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HEALTH INSURANCE FROM A NON-ACTUARY'S VIEWPOINT

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Experts from outside the actuarial profession, including a regulator, hospital administrator and physician, will give their perspective on:

- Why health care costs so much
- Insurers' role in medical care management
- Relationships between treatment decisions and available coverage
- Appropriate use of underwriting
- Paying for uncompensated care

MR. NORMAN E. HILL: Our first panelist is Mr. William Henning, Vice President of Operations at Piedmont Medical Center, in Rock Hill, South Carolina. Bill has been with Piedmont and its parent, AMI, for over nine years.

MR. WILLIAM C. HENNING: To look at it from a hospital administrator's perspective and from an operational perspective, there are several reasons why health care is so expensive. First off, it is a service-driven industry and it is very labor-oriented. If you look from 1987 at our particular hospital, the cost, or the labor hours per person that we treat, has increased 40%. We have seen that big of a jump in the rate of labor we must apply toward the patients that come into the hospital. On top of that, it is very expensive labor; it's highly skilled and highly priced. For instance, several years ago, a pharmacist earned about $35,000 a year. Now, the annual salary of a pharmacist is upwards of $50,000 a year.

Another major reason for increased health care costs has been technology, including new drugs, new treatments, new diagnostic tests, and a wide range of what we call bells and whistles within the health care industry. Those things have been, on the whole, very beneficial. We have definitely saved lives that would not have been saved even 10 years ago. We have shortened the length of stay for many people who come into a hospital. As you know, a lot of treatment is now done on an outpatient basis, where years ago it took several weeks of inpatient hospital treatment. Some of you may remember that going into a hospital to have a baby required staying for seven to ten days. It now takes 24-48 hours. You may remember that when if you were having orthoscopic surgery on your knee, a patient might have

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been in for a week and there were several weeks or several months of physical therapy. The patient is now in and out in one day, and many people are back at work within a week. So technology has provided a lot of good things in the health care industry.

A wide range of new diagnostic tools have been created, and anytime a diagnostic tool is available, it's going to be used. In the area of imaging, for instance, we've gone from a basic X-ray, to Computed Tomography (CT) to MRIs. Positron emission tomography (PET) scanning is down the road. So new diagnostic's tools, while they are letting us learn more and more about what kind of illness somebody has, are very expensive. We've gotten very good with the technology of treating people and generally using that technology to create less expense, but we have a lot more technology on the diagnostic side, which is going to increase expense quite a bit.

Technology has allowed us to extend life. From a personal standpoint, a good friend of mine has cancer, and a year ago he came into the hospital and would have probably died soon, had it been even three or four years ago. A year later he's still living, and is a very productive member of the hospital. A great amount of money was spent to keep him alive this year. That degree of major expense is also, unfortunately, being used in a lot of cases for the older population. I don't mean unfortunately from the standpoint that these people shouldn't have it, but this is the population group for which the hospital receives the least reimbursement. As an example, at our hospital, 65% of the people who are in our intensive care units, our critical care units, or our step-down units, are over the age of 65. These are our most cost-intensive areas. On the other hand, the healthier population, those under 65, make up a larger portion of our less intensive services. So as you can see, we're spending more and more resources on a smaller portion of the population. In essence, we are aggressively treating the very young and the very old. From a hospital administrator's standpoint, those are the two areas from which we see the least reimbursement.

Probably the final thing that has really driven up the cost of health care is uncompensated care, and by that I mean both indigent care, uninsured workers, and Medicare and Medicaid patients. Basically, no health care is free; someone pays for it. At our particular hospital, we give a 63% discount, on the average, to Medicare and Medicaid patients. That means we are giving away 63¢ on the dollar that we will never collect for those types of patients. Of the rest of our patients, 21% of those are indigent, or don't have any kind of insurance, and we end up having to write that off as bad debt. For some, we collect, on the average, 52¢ for every $1.

With the increase in expenses and the lack of payment that 52¢ on a dollar shows, we have a phenomenon called cost shifting that's occurred in the last 10 years. Most of you all probably understand cost shifting. When we do a rate increase, since all prices go up, we calculate the rate increase that we're going to need based on what portion of the population is going to be able to pay, or will pay, for that rate increase. For instance, if we decide that we need a 5% rate increase based on an increased cost in supplies, or an increased cost in labor, but only 50% of the people are going to pay for that 5% increase, then we're going to have to have our overall increase at a 10% level, just so that we can at least try to get 5% of the revenues back. But these increases are not to try to make more money; basically they're to try to survive. At our hospital, we've had rate increases of between 7% and 12% over

the last five years on an annual basis. At the same time though, our operating income, prior to fixed expenses and interest costs, has dropped from 24% to 12% of our gross revenues. So our operating income prior to our fixed expenses has been cut in half as a percent of gross revenues.

Survival is not just crying wolf or being Pollyannish. In our county of 100,000 people, 20 years ago there were three hospitals. Up until a year ago, there were two hospitals; there's now one hospital. A hospital that was in the other end of the county that was heavily Medicare and Medicaid-oriented basically went bankrupt. It had to shut down for inability to meet costs, and had no way of taking care of indigent care. So at our hospital, decreased reimbursement representing a percent of charges from the government sector, combined with increased uncompensated care, have increased our cost shifting by one-third in the last seven years. That means that the insured patients are probably paying one-third more than what they did seven years ago, just to help take care of the people who don't have the money or who can't pay for their bills.

The final reason I want to touch on for increased health care costs is long-term care. A phenomenon you have probably heard or read about is called "granny dumping." We have extended life greatly for many people; they are able to stay alive for quite a period of time. Unfortunately, this also creates a tremendous burden on the family. Yes, we can keep people alive who require round-the-clock care, who require someone to be with them in the home all the time. As many of you probably know, in the two-wage-earner family, there isn't anybody there to take care of the grandparents. So what happens? They have to try to find a nursing home for the grandparent. Unfortunately, in many states, nursing home beds are in short supply. Therefore, what happens if the people can't take care of them at home and can't find a place for them in a nursing home? They end up staying in the hospital. Many of these people are reimbursed under the Decision Resources Group (DRG) Medicare payment. This means, whether you're there three or four days or six months, except for some minor changes in your per diem rate, you don't get any additional money. So who's going to take care of these people, or who's going to pay for these people? Once again, the insurance patient is going to help foot their portion of the bill.

