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EXTERNAL INFLUENCES ON HEALTH INSURANCE (U.S.)

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A panel discussion of the U.S. federal health policy scene.

- Legislative and regulatory issues :
  - Competition or regulation?
  - Health insurance for the unemployed
  - DRG prospective pricing for Medicare

- Economic influences:
  - Financing the care of the non-paying patient
  - Cost shifting
  - Cost-effective interventions

MR. RICHARD J. MELLMAN: We're going to be discussing some of the national health policy issues in the United States and the impact of these issues on the private health insurance business. Too often I believe those of us who are actuaries or in the insurance business tend to regard these problems from an insular point of view whereas in fact there are many players from many different parts of society who play an extremely important part. I would hope that we can open up a dialogue here this morning and get some discussion going as to how our panelists see these issues and how they see our roles and what we might do to strengthen and improve our roles.

Our panel consists of three gentlemen we've imported from the neighboring state of Washington. Dr. Gilbert Omenn first became known to me when he was on President Jimmy Carter's domestic staff as a science advisor with a strong interest in health matters. Dr. Omenn, since graduating from Medical School, has had a most exciting career. Much of that time he's been connected with the University of Washington where he presently is the Dean of the School of Public Health. He has combined the fields of medicine and genetics. He has a Ph.D as well as an M.D. and his career has taken him to many places where he has had research fellow type of assignments. It would take several minutes just to recite these

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assignments. But let me just list some of them. He's been with the Atomic Energy Commission and with Brookhaven Laboratories out on Long Island; he's been at Woods Hole, at the Weizmann Institute in Israel, and at the Brookings Institute in Washington; he was a Woodrow Wilson Scholar at Princeton University, and he's been back in Seattle for a year and a half now.

Our second panelist is Gerald Reilly from Olympia, Washington, who is the Director of the State Medicaid program. I first became acquainted with Gerry Reilly when he held a similar position in the State of New Jersey some years ago. Mr. Reilly has a reputation as a most competent and able administrator of Social Services programs. Gerry has a Masters Degree from the Wharton School.

Next is Dr. Richard Tompkins, the Executive Director of the Public Health Hospital in Seattle. Since graduating from the University of Colorado Medical School almost 20 years ago, Dr. Tompkins' career had taken him to Cleveland, to Dartmouth Medical School and now to Seattle where he's been affiliated with the Public Health movement. He also has a professorial relationship with the University of Washington Medical School and School of Public Health. He is a spokesman in the Congress for the National Association of Public Hospitals. This association is an organization which I believe is a strong natural ally of the private insurance business in opposing the governmental cost-shifting that we now see.

HEALTH INSURANCE FOR THE UNEMPLOYED

So, welcome to our panel. We hope to get an exciting, informal exchange going. Let's start with a topic which is very timely right now. In fact, it made the New York Times just yesterday. The subject is health insurance for the unemployed. As you know, many people in the United States have been laid off in the last year or two. The Congress is giving a great deal of attention to the fact that many of these folks lose their health insurance when their employment relationship terminates. We have bills in both the House of Representatives and the Senate and we have an administration position. They represent three different basic positions. Who will lead off on this one?

DR. GILBERT S. OMENN: We have a peculiar situation in Washington, D.C. politically. We have an administration which has promised that both inflation and unemployment would go away. It's called the Laffer curve. You can make any pun out of that you wish. Belatedly, the Congress and the administration are trying to respond to significant pressures from individuals and from their unions and to some extent from employers. What exists right now is a bill in the House which is estimated to cost $5 billion to $7 billion per year and a bill in the Senate Finance Committee which would cost less than $2 billion per year. Just exactly how people would be eligible, how it would be structured, how it would be financed, what the effects would be on cost shifts how people would be defined as unemployed, and more importantly, how people would be defined as being no longer unemployed all have yet to be worked out. The basic problem is that we still don't have a strategy in this country for dealing with people who are not covered under any of the private insurance or public health

insurance programs. There's little equity in saying that people who have recently been well-paid, employed breadwinners should have priority over those who have no health insurance coverage at all and are disabled or otherwise not employed and not earning, whose assets may be considerably less, whose health needs may be greater, and yet would not be touched by this special legislation. Those people are generally considered to have little political oomph and that's why they're being neglected in the present debate.

My own judgment is that despite all the hooplah, there's a low probability that this legislation will pass. The reason being that the administration is embarrassed, that they have to come up with some special program when they expected the economy to recover; they continue to insist publicly that the economy is picking up just beautifully. It's not clear in either the House or the Senate, where some people are still concerned about deficits, where the money will come from and how long the program will be in place. I think it's quite clear from Congressman Waxman's point of view that this is a step to covering uncovered people in general and the writing of this action is an entitlement which will go on indefinitely. That is perfectly acceptable to the House Democrats. But it's not acceptable to the majority of the Senate Republicans. So you can see a likely impasse. I'll be quite surprised if they're able to hammer out a compromise which will lead to legislation in the next few weeks or months.

MR. GERALD J. REILLY: One other feature that you hear the staff of the Waxman Committee talk about is that they view this program as a counter-cyclical program. And it's so designed in terms of state matching requirements that as the economy improves and states have lower rates of unemployment, states would be required to participate to a greater extent in financing the program. The dilemma for people looking at this program, if they are interested in the long-term goal of universal coverage of an adequate nature for all people, is that there are many serious problems, which Gil has already pointed out, in terms of equity for the covered groups. The issue is, do you take what you can get at the political moment and put it in place and then wait for another moment to address the remaining uncovered groups? That's been the pattern with Medicare being enacted Medicaid being an afterthought, and then basically a long hiatus with some changes in Medicaid to open up eligibility. Another notion that has surfaced again in the Congress is the CHAP program, Child Health Assurance Program. This program was designed to provide coverage for all low-income children. So there is a dilemma for people interested in public policy. It's not perfect. There are many shortcomings. But is it the best possible solution in the short-term? Is it worth pushing? Gil may be right that it won't happen. But the people I talk to seem to feel that it is going to happen and tell us to get ready to administer it in October.

Therein lies another problem. As a person responsible for an administrative agency, I'm concerned this program is going to be extremely difficult to administer because it will require the Employment Security agency to make the basic eligibility determination and the Medicaid agency to pay the bills and design the service package. It's always difficult when you have two agencies involved, particularly in that Employment Security agencies are typically outside of the umbrella Social Service agencies.

A second issue is that the "unemployment health benefit" would be the payer of last resort. And that would require every potentially eligible person to be reviewed by the Welfare agency to see whether they're eligible for Medicaid. So the point of having Employment Security do it to spare people the indignity of having to go to the welfare system is somewhat lost because they're going to have to come there anyway. It's just going to add a convolution to the process. It will be administratively difficult to operate but if it comes I think the states will pick it up and, with some growing pains, handle it.

DR. RICHARD K. TOMPKINS: I'm going to take the position of a special interest group. Gil can be the diplomat and the person who works at a national policy level. Gerry is sitting next to me and is giving you the bureaucratic standpoint. And I'd like to respond from the standpoint of an institution that is suffering the most itself (not to mention its patients) from the problems that the recession is bringing on. Let me just give you some idea of what's going on.

There exists in this country basically a last line of defense for people who need health care and can't pay for it. It is the public hospitals of this nation. I happen to be the Executive Director of one such. There are many more in the state of Washington and hundreds across the country. But these are institutions that either belong to agencies of government or have a mission that requires them to take care of people regardless of whether they can pay. Basically, we do not do wallet biopsies before you get in to see the doctor. Your insurance coverage or your ability to come up with hard, cold cash is not supposed to be a determinate in your ability to get the care that you need at these institutions. And what's happening to all of us is that we're finding ourselves pushed deeper and deeper into a hole.

Several things are impinging on public hospitals. The first is the recession. As the recession goes on longer and more people become unemployed, more people lose their health care benefits. Consequently, these people have no mechanism for getting the health care they need. The second is that people, once they've lost their health insurance and have to begin to pay out of pocket, tend to wait until the last minute to get anything that they need. A lot of people probably don't need the health care that they get when they're insured but certainly after they've lost their insurance coverage and their economic situation has changed, when they come to us they usually have waited past the point that was good for them. So they show up a lot sicker. And when they show up a lot sicker and they've been unemployed for months and months and months, maybe even lost their unemployment benefits and they haven't had insurance for that time period, the chances are overwhelming that they're not going to be able to pay their bills. As a result, we see a rising bad debt charity care figure in our revenue stream.

