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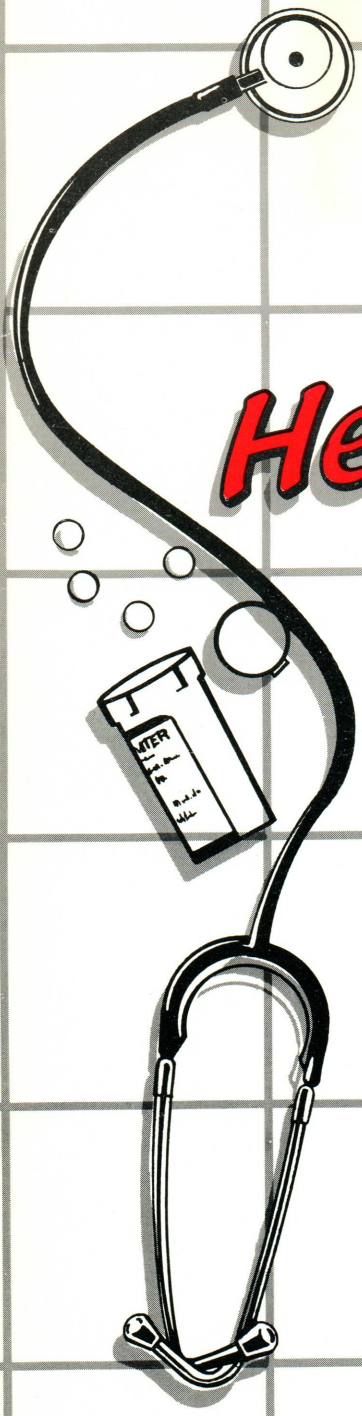
Holding down health care costs : a guide for the financial executive;

John D. Reynolds



Holding Down Health Care Costs

A Guide for the Financial Executive

John Reynolds

AICPA
American Institute of Certified Public Accountants

Notice to Readers

Holding Down Health Care Costs: A Guide for the Financial Executive is designed for reference and educational purposes only. The views expressed do not represent an official position of the American Institute of Certified Public Accountants.

Readers are also advised to be aware of the dynamic nature of the health care environment, including federal, state, and local legislation that can have a significant impact on employer health care benefits.

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Foreword

Holding Down Health Care Costs: A Guide for the Financial Executive is the first of a series of educational and reference books designed to assist CPAs employed in business and industry in carrying out their responsibilities to their employers.

The Members in Industry Executive Committee, in publishing this book, recognizes the important role that CPA financial executives play in the selection, implementation, and administration of employee health care plans. Additionally, readers will find descriptions of strategies that employers have undertaken in an attempt to reduce their share of the employee health care burden. Readers engaged in either or both of these roles will find a wealth of information about the root causes of spiraling health care costs.

This book is published with the understanding that no one strategy for health care cost containment can work for all employers. Also, legislative efforts to address the overall health care problem may render some of the techniques presented herein obsolete. Through updates of this text and other communications with CPA financial executives, we will attempt to keep you up-to-date on changes. We do feel, however, that this book provides an excellent overview of the problems faced by companies in their efforts to provide quality, cost-effective health care benefits to their employees.

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Introduction

Health is a blessing money cannot buy.
—Izaak Walton

Walton may have been right. Health may not be for sale, but that fact has not discouraged some furious bidding. Nowhere have dollars chased after health more relentlessly than in the United States. Americans now spend almost twelve cents out of every dollar produced in this country on health care, and if present trends continue, the share is fated to go much higher.

Much of the cost is shouldered by business. Worker health has very much to do with corporate health these days. No longer is the issue of health care and its attendant costs a trivial afterthought, best left to a subdepartment of the corporate personnel department. It is now a major source of consternation in corporate boardrooms. The cost of health care may be reducing the level of corporate profits by as much as 25 percent, rapidly outstripping companies' ability to pay.

Benefits managers continue to experiment with ways to bring these costs under control. Their efforts often bring them into conflict with one or the other principals in the health care arena, such as—

- Federal and state governments committed to expanding the range and availability of health care services without assuming additional financial obligations.
- Employees and their families who expect employers to provide comprehensive coverage without demanding any greater contribution from them for the cost of their own care.
- Health care providers who are striving to maintain their levels of income and profits in the face of mounting market pressures.

Each of these groups jockeys for position so as to minimize its own burden by passing costs along to the others.

If business alone is unable to control costs, what is the next step? Can we as a nation afford to keep the health system we have? Support

from business is slowly evolving for some kind of governmental solution to the health care cost problem, even for one involving radical surgery that would replace our current system altogether. This may be the result of creeping suspicions that the capability to manage health care costs is not in employers' hands at all.

In the meantime, corporate managers must cope as best they can. Their preoccupation with surging costs has given birth to a new industry: cost containment. Employers must contend with health maintenance organizations (HMOs), preferred provider organizations (PPOs), as well as consulting firms and third-party administrators (TPAs) who specialize in containment science areas like case management, utilization review, health care audits, and the like. Changes in company health care arrangements have become almost annual events in the struggle to keep costs from escalating further. How well do these stratagems work? While few companies can give precise answers to that question, the general impression is, not well enough.

Out-of-control costs have kept some companies out of health care entirely. The National Federation of Independent Businesses found in a recent poll that a third of responding companies do not provide health insurance coverage at all, and that 65 percent of those who do not indicated the reason was that costs were too high.

Between keeping its current program as it is and doing away with health care benefits entirely lies a range of options for the employer to consider. This booklet is intended to—

1. Provide financial executives with an understanding of the various pieces of the health care puzzle.
2. Aid in evaluating the relative merits of various health care cost-containment options. An important theme is that there are many factors which contribute to the health care cost problem, only some of which can be addressed, with greater or lesser effect, by employer cost-containment efforts.

A NOTE ON STATISTICS

Surveys play an important role in evaluating health care programs. Survey statistics can help an employer determine how the company's plans are performing relative to those of other companies. They are also useful in deciding what changes in the existing arrangement hold out the most promise. For this reason, this booklet cites numerous survey reports on the effectiveness of various

programs. Many of these are only slightly favorable or are wholly negative.

Readers should be careful in applying survey results to their own businesses, however, because—

- Much of the consulting firm data emanate from large companies. What is true for a big company is not necessarily true for a small one. There are also wide variations among industries and geographical regions. Finally, results are specific to the provider of the service and the implementing employer. Averages are just that: numbers that balance extremes, falling somewhere in the middle of a collection of some stunning successes, a few dismal failures, and many mediocre performances.
- Many of the programs evaluated are quite new, and it is too soon to draw firm conclusions.
- The environment of the 1980s, when these studies were done, was quite volatile, full of legislative switchbacks, financial shakeouts, and new trends in employee-employer relationships. If the 1990s prove to be either a quieter or a more dynamic time, survey results for identical programs might prove correspondingly more or less favorable.

Finally, there is the matter of interpretation. In some cases, studies seem to draw contradictory conclusions. This is especially true where a hard-number survey (which tabulates actual cost or utilization data) is juxtaposed with an opinion poll (which records respondents' empirically untested impressions of what transpired). The first might tell us that the program made a difference, the second that its sponsors were disappointed anyway and felt that it wasn't worth the effort.

All of this is to say: There is no substitute for gathering your own facts and drawing your own conclusions.

1 The Health Care Cost Problem: How Bad Is It?

The statistics tell the story: According to the U.S. Department of Commerce, national health care outlays were around $599.2 billion ($2,414 per capita). That was approximately 11.5 percent of gross national product, up from 10.1 percent in 1988. Estimates are that health care will consume 12 percent of GNP in 1990, toting up to over $600 billion.

In 1989, the U.S. GNP grew 7.2 percent, while nongovernmental health care spending grew 13.7 percent. Growth in health care spending has outstripped GNP growth in five of the past six years, with an average rate of increase of around 12 percent—a rate that doubles costs approximately every six years. Hospital care costs rose 9.1 percent to $230.1 billion; the costs of physician services rose 13.0 percent to $119.4 billion; and the costs of nursing-home care rose 11.2 percent to $48.8 billion.

These aggregates are partly the result of greater utilization, and partly the result of higher costs for all types of medical services. According to the Health Insurance Association of America, a normal pregnancy cost an average of $4,334 in 1989, up more than 25 percent in three years; with Caesarean sections (which made up 25 percent of deliveries in 1989) included, the average cost was $7,186. The National Association for Hospital Development reports that an overnight hospital stay, which now costs $580, will cost $1,380 in the year 2000.

Neither greater utilization nor higher prices are necessarily bad in and of themselves. Some of the growth in utilization could be the result of genuine needs for additional medical services, while higher prices may be attributable to improvements in quality. Still, higher costs pose problems for business when they are passed along in the form of greater employee benefit plan expenses. A survey conducted

by A. Foster Higgins, Inc., a major employee benefits consulting company, of 1,943 public and private employers with 12.5 million workers showed employer medical costs to be up 20.4 percent in 1989. Average indemnity plan cost was $2,600 per employee, compared to $2,160 in 1988. Adding health maintenance organizations and dental coverage raised the cost to $2,748 from $2,354.

2 | The Health Care Environment

Traditionally, most employer-provided health care has been provided through commercial insurance plans. For an annual premium, insurers assumed financial risk, paid claims, and generally handled whatever was needed in the way of administration, answering questions, and communicating with employees. Coverage was based upon *usual, customary, and reasonable* (UCR) charges, with the insurer reimbursing either the health care provider or the employee for the cost of covered care provided by physicians, hospitals, or both (less any deductible or copayment). These arrangements are known as fee-for-service or indemnity plans.

While most companies still offer some sort of indemnity plan, employers no longer rely on insurance companies to provide full service. Instead, these services have been unbundled, that is, divided among a number of organizations, including the employer itself. For instance—

- If the employer's experience with health care utilization has been good (that is, its workers get sick less often and use less professional care when they are ill), it may prefer to assume more of the financial risk itself, through a self-insured arrangement. Stop-loss coverage from an insurer can be included to protect against unexpected catastrophic claims.
- Claims processing may be turned over to a third-party administrator. The TPA can also be reponsible for compiling statistics that allow the employer to evaluate its experience in comparison to that of other companies.
- Instead of permitting the employee to choose his or her own physician or hospital, the employer may contract with a health maintenance organization (HMO), or preferred provider organization (PPO), to provide services for prenegotiated fees.

- The employer may hire a company primary-care physician.
- The employer may purchase packaged services directly from a hospital or clinic.
- Finally, the employer may hire outside consultants, auditors, and cost-containment firms to oversee the operation in an effort to insure that every available economy is realized.

3 | The Reasons for Rising Health Care Costs

There is no single reason for the rise in health care costs. If there were, it would have been identified and addressed by now, and health care cost-containment would be a subject of little interest. Instead, there are many factors contributing to the upward trend of health care costs. A study released in November 1988 by Hewitt Associates, a major employee benefits consulting firm, ranked some of them according to their contribution to overall cost increases, as follows:

- Medical inflation (32.8 percent)
- Cost shifting (29.5 percent)
- Utilization (16.3 percent)
- Technology (11.2 percent)
- Catastrophic cases (8.8 percent)
- Malpractice (1.4 percent)

A cursory review of these broad categories would suggest that a significant part of the problem is beyond employer control. Reports of employer disappointment with the results of cost-containment efforts so far support the perception that companies may not be able to influence the course of health care costs very much. Still, a closer look shows that some components of these categories may offer opportunities for savings.

Medical Inflation

Inflation generally refers to an increase in price for a given product or service that is not justified by any improvement in its quality.

While pure inflation is often hard to distinguish from qualitative price escalation, we treat it here as a distinct category, largely fueled by—

- Growing demand (the result of demographic and cultural shifts).
- Provider cost structures.

Growing Demand

As is the case with any other commodity, health care services are subject to the forces of supply and demand. If the demand for services increases faster than the supply, the effect is often higher prices.

The demand for health care services has been affected by factors such as the following.

Increasing Expectations. Americans have come to expect every effort to be made to effect a cure. A 1989 Louis Harris poll commissioned by the New York Business Group on Health found that 91 percent of Americans agreed that "everybody should have the right to the best possible health care—as good as the treatment a millionaire gets." They also felt that insurers should pay, even if the cost of an individual's care exceeded $1 million.

Expanded Coverage. Public and private health plans have assumed responsibility for more and more of covered participants' needs. Starting with major medical programs intended to protect the employee from the ruinous costs of hospitalization and surgery, many employers expanded the scope of coverage to take in more mundane things like routine visits to the doctor, dental care, vision benefits, mental health, and other services that might have been regarded as frills and luxuries a decade or so ago.

An Aging Population. Ironically, success in fighting life-threatening diseases may be part of the problem. As people live longer, the number of older people grows, and older people are greater users of health care services than younger ones. The over sixty-five population, which accounted for roughly 10 percent of the U.S. population in 1975, currently accounts for some 12 percent; by 2030 it will be 21 percent, and 13 million of them will be over the age of eighty-five. Demands for expanded medical and nursing services for the aged culminated in the Medicare Catastrophic Coverage Act, which was repealed in 1989 because of its high cost. Scaled-down versions of this legislation have been proposed but have not been enacted as of this writing.

Troubled Youth. A burgeoning population of disturbed minors (who become disturbed adults) results from family instability: separation, divorce, remarriage, frequent relocation, and absent parents when both work. (The growth in this factor can be attributed partly to some redefinition. For example, the withdrawal and resentment common among teenagers, which used to be described as a phase, are now more likely to be seen as a disorder. At the same time, however, there has been an increase in drug dependency among minors with worse-than-average adjustment problems, as well as greater incidence of teenage-concentrated ailments such as bulemia and anorexia.)

ADOLESCENTS AND MENTAL HEALTH

The number of Americans between the ages of ten and nineteen discharged from psychiatric units grew to 180,000 in 1987, up 43 percent from 1980, according to the National Center for Health Care Statistics.

The cost of treatment for minor dependents is a disturbingly large component of the total mental health care cost. A study of 14,000 Tenneco Inc. employees and dependents found that nonspouse dependents showed a larger proportion of hospital admissions for mental disorders than did employees or spouses. Mental health expenses for these dependents accounted for 24 percent of total medical costs for this group (versus around 5 percent for adult groups) and 42 percent when children under age eleven were excluded. Nonspouse dependents accounted for over half of all mental health expenses, and the numbers are growing.

The Employer Health Care Data Center report on a 1988 survey of twenty-one employers with 200,000 employees found that substance abuse treatment averaged 19.4 days at a cost of $8,160 for employees, but 25.6 days at an average cost of $12,364 for dependents.

A 1986 survey of 230 members of the National Association of Addiction Treatment Providers involving 11,000 patients found that—

- Average charges per admission for adolescents (persons under twenty) were 46 percent higher than those for adults.
- The length of stay for adolescents averaged 30.2 days, compared to 22.1 days for adults.

A Growing Problem With Substance Abuse. In some cases substance abuse (both alcohol and drugs) may represent as much as 20 to 30 per-

cent of direct medical costs, a figure that could be higher if deliberate or honest misdiagnoses and accidents were included (according to the National Safety Council, alcohol is related to 47 percent of workplace accidents and 40 percent of workplace fatalities).

