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Effectively Implementing Managed Care in the Small Group and Individual Markets

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Summary: The ability to implement managed care strategies effectively is a key factor for success in the small group and individual markets. Panelists discuss various managed care strategies and their experiences with how well these strategies have been implemented. Substantial audience participation is encouraged to share their success and failures with implementing managed care in the small group and individual markets.

Mr. James T. O'Connor: I'm going to lay the framework of the small group and individual markets and what we need to deal with in terms of talking about managed care and cost management in these markets. One of the key characteristics of these markets particularly the small group market, is the decision maker is the owner. There is no employee benefit specialist, so that emphasizes the importance of the agent. The agent is basically their benefit specialist. They rely heavily on the agents that they deal with. Most agents are involved in selling PPO fee-for-service type small group as opposed to HMOs. The HMOs, as we'll discuss, certainly are now beginning to enter into this market in a more serious way, but for the most part, we're dealing with agents who are selling fee for service plans, discounted or not.

One of the preferences in this market by that owner is to have a single plan. He doesn't have the time or the patience to really deal with multiple plans, such as an HMO or indemnity plan. A single plan is generally what you'll find in most of the small groups.

When I'm talking about small group, my background is primarily in the mini-group market, under 15 lives, particularly under 10 lives. A lot of what I have to say certainly applies to the whole spectrum of small group, up to the 50 lives, that,

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generally, we refer to as small group. However, keep in mind that my background is with groups with under 10 lives.

The other aspect of the small group market is the employer does not want to hear any complaints about this plan. Because of what people hear and say about managed care and, particularly the HMOs, they tend to stay away from that just for the reason that they don't want to hear any complaints from their employees. They know their employees pretty well, particularly in this mini-group market and because of that they know the health status for the most part of those employees. They're in everyday contact with them. If there is a problem with a health care plan, they're going to hear about it. By having a freer health plan where there's less restriction, there's going to be a tendency to have less complaints from their employees.

One of the other characteristics of the small group markets is that for most companies there is very little concentration in any given local area. That puts some limits on what you can do in terms of the managed care that you're trying to implement. There are high policy lapses and high agent termination rates. Basically, what that adds up to is that the groups that you write on your books don't tend to stay around long. You have a limited window in terms of how you can manage their care, and we'll talk a little bit more about that later.

One of the things that's still true of both the individual and small group markets, even in the Health Insurance Portability and Accountability Act (HIPAA) environment and a guaranteed issued environment, is that there is still a definite selection pattern. That selection pattern maintains certain implications in what you can or cannot do or need to do in terms of managed care.

Basically, because of the characteristics of the small group and individual markets, we have an issue of cost management versus managed care. The key focus of small group is on making premiums affordable. That is truly a problem. How do we make premiums affordable? Managed care is only a part of that solution.

These are some of the key components of cost management. We have plan design, underwriting, rating structure, provider reimbursement levels, claim adjudication programs, managed care itself, marketing strategies, and certain conservation programs. I'm going to briefly talk about each one of these to set the framework from which the other two speakers then will give you more actual operational detail as to what their companies are doing.

Plan design is really key for managing costs, not necessarily managing care, but certainly managing costs. It begins in the covered services and supplies. In small group and individual, we see a lot more internal limits on certain services. We see exclusions of services and, certainly, we see some things being covered and other things not being covered on an out-of-network basis. Things like mental health, spinal manipulation, and substance abuse, we'll see quite a few limitations on that, more so than in the large group market. There are also exclusion of certain services. In the individual market maternity is one of the key ones that, generally,

your individual plans will at best have some kind of maternity rider. It's not part of the base plan itself.

Cost-sharing provisions are real key in the small group market. That includes deductible levels, coinsurance levels, and differentiating between in- and out-of-network stop-loss levels. My observations have been that deductibles and coinsurance are increasing. Average deductibles in these markets are tending to be somewhere maybe in the $700-800 range now on average, so that $500 and $1,000 deductibles are probably the rule. You see very little $250 deductibles. One hundred dollar deductibles may be out there, but are priced to not sell.

Prescription drug programs are certainly another aspect of plan design. This is an area of great concern right now in these markets as drug costs seem to be escalating quite a bit. Plan design is real key in controlling costs.

The second aspect is underwriting. The underwriting that goes on in these two markets differs somewhat. Certainly, in the small group market, there's a spectrum of underwriting from being very tight underwriting still in the mini-group markets to being a little more liberal as you get closer to the 50 employee size units.

Guarantee issue, because of HIPAA, is certainly a factor in the small group market now. As I mentioned earlier, it still does not eliminate the good selection in the early durations in this market. Individually, you can still generally underwrite fully, medically underwrite, and reject/accept, rate up, rider and, of course, these things will vary from state-to-state as to what you can do. But underwriting still remains one of the major components of cost management. It plays a much larger role than actual managed care.

Rating structure is also important in terms of managing costs. How you rate your plan relative to your competition becomes very important in any given market. What you can do varies by state, certainly. Tiered or durational rating is still pretty much the rule of the day in the small group market. Recognize again, that some of the good selection in the early durations allows companies to do this tiered rating.

The two markets do differ in terms of their rate presentation. Small group is generally quinquennial in terms of its structure and individual is still pretty much attained-age rates. The attained-age rates certainly allow you to compete effectively and to try to balance your risks off effectively by those rating criteria.

Renewal rating is still very key in the small group market and individual markets. Certainly, we are seeing renewal rating by experience, so that new business rates generally are quite different than renewal rates in the small group market. In the individual market, while there's basically aggregate rating going on there, as companies close blocks they become much more aggressive with their renewal rate increases wherever it's allowed by law. The rates vary, of course, by allowable case characteristics which vary quite a bit by state. Where states have tightened down and gotten closer and closer to community rating, there's less you can do in terms of containing your costs. Managed care then becomes all the more important

because of those restrictions. But in most states we can still do quite a bit of rating by risk classification in terms of these case characteristics. In the rating, depending on what your company's experience is and what your competition is doing, we still see cross subsidies in terms of what is going on in those ratings—young males still subsidizing older age people and females.

