Health Care Cost Management Guide
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EXECUTIVE SUMMARY
EXECUTIVE SUMMARY

General Background

Rapidly rising United States health care costs are a major problem which must be addressed. Health insurers and their regulators have an important responsibility to help moderate the growth of those costs. This responsibility must be shared with policy-makers at federal, state and local levels, by health care providers and by business, labor and consumers.

The United States spends a much larger share of its Gross National Product (GNP) on health care than any other industrialized nation and yet lags behind most of those countries in major measures of health status such as life expectancy and infant mortality. By 1990, the U.S. is expected to spend approximately 12 percent of GNP on health care. By contrast, the cost of health care in other countries ranges from approximately 6 percent to 9 percent of GNP. In an increasingly competitive global economy, health care costs are a major handicap for American business.

In addition, continuing rapid increases in health costs create other major problems. Virtually every regulator has had to deal with impaired or insolvent health insurers and HMOs. Furthermore, high health insurance premiums are one of the reasons that 32 million Americans lack health insurance, presenting a major barrier to access to adequate health care for those persons. Insurers and regulators are also being forced to explain large premium increases to an ever more frustrated public.

There are many reasons for the rapid increases in health care costs. General inflation, particularly the medical care component of the Consumer Price Index (CPI), continues to increase. Utilization of health services also is increasing as the population ages and as various coverages are mandated. Improvements in expensive technology, combined with a fragmented health delivery system, leads to a proliferation of new, expensive equipment. Catastrophic cases, such as transplants and premature infants, now possible because of technological advances, also drive up costs. The normal counterbalancing forces of supply and demand have little impact on health care costs, in part because health insurance serves to insulate the consumer from the effects of costs.

To further compound the overall health cost problem, for persons covered by private health insurance, there is a growing cost shift from public payers to private payers. Hewitt Associates, an employer benefits consulting firm, estimated that health insurance premiums increased by 6.4 percent during 1989 just because of the cost shift. In particular, Medicare and Medicaid reimbursements are failing to keep pace with the underlying growth in costs. Aportion of the shortfall is shifted to private payers who end up paying what amounts to an indirect form of taxation.

In this environment, it is imperative that health insurers actively implement programs designed to encourage wellness and to assure the efficient delivery and utilization of medical care with appropriate recognition of issues involving quality and access. Regulators have a responsibility to encourage and facilitate adoption of those programs. In particular, regulators, legislators and other policymakers should carefully consider the impact of legislation and regulation on health care costs and on programs designed to manage costs.

Programs to Manage Health Care Costs

The guide represents a collaborative effort of the National Association of Insurance Commissioners and its advisory committee on health care cost containment to describe the types of programs health insurers can implement to help manage health care costs. These programs, which are evolving rapidly, are summarized as follows:

A. Health Promotion and Wellness

Insurers are encouraged to assume a leadership role in the United States in encouraging health promotion and wellness. Health promotion programs encourage behaviors that improve participants' health and seek to modify unhealthy lifestyle behaviors that result in increased health care costs.
Insurers can encourage individuals to engage in healthy lifestyle behavior through use of economic incentives and disincentives such as premium discounts. They can also design benefit packages that encourage participation in cost-effective preventive care such as prenatal care.

Many employers have instituted Employee Assistance Programs (EAPs) designed to assist employees with personal problems such as alcohol or other chemical abuse, psychological problems, smoking cessation, etc. These programs not only reduce health costs but reduce absenteeism and employee turnover while increasing productivity. Insurers can assist in the development and marketing of these programs.

B. Benefit Design

Deductibles, copayments and coinsurance serve to reduce health insurance premiums and encourage the insured to use health services prudently. Increased cost sharing does not appear to deter most insureds from seeking needed health care although some lower-income insureds may inappropriately defer seeking needed services if the cost sharing is too substantial.

It is becoming increasingly popular to limit reimbursement to services determined to be medically necessary. These limitations are consistent with the utilization management procedures described in the next section.

C. Utilization Management

A wide variety of utilization management programs have been developed to identify and encourage utilization of the least expensive, appropriate form of medical care. Some of these programs require significant resources and it is important that they be designed to be cost effective.

— Preauthorization programs require patients to receive approval prior to receipt of non-emergency services. These programs have typically been required for inpatient hospital services but are now being applied to selective outpatient services.

— Concurrent review programs periodically review the patient’s care after treatment has begun to determine whether continued care is medically necessary.

— Retrospective review programs examine care already received to determine if treatment was appropriate. If not, the provider is notified and in some instances, payment is denied or modified, with the patient frequently held harmless for the denied charges.

— Discharge planning programs attempt to determine the most appropriate form of post-hospital care.

— Second surgical opinion programs either permit or require a patient to obtain the opinion of a second physician for elective surgery. These programs are found to be most cost effective when applied to specified procedures.

— Individual case management programs are being applied to patients with significant health problems and seek to work cooperatively with providers to find the least expensive, appropriate form of care.

— Profile analysis refers to computerized analysis of patterns of care where inappropriate care is frequent. The patterns may be analyzed for specific providers, for designated diagnosis, or by geographic area.

D. Managed Care Programs

The definition of managed care encompasses a variety of programs designed to manage health care
costs. Included within the definition are the various utilization management programs described in the previous section frequently encompassed within traditional fee-for-service, indemnity programs. The term is also used to describe a variety of alternative delivery systems such as the rapidly evolving variety of HMOs and PPOs.

The development of alternative managed care provider groups offers the opportunity to promote competition and encourages consumers to select the more efficient providers. The popularity of such alternatives is growing rapidly. According to the U.S. Bureau of Labor Statistics, HMOs and PPOs were selected by 26 percent of employees in 1988, up from 14 percent in 1986.

1. Health Maintenance Organizations (HMOs) are prepaid health delivery systems in which a member pays a fixed monthly fee and, in return, receives a wide range of health services, typically including preventative care, with modest additional charges. Providers are often paid a fixed fee per member (capitation rate) placing the HMO and the providers “at risk” if services actually cost more to provide than the capitation rate allows.

The HMO providers are directly involved in utilization control. Primary care physicians act as “gatekeepers” and decide whether a patient should be referred to a specialist.

Studies have shown HMOs, particularly the group model HMOs, to be successful at reducing costs, particularly costs of hospitalization. Under the group (or staff) model HMO, the physician is either the employee of, or receives the majority of patients from, the HMO. Under the Independent Practice Association (IPA) model HMO, physicians also maintain an independent fee-for-service practice.

2. Preferred Provider Organizations (PPOs) are agreements between groups of providers, such as doctors and hospitals and insurers to provide specified services at a negotiated price. Frequently, there is a pre-agreed-upon discount off normal charges. The financial risk to the provider is generally less substantial than under an HMO. Selection of the panel of providers (credentialing) can be managed to select providers who deliver care efficiently and who agree to accept cost controls.

The enrollee typically is able to select a non-preferred provider, but may be discouraged from doing so by requiring higher deductible or coinsurance payments. A new variation of a PPO, called an Exclusive Provider Organization (EPO), limits the choice of providers and is very similar to an HMO.

3. Point-of-Service HMOs (POSHMOs) are newly evolving alternatives combining HMOs and fee-for-service indemnity programs to give the consumers wide flexibility. The highest level of benefits are received when the enrollee receives services at the direction of the primary care physician “gatekeeper.” However, the enrollee can still receive services by self-referral to other providers, albeit at higher personal costs. Ultimately, this new type of program may permit employers to consolidate all their benefit alternatives into one package.

E. Anti-Fraud Programs

The Federal Trade Commission estimated that fraud cost insurers at least $10 billion in 1986. The industry believes the cost to be much higher. Billings for services not rendered, changing diagnosis and/or dates of services to obtain insurance coverage and changing procedure codes are examples of fraud.

Insurers are hiring specialists to detect and investigate fraud. Some Insurance Departments have also developed fraud investigative units to assist private efforts. The National Health Care Anti-Fraud Association, founded in 1985, is a joint effort of commercial insurers, the Blue Cross and Blue Shield system and the Medicare and Medicaid programs to combat fraud. Cooperation among all providers and state and federal authorities is essential to successfully combat this problem.
F. Technology Management

Technological advances are one of the primary causes of our rapid increases in health care costs. Health insurers are becoming increasingly involved in the process to determine when, and under what circumstances, reimbursement should be made for new procedures. Insurers are also becoming involved in determination of fair reimbursement rates related to the new technologies.

G. Practice Protocols and Guidelines

Increasing emphasis is being placed on the development of practice protocols and guidelines. The federal government is prompting much of this activity for its major public programs, Medicare and Medicaid. The American Medical Association (AMA) and several of the national medical specialty societies are developing guidelines and the insurance industry supports such activity. The development of guidelines is seen to offer significant potential to achieve the often conflicting goals of cost-effective, high-quality care.

Implications For Quality

Efforts to contain health care costs must be implemented on a basis that also recognizes issues of access and quality. Federal efforts to contain Medicare’s hospital costs through use of the Prospective Payment System Diagnosis-Related Groups (DRGs) has heightened public concern over quality. The challenge to insurers, providers, consumers and public policymakers is to develop improved means for measuring quality and to develop incentives to adopt cost-effective practices.

Government as a Purchaser of Health Services

Government’s efforts to contain costs have enormous effect on other parts of the health care system. During the 1980s, much of governments efforts to contain costs have focused on reimbursement levels under Medicare and Medicaid. In effect, government has merely shifted costs to other payers thus increasing costs for those covered by private programs.

If health care costs are to be truly managed, the government, private insurers, employers, consumers and providers must cooperate. For example, an appropriately designed DRG reimbursement program appears to offer potential for managing costs, but much of the potential is lost when a large share of hospital revenue falls outside the program. The problem can be compared with a balloon, when one side is pushed in, the other side expands. As long as this is permitted, there is little hope that overall costs can be effectively managed.

