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TRENDS IN MEDICAL BENEFIT PLAN DESIGN TO CONTROL CLAIM COSTS

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1. What has already been tried?

2. What works?

3. What else can be tried?

MS. PHYLLIS A. DORAN: If we agree about nothing else here this morning, we would all say that rising health care costs are a major problem. We have all heard the frightening statistics on the escalation in health care cost in this country. What we would like to do is hear from some people who are working in the area of health care cost containment.

MR. DAVID F. MCINTIRE: It is encouraging to me as a Corporate Director of Employee Benefits to see that the Society of Actuaries has recognized the problem that we employers are having with spiraling health care costs and is addressing the issue at this Spring meeting.

In my role as a Corporate Benefits Director, I am finding this period of time in my career to be both interesting and very challenging. Recently our parent company medical costs have been rising at a rate in excess of General Mills' quite favorable annual sales and earnings rates. For our fiscal year ended 1980-81, our parent company's salaried health plan cost increased 21.6% over the prior year, and our hourly health plan cost increased 22.5%. In contrast, our corporate sales increased 16.4% and our net earnings increased 15.6% for the same period of time. As you well know, this problem is not unique to General Mills. It is the rare exception today where an employer is not experiencing health care cost problems. In fact if you know of one, I'd like to sit down with you after this meeting to find out exactly what they are doing right.

There is no quick solution to this country's health care cost problems. They have been building up over the years, and it will take many years to improve the health care system.

At General Mills we have looked at health care problems in several ways. First, we have taken a look at what is happening around us in the community and have taken active roles in several major community health care projects. Secondly, we have looked within the company itself and have taken some actions and are planning others.

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Let's look at General Mills' community actions. The Company is one of a number of large corporations headquartered in the Twin Cities of Minneapolis and St. Paul. Other major companies there include Control Data, Dayton-Hudson, Honeywell, Pillsbury and 3-M. Interested and committed members of senior management of these and other Twin Cities' companies have rolled up their shirt sleeves to address various community health care issues.

A number of companies contributed financial resources and executive time to the Twin Cities Health Care Development Project in the early 1970's to determine the feasibility of establishing one or more HMOs in addition to an existing consumer cooperative HMO which was organized in 1957 in St. Paul. General Mills did play a major role in the Twin Cities Health Care Development Project. Today we have a total of 7 HMOs in the Twin Cities, only two of which chose to become federally qualified. Approximately 25% of the Twin Cities population is now covered under HMOs and competition does exist among them for new members. For example, one group model HMO has been running a billboard advertising campaign throughout the Twin Cities. Its first ad read, "Before our doctors examine you, we examine our doctors." Its current ad reads, "We make medical bills ouchless." Twin Cities HMOs also use newspapers, TV and radio to attract new members. Spotlights and hot air balloons may be next.

General Mills is represented on the Boards of Directors of two of the three HMOs that it offers to its Minneapolis employees.

The Twin Cities Health Care Development Project was not terminated after it met its local objectives, but rather was reorganized on a national scale and became the National Association of Employers on Health Maintenance Organizations, NAEHMO. More recently NAEHMO was broadened to address other health issues of interest to employers in addition to HMO issues and was renamed the National Association of Employers on Health Care Alternatives (NAEHCA).

The second Twin Cities (and state) effort was the establishment of the Minnesota Coalition on Health Care Costs in July, 1980. The coalition is the result of a recommendation from the Governor's 1979 Task Force on Health Care. Some of the health topics the coalition has begun to deal with since 1980 include:

1. Issuing statements urging reduced scope relative to a University of Minnesota hospital renewal project (estimated total cost of $706,000,000) and a Veterans Administration hospital project.

2. Taking a position on reimbursement systems rewarding price competitive behaviors of providers.

3. Making specific recommendations to the State of Minnesota to improve the cost effectiveness of health care delivery and to reduce the overall growth of health care costs.

4. Support of the implementation of a private hospital utilization review program.

5. Conducting a benefit survey of Twin Cities' employers' health benefit plans to determine to what extent local employers are offering alternative health care plans and how those employers are contributing to those plans.

6. Helping to establish a health care utilization data base that employers can use to compare their individual claims experience with other employers and to monitor existing and future health plan benefit costs.

These are only a few of the projects that the coalition has dealt with since its inception less than two years ago. General Mills is also represented on the coalition's Board of Directors.

A third community health issue which was undertaken by Twin Cities' employers was the establishment of a private hospital utilization review program. The program is intended to identify and reduce unnecessary hospitalization. It is not intended to simply reduce costs nor in any way reduce the quality of medical care provided to employees and dependents. This program was implemented in July, 1981. There are now approximately 15 Twin Cities' companies participating with about 162,500 employees and dependents covered under the program.