I want to talk about what the insurer's role in health care management could be. From a hospital standpoint, what could the insurance companies do to try to help manage health care? First, educate insureds on their coverage. Many people out there don't know what they have until they show up in the hospital emergency room. Yet, from our standpoint, imagine a clerk who makes $5.50 an hour, who only has a little sheet to work with, trying to explain to somebody who has an injured child, in the back of our emergency room, what their insurance coverage is. It's next to impossible. Most people say, "I have insurance, no problem." The diversity of coverage out there is amazing. Many people are suddenly shocked when they realize that they have to pay for the bill. It's amazing how many people think that insurance means that they don't have to pay for any portion of it whatsoever. So what ends up happening is hospital personnel try to explain to people what their insurance coverage is. In many cases, employers have not only one insurance policy, but may have multiple insurance policies, managed care policies, etc. It thus gets really confusing trying to figure out what an employee actually has in the way of insurance.

One other thing that insurers could do is make the insured patient feel some of the financial pain for coming to the hospital. Many policies these days are set so that when somebody reaches their deductible or maximum out-of-pocket expense, it's basically a free ride for them thereafter. There's no subsequent incentive on their part to try to become a cost-conscious consumer or to try to manage their stay effectively or cost consciously.

Next, a word on the area of managed care. If you want to use managed care, don't try to squeeze providers without giving something in return. Many managed care plans, such as PPOs, have come to our hospital basically wanting flat discounts, but not wanting to give anything in return. You must remember, hospitals have to make a profit just like everybody else has to make a profit. Therefore, be willing to use exclusives and to force insureds to go where you have a contract. Don't expect a discount without trying to send volume toward the provider. That's the only way that they make up for giving discounts.

And the other final thing is, don't ask for Cadillac service if you're only willing to pay Chevrolet prices. So many people want the best, but then they're not willing to pay, or they only want to pay for something less. You have to tell the insured people, "Here's what you get and here's what it's going to cost." Don't ask for anything above that, or if you do, realize you're going to have to pay for it yourself.

A couple of points about the treatment decisions. I want to talk a little bit about relationships between treatment decisions and available coverage. I think the most important thing is to remember that the hospital doesn't decide how a patient is treated, physicians decide that. Hospitals have very little input into the treatment pattern. Except for some very broad decisions, such as inpatient-versus-outpatient services or elective procedures, from what I've seen physicians on the whole do not really acknowledge coverage versus treatment. They really don't pay that much attention to it until after the fact, when they're trying to do their billing. This is probably flying in the face of everything you have ever heard, but, in my opinion, a second-opinion requirement is pretty much worthless. We're in a community, for instance, of 50,000 people with two general surgical groups. There are probably four or five major employers that have group coverage, and all of them require second opinions. If you were a doctor in one group who was giving a second opinion for the doctor in the other group, and you had to live with this other group in this town, do you think you would second-guess them most of the time? Ninety-nine times out of 100 they're going to go along, because 99 times out of 100 it's the right thing to do. Maybe in a large metropolitan area, it might make sense, but in an area like ours, it makes no sense to have second opinions for most treatments.

The last thing I want to talk about is paying for uncompensated care. I touched a little bit on this before. This is probably one of the biggest areas for increases in health care costs. The first thing we must do is identify the uncompensated or indigent patients. Most of these are the elderly, the uninsured workers, and the very young. All of these people basically are the ones who generate the most uncompensated care at our hospital.

Second, it's a societal problem. In my opinion, the government has dumped this responsibility on the backs of private insurers and on the backs of employers, because

they are the ones paying for it. If I was a major company in the United States right now, I'd probably be screaming for universal health care. The simple reason is, I know that's the only way that I'm going to keep from having to pay for the indigent in this country. The only way to reduce the costs of indigent care to business and industry is to spread them to all people, namely the taxpayers.

Finally, the type of health care system we have today represents what 80% of the public likes. They get what they want. Most of the public pay very little for that care. Yes, their premiums may be going up, and they're out there hollering bloody murder, but most of them pay very little of it out of their pocket when they actually have to enter a hospital. They have a very large freedom of choice, and those who have insurance, Medicare or Medicaid, get the best health care in the world. We have the best health care in the world for anybody who has insurance, who has Medicare, who has Medicaid, or who can in some way afford it. There's a 20% portion of our population out there who can't afford that care, and they are not getting the best health care available. It's only going to change when those who are feeling the level of cost shift, those who are paying for it, decide there has to be a change. In my opinion, that will only happen when the business and industry in this country say enough's enough, and it's time that we find some other way to pay for this.

MR. HILL: Our next speaker is Harold C. Yancy, insurance commissioner for the State of Utah. He has held this position since 1985. Commissioner Yancy is active in the National Association of Insurance Commissioners, and he has served on the executive committee of that organization. In 1991, he was Chairman of the Life Insurance A Committee of the NAIC. He's currently Chairman of the Education, Research and Training Task Force of the NAIC, as well as being in charge of the *Journal of Insurance Regulation*.

MR. HAROLD C. YANCY: In keeping with all of the dialogue that we've heard in recent weeks about health care politics and Congress and all of the things that have gone on there, I have to tell you a personal experience. I was at O'Hare Airport a couple of weeks ago, got off the plane, went in and used the facilities, washed my hands and turned around to push the button. Somebody had put a little sign above the machine, "Push the button and hear from your Congressman."

During the past three years, I know of no subject that has been talked about more than problems with the health care system, and with the attendant health insurance system. There have probably been more seminars held on this subject nationally than on any other topic. Yet we have seen very little change or improvement overall. We probably will continue to talk about it for the next three years. On the bright side, some states are starting to try and find their own answers. If we are lucky, we might find a developed state program that some of the rest of us might adopt. Hopefully this will happen, but if it doesn't, we can expect Uncle Sam to "solve" the problem and that solution may not be to our liking. The 1980s may become known as "the decade when we should have made changes." The 1990s probably will be remembered as "the decade when we had to make changes." In 1950, the health care cost per capita annually was $81.86, 4.5% of GNP. That figure doubled 12 years later in 1962, totaling $165.88 or 5.6% of GNP. By 1974, the per capita health care cost more than tripled since 1950, to 8.2% of GNP. The 1984 per capita

cost eclipsed $1500 and was more than 10% of GNP. Estimates for 1991 are that health care costs will take up 13% of GNP, an incredible $743 billion. At this rate of growth, a projection for the year 2000 will show $6700 per capita on health care cost, totaling 15% of GNP. This will mean that for family coverage, employers will be looking at a $15,000 bill per employee for health care.

