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EXTERNAL INFLUENCES ON HEALTH INSURANCE (U.S.)

Moderator: CHARLES HABECK. Panelists: MAURICE W. KILEY, WALTER C. WOODWARD. Recorder: DAVID W. KRUEGER*

1. Legislative and regulatory issues (discussion of current federal and state activities)

2. Economic influences (trends in cost and utilization, impact of unemployment, employers' cash flow considerations, federal income tax changes)

3. Cost shifting

MR. CHARLES HABECK: Welcome to Open Forum 25, External Influences on Health Insurance (U.S). I am a consulting actuary with Milliman & Robertson and I work primarily in individual health insurance. Our panel includes Maury Kiley. Mr. Kiley is a CLU and a graduate of the University of Wisconsin. He has made various contributions to the industry. He has been past president of several health underwriting organizations. Currently he is chairman of the Board of Directors of Madison General Hospital and a member of the Joint Long Range Planning Committee for Madison hospitals.

The second member of the panel is Walt Woodward, who is Vice President & Actuary for Blue Cross of Western Pennsylvania. He has been associated with Blue Cross there for 12 years. He has served on both the Blue Cross Association Actuarial Advisory Committee and the Joint Associations Actuarial Subcommittee of the Fiscal Affairs Committee. His current responsibilities include product development, product pricing, marketing support, and financial forecasting.

The agenda calls for discussion of certain external influences. I think as you listen to the speakers the question may occur to you as it has to me whether these are really external or internal. Regulation, for instance, has become so much a part of the industry that we wonder if we are not actually in partnership with the regulatory arm. Maury Kiley will tell us some of his concerns about the external influences.

MR. MAURICE W. KILEY: I am going to discuss current health care financing and delivery from the perspective of a hospital trustee. I have been associated with Madison General Hospital for nine years. During the past five of these nine years I have been Chairman of their Board of Directors. This is a 500 bed community and teaching hospital, closely affiliated with the University of Wisconsin.

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Hospital trustees today are looking at a whole array of influences which they believe will substantially change health care financing and health care delivery. I would like to discuss with you just two of these outside forces.

One of the things we are watching is the increased supply of practicing physicians. An article from the Johns Hopkins Medical Journal, entitled "The Implications of Expanding Supply of Physicians," discusses the great doctor surplus and what it will look like in 1990. It is estimated that primary care physicians will increase 60% by 1990, and that by the end of this decade we will have 120% more family practice people than we had at the start of the decade. The number of internists will increase 90% and the number of pediatricians will increase 80% by the end of the 1980's. Also, internal medicine specialists and plastic surgeons probably will increase 70%. It is estimated that there will be only two specialists or specialty groups that will be understaffed at the end of this decade, anesthesiologists and psychiatrists. By 1990 we will have around 600,000 practicing physicians which will be, by estimate by the Bureau of Health Professionals, 100,000 more practicing physicians than we really need.

Now the traditional economist would say that this oversupply of physicians is good, providing more access to more people and lowering the cost of medical care. But on the basis of our past experience, these conclusions are not true. The areas that have the highest number of physicians per 100,000 of population generally have the highest cost. If you look, for example, at the health service area of Boston you find that there are 357 practicing physicians per 100,000 of population. Annual hospital costs on a per capita basis are about $480. Medicare reimbursement per beneficiary in this area is about $316.

In contrast, the health service area of Central Illinois has 116 physicians per 100,000 population. The cost per capita of hospitalization is $290 per year compared to $480. The cost of Medicare per beneficiary is $177 in contrast to $316. So the growth of our physician population, the number of practicing physicians, the overabundance of physicians, is of concern to hospital trustees. In the City of Kenosha, Wisconsin, for example, the number of practicing physicians in 1985 are twice the number that there were in 1975 and the population has decreased slightly, from 81,000 to 80,000 people. Overall we find that where there is an overabundance of physicians, there is an increase in hospital admissions. The number of doctor's calls per physician may decrease, but there is an overall increase in health care cost to the population.

