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INNOVATIVE HEALTH INSURANCE PLAN DESIGN

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A discussion of alternative approaches in developing health insurance plans, directed at:

1. eliminating coverage for unnecessary medical services,
2. improving cost effectiveness, coordination with providers, and the statistical data base,
3. broadening coverage where appropriate, as for preventive or non-institutional care,
4. responding to changing public needs and desires for this form of protection.

MR. WILLIAM W. KEFFER: This session on health insurance plan design is intended to complement earlier discussions on filling gaps in the U.S. health insurance and on health planning and cost containment.

There is a variety of reasons for the exploration of new ideas in benefit plan design. These include such developments as:

1. changing public views on health coverage,
2. the current emphasis on cost containment,
3. the need for more efficient coverage of smaller groups,
4. government restrictions and directives on the form and extent of health insurance plans,
5. the availability of more accurate data on health care and health care costs, together with the need to develop such data from our insurance plans.

We cannot hope to explore the ramifications of all these developments in any depth today. Each of the panelists will have comments on selected topics of particular interest and concern to him and his organization, and your subsequent reactions and other contributions will be most welcome.

MR. WILLIAM CUNNINGHAM: In July 1978, Pacific Mutual commissioned Louis Harris Associates to conduct a major national survey on the subject of Life Habits and Health Maintenance. I would like to share with you some of the findings and how we have redesigned our products to meet the public needs. Findings of the survey are presented in thirteen chapters which cover a variety of conditions and factors, such as obesity, exercise, nutrition, hypertension, mental health, smoking and drinking, as well as chapters on the role of the physician and the employer in preventive medicine.

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The first objective of the survey was to identify the numbers and types of people who are putting themselves at risk, whether by acts of commission or omission. A second objective was to measure the knowledge of each of these groups and to determine the potential for changing their behavior by health education and giving them knowledge that they do not currently have. A third objective was to explore the motivations both of those who have knowingly changed their life styles (for example, those who now exercise regularly or have given up smoking), as well as the motivations of those who continue unhealthy habits. Fourth, and finally, a series of programs and policies which could be implemented by the medical profession, by employers and by the health insurance industry were tested to find their potential impact in changing the habits of the public. In this discussion, I will discuss only the fourth of the above objectives, that being the programs that the medical profession, employers and the insurance industry could implement.

There is a widespread recognition among the public, employers and labor union leaders of the need for a major shift of emphasis in the American health care system towards more and better health maintenance and preventive medicine programs. While there is a deep concern about the high cost of care, it is believed that giving greater emphasis to preventive health would be one way of limiting the growth of health care costs in the future. Indeed, business and labor favor an expansion of preventive health over all other suggestions as the most effective way of controlling health care costs.

But even more important than a concern about costs is the firmly established belief of almost all Americans that if they changed their lifestyles, ate more nutritious food, reduced smoking, maintained their proper weight and exercised regularly, it would do more to improve their health than anything that traditional health care could do for them. It is therefore no surprise that 51% of the American people say they are more concerned about preventive health today than they were five years ago, while only 1% say they are less concerned about it.

The data in the report demonstrates the enormous importance of the physician in providing not just medication and treatment, but advice and counseling to prevent disease. While the physician already plays a key role in preventive medicine and health education, it is clear that they could be a great deal more effective. Most people have a high regard for their own doctor and have a high trust in their expertise. However, the survey shows that the physician could do a great deal more to change the diet habits and life style of most Americans.

Employers can never be, in any sense, a substitute for the medical profession. Indeed, the survey makes it clear that a major priority for business and labor should be to encourage doctors to do more than they do now in the field of preventive health and health education. On the other hand, the survey data also indicate that employers and labor unions could themselves have a substantial and beneficial impact on the health of their employees, and fortunately many employers recognize the financial benefit of playing a much more positive and active role in the future. The more positive signs are that:

(1) Most employees and their families would be highly motivated to take part in a recognized and structured health maintenance program if this meant a reduction in their own health cost.

(2) A substantial minority think that the development of a voluntary physical fitness program at their place of work would be a very effective way of helping them to get more exercise.

(3) A substantial minority also feel that company-sponsored talks for employees by doctors and other experts about the beneficial effects of exercise would also be effective.

(4) Confidential psychological counseling offered by employers to help deal with emotional problems and mental stress would be widely welcomed by employees, even if this involved an additional cost.

(5) Educational programs offered by employers about health, nutrition and exercise would also be welcomed by a sizable minority.

