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MANAGING HEALTH CARE

Moderator: JOHN G. TURNER. Panelists: PHILIP BRIGGS, MERLE H. GLICK, ROBERT C. OCHSNER, GORDON R. TRAPNELL*

1. Prospects for Cost Containment of fee-for-service health care.

2. Alternatives to fee-for-service system.

3. Management of health care under national health insurance. Discussion to include: Cost containment devices, HMO's - economic impact, cost escalation - self-insurance, stop-loss, claims administration services - loss of State premium taxes and Phase 3 tax problems under NHI.

MR. JOHN TURNER: Health care in the United States is provided by a remarkably diverse number of provider and financing organizations. There have been frequent references to the problems of this non-system, including maldistribution, over capacity, lack of availability, excessive cost and so on. Interest seems to be centering on the fact that health care in the United States currently costs over 8% of the gross national product. This percentage has been increasing continuously since 1948 and many assume it will continue to do so in the absence of any major changes in the mode of health care delivery in the U.S. The title of our session, Managing Health Care, leads us to consider the elements of management - planning, organizing, directing and controlling. Because of our position as related to the insurance industry, relative to the entire total health care picture, we are essentially involved in financing concerns, and as a result, we will attempt to deal with the organization and control aspects of health care delivery. Further, due to our concern about financial aspects, there will be an emphasis on health care cost control.

MR. PHILIP BRIGGS: What I'm going to try to do, is indicate what Metropolitan has done thus far in the area of cost containment. I want to emphasize that some of the cost containment measures that Metropolitan's been involved in have been in use for many years. Others, are very experimental and we don't know at this point if they are really going to have a very important effect. The other major point I'd like to make, is that a single insurance company can only do so much. It needs help from other insurance companies, it needs help from employers and it may in fact need legislative help if it's going to really do a job of cost containment. I guess the basic question is, can we continue to tolerate the kind of increases in medical care costs that we have seen develop over the last few years. Certainly, a large number of employers have come to the realization that their medical care costs have become intolerable and some have been quite outspoken about it. We have a representative from a larger employer here today and he will tell us what he thinks about it. A large number of our customers have taken matter into their own hands, because they feel they have not had

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enough support, at legislative levels and perhaps even from their insurance companies, in doing a job of cost containment. As I said a little earlier, an insurance company can do certain things on its own, but for certain other things it has to have the employer as a partner. And I think this kind of commitment from group customers has been relatively recent. Up until about two years ago, frankly, there were relatively few large employers who understood the seriousness of the matter. Most large employers were more concerned about not antagonizing employees or the medical people in the area, and the word that came to the insurance companies and to us in particular was, pay the claims, pay them fast and don't ask too many questions. I think, to some degree, this has contributed to the present problem. At the Met, we have had for quite some time individuals called Metropolitan Claim Consultants. We have about 50 of them scattered around the country. They are professionals. Their job is to deal face to face, one on one, with hospital administrators, doctors and so on. It is their job to audit hospital records and to question bills that appear out of line; they have done this very effectively for many years. This is a major part of our cost containment activity and has been for a long time. One other aspect of cost containment which is not related to medical care, but has to do rather with disability benefits, is auditing the way disability claims are paid. We found that some employers were rather casual about the way disability claims were paid and the way they maintained their records. During times of recession, they would lay off the people who were taking care of the disability claims. You can imagine what the result was. One of the things we have introduced is an audit program for disability claims and we have been able to demonstrate, very conclusively, major savings to employers.

Not too long ago, the Council on Wage and Price Stability held a series of hearings with representatives from the health care industry as well as from labor and management. The purpose of the hearings was to determine the reason for the escalation in medical care costs. And the first thing that they found, of course, was that there was an overexpansion of hospital facilities and a misallocation of hospital resources. Pretty startling figures came out of these hearings: for example, that on any given day, there were 200,000 empty hospital beds in this country. Also there was extensive duplication of very expensive equipment, such as the cat scanners. Such items as open heart surgery suites were being built at very high costs and in too many hospitals. Also, the length of stay in the hospitals was frequently extended beyond what was medically necessary. Another statistic which came out of these hearings was that if you had a one day reduction in the average length of confinement in hospitals throughout the country, you'd save two billion dollars a year. There are certain things an insurance company can do including auditing records and making sure the obvious abuses are not taking place, but we need some legislative help. Certainly the HIAA is trying to do its part. And we support the HIAA completely, particularly in the area of prospective hospital rate review and certification of need legislation. These are two items which can be very helpful. They've proven their usefulness in the states of Connecticut and Maryland. Connecticut is the outstanding state because for at least two years now, they've been able to substantially reduce the increase in medical care costs compared to any other state in the country.

