

# Cost-Containment

## In General

An outline of the various cost-containment programs presently in practice, with a brief description of each, may be helpful.

### I. General

#### A. Post-Employment Screening

Employees, after being hired, are screened to be as certain as possible that the employees are properly assigned with due regard to their physical considerations.

#### B. Formal Attendance Program

Employees notify employer at once of an absence with pertinent details thereto. This program will make employees very much aware of the employer's interest in absenteeism.

#### C. Monitoring Short-Term Disabilities

Obtain an impartial physician's opinion as to the care and probable duration of a short-term disability. Such opinions should shorten the disability periods and discourage abuse.

### II. Hospitalization

#### A. Precertification

Precertification sets the length of stay, on the average, for the proposed admission. The purpose is to reduce the length of the hospital stay.

#### B. Concurrent Review

This method monitors the hospital confinement from date of admission to the date of discharge. The purpose is to eliminate any unneeded confinement and reduce the length of stay as well as control the cost of care by eliminating any care medically unnecessary.

#### C. Hospital Audits

An audit of duplicates, unordered tests or services, billing errors, etc. The purpose of these audits are to avoid abuse in charges.

#### D. Ambulatory Surgery

Encourage use of outpatient setting for certain selective surgeries. This incentive has substantially reduced hospital admissions.

E. *Pre-Admission and Post-Discharge Testing*

When such testing is done on an outpatient rather than on an inpatient basis, there is a savings in cost.

III. **Surgical/Medical**

A. *Reasonable and Customary*

Benefits are limited to standards and norms to prevent overcharging.

B. *Second Surgical Opinion*

In certain selected nonemergency and selective surgical procedures, a confirming independent opinion is required as a condition to the plan allowing such covered expenses at 100%.

C. *Pre-Operation Disclosure*

The plan may actually seek a surgeon's statement of procedure and price before the procedure is performed.

IV. **Plan Design**

There are numerous plan design modifications that will have as their end result the containing of costs.

- Deductibles, copayments and inside limits
- Penalties for using brand, as opposed to generic, drugs
- Penalties for not following certain cost-containment programs (second opinion, ambulatory surgery, pre-admission testing, e.g.)
- Incentives for using the system better (physicians offices as opposed to hospital emergency room), wellness bonuses, audit bonuses
- PPO vs. non-PPO provider distinctions
- Scheduling of benefits (surgery, dental procedures, e.g.)
- Cafeteria plans that offer differing benefit combinations to plan participants
- COB and subrogation.

V. **Employer Sponsored Programs**

There are numerous programs that may be offered by the employer that will lower plan cost by making the employee group healthier.

- Screening
- Lifestyle modification
- Employee assistance
- Education.

## **Analysis of Escalating Health Care Costs**

### **The Problem**

Health care costs continue to rise in spite of many cost-containment programs in place and during periods with very low monetary inflation. This section analyzes why this result may be expected.

### **Cost-Containment Does Work**

The many programs of cost-containment (plan design; alternate care systems; utilization management; penalties and incentives; wellness and lifestyle programs; cafeteria arrangements and employer coalitions) do work. There have been positive signs of the effectiveness of cost-containment programs (reduced hospital care, insurance increased use of outpatient care, stable surgical use, increasing diagnostic procedure, e.g.). The difficulty is that the powerful forces driving up costs are overtaking all attempts to contain medical costs.

### **Major Forces Escalating Health Care Costs**

The major forces which are escalating health care costs are set forth in the following paragraphs.

**Technological.** We are inventing devices and procedures at a faster pace than we can afford them. Examples are laser surgery, genetic diagnoses, microcomputer applications, lithotripsy.

**Legal Environment.** Court decisions are increasingly being reported that impact directly on the cost of health care: one is how medicine is practiced (defensively with overtesting, e.g.), and what providers have to pay for their malpractice insurance (a very large sum, e.g.).

**Population Characteristics.** Our population is increasing in numbers and also aging; medical costs for the over 65 and/or retired population are great.

**Economic.** Medical care has always been and likely always will be reverse economics: as supply is up, demand is up, which is contrary to textbook economics. Demand for quality care at any price is human nature; when we hurt, we demand relief. Medical competition will often drive up prices. Shortage of health care workers (nurses, e.g.) will often exist when unemployment is high in most other areas. Health care providers have become active marketers (hospital-owned ambulatory surgical facility, hospital mental/core unit, e.g.).

**Sociological.** Family breakdown, substance abuse, increased crime and violence, poor personal health habits all add to out country's health care costs.

**Cost-Shifting.** Providers are being asked to provide more services for less income from Medicare, Medicaid and CHAMPUS at the same time that the providers are faced with more demands from the medically indigent. The result is that the providers are faced with

an increasing cost that must be passed on to the private sector. Also, government is continually mandating that more benefits be offered and more conditions be covered.

***System Related Factors.*** There are many factors that are part of the present health care system which will escalate costs.

