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PANEL DISCUSSION—SAN FRANCISCO REGIONAL MEETING

THE COST OF MEDICAL CARE

A. What are the causes of the increase of costs of medical care?
B. What can be done to keep these costs under control?

Panel Members:

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DONALD C. HARRINGTON:

On March 1, 1954, the doctors of the San Joaquin County Medical Society set up a separate corporation called the Foundation for Medical Care of San Joaquin County. By broad definition, our Foundation could be defined as an organization established by a local medical society for the purpose of assuring the availability of medical care to all people within the jurisdiction of our San Joaquin County Medical Society. At this time, 97% of the active doctors of the Medical Society are members of the Foundation. This corporation was designed specifically to study the problems of bringing medical care within the reach of the population of this area, regardless of their ability to pay. Because of the tremendous growth of voluntary prepayment programs in the field of health, one of the first studies the Foundation undertook was that of current prepayment programs. Specifically, the Foundation set about to evaluate present prepayment programs so as to be, eventually, in a position to advise and assist insurance companies and consumers in the selection of a broad base coverage which is so desirable in prepayment programs. Three goals were established for the Foundation for Medical Care:

1. The formulation of a basis for group prepayment which the Foundation not only would recognize, but would sponsor and endorse.
2. The formulation of an individual and family prepayment program which the Foundation would sponsor and endorse.
3. The study of methods to bring in many of the desirables, who, for various reasons, are not in a position to have group or individual prepayment programs.

To establish such a program, it was first necessary to find what was the actual fee being charged for medical service in this area. A survey of charges was made, resulting in a fee schedule which was used for two years before being abandoned in favor of the CMA Relative Value Schedule with coefficients appropriate for the schedule. As soon as the original schedule was adopted, all members of the Foundation agreed to charge no more than the fee listed for prepayment programs sponsored by the Foundation. Not only does this benefit the patient that has a Foundation-sponsored prepayment program, but the other patients of the doctors, whether covered by insurance or not, are able to ascertain what the usual fees in the area are. Each year the schedule is reviewed and revised where necessary.

The Foundation believes that establishing this fee schedule gives voluntary prepaid medical insurance plans a realistic criterion upon which to base their policies. It should help improve the type of coverage offered in these policies and, in general, raise the standard of prepaid medical insurance contracts. A person seeking this type of insurance has, under the Foundation's plan, the certainty of coverage which he so desperately seeks. He is also able to evaluate any insurance program in relation to what is actually being charged in the area.

While constant work is required on the income levels within San Joaquin County, it is the primary philosophy of the Foundation that a prepayment program must have some application to the incomes of the various families. These various income levels must be applied to reasonable premiums for each income level. If the percentage of a family's income, customarily paid on medical care, reaches a figure that is wholly out of the question from an insurance standpoint, then some other practical solution must be taken. In carrying out this belief, the Foundation for Medical Care adopted three schedules: Schedule "3" for persons making a gross family income of $4,500 or above; Schedule "2" for $3,500 to $4,500 income; and Schedule "1" for income under $3,500.

One of our most important concepts is based upon the belief that most doctors are willing to adjust fees downward for people with low incomes. The Foundation believes that a great deal of medicine's predicament is due to the inability of doctor and patient to get together on their financial arrangements—*i.e.*, both are reticent about discussing it. Because of this reticence, an administrative mechanism that sets up guideposts is needed. The Foundation has, therefore, established a fee schedule which represents an accumulation of fair fees for this area. By and large, these fees represent what is actually being charged. Above this schedule, the doctors cannot go. Any adjusting of the schedule is downward for reasons already stated.

The problems of adjusting fee schedules to income are many and obvious. However, there is no other index that can be used effectively, so the Foundation has used it as a rough "means test." To put this into practice, being fair to both patient and profession, is difficult as there are many unknown and large areas where no information is available.

The Foundation used the information in the Heller report (1948) and the more recent survey by the Health Information Foundation. This sets a figure of 4%, excluding drugs, dentists, and glasses. This is probably low, as it, for the most part, includes mostly uninsured groups at the present incidence of usage. This will, obviously, increase with usage up to a desired point for good health.