Almost every small group plan has a PPO and that's basically what's selling. There's very little indemnity selling from my observation. In the individual market almost the same holds true, though you do see more straight indemnity plans without a PPO feature to them. These are observed particularly in rural areas. One of the things that Jim will speak on more is the whole process of dealing with PPOs, both on regional and national levels.

Usual and customary (U&C) criteria is also another cost containment feature. What we have been observing is that companies are getting more aggressive on their U&C. Companies may have been at the 90th or 95th percentile of HIAA 10 years ago. Today they're probably operating at the 80th percentile or lower. I've seen a company as low as the 50th percentile. Another approach we see is tying the out-of-network U&C to the network discounts that you're getting, so that they'll be some percentage of those network discounts—100% which is the same fee level as what you're getting from your networks or maybe it will be a little more liberalized and maybe up to 110% or something of that sort.

Pharmacy card programs are, as I said before, becoming more and more important. The demand on the street is for the card. At the same time and, certainly, in recent months, certain clients of mine who have card programs are looking more to whether they could get back into putting the prescription drug benefit into the major medical set-up of deductible and coinsurance. That will be interesting to follow over time to see how companies move back and forth in the pharmacy card programs.

The next area of cost containment is claim adjudication programs. Claim adjudication is very important in terms of managing costs. Again, small group and individual carriers focus on this quite a bit, often more than they even will the managed care aspects. There are a lot of vendors out there who are willing to help the carriers in terms of getting prompt payment discounts and case management negotiations. For a share of the savings, they're willing to go to bat for the carriers.

Thorough claim investigation is becoming very important. There's nothing really new in terms of that cost containment. That's been going on for years, but, again, is definitely a key component of cost management. In terms of claim adjudication programs, it's wise that your unauthorized experimental procedures are not too restrictive. Antibiotics certainly don't belong in that category which brings us to managed care.

We have two different aspects of managed care and Catherine is certainly going to get into this in much more detail than I am. Basically, we have our traditional type things, pre-admission certification, both inpatient and certain outpatient requirements. Carriers do different things on the outpatient side certainly.

Everybody has them. Are they effective? Hard to say, hard to measure, particularly in the small group markets and individual markets where the way the doctors practice has already been influenced largely by what's been going on in the large group sector. It seems to me that doctors often times will not vary their practice just because they've got to have a patient in the small group market. That's not to say every doctor is like that, but a lot of the impact of length of stay and admission to hospital is already being reflected in doctors' changing practice patterns which have occurred over the last 10 years.

Concurrent review, discharge planning, large case management, and required second opinions, those types of things are old now and embedded in most of our small group and individual plans. Then there's more innovative managed-care type things. One is identification of potential high cost insureds through the underwriting process. If you're doing full medical underwriting, you're getting some good information about the risks that you're taking on. Evaluating those risks for potential high costs is something that you can do at the outset of taking that insured on and starting to plan your treatment of care for that or at least observation of care for that particular insured.

Disease management is not really too prevalent at this time at least from my observations and my clients. There's not too much being done, but more and more of them are starting to look at what would be entailed in doing this. There are some real problems with things like disease management though. You may recall that I mentioned that there are high-lapse rates and high-agent termination rates here. The length of time any given group is on your books is fairly short, so the ability to really set-up a good disease management program is quite limited in the small group market. They don't have the average duration that you usually see in a large group setting.

Centers of excellence. More and more small group carriers and individual carriers are introducing centers of excellence just like have occurred in the large group market. For the most part, what they key in on are transplants right now. Most of them haven't really moved beyond that, though there are some out there that certainly have and consequently they have a wider network of centers of excellence.

Finally, a real key component is marketing strategies. Jim Hall will talk quite a bit about this, but, basically, where are you going to sell? Who's selling for you? The development of the field force is critical to your ability to succeed in these markets. What kind of control you have over what your field force will say a lot about your ability to succeed in here. You also need to consider your competition. You need to pick your areas. You need to set your rates relative to your competition, but still without sacrificing profitability. That's a real challenge, of course, in these markets, in any markets. Then the selection of provider networks is very important. Who do you select, how many networks do you select, and what kind of discounts are you able to negotiate with them?

Finally, my last area of select conservation programs is reinstatement offers. How do you make reinstatement offers to make a difference in terms of your being able to attract good risks as opposed to poorer risks?

Proactive rate increase programs. Communicating with your insureds as those rate increases go out , rather than just hitting them with a rate increase can make a bigger difference. Explaining why there is a need for rate increase can help in trying to retain them.

Watch for certain non-health insurance offers. We see that there are other programs that insurers are sponsoring, particularly in the association group market that are being sold to individuals in small groups, where they have noninsured programs and different things that they can do in terms of attracting good, healthy clients. Of course, all of these programs have to comply with fair marketing laws and that's important.

Having stated all these different components of cost management, note that true managed care is becoming more important in these markets. It's a new competitive environment because HMOs are becoming much more serious about these markets. The HIPAA, the guarantee issue, and the rating laws have made a difference in terms of being able to do what small groups have done before.

In terms of the HMOs, the saturation of the large group market is basically the cause for having the HMOs now set their sights on small groups and individuals. My observation has been that what the HMOs are doing is basically setting their sights on the larger end of the small group market and working their way down. But, of course, once they open up their plan to small groups, all sizes are fair game because of the guarantee issue rules. They tend to use a lot of the same approaches for small groups as they do for large groups. They are using their managed care that they've introduced in their large groups and trying to apply them to small groups with some variation.

This is going to have an impact as the HMOs grow and become a greater force in these markets because the indemnity PPO carriers will follow suit and put more emphasis on managed care. With HIPAA, of course, the inability to reject clients increases your need to manage high risk patients and it calls for the focusing of things like disease management, and early identification of high risk becomes much more important.

Ms. Catherine Young: I'm going to talk to you more from a practical standpoint. I work for the Ceres Group and I'll explain some things that we're involved in so you'll understand where I'm coming from. I've just been with the Ceres Group for a few months. Since 1975 I've been involved in the business, mainly from medical management, and from claims adjudication and, from a consulting perspective with clients.

