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HEALTH CARE COST CONTAINMENT: HMOs, AN EXAMPLE FOR HEALTH INSURERS?

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MR. HERBERT A. FRITCH: This session will be devoted to the discussion of controlling health care costs in the private sector.

The health insurance industry has been pointed to as a major contributor to the soaring cost of health care. Increasing levels of third party coverage, combined with fee-for-service provider reimbursement and a pay-as-billed philosophy, have been identified as removing supply and demand restraints in the health care industry.

In many areas HMOs have begun to change this atmosphere by introducing real competition among health care providers for patients. This competition has resulted in several innovative approaches to health care delivery. Three of our panelists come from the HMO industry. Each represents a different structure of organization, financial incentives, and control mechanisms that is being used to allow these HMOs to offer an expanded benefit package at premiums which are very competitive with traditional hospital/surgical major medical packages.

We would hope that understanding their method of health care delivery would stimulate thoughts and discussion in regard to how the health insurance industry might consider approaching the control of health care costs.

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MR. STEPHEN J. ROSINSKI: Let's first establish that health care costs do need to be controlled. Since you regularly work with statistical data, I'll try to size the problem with recent historical data along with some authoritative but frightening projections.

The Health Care Financing Administration released a national study on May 16 of this year. The U.S. Health Bill for 1980 will be $245 billion, and projected at the current annual rate of increase to be $758 billion in 1990.

Health care costs are also taking an ever-increasing share of our gross national product.

YEAR	% OF G.N.P.
1965	6.2%
1978	9.1%
1985	10.5%
1990	11.5%

About 40% of our total health bill is the piece called "Hospital Costs." The double-digit inflation we are suffering with today has been the "norm" in rising hospital costs for quite a few years. California hosptial costs have increased 14-18% annually since 1972.

From 1950 to 1979, the Consumer Price Index has risen 202%, but during this same period the cost of a semi-private room in a hospital has increase 1,122%.

From 1967 to 1977, wages have gone up 98% while the cost of health benefit plans went up 284%.

Looking ahead, we find that the number of active doctors will increase at an annual rate of 3% from 1978 to 1990 while our population will average .9% increase per year.

More doctors will mean more treatment, more hospital admissions and increase expenditures for their services.

Locally, the San Diego hospital costs went up 53% in three years (1976-77-78).

That's enough data — health care costs do need to be controlled.

Let's shift gears for a movement and look at some of the causes.

1. Excess Capacity. California has a 65% occupancy rate in its hospitals. We have more health facility than is needed. This leads to unnecessary and inefficient vacancy factors.

2. Duplication of Services. Hospitals express their need to be competitive in a fashion normally not seen in the traditional free enterprise system. Hospitals do not compete on the basis of cost or prices. Hospitals compete in their ability to attract physicians, who will in turn bring in the patients. In order to attract physicians, hospitals make capital expenditures far in excess of local needs. A hospital must have its own cat scanner and heart surgery wing to recruit pihysicians from other hospitals. The result is excessive facility and excessive cost.

3. Powerful Health Provider Lobbies. The provider groups such as the California Hospital Association and the California Medical Association reported $2.5 million lobbying expenditures in Sacramento last year. They are the second highest spender, exceeded only by the local government lobby. They are articulate, well-financed and effectively organized. The consumer is none of the above. Guess who wins.

4. Cross-Subsidization. In California, about 53% of all hospital expenditures are accounted by state and Federal health programs. Government has the best answer to health cost control. They don't pay the full bill! The state program pays about 85% of billed charges. So, the hospitals increase the charges to the private sector to make up the unpaid 15% of the state bill. As taxpayers, we are pleased. As private payors we are being robbed!

5. Consumer Negligence. There is an increasing demand for health services by the insured person. As his out-of-pocket costs decline, both the consumer and the provider perceive medical care as free. Employers and most insurance companies are doing a lousy job of monitoring providers, examining claims and evaluating employee usage. We promptly pay charges on a retrospective basis for ill-defined services. We do not know what we are paying for!

6. A Non-Competitive Health System. It is a great business to be in. Over-capitalization is no problem. The customer (patient) rarely chooses on the basis of cost. A physician decides for the customer (patient) such things as which hospital will be used and the length and type of treatment. When it is all over, the industry gets paid promptly on a cost-plus basis.

Will health maintenance organizations make the industry more competitive in a real sense?

Let's first define a pre-paid health system as an HMO.

This term is generally used to describe arrangements which commonly provide a fixed set of medical services to its members for a fixed monthly payment. The plan locates providers willing to take the member as a patient. Some of these plans have been around since the 1930s. However impetus caused by favorable Federal regulations has caused accelerated

growth in the 1970s. In spite of all the publicity and recent growth, only 4% of persons with private health coverage are involved in pre-paid health plans.

Do pre-paid health systems reduce health care costs? The philosophy behind health maintenance organizations emphasizes primary and preventive health care services, thereby reducing the need for more costly levels of care. With a fixed income, these plans have an incentive to provide health services in a cost-effective manner.

Physicians on salary or contract are not dependent on the number of patients they see or treat. Emphasis is placed on prevention and ambulatory care. The Independent Practice Association (IPA) model appears to be less cost-effective. Member physicians are reimbursed on a fee-for-service basis even though patients are pre-paid members. The financial incentive for these physicians is similar to the usual fee-for-service private practice. Physicians are encouraged, however, to provide conservative treatment since a portion of their "fee" is withheld by the plan. The withheld portion is returned to the physician if the plan operates within a budget. Financial savings ranging from 10-40% as compared with commercial insurance serving similar poplulation groups have been well documented.

