RECORD, Volume 24, No. 2*

Maui II Spring Meeting_
June 22–24, 1998

Session 13TS
Use of Treatment Protocols to Manage Hospital Utilization at the Insurance Payer Level

Track: Health
Keywords: Managed Care, Product Development, Strategy

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Summary: Patient treatment protocols are being used by some payers to manage the routine treatment of hospitalized patients. Such protocols differ from the length-of-stay guidelines currently in use because the protocols react to patient treatment daily rather than benchmarking the treatment after it has occurred. This session briefly:

- *Describes the difference between patient treatment protocols and length-of-stay guidelines.*
- *Discusses how protocols were implemented at an insurance payer.*
- *Reviews the major issues the payer confronted as the protocols were implemented.*
- *Reviews the utilization results following implementation.*

Ms. Donna Kalin: I'm with Milliman & Robertson. With me are Bill Mabe, a vice president of Nationwide Insurance, and Deborah Loveland, a health care management consultant with Milliman & Robertson. They will present a case study of their implementation of protocols at Nationwide Insurance. They would like this to be an interactive session so feel free to ask questions at any time.

Mr. William E. Mabe: These are very challenging concepts. They're easy to talk about, but difficult to execute. I have found that writing strategy and developing

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strategy is not terribly complex if you can get some consensus, but executing strategy can often be monumental. I'm doing some work on the life insurance side with Nationwide and some of the themes in the pension business (or what they call the savings business or long-term retirement business) are moving into the health care business. I see tremendous pressures on the distribution side: getting distribution, costs, alternative distributions developing, access using the Internet, distribution of product using the Internet, service over the Internet, and service and distribution by bankers and broker dealers. A compression of the distribution side is coming about.

The other big trend on financial services side is the open finance model, which involves developing a very intimate relationship with customers. It means giving customers a complete view of their products—including performance tracking capabilities—and access to service and product information at all times of the day. Those trends will move quickly to health care and the benefit side.

Deborah Loveland and I will work as a tag team. When I get to certain points in my overview, she will interject her comments and discussion.

Ms. Deborah Loveland: Even though we had the Milliman & Robertson (M&R) health care management guidelines to work with, integrated medical management is more about process than it is about what's written in the guideline itself. I'm trying to show you the intended and appropriate use.

Mr. Mabe: Another market pressure is capability. You have customer demands for certain capabilities, legislative processes coming in, and competition. We're all friendly competitors in a tough business. With all these pressures coming from different directions, we need to know where our business is going and how we are going to position ourselves for the future. I'm not insurance company-focused or physician-focused; I think you've got to be customer-focused. If you start with the customer focus and work inward, you're much more likely to be successful than if you start inside and try to push the product out.

All my concepts were driven from my vision three years ago of where the market's going to be, where the legislative environment is moving, and what customers are going to be demanding. Then I try to integrate everything because so much medical management is done artificially because of product design, the legislative environment, etc. We wanted to build some sort of mechanism that deals with the real issues, the fact that people may be in different health plans with different kinds of products, covered by workers' compensation insurance (workers' comp), or in group health. Within one geographic area, an employer might be providing an health maintenance organization (HMO) benefit, a point-of-service (POS) benefit,

and an indemnity benefit. Those employees might be in group health or workers' comp. Some employers even provide auto insurance coverage.

The question is, how do you manage across all those product lines? Customers are going to ask, What do my benefits look like over time? and How are you managing the care? Therefore, understanding the broad concept, the holistic view of a customer, is extremely important. An emerging countervailing force are the issues of privacy and confidentiality. Just as we had a backlash to managed care from the provider community in the sense that they're trying to resurrect themselves and become more involved in managed care, I think there's going to be a countervailing backlash on the privacy side.

Progress is a winding road, not a straight course. I'm going to give you a case study of a small organization. For bigger organizations, this is one market, one set of players. But, I wouldn't underestimate the challenges because they're enormous.

First of all, we had to develop a common vision of where we wanted this thing to go, get everybody around the table to agree on that, and then get everybody to play ball and follow along. The cultural issues are much tougher than the strategy. Strategy is relatively simple and straightforward; it's execution that's difficult and I always underestimate cultural stuff.

From the Floor: Where do you want this thing to go? What is this thing?

Mr. Mabe: This is a business overview of what we started with. It's a real snapshot and could be XYZ or any company. Most of you have HMO products, and you may have an HMO company or different lines of business. Here's a small company, a small HMO with 40,000 lives, and a preferred provider organization (PPO)/indemnity company of 60,000 lives. This is a mixed bag. The company has some PPO business, some indemnity business, some small group business, and some individual health business. It has a broad breadth of products plus different distribution channels, network combinations, systems, and people. I used to think this was a tough organization to merge into one. But this was a piece of cake compared to some organizations having to deal with many locations and a half a dozen different systems: admin systems, claim systems, medical management systems, etc. Our case is relatively simple in that we are trying to bring together just two organizations in the same geographic area.

From the Floor: What is your market share?

Mr. Mabe: We're probably fifth or sixth, somewhere around there. United, Anthem, and Medical Mutual (which used to be Blue Cross/Blue Shield of Ohio) are

big players in our market. And there are a bunch of smaller players. The market is both fragmenting and consolidating. It's fragmenting in the sense that there are a lot of small players; it's consolidating in the sense that some of the major players are getting together. In our market, Humana bought Choice Care and United bought Humana. Then you also have many small players developing, so we're mid-range in this market.

