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HEALTH INSURANCE—LEGISLATION AND INFLATION

1. Update of the potential impact of National Health Law legislation.

2. Inflation's influence on
   a. The relationship of actual claim levels to that expected
   b. The design of new benefits and administrative controls and procedures.

CHAIRMAN WILLIAM S. THOMAS: The primary topic today is that portion of the financing of Medical Care expenses that is the responsibility of the private sector. The federal sector through federal employees, Medicare, and similar programs already governs forty percent. What government does with this forty percent affects the sixty percent that is our responsibility.

MR. ROBERT J. MYERS: Although nearly everybody has been predicting that some type of national health benefits legislation will be enacted in the current Congress, the legislative mills are grinding exceedingly slowly in the early days of this session. It is as yet far too early to predict the specific form which the ultimate legislation may take, although it still seems extremely likely that some legislation will be enacted, probably not until 1976.

There are a number of reasons for the slowness of the developments in this area. For one thing, a new session of Congress always takes some time to become organized. This has been especially the case in this particular Congress because of the significant changes in legislative procedures that have been brought about -- in considerable part by the large number of new members. This has been particularly evident in the House Ways and Means Committee in which there have been sweeping changes including a new Chairman and the moving away from the procedure of the Committee as a whole considering every phase of legislation to the subcommittee system.

Then too, the serious economic difficulties facing the nation have tended to draw attention away from the national health field. Also, the financial difficulties in which the Old-Age, Survivors, and Disability Insurance program finds itself, both short-range and long-range ones, have dampened somewhat considerations in the national health field, especially as to the payroll-tax-supported proposals.

Still a further reason for the relatively slow action on the part of Congress in the national health area has been the desirable procedure, particularly within the pertinent committees which handle this legislation, of moving slowly and deliberately when making legislative changes of a significant nature. These committees are well aware from their experience with Medicare and with Medicaid and other public assistance programs that, once a journey down a certain path in the social welfare field is begun, it is virtually impossible to retrace steps and start over again.

Congress has, however, moved very rapidly in one relatively small area in the national health field -- namely, continued health insurance for unemployed workers. This, of course, has always been a problem for the relatively few persons who became unemployed and generally in a short while lost

the health insurance coverage that they had had under an employer-sponsored plan. The problem, however, was greatly magnified under the high-unemployment conditions that we have had recently.

Several proposals in this area have been made in the last few months. In each instance, certain anomalies and difficulties would be created so that perhaps the best solution is the "least worst" one.

Senator Kennedy has proposed that the employer-sponsored health insurance plan (if any) of the unemployed worker should be continued and administered by the same insurance carrier for the time in which he was receiving unemployment insurance benefits. The cost would be borne by the General Fund of the Treasury (i.e., from general revenues).

Senator Bentsen, on the other hand, proposed that such unemployed workers should receive uniform health insurance protection by being blanketed-in to the Hospital Insurance portion of Medicare during their period of receipt of unemployment insurance benefits. The cost again would be met from general revenues.

Congressman Rostenkowski, Chairman of the Subcommittee on Health Insurance of the House Committee on Ways and Means, held hearings on this subject and developed a third approach. He proposed that, over the long run, employers should be required, through the income tax mechanism, to provide continued health insurance coverage for their unemployed workers who are on the unemployment insurance rolls. The cost of this protection would be met by the employer.

In a few instances, the cost might revert to the insurance carrier in the event of the bankruptcy of the employer and the inability of the carrier to collect the premiums owed from the employer's remaining assets. This is different in degree only from the situation with regard to the premium for the grace period for lapsed policies if it is not voluntarily paid by the insured employer. Accordingly, it would probably be necessary to make a small pool charge for this additional cost, particularly with regard to small-employer plans.

This required extension of health insurance during unemployment would be operative for policies newly issued or renewed after the enactment of the bill, or within 14 months in any case. Until it was so operative, the premium payments would come, under the Rostenkowski proposal, from a special fund that would be financed by a 1% tax on health insurance premiums. This tax would continue for several years until it had met the cost for the closed group involved. In the initial period of operation the fund would probably not have sufficient assets to pay the applicable premiums so it would function through repayable loans from the General Fund of the Treasury.

Interestingly, Senator Bentsen swung his support to the Rostenkowski Bill in preference to his original proposal.