Pre-paid systems are popular in California. About 14% of the state's population is enrolled in a variety of pre-paid plans. The largest plan in California is the Kaiser-Permanente Medical Care Plan with about three million members and growing at the rate of 6-7% per year. Kaiser has a much lower surgery rate and a higher occupancy rate than the rest of the health systems.

My personal belief is that health maintenance organizations could keep health care costs down. Their presence in a community makes the independent provider nervous, and that is good. Many independent physicians are joining HMO-Independent Practice Associations in self defense, and that is good. However, there still is no assurance that either system will be cost-effective.

My recommendation to employers is to encourage this competition but certainly to not sit back with the belief that this problem is now under control. What else can an employer do?

First of all, it is difficult to fight the health system alone. because it is a major cost to employers, I suggest that they join organizations of other employers dedicated to do something about the health cost problem. Employer health cost coalitions are forming throughout this country, in cities such as Los Angeles, San Diego, San Francisco, Seattle, Tucson, Cleveland, Detroit, Philadelphia and Cincinnati, to name a few. True cost reduction requires change at the local level. That is, individual physicians and individual hospitals must do something differently than they have in the past. These employer groups help keep the cost issue "alive" with the local providers by "eyeball to eyeball" interface.

Employers should also exchange information on the success or failure of cost containment programs they have implemented. They should also evaluate and take "active" positions on legislation which may impact health care costs.

While we are waiting for the HMOs to control costs, there are specific programs that an employer should examine for possible implementation as health care control techniques.

1. Pre-Hospital Certification. A program where a physician must certify in advance for non-emergency hospitalization, the diagnosis, date of admission and date of release of the patient. The number of days can then be checked against published standards, and variances to standard can be resolved with the physician prior to hospital admission.

2. Pre-Hospital Admission Testing. A program where all physician-authorized tests are preformed prior to hospital admission. This procedure reduces the length of hospital stay.

3. Second Surgical Opinion. A program where a patient may request a second opinion to determine the necessity for non-emergency surgery.

4. Ambulatory Surgery. A program where medically-approved surgical procedures are performed in a setting which eliminates overnight hospital stays.

5. Self-Funding. A program where an employer can avoid insurance "risk" charges and state premium taxes.

6. Self-Administration. A program where an employer controls the administration of the health plan and may realize savings by efficiently processing and carefully reviewing claims before payment. This is one of the most powerful cost containment tools available to an employer.

7. Discount Negotiations With Hospitals and Laboratories. A program where an employer enters into direct negotiations with a health service vendor for the purpose of negotiating lower-than-normal charges.

8. Community Drug Price Information. A community telephone program where individuals may obtain information as to the lowest price in town for various prescribed drugs.

9. Preventive Programs. A variety of "keep healthy" promotions such as stop-smoking clinics, weight reduction classes, alcohol and drug abuse programs, health fairs, blood pressure control programs and cardio-vascular physical fitness programs.

10. Commitment to Stay Involved. An employer who is seriously concerned about excessive health care costs must become, and stay, involved in this issue through personal participation in the health delivery systems. This means involvement in the health system agency, hospital councils, medical associations, hospital boards of trustees, HMO Board of Directors and statewide groups concerned about this issue. It also requires jawboning with hospital administrators, hospital chiefs of staff and individual physicians.

Well, it sounds like a terrible amount of effort is needed, and it is.

But the effort is worthwhile because there is a pay-off called "Real Health Cost Control."

DR. L. ARNO LEJNIEKS: It is very encouraging that people like Mr. Rosinski have taken interest in the health care issue because there is no question that if the health care industry, (hospitals, physicians, nurses, pharmacists, laboratories) are left alone there will be no competition. Therefore, their prices will go up at will as they have done in the last several years.

Control of health costs is nothing new and could be told by a little story. In 1939 in Oregon, a patient got sick and had surgery, pyroglaso duct cyst removal. A fairly major neck surgery similar to thyroidectomy that requires general anesthesia, quite a lot of time and a lot of skill. The surgeon submitted the bill to the insurance company and his fee for that operation was $50. In addition he charged $5 for one visit before the surgery in his office. The insurance company wrote back and said they felt the $50 was already high, but they would pay, however, they didn't want to pay the $5. The doctor responded that the procedure required a lot of time and skill, was similar to a thyroidectomy, and that he should get his $55. I presume the settlement was of $50, but it just points out that there is such a thing as cost control and it did take place some 40 years ago and I presume in some successful fashion.

The Foundation Health Plan (FHP) is an IPA type of HMO. It is qualified as an HMO by the Federal government and also certified by the State of California. The organization has enrolled some 24,000 lives in the two and one half years since it first opened for business. Over 800 physicians participate in the program. All of the major hospitals, likewise, have signed contracts. The territory includes the five counties, namely Sacramento, El Dorado, Yolo, Placer and Nevada. The plan at present is negotiating to extend its territory.

The history of the organization is important. An organization called the Medical Care Foundation (MCF) of Sacramento developed the Foundation Health Plan (FHP). The MCF is still in existence. It administers health insurance in our community for such carriers as Blue Cross, Blue Shield, First Far West, and others. The MCF also was a contractor to the State of California to provide health care to some 35,000 enrollees in the medicaid categories. This contract lasted for four years. This venture was successful, but was terminated because of no agreement on rates. Thus, the organizations have a very successful cumulative experience in the area of pre-paid health care delivery.