- Iatronic disorders (result from medical treatment) and nosocomial disease (result from hospital-contracted germs, e.g.)
- Defensive medicine, meaning overtesting, primarily.
- Complexities of medicines, many arising as a result of specializations.

### **A Look to the Future**

As of this writing, medical costs may be expected to increase at 9%-13% per annum without regard to monetary inflation. If monetary inflation is 5% the increase will be 14%-18% compounded annually. The following lists some of the cost increases that can be expected in the future.

- More for mental/nervous particularly due to substance abuse
- New medical devices and procedures and drugs
- AIDS expansion
- More cost-shifting
- More mandated coverage and benefits.

There are some bright spots in the future.

- Case management, which is helping to contain costs
- Negotiated arrangements with local coalitions
- Increased emphasis on preventive care and education
- More consumer-driven medicine
- Employer-sponsored wellness and incentive care programs
- Restructuring of the system.

## **Managed Care Programs**

### **In General**

Managed care programs attempt to direct the way health care is organized, financed and delivered. Such care is a direct alternative to an indemnity plan. Examples of managed care are these:

- HMO
- PPO
- Fee-for-service with a utilization review factor.

The popularity of managed care is growing and its impact on health care delivery is becoming significant.

### **Advantages and Disadvantages**

Plan sponsors (employers and unions) look favorably on managed care because of its control over both cost and quality as well as the accountability they have over the providers and insurers. Participants look favorably on managed care because it helps them both understand and better use the health care system; it assures them of quality care and lowers their costs.

The major disadvantages of managed care relate to the difficulty in getting such a program started, usually due to these factors:

- Diversity of employer sizes and geographic mix
- Lack of reliable data on utilization
- Nonexistent single in-place network
- Absence of existing base of quality providers.

These are the services that are normally part of managed care.

- Hospital, medical, surgical
- Outpatient diagnostic and rehabilitation
- Mental health
- Substance abuse
- Preventive care
- Medical care management
- Utilization review
- Counseling and referral
- Health education and wellness.

Any plan of managed care must be monitored and controlled.

## **Plan Structure**

In the plan structure, there should be an inducement in the form of higher benefits to use the managed care program. The participant should have a choice of managed vs. nonmanaged every time a provider or service is selected for use. Utilization should be an integral part of managed care.

## **Sponsors Of Managed Care Programs**

Sponsors include a fairly wide and diverse group.

### **Third-Party Payers**

Insurers  
Blue Cross-Blue Shield.

### **Plan Sponsors**

Employers  
Associations  
Jointly Managed Funds.

### **Entrepreneurs**

Administrative Firms (TPA).

### **Providers**

HMO  
Physician Groups  
Hospitals.

Each sponsor has its own merits and demerits as regards geographic coverage, quality assurance, reporting and monitoring and sensitivity to the participants.

## **How Managed Care is Organized**

The usual methodology involves regional networks. Providers must be selected using certain criteria to assure that only the better providers will be selected; also, there must be a method established to monitor the activities of such providers.

## **In General**

A much publicized form of alternative health care delivery system is the health maintenance organization (HMO), which refers to any public or private organization providing a full range of health services to an enrolled population (i.e., generally through employer-sponsored plans) within a defined geographic area in return for a fixed, prepaid premium for all services provided. The two major types of HMOs are distinguished by the manner in which their physicians are organized and are called individual practice associations (IPAs) and prepaid group practices (PGPs).

**Individual Practice Associations.**

An IPA is composed of a central administrative component (e.g., a foundation sponsored by a medical society, a county medical society, an insurer, or a hospital) and a group of physicians in a community. The participating physicians continue to practice in their own offices and are reimbursed on a fee-for-service basis according to agreed-upon fee schedules. The HMO, however, receives a prepaid premium from its enrollees, and it is thus *at risk* financially for providing the stipulated health care services to its subscribers. The individual physicians are also *at risk* in the sense that their fees from the plan may be reduced in the event of poor overall plan experience. Conversely, they may share in any plan profits. The IPA's greatest strength, physicians practicing in their own offices, is also its greatest weakness because it lacks the peer interaction and physician selection that facilitates control of utilization and costs. IPAs usually do succeed in lowering inpatient hospital utilization rates, but they seldom attain the levels associated with effective PGPs.

**Prepaid Group Practices.** A PGP may be a medical group model, in which the plan contracts with an existing or forming group practice, or a staff model, in which physicians are hired by the plan and paid a salary. The participating physicians represent the various medical specialties and practice as a team. Primary patient care is provided in multispecialty clinics usually associated with the HMO's own hospital or with participating hospitals. The HMO receives a prepaid premium from its enrollees and is at risk for the costs of the covered health care services because it must provide them for the predetermined premiums as well as meet their financial obligations to their closed panel of physicians. Employers normally want to provide adequate health care benefits to their employees and their dependents in an effective, economical manner. Following are some of the advantages and disadvantages of HMOs for employers and their employees.

