

# The Changing Health Care Market

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# **The Changing Health Care Market**

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# **The Changing Health Care Market**

Edited by  
Frank B. McArdle, Ph.D.

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AN EBRI-ERF POLICY FORUM

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## Foreword

The Employee Benefit Research Institute undertook a policy forum titled "The Changing Health Care Market" in June of 1986, its fifteenth policy forum since EBRI was created in 1978 as a nonprofit, nonpartisan research organization based in Washington, DC.

EBRI's policy forums differ from conferences in a number of respects. Attendees (listed in Appendix B) consist of invited experts; there is no paid attendance. Invitees are deliberately selected to represent a broad cross-section of expert opinion on the subject, and include corporate executives, staff from the executive and congressional branches of government, academics, members of the news media, and representatives of organizations representing older Americans, labor unions, and other groups. The policy forums follow the format of a day-long roundtable discussion, with papers distributed in advance and ample time devoted to discussion of the issues among speakers and participants.

EBRI policy forums are undertaken to advance the general knowledge of an area of public policy and to raise issues that others may have overlooked. I am pleased that "The Changing Health Care Market" was a particularly successful forum in that regard, thanks to the excellent contributions of a group of renowned speakers. Our interest in the important issue of health care augments the work undertaken by the EBRI research staff and at previous policy forums on "Medicare Reform: The Private-Sector Impact" and "Reforming Health Care Finance."

Finally, by reworking the papers and the proceedings into a concise volume, EBRI hopes to share the knowledge gained at this policy forum with a wider range of readers with an interest in health care.

DALLAS L. SALISBURY  
President  
Employee Benefit Research Institute

## Preface

This book takes the papers and the proceedings of the EBRI 1986 policy forum on "The Changing Health Care Market" and integrates them into a single volume on the subject, supplemented by additional chapters contributed by EBRI staff.

The purpose of the book is twofold: to advance the knowledge of experts in the field, and to serve as a comprehensive introduction for others seeking a better understanding of the myriad changes in health care financing and delivery in the United States. The subject was recommended by the EBRI Education Committee, as members grappled with the difficulty of staying abreast of and absorbing all the changes that are now subsumed in the general rubric of the "revolution" under way in the health care market.

This book identifies those changes; relates them to the current needs, prior efforts, and future plans of employers who have been redesigning their health programs to better manage their costs; and raises the broader public policy issue of concern to us all, namely the provision of quality health care to the broadest number of people at the lowest possible cost.

Rising health care costs have played a particularly strong role in encouraging payers to seek out ways of providing health benefits in more cost-effective ways. The nation's employers, who provide the bulk of health coverage to the population, have taken substantial steps in that direction; and the federal government has also initiated changes in its public programs, particularly in the Medicare hospital insurance program. But it is difficult to know exactly how much these independent efforts have contributed to lower health costs. What is certain is that despite recent declines in the rate of increase in nominal health care spending, health care costs are still rising much faster than the overall Consumer Price Index. In real terms (i.e., adjusted for inflation), national health care expenditures have continued rising. In 1985, national health care expenditures reached \$425 billion—10.7 percent of the Gross National Product. Therefore, inflation in health care has not, by any means, been arrested; and as we remain concerned about managing costs, it becomes all the more important to assess what the implications of various cost-saving initiatives might mean for the quality of health care.

We would like to acknowledge the assistance of Arthur Lifson, vice president for health affairs with The Equitable Life Assurance Society

of the United States, who, from the early stages of planning the forum, helped us to identify key issues and recommended possible speakers. Harry Garber, vice chairman of The Equitable and chairman of the EBRI Education Committee, also was extremely helpful to us in planning the forum. Robert D. Paul, vice chairman of the Martin E. Segal Company and an EBRI trustee, served as a very able moderator of the forum discussion. Stephanie Poe, EBRI education and communications associate, provided major assistance in the organization and development of the policy forum, in editing the papers and transcripts, and in guiding the book through production. Nancy Newman of EBRI also provided invaluable assistance in facilitating the policy forum and in preparing the manuscript for publication.

FRANK B. MCARDLE, Editor  
Director of Education and Communications  
Employee Benefit Research Institute  
January 1987

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## About the Editor

### **Frank B. McArdle**

Frank B. McArdle, Ph.D., is director of education and communications for the Employee Benefit Research Institute. Before joining EBRI, he worked as a senior legislative and policy analyst for the U.S. Senate Special Committee on Aging and the U.S. Department of Health and Human Services, Social Security Administration. A former Fulbright and Woodrow Wilson scholar, McArdle served as consulting expert to the 1981 White House Conference on Aging, Committee on Implications for the Economy, and has published numerous works on Social Security, tax policy, health, and welfare issues.

# Introduction and Background: Private Initiatives to Contain Health Care Expenditures

Robert B. Friedland, Ph.D.

*Editor's note: Over 60 percent of all health care expenditures in the United States are privately paid, either by insurance or directly by individuals. Most people with private health insurance receive their coverage through employer-sponsored plans.*

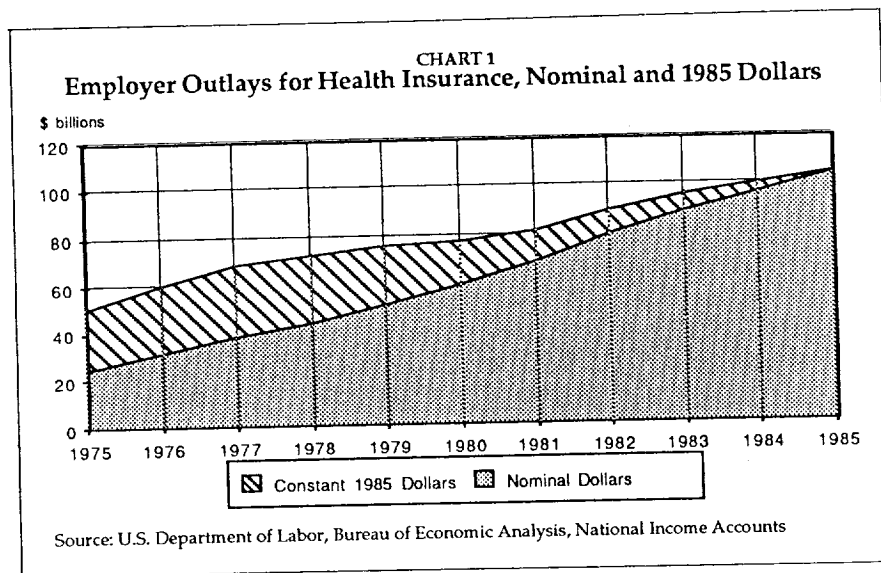
*As health care costs have climbed, the amount employers pay for health insurance coverage for workers and their families has been rising (1) in dollars, (2) as a percent of wages and salaries, and (3) as a percent of Gross National Product. In an effort to manage this rising liability, employers have redesigned their employee health insurance plans in a variety of innovative ways. These private initiatives have, in turn, stimulated change in the way the nation finances and delivers health care.*

*Because the drive to control and manage health care expenditures is a central force of change in the health care market, the following material is provided to set the stage for the subsequent presentations and discussion.*

Substantial improvements in our population's health have been made over the past two decades. Life expectancy has increased and infant mortality has been reduced. Some of the improvement in health may be due in part to increased access to health care, particularly by the poor, and because of technological advances in medicine. Part of the cost for these improvements has been the increased price of health care. To the extent health care expenditures continue to increase faster than other costs, however, employers are worried that their ability to compete with firms in other countries may be impaired. Health care expenditures have increased over 800 percent since 1960, while the Consumer Price Index (CPI) increased 110.6 percent during the same period. In 1985, health care expenditures reached \$425 billion—10.7 percent of the Gross National Product (GNP) or \$1,721 per person.

The rapid growth of health care expenditures has spurred interest in cost containment among all payers of health care—employers, insurance carriers, and government. Employers became particularly

alarmed during the 1982 recession, as revenues and profits declined while the cost of health care continued to rise. In 1970 employer payments for health insurance were 2.2 percent of wages and salaries; by 1985 they had increased to 4.9 percent.<sup>1</sup> In less than seven years, employer payments for health insurance more than doubled, increasing from \$46 billion in 1978 to \$105 billion in 1985. In real terms (i.e., adjusted for inflation), employer expenditures increased 38.3 percent since 1978 (chart 1).



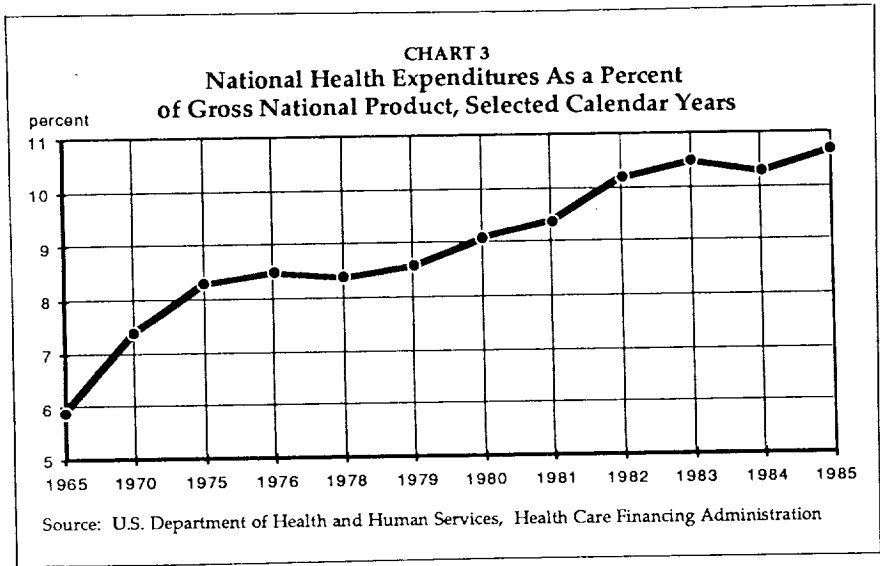
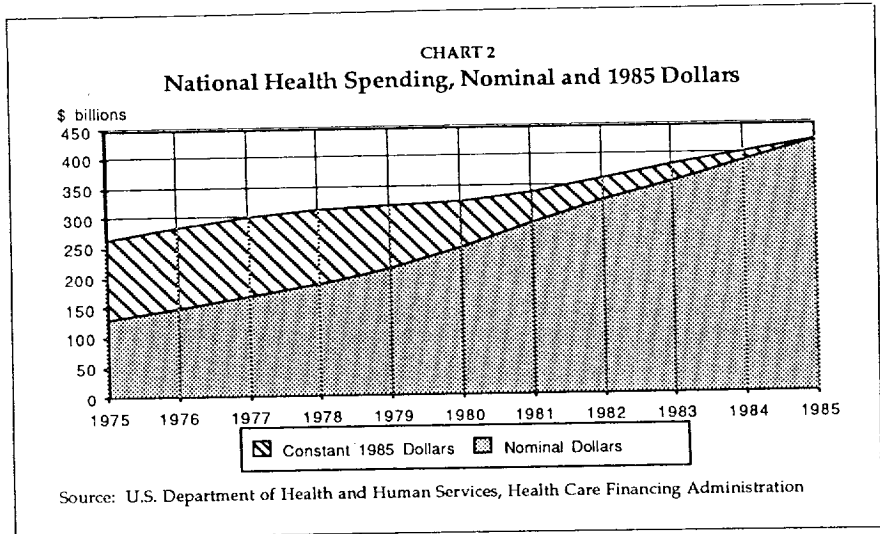
## Health Care Expenditures

### *Reasons for the Growth in Expenditures*

The rise in health care expenditures (chart 2) and the growth in the relative importance of the health care sector in the economy (chart 3) have occurred because of a variety of interrelated factors.

*Technological Advances*—Although technological advances often have been cited as causes of the increase in health care expenditures, it is difficult to generalize about their net impact. While some technologies have raised the costs of treatment by requiring more labor, more specialists, and more tests, they also have changed the fundamental

<sup>1</sup> U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (Washington, DC: U.S. Government Printing Office, July 1986), Table 6.13.



nature of health care and the quality of life. Examples of these technological advances include computed tomographic (CT) and nuclear magnetic resonance (NMR) scanners, which permit diagnostic testing without surgery; renal dialysis; neonatal and intensive care units; coronary bypass surgery; artificial hip joints; and organ transplants. Some of these technologies require substantial capital costs to ex-

and facilities or purchase equipment. Other technological advances, however, have reduced both the labor intensity of medical care and the need for hospitalization. Examples of cost-reducing technological advances include the development of antibiotics and vaccines and the computerization of laboratory testing and reporting.

*Population Growth*—Both the growth and the aging of the population have contributed to the rise in health care expenditures. Aggregate population growth may have accounted for 8 percent of health care expenditure increases from 1972 to 1982.<sup>2</sup> Between 1950 and 1984, the population age 65 and older increased 130 percent, rising from 12 million people (8 percent of the population) to 28 million (12 percent of the population). Because the incidence of morbidity and mortality is greater among the elderly, they tend to spend about three and one-half times as much per capita on medical care as younger population groups.<sup>3</sup> Nine percent of the elderly account for 70 percent of Medicare expenditures for the elderly's health care.<sup>4</sup>

*Inflation*—Nearly 58 percent of the increase in health care expenditures from 1972 to 1982 may have been due to general inflation.<sup>5</sup> General price increases affect the price of supplies and services purchased by physicians and hospitals. In addition, health care labor costs have increased dramatically over the past two decades, in part "catching up" to salaries of comparably skilled workers in nonhealth professions.

*Market Inefficiency*—Market inefficiencies result in unnecessary procedures, which increase the cost of providing health care. The health care market may fail to be efficient at allocating resources for at least three reasons:

- (1) *Third-Party Reimbursement*—The traditional method of financing health care is an important source of unnecessary health care spending. Most health care is financed retrospectively by third-party payers, based on provider cost or charges. Such cost-based reimbursement encourages greater health care supply and use, as well as more expensive health care, and does not encourage cost-effective allocation of health care resources.

---

<sup>2</sup>Comptroller General of the United States, U.S. General Accounting Office, *Constraining National Health Care Expenditures*, GAO/HRD-85-105 (Washington, DC: U.S. Government Printing Office, 30 September 1985), pp. 15-16.

<sup>3</sup>See Chapter XVI, "Financing Long-Term Care."

<sup>4</sup>Karen Davis, "Access to Health Care: A Matter of Fairness," *Health Care: How to Improve It and Pay For It*, Alternatives for the 1980s, no. 17 (Washington, DC: Center for National Policy, April 1985), p. 46.

<sup>5</sup>Comptroller General of the United States, pp. 15-16.



Both patient and physician are insulated from the financial consequences of their health care choices.

- (2) *Defensive Medicine*—The American Medical Association (AMA) estimates that defensive medicine and associated administrative costs contribute \$15.1 billion annually to the cost of health care.<sup>6</sup> The AMA Socioeconomic Monitoring System study indicated that 40 percent of the responding physicians prescribe additional diagnostic tests and 27.2 percent provide additional procedures in response to the growing risk of medical malpractice suits. The AMA found that other studies reported that defensive medicine may raise the cost of treatment 25 to 50 percent.
- (3) *Uncertainty*—Medicine is not a precise science. The uncertainty inherent in both the provision and the receipt of medical care may lead to performance of unnecessary tests and procedures. In a litigious society with an apparent abundance of medical resources, medical uncertainty provides the setting to do more than would be done if medicine were a precise science.<sup>7</sup> (One indication of the apparent abundance of medical resources is hospital occupancy rates. In December 1985, according to the American Hospital Association, the average occupancy rate year-to-date was 63.6 percent.) In uncertain situations, physicians are more likely to practice in a manner in which they feel comfortable: that is, a manner in which local medical protocol prevails and one that will yield the greatest financial returns.

### ***Financing Health Care***

In 1985 over 60 percent of all personal health care expenditures were privately paid, either by insurance (30.6 percent) or directly by individuals (28.4 percent) (chart 4). In 1985 Medicare financed 19 percent of health care expenditures and Medicaid financed nearly 11 percent. More than half of Medicaid spending (55 percent) was federally financed.

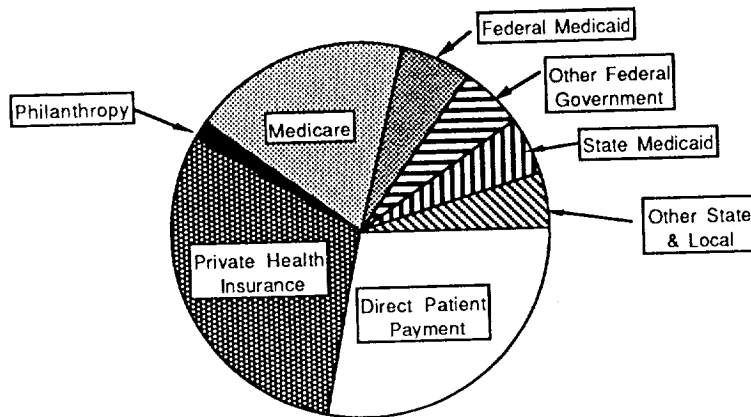
Employer plans are the largest source of insurance coverage. EBRI tabulations of the Census Bureau's March 1986 Current Population Survey indicate that 66 percent of all Americans under age 65 not

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<sup>6</sup>American Medical Association Special Task Force on Professional Liability and Insurance, *Professional Liability in the '80s*, Report I (Chicago: American Medical Association, October 1984), p. 16.

<sup>7</sup>See David M. Eddy, "Variations in Physician Practice: The Role of Uncertainty," *Health Affairs* 3 (Summer 1984): 74-88. This issue of *Health Affairs* was devoted to variations in medical practice.

CHART 4  
**Personal Health Care Expenditures by Source of Payment, 1985**

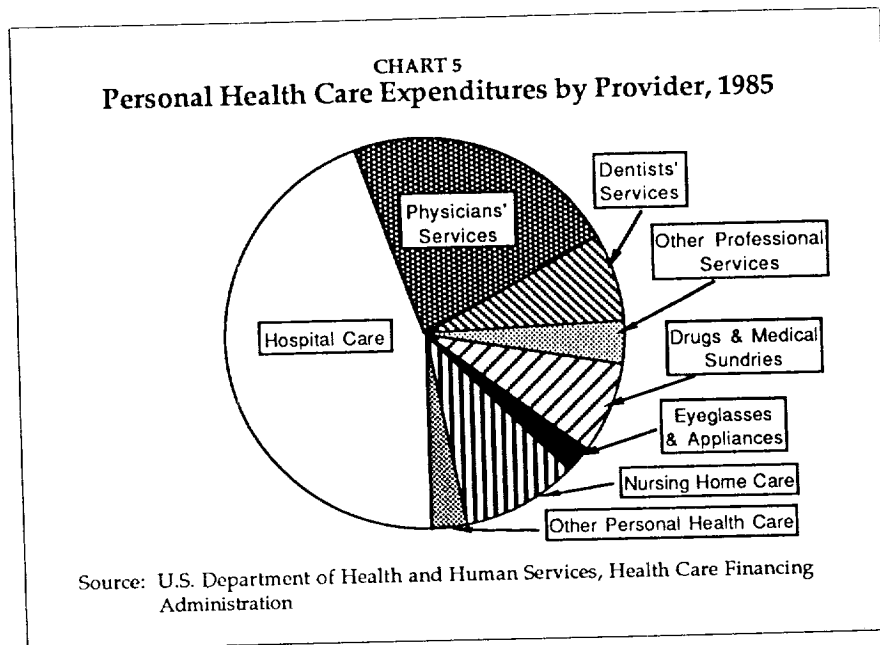


Source: U.S. Department of Health and Human Services, Health Care Financing Administration

working for the military or in agriculture had employer-provided coverage in 1985. Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) together covered 12 percent of the same population, while 4.6 percent were covered just by privately purchased individual insurance. However, 17.4 percent of the nonmilitary, nonagricultural population under age 65 had no coverage.

For nonmilitary, nonagricultural families whose primary earner is under age 65 and steadily employed full time, the percentage of workers and their dependents covered by employer-provided health insurance increases to 80.6 percent. "Steadily employed" is defined as having worked 35 or more weeks a year and 35 or more hours in a typical week.

Because hospitals are the largest source of health care spending (chart 5), most cost-containment initiatives have focused on controlling expenditures for hospital care. In 1985, 45 percent of personal health care expenditures and 52 percent of privately insured expenditures were for hospital care. Hospitals rely on private insurance as their most important single source of health care revenue (representing nearly 36 percent), followed by Medicare (29 percent). Ap-



proximately 69 percent of Medicare spending is for hospital-provided care.

Physician services represent the second-largest source of personal health care spending, at 22 percent of total expenditures for personal health care. In part because Medicare covers physician care less fully than hospital care, physicians receive about 71 percent of their health-related revenues from the private sector: 44 percent from private health insurance and 26 percent from direct payments by individuals. Medicare paid about 21 percent of physician revenues in 1985.

### **Initiatives to Contain Health Care Expenditures**

Over the last few years, all third-party payers have responded to the rise in health care expenditures. Medicare's change to financing inpatient hospital services through a prospective reimbursement system (known as the prospective payment system, or PPS) based on diagnosis is perhaps the best known. Private employers also have been aggressive in their response to increasing health care expenditures. A survey of 1,115 firms found that 97 percent changed their

health plans in response to rising health care expenditures.<sup>8</sup> In fact, 62 percent of these employers had implemented five or more cost containment provisions as of 1984. Two years earlier, only 14 percent had done so. In 1985, 90 percent of plan participants in medium and large establishments had a deductible and/or copayment provision for hospital room and board coverage.<sup>9</sup>

The changes most commonly initiated by employers include cost sharing, preadmission testing, and coverage of ambulatory surgical care, treatment in extended care facilities, and second opinions. In 1985, 46 percent of all health plan participants in medium and large establishments had some provision to require or encourage preadmission testing, nearly 24 percent of plan participants had coverage for a second opinion, and nearly 25 percent encouraged or required outpatient surgery (table 1). Other changes, although less common, include coverage of home health and hospice care, case management and utilization review programs, coverage of annual physical examinations, wellness programs, and coverage through preferred provider organizations (PPOs) or health maintenance organizations (HMOs).

The processes by which these changes affect expenditures vary. Copayments, deductibles, preadmission authorization, second opinions, and case management reduce the frequency of health service use among employees by increasing employees' costs or by helping them use services more efficiently. Other changes reduce hospital use in particular by encouraging employees to have tests or procedures performed in ambulatory facilities or to receive care in alternative settings, such as the home, hospices, or extended care facilities.

Employers also have made administrative changes to reduce expenditures, such as coordinating benefits with other health plans and auditing bills. Many have become self-funded in an effort to control plan costs. Finally, some employers have invested in health, safety, and employee assistance programs in an attempt to reduce health care claims through improved employee health.

The effectiveness of individual cost-containment initiatives is difficult to assess. None have been introduced within the context of a controlled experiment whereby one group of employees was affected

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<sup>8</sup>The Wyatt Company, *1984 Group Benefits Survey* (Washington, DC: The Wyatt Company, 1984).

<sup>9</sup>Employee Benefit Research Institute, "Features of Employer Health Plans: Cost Containment, Plan Funding, and Coverage Continuation," *EBRI Issue Brief* 60 (November 1986).

TABLE 1  
**Distribution of Participants in Plans with Selected Cost Containment Features,  
 by Establishment Size and Industry Group, 1985**

	Cost Containment Features							Summary: one or more features Identified
	Number of Participants (millions)	Incentive for second surgical opinion	Preferred outpatient surgery	Restricted weekend admissions	Separate hospital admission deductible	Preferred preadmission testing	None Identified	
All Participants	19.6	23.8%	24.9%	7.7%	8.8%	45.8%	44.2%	
Establishment Size (number of employees)								
100-249	2.2	19.4	22.8	6.2	9.5	42.5	44.2	
250-999	7.3	25.7	27.7	8.0	10.8	45.4	44.5	
1,000-2,499	3.7	20.0	20.7	6.1	11.5	51.7	39.9	
2,500 or more	6.2	25.8	24.6	9.1	4.6	43.2	47.3	
Industry Group								
Manufacturing	11.1	20.2	20.4	8.3	10.4	43.8	46.7	
Nonmanufacturing	8.5	28.6	30.7	6.9	6.8	48.5	41.0	

Source: EBRI tabulations of the 1985 Employee Benefits Survey (U.S. Department of Labor, Bureau of Labor Statistics).  
 Note: Detail for participants in establishments with fewer than 100 employees is suppressed.

by the change and another group was not. Many changes have occurred simultaneously and most have occurred during the past few years. Furthermore, claims data are generally not available to measure employee responses over time.

Consequently, since empirical evidence is not available, the following discussion of the effectiveness of various initiatives to control health care expenditures relies on the expected or perceived effectiveness of the initiatives. Most of this is based on anecdotal or subjective evidence and the perceptions of benefit consultants and employers.

### **Cost Sharing**

Cost sharing, which includes requiring employees to pay deductibles and copayments and part of the plan costs, has become increasingly common. A deductible is the amount of initial expense an insured person must pay for covered services; a copayment is the proportion of costs for covered services that participants are required to pay in excess of any deductible amount. Department of Labor data show that in 1985, 90 percent of all health plan participants in medium and large establishments had a deductible and/or a copayment provision for hospital room and board and for physician services provided outside of a hospital. Full coverage for surgical expenses are more common; in 1985, such coverage was provided to 28 percent of all plan participants in medium and large establishments. The Labor Department data also indicate that over 65 percent of all plan participants in 1985 did not contribute to their own health insurance premiums, and that nearly 46 percent of all participants did not need to contribute toward the premium for dependents' coverage.<sup>10</sup>

There is evidence that the dollar amount of cost sharing has been increasing. Labor Department data indicate that since 1982 the percentage of health plan participants in medium and large establishments with a deductible of \$100 has declined dramatically, while the percentage of participants with a deductible of \$150 or more has risen even more dramatically. A Hay/Huggins survey of 900 employers found that, in 1985, 44 percent had made hospital expenses subject to a deductible; in 1984, 39 percent had made them subject to a copayment. Forty-one percent of the respondents had made surgical expenses subject to a deductible and an equal proportion had made such expenses subject to a copayment. The survey also found that 45

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<sup>10</sup>EBRI Issue Brief 60.

percent of the firms had raised their plan deductibles, 25 percent had raised the copayments, and 31 percent had raised the percentage of the premium employees were required to pay.<sup>11</sup>

Most plans in medium and large establishments pay 100 percent of the cost of covered services after a participant's out-of-pocket expenses (deductibles and copayments) exceed a specified limit. In 1985, 77 percent of plan participants with major medical insurance coverage had an annual out-of-pocket expense limit of \$1,200 or less. Only 4 percent of participants with major medical coverage and out-of-pocket expense limits had a limit that exceeded \$2,000.<sup>12</sup>

By removing first-dollar coverage, copayments or deductibles make patients more sensitive to the prices of various medical options. This increased price-consciousness may help to reduce unnecessary use of medical services.

An extensive evaluation of reasonable and income-related cost sharing conducted by the Rand Corporation indicates that individuals use health services less when confronted with increased deductibles and copayments.<sup>13</sup> A 25 percent copayment reduced expenditures by 20 percent compared to full coverage. In addition, the Rand researchers found that

- deductibles reduced expenditures for ambulatory care more than for inpatient hospital care,
- cost sharing for ambulatory care but not for hospitalizations reduced hospitalizations,
- cost sharing based on family income affected low- and high-income families equally, but children's hospitalizations in either income group were not affected, and
- service use fell steadily as cost sharing increased.

The Rand study suggests that reasonable, income-related cost sharing reduces utilization of routine care and may reduce the incidence of hospitalization.

Cost sharing, however, does not affect the cost of hospitalization. In addition, cost sharing may actually increase health care expen-

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<sup>11</sup> Bobbi Butler, "Stemming the Rising Tide of Health Care Costs," *Compensation and Benefits Management* (Autumn 1986): 359-368, Exhibit 1.

<sup>12</sup> *EBRI Issue Brief* 60.

<sup>13</sup> See Joseph P. Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine* 305 (17 December 1981): 1501-1507, and Charles E. Phelps, *Health Care Costs: The Consequences of Increased Cost Sharing* (Santa Monica, CA: The Rand Corporation, November 1982).

ditures in the long run if individuals delay seeking medical attention beyond the early stages of illness when treatment may be less expensive. Research evidence, however, has not confirmed that cost-sharing provisions create greater expenditures in the long run.

### ***Incentives to Avoid Inpatient Utilization***

*Preadmission Testing and Ambulatory Surgery*—Many tests routinely performed in hospitals can be performed on an outpatient basis prior to admission. Providing coverage for or requiring preadmission testing may save one or more days of hospital room and board charges.

An estimated 20 to 40 percent of the 18 million surgical procedures performed in hospitals each year could be performed in outpatient settings.<sup>14</sup> Savings depend on the relative cost of care in the outpatient-surgery recuperation room versus hospital inpatient room and board expenses.

Preadmission testing and ambulatory surgery are common cost-containment initiatives and are perceived to be effective. The Wyatt Company 1984 *Group Benefits Survey* found that 82 percent of 1,115 employers covered preadmission testing and 69 percent covered ambulatory surgery. In 1985 *The Equitable Healthcare Survey III*, which questioned 1,250 firms with 500 or more employees, found that 47 percent had introduced financial incentives in the past three years for employees to have tests and minor surgery performed on an outpatient basis.

One employer has reported reducing medical admissions by 2.3 days and surgical admissions by 3.8 days per patient in 1982 by encouraging preadmission testing. Another reported saving \$228 per hospital admission. An insurance carrier found that ambulatory surgery saved an average of \$523 per patient in 1981. (It is important that the physicians and the hospital know that the admitted patient has already had certain tests done and that reimbursement will not be made for valid tests that are repeated in the hospital.)

*Second Surgical Opinions*—Second surgical opinions provide patients with more information on recommended surgery, potentially reducing unnecessary surgery. Studies indicate that between 9 and 12 percent of all surgeries might be avoided if employees seek second opinions.<sup>15</sup> Among other things, mandatory second opinions may act as a quality control screen and help reduce an individual's anxiety about the need for surgery.

<sup>14</sup>Comptroller General of the United States, pp. 15–16.

<sup>15</sup>*Ibid.*, pp. 128–130.



Employer coverage of second opinions for surgery is common. The Wyatt Company's *1984 Group Benefits Survey* reported that 80 percent of employers covered second surgical opinions; *The Equitable Health-care Survey III* reported that 54 percent had introduced coverage in the last three years.

The perceived effectiveness of second opinions in containing health care expenditures, however, is not consistent. Voluntary second opinions may be less successful than mandatory programs; programs that control the cost of the second opinion may be more successful than those that do not. Benefit consultants recommend that physicians rendering second opinions be reimbursed on a flat-fee basis.

One company has reported that 19 percent of second opinions were nonconfirming; in 88 percent of these cases, the individual decided not to have the surgery. This lowered the potential number of procedures by 16 percent for an estimated savings of \$180,000 in 1983.

*Care in Alternative Settings*—Care in alternative settings, such as the home or extended care or hospice facilities, can be substantially less expensive than hospital-based care. Coverage for care in these settings may contain expenditures if preadmission and/or concurrent utilization review is used to identify patients who can leave the hospital earlier and ensure that the care provided outside the hospital substitutes for hospitalization.

Home health care can reduce the period of hospitalization associated with recovery, reducing the cost of care and the risk of coming into contact with other illnesses while hospitalized. Home health care can provide occupational, physical, and speech therapy and various levels of nursing care, ranging from skilled nursing to that provided by nurse's aides. In some localities, home health patients requiring kidney dialysis have access to portable dialysis machines for use in their homes. (Under some circumstances, however, the home may not be conducive to helping the patient recover.)

Hospice care, either at home or in a hospice facility, can substitute for the hospitalization of terminally ill patients. Hospices counsel terminally ill patients and their families and limit medical intervention to administering pain-reducing medication.

Ethical issues surrounding hospice coverage, however, are controversial. Hospice care may only be useful in cases where the terminal prognosis is accepted. Furthermore, coverage is usually predicated on certification by the physician that death is expected within a specified period of time.

In 1982 the Bureau of Labor Statistics found that 62 percent of health plan participants in medium and large establishments had

coverage either for home health care or extended care.<sup>16</sup> In 1985, 67 percent of plan participants had extended care coverage and 56 percent had home health care coverage.<sup>17</sup>

Anecdotal evidence suggests that coverage of care outside of a hospital can reduce health care expenses. One insurance company reported that cervical spine sprains, which require extensive bed rest, can incur over \$9,000 in hospital costs for an eight-day stay, while 30 days of home care would cost \$438. One company provides home dialysis equipment at a cost of \$14,000 per year, compared to as much as \$25,000 for in-hospital treatment. The State of Colorado reports saving 551 hospital days on 1,820 admissions in its first year of covering home health care, saving an estimated \$163,350. One Blue Cross organization reports that terminal cancer patients in the last eight weeks of life incur \$1,290 for hospice care compared to \$5,509 for traditional inpatient care.

*Utilization Review*—Employer utilization review programs focus on the medical procedures used by physicians to hold down expenditures and manage patient care. In the past, retrospective utilization review (examining records after discharge from the hospital) dominated review programs. Preadmission review and concurrent review, however, have become more common in recent years. These programs may be handled in-house or by an outside company.

Advances in computerized claims processing and the desire to contain health care expenditures have made preadmission and concurrent review more desirable than in the past. Preadmission authorization requires physicians to call for authorization before admitting patients for elective surgery. Concurrent review requires examination of a patient's hospital chart to determine whether the physician substantiated the need for continued hospitalization. Norms established for specific problems are applied to a patient to determine whether the length of stay is unnecessarily long.

Utilization reviews put pressure on health care providers to document reasons for hospital stays that are longer than indicated by standards established by the review program. Although this creates more paperwork for the physician, it may induce physicians to monitor their actions and may focus attention on variations in medical

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<sup>16</sup>U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1982*, Bulletin 2176 (Washington, DC: U.S. Government Printing Office, 1983), Table 19.

<sup>17</sup>U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1985*, Bulletin 2262 (Washington, DC: U.S. Government Printing Office, 1986), Table 26.

practice that might be sources of unnecessary health care. Utilization review may also provide assurances to the patient that appropriate medical care is provided.

Utilization review programs are not yet common, since they are relatively more expensive and complex to implement and administer. The Wyatt Company's 1984 *Group Benefits Survey* found that 14 percent of the respondents had a preadmission authorization program. *The Equitable Healthcare Survey III* found that 28 percent of the employers responding in 1985 had introduced a preadmission authorization program and 27 percent a utilization review program since 1983.

Among larger employers, however, utilization review programs may be becoming more common. A 1985 survey of 633 of the largest U.S. employers by the Health Research Institute found that 45 percent had a concurrent utilization review program, up from 17 percent in 1983, with reported savings of nearly 7 percent of paid claims.<sup>18</sup> Preadmission authorization programs were used by 37 percent of the respondents, up from 16 percent in 1983; 30 percent used retrospective review programs, up from 19 percent. Respondents reported saving 8 percent of paid claims for preadmission authorization and 2 percent for retrospective review programs.

The same survey of large employers indicated that 19 percent of the respondents had a case management program and 5 percent had a case management program for disability rehabilitation. Annual savings for these programs were reported as nearly 6 percent and 0.5 percent of paid claims, respectively. Use of pre-discharge planning increased from 1 percent in 1983 to 7 percent in 1985, while the use of patient advocacy programs grew from 1 percent in 1983 to 4 percent in 1985.<sup>19</sup>

## **Initiatives to Encourage Competition**

### ***Health Maintenance Organizations***

The number of health maintenance organizations (HMOs) has increased about 900 percent in 15 years, from 39 in 1971 to 550 as of June 1986, with estimated enrollment of about 24 million people.<sup>20</sup>

<sup>18</sup> Alison Kittrell, "Health Cost Shifting's Popularity Wanes: Study," *Business Insurance* (31 March 1986): 1, 22-23.

<sup>19</sup> Ibid.

<sup>20</sup> InterStudy, Inc., *HMO Summary* (Excelsior, MN: InterStudy, Inc., June 1985), Table 1.