(6) Alcohol abuse programs offered by employers in which employees with drinking problems would receive confidential help, information, counseling and referrals would also be welcomed by a significant minority.

This survey is not the last word in the efforts of employers to have a positive impact on the health of their employees. Many of the companies which have established health maintenance and preventive health programs have done so very recently and are not yet in a position to assess their impact. In this sense, they are at the beginning of a learning curve. It will be necessary to learn from experience as some programs are successful and others fail. However, this survey does show the strong desire of many employers to test innovative new approaches, and the generally positive response such programs are likely to meet if they are easily available and well promoted.

Health insurance is seen as a major cost of doing business by labor and business. Both employers and union leaders believe that in 25% of the hospital admissions, their employees are kept there for more nights than are necessary. Both employers and unions list physicians, hospitals and the insurance industry in this order as the parties having the greatest responsibility for controlling health care costs. There is no support from business and very little support from labor to turn the problem over to the government.

Business and labor believe strongly that money spent on expanding preventive health measures could have a very beneficial effect on health care costs and the premiums they pay for their employees and members. More than two out of every three employers claim that they are taking steps to limit the costs of health care. The most common way is second opinions before surgery followed by monitoring or auditing of hospital and doctor's fees. However, only one out of every eight employers are putting emphasis on health maintenance and preventive medicine; it is clear that they have not put their beliefs into practice.

A major argument in favor of Health Maintenance Organizations (HMO) is that they reduce medical costs. It is therefore very interesting to note that most employers offering the HMO option believe that it, as yet, has had no effect on their costs, and that while 9% report decreases in costs as a result of HMO, 11% report increased costs. The only conclusion that can be reached on this data is that it is too soon to make a judgment about the cost-saving potential of HMOs.

Historically medical insurance policies have rewarded hospital care more fully than out-patient treatment. Hospital care is, by far, the most expensive kind of medical care, yet we continue to encourage hospital care through our deductible practices. Do our practices discourage people from going immediately to their physician, when illness might be diagnosed at an early state and medical cost kept to a minimum? The Harris survey points out what all of us know, that being that the frequency of visiting a doctor is highest among those on Medicare and Medicaid and lowest among those who have no insurance coverage of any kind.

Pacific Mutual has been experimenting for several years on a plan which we have called health maintenance. With the background of the Harris survey, we stepped up our efforts and today issue the plan to all employer groups with two or more employees. The benefits covered by the plan are broken into two parts:

1. Part A, which covers all out-patient facilities, surgery (in or out of the hospital), laboratory tests and x-rays, radiotherapy, all doctors' visits, an annual pap smear and a physical exam once every two years.

2. Part B, which covers all hospital benefits, prescriptions, appliances and nursing.

The lifetime maximum is $1,000,000, and after the deductible we pay 80% of the first $2,500 and 100% thereafter of usual customary and reasonable charges. Part B has a $100 calendar year deductible, but Part A is available with no deductible. Part A can also be sold with a $50 or $100 deductible; however, the deductible is waived for the pap smear and biennial physical exam. To round out our package, options offered are dental as part of Part B and an out-patient prescription card service.

With regard to our experience, our sales results have been overwhelmingly successful, particularly in the area of two to thirty-five employees. It is too early to say what our claims experience will be, but from pilot programs we have had better experience in non-metropolitan areas where we can more easily get the message to physicians that hospital confinement is not necessary, but could be more costly to their patient. We believe, however, that given time and if adopted by more carriers that the program will ultimately reduce costs.

As would be expected, our average claim is lower and the number reported per employee is higher. This does increase our claims paying cost, but this is insignificant compared to the potential long range savings.

As indicated earlier, sales results have been primarily in the smaller case market, particularly our multiple employer trust area. We believe that the program will be successful, but sound pricing and underwriting must prevail over sales pressures. To achieve this control, we insist on Pacific Mutual paying all claims.

Our health maintenance product is a forward step in responding to the public needs for broader coverage, particularly preventive.

MR. CHARLES R. GOULET: Perhaps no concept in the health insurance industry is more elusive than that of medical necessity. Indeed, the concept is the subject of much discussion in the administration of governmental programs such as Medicare and Medicaid.