**Advantages and Disadvantages of the HMO**

**Advantages of HMO.** The advantages of the HMO are as follows:

- Broader coverage with emphasis on preventive care
- Less administrative work
- Coordinated services at one location (only true for PGPs)
- Lower hospitalization rates, i.e., hospital per 1,000 insured
- Potential for greater cost-effectiveness through incentives to the primary care physicians to constrain health care expenditures.

**Disadvantages of HMO.** The disadvantages of the HMO are as follows:

- Loss of freedom of choice of doctors and hospitals
- Limitations in choosing specialists and HMO primary care physicians control access

- Lack of, or inadequate, cost and utilization data collection system
- Geographically limited
- Employee misunderstandings (communication problems)
- Out-of-area coverage problems
- Loss of personal physician relationship
- Location of HMO facilities (Transportation, accessibility problems).
- Concern about the fiscal conditions of HMOs
- The expense of offering and HMO option (which can be material)
- Overall savings not significant. (This has been experienced by many who have been insured under HMOs).
- Satisfaction with existing systems of health care delivery by health care consumers.

Despite the disadvantages, HMOs offer a potential solution to problems found in many traditional health care plans. Such problems include:

- Difficulty in finding satisfactory medical care services; an HMO provides access to a team of doctors of all specialties available at most times.
- The fragmentation of services; e.g., services are at various locations and communication is poor; an HMO team works together at a single location, where patient records and histories are readily available (true for PGPs but not IPAs).
- The costs of services are often high.

High inpatient benefits encourage the use of high-cost hospital facilities. The money saved by an HMO limiting hospital confinement goes, in theory, to provide preventive care and comprehensive outpatient benefits.

## **Other Issues with HMOs**

**HMO Capitation Method.** Contrast the fee-for-service system with the capitation method of payment in HMOs. An HMO receives a fixed amount of dollars per year for each person it cares for regardless of how few or how many health services that person uses. An HMO member prepays to use as much or as little as he needs of an entire system of health care services -- physical exams, eye and hearing care, immunizations, physician visits and hospital care, etc. Doctors within the HMO may be on a salary or may also be paid on a kind of capitation basis. Either way, they and the HMO have a vested interest in keeping HMO members well. If they don't, they will find themselves endlessly treating a patient with no extra money for it. In other words, there is a budget within which to keep patients' care. An HMO keeps within this budget by making maximum use of all kinds of ambulatory medical services. Costly hospitalization is kept to a minimum as HMO physicians are provided with an economic motive to use resources to prevent or shorten it.

**Consumerism Issue.** Much of the health cost-containment solutions revolve around the idea of consumerism – cost sharing with bigger deductibles and copayments – and

education to make people aware of alternative, less costly forms of medical treatment than surgery or hospitalization. The problem with this approach is that it expects cost-containment to be practiced by the consumer but not necessarily by physicians and hospitals. Not only do consumers need economic motivation to shop for efficient health services, but providers need to be stimulated to practice most efficiently as well.

### **Freedom of Choice Issue.**

Access to a physician can be a problem for many families in today's mobile society. Trying to find a physician can be a time-consuming and sometimes frustrating process. Lack of *freedom of choice* of doctors is often cited as a reason not to join an HMO. It may be difficult to change doctors when the participant has an established relationship with one. But the fact is that more and more people are willing to do so because of the economic advantages with an HMO. Most HMOs allow members a choice of several physicians to act as their primary doctor. The participant can readily obtain information from an HMO about a member physician's credentials, and some even allow the participant to visit before making a final selection of one. Selecting a physician this way is a much better alternative than, perhaps, resorting to the yellow pages of a phone book. Continuous comprehensive care, affordability and accessibility make a system of health care that can meet anyone's needs – these are the key components of health maintenance organizations.

## **Preferred Provider Option**

### **In General**

The PPO option is growing in popularity and significance. The key point with the PPO is this: while physicians receive 20% of health care expenditures, they influence directly over 70% of the health care expenditures.

## **Alternate Delivery Systems**

There are these delivery systems presently in place:

- HMOs
- Prepaid plan (Blue Cross, e.g.)
- Traditional care.

The PPO is the fourth delivery system.

## **What is a PPO?**

A PPO is a hospital, physician or ancillary health care provider combined in some type of organization that contracts with employers, unions, trust funds, TPAs and insurance carriers to provide services on a discounted or negotiated fee-for-service

basis to a defined pool of patients. PPOs can be sponsored by physicians, hospitals, dentists, podiatrists, and other health professionals or by employers, unions, trust funds, TPAs and insurance carriers.

Employees are not locked into the PPO providers, but are allowed freedom of choice with built-in financial incentives to induce the employees to utilize PPO providers when health care is required. These incentives can be in the forms of a reduction or elimination of deductibles and copayments, or an increase in selected benefits, such as outpatient surgery and home health care.

PPOs must provide a utilization review program, which allows monitoring of hospitals and physician services for data collection and evaluation. In contrast to HMOs, PPOs do not normally require preselection or mandatory use of contract providers by the employees. They also do not require the policyholder to split plan costs between separate plans.