A coinsurance base was determined using the 4% figure. Utilizing this coinsured base (it finally worked out to 3.8%, including insurance administrative costs), tentative fee schedules and premiums were developed and the number of people involved in each income group predicted.

In attempting to apply the practice of medicine to income levels, it is necessary to recognize that certain procedures are procedures of high overhead, and others are of low overhead. For instance, in a San Joaquin County survey of procedure costs, a routine office visit costs approximately $2.57.

The Foundation has felt from the beginning that a sound program could not be established by merely adopting a fee schedule or schedules and attaching the "prior agreement" principle. The mechanism of "prior agreement with an insured group" was the result. If an insurance company is willing to write a policy based upon the Foundation's three schedules, including the coinsurance and deductible features which the Foundation feels are necessary, this "prior agreement with a group" then becomes an endorsement of the policy. The doctors of the Foundation would charge no more than was stipulated in the contract.

Thus, an indemnity program becomes a service program. The deductibles and coinsurance features are clearly delineated so that the patient then knows exactly how much the fee will be. On items not covered by insurance, such as house and office calls for the dependent, the fee percentages still apply so that a dependent of an employee, insured under Schedule "2," will be charged no more than Schedule "2" rates for an office or home call.

Basic Group Programs

On September 1, 1954, Continental Casualty wrote the first Foundation program. It covered the lathers, plasterers and hodcarriers' union of San Joaquin County at a premium of $11.34. This program fell in Sched-

ule "2." Four years later this particular program is still underwritten at the same premium. During that time the fee schedule has been raised and an additional $1.20 worth of benefits has been added within the original premium structure. Since the income of this group is rising steadily, it is anticipated that they will shortly become a Schedule "3"program. In October of 1954, a second program was sponsored—this on a Schedule "3." Since the group was small and had a high female content, the premium was $15.26. This premium has also remained constant.

A third program was put into effect July 1, 1955, involving Turner Hardware Company, with stores located in Calaveras, Tuolumne, Stanislaus, and San Joaquin Counties. The income of the executives pulled this group up into Schedule "3," making their premium higher than the group could realistically budget. Because of this, the executives elected to be covered under a Schedule "3" program while the store's many employees were covered under a Schedule "2" program. This has created no administrative difficulty. Since this program is also in effect in Stanislaus County, the medical society of that county has accepted the Foundation program and 90 out of 144 physicians in that county are now members of the Foundation.

There are now eight companies offering the Foundation program—Occidental Life Insurance Company, Continental Casualty Insurance Company, Pacific National Life Assurance Company, Pacific Mutual, Intercoast, California Physicians' Service, California–Western States Life Insurance Company, and Connecticut General and Central Standard Life Insurance Company. Several other companies have expressed interest in underwriting the program.

What does this program mean to the doctors?

It gives them local control. It supplies them with a fee list that is based upon what is actually charged in their area. The program can be underwritten by any insurance company. The program is flexible and can react quickly to local situations. When underwritten by an insurance company, it is an indemnity program which can be used outside the Foundation membership and outside of this area.

Comprehensive Major Medical Group Programs

There appears to be public demand for what the insurance industry has termed comprehensive major medical coverage. At the same time various insurance companies have taken the position that quality control is necessary for the survival of this type of coverage. For these reasons the Foundation sponsored its first major medical program in January of 1958. Minimum requirements for Foundation sponsorship include a fee schedule

based on Schedule "3," coinsurance by the patient not to exceed 20%, no more than a $50 deductible per person per year, and maximum benefits of at least $5,000. It is the current opinion of the Foundation that this type of coverage should not be offered to the low income groups.

Basic Plus Major Medical

Several groups have availed themselves of this type coverage and experience thus far with the programs seems to be satisfactory. Probably our most interesting program at the moment is one covering the warehousemen in our area. The ILWU-PMA Welfare Fund has worked out a program with the Foundation giving basic coverage to this group with a superimposed major medical. In our minds this is a much sounder approach for the lower income groups than a comprehensive major medical program with a $50 deductible.