Because Medicare’s DRG-based hospital reimbursement has slowed Medicare’s growth in hospital costs, albeit at the expense of private payers, the federal government is now turning its attention to physician reimbursement where costs have risen dramatically despite Medicare fee freezes.

A new basis for physician payment has been developed based on the extensive developmental work conducted by Harvard economist and actuary, William C. Hsiao. The new system, called the Resource-Based Relative Value Scale (RBRVS), develops relative values for physician reimbursement based on the resource cost required to provide the service.

Congress has approved the adoption of the RBRVS system for Medicare physician payment. The new reimbursement methodology will be implemented with the transition beginning in 1992 with completion by 1996. Limits will be placed on physician “balance billing” to protect Medicare beneficiaries from high out-of-pocket costs.

The new reimbursement scheme will have significant impact on other payers. Health insurers and regulators will need to consider the implications and develop appropriate responses.
HEALTH CARE COST MANAGEMENT GUIDE
INTRODUCTION AND BACKGROUND

Health insurers and regulators have an important responsibility to help assure access to affordable and appropriate health care for all Americans. This is a responsibility which must be shared with policymakers at the federal, state and local levels, by health care providers, by business and labor and by consumers.

The continuing dramatic increase in United States health care costs is a major problem which must be addressed. Health care costs have continued to rise much more rapidly than general inflation. In 1965 the United States spent slightly less than 6 percent of its Gross National Product (GNP) on health care and is now expected to spend 12 percent of GNP by 1990.

The United States spends far more for health care than any other industrialized country and yet lags behind most of those countries in major measures of health status such as life expectancy and infant mortality.

The following chart and table illustrate the rapid growth in health care costs and compare those costs among the major industrialized nations.

National Health Expenditures
and Percent of GNP


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# Health Expenditures and Health Status in OECD Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>(1986 Health Expenditures)</th>
<th>Life Expectancy&lt;sup&gt;a&lt;/sup&gt; at Birth (yrs)</th>
<th>Infant&lt;sup&gt;b&lt;/sup&gt; Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Capita</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>$877</td>
<td>72.2</td>
<td>9.8</td>
</tr>
<tr>
<td>Austria</td>
<td>903</td>
<td>71.0</td>
<td>10.3</td>
</tr>
<tr>
<td>Belgium</td>
<td>826</td>
<td>70.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Canada</td>
<td>1,370</td>
<td>73.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Denmark</td>
<td>800</td>
<td>71.7</td>
<td>7.9</td>
</tr>
<tr>
<td>Finland</td>
<td>900</td>
<td>70.6</td>
<td>5.9</td>
</tr>
<tr>
<td>France</td>
<td>1,039</td>
<td>71.8</td>
<td>7.9</td>
</tr>
<tr>
<td>Germany</td>
<td>1,031</td>
<td>71.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Greece</td>
<td>245</td>
<td>73.5</td>
<td>12.3</td>
</tr>
<tr>
<td>Iceland</td>
<td>1,072</td>
<td>75.1</td>
<td>4.6</td>
</tr>
<tr>
<td>Ireland</td>
<td>549</td>
<td>70.8</td>
<td>8.7</td>
</tr>
<tr>
<td>Italy</td>
<td>764</td>
<td>71.3</td>
<td>10.9</td>
</tr>
<tr>
<td>Japan</td>
<td>831</td>
<td>75.5</td>
<td>5.2</td>
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<tr>
<td>Luxembourg</td>
<td>968</td>
<td>70.7</td>
<td>8.1</td>
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<tr>
<td>Netherlands</td>
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<td>73.1</td>
<td>8.1</td>
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<td>New Zealand</td>
<td>715</td>
<td>71.0</td>
<td>10.9</td>
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<tr>
<td>Norway</td>
<td>1,021</td>
<td>72.6</td>
<td>8.5</td>
</tr>
<tr>
<td>Portugal</td>
<td>310</td>
<td>70.2</td>
<td>15.9</td>
</tr>
<tr>
<td>Spain</td>
<td>486</td>
<td>72.6</td>
<td>10.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>1,195</td>
<td>73.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Switzerland</td>
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<td>6.8</td>
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<tr>
<td>Turkey</td>
<td>140</td>
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<td>N/A</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>711</td>
<td>70.6</td>
<td>9.3</td>
</tr>
<tr>
<td>United States</td>
<td>1,926</td>
<td>71.3</td>
<td>10.4</td>
</tr>
<tr>
<td>Mean</td>
<td>870</td>
<td>7.2</td>
<td></td>
</tr>
</tbody>
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<sup>a</sup> Infant Mortality rates are expressed as the number of infant deaths per 1,000 live births.*
In an increasingly competitive global economy, our health care costs are a major handicap for U.S. based operations. The Chrysler Corporation estimates that its health care costs add $500 more to the cost of a vehicle compared with a vehicle made in Japan.

In addition to the impact on the U.S. economy, the rapid cost increases serve as a major barrier to adequate health care access for many Americans. The number of Americans without health insurance has grown to 32 million. The majority of these Americans are either employed or are dependents of employees. However, neither they nor their employers are willing or able to pay health insurance premiums driven by the high costs of medical care.

Recent rapid and unexpected increases in health care costs, particularly those charged to private payer patients, have created severe financial difficulties for health insurers. Virtually every state insurance department in the U.S. has had to deal with impaired or insolvent health insurers and HMOs.

Employers and consumers are facing dramatic increases in their health insurance premiums. Premium increases exceeding 20 percent have been common, and significantly larger increases are frequently warranted, particularly if previous rate increases failed to anticipate the rapid and unexpected health care cost increases of the past few years.

Hewitt Associates, an employee benefits consulting firm, estimated that employers in 1989 would pay health premiums averaging 21.5 percent larger than last year. Their analysis not only pointed out many of the factors driving the increase in health care costs but also the problem of the growing cost shift from public programs to private payers. They analyzed the average premium increase as follows:

<table>
<thead>
<tr>
<th>Medical Inflation</th>
<th>7.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Shift</td>
<td>6.4%</td>
</tr>
<tr>
<td>Increased Utilization</td>
<td>3.5%</td>
</tr>
<tr>
<td>Improved Technology</td>
<td>2.4%</td>
</tr>
<tr>
<td>Catastrophic Cases</td>
<td>1.9%</td>
</tr>
<tr>
<td>Professional Liability</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21.5%</strong></td>
</tr>
</tbody>
</table>

Medical inflation represents the medical component of the Consumer Price Index (CPI). The same medical goods and services costs were estimated to cost 7 percent more in 1989 than 1988. This accounts for only one-third of the average projected increase in health insurance premiums and is sometimes a source of confusion to the public who would otherwise expect their premiums to grow by 7 percent.

The growth in the cost shift was almost as significant, causing private payer premiums to increase by an estimated 6.4 percent. Much of this shift in costs was attributed to the fact that Medicare and Medicaid reimbursements are failing to keep pace with the underlying growth of medical expenses. Providers will shift some portion of the shortfalls from public payers to private payers. In essence, the private payer ends up paying an indirect form of taxation. The growing uninsured population also accounts for uncompensated, or undercompensated, care which is shifted to private payers.

Utilization of medical services is also growing and was estimated to account for 3.5 percent of the premium increase. As the U.S. population ages, increased utilization of health care services can be expected.
Improved medical technology was estimated to account for 2.4 percent of the growth in premiums. Advances in technology have significantly expanded providers' ability to diagnose and treat illness, thereby prolonging life. However, many of the technological advances are very expensive. Sometimes these new technologies are inappropriately applied in circumstances with unverified efficacy. The fragmented health care delivery system leads to a proliferation of new, expensive equipment driven by the strong desire of providers and consumers to provide and receive the best possible medical care.

Catastrophic cases were estimated to cause premiums to rise by another 1.9 percent. This factor is closely related to the improvement in technology and represents the growth in costs arising from organ transplants, premature infants, HIV infection, etc.

Some may be surprised by the relatively modest growth in costs attributed to professional liability, only 0.3 percent. However, this merely represents the growth in this factor as medical malpractice awards and premiums have recently stabilized. Nevertheless, the growth of malpractice litigation over the past two decades has significantly contributed to the cost of medical care. In the long run, the high cost of professional liability premiums is a cost largely passed on to the consumer. In addition, providers may sometimes practice defensive medicine resulting in increased utilization.

This list of factors is not all-inclusive as there are other causes such as the growth of statutorily mandated benefits. However, there is one additional factor which should be mentioned.

Ironically, it is the very success of health insurers which has helped to contribute to the problem of rising medical costs. Approximately 85 percent of Americans have public or private health coverage. Until recently, much of this coverage, especially for hospital services, was “first dollar,” so that insureds were fully insulated from the costs of health care. While there has been a modest increase in patient cost sharing, most plans still cover the majority of expenses after a deductible has been satisfied. This has served to remove the practice of medicine from traditional market forces. Patients have little incentive to “shop around” for more cost-efficient providers, or to question the fees charged or the necessity of services recommended by providers.

Since health insurance serves to dampen the normal economic market forces, it is all the more imperative that health insurers actively implement programs designed to assure the efficient delivery and utilization of medical care and to encourage wellness. Regulators have a responsibility to encourage and facilitate adoption of those programs in a responsible manner.

This guide represents an effort by the National Association of Insurance Commissioners and its advisory committee on health care cost containment to describe the types of programs health insurers can implement to help manage health care costs. While this guide focuses on cost management strategies for health insurers, it should be recognized that a collaborative effort from insurance regulators, public policymakers, government at all levels, providers, business, labor, and the consumer will be required if the United States is to gain control over its exploding health care costs. In addition, any cost management initiatives must be implemented on a basis that appropriately considers quality and access.
APPROACHES TO MANAGING HEALTH CARE COSTS
APPROACHES TO MANAGING HEALTH CARE COSTS

Introduction

At least seven approaches or programs are currently being used by insurers, third-party administrators, government benefit managers and employers to contain or to use a more descriptive term, manage health care costs. These include: (1) health promotion through positive lifestyle choices, (2) cost-sharing through benefit design, (3) utilization management through pre-, post-, and/or concurrent review, (4) alternative delivery system packaging of provider services, (5) fraud prevention and detection, (6) technology assessment to identify "best value" treatments, and (7) the evolving development of practice protocol and guidelines.