All three of these proposals have certain anomalies. The Kennedy Bill seems somewhat inequitable in that workers who previously had good health insurance have it continued while workers with poor health insurance or none, continue to have poor protection even though the cost of the program is being met out of general revenues. It seems likely that those with the best health insurance protection who would have it paid for from general revenues would be the better off economically among the unemployed. Then too, employers who provided a considerable extension of health insurance to their unemployed workers would be paying for something that other employers financed from general revenues.

The Bentsen proposal seems undesirable in view of the fact that the Medicare program is not constituted so as to cover persons for only a few months at a time. Moreover, many workers would have better health insurance coverage while they were unemployed than if they returned to their former

job. This would hardly be an incentive for reemployment. Furthermore, the Bentsen bill would seem to be an opening wedge for national health insurance of the Medicare form since many unemployed workers would be desirous of continuing thereunder when they became employed again.

It seems somewhat paradoxical that Senator Kennedy, who is no friend of the insurance companies with regard to national health proposals, would advocate a bill whose basis would be continuation of coverage under private carriers at the expense of the federal government. Similarly, it seems anomalous that Senator Bentsen, a former insurance company executive, would put forth a proposal to cover unemployed workers under Medicare.

In my opinion, the Rostenkowski Bill is by far preferable to the other two bills. It puts the cost where it properly belongs -- on the former employer of the unemployed workers -- by requiring continuation of the same health insurance protection which the unemployed worker formerly had. Moreover, the Rostenkowski Bill attacks the problem on a long-range basis whereas the other two bills equivocate by being for only a one-year period. Since unemployment is always a serious matter for the individual, and since some unemployment is always with us, the problem of continued health insurance is very significant. It would seem certain that, under either the Kennedy Bill or the Bentsen Bill, there would be inevitable extensions. Moreover, the Rostenkowski Bill, unlike the Bentsen Bill, would not prejudge the form of national health legislation by starting out down the Medicare path.

As of now, the legislative situation is quite confused. For one thing, there is a question of jurisdiction within the congressional committees since in both the House and the Senate two committees claim responsibility. The Rostenkowski Bill has been agreed to by the entire Committee on Ways and Means after its Subcommittee on Health had approved it. Initially the full Committee deleted the permanent features of the proposal and changed the financing basis of the temporary features from a 1% premium tax to an 8% one. Also, the temporary features would be financed initially by repayable loans from the Hospital Insurance Trust Fund. The temporary plan would be phased out when the rate of insured unemployment fell below 4½% (now at about 7%). Subsequently, the full Committee reversed its action and adopted the original proposal.

Now turning back to the broad question of national health legislation, let me give my views as to what will happen in this Congress. I believe that the legislation which will be enacted will be along the lines of an employer-mandated plan under which each employer must provide at least a minimum package of health benefits for his employees. Such protection would be furnished through the private sector -- insurance companies, Blue Cross-Blue Shield, or possibly a self-administered plan. It is interesting to note that the American Medical Association has swung away from its original Medicredit proposal of tax credits for health insurance premiums to this approach.

Conversely, I do not believe that the payroll-tax, matching government subsidy, public-sector administration or control basis, such as in the Kennedy-Corman Bill and as is desired by the AFL-CIO, will be adopted despite the more liberal complexion of the present Congress as compared with the previous ones. The amounts of general revenues required seem impossibly large in light of other budgetary problems.

The use of payroll-tax financing and more governmental administration do not seem nearly as attractive currently as they did some years ago when the Social Security system was the "fair-haired boy" in both administration and financing. Now, the Social Security Administration has serious administrative problems with Medicare and the new Supplemental Security Income Program

and financing problems, both long-range and short-range, with the cash benefits program.