To give you an example of the magnitude in 1982, my institution had an overall operating budget of about $25 million and we and our physicians gave away $3.5 million worth of charity care. We're looking at a probable rise of that to $4.5 million this year. In our current revenue budget, that's over 12% of our revenues for uncompensated care. And that doesn't include the deductions from revenue that the state Medicaid Agency imposes

by their attempts to cut costs. So not only are there more unemployed people who have lost their insurance (and many of those unemployed are moving towards the poverty line) but also all the governmental agencies are attempting to cut costs. And the health insurance industry and the purchasers of health insurance are beginning to realize that they've been picking up the tab for years through the phenomenon of cost shifting as the governmental agencies cut back on costs. As Medicaid or Medicare cut down on the percentage of the actual costs they pay, hospitals like mine and everywhere else say that's fine, somebody's got to pay. We pass the costs on to the people who have private insurance, which is then passed on to the purchasers in the form of increased premiums. And that's getting worse and worse and the purchasers are beginning to scream because health insurance premiums are now such a large component of their total benefit package. So there's this enormous amalgamation of forces that is attempting to drive down basically how much individual purchasers spend on health care.

Medicare is trying to do this. The new Medicare program is really a cost reduction program. Medicaid agencies across the country, as the Federal budget is cut and as state revenues decrease with the recession, are cutting back on their benefits. And more and more people are becoming unemployed and they're showing up at the public hospitals and so therefore there are more people who are self-pay patients, fewer people who are full-pay patients, fewer patients to whom to cost-shift, and the hospitals are beginning to see a rising bad debt.

So speaking from the standpoint of the providers of care (especially those of last resort, the public hospitals), there exists a need for a policy to deal with the patients who have no health insurance. Despite all the problems that clearly exist in a national policy that's inequitable, it's absolutely essential that some at least regional if not national policy be implemented. I would much prefer as Gil would to see this addressed as an issue that deals with the 20, 25 to 30 million people across this country who don't have insurance who need some kind of health care benefit. If push comes down to shove, I'd just as soon that we dealt with at least a portion of them at this stage of the game and move on because the argument of national health insurance and those 25 million people is going to stretch on and on. So from the standpoint of a provider out there, something has to be done for us. And I'm not sure if the Waxman Bill or the Dole Bill is the answer to this, but they're clearly better than nothing at this point. And we are very much in favor of seeing some action taken as quickly as possible.

COST SHIFTING

MR. REILLY: We're supposed to get to it later in the agenda, but in my view the cost shift is largely a shibboleth invented by the insurance industry.

DR. TOMPKINS: At least you didn't say public hospitals Gerry.

MR. REILLY: Well, we'll go to it later. The cost shift argument is also bought in by the public hospitals and others because it sounds good and it's helpful to their position.

MR. MELLMAN: Thank you for throwing it into the fan Gerry. From the point of view of those of us in the private insurance industry, there are some aspects to this question of health insurance for the unemployed that perhaps actuaries understand better than the Congress or the general public. And I'd like to mention those and perhaps we can get some discusssion going on them, too.

Marty Dickler is in our audience today. Marty is the actuary for the Health Insurance Association of America. He has been doing a lot of work on this subject trying to price the proposals. I know from working with him that one of the difficulties is you can't simply count the number of people who have been laid off and say that that is the number of people who have lost their health insurance. Because some of the stronger unions such as the UAW continue health insurance for up to two years with the premiums being paid by the employer or the union treasury. Whereas many other people lose their coverage almost immediately when they leave employment. Now even though group policies may contain conversion provisions, it's not too good an answer to tell somebody who's without wages that you can continue this insurance on payment of the entire premium by yourself at a time when that person has no income, particularly if that person's employer had been paying 100% or 90% of the cost up to that point. Also, we have a great many second wage earners in the country and when one loses his/her job the other may very well be able to continue coverage on the entire family. So it's very difficult to figure out how many people we're talking about and to put a price tag on it.

Second is the phenomenon of adverse selection. Many people in the economist fraternity tend to think of health insurance as a typical good and service like a loaf of bread or an automobile where there is a fixed price which is the same to all comers. We know that the reason group health insurance works is because typically the employer contributes so much of the premium that enrollment is attractive even to the people in good health who don't expect to use the benefits much. But when you tell people that it's up to them to pay the full cost and particularly in the case of people who have no jobs and no income, only the people who have somebody in their family in extremely poor health where they expect to have big medical bills are going to sign up. And so the premium for that group is just going to be out of sight compared with what a self-supporting premium would otherwise be if everybody enrolled.

Many of these bills do not address the question of who will finance it? If the government would pay for it from tax revenues and cover everybody, that would be one thing. If the employer would continue the coverage, that would be something else. It makes little sense to put the burden on the employer who has laid everyone off, because he may be in such a precarious financial position that he can't afford it. And of course the employers who have stable employment may not be interested in picking up the cost of this for their competitor who's going bankrupt. And so the bills are not terribly specific about whether the individual, the employer, all employers, or tax revenues will pay.

The third aspect is the cost shift. And I would like to ask Dr. Tompkins a question on this. One of the last catchall nets in this is the Hill-Burton program.

The Hill-Burton program says that hospitals have an obligation to provide a certain amount of free care. Some of us have difficulty understanding this because we are reminded of the old tinstaafl saying: there is no such thing as a free lunch. And perhaps free care means that you're actually shifting costs, so that the people with private insurance are paying for it. A second aspect of this is our impression that the public hospitals, as you mentioned, have a larger percentage of bad debts than the hospitals located in the more affluent suburbs that don't serve the inner city and that deal with a population which is largely insured.

In your resume you said that your hospital is run by a 15-member council which is responsible for all hospital operations and for continuing services previously available under federal sponsorship. The hospital is self-supporting and independent of all government subsidies for operations. Now, my impression is that most public hospitals do get a lot of money from government. If you are independent of that subsidy, how do you do it?

UNCOMPENSATED CARE

DR. TOMPKINS: You've asked a whole batch of questions. Let me try to give a little background. First, regarding the uncompensated care issue, I'm going to be very provincial and deal with a single area. I think sometimes looking at the situation in one city or one region can clarify some of the trends that are going on perhaps better than when you look at it nationally. Let me talk a little bit about Seattle in which three of the seven major hospitals contributed over 6% of their revenues to charity care and most importantly, those three hospitals provide 69% of the total charity care in Seattle. The private hospitals' contribution on the other hand ranges from less than 1% up to maybe about 3% of the revenues in the charity care. So there's a very disproportionate amount of charity care provided by a small number of institutions. Those institutions are either public institutions in the sense that they're owned by a municipality or a state or they are institutions like Children's Orthopedic Hospital. (Such institutions have as part of their fundamental mission a provision of care to everybody and they try to compensate for that not only by cost shifting but also by raising revenues through a variety of other mechanisms, not the least of which is philanthropy.) Very few public hospitals in this country are really self-supporting, but many nonpublic hospitals provide large amounts of charity care. And so you shouldn't assume that the hospitals that are bearing a large part of the burden are necessarily public although realistically, the statistics show that the public hospitals do more than anybody else.

Most public hospitals, with the exception of mine, do receive tax funds. But what's happened over the last several years is that the amount of revenue that's provided through the tax base has been going down dramatically. California is the best example in which there have been wholesale closures and divestments effectively of the public hospitals as a result of Proposition 13. Both local municipalities as well as state government are unable to support the institutions and are divesting themselves of them, frequently either closing them down or turning them over to private parties who then run them as if they are private hospitals. And in the process of

doing that they start diminishing enormously the amount of uncompensated care that they're willing to take. As a matter of fact, they also started diminishing the amount of government subsidized care that they'll take because it never pays fully for its cost. So people are being left out by whatever vehicle, either closure or transfer.

In an institution like ours, even though we are publicly chartered by the City of Seattle (but entirely independent in an operational sense) and we have an agreement that we'll be self-sufficient, we do cost shift. Let there be no doubt whatsoever about that. Washington State has a hospital rate setting commission which is part of the rate setting process. This rating process includes the amount of dollars that go into charity care, or bad debt, as an allowable cost in setting the rates.