I've done some feasibility studies recently on small group products. When we talk to small employers, the decision making is based upon two things: the premium cost and if you're going to have any kind of a PPO, the network geographic spread

and is my doctor in the networks. The second question is sometimes not even that important. It goes right back to the first question, which is, what is the cost? So we're all dealing with those same things.

The Ceres Group is a company that is acquiring insurance companies with indemnity business, sometimes managed indemnity and sometimes not managed, and integrating it into a managed indemnity PPO environment. When we acquire companies, we acquire the rules and regulations and all those medical management activities. We have to deal with them until we can refile and do some other things and so you see where we're coming from. We're juggling eggs sometimes and axes other times and trying to get some results.

Ceres Health is a subsidiary of Ceres Group and I work for that organization. We are the cost containment managed-care entity of the organization. What we're looking for is hard savings. As we talk more about medical management, you'll understand what I'm saying. It doesn't mean that some of the things we do in medical management or in other things are not good, but we really measure our activity by hard savings.

We focus, first, on what is currently in place. If you have business, you need to start looking at what is currently in place. Don't think you have to run out and dump what you have before you truly see what is there. I think you'll find some very interesting things. I find very interesting things when I have worked with clients and managed operations and that type of thing.

One of the things is the plan, the actual language. We go in and look at the plan language. If you've ever truly read the plan language, you may find that what you think it says it doesn't say. That's one of the interesting things. You also usually find that your administration doesn't necessarily reflect what's in your contract. You may think so, but truly if you didn't audit your benefit administrative process, you might find that Susie, one examiner, and Joe, another examiner, are, when given the ability, interpreting the benefits differently and they're being paid differently.

You may also find some consistency in that on day one we're paying for item A; on day two somebody else rejects it. That's a problem, if you're paying for things outside of the limit. You, obviously, are spending money where you don't need to, but in addition you are setting yourself up for liability issues. Once you've paid for something that is not within the benefit contracts accepting case management or some kind of program, now the next person down the pipe can come up and ask, "Well, why didn't you pay for mine?" Then you get into all kinds of really wonderful legal things.

We look at PPOs. When we inherit business or buy business, we look at the PPOs in place. Jim's going to talk more deeply on PPOs and how you go about this, but we look at the discounts and test their effectiveness, we redefine the networks. You know, usually you've inherited many PPOs. Because of our business being spread across the U.S., we don't necessarily have clout in any area, so we've inherited a gazillion PPOs. We look at them. The ones that we're totally being taken to the

cleaners on, we try to replace pretty quickly. We're trying to then renegotiate our PPO contracts to get some better access fees and that type of thing.

As quickly as possible we try to make sure that we're limiting the PPOs to two in a local market and one big national PPO and that gives our groups the ability to select. They can select a national or they can select one of the two locals. But once the group selects the PPO that is their primary PPO and that's what we run everything against.

We also have a backup. We have a travel PPO. If you go out of the area (right now we're only dealing with the non-Medicare population, but like many people we're looking at the Medicare age population) the travel PPO is so important. The Medicare age population travels more around the country and have heart attacks in odd places. We also have a secondary PPO network underlay that we can go in and get discounts if a PPO isn't in that area.

We have an indemnity that is a voluntary cost containment and until we can change that, we do try to soft channel them. Our indemnity insureds will have to, of course, pay a higher copayment when you think about it, because there are no negotiated rates for some of the providers they use. When they call in to do voluntary precertification or they call into check their benefit, we talk to them about the networks, the providers they're using, and advise if there is a PPO provider in the area, just so they can be aware of it, that it may make some positive financial impact for them. We put notices in paycheck handouts, on our explanation of benefits (EOBs), all kinds of things to try to get them to be aware that they could have the option of using a PPO.

Surprisingly enough, the voluntary precertification is working. People are calling like crazy. When they voluntarily call for precertification, they receive the ability to know right up front if what they're going to be admitted for or what service they're going to have is truly considered "medically necessary." When the bill comes in they won't be in a situation of suddenly finding out that this item was medically unnecessary and now they're stuck with a bill. Because, of course, in indemnity the provider can balance bill. In PPOs we negotiate that the provider will accept our reimbursement and will not balance bill the member. Even our folks who call in indemnity if they use a PPO, then they're protected and that is working. I honestly did not think that we were going to get many calls but we are getting calls like crazy.

If our PPO patients decide to go out-of-network, we, again, give them an EOB remark. We talk to them up front about their liability if they call in. We give them correspondence and that type of thing to make sure that they do understand when they go out of the PPO that, of course, they're open for balance billing and other changes.

What we do right away, of course, is look at how these out-of-network claims are being paid. We find that many times they are being paid as billed charges. Unbelievable, but true. Many times it is because a claim system, and we've inherited claim systems, don't allow you to do anything "sophisticated," so people

are just paying them. We immediately put a stop to that, put in reasonable and customary.

We're looking at Medicode. The levels depend upon our different contracts that we have, but the idea is to get it to an acceptable reimbursement.

We also then look at a line-item analysis of the claims. What we find quite interestingly enough in these are out-of-network claims. We're finding an interesting apparent abuse in emergency room claims of the CAT scans and MRIs. There are guidelines you can use for MRIs and CATs, but remember if these people are out-of-network and they haven't precertified, then we're finding pretty interesting changes. We also go in and negotiate where we can on the claims and we reprice our outpatient bills and get discounts on those.

The core of what I want to talk to you about is medical management. That's the traditional ideas of medical review of claims, utilization management, and case management. What we look at medical management doing is cost-savings, and also to support consistent care and treatment.

We want to make sure that people consistently get the good care, the care they should be getting, care that meets their needs, and encourage optimum outcomes. We'll talk a little more about that, because that is absolutely critical. When you have negative outcomes, when you have complications, then, obviously, it's more money. You hit your stop loss. We have problems.

We want to evidence efficient use of resources. I would venture to say that most medical management is not focused on telling the doctors how to manage the care, but really how to use the resources effectively. The doctors don't believe that. They always come up with, "This clerk called me and told me to discharge a patient, so I had to." Who went to medical school? It's not true. I've been in this so many years. I know all the arguments and when you really pin them, they don't want to give any additional facts.