Cost management strategies are continuing to evolve rapidly. Some major corporations are beginning to implement health plans that shift more financial risk to health insurers, employees, and the medical community. Insurance companies have begun to offer multi-year rate guarantees. Employees have begun paying an increasing share of their health care expenses and are enrolling in managed care programs. Providers have begun accepting prospective fees, no matter how much it ultimately costs to provide the care.

Major developments which are likely to dominate the evolution of cost management strategies in the next few years include:

-- An increasing use of computer software to automate and reduce the cost of tracking and reviewing health care.

-- The increasing use of methods for measuring medical outcomes, so that insurance reimbursement can be tied to these outcomes. The development of medical practice protocols and guidelines is an example.

-- Continuing federal and state legislative pressure to increase access to health care by mandating specific benefits and levels of coverage, possibly impeding cost management efforts.

-- Increasingly complex and difficult ethical choices as technological advances offer opportunities to sustain life albeit at very high expense.

-- Continuing modification of provider reimbursement from public programs such as the potential Medicare Resource Based Relative Value Scale for physician services.

-- An increasing awareness of the importance of wellness and healthy lifestyle behaviors.

A. Health Promotion and Wellness

Description

The ultimate goal of health promotion and disease prevention programs is to improve the quality of life and extend active life expectancy. The eradication of communicable diseases and the advances in 20th century medical technology have resulted in fairly static mortality rates during the 1970s and 1980s. In modern society, health promotion and disease prevention will not necessarily result in an immediate increase in life expectancy. However, health promotion and prevention intervention can profoundly affect the quality and vigor of healthy life years and reduce the incidence of premature death and chronic illness.

Health promotion programs encourage behaviors that improve participants' health and seek to modify those unhealthy lifestyle behaviors that result in increased health care costs. A healthy insured population will utilize fewer expensive medical care services as a result of fewer preventable deaths, accidents and illnesses. Many employers who have instituted employee wellness programs
through Employee Assistance Programs (EAPs) report that a healthier work force results in lower absenteeism, tardiness and employee turnover, and an increase in productivity. Insurers are now actively marketing such wellness programs as part of group insurance benefit packages.

Researchers have identified those behaviors and preventive measures which directly affect cost containment efforts. They include:

- Cancer prevention
- Stress management
- Nutrition
- Alcohol and drug abuse
- Safety belts
- Smoking and smoking policies
- Exercise and fitness
- Incentives
- Healthy companies
- Employer involvement
- Insurer involvement

Comprehensive wellness plans include:

1. Significant economic incentives to insureds designed to encourage their participation in the practice of healthy lifestyle behaviors. Such incentives may, for example, be in the form of health care insurance premium reductions, benefit enhancements, or in the case of employer-paid plans, direct financial compensation.

2. Significant economic disincentives and penalties to insureds who incorrectly certify participation in the practice of healthy lifestyle behaviors. Such disincentives and penalties may, for example, be in the form of increased deductibles and copayments or surcharges.

3. Economic incentives and disincentives substantial enough to encourage behavior modification.

4. Benefits for appropriate screenings and examinations and designated adult immunizations.

Evaluation

The U.S. Department of Health and Human Services Office of Public Health Service reports that, "... most of the employer investment in workplace health promotion has been based upon the inherent logic that healthier employees are a good investment; that the value to an employer far exceeds any measure of reduction in medical care expenditures; and that the societal trends toward greater attention to assisted self-responsibility for personal health have become an increasingly normal component of workplace culture in the late 1980s."

Yet, employers are increasingly reporting that they can measure the reduction in medical care expenditures; they can quantify improved employee attendance records.

-- At one company, a prenatal wellness program for its pregnant employees decreased the average cost per maternity by 89 percent.

-- Another company found that employees using its EAP referral service were less likely to receive inpatient psychiatric treatment, and used fewer benefits when they were hospitalized.

-- Fifty percent of the teachers in the Dallas Independent School District were placed in a regular fitness program. As a result, the Institute for Aerobics Research found that,
compared to their inactive counterparts, the 7,400 exercising teachers took three fewer sick days per year. The reduction in sick leave pay saved the school district $452,000 in substitutes' pay.

Direct and indirect costs of wellness programs must be carefully estimated in order to determine if these programs result in an immediate reduction in dollars spent. Current studies show that such programs, when voluntary, tend to attract people who are motivated to change on their own. On the other hand, proponents say that whether they save money now or at a later date, workers tend to be healthier and happier and therefore more productive.

A number of large studies have been conducted in the last ten years which can give very specific guidance to those wishing to adopt a wellness program or evaluate its effectiveness. Two of the most recent were commissioned by the country's three largest health care benefit associations:

1. The Health Services Foundation, a research affiliate of the Blue Cross and Blue Shield Association, examined health promotion programs at Blue Cross and Blue Shield Plans in Michigan, Indiana, Ohio and New Hampshire. Each study was different in length and sample sizes varied from 750 to 1500 employees. The first three plans studied the impact of health promotion on their employees' health risk factors, absenteeism, and use of insurance benefits. Results showed that employees who participated in the Michigan programs went from having the highest cardiovascular disease risk to having the lowest. The Michigan and Indiana programs generated fewer days of absenteeism by as much as 30 percent. In another finding, while participants may use health insurance more often initially, over several years such use fell below that of non-participants. The Indiana Plan reported that for every dollar spent on the program, $2.45 was saved in health benefit utilization. The New Hampshire study examined the factors important to the purchase and perceived success of a health promotion program. Not surprisingly, key factors were a high level of organizational commitment and awareness of other companies' participation in such programs.

2. The Lifestyle Preventive Health Service Study by INSURE (Industrywide Network for Social Urban and Rural Efforts) conducted an eight-year study released in September 1988, which demonstrated that preventive health services delivered by physicians can reduce the risk of major U.S. illnesses: heart disease, cancer, stroke and injury from car accidents.

A study sponsored by the American Council of Life Insurance and Health Insurance Association of America concluded that for the well patient, early disease detection and treatment, as well as health promotion, could be accomplished in a more effective manner when physicians use a model based on the patient's age, sex and risk factors. The study confirmed that the cost of preventive services can be controlled.

Insurers and employers should assume a leadership role in the United States to encourage health promotion and wellness programs. Indeed, in the September 1989 study, "Promoting Health/Preventing Disease: Year 2000 Objectives for the Nation," the Public Health Service Department of the U.S. Department of Health and Human Services challenges insurers to:

-- Increase to at least 30 percent the proportion of life insurers that offer lower individual premiums to people who exercise regularly and maintain a regular physically active lifestyle.

-- Increase to at least 80 percent the proportion of people with time-and/or cost-limited health insurance coverage for services to overcome nicotine addiction.

-- Expand to all comprehensive insurance policies coverage for immunization for children and adults.
-- Increase to at least 30 the number of states requiring coverage of screening mammography by health insurance companies doing business in the state.

-- Expand reimbursement for diabetic education and blood glucose self-monitoring to at least 80 percent of all diabetics.

-- Increase to at least 60 percent the proportion of people with health insurance coverage for the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force.

Insurers should be encouraged to develop expertise in the delivery of health promotion and wellness programs, comparable to loss prevention programs developed in the property and casualty companies, and to engage in public education programs which promote their adoption. Individuals should be encouraged to engage in healthy lifestyle behaviors through the use of health insurance plans which provide significant economic incentives and disincentives to do so. The NAIC has adopted a model which encourages the use of such incentives.

B. Benefit Design

Description

Employers can control their health care costs by sharing costs with employees. Methods for sharing costs include: asking employees to pay part of the premium, increasing deductibles and copayments (either for all services or for selected services), limiting the amount of services that will be paid or limiting reimbursement for services determined to be medically unnecessary.

Benefits and utilization payment can also be controlled by coordination of benefit (COB) provisions. These provisions are administered to ensure that benefits from all sources do not exceed 100 percent of medical expenses for individuals covered by more than one group health policy. COB procedures prescribe which plan is primary (pays first) and which is secondary (pays the remaining covered charges).

Evaluation

1. Increasing the costs which must be borne by the employees is effective in reducing the cost of health services to the insurer or employer. Studies have found that cost sharing also produces savings indirectly by reducing the demand for health services. Increased cost sharing saves the employer and/or insurer money directly by reducing the cost per case.

2. Increased cost sharing does not appear to deter most insureds from seeking care for serious health problems. However, there is some evidence that increased cost sharing may deter some lower-income insureds from receiving needed services.

3. Lower cost sharing for outpatient services relative to inpatient services will increase outpatient visits, but may not significantly decrease the overall cost of inpatient care.

4. Employers are offering their employees a choice of health insurance plans or are offering cafeteria benefit plans. However, there is a risk that the less healthy employees may select the option with richer benefits ("adverse selection"), increasing overall benefit costs.

5. Employers are often reluctant to introduce cost sharing for fear of jeopardizing employee and labor union relations, particularly if they are competing with other employers for workers.

6. Many state legislatures require specific levels of coverage for various benefits. These mandated benefit levels sometimes make it difficult for insurers and employers to
introduce cost-saving benefit changes. (There is a sharp debate over use of state mandated coverages because of the inequities they create due to their inapplicability to self-funded, ERISA plans.)

C. Utilization Management

Description

Utilization management refers to a variety of administrative programs designed to identify and encourage utilization of the least expensive, appropriate form of medical care. Some of these techniques can be implemented quickly with relatively little cost, while others require considerably more resources.

