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Managed Care Solutions

for Tomorrow's

Health Care Needs

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

BlueCross BlueShield Association

An Association of
Independent Blue Cross
and Blue Shield Plans

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March 27, 1996

Dear Colleague:

Enclosed is an updated version of a recent Blue Cross and Blue Shield Association publication highlighting innovations in managed care.

The first edition, released in January, contained mid-year 1995 data in several sections. The new version reflects the most up-to-date figures available.

As you know, Blue Cross and Blue Shield Plans are leading the transformation from old-style fee-for-service delivery to patient-centered managed care systems. This publication illustrates this trend with system-wide data, as well as real-life anecdotes. I hope you will find this book interesting and informative.

If you have any questions about this publication, please call me at 202.626.4826. To order additional copies, please contact Brenda Jones Smith at 312.440.6568 (phone) or 312.440.5705 (fax).

Regards,

Alixe R. Glen
Senior Vice President
Communications and Media Relations

Enclosure

contents

USA

Official Health Insurance Sponsor of the 1996 U.S. Olympic Team

"Mana

The phrase alone frightens many Americans. When they hear it, they picture crowded clinics delivering poor quality services. They envision faceless bureaucracies making treatment decisions or denying access to needed services. They fear that managed care systems cannot adequately care for them and their families.

Yet these fears deny the experience of more than 100 million Americans currently enrolled in HMOs, PPOs and point-of-service plans. These patients know that managed care offers tremendous advantages over the old-style fee-for-service system. Managed care patients know first-hand that the quality of their care is equal to or better than the care they could receive in old-style programs, and they cite numerous other advantages.

ged care."

For instance, managed care patients have access to the **full range of health care services**—from preventive tests and primary care to specialty treatment and follow-up—all for only nominal copayments. Even **prescription drugs** are covered with only a few dollars out-of-pocket. Managed care patients don't have to fill out the dizzying array of health insurance claim forms. Furthermore, they know that their doctors are **pre-screened for quality**. Managed care plans carefully select their doctors by making sure their licenses are valid; examining their medical training; checking their malpractice histories; and often requiring them to become **board certified**. These quality tests are much more thorough and detailed than any background checks consumers could conduct on their own. These advantages explain why numerous surveys find managed care patients are more **satisfied** with their health plans than those in fee-for-service.

Doctors also value managed care, because it allows them to **practice medicine more effectively**. Physicians working in managed care settings are more satisfied with key aspects of their practices than fee-for-service doctors, according to a **Robert Wood Johnson Foundation** survey of 4,000 practicing doctors nationwide. The survey found that managed care doctors are more likely than others to feel free to hospitalize patients, to keep patients in the hospital, and to order the tests and procedures they deem necessary.

Managed care doctors enjoy **working in teams** with other doctors and nurses, so that the entire spectrum of **care is coordinated**. Managed care plans also provide doctors with feedback on the quality of care they deliver, so they can recognize what they do well and identify areas for improvement. In addition, managed care plans develop **practice guidelines** to help physicians design the best course of treatment for their patients. This kind of **teamwork** is impossible in the fragmented fee-for-service environment.

Managed care **improves not only the process**, but also the quality of care delivered to patients. For example, women enrolled in managed care plans receive **mammograms** and **Pap smears** more often than their fee-for-service counterparts. Babies born through managed care programs are much healthier than the national average. Managed care patients with cancer are diagnosed and **treated earlier** than fee-for-service patients. And managed care plans offer **expanded benefits** to the people who need them most—the elderly and the disadvantaged.

These quality improvements represent only the beginning of managed care advantages and innovations. Managed care plans are currently engaged in **research** comparing the results and costs of different treatments for a given condition. These **outcomes studies** will help doctors decide which procedures will provide patients with the best **quality of life** and the least pain while conserving scarce health care resources. This art and science of effectively managing health care quality will help American medicine continue its **tradition of worldwide leadership** into the 21st century and beyond.

Managed care plans also help employers reduce the cost of providing care for workers and their families while improving employees' health and **boosting productivity**. By encouraging employees to join managed care plans, employers reduced their health benefits spending by 1.1 percent in 1994–the first decrease in more than a decade, according to a survey of 2,100 firms nationwide conducted by benefits consultants Foster Higgins. The average firm with 10 or more workers spent $3,741 per employee on health benefits, down from $3,781 in 1993. Mid-year 1995 policy renewal rates for traditional indemnity policies show premium increases from 10 percent to 25 percent, compared to 1 percent to 5 percent for HMOs and 7 percent for PPOs.

The 63 independent, community-based **Blue Cross and Blue Shield Plans** are at the forefront of the transformation from old-style, fee-for-service medicine **to organized, coordinated managed care systems**. Today, one in 10 Americans is a member of Blue Cross and Blue Shield Plans' managed care programs, and their **numbers are growing rapidly**.

In this book, you'll see patients, doctors, and employers throughout our nation who depend on Blue Cross and Blue Shield Plans' managed care programs for **comprehensive, high-quality, affordable health care**. The programs described in these pages exemplify the advantages that managed care plans offer—improved outcomes, expanded benefits and **personalized service**. But this book is just a microcosm of the success stories that are unfolding nationwide—a successful managed care revolution that will lead to a **healthier tomorrow**.

Reaching Out

"Preventive care" has become a buzzword in today's health care industry. Doctors, nurses and hospital administrators agree that treating little problems early can help prevent big problems later—and save money in the process. But prevention works only if patients practice it. In these busy times, too few patients take their own health care seriously—and too few doctors have the time to encourage them.

Blue Cross and Blue Shield of New Hampshire supplies patients with free copies of this preventive care guide compiled by the U.S. Department of Health and Human Services.

Despite years of media attention to the importance of childhood immunizations, only 67 percent of American two-year-olds receive on schedule all the shots the federal government recommends. Only one in four women over age 65 obtains a mammogram in any given year–even though these women have higher breast cancer risk than their younger peers. Nearly one in three American adults is overweight. The nation has a long way to go in meeting the federal government's risk reduction goals, known as *Healthy People 2000*. From smoking and consuming high-fat diets to practicing unsafe sex, Americans benefit from advice on making healthier lifestyle choices.

That's why Blue Cross and Blue Shield Plans' managed care programs do more than just pay for preventive services. Health plans are true partners in their

patients' care. Managed care doctors keep track of which patients need cancer screenings and other necessary tests, and they remind these patients to obtain these services on schedule. Sophisticated management information systems allow the plans to track these data over varying periods of time, so doctors can figure out ways to reach the patients who need their advice the most.

Managed care systems' outreach programs improve not only the process, but also the quality of care delivered to their patients. For instance, government statistics show that women enrolled in HMOs are more likely to obtain mammograms than women enrolled in fee-for-service plans. Moreover, a recent study in the journal *Medical Care* found that physician groups with a high concentration of managed care business are more likely to recommend Pap smears to their women patients than physicians whose patients are mostly enrolled in fee-for-service plans. The study, conducted by Woodland Hills-based Blue Cross of California's California-Care HMO, reviewed 11,000 patient records from 3,800 primary care physicians in 81 California medical groups.

In addition to its research efforts, California-Care offers patients a broad range of preventive care programs, both at home and at the office. The HMO's Well Woman Program, for example, allows women to schedule annual gynecological exams without obtaining referrals from their primary care doctors. This seamless approach allows women to obtain mammograms, Pap smears and other preventive services in the easiest way possible. The health plan also offers free prenatal education; discounts on healthy lifestyle classes such as Jazzercise®, Weight Watchers® and Smokenders®; and a variety of free programs on topics ranging from AIDS awareness and back care to stress management and personal safety.

...government statistics show that women enrolled in HMOs are more likely to obtain mammograms than women enrolled in fee-for-service plans.

During annual renewal time, California-Care sponsors health fairs for both plan members and employer groups. Designed to encourage prevention while introducing patients to network providers, the fairs may include screenings for cholesterol level, blood pressure and body fat content. These preventive care efforts help California-Care patients prevent many illnesses and injuries by making healthy lifestyle choices.

California-Care is just one example of the Blue Cross and Blue Shield commitment to prevention. At Buffalo-based Community Blue, the HMO product of Blue Cross and Blue Shield of Western New York, mammography rates have increased 6.4 percent and Pap smear rates have increased 1.6 percent in just two years, thanks to the health plan's Women's Health Project.

"Early reports helped us discover that not enough women in our health plan were getting mammograms and Pap smears," explains Connie Otteni, director of Community Blue's health service and quality management department. "So in 1993, we created the Women's Health Project—an outreach effort designed not just to improve cancer screening rates, but also to reinforce the need for women to see their doctors regularly and communicate openly about any health problems."

"We convened a special committee of primary care doctors, OB/GYNs and health education staff to work on the project," she says. "We decided that the best way to remind women about their needed tests would be to send them a personal letter from their doctor emphasizing the importance of preventive care."

Community Blue's mailing averages 1,500 letters per month, with more than 750 doctors participating. Doctors say they appreciate the health plan's assistance in identifying patients who need the tests. In addition, the reminder system helps doctors keep track of patients who obtain the tests outside the health plan—for example, at a community health fair or shopping mall. When these women receive the letters, they call the doctors' offices to let their doctors know they have already been screened.

Through a similar reminder program, Community Blue has already succeeded in raising its childhood immunization rate from 88 percent to 98 percent. Based on these results in reaching out to women and children, Otteni says the health plan will soon target patients who have not seen a doctor in two or more years to come in for a check-up. This program will help reach men, who are often reluctant to seek medical attention until they are already ill.

Blue Cross and Blue Shield of New Hampshire (BCBSNH) is another leader in reminding its patients to undergo cancer screenings and other important tests. In October 1994, the plan launched a mammography reminder campaign targeted at women age 50 and over.

