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HOSPITAL PERSPECTIVE OF HEALTH CARE FINANCING

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1. Relative roles and interdependencies between providers and insurers - traditional and future.

2. Risks and financial incentives from the provider perspective.

3. Marketplace forces determining trends in inflation and utilization in the health care arena.

MR. ROBERT H. DOBSON: There is a spectrum of different relationships between the delivery of medical care and financing and two extremes have existed for a long time. The traditional or independent system, which I call the open system, is at one extreme. It is a familiar system in which the insurance company provides the financing of delivery care; physicians operating independently are reimbursed on a fee-for-service basis; and hospitals operating independently are reimbursed on the basis of their billed charges. The other extreme I call the closed system. The financing is provided by a health maintenance organization (HMO), which actually employs physicians and owns and operates the hospitals. You can have a hospital owning and operating an HMO which then has physicians as employees. Several countries have closed systems, if you substitute government for the HMO as the financing vehicle.

We have a lot of gradations going from one extreme to the other. I have ranked various financing mechanisms by how much control they have over the delivery system. The first one is a traditional group carrier. This is changing as carriers get involved in more utilization review and other types of arrangements. Next comes the Health Care Financing Administration (HCFA) which handles medicare. I suspect that some of the hospital people say HCFA exercises a great deal of

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control over the delivery system. In theory, it operates independently though the reimbursement mechanisms certainly have a major impact. Next come Blue Cross/Blue Shield Plans. They vary from state to state but have more contractual relationships and more direct involvement with the delivery than either the HCFA or traditional group carriers. Next are preferred and exclusive provider organizations. These take any number of forms, so they could fall anywhere on the spectrum, depending on the model, but we're moving nearer to the closed end. Next come individual practice associations (IPA) and group model HMOs. These HMOs don't actually have physicians as employees, so we are still only moving nearer to the closed end. Next come hospital chain insurance plans which are fairly close to the control end of the spectrum. Finally come staff model HMOs, with physicians as employees. The order of these last two is debatable. I put the staff model HMO at the far end of the spectrum, because the physicians are employees and they order all of the care. You could argue that the hospitals controlling 60 percent or so of the total expenditures would be closer to the control end of the spectrum than the staff model HMO.

Full freedom of choice among providers will be phased out rapidly in the changing environment. Limited choice of providers is here to stay and will quickly take over the whole market. I wouldn't have stated this quite so strongly if it hadn't been for the United Auto Workers agreeing with General Motors to let the preferred provider option be their primary program. That shows that union plans will also move this way. Limited choice is something that we need to accept as part of all of our programs.

A direct consequence of limited choice will be more efficient providers. Inefficient providers will either be forced to become more efficient or leave the marketplace. Trends in rating medical care coverages will be dampened during the transition; this certainly has happened during 1984 and will continue as the inefficiencies get shaken out of the system. Medicare diagnostic related group reimbursement has contributed to what has happened. What happens when all the inefficiencies are out and we have a relatively efficient medical care system? Medical care cost trends will remain above the increase in the consumer price index (CPI) forever because of technology. Medical research is an incredible industry and the demand for technology and research will remain high. As long as new and more costly procedures are being introduced, the medical care trend has to remain above the CPI. Both the aging population and entitlement mentality keep the demand for medical care and technological increases high. The American public believes that everyone has a right to good and unlimited health care regardless of ability to pay.

Wellness relates to entitlement mentality in an important way. I won't argue that wellness isn't good for individuals. In the working-age population, it cuts down on medical care costs, absenteeism, and so on. But when we talk about prolonging life, we're talking about increasing social security payments, and the guy who drinks and smokes and dies of a heart attack at age sixty-five costs the society a lot less than the health nut who lives to age 90.

The forces I've described will result in a major government intervention over the long-term. Medical care costs will remain above the CPI, but it can't equal the entire gross national product, so eventually, I believe Uncle Sam will determine the long-term future of medical care.

MR. WESLEY J. BURBANK: The hospital industry is reevaluating and reorganizing. Hospitals are facing a crisis in losing market share. The insurance industry has stated that it is only going to pay 50 percent or even nothing if certain procedures are done on an inpatient basis. The census in the hospital industry has decreased about 10 percent over the past year - a 10 percent decline in revenue with no corresponding decrease in expense because a great majority of that expense is fixed. Revenues have also declined because the federal government is controlling what they are going to pay through the diagnostic related group (DRG) system. The DRG system has helped some efficient hospitals but has hurt some of the inefficient community-owned hospitals. In response, hospital companies like Humana are getting into the insurance side with preferred provider organizations (PPO) or HMO arrangements. Hospital Corporation of America bought out Hill Richards, a third party administrator (TPA) in South Florida, and they also have bought two insurance companies. AMI in Beverly Hills have bought an insurance company and are now looking for an actuarial and underwriting staff.