Many people have heard of problems with the utilization review (UR) companies. What UR says is we won't certify and then you suffer the results of it. But, truly, using resources effectively with UR is critical and that's where you'll find a tie with case management now which is a real win, win program. It can come in and save you money.

It is a delicate balance. The balance of one design is cost and quality. We're looking at the cost and quality and though it doesn't mean more services, people believe higher priced services equal higher quality. That's not true. But, again, designs not providing enough services and using the cheapest versus the appropriate get into a quality issue. That means that the patient doesn't have quality care, but it also means the patient has complications, doesn't get treated well, has problems, you hit your stop loss, or it really affects your loss ratio.

We're to people who like to sue and then you get sued in D&L coverage. There is a cost effective reason why that balance should be on target and that's what medical management helps you to do and to prove. I think proving it is really critical.

The one area that I would encourage you to really consider avoiding is medical review. Medical review is that claims side that provides medical input into your claims adjudication. I manage claim shops, develop them, and shut them down. I know that good claims examiners, who have examined claims for *x* years, have good judgement. I also know that no matter how good their judgement, they're not medical; just like the good nurse reviewers are good nurse reviewers, but they're not physicians. We each have a level of expertise and we should only act within those areas. What you'll find in claim shops, even if you have a medical review, is that all the things that you should be getting are not being given to you.

Your medical review shop helps you to make sure that you have consistency in what you think you're doing as far as technology assessment, the kind of claims you're paying, the kind of claims you're denying. The high-cost items and high technology are the areas you really need to be looking at. While you can write all kinds of things in your benefit language, that medical decision is critical for precertification time, prepay, sometimes post-pay, and when handling appeals. Medical review is really critical and it works if it's designed to work and if it's really supported.

In the claim shop you get the same answer today as you did yesterday unless the technology changed. The medical review area also has to make sure that they are not slowing up claims turnaround time and that's where you'll find some real interesting things. I find that when I go into shops, the medical review area usually has tons of claims. One of their complaints is they are getting pends from all the other claims areas and they don't know why. Then you ask, "Well, how is the turnaround time over on the other side" in the traditional claim adjudication side and you'll hear, "Well, they're really backed up."

It's been my experience that when claim shops get backed up several things happen. One is you get the thing off your desk and pend it to medical, because it's not on your desk anymore. It doesn't count. The other is, "Gee, I'll shred this or I'll bury it in a drawer." When I go into claim shops I usually ask people to open all the drawers, put everything on their desk, and we go and look at things, because I have usually found things stuffed in drawers. I have hardly ever gone in and analyzed a shop that was in deep trouble that I did not find claims stuffed somewhere. Unfortunately, sometimes data is lost or shredded, so that's even more interesting. But if they're backlogged enough, the claims usually come in three or four times, so it's still in the pile somewhere.

What I would suggest you do if you get into medical review is you just don't go out and hire a nurse because you always thought it would be kind of fun to do claims. It isn't going to work. You're going to spend money and you're not going to get good results. I think it is absolutely critical that whatever you use, whether you outsource it or you do it yourself, that you have highly skilled clinicians with a caveat that they understand claims and that may mean you have to train them.

In my practice one of the shops I was managing was in medical review. We were getting these tremendous mental health claims and started looking at the claim report and realized that things were being paid over the benefit limit.

I did a little a research and went to the nurses and they said one of the psychiatry team approved, it because it was medically necessary. I said, "Well, I understand if the person has a mental health problem it might be medically necessary to get care, but the business part of it is they only bought this product with these limits."

It's very hard to get caregivers to understand the business side without feeling this horrible guilt of, oh, my gosh, they need service. I always explain it as if you went out and bought a really nice Chevrolet, it's wonderful, it works. You can't run around and complain and go to the Rolls dealer and say, "But I want a Rolls, because I deserve it." It just doesn't work that way. You paid for the Chevy, you got the Chevy. Maybe you don't get that fancy hood ornament, but that's part of it. You know, it doesn't come with the Chevy, so it's hard to get them to understand.

When you're really beginning a shop you have to work with the people. You have to have them understand that only certain medical people could put the two hats on and feel comfortable about it. If you get somebody who can't wear the hat, you're giving away the store. At times, because of their own personal prejudices, they deny things and then you have even a worse problem.

Also, you need to get experienced claim technicians in a shop. When you say, "Well, they need clerical support or technical support," bring in a top claims person to do that. They're wonderful in helping to educate and keep that team on the right road, because the claims people usually see the black and white. The medical support team is saying that they need it. They can kind of get together and they counterbalance each other. You occasionally have to referee some arguments, but in spite of that it's okay.

Technology assessment. Don't think that you can do everything in-house. Technology is changing so fast you need to use outside expertise. Subscribe to services. Get signed up with certain companies who will provide you technical assessment, assessment on certain benefits and effectiveness. Because if you do all this in-house, remember, if it ends up in a lawsuit, if it looks as though your employees made the decision, and it's a real high cost and it's been argumentative, there's a problem, because, obviously, you had a financial interest in denying the care. When you pay for things nobody will complain. It's just when you deny that they come back. Get yourself hooked up to the right outside services, but, also, have a gatekeeper on the use of the services.

I had another shop where our physician advisor bill was dramatically increasing. It was a really wonderful national company with subspecialists, great service, but it was coming into things that were just unbelievable. I found out that the nurses said that this doctor was good to talk to and so they were sending everything over there. You need a gatekeeper on that type of service, but get signed up with something outside.

Then utilization management, the old UR you call in. If you're doing it, find out why you're doing it. Are you doing it because every managed care operation in order to have medical management or managed care needs UR? Well, if it's not working and if you're not getting the results, then you probably don't need it. Don't just think because you have it, it's working. Don't think because you have it, it is necessary. I do believe at this time it is still necessary, but in a modified form.

Have you ever looked at your precertification list to see what people have to call in for? People are calling in for outpatient gallbladder removal. I just can't imagine somebody sitting around saying, "I don't have anything to do Saturday, I think I'll have an outpatient gallbladder removal." They're just not doing it. Understand you can say, "That gallbladder doesn't need to come out," and so you could leave it on the list. However, you would need to make sure you're using really excellent criteria to evaluate whether they've had all their tests done. In the end, we're not finding unnecessary gallbladder removal is a big item. We're not finding big unnecessary hemorrhoid claims. Maybe you are, we're not, so really take a look at those.

