patient. Thus, when you purchase managed MHCD services, you're dealing with a network of providers who use MH resources very efficiently. There are places in the country where six weeks are required just to evaluate an extremely troubled adolescent. An equally respected psychiatrist may require a two- or three-hour initial assessment to come up with a treatment plan.

Another difference is that the involvement of the family is essential if the treatment is for an acute condition. Now many of us have had plans in place that do not cover family counseling or family therapy. In managed MH, it's a given that the family is involved, particularly with adolescents. Oftentimes, a managed MH firm will not cover the treatment of an adolescent unless the family commits to participate in that treatment. That's true with CD, and it's true with most acute care. The objective becomes how to get the patients better, how to get them out of a highly structured setting, and how to get them back to as normal a life as they can lead.

Companies are looking at a wide range of options. Managed MHCD impacts cost when you have a network-based MHCD program with an 800-line access to treatment. You do not publish a directory. The program basically hinges on the fact that people who have masters degrees in one of the MH professions answering the phone 24 hours a day. They do an up-front assessment and refer to the appropriate provider. If you have ten psychiatrists, you can't assume that all of them are equally able to treat the person. It's a matchmaker process that happens during the 800-line discussion. That's often the key, or it is one of the important elements of managing costs and treatment appropriately.

There are really five key features. One is access. The 800-number access is available 24 hours a day, seven days a week. The phone is answered by a clinician. The clinician is prepared to deal with any kind of an emergency. These clinicians are called when someone is prepared to take his or her life or take the life of another. They know what to do, they can get the police involved, and they get people to the hospital. This is a highly skilled clinical capability.

As to preferred provider networks, in the old days (by that I mean two years ago) we used to think that more was better in terms of the size of the network. We're starting to see that the number of providers who receive referrals from these MH companies are shrinking in size, rather than increasing, as the PPO gains more experience with how well these providers do what they do. PPOs ideally like to influence 30% of a provider's practice and to increasingly direct patients to providers who have good track records and appropriate credentials. Also, if you are a psychiatrist or a psychologist, you're not being micromanaged to death. I don't like to see a managed MHCD company asking for treatment updates every three visits. You spend half your time on the phone talking to the MH vendor and not as much time as you should be taking care of people. We should be moving toward, and I'm starting to see this in MHCD, an increasing collaboration and partnership between the MHCD administrator and the providers. So that there's less need to micromanage. Also, we're not trying to see providers paid at deep discounts. In managed MHCD care, the savings do not come from discounts. Only about 20% of the savings come in that area, and almost all of that comes from deep facility discounts. You try to find good providers, pay them well, give them freedom, and watch their outcomes; then the quality of care and the savings follow from that.

Case management is not much different than what you're used to seeing; except these case managers stay with people throughout the course of treatment (especially with CD treatment). We find that a carefully managed episode of care for CD that follows that person through the first year of aftercare can significantly reduce relapsing. This is also true with high-risk psychiatric cases. Medication is also very important to watch carefully. Medication is a very important element in successful treatment of psychiatric problems. New medications are coming on-stream all the time, and making sure that they're optimized is very important.

In terms of key features, we're seeing a lot of coverage for alternative care. One type of alternative care is residential treatment. This is 24-hour-a-day care for nonacute conditions for people who simply can't live outside of a structured environment, but who don't need all the high-tech medical horsepower of an acute setting. They need

the structure, but if you can move them off of the campus of an acute setting, you can reduce the cost per day to about 20-30% of what an acute day will cost.

Partial hospitalization is really day treatment. This is how it used to be referred to 10-15 years ago. People go to a structured program during the day and go home at night. An underlying principle here is that you're trying to treat people at the least restrictive level of care. We found in the old days, five years ago, when all we had to choose from were outpatient visits and inpatient care, that the inpatient care was sometimes too much. People didn't need all that structure. They ended up getting dependent on a highly restrictive setting. If you had been able to start them out in residential treatment or day treatment, you facilitated recovery. The savings from these programs are very impressive. We have clients that have reduced their MHCD costs per employee, after they get through paying the vendor, by 50%.

Here are some definitions of alternative care. I have to tell you, though, that I was on the road a few weeks ago with a large client. I asked every MHCD vendor that we talked to that week, and it was three of the five top vendors (American Psych Management in Virginia, Preferred Health Care in Connecticut, and MCC Companies, which is a CIGNA subsidiary located in Minneapolis), to define each of these, and they all had different definitions. So, it's obviously an area that we have to work on.