Changes in Attitude. Today there is a greater acceptance of chemical dependency or emotional adjustment problems as medical problems, and of acknowledging an inability to control one's life in general. The stigma attached to psychiatric care has largely evaporated. In some circles, therapy has become fashionable. In others, it is an accepted response to stress, anxiety, and behavioral problems.

In any case, people are owning up to emotional problems in large numbers. A 1989 Gallup poll commissioned by the New York Business Group on Health found that 25 percent of the work force may suffer from stress-related illness, and that 13 percent suffer from depression. Employees who suffer from mental, emotional, or substance-abuse problems are much less likely to be discharged or suffer other penalties than they were in the past. They are also more likely to qualify for, and to receive, employer-provided treatment for their conditions. This is due to changing social attitudes, greater legal protection along with much broader legal definitions of illness and disability, and labor shortages that make hiring even problem workers a business necessity.

As employees become more sophisticated in the applications and jargon of psychiatry, their demand for psychiatric treatment can be expected to grow. Employee demand is supported by aggressive promotion of mental health services (especially inpatient treatment) by hospitals eager to compensate for lost business elsewhere, which can result in more admissions and longer stays. In the U.S. today, there are some 30,000 psychiatrists, 60,000 psychologists, and 170,000 clinical social workers, most of whom are energetically marketing their services.

The cost of treating these disorders is less certain than it is for more routine physical problems, such as broken bones. Misdiagnosis is more common, either through honest errors (missing underlying causes when identifying physical symptoms) or deliberate fraud committed to make the patient eligible for insurance coverage. Minimum stays tend to be standard from one patient to another, and may be as related to the length of time that is reimbursable as they are to any subjective evaluation regarding the optimum length of treatment.

Provider Cost Structures

Sooner or later, greater demand stimulates greater supply. Higher salaries have drawn large numbers of people into health care professions, and not just doctors and nurses. Administrators, lawyers, consultants, recordkeepers, strategic planners, marketers, financiers, and regulators may account for nearly one out of every four workers in the health care industry. The number of jobs in the health care industry is growing three times as fast as the general population. Thirty-seven out of every 1,000 U.S. workers are in health care, up from twenty-eight a decade ago. The number of salaried health care workers has grown 43 percent since 1979 (to 8.7 million in 1989), while the nation's population grew only 10 percent.

Wages for this ever-increasing number of new medical workers are also rising faster than those of the general population: In 1988, while the consumer price index rose 4.4 percent and the medical care component rose 6.9 percent, physician fees were up 7.5 percent, and those of the ten physician specialties with the highest average fees were up 9.9 percent. According to the U.S. Department of Labor, in the five-year period from 1983 to 1988 the salaries of doctors rose 30 percent, nurses 31.1 percent, physical therapists 25.8 percent, compared to 16.3 percent for full-time wage and salary workers overall.

Physicians. According to the American Medical Association, physician incomes more than doubled between 1978 and 1988, from an average of $64,600 to $144,700. This increase is only partially attributable to attempts by doctors to maintain their purchasing power in the face of a steep rise in the cost of operating a medical practice. Another reason for increased incomes is competition among hospitals for doctors and the referrals they can provide. Some hospitals provide sign-on bonuses of $20,000 to $50,000. A 1987 study by Jackson and Coker (an Atlanta-based physician research firm) found that 95 percent of 114 surveyed hospitals used "income guarantees" as incentives, where the hospital makes up the difference if the doctor's income falls below the guaranteed level. Many hospitals also paid relocation expenses, gave practice start-up assistance, provided free office space, and made interest-free loans.

The pressure on practitioners to maintain income levels will become an especially challenging problem as the number of doctors grows. There were 142 physicians per 100,000 population in 1960, as compared to 240 in 1990. Predictions are that there will be a 30 percent increase in the number of physicians by year 2000. It is too soon to say

whether the increased numbers will put downward pressure on doctors' fees, or whether continued specialization will allow physicians to divide the market into high-income skill centers.

Hospitals. Hospitals are experiencing financial pressures—which must be offset by higher charges—from a number of quarters. According to a January 10, 1990, *Wall Street Journal* article, hospital construction is booming, even though about one-third of the 947,000 community hospital beds in the United States are empty. Utilization rates—64 to 66 percent on average over the past five years—vary considerably, with some urban hospitals full to overflowing. This paradox is explained by the availability of construction subsidies, the need to replace aging plants, and government regulations that make combining separate facilities difficult. The total cost of completed hospital projects was $14.9 billion in 1988, up 17.9 percent from 1987 (according to a report cited in the January 10, 1990, *Wall Street Journal*, much of the cost was subsidized through tax-exempt bonds and federal subsidies).

Hospitals are feeling the pinch of reduced admissions and shorter stays resulting from cost-control efforts that have reduced utilization and moved patients toward increased outpatient care. (The siphoning off of nurses to staff utilization review offices may have contributed to the nursing shortage and resultant wage pressures facing hospitals.) Hospitals also face lower reimbursement levels because of federal cutbacks. Those providing care to Medicaid eligibles have reported experiencing very slow pay rates and may ultimately receive little or nothing for the treatment of some patients.

There are also growing numbers of uninsured whose costs must be passed along to those who are insured. Hospitals absorb about $5 billion in unpaid costs each year, according to a 1989 report by the Health Insurance Association of America. In 1988, $12 billion in unpaid bills was discounted to collection agencies.

As a result, with higher costs and more unpaid bills spread over fewer patients, hospital charges to third-party payers go up.

Prescription Drugs. During the 1970s, drug price increases trailed the inflation rate, rising by only one-half as much. This situation reversed in the 1980s, with drug prices increasing at twice the rate of inflation, notwithstanding the use of cheaper generics. Since 1983, drug prices have risen faster than any other category of medical care consumer price index components: up 65 percent; 88 percent in the past decade.

Part of the spurt is caused by higher research and development costs and the costs of complying with regulatory requirements. Marketing

costs also figure in, with major effect. According to a November 5, 1989, *New York Times* report, pharmaceutical companies provide incentives for doctors to prescribe their drugs, incentives that amounted to $2.5 billion in 1988, or roughly $5,000 for every doctor in the country.

Cost Shifting

A significant part of employers' costs goes to subsidizing government health programs that do not pay the full cost of treatment.

Federal Programs

Employers are not the only ones attempting to control their costs; government health care plans, notably Medicare, are cutting back as well. The combination of promising more benefits and of paying higher prices for them has had the same effect on Medicare as it has on private plans. The difference is that the government had an easy option: transfer its obligations to private employers.

Medicare. Those employers who integrated their health care programs with Medicare watched their obligations grow in the 1980s as Congress forced them to assume responsibilities formerly carried by the public program. Forecasts in 1980 showed Medicare covering only 25 to 50 percent of the projected costs of its promised benefits over the next seventy-five years, so alternative funding sources had to be found. Since then, legislation to make Medicare secondary and employer plans primary has become almost an annual event. Medicare has become secondary (paying benefits for Medicare eligibles only after employer plans have paid full benefits) for the following employees:

- Workers whose benefits are payable under liability insurance (1980)
- Beneficiaries whose eligibility stems from end-stage renal disease (1981)
- Employees and spouses between ages sixty-five and sixty-nine (1982)
- Workers aged sixty-five to sixty-nine with working spouse under sixty-five (1984)
- Workers and spouses over age sixty-five up to no maximum age (1986)

- Working disabled and disabled dependents covered by plans of companies with 100 or more employees who are eligible through Social Security Disability Insurance (1986)

The Omnibus Budget Reconciliation Act (OBRA) of 1989 continued the trend toward reduced Medicare payments by tightening up enforcement procedures to ensure that employer plans meet all of their primary plan obligations. Also in 1989, final Health Care Financing Administration regulations made it clear that employers must offer the same coverage to rehired retirees as they offer to other active workers and that secondary-payer rules apply to self-insured plans as well as to insured ones.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires continued coverage under employer plans for those employees whose coverage might otherwise be discontinued. Of those employees eligible for COBRA continuation of coverage, 11 percent actually took it (although the percentage was higher for smaller employers—employers with fewer than 500 workers—for whose workers the election rate was 22.8 percent), according to a 1988 survey by Charles D. Spencer & Associates, Inc. The survey by this benefits information publisher found that 16.8 percent of plan beneficiaries became eligible for continuation coverage, at an average cost of $3,013. Employers subsidized the continued care, paying up to one-third of the cost. In addition, administrative costs averaged $140 per continuee per year, ranging from as little as $60 to as much as $350.

State Mandates

In the past dozen years, each state has enacted, on average, one mandatory coverage act per year. These statutes now total over 600 nationwide. In 1988 alone, thirty-four states acted on 320 bills governing mandatory coverages. These laws, which generally apply to *insured* health plans (as opposed to self-funded arrangements), require certain specified types of benefits to be made available. More than half of the states require such things as well-baby coverage, psychiatric services, chiropractic coverage, treatment for mental and physical handicaps, optometric benefits, alcoholism treatment, and so on.

Some states go beyond what are now considered more or less mainstream types of mandated benefits. As of the end of 1989, for example, five states required insurance carriers to cover infertility treatment, including in vitro fertilization, at a median cost of between $5,000 and

$6,000 per attempt, even though the success rate is approximately 10 to 15 percent. States have continuation requirements, too. Massachusetts, for example, requires up to thirty-nine weeks of continued coverage (paid for by the employee) following thirty-one days of extended coverage (paid for by whoever pays for active employee coverage).

Utilization

Health care is more and more a game of large institutions. No longer is it a one-to-one relationship between a lone physician in private practice dealing with an individual who pays his or her own bills. By institutionalizing medicine, and taking the patient out of the payment stream, a valuable control on excessive doctoring has been eliminated.

A key focus of employer efforts at controlling utilization, therefore, has been to find a replacement for this patient oversight. The aim is to eliminate those procedures that are unnecessarily expensive, or unnecessary altogether. More than one-third of the nation's hospitals fail to meet standards to guard against inappropriate surgery, unnecessary blood transfusions, and poorly coordinated treatment of patients in special coronary and intensive care units, according to the Joint Commission on Accreditation of Health Care Organizations, a panel established by private health care providers. According to the Rand Corporation, 34 percent of medical and surgical procedures performed each year are unnecessary, to the tune of over $50 billion.

The pattern of these excesses is not uniform; significant disparities between the incidence and costs of certain medical procedures exist from one part of the country to another and from discipline to discipline. As Meg Bryant reported in the January 1990 issue of *Business and Health*, the Children's Defense Fund maintains that 40 percent of young people who are hospitalized for mental health problems do not need that level of care. Institutions have not been restricting admissions to teens with serious disorders like depression and schizophrenia. They have also been admitting those who suffer from lesser problems or who are merely difficult for their parents to control.

Much of this overtesting and unnecessary treatment is a defense against allegations of malpractice. In some cases, however, excessive testing may be related to the physician's ownership of the testing laboratory. New federal rules will require disclosure of financial interests by physicians in laboratories.

New Technology

Medical technology makes headlines almost every day, producing spectacular accounts of organ transplants, microsurgery, laser treatment, artificial organs, and gene therapy. The technology to support these breakthroughs does not come cheap; new magnetic resonance imaging (MRI) scanners cost up to $3 million. This kind of machinery also requires better educated, more sophisticated, and highly paid professionals to operate it. And, once the technology is perfected, everybody wants it. In 1985 there were only thirty-four heart transplant centers; three years later, there were 148.

Even though insurers are often reluctant to cover procedures that are in early stages of development, they do not always have the final say. In a recent New Jersey case, an insurer declined to cover a bone-marrow transplant. Its evaluation program for reviewing the state of medical technology had classified the procedure as "experimental," and therefore ineligible for coverage. A U.S. District Court judge took exception to both the classification and the technology evaluation program that made it. The insurer was ordered to provide coverage for the procedure, which is estimated to cost $135,000.

AIDS/Catastrophic Care

One serious or long-term illness can have catastrophic consequences for an employer's health care costs, especially for a small employer. Treatment for heart disease, spinal cord injuries, cancer, and (as yet) incurable diseases like AIDS can cost more than $100,000—sometimes much more. Neonatal care for premature infants routinely can run into the hundreds of thousands of dollars.

AIDS may prove to be the most troubling because its treatment costs are unpredictable, and it yet may infect large numbers of people. Estimates of the cost of treating one AIDS patient have ranged from $60,000 to $147,000, and cumulative totals of the HIV-infected are projected to run as high as $365,000 by 1992.

Successful new developments in treating patients with catastrophic illnesses do not necessarily reduce costs. The drug AZT, for example, has prolonged the lives of those who test positive for the AIDS virus, but in so doing the drug has extended the length of time they receive costly treatment. The ultimate result may be that total costs in dollars become higher rather than lower.

Liability

Although the malpractice crisis may have eased for the time being—insurance rates are falling—costs can still be high: Premiums run from as little as $3,000 to over $100,000, with an average in high-cost regions like New York and California of around $40,000. Not only does this raise costs by increasing the cost of insurance, it also raises the cost of doctoring by encouraging defensive testing and treatment to avoid being sued. Of all tests ordered, 20 to 30 percent may be unnecessary or of marginal benefit.

Total malpractice claims are running a little over $4 billion; with costs of defensive treatment and testing added in, the cost is much higher. An AMA study found that the costs in doctor bills alone of defensive medicine, insurance, and claims preparation was over $15 billion in 1985.

Congress is considering a proposal to place a cap on damages for noneconomic injury such as pain and suffering. If enacted, the size of awards would be reduced, bringing down the rates for malpractice premiums.

HEALTH CARE REFORM

Many observers place much of the blame for runaway health care costs on federal and state legislation that has broadened eligibility, expanded benefits, and altered traditional methods of providing and paying for health care. Many of those who blame the government, paradoxically, look to more legislation for relief. Organizations such as the American Medical Association, the American College of Physicians, and the Health Insurance Association of America have offered legislative proposals that would, among other things, offer the following advantages:

1. Extend health insurance coverage to those who are presently uninsured
2. Provide cost relief to small employers
3. Create risk pools for those at high risk or who are uninsurable

These proposals follow on the heels of suggestions that the United States adopt a national medical care system similar to that of Canada; adopt a number of Congressional initiatives including the report from the Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) for some $80 billion of additional health care coverage; and initiate a number of state actions that

would control costs by rationing care (Oregon), provide state financed health benefits (Hawaii, Massachusetts, and, proposed, New Jersey), and lower the cost of health insurance for small businesses (see the discussion in the box entitled "Special Help for the Small Employer" in chapter 5 of this book).

4 Employer Approaches to Containing Health Care Costs

General Approaches: An Overview

Employer options for dealing with health care costs fall into several broad categories, implemented through the adoption of one or more cost-containment techniques and programs, which are discussed in the following section. Employers may control their health care costs by—

1. *Sharing or shifting costs.* Generally this means sharing costs with covered employees, through participant premiums, deductibles, or copayments. It can also be accomplished by contracting directly with providers or provider organizations (such as a preferred provider organization [PPO]) to offer discounted fees, shifting a larger portion of the providers' expenses to payers (individuals and employees) who do not participate in such fee arrangements. A third option is to design the plan so that it does not provide benefits that are obtainable elsewhere, such as from the plan of an employee's spouse, through new coordination of benefits provisions.
2. *Controlling utilization.* Even though a plan is committed to pay for a given type of treatment, there are courses of action that may be taken to limit its exposure. The plan may require that a given procedure be approved in advance through a preauthorization or second-opinion requirement. The specific stages of treatment may be scrutinized to see that they are both appropriate and reasonably priced through a utilization review program. Potentially catastrophic cases may be monitored from start to finish through case management.