We are also advising our policyholders to modify their plans in such ways as to reduce the use of acute care hospital facilities. One way of doing that is to provide that certain surgery can be provided in ambulatory free-standing

surgical care facilities, known sometimes as surgi-centers. We have spent a lot of time investigating surgi-centers. We are convinced there are many surgi-centers in this country that can do a fine job. These are establishments where you can go in the morning to have a minor operation, and walk out that afternoon. We encourage employees to use them. We also encourage the use of extended care facilities, pre-admission testing and, of course, the use of alcoholic and drug rehabilitation facilities of various kinds. We're also trying to work with PSRO's around the country and the medical care foundations, and we're trying to see whether we can get concurrent inpatient utilization review. Keep in mind that the additional clerical costs of doing this monitoring of hospital stays is costly in itself and obviously, if we don't reduce the hospital costs by more than we incur in our clerical costs, we're not getting anywhere. Doctors' fees, of course, are another major problem. Doctors' fees have risen 211% between 1965 and 1976 and I think part of the problem has been the big expansion in "reasonable and customary" medical care plans. They have allowed the expenses to creep up gradually and that has contributed to the problem. At this point, we're finding that many more employers are interested in our taking a hard line on some of these matters.

One attempt to control doctors' costs has been the use of second surgical opinions. On the face of it, it sounds like a great idea, but in fact it has not been demonstrated that second surgical opinions really save any money. Nonetheless, we are experimenting with second surgical opinion plans. We now have such plans in force for three of our policyholders and we are watching the results very carefully. Our plan is strictly a voluntary one. We introduced it only after discussion with the medical societies in the area, and it has been approved by the American Medical Association. Under this plan the participants may select a second or even a third surgeon to review their condition before surgery takes place. One of the problems is that you do incur additional visits. There is a question as to whether the additional cost of the extra visits and extra monitoring reduce surgical costs sufficiently to offset the additional cost incurred.

One of the major new developments is a much greater interest in health claim statistics. We are finding a great deal of interest on the part of employers and insurance companies in knowing lengths of stay by diagnosis, and comparing lengths of stay from different areas and different hospitals. Sometimes we find that we do have variations which are difficult to explain. By raising questions with hospitals and doctors about the lengths of stay that do exist in some areas, we are finding that we can make changes in the length of hospitalization stays.

Finally we have a great deal of interest in health education. Metropolitan has been involved in health education for many years. At this point, we are very much in vogue. We find many of our employers are interested in health education. We are putting on programs for various large policyholders which try to bring to the attention of the employees that the long term solution for high medical care costs is prevention of illness. There are many things that can be done to improve the general health of individuals. Life-style has a lot to do with it.

One item I should mention is HMO's. We've been directly involved in three HMO's. We've participated with others in two or three others. Our goal was to see whether we could reduce medical care costs and whether we could provide better medical care. The issue is a bit in doubt as to whether we accomplished either, but we have gotten a lot of experience in the matter and I think we did make a contribution.

One other aspect has to do with the insurance industry's efforts to gather data on an industry-wide basis so as to control medical care costs. A number of people feel that the long term answer to controlling medical care costs requires such a central data facility. Currently, HIAA has a task force which is studying the feasibility of setting up an industry data facility that would gather medical care claim statistics and make them available to the members of the industry. This could be a very extensive program. It might involve very substantial computer costs and a fairly large financial investment on the part of the industry.

MR. MERLE GLICK: I'd like to give you one employer's viewpoint on the problems of health care cost control. Caterpillar employs approximately 60,000 employees in the United States, most of whom are here in the Midwest, and most in smaller communities. As I'll cover later, this affects the kind of job that we can do in influencing health care costs.

Most of our operations and most of our hourly employees are covered by the typical UAW auto-industry full paid medical benefit plans, and have been since 1950. Of course, the plan now covers a wide range of benefits, including prescription drugs, dental benefits, and eye care (which just went into effect). We've been associated with Metropolitan for many years, but we have administered our own claims since 1951. In 1962 the Cat-Met minimum premium plan was introduced and we now have some of the more recently added benefits under an administrative-services-only arrangement.

What have we done with this opportunity to influence health care costs, where we are a large organization in a small community? We've tried a number of things, but with limited success. What we have done is more in the area of what I call claim cost control. Once the claim has been incurred, we do a lot of things to make sure we don't pay any more than we should, and we do this through a fairly sophisticated computerized claim payment record system. We also have the opportunity for much personal contact with the hospitals, doctors, dentists, druggists, and now the optometrists. They know us personally, and this makes for a better relationship. We pride ourselves in fast claim service, good records, and we investigate the matter thoroughly when we think anyone is out of line on fees. They know it, and they respect us for it. We sponsored a special community HMO study a few years ago, with Metropolitan's help, to determine what role Caterpillar should play in the trend as a big employer in small communities. The study involved the local medical society, hospitals, and others, but we found not very much enthusiasm for this new concept. In the meantime, we've worked with the local medical societies in developing a PSRO and some of us serve on health planning agencies. And most of our top executives are on hospital boards, but what has it all brought? Not very much real influence on health care costs except, perhaps, to increase them because of the nature of the full pay benefit plans that we have bargained with UAW, with very few built-in controls.

What is the role of a large industrial firm in the future? Frankly, we like the prospects of HMO's. The first federally approved HMO has come to Peoria on a relatively small scale, and they have approached us regarding our exempt employees. So we're on stream to offer this and I think it will have some success. We like HMO because it is probably the only private enterprise system that can contain or reduce costs. Attempts by government to provide health care or finance it will only create greater inefficiency. Whether it's too late for the HMO movement to be of any major influence in this

problem, I don't know. Additionally, we certainly want to support the PSRO's. In several of our communities, the medical foundations are getting into action to monitor hospital admissions and hospital stays. We want to support that and we want to get more deeply involved.