Residential treatment is distinguished in that it is 24 hours a day. Partial hospitalization tends to vary; it is generally the same program that an acute psychiatric patient will be undergoing. It's during the day, and it can vary in terms of how many days a week and how long. Intensive outpatient is often individualized for a family, or for a patient, but it's lengthier then just a 50-minute session of psychotherapy. Outpatient treatment is up to two visits per week.

As I mentioned in terms of the results, they're really quite impressive. They're not only impressive in terms of the money savings, they're also impressive in terms of outcomes. I'm especially pleased to see the results in CD (i.e., getting the person identified early and getting him or her to an appropriate treatment program). Of 20 CD treatment programs in the San Diego area, some will be great for some patients and terrible for others. Sometimes women undergo special programs. Alcoholism is not the same as crack/cocaine addiction. Different programs do well, depending on the patient's situation. What you're trying to do is get a good match. If you get a good match, and you follow the people to make sure, to the degree possible, they actually finish treatment and stay with the structured aftercare program for a year (I know that sounds terribly long, but this is really hard to beat), they get better, they stay at work, they don't lose their jobs, and their families stay intact. The other thing that's interesting about CD treatment is (we have had some good research indicating this) that the entire family's medical costs drop by 50% during the year or two after successful CD treatment. If you think about someone using drugs and alcohol, it's not surprising that he or she will have medical problems, but the whole family also tends to have more.

The clinical complaints that we're hearing are fairly minimal. Now I have to tell you that I'm suspicious about this. People don't complain when they have a problem with a psychiatrist. They are afraid to talk about their families' dissatisfaction, and they're even more afraid to talk about their own. So you have to be very suspicious

about patient satisfaction data. I'm still not satisfied that we do that very well. But I am very aware of the confidentiality problems and others that get in the way of knowing what's going on with MH. One of the heartbreaks for me is to have clients say they limit their MH benefits to $10,000 a year, and they don't get a single complaint. Who's going to complain to you? No one is going to come and say, "My wife is manic-depressive, and she can't get enough care." They don't come and complain. So you have to be very careful about taking the absence of a complaint as an indicator that the care is adequate, because it may not be.

The last comment I want to make is that the problems that we see with managing MHCD are primarily in the areas of administration. It shouldn't be a surprise to you that psychologists and social workers are not highly adept at paying claims. Dealing with these issues and trying to figure out ways to administer these programs efficiently and effectively has been one of the major challenges.

MS. KIMBERLY C. BABBIN: About 27% of you started your day by going to your travel kit or makeup bag, fumbling around, and finding a prescription vial. You fiddled with the childproof cap, handed it to your child and had him or her take it off, took one with a full glass of water, I hope, and contributed to the second fastest rising health-care cost in the country. Not only are prescription drugs the second fastest rising health-care cost in the country, but they are also consuming a larger portion of employer benefits each day. Employers face as much as a 30% trend in prescription drug plans. The average today is about 24%.

Consumer prices rose 28% from 1983 to 1990. Prescription drug prices rose 126%. Merck's CEO stated in *The Wall Street Journal* in recent weeks that its new pricing policy will be to increase prices at CPI plus about 1% in the future.

Another thing that contributed to prescription-drug price increases is the fact that research and development of a new program is extremely expensive. To bring a drug from the chemical entity in the test tube to the marketplace in 1990 cost $231 million. In 1987, it only cost about half of that. Between 1987 and 1990, of course, azidothymidine (AZT) for AIDS, and DDI to treat AIDS, and many new cancer chemotherapy agents added to the cost of research and development of new products. Interestingly, of the $231 million, approximately 40% of it is attributed to physician marketing and sales directly to physicians. It's a very expensive idea to bring a new drug to market. But it also costs a good deal to get a physician to prescribe it.

Let's look at some of the new products that have been brought to the market in the last two or three years. One of the products that fits most nicely into Joan's category is Prozac. Prozac is an antidepressant that was brought to market in 1988. In 1988, it was the 33rd most prescribed drug in the country. In 1989, it became the 14th most prescribed drug in the country. Today, it's the third most prescribed drug in the United States. This is at a cost of $103 for a 30-day supply.