Each woman in the target group receives a gift from the health plan on her birthday–a greeting card reminding her to obtain a mammogram; a shower tag illustrating how to conduct a breast self-exam; and a copy of *Put Prevention Into Practice*, a personal health guide from the U.S. Department of Health and Human Services.

"We send an average of 1,500 to 1,800 packages a month," says Hilary Frost, the plan's health education manager. "We try to make the material look sophisticated and feminine while supporting our overall message—encouraging patients to have better relationships with their doctors, take more responsibility for their own health care and become more active participants in their own treatment."

Frost says the mammography reminder campaign is just one example of the

health plan's commitment to promoting prevention. In October 1995, BCBSNH expanded the program to women between ages 40 and 50, and included new reminders about obtaining Pap smears and cholesterol screenings. In 1996, the plan will launch a reminder program for men, emphasizing the importance of screenings for prostate cancer, colo-rectal cancer and blood cholesterol levels.

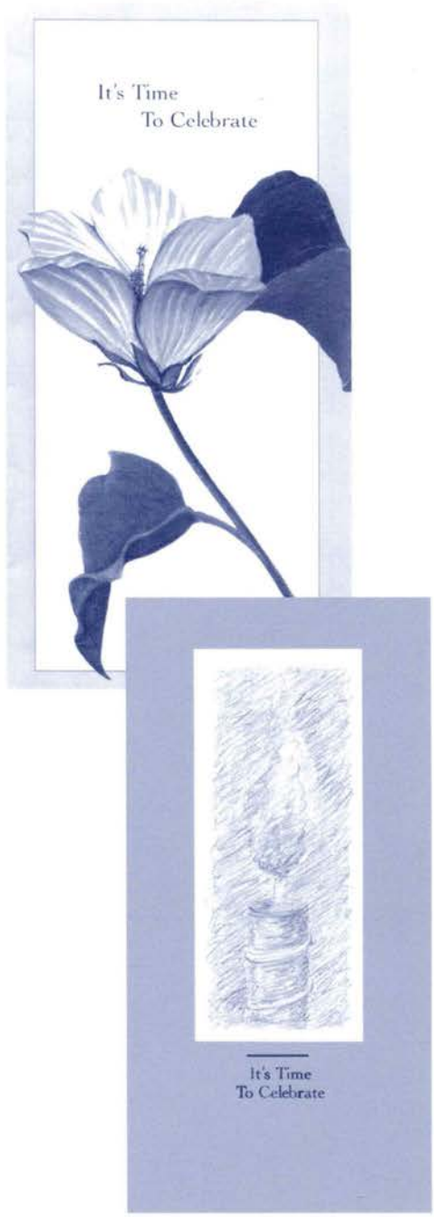
Ensuring that patients receive cancer screenings, immunizations and other recommended preventive services is an important process for keeping patients healthy—but not the only one. Blue Cross and Blue Shield Plans' managed care programs realize that even the most health-conscious patients will get sick or injure themselves from time to time.

When patients begin to notice symptoms, they often don't know if they should see a doctor right away or wait and see if the symptoms disappear. Some Blue Plans offer patients help in making these decisions by providing a 24-hour, toll-free advice line. Registered nurses staff the line by using computer programs to sift through symptoms and help determine whether a doctor visit is needed. For example, a mother who notices that her new baby has a stuffy nose can call the nurse to determine whether the baby has caught a cold or is seriously ill and needs to see a doctor.

Independent Blue Plans in 10 states contract with Access Health to provide the Personal Health Advisor service. In addition to immediate telephone advice, patients can use this system to obtain recorded background information about conditions ranging from chicken pox to cancer. Nurses also advise patients on elective surgeries and support them through recovery.

This service puts patients in charge of their own health care—armed with expert advice. Blue Cross and Blue Shield Plans' managed care programs recognize that encouraging patients to care for minor conditions at home allows doctors to spend more time with the sickest patients who truly need them, while improving the comfort and satisfaction of the rest.

As these examples illustrate, Blue Cross and Blue Shield Plans' managed care programs are leading the way in making sure their patients obtain needed tests, screenings and other preventive services. By reaching out to patients, Blue Plans improve the quality of care delivered while saving money that would otherwise be spent on emergencies.



These cards do more than convey birthday greetings to members of Blue Cross and Blue Shield of New Hampshire managed care plans. They also remind female patients ages 40 and over to obtain mammograms.

Helping Moms deliver Healthy Babies

Preventive care is important not only for adults and children, but also for infants still in the womb. In fact, comprehensive prenatal care is critical for ensuring that babies are born healthy. That's why Blue Cross and Blue Shield managed care plans make sure that mothers and their infants receive all the tests and screenings they need. Moreover, Blue Plans understand that pregnancy can be frightening and stressful for new mothers, so they are committed to making the experience as comfortable and rewarding as possible.

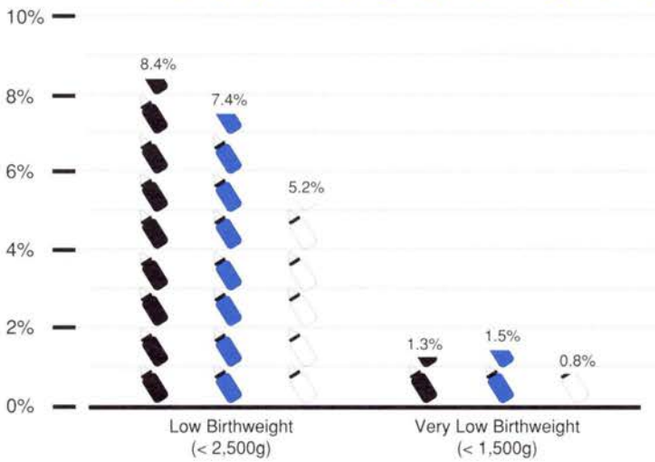
Veda Story knows about this Blue Cross and Blue Shield commitment firsthand. Blue Choice, the Blue Cross and Blue Shield of Rochester, N.Y. HMO, provided "terrific" help when she was pregnant with triplets.

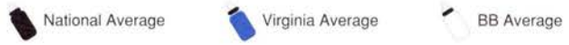
"I already had 20-month-old twin boys at home, so when the doctor put me on bed rest with the triplets, I wasn't sure how I'd manage," she says. "But Blue Choice arranged for me to have a hospital bed, home uterine monitoring, and telephone access to a nurse who kept track of my progress. Best of all, they arranged for a domestic aide to come in five days a week to help prepare dinner, pack lunches and clean up the house. It was a huge relief having someone there to help—and a lot less tempting to get out of bed."

BABY BENEFITS®

Program Evaluation

DELIVERY OUTCOMES





Baby Benefits, a maternity risk management program operated by Trigon Blue Cross Blue Shield, results in women delivering healthier babies. The incidence of low birthweight and very low birthweight among babies born with Baby Benefits care is lower than both the national average and the average in Baby Benefits' home state of Virginia.

Veda delivered three healthy boys after 35 weeks gestation. In addition to the high-quality care she received from her doctor, she says her case manager, Marge, was "a wonderful go-between" whose ability to coordinate the skills of physicians, nurses and aides made her healthy pregnancy possible.

The Rochester Plan is just one member of a proud Blue Cross and Blue Shield maternity and prenatal care family. In a similar effort, Blue Plans in four states contract with Baby Benefits, a maternity risk management program operated by Health Management Corp., a subsidiary of Trigon Blue Cross Blue Shield. The first commercial worksite-based program of its kind, Baby Benefits provides participants with educational materials, risk assessments and toll-free access to a dedicated nursing staff for support and high-risk intervention.

Baby Benefits is designed to help expectant mothers prevent complications from hypertension, multiple gestation, diabetes, preterm labor and other potentially dangerous conditions. Baby Benefits nurse advisors also help expectant mothers quit smoking, reduce their alcohol intake, reduce work-related physical demands, maintain a healthy weight and take other preventive measures to ensure that they deliver healthy babies.

Program Evaluation

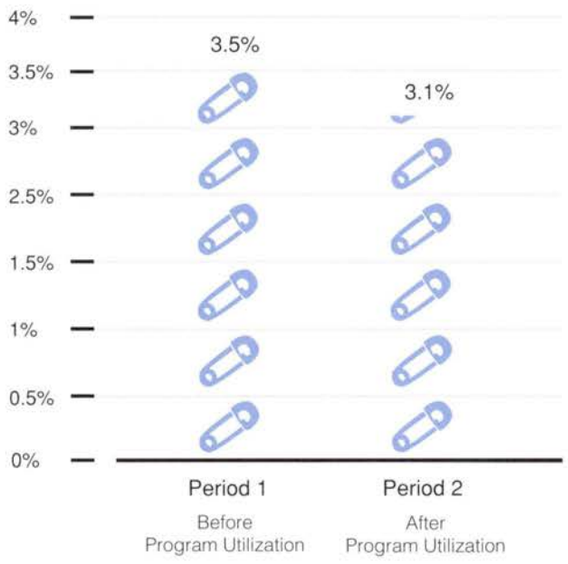
Each dollar invested in the Baby Benefits program saves $3.63.

A recent evaluation found that women who participate in Baby Benefits deliver fewer premature infants than average, even though their risk levels are higher than average. Only 5.2 percent of Baby Benefits participants deliver low birthweight babies, compared to a national average of 8.4 percent. Moreover, fewer than 1 percent of Baby Benefits participants deliver babies with very low birthweight, compared to 1.3 percent of mothers nationwide. These healthy outcomes also cost less than the average birth; all told, the program saves $3.63 for every dollar invested. The program recently won a C. Everett Koop Award from The Health Project, a nonprofit public-private health care organization, for its ability to document results in improving health care quality while reducing costs.