We keep hearing that the problem primarily involves access. In fact, it really is not an access issue, it is a cost issue. Multiple factors make up the problem of cost, including an aging population, excess institutional capacity, an oversupply of physicians in some areas, increasingly expensive and intricate procedures, overtreatment and overtesting of patients, more costly technology, and cost-shifting between those who can pay and those who can't. As you think about this list, you soon conclude that it is not an insurance problem that we are dealing with, but a societal problem. Until society feels the pinch sufficiently for them to change some of their attitudes, significant progress will not be made. The biggest single problem we face is the vested interest of all of the people who now own the health care system. Every entity out there that is part of the system carries its share of the blame for the predicament we find ourselves in. Turf battles continue with little evidence of compromise. Until everyone is willing to give up something, solutions will be slow coming.

For example, let's talk about the companies for a moment. They're in a cycle where their actuaries tell them what premiums need to be for the coming year, and they raise rates accordingly. Pass-through rate increases are the order of the day. But we are approaching crunch time and other solutions must be found. Insurers have been on a crusade to write the best risks. All kinds of tactics have crept into the marketplace, some that are borderline unethical and some that are outright dishonest. The little guy, the small businessman, has been ignored. Equal time is needed to find ways to handle his problems. They could be solved if we worked at it as hard as we have worked to skim the cream from the marketplace.

You and I are part of the problem. We want the best, we want to be able to go to the doctor at any time, have tests, fill prescriptions, the more the better. After all, someone else is paying the bill; usually we never see the bill. Cost control measures are something somebody else should worry about. "Don't raise my copayment or my deductible; after all, my employer has lots of money and he can pick up the tab." The consumer will have to start paying more of the bill. Deductibles and copayments will have to be raised until it starts to hurt. This is the only way you and I will be educated as to the cost of the system.

The doctors and the medical profession are part of the problem, also. Then costs are rising 12-15% a year. Their attitude is to get theirs now because the system will ultimately change. There is little evidence that they are interested in cost containment. All of us have seen evidence of doctor and hospital billings that are outrageous. We shrug our shoulders and we accept it. Generally, doctors don't consider cost when prescribing treatment. They would argue that it is either needed or it isn't. You and I are smart enough to know that there is a large gray area out there, and cost benefit ratios must be considered. Twenty to 30% of everything done by doctors is either ineffective or unnecessary.

Thirty-five percent of hospital beds are empty. Soon there will be one doctor for every 300 Americans. In eight more years, the medical budget will exceed social security and the defense budget put together. In eight more years, we will be spending 25% of GNP on health care. All of this is taking place in an environment where 37 million Americans are uninsured. Obviously, it isn't that we aren't spending adequate funds on health care, it's that there is so much waste and inefficiency in the system it is starting to eat us alive.

What about solutions? Everyone has their own set of solutions. I am far from an expert in this area, but I am smart enough to know that solutions must include the following: (1) effective cost containment, not cost-shifting, has to be an integral part of any solution; (2) a basic no-frills benefit package must be put together with emphasis on primary care: it must be made available to everyone, and it must be tightly managed; (3) the employer-based health system must be expanded, with a safety net for those not employer-based; (4) some kind of community-rating system must be adopted, and that system must include ERISA-type plans; (5) public health prevention and a public education component are important ingredients; we must start the process of changing our thinking about health care; and (6) standardized claim handling should be considered. Someone has estimated that $50 billion a year could be saved with a standardized claim form and a standardized claim system.

I have detected that some feel that state insurance departments should be leading the parade on health care reform. I disagree. Commissioners are regulators, and we are extremely busy and involved trying to provide fair, timely, and effective regulation. Insurance departments need to be players around the table as these issues are discussed and as reforms are made, but we cannot be the originators of legislation, nor the catalysts that get it adopted.

In closing, let me briefly share an example from the state of Utah. As you know, there are something like 28 or 30 states that have already adopted some kind of uninsurable pool. Utah did this two years ago. Funding was a major problem with this piece of legislation. We went in with a request for $5 million, which is a drop in the bucket to handle an uninsurable pool. We were successful in getting $2 million with the promise that we would get $2 million each year until we had $8 million. The amount plus the premiums that are charged for the people in the pool hopefully would be the foundation base that we would need to keep the pool solvent. That remains to be seen. We were successful in getting an additional $2 million this last legislative session. We continue to have to limit the number of people we can insure in that uninsurable pool, and we will have to continue restrictions until we have adequate funding. It's estimated that in the state of Utah, there are about 5,000 people who are uninsurable. That's a figure that we don't really have a lot of faith in, because we really don't know.

That's an example of the type of steps some states have taken to try and put this puzzle together. The message came through loud and clear in our last legislative session that health care will be the number one topic next year. There was very little health care passed during this session, but it was surely on everyone's minds. Depending on what happens federally, I would imagine that same scenario is probably true in most every state. The problem of course, is that there's no money; practically every state is working under a deficit situation. As we all know, the federal

government is operating that way, too. But step by step it will happen, and as the screws turn tighter and tighter on cost, we will have to find some answers. I hope that you and commissioners, companies, actuaries, physicians and hospitals, will be part of the solution and not part of the problem.

MR. HILL: Our third speaker is Peter C. LePort. Dr. LePort is in general surgery in Orange County, California. He's a member of the American Board of Surgery, certified since 1981. Prior to his private practice, he was assistant professor of surgery at Downstate Medical College.

DR. PETER LEPORT: What I'm going to present is probably totally different from what you've been hearing. I'm going to try to present the underlying cause for increases in medical costs, something which I think is being ignored completely today. In order to do it in a short time and try to convince you, I'm going to start with an example outside of medicine, something that hasn't happened yet, but may occur.