3. *Reducing the level of fees.* Buyers need not be subject to the vagaries of "usual and customary" charges. A schedule of fees may be negotiated with providers or a PPO. Buyers may also determine the most reasonable local providers by working through regional health care coalitions. In some states, generic drugs may be substituted for brand-name drugs.
4. *Self-funding.* Instead of purchasing benefit coverage in the marketplace, selected employers may decide that it makes more sense to pay for their benefits directly. Using this method, they are not charged for the (adverse) experience of other employers; their costs are determined solely on the basis of their own claims experience.
5. *Promoting wellness.* An obvious way to cut the costs of caring for sick people is to reduce the numbers of covered sick people. Preemployment physicals, wellness plans, and employee assistance plans (EAPs) are devices for doing just that.
6. *Auditing.* Regardless of any other courses of action selected, the program must be subject to careful oversight to protect against overcharges, inappropriate charges, and duplicate billings.
7. *Reducing benefits.* Ultimately, if costs go beyond what the company can afford, some form of cutback may be necessary. This must be done very carefully for reasons of morale and efficacy. One way of accomplishing this is through the introduction of a flexible benefits plan that lets the employee allocate his or her (reduced) health care dollars in a way that targets those coverages that he or she most needs, bypassing those of lesser importance. Any curtailment of benefits should be handled with care to avoid litigation by those who could accuse the company (in court) of reneging on its promises or those who might claim that careless chopping has endangered someone's health.

Cost-Containment Programs and Techniques

Cost Sharing/Shifting

Sharing Costs With Employees. Companies moved slowly during most of the 1980s to involve their employees in shouldering some of the health care burden. That pace is now increasing (see box on page 21). At the present time, employers can pass plan costs to employees by—

- *Increasing employee premiums.* In addition to upping the cost for the employee's own coverage, workers may be asked to assume an even greater portion of the cost of dependent coverage. Even those companies that still provide free employee coverage may require contributions of between 20 and 50 percent of dependent coverage costs.
- *Increasing deductibles.* Deductibles are minimum amounts that a covered individual must pay before reimbursement for expenses commences. Where deductibles of $100 a year were once common, annual deductibles of $500 or more are no longer unusual. Raising the deductible can have a significant effect on overall employer cost.
- *Increasing copayments or coinsurance.* This is the ratio of employer-to-employee payment for covered expenses after the deductible has been satisfied. A zero copayment would mean that the plan would cover 100 percent of a given expense. More typical these days is an 80-20 arrangement, in which the plan pays 80 percent of the cost of treatment and the participating employee pays the remaining 20 percent.
- *Increasing the out-of-pocket (OOP) maximum.* This is the maximum limit on the amount that the covered individual must pay. It is, in effect, a cap on the overall coinsurance amount (and may include the deductible as well). For example, even though a 20 percent copayment formula might obligate the employee to pay $5,000 of a $25,000 hospital bill, if the out-of-pocket maximum is $2,000, then that is the limit of his or her exposure. Increasing the size of this out-of-pocket limit increases the employee's share and reduces that of the employer at the same time. Individual and family maximums are now ranging from $1,000 to $2,000.
- *Adding a visitation charge.* An employee may be required to pay a flat charge (say, $5 or $10) each time he or she visits a doctor. In addition to defraying expenses, the charge is intended to make the employee pause to be sure the visit is really necessary.

The employee share need not be a uniform percentage for all benefits. It may vary for outpatients as compared to inpatients, for example, with lower employee out-of-pocket costs for outpatient services as a lure to encourage their use (although as outpatient care becomes more expensive, this policy may need to be reexamined).

Similar incentives may be used to encourage the use of other cost-effective plan features (such as lower copayments for the use of a preferred provider, as opposed to one's own personal physician).

One problem with past efforts at cost sharing is that employee contributions did not rise much over the years; the cost-reduction effect was dampened by failure to keep pace with inflation. For that reason, the current round of increases should contemplate future cost-of-living increases as well.

In some companies, proposals to tap employee pocketbooks have been victims of their own success. Shifting a portion of health care costs from employers to employees was supposed to do more than merely offset part of the employer's premium cost; it was also expected to make employees more cost-conscious. That goal was largely achieved, but in some cases with unintended consequences. Once some employees recognized how high health costs were and how much they were expected to pay, they took to the streets in protest. They believed that health insurance was solely an employer's responsibility. Unions whose members were already contributing argued that employees simply could not afford to pay any more for health care. In 1989, health benefits were a major factor behind strikes, involving 78 percent of all striking workers, according to the Service Employees International Union. Major health benefit changes were involved in approximately 60 percent of contract settlements. Metropolitan Life Insurance Company surveyed labor and management leaders to see what they considered to be the single most important issue facing organized labor in the 1990s (*The Health Poll, Summer 1989*). About 70 percent of labor leaders said they considered limiting employee cost sharing for health benefits to be a top priority for negotiations in 1989, whereas 38 percent of management respondents made employee cost sharing for health benefits a top priority.

One potential casualty of higher employee costs is participation. When participation is elective, higher costs can mean lower enrollment. A study conducted by the National Center for Health Services Research of seventeen Minneapolis companies with 5,000 employees found that even relatively small premium increases of $5 or $10 can cut plan enrollment by as much as 10 percent. The impact of the increase varied with the percentage of workers originally enrolled in the plan. Except when the level of cost sharing is onerous, the disenrollment will generally reflect the loss of those with other coverage who see no need to pay for duplicate coverage.

EMPLOYERS AND COST SHARING

The *Business and Health* 1990 National Executive Poll on Health Care Costs and Benefits found that most respondents will increase cost sharing, whereas only 27 percent will opt for the next most popular cost-containment approach: cafeteria, or flexible benefit, plans. According to the Gallup Organization Inc. and the Employee Benefits Research Group, since 1987 25 percent of those responding reported employees paying a share of the premium for the first time, while 32 percent reported increased deductibles. The 1988 Hay/Huggins (a compensation/benefits consulting firm) survey showed that whereas 54 percent of surveyed companies paid 100 percent of the cost of hospital and surgical coverage in 1984, only 26 percent did so in 1988. Similar findings were reported by Hewitt Associates. Of the 227 companies that this major employee benefits consulting firm surveyed, fewer than 30 percent covered hospital room and board without copayments in 1988, a percentage down from the more than half of the companies that extended full coverage in 1984. A survey conducted by the Public Policy Department of the Service Employee International Union (SEIU, AFL-CIO) found that worker premium contributions jumped 70 percent between 1987 and 1989, a rate twice the 35 percent increase in employer contributions.

Coordination of Benefits. Coordination of benefits (COB) provisions are intended to ensure that benefits from two or more plans are not duplicated. As the number of two-worker families has grown, health plan sponsors have encountered a new category of unnecessary expense: paying benefits for an illness already covered by someone else's plan. Employees covered by more than one health plan—that is, covered once as an employee, again as a dependent—could file claims under both and collect twice for the same medical treatment. To prevent double dipping, insurers developed rules on the "coordination of benefits" that determine respective liabilities for two or more plans—whether insured or self-funded—that cover the same individual.

The National Association of Insurance Commissioners (NAIC) has developed model legislation that lays the ground rules for apportioning financial responsibility among several plans. Generally, these rules and the legislation as it has been adopted (with local modifications) by the various state legislatures divide the plans into "primary" and

"secondary" categories, with the primary plans paying full benefits, that offset any benefits the secondary plan would otherwise pay. The rules determining which plan is primary and which is secondary are complex, and they vary from state to state. Generally, however, the plan of the company in which the individual is an active employee is primary and that in which the individual is a dependent is secondary. Additional rules spell out the status for those who are dependents under both plans.

The primary thrust of COB has been to eliminate an employee's opportunity to make a profit by collecting twice for the same expense. Hence, most COB provisions have limited total benefits from all sources to 100 percent of expenses. The trend today, however, is to limit benefits from all sources to what the plan would have paid in the absence of more than one plan (for example, 80 percent of reimbursable expenses). This is referred to as "benefit maintenance COB" or "nonduplication."

A variation of this approach, adopted by J.C. Penney, denies medical and dental benefits to spouses of Penney employees who earn more than the employees themselves. The reasoning was that the higher paid spouses generally already had coverage and did not need additional coverage from Penney. Although this tended to deny coverage to the husbands of Penney's female employees, the practice survived a sex-discrimination challenge.

Managed Care

Managed care is a phrase with more than one definition. Some professionals use the terms *managed care* and *case management* interchangeably to refer to a strategy in which a skilled caseworker, usually a registered nurse or other professional (a psychologist, for example, in the case of mental health care), oversees the program of treatment for a specific patient.

Others perceive managed care as a broader concept: an integrated health care system that manages costs and promotes quality by eliminating unnecessary care and coordinating treatment. Individuals entering the program for treatment would be steered to the most appropriate type of delivery system. As the nature of the treatment required became more involved, it would be subject to greater scrutiny and coordination to make sure the purchaser's dollars were being allocated efficiently. Such a comprehensive program could comprise one or more of the following:

- Health maintenance organizations
- Preferred provider organizations
- Fee-for-service health care subject to third-party utilization review
- Case management

Health Maintenance Organizations. An HMO provides a comprehensive range of health care services through specific providers. Members receive health care services in exchange for a monthly fee (known as "capitation"). HMOs are commonly either "staff models," in which medical professionals are HMO employees, or "independent practice associations" (IPAs), in which medical professionals are under contract to the HMO to provide services at discounted rates.

When HMOs began to boom at the beginning of the 1980s (though the concept is much older), they were enthusiastically heralded as the answer to much of what was wrong in the health care marketplace. They promised an efficient, controlled health care environment that appealed to businesses and regulators alike.

HMO growth during the 1980s was impressive, with enrollment tripling since 1981 from 10.5 million to 32.5 million as of July 1989, as reported by *InterStudy Edge*, published by InterStudy, a Minneapolis-based medical research organization. This rapid growth, as well as competition from innovating insurers, PPOs, and other HMOs, put pressure on them, causing many HMOs to experience financial difficulties. Growth has slowed, and their actual number has declined from around 700 to under 600 today, largely as a result of merger and takeover. The percentage of employers who offer HMOs has held at around 62 percent since 1987, with 33 percent of eligible employees actually enrolled.

Do HMOs lower costs? Though this is a matter on which there is some disagreement (see box on page 25), it is generally conceded that they have not lived up to their advance billing. One contributing factor to poorer-than-expected historical results could be the pricing structure. Under prior law, employers were required to make equal contributions to HMOs and indemnity plans. As a result, when indemnity plan costs rose, HMO costs rose, too. HMOs were also subject to a community rating system that did not permit the setting of capitation rates to take advantage of individual employer experience, resulting in higher costs than indemnity plans providing similar benefits.

Critics also suggest that any economies that HMOs offer in the way of reduced rates may be more than offset by "adverse selection." HMOs tend to attract the younger, healthier employees, leaving indemnity plans with the older, less-healthy ones. This means lower costs for the HMO, but higher ones for the other plan. Where HMO cost savings do not match indemnity plan increases, combined employer costs may actually be higher.

Community rating, adverse selection, and the equal contribution rule in concert could produce a cost increase higher than would have occurred if there had been no HMO at all. The HMO Act amendments of 1988 did away with the equal contribution rule (replacing it with a requirement that contributions not discriminate) and community rating, which could mean better showings for HMOs in future surveys. Some states, however, still have laws in place that are similar to the old federal rules. This means that HMO progress on costs may vary significantly from one state to another.

One problem with traditional HMOs that is a major impediment to achieving greater employee participation is the "locking in" of participants to participating physicians and facilities. The lack of choice and the unavailability of one's personal physician has kept many employees from signing up. This shortcoming is being addressed by a new type of HMO, the "open-ended" HMO. Open-ended HMOs allow members to elect to use non-HMO providers but at higher out-of-pocket costs to the employee. Seventy-eight HMOs, or 13 percent of the total, are available on an open-ended basis. Premium charges for these products are higher, however, with over one-third of them charging premiums 16 percent or more higher than for the standard HMO, according to InterStudy.

Another concern for HMOs is the accusation that they do not provide quality care (see the subsequent discussion of quality). HMO savings start with a doctor who serves as a "gatekeeper." Gatekeepers are supposed to control costs by carefully managing a patient's treatment to minimize unnecessary or redundant tests and treatment. Some HMOs apparently provided bonuses to gatekeepers who minimized referrals outside the HMO. The more successful they were at limiting referrals, the higher the bonus, but the greater the risk that someone was being denied needed care.

How widespread this practice was is not certain. HMO proponents insist that such abuses are rare, and that the potential for poor quality care is significantly lowered in HMOs with specialists in all major categories under contract to provide specialty care to HMO participants.

Proponents also maintain that the gatekeeper concept has not increased the level of risk, but has been successful in controlling access, resulting in lower costs. A survey of 200 managed care plans conducted by the American Managed Care and Review Association and the Council on Medical Specialty Societies found that 96 percent believed that HMO gatekeepers were cost-effective. Unfortunately, these are impressions that are not conclusively confirmed. There are few reliable studies on the subject, most being based on self-reported information or on inconclusive statistics. Given the evidence, employers should be wary of claims of significant savings. When these claims influence the purchasing decision, they should be backed up with internal evaluations, in addition to analyses that take into account other important factors such as benefit design, provider payment policies, consumer incentives, and the like.

Those employers who contract with more than one HMO should carefully evaluate their inventory. In the early surge of HMOs, when employers were first required to make them available, some companies signed up every one that came along, leaving the employee to sort things out. As the industry undergoes a shakeout, the list of available HMOs is pruning itself. Still, employers should carefully evaluate what is available to them, from the standpoint of services offered, the cost, the quality of service, the breadth of specialties, and the HMO's financial health. They should avoid those with unacceptable histories and offer employees only those with the highest standards.

DO HMOs CONTROL COSTS?

The claim that HMOs, on average, offer care at lower costs has some statistical support. A 1988 Health Care Benefits Survey by A. Foster Higgins, Inc. of the Managed Care Plans of 1,600 employers found that when the average per employee indemnity cost was $2,160, the same cost for HMOs was only $1,991. By 1989, however, the HMO cost had risen to $2,319, a 16.5 percent increase. Indemnity costs rose 20.4 percent to $2,600. The study also found that annual per-employee health costs increased from $1,985 in 1987 to $2,354 (8.6 percent of payroll on average) in 1988, an 18.6 percent jump. Insured program increases averaged 13.7 percent, whereas self-insured programs averaged 24.8 percent. HMO premiums, by comparison, were up only 10.4 percent for individuals and 11.1 percent for families. (Results, however, were uneven, with 59 percent of the respondents reporting HMO rates as high or higher than those for their indemnity plans.)

Another survey, this by the Health Insurance Association of America, of 1,165 randomly selected employers showed health insurance premiums rising generally around 12 percent from spring 1987 to spring 1988. This increase closely matched that from the Bureau of Labor Statistics. PPO premiums rose 17 percent, whereas those for staff HMOs rose only 8 percent; IPA HMO premiums rose by 10 percent. (The report noted that these increases were considerably lower than those that had been reported in a number of press articles. The HIA reporters surmised that the lower increase reflects the fact that the press reported only on those plans that experienced increases, whereas almost one-third of the survey respondents reported no increase at all.)

