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Focus on the future

Employee focus groups help University identify health-care concerns.

As the University moves to revamp its medical benefits package, input from employees and retirees has been a major part of the planning process. Options have been reviewed by a systemwide committee of University employees. Public forums have drawn faculty, staff and retirees into the process.

Employee questions and concerns also were examined in a series of focus groups, conducted in May by Towers Perrin, a health care consulting firm.

A total of 85 employees from the University's four campuses took part in 12 different focus groups. Group members were selected based on demographic criteria, such as age and gender, job classifications, marital status, income and health care usage.

In its report, Towers Perrin noted that many of the same concerns raised in the public forums (See related story on Page 3) also surfaced at the focus group meetings. Other issues that were discussed in the focus group report include:

■ **Employee acceptance** will be a key factor in the success of any managed health care program. "A network for which there are no users," the report says, "cannot effectively control health-care costs."

■ **Satisfaction with current medical plans.** Participants feel strongly that a choice of health care plans to meet varying needs is important. They like having choice and are concerned about limitations. They comment favorably about the extent of their coverage and like the ability to pay contributions on a pre-tax basis. Where both spouses are employed by the University, they are displeased with the fact that one spouse cannot be covered by the other employee.

■ **Reaction ranged** from frustration and concern to matter-of-fact acceptance of the University's health-care cost dilemma. All participants in the focus groups were aware of the problem to some extent and the need to address it. Participants questioned the sources of rising health care costs, and are frustrated and confused by a problem they believe is out of their control and too big for the University to handle. Participants said the costs "take a big share out of our paychecks, especially because salaries are so low." Many are eager for national health care reform, and some question the timing of the University's medical insurance review.

■ **Employees are worried** that continued increases in

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Special edition addresses MU's medical benefits

The University is not immune to rising health-care costs that have eaten away at individual paychecks and organizational budgets across America in recent years. In 1988, the University paid out $23.5 million in medical claims; by last year, that figure had risen to $39.1 million. It is predicted that costs could more than double again by 1997, to almost $90 million, if left unchecked.

"It is an imperative that we manage these costs, or we will see the price of medical insurance consume larger and larger portions of employee paychecks in future years," says Chancellor Charles Kiesler. "It also is an imperative that MU faculty, staff and retirees have significant input as we discuss options available for this campus."

In January, UM System President George Russell announced the appointment of a 17-member medical insurance committee, composed of faculty and staff from all four campuses, as well as extension and retiree representatives (See list of committee members on Page 7). It also was announced that Towers Perrin, a St. Louis-based health care consulting firm, would help the committee come up with a managed care alternative to the University's current medical insurance plan. New options will be unveiled this fall, and are expected to take effect next January.

This special edition of *Mizzou Weekly* examines the issue of medical insurance, particularly as it relates to employees' questions about managed care. While a final new plan for the University has not been determined, Kiesler wants faculty, staff and retirees to be kept informed of the various options being considered, as well as have ample opportunity to discuss and receive answers to their concerns.

Dean of Nursing Toni Sullivan opens the floor to questions after Gov. Mel Carnahan's talk on health care.

Nancy O'Connor photo

Delivering quality

Improved health care for all Missourians, especially in rural areas, tops state's agenda.

In spite of the enormous investment in health care, many Americans are without coverage. To underscore the seriousness of the problem, Gov. Mel Carnahan cited some staggering statistics May 24 at a campus forum on health-care access, sponsored by the School of Medicine.

■ In Missouri there are 600,000 people, including 190,000 children, who do not have health insurance.

■ More than 21 percent of Missouri's children living at or below the federal poverty level lack coverage.

■ Nationwide, 36 million people, including 12 million children, do not have health-care benefits. In the past two years alone, the number of children without coverage and benefits increased by 600,000.

■ Medicaid and Medicare costs have risen from 6 percent of the gross national product in 1965 to 13 percent of GNP in 1992. By 2002, these costs will rise to 25 percent, with the additional expenses being more than $300 billion, the cost of our present defense budget.

"The relentless escalation of health-care costs threatens to cripple family incomes and devastate the economic engine of our whole country. Health insurance, even if you have it, doesn't do much good if there are no doctors and nurses to provide the care," Carnahan told an audience of 400 faculty, staff and physicians at University Hospital. "So we must be sure that all Missourians, and particularly those in rural areas, have access to health benefits and health-care providers."

The Missouri General Assembly took some significant steps to deal with these problems in the past legislative session. Under the leadership of House Speaker Bob Griffin, the Health Care Access Bill (HB564) was enacted. The bill, which goes into effect this fall, will be funded by a 4-cent tax on cigarettes and other tobacco products. Highlights of the legislation include:

■ collaborative practice among health-care providers, repealing the requirement that doctors establish a physician-patient relationship before treatment is prescribed. Under a physician's authorization, nurses will be allowed to treat patients and prescribe certain medicines, excluding controlled substances. These measures make health care accessible by allowing more people to provide the care.

■ funds to cover liability judgments and settlements of health-care professionals who provide free primary and preventive care at local health departments, non-profit agencies or at schools.

