RECORD OF SOCIETY OF ACTUARIES
1982 VOL. 8 NO. 3

TRENDS IN MEDICAL BENEFIT PLAN DESIGN TO CONTROL CLAIM COSTS

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This session will address the following questions regarding benefit plan design to control claim costs.

1. What has already been tried?
2. What works?
3. What else can be tried?

MR. JAMES A. MILES: I would like to begin by introducing our panel. David Axene is a Consulting Actuary with Milliman & Robertson, Inc. in their Seattle office. Jerry Lusk is a Consultant with Milliman & Robertson, Inc. in their Atlanta office; his experience is primarily with Blue Cross/Blue Shield type insurance. I am Jim Miles; I work for American United Life in Indianapolis.

I have a few quotes which will set the mood for the meeting today. The first quote is by Alain Enthoven from his book, Health Plan. He writes "I like to describe this financing system as being like an "expensive lunch club". Imagine that you and nineteen friends belong to a lunch club. You agree that you will each pay five percent of the total bill for the group. Each member is free to choose whatever he or she wants. Consider the incentives. Suppose you go to lunch one day, feeling that a $2.00 salad would satisfy your desires and be just fine for your health. You watch your friends order. One orders filet mignon; another lobster. You calculate that if you order the $12.00 filet instead of the $2.00 salad, it will cost you only $.50 more. There is little economic incentive for you to choose the less costly meal. If the waiter expects a tip equal to ten or fifteen percent of the bill, imagine what dishes he will recommend. And if everybody in town is a member of this or a similar club, there is not much incentive for anybody to open an economical restaurant that specializes in $2.00 salads."

The second quote is from Michael Bromberg, the Executive Director of the Federation of American Hospitals. He was writing to the Editor of the Wall Street Journal in response to an article by a Mr. Young and a Mr. Saltman. "Young and Saltman are right that the health market is unique. What other market is marked by ignorance of price on the consumers' part and lack of competition in services delivered? That the health market - with its use of cost reimbursement and third party payment - is different does not mean competition will not work; rather its obvious flaws beg the question of why competition hasn't been tried.

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The success of this approach does not rest on the ability of patients to "control physicians and hospital costs through their choice of insurer," as Young and Saltman would have it. Rather, its success is based on the premise that the benefits of cost-conscious consumers will be felt throughout the system. Clearly, the present system of funding has desensitized providers and consumers to the true costs of health care."

The third quote is by the Chairman of U.S. Steel, David M. Roderick, in a publication put out by Peat, Marwick, Mitchell and Co. entitled World. "If an employee were to worry about the amount of money he is spending for medical services, he would be less inclined to let the doctor prescribe future visits when he feels they are unnecessary. He would begin to view constraint as part of his responsibility. One of the problems we currently face is that people do not view the matter as their responsibility because we have guaranteed a benefit. But we have done very little in the way of containing the cost of that benefit."

David Axene is going to begin our presentation by talking about ways to encourage reductions in utilization. I will follow with a discussion on ways to reduce the cost of service. Jerry Lusk will then follow with a discussion of underwriting and enforcement of contractual provisions as a way of containing the cost.

MR. DAVID V. AXENE: During the past fifteen years health care related expenditures have become an ever increasing proportion of the United States Gross National Product. The Consumer Price Index (CPI) published by the Bureau of Labor Statistics, has shown dramatic increases in cost for medical care related items. During the current recession, the CPI's medical care component has generally exceeded the overall CPI. In fact, in recent months the medical care component has been one of the few items increasing in cost. These substantial increases have caused severe strains on both private and public sector payors of health care expenditures.

For example, the public sector has experienced significant budgetary burdens in the comprehensive coverage provided to Medicare and Medicaid beneficiaries. The combination of recent federal cutbacks and other localized budget problems have increased the problems of state and local governments as they try to provide benefits for Medicaid beneficiaries. For example, in the State of Washington, the Department of Social and Health Services has been forced to significantly reduce Medicaid benefits and the number of beneficiary categories, because of both federal funding reductions and significant state deficits. One underlying cause for these benefit cutbacks has been unusually high utilization rates.

The federal government has also experienced budgetary problems with the Medicare program. Currently, the Health Care Financing Administration (HCFA) is experimenting with alternate approaches to reduce Medicare expenditures. The most recent activity is the Medicare Voucher program. Other financing arrangements are being established, especially ones with cost controls designed to reduce the cost of the Medicare program.