A large chunk of our patients are beneficiaries of the Defense Department and military retirees and their families, and our contract with the Defense Department allows the rates that are set by the hospital commission to be passed on to the Defense Department. So the irony of all this is that while Mr. Reagan takes some money from HHS and gives it to the Defense Department, we take a little bit of it back out in Seattle to try to pay for the care not only of the Defense Department people but also, because hospital rates include charity care as an allowable cost, to provide for the care of some of the poor. Now the fact of the matter is that if we didn't have basically a full payer that comprises such a significant chunk of our patient population, we wouldn't be able to hack the amount of charity care that we provide. As a matter of fact, we're probably butting up against the limit.

Despite the fact that we're butting up against the limit, as we look back over the trend in the last few months in our institution, the percentage of unemployed people who are showing up as new patients in our institution is going up precipitously. About 35% of our new patients are unemployed. I shouldn't say unemployed. They're self-payers. They're uninsured. We don't know whether they're unemployed or not. They don't have any health care coverage and they will pay only a fraction of their total cost. And somewhere along the line, we're going to be faced with the very difficult position of having either to cut back on the amount of care that we provide, which is contrary both to our philosophical principles as well as to our mission, or we're going to have to ask somebody else to help shoulder it. And at that point it will be a tax burden.

The State of Washington is basically bankrupt. I doubt seriously that auditing expenditure dollars to support public hospitals is terribly appealing to the state. The City of Seattle is already putting a fair amount of dough into providing care for uninsured people. A policy decision was made that I endorse which is to put those dollars into primary care in the community and hopefully keep people out of hospitals. I would be very reluctant to see those dollars shifted to concentrate on hospital inpatient care.

We face a real dilemma. And we are not in a position in which we can do much about it at the local level. It requires either state, regional or national action. Now the Hill-Burton issue is something that is certainly

a vehicle available to force private hospitals into doing their fair share. But it hasn't been very effective and it's also up for renewal.

The hospitals sort of determine when they cut off the charity care. And most of them get to their level of charity care very early in the year and don't do much more than that.

MR. MELLMAN: At this point we'd welcome comments and questions from the floor.

MR. MARTIN DICKLER: I would like to ask Mr. Reilly to expand on why he thinks the cost shift issue is not really there.

MR. REILLY: If you go back prior to 1965, there was a larger pool of unsponsored patients. There was no Medicare, there was no Medicaid. There were some small federal program and it had been traditional for the insurance industry and then private payers to take some percentage of their revenues to be diverted to people who couldn't pay. So if you envision a large circle of unsponsored care in pre-1965, what you have in 1982, is a smaller circle in percentage terms of unsponsored care because Medicaid and Medicare have come in and picked up much of that burden. So during that era, the cost shifted from the private insurers to the government. At the same time, the expense for that smaller circle of uncovered people, unsponsored patients, has become a large circle as health care costs have escalated to the point that the insurance industry has begun to feel the pain of paying more and more of their premium dollars for unsponsored patients. The government has not in any large-scale way withdrawn from covering the people that public policy chose to cover. What has happened is the unsponsored pool has gotten more expensive so that what we have is not a cost shift. What we have is the government failing to expand its coverage into that unsponsored pool. Now the insurance industry has characterized it as a shift. It's not. It's the fact that the government has simply not made the next sequential choices to cover more people.

The other part of the shibboleth is that Medicare and Medicaid do not cover their costs. They do. Medicaid in Washington State pays every cent of what it costs to care for a Medicaid patient. What we don't pay for is charity and bad debts. Because the public policy is that we're to pay for our patients. We are not to share in the unsponsored care. If we're going to share in the unsponsored care, the way to do it is directly and expand our coverage, our eligibility. So we pay our full cost. We don't pay capital sinking fund but we do pay capital costs as they're amortized and we don't pay charity and bad debts. But if it costs a hospital $245 hard cost to care for a Medicaid patient today, we're going to pay $245. And with some minor aberrations that were settled in courts, we haven't discounted what we pay. What we discount from is the higher revenue that takes into account bad debt and charity. So that in my view the cost shift is a shibboleth. But most public policy gets made on perceptions anyway. Sometimes deep analysis tends to frustrate policy change because you get all sides of the issue and nothing happens. And HIAA has done a rather clever job of marketing this concept of cost shift.

MR. DICKLER: Well what I hear you saying is that the government has a payoff for a certain section of the people, but is not shouldering its fair share of the charity care incurred by those with no insurance.

MR. REILLY: Government has not made the public policy choice to begin to cover more and more of the population.

MR. DICKLER: This is creating a drain on the public sector.

MR. REILLY: No question. The consequences are the same either way. But the policy choice that has to be faced is whether the Congress and the states collectively want to bring more and more people into the governmentally sponsored pool. I think they should. To characterize it as a shift is a clever marketing term but it's not real.

MR. DICKLER: Well the truth by any other name costs the private industry quite a bit of money.

MR. MELLMAN: I'm not sure that we're going to convince each other. The important point is that we understand it. Take a look at any another business, such as a department store or grocery. Take a grocery store for example. You're the grocer and you're selling eggs. If you sell a dozen eggs to each customer for what the cost of 12 is, you will go broke. Because a certain number of eggs will fall on the floor and crack, a certain number of eggs will spoil by virtue of not being sold promptly, and a certain number of eggs will disappear because of shoplifters. And so you, the grocer, come to me and say that you're going to charge me for 13 eggs. If I refuse to pay because I didn't steal any or drop any on the floor, you're going to go bankrupt. I believe that principle is recognized in all businesses except the medical care, business.

I grant you that the government is in a somewhat different position because if we didn't have Medicaid, those people wouldn't be able to afford coverage and they would all be bad debts as they were in 1965 and prior. However, two things have happened since 1965. First, we have promised these poor people that they now have access to medical care. It's a matter of right and they're not dependent upon doctors charity. And secondly, I don't believe that government has fully lived up to its commitment because as inflation has continued, most states have not kept pace with the indexing of the income limit that makes you eligible for Medicaid. So if we look at these 20 or 25 million people who are without coverage, sure there are a lot of them working whose employers don't provide health insurance or who didn't choose to enroll or whatever. But an awful lot of them are poor people who have not been made eligible under state programs.

MR. REILLY: Well that's a very excellent point. To the extent that public assistance levels have not kept up with inflation you have had a diseligibility creep, where people who would have otherwise been eligible have slipped out of eligibility. That's particularly true in states that don't have medically needy programs; about 17 states don't. So I would concede to that part of it that there has been a shifting. But it hasn't been an overt policy and the shift is not a consequence of Medicare and Medicaid not paying their fair costs. It's a consequence of their not covering all

the people who have need. And that's really a policy choice for the Congress to make. I'm sympathetic to their making it. I would like us to cover those people who are in need. And I believe we can afford it.

MR. MELLMAN: There is a second aspect to this question which, in an audience composed of actuaries, we sometimes tend not to get into. And that is that to the extent that government doesn't pay its share of bad debts and the bad debts have to be recovered from the private insurers, sometimes not all the private insurers share. So in states where Blue Cross also has a cost reimbursement contract, this load falls completely upon the commercial insurers, self-insurers, HMOs and so forth. There are many states, such as the State of Washington, in which Blue Cross pays on a comparable basis to commercial insurers. In these states the burden is at least spread across private insurers.

MR. REILLY: But again, the solution is not for the government to share in bad debts because then the government would be in a slipshod way moving into universal coverage without the appropriate system to make sure the people were getting a sensible basket of services. The way for government to deal with it is to expand the pool of sponsored care, to cover more people with a sensible and adequate program, and not to share in bad debts.

DR. TOMPKINS: Gerry what you're saying is that the government should help us eliminate all bad debts and then it would be paying its fair share of costs. But the fact of the matter is that government also doesn't quite pay for the required long-term capital improvements that are necessary to keep institutions going. So you'd also have to add that in. I think in states which have hospital rate commissions and which attempt to deal with what allowable costs are on a rational basis, it makes much more sense to have everybody paying their fair share of the total costs (hopefully with government reducing charity care and bad debt down to nothing). But that's never going to happen. There's always going to be charity care and bad debt.

DR. OMENN: I think the government has paid more than its fair share of capital improvement, capital expansion.