HMOs provide comprehensive medical care for a prepaid fee to patients who agree to use participating physicians and hospitals. With prepayment, HMOs assume the financial risks associated with health care. Primarily for this reason, and partially because of reports of markedly lower hospital utilization by HMOs, many employers encourage workers to elect HMO coverage as a way to contain plan costs.

Federally qualified HMOs receive congressional support through grants and guaranteed loans. They also receive marketing assistance through the HMO Act of 1973, which requires that employers with at least 25 employees offer HMO enrollment as an option if requested to do so by a federally qualified HMO in the geographic area. Employers have been required to contribute to the HMO at least the same amount per employee as it pays for conventional health insurance. The U.S. Department of Health and Human Services, however, has issued a proposed regulation that would end the equal contribution requirement for employers using federally qualified HMOs.<sup>21</sup>

Individual practice associations (IPAs) have grown faster than other types of HMOs. In IPAs, physicians accept patients under a prepayment arrangement but are also free to accept fee-for-service reimbursement. InterStudy, Inc., estimates that there were 99 IPAs with enrollment of nearly 1.9 million in June 1983. By June 1985, an estimated 181 IPAs were in existence, with enrollment of nearly 4.7 million.<sup>22</sup>

A 1984 study conducted by the Rand Corporation found that hospital utilization among HMO members was 40 percent lower than among people with full insurance coverage without cost sharing, using a fee-for-service physician of their choice. Compared to a group of individuals with a 5 percent copayment requirement on services provided by a fee-for-service physician of their choice, hospital utilization among HMO members was 20 percent lower. A study of 12 HMOs by the General Accounting Office in 1982 found that hospital utilization was 59 percent lower than that of the general population and 38 percent lower than the national Blue Cross average. Both studies concluded that the lower utilization was due to HMO controls and procedures and not the age, sex, and health characteristics of the populations enrolled.

Despite HMOs' growth and their lower rates of hospital utilization compared to that of conventional fee-for-service providers, they may

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<sup>21</sup> *Federal Register* 52, no. 8, January 1987, pp. 1343-44.

<sup>22</sup> *BNA Pension Reporter* 13 (3 March 1986): 390, and unpublished InterStudy data.

not reduce the overall rate of cost increases. Preliminary evidence from the Rand study indicates that employers may get at least a one-time substantial saving for each employee joining the HMO, but it is less apparent that the subsequent rate of cost increase is different.

Whether or not HMOs contain health care costs depends in part on how premiums are determined. HMOs usually use community experience ratings to establish premiums, while rates for traditional insurance for most medium and large employers are based on the overall experience of the firm's health plan. The relative difference in the two rates will depend on the firm's experience relative to that of other HMO members in the community. Differences may vary by employer and region.

The subsequent experience of the traditional insurance plan will depend on which employees choose the plan over the HMO option. If younger, healthier employees are attracted to the HMO, the average cost of the traditional plan could rise. Conversely, if employees with potentially costly medical needs are better served by and select the HMO, the traditional plan's average cost might fall. HMO premiums, however, still would reflect community-wide risk rather than the disproportionate share of risk posed by these employees.

### ***Preferred Provider Organizations***

Preferred provider organizations (PPOs), also called preferred provider arrangements, are agreements between health care providers and third-party payers to provide fee-for-service health care at a discount. The term "PPO" covers a variety of arrangements that have been established by providers, third-party payers, and employers.

In most cases, subscribers to a PPO are free to choose any physician or hospital, but are given financial incentives to choose from among *preferred* providers. These providers, in turn, obtain an increased pool of patients and sometimes faster claims processing. Unlike an HMO, however, they do not make prepayment arrangements with members and, as a result, assume virtually none of the financial risk.

An emerging type of PPO is the exclusive provider organization (EPO), established by self-insured employers. EPOs differ from PPOs in that employees must use EPO providers to receive coverage; PPOs merely offer a financial incentive to do so (by providing fuller coverage, for example). PPOs are subject to state insurance regulation unless established by self-funded employers. These employers consequently can establish EPO arrangements, agreeing to reimburse only for services of the exclusive providers.

A few PPOs have emerged that require the health care provider to assume some of the financial risk of providing care. Such an arrangement could include negotiated per diems at local hospitals or a negotiated fee schedule based on specific procedures or a set of specific diagnoses. This form of PPO is sometimes called a negotiated provider agreement (NPA).

PPOs have grown rapidly in the last several years. The American Hospital Association estimates that 33 were operating in 1982 and 115 in 1984, covering 1.3 million people. A survey by *Medical-Economic Digest* indicated that 195 PPOs were operating in 1985. These included 98 physician contracts averaging 1,792 physicians per PPO, and 97 hospital contracts averaging 28 hospitals per PPO. The Wyatt Company's *1984 Group Benefits Survey* found 7 percent of the employers responding had PPOs; *The Equitable Healthcare Survey III* found 9 percent of employer respondents had formed a PPO in the last three years.<sup>23</sup>

Most of the reported savings are based on the discounted price of services provided through the PPO. Efficient PPO providers, however, could reduce employer plan costs without a discount. To be effective, only those physicians and hospitals whose medical practices carefully use health care resources should be among the list of preferred providers.

If PPOs are based on efficiency, market competition will encourage providers to establish controls similar to those of prepaid plans. This kind of market pressure requires good information on providers' costs and charges and the types of patients they see. These data, which are only now becoming available, may assist in verifying the price discount relative to the price other providers charge, or in determining whether the volume of service is greater among providers that offer discounts.

### **Administrative Changes**

Administrative measures to contain health care expenditures, including self-funding, coordinating benefits, and auditing bills, are mechanisms to administer health plans more efficiently.

Bill audits of high-dollar claims, over \$10,000 for example, are becoming increasingly common. The Health Research Institute's (HRI)

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<sup>23</sup>Editor's note: In its 1986 *Blue Book Digest of PPOs*, the National Association of Employers on Health Care Alternatives (NAEHCA) provides information on 462 PPOs in 43 states, the District of Columbia, and Puerto Rico, "an unprecedented increase of 130 percent" since the 1985 edition, which listed approximately 200 PPOs in 34 states. See NAEHCA, *Blue Book Digest of PPOs* (Key Biscayne, FL: NAEHCA, 1986).

1985 employer survey indicates that 68 percent of the responding firms conducted audits in the preceding two years, compared with 65 percent in 1983.<sup>24</sup> One bill-auditing firm reports that 97 percent of hospital bills it audited in 1984 and early 1985 contained errors resulting in overcharges. The average unsupported or unrelated charge was nearly 4 percent of the average audited bill. One insurance carrier's claims office saved 2 percent of audited claims.

Employers that self-fund benefits retain the risk of providing health insurance coverage to workers. Although stop-loss insurance against large expenses is purchased and employers hire insurance carriers to process claims, the premiums are retained by the employer. The 1983 HRI survey of 1,500 of the largest U.S. employers, including all *Fortune*-listed firms, found that 11 percent of respondents were self-funded and administered their own claims; 25 percent were self-funded but had another party administer the claims.

Employers choose to self-fund for a number of reasons; the relative importance of those reasons has not been substantiated. Those that self-fund retain premiums that would have gone to the insurance carrier as reserves against future claims. Insurance companies' interest earnings on such retained premiums during the late 1970s probably were substantial. Insurers have responded, however, by charging employers installment payments, thus reducing the amount of employer premiums held in reserve.

Unlike purchased health insurance, self-funded health plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA). As such, they avoid state regulation that requires health insurance plans to cover specific services. Finally, employers avoid paying state premium taxes levied on commercial insurers. In the 1983 HRI survey, firms that had begun self-funding reported saving 8 percent of paid claims.

## Promoting Better Health

Public health officials estimate that one-half of the costs of illness are from conditions that might be prevented by staying fit, eating wisely, not smoking, and drinking alcohol in moderation. Employers have begun to incorporate an array of initiatives designed to promote better health. Early reports indicate that this investment reduces absenteeism, lowers health care costs, improves morale, and improves employer ability to recruit better workers.

<sup>24</sup>Health Research Institute, "Health Care Cost Containment Survey," *Bobbin* (February 1984): 49-58. The 1985 survey was reported in Alison Kittrell, "Health Cost Shifting's Popularity Wanes: Study."

*The Equitable Healthcare Survey III* found in 1985 that 26 percent of the firms questioned had initiated a wellness program within the last three years; the Wyatt Company's *1984 Group Benefits Survey* found that 10 percent had initiated such a program. A 1985 Hewitt Associates survey of 1,185 companies of varying sizes found that the most common wellness programs were first aid training, including cardiopulmonary resuscitation (CPR); exercise classes; stress management courses; and smoking-cessation programs.

The Prudential Insurance Company of America examined the effectiveness of a structured fitness program for white-collar workers. Among employees in the program, days of absence decreased 20 percent after one year and health care costs were reduced by 46 percent. The fitness program saved employers \$1.93 for every dollar spent.

### **Response by Public Payers**

Medicare and Medicaid are among the federal government's largest nondefense-spending programs. Estimated federal government spending for Medicare and Medicaid in fiscal 1986 exceeded \$93 billion. As a result of these programs, the federal government is the single largest purchaser of personal health care services in the United States. In 1985 the federal government paid 30 percent of the nation's \$371 billion bill for personal health care. Federal government spending for personal health care has risen at an average annual rate of nearly 13 percent since 1980, somewhat more slowly than the average annual growth rate in the 1970s of nearly 16 percent but faster than the growth rate of other nondefense federal spending.

The federal government's response to rising Medicare spending has been complex. In 1982 Congress authorized a major revision of Medicare's hospital reimbursement formula to allow prospectively determined, fixed-price payment based on patient diagnosis. The prospective payment system (PPS) replaces Medicare's former practice of retrospective, cost-based reimbursement. Medicare prospective payment is being phased in over a five-year period; fiscal 1988 will be the first year that Medicare payments for hospital care are fully prospective.

In addition, Medicare has frozen physician fees and aggressively encouraged physicians serving Medicare patients to accept assignment (that is, to accept Medicare payment as payment in full). The Health Care Financing Administration (HCFA), which oversees Medicare, is evaluating the feasibility of prospectively determining pay-



ment for physician services, particularly for those performed in hospital settings. (President Reagan's fiscal year 1988 budget proposal recommends such payments to hospital-based radiologists, anesthesiologists, and pathologists.)

The federal response to rising Medicaid spending has differed. Rather than focusing on the specifics of states' reimbursement formulas, the federal government has sought to give states more flexibility in designing Medicaid benefits to control spending. As a result, several states have changed hospital payment methods and/or now limit covered hospital days. Many have applied to HCFA, Medicaid's federal administrative agency, for waivers to alter their program structure by limiting beneficiaries' choice of providers, establishing case management programs, or covering community-based care as an alternative to nursing home care.

### **Effectiveness of Cost Containment Initiatives**

Health care expenditures have increased rapidly because of increases in service use and price. Effective cost containment relies on controlling both factors. An individual employer that is not a large-enough buyer of health care to affect price might be able to coordinate with other major purchasers in the community to encourage competition among providers and reduce employer costs. (Alternatively, price can be affected through government rate regulation. Rate regulation can benefit all payers, not just large buyers or those that have initiated cost containment measures. An all-payer rate-setting mechanism also can be used to address other issues, such as uncompensated care.)<sup>25</sup>

Even without coordination, however, individual employers may be able to reduce use of health services by plan participants. Consequently, employer cost-containment initiatives commonly focus on controlling use by removing, for example, first-dollar coverage for hospital and medical care. As we have seen, research suggests that modest cost sharing can have a pronounced effect on routine service use, testing, and hospital admissions with no apparent short-run compromise of the quality of health care.

Plans can also be redesigned to encourage employee use of lower-cost ambulatory care. Common changes include more complete coverage for or required use of preadmission testing and fuller coverage for specific surgical procedures done on an outpatient basis.

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<sup>25</sup>Editor's note: For more information on uncompensated care, see Chapter XIV.

Hospital stays may be shortened by providing plan coverage for home health and hospice care and by managing patient use of non-hospital care effectively. Preadmission authorization and concurrent utilization review also may be effective in shortening hospital stays by encouraging same-day surgery, avoiding weekend admissions, and monitoring emergency-room usage. Finally, mandatory second opinions may assist employees in avoiding some admissions altogether.

Such changes might affect employers' health care costs and could affect the capacity of the local health care system, especially if an employer is large or if all employers in an area initiate similar controls.<sup>26</sup> Otherwise the savings of one employer could become the additional cost of another payer as revenue shortfalls are shifted to those willing to pay.

Administrative changes such as self-funding, benefits coordination, and bill auditing may save an employer money without shifting costs or affecting the capacity of the health care market. However, while these changes improve administrative efficiency, they do not contain health care expenditures, nor do they change the cost of health care.

Finally, as we have seen, employers are turning to HMOs and PPOs to lower their expenditures and promote competition. Competition may work to lower service use among employees, and also lower prices, as insurance carriers compete for groups of employees and as self-funded plans try to lower expenditures.<sup>27</sup>

## Rate of Growth in Health Care Expenditures

Attention recently has focused on the decline in the growth of national health care expenditures since 1981. In 1982, health care expenditures increased 12.8 percent over the previous year. In the most recent year for which national data are available (1985), health care expenditures rose 8.9 percent over the previous year's spending. The slowdown in nominal health care expenditures, however, does not necessarily mean that the cost containment activities of third-party payers have been successful. The primary reason for this decline in the growth in health care expenditures is the decline in prices throughout the economy since that time.

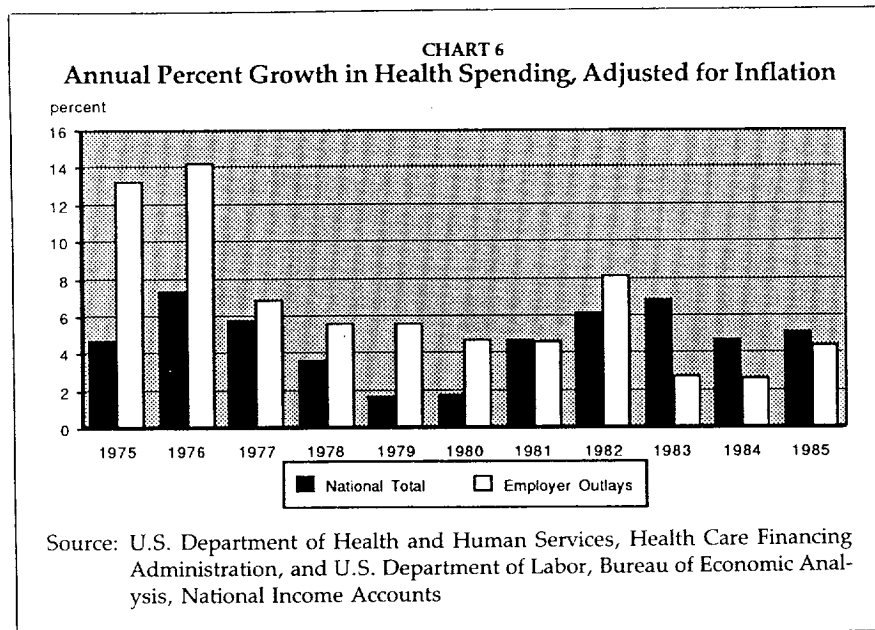
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<sup>26</sup> Editor's note: See Chapter VII for a discussion of the role of employer coalitions.

<sup>27</sup> Richard G. Frank and W. P. Welch, "The Competitive Effects of HMOs: A Review of the Evidence," *Inquiry* 22 (Summer 1985): 148-161. For a discussion of the impact of PPOs, see Jon Gabel and Dan Ermann, "Preferred Provider Organizations," *Health Affairs* 4 (Spring 1985): 24-39.

The slowdown in the rate of growth of health expenditures (in nominal terms) and the apparent timing of this change (since 1982) has led many to believe that the new Medicare PPS, innovations of private employers, changes in provider behavior, or some combination of the three are responsible for the slowdown. This assessment is premature, since most of the slowdown is due to changes in inflation and to trends in health care delivery that began prior to the implementation of cost containment provisions by most payers. These provisions may eventually be responsible for reducing health care costs, but so far there is little evidence indicating that this has occurred.

Adjusting for inflation, it is clear that there has not been any real decline in the rate of growth in health care expenditures. Health care costs continue to exceed general price increases. In 1985, the annual percentage growth in employer contributions to health insurance was 5.2 percent. In real terms (adjusted for inflation) the growth rate was 4.3 percent, while the medical component of the CPI rose 6.2 percent and the CPI for all goods and services rose 3.6 percent. Chart 6 shows the annual percentage growth rate in national and employer health spending adjusted for inflation. Expenditures have increased in each of the years shown by more than the increase in the CPI. Since 1979

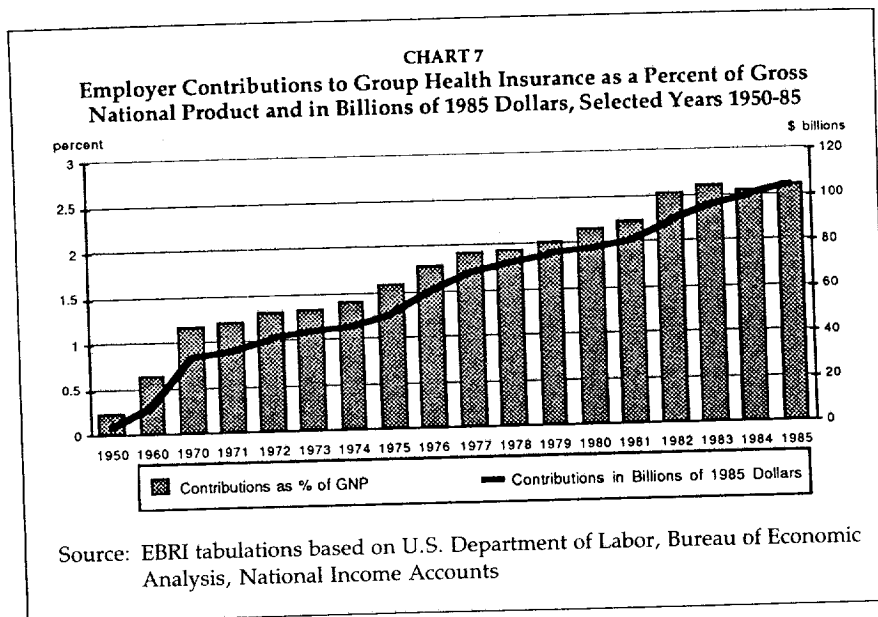


the growth in real national health care expenditures has outpaced the preceding year's growth rate for every year except 1984.

The rate of growth in employer contributions declined significantly from 1976 until 1982, when the growth rate exceeded 10 percent. Since 1982, the real increase in employer contributions to health insurance has been declining. In 1984 the growth rate was 4.32 percent; in 1985 it was 4.34 percent. Chart 7 shows that although employer contributions as a percent of GNP have leveled or declined slightly since 1982, real outlays for health care continue to rise.

Many have assumed that Medicare, as the nation's largest single payer of health care, has been responsible for halting the trend in health care expenditures by moving to prospective reimbursement for hospital services. From federal fiscal years 1983 to 1984, hospital admissions declined approximately 3.3 percent. Since PPS was implemented in October 1983, many assumed it was the cause of the decline. However, an appreciable source of the decline in hospital use was due to a drop in hospital admissions among people who are not Medicare recipients. Among persons age 65 and older, hospital admissions declined 2 percent and among persons under age 65, 4 percent.

Interestingly, while non-Medicare patients drove the trends in hospital admissions, it was the Medicare population that drove the de-



cline in average length of hospital stay. From 1983 to 1984 the average length of stay in the hospital declined 5 percent. Among persons age 65 and older, length of stay declined 7 percent and for persons under age 65, 4 percent.

The decline in hospital admissions and in average length of stay has meant a decline in hospital days, a decrease in hospital occupancy rates, and an increase in the cost of a hospital day. From 1983 to 1984, the decline in hospital days was 8 percent for persons age 65 and older and 7 percent for those under age 65.

These trends in hospitalization began prior to the implementation of PPS. But even if the trends accelerated slightly after implementation, they might not have been directly due to changes in the Medicare program, since PPS payments were only partially in effect the first year. During that year, if a hospital was reimbursed under PPS, only 25 percent of its payments were based on PPS rates. Many hospitals were not immediately affected, since each eligible hospital did not become subject to the new system until its respective fiscal year. Consequently, if a hospital's fiscal year began July 1, for example, the PPS payments for 25 percent of the hospital's Medicare payments did not begin until nine months after the October 1, 1983, implementation of PPS. Furthermore, specific services like psychiatric care and renal dialysis were not reimbursed prospectively, and all hospitals in Maryland, Massachusetts, New Jersey, and New York were exempt from PPS. Thus, the extent of Medicare payments under PPS during the first year of implementation was relatively low. While over 28 percent of hospital revenues traditionally are derived from Medicare, Davis et al. estimate that, at most, 5 percent of all hospital revenues were paid on a prospective basis.<sup>28</sup>

Davis et al. argue that there is no conclusive evidence suggesting that Medicare's PPS is the underlying cause of declining hospital length of stay for the elderly. They suggest that the decline may have been initiated by the restrictions in Medicare reimbursement instituted under the Tax Equity and Fiscal Responsibility Act of 1982. This law imposed a limit on the increase in reimbursement to each hospital. On the other hand, the rhetoric heralding the coming of the new program and the promise of reforms from the private sector may have caused providers to reevaluate their medical protocols. Anticipation of financing reforms may be a very powerful influence.

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<sup>28</sup>Data are from the American Hospital Association, as published in Karen Davis, Gerard Anderson, Steven C. Renn, Diane Rowland, Carl J. Schramm, and Earl Steinberg, "Is Cost Containment Working?" *Health Affairs* 5 (Fall 1985): 81-94, Exhibit 3.

The decline in admissions among the nonelderly is also not well understood. Davis et al. suggest that changes in employer-provided health benefits might be a likely cause. They cite, in particular, utilization review and the growth of care provided in settings other than hospitals. They also suggest that there may be some reduction in access to care for those without insurance coverage as payments are restricted, particularly those by Medicaid.

Finally, in looking at hospital costs, revenues, employment, and capacity, Davis et al. conclude that there is not "any convincing evidence that hospital efficiency or productivity in providing a day of hospital care is increasing at a rapid rate."<sup>29</sup> Although admissions fell 3 percent and inpatient days fell 8 percent, total personnel fell 1 percent. On a per-patient basis, personnel increased 7 percent, suggesting that hospital staff have not declined as rapidly as patient days. This may have contributed to the increase in cost per day, which rose just as quickly from 1983 to 1984 as in the period 1975 to 1983.

In all likelihood, part of the increase in cost per day is due to the decline in hospital admissions and average length of stay. A shorter hospital stay would eliminate the relatively lower-cost days spent in recovery, leaving the more intensive and expensive days of care. Dividing a shorter duration into more expensive days raises the average cost per day. In addition, if hospital admissions consist of relatively sicker patients, this too would tend to raise the average cost per day. Nevertheless, hospitals were able to increase average operating margins, perhaps, in large part, because revenues from patients rose faster than costs.<sup>30</sup>

Trends in hospital admissions and average length of stay may reflect shifts in where and how health care is delivered. Health services may be shifting away from the hospital inpatient setting toward ambulatory settings such as hospital outpatient departments and physician offices; however, the biggest change in personal health care expenditures may be in the growth of the share paid to nonphysician health professionals. From 1984 to 1985, the share of personal health care expenditures going to hospitals decreased from 46.2 percent to 44.9 percent. While physician services increased in share size from 22.1 percent to 22.3 percent, however, the services of health profes-

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<sup>29</sup>Ibid., exhibits 1 and 2.

<sup>30</sup>The operating margin is the ratio of net earnings to revenues. The margin increased from 4.3 percent prior to 1983 to 5.7 percent for that year. Data are from American Hospital Association, *Trends, 1984*, as reported in Davis et al., "Is Cost Containment Working?"

sionals other than physicians and dentists increased from 2.6 percent to 3.4 percent of personal health care expenditures.

### **Implications for the Quality of Health Care**

Whether health care services are effective in improving health depends, in large part, on the quality of care. Quality, in turn, involves the amount of care provided to patients and the technical merits and appropriateness of that care, as well as the interpersonal skills of providers in achieving a working relationship with their patients.<sup>31</sup>

Given the uncertainty of what affects quality, it is not surprising that little is known about how initiatives to contain health care costs affect the quality of health care. It would appear that reductions in health care expenditures pose a potential conflict with providers' abilities to maintain quality and could ultimately lead to sacrifices in quality.<sup>32</sup> In some instances, however, cost containment may enhance quality by reducing unnecessary procedures. The point at which reduced revenues improve or diminish quality is likely to vary among procedures and by individual circumstances.

Initiatives to contain costs may impair quality by impeding access to care, distorting clinical judgment, or both. Clinical judgment may be distorted by reimbursement rules or pressure to meet the challenge of growing competition by minimizing expenditures. Providers may wish to avoid patients with complicated diagnoses, as well as uninsured or inadequately insured patients, as providers lose their ability to cross-subsidize inadequately financed or uncompensated care by passing the charges on to other payers.<sup>33</sup>

EBRI tabulations of the March 1986 Current Population Survey indicate that nearly 35 million Americans (17 percent of the popu-

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<sup>31</sup>Avedis Donabedian, *Explorations in Quality Assessment and Monitoring, Vol. 1: The Definition of Quality and Approaches to Its Assessment* (Ann Arbor, MI: Health Administration Press, 1980), pp. 4–6. For more information on defining quality, see Robert H. Brook and Kathleen N. Lohr, "Efficacy, Effectiveness, Variations, and Quality," *Medical Care* 23 (May 1985): 710–722, and Anthony L. Komaroff, "Quality Assurance in 1984," *Medical Care* 23 (May 1985): 723–734.

<sup>32</sup>See Avedis Donabedian, "Some Thoughts on Cost Containment and the Quality of Health Care," *Administration in Mental Health* 13 (Fall 1985): 5–14. Also Uwe Reinhardt, "Hard Choices in Health Care: A Matter of Ethics," *Health Care: How to Improve It and How to Pay For It*, pp. 19–31.

<sup>33</sup>Robert J. Blendon, Linda H. Aiken, Howard E. Freeman, Bradford L. Kirkman-Liff, and John W. Murphy, "Uncompensated Care by Hospitals or Public Insurance for the Poor: Does It Make a Difference?" *New England Journal of Medicine* 314 (1 May 1986): 1160–1163.

lation) did not have public or private health insurance in 1985. This is an increase of 4.5 million people from three years earlier.

The trade-off between quality and cost raises empirical and ethical issues. Empirically assessing the cost-effectiveness of particular procedures is replete with methodological problems. If clinical experiments succeed in measuring quality, other concerns arise. For example, can the current payers of health care finance all the quality care that will be demanded by a growing population? If not, to what extent should health care be rationed? These questions are of growing concern as employers attempt to reduce spending for health care.

## Conclusion

Inflation in health care costs has led inflation in consumer prices for more than a decade. Rapidly growing health care costs and the growing cost of health insurance have become major public policy issues to which all payers have responded. Employers, in particular, have implemented a wide array of initiatives to contain health care expenditures. The federal government has responded by adopting the Medicare prospective payment system and by giving states more flexibility in redesigning Medicaid benefits to contain health care costs.

In response to the initiatives by employers, insurance companies, Medicare, and Medicaid, the health care market is changing. Provider competition is increasing. Integration of health care services is occurring as providers seek ways to expand their market shares and insurance companies compete for employer-based groups.<sup>34</sup> Non-profit hospitals are marketing new services and reorganizing to compete with the growing numbers of for-profit hospitals. HMOs have expanded and are also undergoing organizational change. Preferred provider arrangements, unheard of three years ago, are now common. Physicians are entering large, multispecialty practices or for-profit specialty clinics in growing numbers. These marketing changes by providers are probably in large part a response to changes initiated by third-party payers.

It would be convenient to assume that cost-containment initiatives were the reason for the decline in the growth of current-dollar health care expenditures, and that health care costs are under control. Adjustment for inflation, however, indicates that most of the slowdown in spending growth was due to declines in prices. Employer expen-

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<sup>34</sup> Editor's note: See Chapter III for a discussion of integration of health care services.



ditures for health care and health insurance continue to rise at more than twice the rate of inflation. In 1985, the growth in employer health care spending was nearly 5 percent more than that of the preceding year in inflation-adjusted dollars.

Any evidence of the effectiveness of cost-containment initiatives becomes questionable when the medical component of the CPI continues to outpace the overall CPI. In the 12 months ending May 1986, the CPI for all goods and services rose 2 percent while the medical component rose 8 percent. In the first five months of 1986, the overall CPI *declined* at an average monthly rate of 0.28 percent while the medical component *increased* at an average monthly rate of 0.44 percent.

The response by employers to rising health care costs and the subsequent decline in the rate of increase in health care expenditures suggests a simplistic cause-and-effect relationship. Careful evaluation of the effectiveness of cost containment initiatives and the trends in hospital usage indicate that the assessment is more complex. More time and additional analysis are needed to fully understand the consequences of these initiatives, and to determine how health care expenditures may be contained.<sup>35, 36</sup>

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<sup>35</sup>The author gratefully acknowledges the research assistance of Mona Seliger and Joseph Piacentini, both of EBRI.

<sup>36</sup>Editor's note: An earlier form of the material presented in this chapter was published as *EBRI Issue Brief* 55 (June 1986).

## **PART ONE:**

# **Changes in the Market**

Dramatic changes in the financing of health care have affected the way care is delivered. One significant change has been the growth in the number of physicians and changes in their specialty and practice patterns. Since 1950 the number of active physicians has grown faster than the population, rising from 220,000 in 1950 to 502,000 in 1982, according to the General Accounting Office. The ratio of physicians to the population rose from 145 per 100,000 people in 1950 to 217 per 100,000 in 1982. Some observers estimate that by 1990 there will be an excess supply of from 35,000 to 70,000 physicians. Some observers also predict there will be an oversupply of physicians in some specialties, particularly in surgery and obstetrics/gynecology, and a shortage in others, such as family practice and general psychiatry.

In addition, physicians are increasingly practicing in groups rather than solo, and many, such as pathologists and radiologists, are becoming salaried employees of hospitals. More physicians also are providing care on a prepaid basis and treating patients in ambulatory or outpatient settings.

One of the more significant changes has been the emergence of for-profit hospital care and multihospital systems. Between 1972 and 1983, the number of beds at investor-owned community hospitals increased 65 percent. Nonprofit hospitals increased their beds by 16.4 percent during the same period, while the number of beds at state and local hospitals rose 1 percent. As of April 1985, 20 percent of all nonfederal hospitals were owned or operated by investor-owned firms.

In the following three chapters, the causes and effects of these and other changes are closely examined.

In the first presentation, Philip Caper explains how the goal of U.S. health policy has undergone a fundamental shift—from one of providing access to quality care without regard to cost, to one of cost containment without sacrificing quality or access to care. Caper shows, drawing from a number of epidemiologic studies, how physicians' behavior can be adapted to cost-containment incentives through the availability of accurate, clinically relevant information on physician practice patterns.

Next, Mark Pauly analyzes the growing role of for-profit providers in the nation's health care market and what the implications may

be. Pauly identifies the factors that gave rise to this change, examines the significance of for-profit delivery to the health care system, and forecasts the roles of proprietary health care providers in the future.

John Moxley and Penelope Roeder discuss health care integration, a phenomenon that is causing the lines that distinguish payers from providers to become increasingly blurred. They also trace the evolution of the U.S. health care system to one in which care is regarded as an economic, rather than a purely social, good and examine what the implications of change might be for the quality of health care.

# **I. The Physician's Role**

Philip Caper, M.D.

I would like to divide my presentation into two distinct parts. First, I am going to sketch out how we got where we are, and then I will describe what some physicians in some places are doing to change their own behavior, because that is the name of the game these days. It is my thesis that the problems of cost, quality, and access to health care will be solved, one way or another. They will be solved better if we can get the physicians to cooperate than if they do not.

## **Recent U.S. Health Care Policy**

Our public policy in health care has been twofold during the period from about 1930 to 1970. When I say "public policy in health care," I mean the joint product of public and private efforts. We do not make public policy solely in the public sector in this country, as you know. For many years, I tried to understand public policy by looking at what the federal or state governments did, and that provides an incomplete picture. It is hard to make sense out of what is going on.

In fact, our national health policy goals for most of this century have been directed toward improving access to care and improving the quality of care, and we have moved a long way in the direction of achieving those goals—although we are not all the way there yet and may never be. Nevertheless, those have been our goals as reflected in both the public and private sectors.

For example, our financing system of third-party payments sent very clear messages to everybody during the evolution of the Blue Cross and Blue Shield plans and through the later entry of commercial insurance companies into this field. A pool of dollars was created, which paid for medical care regardless of cost. Its central feature was cost-based, retrospective reimbursement of usual and customary professional fees.

During the period of the 1930s, 1940s, and 1950s we worked on expanding the pool of dollars in the private sector, largely through employment-related benefits. Unionization helped to accelerate that movement, particularly after World War II as health insurance became a very important employee benefit.

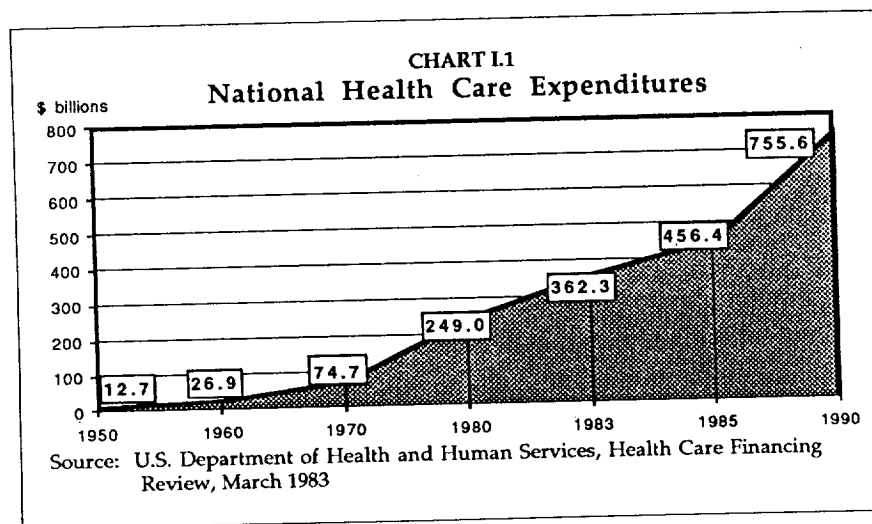
Finally, in the 1960s, since our system to that point was primarily

employment-related, we passed legislation that filled in the gaps; that is, we took care of the elderly and the unemployed in the form of Medicare and Medicaid. This large pool of dollars essentially was directed toward covering the cost of medical care, particularly of hospital care, no matter what that cost was.

We did this job reasonably well. We also did a couple of other things. We worked very hard on expanding the capacity of the health care system to deliver services. We did that through a combination of activities such as the Hill-Burton program, which succeeded in its goal of expanding the number of hospital beds, particularly in rural areas; through state and federal subsidies to increase the pool of health professionals; and through largely federal funding of innovation in biomedical research, via the National Institutes of Health, now a \$6-billion-a-year program.

So, we were expanding the pool of dollars, the number of hospital beds, the number of health care personnel, and the ability to innovate. Even that innovation tended to be without regard to cost. It also tended to be focused on the hospital. And in 1965, with the enactment of Medicare, we dumped all our federal dollars on top of the already-large pool of private dollars available for this.

Federal payment incentives for Medicare were patterned after the private insurance system; that is, they were designed to pay claims without regard to cost. What happened should not be a surprise to anyone, as the accompanying graph on spending demonstrates (chart I.1).



## **Cost Containment As a Public Health Policy Objective**

In about 1970, we began to hear some early alarms about rising costs, particularly in the Medicare program, and in 1972 legislation was passed to try to restrain these increases. In 1974 and 1975, additional legislation was passed at the federal level and the states, too, became more active in trying to restrain costs. These were largely regulatory programs, overlaying a very strong set of incentives that worked in the opposite direction.

Any time you lay a regulatory program over a strong set of counterincentives, people will figure out ways to “game the system” and beat the regulations. We are very good at that. We like to do it. Radar detectors sell very well, and so do computer programs to help hospitals maximize their revenues.<sup>1</sup>

By 1980, state legislatures and the business community had entered the picture, and concern with cost was explicitly added to access and quality as an important public policy goal.