In the private sector, the current tax structure has encouraged expansive health care benefits through employer and union sponsored programs. These benefit plans have become increasingly comprehensive. Beyond the increases in provider costs, a greater proportion of charges are now reimbursed. Over the past 10-15 years, the cost of providing these expanding benefits has

dramatically increased. Plan sponsors are acutely aware of the significant costs. The large rate increases requested by carriers, based on actual experience, have heightened the concern of Plan sponsors. The experience period since 1980 has been one of the most severe periods on record for health insurance carriers. The significant losses and extremely high levels of inflation have led to back-to-back rate increases in excess of 20%. To make matters worse, some Plan sponsors have also suffered financial difficulties, decreasing their ability and willingness to pay continued high costs. The current environment has created a significant interest in any feature which might reduce the cost of benefits. The most popular one is today's topic, cost containment.

In 1973, the federal government formally endorsed Health Maintenance Organizations (HMO's). HMO's were able to obtain low interest rate developmental loans to establish alternatives to the traditional indemnity health insurance. Many HMO's have successfully developed these alternatives. However, several others have failed. Some of these have failed due to high utilization levels and underrating. They were not able to control utilization, and/or change the way the system works. Unexpected high costs have contributed to many of the failures.

Concerned plan sponsors, carriers, and other interested parties are banding together trying to develop controls for the current health care delivery system, and hopefully control of the cost of health care. The overall objective has been to reduce the size of the health care dollar. Corporate employers want to reduce their cost for employee benefits. The patients want to reduce their out-of-pocket costs for the treatment they receive. Federal, state, and local governments want to reduce the cost of the benefits they provide. Insurance companies want to reduce premiums so that fewer groups will self-insure, and carriers will be able to continue their market expansion. HMO's desire to develop cost effective mechanisms to competitively provide their comprehensive benefits.

The remainder of my presentation will discuss various ways that utilization might be reduced to eventually lower the overall cost of health care. My comments are separated into two areas. First, incentives to reduce patient motivated utilization and second, methods to reduce provider motivated utilization. After we have discussed each of these items, I will present other factors which affect the effectiveness of these approaches.

No Claim Bonus Plans have received significant publicity during the past several years. Probably the most publicized application has been the Mendicino School District Plan in Mendicino, California. Their basic approach changed a relatively rich first dollar limited deductible program into two pieces: a $500 family deductible insured program and a self-insured program which covers the first $500 of expense per family. Each employee is credited with any portion of the $500 not used to pay claims in a given year. Fortunately for the Plan sponsor, the original premiums were large enough to pay for the $500 deductible program and to contribute an additional $500 into a trust fund. As health actuaries all agree, the actuarial value of the first $500 is less than $500 (i.e., not everybody will have a claim in excess of $500). Initial reports claimed that the Mendicino plan was saving money since employees were earning bonuses. This particular situation saved the school district money, since fewer dollars were spent on the new program than through the previous fully insured program. However, it is yet to be shown that the actual utilization has decreased. Since the school district contributed more than the actuarial

value of the deductible, some bonus should have been expected, and the actual cost is greater than without the bonus feature. However, a no-claim bonus program can be structured in such a way that utilization can be reduced. In the March 22, 1982 issue of Business Insurance, a new cash incentive program sponsored by the Blue Shield of California was described. According to Ron Newman, the Senior Director of Research and Development at Blue Cross/Blue Shield, cost containment requires the reduction in cost to exceed the subsequent incentive payments. Unlike the Mendicino program, the incentives for the new program will be paid at the end of each Plan year, rather than providing these at retirement or termination of service. The incentive is different for individual versus family coverage, since the actuarial values are different. This modified approach removes many of the initial concerns about the Mendicino program and it will probably be successful.

Another approach to reduce utilization is to apply some HMO utilization controls that have been successfully applied over the years. These could include hospital admittance review programs, medically necessary determinations, preventive services, encouragement of outpatient services, etc. I know of several applications where these have been successfully applied. For example, one of my clients recently implemented a program attempting to transfer costs from the hospital environment to the outpatient environment. First of all, they implemented a hospital admittance program where each hospital stay must be pre-authorized, unless it is an emergency. At the time of pre-authorization, a length of stay is established for the diagnosis code reported by the doctor. The lesser of the doctor's expected length of stay for the patient and the regionalized 50th percentile Professional Activity Study (PAS) length of stay for that diagnosis is authorized. The patient and the provider are informed that charges for stays beyond this pre-authorized length of stay must be verified as to their appropriateness or the carrier is not liable and will not reimburse these charges. They expect to reduce the hospitalization frequency by 3 to 5% and reduce the length of stay by one-half to one full day.

In addition, this company prepared a list of 50 to 75 procedures that will only be reimbursed on an outpatient or surgi-center basis. Any inpatient claim for these procedures will reimburse only the professional component. The hospital bill will not be considered an eligible expense. In addition to these mandatory outpatient procedures, there is another list of voluntary outpatient procedures where the doctor and patient both receive a cash bonus when done on an outpatient basis. This company is also paying a bonus for early discharge on maternity related claims. The new mother is paid $50 for every day the discharge is less than the regional average, and is also given a box of disposable diapers.