A second item that is of interest to hospital trustees is Medicare. Thirteen years ago, a group of researchers at Yale University began studying hospital discharges and hospital admissions. In cooperation with 325 hospitals, they examined 1,500,000 patient records and grouped together admissions and discharges into 467 diagnosis related groups (DRG's). Beginning October 1, 1983, Medicare will institute a system of prospective payment to hospitals on the basis of these 467 diagnostic related groups. If, for example, a Medicare patient is admitted to the hospital for repair of a hernia, which is DRG 161, and if at that particular time DRG calls for $2,500 of payment in that particular area, that amount is what the hospital will be paid. It will not make any difference whether the length of stay is 5 days or 15 days.

I am sure that those of you from California have heard of Mr. William A. Guy. Mr. Guy was hired by the State of California to set up a program of selected provider contracts, to help control the increasing cost for Medicaid patients. We have two classes of government patients: Medicaid patients who are poor or near poor, and Medicare patients who are usually over age 65. During the calendar year 1982, Mr. Guy's responsibility was to negotiate with the 600 hospitals of California for the care of Medicaid patients (called MediCal in California). For example, the San Francisco area has 40 hospitals, but Medicaid patients will be steered to just 8 hospitals. Mr. Guy is also identifying physician groups in California and entering into contracts with them for Medicaid patients.

This California example is another system of prospective payment to hospitals. The bottom line is that the way hospitals are being paid, particularly at this time for government patients, is changing and the picture five years hence will be entirely different than it is today. At that time, the health care of virtually all government patients will be paid on a prospective basis.

Some states are looking to the leadership of California in negotiating with these hospitals and physician groups for the care of Medicaid patients. Other states are looking to the leadership of the federal government and perhaps to a system similar to Medicare's 467 DRGs. This type of prospective arrangement will materially change the way hospitals are reimbursed for these groups of government patients, and will also change the way hospitals are reimbursed for private patients.

Blue Cross of Kansas is already developing a plan of payment for private patients based upon Medicare's DRGs. I can imagine your claim department in the future looking at a hospitalization charge of $4,000, and stating that there is an overcharge because the DRG for that hospitalization is $3,000.

There are also going to be changes regarding the relationships within hospitals. Traditionally, the health care delivery system has been controlled by physicians. This control is going to professional administrators. The CEO of a hospital cannot permit a physician for Medicare or Medicaid patients to practice his style of medicine. The physician who is going to admit a Medicaid patient under a system of prospective payment must practice the hospital's style, not the physician's style. In the future, particularly in the urban settings and the bigger hospitals, there will be a shift in control of health care delivery from the physician to the professional administrators, to the professional managers, and to the CEO's of hospitals.

The relationship between the primary care physician and the specialist will also change. A specialist is no longer called a specialist by his primary care colleagues, rather he is called a consultant. In a prospective payment system, the primary care physician is going to be the gatekeeper. He is going to be the entry point for the patient into the health care system, and determine whether the patient goes to a consultant or a specialist. There is a great deal of difference between the income of these consultants and the income of the primary care physician. I think that these differences will narrow under some of the arrangements with preferred provider or exclusive provider organizations. In reality, the primary care physician, who is the gatekeeper, pays the consultant out of his own pocket. If he thinks the patient should see a dermatologist, he sends him to a dermatologist. With the capitation arrangement, he actually pays the dermatologist

out of his own pocket. Therefore, he says to the specialist, "I'm not willing tc pay your usual and customary charges, and if you want me to refer patients to you, I want a lower fee." Thus, we are seeing a system of physician versus physician in the health care delivery system.

We are also seeing a system of physician versus physician between the general hospital and the teaching hospital. University hospitals or teaching hospitals are traditionally much more expensive. There are probably very few large teaching hospitals that have been included in negotiated contracts with preferred provider organizations. We are going to see a greater conflict between the physicians of this particular institution and the physicians of the general hospital.