It is my thesis that virtually all of the rapid change we are seeing now in the health care system is due to the addition of cost containment as the third public policy goal. The thing that makes it interesting is that we all want to preserve quality and access while restraining cost.

There have been a number of consequences of the addition of that third policy element. First, there has been a major power shift from providers—that is, physicians and hospitals—to the payers—the business community and the government, and to some extent the intermediaries—insurance carriers. This represents a major change in the politics and the power structure of the health care system as a result of attempts by payers to gain more control over costs. Second, there has been increasing patient vigilance, a willingness of patients to question their doctors, to ask for second surgical opinions, to question the necessity of hospitalization, and so on. Finally, there has been increasing demand for accountability by physicians and hospitals at all levels. That message has been heard by the health care provider community.

### **Availability of Practice Pattern Data**

One thing that has been lacking in this picture up until now is good information about how the health care system performs. When the

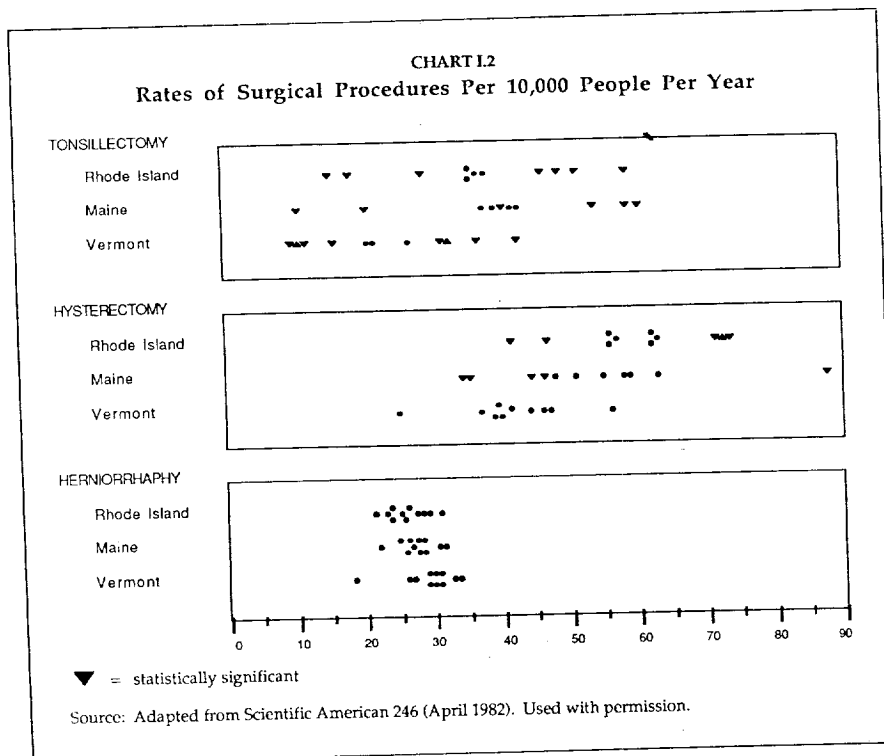
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<sup>1</sup> Editor's note: Computer programs are available that enable hospitals to access medical records and select DRGs to maximize reimbursement.

business community began looking seriously at how health care dollars were being used, they found a real paucity of good utilization data.

Data had been collected that enabled claims to be paid rapidly and relatively efficiently. That was the objective of the information system that developed during most of this century. We have now imposed an additional requirement so that we can begin to evaluate access and quality through our information systems. It has only been in the last four or five years that we have devoted much attention to developing information systems that can accomplish that goal. I believe the work that has been under way at Dartmouth Medical School and elsewhere in New England in recent years is going to form the basis for a very powerful information system with respect to the use of health services.

For example, this graph (chart I.2) is adapted from a *Scientific*



American article by John Wennberg and Alan Gittelsohn<sup>2</sup> showing the rates of surgical procedures in a variety of New England communities. Each of the dots represents the per capita rate of hospital admission for a single surgical procedure—tonsillectomy, hysterectomy, and herniorrhaphy. The measurements are population-based: the researchers examined the health care experience of a defined population and did not count referrals into the area. On the other hand, if a resident in one of these areas went somewhere else for hospitalization, that event was counted against the patient's place of residence. The rate can be thought of as a probability that a person will have one of these surgical procedures performed as a function of living in one of these communities.

The chart shows that for an operation such as inguinal hernia repair the probability does not vary much depending upon where people live. It varies from a low of 20 to a high of 35 admissions per 10,000 people per year. Tonsillectomy, on the other hand, varies a great deal, from a low in one Vermont community of about 10 per 10,000 people to a high in a Maine community of about 70 per 10,000.

The difference in these two procedures is that there is tight consensus within the medical profession about the diagnostic and therapeutic indications for surgery for inguinal hernia. Tonsillectomy is at the other end of that spectrum. There is much disagreement among physicians about when to remove tonsils, ranging from strict indications to prophylactic removal for every 6-year-old child. That gives physicians a great deal of discretion.

One of the reasons for such poor consensus is that the availability of outcome data for tonsillectomies, or for hysterectomies, is not good, whereas for herniorrhaphies everyone agrees that once the hernia is diagnosed, the treatment is surgical. There is little discretion left to the physician once that diagnosis is made. By contrast, there are a variety of ways to deal with these other conditions. Hysterectomy rates range from a low in New England of 30 per 10,000 people in one Vermont community to a high in one Maine community of 90 per 10,000 residents.

In a study published in 1984 in the *New England Journal of Medicine*<sup>3</sup> we found that 90 percent of hospital admissions in Maine from 1980

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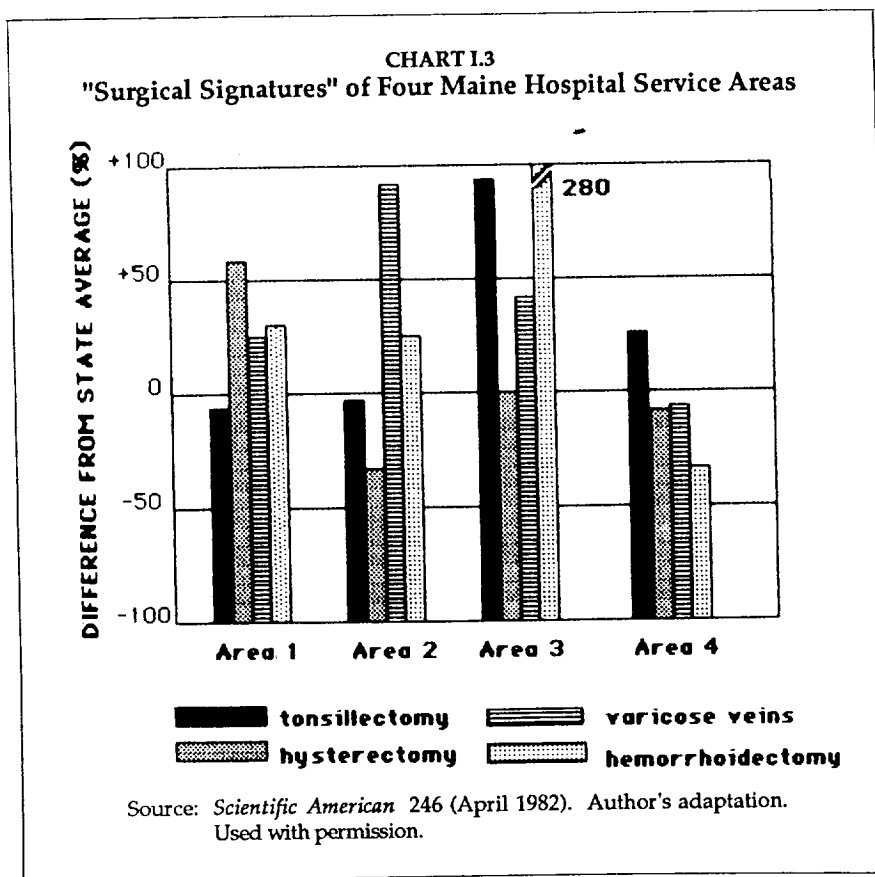
<sup>2</sup>John Wennberg and Alan Gittelsohn, "Variations in Medical Care among Small Areas," *Scientific American* (April 1982): 120–134.

<sup>3</sup>John Wennberg, Klim McPherson, and Philip Caper, "Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?" *New England Journal of Medicine* 311 (2 August 1984): 295–300.



to 1982 belonged to DRG categories with more variability than that for hysterectomy; that is, they showed a variation of more than three-fold in the way physicians actually used hospitals among service areas in Maine. This finding has been duplicated elsewhere in New England and in the mid and far West.

Thus, we have identified patterns of medical practice in these New England communities. Another interesting characteristic of these patterns is that they are unique to individual hospital service areas, as another graph adapted from the *Scientific American* article reveals (chart I.3). These data are for four of the most populous areas in Maine. In Area 3, for example, the hemorrhoidectomy rate is about three times the state average. In Area 4 it is only a little more than half the state average. Each area has a unique pattern of practice, a



“surgical signature,” which can identify the area if you know the data.

Not only are these individual service areas unique, but they tend to be stable over time. In Area 1, the rate of admission for prostatectomy is almost 50 percent above the state average, year after year. The rate of admission for hemorrhoidectomy is only half the state average, year after year. Only two things seem to change this pattern of practice. One is when physicians move into or out of a community. The second is when information is sent back to physicians about their rate of surgery compared to that of their colleagues.

Now, remember that practicing physicians do not conduct these epidemiologic studies. They do not make systematic patient-origin studies and therefore have no way of knowing the denominator needed to calculate rates such as these (the number of procedures per 10,000 population). The average practicing physician sees patients as they walk in the door, and is not able to compute or even infer how his or her rate compares to those of colleagues. Making this data available to physicians can result in behavioral change if it is done systematically.

### **Variations in Utilization, Resource Requirements, and Cost**

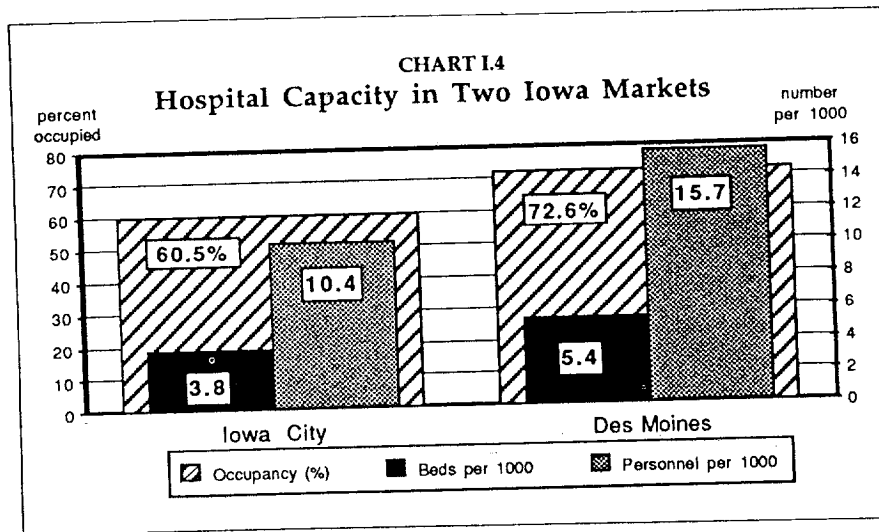
We have also spent a great deal of time worrying about the unit cost per admission or the average length of stay for hospital care. In 1980 we asked the question, “How much does average length of stay contribute to total patient days<sup>4</sup> per capita in a community?” We found that it accounted for less than 10 percent of the total patient days in our statewide study of Iowa. The differences among these communities in the per capita day rate could not be accounted for by differences in the length of stay. However, when we correlated the number of hospital admissions with the patient day rate, we found a strong correlation between admission rates and the number of patient days.

The hospital admission rate thus appears to be a much more powerful predictor of patient day rates, which in turn are correlated with per capita costs, than is the length of stay or the unit cost of an admission. So, utilization cannot be ignored.

We have done quite a few studies in Iowa using this population-based method. A key question asked in this study (chart I.4) was,

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<sup>4</sup>Editor’s note: Patient days are total hospital admissions times length of stay.

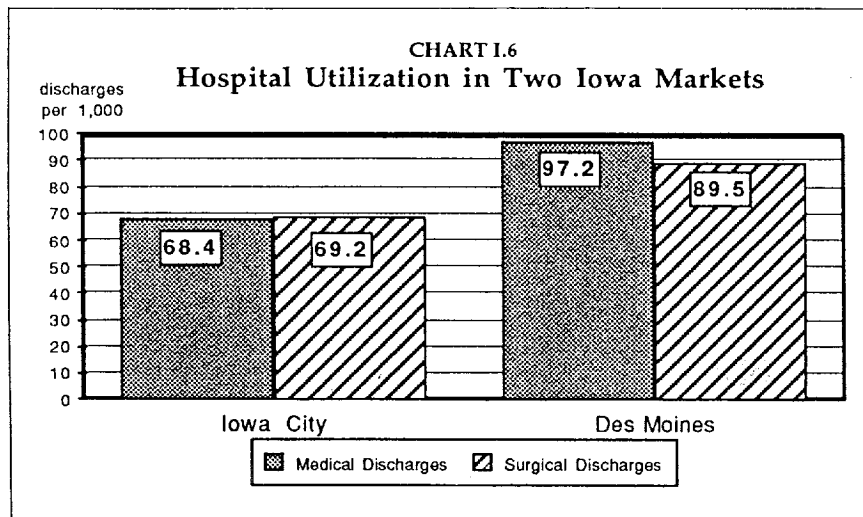
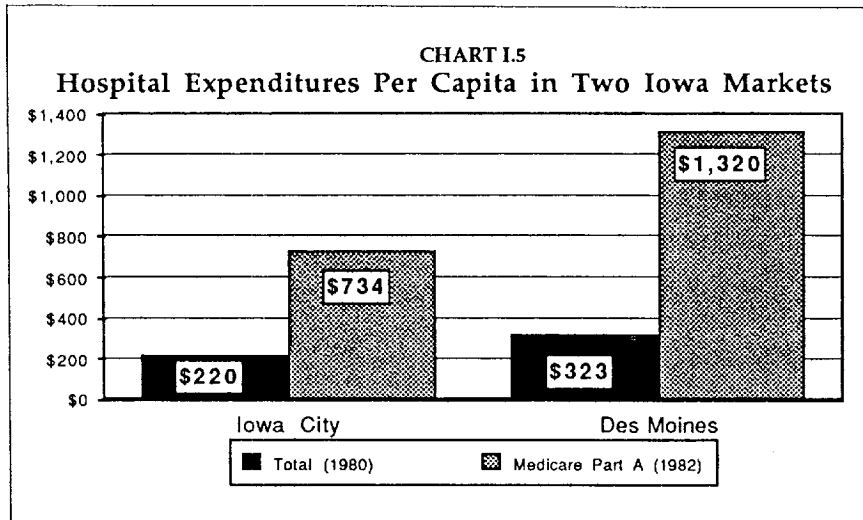


“What is the resource requirement to care for the populations of Des Moines and Iowa City, in terms of beds and hospital personnel?”

Iowa City has the University of Iowa Hospital; Des Moines has seven community hospitals. Des Moines has a bed ratio allocated to its population of 5.4 beds per 10,000 residents, versus 3.8 for Iowa City. Remember that these numbers correct for referrals into and out of the area. These are the actual beds used by the *residents* of these areas, no matter *where* they are used; the beds used in local hospitals by out-of-area residents are not counted.

The number of hospital personnel required to care for the residents of Des Moines is also one and one-half times the number required to care for the residents of Iowa City. If you talk to almost anyone in Iowa before showing them the data, and ask them where they think the high-quality medical care is delivered in Iowa, they will usually say it is in the Iowa City service area, in which care is provided largely by the University of Iowa Hospital. They will also predict that it is the more expensive area, because it is a teaching-hospital area. In fact, it is not more expensive. From the point of view of per capita cost of hospital care, it is more expensive to live in Des Moines than in Iowa City (chart I.5).

If we analyze how the beds are used in Iowa City versus in Des Moines, we learn that the additional bed capacity in Des Moines is more for medical admissions than for surgical admissions (chart I.6). Much attention has been focused on surgical admissions, but, in fact,



the medical causes of admission account for more hospital beds than do the surgical causes of admission.

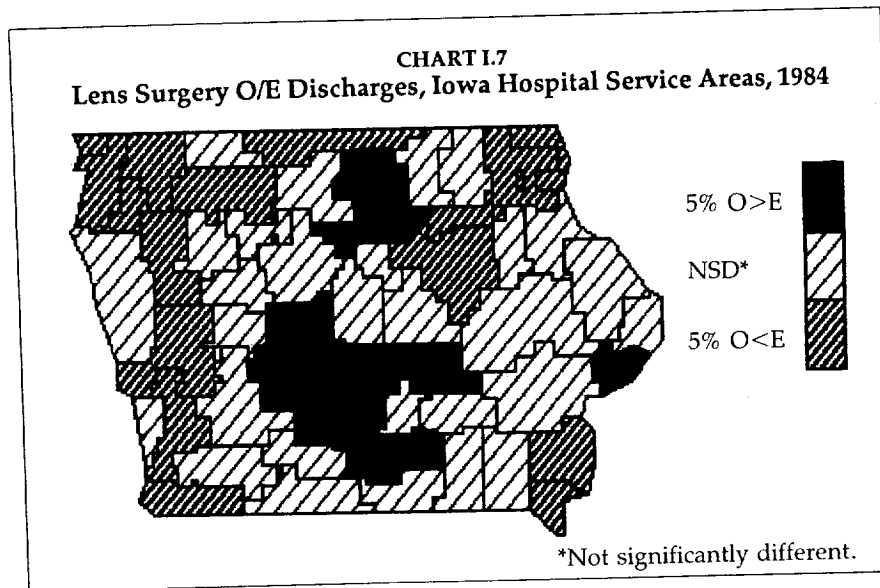
The ratio of expenditures in Des Moines is higher, too (chart I.5). It is one and one-half times as costly to live in Des Moines from the standpoint of hospital care than in Iowa City. For a Medicare beneficiary, it is almost twice as expensive to live in Des Moines as in Iowa City.

Again, the number of admissions and patient days is higher in Des Moines than in Iowa City. If the physicians in Des Moines were to practice and use hospitals the way the physicians in Iowa City do, Des Moines would require 700 fewer hospital beds (table I.1).

**TABLE I.1**  
**Excess Hospital Use by Des Moines Residents**  
**(compared to Iowa City), 1980**

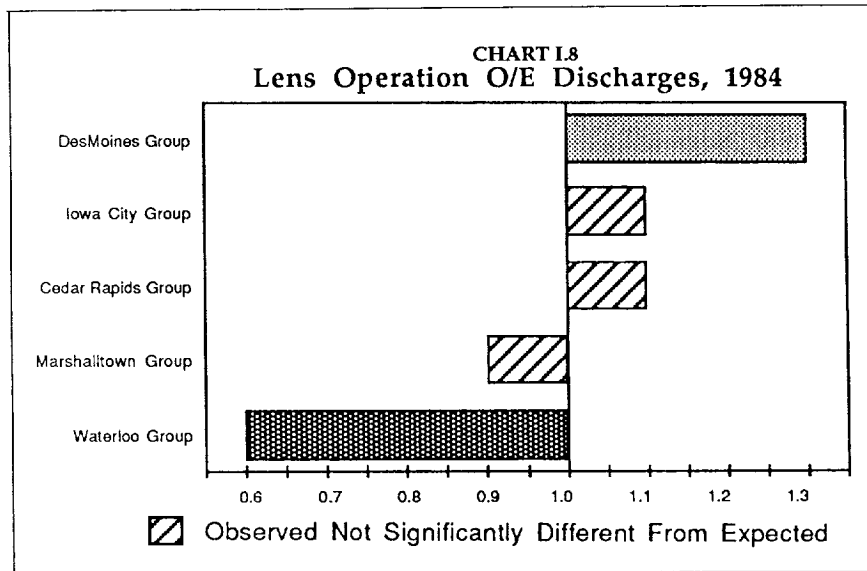
Admissions	+ 21,768
Patient Days	+ 280,892
Beds	+ 707

This map (chart I.7) measures utilization in Iowa. This illustration happens to be of the Medicare population and the rate for lens surgery, which gets me back to one of the first points of this presentation. Information systems are now becoming available that routinely and quickly monitor the utilization of medical care on a statewide basis. We can, for example, map the difference in observed relative to expected (O/E) admission rates for lens surgery in all of the 49 Iowa service areas, with the high-rate areas displayed as solid black and the low-rate areas as gray hatching. We usually use the state average



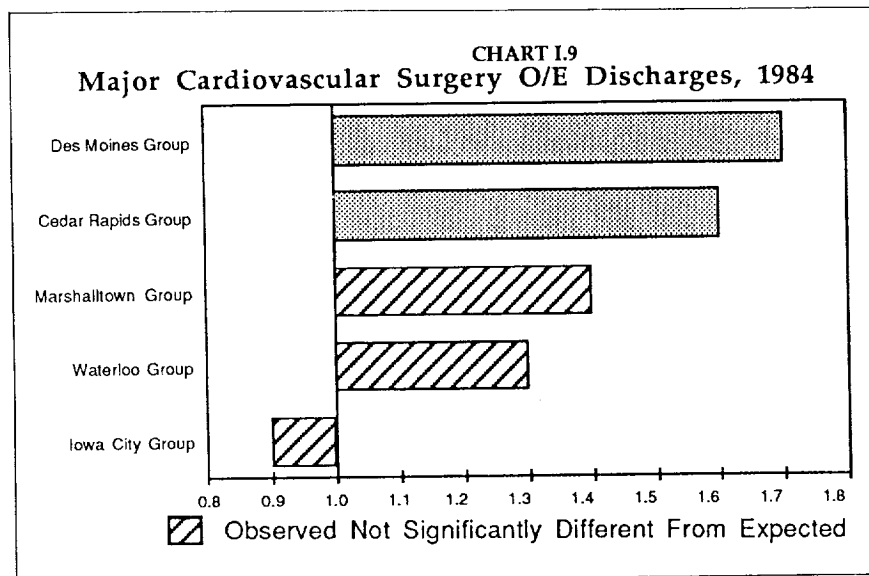
as the expected rate. Although this average has no clinical significance, it is useful as a benchmark to compare areas.

Chart I.8 shows the same information relative to the state average. Every area to the left of the line has an admission rate lower than the state average, and to the right of the line, a rate higher than the state average. The O/E rates are shown as percentages of the state average.



Finally, we can look at the trend over time in admissions for lens surgery in a number of hospitals in service areas in Iowa. The rate of admission for lens surgery was increasing until 1983, then dropped suddenly. What happened after 1983 to change that? Diagnosis-related groups (DRGs). Lens surgery became, essentially overnight, an outpatient procedure because a cap was placed on payment for this operation when performed in a hospital. Such utilization monitoring can be done for any type of hospital admission.

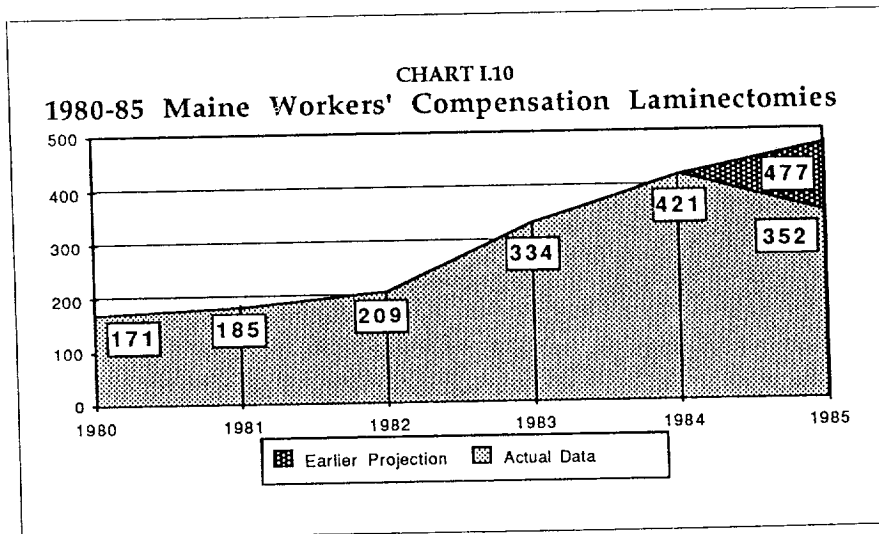
Chart I.9 presents data on major cardiovascular surgery in Des Moines compared to that in Iowa City and the state average. Most of these are coronary artery bypass operations. Residents of Des Moines have twice as great a chance of having major cardiovascular surgery as those of Iowa City. This observation raises some interesting questions from the point of view of physicians; they want to know why this difference exists and where patients are better off.



### How Data Affect Practice Patterns

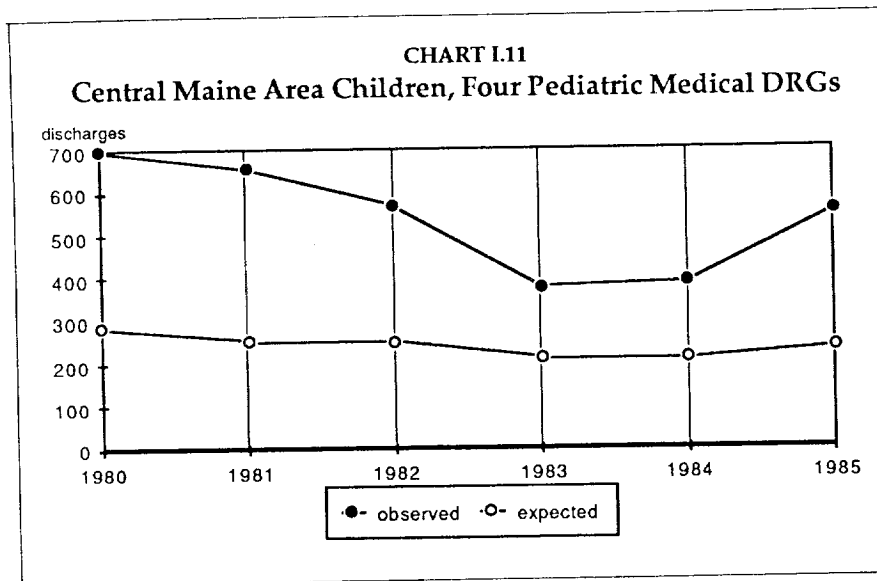
A March 23, 1986, article in the *Boston Globe* described the experience in Maine with the Maine Medical Assessment Project (MMAP). The Maine Medical Association initiated this project in which the physicians in Maine, using the kind of information I have discussed, have begun to examine their own practice patterns and tried to decide for themselves which rates are the right ones. This is being done in the context of quality assurance, not cost containment, but they have tended to focus on the higher-rate areas. They have organized themselves along specialty lines, so that each specialty group looks at the data on its own procedures and other causes of hospitalization and then decides what to do about it.

Here are some of the results the MMAP has published. Per capita rates of admission for workers'-compensation-related laminectomies (back surgeries) are shown for the state as a whole (chart I.10). It shows what happened in one area when some neurosurgeons moved into the state in 1982. Later, you can see the effect of the monitoring program. The physician pool has not changed much; instead, physicians have changed their indications for performing these surgeries because of their interest in examining the results of the cases they have done. The chart shows both the projected trend from earlier



data and the actual rate following implementation of the medical feedback program by the Maine Medical Association.

Data from the Pediatrics Study Group of the Maine Medical Association show how a high-rate service area in Maine reduced admissions through monitoring (chart I.11). The chairman of this





monitoring group was on the staff of the hospital in the community. He presented the physicians with this data, and said, "Look, fellows. Unless we can justify this high rate of utilization, we had better start doing something about it." Each week in the physicians' lounge he posted the names of the patients being admitted and the physicians admitting them. Over time, the rate dropped—a phenomenon commonly called the sentinel effect. Then the chief retired, the monitoring was temporarily suspended, and the rate rose somewhat, demonstrating the need for continuous feedback and monitoring.

I believe this is evidence that physicians operating within a context of cost containment and using good epidemiologic data can begin to modify their own behavior. Much of the work is educational. Physicians are like everyone else: they have been taught to provide high-quality medical care without regard to cost because of the incentives inherent in the system. But it is my thesis that the feedback of good, clinically relevant information will help them adapt to the new incentives.

## II. Advent and Implications of For-Profit Delivery

Mark V. Pauly, Ph.D.

No one will argue against the proposition that the health care market is changing, and for many—both in business and in medicine—one key change has been the growing importance of for-profit or investor-owned firms in the delivery of health services. My purpose is to provide a few facts and a few thoughts about the present influence and the future directions of these types of firms.

I will assert the following propositions.

- For-profit (or for-net-cash-flow) motivation has not been growing especially rapidly in the medical care industry.
- Investor-owned firms have entered in response to external influences. Many of the cost and pricing outcomes associated with investor-owned firms are in fact caused by the external influence; the ownership structure of the firm matters somewhat, but its influence is not overwhelming. Ownership probably does not matter as much as does chain membership, regardless of ownership. But even chain membership means little at the point of service.
- There are market segments in this industry where investor-owned firms are best, and others where not-for-profit firms are best. Absent regulatory distortions and barriers to entry, each type of firm will probably occupy the appropriate niche, particularly if competition is strong.
- The future relative growth of investor-owned firms depends primarily on the projected growth for their niche. Over the next five years or so, I expect there to be slower relative growth or even a decline, but there is a possibility of more rapid relative growth thereafter.

### Size of the For-Profit Sector and Its Effects

In one sense, the medical care industry has always been dominated by agents that earn profits. The bulk of the resource allocation decisions in health care (80 percent, by conventional estimates) are made by physicians, who largely earn their income as profits, the difference between revenues received from per-service prices and the costs they pay. Hospitals, pharmaceutical companies, and suppliers of medical equipment, regardless of how owned, then serve primarily as suppliers of inputs to these profit-motivated general contractor-

agents of patients. While there is some debate over how much of the total physicians determine (I believe it is less than four-fifths), and while physicians, like other businessmen, are not motivated solely by net income, but also care about leisure time, the welfare of their customers, reputation, and the intrinsic interest of the work, that should not obscure the fact that money and profit have always been predominant incentives in this industry.

There are some reasons to suspect that individual physicians at least may be giving up some of their authority as "captains of the team" to hospitals—whether investor-owned or not-for-profit. A switch to a for-profit hospital amounts to shifting the identity of the recipient of profit—from the owner of a physician firm to an owner of the hospital—but not a change in motivation.

If one does suppose that it matters who owns the supplier of the inputs the physician orders, there are some useful numbers to look at. Table 1 shows that the share of investor-owned hospitals in the U.S., though still quite small, has been growing, largely at the expense of governmental hospitals. Many of these public hospitals are located in the same southern and western rural areas where investor-owned hospitals exist. If we add in hospitals managed by investor-owned firms (though answering to not-for-profit boards of trustees), the fraction of beds "controlled" by for-profit firms rises to 14 percent in

**TABLE II.1**  
**Trends in Short-Term General Hospital Ownership Shares, 1965–84 (percentage of total)**

Year	Beds			Hospitals
	Investor-Owned	Not-for-Profit	State and Local Gov't.	Investor-Owned
1965	6.3%	69.5%	24.2%	14.9%
1970	6.3	69.7	24.0	13.1
1975	7.7	69.6	22.7	13.0
1980	8.8	69.9	21.3	12.4
1981	8.7	70.2	21.1	12.4
1982	9.0	70.1	20.9	12.8
1983	9.2	70.4	20.4	13.0
1984	9.8	70.3	19.9	13.5
Annual Growth Rate 1980–1984	3.4	0.5	-1.0	1.8

Source: Calculated from *Hospital Statistics*, 1985 edition, Table 1.

1984. However, it should be noted that management alone does not imply the same behavior or motivation (for the enterprise as a whole) as does ownership and management.

### ***Significance of Ownership***

What difference does ownership make? In recent years this issue has been the subject of a large quantity (though not of especially high quality) of debate. My overall summary is the "15 percent maximum rule." This says that, for virtually any indicator, the maximum difference between investor-owned and other hospitals is, at most, 15 percent (in either direction), other things being equal. While this difference is sometimes (though not always) statistically significant, it is not of overwhelming practical significance, given the wide variation in costs, prices, and the like, even within ownership types (and even within market areas). That is, ownership predicts some variation, especially in price, but it does not explain much of the variation, nor is what it explains very large. Phrased slightly differently, there are probably more people being "overcharged" (if we knew what that meant) by not-for-profit hospitals than by for-profit hospitals. I say this not to excuse overcharging in either circumstance, but rather to give a perspective. In short, the influence of ownership is the proverbial air turbulence caused by a butterfly in a hurricane—it exists, it is measurable, but it is not the important thing.

Even the kinds of numbers generated in the literature are subject to differences in interpretation. For example, an article in the *New England Journal of Medicine* by Watt, Derzon et al.,<sup>1</sup> which compared a set of chain investor-owned hospitals with a comparison group of (nonchain) not-for-profit hospitals, found no significant differences in cost but higher gross inpatient charges for investor-owned hospitals. However, an initial statistically significant 17 percent difference in net patient service revenue per day fell to less than a 10 percent difference once the higher taxes investor-owned hospitals pay and the contributions not-for-profit hospitals receive were netted out. So the measured differences are small.

### ***Methodological Problems***

A more serious problem is that the methods in all these studies are both incomplete and flawed. One reason for the incompleteness has

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<sup>1</sup>J.M. Watt, Robert A. Derzon et al., "The Comparative Economic Performance of Investor-Owned Chain and Not-for-Profit Hospitals," *New England Journal of Medicine* (9 January 1986): 89–96.

been noted by Luft; comparing prices and unit costs does not tell us about total expenditures.<sup>2</sup> One would, for example, want to know whether hospital ownership affects the inpatient admission rate, but no one has studied this. Another reason for incompleteness is that only *hospital* prices and costs have been compared, not the total price for a hospitalization, the most important other component being physician prices. It is surely possible that lower hospital prices may be offset by higher physician prices.

The serious flaw is one that should have been obvious to physician researchers, if not to economists—ownership structure is not randomly assigned to hospitals. This is not like a clinical trial; there is no random control group. Instead (in a sense) hospitals *choose* their ownership form, by choosing where and when to buy (or be bought) and to locate. No matter how hard one tries to “match” hospitals by observable characteristics, we *know* they are not the same—one hospital chose a type of ownership that the other did not.

This is more than just academic nit-picking. Suppose we assume (for purposes of discussion here, although I will eventually argue for its plausibility) that the major difference related to ownership is not the cost or efficiency of production, but rather it is the greater mobility of equity capital that investor-owned hospitals have. Suppose demand for hospital care increases more in one market area than in others. At least in the short run, the profit—or at least the surplus of revenues over minimum efficient costs—will rise there, and one would expect investor-owned hospitals to be more likely to locate in such areas. Of course, even a not-for-profit hospital in that location could earn similar profits and/or charge similar prices, and may well choose to do so; ownership is irrelevant. But the simple fact that investor-owned hospitals choose to locate in more profitable areas necessarily means that they will be more profitable—and have higher margins—than not-for-profit hospitals. In this sense, it is not ownership which leads to higher margins, but rather the possibility of higher profits—and the population growth, better insurance coverage, or lesser competition which make higher profits possible—which causes the for-profit ownership.

### ***Comparative Advantages of Investor-Owned Hospitals***

The real question, therefore, is not whether for-profit hospitals are more profitable themselves. The issue is rather the price and avail-

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<sup>2</sup>Harold Luft, “For-Profit Hospitals: A Cost Problem or a Solution?” *Business and Health* (January/February 1985): 13–16.

ability of care of various types that their presence may make possible. Put more precisely—do for-profit hospitals seem to enter and grow in locations and in types of care for which they offer advantages over the situation in their absence? I will offer some thoughts on answering this question, but, because of the failure of investigators to take the “self-selection by ownership type” into account, my answers will be conceptual and speculative rather than empirical and definitive.