Still, HMOs are not perceived as living up to their billings. Respondents to an A. Foster Higgins, Inc. survey reported that HMO costs were as high or higher than indemnity plans in 54 percent of the cases. Only 33 percent agreed that HMOs were effective in controlling costs (the percentage was significantly higher on the West Coast, where HMO populations are fairly stable, than on the East Coast).

Preferred Provider Organizations. An A. Foster Higgins, Inc. survey found that whereas only 33 percent of the respondents found HMOs to be effective in controlling health plan costs, 60 percent thought that way about PPOs. Hence the growth in PPOs. The number of PPOs as of December 31, 1988, was approximately 700 (ten times the number of five years earlier), available to perhaps as many as 42.2 million Americans, according to *Marion Managed Care Digest* in 1989.

In contrast to the prepaid services provided by an HMO, a PPO is a modification of the traditional fee-for-service arrangement. The modification is that the service providers (doctors, dentists, hospitals) enter into a contract with the employer or a third party to provide medical services at prenegotiated, discounted rates. The discounts may be determined by a scale tied to the nature of the treatment provided. Fees may be payable on a reimbursement basis as services are provided or on a capitation basis similar to an HMO. Some PPOs share the risk with the employer. There are also specialty PPOs that provide only specific types of services, such as vision, dental, or mental health care.

An argument for care in contracting with PPOs is that merely discounting fees does not necessarily produce lower overall costs. Absent risk-sharing arrangements, participating hospitals and physicians have no incentive to reduce the level of services. Instead, the incentive

may exist to do the opposite: increase the level of services to maintain income levels. There are alternatives: payment on a DRG (diagnosis related group) basis, which militates against prolonged stays and extra care; or per diem, which protects against unnecessary services.

PPOs are subject to some of the same complaints as HMOs, particularly with regard to limited choice of physicians. The solution is essentially the same: higher coinsurance for out-of-network services.

Utilization Review. With utilization review (UR) a medical professional (usually a nurse) oversees treatment, and is prepared to recommend less costly alternatives (see box on page 28) to those prescribed by the patient's attending physician. The review nurse is on the lookout for things like weekend admissions, or the last days of inpatient care, where a patient may be occupying an expensive bed but is not receiving a level of care any higher than would be available outside the hospital. When the review nurse and the attending physician cannot agree, the case is referred to a UR physician for negotiation. The UR organization does not override the attending physician's treatment decisions.

Of covered individuals, 50 to 75 percent may be under some form of UR. Evidence exists that there is at least an initial cost decrease, but no evidence that it significantly slows cost increases over the longer term. When the cost of the additional professional is added in along with extended coverage for alternative treatment (such as outpatient care), the net result can by iffy. Hospitalization may go down, but physician services and alternative care go up. To be effective, UR must apply to outpatient care as well as inpatient. It also must keep current, avoiding old out-of-date standards, especially in mental and substance abuse cases.

UR may be performed at any stage of the treatment process: before, during, and after. Stages of UR include—

- *Prospective Review.* The health care provider is required to consult with appropriate medical professionals, including peer reviewers, in advance of or shortly after the onset of a course of treatment or therapy. It may take the form of preadmission certification, which requires prior authorization before certain types of treatment, such as major surgery or hospitalization, are covered. Second opinions may be mandated on the advisability of elective surgery.
- *Concurrent Review.* Actual treatment in process is reviewed to assure its appropriateness to actual clinical findings, or, if

modification to the original treatment plan is needed to meet unforeseen conditions or events, to assure that such modifications meet established professional standards.

On-site concurrent review can mean a medical professional reviewing medical files to track progress, monitoring medical necessity of treatments, and selecting cases for case management. Case review may be automatic after a specified number of days in a hospital.

- *Retrospective Utilization Review.* Although the use of prospective and concurrent reviews should minimize the need for retrospective reviews, there will be instances where further peer review may be called for. Retrospective review consists primarily of auditing charges for services actually rendered, the previous stages of UR having established medical necessity.

COST SAVING ALTERNATIVES

Alternatives to Inpatient Care

The success of UR depends in large part on its ability to come up with less expensive alternatives. Some alternative areas include—

- *Outpatient and Home Health Care.* Once regarded as the automatic low-cost alternative, outpatient care is experiencing rapid inflation, too. Outpatient care cost increases can be attributed to an aging population, more sophisticated and expensive treatment, and improved quality and wider availability of health care services. Ironically, another part of the rise in costs stems from employer and insurer efforts to control costs. Employees who were encouraged to utilize outpatient care as an alternative to lengthy and expensive stays in hospitals have embraced the practice enthusiastically. Blue Cross and Blue Shield statistics show that whereas inpatient days fell 26 percent between 1981 and 1987, outpatient visits per 1,000 people increased by a like percentage over the same period. Meanwhile, outpatient costs increased 88 percent at the same time the cost of inpatient care was rising 77 percent per case.

  Other reasons for the growth in outpatient utilization include:

  - *Convenience.* Twenty-four-hour clinics and walk-in/walk-out treatment centers are prepared to handle surgery and other procedures that once required hospitalization (40 percent of all surgeries were performed on an outpatient

basis in 1986, up from 24 percent in 1983). This has encouraged persons to seek treatment who might otherwise have put it off. One question that cannot be answered yet: Do those who seek earlier treatment avoid becoming high-end major medical statistics down the road, so that short-term increases lead to long-term health care cost savings?

- *Higher reimbursements.* As a way of stimulating interest, some medical plans make outpatient care more financially attractive, providing full reimbursement when only partial payment is available for comparable types of inpatient care.

  There are few cost controls for outpatient care comparable to those that exist for inpatient care. That permits health care providers to raise outpatient rates to cover shortfalls in other areas of their operations, primarily hospitals where occupancy rates have been falling at an increasing rate over the past few years.

□ *Intermediate Care.* Between full hospitalization and outpatient care there is a range of intermediate types of care, such as:

- *Partial hospitalization.* The patient sleeps at home, but spends his or her days in the hospital for the same care that inpatients get.
- *Subacute care.* For persons too frail medically for a rehabilitation hospital, nursing home, or home care, high-quality care in a homelike setting for postsurgical patients for two days to one month can cost one-third of full hospitalization.

Generic Drugs

Generic drugs, prescription formulas without the expensive label, are much cheaper than brand names, at wholesale, so that it may pay to subsidize their purchase. One insurer pays full price for generics, but charges patients 30 percent of their bills for brand-name drugs. This has prompted 29 percent of prescriptions to be generic, as compared to 16 percent before the policy was adopted. Paying full cost for generics can be risky, however, because the savings are often diluted by the time the retailer adds its markup.

Individual Large-Case Management. Often a handful of catastrophic cases can account for a disproportionate share of overall plan costs. Any case that involves extensive hospital confinement, major surgery, cutting-edge technologies, expensive drugs, and/or protracted medical

treatment is a candidate for case management. Although cancer, neonatal care, and spinal cord injuries and diseases probably account for a substantial proportion of these cases today, AIDS is rapidly joining their ranks.

A survey conducted by the International Society of Certified Employee Benefits Specialists using data up to 1987 found that 54 percent of those surveyed applied case management to catastrophic and acute care and, of those, 56 percent experienced significant savings, averaging 21 percent. Still, case management costs money, and any savings must exceed the cost of administering the program for that savings to be worthwhile. One test program conducted from 1984 focused on preselected high-cost events and illnesses: high-risk infants, head traumas, spinal cord injuries, cancer, and AIDS. Of the 120 cases in these categories, medical expense savings were realized in twenty-nine—a total of $430,000. The cost of the program, however, was $684,000, which meant every dollar spent produced a savings of only $.63. (See Henderson, et al., *Business & Health*, October 1987.)

The Company Doctor. Perhaps the ultimate form of managed care and control is to maintain one's own medical facility. Although it is not the solution for small companies, company medical facilities are experiencing a modest resurgence with larger companies that have large concentrations of employees. Company facilities can be cheaper than open-market facilities and can handle such things as laboratory work, X-rays, physicals, and prescriptions. Putting doctors on salary takes away the incentive to raise costs, but it also raises the question of loyalty. Is the doctor's first responsibility to the employee under his or her care or to a cost-conscious employer? Contracting with an outside firm to supply salaried medical personnel can mitigate this problem. Medical malpractice and liability insurance can be problematic and costly.

Balancing Risks and Rewards. Any managed care program can involve additional costs. Whether the employer assumes some or all of the management responsibilities, or contracts them out to an insurer, hospital, or managed care organization, there is an additional level of administration that must be paid for. For managed care to be effective, this additional cost should be offset by savings from lower utilization, lower negotiated fees, and case-management economies.

The system also must have built into it some means of seeing to it that its guidelines are respected: approval procedures for hospital

admissions and penalties for noncompliance. There is sometimes a fine line between firmness and rigidity, however, and there is always the danger that a necessary medical treatment will be delayed, causing complications and lawsuits.

Cost-efficient therapies for certain types of medical problems can involve novel types of outpatient or other nonhospital approaches, which may not be covered by components of the managed care scheme. The employer must then decide whether coverage should be expanded to embrace these approaches, which may save money in some instances but may also sweep in more claims, resulting in a larger health care bill overall. Such decisions cannot be made on a case-by-case basis, lest legal problems ensue.

Cost considerations aside, finding the correct formula, and the right manager(s) for total managed care, may not be so easy. Major insurers, hospitals, and HMO chains are all integrating to provide the necessary blend of inpatient and outpatient services, prepaid and fee-for-service delivery systems, indemnification capabilities, market support networks, and management skills. Making the right choice can be a time-consuming and laborious process, particularly for smaller employers who lack the resources to make painstaking investigations.

Flexible Benefits

Another way of reducing duplicate benefits coverage, or to avoid paying for otherwise unwanted health care coverage, is through a flexible benefits, or cafeteria, plan. (They are also sometimes called Section 125 plans, after the section of the Internal Revenue Code that governs them.)

Flexible benefits plans give employees choices of differing types and levels of benefits. While a simple plan might offer the employee the choice between cash and some nontaxable benefit such as health care coverage, some plans can get more elaborate. In addition to health benefits, these plans may provide employees with optional life insurance, dependent care, 401(k) deferrals, vacation benefits, or cash.

The key is that the benefits are optional, allowing the substitution of something more desirable for something the employee does not want or already has available to him or her someplace else. They also put budgeting responsibility in his or her hands, introducing an element of cost-consciousness.

A Hewitt Associates study of 345 organizations found that most of those who were able to assess the impact of their flexible benefit plans

reported that they were able to achieve their cost-control objectives. Of the respondents 40 percent thought that it was too soon to tell, but 47 percent believed that their plans were successful, with only 13 percent giving negative reports. The survey found that over the period 1986–1988, national per capita cost increases for employers without cafeteria plans were greater than for those with cafeteria plans by 28 percent.

Instead of a more elaborate plan, flexible spending accounts are a starting point for many employers. Employees commit pretax salary reduction dollars for medical care, which may be used to pay premiums, deductibles, and/or copayments. One problem with these accounts is the IRS's "use it or lose it" rule, which says that amounts remaining in the account at the end of the year are forfeited. This prospect can have a damping effect on employee participation unless the program is designed carefully to balance salary reductions and employee costs.

Cafeteria plans are generally popular with employees, providing them with an element of consumer choice and the opportunity to tailor their own benefits package. This enthusiasm can be wiped away if such a plan is implemented in conjunction with a too-sharp reduction in benefits. It may be better to adjust benefit levels incrementally over time, letting the employee get used to the idea that by electing less health care, he or she gets larger helpings of other benefits such as day care, vacation, life insurance, and so on. Plan savings can be realized in later years by maintaining the size of the employee's benefits commitment with a corresponding increase in the employee share of the cost.

Promoting Wellness

Wellness. Making employees healthier would seem to be an obvious way of reducing the eventual cost of making sick employees well. As many as two-thirds of employers with fifty or more employees may have taken some kind of wellness initiative. These range from courses and counseling for weight control, stress management, fitness, blood pressure, and substance abuse, to health foods in the cafeteria and no-smoking environments.

Others offer more elaborate health risk analyses—on-site screening and blood tests to detect problems before they reach expensive late stages. The employer may assume full responsibility for these programs, or they can be coordinated with outside groups such as the American Heart Institute or community health organizations. Another approach

is for the employer to sponsor a program, such as a quit-smoking session, but let employee contributions finance all or part of the cost.

Do any of these programs do any good? A 1987 Health Research Institute study showed wellness programs yielding an average overall savings of $49.74 per employee. It may be difficult to show significant short-term reductions in health care bills, but that might be because the effects may be very long-term ones—a successful no-smoking or fitness campaign may not produce real results until the employee's later years. In the short run, they may have greater impact on such things as productivity, absenteeism, and morale.

Effectiveness may also depend on the character of the group. Smoking and alcohol programs may be less successful in reaching blue-collar and certain minority workers, and dependents, than a white-collar population.

Employee Assistance Programs. Employee Assistance Programs (EAPs) started out primarily as alcohol-abuse counseling programs. In the past few years, however, they have branched out to provide assistance to employees coping with other forms of substance abuse and emotional problems as well. Treatment for depression, drug and alcohol abuse, and stress can account for up to 20 percent of employer health care costs, so this is a prime area for cost management.

A November 1989 Alexander & Alexander study of 20,000 McDonnell-Douglas employees recorded the following facts over a four-year period:

- Employees involved in EAP for chemical dependency missed 44 percent fewer workdays, had 81 percent lower attrition, and filed $7,300 less in health care claims than those who did not use EAP. A similar result was obtained with psychiatric care, although the savings were smaller.
- Of employees treated outside the EAP for drug abuse, 40 percent left the company within four years, as compared to 7.5 percent who were treated through the EAP.
- Employees receiving mental health care through their HMOs were four to five times more likely to quit or be fired within four years than those who used the EAP.

McDonnell-Douglas projected in the study that its EAP would save it $5 million over the next three years in reduced employee and dependent medical claims and reduced absenteeism. The company's

approach is to conduct an initial evaluation by EAP personnel from outside the company and then to provide whatever treatment is deemed appropriate. Although the company monitors treatment carefully and selects only those with proven records of cost-effective care, the focus is not on cost-containment objectives. The whole family must be included, which raises costs but is critical to effectiveness.

Self-Funding

A growing number of companies, small as well as large, are turning to self-funding, or self-insuring, health care benefits. More than 50 percent of employees covered by employer-sponsored health care plans work for companies with self-funded benefits, according to the 1989 *Source Book of Health Insurance Data* published by the Health Insurance Association of America.

Once considered the province of large companies, self-funding mechanisms are being investigated by more and more small-to-midsize companies as means to cut costs. The attractions of such arrangements include—

- Avoidance of state premium taxes that average 1 to 3 percent of insurance premiums (this exemption is under attack in a number of states).
- Avoidance of state-mandated minimum benefits that generally apply only to insured plans.
- Lower risks associated with a given company's low-risk group, especially when coupled with a low-incidence kind of risk, such as disability.
- The availability of stop-loss insurance to cover liabilities that exceed expectations.