■ incentives for medical students agreeing to concentrate on primary care. Loans to these students are increased to $7,500 an academic year, part of which is forgiven each year the physician serves in an underserved area.

■ school health initiatives that encourage schools to become Medicaid providers and to make more primary care services available to students.

"I am pleased with the progress we made with this legislation," Carnahan says. "It is a real start in addressing health care in this state."

Looking to the future, he predicts that the

Please see CARNAHAN on Page 2.

Focus

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health care costs eventually will erode their access to quality care. They are angry at the health care system and at rising prices that erode their paychecks.

■ **Administrative costs** were questioned. Focus group participants do not fully understand why the University is self-insured or what the administrative costs are. They believe the cost of administering a self-insured plan is greater.

■ **Catastrophic coverage** was described to participants as a $1,500 to $2,000 deductible plan with a $5,000 to $10,000 out-of-pocket limit each year. While some faculty were more inclined toward the catastrophic plan, few other University employees expressed interest. They felt a $5,000 out-of-pocket maximum, if applied to more than one family member, would be unwieldly. One said, "I'd have to be paying pennies in contributions to make it worthwhile to take the risk."

■ **Participants encourage** the use of University medical facilities. Group members recognize that the University is both a purchaser and provider of health care. At the same time, they do not want to be restricted to using University medical care as their only option. They see this as an opportunity to control costs by improving the use and operating efficiency of University facilities.

For example, MU participants believe that the University community should be able to purchase prescription drugs at University Hospital at prices competitive with Osco pharmacies. Further, they think University Hospital should give University employees priority access to its doctors.

They also believe that University Hospital should operate under stricter quality performance standards for its physicians and should closely examine its operating costs. Said one participant, "Since we're in the business of educating physicians, we should do a much better job of educating them about cost-effective ways to do procedures while still delivering quality."

■ **Limiting medical coverage** was not favored. As an example, the focus groups believed that to single out mental health care as a noncovered expense would be an unfair burden to people who need that type of care.

■ **Network-based managed health care** concerned some focus group participants. They questioned the medical professional's incentive to take the time to deliver quality at discounted prices. There also were concerns about the restrictive nature of the primary care physician referral process. Employees worried about getting access to needed specialists within the network.

Cost control

Some focus group participants recommended the following to control University health-care costs:

■ ***Provide financial incentives*** for employees who are infrequent users of their health-care coverage. Those incentives could include rebates on contributions, health care "credits" or other innovations.

■ ***Encourage wise consumerism*** through health-care consumer education, including information about wellness, prevention, early detection and risk assessments, as well as how to make cost-effective use of the medical system.

■ ***Vary participant coverage contributions*** by ability to pay. That is, participants recommend that higher paid University employees be asked to pay more for their coverage.

■ ***Reduce the cost of plan administration.*** This recommendation included fewer changes of plan administrators, asking the administrator to improve the efficiency of its claims process, and examining University administration activities for cost savings.

■ ***Provide incentives for the University community*** to use University health-care facilities. On all campuses, participants questioned why University facilities could not provide priority access and discounted fees to University employees for routine illnesses and preventive care.

Quality care

Participants say they consider these factors when seeking a quality doctor:

- Reputation in community
- Medical success rate
- Ability to communicate with patients
- Educational credentials
- Location/office hours
- Waiting time to get appointments or see a doctor
- Professionalism of office staff
- Experience/length of time in practice
- Medical specialties
- Gender
- Medical malpractice record

Carnahan

Continued from Page 1.

nation's health-care plan, to be announced in mid-June, will dominate the attention of most of the states and the Congress for the rest of the year. "When we return to the legislative session next January, we will have a pretty good idea of the direction of federal heath-care reform. But we do not want to sit back and wait to see what Washington does and think that we will pick up then. That would be the wrong approach."

Some states that have already addressed reform include Washington, Florida, Vermont, Kentucky, Oregon, and Hawaii. "We need to learn from them and initiate our own system," he says. "The solutions to accessible health care are not going to come overnight.

"I am going to be impatient; you are, too. I am confident that with the kinds of legislative work we are doing, we are going to be able to move our state forward in the field of providing affordable, accessible health care to all of our citizens."

One question asked of focus groups

If the University offered an incentive for living a healthy lifestyle, which of the following factors should be used to determine if you get an incentive?

	Yes	No	Not sure
Being a nonsmoker	91%	5%	5%
Being at or below average medically recommended weight	60%	21%	19%
Exercising regularly	61%	21%	18%
Having normal blood pressure	66%	17%	17%
Having cholesterol levels in medically recommended range	59%	18%	23%
Having health risk appraisal conducted by my doctor	63%	17%	21%

Demographic profile of focus group members

AGE

Up to 34	18%
35 to 54	64%
55 and over	19%

GENDER

Male	46%
Female	54%

MARITAL STATUS

Married with dependents	54%
Married without dependents	21%
Single/divorced/widowed with dependents	19%
Single/divorced/widowed without dependents	6%