MR. WILLIAM C. L. HSIAO: It is a foregone conclusion that the United States will adopt a national health insurance program. Organizations representing the full political spectrum of our nation, from organized medicine to the AFL-CIO, have all endorsed such a program. Yet, a political consensus has not emerged as to the form of a national health insurance program. Among the issues hotly debated during the coming months will be whether a national health insurance program should be administered by the private insurance companies or by the federal government. At the present time, the likelihood is small for a national health insurance program directly administered by the government. Beside any political considerations, a publicly-administered program requires large tax increases to finance such a program and requires the administrative capacity to operate the program. Neither one of these necessary conditions exists today. Our tax burden is already straining the acceptable limits. With an estimated $75 billion deficit for fiscal year 1976 and a continuation of massive deficit in the later years, there is simply not sufficient additional federal revenue available to finance a large national health insurance program. Furthermore, the huge federal bureaucracy needed to make public administration possible does not exist today, nor in the forseeable future. Many people have always looked toward the Social Security Administration to carry out such a task; however, during the past decade the Social Security Administration has been given the additional responsibility of administering the Medicare program, the Black Lung program, the Supplementary Security Income Program, the Medicare for the Disabled and Chronic Kidney Disease Program. The administrative capacity of the Social Security Administration is strained to the breaking point. Hence, a publicly-administered national health insurance program is not a viable alternative for the next few years. If a program is enacted, it would be in a form which mandates that the private health insurance industry provide certain minimum benefits to all employed persons.

Although the private health insurers may be given a major role in a national health insurance program, its responsibility and its current modus operandi will be significantly altered. In order to see this, we need to examine two effects of a national health insurance program. One major impact of national health insurance is the creation of a general increase in demand for medical service. The immediate goal of national health insurance is to provide financial access to medical care for all the people. The postulate behind a nationwide health insurance scheme is that many people are prevented from obtaining adequate medical services because of the financial cost. It follows then, that there will be an increase in demand when financial barriers are removed. Otherwise, national health insurance fails to meet its primary objective. Experience under the Medicare program shows the utilization of inpatient hospital services by the aged increased by 20 to 25 percent after the enactment of the program. In a like manner, outpatient services increased between 20 to 30 percent when financing was provided by the Medicare program.

Further empirical evidence concerning the potential increase in demand when financing of health care is provided through a third party is given by another program which provides financing of medical care. Experience with the Medicaid program has demonstrated that utilization of medical services by the poor population can be brought up to levels commensurate with higher income people when financing is provided. According to survey information published by the National Center for Health Statistics, the average number of physician visits per capita in 1964 among low income people was 4.3

visits per year. After most states adopted the Medicaid program in the late nineteen-sixties, the average number of physician visits per capita in 1971 among the low income population increased by 30% to 5.6 visits per capita.

Undoubtedly, it is not a surprise to you that national health insurance will increase the demand for medical services. Logically, when the price of a commodity or a service is reduced, the consumer would want more of it. A health insurance scheme in fact reduces the direct cost of medical services to a patient when he seeks service. If the travel expenses to the physician's office and the cost of time are relatively small to patients, then reduction of prices the patient has to pay will lead to greater demand.

A number of economists have made empirical studies of the relationship between the quantity of medical services and the price the patient has to pay out-of-pocket. Among these are Karen Davis, Martin Feldstein, Herbert Klarman, Richard Rosette, and Ann Scitosky. There is general consensus among health economists that quantity of hospital and physician services demanded is responsive to price, although it varies by type of medical procedure. It would be misleading if we say patients exclusively decide what they need, but rather frequently it is the doctor who decides for the patient or it is a joint decision made by both parties. Nevertheless, doctors also base their decisions on the patient's ability to pay. It is well known that physicians are concerned about the total well-being of their patients and that includes financial burden. Before ordering a battery of diagnostic tests or hospitalization, doctors frequently determine the patient's insurance coverage and financial capacity to pay, then vary the quantity of medical services rendered accordingly.

What are the implications of this increase in demand? The new source of financing will disturb the equilibrium of our existing health delivery system. People will ask for a greater quantity of services. If the supply is perfectly flexible, then this additional demand for services can be absorbed without any difficulty. Unfortunately, the supply of medical service is quite rigid. We cannot build new hospital beds nor train more physicians overnight. Also, third party payment weakens market discipline. Consequently, the new pressure on the system will result in higher price inflation and longer queues. The prospect of a higher rate of inflation in medical prices is supported by our experience with Medicare and Medicaid programs. The rate of inflation of hospital costs took a quantum leap independent of the Consumer Price Index after these public programs were inaugurated. In the five year period after Medicare, the rate of inflation in hospital care costs was about twice that of the inflationary rate during the five years preceding the program. Similar phenomena also occurred for the price of physician services. From 1961 to 1966 physicians' fees increased at an average rate of 2.9% per year. Since the enactment of the Medicare-Medicaid program, physician fees increased from 1966 to 1971 at an average annual rate of 6.8%

The additional demand for physician services will create longer queues. More patients will find they cannot gain access to their doctors for care of acute conditions. This will shift more people into hospital emergency rooms and outpatient clinics. More doctors will refuse to accept new patients. Patients will find their physicians, especially primary-care doctors, more hurried than ever. There is already an acute shortage of primary-care physicians.