A PPO puts the employer, union or trust fund in a working relationship with the provider. The more cost-effective the providers are, the more incentive there is for the contracting consumer organization or payer to support and promote the use of these providers. This allows the PPO provider to expect greater potential for acquisition of new patients. In reality, the concept of the PPO is not new; it is just now being evaluated as a viable approach in containing costs.

Most PPOs use a gatekeeper approach. This means the patient's first utilization of the PPO is through a primary PPO physician. This approach is intended to reduce self-referrals to specialists and limits potential unnecessary utilization of expensive specialist services. This is similar to the philosophy of most HMOs. This control in reducing unnecessary referrals to specialists and ancillary services, however, may not preclude a PPO patient from using his or her own family doctor or from using a PPO specialist for more intensive medical care. The PPO also allows an employee to use his or her own non-PPO doctor, while a dependent may still utilize a PPO provider. As stated previously, the PPO does not lock in a patient, as does an HMO which has a more rigid structure. Flexibility is one of the most positive features of a PPO, which substantially enhances its marketability.

## **Characteristics of a PPO**

The characteristics of a PPO are:

- A limited number of selected providers
- Discounted or negotiated fees
- Utilization review
- Patients not locked in
- Economic incentives to encourage utilization of PPO providers
- Rapid claims processing.

## **Incentives in PPO Participation**

The incentives in PPO participation may be seen as follows:

### **Providers**

Defensive strategy

- Protecting or maintaining their market share
- Competition

Offensive strategy

- Increasing their market share
- Competition

Improvement of their financially position by

- Increasing their market share by reducing claim expense through faster turnaround of claim payments.

### **Plan Sponsor**

- Anticipated reduction in total claim dollars spent
- Sense of control over health care expenses – cost-containment
- Increase in benefits (for those employees electing the PPO) with no increase in premium
- Access to a selective and scrutinized provider network
- Agreement with providers committed to prudent medical/hospital care delivery behavior
- Negotiated rate structures
- Collection of claims data allowing monitoring of captive providers' performance and employee behavior.

### **Plan Participants**

- Reduced out-of-pocket expenditures
- Enriched benefits
- Increased access to providers
- Freedom to select providers within or outside the PPO option
- No preselection.

## **Utilization Review**

There are numerous types of reviews.

- Certification of hospital admissions
- Certification before treatment
- Concurrent or ongoing review
- Discharge planning
- Second surgical opinion

- Postdischarge review
- Medical case management.

## **Gatekeeper**

One of the critical elements in any program of managed care is the gatekeeper. The gatekeeper is the participant's primary contact for medical care. When care is sought:

- Participant calls gatekeeper
- Gatekeeper treats or refers; when referred, gatekeeper follows up and monitors.
- Gatekeeper coordinates the providers and the plan benefits.
- Gatekeeper manages catastrophic cases.

## **Medical Care Management**

Medical care management is a program that calls for the most cost-effective and appropriate care for a catastrophic illness or accident. Such case management is usually provided by medical firm vendors who develop and implement such a program with some form of alternate treatment. The key to the success of an effective case management program is early action.

## **Ambulatory Surgery**

### **Background**

The situation, not too many years ago, was that plans paid for hospital care but not for care out of the hospital. This was simple and workable. What developed was that doctors put people in the hospital so that the insurance would pay; as a result, hospitals were overused. About the same time, medical technology expanded dramatically. It became profitable business to invest in new medical instruments and techniques. Examples are:

- CAT scan
- MRI imaging
- Sophisticated anesthesiology machines
- Lasers.

## **Outpatient Surgery**

Early attempts by hospitals at ambulatory surgery were poorly done. The patients were treated as second-class citizens. At this point, the concept of the freestanding ambulatory surgery center entered the scene.

- Care better than in hospital
- Reduced costs
- All-inclusive faculty fee for ease of payment processing
- Friendlier, less dehumanizing atmosphere
- Not all of the hospital's sophisticated equipment would be needed.

From their early beginning in the 1960s to the present, the ambulatory surgical center has proved itself to be safe, efficient and cost-effective. Other factors which have helped such facilities grown and prosper are these:

- Technological advances in anesthesiology
- Enabling legislative enactments
- Cooperative efforts of insurer, provider and Medicare
- Accreditation agencies and adequate supervision.

## **Accreditation Association of Ambulatory Health Care**

This Association is located at Westmoreland Building, Old Orchard Road, Skokie, IL 60077. The member organizations of this association are these:

- American College Health Association
- American Group Practice Association
- Freestanding Ambulatory Surgical Association
- Medical Group Management Association
- National Association of Community Health Centers
- Ophthalmic Outpatient Surgery Center.

## **Enter the Hospitals**

In the 1970s, hospitals entered the ambulatory surgery market by establishing their own facilities, usually close to but not physically part of their hospital. The facilities were owned and controlled by the hospitals, however. Another set of standards, later made consistent with those of the Accreditation Association, was promulgated by the Joint Commission on the Accreditation of Hospitals.