Quality Controls

According to the by-laws of the Foundation, membership is on a one year basis. This is specifically designed for internal control as each doctor must reapply every year. This approach towards quality control within the profession, by the profession, is also furthered by a program of claims review. These are only two of the steps in the direction of self-discipline which the doctors of the Foundation feel are of paramount importance if the profession is to continue its emphasis on the private practice of medicine. The membership on a one year basis also gives the participating doctor an opportunity to reaffirm his faith in the Foundation.

Initially, the Foundation reviewed only questionable billings. This proved to be ineffective. The Foundation soon realized that many doctors were making mistakes in their billing that were due mainly to lack of understanding of the program and of prepayment in general. These mistakes were being taken by those outside of medicine as examples of malicious intent. The Foundation now processes all claims. Each claim is reviewed from both a contractual and a medical standpoint, the latter by a physician of the Foundation. In order to facilitate this part of the program, draft authority has been procured from each of the participating underwriters. This means that the Foundation office not only is processing the claims, but pays the doctor on an assignment of benefits.

The Foundation has written into its agreement that if a patient refuses to assign his benefits, the doctor is not bound by his agreement with the Foundation to accept the fee as full payment.

An Individual Program

In pursuit of the second goal of the Foundation, that of bringing forth a good individual policy to be offered in this area, the Foundation was

pleased to announce that, as of September 1, 1955, California Physicians' Service would offer a rather unique individual policy in San Joaquin County. This policy is based on the same approach of income level as was used in the group insurance.

A rather extensive selling campaign was carried on by both California Physicians' Service and the Foundation for Medical Care. The policy was sold through selected brokers. The policy was offered to each individual and his family with the same varying income levels; hence, the premiums for the various policies vary. For instance: Under Schedule "3," a single male pays $5.95 per month, under Schedule "1" a single male pays $4.85 per month. For three or more in the family, the cost is $14.50 under Schedule "3" and $11.15 under Schedule "1."

The individual program pays surgical benefits in full and has rather comprehensive in-hospital benefits. The unique feature of the program is that there was now available to individuals an adequate out-patient diagnostic and X-ray laboratory benefit. There was also an allowance for 50 doctor visits on an out-patient basis for certain catastrophic diseases.

This individual program, however, still limits initial enrollment to those under age 60, requires a health statement and, by and large, is, as all other individual insurance, much more costly than group coverage. This program has gained momentum slowly.

In summary, the Foundation has, since its organization on March 1, 1954:

1. Set up a fee schedule based on the CMA Relative Value Study, using coefficients which reflect the private practice fees of this area.
2. Stimulated acceptable group insurance programs based on this schedule. These are being offered by six insurance companies and California Physicians' Service.
3. Stimulated a family and individual contract. This is offered by California Physicians' Service.
4. Embarked on a service contract for medical care with ILWU-PMA Fund.
5. Set up an advisory committee made up of interested citizens in the community, to wit: a clergyman, an industralist, a labor leader, a personal representative of city government, a public relations executive, a department store executive, a representative of the teaching profession, and a pharmacist.
6. Projected for the future is:
   A. The inclusion of the noninsured into the program by social service methods
   B. The utilization of insurance methods in the care of the indigent
   C. The coverage of the retired and aged by prepayment.

I should like to close by stressing the following. "Medicine" is a harsh task master, taking its toll on our time and our health. Adequate compensation to the doctor is essential. But I feel it is a privilege to practice medicine. With this privilege comes a responsibility of caring for people within the range of their ability to pay.

In the face of ever-increasing coverage of prepaid medical care insurance, it behooves organized medicine to actively work with the insurance company, the Blue Shield plans and the consumer.

JOSEPH L. ZEM:

I have been asked to discuss with you and our panel the trends in hospital costs. This would, of course, include the trends in hospital usage both for in-patient and for out-patient services.

First I should like to dispel in part the notion that many insurance people have that hospital costs have increased only because of hospitalization insurance. True, you are assisting in financing hospitals, to the tune of approximately 60% to 65% of our revenue. But hospital costs would have continued to increase at approximately 5% per year beginning with 1946 to the present, even if the *insured* population were much smaller.