Higher price inflation will simply nourish the demand for government intervention in controlling hospital costs and fees. If insurance is provided through the private insurers, the federal government will necessarily ask insurers to implement certain regulations to contain medical price inflation. The health insurers' role will be altered significantly.

Companies will be clothed with a social responsibility to control medical prices, although the policy will be set by the federal government. Insurers may very well acquire a quasi-public agency status in carrying out certain of the government's price regulations.

If national health insurance moves towards mandating health coverage and setting a minimum benefit provision, a direct fallout will be a change in the marketing functions of insurers. Because the government has arbitrarily created a demand for health insurance products and limited consumer sovereignty, it follows that the government must protect consumers' interests. This will be done in numerous ways. One area is to promote efficiency to minimize the cost of insurance. An issue will be the amount of sales expenses. Unless sales expenses are controlled, a mandated plan will give salesmen a windfall profit. Many will argue that competitive forces are sufficiently strong that we should let the market place seek its proper competitive level of sales compensation. However, the experience in the casualty insurance field does not give us many promising signs. It has demonstrated clearly that the existing marketing structure is strong and rigid. When states mandated automobile insurance coverages, the level of sales compensation and costs did not drop. They remained at the previous levels.

Another area with which the federal government will be concerned is solvency of insurers. It is likely the government will set certain solvency standards, auditing requirements by outside CPA firms, and financial reporting procedures.

Dr. Charles Edwards who has just resigned from the nation's top health post, the Assistant Secretary for Health, stated recently in an article published in the New England Journal of Medicine: "The pluralistic health-care system as we know it in the United States is moving steadily toward its own destruction, not by design, but by default. The failure of the private health sector to accept a leadership responsibility in the allocation of health resources, in controlling the cost and utilization of health services ...all these indicators of a failure of leadership simply nourish the demand for greater federal intervention in and control of the health care system."

Whether the private insurance industry is ready to meet this challenge of accepting and exercising leadership remains to be seen.

CHAIRMAN THOMAS: That is one of the frankest discussions on National Health insurance I have heard in a long time and it's long overdue. With the pension area, there were gaps in coverage. We have gaps in health insurance and we should admit it. Who has responsibility for these gaps - the employer, the overall system, or general revenues? The Pension insurance plan is a pooled approach, at least for now. The same impacts will be experienced in the health insurance area.

MR. RICHARD H. HOFFMAN: There have been many discussions on the subject of the claims administration procedures used by insurance companies to control health insurance claim costs. Today, I will be discussing some alternatives which strike more at the heart of the problem, namely those which are directed at controlling the cost of delivering health care services. First I'll talk about the types of control efforts designed principally for the so-called fee-for-service health care delivery system, (some call it a non-system) and then go on to the type of mechanisms adopted by a few of the more organized systems.

Hospital costs represent by far the largest share of the consumer's medical care dollar, almost 60%. Physician services are the second most costly component of medical care, comprising over 25% of medical costs. The balance consists principally of drug and other miscellaneous health services.

Probably the foremost problem in connection with the high cost of health care delivery is that hospitals are generally suffering from a highly over-bedded situation. To help counteract this, in 1966 Congress enacted the Comprehensive Health Planning Program under which local agencies were created to pass on all applications for construction of new hospital beds with decisions based on community needs. If any beds were constructed without approval, the federal government reduced its reimbursement to hospitals for Medicare and Medicaid patients. The health insurance industry has been supporting this program by contributing financially and by furnishing manpower to assist in planning activities.

To further strengthen these efforts, about half the states passed certificate-of-need legislation under which no new beds were to be constructed unless approved by an agency designated by the state. In many states this applied not only to hospital beds but construction of any health facility which cost over $100,000, including physicians' offices. Many insurance companies, including my own company, the Equitable Life, have taken need into account as one of the important criteria in passing on loans to hospitals.