The whole health care industry is going through a change; traditional relationships and functions are being replaced by new arrangements. Physicians are signing up with HMOs for salaries of $50,000 to $75,000 but with the HMO paying malpractice insurance. Physician groups are setting up HMOs. Coalitions across the country are being set up; Arizona has one with over 1300 members. They are trying to get the state to set DRGs for all payers. They are trying to get a three-member Arizona health care authority set up and a certificate-of-need review on all capital expenditures in excess of $100,000. That's going to impact on the research.

This change is affecting the financing of hospitals. If we see our declining revenue resulting in reduced profits, we have to find some way of increasing revenues. One way of doing that is to redirect patients from other facilities into our own. And in talking to specific clients, we found that they want the provider to be involved in the risk. Kaiser has been involved in it for many years. Humana is taking the risk also, through either an insurance arrangement providing and redirecting people into our facilities, or through an HMO arrangement where one has no choice. Humana has assumed some of the risk by working to maintain market share from a provider viewpoint, so our financial incentives are still there.

MR. MICHAEL F. KIPP: Signature Health Alliance is a shared services corporation created by Nashville Memorial Hospital, Vanderbilt University Medical Center, and Saint Thomas Hospital, together with their attending physician staffs, for the purpose of offering the middle Tennessee marketplace a preferred provider option. Following that initial offering we are developing a competitive medical plan and a fully capitated option for the commercially insured.

This is the age of discontinuity in health care. Four key events strongly influence market share considerations. With the Supreme Court striking down the time honored "free choice" ethic of the American Medical Association which prohibited price competition, advertising and contract practice opened the legal door to insurance plans and other arrangements which limit consumer choice to a smaller subset of the provider community. The introduction of DRGs, among other things, introduced a product orientation into what historically had been a time sales industry. Aggregate consumers - benefit managers and others who buy health care for as many as several thousand people at a time - have long since given up the idea of health care as a benefit to be given away and are sharpening their capacity to manage what they think is a runaway cost center. Health care has moved into an unprecedented era of horizontal and vertical integration. The integration of greatest interest to this group is the blending of health insurance with health provision. Providers can see a point in the future when the payer will control the flow of patients and the doctor will no longer serve as the gate keeper. As one of the prime advisors to the payer/plan sponsor community, actuaries will have at least a different, if not, an enlarged responsibility.

There is a fundamental misconception that alternative delivery mechanisms, such as preferred provider arrangements, are responses to the pressure for cost containment. Alternative delivery systems have nothing to do with the demand side of the equation. They arise from a condition of oversupply - too many beds, too many doctors, and too much capital. In Nashville, for example, there are ten beds per one thousand population as opposed to the national standard of four; and while many urban areas have a ratio of thirteen physicians per ten thousand, Nashville has something in excess of twenty-six. According to The New England Journal of Medicine, there should be nearly 45 percent more physicians in active practice in this country than there are now by the year 2000. There are literally scores of companies building health care capacity in hopes of being bought up by one of the major chains as the industry consolidates into a more classic market oligopoly. The marketplace is breaking up the supply side into competing groups. The chains obviously have the deepest pockets and widely dispersed networks to sew up market share and dictate other's positions in the industry.

The "Balkanization" of the practice environment where doctors and others are identifying the profit centers in the hospital setting, walking them down the street, and setting them up on a freestanding basis as limited partnerships will reverse itself in a few years. Cardiac catheterization clinics, outpatient diagnostic centers and the like will be bought by larger systems as satellites. Taken together with the loss of market share from outside the health industry to insurance carriers who are converting their "books" to contracted health plans, these are disturbing discontinuous times indeed.

Doctors feel strongly that management is winning the battle for control. The doctors make 70 percent of the decisions but 15 percent of the income. Consumers and health management want doctors to do less and take less for it. In many of the emerging arrangements, some doctors

feel disenfranchised and have a tendency to communicate this to their patients inadvertently subverting the market-oriented reform underway. In a 1984 Harris poll, 48 percent of the physicians surveyed indicated that they would not recommend medicine as a career. Supply is one of three prerequisites to making a market. (Table A). The first prerequisite is the availability of alternatives. So market share pressures do not apply in a town with a small physician community where the hospital is the sole provider. You need genuine choice of providers or in marketing parlance, product differentiation.