The principal utilization management techniques are described below:

Preauthorization programs require patients to obtain prior approval of benefit coverage before receiving non-emergency health care services. These programs have typically been applied to inpatient services, and some insurers have begun to preauthorize outpatient services as well. A number of firms are beginning to market computerized systems for applying preauthorization criteria to a variety of the more commonly performed procedures. Before approval is granted, the proposed care is reviewed to determine if it is medically necessary. In some cases, the treatment setting where care will be given (for example, inpatient versus outpatient) is also reviewed. With these programs, cost savings can be realized fairly rapidly after start-up. However, start-up costs can be significant.

Concurrent review programs periodically review the patient's care after treatment has begun, to determine if continued care is medically necessary. This periodic review helps to minimize excessive hospital days or outpatient visits. For example, a psychiatric patient's need for inpatient care may be reevaluated at the end of every seven days in the hospital. The reviewer may request that the patient be discharged, or moved to a less costly but appropriate setting for further treatment, such as a residential program. Concurrent review programs can be somewhat costly to start up and maintain.

Retrospective review programs examine the patient's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate. Medical necessity criteria are sometimes used to make this determination. In some cases, payment for the completed treatment may be denied. In other cases, the attending physician is merely notified that the treatment falls outside of normal guidelines, in the hope that this information will change the physician's future behavior. To prevent providers from passing the cost of denied care to the insured, some insurers require that the insured be held harmless for denied charges.

Discharge planning programs attempt to ensure that discharged patients receive the post-hospital care that is most appropriate. In many cases, such care can prevent a second hospitalization.

Second surgical opinion programs permit (or require) patients to obtain the opinion of a second physician when elective surgery is recommended. Often this requirement is applied only to a selected group of surgical procedures for which inappropriate use is suspected.

Individual case management programs search for ways to provide appropriate care for less money for cases which are likely to prove very costly, such as physical rehabilitation or psychiatric care. For example, large amounts of money can be saved by treating AIDS patients in hospice or home environments rather than in hospitals, and the patients often live longer and enjoy a better quality of life in these settings. These programs require a large investment of resources in terms of the staff needed to run them.

Profile analysis refers to computer-aided analysis of patterns of care, in order to identify areas where inappropriate use of health care is frequent. These are the areas for which cost control efforts will be most productive. Patterns of use by specific providers, patients, diagnostic categories, or
geographic areas may be examined. Claims data bases are typically so large that patterns of overuse may easily go undetected without comprehensive analysis of these data by computer. Although expensive to implement and maintain, profile analysis systems can yield large cost savings.

**Evaluation**

1. Utilization management methods can produce significant cost savings by preventing unnecessary admissions, reducing lengths of stay, and by determining the lowest-cost setting that is appropriate for a given case.

   -- One study found that a combination of preadmission and concurrent review reduced hospital length-of-stay by 8.0 percent, and reduced overall medical expenditures by 8.3 percent.

2. Studies have shown these methods are most cost effective when concentrated on those cases and those providers responsible for a disproportionate amount of costs; otherwise administrative costs can nullify the savings realized. Sometimes specific providers or specific types of patients may account for health care costs that are far out of proportion to their numbers.

   -- A study of provider care patterns found that 5 percent of the providers accounted for 75 percent of questionable claims.

   -- Case management has proven especially effective for treatment of “big-ticket” areas such as AIDS, substance abuse, rehabilitation, neo-natal and psychiatric care.

3. The strictest utilization management programs save the most money by taking a very active role in the relationship between physicians and their patients. However, such active intervention will be more likely to strain relationships between the physicians and the utilization managers, and may also strain relationships with employees.

   -- Some health insurers have deliberately relaxed utilization controls in order to maintain positive relations with providers. Some employers have done so to maintain good employee relations.

4. Second surgical opinion programs may not be cost effective unless they are designed carefully.

   -- Many insurers have found that “blanket” second surgical opinion programs which cover most or all surgical procedures do not save money. For such “blanket” programs, the administrative cost of securing the second opinions nullifies the savings achieved from the few cases denied. One study found that second opinions agreed with first opinions in 92 percent of the cases. Furthermore, even in cases where the second physician recommends against the surgery, most insurers will pay for it to avoid claims of legal liability.

   -- Second opinion programs can be more cost effective when limited only to those patient situations where the proposed procedure is suspect. By automatically waiving the second opinion for the remaining procedures, substantial administrative costs can be avoided.

5. Utilization management is especially difficult in areas such as psychiatric illness, substance abuse, and outpatient services. There are many different treatment settings, types of providers to be monitored, and standards for appropriate treatment that are less well established.

6. When utilization management controls are applied to specific types of health care services, the result is often an increase in utilization in other types of health care services not subject to these controls.
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-- Many insurers have experienced large increases in the utilization of outpatient services after implementing strict utilization management of inpatient services.

-- Insurers have reported, in response to the prospective payment system, some hospitals have directed more resources to areas not currently subject to this system, such as psychiatric care or rehabilitation care.

7. Utilization management techniques can reduce costs without reducing access to needed care.

-- A study of psychiatric utilization management found that psychiatric hospital lengths of stay were reduced by 41 percent, at the same time that admissions actually increased by 15 percent.

8. Medical surgical utilization review procedures are shifting from site of care to examining the necessity for the procedure itself.

D. Managed Care Programs

Introduction

The term "alternative delivery system" (ADS) is rapidly becoming obsolete as the more generic term "managed care program" comes to describe the many evolving variations of HMOs and PPOs to which the former term has traditionally been applied. These evolutionary mechanisms include the newest concept called "point-of-service HMOs." Other managed care programs consist of cost control techniques grafted onto traditional fee-for-service benefit plans.

The competition among these newer forms of health care delivery is intense. A number of large commercial carriers and the Blue Cross and Blue Shield system are investing hundreds of millions of dollars in managed care products and systems. Independent firms are actively marketing data bases and software to self-funded employers, third-party administrators, and other benefit managers.

The success or failure of managed care programs depends to a great extent on local markets, provider attitudes, availability of medical care facilities and services, and the presence of, and commitment to, public policy goals.

The sections that follow are not intended to advocate one product or concept over another. Health maintenance organizations have been the most thoroughly studied of the cost management strategies, while preferred provider organizations are relatively new and there is very little literature on their effectiveness in controlling costs according to the Employee Benefit Research Institute.

During the 1980s, the federal government has increasingly relied upon "competition" to control health care costs. As indicated earlier, the normal market forces of supply and demand have not worked effectively, in part, because of the success of health insurance. However, the development and expansion of managed care alternatives offers the opportunity to promote competition between provider groups and can provide financial incentives to the consumer to select the more efficient providers.

Managed care programs are growing in popularity. According to a Bureau of Labor Statistics survey, HMOs and PPOs were chosen by 26 percent of employees in 1988, up from 14 percent in 1986. In addition, there has been significant growth in managed care features, such as case management, in indemnity plans.
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1. Health Maintenance Organizations

Description

A Health Maintenance Organization (HMO) is a prepaid health care delivery system in which a member pays a fixed monthly fee to an organization and, in return, receives a wide range of health care services without additional charges or at greatly reduced fees. Premiums are based on expected use of services, and providers are often paid a set fee per member (called a capitation rate), which places the HMO financially "at risk" if health care services exceed certain dollar limits. An HMO provides health care services at one or more centralized locations or at designated physician offices and hospitals. The HMO contracts with these doctors and hospitals for their services; and, except in emergencies, HMO members must either use these providers or pay for services themselves.

Because the monthly premium charged by the HMO covers most services, including hospitalization and surgery, there is rarely a need for members to file claims or wait to be reimbursed for their out-of-pocket expenses. Generally there are no deductibles, although many plans require copayments for certain services, such as office visits and emergency care outside the service area. HMO members can budget their health care costs on a monthly basis and generally avoid the necessity of filing claims for health services they use.

To operate efficiently the HMO depends on careful utilization controls. Primary care physicians usually act as "gatekeepers" and decide if a patient should be referred to another type of specialist. Since the monthly premium covers most acute care needs without additional cost to the member, the HMO must focus on keeping members healthy, holding use of expensive referral physician and hospital services to a minimum, and preventing serious illness. Typical HMO coverage includes "well care," which focuses on preventing health care problems through educational programs, regular physician examinations, pap smears, childhood immunizations, and such.

There are two traditional types of HMOs called "group (or staff) models" and "individual (or independent) practice associations." In group or staff models the physician is either the employee of, or receives the majority of patients from, the HMO. In an IPA model, the HMO contracts with physicians, who also maintain a fee-for-service practice and are typically reimbursed on a blended fee-for-service/capitation basis. A newer form called the "Point-of-Service HMO" will be described later.

Evaluation

1. Studies, particularly of the group model HMO, have consistently shown reduced health care costs by significantly reducing hospital utilization and surgery. Some IPA models have been less effective in constraining costs.

2. Because HMOs limit the number of physicians that employees can choose from, benefits such as well-baby care, free prescription drugs, etc. are added as incentives to join the HMO.

3. In 1988, the federal law requiring HMOs to community rate was amended to allow classification of risks under an adjusted community rated option, which will permit HMOs to reflect some of an employers' health care cost experience.

2. Preferred Provider Organizations

Description

A Preferred Provider Organization (PPO) is an agreement between a group of "preferred providers"—doctors, hospitals and other health care providers—and an insurance company, self-insured employer or its intermediary to provide specified medical, hospital and related services at the negotiated price. A PPO integrates the health care delivery system and the financing system with the goal of delivering quality care while containing costs.
Because PPO development is so recent (and continues to evolve) there is no consensus on precisely what is a PPO. To some it is primarily a marketing device for the providers. To others a PPO differs from an HMO only in that the provider is generally not at any substantial risk. Still others distinguish it because the enrollee has the option to go outside the preferred panel without a complete loss of benefits. But most PPOs have all or some of the following features:

-- A PPO typically retains the concept of fee-for-service but at agreed upon discounts from billed charges. However, some PPOs employ a capitation basis of reimbursement.