I can make this statement because I believe that medical science and techniques have educated our population to the point that the public demand for health care is insatiable. Good health care begets better health care. As an example, modern medicine has extended the life expectancy, increasing the population, which requires additional medical care. The extended life expectancy leads us to new medical problems dealing with the aged, who, as you know, require and use more hospital days than our younger patients. Our average length of stay for persons under 55 is 7 days, over 55 is 10½ days.

It might be well to consider how experts in the field of medical care view the future of hospitals. They feel that the greatest change in hospitals in the future will be a metamorphosis of the hospital from a diagnostic and curative headquarters into a community health center, with all that it entails. The out-patient department will be *at least* of equal importance with in-patient facilities.

The hospital prepayment movement by expanding its scope and level of benefits, and the hospital by enlarging its area of service, must move into position for the future.

We in hospitals have an obligation to control our costs within the framework of our objective of providing the type of care being demanded of us. We must:

1. Explore integration of services among hospitals in the same community to avoid costly unnecessary duplication.
2. Explore and control the relationship of ambulatory out-patient care to in-patient care.
3. Promote the most effective utilization of our in-patient service.
4. Attempt to stabilize our workloads in order to most effectively utilize our beds and personnel.
5. Study our long range needs to avoid overbuilding.
6. Take advantage of every cost control available.

If we do all these things effectively, we can expect a minimum increase of about 5% per year in our costs. If we do not do these things, our costs will increase much greater than 5% per year.

Why are these costs bound to go up at least 5% per year?

1. Chief cause is that hospitals are service institutions.
2. Our opportunities for use of machines with increased productivity is limited.
3. 65% of our costs are payroll costs. Wage levels in hospitals were very low and we must now meet going rates of industry. Last October we gave our employees a 5 cents per hour increase. Last week I read that laborers in the building industry had signed a three year agreement with an increase of 60 cents per hour.

How can we obtain licensed laboratory technicians, who require a degree in science and a one year internship for licensure, at an average wage of $2.00 per hour, when a ditch digger in the same area receives $2.65 per hour?

Unions are invading the field of hospitals and, when they show what they have done for ditch diggers, our people will flock to the unions unless we fairly reimburse them in proportion to their skills and responsibilities.

This is why hospital costs are increasing and will continue to do so. With the present demands of modern medicine, we presently need 2½ employees per day per patient. This comes out to 20 hours of employee time. Multiply this by $2.00 per hour for skilled personnel and you will readily see it comes to $40.00 per patient day for salaries alone. What about supplies, buildings, etc.?

If what we hear is true, we will have to constantly upgrade these people to meet the future demands of medicine.

The only way that costs can be reduced, then, is to reduce the level of care and the public won't stand for that.

This is what you can look forward to, in trends of hospital costs. We in

hospitals are more concerned with keeping these costs down than you are. We have many good minds working on the problem. We need all the help we can obtain.

You in insurance have very serious obligations as well. Extension of coverage to those population groups who do not yet have coverage must be the aim of you in the prepayment movement. These groups in most instances include the so-called "hard risks," but you must remember that a greater and greater number of today's "good risks" will become tomorrow's "hard risks." They include elderly dependents of working people, disabled people, the unemployed, the self-employed, and the aged.

Let's face it! Extension of coverage to these groups does not include new costs to the community. The community has paid these costs and will continue to do so. Health services, as they are known today, and extended as they will be tomorrow, will be paid for, as they always have been. The question then revolves around, "Who pays the bill?" *The economy pays the bill.* Whether the bill is paid from the consumer's wallet directly or by monthly prepayment rates to you, or through the less perceptible medium of tax allocations, or by any combination of these three, will in a great measure be determined by negotiations and the ability of hospitals and prepayment insurance to meet the needs.

The type of coverage the public will decide it wants will be developed by education—education that hospitals and you, as insurers, must help to develop.

One of the principles that must be developed is that one *good* plan is much cheaper for the buyer than two or three inadequate plans. It is your responsibility to upgrade your plans to provide sufficient coverage in order to make unnecessary overlapping and duplicated plans.