When might an investor-owned hospital have a comparative advantage over not-for-profit hospitals? One answer has already been hinted at—the greater mobility of for-profit equity capital may make care available in situations in which the alternative would be less care, or less attractive care. This is equivalent to saying that investor-owned hospitals (and other investor-owned providers) will respond more flexibly to market demands than would an industry with no such firms. Whether or not responding to demand is thought to be beneficial depends on what you think about actual market demand—if it is constrained by demander misinformation, warped by insurance coverage, or distorted by a third-party payment system, one may not be pleased with a responsive system. I think there are some good reasons to be worried about manifest demand (demand as it is now manifested), although I suspect (or hope) that it is getting better as a guide to welfare maximization.

### ***Advantages of Not-for-Profits***

There are also some disadvantages of investor-owned firms that may affect their choices and their success. People have theorized, for instance, that not-for-profit firms have genuine advantages over investor-owned firms in three situations—when consumers are misinformed about quality (and know that they do not know); when the consumption of medical care has altruistic dimensions, and when the physicians who use the hospital need direct financial incentives for efficiency.

The first idea, most closely associated with Henry Hansmann, notes that the imperfectly informed consumer is vulnerable to quality cheating by a profit-maximizing firm.<sup>3</sup> A not-for-profit firm, particularly one whose managers get their real income in the form of higher quality, will not have such strong incentives to debase quality. Consumers who are aware of their ignorance may therefore well prefer the nonprofit firm, reckoning that the dissipated financial incentives

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<sup>3</sup>Henry B. Hansmann, “The Role of Nonprofit Enterprise,” *Yale Law Journal* 89 (April 1980): 835–901.

that require sacrificing a little productive efficiency may be a small price to pay for the weaker effects on debasing quality. The message then is that for-profit firms are good for well-informed consumers and/or products whose quality is less subject to undetectable manipulation, while not-for-profit firms are best when the consumer is uninformed, and knows it.

The second basis for an advantage for not-for-profit firms notes the importance of philanthropy in their motivation and in their financial structures. One way to think about their role in this regard is, as also suggested by Professor Weisbrod, to suppose that philanthropy represents a private-sector substitute for public-sector collective action in the presence of public goods or externalities.<sup>4</sup> The externality here presumably is an altruistic one. As I have suggested in my own work, it is plausible to suppose that people feel better knowing that others are using more medical care, at least if the alternative is less use and relievable but unrelieved suffering and death. But collective action of some sort is needed to operationalize this desire, since the impact of a transfer payment from a single individual will be minimal.

We do use government for this purpose—Medicaid is almost entirely a collective subsidy, and Medicare, stripped of the “trust fund” subterfuge, has the same effect for low-income elderly. When public-sector action is insufficient, or at least not perfectly responsive to the altruistic desires of some subsegment of the population, private charity will be motivated. But when the charitable motive is, so to speak, “commodity-specific,” that is, when we desire to make transfers for a specific good or service, then cash transfers to recipients will not work. If it is difficult for the donor to prevent a for-profit firm from raising price to low-income people by nearly the amount of the donation, vouchers will not work. Paying a subsidy to a for-profit firm will, in the absence of careful monitoring, result only in transfers to the firm’s profits, not help to people in need.<sup>5</sup> In contrast, altruistic donations to a not-for-profit firm will at least go to the recipients; even if some of the donation is absorbed by inefficiency, income-in-kind for managers, or higher prices for the physician staff, more may get to recipients. Moreover, even this income for managers or medical staff may be a useful reward for playing, so to speak, the entrepreneurial role in organizing altruism. All of this means that, where altruistic motives are present but are not being perfectly satisfied by

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<sup>4</sup>Burton Weisbrod, *The Voluntary Nonprofit Sector* (Lexington, MA: D.C. Heath, 1977).

<sup>5</sup>Earl Thompson, “Charity and Nonprofit Organizations,” in Clarkson and Martin, eds., *The Economics of Nonproprietary Organizations* (Greenwich, CT: JAI Press, 1980), pp. 125–138.

the public sector, the not-for-profit firm may have an advantage over its for-profit counterpart.

The third notion is that physicians, who directly coordinate treatment decisions for the patient, may not behave as efficiently when interacting with a for-profit firm as when interacting with a not-for-profit firm.<sup>6</sup> Physicians in for-profit hospitals will face more potential conflict, since higher profits for the hospital will often come at the expense of physicians' own net incomes. Not only will there be less conflict in not-for-profit hospitals, but the greater physician control may actually improve hospital performance.

### ***Disadvantages of Not-for-Profits***

There are also some potential disadvantages of the not-for-profit form. One, of course, is the defect everybody has been looking for—higher cost because of dissipated financial incentives to control cost. There are, I believe, two reasons why the quest to find a definitive version of this defect so far has been unsuccessful. One is something many commentators have noted—that the incentive to for-profit firms to minimize cost does not hold under full cost-based reimbursement, as occurred in the pre-diagnosis-related-group (DRG) era from which virtually all studies have been taken. Usually the point is a bit overstated—there is still an incentive to minimize costs as long as *some* hospital users pay charges and cost-based payers do not pay more than cost—but it is legitimate. There is another reason why it may be hard to detect efficiency differences, one that Philip Held and I pointed out in our study of for-profit and not-for-profit firms providing outpatient kidney dialysis.<sup>7</sup> If there is competition for patients, firms will convert would-be profits from cost minimization into higher “quality” or amenities (in the sense of attributes that attract patients). Depending on the effectiveness of quality in attracting business, the “more efficient” firm may find it profit-maximizing to provide so much more in the way of costly amenities that its unit-cost advantage is erased. I might add that we found evidence of this behavior in the dialysis industry; the for-profit firms were more productive in less-competitive markets, but displayed the same measured productivity as not-for-profit firms (but higher amenities) in more competitive markets.

<sup>6</sup>Mark Pauly and Michael Redisch, “The Not-for-Profit Hospital As a Physicians’ Cooperative,” *American Economic Review* (March 1973): 87–99.

<sup>7</sup>Philip J. Held and Mark V. Pauly, “Competition and Efficiency in the End-Stage Renal Disease Program,” *Journal of Health Economics* (August 1983): 95–118.



The DRG "experiment" should tell the definitive story on differential motivation and behavior of firms of different ownership type. The only analytic problem is that Congress was not kind enough to leave us a good no-intervention comparison group for purposes of evaluation.

Another major difference between firm types is also related to altruistic advantage. In for-profit firms, needed new equity capital—either for the initiation of the firm or for current capital investment in excess of funds generated by the firm's cash flow—is provided by the sale of stock. In not-for-profit firms, the analogous vehicle for investment in risk capital is provided by philanthropic donations. In both cases, the generation of new equity is a relatively free event—but this equity capital plays a role far out of proportion to its fraction of total capital. It is the vehicle that permits the firm to seize new investment opportunities; it is also the vehicle that makes firm debt feasible. Comparing the two forms of ownership, it would seem that the for-profit form would have easier access to risk capital, especially if that capital is to be used to provide services to the nonpoor, for whom altruistic motivation is presumably weak or nonexistent.

#### ***How For-Profit and Not-For-Profit Firms Coexist in the Market***

There are some important consequences that follow from these theories. They predict that both types of firms may coexist in the market but occupy different niches. Not-for-profit hospitals or nursing homes will be more likely for complex types of care, and will locate in markets in which consumers are not well-informed and in which there are larger numbers of low-income people in need of philanthropic subsidies. In contrast, for-profit hospitals or nursing homes will tend to produce more routine types of care (differentiated primarily by amenities that are easy for consumers to detect), and to locate in rapidly growing market areas with relatively few low-income people in need of subsidy.

My sense is that, although there has been no definitive study of the location of different types of firms across market areas, these predictions are in remarkable accord with reality. Although the theory is in many ways quite simple, it has two major advantages. First, it shows that the higher uncompensated and philanthropic care burden of not-for-profit and local government hospitals can provide an *advantage* for them, an advantage in attracting philanthropic subsidies (either voluntary or from taxation), which is not available to for-profit firms. As Bruce Vladeck, no friend of for-profit firms, has perceptively noted: "Those hospitals that survive in the current competitive en-

vironment will be those hospitals that adopt the traditional values of hospital care as their market position."<sup>8</sup> These values, especially providing care to the afflicted poor, are likely to be better served by not-for-profit hospitals. (After all, despite the fact that we speak of different kinds of hospitals "bearing the burden" of care for the poor and those who do not pay, no one would seriously believe that hospital managers suffer that burden. And no one should seriously believe that it is morally praiseworthy for hospital managers to engineer their own private redistribution by cross-subsidizing; Mother Teresa does not sell cross-subsidized products.)

Second, these observations raise the possibility of a new kind of invisible-hand theorem, one in which the locational, pricing, and input commitment decisions of firms of various ownership types just "fit" the circumstances. For-profit firms *and* not-for-profit firms are, then, only bad to the extent that they are in the wrong place. If the external environment can be trusted—remember my earlier caveat about manifest demand—a wrong place is one that does not fit the external environment.

Is this invisible hand theorem convincing? Does the market, even in ownership types, operate today to give us the best of all feasible worlds? The answer is—"maybe," depending on whether the incentives offered by the environment are appropriately structured. For example, if consumers are ignorant about quality but do not know it (or have been convinced that all licensed hospitals and doctors are reasonably good), then they will be prey to quality-minimizing for-profit firms. The first-best solution would be to let them know that medical quality is variable.

Another, probably more important, example concerns the philanthropic/altruistic dimension. If private philanthropy is disorganized or sluggish, not-for-profit firms will not be able to do what they should when the need for such activity increases. A rather more delicate question is the subtle interplay of public and private charity. There is no doubt that there is strong substitution between public and private charity; public subsidization of the poor causes private giving to dry up. But in periods of rapid change—cutbacks in public spending or macroeconomic surges in the need for care for the poor—neither mechanism seems automatically to work well. Private charity, atrophied by decades of generous Medicare and Medicaid support for hospitals, lacks the infrastructure to respond rapidly. Empirically

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<sup>8</sup>Bruce Vladeck, "How Much Indigent Care Should Hospitals Provide?" *Health Management Quarterly* (Summer 1985): 2–5.

the not-for-profit hospitals, especially the nonpublic ones, have failed not because they have cut back uncompensated care, but because they failed to increase it sufficiently.<sup>9</sup> And public support for the poor will respond only to a strong case strongly presented in the political arena; taxpayers will, unfortunately, not loosen their purse strings in response only to moral posturing or dark hints of underservice from health policymakers; they will need to be convinced. Nor, one suspects, will all or even most voters accept the premise that the poor deserve "maximum quality" and "fully equal access and use," once they recognize the price. To mobilize either public or private charity for changing conditions, time and effort will be needed. My own view is that much effort is worthwhile and long overdue; rather than expect "unequal access" to speak for itself, we need to show what is bad about limited access.

In the interim, until voters respond, neither investor-owned nor not-for-profit firms will perform satisfactorily. They will seem resistant to the needs of the poor and more interested in pursuing other objectives. For-profit firms will not respond well to increases in the needs of the poor; philanthropy is not their business. Not-for-profit firms could in principle respond better, but thus far have not done so, largely because of the history just mentioned. The invisible hand seems to falter either way. But in a very true sense, the defect is not with the market mechanism, or with the ownership structure or motivation of investor-owned *or* not-for-profit firms. Instead, the problem is a failure of the systems we use to structure the environment, a failure of the public sector to spend the necessary tax revenues, and a failure of private philanthropy to tap people's altruistic motives. The performance of firms in the industry is, in a sense, only making apparent the messages currently being delivered by those institutions that demand medical care on behalf of the poor. If the message is that neither taxpayers *nor* donors are willing to pay for the poor, less care for them will be forthcoming.

The danger here is that the messenger will be regulated (if not killed) in order to get the supposed outcome to correspond more with what people wish it would be. These efforts will be largely unsuccessful, and distortive and wasteful even when they do succeed. Mandated cross-subsidies via regulatory sleight of hand—subsidies to

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<sup>9</sup>J. Feder et al., "Poor People and Poor Hospitals," *Journal of Health Politics, Policy, and Law* 2 (Summer 1984): 237–50; F. Sloan et al., "Identifying the Issues: A Statistical Profile," in Sloan, Blumstein, and Valvona, eds., *Uncompensated Hospital Care: Rights and Responsibilities* (Baltimore: Johns Hopkins Press, 1986), pp. 16–52.

hospitals for expensive outpatient care and the like—may help the poor a little, but only at the cost of blocking the path to a permanent solution with an inefficient, temporary expedient. While few of us are experts on how to get the political process to reach a reasonable outcome—Professor Arrow having shown it to be a logical impossibility<sup>10</sup>—my own preference is to rely on an explicit political choice mechanism, fueled by concrete and convincing evidence of the plight of the poor and the benefit to be expected from additional spending. This is, in my view, preferable either to limiting the entry and pricing behavior of investor-owned or for-profit firms.

### **The Past and the Future of For-Profit Health Enterprise**

This last point touches on what will be for many people the heart of the issue. What bothers most of us about for-profit firm growth is not so much the firms themselves but the fact that the entry of these firms is symptomatic of a change that is affecting all sellers, *viz.*, a devotion more to the financial bottom line than to the welfare of patients, especially patients who cannot pay. My argument is that this change is the logical consequence of partial withdrawal following the 20-year massive infusion of public funds on behalf of these individuals. While Medicare and Medicaid gradually supplanted non-financial motivations, the consequences of the death of that motivation had been hidden by the generosity of public programs. But when the public payment was cut, the void appeared. The current desire for value for money from both the private and the public sectors did not *cause* a “for-profit motivation;” it only made apparent what was already there but hidden. The for-profit motive was instilled long ago, well before the emergence of its current manifestations. Indeed, one piece of circumstantial evidence for the pervasiveness of the motive is the virtually universal prediction that not-for-profit hospitals in general would respond to DRGs by cutting costs. But this is behavior of a for-profit firm, not of one with other motives.

What is the future of for-profit ownership and motivation, either as it will be or as it ought to be?

Conventional predictions are for continued growth in both the multi-institutional (chain) affiliation of health care enterprises and the growth of for-profit firms within that setting. This is reasonable forecasting

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<sup>10</sup>Kenneth Arrow, *Social Choice and Individual Values*, 2d ed. (New York: John Wiley, 1963).

methodology; it is usually safe to predict that the future will be like the present, only more so. But such predictions can sometimes go seriously wrong—using that method would lead me to predict that my teenage son will be 14 feet tall by the time he is 25. More seriously, one should try to identify the *reasons* for trends, rather than just project a trend.

I have already identified some of those reasons for different ownership types. To forecast the future, one needs to ask how (or whether) those reasons will change. What is likely to change, and how will that affect for-profit firms?

It is reasonable to expect that the profitability of investment in the health care sector in general, and of hospitals in particular, will decline in the near term (say, over the next five years). We are in for a period of shrinkage. The most obvious observation is that shrinking industries are not especially attractive investment opportunities for investor-owned firms. Indeed, precisely the same investment flexibility that has characterized investor-owned firms in their period of investment growth will characterize a period of disinvestment. The fast track goes downhill as rapidly as it goes upward.

Things are not crystal-clear here, of course. (They never are.) Disinvestment that leaves the firm still in existence requires someone to sell to, and I do not envision not-for-profit investors buying back hospitals. Moreover, declines in profitability may simply reduce the current value of the firm and the profitability of *future* investment, although investor-owned hospitals certainly do seem willing to go out of business.

It is also probably (if not tautologically) true that multi-institutional organizations, because of their size, will have greater financial strength to support struggling firms than would separate independent forms. (Investor-owned chains are also generally much larger than not-for-profit chains.) But this strength will erode quickly if hard times hit all hospitals. Moreover, the fact that an investor-owned firm *could* keep its units alive does not mean that it will do so if that is less profitable than other uses of capital. Indeed, the fact that there are no owners with strong incentives to claim or transfer the assets of independent not-for-profit firms may keep them in business longer.

On the other hand, it may be that for-profit owners are better able to manage firms in a depressed industry. The equation of investor ownership with efficiency would suggest this. But I have expressed considerable skepticism about that equation as a generalization. There may be few more poorly managed not-for-profit hospitals that will seek help, but it is likely to take the form of contract management

rather than ownership, and I would not expect it to have a large influence in any case.

If there were areas in health care other than hospitals that would yield profits exceeding those elsewhere in the economy (not just in health care), one might expect for-profit firms to move in. While no one knows what better mousetraps might be just around the corner, my sense is that such extra-profitable health investments are currently rather rare. The bloom is definitely off the HMO rose, especially for new entrants, and entrepreneurs in such high-tech ventures as magnetic resonance imaging have recently been roughed up rather badly. Of course, if the profit in some parts of health care is lower than elsewhere in the economy but higher than in hospitals, not-for-profit firms, with less ability to go outside the health field, may be attracted.

What about the things that make not-for-profit firms attractive? There does not seem to be great change occurring either in the complexity of medical care services or in consumers' knowledge about that complexity. But the other two bases for the not-for-profit form of health care delivery seem to be changing in a more favorable way (to the not-for-profit firms, if not to society). For one thing, the trend toward larger numbers of uninsured individuals seems to be continuing, even though the stimuli of economic downturn and Medicaid cuts have abated. This change is likely to make the greater facility of not-for-profit firms in arranging philanthropy to cover their bad debts an increasingly valuable asset. Paradoxically (and perhaps regretfully), not-for-profit firms do best when the poor do worst, when government fails to care for the poor. If the current trend of public-sector government neglect continues, that will give back to such firms the advantage in tapping altruism that they once had. Conversely, if government does reenter with tax-financed resources, not-for-profit firms will be at less of an advantage, as long as government feels it can monitor how resources are used.

The role of physicians is rather more difficult to assess; their apparent adaptation to hospitals' desires for net income by agreeing to cut length of stay for DRG patients was surprisingly facile. But despite the impacts of larger numbers of physicians on the market, I believe that there is likely to be a counterrevolution in which medical staffs reassert their positions both in supervising patient care and in sharing in net income. Whether the response will take the form of limiting hospital actions (as adversaries) or of joining with the hospital to increase and share in profits is hard to say at this point. But I suspect that not-for-profit hospitals will be better positioned than investor-

owned firms in a shrinking market to cope with this challenge from the suppliers of critical inputs.

In the longer (and fuzzier) run, my sense is that demographics and real economic growth will eventually restimulate demand for health care services. To a considerable extent, prediction depends on what you think about the political environment 10 years out—will it then permit the growth in spending needed to accommodate this demand? If it does accommodate it, then opportunities for investor-owned firms will reemerge.

## **Conclusion**

As far as investor-owned firms are concerned, the bottom line is the bottom line. Health care is likely to be less profitable in the future, so that the fairly modest inroads of the for-profit form of ownership into some parts of the market are likely to slow or stop. It has never been obvious that such firms actually caused the problem of how to care adequately for low-income people whom governments refuse to help; they just did not do much to alleviate it when it got worse (though neither did their nonpublic, not-for-profit counterparts). But if philanthropy returns as a solution, the for-profit firms—whether or not they were part of the problem—will not be part of the solution.

In the longer run, investor-owned firms will play a role, and there is no particular reason to be concerned about that role if the overall market environment can be made sufficiently flexible, competitive, and undistorted. It is not so easy to level the playing field, given the sizable boulders and berms we have built up over the years. But it is feasible, and is probably worth it.

### **III. Integration and Competition in Health Care**

John H. Moxley III, M.D., and Penelope C. Roeder

*Editor's note: Dr. Moxley delivered the following presentation, which he coauthored with Ms. Roeder.*

It strikes me that, as a society, we Americans are traditionally concerned about the rights of individuals. Individual rights have pervaded our thinking in the political process all the way from the Bill of Rights. They have also pervaded our educational system, and, in fact, our health care system.

Any time there is an abrupt change in any system that even seems to infringe upon individual rights, there is resistance. If one looks at the health care area, the progressive implementation of automobile seatbelt regulations and the progressive restriction of cigarette smoking have met with resistance. If you want a more pervasive example one simply has to look at the school integration issue.

I raise the point because it seems to me that what is going on at the present time is that we are seeing that sort of change in the American health care system. As a society we are transitioning rather rapidly from individual arrangements for health care to systems, networks, and other group arrangements. The major catalyst in this rather radical change is the payer, formerly the silent partner.

Payers, be they the government or private employers, are increasingly wanting to call the shots. We are, therefore, moving from a system that has focused on delivering individual units of care and generating revenue to an integrated system that controls cost. More explicitly, we are moving from a revenue-generating system to a cost-control system, and concurrently from a provider-dominated health care system to a payer-dominated system.

#### **Horizontal, Vertical, and Product Integration**

Now let me move on to some specific comments about integration. "Integration" is a term that we in health care have borrowed from economics. Once we borrowed it, we proceeded to apply it to everything in sight, from multihospital chains to hospital joint ventures with insurance companies to joint ventures between hospitals and physicians.



Recently the American Medical Association put forth some definitions that I believe are helpful. The first definition is of *horizontal integration*, the common ownership or control of two enterprises, each of which produces a similar output. Clearly, multihospital systems before they expanded into other aspects of health care were examples of horizontal integration.

*Vertical integration* is the common ownership or control of two enterprises, one of which uses as its input the output of the other. Although it is a term frequently used in health care, I would contend that we do not really have an example of vertical integration in the health care system. If the American Hospital Supply-Hospital Corporation of America merger had gone through, we would have had an example of vertical integration. If one wants to stretch a point and say that a multispecialty group practice, such as the Mayo Clinic, produces a diagnostic output, and that that diagnostic output is used as the input of a hospital, then the fact that the Mayo Clinic and the hospitals in Rochester are now merging might be construed as an example of vertical integration. You have to stretch that far to come up with an example.

The final definition is of *product integration*, the common ownership or control of two enterprises that produce distinctly different, but related, products or services. Clearly, to my mind, most networks, be they preferred provider organizations (PPOs), health maintenance organizations (HMOs), or something else in the alphabet soup, are examples of product integration. The reason is that the essential characteristic of all these delivery systems is that they integrate two or more services under the control of a single organization. The operative word here is "control," the element that is increasingly sought by the payers. That is not to say that, at this point in time, individuals cannot opt out of the system. But if they do, they must increasingly do so at no cost to the payer.

Now let us turn and look at how we got from our individualistic, provider-dominated system to this new state of affairs. In doing so, I would like to comment on three interrelated concepts: first, the *monetarization* of health care; second, the *corporatization* of health care; and third, the *commercialization* of health care.

### **Monetarization**

I do not know when monetarization began, but it was clearly a long time ago when the first provider accepted money instead of an in-kind payment for the provision of health care. It is very closely

related, if not identical, to expanding the pool of dollars that Phil Caper talked about [see Chapter I]. Although its origins go back a long way, it was not until 1984 in an article in the *New England Journal of Medicine* that Eli Ginzberg coined the term.

The fact that it goes back a long way does not mean that it has not been significantly affected in this century. It was very affected, for instance, by the introduction of hospital insurance in the 1930s. Monetization was also profoundly affected by the rapid development of technology and the specialization and subspecialization of providers in the aftermath of World War II. Most recently it was dramatically impacted by the introduction of Medicare.

Medicare created an unprecedented demand for services and new technology, and an unprecedented demand for health care dollars. Additionally, Medicare created a predictable cash flow for hospitals and took the mystery out of hospital finance by demanding uniform accounting procedures. In so doing, it opened the public money markets to the health care world.

### **Corporatization**

At that point, monetization began to transform into corporatization. Several previously very independent units began to be brought together under single-management control into something that was a corpus.

In the aftermath of Medicare, the investor-owned hospital systems were founded and there came a realization that equity markets were an additional source of capital. Horizontal integration began to be viewed as a useful construct, in that bankers and other investors appreciated the reduced risk presented by a diversified portfolio of hospitals as opposed to a single hospital.

During that same period—the 1970s—there were several small not-for-profit hospital systems. They were, by and large, limited to specific issues, such as rural hospital care, or limited geographically to single states, or related to other organizations, frequently churches. They grew slowly, and toward the end of the 1970s, Sam Tibbits in California and Steve Morris in Arizona joined their two small systems. That became the first large multistate, not-for-profit system, which has since evolved into American Health Care Systems. I also could have used as an example the Voluntary Hospital Association, which began in 1977 as a purchasing arrangement and has now transformed itself into a national, not-for-profit health care company.

Then, in the early 1980s, two events occurred in rapid-fire order. First was the business recession of 1980–81, which hit employers very hard. During that time they were able to reduce their total production costs, and their health care costs, therefore, became increasingly obvious and seemingly uncontrollable. Very shortly thereafter the federal government introduced diagnosis-related groups (DRGs), which took the traditional financing mechanism and inverted it. Previously the incentives had all been for inpatient care, but after DRGs were legislated, all incentives after October 1, 1983, were to do as little as possible in the hospital.

The business community took notice of DRGs and became convinced that they, too, could save money by reducing hospitalization. They went about it in a number of ways, not the least of which was the introduction of utilization review systems, which remain in various states of development today [see Introduction and Background].

So, one began to see true corporatization in the early 1980s. One began to see payer, facility, and physician provider interdependence, whether in the form of a formal HMO or PPO or simply something like Chrysler's approved-provider list. At that point, now only a few years ago, we begin to see the commercialization of health care.

## **Commercialization**

Commercialization is often thought to be a byproduct of corporatization, but it really is more one of monetarization, or probably of a combination of the two. We began to see the transformation of health care from a social good to an economic good. This transformation was energized by the forces that energized corporatization, plus a smaller pool of revenue dollars. As an economic good, health care is fundamentally a commodity product and is affected by some simple economics: extent of availability, number of buyers, and, therefore, a competitive market. Attempts to overcome these economic realities have led to the commercialization of health care.

We are now frantically trying to make health care sexy, trying to sell it by giving it a specific value added, such as birthing centers. Providers are trying to make it a differentiable product that can be sold to the American people. In this sense, a social good has clearly become an economic commodity and even a commercial product. This creates complex problems, both in terms of the economics and in terms of the social policy it affects.

## **Where Is the Health Care System Now?**

It would seem that the health care system is not integrated, at least not vertically integrated, as yet. It would appear that it is somewhat commercialized, at least in the sense of using commercial sales techniques. Finally, it would seem that it is competitive to the extent that there is an imbalance between buyers and sellers.

We have not speculated as to whether the current system is desirable. I would argue that it is not, because there is a critical lack of information, a subject that Phil Caper described in some detail in an earlier presentation [see Chapter I]. Economic theory, as I understand it, suggests that there cannot be a rational, competitive market without good information. Yet we often note that health care consumers lack the clinical education to know what they need. It is increasingly evident that payers do not know exactly what they want either. Therefore, even if providers had none but the best intentions, and they do not, it would be difficult to design the products demanded by payers and consumers.

## **The Goal of Quality Health Care**

Amidst all the economic rhetoric that has been pervasive in the discussion of health policy, it seems we have often lost sight of the reason for that discussion: to make quality health care available to those who need it.

All too often we have focused increasingly on the cost side of the equation. It is my judgment that this one-sided focus has led to the current health care arrangements in which almost all parties are concentrating, not unreasonably, on their own piece of the system. Employers are focusing on reducing their cost of employee health benefits. Providers are focusing on how to increase patient loads to maintain income despite declining prices. Patients are focusing on how to find health care plans that will allow them to get as much health care as they possibly want with as little out-of-pocket expenditure as possible.

This is not to say that all the parties to the debate do not want quality, but unlike cost, there is no common currency for discussing or measuring quality health care at the present time. Up until very recently, all our measurements have been very indirect—physician certificate rates, staffing ratios, and so on. Only recently have we begun to generate prospective, hard data upon which some judgments can be made. But we need to go beyond where we are today. We have

the tools. The advent of the computer allows payers and providers alike to amass and sort great quantities of both financial and clinical data. That data can be used either simply to reduce costs or it can be used constructively to study cost/benefit trade-offs. The information from such studies can either be used to develop medical care cookbooks, which in my judgment would halt medical progress, or they can be used to develop norms and guidelines that recognize that exceptions will arise, which will have to be dealt with in creative ways.

I am not suggesting that the process of developing this quality-control information will be simple or fast. The task of identifying quality measurements—whether they are carefully adjusted death rates, infection rates, return-to-operating room rates, or recurrence rates for certain diseases—will take time, but the tools to analyze the situation thoroughly are at hand.

Beyond that, in developing prospective, hard measurements of quality, we have got to stop focusing on hospitalization or its alternatives and begin looking at health care as a spectrum of health-related services. We must look at the full spectrum simultaneously in terms of measuring quality. Perhaps most of all, we will need to achieve a true integration of perspectives if we are going to achieve an economically viable, quality health care system. Payers will have to learn, respect, and use the clinical expertise of physicians and other highly trained health care personnel. Physicians will have to understand, and take seriously, both the economic consequences of their decisions and their professional commitments to patients' real needs, whatever the economic consequences. Patients will have to continue to learn about the health care system and use all of its constituent parts thoughtfully and effectively.

Finally, payers, providers, and patients will have to regard one another as participants in a shared venture, not as adversaries in an economic crusade.

## IV. Discussion

### Change in Physician Practice

MR. PAUL: It sounds to me as though more and more doctors are going to be in roles that involve them as salaried employees instead of as independent professionals. What do you think that change will mean to the kind of medical care that is being delivered in this country?<sup>1</sup>

DR. CAPER: I think it depends on the incentives built in. Physicians certainly are influenced by economic incentives as much as anybody. But one thing that we have discovered in working with groups of physicians is that they are also very interested in what happens to their patients and, in general, they will not do things that they do not think are in their patients' interests. That is why the information we have been able to generate has had the influence it has in Maine. That is also one of the reasons the American Medical Association has started to become actively involved in these data feedback projects.

So, I know that the way physicians are paid is not the only determinant of behavior; I do not even think it is the most important determinant of their behavior, as long as they can survive. Obviously, there are high rollers who are more interested in money than are others in the medical profession. But basically it is a profession, and fundamentally doctors like to think they are doing what is best for their patients. The new information is going to help reeducate physicians; that is really what has to happen in terms of the way resources in the system are used.

DR. MOXLEY: I think that transition Mr. Paul asked about may occur more gradually than many people realize. For a period of about 10 years, which ended about three or four years ago, I was a councilor of the California Medical Association. I found it very interesting over that period to see that a cleavage developed between the younger physicians entering the system and the older physicians.

The younger physicians did not view their independence nearly as highly as the older ones. They did not see an alarming danger in trading off at least a part of the independence of solo practice for more regular hours (although they did not necessarily use that term) and a more predictable cash flow. I think the transition will occur

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<sup>1</sup> Editor's note: Mr. Paul served as moderator for the forum discussions.

more slowly, and I do not think it is going to have a profound effect on how physicians practice.

MR. PAULY: There is a conundrum that still remains to be solved as far as physicians are concerned or as far as our evaluation of their behavior is concerned, namely, what is the correct level of performance? The average is, after all, just a number. It does not necessarily imply that performance at the average is good and performance above the average bad.

There does seem to be a tendency, what I call the "knock me over with a feather" phenomenon, of physicians changing their behavior fairly dramatically in response to incentives that seem fairly minimal. They do so even after years of arguing that they had to do what they were doing because it was in the best of interest of their patients.

The change in length of stay since the advent of DRGs is a good example. Without outcome studies to tell you which level of the coronary-bypass surgery rate is appropriate for which population, it is difficult to know what constitutes a good change and what constitutes a bad change. There is reason to believe, given the current or at least the recent-past financing mechanism, that people were probably pretty far out on the low marginal benefit end of the spectrum. Therefore, some improvement is almost, by definition, desirable. But sooner or later one is going to be wondering whether this can go too far, and how you tell what is too far and what is not far enough.

MR. SEIDMAN: I would like to relate a discussion that took place yesterday at a conference similar to this with somewhat different participants. It was sponsored by the American Hospital Association, and the participants included insurers and Blue Cross/Blue Shield, employers and labor, and physicians and hospitals, and there was some reference in a work group to the material that Phil Caper has put before us [see Chapter I]. The president of the American Medical Association, Harrison Rogers, was there. His feeling was that doctors did not want to be dictated to, but that they are very eager to have the kind of information Dr. Caper and others have developed, and that they would then try to determine among themselves whether the high, low, or average users were providing the best medical care.

It is very important to have data on outcomes, but, unfortunately, some data on outcomes take a long, long time. On the other hand, it seems to me that a reasonably knowledgeable group of physicians have a pretty good idea, among themselves, of what their outcomes have been, even when they have not had the data. When they get the data, obviously that will be better.

DR. CAPER: I agree. The bottom-line question in determining which rate is the right rate is the question of outcome. Outcome studies are difficult to perform. They are expensive and they are long term, although we are developing better ways to look at outcomes using claims data, which do not involve randomized clinical trials and all the expense and ethical problems associated with those trials.

That is the ideal solution and one that should be vigorously pursued. As a matter of public policy, among other things, we should be using the Medicare database to do this study. Why aren't we? There is a gold mine of information in the Medicare database if it were made available for the development of these types of studies. We have some of it at Dartmouth, and there are studies under way at the Rand Corporation, in Canada, and in other places.

But even without that information there is a lot that can be done to change behavior and the way physicians use the system. Unfortunately, we are caught in the trap of being unwilling to effectively address the macroeconomic problem. We have adopted microeconomic solutions to solving the macroeconomic problem. We are trying to regulate things on a very detailed, case-by-case level, and it is not working very well because the tool is inappropriate.

Nevertheless, a combination of the changed incentives we are seeing and good information, even without firm outcome studies, can lead a group of doctors like those in Maine to conclude that they can safely change their patterns of practice and begin to move things from the hospital to the outpatient setting, or it can begin to reduce the rates of back surgery or prostatectomy. The urology group in Maine discovered one of the cohorts of prostatectomy patients had a 40 percent mortality rate within a year following the operation. It may not have been due to the operation, but they are operating on a high-risk group of patients. That information has changed their thinking about the proper indications for that surgery.

I agree that the outcome question is a key question. Even before that, making good utilization information widely available to practicing physicians, in combination with incentives to reduce cost, will lead to dramatic changes in behavior.

MS. CRONIN: Dr. Caper, what are the implications of your research with reference to second-opinion programs? Have you looked at that?

DR. CAPER: Yes, but not specifically second-opinion programs. Our research shows that some causes of admission, about 10 percent, are what we call "low variation" causes. They include such procedures as inguinal hernia repair. That is considered a discretionary proce-



cedure as far as when to do it and, increasingly, whether to do it as an inpatient or outpatient, but not discretionary as far as *whether* to do it. Hip fractures, myocardial infarctions, strokes, gastro-intestinal bleeding, and so on do not belong on second-opinion lists. Many corporations are wasting a lot of time and effort looking at procedures in which there is little discretion on the part of the physician. What one needs to do is look at procedures where there is a great deal of discretion as measured by variation in the way doctors actually approach these problems. Furthermore, very specific information is needed to know where the rates are high. Why bother doing second opinions in a service area where you know the practice is already very conservative?

This kind of information can be useful in focusing not only second-opinion programs, but also preadmission screening programs. You can routinely monitor length of stay. The personal computer can analyze a data system the size of New York's database—3 million discharges a year—and you can have it at your desk. You can greatly improve the efficiency of all of these utilization and review systems and get the doctors' cooperation. Physicians will respond to data if you do not say, "You're right," or "You're wrong, and the other guy is right." Go in and say, "You're different." You may be correct, but it shifts the burden of proof. That has happened in Maine, and it is happening elsewhere.

### **Defining and Ensuring Quality Health Care**

Ms. HERZOG: I would like the speakers to comment generally on the proper locus of responsibility for quality control, not only of physicians but also of hospitals. To what extent should the government—perhaps through peer review organizations (PROs)<sup>2</sup>—take responsibility for quality, versus to what extent should we leave that responsibility to providers, spurred on by competition?

For example, recent hospital-specific data emanating from the Health Care Financing Administration (HCFA)—data which no one, of course, likes—leaves us, as consumers, wondering who takes the next step.<sup>3</sup>

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<sup>2</sup>Editor's note: Peer review organizations are nonprofit, community-based, physician-directed agencies that oversee the utilization and the quality of institutional health care provided to Medicare and Medicaid beneficiaries.

<sup>3</sup>Editor's note: The reference is to data released March 12, 1986, by the Department of Health and Human Services that identifies hospitals whose overall death rates for Medicare patients deviate significantly from expected rates.

Should providers be taking the next step to improve upon the data or should the government be taking the next step?