-- Choice of physicians and hospitals is retained in a PPO plan. However, there are strong financial incentives such as coinsurance differentials to motivate patients to use the preferred providers. A new variation of a PPO, referred to as an Exclusive Provider Organization (EPO) may limit the choice of provider.

-- Preferred providers agree to accept management controls designed to contain costs and ensure quality of care.

The managed care features most commonly found in a PPO are:

-- Prior authorization procedures.

-- Preadmission certification.

-- Second opinion programs.

-- Concurrent review of care.

-- Discharge planning.

-- Retrospective review of care.

Credentialing and accreditation are two methods used by some PPOs in selecting providers. Some groups advertise the reputation for excellence of their panel.

PPOs spend considerable time and effort on information and education for both patients and providers.

Evaluation

1. While the quality of the limited provider panel is the key element of a PPO, controlling the utilization of health care services is key to containing costs. That is because some PPO physicians and hospitals may increase service volume to compensate for reductions in the price per service. On the other hand, PPO utilization management activities may be more effective than that used in conventional insurance according to a recent Rand Corporation monograph. It notes providers are likely to cooperate with procedures they have voluntarily agreed to accept; employees are most likely to be tolerant of stringent review when their use of the PPO is voluntary and they receive financial rewards for accepting the review; and finally, the PPO may be more motivated to review utilization since employee cost sharing is reduced and less likely to affect utilization.

2. PPOs claim typical savings of about 15 percent compared with traditional products. Employers may pass these savings to employees as improved benefits rather than reducing the premium.

3. PPOs sponsored by most insurers and investors (rather than providers) are more likely to have stringent utilization review programs and to choose their provider panels so as to lower costs, according to a study reported in Blue Cross and Blue Shield Association's Inquiry magazine.
4. With Medicare Part B costs still on the rise, the Health Care Financing Administration (HCFA) is turning to PPOs to rein in increasing volumes of service. In 1989 HCFA picked five PPO demonstration sites (out of over 100 applicants) to test a variety of novel efforts.

Enrollment in these pilot programs began in 1989. All are established PPOs and all program physicians have agreed to accept Medicare assignment. The beneficiaries' portion of the fee will vary from plan to plan, depending on the incentives offered, as follows:

-- HealthLink of St. Louis: Reduced copay from 20 percent to 10 percent; waiver of Part B $75 deductible.

-- Blue Cross and Blue Shield of Arizona in Phoenix: Handpicked physicians who accept assignment and no balance billing.

-- CareMark of Portland: Prior authorization of specific procedures; payment of a flat $10 or $12 fee per visit in lieu of a 20 percent coinsurance; waiver of Medicare deductible.

-- CAPP Care of Fountain Valley, CA: Receive normal PPO benefits subject to Medicare's 20 percent coinsurance but no balance billing.

-- Family Health Plan of Minneapolis, MN: Offers incentives determined by participating employers.

3. Point-Of-Service HMO

Description

A Point-of-Service HMO is a new type of health benefit program in which the highest level of benefits is received when the enrollee obtains services at the direction of his or her designated primary care physician gatekeeper, but substantial benefits are still provided when the enrollee obtains care from a provider of choice, without gatekeeper approval. The key elements of these arrangements are:

-- A requirement that enrollees select a primary care physician "gatekeeper" who will coordinate and manage their health care needs.

-- A benefit design which provides greater payment for care delivered through the individual primary care physician gatekeeper. Enrollees obtaining care through the gatekeeper may also be eligible for additional benefits which are not paid on a self-referral basis.

-- A right to self-refer (bypass the gatekeeper) at each point of service. Exercising the self-referral option, however, results in a lower benefit level for covered services.

-- Rigorous utilization management programs which include the primary care gatekeeper program and specialty referral controls, in addition to the precertification of inpatient admissions and selected outpatient surgical procedures, concurrent review, selective second opinion requirements, and individual case management programs.

-- HMO-type financial incentives and risk sharing arrangements with primary care gatekeeper physicians that reinforce and promote the cost effective management of enrollee health care needs.

Evaluation

The Point-of-Service HMO offers employers the opportunity to consolidate their health benefit offerings into a single program with a single risk pool, premium and administrator.
While many employers would probably retain their current HMO and PPO enrollment options for a while, enrollment in these options would probably eventually fall off to the extent a standard option replacement POSHMO program can offer the employee the same benefits.

Employees can also benefit. They can receive the more comprehensive coverage available through HMOs, while retaining the psychological freedom to select any provider "just in case." In addition, employees can in theory be relieved of the confusion and decision-making burden of annual open enrollment periods.

There are many difficult considerations that must be addressed in designing and marketing this product. They include the impact on existing HMO and PPO products, realignment and size of provider panels; benefit design including the size of the downgrade for self-referral, employer interest in multi-year rate guarantees in exchange for delayed savings realization, and the significant investment to be made in state-of-the-art systems support.

While conceptually attractive, the POSHMO concept is just now being tested by a few large commercial carriers and some Blue Cross and Blue Shield Plans. It is not clear if it is possible to achieve significant savings, finance benefits required to satisfy employees and primary care gatekeepers, and maintain a sufficiently large and stable panel of primary care gatekeepers to credibly offer the program as a "standard option replacement."

E. Anti-Fraud Programs

Health insurers, employers, providers and patients must be alert to any attempt to secure benefits by dishonest or unethical means. Specialists in the detection and investigation of fraud are required for an insurer to be effective in the successful prevention, detection and civil and criminal prosecution of fraud. Some state insurance departments have developed fraud investigative units.

Some of the more common examples of health care fraud are the following:

-- Billing for services not rendered.
-- Changing diagnosis and/or dates of service to obtain insurance coverage.
-- Billings from providers with no or fraudulent credentials.
-- Treatment rendered by non-qualified personnel, but billed for by a qualified provider.
-- Billing for brand name medication when generic medication was provided.
-- Changing procedure codes to include false procedures to raise level of payment.
-- Two or more providers billing for the same service to the same patient for the same period.
-- Billing for a manual lab test over two dates when, in fact, it was automated and done on one date.
-- Waiver of copayment and inflated bills to obtain higher reimbursement.
-- Ordering of unnecessary laboratory tests.

The Federal Trade Commission estimated that during 1986, the cost of fraud to the insurance industry was in excess of $10 billion. The insurance industry estimates are even higher, ranging from $20 to $80 billion.
The National Health Care Anti-Fraud Association, founded in 1985, is comprised of a wide variety of commercial health insurers, the Blue Cross and Blue Shield system and the Medicare and Medicaid programs. Their goals are as follows:

-- Establish a pro-active stance in the fight against health care fraud.

-- Conduct national seminars to bring the public and private sectors together to provide effective methods for combatting health care fraud.

-- Expand the investigative capabilities of health care payment organizations through education in the prevention, detection, investigation and prosecution of health care fraud.

-- Provide an information-sharing network with appropriate safeguards, to aid in the investigation of health care fraud.

-- Assist law enforcement agencies to prosecute health care fraud.

In recognition of the importance of collaborative initiatives in effectively combating health care fraud, the NHCAA has formed an advisory/liaison committee, comprised of representatives of provider organizations, regulators, legislative agencies, consumer groups, and payer organizations, to provide input and formulate recommendations to its Board of Governors. Among the organizations represented are the NAIC, American Dental Association, American Medical Association, Health Insurance Association of America and National Conference of State Legislatures.

Evaluation

The Public Health Service issued final regulations in October 1989 establishing criteria and procedures for the activities of the National Practitioner Data Bank. Congress authorized the data bank to collect and release specified information relating to the professional competence and conduct of physicians, dentists and other health care practitioners.

If national figures are even close to estimating the size of the problem, there is considerable potential for savings. However, a close working relationship with both state and federal authorities is essential. This problem requires both civil and criminal solutions. Licensing boards need to act decisively when presented with clear cases of fraud or patient abuse. Insurance departments need to relay consumer complaints to insurers and give them sufficient time to uncover patterns of conduct which often lead to recoveries. Prosecutors and the courts need to make these investigations of sufficient priority and seriousness to make apprehension a probability and sanctioning or prosecution a given.

F. Technology Management

Introduction

The ability of private health insurers in the United States to influence the adoption, diffusion and financial impact of medical technologies has been increasing. A key factor contributing to this has been the expectations of consumers and regulators. This country has always taken pride in its technology, most recently displayed in devices to pulverize kidney stones without the risks of surgery, to make sophisticated diagnoses possible with magnetic resonance imaging (MRI) and many advances in the treatment of heart attack victims. In the decades preceding today’s intense cost awareness, the consuming public viewed providers as being responsible for deciding if, when and under what circumstances such medical technology would be available to patients.

When the rapid growth in health care expenses reached intolerable levels, consumer and regulator expectations changed. Payers of medical care were no longer willing to permit providers to be the final authority in medical technology decisions and health insurer interventions were considered appropriate.
As noted throughout this Guide, it is difficult to separate cost containment from quality or access. Technology assessment is often aimed at quality assessment. How do we move beyond evaluation to maintain or improve quality? That topic is outlined elsewhere but the following is instructive:

Evaluating quality is complex... Moving beyond evaluation to assuring that quality exists requires consideration of difficult issues, such as whether costs should be considered, who should be involved, how quality can be enforced, and whether a multi-disciplinary approach is possible. "Quality Health Care: Critical Issues Before the Nation," Health Care Quality Alliance, March 1988.

It is in this context that the ethical issues in balancing cost savings and quality of care are discussed in the section entitled "Implications for Quality."

Description

To perform quality assessment activities, it is necessary to know the efficacy and appropriateness of the medical interventions and technologies that can be employed in the particular patient care situations. Quality of care studies should ask the question, "Was the right thing done and was it done right?" Technology assessment helps identify the "right thing to do" by evaluating data from clinical studies to determine if the use of drugs, devices, or medical/surgical procedures is efficacious. Studies of appropriateness help to establish the specific clinical circumstances under which efficacious procedures or interventions are worth doing — when the health benefits clearly exceed the negative consequences.