We take a rather discouraging view that plan design can do very much here. Of course, if you have a high deductible, it will deter some medical costs, but politically, I don't think it's in the cards. People just won't buy high deductibles after having Blue Cross/Blue Shield or private plans pay the full load, or almost all of it. Public attitudes are just too deeply entrenched against having much personal financial responsibility in their medical care costs.

We think that corporations have to get involved. We haven't done enough but we intend to do more in the future. The Reynolds people and Motorola people got involved, with results. Some of General Motors' pronouncements on the subject are all in the right direction. The corporate payer of medical costs simply must get more concerned. We need strong active representation on the now federally funded community health planning groups, despite the frustrations of reorganizations, red tape, etc. It does take time, however. Also, I think that top executive representation on hospital boards must be more than rubber stamp members. They must be equipped to challenge hospital administrators.

So, Caterpillar has not done all that it should, but we do have some good ideas and we've done a good job in controlling claim costs after the claim has been incurred, but there are many more things that we must look to in the future to make a contribution to this complex problem.

MR. ROBERT OCHSNER: A health maintenance organization (HMO) is frequently viewed as a socialistic or communistic approach to health care. I believe it's neither; it's more like the consumer cooperative form of organization which has been used to provide many things in this country. And, at the heart of an HMO is a principle that's frequently called dual choice or free choice; that is, no one is ever forced to join an HMO. An HMO will not enroll employees of an employer if the employer attempts to force people into it. It's an alternative health care delivery system and it will always remain an alternative system. There has been substantial growth in the number of HMO's in this country and the number of people who receive their health care from HMO's, but that number changes from month to month. There are about two hundred operational plans in all, in this country, which bear some resemblance to an HMO and they're not all necessarily the type that would be federally qualified. And there are over six million men, women and children who are receiving HMO care now. Those numbers are rising fairly rapidly - the number of qualified HMO's is held back mainly by the process of qualification itself. That can take more than a year of working through HEW's requirements and regulations, because there are a number of levels of review and a number of procedures to be met.

I think on the whole, that if we took our subject today literally, we wouldn't have a panel. That is, I think no one in this country, to any great degree, is managing health care in the sense I understand the word "managing". I agree with everything that Phil and Merle have said, but I think what is being done is merely cost control and it is not managing health care itself. Certainly, that needs to be done. HMO's may be one

way of trying actually to manage care. The reason for that is that they affect both the supply and the demand for health services. We had a very bad experience in this country in the 60's when the federal government decided to provide health benefits for certain segments of our population: the indigent and the over 65 group. They drastically affected the demand for medical services without doing anything about the supply. HMO's bring with them their own resources. They add health resources to a community, where needed. Therefore, they don't upset the balance. We're hopeful that anything which develops along the lines of a national health insurance program in this country, will involve dealing with both sides of the equation. Within the last twelve months, there has been an increasing amount of involvement and interest in HMO's by employers in this country. That is, they are the payors for the largest share of health care now, and they have begun to take an interest in HMO's as a mechanism for cost containment. Now, it has frequently been claimed that HMO's will reduce health care costs. I am not sure that can ever be proven or disproven directly, but it is really not a claim of people who work in HMO's. HMO's will redirect some of the health care dollars. They spend a higher percentage of them doing outpatient services and less on hospitalization, and thereby they may improve the quality of the health of the population over a period of years because they reduce the barriers to getting care. It's prepaid and there's almost no charge to go in for care when you need it. In many plans there is no charge at all. HMO's are putting a lid on cost, because they control the delivery mechanism to a greater or lesser degree.

As I imagine most of you know, there are two broad types of HMO's: group practice and individual practice. The group practice type has a much more direct control on delivery of services. Their rate of cost escalation from year to year has been running at, I would roughly guess, half the rate of increase of comparable insurance plans that we see. I think John said he had measured it in the Twin Cities area at a third of the rate. The reason is that while HMO's are subject to increases in hospital rates, it is only to the extent of something approximating a labor and materials cost increase from year to year. They can continually look at the services they are rendering and direct their resources in the proper direction, and they can continually monitor the appropriateness of the care that they are offering. The normal system of indemnity reimbursement for services after the fact doesn't have and never will have that kind of opportunity for control. Right now, if an HMO provides a nearly total health care service, although relatively few of them have dental and optical and those types of benefits, the cost of that HMO will be just about at scratch with the typical insured or self-insured health benefit plan of a major company. There are some in fact which are lower. That was not true up until the last year or so.

I think the chief reason for that is simply that HMO's have started to gain a pretty good level of membership in most areas. They're realizing some of the efficiencies of economy of scale, and they have really started to bite into the health cost increases that we have all felt.

When the individual is left to go out into the health care marketplace, he is at the mercy of that marketplace in getting services. If the past is any guide, future cost increases of HMO's will be less than those of reimbursement-type plans, and that's going to improve their competitive position.

All in all, you will find HMO's enrolling employees and getting anywhere from about 10% of the employee group, up to sometimes 50% or better. But, since

HMO's are not for everyone, they're not going to exist everywhere, and they are more feasible in a metropolitan area of about a half million people or greater. Because they can not go after every company, they are, as a practical matter, limited to actively pursuing only companies which have 100 or more employees, and of course most of the people in the country work for employers of less than 100. The actual impact of HMO's in terms of the potential total enrollment eventually is probably somewhere in the area of 20 to 30 million people, so they are not going to be the principal factor in health care.