In terms of market segments, we're probably one of the larger small-employer underwriters. Our strategy was to be a niche player in the small-employer market, and I have a bias towards the small-employer market because that's where the action, the growth, and the money is—in the fully insured business. The ASO business is good and, if you can do it well, you can make some money. But a large number of players are chasing that business and the margins are thin. Our history and capabilities led us to a small-employer market. Our $150 million in premium is a little heavier on the indemnity side than the HMO side, but it's a medical business; ancillaries make up a very small piece.

My opportunities are not in manufacturing the small stuff, but in focusing on the medical. We let somebody else provide a solution on the managed care side, which, in itself, creates a different set of problems. It solves one problem, but it creates a different set of problems.

So here's the situation. I had different products and policy designs built over the last 15 years. There's everything under the sun. They all had different words, different definitions, and different sales operations. I had different people selling HMO, PPO, and indemnity products. I had new business, underwriting rules, and new business processes all over the board. I had three different admin systems, claim systems, and medical management systems. I had rental networks and networks we own, HMO networks and PPO networks. And I had different cultures, legends, heroes, and villains. In every organization, you find out who the heroes and villains are, and I think it's just a matter of good people with differences of opinion.

Ms. Loveland: In addition to these differences, there were different protocols and different guidelines across all these lines of business. And if you look at the original use of medical management guidelines, as with the inception of Medicare and retrospective review guidelines, what they wanted to know was how much money you spent. They were looking to justify the spending of public funds. So the accounting system that was set up internally had to do with adding up units and numbers of services, a very different animal than a medical management guideline.

As guidelines evolved over time, they became prepayment review guidelines to ensure that claims were paid the same way. You can tell across the lines of businesses that you would want the claims paid differently depending on the claim system used, the product lines, and so forth. Yet, they still had no medical management guidelines. The so-called medical management guidelines in use at the time were essentially intensity-of-service or severity-of-illness criteria combined with average length-of-stay guidelines, which were the industry standard across the country. These were very prominently used, but still not the type of guideline that Bill was talking about implementing. To make the situation more complex, layer this multiplicity of guidelines and their purposes across all of the lines of business.

From the Floor: What was the driver for the merger?

Mr. Mabe: The driver for the merger was leverage. I originally wanted to leverage the contracting and thought that bringing volume into the marketplace was the key to contracting. That was my initial cut. Later on, the vision became more customer-focused. I started thinking about what I, as a customer, would want a system to look like and how I would want it to work. If I'm a customer and in an HMO and want to move to a POS plan, I'd want to know several things: Do I have to change networks? Do I have to change product designs? Do I have to change benefits? Do I get a new identification card? How much hassle do I have to go through simply to change a plan design? I decided that, instead of working out of a closed panel, I wanted an open access panel. In coming at it from that perspective, I wanted to merge these organizations, take the best of both worlds, and create a model plan that I would want to participate in.

By creating one company, I could offer customers a better product, better service, and a better price. For the employer, I could offer one place to go for benefit designs. In terms of contracting and medical management, I could leverage it across the product lines. Early on, I negotiated the first couple hospital contracts with the idea of leveraging the HMO, POS, PPO, workers' comp, and auto products. I was trying to test the concept out and asked a hospital executive, "If I could have one universal contract that was a standard contract and no matter which line of business I brought to you, I got the same rates or better, would you buy into this?" He said, "I can deal with that and, actually, it would simplify my world." I said it would simplify mine too.

So testing that hypothesis out, I found I got much better rates on those contracts than I could have ever gotten singly. I offered to bring hospitals different lives and different product lines under one contract. That way, they have only one single contract to negotiate, one set of medical management protocols to work through, and one set of administrative rules, position handbooks, hospital handbooks, and so

on. As a result, we were a mid-tier plan in the Columbus, Ohio market getting better hospital rates than some of the larger players.

From the Floor: Could you talk about your premium rate relationships between the two companies? We, too, are in almost every product line. In contracting, we're finding that it's very difficult to balance the relationship between premiums and provider contracts because the customer is expecting a big premium difference between, say, a PPO and an HMO, when in reality, your provider contracts are very close and you can't balance that financially. Did you have that problem?

Mr. Mabe: Yes. What you're saying is that there has to be some rational relationship between the pricing of your products because of the expectations of the customers. They think you're giving them an HMO product with a smaller network and tighter controls, so the premium differential ought to be significantly better than a POS and PPO plan, particularly when your underwriting contracts are the same. Is that right?

From the Floor: They're not far apart.

Mr. Mabe: For us, they were the same.

From the Floor: I thought they were, that's why I'm asking. What did you do?

Mr. Mabe: First of all, the pricing doesn't make any sense in some respects from a customer's perspective. It's the benefit structure that's different. On the HMO side, the benefit structures are richer. We didn't change the pricing. Instead, we said, "Pick your product," because I'm not sure which product—POS, HMO, or PPO—is going to be the winner. I'm not sure which eggs I want in which basket, particularly with the heavy legislation that's being mandated on the HMO side. We might be more competitive by offering them a POS product.

From the Floor: So you're saying you went out there with higher rates on your HMO?

Mr. Mabe: In some cases, we had higher rates for our HMO than we did for our POS plans because we were really trying to push people into a POS, contrary to the popular wisdom.

From the Floor: What about the PPO?

Mr. Mabe: People bought the PPO because they thought it was less managed than the POS when, in fact, we do the same thing across all our products.

From the Floor: What is the difference between your POS and PPO?

Mr. Mabe: The differences really are in the plan designs.

From the Floor: The panels are the same?

Mr. Mabe: The panels are identical.

From the Floor: It's just a question of cost sharing.

Mr. Mabe: Yes.