Some companies are implementing medically necessary determinations for procedures and encouraging preventive services. As these approaches are implemented, there is always the risk that they will not succeed in their attempts to reduce overall utilization. Associated with most of these is an increase in administration costs which must be more than offset by the reduction in utilization. If the cost containment plan actually increases the utilization of one component without any other offsetting decreases, the total cost will increase.

Consumer education has been used by many HMO's and carriers for the Medicaid population. Classes show beneficiaries the most cost efficient way to receive services in the system. It has been documented that more expensive procedures can be avoided if the patient is fully aware how the same service can be provided in a more cost efficient environment. Many HMO's request that new beneficiaries go to a member training class so they can fully understand how to use the new

system. In the commercial carrier sector a similar approach can be implemented, in the form of newsletters or magazine articles, where each person can learn about the most appropriate way to utilize health care services. In a non-controlled environment (i.e., non-HMO), the effectiveness of this is limited. However, some cost savings can probably be obtained if carefully structured.

Second opinion surgery programs have been experimented with by many companies. The Cornell University study and the Program for Elective Surgical Second Opinion (PRESSO) study by the Blue Cross/Blue Shield of New York, have showed varied results depending on whether a voluntary or mandatory program is implemented. Major carriers have introduced approaches where a second surgical opinion for certain procedures is mandatory, and if a non-confirming second opinion is not accepted by the patient, a penalty or reduction in the amount paid for the non-confirmed procedure is applied. Apparently, this approach has been successful as carriers continue to apply considerable discounts to the overall program in recognition of the cost savings. A second surgical opinion program can be readily implemented, but if it is to yield satisfactory results plan designers agree that a mandatory program for certain procedures is a must. A voluntary program has shown very little effectiveness in the marketplace. According to a recently released study by a New York based consulting firm, second opinion plans are very popular and benefit managers of corporations are most willing to do all they can to make the program succeed.

Another way that patient motivated utilization can be controlled is through the development and establishment of health awareness programs. Some of these programs are sponsored by the employer, others are introduced by the carrier (i.e., the HMO or the insurance company). These programs usually emphasize the importance of physical fitness and reduction of the predisposing causes of heart disease. In addition, special programs for alcoholism and drug abuse, as well as stop smoking programs, have been introduced in various corporate settings. These habits programs help reduce utilization by improving the general health awareness and health condition of the beneficiary. Once the attitudes and habits of the general public are changed, the long term utilization of health care services will decline and eventually reduce the cost of health care.

The January 26, 1982 Seattle Times reported on the cost containment activities of three major companies, the New York Telephone Company, Dow Chemical and Campbell Soup. The common thread between each of these programs was telling their employees "what every good mother has told her children: watch your health, stop bad habits and take up good ones". They established programs for health screening, fitness, stop smoking and detections for colon/rectal cancer. These companies estimate yearly savings in terms of millions of dollars. According to this survey, 70% of all employees were interested in such a program and 50% were willing to share in the cost. Health care coalitions are encouraging similar types of studies.

One of the more important causes for our currently expanded health care dollar is the lack of controls on provider motivated utilization. The majority of our current health care delivery system does not require any formal contractual relationship between the provider of the services and the financer of these services. For several years HMO's have been the primary reorganizers of the health care delivery system. In recent years other approaches using many of the HMO techniques have emerged and are attempting to further modify the economics of the health care delivery system. These include primary care networks and preferred provider networks. These approaches attempt to coordinate the financing of provider services with the provider. Preferred provider

networks are quite popular, although relatively new. Some of the more novel approaches are aimed at self-funding of employee benefits (obviously a non-carrier idea).

One approach offers the employer a self-funded employee benefit program with two options for the employee to choose from. The first is a traditional indemnity type benefit where the employee can use any provider, but the Plan reimburses at a specified percentage of the usual, reasonable and customary charge levels, often after a deductible. Under the optional program, the employee must choose a primary care physician from a list of preferred providers (similar to an Individual Practice Association (IPA) or primary care network). The employee is offered a service type benefit with limited or possibly no copays when utilizing these preferred providers. This approach is offered at the same price to the employee. The program's feasibility is based on the desired goal of decreased utilization of expanded benefits and reimbursement at discounted fee schedules to a panel of providers previously contracted with. If the provider can be successfully monitored and controlled, the program will avoid any unnecessary provider motivated utilization. This decrease in utilization, combined with reimbursement at a discounted level, helps the employer offer somewhat expanded benefits, but on a cost controlled basis. Eventually, most of the employees will be on the controlled system according to the proponents of this approach.