From the eyes of a hospital trustee, I see tremendous change over the next five to ten years. Some of my friends who are physicians believe that the greatest single change in Madison will be the financing of medicine and the relationship between the physicians and their patients and the relationship between their patients and the hospital.

MR. PAUL E. HANSEN: Do you believe that in the future some hospitals will be 90% or 100% Medicare-Medicaid oriented, and other hospitals will handle the private sector?

MR. KILEY: It could be that way, but in our particular community I do not see that. Currently at Madison General Hospital, one-third of the patients are government patients. We hope to hold on to at least that one-third. As a matter of fact, we have a closed panel HMO in Madison, which is part of the Puget Sound HMO group. This HMO has approximately 25,000 subscribers, and the State is beginning to steer to this HMO all new Medicaid eligible people.

MR. HANSEN: Is there any force slowing down the universities from producing more physicians?

MR. KILEY: Slowing the physician growth is a very difficult process. Through 1990, 75% of these practicing physicians are already in the pipeline. There was a bill before the Wisconsin Legislature which supported reducing the number of medical students at the two medical schools in the state. However, the bill was defeated.

MR. HANSEN: University teaching hospitals get a great many "special cases", the high cost admissions, which is a contributing factor to the higher cost of these hospitals. Will this continue?

MR. KILEY: Many in the hospital industry believe that some other method has to be found to cover the cost of teaching. At Madison General Hospital, the hospital patient picks up much of the cost of the teaching. Our prices could be substantially less if we did not have intern programs, residency programs, or other teaching programs.

MR. HANSEN: Universities, particularly state universities, train most of the physicians in this country, and are now escalating their tuitions substantially. Do you see any trend in keeping new college graduates from going into the medical field.

MR. KILEY: I think that there are many people who a decade ago would have opted for medicine, are now opting for other professions. At the University of Wisconsin, a student almost has to have as good a grade point average to get into the graduate business school as to get into its medical school.

The question is sometimes asked - Is the hospital's customer the patient or is it the physician who admits the patient? And if you ask the older physician, he will tell you that he is the customer. The attitude of the younger physician is that he has an interest in the hospital. He likes to interact with hospital administration people. He likes to work within the medical staff organization. He likes to participate in peer review activities and the like. We find a great deal of difference.

MR. HANSEN: What is being done about cost containment at your hospital?

MR. KILEY: Madison General Hospital is very interested in cost containment. Our Board of Directors includes many people who are very active in the community. Each year we spend a great deal of time examining the budget for the coming year and we try very hard to keep it down. We also have hospital rate review in Wisconsin, so we must submit our budget to the state. When we follow our budget on a per discharge basis over a period of a decade, we find that the change in the cost of hospitalization per discharge is practically identical with the changes in the cost of living. Yes, we are very cost conscious.

MR. LAWRENCE P. MOEWS: Do you foresee any of the insurance companies banding together more and more, and negotiating prospectively similar to the example in California?

MR. KILEY: Yes. Part of the California law that brought into being the Medicaid negotiation also provided that insurance companies could negotiate on the same basis for preferred providers. One carrier in our state is currently negotiating with hospitals on a preferred provider basis, to which they will steer their policyholders. If you go to the hospital where they have a preferred provider contract, you do not pay the deductibles and coinsurance.

Of great interest also to the hospitals is what private industry is doing. The United States Chamber of Commerce identifies some 150 employer coalitions for health care delivery. These coalitions today are primarily fact finding groups, identifying the high cost physician and the high cost hospital. They want to know the cost difference for the same operation done in different cities, and why this difference exists. These coalitions, particularly for the smaller employer, will become purchasing groups and will purchase from a hospital on a prospective basis just as Medicare purchases on a prospective basis.

MR. MOEWS: Do you expect to see cost shifting continue in the future, as we have seen in the past between government paid patients and other third party patients?