Pharmaceutical manufacturers are spending their $231 million per drug on drugs that are not unique entities or on things that will be lifesaving. In 1991, five drugs were brought to market that were considered to be important gains in therapy. Of these five products, three were considered to be orphan drugs, or those drugs that

represent treatment for less then 200,000 patients across the United States. In that same year, 30 products were brought to market that were considered to be copycat drugs. These are drugs that entered the marketplace to gain some of the market share of a product currently there. So, we're spending $231 million per drug to research and develop new products. Yet the products that we're bringing to market are not those products that are lifesaving, new entities.

Utilization has risen very quickly. A few of things have caused this. With the advent of managed medical-surgical care, we've had a great trend toward outpatient therapy. Many physicians, who postoperatively, give patients more antibiotics than they used to, to combat a potential lawsuit for sending someone out of the hospital early. Second, patients are now demanding drugs from physicians. In the past, the physician knew best, and the physician knew what to put on the piece of paper. Now, thanks to direct consumer advertising, patients are walking into the physician's office, knowing what they want. I don't know how many of you have been exposed to these ads. Ads have been on TV recently for the nicotine patches and Cardizem CD. The onslaught of consumer advertising has also reached *People* magazine and *Reader's Digest*. This is trending toward a situation where patients go to a physician, ask for the product, and expect to receive it. The physician may risk losing the patient if he or she does not comply.

Let's talk about the retiree group. About 12% of the United States population is over the age of 65. It's no surprise that this group has fixed and limited incomes. The scariest part of this is that tomorrow's retirees are the baby boomers. This group is accustomed to a delivery of medical care, particularly prescription-drug care, that is unlike their predecessors'. One of the largest portions of retiree health-care liability is prescription drugs. As much as 40-60% of total retiree health-care costs are associated with prescription drugs.

In 1989, Congress repealed the Medicare Catastrophic Act. Prescription drugs that were to have been covered under that act were still burdens to employers; up to about 28% of total plan cost. Then in 1992, the Physician Payment Reform (PPR) Act was passed, and the resource-based relative value schedule (RBRVS) went into place. At that point, with the physicians being paid less, prescription drugs began to consume an even larger portion of the typical plan cost dollar. So what do we do about it? There are several things, and we'll touch on some of the solutions. We'll talk about (1) generic substitution, (2) mail-service prescription-drug programs, (3) retail pharmacy networks, (4) carving out the entire prescription-drug benefit, and (5) drug utilization review (DUR).

Generic drugs must be a key factor to any employer's prescription-drug program. Look at the savings for HydroDIURIL. It's a diuretic; it's a water pill. If you buy it at the brand-name price, it's $19.26. The generic is $1.92. That kind of significant savings is what is happening; encouraging employers to begin to mandate generic substitution for their employees. These kinds of savings, particularly for retiree programs, can't go unnoticed. There is a trend for most pharmaceutical manufacturers that develop their brand-name products to also manufacture the generic counterpart. This makes questions about generic drug safety and efficacy a nonissue. If the drug comes from the exact same manufacturer, from the same vat of drugs, from the same chemical process, the only differences between the two

products are typically the color and the markings. At this point, we feel very comfortable that generic substitution is a good way to go, and it is a cost-containment measure. Interestingly, about 80% of those generics currently available on the market are made by the same manufacturer.

One of the things that will really drive generics into most employer plans in the next several years are those drugs that are losing patent protection. They will be available genericly. Your children, at some point, have taken Ceclor. It did about $500 million in sales in 1990. It recently went generic. Two drugs that are going off patents in the next 6-12 months that will have a phenomenal impact on the way we practice medicine include Seldane (it's an antihistamine that does not make you sleepy and is one of those that has been advertised directly to the consumer), and Tagamet (an antiulcer drug that represents about $560 million in sales). Seldane and Tagamet will both lose their patents and will then go to an over-the-counter status. These products will have a phenomenal impact on the way employers reimburse drugs. If something is available over the counter, do we pay for a brand name product that is still prescription?

I've had the opportunity to visit most of the large mail-service companies across the country and the majority of the facilities that they own. I can guarantee you that these companies do not hire little monkeys to run around filling prescriptions. They actually use live, registered pharmacists for this function. The advantages to mail service traditionally are (1) high volume; lower unit costs and better prices are passed to employers, (2) higher generic substitution rates than any kind of retail program, and (3) each vendor dispenses prescriptions very differently.