Other activities that General Mills is involved with are: the Washington Business Group on Health and the Midwest Business Group on Health. We have also been pleased with the success that a small, informal Twin Cities employer HMO group has had in discussing mutual interest and concerns with management representatives of the Minneapolis and St. Paul HMOs.

Here are examples of the actions General Mills has taken with its health benefits programs:

ACTIONS ALREADY TAKEN

Department Reorganization. The Corporate Employee Benefits Department was reorganized to better address health care management and cost containment issues and began reporting directly to the Vice President and Director, Corporate Health and Safety. At the same time, retirement and thrift savings plans accountabilities were transferred to the Corporate Compensation Department. This reorganization focuses on group health benefit issues and improves communications and coordination in the management of occupational and non-occupational disability cases.

Plan Design. General Mills Corporate Health Plans have been modified to provide, when possible, medical care in less costly settings without reducing the quality of care. We wish to have employees become more conscious of the cost of their health care. Our salaried employees outpatient benefit coverages were improved June 1, 1981 to direct employee and dependents from more costly inhospital facilities to less costly outpatient services, ambulatory care centers, and doctors' offices. The plan's individual annual major medical deductible was increased January 1, 1982 from $75 to $100 to begin to reflect, in part, increases in the cost of living. We expect to adjust that deductible again in the future.

Convalescent nursing home benefits were added to our hourly employees' Health and Welfare Plan April 1, 1981 to replace more costly hospital care

in convalescent cases. Employee contributions were added September 1, 1981 to the previously fully company paid dental plan for family coverage. At the same time that benefit was improved. Approximately 7% of the General Mills married employees elected not to pay three dollars per month for dependent dental coverage. That 7% drop out reduced General Mills' overall cost approximately $81,000 the first year.

HMO Options. HMOs have been offered to parent company employees in Minneapolis, Buffalo, Chicago, Kansas City, Los Angeles and Vallejo, California and to employees at four of our subsidiary companies. Our experience with HMOs has been positive. HMO annual rate increases have been generally less than our own indemnity plan rate increases. In addition, HMO plans have been well received by our employees, particularly in Minneapolis, where 78% of eligible salaried employees have chosen to belong to an HMO program. Our initial HMO membership in 1973, when we required additional out-of-pocket costs from employees to join an HMO, was 25% of employees.

Private Hospital Utilization Review Programs. This Minneapolis and St. Paul program was mentioned earlier.

Employer Health Care Coalitions. We are actively involved with the Midwest Business Group on Health (MBGH) which is headquartered in Chicago and serves an eight state Midwestern region. The MBGH's focus to date has been on establishing and supporting private hospital utilization review programs, developing a hospital trustee education program for employers, developing corporate health policies, and working toward the improvement of claim data reports needed to manage health benefits and analyze health care utilization and price problems. MBGH members in Minneapolis and St. Paul have met with several insurance carriers to improve the management information reports that they are receiving from their insurance companies.

Hospital Claim Audits. All General Mills hospital claims of $10,000 or more are being routinely audited by the insurance company to confirm the appropriateness of charges made. One example - a recent hospital claim audit uncovered and corrected a $9,000 billing error. There are much more dramatic cases not involving General Mills employees. One was a $250,000 overcharge in a $400,000 claim. Another being a $245,000 bill for a hemophiliac where a $47,000 error was found.

CURRENT AND FUTURE ACTIONS

Plan Design. A complete restructuring of the salaried employees medical benefits will be studied during our fiscal 1982-83. The study will include: considerations of employee medical contributions (which are now fully company paid), 100% self-insurance (we are now on a minimum premium plan arrangement), and the addition of a second surgical opinion provision.

A similar study will be made later on our hourly health and welfare plans in preparation for our 1983 labor negotiations. Consideration will also be given to increasing, effective January 1, 1983, our salaried employees contributions for family dental coverage.

Corporate Health Strategy. Corporate health care strategy and cost containment programs will be developed for top management review and approval so they can be communicated and implemented during our next fiscal year. This action will be in conjunction with the current Business Roundtable's Program, "An Appropriate Role for Corporations in Health Care Cost Management". A major benefit for us of this strategy and cost containment program will be improved direction and coordination to General Mills' many different subsidiary group health insurance plans.

HMO Options. Health maintenance organization plans will be considered for at least five company locations during the next year. Other alternative health care delivery systems such as preferred provider arrangements with hospitals and/or doctor groups will be explored, beginning in the Twin Cities.

Private Hospital Utilization Review Programs. Employers are now working with hospitals and doctors in the greater Chicago area to establish a private hospital utilization review program either late in 1982 or early in 1983. Our South Chicago plant operation will be encouraged to participate. Our Cincinnati and Cedar Rapids locations will probably begin participating in private review programs later in 1982.