Most of these programs are in the very early developmental stages. The preliminary marketing results are most interesting. In the Seattle area, there is growing interest in this type of program by local corporations. The preferred provider network has negotiated favorable fee schedules with both physician and hospital providers. The hospitals are willing to negotiate if they are guaranteed that their facilities will be used by members of this organization. They are able to use this in their budgetary planning processes, recognizing that on the average x beds per day or week will be occupied by persons from the preferred provider network. The most interest is by suburban hospitals who are losing patients to the big, downtown hospitals.

A recent thrust by corporations is the development of health care coalitions. This has been a logical response by corporations to the lack of information provided by the underwriters of their employee benefits. The corporations need answers to many of the questions left unanswered by carriers. A big goal has been a desire for expanded management information systems, where an employer can learn more about his own utilization patterns and compare them to other similar employers. Several philanthropic foundations have offered grants for this development, and the general public has been quite interested. The jury is still out whether or not these coalitions will be able to actually implement any improvement in utilization levels. However, there has been a significant increase in the awareness of this information and probably more good than harm will develop.

A remaining question is whether we in the health insurance industry will be able to actually maintain, over the long term, any reduction in actual costs of employee benefits without a restructure of the delivery system. In other words, is cost containment feasible with our current system? From a practical matter, I know everyone hopes that these attempts will control costs, but as of yet, I am not so sure that everyone will agree that the answer to cost containment has been developed.

Perhaps we should summarize some of the characteristics of the current health care delivery system that make it difficult to control costs. The most common concern about the health care delivery system is that it financially rewards those making the treatment decisions, often resulting in either more services being provided, or those services being provided on a higher cost per service basis. Because of the comprehensiveness of current employee benefits, the patients receiving the care are often completely insulated from the actual cost. There are limited incentives for lower cost and more efficient providers.

Another complicating factor is the effect of distribution of providers by region. I am familiar with a small community in the Pacific Northwest that recorded a dramatic influx of physicians over the past five years. The physician per capita ratio in this particular community has increased 75% in the past five years. A local carrier who underwrites the significant portion of the coverage to this region has observed dramatic increases in utilization during that same time frame. These increases were in excess of 25% after adjusting for changes in the demographics of the underlying population. This is a classic example of how the availability of providers dramatically effects usage of these providers. This observation conflicts with the traditional economic laws of supply and demand. I often use the example; if you had fifteen Ford dealers in a town you could probably get a pretty good price on a Ford, but if you had fifteen times the number of doctors you need, you are probably going to get fifteen times the things done to you.

As the materiality of the health care dollar increases, importance of effective cost containment mechanisms also increases. Underwriters of the health care benefits have an increased responsibility to do something to effectively control this. Their ultimate success or failure may depend on their ability to control the utilization.

We as health actuaries have a significant responsibility to find a workable solution to the current cost containment dilemma. We have one of the most thorough perspectives of the health care delivery system. The carriers and the general public are relying on us to help develop a workable solution. Perhaps the only solution may be a complete reorganization of the current health care delivery system. This will be quite difficult and probably impossible. If the recent health care coverage profitability outlook continues, there will be fewer carriers in the business. The extreme is that the patient may have to pay the entire bill without reimbursement. The health insurance industry has now been in a severe recession for 28 months. This is the longest time since World War II that our industry has been subject to such financial difficulties, more than three times the normal 8-9 month period. If there ever was a time for we as health actuaries to "get off the dime" and do something, it is now.

MR. MILES: Insurance organizations must begin to take a much more active role in cost containment activities. We must do more than point our finger at the government and talk about cost shifting, or point our finger at the hospitals and talk about CAT scanners, or point our finger at lawyers and talk about malpractice suits. We must take active steps to control claim costs or the consumer is going to look at the insurance industry as the "bad guy" and we are not going to have an excuse for what has happened.

The whole key to this issue is consumer education. That may be by forcing the consumer to do something or by teaching the consumer to do something. The consumer still views the insurance industry as a magical money

machine. Statements like, "it didn't cost me anything, my insurance paid for it", are indicative of this mood. If the insurance industry can train the consumer to say, "how much will it cost?", or "is that really necessary?", we will have made substantial progress in this area.

Hospital charges are the most significant portion of health care expenditures. Plan design which encourages wise use of hospital facilities is a must in controlling claim costs. Current plan design seems to run contrary to good sense about hospital usage. Major medical plans which cover the first $5,000 of hospital expenses and plans which cover 100% of room and board and/or hospital miscellaneous without any cost sharing are contradictory to controlling claim costs.

