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HEALTH PLANNING & COST CONTAINMENT

*Moderator: MORTON D. MILLER. Panelists: JAMES L. PURDY, RICHARD G. WARDROP**

MR. MORTON D. MILLER: Our purpose in this session is to concentrate on the roles of the insurer and group policyholder in working toward improvements in the health care delivery system.

The HIAA support of the administration's hospital cost containment stems largely from a realization that we must confront the cost issue even though the proposal includes large elements of pure and simple price control the likes of which we would not want our business to be subjected to by any means.

The seriousness of the cost issue in the minds of the public is strongly brought out by the most recent survey of the public's view of health and health insurance just completed by the Health Insurance Institute. Let me remind you of some of the highlights of the findings.

Under the heading of "Satisfaction with Health Care" the findings were that about 8 out of 10 Americans are satisfied with their access to health care and the same proportion indicates that they are satisfied with the care that they receive from doctors and hospitals. However, only 29% are satisfied with the cost of medical care. This shows a much greater concern than had been evidenced before.

Under the topic of "Serious Problems in the Health Care System", 57% of the public believe there are serious problems in the health care system. When asked to identify these problems, 52% say medical costs are excessive and another 15% say the doctors are too interested in money or that they earn too much money. Concerning the cost of health insurance, 70% of the public feel that the price of health insurance is getting too high for the average family to afford compared with 67% in 1977.

On "Health Insurance Companies and Health Care Costs", only 14% of the public agreed that private health insurance companies are playing a major role in helping to slow down the rise in health care costs. Forty percent disagree and 43% have no strong opinion. Fifty percent of the public believe that private health insurance companies should be tougher with doctors and hospitals and refuse to pay for unnecessary or too costly health care. Only 15% disagree and 34% have no strong opinion.

So you see that the public is holding us significantly to blame in a sense or, if not to blame, as having shortcomings in our performance in this area. We need to counter attitudes such as these and to demonstrate to the public our deep concern for the cost issue.

MR. JAMES L. PURDY: Like good actuaries, many of us have tried to break down the cost problem into some of its components. The cost of health care is influenced by: (1) the utilization of health care facilities; (2) the supply of available services; and (3) the prices for those services. The efforts going on nationally to slow the increasing cost of health care are attacking the problem in these three areas.

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For example, there's a fairly clear correlation between availability and utilization of health care. Therefore a lot of activity in health care planning is directed at trying to limit the supply of facilities in order to cut down on the use of health care. The current planning law which was passed in late 1974 is designed to affect cost containment in communities and to limit the expansion and extension of unnecessary facilities. That legislation set up a combined structure of all health care planning agencies that had existed before. A state agency is responsible on an overall basis for planning and development. The Health Systems Agency (HSA) addresses the health care needs of the community by coordinating available health care facilities. There are about 200 HSAs around the country operating with varying effectiveness.

Frustration has been caused by the requirement that some of these agencies have broad consumer representation. Many of the new people involved in planning have a fairly limited awareness of what the planning process involves and its associated problems. The HIAA has encouraged member companies to have employees become involved with Health Systems Agencies. The HIAA a few years ago had a fairly extensive education program so that when a local company person is involved with an HSA, they have an idea of what some of the long run objectives should be. Unless you've had the opportunity to become involved in some of the reasons for cost escalation, it is sometimes difficult to address what the solutions should be.

There are some current frustrations afoot in the planning "certificate of need" area in connection with the construction of new facilities. Some envision that health care costs could be contained by developing alternative delivery forms, most notably the Health Maintenance Organization (HMO). The HMO is a self-contained medical group under the prepaid group practice variety frequently owning its own hospital facilities. The frustration in planning comes when a new HMO wants to establish itself in a community and build new facilities even though there may be some existing facilities in the area that are being used by other practicing physicians.

One of the key ingredients in the planning process is to have adequate information and statistics on what the community has in the way of resources, what the utilization patterns are and the comparisons that should be made with other communiites. The actuarial role here is clear. The difficulty, of course, sometimes is collecting the data to work with. We've seen some significant steps in certain areas to improve the information base and it's proven to be quite an asset in the whole planning process.

Prices are generally more visible to the general public than the fairly subtle concept of excess capacity. Most of the current publicity has surrounded the cost of hospital care, although the cost of physicians' services is certainly a contributing factor. The major emphasis on hospital budget review has been in the area of the development of regulatory activities in the various states to determine what the use of hospital facilities are and how that is translated into cost.