Employer Health Care Coalitions. The parent company field operations and subsidiary companies will be encouraged to support and participate in local health care coalition efforts, where appropriate. Local management, working with the corporate employee benefits department, will determine what proposed cost containment actions appear to have significant payback which would warrant us becoming actively involved in a particular coalition effort.

Management Information Reports. New management information reporting systems are being developed and will be implemented in fiscal 1982-83. They will provide improved tracking of health and disability claim experience and will facilitate projecting General Mills' benefit plans costs. Medical and disability costs will be recorded by division, by location, and by diagnosis, to identify where costs are being generated and for what medical reasons. We will also begin receiving more detailed health cost data on our employees' and dependents' hospital and physician charges concerning utilization and pricing patterns.

Disability Management and Rehabilitation. "Disincentive" provisions will be removed from our corporate disability income plan and from our subsidiary companies' long term disability plans to encourage disabled employees to return to gainful employment when possible. Top and local management support and involvement in managing disabled employees' individual rehabilitation programs with the aid of professional rehabilitation specialists will be necessary to have this cost containment program be successful.

Corporate Philanthropy. The Corporate Benefit Department will continue to work with the General Mills Foundation Director to help assure that General Mills' corporate contributions to various health projects and programs are in step with its business interests in containing health care costs.

Health Care Resources and Planning Survey. A survey will be conducted by the Corporate Benefits Department to determine what efforts General Mills' employees are actively participating in at local and state levels to accomplish rational allocation of health care resources.

Next, a few comments on how a private employer may look to insurance companies and consultants for help to resolve some of their health care cost problems. We would like to see more innovative ideas and more flexibility from insurance carriers in dealing with health cost problems. Some have already experimented with second surgical opinion programs. Others have supported or developed HMOs. Others have introduced new health delivery systems like Aetna's Choice Plan which is to be up and running fairly soon in the Chicago area. We would like to see more of these types of innovative ideas tried by the insurance area. We would like to receive more meaningful utilization and cost reports. We need to know more about the true cost impact on our indemnity insurance plans when other alternate health care plans are being offered by an employer.

Consultants can help us by acting as a sounding board for internally generated health cost proposals and report to us as a clearinghouse on other employer successes and failures. They can help generate local coalition efforts to provide us with cost projections of proposed plan design changes and to provide useful input in Washington, D.C. on proposed legislative changes.

In conclusion, it is clear that we at General Mills have no quick answers or easy solutions to health care cost problems. We have made good progress this past year but recognize that there is still much to be done to improve the situation. And more importantly, we also recognize that we can only accomplish so much on our own. We need to work with others on a much broader scope to make an impact on our current health care delivery systems.

MR. WILLIAM E. HEMBREE: I hope my talk will generate some new ideas and questions on your part. Some of the things we will talk about today are a little provocative in that they will suggest ways of doing things somewhat differently than they are done today.

As you may know, Health Research Institute conducts a major national survey every two years on the prevalence and effectiveness of industry's health care cost containment efforts. We survey the 1,500 largest employers in the country. In the most recent survey (reported late last year), 507 of the 1,500 employers responded, which reflects a strong desire on their part to control health care costs. Each of your organizations can play a large role by assisting your policyholders in bringing these costs under control.

Because last year's survey was our second biennial survey, we are able to observe trends and get some sense of where movement is occurring. For example, there is a decided shift away from emphasis on the inpatient sector. Many plans' design has concentrated on inpatient hospital care for a long time, but there are a number of different ways to encourage outpatient care, for instance, equal or higher levels of payment for ambulatory care, pre-admission testing, and other alternatives to inpatient care can be created as well. One example is to remove from contracts the requirement that inpatient hospitalization occur before extended care is payable.

That requirement can create three to ten days in the hospital as an unnecessary admission ticket to the extended care facility. Allowing the person to go directly to the extended care facility can eliminate those in-hospital days. Unfortunately, for a long time, employees have been very passive consumers in an overwhelming medical care delivery system -- which is one of the reasons for the costs we are experiencing. Accordingly, employers are beginning to feel that if they can demonstrate cost savings to employees by passing part of the savings on through additional benefits like extended care, employees can be encouraged to reduce hospital utilization.

Another highlight of this year's survey is a considerable interest in controlling providers. Retrospective utilization review, for example, which looks into providers' practice and charging patterns, is of great interest. As another example, the Pratt & Whitney Division of United Technologies has identified and created a panel of very cost-effective providers of certain services. At Pratt & Whitney, an employee may be scheduled for an appendectomy and learn in advance that the surgeon will perform the procedure for $1,200. But if $1,200 is more than the reasonable and customary charge, the employee will have to pay the additional amount - for example $400. The employee is also told that one of the panel physicians will accept reasonable and customary for his charge. All of a sudden, the employee has a financial incentive (about $400) to have the appendectomy done by one of the panel physicians.