From the Floor: Is the basis of payment the same?

Mr. Mabe: Yes.

From the Floor: Is the network the same?

Mr. Mabe: Yes. Five years from now, it is not going to make any difference whether you call it HMO or POS, or whatever; it's going to be a health plan. In fact, in Ohio, the Health Maintenance Organization Association changed its name to the Health Plan Association. The HMO world, the POS world, and the PPO world are artificial political barriers. I don't really care where my customers end up as long as they end up in a managed care product with a consistent set of benefits, medical management, and networks. In fact, we move people from the HMO to the POS and from the POS to the HMO all the time, and it's transparent to them. They ask, “Do we have to have new cards, a new system?” We say ″No, you’ve just chosen a different benefit plan design.″

It's process that's important to me, not product. It's customers that are important to me, not product. Product is simply plan design and benefit differentials. It's the packaging I put it in.

From the Floor: One technical note, then I assume the regulations in your neck of the woods don't give you the opportunity to put risk sharing and other type arrangements on HMO products that are not available for PPO products.

Mr. Mabe: There are no restrictions on our ability to put risk-sharing arrangements on both of those. We've gone into the market as a contrarian. I started with the idea I wanted one network, one system, and one medical management protocol built to the same specs and standards. We came to a fork in the road where we had a choice: to (1) build a PPO network without National Committee for Quality

Assurance (NCQA) quality accreditation activities, or (2) develop a common platform that would need NCQA accreditation. We took the NCQA approach because one day PPO networks will have to be NCQA accredited and all of the accreditation, accountability, and so on is going to roll down. So my perspective was to build it now, rather than wait for someone to force changing networks later on.

The idea was to build one organization positioned to move left or right, depending on politics and the legislative world, and remain competitive. It does create some anomalies in pricing because you can artificially spread the benefit plan designs. Sometimes we thought about doing that, but decided to let them pick their plan instead. Some employers will pick the HMO because it has a richer benefit.

From the Floor: Did your marketing staff struggle with that because customers are struggling with that?

Mr. Mabe: No. It made life simple because all our member handbooks look alike except for the benefit differentials.

From the Floor: The way they sold it was, "You're buying our benefits, so it costs a little more?"

Mr. Mabe: That's true. It's a rational statement, and they're not trying to dance with the numbers. Too many times, we try to force the numbers to be what they're not.

I determined that we needed to have about 100,000 lives to make us legitimate in the marketplace. We wanted integrated, not separate, products, which means you have to standardize your products. We needed multiple distribution because this is the way of the world. The pressures on costs and pricing are going to create all kinds of distribution issues for everyone. Agents and brokers are going to hate it because the Internet is competing with them. And you will need direct marketing capabilities because of the inevitable disintermediation of distribution channels. Agents and brokers are going to have to justify their value equation somehow, and for a small employer, they don't bring much to the table. When it comes to the network, the plan design, and the cost, you're going to have to justify the differences, and it's very difficult when you get into those markets. People who have integrated these products are in a better position to take advantage of alternative distribution channels.

From the Floor: Did your pricing reflect the different distribution systems?

Mr. Mabe: We debated about whether to price differently for different distribution systems. To protect current distributions, we didn't, but there is a point in time when we will. The question is, how?

From the Floor: You haven't done it yet?

Mr. Mabe: No. Until we get this thing rolling, we do not want to put ourselves in a position of biting the hand that feeds us, and that's the same story you have in the life insurance business side or whatever business you're in. If you have a dedicated distribution channel, the emergence of alternative distribution channels is a competitive threat to those people. It's better to have a direct operation or other distribution channel in place beforehand.

We've built one medical management platform and one system for data processing and finance. One of the competitive pressures in the marketplace is that customers are going to demand a single customer database. When you talk about customer intimacy and understanding your customers, you need a single customer database. If you have one database for HMO customers and a different database for POS customers and indemnity customers, you can't manage that.

From the Floor: Don't forget billing. Sometimes you want to get them set up on billing before they select their benefits.

Mr. Mabe: You absolutely must be able to do that.

From the Floor: Or vice versa.

Mr. Mabe: Yes. Your pension brethren might say, "I have to give my customers a complete view of their benefits. I have to tell them what products they have, how they're doing, and what they should do next. I need the same thing. I can't have a pension product with those capabilities and a less-than-spectacular group health product that doesn't." Pressure from your own internal organization will push you toward providing that capability.

Looking forward, I see an individual's health care becoming just as portable as his or her pension. People will want to take their information with them, so how can you give a full history if you have no way of tracking across product lines which changes have been made. Also, if you want to develop in-depth retail marketing capabilities, you'll need that customer database.

Companies doing business on the Internet know your preferences and your history when you go in, and those interactions are just great. Cookies remember all the

things you did. If you can call Pizza Hut, they can tell you what kind of pizza you ordered in the past and what your buying habits are. These capabilities are raising expectations for all of us in terms of what information we can provide. However, the data are not very good because they aren't integrated. There are many different kinds of systems and management reports, and you have to be able to bring it together. I won't tell you we're there yet. We've made a lot of progress, but we struggle enormously with many things, and data information is one of them.

From the Floor: If you're using one medical management system, does that mean that you're not employing any type of gatekeeper system?