It's frequently stated that HMO's are a clinic or they are GI medicine and so on. My experience with them, where they are operational, has not been that at all. As a matter of fact, I think they compare favorably with the waiting time and conditions in doctors' offices in private practice, and they compare very favorably with the hospital emergency room, which is in fact the "family doctor" for millions of people in this country. Millions of people do not have a family physician.

Our last major cottage industry is medicine. Medicine is still practiced primarily by one or two people working alone in an office with assistants. We do not practice law that way; we do not, by and large, offer consulting actuarial services that way.

I believe that the future of medicine is going to consist of multi-specialty group practices. Some of these will form part of an HMO; the majority of them probably won't. The majority of them will still be on a fee-for-service basis.

I was asked to comment on the future of the fee-for-service system as it might be affected by HMO's. I think that there won't be a great effect for two reasons. One, we have seen in countries where there has been a national health system, that you still have private practice, and it always continues to exist. Second, statistics that I have seen indicate that in the 1980's we may be somewhat oversupplied with doctors in this country. As a result, there will not be as great a competition for doctors even if the HMO "movement" (although I'm not sure that's the right word) continues to grow. So, I believe there is still going to be a fundamental place in this country for fee-for-service medical practice and HMO's are going to form an increasing, but not a predominant, part of our nation's health care system. We're hoping that they will help to make it more appropriate to call that a system, rather than simply an aggregation of resources.

MR. GORDON TRAPNELL: Although my colleagues have reviewed a number of fruitful approaches to containing health care costs, I believe that these activities attack only the symptoms and not the basic causes of the volatile increases in health care costs that have been taking place in the U.S. I am also of the opinion that because no serious attempt is being made to address the fundamental causes the measures proposed are likely at most only to restrain the rate of increase temporarily. Further, in the absence of any solution to the real causes of the inflation, it is likely that the pressure of cost increases will lead to a collectivist health care program in the U.S.

In order to explain my reasons for these views, let me review the principal pressures leading to the demand for national health insurance. The primary forces appear to be:

1. The rapid increase in the cost per capita of medical services, and the consequent need to raise health insurance premiums, employer contributions, taxes, and out-of-pocket spending to pay for them.

2. The uneven availability of primary care, and sometimes of emergency care, throughout the country. This problem is most acute for rural and inter-city areas and for migratory and non-English speaking population groups.

3. The absence of any management of health care services for many patients and families, resulting primarily from inadequate primary care. A major symptom of this problem is the tendency of many persons to obtain basic services from out-patient hospital departments, which are not in general organized to view the overall health problems of the patients served.

4. Overemphasis on treatment of specific symptoms, and neglect of preventive services and public health measures.

Of these causes, the inexorable pressure of rising costs would appear to be by far the most powerful. The primary complaints concerning health care are not that services are unavailable, inadequate, or not provided when needed regardless of cost -- but that the collective burden of paying for them is intolerable. Unnecessary services, poor organization, wasteful delivery systems, etc., are of concern because they contribute to the overall cost of care.

The cost of medical care has been rising far more rapidly than earnings and other sources of income. We are now spending $146 billion, or approximately 9% of the gross national product, on health care. By 1982, if the proposed Federal hospital cost control programs are not adopted, we will be spending on the order of $240 billion, or 9.2% of the gross national product. This would constitute an increase in the cost per capita of medical services of 13.3% per year, compared to an annual increase of 6.5% in the general price level.

Let us review briefly the principal reasons why costs, especially institutional costs, are rising so rapidly. Most of the increases are due to readily understandable and acceptable reasons. Included among these are:

-- Inflation, decreasing the value of the currency and pushing all prices up. We can probably expect a 5% to 10% rate of inflation from now on, averaging somewhat higher than the 6% we had during the last year.

-- The compensation of health workers, relative to other occupations, which has transformed the medical field during the last dozen years from one dominated by low paid and volunteer workers to one of highly paid technicians and professional personnel. The dominant professional group, physicians, constitute the highest paid major profession in the U.S.

-- Greater access to services, especially by the poor and aged, but also by those benefiting from the spread of employer-funded group health insurance.

-- The increasing proportion of aged in the population.

-- Increasing use of services per capita, especially of diagnostic tests and prescriptions.

-- Relatively more frequent use of more expensive services, especially specialist services and technically superior diagnostic procedures.

-- New technology and advanced medical techniques.

There are no real villains here, except the general level of inflation, for which the health care field cannot be blamed. The other components have directly benefited patients. This even applies to the high pay of physicians which has attracted a greater share of the ablest young people to the medical profession. Further, it would appear that the U.S. public expects to have the full panoply of feasible medical technology available to everyone. There is no suggestion from any quarter that the quality of care available should be reduced in order to lower costs. To the contrary, any proposal to control costs is accompanied by the insistence that the quality of care will be improved in the process, despite the implausibility of this proposition.

There is, of course, another side to the increases in the cost of medical care.