I took a church group through a very automated operation in Ohio. Robots are involved in the dispensing process. They didn't like it. It was too high tech. We took the same group through a facility in Birmingham, Alabama. It has a very retail pharmacy look, with pharmacists running around in white lab coats, and they liked it. In contrast, I took a group from South Bend, Indiana to a very high-tech facility that uses a lot of automation. They thought it was great. Well, they're from an equipment manufacturing firm. I took them to the same facility in Birmingham, Alabama that looks very much like a retail pharmacy and they said, "These people obviously don't have any kind of cost controls; nor do they have any economies of scale." The way they practice traditionally has to do with their origins and their philosophy of providing service.

If you want a prescription filled by the safest mechanism in the country, mail-service prescription-drug programs are it. There is not a single prescription that goes out of a mail-service facility that has not been seen by two pharmacists. Have you ever asked your pharmacists if they would like somebody to check their work? They'd all love it. This kind of quality assurance provides a level of benefit that cannot even be obtained at the retail pharmacy. When you're a pharmacist, at some point in your life you're going to fill a prescription incorrectly. They tell you that when you go into pharmacy school. If you can't live with that, you need to get out then. Mail-service pharmacists love this quality-assurance check. Their stress level is lower for that reason. Also, pharmacists are attracted to mail-service more than retail facilities because of good hours and a good atmosphere. So you really get some high-quality people working in these organizations.

One thing that I can't stress enough is that because mail service operates on high volume, typically 90-day supplies, it's very important that the benefit design does not give away the store. Mail-service companies came into business ten years ago. Employers put mail service in at zero-dollar copayment and wondered why they lost money. Part of the way that mail service works effectively is through the employees sharing some of the cost, with the employer picking up the remainder at a discount. It's very important to look at the benefit design associated with these kinds of programs.

Let's talk about retail. Many prescription-drug cards entered the marketplace in 1977, particularly companies like Pharmaceutical Card System (PCS) and MEDCO. Those prescription-drug cards got really bad press, because they also had zero-dollar copayments, and you could walk up to the pharmacy and get anything you wanted. Today we're taking those kinds of concepts and putting them in more of a managed-care light by limiting access with networks. Typically, about 50-60% of the available pharmacies in the community are involved in the network. This allows a prescription-drug vendor to offer an employer a discount off of retail price and to decrease the dispensing fee, the charge that a pharmacist has for knowing what to put in the bottle, or their knowledge fee. Retail pharmacy vendors will cut deals with these networks at lower prices (i.e., discounts) to drive volume through the store. Pharmacies are volume-driven businesses. So the more people walking through the store, not only to buy the prescription drugs, but to buy coolers, grills, and toothpaste, is an advantage to the pharmacy.

Let's talk a little bit about what happens to the elderly. Twenty-three percent of all nursing home admissions are due to the fact that the retirees cannot take their drug therapy. This means that either they can't see the vials, read the labels, open the vials, or they take too many of them. Someone, when hearing this statistic, said they were going to start a new business. What they were going to do was call on all these retirees' homes and set up their drugs everyday for them. It sounds like a good concept. The over-65 age group consumes about 25% of all prescription drugs and 50% of all over-the-counter products. Phenomenal amounts of drugs are taken by the retiree group. Needless to say, if you take all these drugs, you have an increased potential for adverse drug reactions and drug interactions, as well as the potential for harm. Fourteen percent of all hospital admissions are due to the misuse of drugs in the elderly population. Think about what you could do to an employer's hospitalization costs if you could provide concurrent, excellent, drug utilization review; an immediate cost savings. It's in soft dollars, because prevention of hospitalization is not directly measurable, but it is a direct link. I don't think it's any surprise to you to hear that retirees comply with their medication therapy just about as well as actives do, and that's very poorly. I won't ask how many of you have left prescription-drug vials in your cabinet at home.