Chicago-based Sara Lee Corp. has contracted with Baby Benefits since 1992. During the first year of the program, the company saved $2.50 in health care claims for every dollar it invested. Inpatient obstetric charges dropped by 10 percent, and inpatient charges for premature babies fell 33 percent. Moreover, Sara Lee employees are extremely happy with the care they receive through Baby Benefits. Ninety-five percent of the company's 370 participants rated the program as "excellent" or "good," and 96 percent said they would recommend Baby Benefits to others.

In addition to ensuring high-quality prenatal care, Blue Cross and Blue Shield managed care plans are committed to reducing the number of unnecessary and risky cesarean sections performed. Data from the Public Citizen Health Research Group indicate that this dangerous procedure is the most commonly performed surgery in the United States—even though it can often be avoided. Although the U.S. Centers for Disease Control and Prevention say just 15 percent of all births require cesarean section, nearly 23 percent of all births nationwide were cesarean sections in 1992.

INCIDENCE OF PREMATURE BABIES AT SARA LEE CORP.



Chicago-based Sara Lee Corp. has found that offering Baby Benefits care to its employees results in fewer and less severe premature births. Moreover, 95% of Sara Lee's 370 participating employees are satisfied with the care they receive through the program.

SEVERITY OF PREMATURE BABIES AT SARA LEE CORP.

In order to reduce the rate of this often unnecessary and costly procedure, the Blue Cross and Blue Shield of South Carolina (BCBSSC) PPO began paying hospitals the same rate for cesarean sections as it pays for vaginal deliveries in September 1993. The new reimbursement initially affected six of the PPO's 57 hospitals, and the policy has expanded throughout the network since then.

"After one year with the equal rates in effect, we saved $67,000 on 77 births at six facilities. That's $870 per case," says Ashby Jordan, MD, BCBSSC vice president and medical director. "This policy not only saves money for our customers, but also means that fewer invasive, painful surgical procedures take place."

By helping expectant mothers deliver healthy babies, Blue Cross and Blue Shield managed care plans ensure that their patients receive first-rate health care from the earliest possible moment. Blue Cross and Blue Shield Plans' maternity and prenatal care programs comprise just the beginning of a lifetime of high-quality health care.


PROVIDING SE

NIORS HEALTH CARE THEY CAN TRUST

Blue Cross and Blue Shield managed care plans expand their outreach programs beyond privately insured patients and expectant mothers. Blue Plans are also at the forefront of caring for people who need health care the most—the elderly and the disadvantaged. In recent months, lawmakers and health advocates have focused on improving the quality of care delivered to these groups while reducing financial burdens on taxpayers. By expanding benefits, coordinating care and providing a range of health plan choices, Blue Cross and Blue Shield managed care plans are helping to propel Medicare and Medicaid out of the 1960s and into the 21st century.

Since 1985, enrollment in Blue Cross and Blue Shield Plans' managed care programs has increased 400 percent. Currently, more than 30 million Blues customers—or 46 percent of total Blues enrollment—are enrolled in managed care networks. But Medicare has lagged behind the private sector, leaving seniors trapped in the fragmented fee-for-service program. The federal government currently contracts with 154 HMOs to care for just 3.1 million, or 9 percent, of Medicare beneficiaries.

Moreover, traditional Medicare is rapidly becoming financially untenable. Spiraling health inflation and the aging of America's baby boom generation are threatening the federal health care programs' viability. The U.S. government spent $280.6 billion on Medicare and Medicaid in 1993, compared to $254.3 billion in 1992. Federal spending accounts for nearly one third of all health care dollars.

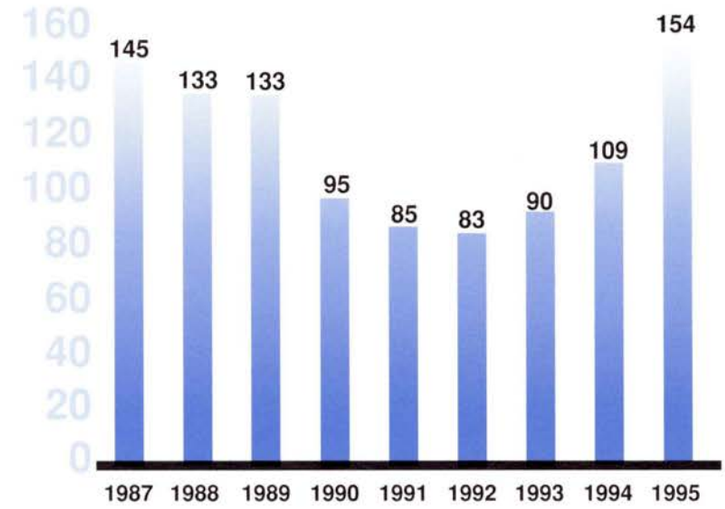
Managed care offers the potential to reduce these expenditures while promoting high-quality care and strengthening the doctor-patient relationship. Although growth in Medicare managed care plans has not kept pace with the private sector, seniors who are already enrolled in managed care plans are happy with them. In fact, a recent American Viewpoint survey shows that only 2 percent of Blue Cross and Blue Shield Medicare HMO members switch back to fee-for-service—even though they have the option of switching every month.

Moreover, the survey demonstrates that even Medicare beneficiaries with chronic and serious medical conditions—such as cancer, kidney disease and pulmonary disease—prefer HMOs over traditional Medicare. The poll found by a three-to-one margin that seniors who have experienced both HMO care and traditional Medicare prefer the HMO approach. These seniors cite HMOs' reduced paperwork, lower out-of-pocket costs and expanded benefits as tremendous advantages over the traditional program.

A wealth of research demonstrates seniors' dissatisfaction with traditional Medicare. While seniors give the program high marks overall, they are frustrated with its limited benefits, confusing paperwork and high out-of-pocket costs, according to focus group research conducted by the Kaiser Family Foundation. Seniors express amazement that the program does not include many services they see as necessities, such as prescription drugs, long-term care, eyeglasses, hearing aids and dental care. Moreover, many seniors feel Medicare provides a false sense of security. Most do not closely investigate their benefits until they face a medical emergency—and only then do they discover coverage limits.

A recent American Viewpoint survey found by a three-to-one margin that seniors who have experienced both HMO care and traditional Medicare prefer the HMO approach.

RISK CONTRACT GROWTH



Rate of Increase/Decrease

1987	1988	1989	1990	1991	1992	1993	1994	1995
	5%	0%	-28%	-11%	-2%	8%	21%	41%

The number of HMOs contracting with the federal government to care for Medicare beneficiaries has grown steadily since 1992.

At Blue Cross and Blue Shield of Minnesota (BCBSM), by contrast, seniors enrolled in the Preferred Seniors HMO have access to a wide range of benefits. In addition to the services covered under Medicare Part A and Part B, Preferred Seniors covers mammograms, routine foot care, Pap smears, hearing and vision screenings, cholesterol tests, immunizations and preventive dental services. Optional coverage is also available for prescription drugs and comprehensive dental coverage. Patients can obtain these services simply by presenting their ID cards—no forms or paperwork are required. In addition,

these services are generally available at each member's primary care clinic, so patients no longer have to run from one doctor's office to another.

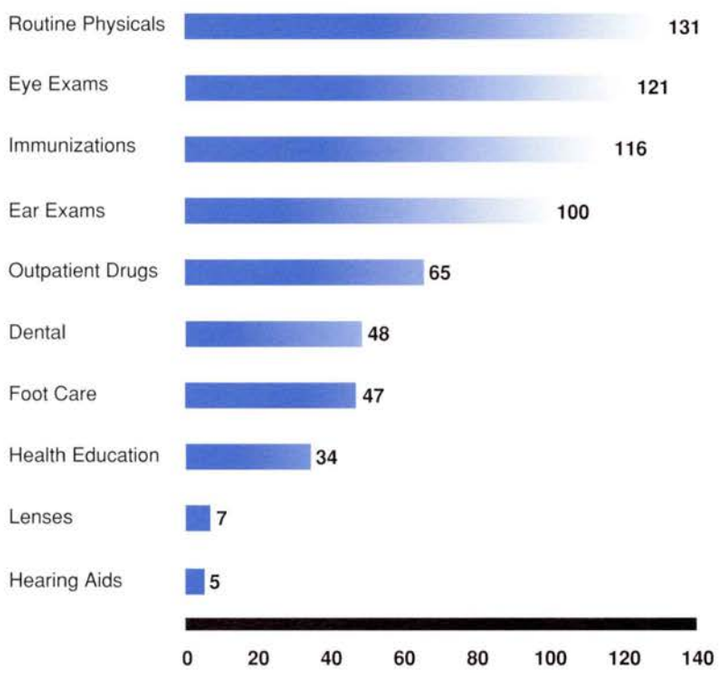
"Best of all, in the managed care environment, seniors develop a relationship with a personal doctor who stays with them for years, and can keep an eye on both their medical and social needs," says Kris Hopko, Medicare coordinator at BCBSM. "This primary care doctor is the hallmark of the successful HMO, because he or she leads a team of doctors, nurses, pharmacists and other providers to make sure that each one knows what the others are doing. Understanding patients' needs and personalities and referring them to the right specialist, and then working with that specialist to coordinate all aspects of care—that's a real strength of Medicare HMOs."

By aligning the incentives of physicians, nurses, hospital administrators and other health professionals, Blue Cross and Blue Shield managed care plans improve the quality and coordination of care delivered to seniors. Because HMO members have access to preventive services, their health problems are detected early, producing healthy outcomes and reducing the need for expensive, high-technology treatment. The Medicare HMO approach thus improves seniors' health while saving money for the government and the patient. In many markets, Medicare HMOs offer "zero premium" plans. Others provide extra benefits such as prescription drugs without charging any copayments or coinsurance.

"HMO-style coordinated care is especially important for patients in nursing homes," says John Mielke, MD, medical director of Aspen Group, a physician group practice serving Preferred Seniors.

"Managed care ensures that nurse practitioners and other providers are available to take care of problems on the spot," he says. "If a doctor is needed and the patient's primary doctor is not available, someone else on the same care team can handle the problem.