MR. REILLY: The problem with that is if you simply share in the bad debts, we'll pick up the people when they get acutely ill and they come to your hospital and you have to care for them. We'll pay our share of that care. If you bring them into a program of care where they get the appropriate ambulatory benefits, the appropriate preventive benefits, the proper prenatal care, and the proper care for children, we can make the whole system less expensive and more efficient by applying the resources at the proper end of the spectrum. If we simply slip into sharing in your bad debts, we're going to help you catch the people who have the acute episode. And that's going to be more costly in the long-run.

MR. MELLMAN: It's interesting how all these things interrelate. Gerry is making the very good point that the solution to the bad debt problem is filling the gaps for the people who have no coverage of which health insurance for the unemployed is one manifestation.

DR. TOMPKINS: I think Gerry is bringing up a really important issue which is the fact that the best way of dealing with cutting health care costs is to help people keep from getting sick. One of the major problems with the recession, from my standpoint, is that people are deferring treatment to the point where when they come in they're sicker and the cost of care is much higher. And then the dollar amount of the bad debt is much greater.

I don't have any problem whatsoever with Gerry's statement on the way to deal with the bad debt issue. Though he's really not addressing the bad debt issue, he's addressing access to adequate primary health care services and preventive services. He's suggesting a program which allows everybody access to these services. Unfortunately, the schizophrenia that exists at the policy level, both nationally and therefore at the states, is exactly contrary to that. The major cuts in the health budgets have gone to cutting the prevention programs that have had some major impacts on keeping people out of the hospitals. Maternal and infant care for instance is going down. As a result of these kinds of cuts, there are states that are showing for the first time in many years increases in the infant mortality rate. While government talks about prevention and costs of care needing to come down, it's doing exactly what it shouldn't be doing in the long-range sense which is preventing people from getting care before they get sick. And instead it's beginning to focus more and more of its dollars on the treatment of end stage disease and the treatment of people who probably will not benefit a lot from the coverage and spending more and more dollars in the process.

COMPETITION OR REGULATION

MR. DAVID AXENE: It's very interesting to hear this discussion. We heard one yesterday where insurance companies were frustrated not knowing how to control their profits and losses and now we're hearing basically that the federal government can't control it either. And I think that perhaps the underlying issue on this whole thing is that if we would encourage this primary care, can we do it on a cost-effective basis? And I maintain that until we have a delivery system that works with normal supply and demand economics, we have no hope of convincing the federal government to put money down a hole to pay for these people. And I think that if we went to the deeper issue of controlling the health care delivery system perhaps we might be able to convince the policy decisions to be made to run a more cost-effective system.

DR. TOMPKINS: You really could start a good argument on the supply and demand issue. I think that the issue of competition in making health care respond to supply and demand is exactly the wrong thing to do. The fact of the matter is that if the demand is controlled by physicians, demand becomes an issue when you become sick. And the competitive marketplace is going to have in my estimation one of the largest negative effects on the way health care is delivered in this country that we're ever going to see. Because it's very simple. If you deal with a competitive marketplace, you only do those things that pay for themselves. And the things that pay for themselves are frequently not the things that make the most sense medically. You're seeing it in California. You're going to see it across the country, in places where competition is becoming a major issue. Hospitals

are going to market those services for which there is a marketplace and they're going to eliminate those services for which there are not. Many of those services for which there is not a marketplace are the ones that are most desperately needed. I think you know the issue of competition is also a shibboleth because while the Reagan government is pushing competition, it's also putting on the health care industry the single largest regulatory system that anybody's ever dreamed up. This prospective pricing system is an immense regulatory system that's being disguised in the form of competition. But it has absolutely nothing to do with competition.

MR. REILLY: I think we know how to control health costs. We know what works. Let's have a rate commission. It's tough and reasonable. Let's try to have prospective pricing systems for hospitals. Let's have the HMO and the capitated care system grow. Let's figure out a way to motivate free-standing entrepreneurial oriented physicians to alter their behavior in ways that aren't radical. Let's not require them to go work for group health cooperatives but let them stay in place and change their incentive structures to help them keep people out of the hospital and we can cut 10% to 15% off the cost we now spend.

Washington State is an object lesson in that. Washington State spends 70% of the national average on inpatient hospitalization. Washington State spends a lot more than the national average on primary care. That goes back to the tradition in Washington State of having physician bureaus which had a financial stake in keeping people out of the hospital, because those bureaus had prepaid arrangements where primary care was prepaid and free once the premium was paid. We still have a problem with the rate of change in Washington State, but if the whole country operated as Washington State does, we'd be at 8% of the GNP and not 10.2%. So competition, pure market competition I think is a shibboleth. But change in some incentive structures is not a shibboleth and offers a lot of promise.

DR. OMENN: Ten years ago, last weekend, I was interviewed by a man named Robert Finch who had been Secretary of HEW under Nixon. In the course of the conversation he said, "you know we're going to fix you doctors. We will turn out enough doctors so that the prices will go down." I said there are at least two things wrong with that. Leaving aside the economic incentives that doctors can quite easily recognize, for the best of humanitarian reasons, doctors lacking other things to do to keep their days full will spread their reach. They'll deal with alcohol. They'll deal with nutrition counseling. They'll deal with fitness and health promotion. They'll deal with all kinds of things which they may or may not be well qualified for and for which their time is much more highly compensated than other people's time who might do it as well.

Secondly, even if the unit price goes down or the incomes of individual physicians rise less rapidly (in fact they are now rising less rapidly), the aggregate cost will balloon. The number of practicing physicians in this country in 1975 was 376,000; and projected for 1985 is 525,000. And most of that increase in that 10 year period is just coming on-line. Because you know how long a training period is when you start increasing the first year medical school class size. When I finished medical school, 18 years ago, there were 8,700 graduates per year in this country from 87

medical schools. Now there are 126 medical schools with 17,000 graduates per year. Figure it out.

MR. MELLMAN: And that doesn't count the ones in Mexico?

DR. OMENN: Right, or the Caribbean.

MR. MELLMAN: This is Roemer's Second Law. Roemer's First Law you know says a hospital bed built is a hospital bed "filt." Roemer's Second Law says the more doctors, the more doctoring.

HOSPITAL PROSPECTIVE PRICING AND DRG

At this point we're moving very naturally into another main subject in our program, Prospective Pricing. Let me define what it is and perhaps we can focus on it. First, the government has just enacted a law which establishes a prospective pricing system for Medicare patients. Much of the debate in the Congress in the last few months on this bill (which moved very rapidly to enactment) was whether it should apply to all payers. It's based on DRG (diagnosis related groupings), as is the system now in effect in the state of New Jersey, although the federal and the New Jersey programs are quite dissimilar. There is also a provision in this law for more state waivers for state programs, state rate-setting programs which apply to all payers under which the federal government does agree that it will pay according to the state rules (which is the sort of thing Gerry Reilly was talking about). We have four waivers at the present time, New Jersey and Maryland and coming on-line Massachusetts and New York, under which the federal government and the state program for Medicaid have agreed that they will pay according to the state's rules, that bad debts will be a valid element of cost, and so forth. This new law permits 50 such programs if they meet certain criteria. And finally, the third part of the broad subject is are we moving toward some sort of a prospective pricing system, perhaps a DRG system for physicians in addition to such a system for hospitals.

DR. OMENN: First of all, how many of you are aware of this DRG business and of the action of Congress in changing the payment system for Medicare? (Majority of audience raised hands.) Oh very good. There's a magazine called the National Journal which has a good political summary of the action taken in its April 2, 1983, issue. It's titled "Who Says Congress Can't Move Fast? Just Ask Hospitals About Medicare." Remember a few months ago when the compromise was struck on what to do about Social Security? That was supposed to be passed by the Congress with nothing attached to it. It was a veto-proof bill and they didn't want anything else added to it. Surprisingly enough, in a very short period, this DRG prospective pricing plan was hammered out by the committees of the two Houses of Congress, and passed overwhelmingly as part of the Social Security legislation. The reason it moved so fast was some previous legislation, namely the Tax Equity Reform and Fiscal Responsibility Act of 1982, which introduced substantial potential penalties beginning in 1984 for hospitals whose costs and reimbursed costs were above the norms in a variety of categories. Hospitals facing those prospects were looking for some hopefully more workable, possibly more equitable system and went along quite readily with this scheme for DRGs.