We're going to talk about two focused DUR topics: prospective DUR that occurs at the point of sale and retrospective DUR. Lets talk about prospective first. You walk into the pharmacy, you have a prescription-pharmacy network in a managed environment, and you present the pharmacist with your prescription and your prescription card. The pharmacist processes the claim, and you receive the drug, and you go on your way. Little do you know that during that time, the computer system in which the pharmacist has entered that prescription has gone through a series of no

less than 75-150 edits to determine that you are eligible, that the day's supply is correct, that the prescription is accurate in dose and in dosage form, that the doctor was eligible to prescribe the prescription for you, and that out of all the other drugs you take, this one won't interact with them. That's probably one of the best cost savings and quality-assurance mechanisms of managed prescription-drug problems. Getting that information in a timely manner is the best way of controlling adverse reactions and drug interactions. It also helps because you haven't left with the prescription yet. If anything comes up in that computer system check, the pharmacist still has the prescription in front of him or her. You wouldn't have ever taken it, and you won't be one of these hospital admissions statistics, due to adverse drug reactions.

The second component is retrospective DUR. This looks at physician prescribing habits, patient compliance habits, and pharmacy-dispensing habits after the fact. Most retrospective DUR is 30-90 days after you completed therapy. It looks for patients who physician shop, pharmacists who dispense all brand-name products and who never use generic, and physicians who prescribe the most high-cost items and never try less expensive but cost-effective products first. These kinds of retrospective studies are traditionally done in any kind of managed pharmacy program. They're very effective, but we have never been able to tie back a direct-cost savings to these programs. There are some out there, but not much. Therefore, I think of this not as a cost-savings mechanism, but as a quality-assurance component. If we can prevent fraud and abuse from the patient, the physician, and the pharmacy perspective, as well as provide the best drug therapy at the best price, I think these programs have worked.

So let's talk about how you could build a successful program. First, the plan-design elements are critical. If you're going to combine a retail-pharmacy network with a mail-service program, employees need incentives to use the mail service. But you don't need to give away the shop. Second, strategies associated with prescription-drug management need to be in line with what you do with the rest of the medical plan. If you have a very strict managed-care network, with very limited access and many of protocols, then the prescription-drug program needs to be aligned similarly. If, for some reason, the medical program is an indemnity plan, it cannot be changed, and the prescription program is used as an adjunct to attempt to control some costs, then we need to think about the fact that the employee is not accustomed to managed care. Interestingly, Joan and I work more with people who have had indemnity plans. Often, we are the first steps before the medical managed-care, point-of-service-type programs are put in. They like to test the waters with prescription drugs or managed MH to see how they work, and then, if they're successful, move into the medical arena. Unit costs need to be negotiated through some sort of major network manager or carrier that has a lot of purchasing power and a lot of volume. It will provide you with the best discounts.

Ultimately, long-term control depends on effective drug utilization review; not only cost control, but quality control. Finally, one of the things that has been lacking to date in any kind of prescription-drug management has been data. Capturing that type of comprehensive data is going to be essential.

I thought I'd share with you a statement from a January 1991 trade journal. The FDC reported that the drug stocks are winners across the board. The article talked about how confident the pharmaceutical manufacturers were in their profit margins; that they were actually investing in each other. Eli Lilly and Company had bought Merck's stock and so on. Well, today it is a little different.

MR. PETER R. BARNETT: I basically want to focus on how to tell a good vision program from a bad one. Why are we talking about it at all? What kind of things go into it? You will gain some basic knowledge of the program; what you should expect one to look like.

In terms of the why; the workplace is getting older. During the next few years, the majority of American workers will be entering their 40s and 50s. More and more people are going to have vision problems.

We did an independent research study of American workers about their views on vision care. Their results were surprising to us. Two-thirds said they'd be willing to give up some vacation time in exchange for vision coverage. About six out of ten said that they'd give up some personal time. About seven out of ten said that they'd use the vision program more than any other free-of-charge health benefit. Employees prefer vision by two to one over dental. Finally, more than two-thirds believed that vision should be part of their employer package. There's no surprise there; people always want that.

Well, there does seem to be a great deal of disparity between the level of importance that Americans place on their eyes and the effort that they make to maintain healthy eyes. Seventy percent said that they were very concerned, but only about a third go and have their eyes examined. About two-thirds, however, said that they would go if exams were made available through their benefits package. Employers are finding out about that. They're hearing about that. In the April 1993 issue of *Business and Health* magazine, an article on vision talks about one of the ways that vision has been used for about the last four years, which is as an offset to changes, usually declines, in the makeup of their medical benefit program.