What does that incentive do to the reasonable and customary tables? If employees are having $800 instead of $1,200 appendectomies, it tends over time to reduce the R&C level from what it would have been otherwise.

There is also a shift away from the base and major medical plan to the comprehensive, front-end deductible approach. However, this may be simply cost shifting. If it does not change consumption patterns, it probably will not be effective over the long-term.

The survey also indicated there is a great deal of growth in dental coverage. There are also significant shifts to more complete coverage for substance abuse, mental or nervous conditions, home health care, hospice care, and other viable alternatives to the inpatient setting.

One of the most effective and positive movements we see emerging in the survey is an interest in health improvement, health promotion, and other wellness activities. We can make an analogy by comparing health care cost containment to a fire engine company. Imagine we are all part of a fire engine company, and the alarm comes in. Certainly, the health care cost alarm is coming in today. We all hop on the fire engine, run down to where the fire is, but drive on to where the smoke is getting close to the ground. We think we can deal better with the smoke (because it is more visible), so we get the hoses out and spray like crazy on the smoke. By contrast, a good fire chief will say that we are not dealing with the problem, rather that we are dealing with a symptom of the problem. The federal government's solution (which we will all have to contend with if we do not get costs under control) in that situation is not to treat the fire, but just get bigger hoses and throw some more money on the smoke. We all know that does not work. A good fire chief would tell us to go back to where the fire is (where the problem is) and not to fight the symptom.

The analogy in cost containment is that so long as we deal only with administrative remedies, reasonable and customary charges, funding and financing costs, coordination of benefits, second opinion surgery, pre-admission testing, utilization review, etc., we do not deal with the problem. We deal with a symptom of the problem which is the cost of health care rather than its cause, which is ill-health.

The fundamental problem is that people get sick. Simplistic as that seems, that is the problem, not the cost of the sickness. There is a recent and very high level of interest in health promotion and wellness in this country. For the first time, we are starting to deal with what creates costs rather than just the costs themselves.

As an example of health promotion and prevention efforts, between our 1979 and 1981 survey, the companies using hypertension screening in the work-place doubled. The proportion providing nutrition education and smoking cessation increased by about 50%. The proportion providing accident pre-vention -- teaching people that accidents are truly preventable -- doubled. The proportion providing health education increased. The proportion pro-viding on-site physical fitness facilities doubled. And the proportion providing reimbursement for off-site physical fitness programs -- joining a Y or another fitness activity -- increased by about 50%.

There is also a distinct movement away from fully-insured, carrier-adminis-tered arrangements. In 1979 about 45% of the companies responding used a fully-insured, carrier-administered arrangement. In the second survey 28% did. Not all of those companies were leaving their carriers; many were moving to a minimum premium, ASO, or other alternative funding arrangement, but staying with their carrier. However, it is significant for you to note that the proportion of companies using self-administration doubled during that period of time. The number of companies using third-party administra-tors increased fairly considerably as well. Insurance companies need to look at what they are doing (and not doing) and how they might recapture some of that market share by becoming more competitive and responsive to policyholders' needs.

We also see a trend of providing coverage for treatments and providers that have not been covered in the past. Coverage for biofeedback treatments, hypnosis, self-care, even things like native-American healing, naturopathic and homeopathic medicine has increased.

What are some expectations for future changes?

For one, we believe there will be a reversal of "rear view mirror planning". Rear view mirror planning is expecting the future will unfold as the past has. The present is changing greatly from the past, and the future will as well. For example, the idea that a certain level of illness and death is inevitable will change. Many people think we have to lose a million people every year to cardiovascular disease -- heart attacks and strokes. About half of the million people are in the labor force, so a significant amount of productivity is lost by the 500,000 deaths in the working age population. In addition, we lose momentum and training, and we have to recruit, retrain, etc., because workers die before they would have otherwise retired.

In the future we will seize opportunities for elderly care, although it is difficult for employers to seriously consider today. A great proportion of U.S. medical care cost is paid for people who are over age 65. As you may know, there is a proposal in Washington to make Medicare secondary for active employees over age 65. That is only one step away from employers having primary responsibility for any vested retiree -- leaving Medicare secondary. Perhaps there will not even be a Medicare system one of these days and employers will be responsible.