You know where those came from is in 1975 when UR began. It was very much a scary thing for the doctors. I would have to meet with doctors and convince them they could do some unusual, very dynamic things like pre-admission testing. They would yell and scream, because, remember, people used to go in the hospital and stay two days. You had to be there before the surgeries. My argument was you've got somebody in two days before. If the test results are bad, they have to be discharged. If the test results show surgery is needed you go ahead with the surgery. Why would you want somebody in there laying around?

The doctors used to scream they would never do this. They did, but their UR at that time was also very stringent. They were really upset about it, because it only applied to Medicare. On day nine they had a sign on the chart that they were really thinking of maybe discharging that patient at some point. And then, again, on day 14 though it got more in-depth. They even had to notify the Social Service department, so that was how it began.

At that time, we honestly did see people who stayed in the hospital extra days because the doctors went on vacation or a variety of reasons. I would go into review records and see that the doctor went on vacation, so the patient had to stay. We found all those things.

We found people doing things inpatient, because outpatient surgeries were the newer things and everybody was afraid of it. I'm certainly an advocate of outpatient surgery, but I also have to tell you I believe that in some cases we are going very close to that line in quality. You know, you could do a brain surgery in the back of a Buick. Does that mean the outcome would be good? Possibly not. Should the patient drive home? Probably not. When we get to some of our outpatient surgeries it's not do we have the skills to do it anywhere and everywhere, it's really what is the support around the process to preserve the quality and prevent a negative outcome.

I really think you need to make sure when you look at outpatient surgeries and you mandate things that you make sure the facilities that are doing them are set up to handle the kind of patients and the types of surgeries. If the patient has surgery at 11 a.m. does their outpatient surgery area close at 2 p.m. no matter what? The choice is admit them or send them home. There's some real scary things either way, isn't there? When you contract find out a little more about that. We used to find things. It was in a transition time.

When I look at the precertification list of some of the things we have now, I think, "What are we doing?" You know, this is costing money. It's irritating to the doctors. It's irritating to the patient. Right now we don't have great education programs and we'll talk a little bit about that.

Target the activities, spend your time where you get the results. Will you still get the results today just like we did before in UR? Vague symptoms, back pain, vague abdominal pain, and vague chest pain, where people come in usually emergency, are not managed well. They come in emergency, some quick testing is done, they're put in the hospital. They're not put in an observation unit. If it's over a weekend some hospitals are still not doing physiotherapy and that type of thing over a weekend. If you just ask the medical professionals the common sense areas are where you need to focus.

You need to focus on areas you're trying to transition. You're trying to make the doctors aware of case management and that kind of support. Use defendable criteria and make sure you use them consistently. Every UR nurse has some judgement, but make sure you use things very consistently. Go back and monitor, monitor, monitor.

Evaluate your program and vendors. If you're using an outside vendor is that vendor able to modify their program to fit your needs or is it "here's the list, this is what we do, we'll give you a report in three months"? As we bring in business I'm looking at reports I can't even decipher in some cases. In one case, nothing was denied. By denied I don't mean that they had the day inpatient and then they denied it, because that's kind of a failure. You shouldn't see denied days. But usually what you'll see is the provider wanted to put the patient in, keep them in six days, put them in two days post-op.

The result of UR and case management is they went in one day post-op, they didn't go in any days post-op, or they were discharged appropriately a day early. That's usually what you see. Make sure what you're having done by your vendor is really what you're paying for. I'm going to guess you might not be.

Case management is the area that everybody loves. It can take over from the old UR and do some really great things, but you need to know where your goal is in case management. I had a company who really loved case management. They couldn't wait. They thought it was just wonderful, because you could get the patient out of the acute care setting into subacute or skilled care, and that was terrific. They were so excited, because they didn't cover subacute and skilled care. They did get case management. They just didn't understand it. If that's what

you're thinking, don't do case management. It's not good. It is extremely important to determine why you're going into this, what you're going to do with it, and where your focus is.

Move beyond the old catastrophic. How many people can fall down 18 flights of stairs and break every bone in their body? How many people get hit by freight trains, that kind of thing? It happens occasionally. It's a big case. It saves a lot of money. But you know the day-to-day garden variety is where we need to be focusing; day-to-day accidents, short-term cases, a lot of those outpatients. You can transition somebody more quickly from the hospital if you provide things in the home and we'll talk a little bit about that.

You need to also cross pollinate for your UR process if you use UR. You need to be talking to case management. Your claims need to be able to trigger cases over to case management. We don't have a lot of time to go into the details, but there are ways of doing that, even in claim shops where they're doing it on a system.

For case management, focus on specific diseases and/or conditions. If you only have so much money where do you apply it? Start applying it to the things that cost a lot or the things that you think you can make some changes in, things like the centers of excellence, transplants, burns, neonates, new babies, and preemies in the hospital. There are things that you can do there.

But, also, case management is in a state of change now. For case management, like utilization management, it used to be you hired a nurse. Case management always has had specialists, nurse specialists, but many people say, "We can only afford one and so we're going to hire a nurse," and that's okay. Hire a generalist, hire somebody who understands claims, hire somebody who understands UR, hire somebody who understands home care, but have that person be able to have resources of certain areas of expertise to help them.

There are companies that are saying that they will take over certain high-tech cases and do the case management. Look into it. See what you think about it. There are other companies who say we will actually carve out certain high-tech high-cost conditions, and we will give you a case rate. You need to do some analysis of that, too, but these things are worth looking into. Decide what you want to use, but never just sign a contract and walk away. You want reports.

You want to be involved in exactly what they're doing. There are no smoke and mirrors. If you're paying for what appears to be a middleman, make sure that that middleman is giving you value for the dollar. What are they really doing? Could you just go out and negotiate discounts yourself? Would a PPO do it? Look at these things. As you outsource or as you start using outside resources, you are fragmenting the process. When you fragment the process you're not in control and so you've really got to think that through.