Connecticut is one of the first states to establish a prospective budget review program. A state law was passed that set up an agency to review hospital budgets. They had some initial success largely because in most areas there's always room to cut out some fat in the early years. After that it gets a little tougher and Connecticut is working quite hard to continue the reduced increases in costs generally. One thing that became

apparent is that it is not enough just to consider the price of a service, one must be able to limit the total revenues of the institution so that there is an indirect control on the use of unnecessary services. In Connecticut a couple of years ago all hospitals lived within the unit price structure but the number of services provided by the hospitals escalated tremendously and, in total, the cost of health care went up more than anticipated.

At the Federal level there has been a lot of activity in the last couple of years with respect to hospital cost containment. Any cost containment legislation must address itself to the government's unique position in being both a purchaser of health care services through public programs and also a body providing regulatory input where necessary.

The Talmadge bill which has been introduced again this year is a bill representing the government primarily as a purchaser and is designed to contain costs of Federal programs. The solutions recommended for containing hospital costs therefore would only apply to public programs. This approach clearly keeps down the cost of the Medicare and Medicaid programs but, on the other hand, it shifts an awful lot of the cost that Medicare and Medicaid would not pay for to the private sector. The cost shifting problem increases as the years go by and the only outlet is the private sector. Under this scenario a higher rate of increase in hospital costs than is really taking place develops because the total increase is being spread over only the private sector.

Under the Talmadge bill an average hospital cost would be established on a per diem basis and a limited reimbursement would be made for costs above that average. High cost hospitals would not get their full cost paid unless they could get down to the average of the rest of the facilities. The HIAA has testified pointing out the concerns about establishing cost containment on a per diem basis as opposed to a total revenue basis and also putting forth the idea of expanding cost containment to the private sector.

There are also some other provisions in the Talmadge bill which limit capital expenditures and provide a mechanism (with funding) for the closing of unnecessary facilities in communities.

President Carter's bill does apply to the entire segment of the hospital community, both public and private. Unfortunately, because of its "cap" concept and "freezing", it still preserves some of the cost shifting that has already taken place between the government and the private sector. The original price increase cap of 9.7% which was introduced into the bill first presented has been revised by one of the committees studying it to 10.9%.

The basis for developing those figures was interesting. In effect health care costs were broken down into various components (e.g., laundry services, cost of insurance, etc.). It was then assumed that the wage-price guidelines announced by Mr. Carter last fall would be effective and that wages would therefore only go up 7%; insurance premiums would only go up by the prescribed amount and so forth. This approach built up a theoretical structure of what would happen to the cost of hospital care if the wage-price guidelines operated on each component. The approach assumes that a lot of improvement would take place in connection with utilization.

The Carter program does provide a state exemption which is one of the main reasons that the insurance business has taken a positive position with re-

spect to Federal cost containment legislation. It is the business's feeling that it is really state control that is appropriate (similar to the business's position on state regulation and insurance).

One of the fallouts of legislation that was introduced a couple of years ago is something called the voluntary effort. Essentially it's a private sector approach that varies from community to community involving tightening administration, educating physicians and educating hospitals. The goal of the voluntary effort was to reduce the trend in hospital costs by 2% each for 1978 and 1979. In 1978 the reduction was 2.8% and it is anticipated that by the end of 1979 the full 4% for those two years will be achieved.

Finally, it is important to comment on what some of the companies and the industry people are doing in connection with cost containment. If I had to single out one word that seems to be paramount in the whole cost containment effort, it is education.

At Travelers we found that the first thing we had to do in connection with cost containment was educate our own employees. Our field staff, our home office employees and claims staff are the ones who are meeting with policyholders, meeting with the public and are closer to the communities where a lot of this activity is taking place. We also encourage these people to become involved in HSAs and other local programs.

The second level of education involves policyholders particularly in connection with proposed legislation. We have had a communications technique set up to inform people as to what the issues are and how we see them.

The third level of eduction involves employee education. We've developed some programs and the HIAA has some literature that they have put together for use by companies. With respect to benefits, we've put a second opinion program in on our own plan and found very little use initially because people just didn't know what it was all about. They were a little nervous about going to another doctor and alienating their family physician. With more education and a little time, these things began to improve.

Private sector review is another important area. Hospitals and physicians should be involved in looking over the other's shoulder, making sure that people aren't put in the hospital unless they need to go, and that when they go they don't stay too long. This approach can be accomplished by physician education, hospital education and outside review.

Finally, we found that many things we have been doing for many years (e.g., effective administration and coordination of benefits, claim cost control, etc.) are still very important in the eyes of our customers.

MR. RICHARD G. WARDROP: I'm here to represent what I believe to be industries' view of health care cost containment, not necessarily the view of Alcoa. Industry has been very slow in reacting to health care cost containment. The reason is unclear. The dramatic escalation in costs in 1975 over 1974 may have gotten the attention of a lot of companies that hadn't been interested in cost containment before. A number of large companies experienced a benefit cost escalation (without any significant change in their benefit plan) of 20% or more in 1975 over 1974. I suspect that your clients were not pushing very hard in 1975, 1976 and 1977 for help in holding down costs and they may not even be pushing you now. I think that this situation has changed or is changing.