Another example of how the future will unfold differently is the idea (which is being accepted increasingly) that cost containment is not an extension of employee benefits. This means that cost containment need not be extended equally for all employees. Currently it is felt that an employee benefit should be available for all members of the workforce equally. Not so for cost containment. Improved data which carriers could gather and report would allow an employer to target a cost containment of health improvement effort to a particular group of employees, or even a particular individual. A weight-loss bonus, for example, may be made available to one individual but not to others.

Our level of expectancy affects our perception and performance as well. Typically we achieve what we expect to achieve. If our expectations are too low, our achievement is too low. We need to encourage employers to look not just at cost containment, but at cost reduction as well. Cost containment implies that we will stem the rate of increase in health care costs but that they inevitably have to go up. We could achieve better results if we expect (and plan) to actually reduce costs.

We need to initiate not react. If we wait for the provider community or someone else to solve the cost problem, the problem probably will not be solved in the way we would like to see it solved.

In the future we will have to measure results. Anything that is worth doing in cost containment and health improvement can be measured -- given some thought on the part of the measurer and the requisite amount of time for the change to take place.

We need to use creative and innovative solutions. Most of the actions we are taking today will not solve the problem. For example, the medical care system behaves precisely the way that we pay it to behave. If we want the medical care system to behave differently, we may have to start paying it differently.

We will have to become more involved in employee life-styles. For a long time we have felt that an employee's life-style was a private matter, and we should not have anything to do with it. Now many recognize that employers are already very involved in their employees' life-styles because medical care plans are paying for the results of employees' health harming behaviors. So some employers are approaching life-style in a very positive way. They are not only changing their medical care plan -- they are making tools available that will help employees change the risk factors they have. For example, everyone knows when they have a broken leg and when they have recovered. If you have high cholesterol or hypertension levels, you cannot stick a dipstick between the seventh and eighth ribs and get a reading on cholesterol or hypertension levels. Consequently, some employers are testing health status and feeding back the results to employees.

Employers are also looking for ways to create competition within the delivery system. There is a great deal of creativity in the insurance industry. Aetna's "Choice" system certainly is not the place to stop. It is just the place to start. There are many other alternatives the insurance industry could initiate and support.

In summary, we are seeing employers give consideration to the idea that cost containment alone may not be sufficient. They are looking at, and looking for, assistance in what can be done to improve the health of and to promote a higher quality of life for their employees. We challenge each of you to take a more supportive (or preferably, a leadership) role in health improvement as well as effective cost containment efforts.

MR. ROBERT E. COHEN: If you are giving the unhealthy employee an incentive to get healthy, what kind of incentive are you giving to the healthy employee?

MR. HEMBREE: In the past, largely none. Today we are rewarding the ill employee who may have helped cause the illness. The provider system does not walk up to an employee and hand him a heart attack pill. Life-style is a large determinant in the illnesses people have today. When an employer decides to try to change these health harming life-styles, the inevitable question is: "What should be done to reward the person who does not have those kinds of behaviors?"

With regard to the future, the situation will be considerably different. There is a pilot study we are involved with in a number of companies that are headquartered in Northern California. It is called the Health Promotion Organization (HPO) pilot study. It creates a way to reward people who are willing to accept much higher levels of small- and intermediate-term risk (because they are healthy). The model is based on a percentage of pay deductible. Most people who would choose this system would have a $4,000-$5,000 deductible. They would receive an allocation from the company (perhaps $1,000-$2,000). If they do not use all of the allocation, the allocation is paid in cash and serves as a reward for either wise purchasing in the medical care system or no purchasing at all. We need to reinforce healthy people as much as we need to try to change the habits of those who are less healthy.

MR. BRENT W. WALKER: How can you provide incentives to employees' spouses to improve their health? Often that has a much larger effect on cost than the employee's health.

MR. HEMBREE: It may be cash. That seems to be a revolutionary idea, but you are asking a pertinent question. If we only concentrate on the employee, we are overlooking 50-60% of our total health care cost. You do have to involve the whole family, not just the spouse. The greatest level of dependent emphasis should be placed on spouses because they are adults and are more likely to encounter serious medical expense than the children. An example -- many employers think that they have an excellent prevention program when they have employee physicals. But they usually make the

physicals available only to employees. If a physical is a good idea to try to detect an illness at its earliest stage for employees, it should be available to spouses as well. Also, if cash incentives (weight-loss bonuses, etc.) are a good idea for employees, why not extend them to spouses as well?

If an employee with a family wants to join an incentive-based reward system like the HPO, the employee is not able to join the HPO without bringing the family. To illustrate why, if an employee finds out he or she has a cholesterol reading of 300, the spouse must be involved in his or her change efforts. The employee eats at least one of his/her daily meals at home so it is hard to make changes in nutrition (and other life-style changes) without the spouse's support.