Quality assessment is concerned with investigating "the degree to which the knowledge contributed by technology assessment is implemented in actual practice." Quality assessment compares actual medical practice with what technology assessment has found to be desirable. Technology assessment is, therefore, critical to valid quality assessment efforts.

As an example of technology assessment, the Blue Cross and Blue Shield Association evaluates new devices and procedures for coverage purposes, and each year evaluates the clinical utility of about 30 medical procedures or devices. These provide the insurer with expert, objective information to facilitate reasonable, consistent coverage decisions that promote high quality, cost effective health care.

There are two other aspects of TEC (technology, evaluation and coverage) that directly influence cost containment efforts:

-- Premature diffusion of technology: the introduction of new, often complex and expensive medical technologies, has frequently resulted in widespread use before their clinical utility and appropriate applications are demonstrated. In the past, it was common for new procedures to be widely used without well-controlled scientific studies on use. To provide quality care it is necessary to know which procedures benefit the patient, and which do not.

-- Setting a reasonable basis for payment: A new technology may be overvalued or undervalued, distorting the incentives for appropriate utilization. The utilization assumptions are the single most important variable in the basis for payment. The fair and proper pricing of new technologies addresses motives of excess profit to their overuse.

The Blue Cross and Blue Shield Association program uses the criteria below to determine whether a technology improves health outcomes such as length of life, ability to function or quality of life. Technologies that meet all five of the following criteria are recommended for coverage consideration:

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.

3. The technology must improve the net health outcome.

4. The technology must be as beneficial as any established alternatives.

5. The improvement must be attainable outside the investigational settings.

Another program has moved from a focus on individual procedures to a focus on procedures which may be overutilized or inappropriately utilized. The rationale is that there are a number of medical technologies which may benefit some persons with specific conditions, but which are used more frequently than good medical practice might warrant. These can be either therapeutic or diagnostic procedures. The Blue Cross and Blue Shield Association's most recent product (developed in conjunction with the American College of Physicians) addresses the appropriate use of preoperative chest x-rays, electrocardiograms and common laboratory procedures. Others have included respiratory care (1982), diagnostic imaging (1984), and cardiac care (1985).

Evaluation: In one study, a group of payers that used an assessment program spent about $400 less per hospital admission, or $40 less per insured, than a group of payers that did not use it.

G. Practice Protocol and Guidelines

An emerging and important activity impacting the cost and quality of medical care is the development of protocols or guidelines. Generally speaking, guidelines specify the appropriate use of a diagnostic or therapeutic intervention and/or describe the appropriate approach for managing a specific condition.

This is not an entirely new development. With the encouragement and assistance of the American Medical Association, medical specialty societies such as the American College of Cardiology, The American Society of Anesthesiologists, The American College of Obstetrics and Gynecology and The American Academy of Neurology have been involved in these programs for a number of years.

There has been greatly increased activity in the guideline development area in recent months as guideline development and use is increasingly being seen to have major potential in allowing the American health care system to continue to achieve the often conflicting goals of high quality but cost effective medical care.

Currently the American Medical Association is working with the Rand Corporation to develop practice parameters. This will result in development of appropriateness criteria for selected medical and surgical procedures, diagnoses and conditions. The Rand Corporation's approach involves convening groups of experts to develop guidelines for optimal care of individual clinical conditions. This consensus approach is designed to bring forth all currently available information on a particular clinical condition and thereby identify those practices that are inappropriate.

The federal government has become most interested in development of practice guidelines for both public programs (Medicare, Medicaid) and for general application. Current congressional proposals would support practice guideline development through funding, coordination and evaluation. Federal proposals generally recognize that the private sector in general and the medical profession in particular should take the responsibility for developing guidelines.

Congressman Henry Waxman has introduced legislation which would create an agency known as "The Forum for Quality and Effectiveness in Health Care" to convene non-governmental panels to develop medical practice guidelines. The forum would provide staff support, but it would not be the role of government to approve or disapprove the guidelines. The private health insurance industry is supporting this legislation.
IMPLICATIONS FOR QUALITY
IMPLICATIONS FOR QUALITY

Introduction

The quality of health care is emerging as an important public concern. For decades, Americans assumed that the quality of their health care was the best in the world. Varying levels of quality among health care providers were not recognized or questioned. Accelerating changes in the health care delivery system have challenged this view. In recent years, the enormous and ever-increasing cost of care has inspired a variety of cost-containment efforts. Benefits management programs, fixed-price payment mechanisms, and capitation programs have, as noted elsewhere in the Guide, worked to restrain the rate of increase in utilization and costs. However, they have also raised questions in some quarters about under-service, inappropriate access, and quality of care. The increasingly visible competition among providers and delivery systems heightens consumer anxiety about quality of care.

Public Concerns with Quality

Quality of care and its indicators, such as hospital-specific mortality rates, have become the subject of widely read articles in the popular press. The Wall Street Journal recently reported on the “scary record” pouring out of government reports, medical journals, risk-management textbooks, and congressional testimony citing high rates of inappropriate surgery, high rates of hospital infection, and wide disagreements among physicians on diagnosis.

Evidence of a new focus on quality among larger employers is clear. Referring to a 1987 survey, the American Hospital Association reported that quality of care was a high priority for 28 percent of business coalitions nationwide. In a survey that same year, the Blue Cross and Blue Shield Association found 54 percent of responding Plans reported that accounts were requesting or inquiring about a quality of care program for preferred provider products. Group accounts expressed interest in consumer satisfaction surveys, reviews of provider credentials, and assessment of medical care process and outcomes.

Large employers like General Motors and the United Auto Workers, Merrill Lynch, and Allied Stores are representative of very specific plans to include various quality of care criteria in their contracts with health care delivery systems.

At the federal level, Congress passed the Health Care Quality Improvement Act of 1986 to promote quality assessment and assurance activities. HCFA is attempting to balance its historic emphasis on cost containment with new Peer Review Organization programs directed toward monitoring quality and with research initiatives to develop new quality assessment techniques.

At the state level, legislative health care cost commissions in Pennsylvania, Colorado, and Iowa have begun to focus on quality of care. In Pennsylvania, state officials have contracted with Health Risk Management, Inc. to compile a data base composed of all medical claims incurred in the state in 1988 and 1989. Data will be gathered from all hospitals and ambulatory care facilities on the cost and quality of health care. Quality indicators such as hospital lengths of stay, severity of illness upon hospital admission, and health status at discharge will be combined with cost information to determine effectiveness of treatment. The data in Pennsylvania will be made available to employers, labor unions and the general public to promote comparison shopping for health care.

If one event can be given credit for precipitating the current quality of care debate, that event would be the introduction of the Medicare Prospective Payment System with fixed-rate reimbursement to hospitals based on diagnosis related group rates (DRGs). Current concern over quality of care is fueled by the very cost containment measures used in that program and described elsewhere in this Guide. They include methods of provider payment, selective contracting, new varieties of provider services packaging, and benefits management. Payers want lower costs but are concerned about unwittingly lowering the quality of care with the potential for legal liability and/or public criticism.
The reality of provider competition, especially among medical doctors, is shattering the long-held mystique of this country concerning "family doctors," the "Hippocratic Oath," and "good bedside manner." As more young doctors are trained, they compete for a limited number of patients. The annual number of surgical operations performed per surgeon has declined in recent years and may decline even further. Recent research has identified a strong statistical association between high surgical volume and low surgical mortality for selected procedures. If competition attracts patients away from high volume, high quality centers so that many providers are performing a low volume of procedures, overall quality of care may decline. In Arizona, ten new open heart surgery units were opened after state health planning regulation ended in early 1985. The new low volume open heart surgery programs reported mortality rates for Medicare patients of over 10 percent, while a major high volume center had a mortality rate for Medicare patients of 3.6 percent. The overall Arizona mortality rate for Medicare patients undergoing open heart surgery increased 35 percent between 1984 and 1986 and was nearly twice the Medicare national average.

Competition among hospitals, physicians, and alternative delivery systems may also encourage price cutting. Competition-imposed constraints on provider income may lead to the performance of unnecessary or insufficiently skilled procedures. However, competition also has the potential to enhance quality of care in the delivery system. Some high volume, high quality tertiary care centers have responded to increased competition with discounted package prices that rely on high volume. The Texas Heart Institute, for example, has offered HMOs and Medicare a fixed price of $13,800 for uncomplicated open heart procedures.

Finally, wide variations in the utilization of specific services and procedures among small, sometimes adjacent geographical areas has been documented but not well explained. Some have suggested that this may stem from medical uncertainty and the lack of definitive medical evidence about appropriate treatment. (See Technology Management, supra.)

Cost containment programs are now maturing as an accepted process. Proposals to increase access to care are being actively debated. The jockeying has already started for good field position to control the quality assessment debate in the 1990s. If government or business demand quality assessment, providers, insurers and other third-party payers will want to control and design the assessment system.

The Health Care Quality Alliance, a coalition of 28 national organizations drawn from national physician, voluntary health, aging-related, and health industry membership associations, advocate a collaborative, multi-disciplinary approach with consumer participation where appropriate. It calls on practitioners "to reexamine their professional culture to rediscover their underlying ethic." It favorably quotes Avedis Donabedian, a leading writer on quality of care issues:

We should rededicate ourselves to the pursuit of quality first, while we also insist that the highest quality we can provide is most efficiently produced. As health care professionals, this is our peculiar, even our sacred, mission.

A large number of proprietary enterprises and consulting firms are marketing quality assessment systems directly to employers for their use in overseeing health care benefits. This could force insurers to conform to a multitude of locally developed quality assessment formats, a process particularly difficult for national commercial carriers.

Add to that diversity the possibility of state-mandated quality review activities not unlike a 1988 Maryland law requiring state licensure of utilization review organizations, and nationally marketed programs would face a nightmare of systems adaptations.