-- The compensation of physicians has reached a level far beyond that necessary to attract an adequate number of competent, highly motivated individuals. It has become so high as to attract those whose primary interest is in making money rather than in providing the most intimate and crucial of personal services.

-- Large sums of money are spent for services that do little to improve health. Some services are performed when there is only a remote possibility of improving a patient's condition. Other services that are probably harmful and have little chance of benefiting patients, are rendered because a patient's situation is so helpless that nothing else can be done. Sometimes treatment is prescribed which at most provides a psychological boost for the patient or his friends and relatives.

-- Many services are performed to satisfy the requirements of an inefficient and inconsistent quality control system -- malpractice suits. Large sums are further wasted in paying for the legal proceedings and judgements.

-- The provision of health services has become encumbered with inefficiencies, encouraged by the reimbursement of all costs incurred by most providers of medical services.

-- Medical care has become a luxury good, with the level of care provided exceeding the general standards of housing, nutrition, and occupational health that the population enjoys. Improvements in public and occupational health would appear to be much more likely to contribute to the overall health of the population.

These manifestations of inefficiencies and unnecessary expenditures, however, are symptoms of more fundamental problems. More important, most of

the major causes of the rapid increases in health care costs have nothing to do with inefficiency, over-use, or any other ready villain, but are directly attributable to the ambivalence and inconsistent beliefs and desires of the American public. I would assess the primary underlying causes of rising health care costs as follows:

1. A set of perverse incentives to providers to offer an unnecessarily expensive level of care. Among these are:

   a. Paying more to doctors who charge more.

   b. Paying more to hospitals that cost more.

   c. Paying more for patients who use more services, or more expensive services.

   d. The tax subsidies to health insurance policies which encourage employer funded insurance, coverage of first dollar expenses, and minimal cost-sharing in order to obtain the maximum tax benefits possible. All of these features encourage an insulation of patients from the actual cost of services and provide overwhelming incentives to use the most sophisticated and complete services available, regardless of the actual cost.

   e. The insulation of the key managers of health care, the physicians, from any substantial concern for the overall cost of care. The result is that the dominant pressures to which a physician is likely to respond are professional pride, in rendering the most thorough and complete services possible (including referrals to any specialist who may know more about a particular condition) and the economic incentives of payments in proportion to the total services rendered. If there is even a small doubt, additional diagnostic tests are likely to be prescribed. Further, the bias toward over-servicing is only reinforced by formal peer review mechanisms and the possibility of malpractice suits.

   f. The incentive to each neighborhood to have the very best facilities possible since the cost is borne collectively by the entire community through the mechanism of insurance premiums.

2. A second fundamental problem is an apparent misconception by the public of the technical limits of medical care. This lack of understanding has several important ramifications.

   a. There appears to be an almost unlimited faith in the efficacy of new technology to invent cures for every illness.

   b. The public appears to regard most instances of disease and deaths as preventable, provided competent medical research is conducted and the results implemented.

   c. The public does not appear to understand the need for judgment in many decisions as to the appropriate medical treatment. Thus physicians are expected to routinely attain an unrealistic standard of competence. Hence damages are sometimes awarded in malpractice suits

when a procedure was not followed which, on the basis of hindsight, might have helped diagnose the condition.

3. The most fundamental problem, however, is the absence of any mechanism through which the society can decide collectively what part of national income should be devoted to health care and the priority with which it should be allocated by type of patient and type of care.

In deciding, for example, to have the Social Security system pay for all kidney transplants (after much publicity concerning individuals who were going to die because they did not have $25,000 for an operation), there was never any public consideration of either the cost to everyone or the other potential benefits that could be obtained through the same expenditure. The public was not offered the choice of paying the additional Social Security taxes in order to be able to have a transplant if it were to be needed. The suffering and deaths that may have been avoided by such alternative expenditures could not be presented to the public in so dramatic a manner as the predicament of those needing dialysis or a transplant.

Most decisions concerning the level of care that will be available are not made by the public, but rather by physicians, hospital department heads, and administrators, and sometimes judges and juries (as in the case of the famous Quinlan trial). Through insurance premiums, however, the public must pay for the cost of the decisions, without having participated in making them.

At present we have no answers to the basic problems outlined above or any means of determining answers. We have insurance policies and government programs that will pay for most of the cost of whatever care is provided, and the relatively small proportion that patients cannot afford is funded by not pressing the collection of bills not paid and by raising charges to others by 5%-10% to make up for the loss of revenue. To hospitals and physicians, the demand for services keeps expanding with every technical innovation. The amount of total care provided also keeps expanding in response to this apparently unlimited demand.

The principal points to be made are that:

-- The potential amount of health care is infinite.

-- Patients and their physicians will use it, in fact are under strong pressure to use it, if the cost is within their means.

-- The present extent and form of insurance policies, government programs, and the redistribution that takes place through bad debts, places unlimited care within the means of most patients in the U.S.

-- Under these circumstances, the decision that is made as to whether an additional test or procedure should be performed will be based solely on whether the potential benefit is positive, and without substantial consideration of the cost.

-- The sick and dying want nearly any kind of care that can be provided, regardless of its probable effectiveness. The technology of medicine would appear to be adaptable to almost unlimited expansion.

The principal types of proposals to manage health care costs may be classified as follows:

1. Administrative procedures:
   a. Detailed claim review.
   b. Compilation of profiles by patients or providers.
   c. Counseling to employers with group health plans.