The final right to make a determination on the necessity for any medical care service is clearly in the eye of the beholder. The patient who requested care, obviously feels that there was a necessity for care. The physician who provided or ordered the care is convinced that his professional judgment is correct under the given circumstances, and furthermore, that his decisions should not be influenced by contractual relationships between his patient and a carrier, or between the carrier, the patient and some other provider such as a hospital. The hospital, confronted with increasing pressures to intensify review of the utilization of services argues that it has severe constraints upon its freedom to effectively impact upon the day-to-day behavior of those who order and direct the care that is provided to its patients, the members of its medical staff, or indeed, upon the patients themselves, and finally, the public, groups who purchase health insurance coverage, regulatory agencies, legislatures and the like, concerned with increases in the costs and utilization of health care services, seem to be convinced that much of the care provided is unnecessary. What is more disturbing is that in their frustration with their inability to effectively identify unnecessary care and eliminate it, they are turning to carriers and urging them to use their economic position at the interface between those who receive and provide care to influence the behavior of both.

One aspect of the issue of medical necessity that should be noted is that very often the question is not with the patient's need for medical care, but rather, a legitimate concern whether the setting in which the care was provided was the most appropriate; for example, certain services might have been provided more economically in an out-patient setting rather than on an in-patient basis. Such questions, while not challenging to the judgment of physicians in terms of the necessity for care, nevertheless, are difficult to sustain with patients.

The role of the carrier is made more complex when consumer groups, labor unions, large purchasers and regulatory agencies introduce into the administration of health care benefit programs the concept of hold harmless. In other words, that carriers, through some contractual arrangement with providers, agree that when services are judged to be medically unnecessary, the providers will not attempt to recover payments for those services from patients. In terms of public policy, this is probably a very acceptable concept but hardly one that lends itself to simple implementation. Indeed, it can be argued that a certain amount of transferance of cost from carrier to patient, in cases of abuse of benefit programs, is good for the soul and in itself will not be resolved today.

Finally, we should not leave the issue of medical necessity without at least making some reference to the fact that the present debate on this subject is centered around the biological or emotional need of a patient for medical services. It does not address the broader social issue of whether needs of the patient should be met at all in terms of the broader social cost and benefit to society generally. Some of the studies which have been completed on case finding techniques, such as examinations of stool specimens contrasted with the incidence of rectal cancer, are interesting. Fortunately, at least until now, it has not been suggested that carriers assume responsibility for exercising judgments over the validity of these and similar diagnostic and therapeutic services.

I have been asked to describe some of the programs which have been undertaken by Blue Cross/Blue Shield Plans in the interests of influencing the utilization of health care services.

First, let me describe the most widely publicized program of our two National Associations: The Medical Necessity Program. This program, which was initiated by the Blue Shield Association in 1976, resulted in announcements during early 1977 that some forty-two medical and surgical procedures and tests were no longer judged to be medically justifiable except in rare instances. The original announcement was followed this past spring by the identification of an additional twenty-six diagnostic laboratory procedures that are now questionable in the judgment of the American College of Physicians, and finally, the broad statement endorsed by both the College of Physicians and subsequently by the American College of Surgeons that "no diagnostic tests, including hemoglobin, urine analysis, biochemical blood screens, chest x-rays and electrocardiograms should be required as routine procedures for patients admitted to a hospital".

This project was initiated in 1976 by the Professional Affairs Committee and staff of the Blue Shield Association in collaboration with representatives of the American College of Physicians, the American College of Radiology, the American College of Surgeons and the American Academy of Family Physicians. The Council of Medical Specialty Societies, although not participating in the review of specific procedures, did agree to participate in discussions and to address the issue of new and evolving medical technology. The American Hospital Association, the Association of American Medical Colleges, and the Blue Cross Association (BCA), which at that time was still a separate organization from the Blue Shield Association (BSA) participated in the discussions. These deliberations centered around the review of procedures identified by the Association's Medical Advisory Committee. The original list of forty-two surgical and diagnostic procedures was prepared and endorsed by the American College of Physicians, the American College of Radiology and the American College of Surgeons. The subsequent list of some twenty-six diagnostic laboratory procedures was originally prepared by the American College of Physicians but was also reviewed and endorsed by the College of American Pathology through the auspices of the Council of Medical Specialty Societies.

The implementation of the program at the plan level involved both notification to institutions and professional providers, independent laboratories, and the like, but more importantly, the identification of those physicians and surgeons, who had within the past year or so, actually submitted claims for payment for these services. In our own case, these individual physicians were identified. They were then personally contacted by members of the plan's medical and professional relations staffs and notified of the necessity for the submission of additional supporting data with any future claims. In the vast majority of cases, it was found that the physicians and surgeons had already made the decision to follow the lead of the national specialty societies. I think it is fair to say that the incidence of these procedures is now practically zero, in Illinois at least, to the extent that our plan is involved.