We report all outcomes in case management, but we only really count hard savings. What do we mean by that? If we have a patient who has many hospital admissions, you can look at the claim reports. They are in and out a lot for

conditions like, asthma, or childhood asthma. If you then get case management involved, you work with the family and get them involved in some community resources for asthma management. You give them a few extra things to help them, and the admissions slow down, that is a true result. Is it hard to log it? You're really doing a projection. Actuaries know how to do that. But really only count the actual days and changes that you've made to their hard costs.

The future can be catastrophic. Right now, you're looking at claims experience before you take on a group. You're finding out who has what problems, and you're underwriting when you can. I worked with a trial program and that actually is looking at claims, and these happened to be HMO claims. Forecasting catastrophic is still something I'm keeping in touch with. I'm not convinced right now. It's certainly not ready to be a public product or anything like that, but it has some merit. It's pretty interesting and so that is coming up in the future. What will you be able to do? You merely hit those people who might be at risk and start working with them. Again, when we talk about the small group, they don't stick around long. The individuals definitely don't.

In the future disease management is a concern. You can manage all kinds of things. Currently, we jump on disease management at the point that is more the terminal stage of the disease, the congestive heart failure who's at that stage where they really are costing you a lot. It's kind of like an intensified case management that's very valid. But in the future, at some point, you'll want to look at newly diagnosed patients. How do you get people on the right track?

I've worked with, interestingly enough, the Physician Hospital Organization (PHOs), who now decide they want PSNs, HMOs. They really don't know what they're getting into. Every time I've worked with the hospital physician groups they can't wait to get a hold of those claims and start paying their own claims. They think they're going to go back to 1975 and they're going to pay everything. They get into more trouble. They don't hire the right people. They don't know that part of the business, so it's been a wake up call for a number of them.

I've done studies with groups like that about getting into a business that looks so hot. Most of the time we come back and say you shouldn't get into this business. You should really look in-house at making your operation more efficient, at making your cost containment more efficient, and making your outcomes more visible, so that somebody will contract with you because you have the best rates and the best outcomes. Focus at your own shop. Do what you do best. Don't jump into this.

Down the road is health risk assessment. It exists now. Would you want to do it? You have to really think about it. Life planning is usually for somebody who's been diagnosed with a long-term disease, and it gives an idea of what to expect up the road. If they don't do this and they don't do that what will happen. All those are interesting, but I think what you need to do is consider those turnover rates. When can you do this cost effectively? When are you just helping your competition? Although, there is an ethical part to this, too; if we can do it and do it effectively, we might want to think about it.

This is what I would suggest. In a new group, untested, you don't have good claims data. Think about the immediate results and really focus your activities on what you should do, what the short-term and good results are, target the activities, the type of case management, and the type of UR. For established groups, groups that you've had around for a while or you have really good data, now, maybe start adding some of these other activities. Pilot things. Never globally go out and make great changes. Never globally go out and add if you don't have to. Target everything for 90 days, so you can refine. Get reports. See what you're doing.

I worked for one company where I had pilot programs around for years. It was wonderful, because I could constantly change to meet the times. I wasn't locked into that "this is the way we do it" mentality. The action steps that we go through start with evaluating what you have now. I bet you're going to find out what you think have, you don't have. Develop a plan. Decide where the biggest pain is and develop a plan to address it. What do we have to do as far as change in those areas, dollars? Implement it, keep it going. Don't get scared. If you've ever cleaned out your garage, you enter that point where you think, "I've now pulled everything out, it's in the middle of the driveway," and you want to walk away. Don't, because right after that is when you find those valuable things that you didn't know were there—the gold buried in the pile of straw. Keep it going. But if you pilot, remember, you've made a commitment to a certain period of time. You pilot it, you stick with it, you stand up, you take credit or blame. Stick with it, because sometimes right at the time you're ready to change is when you'll see the turn.

Measure the results constantly. You have to be able to measure. We measure everything, in dollars per member per month (PMPM). We measure everything we do. We have a target to hit. Every change we put in place we measure, so we know are we hitting. Then we project what we need to do for the next refinement which means make changes as necessary. Do not think complicated. Just keep it as simple as you can, and that's it.

Mr. James F. Hall: I've spent the last year developing products, working with networks, and working with marketing. We sell to individuals and small groups, so I have a strong marketing perception that I'm going to share with you.

I'm not a managed-care expert. As a matter fact, I actually went to a book to look up the definition. One of the exams required you to use the managed-care handbook. I got the definition from the back. Look at the first four words, "a regrettably nebulous term." If you look at the last sentence for a better definition, "The reader is urged to read the book and formulate his or her own," and there's a bunch in between. My opinion is if you work in health insurance today, you work in managed care.

Some real quick things. We sell in the small group and the individual markets, small group guarantee issue 2-50 employees. Rates vary based on underwriting characteristics. I will tell you we do not do business in states that don't allow you to fit within the 1-1.67 rating band. That's the kind of business we are.

We sell to individuals and their families on an underwritten basis. I don't know how many people do association group products, but a lot of people do that now and that's the individual market, also.

I'd like to argue that managed care is a continuum that differs based on markets. In the large group market, there's more opportunity for managed care. The cases are with you longer. We've beaten that subject to death. In the small group and individual market, you're lucky if you keep them for 2-3 years. The average case is 2-3 years, then they move on, they go out of business. Actually, I honestly believe that there are a lot of people who purchase individual major medical insurance like short-term insurance. They're between jobs.

The other thing is in the large group market, you've got to take all the employees. Inevitably, if you're taking on 5,000 employees, there are several of them that represent a bad risk. In the small group and individual market you try to avoid all those people. You don't want anybody that's sick. You're selecting the healthy risks only. Because of that I think that you need to have two different approaches and I'm going to argue strongly to manage cost in the small group and individual markets.

Product Development. It used to be that if you asked somebody what were the three most important things they'd say price, and price, and price. Nowadays, depending on who you deal with, it's price, benefits, and network. I will argue that depending on where you go network may be the most important thing.

Everybody's trying to sell about the same benefits and that leads into the next question, who are you really selling to? All of the insurance we sell is sold through an agent. Agents aren't real sophisticated. They don't want to learn a new product. They like to sell vanilla. If you've got a good price, and good vanilla, and a good network, you generally have a pretty happy agent.