The second prerequisite to creating a market is the availability of information about those alternatives - prices, quality, and outcome. This is essential to creating a "prudent buyer" climate. It is also good to know how many of a certain procedure a particular hospital has done.

None of this will make much difference unless the consumer has a real incentive to shop. The Rand Cost Sharing Experiment proved the point that differences in copayments and deductibles do account for differences in utilization patterns.

Table B shows what the shape of the market looks like to us as providers. I am suggesting nonscientifically that the shape of the health care market is like the confluence of three different variables. On the hypotenuse of the triangle, you have consumer freedom of choice - very high on the left and very low on the right. Up and down the vertical axis are consumer out-of-pocket expenditures, which are going to be high at the top and low at the bottom. Across the X axis is the level of risk a provider is willing to assume. Segment A is the traditional indemnity market where provider risk is very low and consumer choice is very high. You can go anywhere, shop anywhere; we think that is generally going to define about 20 percent of the market. At the other extreme, consumers are sacrificing freedom of choice, choosing from a smaller panel of providers in exchange for lower out-of-pocket costs. That is the traditional HMO market - restricting choice and lowering out-of-pocket costs - and the provider is taking on a greater risk. Sector B is the PPO marketplace where providers are willing to accept a slightly higher degree of risk, and consumers are willing to accept a somewhat limited choice of providers. This is ultimately going to amount to about 50 percent of the market, with indemnity plans being about 20 percent and HMOs about 30 percent. The surviving integrated provider will be in all three segments.

This aggregate picture of the market applies equally as you break down health care to particular fields and specialities. St. Thomas Hospital does 1,400 bypass surgeries a year in a metropolitan area of 500,000. The rate of bypass is about 700 per 1,000,000 population per year. In order to drive that market and maintain that market share, it takes a population base of 2,000,000 or more. The importance to the tertiary care facility of the sole provider in Hopkinsville, Kentucky, and the necessity of establishing linkages so that patients are channeled into Nashville (rather than Louisville) for specialty care is obvious.

The effect on provider selection once these choices are introduced can be dramatic. A 4,000 employee group decided five years ago to encourage competition in the local health care market. Over a two-year period, the company introduced a high deductible Blue Cross plan, two HMOs, and two PPOs. A profile of their "insurance demography" over the course of the next three years is shown in Table C. There were tremendous shifts in enrollment. Interesting questions are raised such as who stays in traditional indemnity plans, why do they stay, and what's the effect of adverse selection? From a provider perspective, the fundamental question is how to get on the positive side of those shifts.

My company looked at a prospect much like this company, where there were a number of factors driving health costs. It was a client where the benefit package of basically first-dollar coverage had been won at the bargaining table. The rates of coronary bypass and heart-related disease were very high. Beyond that, the hospitalization rates on a per thousand basis were exceedingly high. We put together a proposal responding to both the economic and the epidemiological facts of that population. We took a handful of DRGs related to heart disease and gave the customer a fixed price on them. We assumed risk for cost overruns and a large benefit for a very small number of recipients. Then we followed with a block of another ten to twelve DRGs whose incidence we knew was going to be greater in this work force - pneumonia, pleurisies, and normal deliveries - and offered a fixed price on those. Finally we layered in a health prevention and promotion program on the entire work force, whether they selected into our plan or not. Now we question how to rate contracts like those. Imagine having fifty such contracts, all of which are tailored on the characteristics of the specific group. It is mind-boggling and necessitates partnerships with the insurance industry.

Cost is not the issue of the 80s and 90s, quality and appropriateness are the issues. Under the best circumstances in health care, there are quality and appropriateness problems. Hospitals are not risk-free environments. In addition to being costly, they are one of the most dangerous places you can be if you don't need to be there. The combination of oversupply and consumer awareness is going to raise appetites for providers whose quality and appropriateness can be trusted and measured.

Table D shows a two by two matrix of the utilization problem. If a service is needed and delivered, that's fine. If it is not needed and not delivered, that's also fine. The problems are when services are not needed but delivered, or when services are needed but not delivered.