Awhile back, the Department of Labor showed that there had been some significant growth. *Business and Health* surveyed some employers and found that among what they plan to offer, vision ranks sixth. If you had fewer than a thousand people, vision was higher ranking because it's small, it's predictable, it's containable, and it's not subject to the ravages of inflation.

There are five basic areas that you have to consider in evaluating a managed vision-care plan: quality assurance, administration, plan design, flexibility and customization, and the piece that ties it all together, the provider network. They have to be interdependently managed. That's what managed care is all about.

The plan should be producing high-quality care, demonstratively better than that outside the network. You have to have standards of quality and continuous monitoring of those standards. These are basic elements in any type of managed-care program and ones that are clearly necessary in vision as well. You have two elements, which are true for most health care. You have the technical side of the

care, and you have the patient perception side. I think it's absolutely critical that you make sure that any program is involved in both of those areas. Patient perception clearly is important and is one of the areas that is not very well managed in managed care today. A management study done back in the early 1900s, the Hawthorne Study, basically showed that things improved by simply attempting to manage something. In the area of quality, where we have no national standards, where we have very few agreed-upon approaches, often the attempt, the effort made to manage quality, to improve quality, is as important as trying to absolutely define point by point what constitutes quality care. So, although we find ourselves in a position where those standards are not readily apparent, we do want to make sure that there is some attempt made in those areas.

In vision, there are two aspects to quality assurance. One is the alphametric side, the doctors' side, the service side of the equation. All of those things can constitute parts of that. The other side of the equation is the product side, where we're talking about the material component. There is the service and the material or hardware in vision. Both of these components deserve their own quality programs, quality audit, and quality-assurance mechanisms. According to the American National Standards Institute, there is a very high percentage of defects. Not all of these are visible to the naked eye. Not all of these are consumer visible. But, it is important that you understand what the benchmark is. Any program that is implemented must be held to this standard and improve upon that standard. If your provider cannot demonstrate that it is improving upon this standard, then it is truly not managing, it is not being competitive, it is not providing value. Some of the product audit tests would include drop ball, glass lenses, contact lenses, checks, and accuracy. I think it's important that you understand that quality in vision does not need to be puzzling. All of these things are readily understandable and are clearly definable on paper.

The second area that we ought to talk about is administration; finding a program that will ultimately result in better care for the employees. The administration has a large part to play in that. You should be able to have your eyes examined by doctors who are not worried about the ancillary aspects like paperwork and collecting dollars. The more hassle that's involved in that, the less time there is to be involved in patient care. The easier it is for the provider, the better it is for the patient, because how providers treat and care for their patients is the direct result of how the program treats the providers. Administrative systems should be able to handle a variety of pricing options, including capitation and fee for service. It should provide access and toll-free numbers.

Two key factors in determining the effectiveness of the program are flexibility and customization. Your plan provider should be flexible enough to customize in order to meet those unique needs. Vision plans can cover dress eye wear, safety eye wear, and BDT users. Some employers prefer traditional indemnity plans with a schedule of benefits and claim submission. Others prefer either a fixed-dollar allowance, in which employees are given $50, $75, or $100, or a program through which the employer will completely fund basic exams and a pair of basic glasses or contact lenses. These might be a fee-for-service program or a capitated program, and capitated programs can be either full or shared risk.

Vision capitated programs can average about $0.60-1 per member per month for an exam-only program. A full-benefit program, including materials, might cost $2-4 per member per month. Obviously, those prices would depend on the copays. Small copays apparently have very little effect upon the utilization of the program. Programs in vision can have frequencies that range from once a year to once every two years and are typically divided into frequencies for exams, lenses, and frames. A once-a-year benefit would be considered a 12/12/12. If you have a program where frames are only given out every 24 months, you call that a 12/12/24. A biannual benefit, once every two years, has only a small effect on utilization. If you think in terms of the average optical-purchase cycle being once every 2 or 3 years, and the average population running about 60-65% in terms of usage of optical services, you can see that your average annual rate is going to be in the 25-35% range. If you have an exam-only program, you're talking about 10-15% a year.

The final type of program that is talked about in vision that is not managed, but which is considered a vision benefit in the industry at times, is a pure discount program; no funding, straight dollar or percentage. Of course, the question you're going to have to answer is, a percentage off what?