Mr. Mabe: Right. We went to an open access model because, for the most part, 10% of your customers are 80% of your problem. Everybody has to sign up for the primary care doctor initially, but when it comes to medical management, we implemented disease management programs on the back side. We screen everybody on the front end and put them in the appropriate disease management program to manage their care. Instead of trying to manage everyone with gatekeepers, we're going to focus our energy on managing that smaller population—that 10%, 12%, or 15% of people who account for 80% of our cost. We put disease management programs in place to manage diabetes, heart disease, oncology, and orthopedics because those are where the big dollars and the big opportunities are. The physician components are big ticket items and that's where we said we're going to invest our money, time, and energy.

From the Floor: Is there still a primary care physician (PCP)?

Mr. Mabe: There is a PCP selection, but we don't make patients get prior approval. We did that before it became popular because we looked at our business from a customer perspective. We had a limited amount of resources and needed to decide where to put our energy.

From the Floor: If you don't have the gatekeeper requirements, how do you implement disease management?

Mr. Mabe: You can drive disease management a couple of different ways. You can identify people with chronic problems through the underwriting process. If you run your pharmaceutical records, they'll pretty much tell you who all the players are and what medication they're taking. The pharmacy side will drive a lot of interesting discussion. You have to do a good job of data mining your claims data, underwriting data, pharmacy records, and emergency room records.

This is where we put our energy—into data mining activities. And one message I want to get across to you is that the underwriting part is very important in terms of risk selection, proper categorization of risk, pricing that risk, and getting people into medical management early, not after they have claims. Gatekeeping takes place on your underwriting side. Early intervention with people who are chronically ill is the key. The new capabilities are network development and contracting your medical management information systems.

From the Floor: If a gatekeeper's not necessary for referral, why are you bothering to have them select a PCP? I assume you track a selection.

Mr. Mabe: Yes.

From the Floor: Why bother them?

Mr. Mabe: I think it's important to get people associated with a PCP early on.

From the Floor: Do you let the patient make a selection, and then just ignore it?

Mr. Mabe: You can do that.

From the Floor: I'm the administrator, and keeping track of these things seems to be one of our biggest problems. Why bother?

Mr. Mabe: I've had an enormous amount of discussion on that issue, and a healthy debate goes on between me and the medical director on a regular basis. I think it's important for patients to make a selection so they have identified someone they can have in times of need. The debate is about the cost effectiveness and the administrative hassle of it. When people need emergency care or immediate help, it's helpful if they have already developed a relationship with a PCP. One of the tenets I believe in is getting patients aligned with a physician and establishing a relationship early on. You'd be surprised by the problems it causes when they don't.

Ms. Loveland: The early relationship from a medical management perspective is what we were trying to emphasize. In theory, when a patient enrolls in a health plan, that's when case management begins. We wanted a mechanism whereby you could encourage a patient, say, within three months of enrolling in the health plan to visit with the PCP. This way, you get them into the system for preventative care, as opposed to waiting for them to initiate the service when a disaster occurs. That was the thinking behind it, but I don't think we've quite gotten there.

Mr. Mabe: The questions are: Where do you draw the line on the administrative hassle? What are the trade-offs? I don't know that we've fully resolved these issues. There are still a lot of unanswered questions about what's the best way to do this or that.

From the Floor: Isn't the question that disease management should start at an earlier stage for diseases like diabetics and renal dialysis? Those are the people you want to find early, as opposed to when they're in the hospital.

Mr. Mabe: Absolutely.

Ms. Loveland: That's what we were after.

Mr. Mabe: I think that's an excellent point. Utilization management starts from the day a person signs up to be in your health plan; it does not start at the time they're in the hospital. So the assessment and understanding of who the customers are that you've signed up is the first step in utilization management and medical management.

From the Floor: I don't know how you expect the PCPs to find the people who are going to be a problem for you.

Ms. Loveland: It has to be driven from the plan side. When you get enrollment data and there's a PCP Identified, someone usually says, "Have you seen this doctor before? Do you have a relationship? Would you like to make an appointment? Can we help facilitate that?"

Mr. Mabe: There's a need for underwriting to fully assess and understand the people in your health plan. The countervailing forces want no underwriting or limited underwriting. So you're getting pressure from those who want privacy, no underwriting, and community ratings. At the same time, if you want to manage a population effectively, you have to understand their history and the details of their lifestyles. But we're putting so many things off limits that we're delaying the process until we have an emergency event. That's why a detailed customer database with the same information on all folks is the first step. I find that doctors know how to deliver care, but they do not know how to manage care. Lawyers know how to deliver legal services, but they don't know how to manage legal services. There's an implicit assumption that because a doctor has the expertise to deliver care, he or she also can manage care. That's one of the fallacies of managed care, and we push this medical management plan out there and assume the doctors know exactly what they're supposed to do. For example, we found that diagnosing diabetics was not something that doctors did very well. PCPs didn't know their

own patients were diabetics, so they were slipping through the cracks. The plan discovered the diabetics by looking at their medical records and that sort of thing.

From the Floor: Should we just give up the battle on the genetic testing side? Obviously, if we had access to the genetic records, we could identify patient needs a lot better, but the American Medical Association (AMA) has decreed this to be totally off limits.

Mr. Mabe: Then it falls back on medical management. We just passed the golden age of medicine: unlimited payment with not many questions asked. That is golden.

From the Floor: I take issue with this last statement. My point was that you want the integrated health care system, and you want the PCPs to find these people. You shouldn't have to find them by data mining. That's a lost battle. And, in my crystal ball, I think we'll have to give up on genetic testing.

Mr. Mabe: I agree with you on the retrospective stuff. If you find it in data mining, you're finding it late, but you're still finding it earlier than you might otherwise. It's not an ideal methodology, but it's an interim step to getting it on the front end when you really need it. My point on the genetic testing issue is that we need to fight to make the discussion fully articulated. In the long haul, we probably won't have access to this information, but I think those issues have to be debated. We can't just roll over.