FAMILY INCOME

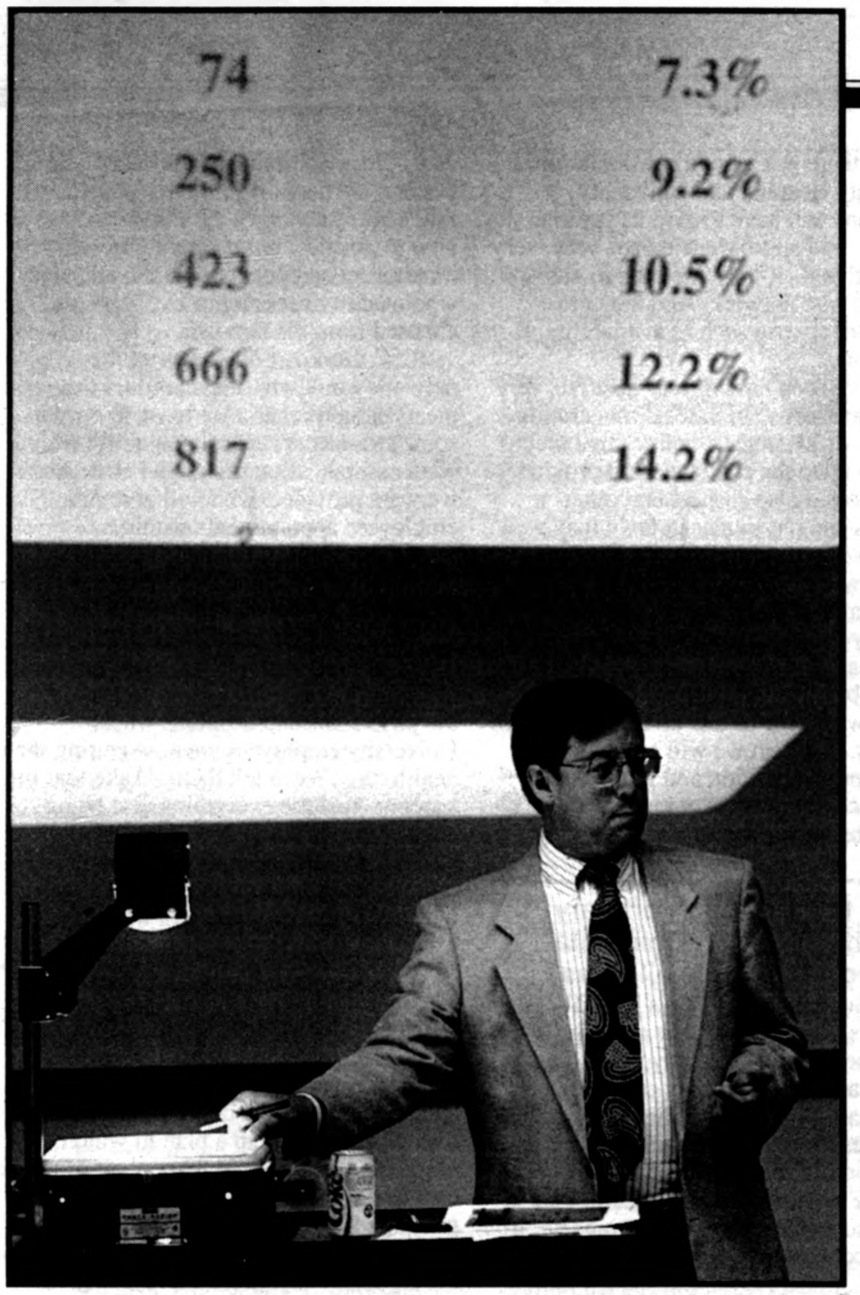
Less than $25,000	16%
$25,000 to $34,999	10%
$35,000 to 49,999	21%
$50,000 to $74,999	29%
$75,000 or more	25%

YEARS OF SERVICE

Less than one year	5%
One but less than four years	21%
Four but less than 10 years	13%
10 but less than 15 years	22%
15 but less than 20 years	15%
20 years and over	24%

JOB CLASSIFICATION

Administrative/Professional staff	42%
Faculty	38%
Nonexempt staff	18%
Extension staff	1%



Forums give employees, retirees the opportunity to air concerns

The issue of health care took center stage at a series of public forums held throughout May for MU employees. For much of the last semester, the University has been taking a hard look at its medical benefit plan to see how it can hold down staggering cost increases without jeopardizing the quality of care.

As part of that review, a UM Systemwide committee of faculty, staff and retirees has been working with the health care consultanting firm, Towers Perrin, to explore options in providing medical coverage to University employees. Soon the committee will make recommendations to UM President George Russell about updating the medical plan.

The public forums gave University employees an opportunity to ask questions about possible changes and raise concerns to University administrators and members of the medical insurance committee. The forums were sponsored by the Faculty Council and the Staff Advisory Council.

Faculty, staff and retirees filled the auditoriums, and questions came fast and furious. Will medical premiums be going up? What role will University Hospital have in the new health insurance plan? Can I continue to see the same doctor?

(See Q&A section beginning on Page 4).

> McGill outlined some options the committee has looked at, but stressed that no decisions have been made.