The willingness to assume these risks varies from company to company and also depends on a firm's perception of its ability to manage a particular type of risk, an assessment that varies from one type of risk to another. Permanent disabilities, for example, tend to occur infrequently. When they do occur they are likely to be very expensive. A disabled employee will often require benefits up to the age of sixty-five, depending on the nature and the severity of the disabling injury or illness.

Short-term disabilities, on the other hand, are the most frequent self-insured benefit because of frequency (most predictable), low exposure in terms of benefit dollars, and high amenability to manage-

ment. Dental expenses also tend to be much more predictable than permanent disability or medical costs. There is also little likelihood of being exposed to enormous per-patient dental expenses, unlike the potential for catastrophic medical expenses that haunts other types of health care.

In order to evaluate the feasibility of self-funding, the employer should make an estimate of overall costs. The costs of a self-funded program, based on actual claims experience, would include—

- Costs associated with charges incurred and payable during the current period.
- Costs associated with events that have already occurred, but which are payable in the future.
- Costs associated with events that have not yet occurred, but which may be expected to occur.
- Costs associated with structural elements of the aforementioned and the operation of the program, such as additional funding for an aging employee population, allowances for inflation and salary increases, reserves for catastrophic expenses (including lawsuits), and operating expenses.

Determining how much of this should be factored in is the job of an actuary. No analysis is really complete without some sort of actuarial estimate as to how big a risk the company is assuming. Though it is tempting to project future expense on the basis of recent experience, that generally will not recognize the expensive potential of those extraordinary liabilities that have not occurred lately, but that could happen at any time. The smaller the group, the less valuable current claim experience is as a useful indicator of future claim levels.

Once the size of the risk has been assessed, a decision has to be made about how much of it the company should assume. Whatever the objection against traditional commercial insurance coverage, it does at least provide the security of guarantees against upside calamity. In forgoing that security, a company can assume the entire risk itself, assume responsibility for only certain types of predictable manageable risks, and/or assume part of the overall risk and spread the rest around. Risk may be spread by:

1. *Purchasing stop-loss insurance* (see box on page 36).
2. *Pooling with other employers.* By spreading the risk over a larger group of employees, the risks to any given employer are

diminished. Employer insurance associations or multiple employer trusts (METs) may be subject to state regulation over and above federal rules regarding administration and funding of employee benefit programs.

STOP-LOSS INSURANCE

Stop-loss insurance covers costs that exceed a preestablished limit. It is designed to kick in when the employer's liability reaches one or more "trigger points." Trigger points can be set for individual cases (at, say, $100,000), and at an aggregate level for the entire plan, (at, say, a level of 20 to 25 percent above expected claims). Trigger points should be adjusted regularly to account for medical inflation.

Like everything else, stop-loss insurance has been experiencing higher premiums. Some larger employers whose risk is already spread over a large number of employees may decide that the smartest economic move is to do without it.

The cost of stop-loss insurance is determined in large part by where the trigger points are—the lower they are, the more expensive the coverage.

Some stop-loss carriers (pressed by the potentially substantial risks associated with diseases such as AIDS) may require claims histories before extending coverage. This might make the coverage either unavailable, unaffordable, or unattractive in that it screens out certain types of risks for which the company especially needs protection.

Once the decision to self-fund is made, the next question is how to do it. Lower level, predictable risks, such as short-term disability and dental expenses, might be covered on a pay-as-you-go basis. Alternatively, for more substantial risks, funded reserves may be established. The Internal Revenue Code provides tax-favored vehicles for funding welfare benefits, for example:

VEBAs. VEBAs, or voluntary employees' beneficiary associations, are associations established for the purpose of providing "life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries" (Internal Revenue Code Section 501[c][9]). Before 1984, voluntary employee benefit associates were becoming the vehicle of choice for funding health care benefits,

offering tax benefits comparable to qualified retirement plans. Tax law changes, however, limited the ability of VEBAs to set aside large amounts of money in advance. This limitation on prefunding lessens their utility for building up protection against catastrophic losses. This shortcoming can be sidestepped through the use of stop-loss insurance, however, so VEBAs are still viable choices for self-funding current benefits. A greater shortcoming is their inability to accumulate sufficient funds for large future liabilities, such as prefunding retiree health benefit obligations.

401(h) Accounts. One answer to the retiree benefits funding problem is a 401(h) account in the employer's pension plan. Pension plans may provide for sickness, accidents, hospitalization, and/or medical expenses for retired employees, their spouses, and dependents, as long as the following provisions apply:

- Such benefits are subordinate to the retirement (income) benefits provided by the plan. This means that the aggregate (cumulative) contributions to provide medical benefits, combined with the contributions applied to the purchase of life insurance coverage, cannot exceed 25 percent of the aggregate contributions made to the plan (exclusive of contributions to fund past service liabilities) from the date medical benefits are first included in the plan.
- A separate account is established and maintained for these benefits.
- The company's contributions to the separate account are reasonable and ascertainable.
- Prior to the satisfaction of all liabilities under the plan, no part of the account may be diverted for any purpose other than for expenses of administering the medical benefits plan.
- The plan calls for the return to the employer of any amounts remaining after all the liabilities have been satisfied.
- Benefits provided for key employees must be separately accounted for.

Health Care Coalitions

One big problem with purchasing health care services is that comparison shopping is difficult. Even when an employer has a good handle on precisely where his or her company's health care dollars are going,

that still leaves important questions unanswered. Is it dealing with high- or low-cost providers? How does its experience stack up against that of other health care services consumers?

One way to answer these questions is through an employers' health care coalition. These are associations of employers formed for the primary purpose of gathering and sharing health care data, both from members and from health care providers. (Some states, such as Pennsylvania, Iowa, and Colorado, make information on hospitals and physicians publicly available.) Although coalitions tend to be local affairs, there are larger entities that have national constituencies, such as the Midwest and Washington Business Groups on Health.

How well do health care coalitions work? A November 1989 AHA survey of 125 coalitions found that only forty-five (36 percent) agreed with the statement: "The coalition has made a difference in controlling health costs in its service area." (The American Hospital Association survey was conducted by the Dunlop Group of Six, an informal forum for discussion of health care issues whose membership derives from the AHA, the AMA, the HIAA, the BC/BS, and the AFL-CIO.) Part of the problem may be that coalitions can be unstable and short-lived, lasting perhaps only three to five years before breaking up.

Some argue that merely compiling data is not enough. They believe that employers have buying-power clout that is not being used effectively. To that end, they advocate the formation of users' groups that would have as their objective utilizing their buying power to press providers for lower fees. Such a group is the Managed Health Care Association, a users' group comprising major employers.

Audits

Regardless of the form a company's health care plan takes, the employer will be paying bills. Those bills, like all bills, will be incorrect occasionally. Some of the errors will be deliberate, and some will reflect honest mistakes. It is generally assumed that most of the errors are on the side of higher charges, which some estimates place at 15 percent of health care billings. (On the other hand, a February 1990 survey of over 17,000 patient bills by Chart-Tech, Inc., an Illinois consulting firm specializing in charge audit reviews, found an average *under*charge of $101.)

The likelihood of errors, and the difficulty of catching them, is greater with medical bills than with other types of expenses. This is caused in part by the highly technical nature of the services provided,

but also by the nature of the billing system, or perhaps we should say *systems* (see box on page 40).

Complex coding systems can easily be defeated, not solely by ignorance, but by well-meaning reclassification. Here the objective is to bypass an insurance rule that would deny coverage for one type of treatment but would reimburse fully or partially for another. This helps the patient by moving a procedure from a nonreimbursable category to a reimbursable one.

In some cases coding errors are deliberate and self-serving. Some physicians engage in a form of "code gaming" to raise incomes. These games might be called the following names:

- "Code Creep" or "Upcoding"—reclassifying a procedure so that it falls into a category that calls for a higher reimbursement.
- "Unbundling"—dividing a single procedure into its separate component parts and billing separately for each. It is analogous to comparing the retail cost of a car to its cost as a collection of spare parts. Dollar rates are assigned to codes, but multiple procedure codes pay at lower rates than those for which each step is a separate code.
- "Fragmentation"—separating out incidental procedures and billing separately.
- "Exploding"—itemizing a series of tests that are performed on a single specimen of blood.
- "Visit Churning"—charging for an extra visit. For example, one visit may produce two bills: a doctor sees a patient in an emergency room, then admits him or her, and charges for a second visit as to an inpatient.

One way employers can maintain some measure of control over deliberate and inadvertent misbillings is through auditing. The audit entails a scrutiny of all charges for health care services to assure that the billed procedure fits the program of treatment, that it was medically necessary, that the overall cost is appropriate, and that the bill is otherwise accurate and without duplications and computational errors. Audits are most effective when directed by medical professionals, not administrative personnel.

Audits should be automated with access to data bases developed through the course of treatment. Automation alone, however, is not enough. Some software has not kept pace with complex and

individualized plan design and managed care. Also, some firms hire low-wage operators, who are not up to the complexities of the job and change jobs quickly.

Audits may be performed routinely by the third-party administrator responsible for processing plan claims, by the insurer, or by a cost-containment firm hired specifically for that purpose. Medical cost-containment firms assist in the claims-management function performed either by the employer or the employer's insurer. Employers hire these firms for a variety of reasons, such as to spread liability for claims of bad faith and to allocate the cost of medical cost-containment services directly to claims handled rather than as an administrative overhead expense. The principal objective is, of course, cost savings, so fees should be more than offset by savings in billings from health care providers. Although a few firms promise a specified level of savings, these are rarely accompanied by any solid guarantee.

Cost-containment firms bill on one of several bases, depending on the nature of services provided:

- A charge per line item audited
- A charge per bill audited
- On an hourly basis
- A percentage of billings reviewed

Where alternative billing arrangements are available, hypothetical charges based on the employer's historical billing experience should be compared.

BILLING SYSTEMS AND CODES

At one time, maximum reimbursements were determined from "usual, customary and reasonable" (UCR) charges for a given treatment. UCR is based on historical fee patterns, however, which means that providers had incentives to raise fees and set precedents, making the system inherently inflationary. Nor were there incentives to reduce fees after the costs of expensive buildings or high-tech equipment were fully depreciated.

Medicare dropped its version of UCR ("customary, prevailing and reasonable") for hospitals and instituted Diagnostic Related Groups (DRGs), a move that was followed by many insurers. One effect of this was an increase in outpatient treatment and a corresponding increase in the cost of outpatient care. To counter the inflation in

outpatient physician fees, Medicare is introducing a resource-based relative-value system (RBRVS), which assigns pricing units to various procedures based on the medical training involved, the resources required, and the time expended. It is intended to place controls on charges while allowing flexibility, which is achieved by adjusting the unit values.

Meanwhile, those bills that are not based on one of the foregoing systems are compiled using a system of medical codes. One such coding system, Current Procedural Technology (CPT), was developed by the American Medical Association to categorize 7,000 different medical procedures, each represented by a five-digit code. Medicare and private insurers currently require these to be included on physicians' bills. The coding is very complicated, and some of the problems stem (understandably) from simple confusion over which codes are the correct ones for a given procedure.

Some critics have argued that the requirement for itemized coded billing has actually increased costs. Line items numbering in the thousands, wide variation from one locality to another in cost of a line item, and in the assortment of line items for a given procedure have all created a system that is difficult to manage.

Reducing Benefits

The original idea behind employer-provided health care was to cover catastrophic hospital, surgical, and other major types of medical treatment that the employee could not otherwise afford. From its simple origins, the concept has expanded so that coverage now extends to all sorts of routine practices including eye care, office visits, and prescription drugs. Not only has this broadened the span of employer liability, but by taking the patient out of the payment process it has taken away a valuable control on costs as well.

Now some companies would like to retrench. In addition to cutting their share of the costs, these companies are looking for ways to reduce the level of covered benefits. One area being explored is dependent benefits. Northwestern National Life Insurance Company surveyed 400 corporate executives representing 3.9 million workers and found that 89 percent were considering some form of cost-containment measure that would restrict benefits for dependents. The June 1989 survey report showed that $.47 of every health care dollar went for dependent expenses. Revised plans could restrict dependent mental health and/or chemical dependency coverage; link the level of family

health insurance premiums to the age and sex of dependents—which would generally mean that employees with adolescent dependents would pay more; and prescreen dependents to deny coverage, increase premiums, or impose a waiting period.

Another, more radical (and, consequently, not very popular) idea is to change the basis for health care coverage. Generally, regardless of the form they take, employer health care plans are open-ended affairs: Their reimbursements or charges are determined by the cost of the care (analogous to defined benefit pension plans, whose costs are determined by the size of the benefit). The alternative is a defined contribution approach, in which the employer establishes a per-employee budget, funds to that level, and stops. Flexible benefit plans, with individual benefit accounts, are a tentative step in that direction. (Hospitalization plans that pay a flat per-diem benefit are in between.) The obvious problem with this approach is that there may be no relationship between the cost of an individual's care and the money accumulated to pay for it. Blanket catastrophic insurance could take some of the pain away.

Once given, however, benefits are not always so easy to take back. Employees react strongly to any form of reduction in their compensation, be it cash or benefits. Even where no union is involved, the possibility of concerted action is still very real. Faced with increasing liabilities for retiree health care (which some estimates have placed as high as $2 trillion), a number of companies attempted to cut back, either by increasing the retired employees' share of the costs, or by doing away with the benefits altogether. Not a few of these attempts wound up in court. So far the courts have tended to back management, at least where the employer reserved the right (in writing) to terminate or alter the commitment.

Another consideration in reducing benefits is the danger of false economy. Taking our earlier example of dependent mental health costs, for example, the conventional wisdom would suggest cutting benefits by placing limits on the length of time benefits are payable (for example, twenty-eight to sixty days) or on the size of payments (which run up to $1,000 a day for hospitalization). Even though health care plans place no caps on hospital stays, many plans have put limits on mental health inpatient stays—often around thirty days. There are also lifetime caps of $50,000 or less, or $20,000 a year, as well as annual caps on outpatient care, no out-of-pocket maxima, and copayments of 50 percent as compared to 20 percent for other types of care. The four-year study of experience at McDonnell-Douglas (a review of

medical claims and absentee records for 20,000 of the company's 125,000 employees) conducted by Alexander & Alexander in November of 1989 found that shortening mental health treatments is penny wisdom. In the long run, costs associated with medical claims and employee turnover are reduced by investing in an EAP, even when that means that initial costs are greater. The study found that providing high-quality care up front cuts costs later on. When the EAP screened troubled employees and referred them for appropriate treatment, the result was a much more cost-effective approach over the long run.

THE QUESTION OF QUALITY

As with economic choice, cost containment involves trade-offs. An important trade-off is savings at the expense of quality. A prominent risk in reducing the level of corporate expenditures for health care is that in so doing the quality of care provided to employees is compromised, exposing the employee to medical complications and the employer to lawsuits.

Utilization review, preauthorization, generic prescriptions—all of these restrict choice and the availability of alternatives. In some cases, there are financial incentives for caregivers to restrict care, such as those offered to their doctors by some HMOs to keep patients out of hospitals. When a connection can be shown between health care policy and improper or insufficient care that has resulted in injury to a patient, the sponsoring employer could be held liable. Hiring third parties substantially reduces the risk.