Ms. Loveland: I think it will have to be a combination of things. I think there has to be more data analysis and mining plus more responsibility on the PCP side. But I can tell you, from a clinical perspective, that I've been disappointed in PCPs' performance. We expect them to do an awful lot, but the truth of the matter is that many of them aren't prepared to do it, don't know how to do it, or don't have the clinical expertise to do it. Then you end up having specialists acting as PCPs, which, in some cases, might be better. We keep wanting to push things in that direction, but if it was working as well as we had originally hoped, we'd know a whole lot more than we do. People still are not getting early intervention to the degree that's necessary to do group health management.

Mr. Mabe: I would like to speak to the critical success factors here. On the member acquisition side, marketing is just not making literature pretty. It's understanding who your customers are, segmenting them by their lifestyles, and providing good two-way communication. Too often, I find marketing in health care companies relegated to marketing services, which is making stuff pretty, when, in fact, marketing has a serious mission: helping you target, market, and underwrite.

There will be continued pressure for no underwriting, but you need to figure out who the profitable customers are, develop customer profiles, and then target those people.

The actuarial folks are essential to helping the marketing people frame the data structure, manage the data, and understand what risk the company does and does not want. If you tell marketing and salespeople, to go hunting, they will come back with a different kinds of animals, so you need to tell them what you want.

The delivery side is extremely important and includes risk assessment, utilization, and care delivery. It's important to build a close relationship between the actuarial, underwriting, and medical management departments. If they are not tightly interwoven, the care falls outside of the system and becomes poorly managed. I encourage all of you to become immersed in the medical world and spend time in the trenches with the triage, care management, or network development people to understand their issues fully. In contracting, network development people are very important.

Ms. Loveland: One of the most difficult areas to measure are what I call the "silent cost drivers." Usually we can get some help in talking about numbers of procedures, numbers of visits, numbers of referrals, and so forth, but what causes costs to triple are delays in services and procedures and in the follow-up care that should happen. Right now, there's a soft system collecting silent cost-driver information; there is no linking at all between inpatient, outpatient, and follow-up. We have three systems and very little linking from the actuarial side to give us support for that. We don't know if sending somebody home in two days produces a better outcome than sending him home in three because we can't link it to follow-up data. Many different needs emerge when you try to manage these decisions.

Mr. Mabe: The actuarial expertise is essential. If you don't have it, you're driving blind. I'm a lawyer by training and I begrudgingly admit that I need financial information to go with the words when I do contracting. I went out and negotiated my first contracts to understand the process. And I can negotiate with the best, so it's very important.

The overarching global success factor is management support from a high level. Your company has to be dedicated to this process. Senior management has to buy into your vision because change in an organization has to be driven top-down; change driven from the bottom doesn't work. People have to see you to believe in the program. If you're not visible, they think it's just another flavor of the month.

Ms. Loveland: At the same time, Bill and I began working together on an integrated medical management process. Nationwide has a company called Gates McDonald that does workers' comp, so we threw that into the process too. I wanted a medical management process that included Gates McDonald, the auto industry, and Mother Nationwide, as they call the home office. Bill was trying to herd several different companies in one direction and needed top-down support to do it, but it was extremely difficult.

Mr. Mabe: The interesting challenge is to get everybody to buy into the idea that managed care is important when you have different product lines. The auto people think you are wasting your time with managed care. However, 25% of every auto claim dollar is medical and 50% of every workers' comp dollar is medical, compared to 80% on the health side. If you have a big auto business, someday managed care is going to be there—on a knee, a back, or whatever—and it takes just as much management. People talk about the liability issues, but sooner or later you're going to be the last one in the food chain, and all the cost shifting for Medicare and Medicaid that went to the commercial side is going to end up on the auto and compensation side. It's only a matter of time.

We had a five-step transition plan to try to make this all work. We wanted to build seamless products and pricing. All of our contracts are the same in terms of definitions of medical necessity, policyholders, members, etc. It's the benefit plans that are different. This makes filing, compliance, update, and product issue tremendously easy. Service is a big issue in this business, so we wanted to build a statewide platform using the enterprise concept to have all the different product lines on the same contract, one medical management capability, a common systems platform, and an integrated managed care company. Finally, we wanted to get all our other customers who weren't on this platform—other than the new ones—to move over to it. That's the big challenge.

From the Floor: Define the word "integrated."

Mr. Mabe: I'm using "integrated" in the sense that we were using the same products in the medical management system and the same processes across all the product lines. We had two companies with different cultures, and we shoved them together. Now, in terms of products, underwriting, systems, and medical management, it is one company.

From the Floor: What administrative expense did you end up with?

Mr. Mabe: Initially, our admin costs went up because we were building the networks and systems. We started with a 13% admin expense ratio, which went up

to about 15% and then dropped back down, so we experienced a build-up bump. We moved away from mainframe systems because all the corporate allocations were coming down to the product lines. As we switched to the smaller desktop AS 400 system, we found our allocations dropped substantially from the lines of business.

From the Floor: Do you think you'll get back to where you were?

Mr. Mabe: I think we will because we're using electronic data interchange (EDI). We are auto-adjudicating about 80% of claims since we standardized our product and service inputs. A big expense is employing claims examiners and service reps. EDI helps you ratchet up your auto-adjudication rates, which cuts down on paper processing, mail room activities, microfilm, etc. You'll have dramatic paybacks on those. We found we couldn't get electronic data up for all the old individual health policy contracts or the small group parts because they were so complex and had so many different wrinkles. When we standardized the contracts, we had enormous paybacks because we could build the auto-adjudication formulas into the system. It's the same thing with hospital contracts. If you standardize your hospital contracts and schedules using the same words and language, you can auto-adjudicate the process instead of having some claims examiner back in the back room flipping through manuals trying to figure out what the appropriate reimbursement is.