MS. MARTHA B. GRAHAM: You spoke of a suggestion that an employee not use his own doctor but see a doctor who will essentially charge less. What happens if something goes wrong? Aren't you liable for suit?

MR. HEMBREE: Pratt & Whitney gives their employees a voluntary choice. They said, "We want you to know ahead of time (rather than afterwards) that you will have to pay $400 because the $1,200 charge is more than R&C will pay. You could choose a panel doctor that would charge $800 (which would be paid in full), and they are board certified and qualified. We have screened them and listed them on the panel. If you make the voluntary choice to use a panel physician, then you will not have to pay $400 -- but it is your choice." Obviously, this has not been tested in court, but because the employee is not being forced in any way, we do not believe the employer has any additional liability.

MR. DAVID E. NORTON: I think that it is appropriate that this topic was scheduled at Disney World in a somewhat surreal type of land. Any of you who think that health care costs are not a problem, or that a quick and easy solution can be found by listening to this panel had your ticket punched to the Magic Kingdom at the wrong door. We do not need to restate the facts about health care costs. Everyone - legislators, regulators, insurers, employers and even patients - has concerns about our inability t successfully control health care costs over the last two decades. Ther a problem and increasing pressure to solve the problem.

To start with, we need to look at that problem in its simplest form. are basically only two ways to reduce health care costs. We either 1 duce the cost per unit of medical service being provided, or 2) reduc amount of services being provided. There is no magic solution - any alternatives to one of those two very hard choices.

The public sector has historically placed a greater emphasis on red the unit price (e.g., maximum fee schedules, retrospective auditin more recently, proposals for prospective budgeting of hospitals). has possibly been effective in controlling some of the cost of th programs. It is also given rise at the same time to a new term -

shifting". Total costs have not been reduced - they have merely been transferred to the private patients who are not restricted by artificial payment limits. If cost controls are to be effective, they must be designed in such a way as to reduce total cost for the entire health care industry, not just a reduction in the price that certain purchasers pay.

The insurance industry has historically concerned itself more with the amount of services being provided. For example, the use of deductibles and copayments are designed to encourage the insured to obtain only those services that are necessary. They have a very low impact on the actual cost of services being performed. Second opinion surgery programs, peer review contracts with medical care foundations, and other benefit designs, exclusions, and limitations are primarily for the purpose of reducing utilization. There are questions as to how much services are truly reduced or if the burden of payment is merely being transferred. An even greater question is, "Do we sometimes eliminate services that are truly needed (in the area of early detection of disease, which may save money in the long run)?"

Neither of these two approaches directly confront an even more important issue - what can society afford to pay for health care, and how do we ration that which we can afford? Has our medical technology advanced to the point that we cannot always afford to do everything that medically can be done? Who is going to make those decisions - how much a life or an extra year of life is worth?

I am going to very quickly pass over that very important question and discuss areas where we can do something without engaging in a major philosophical debate. But any cost control proposal must, by definition, assume some implicit answer to the question of how our medical resources will be rationed to the total population; unless by the magic of Disney or others we can somehow get total cost again reduced to a level where we can afford whatever is available.

Most of us here are employed by or work with organizations whose function is to pay for rather than to deliver health care services. First, I will comment on various aspects of health care financing that are currently being used or proposed to reduce costs.

1. The most common is the use of copayments and deductibles. If they are significant enough, the patient is encouraged to self-ration the use of services. The studies by the Society of Actuaries indicate that to some extent they are effective, but deductibles probably do more to reduce premiums than they do to reduce true costs.

   Two comments on deductibles. First, if they are to be truly effective, they must bear a reasonable relationship to total cost. The survey Bill referred to shows a trend toward higher deductibles to get them back in line with the total bill where they were perhaps ten years ago. Basically, deductibles have not changed that much in the last ten years.

   Second, and most important, we must ask if we are applying the deductibles and copayments to the correct items. Those costs which

we want to encourage (i.e., ambulatory surgery, day surgery, short term hospitalizations) could be helped by removing or reducing copayments. Deductibles may sometimes discourage early treatment of those items at a time when the treatment is less costly. On the other hand, perhaps the patient should pay more for long term hospitalization, or diagnostic and surgical procedures of doubtful value.

2. Second opinion surgery. If you pay for a second opinion, it either confirms the original opinion (costing more money) or requires a third opinion to settle the dispute (also costing more money). The question then remains as to whether the insured will follow the advice of the original or dissenting physician. In most programs, it is the insured's choice.

   Second opinions are very valuable from a medical standpoint. I would not undergo surgery myself unless I was very sure that the surgery was needed. But experience from existing programs has not convinced me that the second opinion programs are cost effective for an insurer.