A group of physicians and doctors in Orange County, California, has just developed what they consider to be a sophisticated screen for quality care, including many different items. Is such a screen useful? If so, should industry adopt it to self-regulate or should the government use it? Which way is most beneficial for consumers?

DR. MOXLEY: In my judgment, there is no specific answer to your question. There are a number of groups that have roles to play, which comes back to the issue of the quality data that is being held exclusively by the providers. I do not think that will be acceptable in the future. Increasingly the quality information being generated is going to be examined simultaneously by providers, by payers, and by consumers. It is within that mix that the decisions in regard to quality care have to be made, against whatever norms that particular system happens to generate at that point in time.

Over time, quality-of-health will merge with quality-of-life considerations. An outcome study done a few years ago by a group at Stanford University concluded that patients handled in one setting survived an average of eight months longer than patients handled in another setting. Then the study raised the question of how worthwhile that survival was, in that the patients who survived longer were involved in a very high-tech system. They were in the hospital most of the time; they were not being kept alive on respirators, but it was approaching that.

Such complex issues cannot be answered by any one group. It is going to require the interaction of the provider, the consumer, and the payer to be able to reach a reasonable judgment.

DR. CAPER: I agree that it is a joint problem. Ultimately, in a more perfect world, of course, the medical profession would take sole responsibility for assuring quality. But we have shown in our work that there is a great deal of disagreement among physicians about most things. That tells me we have tended to delegate the definition of quality pretty much to the medical profession. As a society, we have assumed that quality was taken care of, and that all you had to worry about were some other things like distributing care, and equity, and how to pay for care. We have shown that, because of the many gray areas in medicine, there is an enormous demand for care, not maliciously done, but done because you can tip one way or another.

What is needed now, in the presence of incentives for cost containment, is, again, better information, and it has to be widely available.

It should not be solely the property of the medical profession, or of the hospitals, or of the business community. It should be like census data: It should be in the public sector. You cannot always interpret census data, but at least it demonstrates what the facts are, and that allows you to focus on areas of concern. That is a step forward. That is something we do not yet have, but which we should work toward.

The public databases should be analyzed in such a way that they turn the data into information. That in itself would have a very beneficial effect on quality. We need the help of physicians to arrive at suitable definitions.

MR. PAULY: I think the answer is: "All of the above" should have a role in assessing quality of care. Certainly, information is a product for which markets do not work very well, because you can get it without paying for it once somebody has generated it. That means there is a role for government and a role for public monies in trying to generate and make available better information. On the other hand, there is an appropriate role for competition in the market for information. We do not want to have a quality czar or a quality committee saying, "This is high quality, that isn't, and that's all there is to say about it." We want to have different people coming up with different estimates of quality.

I have a vision—I do not know whether it will ever come to pass—in which providers will generate a fair amount of information on quality, subject, again, to constraints on misleading or false information, in which the high-quality providers find it worthwhile to tell us so. Then there is a kind of trickle-down process. It behooves the next-lowest-quality seller to at least say, "I'm better than the rest of those people."

It seems that all of the above would work. I disagree with Phil Caper here; I do not think that, even in the best of all possible worlds, physicians should have sole responsibility for assuring quality. It is likely to be a general problem, regardless, but I think there are roles for all three groups—buyers, sellers, and government.

DR. MOXLEY: As competition increases and the measurement of quality becomes more precise, we will approach, more rapidly than you think at the moment, a system whereby quality will be the major determinant as to whether one stays in business and how well one does. It is not foolishly optimistic at this point to speculate that that will occur.

MR. MOYNAHAN: I agree that the issues of quality data are critical. It seems to me that another critical issue is to get that information

and the data analysis converted to knowledge, if you will, and in the hands of the health care consumer—the patient—as opposed, perhaps, to the health plan. This would make quality knowledge available to the family of the individual making the decision about accessing the health care system.

I am curious about the liability implications for providers of data on quality, be they health plans, the federal government, or somebody else, when reliance at the consumer level is placed upon the quality analyst.

DR. CAPER: In today's climate, the liability concern is there. One has to make sure the data are accurate; I think that is true of anybody involved in any enterprise. Everybody is worried about liability insurance—physicians, lawyers, and insurance carriers alike. I do not think it is a qualitatively different issue. If the data are released in an objective fashion and you state how the data are provided, then you are protected from liability as well as you can be.

The issue of liability is an important one. As insurers begin moving into the business of sponsoring HMOs and others providing services, they are also stepping into the liability chain more directly than they have in the past. The need for information is going to increase as insurers and employers begin to more actively intervene in the medical care of their beneficiaries or their employees.

### **The Payer's Role in Determining Quality**

MR. MOSER: The concern I have about the shift that you described, Dr. Caper—of adding the payer into the equation—is that if we compare where we, as payers, are in the medical delivery equation to where we, as payers, are in the purchase of any other product, we seem to be spending a lot more time, and certainly a lot more money, in determining quality in the medical field than we are in many other fields. How long can businesses continue to spend large sums of money to determine this quality issue?

DR. CAPER: It is up to you to pinpoint how much you are willing to spend. Business' attention to this problem was most acute during the recession of the early 1980s, when health care was sort of a "recession-proof" expense, from the employer's point of view. Every business person I have talked to shares your attitude. You are really not in the business of providing medical care, and would like to not be in the business of assessing the quality of medical care. But you have been forced to do that because you have had to adopt very specific

approaches to restraining your costs, such as second-opinion programs. There is a danger for the employer, because you could be seen as, in a way, interfering with your employees' medical care, and you do not want to do that.

The medical profession, on the other hand, and physician groups that I have talked to are concerned about the practice of medicine being taken out of the hands of physicians, and that is what flows from employer actions. When a physician in Hanover, New Hampshire, has to call a consultant in Chicago to find out if he can put his patient in the hospital, that is irritating to him, and it should be; that is probably inappropriate. Therefore, the American Medical Association has finally said, "This is an unsatisfactory situation from our point of view, and we are going to become aggressively involved in helping to solve this problem." That is a change. That would not have happened a few years ago. They would have said, "It will go away if we ignore it." That is no longer the case, and now they are saying, "Unless we do something about it, we are not going to be practicing medicine any more. We are going to be reading out of a cookbook."

Quite frankly, physicians are not going to fall on their swords for the good of the country any more than anybody else will these days. Physicians see it in their own professional interest to begin to regain control over the situation, and they realize it will have to be done in a very public forum. To my way of thinking, that is very healthy. So, to answer your question, there is much more hope than there was a few years ago that the organized medical profession will help solve these problems so employers do not have to worry about them any more. I do not think you want to have to worry about them.

Ms. MOON: In part, you may have answered the question I wanted to ask about the extent to which debates and discussion of quality-related issues are likely to go on outside of a cost-containment kind of framework. Much of the debate on quality seems to be motivated and tied to cost-containment efforts. A lot of what you were talking about is bringing to physicians an awareness of quality, but with the specter of cost control always in the background. I wonder whether national networks of diagnostic information and other computerized information systems also hold some hope of helping physicians in different locations to come up with some consensus on quality.

DR. CAPER: The most powerful influence I have seen has been the work I have described where physicians are given information about how they compare with their colleagues. The cost-containment ini-

tiative is clearly the driving force behind the reexamination of medical practices. Without that force, people would go on doing what they have been doing; they do not like to change. Doctors are not any different from anybody else in that regard. The change has to be brought about by some change in the external environment, and that is what has happened. Change is going to occur, but for it to occur in a way that enables us to retain high-quality medical care, we are going to need much better information.

If information is made available in the context of cost-containment pressures, some really remarkable things will happen. We are already beginning to see some change, but you are right about the basic, driving force being cost containment. That is going to have to continue to be the case. But, within that context, the information will provide the catalyst to allow the job to be done well, rather than poorly.

DR. MOXLEY: It seems to me that we all got into this situation because we had a dream, and that dream was that more health care is better health care. As a matter of fact, much of the debate about quality in the 1950s and 1960s really was a debate about access. If one had access to health care, one had quality. That vision soured when we confronted some economic realities in the late 1970s and early 1980s. It became sour not because physicians were wrong in handling payers and consumers. It just got to a point where the system began to have its wheels come off.

We must all work now to try and take that "more is better" concept and put it on a more rational basis. In so doing, payers and consumers have a responsibility, just as physicians do. Again, there is no single answer. All three groups have got to be very interested in this; they have got to watch it; and they must participate if, in fact, we are going to come out with an economically sound, quality health care system.

### **Costs and Methods of Monitoring Care**

DR. HUDSON: Much of the national database that has been alluded to here as creating a sort of breakthrough in information on quality for payers and consumers comes from "nonintrusive" data systems. In other words, the information comes from presently available aggregate data, including uniform hospital discharge data sets (UHDDS)<sup>4</sup>

<sup>4</sup>Editor's note: Uniform hospital discharge data sets are data abstracts of medical record information provided by hospitals to state regulatory agencies.

and billing data available from Medicare and large payers. It will give profiles on individual provider performance.

On the other hand, some providers are possibly seeing different types of patients, sicker patients, or treating those coming from different economic backgrounds. To confirm whether, in fact, some are seeing a different, sicker group of patients requires a much more detailed, "intrusive," and often expensive system of record abstracting. Some of these systems are being developed in the private sector now.

If we are going to move into this more expensive technology, who should be supporting it? Should this development remain in the private sphere, having payers or insurers negotiate with competing entrepreneurs? Or should this technology be developed primarily in the public sector and supported through public funds?

DR. CAPER: All of the above, I think. The data that I presented for Iowa was from the Medicare database, which is routinely collected for billing purposes. That is all that is available for analysis. We have also done these studies on UHDDS databases, on Blue Cross databases, and on Medicaid databases. Generally you can do these population-based studies on any database that has a reasonable statewide market. These particular studies account for differences in referral patterns. Given the population base, therefore, the whole argument of case-mix differences in hospitals does not apply. You are studying the population residing in the hospital service area, not the patient population in the hospital. That is important. It provides a very efficient, relatively inexpensive screening technique that allows us to ask the question, "What should we go in and look at more closely?" In some of these higher-rate areas you can use some of the severity measurements that are becoming available, but you do not have to do that for every patient who is hospitalized. This will allow you, again, to focus your review on those areas where it is needed because it is a routine, systematic, comprehensive, monitored system.

As far as who pays for it, the answer depends upon what database you are analyzing and the uses of the data. The Medicare database should be routinely converted into these kinds of population-based rates and made available as public information to anybody who wants them. Other databases will be analyzed by people interested in specific employers or insurance companies.

We do not like to do things in a single way in this country. You may have noticed that we do not provide the funds to the public

sector to do all of this work. For that reason, we are all going to have to join in and put it together.

DR. MOXLEY: But the analytical approach, it seems to me, ought to be put into the public domain. For instance, we currently have a clinical scholar from the Robert Wood Johnson Foundation who is working with our corporate planning group and the Rand Corporation in analyzing some very specific measurements of hospital outcome. We would not think of trying to keep the analytic tool as a piece of proprietary information. As long as analytical tools become part of the public domain, the issue of who develops them becomes rather inconsequential.

I do think the government, in its traditional role of funding research, ought to support this avenue of research; but there is much room for the private sector to support it as well.

DR. CAPER: I think that is critical, if only for the credibility of the approach. All of these things I have presented have been out in the public domain for 15 years. We are developing tools to apply in specific instances, but the approach is public information. That is the way it has to be.

### **Growth of the For-Profit Sector**

MR. SEIDMAN: In your discussion of the development of the for-profit sector, Professor Pauly, the burden of what you had to say was, first of all, that there has not been much development of the for-profit sector, and, secondly, that even if there has been, it does not make any great difference. I am not going to argue about whether the development is good or bad, but I cannot understand why you minimize the development. In the first place, just looking at data on the proportion of beds—the proportion of hospitals is not the appropriate way to study how this has developed—reveals that the expansion has developed very rapidly. Even in the hospital sector, the change within the for-profit sector from small, physician-owned hospitals to large-chain, for-profit hospitals has had a tremendous effect, not only on the for-profit hospitals but also on the nonprofit hospitals.

The analysis should not be confined to hospitals. This development is taking place in every sector of medical care. It is taking place very rapidly, for example, in the HMO field, and is having an impact not just on the for-profit HMOs, but on the nonprofit HMOs as well. The same thing is happening in home health care. The nursing homes have always been for-profit but, again, there is a change. The for-



profit dominance continues, but the change in ownership involving large chains is very considerable in the nursing home field. All this is having an impact.

In terms of the future, the point you made, that the for-profits do have a much greater access to the capital market than the nonprofits, certainly is going to favor the development of for-profits.

Finally, where I come from, a 10 percent difference is a big deal, not a small deal. It makes the difference in whether a collective bargaining agreement does or does not take place, and I would not minimize 10 percent differences anywhere they appear in this kind of discussion.

DR. PAULY: The question, again, is whether we are talking about the symptom, or whether we are talking about some independent cause, and there is always the counterfactual. Suppose there had been no for-profits. Would things have looked different? My suspicion is that they would not have. The nonprofits that would have existed in those rapidly growing markets where there was a great deal of willingness to pay and a shortage of capital would, for many reasons, including the desire to generate more investment funds, have earned fairly high net-revenue margins.

Where we have looked for differences in behavior related to ownership, not much comes out as being related to the issue of ownership. So it is certainly true that the growth of for-profit ownership had an impact on the apprehension that nonprofit firms have. But whether it has had much of an impact in terms of the quality or price of health care delivered to the American public—well, I just do not see much evidence for that.

On the issue of investments and access to capital, it is true that easier access to capital means that you can bring in capital if there are profits to be made; but it also means that if there are not profits to be made, you can even take capital out. We can argue about the future of the hospital part of the health care industry. I do not see big profits out there for the next five years, and that suggests to me that this aspect of for-profit firm performance may be reversing.

## **PART TWO: Managing Employer Health Costs in a Changing Market**

As discussed in the Introduction and Background, virtually all employers have initiated changes in their health insurance plans aimed at managing costs. In Part Two, the discussion centers around the effectiveness of specific options available to employers.

In the first presentation, Richard Hanley lays out the options available to employers in redesigning their health plans, in particular focusing on the case management approach, in which an employee's health care is managed to ensure that needed care is delivered using the most cost-effective resources available.

The second presentation, by Patricia Nazemetz, illustrates the kinds of things a firm can do from within to control health care utilization and cost while simultaneously maintaining high-quality care.

In the third presentation, Patricia Dempster supplements the discussion about what individual employers can do by discussing ways in which groups of employers can join together in health care coalitions, organizations that develop and share new data sources and collaborate in a number of other ways to influence the health care market.

## **V. The Spectrum and Implications of Employer Alternatives**

Richard J. Hanley

Today's employers are faced with a staggering array of choices in the health care marketplace. How does an employer choose? What choice will bring the best payoff? What are the implications of the strategic moves that must be made?

The rising cost of health care is a serious problem that affects everyone, especially employers. Health care costs of U.S. employers skyrocketed from \$6 billion in 1967 to \$425 billion in 1985. But an employer, when designing a health benefit program, must consider more than just cost. A health benefit program must be tailored to the employer's specific needs and must provide needed services to employees.

So the employer's dilemma is twofold: How can I give as much health care coverage as I am able, the amount that is most needed by my employees, but at the same time give it in a way that can be appropriately controlled so my expenses do not soar overnight?

There are no quick fixes. We cannot wave a magic wand and have the best options become apparent. No program will solve all problems or accommodate all needs overnight. Even the best of programs must be modified and adjusted to meet changing conditions as time goes on. But if we confront the changes in the health care marketplace head-on, and if we are willing to tackle our problems, address our needs, and provide the long-term commitment necessary to make our programs work, we can achieve significant results. We can better control costs not by compromising quality or access to health care, but by improving and making more effective its delivery.

In this presentation, I will discuss several of the options available to employers considering a new or redesigned health care program for their workers. Then I will offer what I think is the best solution for controlling costs and ensuring quality care.

### **Possible Ingredients of a Health Care Plan**

There are several varieties of medical benefit packages. The most generous are basic and major medical plans, which pay for all hos-

pital care, surgeons' fees, and most other health services. These plans usually involve employee payment through deductibles and/or co-payments. For the employer, these plans are the most generous and expensive.

Scheduled plans limit payment for certain expenses—such as hospital stays and surgery—according to set fees.

Comprehensive plans involve deductibles and coinsurance for all benefits and usually set a cap on employees' out-of-pocket expenses, after which the plan assumes payment for all costs.

If employees are asked to share the costs of health care, they will be motivated to use resources more cautiously. They can be asked to pay for a portion of premiums, for deductibles and coinsurance, or for health care expenses not included in the plan. Keep in mind that increasing an employee's premium contribution generally does not affect the use of health services because payments are independent of usage. If, however, an employee is asked to pay a higher deductible or a greater portion of the cost of care, he or she then will be more likely to think twice about seeking medical care. A similar result occurs if an employee must pay for a service not covered by the company plan.

Benefit plans should be designed so that employees have incentives to obtain cost-effective care. All health care plans should have a common, long-range objective: to encourage and enable the employee to become a more prudent and cost-effective purchaser of health care products and services. In my opinion, this is absolutely necessary if health care costs are to be contained on any kind of genuine, lasting basis. Although many efforts can be made on the part of the employer, they will be undermined if the consumer does not begin to take a more active, aggressive role. Consider these possible ingredients of such a plan:

### ***Cost Sharing***

Some elements of cost sharing must be built into the plan. It is a fact that people are less careful about spending money that will be reimbursed by their group insurance. According to statistics from the Rand Corporation, people who are fully insured for medical services spend about 50 percent more on health care than do those with insurance that does not cover the first \$1,000 of expenditures. The objective, therefore, must be to eliminate first-dollar coverage and to require employees to pay a portion of costs through such methods as coinsurance and deductibles.

### ***Flexible Benefits***

Examples of flexible benefit programs include multiple-choice, which allows employees to select from various plans and pay costs over and above the employer's contribution; use-incentive, which gives deferred compensation if employees spend less than a given amount on health care; and programs under which employees can allocate benefits among several choices, such as health care, vacations, extra life insurance, day care, and deferred compensation.

Under a flexible benefit plan adopted in 1978, American Can found that many of its employees moved away from a plan with a low employee deductible and coinsurance requirement (costing the employer \$575 per employee in 1983) to a plan with a higher employee coinsurance requirement and deductible (costing the employer \$215 per employee in 1983). The program offers a core of benefits to all employees as well as credits—based on age, length of service, salary, and family structure—that can be used to purchase additional benefits, including extra medical and life insurance, vacation, disability, day care, and capital accumulation.

Today's new demographics, characterized by a preponderance of two-career couples, should not be ignored. Why should an employer pay health benefits for an employee whose spouse already provides the family with full coverage?

### ***Incentives***

Provide incentives for employees to seek cost-effective services such as outpatient surgery and urgent care centers rather than to use hospital emergency rooms. Another cost-effective measure is to use home health care services so patients can leave the hospital earlier.

As an example, Owens-Illinois previously offered a benefit plan that reimbursed patients for 80 percent of the cost of treatment in most nonhospital settings. Those who received the same treatment in a hospital were reimbursed at 100 percent. The incentive was just the opposite of what the company wanted because it rewarded the patients who chose the more expensive form of treatment. That incentive system has since been turned around. Now 100 percent coverage is provided by Owens-Illinois for outpatient treatment, and only 80 percent coverage is available for unnecessary hospital treatments or admissions.

### ***Mandatory Second-Opinion Program***

This requires an individual to obtain a second opinion before proceeding with certain types of elective, nonemergency surgery or, taken

one step further, before all other nonemergency hospital admissions. Specially trained registered nurses or other medical personnel can assist patients in obtaining second opinions and, at the same time, in understanding the available medical options such as preadmission testing, outpatient versus inpatient surgery, preparation for early discharge, and home health care alternatives. Although the primary purpose of the second-opinion program is to avoid unnecessary cost, it also is very effective in helping patients to evaluate alternative methods of treatment and to avoid unneeded risks.

A mandatory second-opinion program for 8,000 of Owens-Illinois' salaried employees and their dependents saved \$300,000 in 1983, its first year. At the same time, the plan preserved each patient's freedom of choice—the second opinion did not have to confirm the first for the treatment to be covered—and increased employee awareness of health care alternatives. These savings represented a return of more than \$4 for each \$1 it cost to operate the program.

### ***Cost-Effective Alternative Delivery Systems***

These include health maintenance organizations (HMOs) and preferred provider arrangements (PPAs) [also known as preferred provider organizations, or PPOs].

With many HMOs, the cost of care is paid up-front on a per capita basis, so it is in the financial interest of the HMO to avoid unnecessary hospital admissions. The results speak for themselves. HMOs across the country typically average 300 to 400 hospital days per thousand participants, compared to about 700 days per thousand for those in conventional group insurance plans.

Through PPAs the employer generally offers some incentive to employees to use a specific hospital or other health care provider. In return, the employer may receive a reduced rate and a promise of good control over utilization. Such a wide variety of PPAs now exist that it is difficult to generalize beyond that. But it is important to emphasize that, with PPAs, discounts alone might not prove cost-effective. If the price is too high to begin with and then a discount is given, nothing has been gained.

Questions to ask when considering a PPA include: What incentive will there be for the insured to choose the PPA? What evidence is there of low-cost provision of services? How strong is the utilization component of the proposed arrangement? What evidence is there that quality programs are in place and working?

### **Utilization Review**

This process monitors, documents, and in some cases influences how people make use of the health care delivery system. It has three basic elements: preadmission review, concurrent review, and retrospective review.

*Preadmission review* typically takes the form of a preadmission certification program. A patient, or usually a doctor on behalf of the patient, must obtain certification prior to an elective admission to a hospital. This process usually excludes the patient. It deals primarily with the necessity for admission and the number of days that the patient should be in the hospital if no complications occur.

*Concurrent review* monitors the care being received by patients who have been admitted to a hospital. It is most effective in eliminating unnecessary days in the hospital and often is a substitute for the precertification program mentioned earlier. Its weakness as a stand-alone program is that the company does not have contact with the patient prior to admission.

*Retrospective review* examines patterns of health care delivery for costs or practices that seem to be out of line. The kind of data provided historically by insurance carriers dealing with claims and cost figures are not enough. A company needs to know not only what the costs are but why those costs were incurred. A good retrospective review program should show key patterns of hospital utilization based on a reliable case-mix index. It should be able to fairly compare charges and length of stay, hospital by hospital, and should measure those items against local, state, and national norms. Accurate, meaningful information of this type is the foundation on which a company should base important decisions such as the future structure of a health benefit plan.

### **Catastrophe Insurance**

A more drastic option for employers to consider is an alternative to traditional health coverage, but one that is more in keeping with life, disability, and other insurance designed to protect against serious disruption in a person's life. Catastrophe insurance covers only financially catastrophic medical events and would begin to pay for health expenses only after they reached a certain annual limit. Catastrophe insurance would save employers a great deal of money, and employees could benefit if they were to share those savings. If adopted by many companies, catastrophe insurance also would reduce the rate of cost inflation for items no longer covered. Consumers would

have the motivation to comparison-shop for the uninsured areas of health care, just as they do now in other marketplaces. The premise is that individuals, not companies, should take on the costs of primary health care, just as they do for food, housing, and clothing.

### **Other Considerations**

Besides these design elements, an employer also must determine the scope of a health benefit plan. What should be included? Should a benefit program cover expensive liver transplants, artificial hearts, and all the other medical procedures made possible by ever-improving technology? At what cost? An employer must be sensitive yet specific, careful not to reject automatically the expensive treatments made possible by technology but instead to make decisions appropriate for the employees in the plan.

An employer also must be cautious about the breadth of the plan. As an example, plastic surgery after a disfiguring car accident may be a legitimate expense for a company's health care plan, but should employers pay for nose jobs, breast enlargements, or other cosmetic procedures?

Other areas to consider when deciding what to include in a plan:

#### ***Mental Health***

Traditionally, mental health coverage has lagged behind that of coverage for other medical care. Currently over 49 percent of those covered under private insurance are protected for psychiatric illness on the same basis as for other medical problems. Unequal coverage for treatment of psychiatric patients may have resulted from now-disproven myths about mental illness. Among them: The costs of psychiatric treatment are uncontrollable and unpredictable; mental health care is not cost-effective; psychiatric treatment is not subject to utilization review; public facilities offer enough services to care for the mentally ill.

Now is the time for companies to take steps to correct the disparity. Experience indicates that mental and physical illness often cannot be separated and still be effectively treated. In addition, a more open cultural environment now makes it easier for people to admit their need for and use of mental health services. As a result, more employers are beginning to offer counseling, employee assistance, and stress management programs. Acute care in a hospital is one avenue of meeting need, but sometimes an outpatient or rehabilitation program can offer adequate care at less expense.



Similar consideration should be given to drug and alcoholism treatment programs.

### ***Rehabilitation of Disabled Workers***

An employee permanently disabled on the job at the age of 40 can cost a company more than \$1 million over the rest of his or her lifetime. Alarmed at such a prospect, many companies believe it pays to rehabilitate disabled workers to get them back to work, either at their original jobs or another more suited to their capabilities.

### ***Retiree Coverage***

Cutbacks in the Medicare program cause retirees to turn to their company plans to pay more of their medical bills. An additional area of concern is employees who take early retirement and are not yet eligible for Medicare, and whose health insurance coverage is still at preretirement levels.

As life expectancy increases, so does the time in which a retiree collects health insurance benefits. Without prefunding of future health care costs, it is pay-as-you-go—and a fantastic liability.<sup>1</sup>

### ***Wellness Programs***

Much money can be spent here. The promotion of healthy lifestyles and disease prevention is crucial to an effective health benefit plan. Wellness programs range from the very expensive—building recreation and fitness facilities for employees—to the much less expensive, e.g., organization of family hikes and swim parties or setting aside space within the company for daily aerobic workouts.

As many as 53 percent of Americans who die before the age of 65 do so because of lifestyle-related diseases. In addition, wellness programs can increase employee productivity by improving morale, job satisfaction, and mental alertness.

The biggest weakness of wellness programs is that their benefits are long-term and almost impossible to evaluate. But the premise is hard to argue with: Keep your employees healthy and they will not need the health care system. I am convinced that wellness programs are just about the best single investment in cost containment because they do not have to cost a great deal of money. And if the programs can get people to start thinking and acting differently about them-

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<sup>1</sup> Editor's note: For further discussion of retiree health insurance, refer to Chapter XV.

selves and their lifestyles, the payoff—in terms of a reduced need for health care in the future—can be tremendous.

### ***Nursing Homes***

In the past quarter century, nursing home expenditures have grown faster than any other component of the health care market. From a base of \$480 million in 1960, they reached \$28.8 billion in 1983, for an annual increase of 19.5 percent. The nursing home population also increased from 470,000 to 1.4 million. The public share of nursing home costs increased from 28 percent in 1960 to 55 percent in 1982. Medicaid now accounts for 89 percent of the total public payments to the nursing home industry. Whose responsibility is the future cost of caring for the elderly?<sup>2</sup>

### ***Indigent Care***

Questions of corporate responsibility go beyond the care of the elderly in nursing homes to the broader issue of uncompensated indigent care. One effect of cost containment has been the inability of hospitals and other providers to shift the costs of indigent care onto the shoulders of those who could afford to pay.<sup>3</sup> Should employers that previously covered the cost of that care now pay a moral debt to society in another way?

The National Health Policy Forum informally surveyed representatives from leading corporations and such organized industry groups as the Washington Business Group on Health and the National Association of Manufacturers to get an idea of where the corporate community stands on the issue of financing for those who are uninsured or underinsured. In the survey, the representatives indicated that business should and would be prepared to meet societal obligations and continue to bear a significant portion of those costs. Most agree that research must be done to accurately identify target populations, determine the legitimate costs of indigent care, and develop solutions through local, community-based initiatives rather than major federal reforms.

But these are broader issues best left to another discussion. Now that I have laid out some of the many possibilities that should be considered when developing a benefit plan, let me present to you

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<sup>2</sup>Editor's note: For a discussion of financing long-term care, see Chapter XVI.

<sup>3</sup>Editor's note: For more discussion of how indigent care may be financed, see Chapter XIV.

what I think is the best approach to all of the topics I have mentioned: case management.

### **What Is Case Management?**

An employer, when designing a benefit plan, cannot know what will best suit each individual who will use the plan. What may be right for one will not be for another; yet many health benefit plans do not offer enough room for variations that could save money. A person who could receive adequate care as an outpatient could wind up in a hospital instead because hospitalization is covered under the benefit plan.

Case management offers the flexibility to run the gamut of employee needs because it provides consumers with no more and no less than those needs. This approach involves identifying a person's needs and problems, then "managing" that person back to wellness according to those needs.

A key component of cost containment is ridding the system of overutilization of services. Case management means that an employer can rest assured that any utilization is a result of predetermined medical necessity. Case management provides quality medical care to those who need it but at the same time controls the cost of that care.

An estimated 80 percent of today's health care costs are incurred by 20 percent of the insured. What I am saying is this: Hire some qualified personnel to manage that 20 percent. Take the initiative to adopt a more active role in working not only with physicians but with home health care and social service agencies and whoever else can help care for these high-cost patients.

Case management involves assisting the patient in the decision-making process by providing counseling from medical professionals. In addition, case management

- helps patients obtain second opinions, understand the available medical options, and make the best decisions;
- educates insured employees and dependents to become more prudent purchasers of health care services. In this process, a third party does not make decisions for the patients. They do it themselves, and they learn in the process;
- provides such long-term benefits to a company as assurance of appropriate care, avoidance of unnecessary treatments, elimination of marginally effective procedures, increased involvement in life-style-

improvement programs, reduction of future health risks, and proliferation of informed choices from among treatment options; and

- offers quality services, whether for alcohol or drug treatment, mental health problems, rehabilitation therapy, or care for such chronic illness as multiple sclerosis.

The degree of management differs according to each case. Obviously, the amount needed for removal of gallstones will differ from that for alcoholism rehabilitation. Still, all take some form of individual examination and identification of how each person's needs can best be met.

Case management is not an attempt to take shortcuts in the provision of health care services. Rather, it is a systematic approach to offering quality services to employees while at the same time getting the best value for each health care dollar. The objective is to trim the waste out of the system.

Case management is not new. It has been practiced informally for years by physicians, social service agencies, and hospitals in meeting the individual needs of clients and patients. Now, however, case management is becoming a more formalized process and a viable strategy for a comprehensive health benefit plan.

### ***Types of Case Management***

I have already touched upon some elements of case management, including HMOs, preadmission screening, and utilization review. Some insurers and providers consider these to be forms of case management, but I suggest that simply monitoring or limiting services is not enough. Instead, these aspects must be integrated into a comprehensive case management process that combines assessment, planning, coordination, referral, treatment, progress monitoring, and, most importantly, determination of future needs.

Comprehensive case management must be tailored to the needs of the individual and so, to be truly effective, should include social as well as medical considerations. If allowed a broad range of options, comprehensive case management can handle any health-related problems an employee may have, ranging from chronic illness to a one-time surgical procedure.

Such strategies could include provision of extra benefits and selective waiving of restrictions to care, limiting open-ended free patient choice, and facilitating information transfer and coordination of care among health professionals who normally have no regular interaction.

There are three general forms of case management. The first, *social case management*, is often a key way to address the needs of retirees and the elderly. Most older persons do not suffer from a disabling condition despite the fact that the elderly as a group are more prone to chronic illness. Yet the elderly often have minor medical or social needs. If those needs are addressed through case management, institutionalization often could be prevented or delayed.

*Primary-care case management* is more medically oriented. A physician or other qualified person provides primary care and regulates other health service needs, including specialty referrals, hospital admission, and coordination of a patient's care while in the hospital.

The third form, *medical/social case management*, is geared toward those who have been or could be institutionalized, such as stroke victims needing rehabilitation, arthritic patients who could remain at home with the help of others, or the terminally ill who could return home from the hospital with the help of home health care workers or a hospice program.

Not all of a company's employees, retirees, and dependents would need all of these services, but it is important to design the program so that those who do need them have access to them. Sometimes these broader options for care will be more expensive, but keep in mind that case managers are trained to select the least costly mode of care. The higher expense for one case will be offset by healthier employees who need very few services.

### **Employee Concerns**

To many employers, close involvement in employees' personal lives, life styles, disabilities, and need for medical care is a foreign concept. They see such involvement as an intrusion, as do many employees.

Now, however, employers can no longer afford not to get involved to insure that health care services are being properly utilized and costs are being properly controlled. Employers are beginning to realize that management of their employees' medical needs is too important and too expensive to be left to the providers, and so they are becoming involved themselves.

If comprehensive case management is implemented properly, employees can be made to understand the benefits on both sides. But an employer must be willing to stand up to invasion-of-privacy charges by saying: "Yes, I am trespassing, but I have a right to because I also am paying the bill. As long as I am paying the bill, then I will have to trespass on your privacy. I, as an employer, am no longer going to pay for something without guarantees that it is needed." Times

have changed, and in this new era an employer's representative will be looking over the shoulder of health care consumers.

I think you will find that employees, given adequate information, incentives, and assistance, are both willing and able to be cost-effective health care consumers. Patient involvement in the health care process is the key to success. But regardless of their understanding, employees must learn to play the game by the new rules. They must learn to be responsible in their health care choices, or they will pay more. To be reimbursed, they will be subject to case management.

The same hard scrutiny must be given to physicians. Alexander Leaf of the Harvard Medical School has found that an estimated 15 to 30 percent of what physicians do is ineffective, too expensive, redundant, or outright harmful. In most cases, however, it is difficult to determine which of the 15 to 30 percent of physicians' activities fall into those categories. We can no longer afford to take a doctor's word for it. If one doctor says a treatment is needed, we will ask another to be sure.

I admit this is a relatively new concept. Many employers have never thought of inserting themselves into medical decisions and situations, and it goes without saying that an employer that misuses information received from or about patients opens the company door to discrimination and other charges.

But this is just the beginning. The results will be too good to ignore.

## **Effectiveness and Examples of Case Management**

Although I wholeheartedly support the concept of case management, I admit that questions remain as to its proven effectiveness. Although forms of case management have been introduced in about 20 state Medicaid programs, most have been operating less than four years and their effectiveness has not been determined. Many private-sector programs incorporate elements of case management, but it is difficult to isolate the effects of those components to determine cost-effectiveness.

Case management as a comprehensive strategy is a relatively new idea, as is evidenced by the estimate that less than 1 percent of the nation's employers currently use it. Other statistics show more companies are beginning to use different aspects of case management. A Health Research Institute (HRI) survey of the nation's 1,500 largest employers indicated that the number of companies using concurrent utilization review, one component of case management, grew from

4.1 percent in 1981 to 17.3 percent in 1983.<sup>4</sup> That survey also indicated that reductions for some companies reached 25 percent in continued-stay days, 19 percent in length of stay, and 15 percent in surgeries, with a 25 percent first-year savings for some.

One company responding to the HRI survey reported savings of \$4.5 million on 110 cases. Average savings were more than \$41,000 per case, with some per-case savings topping \$100,000. HRI research indicates that case management could save 8 to 10 percent of paid claims if externally provided, and even more if internally provided.

At Owens-Illinois—as a result of case management, the second-opinion process, education, and counseling programs—the estimated reduction in hospital stay for salaried employees was 655 days in 1983. Savings were estimated at more than \$260,000. Avoided surgeries and shortened hospital stays also reduced the number of work days lost to health care problems, for an estimated productivity gain of nearly \$90,000.

One midwestern company obtained good results after hiring a coordinator to advise employees on how to use health care systems, to monitor the use of benefits, and to act as liaison between the company, the plan administrator, and providers. That company reported that hospital days per 1,000 covered employees and dependents dropped from 825 to 688 in the first year of the coordinator's activities.

Another example of internal case management is the Chicago-based Lindberg Corporation, which implemented a health management program in 1983. The program counsels employees about hospitalization and other services and helps them make cost-effective decisions. As a result, Lindberg built a \$342,000 surplus in its self-funded account by the end of calendar year 1984, which allowed a 20 percent health premium reduction to be applied to each of the company's divisions.