Until recently, I headed the Medicare operation for Ohio. We cut the 1,000 employees in that organization to 670 in five years. We have the lowest unit cost in the country because we have a standard product and an 80% EDI rate.

From the Floor: You said the big challenge is getting your customers to accept the standardization. What obstacles do you have?

Mr. Mabe: The biggest obstacle is our salespeople because they don't want to disturb a happy customer. I want them to convince customers that we have a better deal, that's a challenge. Sometimes we do some pricing adjustments, which I know is a dirty word, but in a lot of the situations, we ended up with significantly better contracts than the old ones we had. In some cases, I'd give a 20% discount with a new contract, whereas I had been giving a 45% discount. It was that dramatic in some situations. And the physician reimbursement was better. Therefore, in some cases, we could price our contracts a little bit better.

Pricing is the way to move customers, but the biggest hurdle has been getting indemnity salespeople, in particular, to change their understanding of medical management. I thought this was going to be an easy sell because I was offering a

better benefit plan, better networks, and better pricing, but getting the salespeople to move customers to this new platform was more of a struggle than I thought. I went through one year of trying to move them with moderate success. Finally, I said, "You are either going to do it or you're gone." I was just about that blunt, and we lost some salespeople.

From the Floor: So you're saying you needed pricing and sales incentives?

Mr. Mabe: Yes.

Ms. Loveland: While Bill was fighting with the sales force, my biggest challenge was in the claims department. Their definition of medical management is retrospective: Pay it as is, the case managers can't even know what the benefit levels are, it takes a three-day decision, and that type of thing. Changing these processes was a big battle in a claims shop as big as Nationwide's.

Mr. Mabe: On the data side, the toughest problem is garbage in, garbage out. It starts in the physician's office and gets worse. PCPs don't do a good job of coding forms (specialists, though, are code experts). Then it goes to the claims people, and they do a good but not quite an expert job, so by the time we get it, it's a mess. This is where EDI will improve your results because everything has to be entered correctly. Therefore, the quicker we get physicians inputting their claims data directly, the better.

From the Floor: On the claim side, you have customers changing to a new system, and the claims department is also as conservative as the salespeople, if not more so. What difference do you find in successful treatment protocols on specific types of diseases to convince everybody to buy into it?

Ms. Loveland: You mean to switch the way they would do a treatment? I think it had more to do with putting together customized plans, which is where the guidelines come in—as opposed to protocol. The difficulty on the claims side was that they were used to doing retrospective dollar management, but there was no thought given to a patient's response to a given treatment. It was strictly pay if the claim was within the benefit guideline. What we were trying to do on the front end was to get to the point where somebody would describe the desired response, measure and monitor it frequently, and then adjust it accordingly. That's a big switch. The claims people were afraid of the dollar pieces because there are instances when it costs more to do something because the outcome will be better from a medical perspective. It was the benefit exception piece that probably caused the biggest stumbling block. And that involved a lot of education because, even in the medical management area, we find that clinical competency is a major issue. A

lot of nurses, for example (and I can say this because I'm a nurse), went into utilization management because they didn't want to work in hospitals any more. Some of these people haven't set foot in a hospital for 20 or 30 years and haven't a clue about how things work today. Those in the claims area have been out of it even longer. Not only have they been away from hospitals, but they've been in an insurance company for years, so it's even worse.

Mr. Mabe: We try to use one contract for all product lines. The schedule might change but the words stay the same. This links your administrative manual to your hospital manuals and your product design.

Ms. Loveland: And it links to medical management and timing issues.

Mr. Mabe: The program's consistency also has to apply to ancillary networks for urgent care, home health hospice, physical therapy, chiropractic, pharmacy, lab, radiology, etc. Often we think in terms of hospital only, but you're pushing people from a fairly controlled hospital environment to a very uncontrolled environment outside the hospital using a plethora of providers. What kind of reimbursement schedules do you have on ancillary services providers and what kind of utilization do you have in place for those folks?

Ms. Loveland: What kind of quality monitoring do you do for these services?

Mr. Mabe: The big challenge is managing outpatient services that are not in a very controlled environment. The Health Care Financing Administration is experiencing that now with Medicare. There's been an explosion of ancillary service providers; everybody and his brother has developed a home health care company. The other issue is that the liability exposure in the home health care market is significantly higher than it is in a more controlled setting. Some people delivering care are not very sophisticated or are learning on the job. And there are a lot of new companies. You should be very selective about contracting with companies for these types of services.

From the Floor: What portion of physicians in hospitals in your market area do you have?

Mr. Mabe: Probably 75–80%. It's difficult to say because many physicians are academics that are not practicing, but that's a good estimate.

Ms. Loveland: Everybody in that marketplace belongs to everybody else's network.

From the Floor: In other words, it's the most willing provider network?

Mr. Mabe: No, we were fairly selective. Some of the hospitals are not in our system and we got a lot of grief for that. But deselection is something you do not want to do. It's like underwriting; you want to do good job on the front end because getting a provider out of your network is a very costly affair. I would encourage you not to do it if you don't have to.

Ms. Loveland: There's some challenge on the workers' comp side, though, because the providers that generally take care of the workers' comp issues are not necessarily the same PCPs you find on the HMO side.