Imagine you own a restaurant, a large, respectable restaurant, and your business manager walks in one day and says, "Washington has just passed a law. We must supply food to everybody over 65 and all those under the poverty line. Food is a right for the people, they have to eat it, they're going to die if they don't get it, restaurants are already set up to deliver food cost-effectively, and this is what we are going to do." You sit down and try to figure out now what in fact you are going to do. How much meat am I going to order tonight in my restaurant? Am I going to order more fish? Do I need more alcohol or soda? Will I have any customers coming at all, or are they going to go down to my competitor, who seems to have been doing a better job in the last year or two than I have? What you decide is essentially to do nothing and wait and see what happens, what is going to happen as the demand for food goes up. Essentially, McDonald's is going to go out of business, and all the whole cuisine restaurants are going to be making a fortune. The government's paying for it, people should have as much food as they need, and why not the best quality? Does this sound fantastic? I don't know much about the insurance industry today, I'm certainly not an actuary. I'm assuming that you make your premium calculations based on death rates, injury rates, illness rates, sex differences, and geographic differences, and also on the cost of hospital construction, the cost of running hospitals, the cost of ambulance care, things of that sort. Then, Washington decides to pass a regulation. Discrimination is bad, we shouldn't discriminate between men and women. Hospital insurance policies, life insurance policies, and auto policies new and old should be the same price regardless of sex. What happens to your insurance policies, which have previously been based on statistical analysis and past occurrences that reflect actual cost differences between men and women? Some of these policies may have annual premiums that are guaranteed for a certain number of years. The likely result is that somebody is going to lose money somewhere.

What if Washington says health care should be the same in the richest urban enclave and the poorest rural area? It's irrelevant that people get killed more frequently in the latter area, and that the disease rates are higher; we have to have the same cost. Again, some insurance companies are going to react to it and know how to cope, others are going to go out of business. What actually happened in medicine? In 1965, Congress passed Medicare; they said we needed more hospitals to take care

of people. We also needed more doctors, so they increased funding for hospitals and medical schools. How did this change affect insurance policies 15 or 20 years later, when financial consequences finally came into being? How could anybody have projected what that would be? They essentially couldn't. As far as I understand health insurance policies, they've gone from premium increases every five years to every year. Now some of my patients say Blue Cross is raising its rates every three months. How can the insurance companies avoid doing that if they don't know what their cost is going to be three months later?

Why am I talking about calculations? Calculations, being able to project in the economy, are just one obvious symptom of what's going on. We're moving from a market economy to a socialist economy, and medicine is in a sense leading the way. In a market economy, the buyer determines the value of the object. They either buy it or not, they determine how much they're willing to spend for it. In a socialist economy, bureaucrats sitting behind the desk decide how many hospitals there should be and what the cost of each hospital should be. They decide which diseases should be treated and which shouldn't, and since they can't go around and get inside everybody's head, they don't know who wants what. Therefore, they just decide for themselves arbitrarily. It may sound a little fantastic, but take a look at eastern Europe and Russia and what is going on today in the world. Those economies were purely socialist economies, but now they've gotten down to the stage where they're totally falling apart. Everything was free, people supposedly had whatever they wanted, and they ended up with nothing. What are the politicians and the newspapers saying today is the cause of our medical costs going up? They claim that doctors are charging too much money. Before 1960, physicians earned seven times the per capita income. After 1960, up through about 1970, the relationship went up to 12 times. It is now down to nine times and dropping. In 1929, 27% of health care costs were physician-related; in 1950, it was 25%; today it is 20%. Is this just being used as an excuse? Why are all these figures completely ignored?

How about the insurance companies? They're charging a tremendous amount of money for their policies, and the complaint is, people can't afford it. Supposedly, that's why we have all these uninsured people. What do people expect insurance companies to do? Lower their prices and go out of business? We know that costs are increasing. Medicare actually pays $22 billion less than actual charges that occur in hospitals. Somebody has to pay that $22 billion and the insurance companies are now covering it.

We also hear about the lawyers and malpractice. There's no doubt that malpractice insurance in some areas of the country can be $100,000 or $200,000 a year per physician; it drives up cost. But why is that occurring and why now? Are all doctors suddenly ignoring what they should be doing and is everybody being mistreated? I say no. What's happened is a shift in Washington on the meaning of negligence from, "You have done something wrong and should have known better" to "Whatever the outcome is, if the outcome is bad, then the physician must have been at fault and therefore he or she loses in court and pays tremendous damages."

Is technology actually causing an increase in medical cost? Well, if so, how come it's the only field where technology is causing an increase in prices? I remember when calculators first came out, they cost $100 and could only add and divide. Now they

are under $10, and they're almost like a computer. Twenty years ago, you had to have a whole room devoted to a computer. Now you have a computer on your desk for $1,000 that can do what could not even have been imagined in the 1960s and 1970s. Cameras, FAX machines, and the like have all reduced prices, increased their quality and increased our standard of living. Why not in medicine?

CAT scans, MRIs, and angiography appear very expensive, but are they actually? I remember when I was in training in the 1970s, a CAT scan cost $1 million and it was $1,000 an exam. Today the cost for the machine is $2,500 and the exam costs $200-300. That CAT scan exam probably saves two or three other exams, which we would have to do if we didn't have it. In essence, it's brought the cost down, not up. That's the way technology works, not just in medicine, but in every field.

Let's go back to the restaurant example. I want to do this to show what economic conditions are. Supply and demand are usually what people think of as running prices, which they in fact do. Washington unleashed that demand for food. People could get as much food as they wanted at the best quality. Allegedly, food is a right for the people. Since they can't starve, demand goes up, and, more notably, demand on the high end goes up. McDonald's goes out of business, and restaurants like Lutece and other places are making a fortune. Of course, prices keep increasing. Who's the cause of it, greedy restaurant owners? They've raised their prices in order to keep the line outside. How about lawyers? Well, they're suing right and left on the basis of discrimination, because people can't get into restaurants, the lines are too long, and restaurant owners should have known better. Of course, many have stomach aches after eating all that food, and restaurant owners should have told people not to eat so much. This allows lawyers to sue on that basis as well. Insurance companies raise their rates because liability exposures have gone up. And what about all the new food products we have, food processes, the irradiated food that makes everything healthier? That's very expensive as well. Again, this analogy refers to the same phenomena that is happening in health care today. They're all excuses for something underlying it.