Lawrence Seidman, in an article in The Journal of Risk and Insurance, listed four reasons why first dollar hospital insurance seems to be so popular today. First, tax law makes it advantageous for an employee to take additional compensation in the form of additional insurance. Second, the availability of medical loans is uncertain, so insurance serves an "artifical" loan function. Third, unions may "choose" more insurance than an employee needs or wants, and fourth, employers are reluctant to have income-related cost sharing, so the only way to protect the lowest paid employees is to buy insurance with little or no cost sharing.

If there is a demand for first dollar coverage and insurance companies continue to meet that demand, then we are not going to have any effective control over claim costs. We need to examine what the alternatives are. The most obvious alternative is to no longer offer for sale plans which have heavy first dollar coverage. At least one insurance company will no longer quote first dollar coverage and has an active compaign under way to get their existing groups to change over to plans with high deductibles and coinsurance.

Another alternative is to encourage the wise use of outpatient services such as Ambulatory Surgical Centers, Emergency Rooms, Pre-Admission Testing and Homebirths.

The five most common potential outpatient procedures account for about one-sixth of all inpatient procedures combined.

The 1981 Health Care Cost Containment Survey by the Health Research Institute estimated a savings of 1.9% for plans that included an active effort to encourage Ambulatory Surgery. Since it represents a potential loss of revenue to hospitals, the development of stand-alone Ambulatory Surgical Centers will be slow.

The State of Illinois' employee plan lists certain procedures which are only reimbursed if performed on an outpatient basis. If performed on an inpatient basis, the insured receives no reimbursement.

If the difference in reimbursement levels is only marginal or even non-existent, then the insured probably will not choose outpatient surgery. He is going to go the inpatient route because he views it as less "risky".

There are several methods which can be used to encourage outpatient surgery:

1. Reimburse outpatient surgery at a higher coinsurance level than inpatient.

2. Reimburse usual and customary surgical charges, but do not reimburse for the first day of hospital room and board.

3. Pay a "bonus" to the insured for a procedure done on an outpatient basis. The bonus could be used to pay the insured for services during recovery that he might have received in the hospital, such as catered meals, housekeeping, etc.

4. Specify procedures which will only be reimbursed if performed on an outpatient basis.

Robert J. Smith, a professor at California State University, conducted a study of emergency room use. Each incident was classified into one of five categories from "no emergency treatment was required" to "emergency treatment was mandatory". His conclusion was that 72% of the emergency room admissions were not necessary.

Since many plans reimburse emergency treatment on a first dollar basis and do not cover routine treatment in a doctor's office on a first dollar basis, "emergencies" are encouraged. Additionally, the emergency room is sometimes more convenient for the insured and no appointments are necessary. Since emergency rooms must be equipped to handle almost anything that can happen, they are expensive to operate.

There are several methods that are available to discourage the use of emergency rooms.

1. Do not reimburse for the charge of the emergency room. Only reimburse for the professional charges of the doctor. Then the insured would be no better off financially by going to the emergency room as opposed to going to the doctor's office.

2. Reimburse emergency room treatment on a first dollar basis if at the time of treatment there was an apparent emergency, otherwise the treatment is reimbursed under the normal provisions of the plan. It is the judgement of the claims adjustor as to whether an emergency actually existed.

3. Do not include first dollar coverage for emergency treatment, treat it as a normal expense.

Pre-admission testing is another outpatient service. The 1981 survey by the Health Research Institute estimated a savings of .8% in the claim costs through the active use of pre-admission testing. One hospital has even begun advertising in the newspaper to encourage persons to be tested at their facilities before they enter the hospital.

One problem with pre-admission testing is consumer awareness. Most people probably are not aware that that option is available to them. Another problem in some locations is the availability of outpatient testing facilities.

Methods to encourage pre-admission testing are:

1. Eliminate first dollar hospital coverage.

2. Do not pay for the first day of room and board during a hospital stay if the tests that were done could have been done on an outpatient basis.

3. Reimburse tests performed prior to admission differently than those performed during admission, if they could have been performed on an outpatient basis. For example, use different coinsurance levels. Again, the claims adjustor would make the decision as to which tests must be done in the hospital and which ones could have been done outside the hospital.

4. Pay a small bonus for having tests done on an outpatient basis.

   One of the biggest inhibiting factors in outpatient testing is that the employers do not go along with it. If you are sick and go to the hospital you are covered under the sick-leave program, but if you choose to leave for part of the day to go get some testing done you may not be paid for that time or it may be difficult for you to leave.

The last example of outpatient services that I will examine is home-birth. Most plans probably pay something for home-births. If your plan covers home-births, does it reimburse for mid-wives? Does it provide reimbursement for ancillary services, such as housekeeping, nurse practitioner, catered meals, etc., that are obtained at a hospital and are not directly obtainable at home?

Products not subject to the "same as any other illness provision" could just set a low maximum reimbursement for maternity benefits, such as $500.