Early this year, following a continuing dialogue between the American College of Physicians and the Blue Cross/Blue Shield Associations, an announcement was made concerning the recommendation of the College, subsequently endorsed by the American College of Surgeons, that diagnostic tests including laboratory tests, chest x-rays, electrocardiograms and the like, should no longer be performed as a result of routine standing orders established by medical staffs or individual physicians except where they are based upon the medical needs of specific patients or groups of patients. It is important to make a distinction between routine tests and what is commonly referred to as "standing orders". The announcement of the program does not challenge the right of physicians and institutions to maintain standing orders where they are appropriate.

I should point out that there was some confusion initially, concerning the implementation of the program in individual plan areas and in specific hospitals because of the general impression that the Joint Commission on the Accreditation of Hospitals had a long-standing standard which required the performance of certain routine laboratory tests for all patients admitted to hospitals. In May of this year, the Joint Commission reiterated its position that "the Hospital Accreditation Program standards do not mandate routine clinical laboratory tests or x-ray examinations for hospital admission". Their announcement clearly stated that they "would expect any blanket testing requirements to be appropriate under only the most extraordinary circumstances clearly justified by a demonstratable benefit to patient health and safety, by statute or by risk management consideration".

The implementation of the program by local plans again involved notification of physicians and hospitals followed by meetings with Medical Societies, Hospital Chiefs of Staff, and finally, institution by institution review of the actions that were or are being taken in response to the program by medical staff departments and medical staff governing bodies. The response to date, has been most encouraging. It is difficult to measure the economic impact of such a program, and perhaps, we will never be able to measure it. Nevertheless, the program has served as an example of the types of issues that can be effectively addressed by specialty groups as well as hospital medical staff. In our own case, our medical director has had conversations with over twenty specialty societies in the state. These discussions have led to the identification of additional tests and procedures which have been added to the BSA list for application in Illinois. Similarly, the discussions with hospital medical staffs leads to a fuller discussion of the whole issue of routine orders in such areas as the necessity for typing and cross-matching blood prior to major surgery. These programs, to the extent that they establish a more critical professional attitude, hold promise of having a positive impact upon both the utilization and cost of health care services.

On the broader issue of medical necessity and control of utilization, it has been the position of most plans, including our own, that we have a legitimate role to play in encouraging institutions and physicians to examine on a peer basis, the utilization of services; and in so doing, to influence both institutional and individual physician behavior so as to improve both the quality and cost effectiveness of health care services that are provided, and to do so without engaging in massive retroactive denials of claims for service and thus transferring costs to patients. We have assisted hospitals and physicians in carrying out this activity through the use of our data base. Data on the utilization of services by institution on an age, diagnosis and procedure specific basis can be arrayed. For example, we have found institutions with a high incidence of one day and two day surgical stays. These institutions are excellent candidates for the introduction of ambulatory surgery programs.

A similar data system has been utilized by our plan and other Blue Shield plans throughout the country in analyzing practice patterns of physicians. By comparing the utilization of services by patients with specific diagnoses, we are able to isolate practice differences for further investigation by members of our Medical Department, and if necessary, for referral to Medical Society Peer Review Committees.

Our examination of utilization patterns is thus focused on specific behavioral variations which we note within the provider community. We have taken this approach in an effort to demonstrate that is is possible to impact utilization

by focusing limited resources on very specific perceived problem areas and by seeking solutions through professional cooperation, not solely through denial of benefit payments.

For example, our focused utilization review activity also led us recently to embark upon an innovative in-hospital review program of psychiatric care. Through the use of trained psychiatric nurses who visit hospitals daily, we are able to accumulate the necessary information to permit our Medical Department, including our consulting psychiatrists, to carry out a form of concurrent review of care and thus ensure institutions and members of their staffs that we stand ready to pay for necessary care. Since the introduction of this program we have noted a significant reduction in the average stay in those hospitals involved in the program and almost no professional dissatisfaction with the application of benefit guidelines.

We have also introduced a utilization review program which is similar to the waiver of liability program introduced a few years ago by Medicare. In this program we accept the decision of a hospital's Utilization Review Committee as the basis for payment of covered benefits, provided that our subsequent post-payment review of those services results in an anticipated denial rate which is below a preset parameter. If the post-payment review shows a higher rate of denial than the parameter, the institution agrees to hold both our member and the plan harmless for payment. We firmly believe that this approach will be successful because it places responsibility for making decisions at the point of service. We support these programs by providing utilization review specialists who work with individual hospital committees and staffs through the provision of data bases and through a corporate commitment to design innovative experimental programs with providers such as those that I have mentioned.