## **Enter Medicare**

Medicare endorses the concept of ambulatory surgery and has set forth an extensive list of candidate surgeries that it believes are suitable for ambulatory surgery.

## **Recent Ambulatory Surgery Costs**

As ambulatory surgery grew in popularity and proved to be both safe and cost-effective, plans were rapidly amended to pay 100% (as opposed to 80%) and also waiving the deductible when surgery was done on such basis. The ideal of the *carrot* induced such election by the participant and physician. The economics resulted, however, in the ambulatory facilities raising their prices to the point where, ambulatory at full (e.g., 100%) is nearly as costly as having it done in-patient. Plans have begun to back away from the full benefit and are returning to treating it as any other charge.

## **Preadmission Testing**

### **In General**

The purpose of preadmission testing is to help contain hospital costs by reducing the number of hospital patient days by having the necessary x-rays, laboratory tests and examinations conducted on an outpatient basis, prior to a scheduled hospital admission and reimbursed as if on an inpatient basis. It is important to note that preadmission testing is not an outpatient diagnostic benefit program, but is offered as an inpatient reimbursement alternative to a longer hospital confinement or, in some cases, to an unnecessary hospital confinement.

### **Advantages to Participants**

The advantage for the patient who is being admitted for medical care is that treatment can begin immediately. This is far better than admitting the patient a day or two ahead of time to have tests run and then waiting for the results before treatment is begun.

It reduces the possibility of patients being admitted on weekends for routine or elective surgery and necessary tests scheduled for the following week. It allows the patient to become familiar with the hospital before admission, and means alleviation of anxiety as well as less time away from home and job.

### **Advantages to Physicians**

Getting test results early -- especially in cases where there is a history of heart disease, diabetes, and the like -- is a great advantage to the patient's physician. It helps the provider get a jump on planning the course of treatment. Should there be negative test results, the admission can be cancelled before the patient comes to the hospital. The physician who is able to confirm a diagnosis and develop a plan of treatment before the patient is admitted is also able to begin treatment promptly upon

the patient's arrival. Once the test results are available and the physician is sure of the admission, all the admitting department has to do is type the bed assignment and date of admission on the admission form and wait for the patient to show up. Because all of the paperwork can be prepared in advance, the admissions process is prompt and smooth. The tests also are available for the anesthesiologist's evaluation prior to the patient's arrival for surgery. This enables the anesthesiologist to determine the proper type and amount of anesthesia in an unhurried atmosphere.

## **Preadmission Testing in Practice**

Preadmission testing benefit programs, which are relatively easy to add to existing benefit plans, are provided at no additional cost to employers or employees. Effectively utilized, they can generate cost savings. Preadmission testing programs alone can help to reduce hospital lengths of stay when combined with a hospital utilization review program evaluating the necessity of a hospital admission, the quality of care, and the length of stay for a given diagnosis. Preadmission testing has considerable potential to encourage hospitals to improve their admission and presurgical testing procedures. Ultimately, it usually is the physician who decides whether to use preadmission testing, but the decision can be influenced by the patient concerned about the escalating costs of medical care.

## **Second Surgery Opinions**

### **In General**

*Second Opinion* has been defined as a prospective screening process that relies on a consulting physician's or surgeon's evaluation of the need for surgery that another surgeon has recommended. Thus, anyone for whom elective, nonemergency surgery is recommended is well-advised to obtain a second opinion before proceeding. For example, while one doctor may recommend surgery, another may recommend medication or postponing an operation. A second opinion encourages doctors to review the necessity and advisability of surgery, instills patient confidence by reducing anxieties, and discloses alternatives that may avoid or postpone surgery. The decision whether to accept surgery or alternative treatment is still the patient's.

### **Possible Candidates for Second Opinions**

*What kinds of surgery are suitable for second opinions?* The following are typical procedures often suitable for a second surgical opinion:

- Dilation and curettage
- Surgery of the thyroid, tonsils, or adenoids
- Surgery of the back, hip, or knee joint
- Surgery of the colon, duodenum, or stomach

- Surgery of the gallbladder or prostate
- Surgery for hernia
- Hysterectomy
- Surgery of the breast
- Surgery for hemorrhoids
- Surgery of the heart, veins, or arteries.

This is a partial list, because many observers say that almost 90% of all surgery can be categorized as elective and nonemergency. It is important to remember second surgical opinion programs usually do not cover second opinions for the following:

- Normal pregnancies
- Elective abortions
- Occupational accidents or diseases
- Surgery involving local infiltration anesthesia
- Surgery that may be performed in a doctor's office, such as incision and drainage of an abscess
- Cosmetic surgery
- Dental surgery
- Sterilizations.