What's the next solution the government might mandate? They'll say that they can't afford to pay these kinds of prices for food so they'll allot people $1 for a hamburger, $2 for a steak, $3 for shrimp, and $4 for lobster, and that's all anyone gets. What happens now? The big restaurants obviously cannot stay in business. At that level of price, they go out of business, so McDonald's is getting geared up to start all over again. Of course, they were out of business and since they have to start all over, they must be allowed a big price increase. As prices continue to go up, the next response is that people must serve the food themselves. Next, all restaurants are nationalized. In the short run, that seems to work. The social consciousness of the country is high, people don't need to go out and instead eat at home. Of course, the joke on the street is that whenever you go to a restaurant, all you get is sawdust.

Again, does this look like a fantasy? Take a look at what's happened with Medicare. Medicare started in 1965. Its projected budget for 1990 was $9 billion. The actual cost was in the realm of $95 billion. Nobody saw what was happening until the early 1980s. Of course, it took about 15 years for the demand for health care to increase. Everybody all of a sudden finally realized that health care is for free, and

people can get as much health care as they want. That realization started prices going up so high that now the government can't afford it any longer. They have already introduced rationing in the form of DRGs. In essence, the DRG is the analogous restaurant example. A hospital gets paid a certain amount for a heart attack, a certain amount for an appendicitis. If it can cover expenses for that amount, it makes money; if it can't, it loses money. So what are hospitals doing? They want to keep really sick patients out of the hospital. Therefore, if you're only barely sick, they're willing to take you.

Is what I've described how a free country runs contracts between a patient and his or her physician? It sounds more like a dictatorship that's being run by some bureaucracy, which is what's happening. Can this be helped? With prices still rising and nobody understanding exactly what's on the line, all we're hearing from either conservatives or liberals, Democrats or Republicans, is that we need national health care. As far as I can see, that is what is coming. If you look around the world, everybody talks about national health care and how it works. Of course, in England, if you're over 55, you can't get a coronary artery bypass. In Italy, if you're over 62, you can't be on dialysis. In Canada, there's a six- to eight-month waiting list for hernias and hip replacements. That's how health care gets rationed.

Once older people are no longer working, they're not paying taxes to the government. They're just people who are sapping up and using resources that could be used for younger people who are paying taxes. How about quality, why does the quality go down? I don't know how many people remember the brain dream that was talked about in Canada or England in the 1970s. Physicians left those countries as national health care came into being. Generally, good physicians left and came to the United States.

What does the future hold for us? Probably very high costs. I don't think any of the things offered to date are going to keep costs down. Eventually we won't know about it, because the government will be controlling prices. If the government says a coronary artery bypass will cost $2,000, that's going to be the price of it, and no one will know what the actual cost is. Quality will be down, because physicians who could offer it are not going to be willing to be told how to treat a patient, they're going to leave. As to physicians who are willing to be told how to treat their patients, you wouldn't want to have them treat you.

Again, look at eastern Europe and Russia. Look at the hospitals, and listen to doctors who are coming back after seeing what kind of care is going on there. It's absolutely horrendous and it was all for free. Rationing of that sort will continue on all levels in the country on the basis that it's cheaper to allow patients to die than to actually treat them. Can this be reversed? I would hope so, but I seem to doubt it. All signs in medical care and certainly in almost every other field are that we are going to a socialist economy instead of a capitalist type of economy. While the rest of the world seems to be moving toward less socialism, we're not. People need to see that controls do not work, regulations do not work, they never work. Regulations merely lead to more regulations. In the short run, people see that they're going to get an advantage, but they need to start looking, that in the long run, nobody benefits from any controls over the economy by the government. People need to realize that individual rights need to be protected. There are no group rights, there are rights only

of individuals in those groups. Unless we stop interfering with the right of a doctor to treat his patient, the right of a patient to contract with a physician in medicine and in every other field of economic endeavor, we're going to continue to spiral downward. We need to learn that initiation of physical force against an individual who is not forcing anybody else to do anything is morally wrong, it doesn't work on any level and it will only bring disaster. In other words, we need a basic philosophic change in this country. People have advanced to something only glimpsed at before, a protection of individuals against groups, a constitution that's consistent on this point and enforced.

In summary, I'll leave you with just a basic idea. Increased medical costs today are not due to anything other than increased regulations, and as regulations increase, costs are going to increase. Eventually the government is going to have to try and hide it from us, namely by socializing the entire system. Increased regulations are due to a decreased respect for individual rights, for people being able to pursue their own efforts and earn their own living. Unless we advance to constitutional protection of those rights, I think the economy will continue to deteriorate. We're going to be open to some form of dictatorship, whether of just the economy or even broader. I hope this can be avoided. The reason I came here is try to fight against it, and I hope some people will be able to join me.

MR. WILLIAM J. SCHREINER: I was very interested in Dr. LePort's references to a market economy, but that leads me to a question for Mr. Henning, and I hope this question is not misunderstood. You suggested that with respect to uncompensated care, hospitals are providing too much service to the young and to the very old, relative to compensation they receive for that service. That suggests that the market is not working with respect to that, and I wonder what your views are as to why the market is not working.

MR. HENNING: In general, we provide a large amount of service to the elderly, and to the young who are covered. In the state of South Carolina, for instance, many of the young are covered by Medicaid, and the elderly are covered by Medicaid and Medicare. The market economy really has no impact whatsoever on charges or cost from that standpoint. Since these patients don't have to pay anything for treatment, there is no incentive on their part to try to find either the most cost-effective hospital, the most cost-effective doctor, or the best way to try to solve their problem. If you don't have any financial incentive out of your own pocket to try to find the best way or the most cost-effective way to take care of yourself, you're just going to go wherever it is that you can get that care, because there's really no impact on you.

MR. SCHREINER: And the reason the hospital provides that?

MR. HENNING: It's because we are required to by law. We are a Medicare provider, and morally, since we're the only game in town, I'm not particularly going to want to turn somebody away.