2. Financial incentives:
   a. Cost-sharing.
   b. Payment for alternative care in lower cost settings.
   c. Incentives to HMO's.

3. Regulatory controls:
   a. Per prior authorization for elective procedures.
   b. Utilization review and PSRO's.
   c. Standards for practitioners (especially surgeons).
   d. Second opinions.
   e. Financial disclosure (e.g., physician incomes).
   f. Introduction of assessments by independent review panels as state's evidence in malpractice suit trials.

4. Financial controls:
   a. Cost controls (or revenue controls) for institutions.
   b. Predesignated budgets for institutions.
   c. Fee controls.
   d. Comprehensive national budget for health care.

5. Direct Federal (or state) control.

6. Education (e.g., persuading people to live healthier lives).

7. Public health measures (e.g., reducing occupational hazards, improving the environment, reducing motor vehicle accidents, etc.).

One looks in vain among these measures for answers to the three fundamental problems posed above. The administrative and regulatory measures may help to rationalize the pattern of health services delivered. To judge the long-term effectiveness, however, one need only observe that the standards in each case are relative and not absolute. The concept of a "necessary" health care service depends entirely on the current pattern of care. The standard as to which patients are treated at home and which patients are treated in hospitals is set through the collective judgment of physicians. Utilization review, review by PSRO's, second opinions, and claim review merely standardize these judgments over all patients.

If there is an absolute standard, it is based on the probability that a service will improve the health of a patient compared to the probability that it will harm him.

In order to be effective, any regulatory agency must have public acceptance. Otherwise, its sanctions will simply be ignored and not reported. Questions as to the medical necessity of services are too complex for the public to understand. Consequently the judgments of the regulatory agencies are likely to be altered through the political process and court review.

Another serious deficiency with the regulatory approach to containing health care costs is that it does not address the principal causes of the increases in spending for health care. The primary reason why hospital costs have been increasing so much faster than other prices is that the hospitals are providing increased quality of care. Part of this improvement is attributable to new techniques and to teams of specialists whose cost is too great to be borne by those patients served. These services are available to all patients but used by only a few. The cost of this large and increasing overhead is borne by all patients through the room and board charges and by the community through health insurance premiums.

Planning agencies may have some temporary restraining impact on the increase in the general level of overhead borne by a community. They cannot, however, prevent the introduction of any new apparatus or new medical techniques. If they were to prevent the introduction of any innovative technology, this action could be represented in the news media as denying life to particular individuals. The political process would quickly override the planning decisions. Knowing this, opponents will present each new innovation as a potential life-saving process. Against strong pressures like these, no regulatory scheme can have a lasting impact. The actions of the regulatory body will inevitably reflect the prejudices and beliefs of the general population. As long as the population does not perceive that it has a direct interest in the cost of care, the erosion of regulatory restraints is inevitable.

Controls on revenues or costs of institutions are likely to go the same way as regulations. As demonstrated by the economic stabilization program in 1972-74, cost controls can temporarily restrain the overall increase in spending by hospitals. In the long run, however, these controls will fail to restrain cost increases for a number of reasons. Revenue or cost controls are necessarily arbitrary. They allow high cost hospitals to continue operating with high costs, while forcing low cost hospitals to be far more efficient. Exemptions must be allowed for special factors affecting the cost increases of some institutions but not others. Within a few years either a large proportion of hospitals will be obtaining exceptions or they will be winning court suits based on the basic inequities of the controls.

The attempt may be made to reimburse hospitals based on an estimated cost of care, given such factors as the age, sex, and the diagnosed diseases of patients admitted; the cost of hiring personnel in the area; the special services provided by the hospital, etc. But the data base and level of understanding required for such a program to be equitable does not exist and probably could not be assembled during the next five years.

A more fundamental problem is that revenue controls are essentially like planning agencies in that they require public understanding and acceptance. This is unlikely to occur in the long run unless the public perceives increases in hospital costs as being paid directly by them.

Fee schedules for physicians are similar in many ways to revenue controls for hospitals. There are many ways in which physicians can avoid their impact.

The potential effect of a national health budget is much more difficult to assess. The budgetary process included in the Health Security Proposal (the Kennedy-Corman bill) undoubtedly would be very effective if it were tried. But it would appear to be very unlikely that the Congress would relinquish control to a group of independent technicians for the spending of $150 billion a year.

A revision of the financial incentives toward high cost services would appear to be the most promising approach to containing health care costs. In particular, HMO's have demonstrated that cost increases can be restrained within a suitable environment. It should be noted, however, that some of the economies of HMO's are achieved at the general expense of the public. There is much evidence that members of HMO's use fewer days of hospital care. They are thus charged less than their share of general hospital overhead. Further, the hospitals owned and operated by HMO's do not maintain all services available elsewhere. Those services are available to HMO members, however, if needed. For these economies to take effect, however, the savings enjoyed by HMO members must accrue directly to them. In our present system of employer and government financed health premiums, this incentive is reduced.