MR. KILEY: Yes. At our hospital, the government getsa different rate for Medicare patients. The Group Health Coop gets a different rate for its patients. Compcare, which is a Blue Cross closed panel HMO, gets a different rate for its patients. Hancock Dykewood will soon get a different rate

for its patients. There will be all kinds of special rate categories, based on negotiations.

MR. WILLIAM J. THOMPSON: What effect, if any, do you think the implementation of DRG's with the Medicare population will have on the cost shift.

MR. KILEY: DRGs come on line in late 1983 for Medicare, to be phased in over a three year period. By the time DRGs are fully implemented, I hope that insurance companies will be negotiating on a prospective payment basis. In addition to having an excess of physicians in Madison, we have an excess of hospital beds. I think this change to the competitive mode may reduce some of our excess beds. I also hope that the commercial insurance companies will negotiate in a manner that prohibits cost shifting from government to them or from one group to another group.

MR. THOMPSON: To the extent that DRGs are used on a fairly wide scale, do not they have the tendency of removing some of the incentives to prepayment plans like HMOs, who have the more cost effective doctors and reduced hospital stays? Are the cost savings that are currently being generated lost by paying everybody on an average DRG?

MR. KILEY: I think that some of the least cost hospitals are going to raise their rates to the DRG level. But I think that if the DRG is $3,000 and you can do this patient well for $2,800, the hospital can save the $200. This is much the same incentive that the HMO has in reducing the hospital admissions and keeping the hospital charges down, except that in the case of the HMO, the savings goes to the physician, rather than to the hospital. There is, within this bill, a provision that the federal government should also study a system of paying physicians on DRGs. There are those who believe that the government will pay the hospital for the DRG which will include the hospital increment and the physician increment, and then the hospital will pay the physician.

In a hospital you have three groups of individuals - you have the directors who are responsible for the policy of the hospital and for the financial soundness of the institution; then you have the administration who manages the hospital on a day to day basis; and then you have the medical staff. The hospital has always been looked upon as a three-legged stool. All of these three elements must come closer together in the future. One of the things we teach at Madison General is togetherness. We are in this together and its going to be the physician in it with the hospital. The hospital administrator will not be able to tolerate a physician who does not join the team.

In summary, it is my belief that a prospective payment system will do a much better job for this nation in controlling health care costs than the former cost base reimbursement system has done.

MR. WALTER C. WOODWARD: It is a pleasure to have the opportunity to exchange our perceptions of how the outside world keeps forcing changes upon us. There is little question that external forces on health insurance continue to expand as the rapid rise in health care costs goes unabated.

I will be speaking from a Blue Cross perspective, and more particularly from the perspective of our Blue Cross experiences in western Pennsylvania. I

will discuss the Legislative/Regulatory influences, the economic influences and the much talked about cost shifting phenomenon.

Let me begin with legislative/regulatory influences. Being a Blue Cross Plan, we have experienced over the years a trend by the Insurance Department to superimpose its judgment upon the Plan's marketing/pricing practices.

Two fairly recent examples come to mind. Through 1976, we had maintained our Medicare complementary coverage program on a self-sustaining basis. From its inception in 1966, we maintained that the program's rates should cover its full cost and not be subsidized by monies from any other block of business. While we had indirectly subsidized the 65 and over population prior to Medicare because of their high utilization level and our non-use of age rating, we held that under-65 persons were paying for the Medicare program through payroll taxes and to require further subsidy would be putting a double burden on the under-65 population.

For more than a decade the Insurance Department concurred. However, in 1976, they refused a requested rate increase on the grounds that the rate was not subsidized. We challenged the Department through administrative hearings and the court. After two and a half years of substantial underwriting losses, the court held the Department had such authority. As a result, today the price of our Medicare Complementary program reflects a level of subsidy. Now the Department argues that we are not subsidizing enough, without saying how much enough is or where the money is supposed to come from.

My second example also deals with a Medicare Complementary Coverage program, supplemental drug benefit. After about two years of very favorable underwriting results in a newly introduced Major Medical program for Medicare enrollees, we expanded the drug benefit. The insured's ID card would be shown to the pharmacist, a copayment would be paid by the insured, and Blue Cross would reimburse the pharmacy for the difference.