Another alternative to hospital care is facilities which provide treatment after a hospital stay or as an alternative to a hospital stay such as extended care facilities, hospices, home health care and alcohol treatment centers.

Most plans seem to make some type of provision for extended care facilities or nursing homes, although in some cases it is pretty limited. It is a much more significant benefit in the medicare supplement market than it is for people under age 65.

For plans that provide for extended care facilities the active enforcement of the medically necessary clause, which is contained in most policies, will encourage the insureds to move out of the hospital rather than stay. One company, as part of the medically necessary clause, has a mandatory arbitration procedure you have to go through if you contest their medically necessary enforcement. There are incentives that can be used to encourage movement out of the hospital:

1. Set up a schedule of procedures which allows so many days of hospitalization per procedure. Stays beyond that allowance would not be reimbursed or reimbursed at a lower level.

2. Provide usual and customary coverage of extended care facilities after a hospital stay, coupled with a medically necessary clause to avoid abuse.

3. Educate the insureds that extended care facilities are more than a haven for the aged.

Dr. Adolph Hutter and his colleagues at Massachusetts General Hospital did a study of early hospital discharge after a myocardial infarction. They published their study in the New England Journal of Medicine. Patients were evaluated as either "complicated" or "uncomplicated". Uncomplicated patients were assigned on a random basis to either a two week or three week stay in the hospital. A six month followup study was done for these two groups of people. During that six month followup time period, there was no observed difference between survival, ability to return to work, ability to function, etc. Duke University did a similar study with similar results. A study of stroke patients done in New York found better results with the group that was discharged early as opposed to the group that stayed in the hospital.

I do not advocate that insurance companies take over the role of doctors in prescribing hospital stays. However, there is significant evidence that many extended hospital stays are unnecessary. Medical benefit plan design should have a mechanism in it to encourage the insured to question a long hospital stay.

A problem with home health care coverage is how to define what is a covered expense. One method to avoid this issue is to pay a flat bonus for early discharge from the hospital to cover expenses for housekeeping, catered meals, etc. But, what professionals and services should be covered? Do you cover nurse practitioners or physician assistants? What kind of therapists would you cover? Do you cover licensed practical nurses? Another method is to pay for certain named services and not pay for the ones that are not named.

One drawback of extensive home health coverage is that you might incur claims that would not otherwise be covered by your policy. However, this is a case where increasing benefits under the plan actually should have the effect of lowering the overall claim costs.

Hospices are another facility or service which can be utilized instead of hospitals for extended stays. However, hospices are not widely available at the present time (as of October, 1981 there were 443). One recent survey indicated that 13% of the plans surveyed had some provisions for coverage of hospices. Christopher K. Goldsmith, a consultant in the office of Johnson and Higgins, states that the relative absence of room and board charges and inpatient ancillary charges means that hospices offer great potential in cost containment efforts. There is also benefit to the patient and family from the additional counseling available through a hospice program.

Currently, hospices that are not licensed as health care agencies generally are not reimbursed by third party payors, so many of the newer hospices provide free services and seek funding through other means.

You can control the abuse of hospices by putting a dollar amount in the policy or limit the number of sessions that can be attended. There are usually provisions for families to attend after the actual death of the insured; these sessions could be limited in number.

There are other methods of cost containment that are available besides using alternative services.

A method that has been suggested recently is to return to fixed dollar schedules, such as surgical schedules or fixed dollar room and board allowances. Policies like that were standard a few years ago.

Fixed dollar schedules do not seem to be a practical means of controlling claim costs through plan design. It is true that the schedule would have the effect of reducing claim costs, but there are drawbacks.

1. Schedules must continuously be updated.

2. Schedules that are fair in one locality are not necessarily fair elsewhere.

3. Tendency would be for low chargers to raise their fees to the level of the schedule and thereby escalate costs.

4. Schedules are awkward to explain and illustrate in sales material, especially when it comes time to pay a claim and the insured is not sure what he is going to be paid.

Another method is the active enforcement of reasonable and customary limits. This method does help curtail the costs of the most flagrant abusers, but its overall effect is limited, particularly because of the high level percentile that many insurance companies use. In fact, when they use reasonable and customary tables they probably end up paying most everything anyway.

Related to reasonable and customary charges are charges for unnecessary or non-performed services. Insurance companies should encourage the insured to review his bill and dispute questionable services or charges. The insurance company should serve as an advocate for the insured when disputing a hospital or doctor charge. There are agencies currently available for insurance companies to use in reviewing claims for unnecessary or non-performed services. It would seem though that the consumer could perform a similar function and be given some percent of the savings for what they find on their bill that wasn't really supposed to be there. I refer you to the May 17, 1982 issue of U.S. News & World Report. There is a rather graphic article in that issue about abuses that have taken place in recent months; it even has consumer tips on ways to go through the hospital bill and how to question it.