There is one area in which the present pattern of financing health care produces very strong incentives to control costs. The principal burden of paying for increases in health care costs in the U.S. falls on employers. Any employer could obtain an advantage over others by substantially reducing his health care premiums. Restricting employer contributions to employees who enrolled in HMO's would appear to offer great savings to employers. But, virtually none have done so. This fact raises great doubts as to the efficacy of any cost-containment program based on a revision of the financial incentives to high cost care.

Further, HMO's are subject to the pressures generated by the public expectation of having all technically desirable health care available at virtually no cost. HMO's must thus compete with non-HMO hospitals in the services offered. As long as the membership does not directly share in the cost of the HMO, or shares at a much reduced rate, it is unlikely that costs can be contained in the long run.

In view of these shortcomings of the present system and the inadequacy of the types of measures proposed to more than temporarily restrain cost increases, what is the likely fate of health insurance in the U.S.? Most of the proposals for national health insurance simply speed up the process described above. These proposals would not produce an equilibrium in which pressures to change would be contained. Costs would continue to rise rapidly, as they do now; in addition, there would be a large new Federal program to pay for.

What then would be a stable state in which the pressures for further change would not be overwhelming? I can visualize several which are described below.

1. The free market model.

   Under the free market model, third-party payment would be limited to less than one-third of all medical services. All other policies would

be taxed out of existence. There would be a family deductible somewhere around $1,000 in all insurance policies or government programs providing health insurance. With deductibles of this size, around two-thirds of all medical bills would be paid directly by consumers to providers.

Services in excess of the family deductible would be paid for through a public program financed by a universal tax, such as a payroll tax or value-added tax. The level of payment to providers would be determined with reference to the rate negotiated in the private market. Those services, which routinely involve payments in excess of the family deductibles, would be provided through a separate program modeled on the Health Security Bill. Included in this program would be long-term psychiatric, nursing home, and home health care. Also included would be renal dialysis, organ transplants, intensive care units, and other expensive procedures.

The free market model is interesting only as a theoretical concept, since in the context of the expectations of the American public it is totally impractical. The American public expects insurance to pay for virtually all health care, certainly all surgery and hospital care.

2. Health credit card model

Under this alternative, there would be no insurance or government program paying for most types of health services. The entire population would be issued health credit cards. These cards would be used to charge virtually all health services received. Payments would be spread over time, perhaps as much as a year or two for expensive services. Any family with monthly payments that are high relative to their income could obtain relief, either through spreading the payments further into the future or by direct subsidy by the government. These income-related subsidies would provide the insurance function of spreading risks. Draconian measures would have to be employed to collect the monthly payments, including attachment of salaries and transfer payments.

The basic principal underlying this scheme is that patients spend their own money and not someone else's. They're insured, however, against having a financial loss that they cannot afford. Thus they would be forced to face and answer the three crucial problems posted above.

3. The HMO model

Under this model, there would be a large number of competing HMO's and at least several in each medical service area. Again, there would be no insurance or government programs paying for medical care, so that the only insurance available is through an HMO. In order for there to be competition among HMO's to provide quality services at a reasonable price, there would have to be periodic open enrollments. To undermine incentives to select against the better quality HMO's, the premium rates charged by the HMO's would have to reflect all actuarial characteristics of the insured, including age, sex, location, occupation, and health status. Some of the incentives to anti-selection could be removed by government subsidies that reduced the variation in cost by age, sex, and health status.

There are several problems with this model.

a. The providers, especially the physicians, are adamantly opposed to it, although they would be much better off than under any likely long run alternative.

b. Acceptance of this type of model will require a major change in the outlook of a large proportion of the population.

c. There would appear to be no practical way to bring about such a world.

If we had been theorizing a decade or two ago about the probable implications of the rise of insurance, the subsidy to employer payment of group insurance premiums, and new government programs for the aged and poor -- we might have speculated that this system would lead to employers requiring all employees to join HMO's. Unfortunately, it has not. It is thus hazardous to speculate that providing proper incentives would lead to the logical results.

4. Regulatory model

Under this model, all important decisions are made by civil servants. These decisions include what care is available, who uses it, how long they wait for it, and the level of compensation to each practitioner or institution. The opening of a practice or a facility requires a license from the planning agency. All "elective" services require prior authorization. All providers are subject to an intense review of all services performed according to standards promulgated in government regulations that are many inches thick. All rates of payments for services are determined by government promulgated fee schedules, both for institutional services and for physician services. The level of these are determined in negotiations between providers and the government, with occasional strikes by providers.

Funds to pay for services may be raised through required employer premium payments, payroll taxes, or general revenues -- it really does not much matter. Insurance companies may be the administrative agents for paying the claims, however, they would do this according to detailed regulations promulgated by the government. The overall cost of this system would be contained primarily by the general level of public skepticism about the cost effectiveness of the services received.

5. Federally budgeted health care

The model for this alternative is the Health Security program. All health care is funded through the Federal government, supported by general taxation (perhaps including a payroll tax). The type and level of services available in all parts of the country are determined politically, i.e., through the Congressional appropriation process. Services would be free or virtually free to all patients. Services in excess of those that practitioners are willing to provide under the incentives provided by the system would be rationed through waiting lines and similar devices.