This program sold well, especially since management chose to offer this expanded program at a rate lower than that required to support the benefits, in order to burn off some of the underwriting gains that had been accumulated over the prior two or three years. We presented this program to the Insurance Department along with our plan to incrementally increase the rates to the required level over a two and one-half year period. In short, we wanted them to be fully aware of our marketing/pricing strategy. They quickly approved the initial contract and rates. We were off and running.

However, with each of the planned rate increases, some of them heavier than projected, the Department became more and more reluctant to approve the requested rate, and usually ended up cutting the rate increase even when that requested rate level was demonstratively inadequate. In the end, they denied a rate increase outright, and instructed us to restructure the benefit program. We reviewed the benefits and proposed to return to a major medical type program. We made the necessary filing and attended the public hearing called by the Department.

The elderly were up in arms. They maintained that the copayment drug feature enabled them to manage the cost of their required medications on a systematic budgetable basis. The program had freed them from the financial

uncertainty of continued prescriptions. We tended to side with the elderly. Our point to the Department was that the market place should decide the fate of the program. We maintained that an adequate rate should be approved and then let the consumer decide upon the value of the program. However, the Department would not change its view and finally approved the major medical type coverage.

About 33 per cent of our subscribers dropped the program because they believed the original program benefits had been destroyed. I believe we would have retained a much higher per cent of the elderly subscribers in spite of the required rates if the original drug program had been approved.

Our biggest ongoing problem with regulatory authorities is lethargy and slow motion - the length of time required to obtain a decision on rates and policy provisions. This slowness of action has an obvious negative financial impact on our operating results. In addition, we spend an inordinate amount of time trying to answer unanswerable questions.

We are a nonprofit community service organization and the largest underwriter of health insurance in Pennsylvania. However, the department acts as though all of the social problems of inadequate income, poor health, lack of access to care, and high cost of health care can be solved by pressuring Blue Cross. In addition, we experience a lack of understanding of the Blue Cross service product, and a fanatical dedication on the part of some Insurance Department staff members to develop a lengthy detailed record to protect and insulate themselves from public and/or bureaucratic criticism.

We have experienced special regulatory problems regarding HMOs and multiple employer trusts. Currently, under Pennsylvania law, Blue Cross cannot offer HMO coverage as a line of business. We would need to form a subsidiary corporation with the appropriate capitalization and board structure. This added structuring by the department seems to put another road block in the natural way of expanding HMO coverage.

The second special regulatory problem deals with multiple employer trusts. We, in Pennsylvania, believe that the lack of regulation of these trusts is a serious disservice to citizens and groups in the commonwealth. In the past two years, 1981 and 1982, we competed with a MET that offered to replace our accounts of Blue Cross/Blue Shield coverage across the board, for a fraction of the existing Blue Cross/Blue Shield rates. In addition, this MET further promised to guarantee that future rate increases would be limited to the change in the consumer price index, and was willing to go on a straight paid claim basis with no accrual for unpaid claim reserves. Our actuarial staff was accused by our marketing people of not being responsive to the marketplace and not knowing as much about pricing the product as our competitors seemed to know. We stood our ground and took some blows to our egos but after two years we were vindicated. That particular MET, which had a very successful track record for attracting away our own customers, went bankrupt.

I will now turn to some of the economic influences on health care. First, I should point out that since Blue Cross/Blue Shield plans tend to provide service benefits to our subscribers, the cost of our programs are extra sensitive to economic changes. With the hindsight of the past three years of the rapid increases in medical costs, our sensitivity to these economic changes is more tender than ever before.

When we are forecasting cost and utilization trends into the future, which is usually a horizon of 18 months to two years, our crystal ball must be extra clear. There is a great likelihood, or near certainty, that whatever we forecast as a trend is not going to be realized. But, for us to stay in business, the probability has to be high that our estimates are in the ball park or that the variance is within tolerable limits either way.