Concerns raised by MU employees were not unexpected. "Any time people talk about change, there is a general feeling of apprehension," said medical insurance committee member Keith Schrader, professor of mathematics.

Jim McGill, UM System vice president for Administrative Affairs, moderated the public forums. He outlined some options the committee has looked at, but McGill also stressed that no decisions have been made.

"This is a subject critically important to all of us," he said. "We want to make sure that the committee working on this issue is aware of the concerns of employees. We're doing what we can to design a plan that will address those concerns."

Jim McGill, vice president for Administrative Affairs for the University of Missouri System, explains the rapid rise in health-care costs. The forum on May 20 was one of three held at MU to discuss the future of University health care.

Rob Hill photo

Health care & Q&A

Here are some questions that faculty, staff and retirees are asking about the future of health care at Mizzou. Many of the questions were addressed at open forums by Jim McGill, UM System vice president for Administrative Affairs, and Ken Hutchinson, UM associate vice president for Human Resource Services.

For answers to other questions, *Mizzou Weekly* asked the faculty, staff and retirees who represent MU on the medical insurance committee.

Q. Why can't we stay with our present health-care delivery system?

A. The University could elect to stay with its current system, which has been in place since 1987 and offers a Preferred Provider Organization, but faces the prospect of continually mounting costs if it continues to do so. Money spent on the University's contribution to our health care is money not available for faculty or staff raises. And, since employees pay for one-third of the cost of health insurance, it will continue to take a bigger and bigger bite out of paychecks.

Although the PPO has helped in holding down costs to a degree, University health-care claims nevertheless have almost doubled in the past five years and could double again by 1997 if nothing is done. The PPO does offer discounts to employees for using certain physicians, but there are no incentives for controlling costs — for instance, by limiting services or procedures to those deemed absolutely necessary.

Managed care, on the other hand, does aid in controlling costs. The most popular types of managed care are Health Maintenance Organizations (HMOs) and Point of Service plans (POS). The latter makes use of a primary care provider as the patient's "entry" into the network and management of care thereafter.

Q. How would a managed care plan with primary care providers work? Would an employee choose a physician or have one assigned?

A. The primary care network probably would work like this: There would be a panel of primary care physicians, and when employees sign up for the network, they would have an opportunity to shop a little before selecting one. "It's important that both the patient and the physician feel comfortable with each other," McGill says. The physician would determine the type of care appropriate for the person's situation, and would order any necessary tests. "In a sense, this system harks back to the 'family doctor' concept that we had years ago," McGill says. If a specialist is needed, the primary care physician would refer the patient to one in the network.

He stresses that the patient still has choice. "You can go outside the network and choose your own specialist," McGill says. However, in those cases the University plan would reimburse you for a smaller amount of your costs — perhaps 60 percent, instead of the current 80 percent.

Q. Who would be the providers in the network? Will this be limited to University Hospital, or will it include Boone Hospital Center, Columbia Regional Hospital and local physicians?

A. The medical insurance committee is looking at an option that would include University Hospital and Clinics and University Physicians in some structure of care providers, and another Columbia hospital and some of the non-University physicians in town. "Input and advice from faculty, staff and retirees will have a role in this," McGill says.

Q. Is the medical review process being played with a stacked deck? In other words, will the specifications be written to shut out providers other than the University?

A. "As a University, we have two interests," McGill says. "One, it is important that the University Hospital remains viable. It's here because we have the responsibility for medical education.

"But there is a second consideration. University Hospital and University Physicians will have to give us appropriate prices — and appropriate means very, very competitive — if they are to be in our managed care network. And they must meet other criteria such as availability of physicians.

"We've been having very positive, very good discussions with the administration of the medical center. I believe that they will step up to the challenge and provide good prices. I also suspect that other hospitals and physicians in town may well present very competitive prices as well.

"We will go out to the market and link up with a third party — an insurance company such as a HealthLink, or Prudential, or Traveler's. It will be their responsibility to put together the managed care networks for us and do the negotiation of prices. I suspect we will see a fair amount of competition and will receive good prices. We're not going into the process by excluding anyone."

Q. Are there enough primary care physicians in Columbia right now to handle all of us?

A. "Good question," says McGill. "The answer is, 'maybe not.' The company that establishes the network may have to bring in some additional primary care physicians. Or they might have to provide incentives for internists, pediatricians, or those who practice more specialized medicine to do more primary care. That is a real issue, and is one of the things we'll have to consider carefully."

Q. How many MU employees and retirees currently use University Hospital and Clinics?

A. Figures show that about 50 percent use University Hospital.

Q. In the process of setting up a network of medical care providers, how will the hospitals and physicians bid to be included? Will they bid on the fee they charge for a specific diagnosis, or perhaps a certain charge for each visit?

A. Those are issues that the third-party insurance company would deal with, says Ken Hutchinson. "Prudential, or HealthLink, or whomever, would go to the hospitals and doctors and negotiate the best deal they can get. Then they would come to the University with a product they have developed," Hutchinson adds. "They would come to us with an entire array of pricing and specifics about services they will offer, who's in the network, quality control, how access will be guaranteed, and so on. Then we would evaluate the overall product. We're not going to be evaluating the individual discount they negotiate with a particular provider."