MR. JERRY E. LUSK: My remarks will primarily focus on the basic approach to cost containment that concentrates on insurer-specific or group-specific goals. This is an area where considerable interest is currently being shown since it highlights the question of "How can my costs be reduced?"

I agree with Mr. Axene that cost containment is an issue that needs stronger attention today by the health insurance industry and, in particular, by health actuaries. During the past six to eight years, most companies have considerably increased their cost containment efforts. However, in most cases these companies have been ineffective in communicating any tangible results from these efforts to their customers. This ineffectiveness has in turn led to discontent on the part of the group customer. As a result, many of these customers have chosen to either seek a new insurer that claims to be more successful at cost containment or have taken the matter into their own hands by seeking better cost containment through their own administration or through the administration of another party.

Along with this there has been considerable opportunity for entrepreneurs to enter into the health insurance industry and to develop products aimed at meeting this cost containment demand. U.S. Administrators, Inc. is an example of a company that has been highly successful in communicating to their customers the saving aspects of cost containment programs. The article titled "Private Sector Shows How to Cut Health Care Costs", published in Forum magazine in October, 1980, indicates that the U.S.A. cost containment system reduced health benefit costs by 25%. At that time, U.S. Administrators had an enrollment consisting of 20 large corporate and 99 union groups with an average size of approximately 17,000 members and annual claim payments of $500 million.

The success of an organization such as U.S. Administrators is again indicative of the demand being placed on the health insurance industry by groups to achieve tangible results in cost containment activities. In order to avoid further losses to third party administrators, health care insurers will not only need to enhance their cost containment programs but they will also be required to communicate the results of these programs to their customers. This is an area where health actuaries can assist the effort by designing statistical reporting systems and assessing the implications of the statistical results such that savings can be shown as direct premium rate reductions. This is probably the most effective way of demonstrating to groups the success of cost containment activities. Insurers that have taken this initiative and have shown cost containment savings in their renewal rating presentations have, by and large, been more successful in retaining their group customers.

Often when an insurer becomes really serious about its cost containment efforts, it also becomes more aggressive in its underwriting and contractual administration efforts. Both of these areas have significant cost implications and, in many instances where procedures have been lax or ineffective in the past, these activities have immediate potential to reduce health care expenditures. For example, in the area of more effective underwriting, tighter rules on medical underwriting and pre-existing condition exclusions can screen out claims at the front-end of the process which are essentially non-insurable risks. Stronger or more rigid enforcement of enrollment participation requirements can also lead to more cost effective benefit payouts by reducing the member's control over his own utilization.

There are several areas where most insurers can reduce their benefit costs through more effective enforcement of contractual provisions included in their policies. Provisions related to coordination of benefits, subrogation, benefit reimbursement limitations, claim submission time limits, and definition of medical necessities, all have significant claim cost implications. Effective administration of these items are a necessity for any good cost containment program. These are also areas where results can more easily be quantified. Coordination of benefits, for example, has been reported by some insurers to save as much as 8-10% of total benefit costs. Similarly, provider reimbursement reasonable and customary limitations can oftentimes be shown to save considerable benefit costs.

Closely tied to more effective enforcement of contractual provisions within the claim adjudication system are those utilization review activities directed at provider practices and actual procedure utilization review. Direct reviews of provider income levels, frequency of services, average charge amounts, average number of patients, and average number of services in relation to standards or norms for similar providers can often highlight areas of abusive utilization. Laboratory services is a typical example of where providers can attempt to take

advantage of an insurer. A claim that was recently brought to my attention by one of our clients showed charges of $385 for lab services. After reviewing this claim as a potential abusive utilization, it was found that the actual lab bill payable by the physician for these services was $25.50. It should be noted here that this was not an isolated example and further investigation showed that considerable overpayments had been made in past years in similar situations. There are many other examples like this that could be brought up that all point toward the need to review what actually should be paid before you pay for it. While this really is not a new idea, it is an important aspect of any cost containment program.

In summary, then, I would like to point out the importance in a cost containment program of going back to some of the basic elements of insurance, these being more effective underwriting and benefit administration. Closely linked to these activities is the need to quantify any perceived cost reduction and to communicate these savings to groups such that they realize the direct reductions to their premium rates.

MR. MILES: I will open it up at this time for questions and comments from the floor. If you are presently associated with a company that is doing something actively in a cost containment area we would appreciate hearing what you are doing and what you perceive the effects or ramifications have been.

MR. GREGORY W. PARKER: Mr. Axene, in your presentation you mentioned that the hospital admission review was being proceduralized. How do the hospitals react? Were they willing to go along?