## **Reimbursement for Second Opinion Fees**

In specifically designed second surgical opinion programs, the manner of reimbursement may be as follows:

- One hundred percent of the first \$100 of such charges and 80% of the balance of such charges are payable. No cash deductible applies.
- A fixed fee (e.g., \$50) is payable to the consulting surgeon if he or she agrees to accept the fee as payment in full. Charges for necessary x-rays and laboratory tests, up to a fixed limit (e.g., \$75) will be reimbursed in addition to the fixed fee payable to the consulting surgeon. No deductible or coinsurance provisions are applicable to this benefit.
- One hundred percent of usual, customary and reasonable charges incurred in seeking a second (and third) opinion from a consulting surgeon, prior to being hospitalized for the proposed elective surgery. This surgical consultation benefit also includes any charges for additional necessary x-rays, laboratory tests and other diagnostic studies. No deductible or coinsurance provisions are applicable to this benefit.

## **Voluntary vs. Mandatory**

A second surgical opinion program is instituted either on a voluntary or a mandatory basis. The major problem with the voluntary program is underutilization. Indeed, many employees do not understand the second surgical opinion option. The degree to which voluntary programs are used often hinges directly on the enthusiasm of management in

promoting the concept and the inclusion of an incentive. For example, surgery without a second opinion is reimbursed at 50%, whereas surgery following a second, or even a third opinion, is reimbursed at 100%. Mandatory programs, which require patients to seek a second opinion before insurance will pay for the surgery, have been subject to many objections. They concern the denial of payment if second opinions are not obtained; payment of a reduced benefit if the claimant has surgery without getting a second opinion or after receiving a nonconfirming second opinion; regimentation that takes away from the patient's right of free choice; and possible adverse effects on the physician/patient relationship. Enforcement is a problem for mandatory programs, as well as denial of payment which can cause employee dissatisfaction. Despite the objections and concerns, mandatory second surgical opinion programs show promise as an effective cost-containment technique. Under either type of program, and regardless of the consulting surgeon's opinion, the final decision of whether to go ahead with the operation lies with the patient. The potential for cost savings in a second surgical opinion program lie primarily in the following areas:

- Surgeries not confirmed and not performed
- Surgeries performed on an ambulatory rather than an inpatient basis as initially recommended
- General reduction in surgical claims because of physician awareness of the program. This is known as the sentinel effect.

## **Prescription Drugs**

The three common methods of cost-containing prescription drug costs are these:

- Alternate drug distribution system
- Using a higher deductible for brand than generic drugs to discourage the use of brand drugs
- Having a program of drug utilization review.

## **Drug Utilization Review**

A drug utilization review program requires a database that ideally will link the following items:

- Prescribing physician
- Medical condition of patient
- Age, sex, race, etc., of patient
- Participant's prescription records.

Ideally the utilization technique will flag problem prescriptions. Once a problem prescription is identified, it is responded to in the following manner:

- Individual letter to physician
- Newsletter and report
- Phone call to pharmacist
- Drug prescribing protocols
- Lectures, seminars, etc.

While excellent in theory, drug utilization techniques miss many problem prescriptions. Interventions are often ineffective, too little, too late. There are numerous cost-effective utilization techniques that may be cited, however.

- Prescription made where none was indicated
- Expensive drugs prescribed when less expensive drugs would be as effective.

## **Wellness and Preventive Care Programs**

### **In General**

The general health status of the U.S. population has improved in the past 20 years. Life expectancy has increased dramatically; deaths from heart problems and cancer have declined; deaths from infectious diseases have declined due to antibiotics. Chronic conditions resulting from aging (arthritis, respiratory and digestive) are major health problems that cause almost 80% of the disabilities. Use of tobacco and drugs and poor diet contribute substantially to the nation's medical problems.

## **Prevention as a Cost-Containment Program**

Clearly, prevention is the best cost-containment program. Consider the following facts:

- Diet can prevent many morbid conditions (diabetes, colon cancer, e.g.).
- Alcohol leads to cirrhosis of the liver.
- Use of tobacco is the cause of the largest number of preventable deaths there is.
- Overweight and lack of exercise is a direct contributor to diabetes and heart disease.
- Other factors (seat belts, stress management, e.g.) must also be considered.

## **Employer-Promoted Programs**

There are numerous programs that are or may be sponsored by employers and/or unions that promote safety and good health. These programs also add to worker job satisfaction, reduce absenteeism, increase productivity and lower both health care and worker's compensation costs. Specifically, the programs that are both practical and reasonably productive are these:

- Smoking cessation
- Stress management seminars
- Accident prevention
- Weight loss and nutrition education
- Blood pressure/cholesterol screens
- Fitness and exercise inducements
- Health risk appraisals.

The form of the program is a factor for the employer/union to consider:

- Educational only?
- Employee intervention on a direct basis?
- Evaluation and follow-up?
- Direct employee to specific corrective program?
- Employer-provided facilities?
- Use of local providers of health organizations?