Q. How would a managed care network help the University hold down medical costs?

A. Network administrators are able to negotiate lower rates with physicians and hospitals in exchange for guaranteeing a larger volume of business. In addition, McGill says, networks have better information on how physicians in those networks are practicing medicine.

"They're collecting the data to see what the referral rates are, to see how many medical tests were given, and to see what kinds of symptoms were presented," he adds. "In a well-managed primary care system, the networks monitor physicians' practices. They don't tell the physicians how to practice, but there is some monitoring and peer review. Physicians who tend to over-refer or over-test are excused from the network.

"The third party that sets up the network would provide a product that meets certain criteria we have. We want some assurances regarding quality; we want assurances on prices and cost. And we want providers who will give our employees appointments within a reasonable time.

"Another advantage, and cost-saver, is reduced paperwork in billing patients.

"There will be important criteria when we go to the market. We'll provide the insurance companies with information on the physicians and hospitals where University employees are now getting their health care. We'll tell them: 'Take that into account, because everything else being equal, we want to disrupt as few people as possible in where people are getting care now.' That is something that will be factored in our evaluation of networks."

Q. Is it likely that the current plan for retirees will change?

A. Probably not, say McGill and Bob Daniel, professor emeritus of psychology and a member of the committee. Retirees over 65 participate in a plan in which Medicare pays the first 80 percent of the cost of treatment, with the University picking up 80 percent of the remainder. "We don't foresee any dramatic change in this," McGill says. However, younger retirees who are not Medicare-eligible — those for whom the University plan provides the primary coverage — most likely will face the same options this fall as current faculty and staff.

Where to from here

THIS SUMMER Faculty, staff and retirees ask questions and share concerns with members of the medical insurance committee and the MU health insurance communications coordinating group (See names and phone numbers on Page 7)

EARLY JUNE Medical insurance committee submits report to UM System President George Russell, outlining its general recommendations

MID-JUNE The University asks potential managed care providers to submit proposals that meet or exceed the standards set by the University

LATE JUNE After reviewing the report, Russell discusses recommendations with the Board of Curators

SEPTEMBER After reviewing responses to determine if they meet its standards, the University will select the firm, or firms, that will administer the program. The Board of Curators must approve the selection

OCTOBER Specific details of the new program will be provided to employees and retirees

NOVEMBER Employees and retirees choose the program in which they wish to participate

JANUARY 1994 New programs implemented

1994 The new plan will be monitored throughout the year, and beyond, by the University to ascertain that those insured are receiving high-quality care and that cost-containment objectives are being met

Q. What provisions will be made for retirees who have moved to another state?

A. Daniel emphasizes that those retirees will not lose their medical insurance. Retirees and extension field staff will be eligible for a program similar to what they have now. "We certainly will not leave them out in the cold," McGill says. He adds that the same type of provisions will be made for faculty who travel extensively and other MU or UM System employees living away from Columbia.

Q. Will I be eligible for the same types of medical tests and procedures as is the case now?

A. Yes, says Lisa Wimmenauer, administrative associate II in Business Services and a member of the medical insurance committee. "From blood tests and minor surgery to regular checkups and major surgery, the same types of procedures will be available to you," she says.

Q. In an emergency, what if you have to get your care from a physician or hospital that is not in the network?

A. "If you are signed up in a network, you probably will pay as if the emergency provider were in the network," McGill says. "There will probably be an obligation for you to contact your primary care physician within a couple of days and confer with him or her about the ongoing care. But in an emergency, if someone is not near the network, that person shouldn't be penalized for having to get care outside the network."

Q. Will dental benefits be affected?

A. No. The University's dental plan is separate, and is not a part of this review.

Q. My spouse and small child are covered under my plan. Under the new plan, would they all have the same primary care provider?

A. Probably not, Wimmenauer says. "I can envision a scenario where the husband would have a general practitioner as his primary care provider, the wife could have an obstetrician, and a small child could have a pediatrician," she adds. "Those are the providers that would get you into the network and refer you to specialists if necessary."

Q. Have you considered using nurse practitioners in that gatekeeper role?

A. A lot of the good, successful HMOs use nurse practitioners in a very significant role. "We've been careful to use the words primary care providers rather than primary care physicians as we work through what that relationship is," says committee member Susan Taylor, professor of nursing.

Q. Will mental health still be included in my medical benefits?

A. Yes. The medical insurance committee has discussed changing some parts of the mental health coverage, Wimmenauer says. "We're not sure what the final result will be, but we feel confident that the changes will be positive," she adds. Currently, eligible doctors' charges for treating mental conditions are limited to $30 for each outpatient visit. The University's medical plan pays 80 percent of the charge when the patient is hospitalized. Hospital charges for treating a mental condition are covered on the same basis as any other illness. Treatment for chemical dependency in an approved facility is covered for up to 30 days, and the plan pays 80 percent of eligible expenses.