In at least one case, consumers have gone beyond philosophical disagreement and taken their business elsewhere. In the 1988 case of *Teti et al. v. U.S. Healthcare et al.* (No. 88-9808, U.S. District Court for East Pennsylvania), plaintiffs sued for a return of all premiums paid to an HMO by some 900,000 members. The complaint charged that the HMO failed to disclose financial incentive arrangements that discouraged physicians from recommending hospitalization and specialists. Funds dedicated to these services that remained unspent at the end of the year were divided among the physicians, a strong incentive for physicians to prescribe these services sparingly (the intention of the program in question and similar programs of other HMOs).

Of course, it does not necessarily follow that lower cost means poorer quality. There is some evidence that higher cost care may be that way because of inefficiencies. These same inefficiencies may result in lower quality care, producing the anomalous result that poor quality actually costs more.

Still, there are issues to be concerned with. One study found that institutional death rates were declining until 1983, and were projected to continue to descend. At that point, however, they became flat, suggesting a connection with federal government cost-containment efforts imposed at that time.

The nexus between cost cutting and quality of care is strong enough to justify making careful oversight of treatment standards an integral part of the containment effort.

5 | Developing a Cost-Containment Strategy

The foregoing should reinforce the perception that cost-containment is, as yet, neither art nor science. Meticulously planned strategies, careful implementation, and diligent management can still produce results that are other than expected and not infrequently disappointing. Meaningful cuts in employer expenses can be achieved only by drastic cuts in benefits and/or big boosts in employee contributions, both of which are so far unacceptable to most corporate managers. Smaller cuts and boosts have predictably less spectacular results. Curtailments in the rate of increase are possible, though not assured, through managed care, audits, self-funding, and the like. These are well worth considering even when they do not provide a short-run cost solution.

In short, benefits managers need to consider the best the state of the art has to offer because they cannot afford otherwise. The threat to corporate profitability is too great to leave any stone unturned.

The first essential in effective comprehensive medical cost-containment is an employer-devised strategy for providing the desired benefits at manageable cost. Developing that strategy includes the following steps:

STEP 1. DEFINE THE PROBLEM

In order to select the most effective approach for managing costs, it is best to determine precisely where and why the costs are out of control. Is the problem generalized, or is it largely attributable to a single or a very few elements of the existing program? For example, are there particular problems with dependent coverage, retiree benefits, or a small number of catastrophic cases? The answers to these questions involve—

- ☐ Assembling precise cost and experience data, broken down as finely as possible so that each separate component and subcomponent of the program is accounted for.
- ☐ Comparing data for the current period with that of prior periods (and projections for the future, if possible) to establish trends.
- ☐ Comparing the data to that of other similarly situated employers to see if plan experience has been better or worse than average. This comparison may be done with the help of a local employer health care coalition.

STEP 2. REEXAMINE THE COMMITMENT

In the light of the data assembled in the first step, reconsider the types and levels of benefits being offered in light of overall company objectives. Does each offering contribute significantly to employee recruitment, retention, and morale, as well as to other corporate goals that would justify the expense of maintaining the health care plan or plans? Is the plan intended to provide a safety net to protect employees from calamitous expenses, or is it an additional form of compensation that is designed to pay for all but the most trivial of medical expenses?

At the same time current types and levels of offerings are being evaluated, it is a good idea to look for benefits that are not now being offered but that should be. The reason for this is that it is difficult to take away a benefit once it has been given (it's much easier not to give it in the first place), but the discomfort is eased if something else is offered in its place. For example, eliminating employer-pay-all dependent benefits is less irritating to employees if a (less costly) child care benefit is offered in its place.

This review should produce a list of benefits that must be maintained, those that could be eliminated, and those that might be considered as additions, cost permitting. It would be remarkably good luck if the components that are producing the biggest cost problems are also the ones that are most expendable. As this is not commonly the case, the employer must proceed through the remaining steps.

Where no single array of benefits meets the needs of all employee groups equally well, flexible benefits plans should be considered to allow employees to make their own choices.

SPECIAL HELP FOR THE SMALL EMPLOYER

Small employers, those with fewer than 50 employees, have been especially hard hit by health care cost increases. Very small employers are especially vulnerable to the costs of state mandated benefits, as they are less well positioned to self-fund, and must rely on insurer offerings to which the mandates generally apply.

A number of states have recognized the burden that mandated benefit legislation, however well intentioned, has placed on these employers. States such as Florida, Illinois, Minnesota, Missouri, Virginia and Washington have introduced special statutory exemptions for employers with fewer than twenty-five or fifty employees, depending upon the state. (Connecticut has also passed legislation aimed at reducing small business health costs, but it does so through fee caps, risk pools, and coverage guarantees, leaving mandated benefits requirements untouched.)

By lifting some mandated benefits requirements for these employers, these states permit insurers to offer "bare bones" coverage at prices 20 percent or more below those for full-mandate policies. Some restrictions apply! Some of the exemptions cover only employers offering health care coverage for the first time, thereby preventing companies from switching to cheaper, less comprehensive coverage.

STEP 3. DEFINE ROLES AND RESPONSIBILITIES

Once the problem areas of the current program and the essential elements of the ongoing program have been identified, the next decisions relate to who does what and how much.

Employer vs. employee. Few employers are willing to bear all of the costs of employee health care anymore. The question, then, is not whether employees should share the costs, but how much can reasonably be expected of them. Consider making at least part of the employee share tax-deductible through flexible spending accounts.

Employer vs. insurer. Even small employers are looking seriously at self-funding some of their benefits costs, as a device for realizing savings from avoidance of state mandates, or for capitalizing on the favorable experience of the covered group that might not be fully reflected in insurance rates.

STEP 4. CHOOSE PROVIDERS

Once the strategic decisions have been made, the employer must choose the insurer or insurers, HMOs, PPOs, and other health care facilities and providers, cost-containment firms, third-party administrators, and/or others who will be enlisted to implement the plan.

This is the stage at which bids and proposals (based upon the parameters set out in the preceding steps, revised if necessary in the light of new information) are compared. The temptation to evaluate on price alone should be resisted for the following reasons:

- First year prices may be artificially low and can be followed by whopping increases in subsequent years once the provider has experience with a year's worth of claims.
- Proposals are seldom precisely identical. Low bidders should be scrutinized carefully to see what has been left out. (The matrix in appendix A will help you evaluate proposals.)
- Low costs in one component can mean higher costs elsewhere, as when a low-priced HMO draws healthy participants from an indemnity plan.

STEP 5. COMMUNICATE WITH EMPLOYEES

As soon as the plan and providers have been selected, preliminary notices to employees, explaining the need for the change and the general nature of it, should be posted and a copy delivered to every employee. Early (and regular) communication is a way of promoting acceptance of the new program and heading off grumbling and complaints later on. An employee committee might share the task of selecting from among providers, or employees might be asked to vote for the provider and the plan.

STEP 6. MANAGE THE PROGRAM

Once the program is in place, constant attention is required to ensure that the objectives are being met. This oversight takes the form of audits, utilization controls, and statistical analyses to see what is working and what is not. This means determining who (employer, insurer, cost-containment firm, third-party administrator) will be responsible for maintaining

comprehensive data on claims and expenses, and how such data will be used. Data may be gathered from insurers, HMOs, workers' compensation, and so forth, and may include such details as—

- Inpatient admissions per 1,000.
- Inpatient hospital days per 100 covered persons (employees and dependents).
- Average length of hospital stay per 1,000 covered persons.
- Surgery per 100 covered persons (inpatient and outpatient separately).
- Outpatient sessions per 100 employees.
- Outpatient sessions per patient.
- Cost per case.
- Total inpatient and outpatient costs.
- Year-to-year trends.

These data may be compared with the experience of similar groups to identify problem areas and irregularities.

GOING FOR HELP: SOURCES OF PROFESSIONAL ADVICE

The preceding outline is addressed to employers who wish to proceed on their own. Even though some (large) employers may have the resources and expertise to make the necessary evaluations, they usually rely to some degree on outside advisors. These fall into several categories:

- *Employee Benefits Consultants.* A competent consulting firm, or the employee benefits division of an accounting firm, should be able to assist the employer with all phases of decision making, from start to finish. A consulting report should analyze the current program for problems, provide a basis for comparison with other similarly situated employers, recommend improvements, prioritize areas for cost savings, recommend providers, and provide an outline for ongoing administration. The consultant will also answer management's questions as they arise and assist in negotiating with insurance carriers, HMOs, and others.

If this sounds too good to be true, it is. Consultants vary considerably in quality, can be very expensive, and are not always able to deliver on their promises of cost savings (though this is often due to circumstances beyond anyone's control). Obviously, those with the best track records, as evidenced by their references, should be considered first.

Even relatively small companies should solicit proposals from local consultants. Fee ranges are available up front, so affordability can be established at the outset. Even when the fee seems high relative to annual health care expenditures, solid advice can produce savings (in forestalled increases, if not in immediate reductions) sufficient to pay for the cost of the consultation.

- *Insurance Companies.* The advantage of dealing with insurance companies is that they will generally provide an employer with an analysis and a proposal free of charge. The disadvantage is that the analysis is geared to their own product, and will not give the employer much insight into other options. Knowledgeable representatives can provide useful information and education, however, at a cost that may be especially attractive to small businesses.

- *Cost-Containment Firms.* There is considerable overlap between cost-containment firms and employee benefits consultants, and some with third-party administrators, as well. What distinguishes cost-containment firms is that their fee schedules are tied to ongoing monitoring services and *may* also be linked to actual cost reductions (although more often, they may not).

  As with all professional advisors, a review of their historical performance should be an integral part of any evaluation. The volatility of the health care environment complicates these evaluations, however, and the relative youth of many cost-containment firms complicates things further.

Appendix A | Health Insurance Proposal Analysis Checklist

The purpose of the Health Insurance Proposal Analysis Checklist is to aid the decision-making process when evaluating the characteristics of various health care plan options. It is a flexible tool that can be used by an employer in selecting among proposed plans, comparing an existing plan to options that may be available through other vendors, or simply keeping track of changes to existing plans.

Here are some steps to follow when using the checklist to compare the characteristics of proposed plans:

1. Customize the format of the checklist (that is, the components in the left-hand column) to meet the specific realities of your organization.
2. Send a blank copy of the checklist (with room for three or more proposals) to each vendor interested in preparing a proposal.
3. Put all the proposals received onto one spreadsheet, assuring that all information on each line item is quoted in comparable terms.
4. Identify the key factors that differentiate one proposal from the next. Comparing these key factors should allow you to pare down the list of possibilities to a manageable few.

Information accumulated on the spreadsheet can be used—

- ☐ To negotiate among competing vendors.
- ☐ To summarize the competing proposals for the ultimate decision makers.
- ☐ To explain the rationale to employees once a decision has been made.

	Proposal #1	*Proposal #2*	*Proposal #3*
Insurance Company			
Plan			
Agent/Date			
Deductible—			
Individual			
Family			
Copayment—Individual and family			
Maximum out-of-pocket—			
Individual			
Family			
Prescriptions			
Maximum benefit			
Accidental injury expense			
Hospital and surgery—			
Preadmission review			
Penalty			
Second surgical opinion			
Penalty if none			
Preferred provider incentive			
Penalty			
Preexisting condition			
Chiropractic			
Hearing aid			
Eye care			
Major transplant			
Maternity			
Well-child care			
Mental health—			
Inpatient			
Outpatient			
Lifetime			
Alcohol/Drug abuse—			
Inpatient			
Outpatient			
Lifetime			
Hospice			
Wellness/Preventive			

	Proposal #1	*Proposal #2*	*Proposal #3*
Cost—			
Individual			
Family			
One other			
Two others			
Life insurance company—			
Amount required			
Cost			
AD&D			
Dental—Company—			
Deductible			
Preventive			
Basic restore			
Major			
Orthodontics			
Maximum per year			
Cost—			
Individual			
Family			
Discounts available			
Claims turnaround time			
Address to which claims are sent for processing			
Other			

Appendix B | Health Information Resources

Government

Agency for Health Care Policy and Research (AHCPR)
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4100

Alcohol, Drug Abuse and Mental Health Administration
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3783

Bureau of Labor Statistics
441 G Street, NW
Washington, DC 20210
(202) 523-1221

Centers for Disease Control
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-3311

Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201
(202) 619-0287

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207
(301) 966-3000

Health Resources and Services Administration
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-5487

Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224
(202) 566-5000

National Center for Health Care Statistics
6525 Belcrest Road
Hyattsville, MD 20782
(301) 436-8500

National Health Information Center
P.O. Box 1133
Washington, DC 20013-1133
(800) 336-4797 or
(301) 565-4167

National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20892-0001
(301) 496-4000

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161
(703) 487-4650

Pension and Welfare Benefits Administration
200 Constitution Avenue, NW
Washington, DC 20210
(202) 523-8921

Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235
(301) 965-1234

U.S. Department of Commerce
Herbert C. Hoover Building
Fourteenth and Constitution Avenue, NW
Washington, DC 20230
(202) 377-2000

U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
(202) 523-6666

U.S. General Accounting Office
Document Handling and Information Facility
P.O. Box 6015
Gaithersburg, MD 20877
(202) 275-6241

U.S. Government Printing Office
Superintendent of Documents
941 North Capital Street, NE
Washington, DC 20402
(202) 783-3238

Associations and Nonprofit Organizations

Administrative Management Society Foundation (AMS)
Suite 1100
1101 Fourteenth Street
Washington, DC 20005
(202) 371-8299

AFL-CIO
Employee Benefits Department
815 Sixteenth Street, NW
Washington, DC 20006
(202) 637-5204

AFL-CIO Occupational Safety and Health Department
815 Sixteenth Street, NW
Washington, DC 20006
(202) 637-5366

Alcoholics Anonymous
General Services Office
Eighth Floor
468 Park Avenue South
New York, NY 10016
(212) 686-1100

American Association of Healthcare Consultants (AAHC)
Suite 109
11208 Waples Mill Road
Fairfax, VA 22030
(703) 691-2242
[(703) 691-AAHC]

American Association of Homes for the Aging (AAHA)
Suite 500
901 E Street, NW
Washington, DC 20004
(202) 783-2242

American Association of Preferred Provider Organizations (AAPPO)
Suite 2200
401 North Michigan Avenue
Chicago, IL 60611
(312) 644-6610

American Cancer Society (ACS)
1599 Clifton Road, NE
Atlanta, GA 30329
(404) 320-3333

American College of Health Care Administrators (ACHCA)
325 South Patrick Street
Alexandria, VA 22314
(703) 549-5822

American College of Physicians (ACP)
Independence Mall West
Sixth Street at Race
Philadelphia, PA 19106
(215) 351-2400

American Health Care Association (AHCA)
1201 L Street, NW
Washington, DC 20005
(202) 842-4444

American Heart Association (AHA)
Inquiries Section
7320 Greenville Avenue
Dallas, TX 75231
(214) 373-6300

American Hospital Association (AHA)
Office of Health Coalitions and Private Initiatives
840 North Lake Shore Drive
Chicago, IL 60611
(312) 280-6000

American Insurance Association
Suite 1000
1130 Connecticut Avenue, NW
Washington, DC 20036
(202) 828-7100

American Managed Care and Review Association (AMCRA)
Suite 610
1227 Twenty-Fifth Street, NW
Washington, DC 20037
(202) 728-0506

American Medical Association (AMA)
515 North State Street
Chicago, IL 60610
(312) 464-5000