What is "Quality of Care"?

The most widely accepted definitions of quality of care build on the landmark work of Avedis Donabedian. Donabedian divides medical care into technical and interpersonal components. Technical care is the application of the science and technology of medicine to the management of a personal health problem. The interpersonal component is the social and psychological interaction
between the patient and the practitioner. The degree of technical quality is defined as "the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits." According to this definition, unnecessary or excessively risky care would be considered poor quality care. Building on Donabedian's definition, the Office of Technology Assessment has defined quality of care as "the degree to which the process of care increases the probability of desired outcomes and reduces the risk of undesired outcomes."

A broader definition of quality of care advanced by the American Medical Association incorporates Donabedian's concept of maximizing benefit to the patient but also addresses the interpersonal component of care and aspects of a total delivery system. In addition to producing optimal improvement in patient health status, high quality care should:

1. Emphasize health promotion and prevention;
2. Be provided on a timely basis;
3. Involve the patient in decision making;
4. Be sensitive to patient emotional status;
5. Use appropriate technologies based on proven medical science;
6. Make efficient use of health care resources; and
7. Be sufficiently documented in the medical record to enable peer evaluation of the quality of care.

The last point in the AMA definition is particularly noteworthy. Increasingly, if elements of medical care are not documented in the medical record, they will be presumed to have been omitted from the process of care. Adequate documentation is essential to quality assessment.

As noted in the section on Technology Management, quality health care is defined as being "efficient and appropriate care properly implemented to achieve optimal improvement in health outcomes." Efficacy is a fundamental aspect of quality and is the cornerstone of the scientific foundation of medicine. It describes the ability of a treatment or medical practice to achieve its therapeutic goals.

Evaluation of quality of care, as defined above, is generally conducted through the assessment of the structure, process, and outcomes of care. Structure refers to the fixed and enduring features of the health care delivery system, such as facilities, equipment, board certification, payment mechanism and the organization of practice. Process refers to all that is done for individual patients, including diagnostic techniques and treatment modalities. Outcomes are the results of the medical intervention, such as patient status, morbidity, mortality and patient satisfaction.

The Roles of Quality Assessment and Quality Assurance

Quality assessment is the measurement of quality in all its aspects and approaches. Quality assurance, on the other hand, implies a responsibility for, or guarantee of, the quality of care provided. Quality assurance programs build on quality assessment findings to safeguard and improve the quality of care by taking direct action to correct any deficiencies detected. Quality assurance is conducted by providers of care. As managed care delivery systems evolve, quality assessment programs may develop into quality assurance systems.

A spectrum exists with quality assessment at one endpoint and quality assurance at the other endpoint. In between is a function termed quality management. This is an administrative function whereby payers should promote quality of care through the administration of benefits and the structuring and oversight of products. These activities for an insurer may include: informing providers of quality assessment findings, monitoring changes in quality in response to the findings,
providing payment and administrative incentives for improvements in quality, and imposing sanctions when improvement does not result. The sanctions do not include directly intervening in patient care delivery. They are administrative sanctions, such as termination of a provider contract. Payers cannot prevent providers from practicing in a substandard fashion, they can only seek to avoid contracting with substandard providers. Managed care systems in particular move closer to quality assurance when they enforce clinical protocols or exclude providers from the practice setting entirely.

The Scope of the “Quality Problem”

The potential negative impact of cost containment efforts in quality of care has raised questions about deterioration in quality. Surprisingly few studies have looked directly at the relationship between cost containment and quality. Under a HCFA contract, the Commission on Hospital and Professional Activities (CPHA) used its medical record abstract data base to study the impact of the prospective payment system on several indicators of quality of care. CPHA found no evidence that quality of care for Medicare patients had declined in 1984, the first full year of DRG-based payment. However, another study reported in Health Care Financing Review in 1987 examined the relationship between the introduction of state prospective payment programs and mortality rates for elective surgery and found that prospective reimbursement “may be increasing surgical mortality.”

Several more recent studies, while not definitive, highlight the need for continuing attention to the relationship between cost containment and quality of care.

Conclusions

Defining and measuring health care quality are controversial and costly endeavors. Those who are engaged in influencing the evolution of the nation’s health care delivery system should consider the conclusions reached in an issue brief prepared by the Employee Benefit Research Institute, “Managing Health Care Costs and Quality,” EBRI #87, February 1989. In a section on “Policy Implications” the following observations are made:

The market may be unable to produce the amount of quality assessment necessary to ensure the provision of cost effective care.

The challenge for public policy is to promote both the research necessary to evaluate the quality of care and the incentives for providers to adopt cost effective practices.

The market cannot provide cost effective care until it can be determined what care is cost effective and exactly what the tradeoffs are between cost and quality. The relevant policy question is how to develop the capability to perform quality assessment.

Health care cost inflation arises in part because purchasers are unable to determine exactly what they are purchasing. Providers have been reimbursed for the inputs they supplied to the production of health care services rather than for the health care they actually produce.

Defining the quality of health care essentially defines what is being purchased, a prerequisite for an efficient market for health care services. If health care cost inflation is brought under control, it will be because the buyers of health care have gathered the information necessary to make informed purchasing decisions.
GOVERNMENT AS A PURCHASER OF HEALTH SERVICES
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Introduction

Government's efforts to contain its costs have enormous effects on all other parts of the health care system. Medicare will soon take 10 percent of the federal budget. Medicaid is one of the three largest and most expensive programs states administer. Over 20 percent of the nation's work force is employed by government and virtually all are entitled to health benefit coverage. Millions more receive benefits as retired public employees.

To date, much of the government's efforts to contain health care costs as a purchaser have focused on reimbursement levels. As indicated earlier, this often has increased costs to private payers because of the cost shift.

In order to be truly effective in reducing overall U.S. health care costs, the government, private insurers, employers, consumers and providers must work collaboratively. For example, an appropriately designed diagnosis related group-based (DRG) hospital reimbursement program would appear to offer potential for significant cost savings, but much of that potential is lost when a large portion of hospital revenue falls outside the program. As long as there is a possibility to shift costs, the overall cost-saving potential is minimized.

Research should be conducted in those few states which have adopted coordinated benefit programs, i.e., all-payer DRG programs, to determine whether those efforts should be expanded.

It should be noted that federal policymakers have made major modification in physician reimbursement under Medicare. Because of the potential importance of this initiative, background information is now provided.

The Congressional Budget Office estimates that real spending per enrollee grew at a rate of 3.0 percent per year from 1985 to 1989, compared with a rate of 7.2 percent per year from 1980 to 1985. The reason for the decline in the rate of growth of spending per enrollee is due to the significant drop in Medicare's inpatient hospital spending. The reverse was true for physician spending which increased during the last half of the 1980s and outpatient hospital spending which grew significantly from 1985 to 1989.

Since 1983 when Medicare began its policy of paying hospitals a specific amount for inpatient services based on a system of DRGs, there has been a drastic reduction in the rate of growth of inpatient hospital reimbursement by Medicare.

Despite congressional efforts to control Part B costs by implementing fee freezes and initiating programs to increase physician acceptance of Medicare payments as payment in full, Part B costs continue to escalate. Increases in patient demand, over-utilization and the provision of unnecessary services, and technological advances are key factors behind these continued Part B cost increases. Citing the success of Medicare Part A payment reform and recent annual increases of as much as 17 percent in Part B cost, the federal government is now looking at ways of regaining fiscal control of Part B and outpatient costs.

Congress mandated a study to investigate the possibility of replacing the current customary, prevailing or reasonable (CPR) physician reimbursement methodology with a resource-based relative value scale (RBRVS). Under the current system of physician reimbursement, Medicare pays physicians based on what they charge, with an adjustment based on the customary charge screen and the prevailing charge screen. There is general agreement among payors and providers that the CPR system is inherently inflationary and inequitable. The RBRVS, on the other hand, would develop relative values for physician services based on the resource cost required to provide that service.
During the three year intensive development of the RBRVS by William C. Hsiao, Ph.D. at the Harvard School of Public Health, the Physician Payment Review Commission (PPRC) was conducting simultaneous simulations of the RBRVS methodology and its impact on the beneficiary and physician communities. While the Harvard researchers issued their report to the Department of Health and Human Services (HHS) in September 1988, the RBRVS underwent close scrutiny by the PPRC, which had by now become a key player in the development of federal physician payment policy.

The Physician Payment Review Commission's 1989 report to Congress proposed a massive overhaul in the Medicare Part B Program. Based on recommendations made by the PPRC in this annual report, Medicare Part B payment reform would consist of three major components, as follows:

1. Establish a fee schedule based on resource costs to reform Medicare Part B payments;

2. Place limits on balance billing to protect the beneficiaries from high out-of-pocket costs; and

3. Set a national expenditure target (ET) and develop practice guidelines to contain costs and volume of services.

Using the Hsiao measurements of physician work and practice costs, and fine-tuning other aspects of the Hsiao methodology, the PPRC has developed a rational fee schedule that would reimburse physicians for work provided. In addition, the PPRC's relative value scale treats professional liability costs as a separate variable and recognizes only practice costs in geographic variation.

Volume of Services

The most controversial aspect of the PPRC proposal was the recommendation to set national Medicare expenditure targets. Recognizing that a major portion of the increases in Part B spending can be attributed to increases in volume of services, the Commission recommended that Medicare set a national spending target in an effort to control volume. The PPRC reports that volume of services per enrollee grew 8.5 percent annually between 1980 and 1985. The ET proposal links future fee increases to the target. If Part B charges exceeded the target in one year, then cuts would be made in the next year's scheduled fee update.

The American Medical Association (AMA) strongly opposed the ET proposal and endorses instead the PPRC recommendation to increase effectiveness research and to develop and disseminate practice guidelines. Practice guidelines can be used to affect patterns of use of services both through the provision of educational material to physicians and through the development of sound criteria for utilization review.