Q. In moving to a new set of managed care products, what's the best-case scenario for projected savings?

A. There are a number of things that cause medical prices to increase: overutilization, expensive new technology, cost-shifting by hospitals and a much higher inflation rate for medical services. The projected difference in the University's annual medical payments between 1992 and 1997 is $50 million. "If we could cut the trend in half and save $25 million, I think the committee would feel reasonably good about it," Hutchinson says. "Ideally, we'd like to see medical inflation at the same level as general inflation, but initially that may be too aggressive. We're still seeing medical inflation double that, and that's going to be difficult to tackle."

There will be a precise answer to the question once the University chooses an insurance company with its networks. "I am hoping that the rate increases over the next five years will be well down into the single digits — 6, 7 or 8 percent — but we'll have to see," says McGill. "We will have a better sense by September."

Please turn to Page 6.

CLASSIFIEDS

WANTED

WANTED TO RENT: Aug. 1. Three- to 4-bedroom house with garage and basement. Mature couple with one college-age daughter. Have neutered, declawed cat. 474-0928.

PhD STUDENT seeking house-sitting position for Fall 1993. (618) 462-3400.

The Classified Advertising Section is open only to faculty and staff members and retirees. A home phone number is required in all classified ads. No refunds will be given for cancelled ads.

Ads must be typed.
Rates: 30-word maximum $3.
Publication deadlines:
June 7 deadline for June 16 issue
June 21 deadline for June 30 issue
***Mizzou Weekly* Classifieds:** Make your check payable to University of Missouri and send to: *Mizzou Weekly*, 407 Reynolds Center, Attention: David Roloff.

Due to the unscheduled nature of this special issue, classified ads that were requested before this issue was decided were not accepted. We regret any inconvenience this may have caused.

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Q. The amount the University spends on medical care has almost doubled in five years, to $39 million in 1992. How much of that increase is due to administrative costs?

A. About 4.7 percent of that $39 million is administrative costs, McGill says. "It includes what we pay HealthLink for putting together and maintaining the preferred provider network, and for doing utilization review. It includes what we pay General American for claims processing. It includes what we pay consultants and actuaries and a few people in the staff benefits office who work on medical claims. Administrative costs have risen 5 percent a year in the last two years while overall costs have gone up 15 percent."

Q. How do the University's medical costs break down into different categories?

A. Roughly 8 percent of the cost is for prescription drugs. Approximately 8 percent is for mental health and chemical dependency treatment. Physician fees account for about 30 percent of the University's medical costs, and hospital costs make up most of the remainder.

Q. Will there be any opportunity for employee input after details of the plan are announced?

A. University officials will welcome comments on the plan when specifics are announced this fall. In addition, Wimmenauer emphasizes that the plan "constantly will be changing," as physicians are added to or leave the networks. "The employees will be able to shape the networks," she points out, adding that faculty, staff and retirees could urge their regular physicians to join. McGill stresses that point as well. "It's important that employees encourage their doctors to join the networks," he says.

Q. Would non-smokers or others who participate in health-conscious practices be eligible for discounted rates?

A. That may be a possibility in the future, McGill says.

Q. Is the managed care plan likely to change the way we receive and are reimbursed for prescription drugs?

A. "I think the committee will recommend that we do something different with prescription drugs," McGill says. "Those costs have been rising very steeply in the past few years.

"The committee has been looking at the following things: For chronic, maintenance drugs — high blood pressure, arthritis, allergies — they're looking at having a prescription mail order option. The idea is that if your physician has you on a prescription for a chronic condition, every two or three months you make a phone call or drop a note in the mail, and in two days your mail-order pharmacy will send you a supply of the medicine. There are substantial cost savings from buying maintenance drugs that way. Because those mail-order drug companies buy in great volume, they get excellent discounts.

"For other prescription drugs — the ones that aren't for chronic conditions — there are managed-care ways of buying those drugs as well. Perhaps we would have a company like Wal-Mart or Kmart to provide those drugs at a discount."

Health-care terms

Working your way through the health-care system can be confusing. Here are explanations of some of the terms that are used in the University's current review of its medical benefit plan:

Preferred Provider Organization (PPO) This is a group of doctors and hospitals that have negotiated discounted fees in return for financial incentives to patients who use the PPO. For instance, a hospital might waive first-day hospitalization charges, or there might be a lower deductible amount patients pay for physician visits. Medical providers in the PPO benefit from a higher volume of business and patients receive care at a lower price.

Primary Care Physician A doctor who provides initial care for a patient, and if necessary refers the patient to a specialist. The physician might be a family practitioner, a general internist or pediatrician. For routine maternities, a primary care physician could be an obstetrician.

Primary Care Provider plan Also called a "Point of Service plan." Under this plan a primary care physician is the gatekeeper to the health-care system and manages a patient's treatment. For instance, if the patient needs to be hospitalized or see a specialist, the primary care physician would make the referral or determine that hospitalization is necessary. Usually, a patient makes a small co-payment for each visit, and generally the deductible is low.

The primary care physician, and the other doctors and hospitals that patients are referred to, are members of a network that has negotiated lower rates for medical care. If patients decide to go outside the network, they typically would pay a substantially higher deductible and co-payment.