MR. AXENE: So far this has been working quite well. What they have done is rented a room in the hospital that they are using as an informational place. The hospitals obviously do not want to lose revenues but then on the other hand they do not want to be stuck with bills that someone is not going to pay either, so they are happy for it basically. It's fair to say though in the Northwest there are significant hospital commission activities and all kinds of regulations on hospitals already, so the hospitals are accustomed to big brother looking over their shoulders.

MR. PETER B. HUTZEL: We work with client corporations trying to encourage them to take a more active role in cost containment and, frankly, it is amazing how weak the response has been considering that these employers, almost all of whom are self-insured or close to self-insured, are footing the bill. There is a lack of interest on their part in cost containment. Part of the problem is that the benefit managers, in general, see their role in the company as producing rows and rows of happy employees. They are terrified of the situation of having one unhappy employee because a claim, valid or not, is denied and that is the greatest obstacle to encourage cost containment. The benefit managers at our clients are really not behind it.

MR. MILES: Does the fact that a plan is union negotiated contribute to any of the problems you have mentioned?

MR. HUTZEL: No, very few of them are negotiated. The negotiated ones, yes you do have an issue if you do something that is really not part of the contract or could actually violate the contract. Many of the things that could involve cost containment would not effect a negotiation. Obviously if you would want to change the deductible or a co-insurance you would have a problem.

MR. MILES: Do you have any method that you are using to coerce managers or whoever to change?

MR. HUTZEL: Frankly no. We have taken the position of simply going to each of them and saying "look, this service is available, it will save you money". We have even made some of the services available on a free basis and found a very weak response. We provide a communication packet; an audiovisual service which you can show your employees, it explains to them why the individual employee should be concerned about cost containment. The fact that it ultimately affects him directly or indirectly. No more than a quarter of our clients have gone to the trouble of showing that audiovisual to their employees.

MR. AXENE: That is real interesting. Most of the major corporations that I work with are in the Northwest. They are timber industry type clients and their financial statements are such that they are concerned with anything that they can cutback. They are probably the most aggressive people I have ever talked to about cost containment. It would be interesting to compare the profitability of the companies you work with.

MR. WILLIAM E. BROOKS: When you are talking about the bonus paid to patients, when they either use outpatient services or get out of the hospital earlier than anticipated, is there any tax implication on the bonus paid to these people?

MR. AXENE: I am not sure about that; the bonuses that I am familiar with are actually the waiving of co-insurance provisions, and it specifically states that as a policy provision. I do not think that there are any tax implications when it is in that form. If it was in the form of cash that came back you might have some tax consequences.

MR. BROOKS: When you were talking about usual and reasonable profiles that many of the companies use, they basically cutback very few claims. Do you have any feel on what percent of the claims actually have any cutbacks?

MR. AXENE: The clients that we work with are typically setting their profiles between the 80th and 95th percentile, so hopefully there is between 5-20% cutback by doing their job right.

MR. MILES: A company that I know of started a program where groups that are associated with them as true groups, and these are not the super jumbo groups but usually in the neighborhood of 100-250 lives, were offered free of charge or free of an identified charge the Health Hazard Appraisal. It is a consumer awareness questionnaire that asks health and habits type questions. It then sets up your age based on those parameters and identifies for you what age you could attain if you stopped smoking, stopped drinking, or wear your seatbelt, etc. It is not something that you can really measure the effect of right away but the groups that have participated in it so far have given a very warm response to it. The company is continuing to do it feeling that it is a way in the long term to control claim costs. The cost of the questionnaire to the company is minimal, depending on the size of the group, but it could be as low as $5.00 per person.

Has anybody had any experience with underwriting the applicant based on income and then restricting the deductible that they could purchase based on that income level? I heard there were a few companies that had tried it on a group basis but what happened was they were being sold supplementary coverages to fill in that gap so it really did not accomplish anything.

Does anybody change their commission scale to encourage the sale of different types of plans? For example if you sell a $500 deductible plan, does it pay a comparable commission to a $100 deductible plan, or is it just a percentage of the premium?

MR. JAMES L. TILLOTSON: You mentioned the PAS average length of stay. Are these statistics generally available to other carriers?

MR. AXENE: Yes, they are published out of some commission (CHCA out of Chicago) on health activities and they are regionalized, they are by diagnosis, they are by age, they are by all kinds of things by percentile.

MR. TILLOTSON: Do you know of any major carrier invoking their current reasonable and customary language for hospital stays? For instance, if you have an eight day stay that is normally a four day stay can you cut this charge?

MR. AXENE: If the contracts are worded appropriately and if you have a formalized way of doing it, I see no reason why you cannot.

MR. TILLOTSON: Do you know of particular carriers that are doing this?

MR. AXENE: Yes, very few, but yes.