The Foundation Health Plan is an IPA type HMO. Two types of HMOs were established by Congress. The closed type of an HMO is best represented by Kaiser-Permanente with usually one hospital and a closed salaried physician staff. The open HMO, or the IPA, usually has more than one hospital where they place their patients. The physicians continue to practice in their offices. The physicians may have few or many HMO patients. This type of HMO has also been described as a practice "without walls."

The IPA-HMO corresponds more to the commonly accepted, traditional private practice of medicine. But at the same time, it also carries a true or mythical stigma that private, traditional fee-for-serivce, medical practice is more expensive and allows for unlimited utilization. This type of practice is often accused of having made medical care financially inaccessible to most americans, particularly to the working population. what then has the Foundation Health Plan done about it?

There are two areas where most of the medical expenses occur: In the physician's office and in the hospital. It is estimated that among the working population in California in the indemnity insurance segment there are some 550 hospital days per 1,000 enrollees per year. Kaiser closed panel group claims some 350 days per thousand enrollees per year. Our present data would seem to indicate some 380 days per 1,000 enrollees per year. These days include maternity days, however, newborn days of uncomplicated deliveries are included in the mother's days. We started our plan with an estimated 447 days per 1,000 enrollees per year, but later decreased that estimate to 400 days. This significant accomplishment has been possible because of our Certified Hospital Admissions Program ("CHAP").

CHAP has a history of some 10 years. It is operated by the HMO which in Sacramento is the Foundation Health Plan. The basic feature is that we hire registered nurses. These registered nurses are totally responsible to us - the FHP. The hospitals allow the nurses on their premises, but they do not render medical care. All of the R.N.s , however, have had acute hospital patient care responsibilities just before employment with the FHP. There are also a number of physicians representing various medical specialities who are advisors to these nurses. However, because of their medical expertise, the R.N.s are able to make positive decisions. Negative decisions, or denials, need consultation with the advisor. We are thus able to accomplish pre-admission certificateion, evaluation of surgical diagnoses, and daily close follow-up of each patient in the hospital.

To illustrate, allow me to follow a case with you. Let's say that there is a surgical patient requiring gall bladder surgery. The surgeon has evaluated the patient in the office. The appropriate examinations and tests have been performed and the decision has been made in regard to the diagnosis and the procedure to be done. The surgeon's office personnel send a form to the foundation which indicates a diagnosis, the procedure to be performed, and the date of admission. This information can also be called in if there are time restraints. The CHAP registered nurse will check the diagnosis for appropriateness. If additional information is required, such will be requested. If there are unusual features, a second opinion may be also requested. The surgeon's office and the hospital will then be notified and the admission certified. It will also be determined whether the patient can be admitted on the day of surgery or the evening before surgery. If there is a mismatch of any of these or related questions, clarification will follow. It will be arranged that only participating physicians do consultations and administer anesthesia. For example, if laboratory tests or radiological procedures can be done prior to admission on an outpatient basis, such will be accomplished.

Subsequently, patient surergy is uneventfully finished. Each day the patient's course is followed by the registered nurse. She keeps a daily record of her own. This record serves as a good measure of quality control. If there is treatment or test or procedure over-utilization such is corrected on sight with the attending surgeon, or an eductional process may be set in motion to prevent future occurences. There is much that can be corrected in this fashion: intermittent breathing treatments are frequently over-utilized; daily tests may be ordered and forgotten; single tests such as a potassium determination may suffice in comparison to all electrolyte determination; frequently, arterial blood gases are over-utilized.

Should the patient develop complications, the length of stay will be extended. However, should the patient do better than expected and perhaps may need not as long a hospitalization, then the length of stay will be shortened. Should the surgeon not recognize this, then either the R.N. or the advisor physician will contact the surgeon and discuss earlier discharge. The patient is discharged fully recovered and the detailed CHAP record is transferred to the Foundation Health Plan offices. When the hospital bill arrives at the HMO office, a final sequence takes place. The hospital bill is scrutinized against the CHAP notes in regard to length of stay, operating room charges, medication records, levels of care, etc. Any adjustments can be made which further allows for considerable savings.

It must be recognized that each step described above provide for potential savings which may decrease medical costs. At the same time, the treatment routine is disturbed as little as possible. The hospital, the physician, and particularly the patient in 90% of instances, has experienced minimal, if any, disturbance.

The laboratory services, both inpatient and outpatient, can likewise be of benefit to an HMO. Laboratory prices in some areas have risen very slowly. This is because of the competition and also because of the automation, but still tests performed in a hospital are about 30% to 50% higher than the same tests in a labortory not related to a hospital. Thus, we insist that no outpatient laboratory work is done in a hospital laboratory unless the test can not be obtained elsewhere. The laboratories also benefit from the FHP. We provide volume, and with today's automation in order to survive, laboratories must have volume. We also eliminate direct billing to the patient and thus eliminate bad debts and excessive waiting. We also pay semi-monthly with one check. Therefore, we are able to contract with the laboratories specifically for specific rates, and I think that also provides considerable savings.

Community hospitals, likewise, gain much from on open IPA-type HMO. We do assure new patients to a hospital, unlike closed panel HMOs we try to work with most, if not all, hospitals. Hospitals are able to influence the action of an HMO if included in the decision process. They have a local corporation to deal with. Most likely a good hospital is assured of our patients for years to come. For these reasons, it is mutually beneficial for a hospital and the FHP to sign specific defined contracts that will limit the HMO's financial liability.

The hospital portion of the medical bill is very easy to define. There are relatively few admissions. In our HMO, at present, there are perhaps 150 to 200 admissions per month. The bill is in great detail.