For practical reasons, I am of the opinion that the pressures of rising

health care costs are pushing us inevitably toward the last of these possible alternatives. The only possible escape from this path would appear to be if there were a strong movement by employers to cover employees under HMO's. Even this path is probably blocked by the opposition of organized labor to any solution other than the Health Security Proposal. Further, in political terms, time appears to be running out. Each year that passes increases the cost of whatever solution is found, and make a collectivist solution more likely.

MR. TURNER: I have one comment relative to HMO's. Mention has been made of the Twin Cities area where my company is located. We have a kind of unique situation because there are seven HMO's in that metropolitan area, some of which are more viable than others, but all of which are competing very aggressively for new business. My company is involved fairly extensively in a couple of the HMO's and we are watching the situation very closely. Although we do not yet have real hard data to prove it, it appears that the existence of the HMO alternative is having an effect on certain segments of the provider population, physicians in particular. I think we have a little more stable situation as far as that aspect of medical care costs. It does not appear hospital costs have been affected materially because the HMO's all use existing hospitals just as any other third party mechanism uses them. But, using one piece of hard data, one HMO with which we have been involved heavily over the last five years has had, over the period from 1973 to 1977, an average annual increase in capitation rates of 7 1/2%. We have developed a kind of index of claim costs for the health insurance indemnity plans of several of the large employers that have offered that HMO as an alternative. The indemnity plan claim costs for these employers during that same period have increased at an annual average rate of 19%. So assuming that the trend continues, we can see the point not too far in the future where HMO care will have a distinct cost advantage over indemnity plan care in that particular situation.

The panel has discussed many problems and has suggested some solutions. Gordon seems to think that efforts in the private sector may not prove to be successful in accomplishing the objective of cost control. Possibly others of us feel differently. I have a question for Bob Ochsner relative to the potential he thinks that HMO's have for exerting a meaningful influence on medical care costs in the future.

MR. OCHSNER: I think that where they exist they are going to serve as an example. They will directly affect costs for those people who belong, and I think you know that what you said about the Twin Cities would come true in many areas. It's going to serve to ameliorate the increases that physicians request.

MR. TURNER: Gordon, do you believe there are any set of circumstances under which the expansion of prepaid health care can be such that a meaningful influence will be exerted on cost in the private sector?

MR. TRAPNELL: Certainly, I think it's feasible, but I just do not think it's likely. It has taken so long to get the relatively small development that we have had, and it has not been painless. I do not think the public realizes or has any idea of the stakes involved in whether they are going to have bureaucratic medicine or consumer sovereignty. I think that

private corporations, especially the large ones with some financial buying power, could exercise a great deal more influence. The only thing I can see to avoid bureaucratic medicine, is a fundamental change in the instincts of the American public about more government. If they start seeing the health security program as medicine from the post office, this could have some effect on the attitudes of the American public.

MR. OCHSNER: I am more hopeful than you are that it is going to turn around, as I see a tremendous amount of interest among larger employers in starting HMO's. I was in Kansas City yesterday, looking at an HMO that opened in November, and in Winston-Salem where R. J. Reynolds has opened one. I think that kind of pattern is going to be repeated in the next two or three years. I do not pin my hopes on the American public, the average person, changing his attitude in order to lead the change. I do not think the public has strong beliefs about health care delivery. They would have to form them and that would take much longer.

MR. TRAPNELL: I might add one more thing about the choice between bureaucratic medicine and competing HMO's, which I think are the feasible choices. It very much serves the purposes of politicians to have bureaucratic medicine, especially if those politicians happen to be union leaders. It gives them an infinite supply of favors that they can convey to their constituents. They are not opposed to this solution because they are not blamed for the problems and they are praised for the favors.

MR. OCHSNER: Well, I do not disagree with anything you have said and I guess it is also fair to point out that even if you're not cynical before you get involved in some of these considerations, you will be after you are done. And, obviously, both of us are somewhat cynical. But, I have not really seen that kind of attitude too much in the union people I talked to. I think some of them would go down the line for the HMO concept just on theory, and in fact in Cleveland and New York and places like that, they have.

MR. BRIGGS: I just want to make two quick comments. First, I do think that the mechanisms for controlling medical care costs are available. They are being used in some areas and I do not think we should give up too quickly on making them effective. As I said before, in the state of Connecticut, they are controlling hospital costs. I think HMO's and other devices can help control doctors' costs and I think we can make progress within the private sector and I do not think we should give up too easily on it. It will take an effort on the part of lawyers, concerned citizens and insurance companies, but it can be done.

We have next door to us in Canada, a good example of what can happen under a government health care program. Since I happened to live in Canada for five years, I have some personal experience with it. I was there during part of the time the government program was being instituted. I would advise any actuary who is really interested in this whole subject to study carefully how it happened in Canada, what has happened in Canada, and how the people like it. It can be the subject of a complete day's discussion.

MR. TURNER: I think Phil expressed very well my personal views on the prospects. However, I think it's interesting there has been no mention so far of foundations. Merle mentioned a PSRO, but I guess I tend to view that as an example of a kind of passive role that insurers and employers played

in the past in attempts to control health care costs. Such organizations have not proved to do the job in the past and therefore we do not look in that direction for much progress in the future.

Just one final point. I would recommend that you review the book, the Complex Puzzle of Health Care Costs put out by the Council on Wage and Price Stability, December of 1976. For anybody who is interested in a picture of what's going on around the country, I heartily recommend it.