## **Employee Assistance Programs**

### **In General**

Employee Assistance Programs (EAP) are programs that help employees and their families with certain problems (marital, substance abuse, child care, financial pressure,

legal, depression, personal or emotional problems). The program identifies, intervenes, treats and follows up.

## **Purpose of an EAP**

Personal problems of the employee are an expense to the employer. Substance abuse by itself is highly significant. Problems to the employer take the form of absenteeism, theft, poor productivity, on-the job accidents, high employee turnover, retraining costs, health care plan and workers' compensation costs, sick leave and higher health benefits.

## **Reason for EAP**

EAPs reduce the employer's problem as set forth above. They give the employee an easy access to needed professional care; such care should be of high quality and be appropriate and should prevent more expensive hospital care. Ideally, EAPs should contribute to the savings of an employee's life and job – as well as being cost-effective to the employer. Behavior health care costs represent approximately one-fourth to one-third of total cost and is increasing at a rate faster than regular medical-surgical cost.

## **Type of EAPs**

There are many types of EAPs, depending on such questions as these:

- Extended to employee's family dependents?
- All employees or a selective few?
- Extent to which problem areas are to be subparts of EAP?
- Bases of professional assistance?

## **Typical EAP Model**

Most of the problems addressed by the typical EAP will be as follows:

- Presence of substance abuse will lead to adolescent and marital difficulties, domestic violence and legal problems.
- People use drugs and alcohol to relieve their stress-filled lives.
- Substance abuse intervention is a family matter.

## **Developing an EAP**

### **Design Considerations**

A number of considerations will enter into the design of an EAP:

- What resources and levels of care are available?
- What treatment alternatives are there?
- What geographical areas are to be served?

- Who is providing the appropriate care?
- Who will monitor post hospital treatment?
- How is recidivism or revolving-door problem to be handled?
- How will utilization (preadmission and concurrent ) reviews be handled?
- How will plan abuse be limited?

### **Program Services**

A number of factors must be considered. Crisis intervention, 24-hour availability, handling of referrals, employee education, union-employer education, treatment assessment and use of managed care techniques are but a few of the program services to be considered.

### **Implementing the Program**

A number of steps or analysis are helpful before establishing an EAP.

- Claims analysis
- Union-employee-management advisory group
- Definition of objectives of program
- Benefit design changes proposed
- Effective communication packages
- Notification to provider.

### **Managed Care**

Managed care in effect establishes a gatekeeper function over all mental/nervous and substance abuse claims. Certainly utilization is part of such managed care. As with any managed care program, there must be professional monitoring, restructuring of plan design, claims utilization, use of some sort of database and follow-up evaluation. Options between hospital and outpatient care will always be a prominent factor in the managed care review.

### **Objectives of an EAP**

A number of EAP objectives should be enumerated.

- Achieve easy access to needed professional care.
- Promote quality and effective care.
- Identify problems as soon as possible.
- Monitor for managed care results.
- Assist with handling of problem or recalcitrant worker.
- Provide data for utilization reviews.
- Reduce hospitalizations and lower costs.
- Promote care on an outpatient basis.
- Reduce repeated confinements.

- Achieve early hospital discharge as soon as possible.
- Lower health care and workers' compensation costs.
- Assure quality care at the most economical cost to the employer.

## **Communicating an EAP**

The understanding of an EAP by the employees is very important. Initial communicating may be done by home mailings, bulletin board posters, brochures or meetings. Certain features of the program should be communicated in an effective manner:

- Purpose
- Services provided
- Confidentiality
- Voluntary or involuntary
- Where to call
- Program philosophy
- Referral procedures
- Disciplines
- Drug testing, if any.

## **EAP Provider**

A provider to manage the EAP must be selected. Such selection is normally a significant factor in the success of any EAP. Many factors must be considered: sample contract; provider's reputation, references, qualifications, promotional items, staffing, ownership; services available from the provider; method of controlling and monitoring are but a few of the factors to be considered.

## **Alternate Care**

### **In General**

There are several ways where health care may be provided on a less costly environment and which will encourage less costly care in the future. Examples of these include:

- Home health care
- Hospice care
- Birthing centers
- Preventive care
- Skilled nursing care.

## Home Health Care

Like skilled nursing care (care in an extended care facility, nursing home, or convalescent home), home health care is an alternative to costly inpatient hospital care. A comprehensive range of health care services (e.g., part-time or intermittent nursing care provided under the supervision of a registered nurse, physical therapy, occupational therapy, medications and laboratory services, and part-time or intermittent services of a home health aide) can be provided to a patient at home. Decisions to use home health care benefits are based on such factors as family capabilities and patient desires. Home health care programs are appropriate for chronically ill or disabled persons as well as for patients who require only monitoring during rehabilitation or maintenance care. Home health care provides supportive care at costs that are considerably less than hospital confinement and in an atmosphere often far more restful to the patient.