A few states have also enacted another form of legislation which is designed to control costs through public approval of hospital budgets and charges. One law that became effective last year in Maryland requires that hospital budgets and charges be approved in advance by a state agency and that charges be equal for all users except Medicare patients. Another was in Connecticut, where hospital charges and total hospital costs must be approved in advance. Other states, such as New York and Massachusetts, also have hospital rate laws, but these have not proven to be effective because regulation is limited to Blue Cross and Medicaid reimbursement rates and leaves wide open charges to patients who are covered by health insurance companies or uninsured.

At the end of last year, Congress, with the full support of the Health Insurance Association of America (HIAA), enacted a new Comprehensive Health Planning Program. It establishes an organizational framework for coordinating federal and state government and local planning efforts in determining health needs and establishing priorities, with the opportunity for input from the private sector such as insurance companies. This process is to be administered by the states subject to Federal guidelines.

The new Act effectively replaces the Hill-Burton and Regional Medical Programs and the former Comprehensive Health Planning Act. It is designed to lead to greater emphasis on out-patient care by promoting the development of primary-care medical group practices, HMO's, and physician assistant training programs. Furthermore, it will encourage health education and disease prevention activities, including studies of the nutritional and environmental factors affecting health. Coordination and consolidation of institutional services, principally hospital, and arrangements for sharing support services will also be promoted.

Secondly, the new Act introduces a method of evaluating "continuing appropriateness" of services and facilities. In other words, they are to be "recertified" at five year intervals.

Thirdly, it requires all states to adopt by 1980 certificate-of-need laws that meet federal standards or lose their federal funds under the Public Health Services Act or any related Acts. The new laws will be more effective than the old because they will provide for a prohibition on unneeded construction whereas the old law merely instituted financial penalties.

Lastly, a national accounting system is to be developed, experimentally, by the Secretary of HEW for reviewing the volume and cost of services

provided by health facilities. Charges on an all-inclusive rate basis are to be established in such a manner that one class of patients do not subsidize other classes. This applies both to treatment categories, such as for maternity versus pneumonia cases, and to the various classes of purchasers, such as health insurers versus direct service payers. The Act authorizes demonstration projects in six states to test the effectiveness of such a system.

It would appear that this new legislation has strong potential for affecting health care delivery costs.

A more direct approach for controlling health care delivery costs which has received increasing attention over recent years relies on organizations of physicians, known as foundations for medical care, to monitor utilization and physician charges. At the Society's meeting held a year ago in Boston, Mr. John Mahder fully described the operations of the two prevalent types of foundation programs and I will summarize. Under the first type, the Foundation takes over from the carrier the functions of reviewing and issuing payments on all claims. Furthermore, there is a prerequisite that the health insurance plan provide a level of benefits which meets the Foundation's standards. The second type was developed and is being sponsored by the HIAA. In this case the Foundation reviews only those claims referred to it by the carrier and the carrier retains the claims paying function. There are no minimum benefit requirements.

Under the Foundation-sponsored type plan, control of physician charges is achieved by the use of a uniform fee schedule, whereas under the HIAA-sponsored approach, screening guides are developed, an important element of which are the actual fees previously submitted to the carriers as claims. The guides are used as the basis for referral to the Foundation of claims for review. With respect to hospital utilization, both use specific criteria by diagnosis to monitor the duration of confinement during the patient's stay. Some also use preadmission controls, such as precertification for non-emergency admissions and preadmission testing. Nurse coordinators are generally utilized to administer the program, with problem cases referred to a physician for review. It is clear that such concurrent review is much more effective than a retrospective denial approach. Mr. Mahder indicates that results vary, but some Foundations have reported hospital utilization reductions of up to about 15%.

Professional Standard Review Organizations (PSRO's) is a subject which is mentioned in the press quite often. They are modeled after the foundation programs. In 1972 Congress amended the Social Security Act so as to require medical societies to set up such organizations which would review in-hospital services furnished to Medicare and Medicaid patients.

Under this program, which is yet to take effect, the country has been subdivided into over 200 areas, within each of which the local medical society must create a PSRO. Each PSRO must write a contract with HEW for carrying out the required review procedures. This program has met with a great deal of resistance from the medical community. It is scheduled to be in operation by the end of this year, but it is not clear how effective it will turn out to be.