Only experience with good plans will lead the public away from inadequate plans and the necessity for duplication. Education in this regard will prepare and encourage the public to pay an increased prepayment rate in return for extended coverage.

Our basic problem, yours in insurance and ours as providers of services, is to provide the maximum health care most economically. Industry calls this process "productivity."

To summarize, then, you must:

1. Solve the problem of duplication of coverage.
2. Extend coverage to the uninsured.
3. Extend the benefits, both out-patient and in-patient.
4. Work with us in controlling unnecessary utilization, by education and supervision rather than by manipulation of benefits and other financial deterrents.

Only through joint cooperation shall we be able to provide the public with the kind of care it demands, at a price it is willing to pay.

CHRISTOPHER H. WAIN:

Trends in Medical Care Costs

Between 1948 and 1957 total spending for medical care in the United States nearly doubled, climbing from $7.6 billion to $15.1 billion. This amount almost certainly increased past the $16 billion mark in 1958. During this same period, though, the dollar was decreasing in value, and the population was increasing. When adjustment is made for these factors, we find that, in 1948 dollars, per capita medical care costs rose from $52.03 to $64.35. It is this increase in real per capita costs, in a single decade, of 23% to which our attention must primarily be directed. Obviously, the providers of care cannot be expected to absorb the effect of inflation.

These over-all trends cover up many dramatic differences in areas. For instance, as a westerner, I am particularly impressed by the evidence that aggregate costs in Southern California may be running as much as 65% above the average of the rest of the country.

Causes of Increases in Medical Care Costs

Much of the increase in the cost of medical care arises from advances in the science itself. This requires a higher order of skill and more training for doctors; increasingly expensive equipment and more personnel per patient in a hospital; and more expensive medicines. These can best be elaborated on by the representatives of the providers of care—and are certainly costs we would want and expect our insurance to help cover.

Other causes we cannot feel as favorably about, especially in those instances where we can suspect that the cost increases have been aggravated by insurance. In some rapidly growing areas such as Houston and Los Angeles, public support has been inadequate to permit the traditional nonprofit hospitals to meet the need for their services. This gap has been filled by proprietary hospitals which have rendered a necessary service. However, they have often been financed by comparatively short term funds at relatively high interest rates. These amortization requirements force a high price structure. Also, some of these hospitals have sought fairly substantial profits. It is interesting to note that their price structures have usually featured low room and board rates, and high charges for extra services, an insurance benefit that is traditionally unscheduled.

In handling claims involving doctor's services, we have noticed some charges that appear extremely high in relation to community averages. These aren't really a problem, however. The total dollars are a small part

of our claim dollars; an explanation of the operations of insurance by a skilled adjuster often produces salutary results; and if this fails, medical association fee committees can work effectively on these charges. A greater problem is presented by treatments that appear excessive in relation to the condition, or the inching up of fees at a greater speed than the advances in the cost of living. There is also some indication that excessive treatments including laboratory tests and analyses may be arranged to protect the physician against danger from malpractice suits.

The insurance industry as a whole has undoubtedly contributed to the increase in medical care costs. An important cause would be the coverages such as hospital expense that will pay for services received in a hospital, but not if they are performed in a less costly location. Likewise, the practice of insuring the full cost of certain services discourages interest by the patient in the bills he is incurring or the amount of those services he receives. Finally, the duplication of group insurance benefits with other coverages, including other group, personal insurance, and special coverage such as automobile, can only lead to increasingly severe problems in the future. This is because progressively more of the public will have protection covering greater portions of the medical care bill than were generally insured in the past.

In the future, other causes for unnecessary increases in medical care costs will become apparent. For instance, unless voluntary community planning forecasts fairly well the estimated needs of an area, it is possible some overbuilding of hospital beds or other facilities will occur. This would increase the fixed costs that must be absorbed by those requiring treatment. Also, as time goes on, the number who have coverage for medicines furnished outside the hospital will increase. Some type of controls perhaps not yet developed may be needed to prevent excessive prices or uses of these medicines developing because insurance benefits are available.