There are many things that companies can do in the "self-help" area. One of the first things that companies should be looking at is the question: Am I providing the health care benefits that have been decided upon in the most efficient manner? It's hard for me to understand why any large company today is totally insured for health benefits. Many large companies have not really looked at their insured arrangement to decide what it is they are paying risk charges for. I think there are going to be a number of companies moving toward self-funding arrangements. It is important to emphasize that the trend would be toward self-funding but not necessarily self-administered arrangements. I find it difficult to understand why more large companies have not moved to an administrative services only contract. I can understand remaining insured for hospital benefits where Blue Cross gives big discounts. Bob Froehlke in his address to open this meeting commented that insurers have been collecting premiums and paying claims in the most efficient manner possible. I disagree with this assessment. Carriers have had a good thing going and we, as buyers, were possibly overawed and possibly not very bright. However, companies are beginning to understand the situation more clearly. I think we've come to find that the insurance company's role in this business is largely providing administrative services. We soon will be able to hire professional administrators. At that point, the insurer's unique position will have disappeared.

What are the other kinds of self-help things that companies can do? They can look at the design of their plan. In this respect the carriers have a role with their experience as to what is good plan design. It's appalling to find large companies that do not have any coordination of benefits provision in their plan. We don't find much of a problem with coordination of benefits in dealing with unions. The greatest disadvantage we find that a union member has with coordination of benefits is it takes longer to pay a claim.

Another matter of design is making sure that the plan doesn't force people to be hospitalized when treatment can be given in a more efficient manner. Most companies are moving in the direction of providing service on an outpatient basis where it does not have to be done in the hospital.

If a company is a significant employer (at least 10% of the total workers in a community) health care providers are interested in that company's problems. One of the things that we did was to invite the medical community to come talk with us. We give them a tour of the plant in the afternoon, then give a dinner party where we talk to them about our concern with health care costs.

A significant part of our health care cost is our wage replacement cost. Out of one such meeting we learned the following:

1. Doctors thought we only wanted people to go back to work on Monday. One of them produced a form on which "Monday" was preprinted and the doctor filled in the date the employee was to return to work. Since the form was printed at the plant, the doctors had some basis for thinking that we only wanted people back to work on Monday.

2. We found that many doctors thought we only wanted somebody back when they were 100%. We have made arrangements so that they can check with us when they have someone that they think could return to work, safe to himself, and safe to us.

One thing we've come to realize is that the efforts we made 15 years ago in getting people on hospital boards was not in the best interest of the community. We found that we had the works manager at one of our locations on the board of a hospital. He soon became a chairman of the board partly because the other board members knew he had access to Alcoa Foundation money. The board members felt that our works manager could make theirs the biggest and best hospital in town. We found that another company just down the road had their works manager doing the same thing for another community hospital in the same town. What we were doing was playing oneupmanship with each other's time and money to the disadvantage of the community and us. A number of companies including Alcoa have brought all these hospital trustees into training sessions to explain that their responsibility as a trustee transcends that of their own individual hospital. Thus companies' influence on hospitals and hospital boards is changing direction.

Companies should also get involved with the health planning process through the HSAs. Most companies in 1975 were not aware of what happended in the planning process. Cut of 25 companies in a group called the Council on Employee Benefits, only about 8 had awareness involvement or commitment to HSAs. Some people believe that companies can't do anything in an HSA because of the required consumer ratios. I'm inclined not to believe that. We asked the executive director of our HSA how to get involved. He said to get some people to fill out applications to work on committees. Before a person gets on the board of an HSA, he often must serve on a subcommittee.

To us, the HSA is the community. Some people say that it's a government program. Well it will be a government program if we let it become a government program. The legislation is a piece of Federal legislation, but it is the only act in town where you can have input in the planning process. Though the legislation may be undesirable, if companies don't get involved, the next act is going to be in Washington.

Companies can also help their own cause by supporting HMOs. Why haven't companies supported them more than they have? Well, partially because the legislation passed in 1973 angered most companies. HEW Secretary Califano is trying very hard to change the attitude of large companies. Two months ago he had the chief executive officers of 18 companies for breakfast trying to get them to do something more than they have done about HMOs.

We've been very frustrated about HMOs as have a number of other companies. We have yet to see an HMO offering that we can honestly say to employees "that's better for you." The employee usually stands to save a little money on doctor visits in an HMO, but he also stands to lose in certain areas (usually in mental health coverage). I think industry will become more active in the HMO. However, we don't find the 30% savings that Secretary Califano has mentioned.