ADDITIONAL BENEFITS OFFERED BY MEDICARE RISK CONTRACTS



The nation's 154 Medicare risk HMOs provide many benefits that are not covered under traditional Medicare. These expanded benefits appeal to seniors who seek comprehensive, high-quality care at the lowest out-of-pocket expense. This graph provides examples of these expanded benefits and the number of risk HMOs that cover them.

Patients love having access to a health professional whenever they need it. And the improvements in quality and efficiency are really quite profound."

David Chellappa, MD, corporate medical director at Anthem Blue Cross and Blue Shield—of Indiana, Kentucky, and Cincinnati—agrees that coordination improves the quality of care delivered to elderly patients. Anthem launched its Medicare HMO, HMP Medicare, in fall 1994.

At Blue Cross Blue Shield of Minnesota, seniors enrolled in the Preferred Seniors HMO have access to a wide range of benefits.

"The major focus of managed care is on addressing the patient's total health care needs—which is especially challenging in the senior population," Chellappa explains. "Old-fashioned, fee-for-service Medicare concentrated on episodic illness—treating each illness or injury as a separate, unrelated event. But managed care has changed that. Physicians are now rewarded for anticipating and preventing future problems, and making sure that all prescriptions and other services are coordinated in a sensible way."

Health services research supports these doctors' observations. A recent article in the *American Journal of Public Health*, for example, found that seniors enrolled in Medicare HMOs had cancer diagnosed at an earlier stage than seniors in the traditional program.

"The earlier detection of certain cancers among HMO enrollees may result from coverage of screening services and, perhaps, promotion by HMOs of such services," the authors wrote.

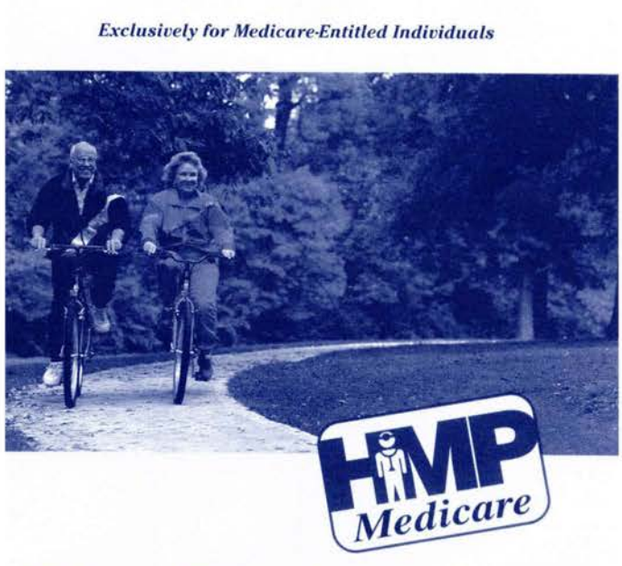
KeyCare 65, the Medicare HMO affiliated with Independence Blue Cross' Keystone Health Plan East (KHPE) in Pennsylvania, initiated a special program to ensure that patients' underlying health problems are detected early. KHPE doctors know that inappropriate use of prescription drugs can cause adverse reactions, hospitalization and even death, while adding $20 billion annually to the nation's health care tab. A recent Harvard Medical School study found that physicians prescribe inappropriate or potentially dangerous drugs to one quarter of all elderly patients. To prevent medication problems, KHPE launched a prescription drug "brown bag" program. Along with the membership packet, the HMO sends each new member a brown bag to fill with their prescriptions and take to their first doctor visit.

"We know that elderly people have been prescribed a large number of prescriptions from different doctors, and sometimes these drugs conflict with each other," says Gary Owens, MD, senior medical director at KHPE. "We estimate that about 10 percent of our patients have a potentially disastrous problem of drug interaction or over-medication. Of those who bring in their bags as instructed, about a third have medications that can be eliminated. So the program saves the patients from

"The major focus of managed care is on addressing the patient's total health care needs–which is especially challenging in the senior population."

experiencing complications while saving money that would otherwise be spent on treating those complications."

In addition to preventing drug interaction problems, KeyCare 65 has created a special program to treat patients with congestive heart failure (CHF). First, the health plan identifies CHF patients by examining records from emergency department visits, physician referrals, hospital admissions and other sources. Next, a case manager contacts the identified patients for permission to enroll them in the program. KHPE's home care agency then sends a nurse to each patient's home to conduct a



Anthem Blue Cross and Blue Shield works hard to ensure that its senior members understand how Medicare risk HMOs work. This enrollment kit and handbook is just one source of information for seniors making health care coverage decisions.

physical and mental health assessment; find out when the patient last visited a primary care doctor or cardiologist; record the patient's eating habits; and give the patient a scale and record book to track his or her weight daily.

The nurse then calls the patient once a week for daily weights. If the patient's weight is increasing, the nurse knows that the patient is probably retaining fluids—which might require an emergency department visit and hospital stay if left untreated. Instead, the nurse contacts a doctor for further instructions. This contact may lead to a doctor visit, or a home visit to provide intravenous medicine. This approach heads off a potential emergency while allowing the patient to rest comfortably at home.

"We have found a statistically significant improvement in quality of life as a result of this program," Owens says. "In addition, we've observed a decrease in emergency department visits and hospital admissions. We're so pleased with the results that we've expanded this program beyond KeyCare 65 to all of our HMO members. We also offer a similar program for asthma care, and we're developing one for diabetes."

"Medicare managed care gives seniors the assurance that we are watching out for them."

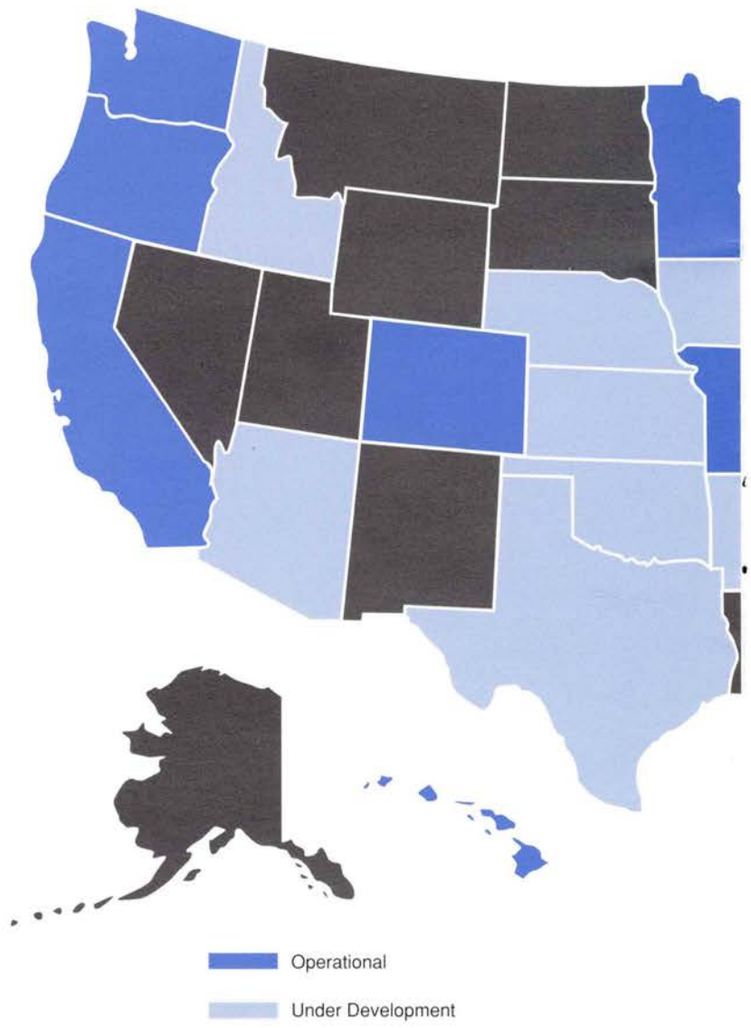
"Medicare managed care gives seniors the assurance that we are watching out for them," Owens concludes. "It gives them the security they often lack in the traditional program."

Blue Cross and Blue Shield Medicare managed care plans also provide seniors with economic security as the traditional program becomes increasingly unaffordable. Since traditional Medicare imposes high cost sharing requirements—and because it covers neither prescription drugs nor long-term care—it finances only 45 percent of all health care spending on the elderly, according to the Kaiser Family Foundation. Beneficiaries pay directly for 49 percent of their costs, or purchase supplemental policies to cover them. The remaining 6 percent of expenditures are derived from other public sources.

Managed care changes the equation by offering seniors a range of health plan options to suit their individual needs. Blue Cross and Blue Shield of Florida (BCBSF), for instance, offers seniors access to an HMO and a Medicare Select PPO in addition to traditional Medicare supplement products.

"Managed care offers options to seniors who otherwise could not afford to keep private coverage," says Bill Simek, BCBSF director of individual product and market management. "Our results

BLUES' MEDICARE MANAGED CARE NETWORKS

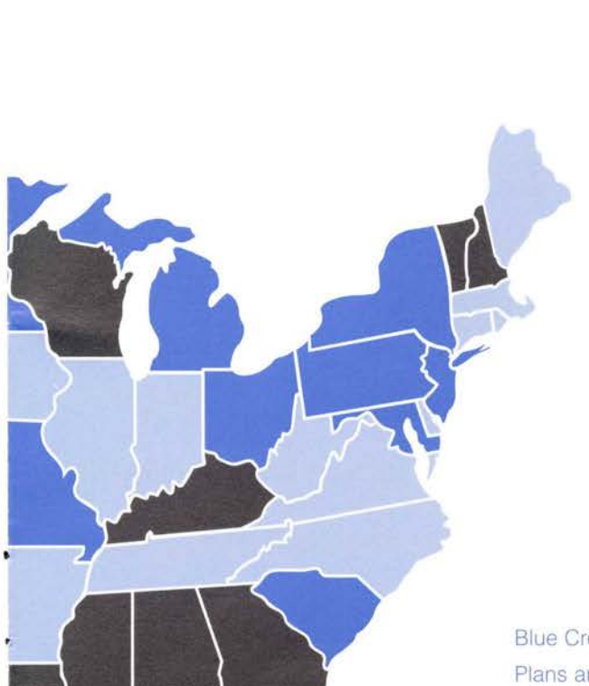


indicate that 40 percent of seniors purchase Medicare supplemental products when they turn 65. But over a five-to seven-year period, they realize that they are outliving their assets—their disposable income has decreased to the point that the supplemental insurance is no longer affordable. That's when Medicare HMOs, which impose no premiums or deductibles, become a favorable alternative product."