We all see pressure building on the health industry to get the rate of increase down and we believe it must come down and it will come down. But in quantitative terms we are faced with determining when it will come down and by how much. Needless to say, it's a risky business particularly with the current sagging economic conditions around the country and especially in western Pennsylvania.

These economic cutbacks and plant closedowns are forcing companies across the country to critically examine their employee health care benefit programs. Business is seeking every way possible to slow the rapid rise in costs, particularly in the highly visible areas of health care benefit programs. Some of these efforts include cost shifting, increased deductibles, benefit designs, and mandating second surgical opinions. As a result we see a mix of regulatory, voluntary and competitive thrusts which are all aimed at the single goal of stemming the rapid rise in health care costs. The state regulators are taking an increasingly critical look at benefit design of new and existing products, as well as cost and utilization trends that are being forecasted by carriers. As a Blue Cross plan, we are very much regulated, including how much trend we can put into rates that we are quoting for 1983-84.

I mentioned earlier several historical samples of the Pennsylvania Department's imposition of its "social conscience" with respect to several of our Medicare supplemental offerings. I expect this kind of thinking will soon spill over into all aspects of the way we do business. The impact on the health insurance industry, particularly the highly regulated segments, such as the Blues, and in some cases the HMOs, may range from minimal, if the economy improves, to catastrophic.

The voluntary efforts that I mentioned earlier are evidenced by the formation of business coalitions in all major areas of the country. Businessmen are angry and in many cases are even excluding both health care providers and insurers from their coalition activities. They want changes today that providers and carriers have not been able or willing to implement. Coalitions seem to be concentrating on establishing a forum for discussion of cost control on benefit programs, for promoting alternative delivery systems, and by developing comparative data on the use and abuse of community health care resources. Also supporting the voluntary efforts is the Robert Woods Johnson Foundation's "Affordable Health Care Program", offering grant money to communities and non profit organizations, who are willing to develop, implement and experiment with innovative programs that contain the rate of increase in health care costs.

On the competitive side we are seeing the federal government moving headlong into a plan to pay a flat amount of hospitalization for a given diagnosis, the DRG concept. It is expected that providers will be sharpening their cost accounting and competitiveness, so that they will be able to make a "profit" on the services provided. Another competitive concept being promoted is

preferred provider organizations with its selective benefits provided to a restricted clientele.

Added to this jungle are the regulatory efforts of mandated benefits, mandated dual choice and rate setting programs in some states. What will fall out of these efforts is hard to predict. In fact, this activity makes forecasting health care cost trends on a national and even on a local scale riskier than ever.

Mandated benefits have become an ever increasing problem to the industry, to insurance companies and to the Blues in recent years. Special interest groups have become more visible and more widespread in the past few years than perhaps in the preceding thirty years. These special interest groups typically are specialty provider groups, consumer interest groups, and sometimes a combination of these. Examples of provider groups lobbying for mandated benefits in Pennsylvania include psychologists wanting to be treated the same way as psychiatrists by Blue Shield and insurance companies and optometrists who want to be treated the same as ophthalmologists. Chiropractors, nurse midwives, and birthing centers are other examples of special interest groups.

Consumer interest groups have helped sponsor other legislation, including the "Baucus Amendment" changes to Medigap policies, coverage for physically and mentally handicapped children, immediate coverage for newborn children (even when the child's mother is not an insured), and conflicting provisions regarding coverage for abortions. The primary problems of mandated benefits are the costs associated with these benefits and whether we can get the price approved on our non-experience rated business. Another significant problem is the employers' reluctance to provide and fund the benefits which are beyond the scope included in a labor contract or in the insurance contract. Also, there are the administrative problems associated with varying coverages required for multi-state plans.

Finally the Blue Cross plans face the added dimension of significant one-time costs which may result from termination or changes in our contractual relationship with our providers.