The outpatient portion of the health dollar is a much more elusive subject. A physician's bill may consist of a single office visit, or perhaps an injection, or a single laboratory test. At present, there are perhaps hundreds of such bills arriving daily. But we do have a system of approaching this problem.

The review is based on guidelines which have been prepared gradually and based on actual experience over the last ten years. There are continually changed and updated. The guidelines provide for "trigger points." For example, there may be a guideline to review a claim if more than three

visits occur in two months. Certainly, all claims of a provider will be reviewed if injections are used. The key feature is that claims which are inappropriate can be denied, of course, subject to an appeals mechanism. The physician and other provider contracts provide for such a feature. If necessary, a physician or a provider may be placed on a total review. In such instances, all of the claims are reviewed. Again, we use a specialty review approach. It means that almost all specialities and sub-specialties have reviewers. Thus, the particular intricacies of one specialty can easily be considered.

About ten years ago, every hospital developed a fully staffed emergency room. There is no question that this has provided for an easy access when real emergencies occur. However, the large majority of emergency room visits need not be seen there. The cost differences are astronomical. An office visit may cost $25 or less, whereas, an emergency room visit with the usual large number of laboratory tests may be in the neighborhood of $150 for a relatively uncomplicated condition. It is very obvious that such visits need to be reviewed in some detail. A co-payment will help some. However, in addition, one needs a well-established patient education system. Emergency room over-utilization to a great degree must be attributed to the patients. Patients must know how much it costs and also must understand that the HMO will help them to find a physician and thus feel secure when illness strikes.

Much has been said and written about assigning patients to a primary physician. In such systems, no referrals can take place unless referred by the primary physician. We have not adopted such a system. But some modifications may be necessary.

Certain specialties, like allergy, dermatology, neurology, ophthalmology, and others, develop its own patient clientele. Thus, one patient may be seen by multiple physicians, at times for minor problems. It is all together possible that minor hay fever and uncomplicated skin problems can well be cared for by a primary care physician. We are attempting to identify such problems. This is both a physician as well as a patient problem.

These are then some of the attempts we have made to control unnecessary over-utilization. In an open HMO, our efforts must be much greater because of the very size of our HMO. However, we are sure it can work. We cannot promise miraculous reductions in health care costs. However, we do believe that we can remain competitive with other segments of health care delivery.

MR. LAROY VAN DYKE: I appreciate the opportunity of being here this morning and presenting to you this innovative idea that started several years ago. We began in the Sacramento area very close to where the Foundation Health Plan is now operating.

The most serious threat to our present way of practicing medicine is spiraling costs. As costs of medical care continue to escalate there is more searching for rational and practical ways to halt the cost sprial. One of the major problems is that all of the involved parties are insulated from the cost implication of their individual decision. Employees and unions are pressing for first dollar coverage of all medical and dental care becasue these benefits are not taxed whereas salary

increases are. Insurance companies are protected by their ability to pass along increased premiums in a non-competitive environment. Physicians are insulated by the third-party payment mechanism. The current fee for service third-party reimbursement system is behaving exactly as it was structured to behave. Cost will continue to escalate as long as patient, physician, hospitals and insurance companies are insulated from the cost implications of their individual decisions.

Physicians, because of their key role as decision-makers in the medical delivery system, determined either directly or indirectly most health care expenditures. The insurance companies, foundations and health maintenance organizations have no way of controlling expenditures except through physicians. We believe the challenge for a participating physician is to use his pivotal position to effect some control of escalating medical costs within the private sector, and thereby avoid further government regulation to control the escalating cost.

In the past two years there has been a reawakening of interest in structuring of the medical marketplace that would promote cost control by competition between groups of providers. If competition within the private sector is to remain a valid public option to more government regulation and government control of the medical delivery system, then there must be expansion of alternative delivery systems which aim to impede escalating medical costs by organizing the delivery system more efficiently. These efficient alternative delivery systems can take many forms. Close panel HMOs such as Kaiser-Permanente, group health cooperative of Puget Sound and others, have proved their ability to substantially reduce hospital admission rates and health care costs. Foundations and other types of Independent Practice Association have in some cases altered practice patterns of their participating physicians by imposing strong utilization reviews in order to lower the medical care cost. This occurs especially in an area such as Minneapolis where there is strong competition from other HMOs. An alternative to imposing controls on physician's use of hospitals to contain cost is restructruing the incentive in such a way that the physician is vested in the savings which result from the his efforts to control costs and maximize efficiency in the delivery system.

One type of incentive reimbursement system is exemplified by United Healthcare, a capitated primary care network type of Independent Practice Association. This is a private sector, office based, incentive, reimbursement plan which restructures the incentives in order to encourage physicians to control costs and maximize efficiency. This model was initially launched five years ago in Northern California and Washington State by Safeco Insurance Company with headquarters in Seattle. It was initially called Northwest Health Care in Washington State and the Safeco Health Foundation in California. It has recently expanded to Utah and has taken on the new name of United Healthcare in all three areas.