Finally, I should point out that perhaps one of the greatest stimulants to improve the utilization of services is the introduction of alternate delivery and financing systems, for example, Health Maintenance Organizations. I have had long involvement with this phase of Blue Cross/Blue Shield activity and the results we have found in Illinois, where we have five programs in place, are most gratifying. The performance of these programs and public satisfaction with them provide another example of what can be done by the private sector in improving the utilization and cost effectiveness of medical care services. That is what our plan is all about--helping institutions, professionals and our members improve the quality, accessibility and cost effectiveness of health care services in Illinois.

MR. HENRY A. DIPRETE: Before I describe the Voluntary Cost Containment Project of the Health Insurance Associates of America (HIAA), let me review briefly the factors which give so much urgency to this proposal.

The central concern underlying our project is, of course, the cost of health care which continues to rise despite regulatory efforts, private sector initiatives such as the voluntary effort of the health professions, and initiatives by our business. There are a complex of factors responsible for fueling costs, including the overutilization of services, declining productivity and more complex services and expensive technology, overall economic inflation, and competitive pressures leading to more high benefit, minimal cost sharing packages. As costs go up, the risks for our business increase correspondingly. First, inflation accentuates the trend toward self-insurance. And, second, it intensifies the pressures toward excessive regulation that could stifle our business.

It was against this background that the HIAA appointed a Voluntary Cost Containment Committee to define objectives, set priorities and lay out a blueprint for a leadership initiative by our business in helping to reduce the rate at which costs are increasing.

Our first step was to agree on objectives. We wanted an effective industry-led program that would:

1. Position the health insurance business as an essential element in cost -containment with a strong commitment to a workable solution; and

2. Effect such a solution based on voluntary efforts which demonstrate high visibility and early cost saving results.

Out of these objectives flowed the concept of a cost control project to be undertaken in an employer community where we could bring to bear tested cost containment techniques.

To see whether this concept would fly, the HIAA contracted with the consulting firm of Booz-Allen to undertake a feasibility study to help us identify some possible project sites and develop an implementation plan with a reasonable chance for success.

There were five basic criteria for determining the feasibility of the project:

(1) A suitable site selection;

(2) Voluntary support of the community leadership in business, labor, health professions, health insurers and other groups;

(3) Early results and high visibility;

(4) Cost-benefit measure; and

(5) A project capable of remaining in place as a self-sustaining program.

The Booz-Allen study confirmed the feasibility of the project based upon these criteria.

With respect to selecting a site, it was agreed that such a community should have:

(1) Moderate size population - over 250,000 but under 750,000;

(2) Insurance company basic hospital coverage for at least 50% of population;

(3) Site with minimal "spill over" from nearby cities; and

(4) Effective utilization review process in place.

To allow for a gradual and orderly implementation in whichever site proves most feasible, a three year project is envisioned. The first six months of the project would involve planning and mobilization. During this period all necessary market research would be undertaken including baseline measurements for periodic evaluation of how the project is progressing. The project design would be refined and the implementation plan worked out in all its detail.

The project would be carried out over at least a two year period under the direction of a full-time project director. In addition, we would hope to have up to three company people made available to the project on a full-time basis. Also, the project would link directly into our industry's Health Insurance Communications Program, with advertising and public relations activities being undertaken to give high public visibility to the effort.

The real key to success will be the cooperation of the community. To this end, a Community Council or Steering Committee would be created, comprising representatives from employers, labor, medical groups, consumer organizations and other groups. Together, project staff and the Community Council would carry out a plan revolving around three basic components, three techniques that are technically feasible and have major potential if the approach and incentives are carefully designed. The techniques are:

(1) Utilization review of all insurance carrier patients;

(2) Health education focusing on proper use of health services; and

(3) Benefit plan modification.

Let us look briefly at each of these techniques.

The cost containment benefit for utilization review could be substantial. A first step would be contact existing foundations for medical care to carry out a well defined utilization review program, a program that would involve such components as pre-admission testing, admission certification, length of stay review, review of ancillary service, discharge planning and continued evaluation of the review process. Effective utilization review could impact favorably in four areas resulting in significant cost savings. The four areas are:

(1) Lower hospital admissions;

(2) Reduced length of stay;

(3) Better patient management; and

(4) Improved pattern of utilization of medical services.