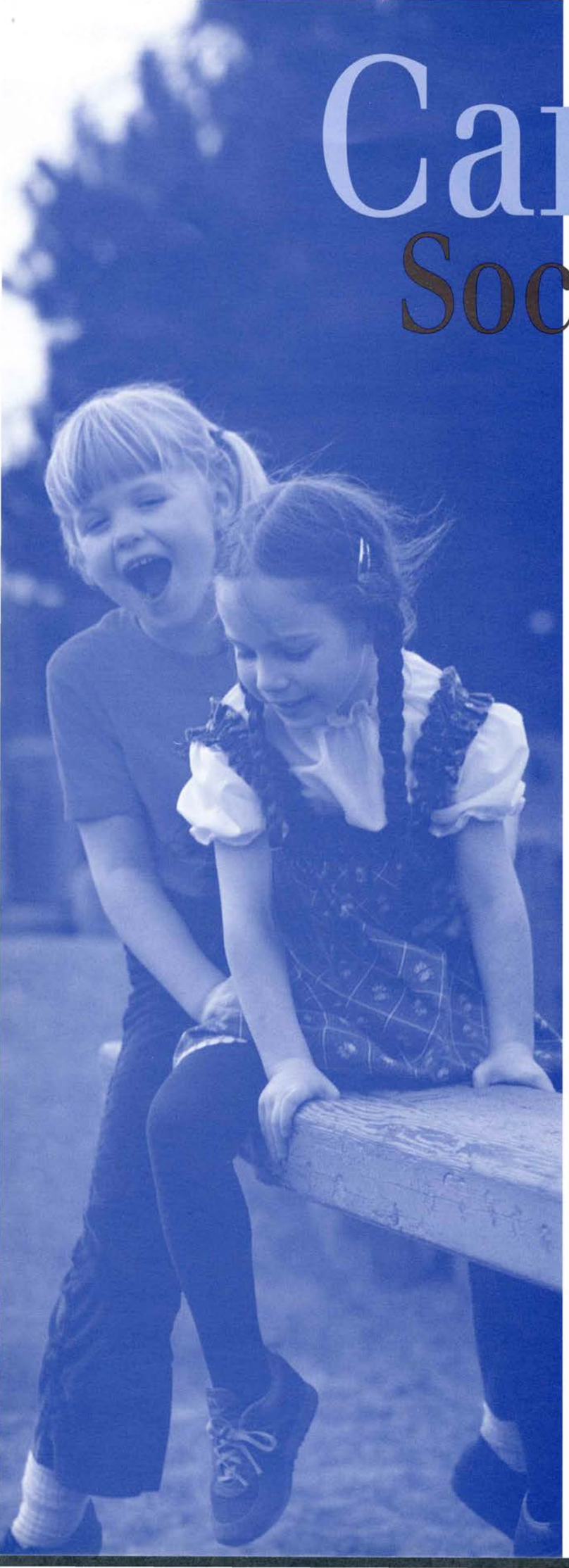
The advantages of HMOs over traditional Medicare—expanded benefits, reduced out-of-pocket costs, increased access to preventive services and better quality of care—will only become more apparent as enrollment in the plans increases. Medicare HMOs are becoming increasingly popular among large employers who offer retiree benefit plans. To meet this growing need, the Blue Cross and Blue Shield system will launch a national Medicare HMO network, Medicare Blue USA, in 1996.

By linking together independent Blue Cross and Blue Shield Plan-related contractors throughout the United States, Medicare Blue USA will offer seamless health care coverage for seniors who travel frequently or reside in more than one state. Research indicates that this portability feature is critical to the over-65 population. Seniors took 182.7 million trips of 100 miles or more in 1993, according to the U.S. Travel Data Center. In addition to these benefits for seniors, the network will reduce employers' administrative and paperwork burdens.

Blue Cross and Blue Shield managed care plans' efforts to improve the quality of care delivered to seniors while expanding their benefits and improving their access will continue to grow as lawmakers revise and improve the Medicare program. Blue Plans are eager to offer their expertise in care management to new senior members and retirees—and the number of Blue Plans serving Medicare patients is growing rapidly.



Blue Cross and Blue Shield Plans are actively involved in providing seniors with a variety of health care coverage options. Medicare Blue USA, a national network of Medicare risk HMOs, will offer unprecedented portable coverage for seniors in 1996.



Caring for Society's Most Vulnerable Populations

Medicaid, the combined federal-state health care program for poor, disabled and elderly citizens, represents another area of explosive managed care growth. Forty-three states and the District of Columbia have turned to managed care plans for help in providing Medicaid patients with expanded benefits while reducing their dependence on high-cost, hospital-based health care. Medicaid spending costs taxpayers $162 billion annually—a burden that, like Medicare, shows no signs of slowing unless managed care growth continues.

Nearly 7.8 million Medicaid beneficiaries were enrolled in managed care plans in July 1994, according to the most recent government data. Nearly 4 million of these patients were HMO members, with the remainder enrolled in PPOs and other managed care products. The Blue Cross and Blue Shield system of independent Plans is at the forefront of this trend, collectively enrolling nearly 1.1 million Medicaid patients in managed care plans in 19 states.

Medicaid patients typically present a host of challenges to health care providers. Because these patients have low incomes, they often suffer from poor nutrition, and they may not own automobiles or telephones. These social needs limit their access to immunizations, cancer screenings and other preventive services. Many Medicaid patients delay treatment until they are

seriously ill, and then turn to hospital emergency departments for care. Managed care plans change this episodic, fractured care process by providing patients access to their own personal doctors.

"Managed care offers many advantages for individuals who are low-income, because the features of managed care emphasize a holistic approach," says Vincent Pearson, MD, Medicaid medical director at Keystone Health Plan East of Pennsylvania. "Our coordinated teams allow us to send nurse specialists into people's homes and follow up on chronic illness. Keystone has several disease management programs targeted to address illnesses such as congestive heart failure, diabetes, HIV and asthma that simply wouldn't be possible in a fee-for-service environment."

"Fee-for-service Medicaid also has no way of attending to patients' social needs, such as translation and transportation," Pearson says. "Many Medicaid patients need to be reminded to come in for follow-up. Others need someone to watch their children while they attend doctors' appointments. At Keystone, we offer a whole range of programs to address these needs."

"State programs are not equipped to ensure access," adds Wendy Brown-Blau, vice president of KHPE's Medicaid programs. "Managed care plans conduct computer searches to match providers to patients so that our patients have geographic access. We also have systems in place to monitor attendance at our programs that state officials just can't offer."

These efforts are succeeding in making the health care system more approachable for thousands of disadvantaged Pennsylvanians. KHPE has helped improve Medicaid patients' access to preventive and primary care, as well as specialized treatment for serious illnesses. Perhaps most significantly, membership in a Blue Cross and Blue Shield Plan restores patients' dignity. Carrying a Blue Card removes the barriers of humiliation and embarrassment that often accompany government assistance—and these barriers alone may prevent Medicaid patients from seeking care.

Anne Mockabee, manager of government programs at Blue Cross and Blue Shield of Oregon, agrees that managed care has improved access for a population who previously faced tremendous difficulty in obtaining health care services.

"Under the old fee-for-service system, people had their little health cards, and when they went out into the marketplace, many doctors wouldn't see them," she says. "And even when they could find a doctor, often the doctor did not have the time or the motivation to address the social issues in their lives. Managed care has changed all of that."

Blue Cross and Blue Shield of Oregon's HMO Oregon has accepted Medicaid patients since 1986. But the plan has grown quickly in the past two years under the state-run Oregon Health Plan (OHP).

OHP expands the state's Medicaid program to cover 120,000 previously uninsured persons living below or slightly above the federal poverty level. The program covers virtually all Medicaid services, including

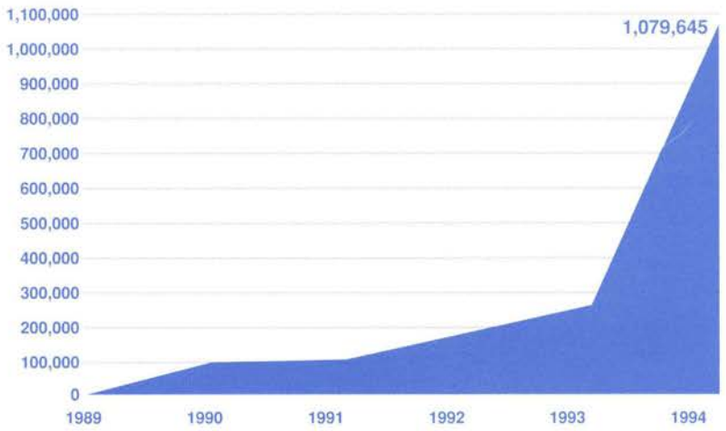
By providing Medicaid beneficiaries

preventive care and screenings. In addition, OHP offers disadvantaged Oregonians access to dental care, hospice care, prescription drugs and most transplants—none of which is covered under traditional Medicaid. OHP members must join one of 20 managed care plans. Two-thirds of OHP patients are members of HMO Oregon.