The history of this goes back many years. It's been in place as a demonstration project in New Jersey and without too much serious complaint; although you do hear a lot of different stories from different people. The way it is in New Jersey and the way it will work here is that a confinement is priced according to what the patient's diagnosis is. The way we do it now of course is to reimburse for all allowable costs. So the more you run up your costs, the more reimbursement you get. And that's a runaway cost situation which accounts for a large part of the reason why over the last decade hospital costs have been rising at 15% or so annually and at least 5% higher than general inflation. There are 467 diagnostic related categories: things like fractures of various kinds, appendectomy, different kinds of surgeries, and different kinds of medical treatment problems. Some take into account the severity of the illness and the complications of the patient. Further, there are corrections for age and other factors. All are efforts to be fair about what kind of a cost is appropriate for a definable group of patients, some of which are much more numerous than others, the number of patients per hospital per year. Most categories are large enough that the effects of any individual case would be averaged inadequately. Nevertheless, there is provision for outliers. If you are really stung by one patient or several patients who had extremely complicated courses, there are ways of getting corrections for those as well.

One of the important questions raised about the DRGs is whether they will save any money for Medicare. Because, as you all know and it's next on our agenda, the Medicare Health Insurance Fund is due to go bankrupt in this decade. It's the Social Security story all over again. And the reasons are pretty obvious. Revenues are down and costs are up above estimates. Every quarter for years now the costs have turned out to be higher than the actuarial estimates from the Social Security Administration. If there's any area in which you as actuaries could contribute a great deal, it's this whole business of the projections for Medicare and the analysis of the functions which contribute to the costs and the DRG scheme.

Specifically, the compromise that was developed is that there will be nine regions around the country. Not a national DRG rate but nine regional DRG rates in the first year. There will be urban and rural differential. There will be special treatment for teaching hospitals and public hospitals. Certain kinds of hospitals will be outside the system, that is rehabilitation hospitals, children's hospitals, psychiatric hospitals, and long-term care facilities, and will be phased in over three years. So that for the year beginning October 1, 1983, the reimbursement will be 75% still based on that hospital's own cost basis and 25% based on the DRG system, all regional rates. Next year it will be 50-50, then 75% DRG and then 100% DRG. And the DRG contribution itself will be split between the regional rate and the national rate so it will be 25% national, 50% national, 75% national and then 100% national. So it's phased in to be a national 100% DRG system in the fourth year, which begins 10-1-86.

We don't expect that there'll be any cost savings in this. The system in fact was set up in the calculations by the staffs of the two Congressional committees with the analyses being done by the Congressional Budget Office to be what's called budget neutral. So that effect should be a wash in

comparison with what would have occurred, under the changes introduced in the 1982 TEFRA. No further savings are anticipated.

There are many ways in which this could turn out to be quite costly. I have for example a substantial prospectus from a company that wants to do DRG financial modeling for hospitals. This is going to be a bonanza for consultants to hospitals. Because there are a zillion ways you can analyze: by DRG (there are 467 of those), by physician and by group of physicians (so that you can see which physicians for each and every DRG are running up costs higher than what the DRG allows), and by kinds of patients. And if you're not in a hospital of last resort situation as Dick Tompkins is, it's not beyond one's imagination to project that hospitals will decide that some patients are more easily served well within the DRG reimbursement rate than others. Furthermore, the hospitals may find ways to encourage people served least well to go elsewhere for their care.

All kinds of studies are mandated in this legislation, although the Secretary of HEW might prefer a mandate not to do any studies of any kind. The data are generally devalued. But there's a mandate here. And it's going to be managed not by the Department but by a new arm of the Office of Technology Assessment of the Congress to try to assess what really does go on and to try to figure out what kinds of shifts of these sorts can be detected. In New Jersey, as far as I can understand there has been very little evidence of manipulation to try to game the system for these kinds of advantages, in terms of volume adjustments or in terms of other shifts that could be made among patients. Perhaps that's because it was thought to be a demonstration that was adequately compensated and they didn't realize how much of a pacesetter they'd turn out to be. But others of you may have different views on that.

MR. REILLY: One concern that we have in Washington State concerns the fact that the system is a giant geographic pivot. While federal revenues (Medicare revenues) to Northeast hospitals will come down, in the West, in particularly the Northwest, they will increase. Our hospital association in cooperation with the California hospital association has been running some simulations of what this is going to mean to Washington State and they're all smiling. They're going to get enhanced revenue. Now I'm happy for the hospitals but I'm concerned because revenue tends to create expense. And I'm concerned that Medicaid is going to be tugged along in the wake of a hospital system in our state that will become more expensive by virtue of a glut of money coming in through the DRG system. And the other concern you have to have too is what's really going to happen in the Northeast when the consequences of this begin to become clear politically for these rather dramatic shifts of funds from that region of the country elsewhere.

The Washington State Hospital Commission has convened a meeting in Seattle of major purchasers and providers in the state to discuss whether Washington State should go for a waiver, where we would get off the DRG and go in with our own system with all payers participating. And the position of Medicaid is that we're interested in doing that. It may be that the hospitals will be reluctant to do that in the face of this revenue enhancement that's possible for them. We'll see if they can rise to the occasion of the common good. We'll know more in a week or so.

DR. OMENN: Where do the health insurers stand?

MR. REILLY: Well I think the health insurers will take a national perspective and will favor an all payer system, unless you have some health insurers that are local and only writing insurance in Washington State. These health insurers may be reluctant to participate in an all payer system because they see some relief in this Medicare money pouring in.

DR. TOMPKINS: Let me just give you an idea of the kinds of games a hospital can play. Gil referred to some of them in which it's really very easy to look at which patients bring you profit and which ones bring you loss. I also see the situation in which hospitals will monitor the actual costs of care very, very closely. When these hospitals start butting up against the Medicare reimbursable rate through the DRG, they will start discharging patients only to admit them to another hospital as part of their multi-institutional chain. They can then start the whole process all over again. So I think you're going to see a lot of not only cost shifting but probably patient shifting. That may be especially true in areas like California which have a lot of affiliations between hospitals. Not so much true in Washington State.

The other kind of thing that's likely to happen is that hospitals will begin to select not only the patients whose DRG best fits their economic incentives or the economic program that they have but more importantly will even work harder to eliminate those patients who don't have them. The Medicare market in Seattle for instance is going to be a very profitable market as Gerry pointed out. And to the extent that people try to appeal to those patients, they're going to probably be developing a lot of programs that will be in place and may very well generate more cost for everybody in the future. I think the incentives for the hospital administrator are very, very strong to not control costs so much but to try to direct costs such that they're handled appropriately.

On the positive side of the DRG issue, one thing that it is going to force and which if it works may be the most positive result from the whole issue is that it's going to force the physicians and the institutions (the hospitals) to work together much more closely. In the past, there's been a certain amount of tension between the physicians and those who run the hospitals. For the most part, hospitals have served like hotels, hotels for physicians, places where physicians can have the ultimate in new technology and amenities and as a result will admit their patients there. Hospitals do not market to patients; they market to doctors. Much of the cost increase over the years has been related to the fact that hospitals buy goodies, buy the latest high technology machines that doctors will use. The doctors will then bring their patients and therefore the hospital will do well economically. The DRG system is going to force much more interdependence between physicians and hospitals and is going to force the hospitals to get physicians to practice kind of medicine that the hospital sees as being appropriate for the economic incentives that are there. And indeed if that major tension between the two groups of providers is diminished, we may begin to move towards a more rational way of organizing health care. That may be an optimist's viewpoint, but hopefully we'll get results like that.

DR. OMENN: One fortuitous result of this phasing in, which is a political compromise, is that in the first year 75% of the reimbursement will be based upon the hospital's specific costs and only 25% on the DRGs. And then 50/50 the next year. So the hospitals have to make a balancing, some kind of optimization between increasing the costs for which they'll be reimbursed and cutting their costs relative to the DRG compensation, so that they end up with excess reimbursement. It's possible that those two factors will in fact lead to less gaming at the start than otherwise might have occurred.

MR. MELLMAN: In New Jersey, we have seen the sort of thing that Dr. Tompkins and Dr. Omenn have talked about. First,hospital administrative staff, boards of trustees, and full-time medical staff have found that their management role has been enhanced and growing because of the reverse in the customary incentives that the reimbursement systems produce. Now the administrators can put pressures on the attending physicians who have long stays, who perform all the tests in the book, who bring patients in on Saturday morning and let them lie there until Monday, because there is no additional remuneration coming in. And while it has been a bonanza for the consultants and the computer programmers to figure out how to optimize under the system, in my opinion there is not nearly so much gaming as under the previous system. With the previous system it didn't take a computer to figure out that if you brought the patient in on Friday night or Saturday morning or performed all the tests or kept them there an extra day or two that meant more money. The more things you did, the longer you kept them for, the longer you did them for, the more money.