Mr. Mabe: That's absolutely true. You get all kinds of healers on the workers' comp and auto side using different definitions.

From the Floor: I take it from your comments that, in Ohio, you're allowed to direct patients in workers' compensation?

Mr. Mabe: Yes, there are some direct mechanisms now. It's fluid, though, because managed workers' comp has just rolled out in the last year. I don't know where it's going to end up, but you can direct.

Ms. Loveland: A lot of it's soft, too.

Mr. Mabe: When you redesign medical management, the areas we try to attack are the structure, processes, information, people, and culture. When you want to do hospital utilization management, for example, you should think, "Where is the entire organization and how are we managing?"

Ms. Loveland: Most of it is still telephonic. We don't have on-site nurses at the facility, so there are pluses and minuses to that.

From the Floor: Do you recommend case management at the hospital?

Ms. Loveland: Yes. When we did the implementation, training, and roll out, the hospital case managers came to the same training sessions that the Nationwide case managers went to. We did role training using the guidelines as examples and actual charts from the hospitals as the vignette.

Ms. Loveland: One problem we found through the initial review was that it was quite possible to have an admission on Friday that wasn't reported until Monday afternoon that wasn't picked up until Tuesday afternoon. Sometimes there was a five-day time lag.

Mr. Mabe: If you have people on site, it's much more effective. One of the most revealing things we did was go to all the hospitals and conduct selective audits on customers that had gone through the system. I was amazed by the downtime for doctors waiting for tests and for patients just waiting.

Ms. Loveland: The system delays are the hidden cost drivers.

Mr. Mabe: The downtime is the result of administrative delays, not something being done for the well-being of the patient. And I was surprised by which hospitals had bad administrative systems. Sometimes they were the premiere hospitals in town.

Ms. Loveland: We found that about 45% or 50% of the hospital days were unnecessary because of delays in services—not patient conditions or complications.

From the Floor: When the case management staff at the hospital says, "We plan to do this tomorrow," do you say something like, "We hope to see this?"

Ms. Loveland: That's exactly what we would do, and this is a good place to interject the M&R guidelines. Bill did elect to use M&R guidelines, although I don't think it would make that much difference in terms of what we did in the process.

The M&R guidelines are not length-of-stay guidelines. The world has operated on length-of-stay guidelines for the last 20 years, based on Medicare guidelines. When we talked about two days targeted, it wasn't an absolute number and it wasn't an average; it was an optimal number. Now, we want to cover up the number and talk about an individual patient's response and outcome. If you've had surgery, you're out of bed, your pain is controlled, and you're eating, then you might be ahead of this person who is still in pain and throwing up. We're not managing on averages, but on patient conditions. This involves a daily review using an M&R target, an AMA target, a Society target, or any target that you choose. The concept is to try to do the best you can, when you can, for the uncomplicated patient because you can't do anything about the complicated one. That was the basis of Nationwide's medical management program.

Mr. Mabe: You don't want to treat everybody the same. The point is to tailor the management around your particular customer. That's the big difference between length of stay and managing with the guidelines we're talking about.

Ms. Loveland: The idea is to be proactive, not reactive, and eliminate system delays. That's basically the crux of all of the processes.

From the Floor: So the Nationwide case managers are evaluating conditions and updating the length of stay.

Ms. Loveland: Exactly. They're not assigning lengths of stay. They are asking about the patient's condition, collecting clinical information, and feeding it back to the case managers at the hospital. The case managers might say, "I want to know when the patient is eating, when the doctor thinks he's ready to go home, and what the clinical parameters are." They look at the M&R guidelines as a benchmark, but they don't cite it. They don't say, "M&R says two days," but it's there as a benchmark, which is much more positive.

From the Floor: Do they still authorize a number of days stay?

Ms. Loveland: On the hidden side, not on the verbal side. I think a lot of this has to do with how it's communicated. On the backside, yes, there is an authorized stay that is determined.

From the Floor: You had something called "free treatment guidelines."

Ms. Loveland: These refer to the use of diagnostics and things of that nature. We do have diagnostic guidelines, and Nationwide has some of its own in place as well. The trick is that the guidelines in many situations don't kick in until after an admission happens. During admissions, the providers sometimes don't even care about the diagnostic piece of it, so you have to change your timing on that piece.

Mr. Mabe: That should come in through this quality monitoring process. I don't believe in the NCQA process—it's all bureaucratic. However, it should monitor quality improvement and data reporting in your system.

From the Floor: What kind of provider contract support or changes do you put in to be able to do these kinds of things?

From the Floor: Couldn't you push that further? You're actually dealing with the hospital to authorize the days, so why not just give them the book and say, "Here's what we think you ought to do," and get some kind of cooperation.

Ms. Loveland: They have the book, and most of them use it as credenza wear. They still operate on state peer review organizations, which all use Medicare criteria and the entire hospital system is set up to deliver that type of information on a 24-hour basis. To get your days approved, you have to do a procedure on that day. So why do two procedures in one day, when you can get your day approved by doing one the next day. So you can get approved for an IV at 125 c.c.s an hour, never

mind whether it needs to be given then or not. Hospital utilization review departments are set up that way. A lot of nurses in hospital utilization review departments report to the finance department, which gets very upset if days are denied. So they're not there to manage, but to stay closely tied to the health plan's patients. They're there to get days approved from Medicare and Medicaid. Honestly, this is the attitude. The management to the level that the health plan needs it is the plan's problem, not the hospital's problem. This will be the way they go until hospitals' income from Medicare or Medicaid drops dramatically enough that they need them a little bit more than they need them right now.