MR. ALAN N. FERGUSON: I think it's kind of ironic to say that the problem that we face in cost is one of overregulation and a stifling bureaucracy. And here we are in Las Vegas, which couldn't be more laissez faire if it tried. Dr. LePort, you said that one of the problems was that in fact you're puzzled by increases in cost, when costs

in technology have come down. Well, that may be true, that costs of each piece have come down from $1 million to $250,000, but there's been a proliferation of those kinds of equipment that we have found in hospital after hospital. And I wonder if really there aren't far too many pieces of equipment. In fact, I was kind of pleased to hear Mr. Henning say that one hospital in his area went bankrupt. I guess that sounds cruel, but maybe it simply wasn't needed, or maybe we can get by with fewer facilities and fewer technological devices. Can you comment on that?

DR. LEPORT: Knowing how the economy works and what technology does to it, when something new is invented, it is definitely more expensive. When cars replaced horses and buggies, they were initially more expensive. Imagine how we would monitor somebody's health without a coronary artery bypass; how many more people would be dying? Once technology is introduced, it becomes cheaper, and it eliminates many more things that were much more expensive to do than with current technology. Computers are a typical example of that. If you had to keep manual track of everything, including paperwork that you have to keep track of today, it would be almost impossible. And it would be much more expensive doing it by hand than doing it with a computer. Technology itself in the end brings down the cost of care.

When the government is supplying unlimited funds for health care, hospitals may make unwise economic decisions, such as buying new equipment and adding new wings. When government funding is suddenly lowered, the resulting financial load on the hospital may simply force it out of business. Unfortunately, the hospital had no incentive to study economic forces before making these decisions, because no such forces were operative.

FROM THE FLOOR: Dr. LePort, I think that Mr. Henning referred to prolonging life through the kinds of care that are now available. Now I'm sure you can prolong many breathing times over. However, the consequence has vastly increased cost without quality of life.

DR. LEPORT: Let me just point out one thing. With technology, we are able to keep alive somebody who's 80-90 years old, whom I know would otherwise die in two weeks. I could probably keep him or her alive for a month. The cost would be anywhere from $200-300, to maybe $400,000. At this point, I go to the family and say, "With technology and tube feeding, I can keep your mother or father alive for some time. I can't be sure for how long; I'm certainly not a soothsayer. You have to decide, do you want your mother treated that way or not? If it's not costing you anything, but I and the hospital are going to invest $200 or $300,000, are you going to say yes or no?" Statistics that I know of show that the average person spends two-thirds of his or her entire medical bill for their whole life in the last three to six weeks of their life.

That's what technology has brought us the ability to do, but it's not controlled by economic forces. You have to do as Mr. Henning said, if you're spending the money. I know I asked my father about this dilemma, if he had three weeks left. His answer was that if he had to spend $300,000, he'd give it to me, and he'd rather die than live three extra weeks. I doubt that there are very many people who would object to that choice. But if you had the money, and you had earned $2-3 million in your

lifetime and you wanted to spend such a sum in the last three weeks of your life, that's your choice. Medicare has forced every person in this country on an involuntary basis to live on an allotted sum. I can't tell a patient I'm not going to do such life-prolonging, tube-intensive procedures.

Give the people who are buying the care the ability to buy it or not at their will, instead of the government saying it's free. By making it free, government is making the demand infinite. When demand is infinite, the price goes up infinitely.
Let me follow up on that by a question for Mr. Henning. You referred to the problem that you see when deductibles or coinsurance run out, and afterward there's no incentive to control costs. Would you have any suggestions for that?

MR. HENNING: Part of my answer is what my own company is doing for employees whom we have insured. We're basically saying that there must always be some percentage of employee copayments. If you go in and incur a $100 bill today, you're going to pay 10% of it. If six months from now you have another $500 bill, which may have been over your $250 deductible in the past, you'll still pay 10% of that. In other words, you keep paying a portion of every bill that comes out. It makes you conscious of the fact that there are no "freebies" and that, once past the deductible, there is still nothing "free." Basically employees have to pay for a portion of everything used. If they know some of it's going to come out of their back pockets, greater thoughts will go into decisions about medical care. To follow up on the doctor's comment, if you're a Medicare patient, you have, I believe, a $600 deductible. After that, there's no charge to the patient. If he or she is admitted to the hospital, our cost for the patient's stay may have been $100,000. If we're lucky, we might get a DRG payment back of $5-6,000 for that patient. There's no incentive for anybody to try to manage their care. This problem, of course, is not just with Medicare patients, it's for insured patients, too.

MR. JOSEPH P. MACAULAY: Dr. LePort, I just heard you quote a statistic that I've never been able to find a reliable source for, and that was where in the last three to six weeks of life, people use two-thirds total medical expenditures, or something like that. Is there a good statistical source for that statistic?

DR. LEPORT: That's what I've heard also through the hospitals, but I would have to find the exact source. If I'm not mistaken, there's a private practice magazine for MDs in which some article showed the statistic (Milton Friedman or someone else had researched into it).

FROM THE FLOOR: I've been doing a fairly significant search of literature to try to find any statistic of that nature. One of my clients is concerned that if that's the situation, then he needs a different approach for funding it. Mr. Henning, I know as an actuary I like the idea of cost controls; I like the idea of substantial copayments. I do believe for some that there's the need for some level of individual stop-loss to a person. If someone needs $150,000 of medical services, by the time he's paid $3,000-4,000, I think that there is an argument that there should be a stop-loss beyond some number for an individual.

MR. HENNING: I'm not sure if I misstated my point, but there could still be some level of maximum, but it probably needs to be more than prescribing out-of-pocket

expenses right now. Effectively our maximum out-of-pocket expense in our company right now is, I believe, $2,000. Maybe it needs to be higher than that.

FROM THE FLOOR: I'm a property casualty actuary. Mr. Henning, you said that somebody has to pay, and then you alluded to some form of discounting. When workers' comp is involved, it seems that when there is a problem of trying to elevate charges, the easy route to go is with the workers' comp claim, because it's on a first-dollar basis. My second question involves fraudulent claims. In a study of about 100 false claims, 46% were not for overcharging, but for services never rendered. I want to ask Dr. LePort if the AMA is doing anything to control those types of fraudulent claims.