I would like to comment on the cost-shifting phenomenon. I will argue that the private sector, commercials and Blues alike, are facing it on two levels, benefit cutbacks and payment cutbacks. As the Federal Government increases the Medicare deductibles and copayments, and cuts back in other benefits, medicare supplementary programs of the private carriers continued to be faced with huge rate increases.

We see providers looking for ways to increase their prices to the private sector patients, thereby attempting to make up for the "expected" shortfall, as the Medicare provider payments are cut back. We at Blue Cross do not like this cost shifting anymore than any other carrier. However, we believe focusing on the shifting phenomenon is to be looking at the wrong ball. What is needed is cost cutting and cost effectiveness by the providers. When the government pays less, the providers have to learn to deliver their services for less. I believe we will all be further ahead by focusing our attention on the whole doughnut and not the hole in the doughnut.

MR. KILEY: Do you have a professional review organization (PRO) either for profit or not for profit, within Pennsylvania, that will do private patient review, as the PSRO's have done for medicaid and medicare hospital patients?

MR. WOODWARD: Within our hospital reimbursement agreement, we have a provision whereby a hospital maintaining a PRO will receive an incentive or an additional payment. I believe most or all of the hospitals in western Pennsylvania do, in fact, have their PROs, for both government and private patients.

MR. KILEY: I believe that commercial insurance companies should use organizations that do private patient review, especially in areas where the carriers have a concentration of policyholders. A private patient review organization will examine first, whether the hospitalization is necessary, second, whether the care given during the hospitalization is appropriate, and third, whether the length of stay is appropriate. If physicians exhibit a pattern of keeping patients in the hospital longer than is traditionally necessary, for a particular condition, then an effort is made to talk to the patient or the hospital about the length of stay.

At our hospital, the length of stay is coming down very rapidly because we have a program of encouraging physicians to get the patient out of the hospital when appropriate. We discourage weekend admissions and encourage same day surgery. Thus, our average length of stay is right now a shade under five and one half days. The Fox River Valley in our state has an average stay slightly under eight days, partly because private patient review has not been made part of the hospital program.

MR. WOODWARD: Within our hospital and subscriber contracts, we have the right to cut off a case based on PRO review. We inform the doctor and the hospital in advance about the discharge date. Payment for medical care is terminated beyond that discharge date.

MR. KILEY: Some hospitals, called delegated hospitals, do have their own hospital employees doing the review and send the data to the professional review organization. Non-delegated hospitals are hospitals in which the professional review organization actually has its own employee reviewing the charts. Hospitals with delegated authority require review and audits, to make sure that the PRO standards are being followed.

MR. RICHARD W. GARNER: Both panelists mentioned professional review exercises that are followed in their particular states. Are the following items included in your professional review exercises: pre-admission certification or review, and development of a course of treatment in advance of a hospital stay for non-emergency hospitalizations?

MR. WOODWARD: Every non-emergency hospital admission is subject to pre-admission review with an assigned length of stay, so that the attending physician knows what the expected discharge date should be. As I mentioned, we maintain the right to cut off a case. The attending physician, of course, has a right to go to the PRO and say, this length of stay should be extended from the seven days originally assigned to ten days.

MR. KILEY: We do pre-admission certification just for government patients in our community, but this will be a good practice in the future for private patients.

MR. HABECK: Walt described a regulatory situation in a state that is not the model for most of the states with whom we come in contact. In Illinois, it seems to me that the State Insurance Department encouraged the Blue Cross organization to change its structure to that of a mutual insurance company because of the advantages that would accrue. What was the underlying philosophy?

MR. RICHARD B. SIEBEN: In Illinois there was a period of about three years, starting in 1976, where non-experience rated programs and the medicare supplement programs were granted no rate relief whatsoever. A combination of events and motives led to the mutualization. Severe losses were incurred for three or four years, because of the freezing of programs at 1976 rate levels. The insurance department liked the idea of the competitive marketplace for health rates. The department then could avoid the impossible issue of having to deal with solvency on one hand, and all the consumer pressures on the other side.