Other examples: A 17-year-old girl suffered a spinal cord injury after a skiing accident, and was hospitalized for intensive physical and occupational therapy. A special facility could have provided the same therapy during the transition home but was not covered under the insurance contract. The case manager arranged for payment, resulting in an estimated savings of \$57,000. A teen-ager became a quadriplegic after a car accident and underwent a lengthy hospital stay. To get the patient out of the hospital faster, his home was mod-

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<sup>4</sup>Editor's note: Additional survey findings are discussed in the Introduction and Background.

ified to include wheelchair ramps, an expanded bedroom, enlarged doors, and a remodeled bathroom. A ventilator and respirator also were purchased. Despite those expenses, six-figure savings were projected in the case.

Despite a lack of comprehensive, conclusive research results, case management makes sense, if only from the perspective that an employer, confronted with a myriad of health care choices, can well appreciate the coordination of services provided by this strategy.

### **Administration of a Case Management Program**

Crucial to a successful, comprehensive case management program are accurate data, sufficient planning, adequate funding, and taking the time necessary to implement the plan into the organizational structure.

Companies that have historically not played an active role in employees' lives should carefully plan implementation of case management so their intentions are not misconstrued. A company considering this approach also should examine past experience with illnesses and conditions that often are good candidates for case management. These are often costly and long-term, such as organ transplants, burns, high-risk infants, major head trauma, cancer, and psychiatric, respiratory, or cardiovascular conditions.

A key ingredient in case management is building a relationship of trust with employees. Case managers should be fully trained in patient counseling and cost-effective health care alternatives. They should have the authority to act in a clinical capacity to grant waivers of second opinions due to timing, lack of a qualified second-opinion physician in the patient's location, and other appropriate variables. They also should be available to answer questions to clarify surgery decisions and to provide counseling on a wide range of health care subjects.

It is likely that comprehensive case management will incur additional costs because of the additional personnel needed to provide the service. But the point is this: Traditional insurance does not manage individual cases from a cost-savings standpoint. If you properly manage each case, particularly the high-cost users, you will make up the additional cost. The old adage says you have to spend money to make money. The same thing applies to containing health care costs. You have to spend some money to save money.

Cost savings can be achieved in the short term by using one or more of the many case management options available. But often, use of



one will just shift costs or will fail to eliminate ineffective practices. For example, if utilization review succeeds in lowering use, health care suppliers can raise the price per visit to make up for the decrease. If use of more-efficient delivery sites is encouraged but not required, less-efficient facilities will continue to drain benefit coffers.

A good rule of thumb is that for every dollar you spend, you can expect to save \$3 or \$4. Some providers promise savings of \$10 or \$12, but I doubt those figures are realistic. Be conservative in your estimates.

It is important to remember that cost savings are more likely to result from long-term rather than short-term case management programs. Time is required for both providers and patients to accept and use case management effectively.

Case management can be provided internally, externally, or from a combination of both sources. Accurate, extensive data are required when making these choices. Case managers charge for services in numerous ways, most frequently per capita monthly rates and fee-for-service charges. A general guideline might be that an employer could expect to pay up to \$2 per employee monthly for a full range of case management services or about 1 percent to 1.5 percent of paid claims.

Companies that are self-insured might consider a third-party administrator or an organization selling a complete case management program. If such a program is unavailable in your area, multiple specialists might be needed. Having a dozen specialized case managers is not the ideal situation, but if enough companies create a market for this strategy, we will soon find experts in managing all components of a program.

By the way, many major insurers think they can offer comprehensive case management now, but I have yet to see one that truly can. I give credit to a number of insurance companies trying to address those kinds of needs. They see the signs on the horizon that case management is here to stay.

## **A Solution for the Future**

Many employers already use case management for pieces of their health benefit programs, such as psychiatry, pregnancy, and medical/surgical second opinions. The most effective use of case management, however, is to take all of those pieces and put them into one well-rounded, comprehensive package, and concentrate on the 20 percent of the users who generate 80 percent of the costs.

Employers are beginning to recognize the benefits of this approach in lowering health care expenses. Health care insurers and providers also are realizing that their costs do not have to climb in order for them to remain profitable. Improved efficiency also can lower costs.

Comprehensive case management is the solution to quality health care in the future. I encourage employers to begin to develop case management as their choice of a health benefit program.

## **VI. Cost and Utilization Management from Within**

Patricia M. Nazemetz

To put health care management in the proper perspective, we need to consider it within the framework of the business climate in which we operate.

The cost of health care is a major expense for Xerox just as it is for most U.S. corporations. Along with the recognition of the magnitude of health care cost comes the realization that these costs must be managed, as are other corporate expenses. Health care decisions must and will be made with sound business judgment. Management must consider the impact of health policy decisions on the state of the overall business.

One thing has become very clear in the past several years. The marketplace where Xerox does business is changing. Competition continues to intensify and will remain a way of life. We have had to change the way we respond to the marketplace to meet that competition. This has required a complete reevaluation of every phase of the business, including human resource programs. We have had to reconsider the way we do business and determine how we can work smarter, more efficiently, and more effectively.

### **Xerox's Philosophy**

Out of our introspection and reevaluations, we have set our philosophy, which in turn has influenced our business priorities and directions. The key points in our philosophy are these:

- we succeed through satisfied customers;
- we aspire to deliver excellence in all we do;
- we require premium return on assets;
- we use technology to develop product leadership;
- we value our employees; and
- we behave responsibly as a corporate citizen.

Each of these tenets has a profound influence on how we do business. The last two in particular affect our human resource programs,

as does our requirement for a premium return on assets (since this, in turn, drives cost management).

Our business priorities flow from our corporate philosophy. Currently, our key priorities can be stated as follows:

- improvement in return on assets through cost reduction, profit improvement, cash usage, and asset utilization;
- customer satisfaction; and
- market share.

### **Efficient Cost Management**

Managing our costs carefully and efficiently is thus a chief priority in every phase of the business, including human resources. The questions are these: Are we buying the right products and services? Are we paying the right prices? Are we getting the right return—quality and “customer” satisfaction—for our investment? If the answers are not affirmative, what do we need to do to improve the outcomes?

Interestingly, in targeting customer satisfaction as a priority, we can identify three distinct customer populations:

- our traditional customers, i.e., those who purchase our products or services;
- shareholders—those who invest, through stock purchase, in the future health of our business; and
- our employees, through whose efforts we serve our traditional customers and generate a favorable return on our shareholders’ investments.

Management’s goal is to develop the right balance among these groups to create a supportive interrelationship and to minimize or eliminate conflict. This goal has implications for the human resources strategy. It becomes the job of the human resource specialists to find the right balance between cost efficiencies and employee needs, or, more simply, between the company’s financial and human resources.

There is a common link that unites the needs of employees with the cost effectiveness of running the business. That link is productivity. Improvements in productivity result in greater cost effectiveness. On the other hand, properly motivated, healthy employees will be more productive. So, finding a way to keep employees healthy and properly motivated should find a way to the company’s bottom line.

## **Changing Human Resource Environment**

The human resource environment in which we operate is an evolving one. We have moved from a predominance of what was once considered a "traditional" work force and family structure, i.e., employed male head of household with a wife and children at home, to a much greater work force diversity where the "traditional" employee has become a minority. This diversity is likely to continue. We have moved from a time when employees could be expected to work for one or two employers for their entire careers to one where employees enjoy much greater mobility and may have many employers throughout their careers.

Our work force is aging and will continue to do so into the foreseeable future. Until recently at Xerox we had very few retirees compared to our active population. Those whom we hired in our explosive growth years in the 1960s are now nearing retirement eligibility. Our retiree population has increased significantly during the past few years and will continue to do so into the future.

We have gone from a climate that fostered the concept of a full-time "permanent" work force to one where the realities of competition and the uncertainty of the economy have required reductions in our work force. To reinstitute stability in employment we must consider a "buffer" work force concept. This would allow us to maintain a regular, full-time work force with a maximum sense of permanence while offsetting changes in manpower needs by filling the gaps with temporary and/or part-time "buffer" employees. This means that, with respect to some human resource programs, we are moving away from a history of a work force that is fully covered for all of the benefits provided to employees. We are moving toward one with more restrictive coverage criteria and possibly to a potentially uncovered buffer work force that cannot participate in many of the employee benefit programs. This dilemma needs to be studied carefully to properly weigh and balance the financial and human resources.

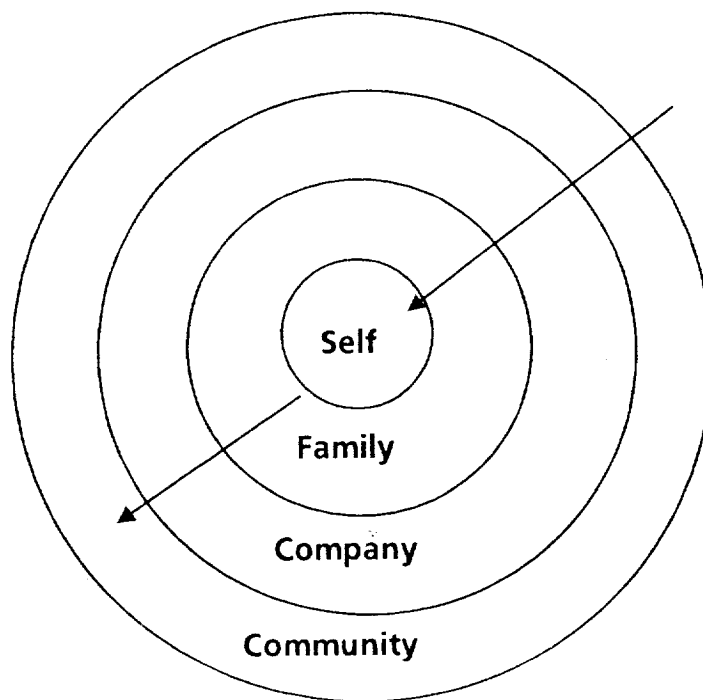
As we find ourselves in the midst of an evolving human resource environment we must continually reassess the nature and value of our employee programs. We must make the changes necessary to manage these programs to the needs of the employees while keeping in focus the long-term needs and goals of the company.

## **Managing Health Care Programs**

Key among the programs that need careful monitoring and management are our health care programs. These programs, potentially

viewed as parts of an overall health care plan, include medical and dental reimbursement plans, disability income, workers' compensation, occupational safety and health, employee assistance, and health promotion. The role of our health care plans is to help employees meet and effectively deal with their health care needs and those of their families. They are also intended to help employees maximize their health potential and to maximize safety and health in the work place and in the community environments where we live and work.

Graphically, our health and safety model can be illustrated in the following way, by adapting a model used by our Japanese associates at Fuji Xerox.



This demonstrates the multiple layers of responsibility as well as dependency. Employees have a responsibility for all aspects of their health—improvement, safety, prevention—as well as for the health of their family members. They also have a responsibility to help maintain a safe and healthy environment within the company and within

the communities in which they live and work. Conversely, employees depend on the community as a source of health care support and services. They depend on the company, which has a responsibility to employees and their family members to provide a safe and healthy work and community environment as well as appropriate programs to support the health care needs of employees and their families. Company attention must also be given to the health care needs within the community, particularly with respect to environmental safety and health.

Like the human resource environment, the health care environment in which we operate is also evolving. In the past few years, change in the health care system has become more pronounced and our efforts to address a variety of health care issues have intensified. As we find ourselves in the midst of constant and significant change, we attach a new importance to the need for a clearly established direction in which to set corporate health care policy.

### **Goals**

Our goals include greater and better-articulated coordination among the functions within the corporation with responsibility for various aspects of health, greater integration in the design of different health care programs, and, hopefully, better management of costs. To accomplish these goals we will need to spend more time with research and development, i.e., pre-implementation of a program. With the stakes so high from both a health-status and financial standpoint, it is important that as we develop or change our health care programs we "get it right the first time."

A coordinated, strategic approach to health care will give us the ability to respond to health care changes, like new technology, new diagnoses, new forms of treatment, etc. We will then be much less reactive and in a better position to *manage* change.

### **Recent Design Changes**

In recent years, we have moved from a health care reimbursement system based solely on a fee-for-service (FFS) mechanism to one that incorporates not only plan redesign to improve incentives for appropriate utilization in the FFS program, but also the inclusion of alternative delivery systems (in our case, health maintenance organizations). Our efforts will not stop there, however. We need to take the next step to managed care systems. We are developing a plan that will move us in that direction.

Historically, we focused our attention and negotiating skills on our dealings with insurers to obtain the best possible premium for the richest possible benefit program. Within the last decade, we very adroitly changed our focus from insurance to administrative services contracts, crediting ourselves with the financial gains that resulted from the release of insurance company reserves back to the corporation. We also felt that we had better control over retention-type costs by moving out of the insurance arena and into a purely administrative one. As a result of these efforts, we discovered that we were managing the 5 to 10 percent of plan costs associated with administration while the remaining 90 percent or more was virtually unmanaged.

Not until escalation in health care costs began to exceed 20 percent annually did we begin to focus on the management of total plan costs. Our first steps toward this management have been taken through plan redesign. We have addressed the inconsistencies within the plan that led employees to choose a more costly form of health care in order to reduce or eliminate *their* out-of-pocket costs. Inappropriate use of hospital emergency rooms and unnecessary hospital admissions (for procedures that could be performed in another setting) were among the preferred employee options under the old "first dollar" plan design. This is not surprising, since these courses of treatment were "free" to employees, requiring no cost sharing on their part. Under the new plan design, the place of treatment no longer dictates plan reimbursement levels. Employees receive equal reimbursement no matter where they receive their care.

Since employees now share some of the cost for all of their care, their incentives in using the health care system have been reversed. It is now in their financial interests to select the most cost-efficient form of health care available. Just as they minimized their costs under the old plan by using a hospital setting for care, they are now minimizing their costs by getting treatment in nonhospital settings when there is a choice. For example, in the first year of the new plan, overall hospitalization decreased by more than 20 percent, while surgical admissions dropped by 30 percent. Hospital admissions for elective surgical procedures declined by 38 percent over the prior year. Claims for less than \$500 for use of hospital outpatient facilities decreased by more than 20 percent. However, medical claims (nonhospital and nonsurgical) decreased by only 1 percent. These utilization changes continued through the second year of the plan (1985), when a slight decrease over the 1984 claim levels was realized. The plan design appears to be working.



### ***Easing the Transition from Old to New***

To ease the transition from the old plan to the new and to ensure that the cost-sharing approach of the new plan did not discourage access to the health care system when appropriate, we established flexible spending accounts for employees. These accounts address a variety of needs, from helping employees to meet the expense of deductibles and copayments, to facilitating the purchase of preventive care not otherwise covered by the health care plan (old or new). And although the plan deductibles and limits on out-of-pocket expenses are tied to employees' pay, the flexible spending account is the same for all employees and is currently more than the average deductible.

### **The Next Step: Purchaser-Directed Competition**

While the redesign of our health care plans has been a very positive step in the direction of managing health care costs, it is not a final step. We now need to turn our attention and our negotiating skills to provider contracts. Until recently, providers have controlled the health care market in a very noncompetitive environment. Recent attention and pressure on the health care system has created some provider-driven competition as alternative delivery systems begin to compete for market share. Major employers, acting as health care purchasing agents in the process, have attempted to encourage competition by encouraging diversity and (in some cases) requiring some greater utilization efficiencies. From Xerox's perspective, the next step is toward *purchaser-directed* competition. In collaboration with the provider community, we will begin to define the health care products and services that we want to buy. We will develop provider specifications that will allow us to design plans that are tailored to the health care needs of our employees and the long-term objectives of the company.

We realize that the purchase of poorly defined products and services at undefined prices is not consistent with good business practice. It does not meet the standards of the quality improvement process that is applied to every other aspect of our business. While we have taken steps toward cost containment, through plan redesign and expansion of alternative delivery options, we continue to purchase off-the-shelf products that do not necessarily meet our customer requirements. A logical "next step" will be to define our customer requirements for health care products and services, with the appropriate input from the provider community. Then we will be in a position to request

proposals from providers and select those that can conform best to our specifications.

### ***Select Provider Program***

Within the company there is already a model that we will use for the select provider process. That model is our central commodities management program (CCMP). The goal of this program, started over five years ago, is to reduce the number of outside vendors used at the company's North American manufacturing division to 10 percent of preprogram levels while improving quality and productivity and thus reducing costs. During the five-year life of the program, the number of vendors has been reduced from more than 5,000 to about 450.

Standards set for the vendors require 100 percent conformance to our customer requirements. Systems are in place to monitor and measure conformance to specifications and quality improvements. CCMP has significantly diminished the need for an internal quality-control function. Through the program's planning, the quality control is built in at the front end and the primary responsibility for quality rests with the vendor.

To realize these significant results, we worked with several of our key vendors from the onset of the program to develop realistic, achievable customer requirements that would result in products or services of the highest possible quality. Once the vendors are selected, they are included in training and educational efforts along with their Xerox counterparts. This helps to solidify the partnership and eliminate surprises. The selected vendors become a part of the team.

Although the standards are high and conformance to Xerox specifications is rigorously maintained, the opportunity for increased market share makes the conformance feasible and desirable for most vendors.

Many of the parallels between CCMP and our select provider program are obvious. We intend to follow CCMP's lead to develop provider specifications for benefit levels, service requirements, quality standards, and price. Our goal is to identify our customer requirements and to collaborate with our key "suppliers" in the provider community to develop product or service specifications that meet those requirements.

We realize the importance of developing measurement systems up front, including a customer satisfaction measurement mechanism, that allow all the parties involved to determine if we have achieved conformance to customer requirements. The measurement system must allow us to determine if service and quality standards are being met and if benefits are being delivered at the right level for the ne-

gotiated price. Conformance to service standards will be determined through employees' input, since as end-users they are in the best position to measure this. Customer satisfaction measurement surveys, like those used in other areas of our business, will be used for this input.

Measuring quality will be much more difficult. The key will be to identify and agree upon those things that are appropriate quality indicators, at the onset of the program. For example, we may need to consider time lost from work, hospital readmissions, relapses, infections, etc. While these measurements may need to be refined over time, they must make sense and be feasible at the onset.

As with CCMP, our select provider program is intended to refine and focus our provider programs. We hope that it will allow us to sift through the ever-expanding delivery systems and to reduce the number of systems with which we deal to a manageable and appropriate *few*. For providers selected to participate in our health care programs, they too will have an opportunity for increased market share. As with our vendor program, our goal will be to engage the select providers in a partnership with Xerox (and our employees) to share in the risks and rewards of our health care strategy; to effectively deal with the health care needs of employees and their families; to maximize employees' health potential; and to improve safety and health in the work place and community environments.

As we evolve toward select managed care systems, the fee-for-service system is likely to diminish in importance. While it will continue to be available, it will require greater levels of cost sharing on the part of employees and will have reimbursement levels that are driven by the managed care model.

The task of developing a select provider program will require time as well as coordinated efforts of several functional areas within the corporation. The medical benefits, disability, and occupational safety and health staffs, as well as the employee assistance and wellness program managers, will be working together to ensure that the customer requirements of each of these functions are adequately represented and that common goals are established at the onset of program development.

We will need to coordinate products and services as well. We must identify those services that can be provided best from within the company and those that should be purchased outside. For example, programs such as employee assistance, health education, and work-site safety must be evaluated to assess the need, and therefore the scope, of the programs. We must then determine the best source (or

combination of sources) for a product or service to meet that need. We also need to identify special market segments that may require unique or specially tailored programs. For example, psychiatric care or "super-catastrophic" care such as organ transplants may need special consideration. It is not yet clear how these situations will get factored into the total program. But as many contingencies as possible will be addressed in the early stages of program development.

## **Summary**

In summary, we intend to develop a health care purchasing program that enables us to apply the logic and discipline involved in any major business decision requiring the significant financial expenditure of even a fraction of our health care program cost. As with other business decisions, a key objective is to minimize and manage risk whenever possible. Our goal is to manage not only the financial risk to Xerox but the health risks to employees and their dependents as well. We intend to help employees improve their health through the right use of the health care system, for the best (and most manageable) cost to the corporation.

## **VII. Managing Employer Costs through Market Influence**

Patricia Dempster

My role at this forum is to concentrate on the influence of health care coalitions on the pricing and provision of health care services in their communities. As chairman of the Employers Health Care Coalition of Los Angeles, I am also involved with the California Council of Employer Health Care Coalitions, which is a coalition representing the 13 coalitions in California.

Managing health care costs is a very complex issue. When medical insurance costs began rising at 20 percent per year during the late 1970s and early 1980s, corporations like TRW began looking desperately for ways to manage these costs. By that time we were familiar with inflation, but these medical costs far outstripped inflation and there was no end in sight.

Most companies began their cost-control programs by becoming more prudent purchasers. They, as well as TRW, negotiated with their carriers to control the costs for handling the medical benefits. There were reduced retention fees, minimum premiums, administrative-service-only contracts, and multiple combinations thereof.

It became obvious, however, that influencing the administrative cost of providing medical benefits—the 5, 6, 7, or 8 percent of the total cost—was certainly not doing the job. Somehow we had to affect the other 92 percent or more of the cost.

Employers like TRW were very reluctant to reduce benefits. We had built reputations with our employees of having “good” benefits that were responsive to the needs of our employees and their families. We attracted the high-quality employees we needed, in part, by offering attractive benefit packages. Therefore, we introduced a series of positive programs—voluntary second surgical opinion programs, hospice care, outpatient preadmission and posthospitalization testing, outpatient surgical benefits, and the like. These programs were all good, but they were nowhere near adequate to the task. The costs kept on rising.

### **Emergence and Development of Health Care Coalitions**

During the late 1970s, the notion developed that health care coalitions might be helpful in controlling these runaway medical costs.

Although they are just one tool among many being used to deal with escalating costs, health care coalitions have a particular appeal. They are nongovernmental. There are no regulations. There are no compliance agencies or reporting requirements to deal with. The people involved in coalitions are the employers and sometimes the providers that have a direct interest in the actions and outcomes. They can channel their energies to those action items where they can realize the greatest impact on cost. These items may be different from community to community. If the coalitions are no longer needed or no longer effective, they can disband without any residual bureaucracies, taxes, or obsolete laws on the books.

Memberships of coalitions vary. Many are provider/employer coalitions, but I think most of them are employer-only coalitions. The most frequently reported interest group is business. Activities include education of members, surveying members for information, benefit design, and data studies. Other activities are communications programs for employees, legislative advocacy and analysis, and alternative delivery systems. In 1977, TRW in the Cleveland area was instrumental in founding the first health care coalition in the U.S. It was a coalition involving employers and providers that met monthly, and a great deal of energy was devoted to working together and formulating plans of action. They were successful in gathering data on hospitals and occupancy, and on the number of available beds in the Cleveland area, thereby preventing some costly further building.

They learned, however—as companies, providers, and coalitions throughout the country have learned—that the subject of controlling medical costs is extremely complex and rapidly changing, that there are many constituencies involved, and that we are not dealing with a simple supply-and-demand system. There is no end to the creativity of those who would like a share of that very large pie—10.7 percent of the Gross National Product in 1985.

During the 10 years since that first coalition was formed, health care coalitions have emerged at an ever-increasing rate. Some, including the Cleveland-area coalition, have gone out of business; most have changed or evolved from their initial ideas. All, however, seem to be dedicated to the notion that by working together they can identify issues and concerns of all the constituencies and begin to influence the system.

Coalitions have directed their attention in many directions. Some have formed preferred provider organizations (PPOs); others have become heavily involved in the legislative process. All have become educational forums for their members.

In the quest for medical care cost management, companies and coalitions are discovering the marketplace is shifting and ever-changing. We initially discovered that about 40 percent of our dollars were going to pay hospital bills. Coalitions looked at hospitals and identified costs per day, costs per stay, length of stay, the number of beds compared to norms, the mortality rates, the infection rates, the services provided or not provided, which hospitals were profitable, and which ones were losing money. We studied cost shifting, hospital audit programs, utilization review, precertification programs, and concurrent review programs. Our member companies changed their plan designs to provide incentives for outpatient surgery, home health care, and skilled nursing care facilities. Changes have occurred! We find that the average length of stay has been reduced; more surgeries are performed on an outpatient basis; and, due to the fact that the more severe surgeries are performed on an inpatient basis and the daily services are more intensive, the average cost per day in the hospital has increased.

But companies and coalitions are finding that hospital costs as a percent of total medical costs have not been substantially reduced. We have an older population in the U.S.; surgeries and procedures are performed today requiring lengthy hospital stays for the same types of patients who would have died a number of years ago; and hospitalizations for mental, nervous, and substance-abuse illnesses are on the rise.

Two marketplace areas that are receiving coalition attention these days are the quality issue and how to provide care for the medically uninsured.

## **Quality of Care**

As we have increasingly turned our attention to the price of medical care by offering PPOs, publishing the charges of local area physicians and hospitals, and providing incentives for our patients and families to examine their hospital bills and use less-expensive settings for care, we must become concerned about how we measure the quality of care. In the past, employers did not worry about quality. The employee/patient chose his or her physician, who in turn selected the hospital. Quality was the individual's problem.

Quality medical care, however, is not necessarily inexpensive. If we are encouraging our employees to use less-expensive physicians or hospitals, are we pushing them in the direction of lower-quality medical care? How do we determine which physicians provide a high

quality of medical care for a competitive price? How is quality measured? Employers working with the provider community in a coalition can begin to examine these issues and develop community standards or measures. Employers certainly cannot do it alone.

### **Uncompensated Care**

The issue of uncompensated care is also extremely complex.<sup>1</sup> The Consolidated Omnibus Budget Reconciliation Act of 1985, which requires the extension of medical benefits for widows or widowers, divorced spouses, over-age children, and laid-off or terminated employees will reduce the number of people without coverage. But it will not solve the problem by any stretch of the imagination.

There are numerous programs for providing medical care for those unable to afford the care. Unfortunately, there are many people who either do not qualify or do not understand and apply for these programs. These people often receive care at inner-city hospitals that are shouldering far more than their fair share of the burden of providing care for the medically indigent. Some of these hospitals are the ones that are now threatened with bankruptcy because of uncompensated care and reduced occupancy.

Employers have, to a large extent, ignored these problems. But health care coalitions working with the provider community can help develop some strategies. At the very least, they are in an ideal position to publicize the issues and enlist the aid of their companies or influence legislation to make sense out of the current plethora of programs for the medically needy. Although another tax is abhorrent to most of us, Florida has instituted a tax on hospital bed occupancy with the proceeds going to those hospitals that provide care for which they receive no compensation.

### **Health Care Coalitions Today**

The American Hospital Association's (AHA) Office of Health Coalitions and Private-Sector Initiatives publishes a directory of health care coalitions in the U.S. from data provided by the individual coalitions. According to the AHA, the number of coalitions increases each year. In December 1985, there were 151 operational and 14 developmental coalitions in the U.S.

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<sup>1</sup>Editor's note: For more information about indigent care, see Chapter XIV.



Coalitions are expanding their memberships. The number with paid professional staff has doubled. The number with a cash budget has also doubled. Coalitions are operational in 40 states and Washington, DC, and exist in all but six of the 100 largest cities in the United States. Ninety-one are incorporated.

The Los Angeles Employers Health Care Coalition is made up of over 30 of the largest employers in the Los Angeles area. We have business and government employers as members. We have providers as advisors. They are not members, they are non-dues-paying and nonvoting. The advisors clearly understand what we as employers are trying to accomplish, and they have been very supportive and helpful. We do not always agree. Some of our discussions are heated, but there is usually good will and understanding on everyone's part.

Our biggest project in the Los Angeles Coalition has been a data tracking project, which we have done for four years. The most recent information from the project is from our 1985 study, which included data of nine of our companies, representing 151,666 lives in the Los Angeles area and \$136 million in claims, or \$897 per insured. That is a high number for most people to accept.

Some of the study's numerical highlights show a per capita increase of 13 percent over the prior year, an increase in inpatient daily hospital costs of 3 percent, and a 3 percent decrease in admissions. The average length of stay, however, went up 6.4 percent, and the number of patient days increased 4 percent. Overall data showed an 11 percent increase in the average charge per admission to \$6,919 and a 3 percent increase in the average per-day hospital charge to \$742. All of that increase was due to rises in ancillary charges.

Those are cost issues. One area we regard as a quality issue is the percentage of baby deliveries done by Caesarean section. Twenty-six percent of the deliveries to employees of the nine employers in the study were done by Caesarean section. The national average is 21 percent.

Looking at plan usage in relation to that of other large employers in the same market enables the benefit managers involved in our coalition to determine whether their companies are part of the trend, are bucking the trend, or are unique. We are finding that national norms are not very helpful. Comparing ourselves to other companies in the Los Angeles area is about the most helpful comparison. It also gives benefit managers feedback on the effectiveness of past design changes and pinpoints areas for future change. These data for the Los Angeles area are especially helpful as it becomes more evident that medical patterns of practice do vary from area to area, and that illness

patterns vary. For example, our study showed that 40 percent of the hospital days during 1985 for the nine employers represented was for psychiatric care and substance abuse. I hope that is not a national pattern.

At each coalition meeting, we also have an employers' roundtable discussion to update each other on plan design changes and results of data collected on such changes to show whether they are effective. We compare notes on approaches in dealing with hospital costs through PPOs, health maintenance organizations (HMOs), or individual contracts with hospitals. Ninety-five percent of the companies in the coalition have redesigned their plans, and 75 percent now have pre-certification or utilization review.

PPOs, HMOs, and contracts with hospitals abound. Member companies have set the pattern for other companies in the Los Angeles area. Some of our members have stated that the roundtable discussions we have at each meeting are worth the price of admission all by themselves.

It is hard to measure our success. The hospitals in southern California say to us, "You're getting to us. Our occupancy is down; our costs keep on going up. You're really hurting us." But when we read data about the profitability of hospitals, we find that many of them are still quite profitable.

Our cost per covered life in 1984, as I mentioned, increased 9 percent over 1983. For the prior year, the increase was 15 percent. However, increases in medical costs nationwide abated somewhat during that same period of time. In 1985, our cost per covered life increased by 14 percent over 1984.<sup>2</sup>

As for future actions, we are very interested in seeing how we can get at the quality-of-care issues. One of the things we intend to do is share information about some of the abusing providers in the Los Angeles area. We hope to do this in a way that will not get us sued.

We are also looking at the data to figure out what can be publicized, and then publicize it all we can. The Los Angeles County Medical Association, one of our advisors, has agreed to help us look at some of that data and determine which we can have strong confidence in and can publicize. Each year the quality of the data has improved, and now we feel ready to go public. We intend to talk about specific hospitals and perhaps about specific areas of the city.

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<sup>2</sup>Editor's note: See the Introduction and Background for more discussion of health care costs.

Other health care coalitions have also been active. In San Diego, the Employers Health Care Coalition formed a coalitionwide PPO and required peer-review data on quality from every physician who wanted to participate. It became operational in November 1984 and has since been spun off as a separate entity; it is one of eight PPOs in San Diego. One small company, through the use of a PPO, reported that it saved between 25 and 30 percent in hospital costs. The coalitionwide PPO has become so successful that it is now establishing dental care, workers' compensation, psychiatric care, and substance abuse preferred provider networks.

The South Florida Health Action Coalition created a database for the selection of preferred providers by collecting provider-specific price and utilization data. Six employer members of the coalition went on to create their own preferred provider organization.

In St. Louis, the Business Only Coalition devoted its resources to assessing the financial conditions of the local hospitals and producing reports on each hospital's profitability. This information was used to dispel the notion that some hospitals had experienced tough times.

In Columbus, Ohio, the coalition, working with the local Blue Cross/Blue Shield association, published a buyer's guide for purchasing health care and distributed it to employees in its companies. The guide presents the average charge and length of stay for each of 40 hospitals for the 25 most frequently occurring diagnostic categories, such as heart bypass and tonsillectomy. It will be republished by the coalition without Blue Cross participation. I think it is an interesting approach. I am not sure how many people choose a hospital by picking the least expensive one, but perhaps the length-of-stay information is helpful.

In Arizona, the 1,200-member statewide coalition introduced hospital rate-setting legislation to control medical costs. This action gained the coalition a great deal of publicity and attracted several more pieces of legislation to be voted on, but it failed in a costly and public political confrontation with the local hospital industry.<sup>3</sup> When I say it failed, I mean it was not voted in. I am not sure that it failed entirely, however, if it raised the awareness of the voters in Arizona as to what was going on there with regard to hospital costs.

Coalitions have been instrumental in stopping the construction of new hospitals, killing legislation that would increase medical costs,

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<sup>3</sup>Editor's note: See "Voters Defeat Arizona Health Care Propositions" in *Employee Benefit Notes*, November/December 1984.

salvaging state laws that permit PPOs, and, in California's case, helping to preserve our state data-collection process.

## **Conclusion**

My enthusiasm is real. There is a limitless array of issues to confront, and new ones emerge every day. In a medical care delivery system as complex as ours, control in one area seems to create lack of control in another area. You push down here, and it squirts out over there.

Coalitions have had, and can have, an impact on local health care delivery systems by exercising market clout, gathering and sharing information, setting patterns, and forming, where needed, more efficient and effective medical care delivery systems.

William M. Mercer-Meidinger, Inc., an employee benefits and compensation consulting firm, conducted its ninth annual employer attitude survey,<sup>4</sup> obtaining opinions from 886 chief executive officers (CEOs) of the largest employers in the U.S. These CEOs believe the country still faces a health care crisis, and I think all of us would agree. They are, however, optimistic that large multihospital groups can increase competition among health care providers, cut costs, and improve the quality of medical care.

The CEOs do not have much faith in government as the primary solution to the problem. They do believe that by the year 1990 it will be employers and employer-provider coalitions that have the most effect on health care cost containment.

Employers must continue to search for new ways to control medical care costs. Today's program is not tomorrow's answer, as the market shifts and the needs change. Providers are in some cases fighting for their very existence and they will do all the fancy footwork necessary to ensure their survival. Although health care coalitions are only one of the many avenues employers have used to understand and help control medical costs, they are one partnership that holds promise of influencing the medical care delivery system toward the goal of providing high-quality medical care at a reasonable cost.

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<sup>4</sup>William M. Mercer-Meidinger, Inc., *Employer Attitudes toward the Cost of Health* (New York, NY: William M. Mercer-Meidinger, Inc., 1985).

## VIII. Discussion

### Case Management: Implications for Privacy, Liability, Choice, and Quality

MR. PAUL: Let me begin the discussion by asking Dick Hanley to respond to a question. It has to do with privacy, the issue of whether an employer has a right to have some access to information about the medical care situation of its employees. I think it is a question that other employers may have an interest in. What rights do you think an employer has to be involved in the issue of privacy about medical care delivery to employees?

MR. HANLEY: First of all, many, many employers already have that information, if they happen to be self-insured and self-administered. Most employers have had that data and will continue to be more involved in accessing it.

The liability question is a tricky one. I believe, though, that it can be worked out, just as we have worked through other concerns about privacy. Liability certainly has to be considered, but I would not let that stand in my way in trying to develop true case management. I would seek good legal counsel while putting the plan together. I would not just dismiss the idea of case management because I was afraid of the privacy question.

The information is nothing more than we have had access to in the past. It is just a question of how to use it. If you misuse it, you are going to get burned.

MS. NAZEMETZ: I think it goes beyond the legal liability. I am sure that it is an issue. Everything is a legal issue these days. But one of the other issues that we came up against, when we were instituting our employee assistance program six years ago, is the issue of access. To the extent that employees feel that an employer is looking over their shoulders and monitoring their health care, there have been instances (at least, employees have pointed this out to us) where they will not go through the system, simply because they do not want an employer to know their medical history. So there is a secondary effect. To the extent that an employer is interested in the health of its employees in the long term, one must be careful not to prohibit access.

MR. HANLEY: I recommend the use of health care providers as professional case managers. You could rely on their credibility and

training to use the data effectively and appropriately. So I am not saying that you turn it over to the typical employee benefits department. I am suggesting that you either bring professional case managers onboard or hire companies that are in business to provide those kinds of services and have the professional training and understanding to perform case management appropriately.

MS. CARMICHAEL: At our company, we encountered difficulties where we were handling the medical treatment for alcoholism and drug addiction internally. People needing the care were not availing themselves of the opportunity because of the privacy considerations. So, in moving it outside and making provisions through the medical plan for coverage, we contracted with an external consulting firm to do case management for us, and that is probably a good solution.

MR. SCIOLI: If one of the goals of case management is to direct a patient or an employee to the lowest level of appropriate care, that can be easily defeated in an environment lacking suitable privacy protections.