One of the sensitive problems that will probably face the hospital industry soon, if it hasn't already, is that, to the extent that efforts to reduce utilization are successful, it will be necessary to close down existing beds. Failure to do so will materially reduce the cost savings produced by lower utilization because the same fixed overhead will remain and result in higher unit costs.

These efforts, particularly in relation to hospital costs, are producing

some very beneficial results. On the other hand, many, including myself, believe that real progress can only be achieved through a significant increase in productivity in the health care delivery field, and to accomplish that, fundamental changes must be made in the structure and organization of our health care delivery systems.

There is little question that controls under more organized health care delivery systems, such as Health Maintenance Organizations (HMO's), are potentially much more potent than those previously described. This is because of several key design characteristics of such programs which make possible effective controls.

The first is a close relationship, usually contractual, between the providers of health care services and the entity which is responsible for managing the plan. The second, and just as important, is the agreement by the consumer joining the program to obtain all of his covered health services from the providers designated by the plan, except when he is outside the plan's service area and is faced with a health emergency. These two characteristics make it possible for the program to establish controls that can strongly influence the form of delivery and the number and cost of services provided under the program, as well as overseeing quality. Without such relationships with providers and consumers, there can normally be no more control than what has been developed under conventional health insurance programs. With these relationships, much more can be accomplished.

Another important characteristic of these more-organized health care programs which reduce resistance to controls by both patients and physicians, is that they offer a comprehensive range of health services, emphasizing ambulatory care, with little or no copayments on the part of the enrollees. This also carries with it a disadvantage, namely that, in spite of better controls, the premiums charged must be significantly higher than most insurance plans since the latter either do not cover such a broad range of services, or else, if they do, impose deductibles which substantially eliminate benefit payments for ambulatory care.

Now to illustrate some of the types of mechanisms that can be created. These health delivery programs can take many different forms, but there are two fundamentally different prototypes. One is called the individual practice open-panel type and the other the group practice closed-panel type.

A good illustration of the individual practice type is the program developed by the Physicians Association of Clackamus County, Oregon, which has been in operation for over 30 years and has about 30,000 enrollees who buy their health care coverage directly from the Association. Almost all the physicians in the county are participants and the program accounts for about one-sixth of their patients on the average. Physicians practice in their own offices and are paid on a fee-for-service basis but jointly underwrite the risk that the premiums collected will not be sufficient to finance the program.

Thus, the physicians are strongly motivated to institute effective controls. Under the system, which they have developed over the years, the initial attending physician is financially responsible for the total cost of care for each diagnosis. This includes the physician's own fee-for-service charges, any hospitalization, the cost of any referral to other physicians, and all other services. Each month the physician's average case cost over the previous 12 months is computed. It is compared against corresponding county-wide average case costs, which recognize that physician's diagnosis profile, and is increased 15% to allow for variations in treatment. If a physician's average exceeds this figure, the excess is charged against the fees due him from the program.

A utilization committee composed of member physicians meets once a week, without pay, to review hospital and extended care utilization for current patients. If the committee spots an unnecessary hospitalization or abnormal length of stay, they contact the attending physician. They also check to see that patients are transferred out of the hospital to an extended care facility when appropriate.

A surgical tissue committee passes on each surgical case based on an operative report and a pathologist report before the surgery will be paid for. If the surgery is unnecessary, the case can be brought to the Medical Society grievance committee or the physician might be charged with the total cost of the case.

Per diem hospital charges to the Program are studied and if a hospital is out of line with the others, the hospital administrator is called down to explain the situation. Oftentimes the hospital reduces its charges as a result.

Lastly, bills for all medical services are carefully audited by administrative personnel and they are sent to the primary physician in each case for his review. Copies are also sent to the subscriber so that he might better appreciate the value of his coverage.

At this point, I think it would be of interest to mention that my company, in conjunction with the Nassau County Medical Foundation and the local hospitals, has just begun the operation of an individual practice plan for residents of Nassau County. It is called the Nassau Health Care Plan. We are developing some of the same controls as Clackamus County.

Now I would like to turn to the controls that might be used by a group practice closed-panel type plan. This form is in marked contrast to the individual practice type. Although the covered services and the costs may be comparable, the method of delivery is significantly different.