For a managed-care program to work, the provider network has to be large enough to guarantee easy access, but it cannot be so large that you're not providing enough work or traffic to individual providers. One of the most difficult things in selling the client is helping them understand that giving somebody a contract when they have five or six extra procedures in a year does not amount to a reason to discount their fees or even to contain their fees. So the provider-network trade-off is absolutely critical. The American Optometric Association took a look at why people purchase where they do. Convenience and one-stop service were two of the top three responses, representing about 60%.

I think it's critical that you focus on the need of the customer and ask these five questions to be able to give them what they want. First, do you have the quality-assurance mechanisms in place? In terms of administration, is it patient oriented? Is it information oriented? Can you decide, can you respond because of it? In terms of plan design, does it build in the cost containment? Does it give you additional value? In terms of flexibility and customization, does it fit with your philosophy? Does it meet the needs of your employees? Does it offer them something of added value and perceived value? From a provider standpoint, is it large enough? Is it small enough? Is it convenient? Ask yourself please, in any program, is it customer oriented? Because if it's not, in the end you have to ask the question, is it really managed care? Because that's the decision that you have to make when you look at all of the pieces put together.

MR. RONALD E. BACHMAN: I'd appreciate any comments on why the cost of utilization review in managed MHCD care seems to be so high. So few people, as you indicated, need care. When we split it out, it seems to cost almost as much as medical-surgical, about $1-1.50 per employee per month.

MS. PEARSON: I gave the vendors a list to determine how much of the money was going to network development, assessment and referral, claims adjudication, accounts service, etc. What you're buying with managed MHCD is many clinical services.

They're doing a lot of work up front, in terms of the assessment. They follow cases very closely. There's a lot of physician advisor involvement. Essentially what's happening is that some of the dollars that you were formerly paying in claims are going to pay clinicians at the MH administrator, to direct traffic and to oversee the care. That's where a lot of it is. You can't make a direct comparison between that and a third-party administrator's (TPA's) fees. I try to avoid carving out if we don't need to, because then you just add many more claims administration fees. It will run a dollar per employee per month to carve out the MHCD piece. You have to be very sure that really makes sense. Sometimes it does, sometimes it doesn't.

MR. BACHMAN: Is there an overkill there with the clinicians at the front end?

MS. PEARSON: I don't think so. One of the interesting debates that's going on is the degree to which it make sense to manage outpatient MH. That's where all the people are; between 40-60 people per-thousand covered lives will use outpatient MH services. But 5-7 per-thousand covered lives use inpatient MHCD, and that's where all the dollars are. I'm encouraging many clients not to provide network outpatient MH benefits, because it's expensive to adjudicate, and it's clear to me that the return on investment for assessment and referral is not there. For a variety of reasons, however, I like to encourage clients to have a voluntary assessment referral, where people can call, but there isn't a higher benefit for going to the provider to whom they're referred. It's a service. Also, if you've had many problems in the past, you can get with a network provider and not have to worry, if you need an admission, about discontinuity of care. It generally makes sense not to provide a network benefit. So that cuts a lot of the costs back. When you do that, you don't have to carve out the claims. Just have the managed care really focused on the high-risk, high-cost care. I'm finding that makes more sense for many clients.

MR. BACHMAN: When you carve out prescription drugs, MHCD, or vision, to separate networks, compare the network-access fees and the overlap, or the excess cost as opposed to doing it with a single carrier. What are the problems of carving them out to separate pieces? Are there efficiencies in terms of available providers in each of those areas with expertise to make it worthwhile to carve out separately?

MS. PEARSON: Let me just answer on the MHCD side. Sometimes it doesn't make sense to carve out. But many clients with point-of-service plans are having Metropolitan in this area, CIGNA in this area, Aetna in this area, and an HMO in this area. By the time you start building all the necessary interfaces, you have got an extremely complex situation, and that's often what a client will choose to do. Where you have multiple carriers involved with the medical-surgical piece, the argument for carving out starts to become more compelling. Setting that aside, if that's not what's going on, I will often recommend not carving out. Generally, the easiest way to avoid it is to not have a network benefit for outpatient MH and to have a voluntary referral. The volume of claims starts to get real small, and you don't need a complex electronic interface to pay the claims properly.