MR. HABECK: Another regulatory question covers multiple employer trusts and various self-funded plans. What does it take to make a MET profitable, and what has been the pattern of problems that we have discovered in looking at METs, whether they are self-insured or connected with insurance companies?

MR. DAVID W. KRUEGER: The main regulatory thrust in Illinois and California has been to bring the self-funded METs under state jurisdiction. The self-funded METs have been escaping state regulation by claiming that they are regulated by ERISA, and thus exempt from state insurance department rates. Because of continued insolvencies of some of these self-funded trusts, insurance departments wish to bring them under their direct control, to protect employees and providers. Also, the Erlenborn-Burton Amendment to ERISA, passed in late 1982, gives the states more power to regulate self-funded METs.

Another situation involving regulation and METs might be the multiple employer trusts underwritten by small insurance companies. If such trusts are mismanaged, the risk taking company may not have the resources to pay all the incurred claims. Insurance departments may be making closer reviews of such situations under their jurisdiction.

A third area in which regulation may influence small group trust business concerns "substandard" employer units. We gradually have moved from a guaranteed issue basis to some form of medical underwriting on these small groups. This underwriting may just consist of short-form questions, or include follow up questions on specific medical problems. What may happen in the future is that those employer units or those insureds within the small employer units who have claims may be denied coverage or rated very high. These employers are prohibited from enrolling in a new trust because of the pre-existing conditions clause. Carriers try to improve their block of business by selecting the better risks. How are these people going to be covered? The answer might be a sub-standard class of insureds or some type of risk rating pool administered by the insurance department.

MR. ROBERT C. NUDING: In the New York legislature, there is a draft bill in committee which would address the questions of solvency and disclosure of self-insured arrangements, including the overall question of an uninsured MET. If solvency review is to be a part of this bill, the department may need additional resources, and thus require some sort of a premium tax or

financing arrangement. Otherwise, it appeared to me that the bill was requiring the commercials to support their competitors even more than they are perhaps doing now.

MR. HABECK: Bob, would you care to comment on your staffing needs and budget requirements? It may relate to some of the delays that people have talked about.

MR. NUDING: We have had some turnover among our actuaries, and have encountered budget freezes. However, we are not falling substantially behind in our backlogs of reviews.

MR. HABECK: I would like to compliment the department on the practice of acknowledging the letter upon receiving it. Then we know that the correspondence is in line for review.

MR. SIEBEN: Blue Cross plans will feel the effect of the small company or self-funded MET failure rate. These organizations may set competitive rates against Blue Cross coverage, and after taking a portion of the business may go bankrupt. The state guarantee fund may pay off the outstanding claims, but then assesses the carriers that have business in the state. Blue Cross usually has a large percentage of the market, and thus has a high assessment plus the loss of business to the bankrupt company. We should help regulators obtain the budgets necessary to do an appropriate solvency review.

MR. HABECK: A federal issue that could be occurring in some states is the risk classification requirements that may be passed by Congress. I would call this an external influence since it clearly comes from a federal level. Does anyone have any plan to cope with that requirement?

MR. THEODORE W. GARRISON: Those of us who have opinions on the subject of risk classification should certainly be in touch with our legislators, senators and representatives. There will be ramifications of the law if it is passed as now proposed, that I think if some of the proponents of the law appreciated what the impact was going to be, they would not have necessarily supported the law.

Insurance companies are not going to continue to offer benefits that are sure losers, and the pricing actions and the availability of products will be based on the expectation that these products are self-supporting. Perhaps the Blues will be forced to subsidize certain classes, but insurance companies will have a little more freedom.

The risk classification law would be, in effect, a prohibition against selling life insurance to females at reasonable rates and a prohibition against selling reasonable insurance policy annuities to males at reasonable rates. Those products will not be available. The rating of risks will have to reflect the risks that are actually sold. The individual health insurance policy probably will generally not be available for people under about age 40, because every policy will have to anticipate the payment of a maternity claim.