In group practice plans, most non-hospital services are furnished in a central ambulatory care facility. Secondly, the plan hires or contracts with a limited number of primary and multi-specialty physicians, most of whom work full time and are remunerated on a salary or a salary plus bonus basis. In contrast, under the individual practice foundation type, physicians provide services to the program in their own offices on a part-time basis and are paid fee-for-service.

An example of such a group practice plan is the Kaiser-Permanente Program which operates in five states, principally in the West, has about two and three-quarter million enrollees and is by far the largest HMO in the United States. It furnishes care for most of its enrollees through its own ambulatory care center and hospital complexes. Each complex is manned by an approximately 100-member Physician Group and services about 100,000 enrollees.

The key point here is that control is achieved through direct management of the entire system. I might add, there may be no really effective substitute.

Kaiser has created an organizational structure that allows central control over the costs and scope of the program and, at the same time, permits considerable freedom of action by the Physician Groups. This is achieved principally by organizing the physicians in independent partnerships and dealing with them through a contract with the Health Plan that is renewed annually.

The contract provides that the Physician Group will furnish medical services to members enrolled with that Group in return for a fixed monthly payment per member. The basis for determining the size of this fixed per capita amount is a very detailed budget prepared by the Physician Group and reviewed and approved by the Health Plan.

At the end of the year the difference between the budgeted amount and actual operating costs is computed and any excess serves to increase physicians' income and vice versa. In a similar manner, a hospital budget is prepared and the difference between actual and budgeted costs is shared by the Health Plan and the physicians.

Thus, in order to maintain the stability of their staffs and to attract good personnel, the managements of the Physician Groups have strong incentives to control costs.

Other means of control which the plan has readily available are the number of hospital beds constructed for its membership and the number of physicians which it hires and their mix by specialty. The use of ancillary personnel to perform many of the health services that do not necessarily require physicians also reduces delivery costs.

I think it is clear that, if it is possible to create plans like Kaiser's and enroll a sufficient number of members, this approach holds the most promise for controlling costs and producing maximum productivity. On the other hand, to develop new programs of this type is very risky. They are extremely expensive to develop and difficult to market, particularly in competition with group insurance. Consumers have not been overwhelmingly attracted because in most cases they would have to give up relationships with their existing providers and pay higher premiums than for conventional health insurance. The mandatory dual-choice provision of the 1973 HMO Act may ease marketing resistance by forcing employers to offer HMO Plans, which become federally qualified, to their employees as an option under their health benefits programs.

Now let's examine the relative success of the individual and group practice type programs in controlling utilization. One of the best illustrations of this can be obtained from the Federal Employees Health Insurance Benefits Program. Under this program, all federal employees have the option of choosing one of two standard plans or any of the authorized local individual and group practice type programs. The two standard plans are Blue Cross/Blue Shield and a plan sponsored by the insurance companies called the "indemnity plan." A comparison of the hospital utilization results for the year 1968, the latest data available, is shown in Table 1 in annual number of days confined in a hospital per 1,000 persons covered. It indicates that the aggregate of individual and group practice plans, and the Clackamus and Kaiser plans in particular, run less than 450 days, while the two standard health insurance plans run about 880 days.

Data has also been published regarding frequency of surgery performed in a hospital under the Federal Employees Plan for 1968 comparing Blue Shield and the group practice plans. It is shown in Table 2. It indicates that the subscribers to group practice plans had less than half the amount of in-hospital surgery as Blue Shield subscribers.

In conclusion, I think you can see what can be accomplished. It is clear that the health care field, taken as a whole, badly needs the introduction of better controls, and the kind that I have described ought to be carefully considered for wider introduction.

TABLE 1

FEDERAL EMPLOYEES HOSPITAL UTILIZATION

Annual Days Confined per 1000 Persons

Option	Days/1000
Blue Cross/Blue Shield	879
Indemnity	885
All Individual Practice	472
All Group Practice	419
Clackamas County	438
Kaiser-California	448

TABLE 2

FEDERAL EMPLOYEES IN-HOSPITAL SURGERY

Annual Rate of Surgery per 1000 Persons

	Blue Shield	Group Practice
Tonsillectomy and Adenoidectomy	6.9	2.4
Female Surgery	9.2	4.8
Appendectomy	2.1	1.5
Gall Bladder	2.1	1.5
All Types	75.0	34.0

MR. J. MARTIN DICKLER: Two of the panelists predict that a national health insurance plan would probably take the form of a mandatory employer-provided plan. Would the panel comment on the experience rating formulas under such an approach?