From the Floor: How have the hospitals reacted to these plans?

Ms. Loveland: Two of the hospitals have been extremely cooperative, and one has yet to call back. When they initiated use of the criteria, I was there listening to the nurses make their telephone calls, and there were some hostile reactions on the other end of the phone. "You're using that M&R stuff," they said, followed by some bad words. Then they'd want to know which criteria we were using, and we didn't tell them initially because we never gave out that type of information. Finally, I told the nurses to give them the page number in the book and talk about it. It's not anything that you need to keep hidden from them. But the biggest objection initially was our request for daily reviews.

Mr. Mabe: They do, however, develop more respect for you know what's going on and keep everyone on the task. We tried to organize with medical leadership. If you can tie your networks, medical management, and quality together, it's a stronger package.

Ms. Loveland: We instituted a triage concept using an 800 number for all lines of business. When a call comes in, it's screened by a person and routed to the various case management areas. That's how we got all the products integrated. It is seamless to the patients. They didn't have to hear, "You've got the wrong number. Call this one, instead" or "No, this is the wrong case management department. You need to talk to the claims manager." It's a value-added 800 customer service number that's triaged and routed.

We stopped the fragmentation of the roles. Where there had been pre-cert nurses, concurrent review nurses, and case managers, we now have nurses that can do all three. There was tremendous turnover. Bill, I think you lost about 80% initially.

Mr. Mabe: Yes, but that was positive.

Ms. Loveland: They didn't think so at the time.

Mr. Mabe: They had the wrong people for the job.

Ms. Loveland: As I said earlier, a lot of nurses retired from nursing and didn't want to get back into this clinical piece, but from a professional standpoint, it's not an unusual thing to ask a nurse to know what's going on with a patient and follow a patient from admission to discharge. Basically, I was just replicating the idea of nursing. We combined and eliminated roles. Now, there are triage people and case managers, who are combined into units or teams so that there's coverage where needed. They had care management registered nurses and some specialized case management nurses such as for oncology and neonatology. The latter are highly specialized, but we wanted good, basic medical-surgical nurses with recent hospital experience who could pick up and follow patients.

Lack of medical leadership can be an issue with carriers. Bill is fortunate. He had a lady who had no real managed care experience, but who worked very hard and has done well. Without medical leadership, none of this is possible. The old fashioned carrier has a medical director whose idea of a medical opinion is, "It's not a covered benefit, so it doesn't belong here." You have to get into one that's more interested in taking on the clinical issues and driving the processes.

Mr. Mabe: It's not the medical director you wheel out for presentation; it's somebody who rolls up his or her sleeves and tries to understands data, who is not afraid of managing and dealing with data. One of our physicians came from the Centers for Disease Control, and she was very familiar with population-based disease.

Ms. Loveland: That helped a lot because sometimes getting physicians to understand population-based management is a real challenge.

Ms. Loveland: The majority of the contact is still with the hospitals, but the phase in process involved putting together plan-based physician committees to modify protocols and to develop additional ones. The idea was to get more physician involvement and interaction. Case managers still do, on occasion, talk directly to doctors' office staffs more than to doctors themselves, but there still are connections with the doctor.

Mr. Mabe: It is also important to have readily available information resources. The nurses and claims people on the front line need to speak from good authority, so you must give people the tools to do their job. Often that's the last thing we do, which is why we hear a lot of horror stories.

Ms. Loveland: That was part of the fight between the claims manager and the frontline case managers. Initially they had to send a claim downtown and wait three days.

Mr. Mabe: We had multiple criteria for utilization management and now we have one set of guidelines. Instead of multiple policy definitions, there is one, such as, for example, "medical necessity." Instead of paper-based referrals, we have an electronically consolidated medical management system. Instead of one-size-fits-all, we try to tailor it to the customer, which is really important. We provide continuous follow-up, quality improvement, and customer and provider surveys.

Ms. Loveland: At the same time that all this utilization management and system redesign was going on, Nationwide also was going through NCQA accreditation.

Mr. Mabe: And we were successful. The case managers used to use sticky notes and now they use the online system. We have one system now—one claim system, one admin system, and electronic-based disease management programs. We've improved the reporting, but we desperately need to improve it more. It's still not driven down to the level of detail that we need to manage it.

From the Floor: On the utilization management, how do you deal with customers who are trying to standardize it?

Ms. Loveland: You do it by contract.

Mr. Mabe: You standardize the process and tailor it through the M&R guidelines when interacting with the customer.

Ms. Loveland: For instance, I've worked with a lot of carriers that have unions, and they have specific national contracts that have to be administered. It's triaged through the same 800 number. We would apply the criteria the same way, but put benefit limitations on the claim to reflect the union contracts.

Mr. Mabe: This is the way the system should work. You get your data in, it goes through your data engine, and you have a consolidated database. Your opportunity for real involvement is getting into that database.

The medical, surgical, and total days per 1,000 have dropped, as have diagnostics. Physician reimbursement, on average, stayed about the same and pharmacy increased. This is per month, per member, in current claims.

From the Floor: What's the definition of diagnostics?

Mr. Mabe: Lab, X-ray, and home health care. Primarily lab and X-ray is where most of the decrease occurred. A lot of that is due to better contracting more than anything else because you have a whole different mindset on diagnostics.

Ms. Loveland: We saw a year of hard fighting and then things began to fall into place. It will probably be a little further out before you see exactly what you want.

Mr. Mabe: This system will not compensate for competitive pressures, bad pricing, bad underwriting, or expense management problems. This is about having a strategy and how to execute it.