To give you just a little idea of how we differ from the more traditional HMOs, there are four basic functions or components of an HMO: First, the facilities that it uses; second, primary care reimbursement; third, referral care reimbursement; and fourth, risk. A group practice or a close panel model uses discreet facilities. Many times they are new and the people must go to the specific facilities that are designated within a service area. This can be very costly in many areas because they do have

to build new facilities. The primary care reimbursement is done either on a salary basis if its a staff model, or if they have contracted with a group practice program it would be paid on a capitation basis. All other care is paid either against salary if it is a staff model, or on a fee per service if they do not have facilities within and must refer out. The risk is on a group pooled basis, that is, the total of the physician participation is at risk for whatever the outcome is. The IPA or foundation model, in the same areas use existing resources, reimburse their primary care physicians on a fee per service basis (many times this is on a scheduled arrangement whereby the primary care doctors will accept less than the normal fee for service arrangement), reimburse all other care on the fee for service basis and the risk is on a group pool, that is all the participating physicians share in the risk on an equal basis.

The United Healthcare model, or as it has become known more recently the primary care network, deals basically with primary care physicians. The IPA will contract with physicians. specialists included, in a geographic area. We are like the IPA in that we do utilize the existing resources. We do not go out an build new facilities. The primary care reimbursement is paid on a capitation basis after an experimental, or an initiatory period, where we and the physician become knowledeable of each other's operational methods. We do reimburse referred care on a fee for service basis as both the IPA and the close panel HMOs. When a person enrolls in the program, they must select from the list of primary care physicians, a physician through which they will channel all of their medical care needs, and because we enroll most of the primary care physicians in a community, this is not a real problem. Very few patients have to change doctors since most of the time their primary care doctor is already participating in the plan.

We have determined through past experience and through looking at the current system on a regular fee for service basis that the primary care physician is a very key element in being able to monitor the cost of medical care. He is in a strategic role in the delivery system. It is possible to channel the medical care needs of the participant, or the patient, through a primary care physician and thereby placing him in a coordinating or a manager role. He now becomes the coordinator for all medical care needs of the enrollees that choose him as their primary care physician. We feel that this, even more so than the risk element, is the key to the success of our particular program.

When we talk about primary care physicians we are dealing basically with family practice, general practice, pediatricians, and general internal medicine physicians. We do have occasion where an OB/GYN does a lot of primary care and they're able to participate. Also, there are some areas where general surgeons do a lot of primary care along with general surgery and they're able to participate, but generally speaking it is the first four types mentioned.

United Healthcares' responsibility is that of marketing, administration, and reinsurance. The program is fully reinsured and as we get into this you'll see perhaps why this is important to the success of the program. The physician's responsibility is to monitor the medical care both on an outpatient and an inpatient basis (regardless of the reason for admittance into the hospital). We offer a program that's very broad to the enrollees. Virtually everything is covered on a paid-in-full basis, the

only area of co-payment is prescriptions. There is a $2 charge for each prescription and refill. It's important that we provide this broad of a program to the enrollee and for the physician to be able to manage the care on an economical basis. A structure where all is covered means there's no limitations as to where it has to be done, in-hospital or outpatient. Wherever the doctors feel that it is most economical to provide the care will be covered by the plan thus eliminating the major problem that has occurred in the past of insurance plans contributing to the rising cost of medical care by encouraging hospitalization in order to have benefits covered.

We market the program to the enrollees on a group basis through employers. The premiums are collected and United Healthcare receives an administrative fee to cover the cost of administration, marketing, and reinsurance. The balance of the funds are placed into the provider account. An account is set up for each individual physician and the money that goes into that account is based on the age and sex of the enrollees that choose him as a primary care doctor. There will be a different amount placed in the account for a 6 year old child than for a 38 year old female enrollee. The administration fee varies from 10% in our more mature areas to 14% in our newer areas. The objective is to get it as low as possible in an area. The provider account is individual and there is a possible surplus/deficit situation. If there is a surplus at the end of the accounting period it is shared with the physician and the enrollee, it is not shared with United Heathcare. When we say it is shared with the enrollee, we mean it is used either to offset inflationary pressures to increase price or we are able to add additional benefits, if this is the decision of the program. If there is a deficit, this is between United Healthcare through the reinsurance policy and the physician. However, there is a limit on the risk the physician picks up. We do not want a physician to become so concerned about cost that it affects the quality of the medical care that is delivered. If the patient does legitimately need open heart surgery than we want him to have it. If the physician was fully at risk for that particular procedure, it would definitely influence his decision. So, there is a limitation on this that I will explain later. The provider account is divided into two areas. There is office services which normally accounts for office visits, hospital, lab, X-ray and minor surgery that is performed in the hospital or an outpatient setting. Other services are handled as referred services which includes hospital, pharmacy, and out-of-area or other emergency care.

We reimburse the provider account and the provider in two different methods. For the office services, from 0 to 199 enrollees we reimburse on a fee per service basis less a 5% administrative savings factor. If they have 200 or more we negotiate a capitation arrangement with them. All referred services are paid on a fee per service basis with the primary provider approval, and this is a very key element in the program.

The maximum financial risk to the provider, or primary care doctor, is limited to 10% of the revenue that he has received from the plan for his services if he has under 200 enrollees. If there are 200 or more it's limited to 5%. The reasons for the reduction is that there is some risk when a physician goes on capitation. Now, when we settle up with the physician we do remove any catastrophic claims from his account recognizing that in those instances he may not have any control over them. For instance, he may have a severe accident that could run up

thousands of dollars and he'd have no control over that. We do not feel that it is justifiable to punish or to place the physician at risk, on that. Afterall, he is not an insurance company. We do leave any charges under $5,000.00 there and they are charged against his account. That's what determines whether there is a surplus or deficit. If there's a deficit he's asked to reimburse us on this basis, 10% if he is under 200 enrollees and 5% if he has over 200. It's actually 50/50. He shares in the deficit 50/50 up to a maximum of 5% or 10%. If there's a surplus, he receives 50% of that.