Anyone disagree with that? I think that's reality in the market. It may not be for the HMOs, but for the health insurance market today, I honestly believe that that is reality.

Product Development Benefits. Remember when we all did copayment plans and you had a copayment for this, and a copayment for that, and a copayment for the other thing? We wanted it to mimic the HMOs. We thought that was the way to go. The problem was in order to get our costs down to where the copayments were, you had to have lots of them, they had to be big, and it became very confusing. It became very difficult to sell, because people didn't really understand what they were buying. From a product development point of view, I don't discourage copayments, I just discourage having a lot of different ones that can't be defined and are difficult to understand.

Coinsurance differentials can't be 10%, they need to be 20% or more between in and out-of-network and you can push the 30%. One of the things that you find though is some of the states don't let you go much deeper than 20-30%. If you're

going to introduce a product and you want to introduce it on a national basis, you've got to have the right number.

Going along with coinsurance, one of the other things I find from a marketing side is that you have to have simple to explain out-of-pocket maximums. I've seen a lot of brochures where they don't even don't talk about the out-of-network benefits. The agents pick up on that and they don't sell those products, so you have to have a product that can be explained.

The reason I've included out-of-pocket here is that, ultimately, you need to be able to point to one number and say this is going to be your maximum out-of-pocket. You know, you have in network, you have out-of-network. Are they two separate numbers? Do you have to add them together? Do they work with each other? If I satisfy my in network one and then I go out-of-network do I have to start satisfying another one, a different one? They need to work together. I think that's really an important thing. I've been beaten up about it a lot by agents.

Networks. I honestly believe that no one can afford to pay billed charges anymore. It's easy enough to contract with them. I don't think that any product should be out there today that doesn't have a network. Now, the question from there is, do you want to have a national or a regional strategy? You have to pick, make your own choice. Different companies do it different ways. The next question then is, which networks are the best? That's a real important thing. I want to go back to this final point about the agent. I honestly believe the primary customer you're dealing with is the agent.

I'll talk about what the company I work for does and what our answer to managed care is. We have a dual PPO strategy. We have a PPO product, a full blown product. It's a PPO plan, 20% differential. We deal with regional networks. We also have a hospital only product. Remember that half of your claim dollars go to hospitals and I'll refer to my comment that you do not want to pay billed charges. We have an indemnity like plan that really is a PPO product that uses a national hospital only network. It's not an indemnity plan, it's a hospital PPO plan. It's packaged and it may be sold that way. It sells in areas where they don't have doctors. There's more of an incentive to use the hospital PPO, but I mean it's targeted to rural areas.

From a selecting networks' point of view, networks are constantly changing. You can't analyze every single network to the nth degree and set your prices differently. Our strategy is to select networks to provide a targeted level. I don't want to say discounts. Discounts is probably inappropriate. Provide a targeted level of cost and I'll get into that a little bit later. They have the key hospitals and people will sell them. The sales force agrees that they are a saleable network.

I was recently involved in an offer of coverage to insurers from another carrier, where the other carrier was leaving the market and we basically got tied with a certain network. The primary reason that the offer was not very successful was the network. The sales force didn't like the network. I really have to stress that a big

part of your picking the network decision is whether or not people think it can be sold.

One of the other things that we do, is we have dozens of ancillary contracts for durable medical equipment (DME), home health, other things like that. We actually have a procedure in place in our claims department. If a DME claim comes in and it's more than $200, we send it to one of the medical management people. They will find the contract that it's covered on so we get a discount. Almost all of them are that way. You didn't discuss that, but I'm sure that you have that same thing. You can get contracts with these vendors, home infusion therapy, things like that. Just send your claims to them.

UR is done by an outside vendor. It's used primarily for a sentinel effect and to identify large claims. We have case management. It's either done by internal staff or a subcontractor to our UR vendor targeted at large claims. It's also targeted at certain states' mandated benefits. In Massachusetts, I think you're required to cover in-vitro fertilization or other infertility treatments. There are a number of states that have some benefits that are subject to abuse and so they are targeted.

Our case management area is targeted at dealing with those specific things. We use drug cards for two reasons: to get the discounts and because administering drug plans is very expensive. My last comment on managed care would be that our strategy will change over time.

Picking the networks. What do the networks really want from you? They want high access fees, they want volume, they want you to pay all the claims immediately. They're in the business of making their providers happy. They're in the business of bringing the lives to their providers and they don't want any disputes. Most of them today want an exclusive relationship. It's very competitive out there. It's easy to get a contract with a network if you promise to be exclusive, if you're going to bring them lives, pay them, and pay all the claims.

What do you really want from them? You want quality coverage, you want huge discounts, you want the lowest costs you possibly can get, you want low access fees for your insureds, you want a directory and you want an 800 number. Remember, the minute you hand out a directory, it's already six months out-of-date. But, on the other hand, you do want to hand out a directory, because a lot of the people in there still are in the network, so you need a directory and you need an 800 number.

The other thing you want from the network is if you're having them do the repricing, you want great turnaround time. You want very good service from the network and there's a reason for this. There are a handful of states today that require you to pay the claim within x number of days. I think Texas has just changed to something like 15 days. If your claim's off of the network and they're not repricing it quickly enough, the state doesn't care, it's you. It's not the network who's sitting on the claim, it's you.

What's the right mix of discount and coverage? I believe you need to have the right hospitals. You can determine the right hospitals based on looking at your own experience. You can determine what the right hospitals are based on asking the field sales force.

When you contract with a network understand you get the discounts or the prices that they've already negotiated. You don't go in and negotiate a new set of prices. You're really basically negotiating an access fee. The access fees can be anywhere between $2-5, probably more towards the lower end of that and it really depends on what services you're buying from them.

When you pick the network and they've got the hospitals, the first thing I would do is I want to look at their hospital contracts. I don't want to see any percentage of savings contracts. I don't want to see any discounts. I want to see per diems. I'd love to see $800 per diems. I'd love to see $1,500 package rates for two day maternity. You know, those are the things you want to look for. The other thing you really want to look for is what their stop loss provision is. They can have great per diems, but if they kick to 30% savings over $25,000, you're not going to save as much money. You need to look at the hospitals and you need to look at the hospital contracts.