Association for Healthcare Philanthropy (AHP)
Suite 400
313 Park Avenue
Falls Church, VA 22046
(703) 532-6243
[(703) 532-NAHD]

Blue Cross and Blue Shield Association
676 North Saint Clair Street
Chicago, IL 60611
(312) 440-6000

The Center for Corporate Health Promotion
Suite 520
1850 Centennial Park Drive
Reston, VA 22091
(703) 391-2400

Children's Defense Fund
122 C Street, NW
Washington, DC 20001
(202) 628-8787

Council of Medical Specialty Societies (CMSS)
P.O. Box 70
Lake Forest, IL 60045
(708) 295-3456

Employee Assistance Professional Association
Suite 1001
4601 North Fairfax Drive
Arlington, VA 22203
(703) 522-6272

Employee Benefit Research Institute (EBRI)
Suite 600
2121 J Street, NW
Washington, DC 20037-2121
(202) 659-0670

Employers Council on Flexible Compensation (ECFC)
Suite 1000
927 Fifteenth Street, NW
Washington, DC 20005
(202) 659-4300

Group Health Association of America (GHAA)
Suite 600
1129 Twentieth Street, NW
Washington, DC 20036
(202) 778-3200

Health Care Financial Management Association (HCFMA)
Suite 700
Two Westbrook Corporate Center
Westchester, IL 60154
(800) 252-4362

Health Insurance Association of America (HIAA)
1025 Connecticut Avenue, NW
Washington, DC 20004-2599
(202) 223-7780

Institute for a Drug-Free Workplace
P.O. Box 65708
Washington, DC 20035-5708
(202) 463-5530

Institute for Professional Health Service Administrators
Suite 601
1101 King Street
Alexandria, VA 22314
(703) 684-0288

International Dental Health Foundation, Inc.
11484 Washington Plaza West
Reston, VA 22090
(703) 471-8349

International Foundation of Employee Benefit Plans (IFEBP)
18700 West Bluemound Road
P.O. Box 69
Brookfield, WI 53008-0069
(414) 786-6700

International Society of Certified Employee Benefit Specialists (ISCEBS)
18700 West Bluemound Road
P.O. Box 209
Brookfield, WI 53008-0209
(414) 786-8771

InterStudy
Center for Managed Care Research
5715 Christmas Lake Road
P.O. Box 458
Excelsior, MN 55331-0458
(612) 474-1176

Midwest Business Group on Health
Suite 200
8303 West Higgins Road
Chicago, IL 60631
(312) 380-9090

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
(800) 458-5231

National Association of Employers on Health Care Action (NAEHCA)
Suite 110
240 Crandon Boulevard
Key Biscayne, FL 33149
(305) 361-2810

National Association of Health Data Organizations (NAHDO)
254B North Washington Street
Falls Church, VA 22046
(703) 532-3282

National Association of Insurance Commissioners (NAIC)
Suite 1100
120 West Twelfth Street
Kansas City, MO 64105
(816) 842-3600

National Association of Addiction Treatment Providers (NAATP)
Suite 100
25201 Paseo de Alicia
Laguna Hills, CA 92653
(714) 837-3038

National Association of Private Psychiatric Hospitals
Suite 1000
1319 F Street, NW
Washington, DC 20004
(202) 393-6700

National Association of Rehabilitation Facilities
Suite 200
1910 Association Drive
Reston, VA 22090
(703) 648-9300

The National Center for Health Promotion
3920 Varsity Drive
Ann Arbor, MI 48108
(313) 971-6077

National Council on Alcoholism and Drug Dependence, Inc.
12 West Twenty-First Street
New York, NY 10010
(212) 206-6770

National Employee Benefits Institute
Suite 400
2445 M Street, NW
Washington, DC 20037
(800) 558-7258

National Federation of Independent Business (NFIB)
150 West Twentieth Avenue
San Mateo, CA 94403
(415) 341-7441

National Health Council
Suite 1118
350 Fifth Avenue
New York, NY 10118
(212) 268-8900

National Heart, Lung, and Blood Institute
Information Center
Suite 530
4733 Bethesda Avenue
Bethesda, MD 20814-4820
(301) 951-3260

National Leadership Coalition
for Health Care Reform
555 Thirteenth Street, NW
Washington, DC 20004
(202) 637-6830

National Safety Council
Box 11171
Chicago, IL 60611
(312) 527-4800

The National Wellness Institute
South Hall
1319 Fremont Street
Stevens Point, WI 54481
(715) 346-2172

New York Business Group on
Health
622 Third Avenue, Third Floor
New York, NY 10017
(212) 808-0550

The RAND Corporation
P.O. Box 2138
Santa Monica, CA 90407-2138
(213) 393-0411

Self-Insurance Institute of
America
P.O. Box 15466
Santa Ana, CA 92705
(714) 261-2553

Service Employees International
Union (SEIU)
1313 L Street, NW
Washington, DC 20005
(202) 898-3200

Society for Human Resource
Management (SHRM)
(formerly American Society
for Personnel Administration)
606 North Washington Street
Alexandria, VA 22314
(703) 548-3440

Washington Business Group on
Health
Suite 800
777 North Capitol Street, NE
Washington, DC 20002
(202) 408-9320

HMO Quality Review Organizations

Accreditation Association for
Ambulatory Health Care
Suite 512
9933 Lawler Avenue
Skokie, IL 60077-3702
(708) 676-9610

Joint Commission on
Accreditation of Healthcare
Organizations
One Renaissance Boulevard
Oak Brook Terrace, IL 60181
(708) 916-5600

Center for Consumer Health
Care Information
1821 East Dyer Road
Santa Ana, CA 92075
(800) 627-2244

Appendix C | AICPA Services for Members in Industry

Introduction

The CPA title holds a special value for you, the member in industry. The designation is recognized by your colleagues, your employers, and your community as representing excellence and professionalism.

The composition of members of the AICPA has been changing steadily over the past fifteen years. In 1975, there were approximately 35,000 members in industry, representing 31 percent of the AICPA membership. Today, there are approximately 120,000 members in industry, representing over 40 percent of the total membership.

The Members in Industry Executive Committee represents the interests and needs of CPAs in business and industry in the activities of the Institute. The Committee's purpose is to enhance the benefits of membership for business and industry members by monitoring, recommending, developing, and overseeing related programs or services of the Institute.

The Committee encourages the active participation of members in business and industry in their professional associations.

This Appendix briefly describes many of the programs that are of interest to industry members.

Conferences

To maintain and strengthen the high level of competence associated with the CPA designation and to better prepare industry members for today's business challenges, the AICPA sponsors conferences designed to provide industry CPAs with the latest information on technical and management topics.

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Each year, the **National Industry Conference** is held in a major U.S. city. The conference provides a wide range of subject matter in a format that permits you to select only those sessions of interest to you, and still obtain twenty CPE credit hours.

Examples of sessions presented at recent National Industry Conferences are—

- ☐ Increasing Negotiation Skills.
- ☐ Health Care Cost-Containment Strategies.
- ☐ How to Prevent a Firing From Backfiring.
- ☐ Expert Systems for CPAs in Industry.
- ☐ Listening and Rapport—Essential Skills for Managers.
- ☐ Taking the Company Public.
- ☐ Achieving Peak Motivation.
- ☐ How to Obtain Venture Capital.
- ☐ Ethics and the Industry CPA.
- ☐ Internal Auditing in the 1990s.
- ☐ Presentations to Top Management.

In addition, the conference provides annual updates on accounting standards, SEC reporting, income taxes for small and large businesses, and developments in information technology.

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The Industry Committee is working to make the **Annual Meeting and other AICPA Conferences** more relevant to the member in industry. By sponsoring or organizing conference sessions covering management accounting, internal auditing, and financial management topics, and by commenting on the content of other sessions, the committee lends an industry perspective to AICPA programs.

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Among other AICPA Conferences, the **National Conference on the Securities Industry**, the **National Microcomputer Conference**, the **National Conference on Banking**, and the **AICPA National Conference on Current SEC Developments** have proven to be of interest to industry members. They are designed to appeal to all CPAs with an interest in the conference topics.

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To encourage increased activity among state societies and coordination between the AICPA and state society programs, the Members in Industry Executive Committee sponsors the annual **Conference for State Society Industry Committee Chairs and Executive Directors** on the day before the National Industry Conference. The conference provides an important forum for the exchange of ideas on how best to serve industry CPAs.

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For more information on conferences, call the Meetings Department, 212-575-6451.

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Technical and Managerial Assistance

As a benefit of membership in the AICPA, you have access to a wealth of technical accounting knowledge without charge. All you need to do is pick up the telephone and present your problem.

The Technical Information Service responds to member inquiries about accounting problems (except tax and legal questions and those involving litigation). The staff CPAs can help find the answers and provide citations of authoritative reference sources.

	Toll Free Calls
United States (including Puerto Rico and Virgin Islands)	**800-223-4158**
New York State only	**800-522-5430**

★ ★ ★ ★

Continuing Professional Education helps you keep pace with the rapidly changing environment in which you work. That's the reason behind the AICPA's new CPE requirement. All members of the AICPA, except those in retirement, must now complete a prescribed amount of CPE to retain membership in the Institute. Industry members must complete sixty hours of CPE for the first three-year reporting period beginning January 1990 with a minimum of ten hours each year, and ninety hours of CPE for subsequent three-year reporting periods, with a minimum of fifteen hours each year.

To meet the CPE requirement, you may select from a wide range of courses on critical management issues, late-breaking technical developments, or issues vital to your own specific industry. The AICPA's CPE Division offers courses to suit the learning needs of members in industry. A wide variety of seminars are available, including "Today's Controller—

The Total Manager," "Business Cash Management—Maximizing Your Cash Flows," and "Basic Cost Systems." The AICPA also produces in-house CPE materials, including video and individual-study programs, which make CPE convenient for members in industry.

CPE Information	
United States (including Puerto Rico and Virgin Islands)	**800-AICPA-NY**
New York State only	**212-575-5696**
For Questions on AICPA CPE Requirements	**212-575-8708**

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The AICPA Library researches members' requests for information, provides bibliographies, and loans material by mail. The Library has the annual reports of 6,500 companies on Microfiche. With Laser Disclosure the Library provides access to 10K and annual reports. The Library also produces the **Accountant's Index,** a reference guide to current accounting literature, available in print and online.

	Toll Free Calls
United States (including Puerto Rico and Virgin Islands)	**800-223-4155**
New York State only	**800-522-5434**

Through the **National Automated Accounting Research System (NAARS),** industry members can research financial statements, footnotes, and auditors' reports from thousands of corporate annual reports to shareholders. NAARS may be accessed through an IBM PC at a reasonable cost.

For more information call **212-575-6393**

Through the **Total On-line Tax and Accounting Library (TOTAL),** members can subscribe to Mead Data Central Inc. LEXIS/NEXIS services.

For more information call **212-575-7075**

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AICPA Software can help make industry members' jobs more productive, less time-consuming, and more cost-effective. Among others, there are programs to compute compound interest and loan amortization, to research professional and technical data bases, and to extract and analyze computer files from mainframes, minicomputers, and other microcomputers. For a catalog of software products, call the **AICPA Software Marketing Coordinator** at 212-575-5715.

The Professional Ethics Division responds to members' questions about the application of the code of professional ethics to specific situations. The division also investigates complaints of alleged violations of the code of professional ethics.

For more information write to
Technical Manager
Professional Ethics Division
or call **212-575-6216**
212-575-6299
212-575-6736

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Voluntary Dues-paying Membership Divisions have been established for AICPA members who have special interests in **taxation, personal financial planning (PFP)**, and **management advisory services (MAS)**. Membership in these divisions includes practical benefits, such as publications, newsletters, and surveys.

The AICPA Council approved the formation of a new membership division at its May 1991 meeting. The **Information Technology Division** is designed to increase the knowledge and skills of CPAs in the application of current and future technologies in the workplace. For more information about this division, call 212-575-5715.

Each division also holds national meetings, which members are encouraged to attend.

For more information call
Tax Division **202-737-6600**
PFP **212-575-3644**
MAS **212-575-6290**

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Publications

The Members in Industry Executive Committee is planning a series of educational and reference books designed to assist CPAs employed in business and industry in carrying out their responsibilities to their employers. This publication, **Holding Down Health Care Costs,** is the first of that series.

Studies and guidelines on subjects of interest to members in industry are issued by the **Accounting Standards, Auditing Standards, Federal Taxation**, and **Management Advisory Services** divisions and by the **Accounting and Review Services Committee**. Publications may be purchased through the Order Department by calling

United States (including
Puerto Rico and Virgin Islands) **800-334-6961**
New York State only **800-248-0445**

★ ★ ★ ★

The ***CPA Letter*** provides members with information about current technical and professional developments.

The Financial Manager's Report: A Quarterly Update for CPAs in Business and Industry will appear four times per year as a special insert in **The CPA Letter.**

For more information call **212-575-6274**

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The ***Tax Adviser*** publishes tax articles, interpretations, tax-planning pointers, and recent developments.

For more information call **212-575-6317**

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Do you have interesting professional information you'd like to share with your CPA colleagues?

The ***Journal of Accountancy*** invites industry AICPA members to submit article ideas about subjects of interest to other industry accountants. Subjects can range from research you've conducted to ideas for making your work more effective and efficient.

In addition, the **Focus on Industry** department appears regularly in the **Journal.**

If you would like to submit an article or comment on **Focus on Industry** contact the **Journal** at the address or phone number below:

Journal of Accountancy
1211 Avenue of the Americas
New York, New York 10036-8775
212-575-5519

★ ★ ★ ★

The ***Accountant's Business Manual*** contains up-to-date information on a wide range of business services: taxes, insurance, investments, bankruptcy, etc. The manual is published as a single, loose-leaf volume; updated supplements can be obtained semiannually. Call the Order Department:

United States (including
Puerto Rico and Virgin Islands) **800-334-6961**
New York State only **800-248-0445**

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The Industry Member Forum Program encourages members in industry to meet on an informal basis to discuss technical and professional topics of common interest. Many state CPA societies sponsor industry member forums.

The ***Industry Member Forum Manual*** explains how to organize a forum, and offers ideas for topics to be discussed.

212-575-6439

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Professional Recognition

The **Communications Division** coordinates national public relations programs and media campaigns to enhance the understanding of CPAs among various groups, including Congress and Washington opinion leaders. Additionally, it works to improve the CPA's image and provides marketing support in the form of speeches, videos, slide presentations, and brochures.

212-575-5574

★ ★ ★ ★

The **Examinations Division**, under the direction of the **AICPA Board of Examiners**, prepares the **Uniform CPA Examination** and operates the **Advisory Grading Service**; both are used by all boards of accountancy to license CPAs. The Uniform CPA Examination ensures that CPAs possess a minimum level of technical competence.

Also, the Examinations Division, under the direction of the **AICPA Specialization Accreditation Board**, develops and manages the **Accredited Specialist Designation Program** and prepares and grades the **Accredited Personal Financial Specialist (APFS) Examination.**

212-575-6495

★ ★ ★ ★

The **Relations with Educators Division** develops recruiting literature, videos, and other programs to keep educators and students informed about the opportunities in the accounting profession. Through its **Educators Practicum** program, the division offers members in industry the opportunity to use fully qualified and licensed CPA educators on a consulting or other short-term basis.