I would like to return to one comment you made Gil. You said that you think the system will be neutral because it's designed to be budget neutral for the federal government. And as Gerry said, it will be a windfall for hospitals in the Northwest because of this giant pivot action. The places that hurt will be the high cost areas like the Northeast and I presume Southern California. We in the private insurance business are paranoid about this, we tend to fear that in the areas which are presently below average cost, this windfall will improve the balance sheets of the hospitals and only some of it will flow back in the form of not reduced charges but more slowly escalating charges than otherwise. Whereas in the above-average cost areas, it may not produce real economies but may just exacerbate the cost shift.

DR. TOMPKINS: We're going to get you both ways.

DR. OMENN: In fact in the Northeast, the most populous states, namely New York, New Jersey, and Massachusetts, are already operating under waiver systems. So that the proportion of the total cost to the Northeast which this pivot will work on is very substantially reduced. I think with the incentives that are present for all payer waivers and very clear instructions to HHS that if a state makes an adequate representation of its plan and meets rather easy criteria, they can get a waiver and do an all payers plan per the state. I suspect there will be considerable interest in that in the northeast states.

MR. REILLY: Perhaps we won't have a budget neutral result. We'll have a budget expansion because all the states who are disadvantaged will stampede to their own all payer system and the states who benefit will get on the DRG bandwagon and will have expense and no balancing.

MR. MELLMAN: I'm sure the Congress will be able to figure out a solution to that.

MR. REILLY: Not necessarily.

DR. OMENN: Judging by how well they've done on hospital cost containment over the last decade, I wouldn't be too confident.

PROSPECTIVE PRICING FOR PHYSICIANS

MR. MELLMAN: Could we get to another question, the possibility of a DRG for physicians?

DR. OMENN: There's no question that the next thing down the line is ambulatory care and physician payments. In fact there is so much ambulatory surgery now being organized, that it is truly a bottomless pit. In most good hospitals, the census is so high that it's very hard to get patients in for elective surgery. But in a surgicenter or doctor's office, there's no limit (especially if you have enough doctors looking around), for things to do, for the number of moles that can be taken off, the number of gallbladders that can be done electively, the number of more or less elective surgical procedures. And there have been discussions, where I've been present, among surgeons about how they feel worried about the quality of care in these kinds of settings. Because in a hospital, there's a pathology lab and there are other doctors are anesthetists and other specialists around. But in the surgicenter, especially in the individual doctor's operation, there's much less control over all the parameters, some of which are risky. And there's a very large population out there for whom procedures could be done if the patients are willing and the doctors are available. There are people working on systems now for DRGs for physicians.

DR. TOMPKINS: As I recall the current prospective pricing system legislation requires that the Secretary report back to Congress within two years about a mechanism that might be set up to include physician charges in a DRG based system. It's unclear to me whether that legislation means that the hospital based component of the physician charges really is going to look at overall costs which include outpatient setting in a DRG based system. That's going to be much more complicated primarily because the data systems that exist out there in the real world for ambulatory care are way behind the systems that exist in hospitals. And there are really very few places in which you can get an adequate database on ambulatory care to begin to figure out what the components of care are. In addition to which there are only 476 DRGs in hospitals. The things that bring patients into a doctor's office or into an outpatient clinic are vastly different from those DRGs and have a much larger spectrum, much of which is poorly defined at best because one thing that you do in outpatient care is you try to take care of the patient and not necessarily make a diagnosis. So there are a

lot of problems and symptoms that are treated without a very specific diagnosis being made. So it's going to be much more difficult on a methodologic basis to come up with that kind of a system. There is absolutely no question in my mind though that something is going to be developed to begin to deal with Part B of Medicare, with the physician cost component, if not in the ambulatory care area then certainly in the hospital. And that's imminent. It's just a question of how fast and whether people are willing to bite the political bullet to deal with it.

MR. REILLY: Isn't it kind of silly to try to develop DRGs for outpatient or primary care instead of simply getting more rigorous with the fee schedule? That would be a lot simpler. Simply decouple from the usual and customary concept and go to some "should cost" concept like Medicaid agencies do and price their outpatient procedures. They could save a lot of money without the razzle dazzle.

DR. OMENN: Both of your points are well taken. I think the fee structure for physicians is grotesquely irrational. Take coronary bypass surgery. We are still compensating that surgeon as though it were a heroic, one-time pioneering procedure. In most big hospitals it is more frequently done than appendectomies now. And it is sort of a regular, routine procedure. It isn't obvious to me that a cardiac surgeon should make $300,000 or $500,000 on fees per year and an excellent cardiologist or neurologist or pediatrician should make $50,000 to $80,000. What's the basis for that?

Blue Shield committees which set fees for physician compensation are generally dominated by surgeons. And it's an irony of the social structure of medicine and the professional social structure of medicine that internal medicine which includes a vast array of specialties is organized as one big field. In the medical and surgeon subspecialty society, internal medicine gets four seats. But the surgeons who have separate societies and the medical schools who have separate departments for urology and neurosurgery and cardiac surgery and gynecologic surgery and reconstructive surgery, they get 21 seats. Thus it's not too surprising from the above and a zillion other similar manifestations including the fact that surgeons are much more active politically, that surgeons can make their target incomes in fewer hours per week and are very much more highly remunerated per hour or per procedure or per thought than internists and pediatricians.

MR. REILLY: Our fee schedule is for medical assistance. We're paying about 45% to 50% of usual and customary for surgery and we're paying about 70% to 75% in primary care. And that's by design. But I've always wondered why we've never gotten a beef out of the surgeons. And now I understand; 50% is just fine.

MR. WILLIAM HSIAO: I'd like to comment on the DRG a bit. I think one thing perhaps has not been brought out. The DRG system as Dr. Omenn said, which has 467 categories, actually is heavily in favor of surgical procedures. Let's say you go into a hospital with an ulcer. If it's treated medically, that DRG category which reimburses you is one-fourth as much as if it was treated surgically. That's going to be one of the serious problems under the DRG system which I don't think many people are aware of. I think the comments criticizing DRG seem to have been premised

on the question: is this an optimum or the best system? And I don't think anybody's arguing that this is the best system. On the other hand, as Dick Mellman pointed out, is it better than our current system? For people like myself, looking at the current system it appears that the hospitals are given an open checkbook. As long as you do not commit fraud, if you can document that you have incurred the cost, we're going to pay for it. And the important aspect of DRG which I think may have been overlooked is the prospective payment system. Whether a prospective payment system in which the rate is set in advance, is based on DRG, a global or departmental budget, or whatever, may be more important than whether or not it's a DRG system. So I'd like to differentiate between what I see as two characteristics of the new system: it's a prospective payment system and it's DRG specific. In that sense I think the DRG may be working better than some other prospective system, because hospital administrators, if they are trying, I don't know what they try to do whether break even or make profits or serve doctors. But certainly DRG does set up a tension between doctors and the hospitals. Before, whatever the doctors wanted to do, as long as the hospital could pay for it, they'd just do it. And now I think that the interests of the hospitals and doctors are beginning to diverge under the DRG system. I think you may see that actually DRG has a bit more effect than some other kinds of prospective payment systems. And as far as a DRG for physicians, I agree with the comments here. It's very difficult to design. On the other hand, you can definitely shift the payments, that is, the fees between surgery versus internal medicine. There are a number of studies including my own which show that one standard hour of work for surgeons, particularly ophthalmologists, is paid about five times more than that internal specialists. And there is no rhyme to that. On the other hand, no one has been able to wrestle with this question yet, because it touches the key interest of the doctors and that's so powerful.

MR. MELLMAN: Bill I think you raise some excellent points. I would like to comment on them. People call these systems prospective reimbursement, prospective payment and prospective pricing. And I would hope we could agree on the term prospective pricing because it's a conflict in terms to reimburse in advance. We're not paying in advance either. We're setting the price in advance, prospective pricing.

Secondly, you talked about tension between the physician and the hospital and some people think that tension is a bad thing. You know, doctors tell us to avoid stress and so forth. But this is the good kind of tension you're talking about which is also known as management. We have it in our own employment and I believe it's highly desirable for the medical staff to have that kind of relationship with the hospital.