Health Maintenance Organization (HMO) Under this plan, the HMO organizes a network of doctors and hospitals. Each person is charged an annual fee to enroll in the HMO and receives complete health care at very little additional cost. The HMO provides all medical services, including physicians, hospitals and drugs, and typically there are little or no deductibles or co-payments.

This gives HMOs an incentive to practice efficient medicine, because in a way they take on some of the financial risk for providing health care. However, most of them require patients to receive all their care through the HMO. Some HMOs have good track records and some have not been as effective at controlling costs or providing quality health care.

Catastrophic Medical Insurance As the word "catastrophic" suggests, this is a medical insurance option that provides benefits for people only when they're faced with a major medical problem. However, the premium payments are much lower than a regular insurance plan. This type of insurance carries a very high deductible and usually high co-payments from the patient as well.

Q. What if my doctor doesn't want to be part of the managed care network, but is willing to match the fee charged by physicians in the network? Why put a penalty on going outside the network if the costs are the same?

A. Keith Schrader, professor of mathematics and a member of the committee, points out that the discount an out-of-network physician gives you is not the entire story. "Out-of-network physicians will oftentimes give you a discount, but then make up the difference with a higher claim to the insurance company. So we wind up paying for it anyway.

"If you say, 'Well, why not let doctors participate after the fact?', I guess that's like bidding a building — you don't let the other bidders participate after the fact. The business all goes to the one guy as the reward for his low bid. And you tell those other bidders, 'We'll rebid this again in the future, and that's the time to discount your prices.'"

There is another consideration, Taylor adds. The services provided by an in-network physician would include processing the paperwork and reporting to the network on quality-assurance issues. "Though the dollar cost appears the same, you're really getting different services for that same amount of money," she says.

Q. Will the new plan offer incentives for wellness and preventive care, such as annual physicals, childhood immunizations and cancer screenings?

A. Bob Stewart, professor of practical arts and vocational-technical education and a member of the medical insurance committee, says the group is interested in some effort to make those types of procedures attractive. "We think there will be more emphasis on preventive measures, which really is a cost-containment strategy," he adds.

Q. What about employees who have chronic medical conditions? If they have established a relationship with a physician who is outside the network, will they be forced to change physicians? If they regularly see a specialist, would they still have to go through a primary care gatekeeper each time?

A. No, McGill says, but there may be additional costs for the employee. That also raises the question of how the University will handle a transition from the current medical plan. "It's an important issue," McGill says. "In a transition period, how does the University minimize the amount of disruption? We have to be reasonable about how we do it."

In the case of chronic conditions, when a treatment plan has been established, employees probably would not be required to go through the gatekeeper physician each time they see a specialist. In those cases, the primary care physician would likely make a single referral to a specialist, then would continue to monitor the treatment a patient receives.

Q. MU isn't alone in facing the staggering increases in medical costs. There's talk about a national health care plan. Shouldn't the University wait for the national debate to sort out before it makes sweeping changes to its own medical plan?

A. "The national issues are so gargantuan and different from ours that we need to step ahead and do what we can to control our costs," McGill said. "The issues on the national agenda are huge — 37 million Americans do not have health insurance, and these are not all poor people. The estimates for providing them with health care coverage range from $50 billion to $150 billion.

"The word we have is that large employers like the University need to go ahead and take the next steps in terms of managed care. Further, whatever is proposed in Washington is expected to take a long time to implement."

Q. You're providing faculty, staff and retirees a fairly extensive network of ways to contact the medical insurance committee. What types of information would be most helpful to the committee?

A. We need to hear the things you're particularly concerned about," Hutchinson says. "As this plan develops, we want to make sure we have excellent communication channels built and ready to go. That way we can respond directly and in a focused way to the questions and concerns that come up."

MIZZOU WEEKLY

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Faculty, staff and retirees represented on panel

MU members of the UM System medical insurance committee welcome your comments and questions. "Only by broad participation can this system be effective," says member Lisa Wimmenauer.

Members are:

- Keith Schrader, professor of mathematics, 882-4564.
- Bob Stewart, professor of practical arts and vocational technical education, 882-8391.
- Susan Taylor, professor of nursing, 882-0261.
- Lisa Wimmenauer, administrative associate II in Business Services, 882-7254.

In addition, Bob Daniel, professor emeritus of psychology, is the retirees' representative to the group. He may be reached at 442-7193.

Group will coordinate communication

A 10-member task force has been formed to coordinate communication of a managed health care plan on campus. The MU health insurance communications coordinating group hopes to ensure that faculty and staff are fully informed and have the opportunity to participate in the process.

The group helped in initiating this special edition of *Mizzou Weekly*, and will assist in scheduling on-site briefings for those employees whose work does not permit them to attend public forums. Managers who would like to schedule on-site presentations should call Patsy Higgins at 882-7254.