Now for some of the results that we have seen from this particular program. As I mentioned before we offer the program to the enrollees. We sign up a minimum of 60% of the areas physicians. As the program matures, we have approximately 85% to 90% of the primary care physicians participating in the plan so the enrollees have a wide selection of primary care physicians. We do not restrict the physicians as far as the specialists they can refer to. However, we do provide to them information on the average cost of the various procedures that may be performed in the community so that the primary care physician can start comparing between hospitals, between specialists and things of this nature. Thus he can become aware of the overall cost of medical care and begin influencing the referral patterns, the hospital admission patterns, and so forth, that involve his particular patients.

One thing that we have seen happen in the particular program as compared to the standard Blue Cross/Blue Shield arrangement, is the percent of the health care dollar that is paid to the physician. In the standard program 33% of that dollar normally goes to the primary care physician, with 67% to the specialist. Under United Healthcare's arrangement it's 52% and 48%. We feel this has a significant impact on the program because specialists do have a tendency, in our experience, to hospitalize a lot for testing, diagnostic work-ups, and things of this nature. By getting control, this program eliminates this self-referral, thus eliminating a lot of duplication of services. By channeling all medical care through a primary care physician and coordinating the care, we eliminate many of the duplicative services.

When comparing data on Blue Cross/Blue Shield, group health in the Seattle area and United Healthcare, we see very little difference in the number of office visits per year. This is about 4.1 for all three plans. This is one area of concern. People felt this particular program might encourage increased office visits, but it really does not do that. Hospital admissions per thousand were also very close to Group Health of Puget Sound, a close panel HMO, at 84 per 1000. Normally the close panel HMO's have a much lower admission rate than traditional IPAs. The length of hospital stay shows a significant difference with group health at 4.2 days, Blue Shield at 4.9, Blue Cross at 4.8, and United Healthcare at only 3.5 days. Bed days per thousand shows a similar difference with 528,392,342 and 295 days respectively. In California the bed days per thousand for United Healthcare runs between 300 and 320 instead of 295, but that's still a significant difference.

All of these factors do have an affect on the premiums that are being charged by the program. There the premiums that are being charged by United Healthcare are lower than those of the other type of plans. Group Health's HMO benefit package is similar to United Healthcare package and

cost is very close, but the cost for Blue Cross and Blue Shield is higher even though the program used for comparison did not cover any preventive medical care such as well baby care, immunization, routine physicial, and things of this nature. So we feel that the data that we've collected thus far does demonstrate that you can control costs of medical care within and the existing overall system, by restructuring the components of the system.

One of the other results that we have seen through this particular program, demonstrated by the data, is that hospital utilization patterns have been altered. Again we feel this is because we get someone involved who is looking at the long term relationship with the patient, the primary care physician. I think all of you would agree that as you review your relationship with your primary care doctor, it is a different type of relationship than that with a specialist. The primary care doctor is genuinely interested in the overall health care of the patient and generally is not going to make decisions that will hamper or hurt the quality of the health care being delivered. As for the specialist, they're good, they're qualified, and we're not knocking them in any way, shape or form, but here we are looking at a surgeon who sees a patient, treats him, and may never see him again. The relationship is different.

We have seen behavioral changes in the area of ambulatory care. For instance, one of the standard problems is in the use of the emergency room. Many times if we have a problem after five o'clock or six o'clock we go to the emergency room because the doctor says he doesn't want to be bothered. This is a very costly way to receive medical care that could be given in the office. As soon as we start floating these bills across the primary care doctor's desk and he sees what that cost is, he very rapidly changes. He will contact the hospital emergency room and tell them to ask who the person's doctor is, and if he's their doctor he wants to be notified, unless it's an emergency. If it is a true emergency, the emergency room physician will give the patient the care that's needed, but if he's stopping by with a headache, stomach ache, or whatever, the doctor will be called so the problem can be discussed. Many times he may be aware of past problems and can give recommendations over the phone to solve some of the problems, or make arrangements to meet him at the office. We've seen this happen.

Another situation: chest congestion. One physician called to our attention someone who came in who had had chest congestion for a couple of weeks and did not seem to be improving. He automatically sent him to an internist to have a work up. He saw him again and everything seemed to be taken care of. Under this program, again, all referral bills for a particular patient, go to that primary care physician. One physician saw work ups coming back for $350.00 and he thought that was really out of line so then he changed. He started indicating, on the referral, that he was requesting only a two view chest X-ray by the specialist and a review of that. Then the specialist can talk with the physician, truely developing a consulting relationship between the specialist and the primary care physician. As a result, 75% of the patients that he was referring out were receiving only a two view chest X-rays at the end of six months. The other 25% were having additional workups because they needed them, but instead of 100% receiving the $350.00 workup only 25% were.

Another patient was seeing an O.B. specialist. A workup was done and the patient needed further treatment and was hospitalized. The next day the specialist went in and did another complete workup and charged $80 exactly duplicating the services. The primary care doctor saw this and got very upset. He got in a discussion with the specialist and the specialist agreed not to do it again. Also, he did not get paid for that particular procedure because it was a duplication and was not necessary.

These are some of the things that have to happen, but it must be the providers, not just the patient. We can educate patients and enrollees, but they are still going to do basically what the provider tells them to do.