3. Ambulatory surgery is another obvious way to reduce hospital costs - the largest part of any insured plan's budget. But there is very little incentive to encourage its use. Only recently is it even allowed in some insurance contracts. To begin with, is it possible to waive copayments or reduce deductibles for such surgery? Second, we need to reimburse the physician appropriately for the extra overhead caused by not using a hospital's facilities. One of the provider's biggest complaints is that they get paid the same thing for doing something in their office that they could do in the hospital, yet they have to pay for the overhead when they do it in their office.

4. Hospital audits were referred to by Dave McIntire. Based on the results stated by some insurers at a recent Society of Actuaries' workshop, I am surprised that all insurers are not making extensive use of hospital audits. The results seem to be extremely positive. However, this does not produce a true cost savings. It assures an equitable billing among patients. If overcharges by hospitals are eliminated, then that will mean that they will have to raise fees to cover their unchanging costs.

5. Another recent innovation that has been used primarily in the State of New Jersey (where it is mandated) is reimbursing hospitals on a per admission basis according to diagnosis related groups (DRG). The reimbursement is not affected by length of stay as long as it stays within some established norms.

   The purpose of this approach is for hospitals to discourage excessive lengths of stay. The history of this program points out how important it is to think carefully about a program to ensure that it will accomplish what we want it to. There is no

> incentive for either the physician or patient to reduce the stay and they have more control over that decision then the hospital does. Also, several of the HMOs in New Jersey (who are probably some of the few organizations that were already doing something about trying to reduce the costs in that area) reported an increase in hospital costs of 35 to 60% when this program went into effect because the program totally refuses to recognize the shorter average lengths of stay that the HMOs have had and their more frequent use of day surgery and preadmission testing. So, for at least part of the population, that approach has been counterproductive rather than helpful.

Any changes that we make in financing have to be considered carefully. The actuary needs to play a very important role to assure that whatever incentives are put in are encouraging the desired behavior. We now have much improved data processing capabilities. Certain innovations that have been impractical in the past are real possibilities now and need to be taken advantage of.

Next we will look briefly at some issues in the delivery system rather than the financing system. We may not be able to do a great deal about them, but we should be aware of them. The first is the supply of health care providers - physicians, hospital beds, etc.

There is abundant evidence that an increased supply of providers increases total costs. In the City of Miami, there are over twice as many surgeons per capita as there are in any other area of the country. Even after adjusting for the older age population that exists in Miami, the difference is still quite significant. Yet according to the latest Medical Economics survey of physician's earnings, the average earnings of the surgeons in Miami is above the national norm. It does not take an actuary to figure out there are only two ways to get there: higher fees or more surgical procedures per capita. The data in the Miami area indicates both of these.

Health planners for years have operated under the assumption that excessive hospital beds increased the cost of hospitalization. This is contrary to the classic laws of supply and demand.

The second issue is that of increasing technology. The recent study by Arthur Young and Company for the National Center for Health Services Research stated: "Despite intense competition within the industry, the medical technology market has become price insensitive ... Buyers are generally more interested in service and product names than in price ... Price increases stem from increased and constant demand, (which are) met by insurance and government payments through Medicare and Medicaid." In other words, price is not an issue because the buyer of health care services is not the one who is paying the bill. The providers who order the services are not concerned about the price because they are not paying the bill.

Is there a solution to this problem? There are solutions, but it will require insurance companies to cease pretending that the delivery of health care services and its financing are two unrelated issues that can be approached independently. The people - physicians primarily - who are ordering medical services, must become involved in the financing issues.

There is an implicit assumption in the methods that I will suggest. That is that the physician, not the patient, is the best qualified person to control the rationing of at least a minimum level of health care services, although there is a definite role for the patient, as I mentioned earlier, to move toward more cost efficient means of health care.

There are two general approaches which have not been tried enough.

1. More tension on peer review. Peer review by medical foundations or other groups of physicians has been used in many communities with varying degrees of success. That success does nothing to reward those that brought it about. If there is some way for providers to share in the risk of what they are doing and be rewarded for the possible management of that risk, then the incentive to perform effectively may increase. For example, in the Medicare and Medicaid programs it would be very simple to upgrade the fee profiles for providers in an area to pass through a portion of the utilization savings that were accomplished through peer review. The providers could be rewarded, have their incentive to perform and the overall cost of the program would go down because of the reduced utilization. If done strictly for the public sector, it would indirectly benefit the private payers by reducing the level of cost shifting that currently occurs from the public to the private sector.

2. More importantly, and this point was raised by both of the earlier two speakers, we must increase competition among providers in a way that will produce incentives to reduce cost. The competition is already intense in many communities, but as noted in the Arthur Young study, competition is not price sensitive. It focuses more on the availability of services than it does on the cost of those services. We must design reimbursement systems that reward the more cost efficient providers without sacrificing the quality of care.

