

# **Managed Care-Technical Challenges**

## **MEASURING MANAGED CARE EFFECTIVENESS**

Recordkeeping is the challenge. Which computer system is used and what reports can be produced? As managed care has evolved, so have a small percentage of computer systems; in most instances the systems are woefully behind. The industry has graduated from the first generation systems (simple utilization review reports, e.g.) to second generation (deals with managed care choices) to third generation (models all care from all providers on an integrated and per episode of illness basis). Future computer systems/models might factor in overall health indices (not just medical plan), such as disability, lost worker productivity and behavior modifications; this would be the fourth generation system.

## **RISK SHARING EXTENSIONS**

### **To Consultants**

Arrangements in which consultants, providers and benefit management firms share the risks with employers are increasingly common in the era when employers aren't willing to spend money on cost-savings programs that don't work. Effective risk-sharing arrangements set cost containment targets and include penalties for cost increases exceeding targets and financial rewards for reduced expenditures.

### **To Drug Makers**

One drug maker has set up a risk-sharing arrangement with 500 hospitals whereby the company guarantees the hospitals will save 20% on costs of a particular type of antibiotic. The drug maker guarantees that by using the company's brand of antibiotic, the hospital's cost will be only 80% of the previous year's total for the same category of drug. If the hospital population needing the treatment varies by more than 5% between this year and last, the cost is adjusted to reflect the changing patient numbers. At the same time, each participating hospital must agree to prescribe the drug in at least 80% of the situations where the antibiotic is appropriate.

## **EMPLOYERS UNDERWRITING HEALTH RISK**

To the extent permitted by law, employers are increasingly underwriting their employees' health and habits risk. Employers seek to hire younger, healthier employees with healthy dependents; those who are older, sicker and have children with medical or emotional

problems will find themselves clustered at nonprofit and government jobs; or at small businesses that have no coverage.

## **HEALTH CARE CLAIMS DATA**

The following are usual sources of claims data available for research:

- Claim forms (HCFA 1500, for the physicians bill and UB-92, for the hospital bill)
- Utilization review data
- State database committees (hospitals and ambulatory surgery)
- Centers for Medicare and Medicaid services (Medicare data)
- Commercial data firms:
  - Medstate of Ann Arbor, Michigan
  - Corporate Cost Management of Alexandria, Virginia
  - Corporate Health Strategies of New Hanover, Connecticut
  - HEC of Dallas, Texas.

## **ANTI-SELECTION PROBLEMS WITH BENEFIT OPTIONS**

### **In General**

There are three types of anti-selection:

- **External**  
Participants want coverage when they are – or think they are – going to need it.
- **Internal**  
Selecting between a high/low or HMO/PPO/Indemnity option.
- **Cumulative**  
Healthier leave; sicker remain as with COBRA; better groups leave and poorer groups remain as with MEWAs.

Underwriting controls external; internal is irksome; cumulative is deadly.

*Examples of Internal.* Well and younger people select the HMO and the older, sicker stay with the indemnity; Older and sicker people select the rich plan while the younger and well people select the lean plan.

### **Controlling Cumulative Anti-Selection**

There are several techniques of controlling cumulative anti-selection.

*Durational rating.* This method simply rates up as claims experience matures (or sours). This has been much criticized and has been condemned in health reform circles. A way of softening the evil (alleged) of durational rating is to put up reserves in the fat years to pay for the high claims in the lean years.

*Benefit modifications.* Offer new plans, at reduced benefits without price increases as a way of retaining the good lives.

*Macroscopic pricing.* This is the one pool of risk concept; all members share the risk of all members.

## Research in Anti-Selection

There are numerous work groups within various organizations that are studying anti-selection (particularly the Society of Actuaries). Some of significant facts so far developed by the anti-selection work groups are these:

- Not all HMOs will agree they get only the younger and healthier risks; it depends upon the HMO (staff v. IPA; geographic, etc).
- Some HMOs are beginning to experience-rate employers.
- Anti-selection can be somewhat controlled by carving out certain coverages (prescription drugs, mental, substance abuse, e.g.).