MR. ROBERT MACK: Today I was asked to discuss the techniques group and staff model Health Maintenance Organizations (HMO) employ in controlling costs. In discussing these cost savings, I would first like to make several distinctions. Group or staff model HMOs are frequently called close panel organizations. The Individual Practice Associations (I.P.A.) are frequently called open panel organizations. From the view point of management theory, the group or staff model is a centralized operation and the I.P.A. is a decentralized operation. The group model and the staff model differ slightly. In the staff model the physicians are employed directly by the HMO corporation. In the staff moedel the physicians are a separate corporation contracting with the HMO Corporation. Since the centralized HMOs employ the providers directly or indirectly, the organization's orientation to expenses is generally one of a wholesale purchaser. Since the decentralized model contracts for services but does not employ the providers, the orientation is frequently one of a retail purchaser. These two distinctions, centralized vs. decentralized, and wholesaler vs. retailer, give the group and staff model HMOs a significant advantage in operating efficiently. It is important to realize that the group/staff model HMO through its wholesalers approach and centralized organizational structures has several distinctive advantages over the insurance industry and even the I.P.A. Model.

First there is the wholesale advantage. The group and staff model HMO can provide physician, laboratory, X-ray, pharmacy, home health, physical therapy, and health education through salary employees. Consequently, they are not paying the retail price that other health insurers are paying. Conceptually these HMOs are paying the staff a salary, and paying other associated administrative costs. It is a wholesale approach. The consumer purchases the HMO and not the physician.

Second, the centralized model can apply its bulk buying power. Contracts can be developed with outside medical providers such as specialists and hospitals as well as any other outside medical providers or vendors. This is a major cost saving means. There are also certain approaches to the internal operation of the HMO and its relationship to its external environment.

The effectiveness of these approaches is dependent upon the quality of the organization's management. It is competent management that contains costs through various techniques. For simplicity, I am discussing these techniques in the arbitrary order of: the HMO's staff, hospital, financial, health education, and philosophy. Now let's discuss how group and staff model HMOs are able to cut costs in these areas.

First, you get what you deserve or what you pay for. It is my observation and the conclusion of several research papers that a prime reason HMOs succeed or fail is the quality of its management and the quality of its Board. There are other reasons but they are peripheral to staff/group models. There are too few managers in this industry who have had years of experience in HMOs. HMOs are a relatively new industry. They are a complex industry. There are a few who truly recognize the interrelationships of marketing, finance, operations, physicians' needs, consumer needs, hospitals and public relations. Few managers realize the total implication of a change in one functional area throughout the organization. Competent management is simply a capital investment that will save the organization and the consumer money, and insure the organization's viability. The same point is true of the board. A truly successful board is a working board. They must have a commonness of purpose. They will guide the organization and they should be rewarded for their efforts. As we discuss the techniques in controlling costs, the relationship to these points will be evident.

The group or staff model HMO can tailor its physician staff to its needs because it is generally recruiting its physicians from the community or from outside the community. The utilization of the physician will therefore be, after the initial startup years, at a cost efficient point immediately. For example, when an HMO is projecting growth they can project their physician needs by medical specialty and month of need. The physician may come on board three months early or later than desired, but the demand generated by the other professional staff and the consumer is elastic. He will be used. This is assuming, of course, the planning needs and marketing projections are appropriate. If he is a specialist and brought on later than planned, the HMO has the capability of "queuing" or holding appropriate elective procedures through its protocols. The HMO can also elect to use outside physicians in the fee for service community. This option provides a flexibility not present in the decentralized model or insurance industry. Where a medical specialty is required less than full time, the HMO can make arrangements with outside providers. The arrangements can be normal (U.C.R.) reimbursement, or they can be negotiated. The HMO has bulk buying power. It can present to a medical specialist or specialty group all of is specialized cases for its HMO membership. Who else can annually present 500 or 1,000 or more referrals to a specialist or specialty group? Consequently, contracts are normal and equitable and below retail medical costs.

The HMO can also utilize its staff more efficiently. Physicians can be used where they are medically needed. Midlevel personnel can be utilized in lieu of a physician at 25-50% less than the primary physician's salary. Under proper professional supervision and protocols, production, quality and patient satisfaction will be achieved. This statement may be challenged by certain professionals. And there may be isolated cases of inappropriateness. However, with proper protocols, it works, costs less, and provides quality. Some midlevel areas are nurse practitioners under a physician's supervision for physicials, OB/GYN, and minor episodic cases. Another example is using optometrists for eye examinations and using opthomologists for treatment of eye diseases and eye surgery. Also using an optometric team with the optometrist will further increase productivity and cut costs. A receptionist can make appointments and opticians can assist patients in selecting and fitting eyeglass frames. This frees the optometrist time for staff supervision, eye refractions, and patient

referral to the opthomologist. This is an efficient use of the optometrist that increases productivity and cut costs. Add some of the new technology intensive equipment, management system flow of data, patients and supplies with vertical integration of a laboratory inside the HMO, and a negotiated contract with bulk buying of eyeglass frames and you have a detailed example of how a staff/group model can cut expenses. These same ideas can be used in varying degrees for dental care, mental health care, pharmacy, and other associated operating medical service areas.

Another major technique for cost containment in the group or staff model is controlling the consumer's access point. Many staff/group HMOs initially require the patient to see a primary care physician. The patient must do this before they can see a specialist. This directed entry is criticized by some members of the general medical community and is perceived by many patients as an inconvenient barrier to health care. However, the consumer frequently will not realize the primary physician's ability to medically deal with minor problems. Minor dermatological problems being treated by a primary physician in lieu of a dermatologist is a simple example of a medical service being provided at a lower cost by a primary physician in lieu of a specialist at a higher cost. Recently, I have spent a great deal of time investigating this issue. The actual experiences of several HMOs indicate that controlled access as opposed to free access to any medical specialty results in a 5% lower premium.