## Hospice Care

Hospice care is a mode of care aimed at providing terminally ill patients (i.e., patients whose prognosis for life expectancy is six months or less) with an alternative to traditional modes of treatment. The hospice concept gradually emphasizes palliative care (medical relief of pain) rather than curative care for patients for whom there is no chance of a cure. While there is no standard definition of a hospice, there are four basic principles that distinguish hospices from the traditional health care system:

- Patient and family are both treated.
- Team of physicians, nurses, social worker, psychologists, etc., work with patient and family.
- Pain is controlled but no heroic efforts to save the life are expended.
- Bereavement follow-ups are made.

Hospice care is currently delivered through a variety of program models, including:

- The freestanding hospice, with or without direct affiliation with a hospital
- The hospice unit within a hospital
- The hospice team within a hospital
- The hospice unit is a skilled nursing facility
- The so-called *hospice without walls*, or home health care
- The case manager model, which provides home health care services but through existing service providers rather than through its own personnel.

## Birth Centers

These centers are a popular, cost-effective alternative to hospitalization for low-risk deliveries and postpartum newborn care. The centers, which are usually owned and operated by obstetricians or nurse-midwives, are close to a full-service hospital which allows easy transport for any complications that may arise during the childbearing

process. Because of the popularity of these centers, hospitals have been creating these facilities within the walls of the hospitals.

## **Preventive Care**

Traditionally, medical care has focused on treatment rather than on prevention of illness. However, many health experts today believe the incidence and/or severity of illnesses, such as heart disease, stroke, and cancer, can be greatly reduced through proper preventive care and early diagnosis.

Preventive care can take many forms, some of them being periodic physical examinations to minimize complications through early detection, well-baby care (under 2 years: including immunizations), well-child care (2-15 years; including immunizations), and patient counseling by physicians for nonillnesses (e.g., smoking cessation, weight control, diet counseling, physical fitness, nutrition). Plans are increasingly involved in examining the value of all of these forms to determine which preventive measures are health and cost-effective. For example, some differences of opinion exist, even within the medical profession itself, concerning the value of annual physical examinations vs. cost and the most effective use of physicians' time. Those who approve the concept of preventive physical examinations lean toward providing specific tests periodically, the frequency being based on age and sex. Ultimately, say the experts, preventive care may reduce a company's health care costs, though results are difficult to measure.

## **Skilled Nursing Care**

Skilled nursing care refers to care that is usually furnished in a skilled nursing facility (SNF) and can only be performed by, or under the supervision of, licensed nursing personnel. The care in an SNF includes room and board charges, registered nursing services, physical therapy, drugs, supplies and equipment. Intermediate care is generally not covered. The shift in emphasis today to out-of-hospital care (i.e., insurers providing less costly alternatives to hospitalization without sacrificing the quality of the care) has resulted in development of a concept sometimes referred to as *progressive care*. In this environment, a patient proceeds through various levels of care, as dictated by his or her health condition, not necessarily beginning with a hospital confinement. For example, these levels could include intensive care, normal acute inpatient hospital care, confinement in a skilled nursing facility requiring limited medical attention, and home health care. It is well recognized that the latter days of a hospital confinement require a lesser level of care than provided in a general acute care hospital. Accordingly, if a plan includes skilled nursing care and home health care, the patient with the concurrence of the attending physician could be prevailed upon to transfer to a lesser level of care. The obvious cost savings relative to these levels of care is greatly reduced per diem charge, compared to a hospital's room and board charge.

## **Cost-Shifting**

### **In General**

Cost-shifting comes about in one of two ways:

- Medicare-Medicaid-Champus cutbacks
- Increasing significance of the uninsured.

As the federal government cuts back on the amount of funds it makes available to hospitals for the above-cited programs, the hospitals must obtain additional revenues. As more medically indigent present themselves to hospitals for care, hospitals must obtain additional revenues. In both of these instances, hospitals look to the private sector for more funds. This is the cost-shift. The problem is dramatically compounded when new technologies are legally mandated for the medically indigent.

### **Results of the Cost-Shift**

Private plan health care costs have risen sharply in the past few years as a result of cost-shifting. Also, numerous insurers have withdrawn from the health care market due to cost-shifting and its effect on pricing.

### **Other Forms of Government Intervention**

There are other forms of government intervention that have an impact on the cost-shift and in fact are part of the cost-shift.

- Requirement regarding pregnancy intervention that have an impact on the cost-shift – and in fact are part of the cost-shift
- Older member benefits (Age Discrimination of Employment Act)
- Mandated benefits (end stage renal disease, e.g.)
- COBRA
- Requirement that Medicare-Medicaid-Champus are secondary to private plans.
- Laws requiring that persons with disabilities not suffer discrimination as a result thereof.

## **Benefit Penalties**

Often there will be benefit penalties where certain actions are appropriate and available and not used. The benefit will be determined with either an additional deductible, a reduced copayment or both. Examples include the following:

- Second opinion not obtained
- Preadmission testing not used

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- Hospital emergency room used when not an emergency
- Brand-name drug as opposed to generic drug
- Weekend stays
- Stays in teaching hospital.