I have a personal prejudice, obviously, from my current job, that HMOs offer one approach to this competition dilemma because they do incorporate the financing and delivery of health care within the same system. The experience of several cities, particularly the Twin Cities (Minneapolis/St. Paul) indicates the competition from HMOs can influence other non-HMO providers to become more aware of cost control efforts and reduce the overall utilization of health care even among the non-HMO population.

Other approaches besides HMOs can be used. The "preferred provider" approach was referred to earlier. Aetna is experimenting with their Choice program. In such a system, the patient is encouraged (primarily through either reduced copayments or expanded benefits) to use those providers that the insurance company or employer has predetermined are the more cost efficient providers.

These providers may have direct contracts with the insurer or employer or they may just be those that are identified by the data system as more cost efficient providers. But by giving an incentive to individuals to use those providers, the insurer believes it will better control utilization and/or charges and allow eventually for lower rates.

Employers really need data - much more data than they have historically received - to identify those who are the high and low cost providers so that they can know where the problems are and where they need to attack.

In any case, the solution must rest with an increased cooperation between the provider who is the seller and the insurer/employer who is the buyer. There must be appropriate incentives either through benefit design or reimbursement design to assure that efficiency is rewarded and the classic laws of supply and demand can take their place in the health care system, at least to some extent.

MR. JAMES K. HUTCHINSON: Are there any of the cash incentive program experiments mature enough so that we know anything about their effect on utilization?

MR. HEMBREE: A quick answer is no. In fact, some of the experiments that are going on are not collecting adequate data. So in some of those experiments we will never know that answer. We will know something about overall costs eventually but not utilization specifically.

MR. HUTCHINSON: In the absence of facts, do you know if there was any anticipated effect on utilization?

MR. HEMBREE: Mendocino Schools is used as an example. It is expected that any change in utilization would probably not occur with those people that were going to go well beyond the first $500. That is what is being seen by Mendocino, although they are not doing a good job of capturing the right data. Their anticipation was that the people that would have not normally gone over that $500 are paying them themselves, claiming them on their income taxes and having a lot or all of that $500 going into the side fund. So they do not have to process a lot of small claims. The Mendocino experiment is not going to have a great deal of effect on the long term utilization of the high utilizer because they are not educating employees about symptomology and other things.

MR. WALKER: I might spend a couple of minutes to tell you folks about some things that have happened in Australia which have really forced the costs up. In the early 1970's, health care costs in Australia ran about 5-6% of the gross national product. Now they are running about 8-9% of the gross national product. There is a very interesting history as to why we have had this enormous increase in costs.

Prior to the early 1970's the medical programs offered by the insurance carriers typically covered about 100% of hospital charges but only about 2/3 of all medical charges including the medical charges of the hospital. That really was a limiting factor. People just did not go to the hospital for unnecessary operations because they would have to pay 1/3 of the medical costs. Insurance carriers also used such words as "necessary" and "essential". There was always an element of doubt in the doctor's and the patient's mind as to whether or not they would get reimbursed for the treatment that they were going to get, unless they were quite sure that it was necessary.

In 1972, the government changed the whole scheme around. They insisted that insurance carriers provide almost 100% of medical charges as well

as 100% of hospital charges. There was a $5 gap, maximum, on any medical service. That, combined with the introduction of the Medibank scheme literally caused medical services to increase something like 30% in a very, very short time. The government insisted that insurance carriers remove from their rules the words "essential" and "necessary". The carriers had not used them very often but had occasionally. This took the element of uncertainty out of the system and forced charges and utilization up even further.

The only way that the insurance carriers have been able to combat this in recent times is by employing medical practitioners from the start and using computer systems to generate big data bases on utilization. We can profile doctors, hospitals, individual contributors, and individual patients to see what is happening. We can start to make some moves on the hospitals or the medical practitioners that are not doing the right thing. The organization that I work for has been very successful in this. We have black lists of doctors for whom we take a very long time to pay, and a lot of questions get asked - though we eventually pay them I suppose. We have black lists of contributors that have the same sort of problem. We have a medical arbitrator, a very respected doctor. He rings up his compatriots every now and again and says, "Doctor so and so, what are you doing to this patient? Why does she come to see you every day when she only has bronchitis? I think this organization should not be paying for more than one visit a week or one visit a fortnight. How about limiting it to that?" It is surprising what happens. We suddenly find that we are only getting one bill for every fortnight instead of one bill a day. These are some of the things we are doing in Australia to combat it. It is a very difficult task. The main reason that I am over here is to look at health maintenance organizations because we see that there is a great future in Australia for such organizations to limit the cost escalations that we have had in the past.