MS. BABBIN: From the prescription-drug side, it makes sense to carve out prescription drugs only in one instance, and that is when you feel like the carrier, or TPA who's providing medical services, cannot provide the point-of-sale technology or the concurrent drug utilization review in those items that you need. I'm a very big

advocate of leaving the prescription drug component with the medical-surgical vendor, because the physician has control over what is put on the prescription pad, and the managed-care medical vendor has control over the physicians' prescribing habits through its pocket. It's a very good incentive for them to prescribe accurately and cost effectively. In the past, I have seen large amounts of carve-out prescription-drug programs, because the major carriers were carving out their own to provide that point-of-sale technology. Today, they're becoming more and more sophisticated. We're finding that carve-outs aren't needed as much. Interestingly, it's actually somewhat cheaper to provide services through a carve-out prescription drug vendor than through the medical claims administrator. Medical claims administrators charge anywhere from $5-8 to process a claim, regardless of whether it's a medical-surgical claim or a prescription-drug claim. Whereas, in the carve-out environment, it probably costs somewhere in the range of $0.75-1.25.

MR. BARNETT: In terms of vision, I think it's very simple. Vision seems to be able to stand basically on its own, because vision represents about 1% of the health-care dollar. None of the majors seem to have the systems and the understanding of vision, from a primary-care standpoint, to be able to compete with the independent vendors. There are very few interfaces that are necessary, so you're not overlapping, and you do not seem to have a problem carving vision out.

MR. BRUCE T. CAMPBELL: What is the role of utilization review in a mail-order pharmacy situation, and is it effective?

MS. BABBIN: I think it depends on whether you're talking about just a plain mail-order component, or if you're talking about it being integrated with the real retail network, and I'll address both very briefly. A mail-service prescription-drug program that is an adjunct to a program does have concurrent DUR components that are accepted industrywide. Retrospective DUR in those programs is growing, but it has not been as strong as it could have been. For integrated programs (those programs where an Aetna combined services with a Walgreens, for example, to provide both the retail network and the mail-service component), the drug utilization review component is done by the major insurance carrier.

MR. HARRY L. SUTTON JR.: What do you think about splitting the MH out of the HMO, as well as out of the indemnity, where you have options with the employer?

MS. PEARSON: HMO-managed MHCD is interesting. The issues really seem to be access. The benefits are okay, it's just that nobody can get in there. The waiting times tend to be so long for access to any kind of MHCD, and that's where the employer dissatisfaction comes. Employer assistance programs (EAPs) have been crying in the wilderness about this for years. As companies are starting to look at their MH cost, EAPs are starting to move into the mainstream, and their complaints about HMOs are being heard. My clients come to me for help in this area, because they want to save money. Making managed MH services available to HMO enrollees increases their cost a lot. The thinking is that there is as much demand for MHCD in an HMO population as there will be in any population. In fact, there's pent-up demand. So I think it comes down to a cost issue. Do they want to take it on? Sometimes it will come out in a bargaining situation. In California, a number of clients will carve out their MHCD plan and make it available to HMO enrollees in a bargaining

situation to get managed MHCD. But there's much reluctance to do that, because the bottom line is dollars. Again, I think much of the issue is not the providers of the HMOs, not the benefit design, but the waiting times.

MR. MARTIN E. STAEHLIN: Going with that question about the bottom line, I think it was Joan who said, there's not much savings from discounts; the key is to find quality providers. Isn't the key to start to weed out some ineffective providers, and how are each of the three of these programs doing that?

MS. PEARSON: With MHCD, 80% of the savings are attributable to reducing the length of stay of inpatient confinements or substituting alternative care. Discounts are almost all coming exclusively from inpatient facilities, which are discounting their average daily rates by 50%. It's very high. In terms of providers, we're seeing more and more honing down in terms of the numbers of providers in networks, or at least those that are receiving referrals. As companies get better at monitoring performance, particularly of psychiatrists who generally control the inpatient treatment and more severe cases, there will be a lot of scrutiny in identifying who's really good at this.

MS. BABBIN: From the prescription-drug side, traditionally vendor management has been very poor in eliminating pharmacies that have not been cost-effective providers. It's been one of those areas in which credentialing has been very slight. If it is governed by the state board of pharmacies and meets the requirements, then it meets the vendor requirements as well. So that's a flaw of the system as it is today.