What Can Be Done about Increasing Costs

There are more actions that can be taken to control costs than time will permit describing here. The important thing is, of course, to adopt a balanced program, rather than just one or two dramatic items. The ultimate objective is to have the cost of medical care of all types the same as it would have been in the absence of insurance, assuming those insured had the ability to pay for the care. Achieving this requires both work of a public relations nature and adequate technical and administrative measures.

In the public relations field, the following stand out particularly:

1. More of our individual insureds should understand that they ultimately pay for the services they get. This can be most effectively done in the group insurance field because the policyholder has a vital stake in getting this message to his employees and also to the providers of care. Group insurance booklets can encourage patients to be sure they find out what the level of fees charged will be; patients covered under major medical plans should understand that amounts in excess of usual and customary charges will fall on them. Plan administrators and members of our field forces should carry this message. This will, of course, never be completely successful; but if even a small portion of our insureds had this in mind when negotiating for services, the results could be valuable.
2. We should work at the local levels with the providers of all types of care. We should learn their problems; and when they are caused by defects in our insurance, we should try to correct the product. In turn, we can help them understand our problems as insurers, and encourage them to develop their own standards of usual and customary charges. The local committees of the Health Insurance Council provide an excellent opportunity for this work.
3. As citizens of our communities, we can probably find ways to be helpful in projects for planning the need for nonprofit hospital facilities in our areas. Perhaps, too, we can at least furnish manpower to help raise the necessary funds.
4. Finally, perhaps we can find ways to educate the buyers of our products on the types of insurance plans that will be likely to produce minimum increases in cost from year to year.

There are important internal measures as well:

1. Close control measures that will enable us to pick out quickly areas or types of medical care in which costs are getting out of line will be increasingly important. In other words, we should be set up to find problems fast, so we can get an early start on finding solutions.
2. Our coverage should maximize the interest of the individual in the charges he incurs. This probably means it should exclude minor illnesses, by a deductible or otherwise, and impose enough of a financial burden on the insured to keep him interested in any charges he incurs.
3. As conditions permit, ways should be found to minimize duplication of coverage between various types of insurance contracts.
4. Adequate claim facilities should be provided to administer any contractual provisions limiting liability to usual and customary charges for reasonably necessary services. This means that in unscheduled

policies, relative value schedules and standards for hospital charges should be an integral part of the claim handling practices. Further, these tests should be applied to all claims of all sized group policies and to individual policies. In this connection, some success has been had with carefully designed letters for doctors whose charges are in excess of the usual, setting forth the basis for determining insurer liability and stating that the balance is a matter between him and his patient.

In conclusion, many measures can be undertaken to help control excessive costs of medical care. An insurer who embarks on a program should recognize that this program will require constant review aimed at eliminating ineffective approaches, and substituting new ones as required by developments.

CHARLES N. WALKER:

The first question asked of the panel—"What are the causes of the increase of costs of medical care?"—is an absolute imponderable. The causes for the increase are many, indeed, and even a simple listing would be impossible. In addition to this, the causes are not mutually exclusive, so their interrelationships become quite complex. Let me, therefore, try only to stress a few of these points, and these from the particular point of view of one who works with individual A&S insurance.

The greatest cost of increase in medical care has been on hospital expenses. Here, increases have far exceeded the general increase in the cost of living. Probably the most important underlying causes are, first, labor costs and second, the effect of technological changes in the fields of medicine generally.

Labor makes up 65% to 75% of hospital costs. Over the past 25 years hospitals not only have had to materially shorten working hours, which has required a corresponding increase in labor costs, but also have had to materially increase wage rates in order to successfully compete for labor in a tight labor market. These two factors have compounded each other, driving hospitals costs up at a much faster pace than has been the case with other day-to-day expenses.

Technological advances and changes in therapeutic methods have also tended to raise costs on several counts. For one thing, a considerable amount of new equipment has been required, expensive not only of itself, but also because old equipment has become obsolete far short of its expected useful life.