Let me comment on services not delivered that are needed. One of the specialties which is particularly vexing from the cost management standpoint is the whole nervous and mental disorders arena. We worked with a company a short time ago that was particularly concerned about this and discovered that in many of their hospitalizations, there was nonmedical intervention for three months before or three months after the period of hospitalization. These cases were poorly managed and consequently more costly because of neglect, both before and after the

fact. The providers that survive in the long term are going to be the ones that concentrate on quality and appropriateness and are able to prove it.

Survivors are also going to be those who develop a genuine market orientation rather than a fixation with the product or the technology. You want to be there as a health provider delivering good quality care consonant with the changing use and cost patterns in the marketplace.

Survivors will also know the importance of choosing the right partners. A selection process of choosing insurance partners is going on across the industry as we move into an era of horizontal integration. Every insurance company, as well as provider, is looking for market share, so there are tremendous temptations to form quick liaisons. Choosing the right kind of partnerships in TPAs and insurance carriers is going to be fundamental to success.

The time is approaching when the payor not the doctor will control the flow of patients. This means three broad implications for the actuarial community. As the health care environment changes, so must the actuarial "product". The requirements for horizontal integration within the actuarial community are probably almost as great as they are in the health care community, much like the banks getting into insurance or CPA firms getting into the consulting business. There is going to have to be a multidisciplinary approach incorporating substantive areas outside actuarial science to protect your market share. Your challenge might be one of making responsible providers profitable, seeing to it that they are around to do what needs to be done.

MR. ROBERT C. BENEDICT: Some of those insurance companies setting up PPOs maintain that preauthorization of hospital confinement and monitoring length of stay is essential to the success of the PPO. How do the hospital chain representatives on the panel react to the contention that allowing the hospital to control utilization review or patient management is allowing "the fox in the henhouse"? Does your chain or will your chain redirect patients to an outpatient facility in the normal course of action for certain low-risk procedures?

MR. BURBANK: Given that hospital chains are marketing fully insured products whereby they are assuming the risk of insufficient premiums, they will lose on the insurance operations if they do not use their preauthorization and utilization review procedures to redirect people to an outpatient setting.

MR. KIPP: My entity is a separately incorporated preferred provider organization. The quality review and utilization management system we use involves an externalization of the preadmission screening. It also involves a surgical indicators monitoring program and a stiff concurrent review program where in the case of one of the hospitals, eight nurses review every patient's chart every day for appropriateness of continued stay.

MR. DOBSON: I would say that my feeling is that hospitals are going to have to do that to survive. The ones that are delivering unnecessary care or inefficient care are not going to make it in the changing marketplace.

Table A

PRECONDITIONS FOR "MARKET"

1. AVAILABILITY OF ALTERNATIVES
2. INFORMATION ABOUT PRICES
3. INCENTIVE TO SHOP

Table B

HEALTH MARKET SEGMENTS

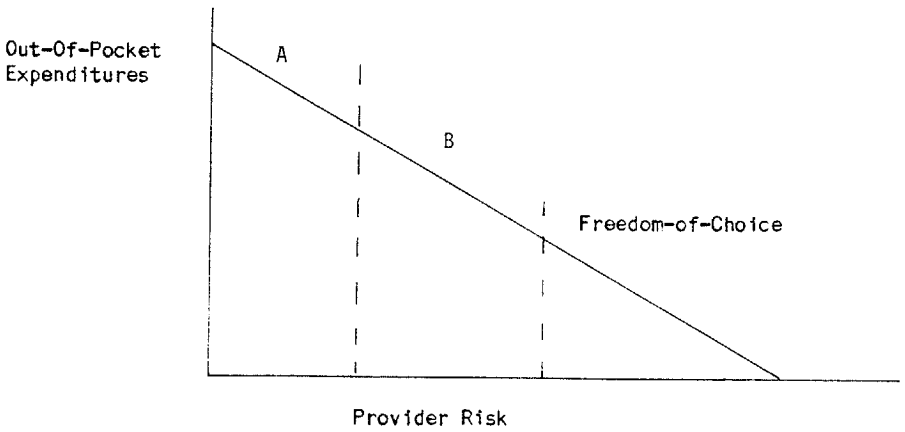

Table C

XYZ CORPORATION

SHIFTS IN PLAN PARTICIPATION

	1981	1984
Traditional BC	55%	21%
Deductible BC	3	3
Kaiser	24	19
Health America	6	12
PPO #1	4	34
PPO #2	4	8
	96	97

Table D

THE UTILIZATION PROBLEM

	DELIVERED	NOT DELIVERED
NEEDED	OK	UNDER UTILIZATION
NOT NEEDED	OVER UTILIZATION	OK