OHP gained nationwide attention in 1993, when its architects developed a "priority list" of health care conditions and treatments. The final list contained 696 conditions and treatments, and 565 of these are now covered benefits. Although the list was controversial outside Oregon, there is widespread consensus in

Blue Plans' Medicaid HMOs Enrollment

By offering expanded benefits and personalized care, Blue Cross and Blue Shield Plans are helping state lawmakers reform their Medicaid programs. Nearly 1.1 million Medicaid beneficiaries have joined Blue Plans' HMOs.



Source: BCBSA:HCFA Medicaid Enrolllment Report, June 1994

the state that OHP is a success, according to a recent program evaluation conducted by the Kaiser Family Foundation. Oregonians agree that the program has performed a valuable public service by reaching out to previously uninsured patients.

"OHP has provided needed health care services for thousands of people—mostly women and children—who previously had no health care coverage at all," Mockabee says. "Moreover, the program allows health plans like HMO Oregon to reach the hinterlands of our state. One of our nurses actually went out into the middle of the woods to find a patient's house. When she realized how difficult it was to find the house, she spray-painted a rock in the road so emergency people would know where to turn."

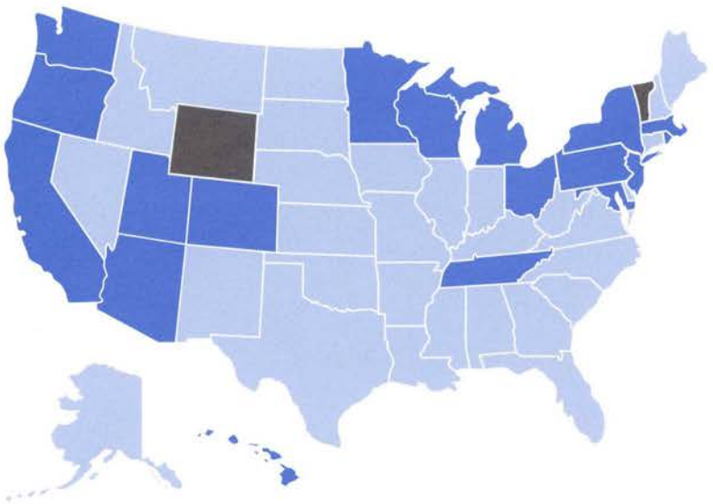
"The Medicaid population is an extremely gratifying one to serve," she continues. "All the little kids who otherwise would have no health care resources are now getting their health care needs met for the first time in their lives."

Blue Cross and Blue Shield of Tennessee (BCBST) is achieving similar success in improving access to health care through the state's expanded Medicaid program, known as TennCare. Through TennCare, the state contracts with five PPOs and seven HMOs to cover inpatient and outpatient hospital care, physician services, prescription drugs, lab and x-ray services, medical supplies, home health care, hospice care and ambulance transportation. Although TennCare was quite controversial initially, a recent University of Tennessee survey found that the state's uninsured rate has dropped nearly in half. TennCare now provides health care services for more than 320,000 previously uninsured patients. Nearly 200,000 of these are BCBST members.

access to their to their own personal doctors, McIntyre says Healthy Options

Jane Werly, BCBST advertising manager, says TennCare has allowed Medicaid patients access to specialized individual treatment that they could not have received under the fee-for-service program. For example, BCBST recently cared for a pregnant woman with placenta previa, a potentially dangerous condition causing pre-term labor and bleeding. The patient lived 75 miles from the nearest hospital equipped to treat her condition. BCBST's case management staff arranged for the patient to stay in the hotel adjacent to the hospital until delivery. Staying next door to the hospital allowed the patient easy

Blue Plans' Medicaid Managed Care Networks



Blue Cross and Blue Shield Plans are at the forefront of Medicaid managed care, offering beneficiaries a range of high-quality health plan choices.

States with BCBS Medicaid HMOs

States with Non-BCBS Medicaid Managed Care Products

No Activity

Source: HCFA Office of Managed Care, Medicaid Managed Care Enrollment Report, June 30,1995

access to her doctors and the hospital staff without having to be admitted or travel. Thanks to this specialized treatment, the baby was born healthy at 36 weeks and required no additional care.

Like the Blue Cross and Blue Shield Plans in Oregon, Pennsylvania and Tennessee, Medical Service Corp. of Eastern Washington (MSC), an independent licensee of the Blue Cross and Blue Shield Association, is helping state officials make their Medicaid managed care program a success. Launched in 1992, Washington State's Healthy Options program offers high-quality health care with an emphasis on prevention to 376,000 previously uninsured women and children with family incomes below 200 percent of the federal poverty level. Nine percent of these patients are members of MSC managed care plans.

"Before Healthy Options, it was very difficult for these patients to get appointments, because some physicians just didn't take Medicaid beneficiaries, and others just took a few," says Campbell McIntyre, MD, medical director of MSC's Healthy Options plan. "Now doctors are more willing to work with Medicaid patients, and we have eight member advocates who track patient comments and make sure their concerns are addressed."

Under the old fee-for-service structure, Medicaid patients visited hospital emergency departments about four times more often than privately insured patients. By providing Medicaid beneficiaries access to their own personal doctors, McIntyre says Healthy Options has decreased emergency department visits—and costs—by 50 percent.

"This is money that is much better spent on preventive care services, like prenatal visits and immunizations," he says.

has decreased emergency department visits–and costs–by 50 percent.

Blue Cross and Blue Shield Plans throughout the nation are playing a key role in helping Medicare and Medicaid transform themselves from the last bastions of old-style fee-for-service medicine to the future of managed care. By expanding benefits, reaching out to underserved populations, promoting the doctor-patient relationship and emphasizing prevention, Blue Plans are improving the quality of care delivered to society's neediest patients while reducing cost burdens on taxpayers. In pushing for growth in managed care, federal and state officials can replicate the successful innovations that Blue Cross and Blue Shield managed care plans have already achieved in the private market.

Responding *to* Rural America's needs

The conventional wisdom about managed care suggests that HMOs and other health networks cannot work in rural America. Some health care analysts believe that sparsely populated areas make spreading health care risk difficult; others fear that managed care systems would require rural patients to drive long distances to receive health care services. But Blue Plans are rising to the challenge of serving America's most remote regions.

Blue Cross and Blue Shield of Montana, for example, is debunking the myth that managed care works only in densely populated urban areas. The Plan launched HMO Montana in March 1987 with 15 primary care physicians and about 200 patients. Today, HMO Montana is the state's only statewide managed care plan, with more than 250 physicians and 21,000 members.

Although many Montana towns have only one or two doctors—and some have no doctors at all—HMO Montana is proving that managed care can be tailored to individual community needs. Charles Butler Jr., the Plan's vice president for government and public relations, says managed care has improved patients' access to care by focusing on the doctor-patient relationship.

"We believe that managed care works in rural communities because it returns them to the old days of the family doctor," he explains. "HMO Montana places a strong emphasis on prevention and primary care. We make sure that each patient has a relationship with a personal doctor who understands the health history of the entire family—just like the old-fashioned Marcus Welby type. We make sure that our patients can see a doctor if not in their own town, then only a few miles away."

"Convincing people that managed care will improve their access—not reduce it—has been one of our greatest challenges," Butler acknowledges. "When we first launched our HMO, some people feared that we'd expect them to drive into Billings or Helena for all their care. But we explained that managed care is just the opposite—HMOs encourage patients to visit the providers right there in their own communities. Those local doctors are the ones who know them—and in addition, it's less expensive to treat folks at home than to send them to big-city hospitals. Once our patients realized that we wouldn't drive them out of their homes, they found they actually prefer this system."

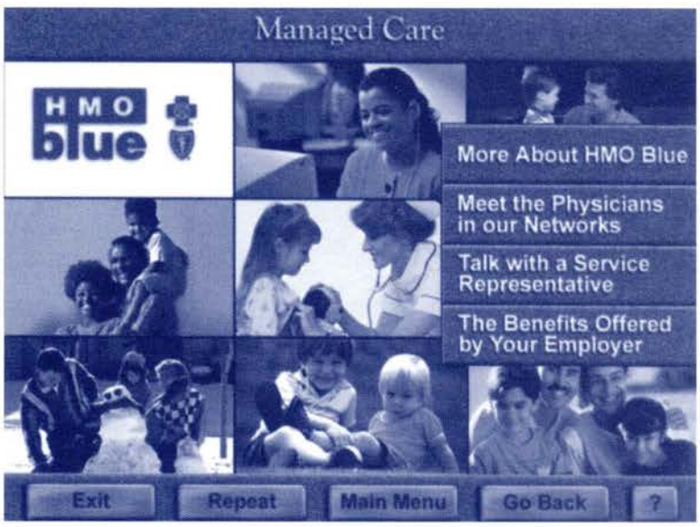
Butler's hard work in educating Montanans about the value of managed care is paying off. Although membership in HMO Montana grew slowly during the plan's first five years, enrollment figures are now doubling from one quarter to the next. Moreover, Blue Cross and Blue Shield of Montana is exploring new managed care arrangements in previously underserved parts of the state. The Plan recently launched a new joint venture to create a community-based integrated delivery system with the Great Falls Clinic, one of the state's largest multispecialty group practices.

These innovations demonstrate the Blue Cross and Blue Shield commitment to serving rural America.

Breaking New Ground

Blue Cross and Blue Shield Plans' managed care programs are leaders not only in the quality of care, but also in affordability and accessibility. In order to provide health care services in the most efficient way possible, Blue Plans seek out new technologies that make it easier for patients to schedule appointments, change doctors, pay bills and access the health care system.

For the past several years, Blue Cross and Blue Shield of Massachusetts (BCBSMA) has been developing a health care information system to meet the needs of its providers, employer accounts and nearly 2 million members.