We have all watched the average length of hospital stay decline 20% to 30% in the past few years. Have we realized, however, that this does not necessarily reduce costs? The shorter stay is the by-product of new medi-

cal discoveries and of more intensive therapy. Both tend to increase, rather than decrease costs—the one because new drugs, etc., are more expensive than the old; the other because more intensive therapy demands a higher level of personal services by both hospital and medical personnel.

However, another quite important factor in the increase in medical costs is of our own doing. The insurance mechanism of itself necessarily increases medical costs in two ways. One of these is the inescapable fact that, even in the absence of what we ordinarily term "abuse," the existence of insurance leads to increases in costs by making money available at the time of illness to cover a significant portion of the medical bill. To an insured patient (and this, of course, is the case with the great majority of hospital admissions today), a semiprivate room does not cost $16 or $18 or $20 a day. If he is insured by a Blue Cross Plan, it customarily costs him nothing. If he is insured by a commercial plan—even a commercial plan which includes some degree of coinsurance—it costs him only $2 or $3 or $4 a day. True enough, he paid the other $14 or $15 or $16 a day, but that was paid in innocuous doses at some other time. Similar phenomena occur, of course, with respect to ancillary charges and surgical bills and, depending on the type of coverage, other current illness costs, too. This is exactly the way insurance should operate, but note the corollary effect which occurs. The fact that so much less immediate cash outlay is required, as compared to an uninsured situation, just naturally leads this insured patient to demand a far better standard of care than would otherwise be the case. Why should he use ward facilities when semiprivate facilities apparently cost so little? The natural result of this phenomenon can be seen in any newly constructed hospital—ward facilities are becoming a thing of the past.

Why should the insured patient or his physician concern himself with the amount of ancillary services used? I am not suggesting that the typical patient will act like a 5 year old with a charge account in a candy store—far from it. I cannot help thinking, however, that when insurance picks up the tab for ancillary charges there is far less incentive for the physician or patient to get by on a minimum amount of information and expense. Nor is this "deluxe mindedness" limited to *insured* medical costs, either. With the major medical expense items substantially reimbursed through insurance, money that would otherwise have to go for basic hospital and surgical expenses is now available for other services—services which would, in the absence of insurance, be apt to be limited or eliminated entirely. I can cite, from personal experience, instances where private duty nursing expense was used for several days following surgery—an expense medically desirable, but not in any way an absolute necessity.

It is not my purpose, in this recital of the manner in which insurance increases medical costs, to condemn or criticize. Quite the contrary. Most of this cost increase is highly desirable, constituting as it does the difference between adequate and minimum standards of medical care. It is, however, important that all of us—actuary, agent, policyholder, physician and hospital administrator—recognize it is true, not only so that we can appreciate the important role of the insurance mechanism in the economics of medicine, but also so that we can be alert to the manner and extent of abuses which occur.

This whole pattern is closely connected with one cost control device which, particularly in the individual insurance field, is to my mind extremely important. Actually, it is really not so much a cost control device as it is an index. This is the various expense items which must be an integral part of our price structure—commissions, billing and collection expense, rent, furniture and fixtures, salaries, etc.—items we can classify together under the general term of overhead. This item is, in the individual field, one of the more important considerations of policy design and, in a sense at least, it might be thought of as more important than any other.

From the policyholder's point of view, medical costs consist only of two types of expense: first, those expenses incurred which are *not* reimbursed by insurance, and second, insurance premiums. Expenses reimbursed by insurance are most emphatically *not* a part of policyholder's medical costs but the premium paid for his insurance most emphatically *is*. Looked at in this light, our overhead expense becomes most important because, in the individual field, it is high. Typically, our overhead will be 30% to 35% of gross premiums. This means, of course, that we are increasing our policyholder's medical costs by 40% to 50% of the actual claim costs we reimburse him for. Again, this is not meant to be a condemnation or criticism. The operational pattern of individual insurance is such that we cannot expect our overhead costs to be significantly lower than this. The magnitude of the charge is such, however, that we must be as careful as we know how in the manner in which we spend our policyholder's money. Unfortunately, we have not always been as careful as we should be, in that the product we sell has not always been designed with a view to keeping the policyholder's outlays for our overhead expense as low as possible.