Several articles have appeared in the past few years on the HMO's savings in hospitals. The savings are generally attributed to a lower utilization per 1,000 than the insurance industry. Facts indicate HMOs hospitalize less. 360-450 bed days per 1,000 for HMOs compared to 500 to 600 and more bed days per 1,000 range of the insurance industry on the west coast. There is a wider spread in other parts of the country. Now why? First the HMOs emphasize ambulatory surgery when it is appropriate. This cuts costs. Second, second opinions have generally been implemented in HMOs for a long time. Third, generally, all elective procedures are approved by the Medical Director or department head. All emergency operations are approved after the fact. In addition to receiving approval of the procedure, the physician will state how long the patient's hospitalization is planned. This planned stay will be monitored, and extensions or discharge planning performed. An emphasis is also made upon pre-admission workups. It costs less. An emphasis is placed upon discharging when it is medically appropriate. An emphasis is placed upon the patient being in the hospital only for medical reasons and not at the convenience of the family. An emphasis is placed upon transferring appropriate cases to convalescent facilities. They cost less than the hospital. Ideally, this is done by the physicians working together with a commonness of purpose. It is interesting to note that it is my observation, and Dr. Paul Ellwood's of Interstudy that it is not only the HMOs that have lower hospitalization but also the well established medical groups providing fee for service care. There are also apparently some psychological and social factors present among the physicians. Now, that is the physician's orientation and approach to hospitals. What about the financial approach of these HMOs?

The large staff/group model HMOs have cut costs simply through vertical integration. They own their own hospitals. Kaiser and Group Health Cooperative of Puget Sound are two examples. This approach completely

removes the profit factor of the hospital, and reduces the need for a portion of the overhead being attributed to the vacant beds and staff that are in one respect fixed. The HMO can project its occupancy and operate more cost efficiently. This also permits the HMOs to place the hospital based physicians on salary. This is a classic example of vertical integration. It provides a 5% premium advantage over the HMOs without hospoital ownership. For HMOs without a hospital, the wholesale approach is valid. The HMO can use its bulk buying power to deal with hospitals. Contracts at less than the prevailing rate can be negotiated. The HMOs in this situation have a great deal to offer the hospital. A relevant point is understanding that the patient does not select the hospital. The physician selects the hospital. Consequently, a variety of management systems, physician's orientation, emphasizing outpatient workup, ambulatory usage, vertical integration or contracts combine to cut the cost of the hospital expense in the HMO.

There are a variety of financial aspects that HMOs utilize to control costs. First the fact that most HMOs are non-profit should be recognized as an advantage. For profit HMOs exist and will prosper. However, given a competent management the non-profit HMO has an advantage over "for profit" HMOs and insurance companies; no corporate taxes.

Some HMOs require the group account to pay at the beginning of the month, not at the end of the month. That's the pre-payment aspect. This provides a cash flow with obvious financial management uses. Other HMOs are using bulk purchasing in the manner of private corporations and large hospital corporations.

Other HMOs are placing, to the concern of the insurance industry, an emphasis on coordination of benefits (C.O.B.). Yet others are closely controlling the costs to outside specialists by authorizing a medical procedure, dollar limit, and requiring additional authorization for further treatment or hospitalization. The HMOs are also tracking the utilization and cost data for staffing purposes. These processes are each cutting expenses one-half to one percent, and they add up a significant amount.

I have left Health Education and Philosophy for last. They are intangibles. It is hard to place a savings on an intangible. But it is easy to place an expense on the staff and materials performing the intangible service. So I will point out the intangibles and trust you to your own analysis.

HMOs in philosophy are oriented to preventive care. HMOs have health education programs. They have health educators, newsletters, pamphlets, video tapes, health classes, and even jogging clinics. The health education was originally oriented to prevention, early detection, and home treatment. Health education is increasingly becoming oriented to lifestyling related to positive mental health, nutritional health and physical conditioning. After automobiles, it is the food, stress, alcohol, overweight and lack of exercise that is killing us or causing absentism at work. HMOs hire a non-physician professional staff for health education. They place it into their premium. The physician in private practice can practice health education as part of his personal beliefs or for public relations. But he will not be paid by the insurance company or the patient. The HMO staff is paid. Now what about the payoff. Does this cut costs? I can't say that it does.

We do know Seven Day Adventists do not drink caffine, do not smoke, and do not generally eat meat. There are some indications that as a subset of the general population, these people live approximately five years longer than the general population. It was in the early sixties that John F. Kennedy started the U.S. on the road to physical fitness. It was almost twenty years later that a book on jogging became a best seller. Health education is an investment. It will take time.

The group and staff models have another psychological advantage. It is a combination of philosophy and organization. Everyone in the HMO has a commonness of purpose. Despite any internal conflict the staff have a basic understanding of their purpose. The commonness facilitates the organization's efforts to develop and provide services. Placing the physicians and services under one roof facilitates the medical aspect of this purpose. Placing physicians on salary as opposed to the fee for service system provides an incentive for appropriate treatment as opposed to expensive treatment.

The group and staff model HMOs are containing costs through centralization, vertical integration and the attitude of a wholesale purchaser. Qualified competent management, management systems, health education and commonness of philosophy contribute to this cost containment. Providing all business functions and medical services through one organization also provides a psychological advantage. All of these factors cut costs and place the staff/group model HMO in a competitive situation.