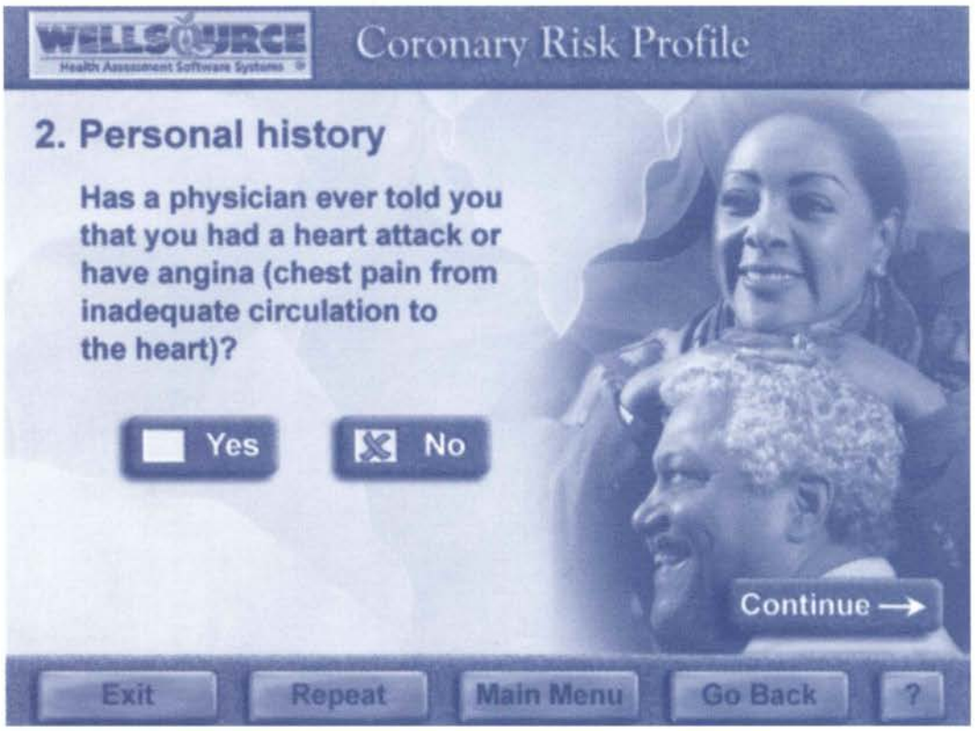


Blue Cross and Blue Shield of Massachusetts is on the cutting edge of health care information technology. The Plan's Health Navigator kiosk provides Plan members and the public with details about the company's health care coverage options.

In 1992, the company began to look for technology solutions that would eliminate costly errors in claims and billing. One year later, BCBSMA launched HealthWire, a computerized "all-payer" claim system for providers. HealthWire allows physicians and hospitals to send claims and perform managed care transactions electronically from their offices to more than 125 insurers. Doctors pay $50 per month for access to the system, and reimbursements take about 18 days—roughly half the previous processing time. More than 6,000 doctors currently use HealthWire to submit claims, make specialist referrals, and check enrollment status, eligibility and benefit levels.

"The instant on-line access to patient coverage information has resulted in less paperwork, fewer claims errors and fewer rejected or pending claims," says Russ Ricci, MD, president of BCBSMA's New Health Ventures Division. "More than 80 percent of eligibility and referral inquiries are now handled on-line. About three-quarters of referral authorizations are automated, and nearly 80 percent of claims are processed electronically. These innovations mean patients and doctors' offices spend less time on the telephone, or running from one doctor's office to another."

The Health Navigator kiosk helps patients assess their health risks and make healthier lifestyle choices.



In addition to the computer links between doctors and the health plan, more than 600 employers representing more than 1 million members have direct interactive links with BCBSMA through AccountLink. This program gives companies on-line, real-time data entry and processing capabilities, which result in more accurate billing and faster payment. Members receive their identification cards within three to five days, and they can join the plan, update their enrollment data or change primary care doctors instantly.

"This increased efficiency actually results in lower administrative costs at BCBSMA, which frees up more dollars to spend on member services," Ricci says.

Ricci says HealthWire saves BCBSMA about 50 cents per claim over the old-fashioned paper process, and about $1 each for eligibility and referral questions formerly handled by telephone. AccountLink saves the company about $3 for each enrollment transaction and customer service call.

In recent months, BCBSMA launched two new consumer-friendly ways for patients to interact with the health plan: a "health care ATM" computer kiosk and a Home Page on the World Wide Web.

The Health Navigator kiosk works like an ATM. Using their membership cards, patients can search for a doctor by location, specialty and network participation. The kiosk screen displays information about the selected physician and his or her practice. Members can also use the kiosk to change their primary care doctors or receive a print-out of their member profiles. The kiosk also includes a health library.

BCBSMA has also launched a Home Page on the World Wide Web. At the address "http://www.bcbsma.com," patients can obtain a wealth of information on health and wellness issues, as well as information about BCBSMA for both consumers and employers.

Ricci says these interactive advances mark just the beginning of BCBSMA's commitment to using technology to improve patient care. In spring 1994, the company created its New Health Ventures unit, charged with assessing and piloting new technologies.

"Beginning next year, we will introduce new computerized health assessments to assist physicians with patient interviews and provide information on topics that patients frequently find difficult to talk about, such as depression, marital problems and sexual history," he says.

Providing physicians with new tools to help them deliver the highest quality care is a priority throughout the Blue Cross and Blue Shield system of independent Plans.

In rural Pennsylvania, Pennsylvania Blue Shield is teaming with Hershey Medical Center to bring high-technology specialty care to some of the health plan's most remote areas. Under a six-month pilot project, community radiologists in two rural facilities send digitized radiology images to the medical center for consultation and evaluation. This process, called teleradiology, allows doctors in one location to examine patients in another location, using telephone, television and cable connections.

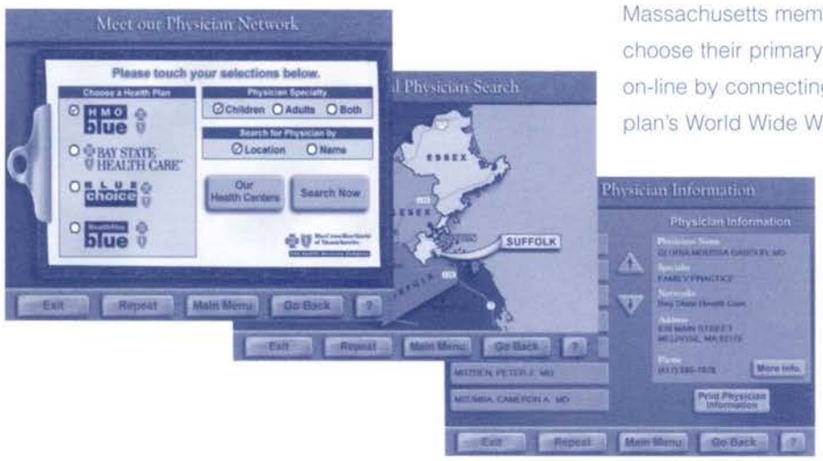
The pilot project uses the Pennsylvania Rural Health Telecommunications Network to send magnetic resonance images (MRIs), CT scans and nuclear medicine images over a fiber-optic communications network. Images sent by a primary care doctor in a rural clinic can be reviewed instantly by a specialist at Hershey. This process saves time in making a diagnosis, and saves the patient from having to drive into the city for an appointment with the specialist.

"Our long-term focus is on determining the value of teleradiology to rural health delivery in Pennsylvania," says Donna Wenger, assistant director of the Pennsylvania Blue Shield Institute, the health policy division of Pennsylvania Blue Shield. "We will address three key questions. First, does subspecialty consultation save money by reducing the need to transfer patients from one facility to another and by limiting the number of follow-up studies? Second, does subspecialty consultation improve the diagnosis pattern at rural sites? Finally, does teleradiology reduce the turn-around time for consultation?"

"We hope to find that teleradiology does in fact enhance patient care," Wenger continues. "In addition, we want to measure whether teleradiology saves enough money to justify the initial cost of investing in the systems."

Although Wenger and her colleagues are just beginning to collect data on the project, they are already seeing anecdotal evidence of its success.

"We're only beginning to examine the outcomes of teleradiology care, but we've already realized that teleradiology can produce quality improvements in the technical process of care," she says. "The teleradiology pilot has improved rural radiologists' seeking consultation. [In the past,] radiologists would perform an exam, put the film in a Federal Express package, and someone would read it the next morning. Now, radiologists are trained to read exams off glass, in real time—from a computer screen, for instance. Rural radiologists get immediate feedback on technique from their peers at the medical center. So we're seeing improvements in how the rural radiologists approach their work."



Blue Cross and Blue Shield of Massachusetts members can choose their primary care doctors on-line by connecting to the health plan's World Wide Web site.

As these examples illustrate, Blue Cross and Blue Shield Plans' managed care programs' investments in technology improve both the quality of care delivered to patients and the plans' customer service functions. The Blue Cross and Blue Shield system is committed to investing in appropriate technologies to lead the health care industry into the 21st century.

Partnering *with* Employers

Blue Cross and Blue Shield Plans' managed care programs actively seek out partners to join them in efforts to promote patients' well-being. For example, employers are increasingly active in promoting healthy lifestyles among their workers, in order to reduce absenteeism and boost productivity. Blue Cross and Blue Shield Plans are teaming up with employer benefit managers to study health care outcomes, promote continuous quality improvement, and bring health education into the workplace. Managed care settings are ideal for studying outcomes, because they offer defined patient populations whose health can be tracked over extended periods of time. Moreover, managed care plans' provider teams are uniquely prepared to implement "disease management" techniques—shifting the focus of care from treating acute episodes to managing chronic conditions on a day-to-day basis.