Designing an A&S policy is frequently a matter of compromise between what the insured needs and what he will purchase. We could all, however, profit by keeping more closely in front of ourselves some of the undamental axioms on which the insurance mechanism operates. Mr·

J. H. MaGee, in his text on *General Insurance* (I quote him since this was the text I used in college), describes an insurable risk thus:

> As a matter of theory it might be stated that all risk is insurable. Because of the element of expense in carrying on the business of insurance, premiums are weighted with a charge to provide for this cost. In the instance of risks that carry with them a threat of no great consequence, it becomes apparent that the cost of handling the business would make the rate prohibitive. Hence, in order to make a risk insurable, as a matter of business practice the danger of loss must be sufficiently great to make the cost element a minor factor in the premium charged.

This merely emphasizes, of course, that the over-all cost of medical care will be lower without insurance than it is with it. Since this is an inescapable fact, it places on us an obligation to design our coverages in such a way as to be as effective as possible in the dual role they plan—that of protecting the policyholders from unexpected and excessive loss on the one hand while, at the same time, minimizing his over-all medical cost by minimizing the amount of economically inconsequential benefits we include.

This thinking leads, of course, to major medical and deductible insurance coverages. It leads to product design, which is always striving to shift its area of protection to the higher levels of medical expense, while at the same time eliminating from coverage that portion of the medical expense costs which can be readily (and in the process more cheaply) handled by self-insurance. This is an entirely proper role for the insurance carrier to play—to guide our salesmen and, hence, our policyholders into forms of insurance most appropriate for the needs to be covered. It is, too, an area of cost control solely within the province of the insurance industry. No cooperation with other interests is required. I would urge us all to take the fullest possible advantage of it.

Following the formal presentations by the four panel members, the Moderator, Mr. Clarence H. Tookey, led a short discussion period in which questions from the floor were directed at the panel.

DR. HARRINGTON was asked to explain his statement that the fee schedule for the San Joaquin Medical Foundation plan was based on the level of charges actually being made and that fees are adjusted each year when 97% of the doctors in San Joaquin County are already participating in the program and abiding by this fee schedule.

He stated that no relative value fee schedule was adopted until the plan had operated about two years, at which time the change-over resulted in an average increase in fees of about 5%. This increase was absorbed with-

out a change in the premium structure. However, only about 7% of the local population is insured under the plan, so there are large areas where samples can be taken of fees being charged in noncovered cases. He visualizes that when the total population becomes covered under this service-type contract, the schedule of fees will have to be volitional and tied to the cost of nursing care and medical care and the general cost of living.

MR. ZEM was asked how many hospital employees are needed to provide the patient nursing care where approximately 2½ employees are required per bed patient. He stated that about ⅓ of the employees are directly involved in patient nursing care and the remainder in ancillary facilities, including X-ray, laboratory, pharmacy, dietary, laundry, power plant and the other departments. Thus, there are two employees backing up each nurse in the hospital.

He further explained that the Southern California Hospital Council considers the daily room charge to include the room, complete linen service, meals (including special diets and nourishment), services of student trainees, nursing services 24 hours each day, the use of hospital equipment and instruments, routine drugs, routine supplies, and a certain percentage of the depreciation or maintenance cost of the room.

Mr. Zem also discussed the program of the Joint Commission on Accreditation sponsored by the American Medical Association, the American College of Surgeons and the American Hospital Association, which requires high standards of patient care for accreditation of the individual hospital. This program applies to hospitals with twenty-five or more beds. The patient is protected against unnecessary surgery by the operation of the tissue committee (which examines every piece of tissue removed in surgery) and against improper treatment by the medical review committee (which reviews the nonsurgical cases) required under the accreditation program. Most hospitals of 100 beds or more are accredited, giving maximum assurance of adequate care to the patient.

Mr. Zem, on further questioning, stated that he favors "adequate coverage" for the patient rather than "complete coverage." He feels that "deductible" provisions and "coinsurance" features are proper in an adequate program of coverage.