If you have questions or need more information call **212-575-6357**

★ ★ ★ ★

The **State Legislation Department** works closely with the state societies on state accountancy legislation that protects the interests of all CPAs and the general public. The department also provides a national perspective on state legislative and regulatory matters.

For more information call **202-737-6600**

★ ★ ★ ★

The **Federal Government Division** monitors federal legislation and regulations and submits comments to legislators and regulators on matters affecting industry members.

For more information call **202-737-6600**

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Member Benefits

Insurance

As a member of the AICPA, you are entitled to personal insurance coverages at rates that are substantially lower than those offered commercially.

Many members have discovered that the savings obtained by selecting AICPA life insurance exceeds the cost of their yearly membership.

Currently, the following are available:

Life Insurance Plans include the **CPA Plan** (for individuals), which provides up to $750,000 of life insurance plus $750,000 of accidental death benefits.

Spouse Life Insurance for eligible spouses of CPA Plan participants, provides the same levels of coverage as are offered under the CPA Plan.

The **Personal Liability Umbrella Security Plan (PLUS Plan)** for members provides up to $5 million in coverage for claims for personal liability, bodily injury, or property damage that exceed primary automobile and homeowner's or renter's coverage.

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The **Long-Term Disability Income Plan** for individual CPAs includes liberal definitions, a rehabilitation program, and monthy benefits from $500 to $5,000.

★ ★ ★ ★

For more information call the **Insurance Plan Administrator,** Rollins Burdick Hunter Company.

	Toll Free Calls
The CPA Plan	**800-223-7473**
The Group Plan	**800-231-3019**
The Long-Term Disability Income Plan	**800-221-4722**
In New York call collect	
The CPA Plan	**212-973-6431**
The Group Plan	**212-973-6200**

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Benevolent Fund

The Benevolent Fund helps members, former members, and their families through periods of financial difficulty.

For more information call **212-575-5388**

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The Members in Industry Executive Committee welcomes your views concerning existing programs and ideas for new activities to better serve you.

Please write

AICPA
Manager, Industry
1211 Avenue of the Americas
New York, New York 10036-8775
212-575-6439

Glossary

Accumulation Period. A specified period during which a covered employee must accumulate eligible medical expenses to meet the plan's deductible requirements.

Actuary. A person who mathematically analyzes and prices the risks associated with providing certain coverages. This analysis involves the morbidity and mortality rates associated with the group, along with underlying costs and administrative expenses.

Administrative Manager. An organization or individual who provides administrative services to an employee benefit plan.

Adverse Selection. The tendency of persons to choose health options that are financially most beneficial to them (and least beneficial to the health care program or insurer) in the light of their known physical conditions. Those with known health problems elect more insurance; healthy persons elect less or none at all. (Also known as **antiselection.**)

AIDS. Acquired Immune Deficiency Syndrome.

Alternate Delivery System. Alternatives to traditional health care programs. (See also **health maintenance organization** and **preferred provider organization.**)

Audit. A retrospective review of provider services and charges to see that all billed services were actually provided, that the charges for these services were accurate, and that the fees were reasonable.

Average Length of Stay (ALOS). Average number of patient days per inpatient for a given period.

Beneficiary. A person entitled to receive benefits under a plan, including a covered employee and his or her dependents.

Benefit Period. Period over which benefits are payable under a plan or insurance contract; alternately, a period for satisfying a deductible requirement.

Cafeteria Plan. A flexible benefits plan; generally one that complies with the requirements of IRC Section 125, and offers a choice of two or more "qualified benefits," or between cash and one or more qualified benefits.

Capitation. A form of payment used by HMOs in which members pay a preset fixed fee for which they receive as much health care service as needed. This is an alternative to a fee-for-service arrangement.

Carry-Over Deductible. An arrangement that allows expenses incurred in a prior coverage period (plan year) to be carried over to the following year and counted toward the satisfaction of that year's deductible.

Case Management. A form of utilization review used with high-cost cases that monitors and manages treatment and suggests alternatives to lengthy hospital stays.

Cash or Deferred Arrangement (CODA). A provision that permits employees to elect to take cash compensation, or to defer the receipt of the income (and the taxes on it) by directing it to a tax-exempt trust. These arrangements, also known as 401(k) plans, can be made available through cafeteria plans.

Claim. The request for reimbursement from an insurer or plan for a covered expense.

Closed Panel. A health care program that requires participants to use providers or pharmacies from a list of such providers provided by the plan, with whom the plan has established a contractual relationship. The alternative is an open panel.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, which permits covered employees and beneficiaries to continue their health care coverage for a period of up to thirty-six months after it would normally terminate. The continuation of coverage requires the individual to pay the premium.

Coinsurance. An arrangement that apportions expenses between the covered individual and an insurer; for example, 80 percent to be paid by the health insurer and 20 percent by the employee.

Community Rating. The determination of a single average premium rate based upon the characteristics and claims experience of the entire membership (in an HMO or insurance pool), rather than separate premiums for individual member groups. (See also **experience rating.**)

Concurrent Review. A form of utilization review in which hospital admissions are reviewed and certified within twenty-four hours following admission, and are monitored for appropriateness thereafter.

Coordination of Benefits (COB). A cost-control mechanism to prevent an employee from receiving duplicate benefits from two or more insurers or health plans.

Cost Containment. Any activity or practice aimed at holding down health care costs, or reducing their rate of increase.

Cost Sharing. The apportioning of health care costs between a health care plan and individual participants through employee contributions, deductibles, and coinsurance.

Cost Shifting. The increasing of charges to a patient or group of patients to make up for losses incurred in providing care to other patients.

Coverage. The employees who are eligible to receive benefits under a plan, or the nature of benefits provided under the plan.

Covered Expenses. A covered expense or covered benefit is one for which a health care plan will provide reimbursement.

Deductible. A set amount that a covered individual must pay before an insurance program begins reimbursing for expenses.

Diagnosis-Related Groups (DRGs). Groups used to determine the amount Medicare reimburses each hospital that provides its insureds with service, as part of its prospective payment system. Each DRG corresponds to a patient condition.

Direct Reimbursement. A non insured dental program in which an employer agrees to pay for a specified percentage or amount of dental expenses.

Disability. The inability to perform all or some portions of the duties of one's occupation or, alternatively, any occupation, as a result of a physical or mental impairment.

Dual Choice. The requirement that, upon request, certain employers must offer a federally qualified HMO as an alternative to its conventional health plan.

Duplication of Benefits. Similar or identical coverages provided to the same insured by two or more plans.

Eligibility. The conditions imposed for coverage under a plan, such as full-time status, length of service, and so on.

Elimination Period. A period that must elapse before benefits become payable under a disability or health plan.

Employee Assistance Program (EAP). A program of counseling and other forms of assistance to employees suffering from alcoholism, substance abuse, or emotional and family problems.

Employer Health Care Coalition. An association of health care sponsors who pool resources to gather information on and negotiate with insurers and other health care providers.

Exclusions. Specific illnesses or treatments that are expressly not covered by a plan or insurance contract.

Exclusive Provider Organization (EPO). A more rigid type of PPO that requires the employee to use only designated providers or sacrifice reimbursement altogether. PPOs encourage employees to use "preferred" providers through more generous reimbursement, but will still reimburse for nonpreferred providers.

Experience Rating. A method of determining premiums that adjusts a group's rate based upon the demographic characteristics and utilization experience of that particular group, as opposed to using averaged data for multiple groups.

Financial Accounting Standards Board (FASB). An organization that establishes standards for accounting statements. The board recently issued some significant standards on accounting for retiree health care liabilities.

First Dollar Coverage. A plan that covers health care costs with no deductible or copayment.

501(c)(9) Trust. See **voluntary employees' beneficiary association.**

Flexible Benefit (or **Flex**) **Plan.** A plan that offers employees a choice among a number of alternative benefits. (See also **cafeteria plan.**)

Flexible Spending (or **Reimbursement**) **Account.** An account funded by an employee salary reduction, employer contribution, or both and used to pay the employee's share of the cost of certain benefits, or to reimburse him or her for expenses. It is a device for converting after-tax expenses to pre-tax ones.

401(h) Account. A separate account of a pension plan that, under provisions of IRC Section 401(h), may be used to fund medical benefits for retirees and dependents.

Gatekeeper. An HMO physician who controls costs by managing a patient's treatment to minimize unnecessary care.

Health Maintenance Organization (HMO). An organization that, for a prepaid fee, provides comprehensive health care services to a voluntarily enrolled membership. HMOs are sponsored by large employers, labor unions, medical schools, hospitals, medical clinics, and even insurance companies. Development of HMOs was spurred by the federal government in the 1970s as a means to correct the structural, inflationary problems with conventional health care payment.

Health Promotion. Behavioral modification programs intended to modify lifestyles and habits to promote better health. (See also **wellness programs.**)

Health Risk Appraisal (HRA). A survey used by employers to determine the likelihood of an insured's experiencing death, illness, or injury in the future. It helps employers decide whether wellness and other preventive care programs are necessary.

Hospital Indemnity. A program that pays fixed benefits for hospital stays on a daily, weekly, or monthly basis. The payment is in no way related to actual expenses incurred.

Indemnity. Any benefits paid to cover a loss insured against by a policy.

Individual Practice Association (IPA) Model. One of the four different models according to which HMOs are organized. The others are the group model, the network model, and the staff model. The IPA model is a mixture of physicians from solo and group practices.

Intermediate Care Facility. A facility that provides health care or nursing services to patients who do not require the level of care offered by hospitals or skilled nursing facilities.

IRC. The Internal Revenue Code.

Major Medical Insurance. Coverage characterized by larger maximum limits, which is intended to cover the costs associated with a major illness or injury.

Mandated Benefit. A specific coverage that an insurer or plan sponsor is required to offer by law. Mandated benefits in insurance contracts vary from state to state according to each state's insurance laws.

Mandated Offering. Similar to a mandated benefit, except that instead of being a requirement in each policy, the coverage need only be offered to a policyholder who is not required to purchase it.

Medicaid. A medical benefits program that is paid for by state and federal governments, but administered by the states, and that provides medical benefits to persons who meet certain criteria and whose incomes fall below specified maximums.

Medicare. A federal program of medical care benefits, generally for those over age sixty-five. (See also **Part A** and **Part B.**)

Multiple Employer Trust (MET). A mechanism that allows small employers in the same or a related industry to provide affordable, quality group insurance to their employees under a trust arrangement. Without a MET, these companies would be unable to purchase group insurance. A MET is most common among employers with ten or fewer employees.

Nondiscrimination. The general requirement that employee benefit plans not provide significantly greater benefits to higher paid employees and owners than to lower paid employees. While some disparity is permitted, there are limits, notably those imposed by IRC Section 89 on health plans.

OBRA. The Omnibus Budget Reconciliation Act of 1986, which made employer plans primary for participants eligible for Medicare.

Open Panel. A health care program that permits participants to purchase services or drugs from a provider of his or her choice.

Out-of-Pocket Maximum (OOP). The maximum amount that an insured employee will have to pay for expenses covered under the plan. It is usually $500 or $1,000.

Part A. The portion of Medicare that covers expenses incurred in hospitals, extended care facilities, hospices, and so on.

Part B. The portion of Medicare that covers physicians' services and other types of care not covered under Part A.

Pool. A large number of small groups that are analyzed and rated as a single large group.

Preadmission Certification. A form of utilization review that requires a patient to receive authorization from a medical review agent prior to being admitted to a hospital.

Preadmission Testing (PAT). A cost-control mechanism intended to reduce hospital stays by encouraging employees to have routine hospital testing done on an outpatient basis before being admitted to the hospital. Reimbursement is sometimes made on a more generous basis for PAT.

Preferred Provider Arrangement (PPA). An agreement between providers and another entity, as opposed to a **PPO**, which is an organization of providers.

Preferred Provider Organization (PPO). A health care provider arrangement whereby a third-party payer contracts with a group of medical care providers that agrees to furnish services at negotiated fees in return for prompt payment and a guaranteed patient volume. PPOs control costs by keeping fees down and curbing excessive service through stringent utilization control.

Premium Tax. A state tax on insurance premiums, including group insurance premiums.

Prepaid Group Practice Plan. A plan wherein participating physicians provide specified services to plan members in exhange for a fixed payment in advance. This is one form of **HMO.**

Primary Care. Routine medical care provided by a family physician, normally in the doctor's office. Referral to specialized secondary care may be made as necessary.

Prospective Payment System (PPS). A standardized payment system implemented in 1983 by Medicare to help manage health care reimbursement, whereby the incentive for hospitals to deliver unnecessary care is eliminated. Hospitals can expect a fixed reimbursement based not on the number and kinds of services delivered but on the diagnosis of the patient.

Qualified Benefits. Nontaxable benefits that are includable in a cafeteria plan, including group term life insurance, accident and health insurance, dependent care assistance, and cash or deferred arrangements.

Qualifying Event. An event that terminates an individual's normal coverage under a health care plan, but that qualifies the employee or beneficiary to continued coverage under **COBRA**. Examples include death, termination of employment, and divorce.

Reasonable and Customary (R&C) Charge. The maximum amount an insurer will reimburse for medical care expenses covered under group health insurance plans. Insurers use R&C charges to control health care costs. (Also known as **usual, reasonable, and customary [URC] charge**.)

Residential Care Facility. A facility that provides adults with food and shelter and some additional services.

Respite Care. Temporary care provided in a patient's home to provide the primary care giver with time off from the demands of taking care of a family member.

Risk. The possibility that costs associated with insuring a particular group will exceed expected levels, thereby resulting in losses for an insurance carrier or self-insurer.

Salary Reduction Agreement. An agreement between an employee and employer to reduce the employee's taxable income. The amount of the reduction is generally applied to the employee's share of the cost of providing nontaxable benefits.

Second Surgical Opinion (SSO). A cost-control mechanism to reduce unnecessary surgery by encouraging individuals to seek a second opinion for elective surgery.

Self-Funding. An arrangement in which some or all of the risk associated with providing benefits is not covered by an insurance contract. The plan sponsor establishes the necessary reserves, often through a **VEBA**, to assure payment of claims.

Skilled Nursing Facility. A facility that provides inpatient care for persons requiring skilled nursing care, either as part of a hospital or as a separate nursing home.

Stop-Loss Insurance. Insurance that reimburses a plan or plan sponsor for losses in excess of certain limits, usually expressed as a percentage of expected claims, or a specified dollar amount.

Surgical Schedule. A list of amounts payable by a health insurance program for different types of surgery.

Third-Party Administrator (TPA). A person or organization that provides certain administrative services to group benefit plans, including premium accounting, claims review and payment, claims utilization review, maintenance of employee eligibility records, and negotiations with insurers that provide stop-loss protection for large claims.

Utilization Review (UR). A cost-control mechanism used by some insurers and employers in recent years that evaluates health care on the basis of appropriateness, necessity, and quality. For hospital review, it can include preadmission certification, concurrent review with discharge planning, and retrospective review.

Voluntary Employees' Beneficiary Association (VEBA). A method of self-funding an employee benefits plan. It is used almost exclusively by large employers. (Also known as a **501[c][9] trust**.)

Wellness Programs. Programs that reduce health care costs by encouraging fitness, preventive care, and early detection of illness.

Workers' Compensation. State programs that require employers to carry insurance to compensate employees for work-related injuries.