MR. HENNING: First, as to workers' comp, there is not, as far as I know, any hospital in which a concerted effort is made to try to shift costs to workers' comp any more than to other areas. What happens is, as more and more discounts are given to one particular sector, you're going to have to raise rates more overall to be able to earn as much. Therefore, if we have to have a 10% rate increase because we know we can get 4 or 5% effectively out of that, that 46% increase will apply to workers' comp as well as to other sectors. But it's no different than cost-shifting to any other part of the population. I don't think there's any fraudulent aspect to trying that. As to errors in hospital bills, there have been surveys showing that anywhere from 5-10% of the hospital bills are incorrect.

FROM THE FLOOR: I think this primarily concerns physicians' costs. The small sample of maybe 1,000 includes 463 known to be not overcharging or undercharging, but charging for services never rendered on another bill.

DR. LEPORT: The answer is that the AMA and the American College of Surgeons all have their own set of ethical standards. What you're talking about is really fraud, and doctors who do that should be prosecuted by the government. That type of fraud goes on in every industry. Not every doctor's honest, and those who are dishonest deserve to be thrown out.

MR. YANCY: Let me just make a comment about the cost-shifting area, particularly in workers' comp. Some studies were done not too long ago, I think by the National Council on Compensation Insurance (NCCI). They found several cases where, for the identical injury, somebody was treated under workers' comp, and then received duplicative treatment for that injury where Blue Cross paid the bill. In many of those situations, treatment under workers' comp involved a bill of say $2,600, and the bill that Blue Cross paid was $1,600 for identical injuries, identical treatment. There isn't any question that there is considerable cost-shifting taking place in workers' comp. Why? Because it's first-dollar paid, and it's unlimited. I'm not saying that they're doing it intentionally, I'm saying that it's a common practice, and the workers' comp carrier ends up paying the tab.

MR. JEFFREY P. PETERTIL: I'm an independent consulting actuary. I just wanted to make a comment on Joe Macaulay's question about how much of the cost goes into the last period of life just before death. We heard numbers such as two-thirds and now 40%. The alternative number that I saw most recently was something like one-seventh of the aggregate cost for the last six months or the last year of life. I think

this makes much more sense. Just using your two-thirds number, we've got a health care economy that's $700 billion. Two-thirds of that number would be between $400 and $500 billion.

We have maybe two million people dying each year. If we were to figure that out, that comes to about $200,000 per death, and that's just not possible for expenditures during the last few months of life. As I say, I have not found out exactly where the one-seventh number from the journal comes from.

DR. LEPORT: I have trouble with the one-seventh number. At our particular hospital for instance, two statistics that jump into my mind are that about 65% of the people in our critical care areas are over 65, whereas in normal medical surgical areas, they only make up about 35% of the population. The other thing is from a pure revenue billing standpoint; about 65-70% of the billings that we send out are for people over age 65, and the other 35% is for younger ages. So that makes me tend to believe that while two-thirds may be high, a large portion of that money is going toward people who are 65 years of age or older and in the final stages of life. Therefore, I would think one-seventh is a little low.

FROM THE FLOOR: I attended the last Society meeting and I believe the opening speaker addressed some of these statistics in May last year. So maybe you'd look in the journals and records of your source.

MR. THOMAS JACOB LEIBOWITZ: I work at Blue Cross in Massachusetts and I would like to address a question to Mr. Yancy and actually to all the members of the panel. As far as cost containment goes, I was wondering how the three of you gentlemen feel about preventive care in general, and more specifically, prenatal care. As most of us are aware, child vaccinations are a very high expense for newborn babies mostly born to poor mothers. The same problem applies to high emergency care costs. I was wondering if you gentlemen could address that, but more specifically, Mr. Yancy, since he's in charge of regulating such things.

MR. YANCY: I can only speak from my own situation. In Utah, for example, we do not regulate hospital medical costs. We regulate medical costs under workers' comp, but we do not regulate medical costs for health insurers. To be very honest with you, I have no opinion particularly about that, but I think there was one thing that does need to be clarified. The statement was made earlier that we have the very best medical care in the United States. In a lot of areas that statement is not true. We are paying for the very best, but we are not always receiving the very best. I think we rank something like eighth or ninth in the world on infant mortality, for example, and you could cite other areas where we are down in the middle or the lower end of the echelon. So I guess I take exception to the flat-out statement that we are receiving the very best medical care.

FROM THE FLOOR: A question for Dr. LePort. I think we may conclude that the end-of-life cost is somewhere between 50% and 65%, give or take a few percent. Next, I have a question on workers' compensation. One of the problems with the difference in prices with workers' compensated care and nonworkers' compensated care is that you can have managed care generally for nonworkers' compensated care, but in many states you can't manage it for workers' comp. And if you can't manage

it, then you can charge whatever you like. Another reason, going back to personal responsibility, is that if it's a mental health condition, but couldn't, however, remotely be caused by stress on the job, then it will tend to be a workers' compensation case. This means it will be compensated on a 100% basis. So what interest does the patient have in managing or confirming any aspect of his costs?

Dr. LePort, you said at one point that you wouldn't want to go to a doctor who was told what to do. Aren't there a lot of things that can be very effectively done in managed care through utilization controls? More specifically, by looking at practice patterns, and at aberrations, aren't there doctors who do too much so that costs could benefit from reduction? I just looked at another area recently where for one procedure, the utilization rate is seven times the national level.

And the final question is for Mr. Henning. You said that if we came to you and contracted for some discount or whatever, you wanted something in return. Maybe you could be a little more specific about the kinds of things that you would like to see.