Assignment and Balance Billing

The PPRC recommended that the RBRVS include limits on balance billing. The current balance billing limits based on the maximum acceptable allowable charge (MAAC) policy would be eliminated and replaced with specific limits in excess of the fee schedule payments, probably of either 115 percent or 125 percent, for all physicians. This policy is designed to limit the out-of-pocket expenses that could be incurred by the Medicare beneficiary.

Congressional Response

Congress completed action on the 1990 budget reconciliation package, including approval of the Medicare Part B physician payment reform. An RBRVS based payment schedule will be implemented; the transition begins in January 1992 with a blended schedule, moving to a full schedule in 1996.

The annual conversion factor and its update are set by Congress with recommendations from the Secretary of HHS and the Physician Payment Review Commission. Rather than expenditure
targets, the Congress established a Medicare Volume Performance Standard (MVPS) to measure the growth of physician services. The MVPS will reflect increases in payments under the fee schedule, number and age of beneficiaries, new technology and other changes that could impact on volume. There is some limited linkage between the conversion factor and the MVPS, but there can be no rollbacks in the conversion level. Specialty differentials have been eliminated. Balance billing limits were approved.

The new reimbursement methodology is likely to have a significant impact on the private insurers as well as other payers. Therefore, it is important that insurers and regulators consider its implications and develop an appropriate response.
GLOSSARY
GLOSSARY OF TERMS

**Alternative Delivery Systems.** A term describing a variety of new organizational structures as options to the traditional fee-for-service insurance system. Example: HMOs, which combine organization, delivery and payment for health services, and PPOs, which rely on reductions in charges as incentives to promote use of selected providers to hold down health care costs. These programs are also described by the term Managed Care Programs.

**Anti-Fraud Programs.** Programs designed to prevent, detect and prosecute dishonest or unethical attempts by providers or patients to secure benefits to which they are not entitled.

**Capitation Reimbursement.** A reimbursement mechanism wherein providers are reimbursed on a predetermined per person basis for delivering a specified range of services to a group of people, typically without regard to the actual costs of providing those services.

**Case Management (or Individual Case Management).** Programs designed to select the most cost-effective, appropriate alternatives of care, such as home treatment versus hospitalization. Treatment options and health care personnel selection are individualized, case by case, to provide cost-effective, quality medical care. While cost is a factor, the primary thrust addresses the clinical requirements of the patient. The process entails assessment of the patient's condition, selection of providers (possible specialists) and treatment sites (inpatient, outpatient, office, home) the patient's financial situation, coordination of the patient's treatment by a case manager, and concurrent assessment of the program to assure appropriate delivery of services and resources and to determine the patient's progress.

**Coinsurance.** That portion of charges for covered services which is paid by the insured, the remainder of the eligible charges is paid by the insurer. Coinsurance is typically expressed as a percentage, and the amounts may vary by service. Example: Many insurance plans have 80/20 coinsurance for physician visits. The insured pays 20 percent of the allowable charge; then the insurance plan pays the remaining 80 percent.

**Concurrent Review Programs.** Periodic review of a patient's care after treatment has begun, to determine whether continued care is medically necessary.

**Copayment.** The same concept as coinsurance, except that the portion paid by the insured before the insurance plan begins to pay for covered services is a fixed dollar amount rather than a percentage. Example: Many plans require a $25 copayment for use of emergency room services.

**Customary Prevailing and Reasonable Charges (CPR).** Refers to a list or schedule of professional fees for a given health care service which has been approved for payment by an insurer or third-party administrator. Charges have been determined for a specific geographic area based on criteria including the individual physician's usual fee, the fee that is customarily charged by other physicians in the same area, or the fee determined by the insurer to be reasonable for that service.

**Deductible.** The amount paid by the insured before the insurance begins to pay. May be applied to outpatient services, inpatient services or both, and may be required for the contract holder only, for each covered person in a family or for a family. Example: You receive a $1,500 hospital bill and a $250 physician charge. Your insurance plan requires a $200 deductible and 80/20 coinsurance:

| Total Bill | $1,750   | ($1,500 Hospital; $250 Physician) |
| You Pay    | $ 510    | Deductible, $200 Coinsurance, $310 |
| Insurance Pays | $1,240 | (80 percent of covered charges after deductible) |

Typically, the deductible is required once each calendar year for all charges or for each cause for confinement in a hospital or for a combination of the two.
Diagnosis Related Group Reimbursement (DRG). Medicare's Prospective Payment System employs a DRG based system which reimburses hospitals prespecified amounts per patient based on various diagnoses without regard to the actual cost of delivering the care. The amounts are predetermined and are typically adjusted once each year.

Discharge Planning. Programs which attempt to ensure that discharged patients receive post-hospital care that is most appropriate.

Employee Assistance Program (EAP). A confidential intervention program designed to assist employees with personal problems - drugs, alcohol, marital, financial, legal, or psychological - affecting their performance on the job.

Exclusive Provider Organization (EPO). A variation of a Preferred Provider Organization but which restricts access to an exclusive panel of providers.

Fee-for-Service or Indemnity Plans. As contrasted to HMOs (or other prepaid mechanisms), indemnity plans typically pay providers or insureds for medical, hospital, dental or other covered services based on fees charged by the providers. Insurers may condition payment upon the medical necessity of treatment and limit the amount of payment to the reasonable amount of the provider's charge. One of the many significant marketplace changes has been that traditional fee-for-service insurers have adopted managed care principles (e.g. contractual arrangements with providers such as PPOs) and created new products incorporating various utilization management programs.

Health Maintenance Organization (HMO). A type of alternative delivery system in which voluntarily enrolled members pay a predetermined, fixed monthly fee to an organization which provides or arranges for a wide variety of health care services, usually without additional coinsurance or deductibles.

Home Health Care. A wide range of health care services provided in an insured's home by health care professionals, usually but not necessarily following hospitalization.

Hospice. Organizations which provide a multidisciplinary approach to the emotional and physical needs of patients with terminal illnesses and their families. Whether this care is delivered in a freestanding facility, in a section of a hospital set aside for the purpose, or at the patient's home, the objective is to allow the patient to remain at home as long as possible, without extraordinary support systems (and their attendant costs).

Managed Care. Although this phrase is seen with increased frequency, its definition depends upon the context of its use. In general, it relates to restriction in the access to health care resources and services in the interest of cost containment. It may include utilization review, second opinions, predmission certification and case management. Managed care also refers to the organization of health care resources in alternative delivery systems such as HMOs, PPOs and their hybrids.

Mandated Coverage. Benefits or provider services required by state or federal law to be included in programs offered by health insurers or HMOs.

Point-of-Service Health Maintenance Organization (POSHMO). A newly evolving type of program combining elements of HMOs and fee-for-service indemnity plans. The highest level of benefits is received when an enrollee receives services at the direction of the HMO's primary care physician, but substantial benefits are still available when care is obtained from a provider of the enrollee's choice, with referral from the primary care physician.

Practice Protocol and Guidelines. Practice guidelines specify the appropriate use of diagnostic or therapeutic medical interventions or specify the parameters for the management of specific medical conditions.

Preauthorization Programs. Review by an authorized individual or group to provide prior approval of benefit coverage before receipt of non-emergency health care services.
Preadmission Testing. Tests performed on an outpatient basis to avoid unnecessary hospital room and board charges. Such tests, performed prior to admission for elective (not emergency) surgery, may be required for diagnostic purposes or to determine the patient's ability to cope with the clinical services to be provided.

Preferred Provider Organization (PPO). A contractual arrangement between a group of providers (physicians and/or hospitals) and a third-party payer such as an insurance company or self-insured employer. Contracting providers usually deliver services at a pre-negotiated fee below that charged by non-participating providers and agree to accept cost management controls.

Profile Analysis. Computer-aided analysis of patterns of care to identify areas where inappropriate use of care is frequent. Patterns may be selected by provider, patient, diagnosis or geographic area.

Provider. The person, organization, or facility which provides health care goods and services to a patient, i.e. a physician, a laboratory or a hospital.

Resource-Based Relative Value Scale Reimbursement (RBRVS). This newly developed physician reimbursement methodology defines the service provided by a physician based on resource costs including level of difficulty, necessary education and training requirements, and type of work (time, judgment, mental effort, knowledge, technical skill, physical effort and stress). The research identifies links from one specialty to another so that all physician services are compared on one scale. Geographic adjustments reflect the costs of practice and the costs of malpractice premiums.

Second Surgical Opinion. The requirement in a health care plan that a patient whose physician recommends surgery seek the opinion of a second qualified physician to verify the necessity for performance of the procedure. As an incentive, many plans provide full payment for this second opinion and any related diagnostic tests or X-rays and may provide lists of procedures which routinely require a second opinion. Such programs may have voluntary or mandatory requirements.

Technology Management. Programs designed to evaluate the circumstances under which new technologies should be reimbursed by insurers and to determine an appropriate reimbursement basis.

Third-Party Administrator (TPA). The person or organization under contract to an employer (usually self-insured) to process claims received from health care providers and/or provide routine administrative services. The TPA determines whether patient obligations, such as deductibles and copayments, have been met and screens claims to be presented to the employer for payment. The TPA may be an enterprise established solely for this purpose or be part of an insurance company. In any case, the TPA does not share risk.

Utilization Management. Refers to a variety of programs designed to identify and encourage utilization of the least expensive, appropriate form of medical care. Includes various pre-authorization, concurrent review, retrospective review, discharge planning and individual case management programs.

Wellness. The concept that a deliberate effort on the part of an individual to establish and adhere to a lifestyle promoting healthy habits will result in a longer life with fewer illnesses. Elements include proper diet, adequate exercise, stress control and avoidance of harmful substances, such as tobacco and drugs. The anticipated result to an employer is increased quality of work performance, lower absenteeism and reduced health care claims. Many employers, large and small, conduct scheduled instructional programs on-site, often during work hours, to instill the concept of wellness in the minds of their employees.
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