The group welcomes your comments and questions. Members are:

- John Beahler, assistant editor of *Mizzou Weekly*, 882-5918.
- Ken Brogdon, interim director of the MU News Bureau, 882-6211.
- Bob Daniel, professor emeritus of psychology and a member of the UM System medical insurance committee, 442-7193.
- Patsy Higgins, manager in Business Services, 882-7254.
- Terry Jordan, editor of *Mizzou Weekly*, 882-5914.
- Chris Koukola, convener, assistant to the chancellor for University Affairs, 882-4523.
- Keith Schrader, professor of mathematics and a member of the medical insurance committee, 882-4564.
- Bob Stewart, professor of practical arts and vocational technical education and a member of the medical insurance committee, 882-8391.
- Jo Ann Wait, interim manager of public relations at University Hospitals and Clinics, 882-6942.
- Lisa Wimmenauer, administrative associate II in Business Services and a member of the medical insurance committee, 882-7254.

Easy access

Extra telephone numbers available to express concerns about coverage.

MU employees and retirees in the Columbia area who want to share their opinions about the proposed managed health-care plan with the UM System committee on medical insurance may call 882-2600. The new toll-free number for outstate Missouri is 1-800-676-1500. The committee, which began its work in February to find ways to slow rising medical costs while improving health care, is to issue a report to UM System President George Russell soon.

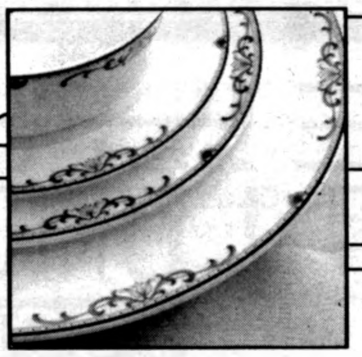
"Everyone is still welcome to call or write members of the committe directly, but for those who find those methods inconvenient, we're offering additional channels to encourage communication," says Chairman Ken Hutchinson, UM associate vice president for Human Resource Services.

The telephone numbers are answered by a voice message system 24 hours daily. Callers may remain anonymous; however, the committe suggests that employees or spouses provide the name of their campus. Off-campus extension employees, retirees and spouses, or surviving spouses of retirees, are asked to identify themselves as such so the committee can more clearly identify various groups' concerns.

Employees who prefer to put their comments in writing may do so through electronic mail. E-mail often identifies the source automatically. When this occurs, names will be disregarded unless senders opt to include their names in the message text.

- Employees who have access to cc: Mail may send messages to the Health Spectrum mailbox listed in the cc: Mail directory.
- Employees who communicate through Internet should send their messages to UMCCFGW.HEALTHS@SSGATE.MISSOURI.EDU.
- For those who use some other form of e-mail, the node is UMCCFGW and the userid is HEALTHS.

Information gathered weekly from the telephone and e-mail systems is sent to the committee's 17 members. "The feedback we get from employees and retirees will help the committee in its decision-making," Hutchinson says.



University CLUB

Please note: New hours for summer season

With the coming of those lazy, hazy days of summer, we have shortened our lunch and dinner hours. Lunch will now be served from 11:30 a.m. till 1:30 p.m. and dinner hours will be from 5:30 p.m. till 8:30 p.m. We will also be featuring more summer-ish daily specials. Reservations may still be made every day except Sunday by calling 882-0844.

Discover excellent beers from microbreweries...at the Club

On June 17, we'll uncap the first of our summer beer tastings featuring exceptional products from microbreweries in St. Louis and Kansas City. You can sample a dozen or so labels, from the St. Louis Brewery and Boulevard along with, appropriately, bratwurst and sauerkraut. Dress, of course, is highly informal. The time is 6 to 8:30 p.m. The cost, $10 for everything. Call 882-ALUM (2586) for reservations. An interesting and casual way to introduce the Club to your friends. P.S. Imports are next.

We'll make Dad "King for a meal"

Take your choice. Friday or Saturday evening, June 18th or 19th, offers regal dining for dear ole dad. We'll be serving Surf and Turf, featuring a 6 oz. Lobster Tail and a 6 oz. Filet with Truffle Butter or Bourdelaise Sauce, or Broiled Salmon Steak with Choron Sauce, or . . .a 14 oz. T-Bone Steak with Herb or Steak Butter and Sautéed Wild Mushrooms. Accompanying will be Imported Beer, Caesar Salad, Vegetable and Starch Du Jour and Blackberry Cobbler. It's all Dad's for $21.50. (He might like this a lot more than a tie.) Call 882-0844 for reservations.

A July alert!

The Club will be closed all day Monday and Tuesday, July 5th and 6th. So, enjoy your Fourth holiday on the 5th, but please don't look for us till the 7th.

Guests on Campus...Bring Them to Visit Us Also

Complimentary continental breakfast hours are 7-9 a.m. Monday through Friday. Lunch is 11:30 a.m.-1:30 p.m., Monday through Friday. Dinner is served 5:30-8:30 p.m., Monday through Saturday. Our lounge opens at 11 a.m., Monday through Friday and at 4 p.m. on Saturday. For reservations for lunch and dinner, call 882-0844 Monday through Saturday after 8 a.m. Located on the second floor of the Donald W. Reynolds Alumni and Visitors Center.

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