## PRICING FLEXIBLE BENEFITS

### In General

The pricing of benefits offered on a flexible basis is a challenging task; the proper handling of anti-selection is one of the tougher tasks. Benefits include dental and disability. The choice ranges include:

- Dual option (indemnity and HMO)
- Indemnity and EPO
- High-low plans.

### Nature of the Selection

With choice will inevitably come anti-selection; the financial effects of anti-selection may be dramatic. Consider an example of a \$150 deductible plan after three years:

Option	Benefits	Participant Split	Benefit Content	Employee Contributions
A	Indemnity \$500 Deductible	50%	120%	\$120
B	HMO	50	100	100

Option	Expected Loss Ratio	Actual Loss Ratio
A	75%	95%
B	63	55

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69%

75%

What happened in real world terms was that the rate increases for plan A killed the indemnity plan.

## **Underlying Reason for High Loss Ratio of Plan A**

The healthy and younger risks went to Plan B leaving the Plan A with an older and sicker group. In broad terms, people with actual or perceived needs will gravitate to the high benefit plan, thereby causing fewer contributions to go into the plan. There are several *dampeners* to the forces of anti-selection, however:

- Some people, out of fear, gravitate to high benefit plans.
- Unless the price spread is large, why choose the low benefit plan?
- Employers can powerfully influence the choice by communications.
- People in poor health have a *mental block* against recognizing this fact.
- People are not sufficiently informed or sophisticated to *outguess* the system.

## **Perils of Anti-Selection**

The horror story to avoid is where anti-selection is so severe that it causes the high benefit plan to self-destruct. The few healthy ones in the pool will refuse to carry the increasing number of sick ones and the *death spiral* is on.

## **Controlling the Anti-Selection**

Given that anti-selection is a fact of life, what may be done to control such?

- *Limit the choices*  
The high-low spread is narrowed with only the two choices, e.g.
- *Slave benefits*  
Slave medical and dental so that the low medical and high dental option is precluded.
- *Core benefits*  
Require a minimum and basic package.
- *Individual underwriting*  
Once elected, an upgrade is permissible only with a health questionnaire.
- *Graded benefits*  
Go from *lean* to *fat* dental benefits on a grade-in basis by benefit year.
- *Pricing*  
Introduce age-rated participant contributions (for self-funded plans only, however).
- *Offsetting selection*

Subdivision of the high option by the low option as part of the plan's funding practices may be necessary.

## **Pricing the Benefit Options**

The traditional pricing objectives are these:

- Contributions sufficient to pay claims and expenses
- Equitable distribution
- Encouragement of cost containment
- Simplicity.

The basic pricing procedure is as follows:

<b>Step</b>	<b>Action</b>
1.	Gather data and analyze it.
2.	Project future claims with trending.
3.	Estimate populations by option.
4.	Factor in anti-selection.

## **RISK MANAGEMENT DIMENSION TO MANAGED CARE**

Obviously when the employer self-funds, it brings in the risk management dimension to the management of the care. In what other ways might risk management be involved?

- Setting managed care strategies
- Installing and monitoring wellness programs
- Applying Monte Carlo techniques to stop-loss
- Handling problem claims.

## **MANAGED CARE AND INFORMATION SYSTEMS**

Computer systems to track physicians' fees are indispensable with managed care. The following are the groups which have a strong interest in physician fees:

- HMOs and PPOs
- Insurers
- TPAs
- Self-funded employers
- State governments
- Providers.

There are presently in place fee schedule database firms that assist in physician fee discounts. Simply - good data translates into good discounts and good managed care.

What is particularly noteworthy are the many new technologies that are emerging to further the goals of managed care. There are, e.g., four fairly significant technologies:

- Electronic data exchange
- Client/server technology
- Case-based developments
- Imaging.

Other indications of the risks to high-tech are as follows:

- Social Security numbers on health care plan-covered dependents are required by the 1993 Budget Reconciliation Act.
- Federal government is pushing high-tech with their information bulletin boards and on-line information systems.
- High-tech claims and recordkeeping is held out to be the salvation of health care system.
- Only with good data will good results be possible; this is the song sung by all of the experts.
- The big players believe their high-tech data management is reason enough to let them have all the business.
- The number of high-tech data handling vendors has grown dramatically.
- The big-big players are thinking satellite-connected world wide networks.