MR. HSIAO: The experience rating formulas would probably be changed in that they would involve pooling of catastrophic costs, costs of covering the unemployed, costs of covering sporadically employed individuals, etc. Otherwise, there would be little change in the current procedures used by the insurance industry.

CHAIRMAN THOMAS: Some of the cost will have to be redistributed through the experience rating process. I call this a socialization of the risk. A system existed in Alberta, Canada prior to the installation of a national health insurance program there. Each carrier ran his own business, but received further risks from a central pool. The approach worked and offers encouragement to the concept of socializing the risk.

MR. ALAN M. THALER: A promising proposal has just come out from Congressman Rogers. This proposal to extend health insurance during unemployment modifies the Kennedy proposal. It also takes care of the unemployed who were without previous coverage under the Medicaid program. Financing would be provided through general revenues. Would Mr. Myers care to comment?

MR. MYERS: As I understand Congressman Roger's proposal, it would make unemployed workers who did not have health insurance when employed automatically eligible for medical care benefits under the Medicaid program regardless of their income or assets. This would be very undesireable.

For one thing, these programs differ so widely between states that there would not be consistent or equitable treatment of beneficiaries. Further, the Medicaid program is so poorly administered in many states that both beneficiaries and providers of services are very dissatisfied with it.

Finally, I do not like the approach of financing the cost from general revenues when it can be assessed more properly and directly to employers as it is in the Rostenkowski Bill. I deplore the use of government subsidies - whether in OASDI, Medicare, or other Social Benefit Programs - whenever this procedure can be reasonably avoided. Such subsidies have too much of the element of "manna from heaven". Their use produces a lack of responsibility on the part of much of the citizenry who may well feel that the promised benefits will be paid for, not by themselves, but by somebody else.

MR. LAWRENCE J. RUPP: A recent Rand survey indicated that only doctors' and not hospitals' fees would increase with implementation of a national health insurance plan. Does the panel care to comment?

MR. HSIAO: The Rand conclusion used the theory that the usage of doctors and hospitals are independent and that increased demand for hospital services would be covered by available bed space. The Rand study forgot that doctors use hospitals as their workshops. The cost of hospital care will depend greatly on technological developments and decisions made by doctors.

MR. MYERS: I cannot agree with Mr. Hsiao's earlier statement that Medicare was the major cause of the price increases in medical care costs following its inauguration in mid-1966. It may have had some effect in this direction,

but the major cause was the general price inflation resulting from the war in Vietnam.

It is true that since 1966 hospital costs and physician fees have risen rapidly, but so too have the general price and wage levels. In fact, the relative relationships of these various elements have remained the same in the period of the late nineteen-sixties as they were before then. In the late nineteen-sixties, hospital costs increased about 14% per year; both general wages and physician fees increased about 8% per year; and general prices increased about 4% per year. In the earlier years, all such increases were only about half as large, but the same relative relationships had held true.

If somebody had told me in 1964 what the trend of general wages or general prices was going to be in the late nineteen-sixties, it would have been possible to make assumptions for the trend then of hospital costs and physician fees that would have closely matched the actual emerging experience. And then the cost estimates for the Medicare program would have been really great!

MR. JAY C. RIPPS: Under a mandatory employer-provided plan approach to national health insurance, a lot of people would not be covered. How do the rest of the people obtain coverage? Also, would Mr. Myers elaborate on the administrative and financial problems of the Social Security Administration.

MR. HSIAO: Some estimates of the number of people not covered under the employer approach range from twenty to thirty million. This could only be handled by some method of public financing where insurance was purchased for these people from a pool.

A mandatory employer-provided plan approach might include provisions under which private insurers form state or regional pools with the cost financed from the Federal Treasury. Such an approach would eliminate the Medicaid program.

MR. MYERS: Unfortunately, the Social Security Administration (SSA) in recent years has been having great administrative problems with the programs for which it is assigned responsibility. This is evidenced by the slower adjudication of claims of all types and the worsening experience for disability cash benefits. The SSA has had great difficulties, not only with the Medicare program, but also with the Supplemental Security Income and Black Lung programs. It is no longer like the days when there were only OASDI cash benefits and SSA was a paragon of administrative efficiency.