I learned from my experience on a committee dealing with ethical issues related to the AIDS [acquired immune deficiency syndrome] question in our state of New Jersey that one of the arguments against a registry is that registering positive test outcomes for exposure to the HTLV-III AIDS virus will influence both the employability and insurability of certain segments of the population. That is a real concern. The issue of alcoholism in the work place is another vital concern. If these protections are not offered, the outcome will defeat the very intent of case management. If these protections are offered, then state legislatures ought to be sensitive and involved, and open a dialogue around the need for further protections.

MR. JACKSON: I am troubled by one part of the case management discussion. Case management as a term is a rather sterile one. Nobody is really for case *mismanagement*, I suppose, so it must be something we are all for. I find myself much more in favor of case management for everybody else's health care. If my wife needed something and somebody were managing her case and decided to do various things, it strikes me as getting right back to a very personal aspect of the coverage.

It seems to me that cost shifting has been denigrated recently as being nothing more than employers ducking out on their responsibility and shoving the cost back onto the employee. If the employee does not want to have those important details of his life managed by

his employer, maybe he has to pay more of the cost himself. From the employer's standpoint, it is all labor costs. But I am a little concerned about the aspect of case management whereby an employee accepts a job, and instead of getting "x" dollars and then being able to handle the medical decisions on his own, puts some very fundamental decisions in the hands of his employer and, in effect, is stuck with them.

MR. HANLEY: Times are changing. With the cost of health care as it is, and with my employer paying nearly 100 percent of it, I personally believe that if employers insist that they want some role in the management of the delivery of that care, they have a perfect right to ask for it.

On the other hand, I do believe that, by giving the responsibility to respected providers, you can accomplish that and avoid the very close relationship that might otherwise develop. This does not change things much, except that an agent is acting on your behalf. If my wife were undergoing such scrutiny, I would consider it appropriate, and believe that it would enhance the quality of care because of the direct involvement of very creditable providers.

MS. DEMPSTER: The positive side of case management is that perhaps you can make sure the patient receives the most appropriate care. You can get a person into a hospital that routinely handles a certain disease rather than have the patient linger in a hospital that has never dealt with it before.

We have a very successful case of a 14-year-old girl who developed a drug problem. Through medical case management, we arranged for some home health care and for counseling for the whole family, rather than putting her into an acute care hospital. It is one of the few cases that I know of where a youngster with a drug problem came out all right. It was because of the family counseling, which we would not have paid for without medical case management because the family members were not ill.

MR. BOYD: Professionally, we do some case management under our medical plans at our company. And I believe in case management, as a consumer. But while the medical community may overdo medical delivery, I question whether the corporation and the insurance company are not going to *underdo* it. While too much medicine is not necessarily good, too little is not good either.

I wonder how we convince people that the corporation and the insurance company will act on their behalf to a greater extent than

the medical community. While I basically support case management, as a consumer I would rather see it performed by my physician rather than by my insurer or employer.

MR. HANLEY: It depends on who administers the comprehensive case management program. Again, I would suggest using only professional people, including physicians and other medically trained personnel, as well as psychologists, clinical social workers, and others who can get into many of the cases that tend to be the very expensive ones. Frankly, I would have some concern about relying entirely on my employer or my insurance company to provide an objective evaluation and treatment process.

Again, the way it is structured would, over time, build credibility among employees, retirees, and their dependents. That will not happen overnight, but there is some good evidence to suggest that these kinds of programs would go a long way toward improving the quality of health care, while at the same time putting some restraints and controls on unnecessary health care costs.

### **Employee Involvement**

MR. MOYNAHAN: My question is for Pat Nazemetz. We have had much discussion about managed health care programs, and obviously what your company is evaluating and moving toward now is inciting people toward managed health care and, in effect, the purchasing of care. I wonder if you can share with us or comment about how you see incentives and plan design worked into that? Do you foresee involving yourself in an exclusive provider arrangement? How do you deal with the issue of freedom of choice of the practitioner? And are you considering, as you are going through these deliberations, offering your employees a variety of health plan options?

MS. NAZEMETZ: Basically what we see evolving are select provider programs, several systems that an employee can choose from, but make a single election on an annual basis, or maybe less frequently than that. Currently we are doing it on an annual basis. The fee-for-service option would be maintained as well, so that an employee who decides not to have his or her care managed has the option of using a fee-for-service type of system.

The difference between this approach and what we are now doing is that instead of having "reasonable and customary" or "usual and prevailing" reimbursement, the reimbursement levels will be driven by the managed-care system. Let us say, for example, that care for a



tonsillectomy costs \$1,000 in a managed-care program and a provider's reasonable and customary fee is \$1,500 in a fee-for-service program. The employee has the option to use the fee-for-service program, but the reimbursement level will be based on the \$1,000 it would cost in the managed-care system.

In terms of incentives, if you mean things like higher levels of reimbursement if you use one system over another, we are tending not to go in that direction.

MR. MOYNAHAN: You are considering using disincentives rather than incentives?

MS. NAZEMETZ: Yes, we are.

MR. NEISWANGER: I have to support managed care. We are doing it at our company. I think that if you do it very carefully, employees will know you are really trying to help them.

I was at a meeting yesterday at which a representative of a large employer from Minneapolis voiced a concern that so many of their employees are in many different HMOs that are now competing with each other. They are not taking patients from fee-for-service; they are taking them from other HMOs. The company is beginning to get concerned with the issue Bruce Boyd raised—that in a highly competitive, managed-care world, managers may see their job as one of solely reducing costs. That could be a problem downstream. Unless employers are very careful about how a managed-care program functions, they may have problems.

DR. MOXLEY: I mentioned earlier that our society has an abiding interest in individual rights. Some of the questions we are hearing now about managed care come back to that issue.

All of us have viewed our health care as an individual right. When it becomes managed by somebody else, we do not like it. Certainly, as we are managing care for our employees, I can assure you that they do not like it. They are going along with it but there is not a great deal of enthusiasm because, in some instances, it means changing the arrangements they view as something they individually arranged and would prefer to retain.

MS. ROEDER: I am curious about the vocabulary we use when we talk about case management, which I personally feel has many positive aspects. We are talking about *control*; we are talking about *management*; we are talking about *costs*; we are talking about *helping employees*. In some cases we have had many good examples. But we

are not talking about teaching employees to use the system more effectively.

I have heard of work that has been done on how much better people learn and make decisions when they are well than when they face a stressful or traumatic situation. Are any of you looking at, working on, or advocating a system that helps employees understand how to use the health care system before they get into a crisis situation, i.e., how to use those people who will be given to them as managers—so that it can be a shared activity, not an imposed activity?

MR. HANLEY: I will step back in time to a couple of years ago when my former employer, Owens-Illinois, implemented what we called a “patient services program.” It was a first step toward what we would now call case management or total health management.

First we developed a very strong communications program to tell our employees we wanted them to start participating in the health care plan. They have access to nurse coordinators and counselors on a toll-free-number basis so that they can discuss their medical situations with professionals. If the nurse does not feel qualified to answer a question, it is turned over to the corporate medical director or another physician on retainer to provide the information to the employee.

Believing that the long-term answer is to get the user of the system more involved and to better understand the system, and also believing that he or she has the ability, in most cases, to comprehend what would be reasonable in terms of how to participate in the selection of providers or the procedures recommended by the providers, we encourage employee involvement. We have had a great deal of success. In surveys done every six months for about the first two years, we received very positive feedback from employees about the opportunity to participate, to be able to ask questions, and to be counseled about what questions to ask their doctors, things the doctor may have overlooked.

So, in my concept of a case management program, employee education is vital. It ought to be a key part of any case management initiative undertaken by a company.

MR. MOYNAHAN: I want to add one thing on the educating of employees. At our own company, we established a health care “help line” to educate people on how to access the system when they are about to use it. They are still in semi-crisis at that time, because they are going to access the system in some way; but it is not a serious crisis.

One other thought concerns the language used so far in discussing case management issues. Specifically, the “mandatory” aspects of case management are not necessarily mandatory. There are programs and approaches to the use of case management service and facility that are varied. It is not necessary to require that a patient and/or the attending physicians cooperate in case management. Some programs may wish to do that, but some programs do not. Some programs work only when in active cooperation with the physician in charge of the case. So it is not necessarily a matter of turning over the care of a severely ill patient to someone who is not appropriately involved in the case, although it could be, depending on the plan design. It is a very positive thing on balance, much more so than it is in any way a negative thing.

### **Danger of Underutilization**

DR. CAPER: I want to respond to Bruce Boyd’s earlier concern about underutilization in managed-care programs and HMOs. I think that is a legitimate concern. The danger of underutilization is just as great as that of overutilization in a fee-for-service system. We probably know as little about the appropriate rates of care on the underutilization side as we do on the overutilization side. One answer to that, again, is the more or less public availability of information. I do not mean just data; I mean information that relates to what is going on in the medical care system.

The outcome measurement issue, of course, is the bottom line. We do not know how to do that very well, but we are working on it. We do know how to measure utilization rates quite well, and let me urge you to look at the experience of the population being served, not of the providers. In fact, for us, the only way of detecting underutilization is to look at per capita rates of service to a defined population. For most corporations, that is going to require pooling of data at some level on a geographic basis, either through coalitions or through state government. But that is one way to routinely monitor the rates of utilization of care. I emphasized overutilization in my talk because that is what people have tended to be concerned with. Underutilization is as big a quality-of-care issue as anything in the evolving capitation system of payment.<sup>1</sup>

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<sup>1</sup> Editor’s note: Capitation is a system of paying for health care prospectively, via a per capita payment that is independent of the number of services used. For more about capitation, refer to Chapter IX.

DR. HUDSON: Some of us would feel better if some legal determination could be made of the circumstances under which an employer needs information about the health and the health practices of an employee. There must be some instances where, for the safety of other employees, this possibly is mandatory. But in most instances, I would posit that should be completely private information, except under certain circumstances of common concern, common worry, common danger. If you could set up a system where it was assured that the information does not get into the hands of a direct supervisor, an employee would feel more comfortable.

The other question is this: What safeguards should you develop to assure that the physician group does not end up as, in a sense, the "company physician," as in the situation of the factory doctor who is intending to get an employee back to work and is really working for the company? Could this be resolved by some sort of a system in which a layperson, a quasi-governmental person, or a labor union representative could be part of patient advocacy within that physician group?

MR. JACKSON: One of the suggestions Dick Hanley made was that the employer, instead of managing the case himself, would get a doctor or rely on professionals to do this. I have been a pension consultant for many years, and have used the argument that we are independent of insurance companies. If you go to an agent of an insurance company who is paid by the insurance company, you might not get totally impartial advice. If you go to an agent of the employer, whose interest is holding down costs in the medical area, you might not get impartial advice. If anything, it is going to err on the side of providing less rather than more. Viewed purely from a cost standpoint, that is all right, but as an individual, I would rather have the feeling that the doctor is on my side. This is not an entirely economic transaction here. Faith in the doctor is a large part of the recovery process, it seems to me.

A second point: Phil Caper was talking about capitation and the dangers of underutilization. The worst "rip-off" that I have seen in 35 years of working in employee benefits came under a capitation plan, a dental plan that was operated by a collection of crooks. They did not announce the benefits to the employees. Of course, if you do not hear that you can go to a specific dentist who will charge you nothing, you go to your own dentist and pay. There was no publicity about the plan at all. They got "x" dollars a year, and in terms of

where the money went, there were all sorts of organizations in there collecting, but it was impossible to track down.

With an insurance plan, at least, you can get claim records from a third party. These dentists had their own internal records. "Oh, yes, we treated thus and such a person, and here is his chart; seven fillings and two teeth were pulled on thus and such a day." Well, if the dentist collecting the money is a crook and is completing those records as input to the system, there is absolutely no way of getting control over the situation.

I am afraid that just changing the mechanism for delivering the service from fee-for-service to capitation is not necessarily going to improve things. There are just as many crooks out there who will find ways of taking advantage of a capitation system, too.

MR. GARBER: I disagree that the employer's only interest is in setting cost. There are those of us who work for large employers who believe that quality of care for the lowest possible cost is the objective. Therefore, the mechanisms set up should make sure that quality takes first place and cost follows. But they are related.

Quality of care is probably going to be the most important factor that determines how this industry shapes up down the road. There will be charlatans, as there are in any business; in the end they will be exposed and destroyed, but they will exist as they do with any kind of program.

MR. SEIDMAN: I want to emphasize a point that Dr. Hudson made. Where you do not have collective bargaining, I do not see how you can have anything but a unilateral plan that is run by the employer, and anybody who works for the employer has to work under whatever incentives that employer provides. Where there is collective bargaining and a union that is genuinely representing the interests of the employees, there will be a greater degree of confidence among the employees.

The union also is subject to some of these same incentives, particularly if they know that the alternative to having a managed care system in whatever form it takes is a reduction in health care coverage or cost shifting or whatever it may be. So the union has to do an educational job of explaining to its members what the alternatives are, and eventually the members will make that determination.

MR. MOSER: I do not see the same problem with capitation that Paul Jackson raised, as far as gaining control over use of health services. At our company we have always determined the level of ben-

efits, generally through insurance of some sort. I do not see why capitation provided through a means other than the employer does not offer the same conditions and the same controls as under an insurance plan.

If we head toward a capitation plan—I am not saying we will or will not, but if we do—I would not propose that we do it on our own. We could do it through another agent, and impose on them the need for control and the need for quality, just as we do in the delivery mechanism that is essentially provided through insurance.

### **Patient Choice and Access to Care**

MS. ANDREWS: I want to ask a question that focuses on some of the issues Paul Jackson has been raising. In the area of health care, choices are not always black and white. There is often a range of choice: Do you want this procedure or another procedure? There is a range in the way doctors prescribe treatment, and a range of appropriate treatments are available. What is the degree of patient choice in a managed-care system when decisions are not necessarily black and white, when people might want to decide on the trade-offs themselves, and on what they want to do?

MR. HANLEY: In my managed-care scenario, I would direct my attention to the chronic users of health care and not worry so much about the routine delivery of health care, in which we have all gotten caught up, at least in terms of the first generation of cost-control processes.

The chronic users are those who continually involve themselves with some form of the medical delivery system. Therefore, if you can put programs in place to help them deal with that need, to rehabilitate them, although you will spend more up front you will spend less money over time. It depends on how it is organized. The chronic user certainly has some rights to determine exactly what those kinds of treatment programs should be. That ties back into the question about employee education, or user education, and I am reminded of the case of the alcoholic. There are different treatment programs out there, and between them, the provider and the patient can decide which one is best for that particular patient.

I do not envision the company insurance plan as having detailed protocols on how to handle each of those situations, so that considerable flexibility and options are left to the user, at least as I perceive the managed-care process.

MR. PAUL: I wonder, Mr. Hanley, if you would discriminate between the kinds of cases by talking about the chronic user. It seems to me there ought to be a way to describe it somewhat differently. Having gone through the family experience of needing large amounts of esoteric medical care, I learned a great deal about the access issue. Knowing how to access the medical care system and knowing how to deal with it became important ingredients in getting the right kind of care, let alone managing costs.

I wonder whether part of this is a question of distinguishing the large events, the major surgeries, the illnesses that are often life threatening, where the managed care has a value quite beyond cost containment. In those very serious situations, helping the patient and the patient's family get the best possible medical care is an ingredient that may be getting lost in discussing questions of privacy and the other questions we have brought up today. I assume you are talking about trying to deal with the large-dollar cases which inevitably are the serious illnesses.

MR. HANLEY: Not so much the large-dollar cases. We all know coronary bypass surgery is a very expensive procedure, but once performed and the patient is put on an appropriate rehabilitation program, he or she should be pretty clear of related health problems for some time to come. There are few types of illness that really drive the majority of health care costs, and you can certainly exclude such one-time expenditures. But if you look at alcoholism, at chronic cigarette smoking, at high blood pressure, at stroke, and at other such illnesses, that is where managed-care programs are of considerable benefit to, first, the employee, the retiree, or his or her dependents, and, second, to the company, in terms of being able to manage health care.

MR. MOYNAHAN: In the wide-open, fee-for-service market there comes a point at which the patient or the patient's family turns over the management of their case to the physician they have selected. So, at some point, you turn over the management of your case to somebody in the profession. In the most restricted forms of managed care, a capitated HMO with a lock-in provision, in a sense you are turning the management over to the staff of that HMO to make decisions. The patient can discuss treatment with them, the same way as with a fee-for-service doctor, and also discuss, to the extent that the patient can, the application of the various technologies to the cure of the condition.

It goes back to this option issue, then, as to whether you deal with

barriers and lock-in enrollments under managed-care programs, or whether you actually have choices, and whether the choices are influenced by disincentives or incentives one way or the other, so that if you disagree with the physicians involved, you have the opportunity to be covered in other service arenas, albeit totally unmanaged, fee-for-service access.

That is the kind of program we see emerging. There are certain merits to overcoming this barrier issue that many people are very much afraid of when they look at managed-care systems, and I think it bears overcoming.

### **Provisions of COBRA**

MS. MOON: I would like for someone to comment about the implications of public policy changes, such as the provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) that will require continued coverage of health care after, for example, divorce or death of a spouse, and for workers over age 69.<sup>2</sup> These provisions potentially could raise employers' health care costs.

MR. DEMPSTER: I welcome the changes brought by COBRA. We now pay for the group medical insurance of our employees regardless of their age, so we do not have to keep track of when they reach age 70.<sup>3</sup> That is a very positive program.

I talked to a widow of one of our employees recently. The employee died at age 54 and one-half, and the widow would have been covered if the employee had been age 55. How do you explain to this woman, who has been covered by TRW group medical insurance for 25 years, that all of a sudden she is not going to be covered? TRW has some responsibility for these people. It is a limited amount of coverage under COBRA, but it seems to me that we do have that responsibility.

### **Coverage for Buffer Work Forces**

MR. SEIDMAN: Anybody, like myself, who has been in an HMO for many years not only accepts but very much values case management.

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<sup>2</sup>Editor's note: For a discussion of the continuation-of-coverage provisions of COBRA, refer to the Introduction and Background and to Chapter X.

<sup>3</sup>Editor's note: In October 1986, Congress passed H.R. 4154, which abolished mandatory retirement at age 70 and recodified the COBRA provision requiring employers to continue group health coverage for workers over age 70.



What we missed more than anything else during the years that my family and I were in Europe was having access to a health care system that provides case management.

I have a different question for Pat Nazemetz, and it relates to your very brief allusion to a buffer work force at Xerox. It was not clear to me whether they have health care coverage during the period they are on the job, and for how long, if at all, when they are off the job. Or are they part of the uninsured population?

MS. NAZEMETZ: Neither, right now, because we do not currently have a buffer work force. It is something that we are incorporating into our longer-term strategy; it is an open issue.

The purpose of setting up a buffer work force obviously is to give the rest of the work force some job security and at the same time control costs. Typically these people come in at a lower wage and for fewer hours or with less permanence. There are two arguments being put forth. One is that if you really want to keep costs down, you cannot afford to incorporate these people into a benefits package, because it adds significantly to the cost and, therefore, detracts from your competitive position. The other argument is that you do not want to leave them as part of the uninsured or the underinsured.

I do not have an answer for you, in terms of where we will come out on that one. Clearly, the preference among the human resource people is to take a hard look at some effective way of providing health care coverage for these people. Since we are not there yet, it is not a real time problem, but one that we are trying to anticipate so that if, in fact, we do establish a buffer work force down the road, we will have the right answers.

MR. SEIDMAN: I presume they would be in and out of the work force. Would you give them group coverage on any basis at all during the interim periods when they are not working?

MS. NAZEMETZ: Even if we did give them company-paid coverage while they were employed with us, we most likely would not provide coverage while they were not employed.

MR. SEIDMAN: Would they have access to the group plan?

MS. NAZEMETZ: That is a different question; legislation might require us to do that. But that is one of the other considerations we must take into account.

## **PART THREE:**

# **Social and Policy Issues**

In grappling with rapid change in its system of financing and delivering health care, the United States must confront a number of social and policy issues.

Determining the appropriate level of health care spending is one of the most fundamental decisions a society must make. As we saw in Part One, the nation's explicit health policy goal has long been access to quality health care for all residents. In recent years, the goal has been expanded to include high-quality care at the least possible cost.

Access to health care depends, in part, on the ability to pay for care. The United States devotes a larger portion of its Gross National Product to health care—10.7 percent in 1985—than other industrialized nations. In 1984, 65 percent of the population had employer-sponsored health coverage; in the same year, four out of five Americans under age 65 had coverage from some source, public or private. And almost all Americans age 65 and over are covered by Medicare or Medicaid, federal programs that have experienced sharp increases in expenditures over time.

Yet many other Americans are uninsured for health care expenses. In 1984, 34.7 million people under the age of 65 and not living in the families of military or agricultural workers had no health insurance—an increase of 4.4 million in two years. This rise in the number of uninsured people was brought on largely by an employment shift since the 1982 recession from industries and firm sizes that typically offer coverage toward those that do not. Among people who have insurance, the coverage may not in all cases be sufficient to meet their needs. For example, some 10 million Americans have insurance that would not adequately protect them from the risk of catastrophic illness expense, according to the report on catastrophic health care coverage released in November 1986 by the Department of Health and Human Services.

In this policy forum, employers, physicians, and others caution that as the drive to contain and manage costs changes the ways in which care is financed and delivered, our society must remain alert that concern over cost does not restrict access to quality health care—among both those who can pay for it and those who cannot. And in

the effort to contain health care reimbursement, care must be taken not to handicap the development and utilization of new, helpful medical technologies or necessary medical education.

Another factor affecting access to care is the availability of providers. There would seem to be an abundance of providers—the ratio of physicians to patients has steadily risen, and hospitals are increasingly operating well under capacity. Yet many people in rural and less populous areas may have difficulty obtaining health care because providers are not always easily accessible.

Demographic changes also are bringing important implications for health care. People over the age of 75 represent the fastest-growing segment of our population. Medicare's Hospital Insurance trust fund is projected to be depleted during the late 1990s, yet at that time the oldest members of the "baby boom" generation will have just reached their early fifties. The "graying" of our population is creating an increasing awareness that our system of financing and delivering health care will be challenged to meet the special needs of older people.

Some of the most vigorous policy debates currently taking place in the United States center around the dilemmas of how to finance indigent health care, retiree health coverage, and long-term care. These issues are fully explored in the Postscript, but emerge frequently in this section as well.

In the first presentation, William Roper discusses the Reagan Administration's health care policy agenda, particularly with regard to Medicare and Medicaid. He also explores ways in which the private and public sectors can work together in shaping health policy.

Next, Representative Bill Gradison discusses congressional health policy objectives, including specific legislative initiatives. He also talks about the challenge of shaping health policy during a time of stringency in domestic federal programs, and about whether Medicare's policy of reimbursing hospitals prospectively may be providing incentives to hospitals to discharge patients "sicker and quicker."

Stuart Altman then discusses the important effects the Medicare prospective payment system has had on the financing and delivery of health care in the United States, including the implications for quality of care. Altman also explains why people in the private sector should be concerned about Medicare's reimbursement policies.

In the next presentation, Morris Abram explores the role of the individual in influencing the cost and quality of health care. Central to his discussion are the changing patient-doctor relationship, the need for greater communication between patient and doctor about

the patient's medical treatment, and how a patient's family often becomes the agent that monitors quality of care. Abram served as chairman of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which explored social and ethical dilemmas associated with health care financing and delivery and medical research. The summary volume of the commission's final report opens with the following passage, which articulates some of these difficult questions:

Who will live and who will die? Who decides, and on what grounds? Are there certain characteristics—when “defining” life or setting the boundaries of permissible genetic experimentation—that are essential for “humanness?” In distributing risks and benefits, when should choices be left to the consciences of individuals and when should they be constrained collectively—by expert or lay groups, legislators, administrators, or judges?<sup>1</sup>

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<sup>1</sup>President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Summing Up: The Ethical and Legal Problems in Medicine and Biomedical and Behavioral Research* (Washington, DC: U.S. Government Printing Office, March 1983).

## **IX. Health Policy Priorities under the Reagan Administration**

William L. Roper, M.D.

I am excited about the opportunities that lie ahead for the Health Care Financing Administration (HCFA), for Medicare, for Medicaid, and for health care in our nation. I am grateful to President Reagan and to Health and Human Services (HHS) Secretary Otis Bowen for choosing me for the job. While I miss my quarters and accommodations at the White House, I really have not had much time to think about that, because the three weeks I have been on the job have been a very, very busy time at HCFA.

I will continue to do one thing I did at the White House: chair the Working Group on Health Policy, one of the standing working groups under the Domestic Policy Council (DPC). The DPC is the body through which President Reagan gets policy advice on domestic affairs. In that role I will continue to be the administration's lead person for health policy.

Several people have asked what my goals are for HCFA. I would like to share some thoughts with you, and then talk about what I think the private sector and the government can do together.

My immediate goal, and one, I am pleased to say, that is largely already realized, is to recruit a number of highly qualified people to fill vacancies at HCFA. Some of these vacancies have existed for a number of months. I have been pleasantly surprised at the willingness of highly qualified and motivated people to come into government at this time. Most of them are already onboard, and the whole team will be in place very shortly. It is an exciting time for me to be able to recruit good people, and Secretary Bowen has certainly been a help in that regard.

My other major goal is to use the next three years not simply as a time to "keep house" for the remaining years of President Reagan's second term, but rather to push ahead on a health policy agenda consistent with the overall strategy he has articulated. We will try to further reform America's health care system, and do it in a way that is good for all concerned: beneficiaries, providers of health care services, and taxpayers. And, no, we do not have a blank checkbook with which to do it.

## **Major Policy Goals**

HCFA will play a supportive role in some of Secretary Bowen's policy goals. For example, we will assist him in the study of catastrophic illness expenses requested by President Reagan and what should be done to further the work of the private and public sectors in dealing with these expenses.<sup>1</sup>

### ***Catastrophic Health Care***

One part of Secretary Bowen's study focuses on acute-care services and catastrophic expenses under Medicare. Before he became secretary, Dr. Bowen wrote a paper in which he described one way of dealing with the problem of catastrophic health care expenses. He suggested that a small monthly premium could be added to the current Part B premium to provide acute inpatient and outpatient catastrophic coverage. But, as he has made clear, while that is an option under consideration, it is only one option. Other options are also being entertained as possible ways for the private and public sectors to work together on catastrophic health care expenses.

An interesting part of the study is the question of how to pay for the catastrophic health expenses of people who have no health insurance. These are largely people who are either unemployed and without insurance but do not qualify for Medicaid, who are employed but for some reason do not have health insurance, or who have health insurance that is inadequate. That clearly is a question on which the private and public sectors can work together.

### ***Long-Term Care***

Another issue we will work on is long-term care, which is related to the study of catastrophic illness but merits being addressed on its own. This issue has been on the Washington health policy agenda for some time, and our answer has long been, "Yes, it is a problem. Yes, thoughtful people ought to be concerned about it. Now can we get on to the next issue?"

We have not done a very effective job of dealing with long-term care, although it is an issue that involves more than just building

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<sup>1</sup> Editor's note: The study was submitted to President Reagan on November 20, 1986, and calls for (1) catastrophic protection for older Americans through Medicare, financed by an additional premium, (2) public education, (3) encouragement of personal savings and private insurance to finance long-term care, (4) promotion of state initiatives, and (5) full health insurance tax deductions for employers that include catastrophic protection in their employee health plans.

nursing homes. It is a question of the demographics of our society and of an aging population; the fact that we as a society do not save very much for our later years; and a realization that, with governmental resources limited, the private sector needs to step into this area. I am gratified to see that this is now coming about. For example, Carol Kelly, now with The Equitable Life Assurance Society of the United States, worked on the idea of private-sector long-term care insurance when she was at HCFA and continues to do so in the private sector.

### ***Health Programs for the Poor***

The president has also asked Secretary Bowen to evaluate the effectiveness of HHS programs that address the problems of low-income Americans. Medicaid provides health care to this group of Americans. HCFA will examine what it can do to give the states more ability to deal with the problem of providing adequate health care for the poor.

### ***Tort Reform***

Another concern of Secretary Bowen, and one in which I hope to assist him, is the issue of medical liability tort reform. It is a truly pressing problem for America's health care system, one that causes large additional, and often unwarranted, expenditures. Beyond that, some people do not have adequate access to health care because of doctors' and others' fears of malpractice liability. Some physicians no longer deliver babies. There are other developments equally as devastating. We need to address this problem.

The Reagan Administration has developed eight recommendations for tort reform. We are now assessing whether the federal government should step into what has traditionally been a state matter, or whether we should simply recommend these reforms to the states.

### ***Quality of Care, Capitation, and Prompt Payment***

There are three other items that are of major interest and concern to me and to Secretary Bowen. The first is a general interest in quality of care under our programs. I had the privilege this morning of testifying before the Senate Finance Committee on the issue of quality of care.<sup>2</sup> I made the point to them, as I did at my confirmation hear-

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<sup>2</sup>U.S. Senate Committee on Finance, "Examination of the Quality of Care Under Medicare's Prospective Payment System." Hearing June 3, 1986; document forthcoming.

ings, that I am not eager for us to be hauled before the Congress simply to present data proving that things are not as bad as Congress says they are. That is a terrible predicament for us to be in. Frankly, I do not want us to be defensive. I want us to say that we can improve quality of care under Medicare and Medicaid. I want us to push ahead on that idea. To the extent we can, it will require us to do things other than make broad assertions about quality being good, or quality being bad, or that it is getting better or getting worse.

Frankly, we need to be able to measure quality. I announced in my testimony this morning that we in HCFA, with the help of others, are going to sponsor a conference this fall on how to measure quality in health care.<sup>3</sup> We need to go further than, to paraphrase the late Justice Potter Stewart's comment, "I know quality when I see it." We have to do better than that. We have to be able to measure quality and compare providers, to know which are the good doctors and which are the good hospitals, and then we need to be in a position to release that information.

Information should be made available so that people can make informed judgments about which providers to seek out. We have some mechanisms in place; we will shortly have others in place to monitor quality of care. Peer review organizations (PROs) are an important part of that effort, but at the base we depend upon the professionalism of America's doctors and hospitals and other health care providers to ensure the quality of care within the system. It is simply not possible, even if it were wise, for us to look over the shoulders of all providers in America to see whether they are doing the right thing. We have to depend fundamentally on professionalism and good-faith efforts by people providing health care services.

A second item of special concern to me is the idea of the private health plan option<sup>4</sup> as a form of payment for health care services. This option is the logical next step. We are now paying an amount of money for *each hospitalization* under Medicare. The private health plan option would pay an amount of money for health care services for a *period of time*.

Much of the debate over the quality of care question focuses on the immediate posthospital period. People are asking questions about lengths of stay. People are being discharged earlier and, some would say, "sicker and quicker." Are they getting adequate health care ser-

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<sup>3</sup>Editor's note: The conference was held in December 1986.

<sup>4</sup>Heretofore referred to as "capitation."



vices beyond hospitalization, and whose responsibility is it to pay for it? What about adequate supply of services in that period? The answer is not for us to construct another benefit package for posthospital services and find a new way to pay for the posthospital care. Then we would have prehospital, hospital, and posthospital benefit packages, and we would have to jiggle payment rates to get the appropriate mix of services.

What we ought to do is say that we will pay for care over a year's time and give a health plan—a provider community, if you will—the incentive to manage care efficiently, to deliver it effectively, to keep people well to the extent possible, to keep them out of the hospital, or at least to treat them at the most appropriate level. To me, that is far better than embarking on yet another benefit package and the further jiggling of payment rates.

Finally, a matter of interest to me is the operation of HCFA as a business and how well we are doing our job. I have heard from a few people who think we are late in paying our bills. We will spend substantial time and money to speed up the payment of our bills, because we need to be more timely than we have been in the recent past.<sup>5</sup>

### **Cooperation between the Public and Private Sectors**

Let me turn for a few moments to what I think are important things being done in the private sector and some things that the public and private sectors can do together. For a couple of years, I have been saying in speeches around the country that the private sector is the driving engine for change in America's health care system. I think that is truer now than ever before. Employment-based health plans are shaping new alternatives and we at HCFA and other public agencies are running to try to catch up with what private employers are doing. Frankly, that is good for us, because we are not blazing new territory. Rather, we are learning from their experiences and building on them.

One area that is especially active now is the idea of the private health plan option and managed health care. Case management is an idea whose time has come. Again and again, evidence is building

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<sup>5</sup>Editor's note: As a result of budget reconciliation legislation passed by Congress (P.L. 99-509), a 25-day deadline for payment of Medicare claims must be fully phased in by 1989, beginning with a 30-day deadline effective October 1, 1987.

that, by taking prudent measures to manage health care, the same amount of care can be given at higher quality for fewer dollars.

It is encouraging to us in government to have, for example, the Chamber of Commerce's recommendation that Medicare move ahead as rapidly as possible to the use of vouchers.<sup>6</sup> Much of the effort under way in the private sector is helpful to us, and I predict we will see a time in the not-too-distant future when capitation is not a strange idea to Medicare beneficiaries. Rather, it will be something to which they are accustomed, having experienced it in their working lives. They will be quite comfortable remaining in those plans after they retire, or seeking out those plans once they become Medicare eligible.

The other exciting thing about the private-sector activity is that while for 10 years we have heard a lot of rhetoric about private-sector concerns over the cost of health care, reality is now coming to the fore. It is no longer just rhetoric; it is true. There is real action taking place among employers in dealing with providers, health plans, and others to hold down costs. They are doing it not simply by "jawboning," which is not terribly effective either with steel prices or health prices. Rather, they are using their economic clout, as they rightly should, to say, "We have responsibility for and we pay for health care services for large populations of people, and we will drive hard bargains to see that we get value for our dollars." That is altogether as it should be. I applaud their efforts in that regard and repeat that we are eager to work with the private sector where we can.

## Conclusion

In closing, let me say that the future is not altogether clear. After all, we really are in the midst of a revolution in America's health care system. But a few things are clear. One is that tomorrow's health care will be even better than today's. I am convinced of that because we are targeting resources on bottom-line results. We are focusing attention on outcomes and looking to see if people really are better for what is being done for them. That focus will continue and, in fact, be enhanced.

Second, we have reason for optimism because there will be an even greater reliance on competition and further incentives for efficiency in America's health care system.

Finally, we have reason for optimism because we are moving away from the past's greater reliance on government regulation and gov-

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<sup>6</sup>Editor's note: Dr. Roper discusses vouchers more fully later in this chapter.

ernment intervention. The experience to date has shown that we are headed in the appropriate direction. Some significant questions remain to be addressed, but the future is a bright one.

## Discussion

*Editor's note: Immediately after his presentation, Dr. Roper accepted questions and comments from participants.*

MS. ELIOPOULOS: Former HHS Secretary Joseph Califano recently proposed to HHS that the Chrysler Corporation be paid 95 percent of the rate for Medicare. In return, Chrysler would take care of all the health needs of its retirees. Do you foresee that as the wave of the future, and do you plan to approve that proposal?

DR. ROPER: I am not ready to sign off on it yet.<sup>7</sup> Our people are in touch with the Chrysler folks and we are talking with them as well as with a number of other large employers, unions, and other groups. The idea of using capitation to deal with a large number of existing groups is an attractive one. We are going to be looking at it carefully.

DR. HUDSON: Along those lines, where does the administration now view the so-called "privatization" of the Medicare program to individuals outside the Social Security system? I am talking about a plan whereby individuals develop vouchers on their own during the course of their employment and upon reaching age 65 can purchase private coverage in lieu of Medicare.

DR. ROPER: Some of the proposals for reform dealing with catastrophic illness costs are of the sort you describe. For example, one proposal would have the Medicare program provide a residual catastrophic benefit. Before that would come into play, individuals could save through medical individual retirement arrangements (medical IRAs) or other kinds of vehicles for more routine health care services. That option is being debated in the public sector.

The administration's policy is that we want to further the use of vouchers for people to enroll in private health plans. The matter you raise is being discussed.

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<sup>7</sup>Editor's note: President Reagan's fiscal year 1988 budget proposal recommends legislation that would "allow employer-based plans to assume responsibility for providing Medicare benefits to their retirees in exchange for a fixed government contribution." As of early 1987, negotiations were continuing between HCFA and the Chrysler Corporation, along with labor unions and other employers.