The second cost containment technique, health education of employees and their dependents, has considerable potential for improving health status and thereby reducing demands on medical services. Basic health education approaches would be designed to:

(1) Educate employees, policyholders, and the general public on how to use health insurance benefits and health services wisely;

(2) Educate the medical community on their impact on health costs and stressing the need for voluntary action to contain costs; and

(3) Encourage preventive health measures among all segments of the population.

Finally, we come to the unique role participating insurance carriers can play in our project, the designing of benefit plans that maximize cost saving incentives. Such incentives are very familiar to us and would include:

(1) Coverage of preventive care services, pre-admission testing, one-day surgery, second-opinion surgery, home health care and extended care;

(2) Benefit payment based on length of stay criteria;

(3) Excluding coverage for medically unnecessary care; and

(4) Flexible deductibles to encourage out-of-hospital care.

As I have indicated, there would be a two-year period for implementing our project. Over this two-year period, there would be ongoing evaluation of the project. This would be followed by a final six-month period of intensive post-project evaluation. This would entail a thorough assessment of the overall impact on community attitudes, on utilization, on the delivery system and on claim costs.

Such a program, properly executed, should have high visibility and demonstrate early cost savings. It should be designed not only to leave a self-sustaining local program in place, but further develop our industry expertise and products useful in other markets. It should, in short, yield competitive advantages. In addition, the project could help shape the future of industry regulation.

Certainly such a project would enhance the image of our business by creating a forceful role for us in mobilizing local initiatives, altering consumer attitudes and advocating and helping to establish voluntary programs. There is no more critical time than today for our business to be perceived as fulfilling such a role. In a word, the opportunity for leadership is extraordinary.

But industry efforts as I have just outlined will not do it alone. To impact in a more permanent way the rate of increase in health care costs there must be more fundamental change brought about in our system of reimbursement for and patient utilization of health care services. Health insurance benefit design in this country, largely responsive to competition from Blue Cross and labor negotiated benefit packages has moved away from scheduled and per diem plans that often contained built in reimbursement limitations, to a system of full service hospital plans and comprehensive medical plans. Under the former plans, the patient knew the reimbursement limits and was at risk for higher charges and fees. The patient had a choice, although limited, to exercise restraint. However, the current system fuels inflation and contributes to the health care cost crisis. Because of this spiral, change is inevitable.

There are numerous proposals to impact on the problem. Senator Kennedy's proposal to ration health care is one and President Carter's proposal to cap hospital costs is another. Another movement is the growth and development of the HMO movement. Successful HMOs seem to instill certain cost effective disciplines that show promise.

I propose that still another concept could bring about sufficient change in the system so as to have a positive effect. Allow me to outline it for you.

Today an employee basically has two choices. He can obtain the employer provided indemnity or service plan or if there is an HMO in the service area, he can opt for coverage in it. Suppose there were a third choice? Suppose

a carrier had the capacity to put a package together that offered either the same benefits as the indemnity plan for less money or more benefits for the same money. Such a plan would contain only mild trade-offs to the employee, these being additional procedures or mild inconvenience, but certainly economically acceptable to the employee. The procedural trade-offs might include a second opinion for any non-urgent surgery, pre-admission testing on an out-patient basis, pre-statement filing by the physician similar to common practice in dental insurance and other potentially cost-effective procedures exercised before the delivery of services. The convenience trade-offs might include payment in full for procedures and confinements in hospitals or surgical centers designated in the plan description for major diagnosis. In other words, a gall bladder operation covered in full in Hospital A, B is covered at only $X in Hospital D, E and F.

Course, such a plan would require certain behavioral changes of carriers, employers, employees and providers. In addition, investment will have to be made to educate each of the interests in such a plan. But more importantly, the carrier will have to possess systems capabilities not usually present in today's claims payment environment. Today, most carriers collect charge data and process payments with little need to maintain provider profiles, and less need to assimilate charge data on disease specific codes. Carriers would have to orient data collection around a spell of illness. This would represent a major departure from today's orientation around a specific claim. In addition, the quality of care rendered will become as important as the cost of care. Since diagnosis will be a key in benefit payment, accuracy of statistics will be most important. To be sure, critics of our taking a stronger role in cost containment would welcome our failure because of inadequate and inaccurate data.

In my opinion, someone somewhere soon will show enough initiative to introduce new market mechanisms into our system for financing health care. The public is just about ready for it.