Thirdly, you talked about the bias in favor of surgery. There's nothing set in cement in those 467 DRGs. The ones in New Jersey happen to be based totally upon the historical pattern in those hospitals, where they kept track on paper of what the charges had been for a particular procedure with and without surgery. They took the average and brought it up to the present by adjusting for two years of medical price escalation. But there's no reason why the omniscient planners and directors of this system can't say: next year, in order to encourage more cost- effective medicine

or whatever, we're going to raise this one a little more and cut that one a little bit to encourage the ambulatory or whatever.

MR. REILLY: I don't think that can happen at the national level. Maybe the optimal solution is a state-based DRG system under a waiver. If DRG has a lot to recommend it, let individual states design their own systems. Let Medicare buy into them and then you can customize them so you don't get this pivot across the country. This would be more along the lines of the New Jersey system. It won't work out of Washington, D.C. It won't change that quickly.

DR. TOMPKINS: I'd like to pick up on the comment that you made about management. I'm not entirely sure what you had in mind but I think if we're going to look at costs across the board and deal with them in a rational way, the key issue that we have to face is that there is essentially no coordination of management between the physicians, hospitals and all the other actors in the health care system. This goes back to something that Gerry said some time ago. The real way in which you begin to deal with the cost issue and at the same time maintain the quality, especially on the preventive side of the health care system, is to begin to deal with a much more rationally constructed system in which you have people working together to produce a product or to provide services.

HMOs are so structured that they offer promise of accomplishing this, but one of the biggest drawbacks in HMOs is that in time they become bureaucracies in and of themselves and they limit free choice and access and so people tend to go elsewhere. So there are some major problems in dealing with an HMO.

An institution like ours, I think, is much closer to what people are going to want in the future. We are a medical center that is a joint project effectively. It's an amalgamation of two corporations, a hospital and ancillary services corporation and a physician nonprofit corporation, that are put together in such a way that they work together in planning and in managing the corporation. And we're the only hospital that I know of in the state of Washington that's dropped its length of stay in the last couple of years. Everybody else, as the demand has gone down, has upped their length of stay to make sure their revenues stayed the same. We keep shooting ourselves in the foot and dropping our length of stay.

We've built incentives into our program which do not provide incentives for the physicians to admit patients unnecessarily. We should not provide incentives for the physicians to do procedures. We do not compensate physicians on the basis of the number of cases that they have in the hospital, the amount of days that they accumulate, or the number of procedures or amount of surgery they do. They all receive a salary. And the salary is basically the same for the surgeons as it is for the internists and the pediatricians, within the constraint that we have to deal with the reality outside. And these salaries are considerably below what these people could earn in private practice.

But as more and more physicians enter the market, there are fewer and fewer of those private practice opportunities. It seems to me that at this stage

of the game, the potential for organizing health care into a rational system becomes much greater because of the glut of physicians. I'm concerned that the DRG issue and the entire way in which prospective payment is approaching are really not focusing on the reorganization of that health care. Although there are some incentives at the Medicare level, there are not as many incentives as there should be for people to reorganize into a rational health care system. Now the administration argues that the HMO is a good deal, that it makes sense for investors to put money there. A recent issue of Barrons discusses HMOs as an investment opportunity. I think to a certain extent that's true. People are recognizing that HMOs are a good potential investment in the marketplace. And maybe we're going to see the formation of more health care systems that provide care in a rational sense. But that's the way we've got to go. I mean the regulation is important, Competition may be as important too, but more important than that is a fundamental change in the way in which health care is organized at a community level to allow us to get the controls over the health care system. Control should be obtained in a way that will reduce costs eventually and provide the kind of care our people need. It should not be the kind of care that the government is willing to pay for through the DRG and the procedure-oriented payment systems that we currently have.

MR. ROY GOLDMAN: There are two questions I want to ask. One is with regard to the comment that was made that the prospective pricing system for Medicare is going to be neutral. There was then some discussion on how, with some of the populous states in the northeast going to all payer systems, perhaps it won't be neutral after all. It may actually increase expenditures. The first question is, if it increased expenditures in the first couple of years, is there a likelihood that costs will increase more slowly for hospital care for Medicare patients in the future? The second question is, even if it does slow down the increase in hospital costs for Medicare patients, will the fact that this system is not all payer inhibit it from slowing down hospital costs in the country as a whole?

DR. OMENN: I guess the answer is we don't know. There are perverse political implications in what you said. I think if the system turns out not to offend anybody in its budgetary ramifications, it will be given a longer period to be implemented without drastic changes. If the costs in the first year or two rise nationally, much more than has been projected, then there will be urgent moves in the Congress and the administration to somehow reduce the rate of increase of costs and it could be even a bigger change than would have occurred on a more gentle slope. I think that was what was implied in what you said. I think that's often the way our political system operates.

MR. GOLDMAN: I was just trying to draw a distinction between costs rising for the government for Medicare versus costs rising for insurance companies, for people paying privately, for national costs.

MR. MELLMAN: You should understand that Roy is the actuary on the American Association of Retired Persons case. Consequently he has a considerable interest in how much of this ends up as copayment or excess charges to the elderly.

DR. OMENN: I think political action will be determined mostly by what happens to the federal budget and much less by what happens to other premium based health insurance. Having said that, there is every push around the country to try to get all payer systems. It's very clear in this legislation for DRGs and prospective pricing for Medicare.

It's also very interesting if we get to Medicaid, what's happening in California. However well it works out, California instituted a dramatic change in the way it administers Medicaid. They've introduced a negotiator called a Medicaid czar to select hospitals based upon bid prices. The program began in July, 1982 and for the year that begins July, 1983, that system is available to all payers. It will be very interesting to see how many health insurance companies (whether Blue Cross or Blue Shield or other parties to this action) are willing to really get engaged in a system where people are willing to put up systems of care (not just individual hospitals or individual doctors but preferred provider organizations). These systems would be founded on networks of primary through tertiary care on the basis that it is at least proposed to be more cost-effective. That would deal with all payers all through the system if it works.

MR. REILLY: I think the likelihood is that costs will continue to go up unabated because no single intervention will be effective. And the current administration's attitude about intervention in the health care system is that we, Medicare, will be a prudent buyer and the rest of the system can do whatever the rest of the system wants to do. It is inappropriate for the federal government to take a regulatory role either in utilization review or in planning.

Fortunately, in my view the Congress hasn't bought that and the Congress has continued to reinsert into the program PRO, health planning, and so forth. But there is no coherent national policy to deal with health care cost containment systemically. HCFA will continue to simply want to be a prudent buyer and let the rest of the system go its own way. The rest of the system going its own way will be driven by all of the incentives that have driven it for the past 15 years and will continue to escalate. If I had to guess, ten years from now the system will look more like it does today than like anything else.

There is one issue that we haven't touched on today and that is the extremely high cost of the last two weeks of medical care and the last year of care and these kinds of issues. The demographics of the elderly alone are going to be huge drivers of absolute cost increases.

DR. OMENN: It also needs to be said that whenever we talk about cost shifts we should not neglect the cost shift from the health insurance or the government sponsored insurance to the individual. For instance to reduce the rate of growth of Medicaid and Medicare expenditures by using copayment deductibles, by making people pay it out of their own pockets, runs counter to the social policy reflected in Medicare and also runs counter to the facts on Medicaid. Very few people seem to understand that most of Medicaid goes to the aged and disabled and blind. For the State of Washington they account for about 80% of the dollars in Medicaid. It is not the stereotype welfare program where the welfare queen picks up her

benefits periodically. In terms of eligibility, of course, most of the people are in the AFDC population. But in terms of the use of Medicaid and the dollars that are expended, it's mostly for the same population that's covered by Medicare. And without it, Medicare would be in big trouble.

MR. RON SOLOMON: I'd like to clarify I think a misconception about the actuarial projections done by the Medicare actuaries, a slightly different subject but one mentioned by one of the panelists. The Social Security trust funds which include of course hospital insurance are required to put out an annual trustees report. The Board of Trustees of those trust funds are three members of the administration, the Secretaries of Treasury, Labor and Health and Human Services.