DR. LEPORT: As to the question about telling a doctor what to do, what I said is that the patients should be telling the doctor what they can afford and how to deal with it. What's happening now is that the gatekeepers at the HMO are telling the doctors what to give the patients, and also telling them not to tell the patients what they have just been instructed. Now I know physicians who get EKGs to read at 7:00 in the evening, and if there's something wrong, they decide immediately whether to put the patient in the hospital. To make this decision means staying from 7:00 on Friday evening until midnight. But a more subservient type of physician would think "maybe" they're wrong, they'll have to argue with everybody. Instead, this sort of practitioner would say, "Just leave it there until Monday morning, and then I'll deal with it." When a patient is paying for himself, he or she would not have to worry about whether his doctor's going to take the weekend off and start care again on Monday. Yet, this attitude to treatment is what is going on in Medicare and in all HMOs. Many physicians, especially the older physicians, will not tolerate it. They get out of medicine rather than refrain from telling a patient what has to be done. Doctors who stay will tell the patients to call the HMOs, and they will perform a given treatment if the HMOs allow it. Those patients are being mistreated, but they'll never be seen in any statistics because physicians who won't go along with that system get out, and those who do go along with the system just don't talk about it.

FROM THE FLOOR: I would say that most of your patients are not educated consumers.

DR. LEPORT: I disagree with that.

MR. HENNING: Just to answer your other question about what we would want in return. What has happened to us many times is that a PPO or an HMO comes to us, and says it wants us to take a 20-25% discount, a cut in our rates. "Oh, by the way, we're going to cut the same deal with your competitor across the street." Based on straight economies, what incentive is there for me then to give you that kind of rate? If I'm going to give a discount, I must make up that income

somewhere. I need the PPO to drive volume to me, which may mean changing a benefit plan so that the person who has insurance uses my hospital, unless he's willing to pay more out of pocket for going to someone else. That applies whether there's utilization review or other options. But the point is, an employer must be willing to tell someone, "I'm paying the bill, you're going to go here." If the employee's are going to pay for it themselves, they can make their own choices.

DR. LEPORT: If they're allowed to.

MR. KENNETH R. SMITH: I guess I'd like to challenge a couple of the free-market assumptions that Dr. LePort put for us. I guess number one is the point that was just touched on briefly by the last speaker, the purchase of medical care is not usually a totally informed decision. The doctor has much, much more information than the patient could possibly have or understand. It's frequently made under a time of stress, and it doesn't, in my view, operate according to the free-market economy. Second, medical care does not have the same relationship between cost and quality as many other things do. There are a lot of data available that show that as the quality of care goes up, the cost goes down rather than up. A coronary bypass for example is a case at point. There's also, I think good, some data that indicate that in a relatively free market, practice patterns vary greatly among physicians. Certain types of optional elective surgery are much higher in one community than in another community with very similar population demographics. This indicates again that physicians are not doing a very good job of governing themselves. And finally, I guess, your examples of the free-market economy, or the failure of controlled economies, all come from eastern Europe rather than from the economies of Germany and Japan, which are beating the pants off of us economically, and that have very controlled and regulated purchasing of health care.

MR. HILL: I guess your comments are really in the form of the question -- does the free market really work in the medical area?

DR. LEPORT: You brought up a lot of separate points and I couldn't even remember each one to deal with each one particularly. The last one is easy to deal with. Japan and Germany at this point probably have freer economies than we do. Yes, they do have medical care that is paid for. But if the United States tripled its medical care budget, which is what those countries have done, then we could have "good," even more elaborate, medical care also. Of course, there would be people starving, because food would not be able to be delivered.

MR. YANCY: Their medical care bill is less than ours as a percentage to their gross national product.

DR. LEPORT: That also has been questioned. As for Canada, the argument is made that they are paying less than the U.S. However, many actual costs of taking care of the Canadian medical care system are excluded. When they add in all the bureaucratic costs that go with socialized care, total expenditures wind up greater for Canada. You're questioning a basic economic principle to which medicine and food alike are subject.

FROM THE FLOOR: Is not a doctor-patient relationship a very different relationship than when I go to a grocery store?

DR. LEPORT: It actually is not. If you go back before 1965 to the 1940s and 1950s, there were very few people who could not get treated, whether they had money or not. It was only after 1965, when the government decided that medical care was free and that it could be supplied, that we got county hospitals for the indigent population and all that. The doctors started saying, "Well, we're already paying taxes for this, this is not my responsibility." Before that time, patients got treated no matter what their standard was, and they dealt directly with the physician. Care was excellent, or at least better than anywhere else in the world, and nobody was refused care. No hospital turned away patients as they sometimes do today and no doctor did. You have to ask yourself what has changed between 1950 and now, and the only thing that's changed is that the government said it was going to take care of it. And doctors and hospitals are going along with it. I admit I'm a real minority in physicians. Most are saying, "Yes, go ahead, you take care of it, I don't want any responsibility anymore." And that's what happens in every industry. Look at the post office, and the telephone systems when they were overly regulated. That's what they have in Europe, that's what they have in England, and we're going to have it here.

MR. GEORGE CALAT: Whether the right number is one-seventh or two-thirds, as far as the portion that's spent in the last six months or the last year of life, that's a big number in any event. My question is if Dr. LePort or the AMA has a position on the kinds of things that need to be changed to allow physicians to not treat a patient or provide care to a patient who's in their life one week. We all heard about that baby who was born without a brain, without a brain stem, and survived for a week or so, and I would imagine that the majority of people would say that was poor medical care, when all doctors knew that the baby would die.

DR. LEPORT: Essentially, whenever the government tries to introduce any regulations, the AMA says we're going to be stuck with this anyway, no matter what, so let us write the regulations. That's how Medicare got started, that's how DRGs got going, and the AMA is just as bad as every big business in this country. It is seemingly pushing for controls because it is afraid the government is going to knock them down if it fights it. If the AMA were to ever stand up and say it was not going to put up with this anymore, and doctors got together, the whole thing would fall apart overnight. I don't think that's going to happen. I don't think the AMA has any position officially, and it would be very difficult to have a position other than "you know we're going to help the patient as much as possible."

MR. HENNING: I think that hones it down to the essence of the problem. Nobody's required to make a choice. The doctor doesn't have to make a choice because he's going to get paid. The hospital doesn't have to make a choice; it is going to get paid, maybe not as much as it wants, but it is going to get paid. The patient doesn't have to make a choice either, because he or she doesn't have to pay for it. I think the only way health care is going to have its cost brought down, or at least stabilized, is by putting choice back into it. Choice is going to mean some hard choices: do you treat everybody, do you treat everybody for everything? We can, but it's going to cost a lot of money.