Outpatients. It would be great if they have outpatient hospitals. It would be great if they were all on ambulatory surgical centers (ASCs). I don't know that a lot of them are. That's the way Medicare's paying them. It's something they're familiar with. You'd like to see 30% discount if they don't do ASCs. The other thing is, you would like to see fixed charges for things like MRIs and CAT scans.

Physicians. I honestly believe that you want to have an adequate number of physicians, enough such that you can sell the product.

Surgery. One of the things about physicians is you can look at what they're paying for office visits, but you're not going to get killed over what they're paying you for office visits. If the office visit is $35-50, it really doesn't matter that much. What you really want to focus on is what their surgery fee schedule is. You'd like them to have one fee schedule. You'd like it to apply to all their people. You don't want to have specialty groups carved out. I've seen contracts where they were at 100% of Medicare, but, this one specialty group was carved out and they had their own deal, and they were this huge group and everybody used them. The fact that they had a fee schedule of 100% of Medicare really was of no value.

Other things about the network. One of the big issues that I don't know that people spend a lot of time with is you're relying on them for service. If they're doing their repricing, they've got to be really good at it. They've got to get it back to you. They are now the same as you from a Department of Insurance perspective. You know, you're subcontracting some services out to them, so they better have quality service. I'm aware of a couple of networks where the field complains about the service problems of the network and you really don't want to have that happen.

Provider turnover. If you lose a few key hospitals that network isn't that good anymore. You need to be on top of how quickly they're adding people, who's leaving them, particularly the hospitals. The hospitals are pretty key. Look at their financial stability; there's a lot of consolidation going on with the networks today.

The sales force. Probably one of the things that I have found is that the marketing guy from the network plays golf with the sales guy, the guy who's selling your product. If you have a large marketer in an area, he's probably playing golf with the marketer for the local networks and he probably knows the networks as well as anybody. He knows what hospitals are in them. He doesn't know their discounts, but he knows which ones he can sell. He knows which hospitals they have, which providers they have.

If you want to pick a network and you're not an expert in the area, go to the person who's selling to them and ask, which are the top three? Generally, one of the top three's a pretty good network. When you give him one of the top three, he'll go out and sell it. The other thing is, is that the local marketing people will tell you when the networks are having problems when they lose a hospital, so they know the local networks very well.

Contracting issues, access fees. I said $2-5. It really depends on what's in there. You have UR in there, you have directories in there, you have mailing of directories in there. The access fee is really a $2-5 range. You need to understand what's in it.

We contract UR with a nationwide vendor. Some of the networks want to do the UR and, actually, insist on it, so in some states we let the network have the UR. One advantage of letting the network have the UR is they're more likely to direct the people. If somebody calls up to precertify something they are going to direct them. It's also one less phone number that you have to have on your I.D. card. Now, think about your I.D. card. It has your phone number, the network's phone number, and the UR company's phone number.

Benefit differential requirements. Some networks actually provide different access fees or different fee schedules depending on your benefit differentials. Not many, but some do. If you want to get the better level of fee schedules from the network, they may require a 30% differential instead of 20%. All of them have some sort of requirement. Some of them are very minimal.

In-network plans. Again, who reprices and how quickly? It's become an issue at our company that there are some networks that have a contractual requirement that says two or three day turnaround time in repricing, but aren't anywhere near meeting it. That's our problem, it's not their problem. From a contracting point of view, what are my options? When can I go back? Do I get a discounted access fee? No, it's not in the contract. My only real option is to terminate them.

If there's one thing I could change about the contracts that we have is I'd like to give us some teeth for when the network doesn't hold up their end of the bargain. The only teeth that are there today is the ability to terminate the contract. That's

probably not something that I want to do every time a claim doesn't get repriced quickly or every time a provider drops out of the network. Terminating a network contract involves providing notice to all of our insureds, doing a mailing, going out and contacting another network. I don't like to change networks. It's a lot of work and you will lose insureds just because you've changed your network.

Clean claim turnaround time. We're all in individual and small group. Who here doesn't do investigations? Anybody? When the networks go out and contract with their providers they talk about clean claims and paying them in 30 days or you don't get the discount. For a provider a clean claim means that the claim form is filled out completely. They don't understand the concept of somebody bought insurance yesterday and had a heart attack today, so you might want to spend a little time investigating. That's another thing I would change. Unfortunately, the issue there is the contract between the network and the provider has something in it that says that clean claims will be paid in 30 days.

Data. What format and how often? We try to force everybody to use our format. It's a lot easier with PCs nowadays. The networks, generally, aren't as sophisticated as most of our data processing departments. How often do you get loads? Do you get provider loads once a month? Can your data processing department load them once a month? Are they in a format that's generally very easy to put into your system?

Eligibility. What do they want? Some networks don't want anything. Some networks want the dependent's Social Security number, not the insureds, they want the dependent's. You've got to be aware. All these issues are in the contracts.

Legal Items. Probably the number one issue for the legal items are, are they in compliance with state laws and will they work with you if you have to file the network?

I'm going to go through the numbers real quick. We're focusing on getting people in the network and maximizing our savings. In 1997, 62% of the dollars went through the network. We saved 26%. Probably the interesting thing here is the anesthesiologists. Most networks don't have enough of them. One of the things we do with anesthesiologists if somebody picked the right hospital, the right surgeon, the right everybody, and the anesthesiologist just shows up and he's not in the network, we pay him as in network anyway.

Went to 69.5% in 1998, 25.4%. Seventy-three percent on paid claims so far in 1999. We're trying to get as many dollars through the network as possible. Trying to make sure we have a reasonable level of discount. That way we avoid all kinds of issues our with R&C complaints about how we do things.

Measuring the impact is difficult to do. You need to validate your pricing and your network. If you're having a significant change in your business, you may need to move. We've moved out of Florida, New Jersey, and Massachusetts. If you compare our results one year to the next, the results may be misleading. You really need to understand what's going on with your underlying block of business.