The administration frequently wants to have a large say in the economic assumptions that are used in those trustees reports. In particular, in 1981, when there was a big push for supply side economics and very optimistic projections, they had a large say in the economic assumptions. The actuarial certification was voluntarily undertaken by the Chief Actuaries of Health Care Financing Administration and Social Security. However, the health care actuary would not certify to those assumptions in 1981. There's a paper in the recently issued transactions which discusses all the reasons for that.

The situation, however, has now changed with the new Social Security amendments. The new Social Security amendments require a certification by the chief actuaries. However, they also require that the chief actuaries cannot comment on the economic assumptions. So that if the administration wants to choose the economic assumptions and force them on the chief actuaries, the actuaries can't say anything about them.

DR. TOMPKINS: That comes under the heading of if you don't want to find scorpions, don't pick up rocks.

MR. AXENE: I fully agree with Dr. Tompkins. When I was talking before about the supply and demand issue, that's what I was talking about, not competition. I purposely did not use the word competition. The thing I wanted to mention is that no one has mentioned the impact of DRG upon third party payers like HMOs and insurance companies. Probably the most common talk that we have today in structuring the delivery system is trying to eliminate unnecessary bed days. One way that we do this is by shortening length of stay. DRG goes completely in the opposite direction of this unless you're an outlier at the very bottom end because you pay the same price no matter how many days you're in there. And I think that HMOs that buy their hospital days from community hospitals are extremely frustrated with the possibility that their Medicare patients are not going to contribute to the cost savings that they need to be competitive. From an actuary who works in this area quite extensively, I think that what we need to maybe look at is a way of continuing the incentive by eliminating days, maybe by using all-inclusive per diems or some other approach.

MR. MELLMAN: You raise a subject about which the HIAA feels rather strongly. And I'd like to step out of my moderator role for just a moment. We feel that consideration should be given to the special incen-

tives that HMOs have and to solutions that can be accomplished within the system. But we would deplore the definition of a solution as a complete exemption for the HMOs because one of the things that got us into the present mess is the fact that certain payers were exempt from the system. So to create an all payer system and then exempt somebody is likely to produce the same inequities, particularly if the exempt payer's marketshare grows. So hopefully there is a way of reflecting that within the system.

MR. AXENE: I'm aware of one approach that's using DRG to establish all inclusive per diem type things. For example if you're in for a maternity stay or you're in for a surgery stay or whatever, you have sort of a diagnosis-related per diem which to me makes much more sense than a diagnosis-related per stay. I think the impetus for this whole program was to try to cut costs, not necessarily restructure the system. I think when you're trying to restructure the system you have a much different objective than that.

COST-EFFECTIVE INTERVENTIONS

MR. REILLY: Gil, you talked about runaway ambulatory elective surgery. How do you feel about the effectiveness of second opinion surgical programs?

DR. OMENN: Gerry, I think it's quite a mixed story. It depends a lot on the procedure. Obviously, a second opinion isn't going to get you any different result if the people who provide the opinion have a widely held consensus about the indications for doing the procedure. It's likely to lead to disagreement in areas where there is considerable disagreement about how often and for whom the procedures should be done. Also, for years the point has been made that if you ask only surgeons whether surgery should be done, you may not be getting the fullest diversity of opinion.

MR. REILLY: We put in a mandatory second opinion program in Washington State about a year ago for four or five procedures, including gallbladder, T&A and hernia. Our experience after a year is that we saved $700,000 to $1 million. We did it in a very limited way. We left ultimate choice to the patient. In these procedures, you must get a second opinion. We have a series of physicians around the state whom we've screened and who said they're willing to do it. The ultimate decision is the patient's to have it or not have it. Even if the second opinion is contrary, we leave it to the patient. We saved about $1 million. On some of the procedures, there was no difference. Cholecystecomy there was no difference. So we'll probably abandon that one and we'll pick up a couple of other procedures next time around and put them into mandatory second opinion. It's clearly working for us, but we went at it very slowly and very carefully. The question the doctors always asks us is what's the longitudinal impact? Are you following these people over time? It's making sense for us in Washington State at this point.

DR. TOMPKINS: I'd like to make a critical statement about the insurance industry. We've talked about what the federal government is doing and what the hospitals and doctors are going to do with all this, but we really haven't talked very much about what the insurance industry can and should

do. One of the most frustrating things for me in the last year has been my inability to get insurance people to talk about programs which would reduce care to the people that they insure. Frankly, the insurance industry has or has had in the past very little incentive to do anything that will reduce costs. They can simply pass the cost right through in the form of higher premiums. As a matter of fact, there's a great disincentive to do anything new because it requires the insurers to begin to change their mode of operation and to begin to think of new programs that they might have to market and to change their data systems and a whole batch of other stuff. So when you get into a situation in which you're willing to contract for instance on an all-inclusive per diem rate or an all-inclusive per stay rate, in order to reduce costs and to change the incentives, you can't get the people in the insurance industry to talk to you. I have much better luck talking to the purchasers, the business people, than I do to the insurance folks. They just plain don't want to get into this game.

Now what I would submit is that we have the typical passing of the buck routine among three parties: the insurance folks, the providers, and the business people. And that buck just keeps going right around. It's not going to stop anywhere. I think you all as professionals in this group have to recognize that you're a big part of the problem and that until your companies begin to deal with the issue (that restructuring the health care system is going to require the insurance folks to get on that bandwagon too), we're not going to get anywhere. And I don't care what Medicare does, it's not going to have that much of an impact unless of course it's changed in the private sector, too. The HMOs, the case management, all of the systems that make some sense are going to be impossible to maintain as a major portion of the marketshare until the insurers get along. All of the HMOs that I know of are beginning to get more and more into the fee for service side of things because they recognize that in the competition that's going on they've got to offer that as an option and they're not getting any help from a variety of other parties to do differently.

DR. OMENN: There is an area in which you as actuaries and insurance companies in general could be a lot more active and for which there is some data emerging. This has to do with the very popular rhetoric about health promotion. We've had a lot of discussion here about a number of allusions to the value of preventive interventions, of things people can do for themselves, and of services that can be provided that would reduce the likelihood of serious illness and injury.

Smoking accounts for an estimated 320,000 premature deaths a year in this country. Alcohol and related events, alcoholism 200,000. Automobile accidents another 50,000. Homicides and suicides with guns another 30,000. Those four biggies, 600,000 excess deaths per year. More than a third of all deaths. And not only that, it's highly skewed toward lower age groups. So in terms of years of productive life before age 65 lost, the impact is tremendous. These statistics are published by the Centers for Disease Control in their well-know mortality morbidity weekly report.

In 1979, the Surgeon General published a volume called "Healthy People" looking at health services, public health interventions of the sort of air pollution control and such, and personal lifestyle decisions about smoking,

weight control, nutrition and so forth. The following year, a document which is much less well known called "Health Promotion Disease Prevention Objectives for the Nation" laid out for each of those 15 high priority areas, by age group, numerical targets for what people agreed feasibly could be accomplished by 1990. That's only 7 years away now.

And there is plenty that could be done in these areas and plenty of very useful incentives that could be provided through insurance policies. Some companies have special rates for nonsmokers. And others have rates for people who certify that they use their seat belts and so forth. I think there could be a tremendous push along these lines in a way that would really get the public's attention and that would be actuarially based.

Furthermore, concerning the discussion which we're not going to get to today about the soundness of Medicare, there's going to be a conference that the Congressional Budget Office is sponsoring in the fall. Most of the proposals on this topic were how to reduce benefits or otherwise change the system of most of the acute care services, and very little attention has been given to what you could do with health promotion. In fact, many people are scared to death of it because they feel that what it will do is keep more people alive longer into the elderly years so that the long-term effect on Medicare might be an even bigger cost. What's missing in all that analysis is what the contribution might be from these four biggies and from others for which there are numerical sources available that could be actuarially analyzed, I think quite fruitfully. Also at issue is what the impact would be on Medicare revenues. That's to say, how does all this affect payments into the HI Trust fund from people who are in fact able to keep working through all their productive lifetime. And it's not an insignificant number I am certain. Furthermore, there are direct health care costs in the system that would be saved even though those people are not directly in Medicare.

MR. MELLMAN: Our time is up. I'm sure we all realize that although we recruited this panel from the neighboring state of Washington, many of the other states also have people who occupy positions of similar responsibility to our three panelists. In other words the problems that we've discussed today are by no means unique to the state of Washington. However, if you believe as I do that our distinguished panelists have truly been an all-star panel, I hope you will join me in expressing our appreciation to them.