Alliance Blue Cross Blue Shield (ABCBS), the managed care subsidiary of Blue Cross and Blue Shield of Missouri, is one of 16 managed care companies nationwide—including five other Blue Plans—participating in a joint health plan-employer effort to improve health care outcomes. The project is sponsored by the Managed Health Care Association, an organization representing employers who provide managed care plans for their workers.

The project's first phase targets asthma—a significant source of disability in the working population. During the study's first two years, employers and health plans gathered baseline data to use for future comparisons. Health plans also developed interventions to improve the quality of care delivered to asthmatic patients. The consortium is now measuring the effectiveness of these interventions.

"Our intervention was targeted to both patients and physicians, because both parties play equally important roles in controlling asthma symptoms," says Mary Kay Jones, manager of outcomes and practice guidelines at ABCBS. "One of our vendors, Mosby Publishing, donated an asthma 'management kit' for patients, which consists of a self-care book and video. The drug manufacturer Glaxo donated peak flow meters for distribution to patients. And we hosted classes at our education centers on how to use the peak flow meter properly and how to record asthma symptoms in a diary."

In addition to these patient education efforts, ABCBS sponsored a problem-based learning program for its physicians, funded by an educational grant from Fisons Pharmaceuticals. The health plan also assigned a case manager to a randomly selected group of study participants with moderate or severe asthma, so that the sickest patients would have telephone access to a nurse adviser.

Jones says ABCBS's partnership with employers in the Managed Health Care Association has helped the plan develop innovative approaches to caring for the chronically ill.

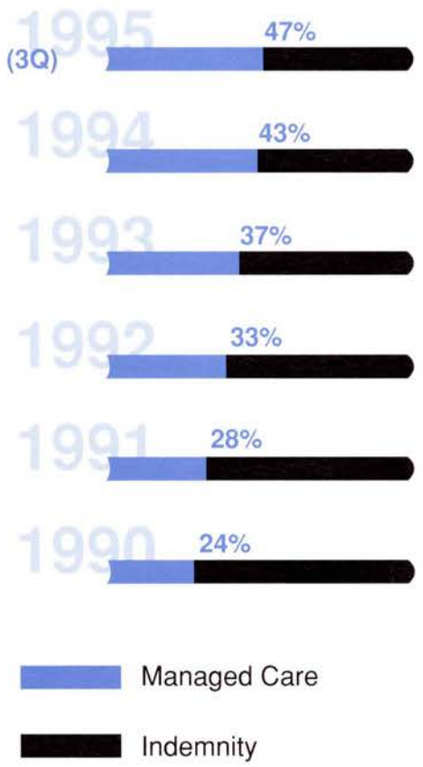
"Any patient who is not fully informed about his or her condition—or is not taught how to take care of it—can end up very sick," she says. "We support patients' care and provide them with varying degrees of education about their conditions. We know that an informed patient is a healthy patient."

ABCBS is not the only Blue Cross and Blue Shield Plan that has teamed up with its employer accounts to promote patients' health. Blue Cross and Blue Shield of Western New York's Community Blue, for example, is a leader in bringing health education programs to the worksite. In fact, the plan recently won a national award from the Association for Worksite Health Promotion for its Alive & Lively health education program.

"Our Alive & Lively worksite program is unique because it is specially tailored to the needs of each employer," says Phil Smeltzer, Community Blue's manager of health promotion. "The course consists of eight to 10 hours of core curriculum in stress reduction, ergonomics and physical fitness. Then we provide additional coursework dedicated to the specific needs of the group."

Smeltzer's staff interviews both managers and rank-and-file employees to find out which health topics the group is most interested in studying. Next, the health promotion professionals examine claims data from the employer account to identify trends in the workers' health experience. Finally, the staff conducts a thorough risk appraisal for the group and chooses appropriate course content.

MANAGED CARE AS A PERCENT OF TOTAL MEMBERSHIP IN THE BCBS SYSTEM



"We recently assessed a group of employees mostly under age 30, and in analyzing their lifestyle habits, we found that a lot of them were at risk for complications from overuse of alcohol," Smeltzer recalls. "We were particularly alarmed to note that a high percentage of them admitted to driving while under the influence of alcohol, or riding with someone who did. In addition, quite a few of these people admitted to driving 10 or more miles over the speed limit and not always wearing their seat belts."

"Next, we asked the managers about trends in absenteeism," he continues. "Not surprisingly, the most commonly missed work day was Monday—especially the Monday after an important Buffalo Bills game. All of this information told us that this employer group could benefit from education about the health effects of alcohol consumption, the risks associated with drunk driving and the importance of safe driving."

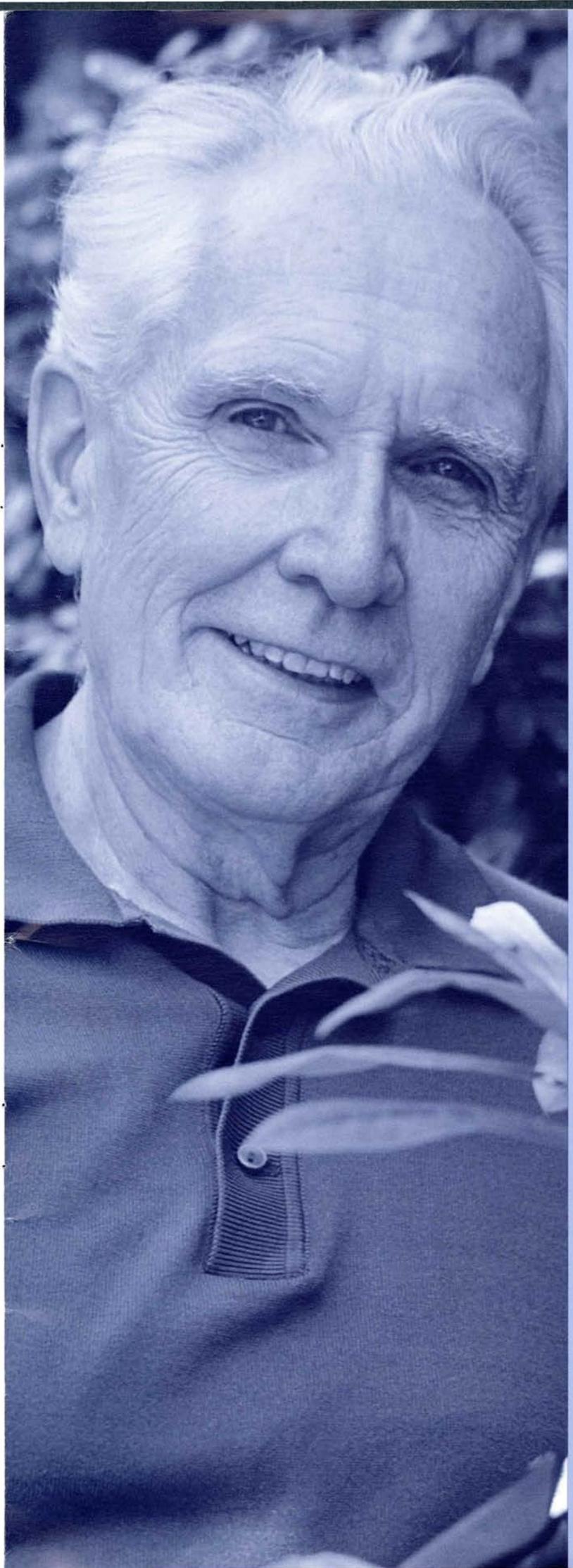
"This kind of risk appraisal is critical to making sure that your patients actually benefit from your advice," Smeltzer continues. "The employees involved in the program were mostly in their twenties, and they just didn't care about cholesterol and high blood pressure yet. They probably would have tuned out a lot of traditional health advice. But I think our classes helped them think twice about some of their choices."

In addition to its worksite programs, Community Blue offers patients more than 300 free wellness and health promotion courses through 75 providers located in the plan's service area. Under the plan's Alive & Lively program, patients can self-refer to any of these courses simply by selecting them from a catalog. Topics range from nutrition to prenatal care to exercise to smoking cessation.

One of the most successful Alive & Lively programs is StayWell, a broad-based program to help seniors practice better nutrition, get more exercise and improve the quality of their lives. The program includes both classes and support groups, and is operated by a local hospital through its wellness center.

"We are just thrilled with the success of this program," Smeltzer says. "More than 200 people participated in an early StayWell session. Thirty-six percent of them said their health improved because of the class, and more than 92 percent of them said their quality of life improved. They also experienced a decrease in their dependence on medications. Before the class, these seniors were on average of more than three prescription drugs. Now they're on an average of just two."

Whether at home, in the doctor's office or at worksite, Blue Cross and Blue Shield Plan-sponsored health education courses share the common goal of empowering patients to play more active roles in their own health care. Blue Plans create teams of doctors, nurses, pharmacists and other health professionals to work together in promoting patient welfare—but they understand that patients are the most important team players of all.



Putting It All Together

These examples of managed care at work illustrate just a few of the Blues' innovative solutions for Americans seeking high-quality, affordable health care. By coordinating health care services, emphasizing prevention and providing each patient access to a personal doctor, managed care improves both the process and the quality of health care delivered to more than 100 million Americans. Managed care plans are also helping to alleviate the problems of access and affordability facing the Medicare and Medicaid programs. And managed care is at the forefront of research that will improve health care outcomes for even the most serious diseases.

The managed care programs described in this book represent only a fraction of the exciting initiatives taking place every day in the Blue Cross and Blue Shield system of independent Plans. As the nation's leaders in managed care, Blue Plans are pioneering new programs to address our nation's emerging health care needs.

For more than 60 years, the independent Blue Cross and Blue Shield Plans have cared for America's families from maternity through maturity. Blue Plans are committed to continuing this tradition of excellence while developing new managed care solutions for the ever-changing health care marketplace.

BlueCross BlueShield
Association

An Association of Independent
Blue Cross and Blue Shield Plans