MR. MOSER: You mentioned that you wanted to encourage businesses to examine methods of dealing with some of the problems you outlined, to act in concert with HCFA. Yet some of the current tax laws are contradictory to business doing anything actively. Specifically, I am talking about the long-term care issue. For example, if businesses wanted to fund long-term care for their retired population, the current tax laws require disbursement of monies from the fund by the time the insured reaches age 70 and one-half, which is before the age at which many people would need money for long-term care. Are you considering any changes in tax laws that would relate to this issue?

DR. ROPER: So much is up in the air with tax reform right now that it is hard to respond, except to agree that things like those you mentioned need to be remedied.

MR. SEIDMAN: I would like to pursue what you call "capitation." I have always understood "capitation" to mean that in return for prepayment by the person, himself or herself, or on behalf of that person by somebody else, that person then has access to comprehensive care. That is the way it is in an HMO. That is the way it is in the British health system. You have said that you regard capitation as an alternative to another benefit. The problem is that we do not now have another benefit for, let us say, long-term care—certainly not for institutional long-term care—and not even for some kinds of health care. I would like to have a broader understanding of what you mean by capitation. Capitation paid to whom, and for what? What does it involve? Does it assure people that they are going to have access to the care they need?

DR. ROPER: I invite your reading of many things that are on the record, including our voucher bill which is before the Congress.<sup>8</sup>

MR. SEIDMAN: That only gives people a certain amount of money to go out and try to purchase what they need; but people do not have the same needs. People who have the greatest need obviously require more money to do that than the people who have lesser needs.

DR. ROPER: You raised several questions. To begin with, the world I envision is one in which Medicare beneficiaries, if we are just talking about Medicare, would be given the ability through a voucher to go

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<sup>8</sup>Editor's note: The administration's Medicare voucher bill did not pass the 99th Congress. The proposal will be reintroduced, along with similar proposals by a number of sponsors, during the 100th Congress.

out and enroll in a variety of plans, some of which would be traditional HMOs, others of which would be health insurance plans that might pay doctors or hospitals on a fee-for-service basis. Other plans might choose to have a closed panel of providers.

As to the benefits that would be provided under the existing TEFRA [Tax Equity and Fiscal Responsibility Act of 1982] HMOs and competitive medical plans, and also under the voucher bill, these plans would be able as a marketing tool to distinguish themselves, to add extra benefits beyond the standard Medicare package to attract enrollees.

MR. SEIDMAN: How would those extra benefits be paid?

DR. ROPER: Through the savings made by managing care more efficiently. That is happening now. There are 126 such TEFRA HMOs and competitive medical plans enrolling 600,000 Medicare beneficiaries, and it is working.<sup>9</sup> My contention is that some of the care, perhaps immediately posthospital or other kinds, can be offered by these plans without additional cost because of the efficiencies in managing the existing benefits.

MS. KELLY: In the last several months, the administration decided not to assume additional PRO responsibilities for quality of care in capitated payment plans. The decision was made to encourage the private sector. Are you aware of what the private sector is doing in this area, and are you pleased with the progress?

DR. ROPER: We are keeping up with it. We soon will establish the Office of Prepaid Health Care within HCFA which will bring together all of our activities in connection with capitation.<sup>10</sup> We are eager to see some private-sector alternatives developed for accreditation and quality control. The Senate and the House took note of that in their language in connection with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and we are hopeful that we can develop a broad base of support that can be used in establishing quality control.

You asked pointedly whether I am pleased with the private sector's progress. No, I am not pleased. I think it is coming along slowly, despite efforts to get them to move ahead. Congress has indicated it wants PRO review of HMOs. I do not think that is wise, frankly,

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<sup>9</sup>As of December 1986, there were 149 TEFRA HMOs and competitive medical plans enrolling over 810,000 Medicare beneficiaries.

<sup>10</sup>The office is now directed by Kevin Moley.

because the PROs are burdened already with their duties, and I am not eager for us to add another responsibility at the moment. But if the private sector does not get its act together, we are going to have PRO review of HMOs.<sup>11</sup>

Ms. KOSTERLITZ: There have been some accounts about a General Accounting Office (GAO) report on various aspects of Medicare and HMOs, regarding subcontractors and so on.<sup>12</sup> Can you comment on some of their criticisms?

DR. ROPER: I have not seen the report. As to the question of overpayment, the determination of how much to pay is an extraordinarily technical matter. I am not satisfied that we are doing the best job we can, but we are pushing ahead. Our new Office of Prepaid Health Care will have as part of its charter the task of figuring out how better to calculate how much we ought to be paying. For example, at present, we pay a different amount for each county in the country. That is maddening, to say the least, to providers trying to participate under this arrangement.

Regarding the question of regulating agreements between providers and subcontractors, again, I have not seen the GAO report, but I, for one, would not be eager to see the government regulating those kinds of arrangements. We think that those ought to be contractual agreements, worked out by the respective parties in the best way they see fit.

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<sup>11</sup> Editor's note: The Consolidated Omnibus Budget Reconciliation Act of 1985 expanded federal peer review to include HMOs and competitive medical plans under contract with Medicare. The provision's effective date was delayed pending development of a system of review by private organizations. Under the 1986 Omnibus Budget Reconciliation Act, these independent review bodies will be eligible to conduct reviews in 25 states, effective April 1, 1987.

<sup>12</sup> Comptroller General of the United States, U.S. General Accounting Office, *Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations*, GAO/HRD-86-97 (Washington, DC: U.S. Government Printing Office, 1986).

## **X. Congressional Health Policy Issues**

Rep. Bill Gradison, Ph.D.

Government health policies have many goals. The ones we talk the most about are cost containment, access, and quality. Today the stress is obviously on cost containment, which brings into sharp focus the inherent conflict among these three goals.

At some point, insistence on any one goal impinges on the other two. In the past, tough choices have been minimized by simply adding more dollars or starting new programs. However difficult such health policy choices may once have been, they are far tougher in what I would describe as the Gramm-Rudman-Hollings<sup>1</sup> revenue-neutral, budget-neutral world.

### **Health Care Versus the Budget**

While Gramm-Rudman-Hollings was very controversial, there seems to be a consensus with regard to two goals, among both those who voted for it and those who opposed it. They seem to be what we called at Harvard Business School "currently useful generalizations."

One is that we want to hit the \$144 billion target for the next fiscal year and no more. The second is that we do not want sequestration (i.e., automatic across-the-board spending reductions under Gramm-Rudman-Hollings). We want the budget cuts to be made in a more rational manner. To accomplish this, both on the tax side and on the spending side, we have got to do something that the federal government is not accustomed to doing—taking from Peter to pay Paul.

For the last four years, there have been impasses between an executive branch that favors defense and foreign aid over domestic spending programs and a Congress that is more supportive of domestic spending programs. These impasses have been resolved by spending money for both, a compromise only a politician can love. This is no longer possible or, at least, easy to accomplish, so health care spending must compete with other public or private spending. Treatment competes with research, prevention with care, and the old with the young. Vexing issues that once, perhaps, could have been put aside and handled by just throwing some more money into the pot are intensified and must be discussed.

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<sup>1</sup>Editor's note: Named after its congressional sponsors, this legislation (P.L. 99-177) set annual federal budget deficit targets designed to eliminate the deficit by 1991.

Some issues important to Congress are: How far can costs be reduced without having an impact on quality? Does the present diagnosis-related group (DRG) payment mechanism for hospitals under Medicare provide a fair distribution of adequate care among patients of different hospitals? Does the DRG system require hospitals and physicians to make decisions that are not in the best interest of their patients? Does fee-for-service reimbursement encourage overutilization of physician services? Do health maintenance organizations (HMOs) and comprehensive medical plans encourage underutilization? How is quality to be measured, and by whom?

The Congress, following the plan of the founding fathers, is a responsive, not an anticipatory, body. You cannot have both. Crises, real and imagined, that show up on the nightly news tend to move us to action.

Right now, we have anecdotal information suggesting that the DRG system has had a negative effect on quality. It is difficult to tell how serious this impact has been. This has an impact on policy, and it has an impact on legislation. In the most recent budget reconciliation bill, which covered a wide range of departments and activities of the federal government, there were, by one count, 51 separate provisions involving Medicare. That bill, by the way, is known by an acronym. It is the Consolidated Omnibus Budget Reconciliation Act of 1985, but it is called COBRA. Those in the field believe that COBRA has a definite double meaning because of some of the provisions we have included here. Certainly some of the providers feel that way.

In a broad sense, what we were trying to do was fine-tune the DRGs. We did this in COBRA in many provisions. For example, wage indexes were modified to try to provide greater equity between rural and urban hospitals. The direct and indirect medical education add-ons were revised. We increased payments to hospitals serving a disproportionate share of low-income patients, and provided a timetable—which I think will hold up—for transition to national DRG rates. As a matter of fact, Oregon is already there.

We increased payments to participating physicians as an incentive to increase participation. We clarified the responsibilities of Medicare hospitals in emergency cases. This is the matter of patient transfers, or so-called “dumping.”

We also dealt with an issue that I want to use as a point of departure here—the matter of continued health coverage. One of these 51 items in COBRA amends the Internal Revenue Code, the Employee Retirement Income Security Act of 1984 (ERISA), and the Public Health Service Act to require that an employer with 20 or more employees



that maintains an employer-provided group health plan must provide a continuation option to certain qualified beneficiaries.

These beneficiaries are widows, divorced spouses, and spouses of Medicare-eligible employees, as well as dependent children of such beneficiaries. They must have the option to continue group health coverage for up to three years. They will pay for this, but payment is limited to a maximum of 102 percent of what similarly situated beneficiaries would have to pay. We also have an 18-month continuation financed in a similar way for terminated employees. That includes voluntary and involuntary terminations, except those whose termination resulted from gross misconduct.

### **Improved Access**

This leads me to comment briefly on the Improved Access to Health Care Initiative, a bill of which I am a cosponsor.<sup>2</sup> This is a highly controversial piece of legislation. It builds upon some of the steps recently taken, and, in particular, on the COBRA continuation provision to which I referred.

It is also an outgrowth of statistics that suggest 75 percent of all Americans without health insurance are employed or are the dependents of employees. To be frank, that is different from what I would have expected years ago. It may help explain why some of us in Congress are looking at the employment relationship to see what can be done to encourage, force, or dragoon employers into broadening their coverage for some of these now-uncovered groups.

We would extend coverage of employer-paid health insurance to laid-off workers and their dependents. We would follow the example of nine states that now have subsidized health insurance pools by requiring the other states to set up such pools.

We would require that states establish a mechanism to fund hospital charity care or develop a plan to provide health insurance to all uninsured residents. In certain respects, this builds on what is already being done in New York, New Jersey, and Florida, which have funding mechanisms for uncompensated medical care. We also would attempt to find some way to encourage the self-employed to take a more positive view toward covering their employees, because

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<sup>2</sup>Editor's note: The Improved Access to Health Care Initiative (S. 2402, S. 2403, and H.R. 4742) was not passed by the 99th Congress. The provision mandating establishment of state health insurance risk pools was incorporated into the House version of budget reconciliation legislation, but was not part of the conference agreement.

about half of the people who are employed but uninsured work for self-employed individuals or small businesses, so that is a special problem.<sup>3</sup>

## **Medicare Reforms**

Another related bill in the 99th Congress is the Medicare Quality Protection Act. It is probably less controversial. To me, the most important provision is one that would require the Department of Health and Human Services (HHS) to develop within the next 18 months a legislative recommendation to refine the prospective payment system (PPS) to better account for variations in severity of illness and case complexity.<sup>4</sup>

I personally think that the greatest weakness in the DRG system today is its lack of a severity or intensity factor. I am not aware of any hard data on which to base action right now, so this is an attempt to get such information. I say an "attempt" because those of us in the Congress who are concerned about these issues have had a chronic problem, particularly during this administration, in trying to get timely reports from the Health Care Financing Administration (HCFA) on very important issues. We set deadlines that often are not met. In many cases, the reports have been completed but the Office of Management and Budget will not let them out.

I mention this because some of us believe that it may be necessary to turn to other groups to get timely reports. HCFA is not the only group that does studies, and they often contract these out, so it may be possible for us to turn to the Office of Technology Assessment, the Library of Congress, the General Accounting Office, or to consultants directly, if necessary, to get the information we need.

## **Government Attitudes toward Health Care**

Let me summarize what I think reflects current government attitudes toward health care. First of all, I think we are going to be in a

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<sup>3</sup>Editor's note: The Tax Reform Act of 1986 permits the self-employed to deduct from gross income 25 percent of the cost of providing health insurance for themselves and their spouses and dependents, provided they offer their employees coverage under a nondiscriminatory health plan. This change is effective for tax years beginning on or after January 1, 1987.

<sup>4</sup>Editor's note: The Medicare Quality Protection Act (H.R. 4638) was incorporated into budget reconciliation (P.L. 99-509). One provision states that the Secretary of the Department of Health and Human Services must within two years submit to Congress a legislative proposal to improve classification and payment under PPS to better account for severity of illness and case complexity.

period of continued uncertainty. That will be the most important thing to keep in mind when viewing government policy toward health care financing. That is going to be true not only in direct health issues, such as Medicare, Medicaid, and medical research, but in the very broad context of fiscal policy. Putting it another way, federal dollars are soft dollars, not hard dollars. If I were a recipient of federal funds, I certainly would view them in that way.

The second point is that, following the lead of the private sector, the federal government will try to become a more prudent buyer of health services, perhaps a downright stingy buyer, if it utilizes its potential market clout. Greater emphasis will be placed on health maintenance organizations (HMOs) and capitation in general. That will tend to reduce the federal role in defining the required scope of services. It also will mean we will increasingly look to outside groups to measure quality.

What that says to me is that as the pressure from both the private and public sectors is reduced for implicit subsidies for uncompensated care, some more explicit means of payment will be required. It also says to me that if the federal government truly utilizes its market potential through, let us say, a preferred provider arrangement, it is probably going to make it more expensive or more difficult for nongovernmental groups to figure out how to pay for health care. That is because the federal government, which pays something like 40 percent of all hospital bills, will not be paying as much as had been anticipated.

The third point is that Congress is near the end of the road of legislated health budget cuts; you can see that in both the House- and Senate-passed budget resolutions. But do not rest comfortably at that thought. Attention is shifting to budget restraints through regulatory, rather than legislative, action with occasional expressions of congressional outrage, as in the case of the administration plan for capital reimbursement under Medicare. The squeeze will continue to be on providers, not beneficiaries. I will give you a few examples of what I am talking about, and these are "big buck" examples.

For two years in a row, HCFA has proposed virtually no increase in the pool of money which is divided up under the DRGs. For the current fiscal year, the Prospective Payment Assessment Commission (ProPAC) proposed a little over 2 percent. HCFA proposed zero.

For the 1987 fiscal year [which began October 1, 1986], the president's budget proposal included a 2 percent increase, described by a word I had never heard before, and have not heard in any other context: a "placeholder."

I thought there was some consensus developing because ProPAC suggested 2.8 percent, but HCFA very graciously proposed regulations calling for an increase of one-half of 1 percent, and that was done only after a heated meeting between HHS Secretary Otis Bowen and some of the hospital groups.<sup>5</sup>

Probably even more important in dollars, HCFA announced its intention to terminate the periodic interim payment (PIP) program for hospitals. If this is approved, institutions are going to have to increase their borrowing.<sup>6</sup>

I am very disturbed about slow payments to the Medicare claimants—providers, suppliers, and beneficiaries. I will introduce legislation to apply the concept of the Prompt Payment Act to Medicare reimbursement.<sup>7</sup> It would simply say that “clean” bills presented to carriers and fiscal intermediaries not paid within 30 days would carry interest after the 30th day. I also intend to include a provision in the bill to maintain the present PIP arrangements by stopping the administration’s proposed regulations from taking effect.

The fourth point is that, as federal funds for new programs become harder to find, the private sector will be required to carry the costs of activities previously financed by the government. Medicare, for example, can now be the secondary payer for the working elderly. Also, I have already mentioned that employers that maintain an employer-provided group health plan must offer a continuation option for certain groups. I know this is controversial, but it is not especially revolutionary. Look at the many state laws that mandate insurance coverage of a wide range of services, providers, dependents, and diseases. I think that trend is going to grow, and has already spread to the federal level.

My fifth point is that there may not be many bills passed by Congress limited to health or Medicare. We are in an era of what I call “megabills,” bills which encompass several areas and which may

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<sup>5</sup>Editor’s note: For an update on the Medicare rates for 1987, see the postscript to Appendix A.

<sup>6</sup>Editor’s note: PIPs were implemented prior to establishment of the prospective payment system to ease the cash flow of hospitals receiving Medicare reimbursement. A hospital received payment from Medicare every two weeks based on its total Medicare reimbursement for the previous year; at year’s end the cumulative amount paid was adjusted to reflect actual expenses. In budget reconciliation legislation (P.L. 99-509), the 99th Congress eliminated PIPs for all hospitals except those in rural areas and those serving a disproportionate share of low-income Medicare beneficiaries.

<sup>7</sup>Editor’s note: The proposal was incorporated into budget reconciliation (P.L. 99-509). It requires that a 25-day deadline for payment of Medicare claims be fully phased in by 1989, beginning with a 30-day deadline effective October 1, 1987.

include recommendations from a number of committees. The tax reform bill (H.R. 3838) is a perfect example. Who would have ever thought that the Internal Revenue Code, as it applies to both individuals and corporations, would be put on the table and proposals for change incorporated into a single bill? Continuing resolutions for appropriations are another example. We are supposed to have 13 appropriations bills. Last year, only six were passed separately. The other seven were put together in a continuing resolution, a megabill; the biggest of these is the budget reconciliation device I mentioned earlier in connection with Medicare changes. Such bills are likely to be an annual vehicle for program changes, and in the health field will largely be on the margin of policy.

Efforts will continue to make the DRGs workable and fair. Expensive new benefits are going to be proposed and considered. At the moment, I think they are unlikely to be added, for many reasons. Some of those are partly because of the Gramm-Rudman-Hollings environment, partly because of administration opposition, partly because major studies of catastrophic care are under way, and partly because the Medicare trust fund faces possible depletion within a decade.

My final point, and this is probably the most obvious of all, is that financial stringency will heighten the awareness of ethical dilemmas that have been there all along but which we have tended to cover up. It will stimulate needed and valuable debate and analysis, but in the end, members of Congress will be the last people in the country to have their fingerprints on any policy that appears to ration health care. We will "allocate" scarce resources, but we will not "ration" health care.

## **XI. Why the Private Sector Should Care about the Medicare DRG System**

Stuart H. Altman, Ph.D.

What Medicare and the federal government do very much affects the private sector, but they are not going to wait for the private sector. Congress is going to pass laws that might look like they only affect the Medicare program, and since employers are knee-deep into worrying about people buying Xerox machines or what bank to invest in, they could say, "Gee, that's not that important to the private sector or my employees."

I am here to tell you that the medical care system is a partnership. Whether employers like it or not, if one partner goes out and decides to knock down his part of the house, it is going to get drafty on the other side. So, I would like to put in a plea for the private sector to become concerned about some of the Medicare issues that have come before us at the Prospective Payment Assessment Commission (ProPAC), issues which we believe are not being handled well by the administration. With the new direction at the Health Care Financing Administration (HCFA) started by Dr. Roper,<sup>1</sup> maybe I will feel differently in the future.

Some people may remember the concerns expressed by representatives of the insurance industry in the early 1980s about the shifting of costs from Medicare to the private sector. Medicare paid 77.1 percent of the charges paid by private patients in 1980. This relative Medicare payment rate fell and continued to fall and reached 71.8 percent by 1982. Many employers learned the hard way as they found their premiums going up, not by the 10 or 15 percent that they expected, but by 30 to 40 percent. One of the reasons that happened is that hospitals did not voluntarily accept the Medicare reduction. They looked around for another deep pocket. And guess who it was?

### **Medicare Pays Larger Share of Patient Charges**

While these past statistics may be well known, what is interesting is what has happened in the last few years. This information comes

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<sup>1</sup>Editor's note: For a discussion by HCFA Administrator William Roper of his policy agenda, see Chapter IX.

from the Office of the Actuary, and economists have learned to respect actuaries, even if we do not understand them. Wilbur Mills<sup>2</sup> once said, "Get all the economists out of here. I want to see an actuary."

These HCFA figures show that since 1982, the 71.8 percent rate rose to 75.7 percent in 1983, and to 82.9 in 1984, indicating that Medicare is now picking up a larger and larger relative percentage of private patients' charges. This should be wonderful news to employers, because it means that they are less likely to be cost-shifted against. But this number could turn down, and that is what I want to talk about.

Congressman Gradison indicated a number of reasons why this is likely to happen as the government becomes a tougher, more prudent buyer. I also want to focus on the issue of how we should pay for new medical technology.

### **Is the DRG System Responsive to New Technologies?**

When Congress passed the PPS/DRG [prospective payment system/diagnosis-related group] system in the early 1980s, I do not think it wanted to freeze the medical care delivery system with the technologies and procedures that were in place in 1981. It recognized that it was putting in place a totally new system, which had many positive incentives in terms of making Medicare providers more concerned with costs and trying to find the most efficient method of providing hospital care. But Congress also realized that it was putting in place a payment system that might not be responsive to new kinds of medical technologies.

There was no problem with technologies and procedures that saved the hospital money. That the DRG system does in spades, and no one needs to be concerned about that. But there are other kinds of technologies. We can dismiss those technologies that are both cost increasing and bad for health care, and good riddance to them. We know they exist, and I think the DRG system provides the right incentives to eliminate such technologies.

But what about two other kinds of technologies? The first type is that which increases costs to the hospital but reduces costs for the total medical care system. Most employers are not concerned about hospital costs alone. They either pay total medical care expenses or insure total medical care expenses, and, therefore, have to be concerned about a system that only worries about part of the total.

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<sup>2</sup>Editor's note: Wilbur Mills is a former congressman and chairman of the powerful House Ways and Means Committee.

The other type of technology is that which is cost increasing, not only for the hospital but for the entire medical system, but which also increases the quality of care or improves a patient's life style. I know most employers are not so hard-hearted that they only think about the bottom line. The discussion at this policy forum clearly indicates the importance that many employers place on increasing the quality of our medical care system.

Where does that all take us? I want to focus on three issues that have come before ProPAC in the last two years. I am not saying that we at ProPAC have come up with the right solution. As a matter of fact, I am going to suggest that in at least one case we may have come up with the wrong solution. But we are trying to address these issues.

### **DRGs Fail to Adjust for Price Differences**

The first example I would like to use is the cardiac pacemaker. I have never seen a pacemaker, and I hope I never need one, but for those of you who know less than I do, there are several different types of pacemakers. Some are rather simple; they are not programmable and they have one chamber. Then there are dual-chamber units, and there are dual-chamber pacemakers that are programmable.

As you might expect, the more sophisticated units are much more expensive. Unfortunately, the DRG system does not adjust for any of these financial differences. While there are different DRGs for pacemakers, they are based on whether the pacemaker is put in during a myocardial infarction, or whether it is a replacement, but it makes no adjustment for differences in the cost of the device.

Now, to make the numbers simple, let us say the less complicated one costs \$2,500 and the more complicated one costs \$5,000. You could almost double that difference when you finish with the extras, e.g., surgeons' fees.

Well, just think about the pressure on the hospital. The hospital gets one payment, and, say, the payment is the average of the two, or \$3,750. That means every time the more expensive pacemaker goes into a body in that hospital, the hospital loses \$1,250. Likewise, when the less expensive model is used, the hospital gains \$1,250.

When you hear a lot of hoorays, it is when a doctor implants the less expensive unit, so the hospital is happy. Well, that sounds great, except there are times when the patient really needs the more complicated device. It is not clear to me that I want to see that much of a financial incentive to implant the less costly unit. Suppose the difference was \$2,000 and \$10,000 or \$2,000 and \$20,000. Since the



DRG system is non-device-specific, these cost differences do not translate into differences in payment to the hospital. It was designed that way and there is, in fact, a religion built up supporting the notion that the DRG payment amount should not be related to the cost of the medical devices used.

We at ProPAC have had to grapple with this issue. Of course, the pacemaker industry educated us on this problem. We had a variety of choices, but it all comes down to the question of whether to split the DRG system based on whether it is a single-chamber or dual-chamber device, or create an alternative based on a mixed payment system.

The commission decided to split DRGs based on whether the device used was a single-chamber or a dual-chamber model. We had three basic alternatives. We could leave it alone, which I suspect is what HCFA will do; they are much more religiously inclined. But, as is true in many religions, the rules are violated many times by the faithful. So, too, in the DRG system. For example, if a patient needs surgery, a new DRG is assigned. Surgery, after all, is a medical procedure. So why not accept some procedure or device DRGs on the medical side?

The commission recommended that we split the pacemaker DRGs because it believes that the current system is not good for high-quality care; it does not establish the right set of incentives. I support the commission. I think we need to make such a change. The reason I bring this issue to your attention is that once the decisions are made by Medicare, the private sector will not be free from the implications. The hospitals will stock a more limited number of the higher-cost pacemakers, or they will make sure that all the high-cost pacemakers go to employers' patients because employers are better payers. Or, employers are going to find themselves paying for the more expensive units through their Medicare wraparound plans.

### **Current System Does Not Allow Supplementation**

One other item: We currently have a system that does not allow supplementation, which means that if my doctor and the hospital decide I should get the single-chamber pacemaker but I want a more complicated device, I cannot pay the extra amount to get the more expensive unit.

Most of the pacemakers being implanted today, even with this negative incentive, are the more expensive devices. But who knows what will happen when things really get tough? Understand this: The DRG

system has been an easy system up until now, but, as Congressman Gradison pointed out, you cannot be sure that will continue much longer. Hospitals might then get a little tougher than they have been.

I had proposed an alternative mechanism for paying for such devices by basing the payment on the hospital's specific cost of treatment (50 percent) and on a national rate for that diagnosis (50 percent). My reason for doing that is that I believe the country has overlearned the lesson that economists and others were arguing. Under a cost-based system, we said, "You have no incentive to reduce expenditures." The hospitals, in that case, or the medical community had a blank check. There is no, in the vernacular, coinsurance.

### **Cost Incentives Versus Quality**

Now what have we done? We have flipped the system completely on its ear and have said to the hospital, "You have a 100 percent coinsurance rate for every device you use. Every time you spend any money beyond the minimum necessary to treat the patient, the hospital receives no extra compensation." From an economist's point of view, this is too drastic a change. We love margins. We do not believe that there should be all-or-nothings in this world. So, what you want to do is put a reasonable coinsurance rate in place that says to the hospital, "If you use the most expensive procedure, you're going to have to pay something for that. You shouldn't always use the most expensive device. And, if you use the least expensive, you will make a profit, but the difference either way will not be so strong that it might force the medical community to deviate from what is good medicine."

If you work out the arithmetic, you will see that if you put 50 percent of \$2,500 and 50 percent of the average of \$3,750, you come up with a coinsurance of about 12.5 percent.

The important message of this example is that the DRG system is not a simple technique that can be left alone. Regardless of the rhetoric that got the legislation passed, this is a very technically complicated piece of legislation.

In spite of the rhetoric that suggests we now have an "Adam Smith" hospital payment system that can be left alone, if Adam Smith does not work for HCFA it is not going to be changed, and if it does not change it is going to get worse.

The old cost-based system was like Silly Putty. If somebody in a white coat decided what piece of medical machinery should be bought by the hospital, it would be bought and the costs would filter through

the cost report. Out on the bottom would come a statement, and the Medicare system would have to pay. While we did not like this system for many reasons, nobody had to make a big decision about how it operated. Now we do have to make big decisions on how to pay, and the biggest one I see in the immediate future deals with magnetic resonance imaging (MRI). I do not have any stock in an MRI company, nor do I care about MRIs per se, but I do care about the types of incentives that the current system will send to the next generation of MRIs.

MRI is a very expensive technology. It costs a couple of million dollars to buy. It might cost a half-million to a million dollars to operate. Currently the capital side is passed through, but many of us believe that at some point capital ought to be added, in some way, to the DRG payment.<sup>3</sup> HCFA has announced that MRIs are a wonderful new machine and should be added to the medical armament.

How is the hospital going to get paid for the MRI? Well, one way to do it is what we call recalibration, the old trickle-down approach. Let me explain how the trickle-down system is supposed to work.

The MRI affects maybe 100 DRGs, which means that the cost of operating all the MRI machines will be spread among all the patients who are hospitalized for those 100 DRGs, regardless of whether they had a scan or not. That is, the reimbursement for each patient that does have a scan may increase by a nickel.

Just think of what kind of incentive that provides to hospital administrators. How would you like to be the salesman for the next generation of MRIs who tries to explain to the hospital why it is in the hospital's best interest to buy this new machine? Again, it is not MRIs that are important; they are already in production and have proven to be a valuable addition to diagnostic radiology. It is whether we want the health system to have a balanced set of incentives.

ProPAC grappled with this issue and finally said, "Yes, we need to make a major exception to the way other DRGs are priced. We need an add-on payment for each MRI scan provided, at least for the next couple of years. The add-on should be a fair, but limited, amount. It should not be a giveaway. It should be based on the cost of operating a machine in the most efficient manner. The hospital should not make

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<sup>3</sup>Editor's note: Medicare currently reimburses hospitals for their capital expenditures through a payment mechanism separate from the DRG payment. (In fiscal year 1987, the reimbursement is 96.5 cents for each dollar of capital costs, and will decline to 93 cents in fiscal year 1988 and 90 cents in fiscal year 1989.) There are various proposals to change this approach by including capital costs within the prospective payment system.

money by simply doing scans on every patient. If a scan is done on a patient, regardless of whether the hospital owns the MRI, the hospital should get paid an extra amount of money. If the hospital owns the MRI, it should get a smaller amount because it is getting its capital passed through. But if the hospital does not own the MRI, and has to go out and purchase it either from another hospital or an outpatient unit, then it should get a payment that includes something for capital. But the amount will be tough and, in most cases, will be inadequate to pay for those MRIs in institutions that are not using their machines efficiently."

This may not be the best method of paying for the new technology, but at least it says to the medical technology world, "If this technology is valuable, and most medical people think it is, it should not be overused, but it should be available." Employers, too, need to be concerned with this issue, because either they are going to wind up paying disproportionately for it, if Medicare does not, or it is just not going to be available. Employers should voice their collective or individual impressions on what needs to be done.

### **Inpatient Versus Outpatient Charges**

One other issue I would like to mention is that the DRG system suffers from a serious problem, one that, unfortunately, happens in the federal government all too often. The federal government likes to fight with the hospitals. There are few of them and they are standing targets. The federal government does not like to fight with the doctors. They are not fixed targets, and congressmen and administrators know doctors and often like them.

So, just like we did in Medicare during the 1970s when we were very tough on inpatient care and did little to control outpatient spending, so, too, today we are very tough on the inpatient side of the DRG system. Just think of what the health care world is going to look like if we keep tough controls only on inpatient care. Not only will the hospital not get the operating money for the MRI, it will not get the capital payment either. It is going to get a fixed amount of money per DRG, regardless of how much is spent for the patient. It will, however, continue to pay for outpatient care on a cost basis or some other rate.

How complicated do you think it is going to be for a hospital to put every piece of equipment on the outpatient side of the ledger? Then the government will pass a law that says outpatient care cannot be in the same building, so you will probably see a knife come down

and chop the hospital so that there will be a two-inch margin between the inpatient side and the outpatient side, or they might require a minimum distance of 500 yards, so we will have to build tunnels.

It is a bad system. I think everybody who knows about it agrees. We have several choices. Many people, including Dr. Roper, are supporting the need to go to capitation, full payment, vouchers. Others are talking about including an ambulatory DRG.

While capitation is very attractive, and vouchers are very attractive, I would like to add a cautionary note: It is one thing to look at capitation when it is 5 or 10 percent of the health care system and all of the needed redundancies are being picked up by the fee-for-service system. But what happens when the percentages flip completely the other way around and you have 80 percent capitation and 10 or 20 percent fee-for-service? Can we be sure that all the incentives that were good and virtuous for the prepaid capitation will continue, and can we be sure that the set of incentives that exists today will continue? I am not so sure. As a matter of fact, I am almost sure that they will not be. It may be that the worst thing we could do for capitation would be to overburden it.

I believe we do best legislatively when we offer choice. We do worse when we mandate A or B. I would like to see capitation grow. But I would fear very much if, in the process, we forgot about the fee-for-service DRG system altogether. Sometimes I have the feeling that some people are doing that, or that we penalize fee-for-service so much that we reverse history and put the same burden on fee-for-service that used to be on capitation.

Let me end by reiterating what I said when I began: This is not only for the Medicare program. Employers cannot run their one-half or two-thirds of the health care system without the other third in sync. Employers must make their voices heard.<sup>4</sup>

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<sup>4</sup>Editor's note: For further elaboration of Professor Altman's views regarding the Medicare DRG system, see Appendix A.

## **XII. The Individual's Role in Controlling Cost and Quality**

Morris B. Abram, J.D., Ph.D.

The subject of this panel is "Social and Policy Issues in a Changing Marketplace," and as I have listened to the discussion this afternoon, and as I read the papers that have been presented, including the background papers, I decided that maybe I agreed with the 18th century poet Alexander Pope when he said, "For forms of government let fools contest; Whatever is best administered is best."<sup>1</sup>

I am rather inclined to believe that the health care system itself is not as significant as the way in which the system is employed. You will see what I mean in a moment, and I hope you will forgive me, because I am going to be very personal in my remarks, speaking from my experience as a patient who fell ill of acute myelogenous leukemia in 1973 and has been in remission since October 1973, and as one who has had a good deal of experience with doctors in the treatment of a fatal disease, and also through my work on the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Some very learned remarks have been made today on some dramatic and some marginal shifts that might be made in the current health care system to get control of burdensome costs. The Congress, as Bill Gradison says, is certainly not eager to resort to one of the ways of dealing with that—rationing health care—and I do not blame them. We hope it does not have to come to that.

But we are also concerned with quality, and I would like to suggest to you that the medical care system in this country is driven by some inexorable ties which make the problem ever growing and ever more difficult to resolve.

### **Societal Factors Influencing the Medical Care System**

There is, first of all, what I would call the greed for life, the greed for the extension of life. For who wants a greed for death? Then there

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<sup>1</sup>Editor's note: Mr. Abram's eloquent address is all the more remarkable for having been delivered from notes rather than a prepared text. This chapter is edited from the transcript of an audio recording of his remarks.

is the doctor's oath and determination to satisfy that greed for life. But who would want doctors trained otherwise?

Then there is the increased technology, often very expensive, which makes it possible to extend life, particularly at the margins. Given the philosophy that governs the medical care system in this country, which is one of ethically providing a person with that care which the person, as an autonomous individual, needs—rather than the philosophy of a utilitarian society, which is to provide in an ethical way the greatest good for the greatest number of people—we are inevitably going to have a set of very difficult problems.

We do not want a society that operates health care in an authoritarian manner, by punishing people who smoke or who eat too much or who engage in other practices—preventable by willpower—that could have a significant impact on health and on national health care costs.

So we are dealing with a system that places enormous emphasis upon the preservation of the individual and the individual's rights and on the protection of the medical profession in its increased use of technology.

Recently, at the National Leadership Commission on Health Care, a discussion took place where it was said that we have a society with wish lists. The patient wants everything that might be good for him. The doctors want to give everything that might be good for the patient. Everybody wants more technology. And society wants lower costs.

You know, this was all possible at one time, and that is the strange thing. It was all possible at the beginning of my lifetime. You could have had every one of these things. I admit we did not have them, because medical care was spotty. But where I grew up in South Georgia, the best of medical care, which my grandfather was administering, was available so cheaply: nitroglycerine, quinine, a few simple operations, a few simple anesthetics, home delivery of most babies, and no antibiotics. It was not difficult to provide all of the things that medical technology could afford or knew about at that time without much of a drain upon the national product. That is certainly not true today. But something else was plentiful then that seems to be less available today, and I am going to speak about it rather bluntly. One of the missing ingredients is that the medical profession back then was a much more caring and personal profession.

My grandfather was a doctor. He graduated from Jefferson Medical College in 1881. He put his sister through the Women's Medical College of Pennsylvania in 1879. By 1904, however, she had ceased to

be, as they were then called, a heliopath, because she claimed she could not do much for people. So she ceased to be a general doctor, much to my grandfather's disgust. She went to the Philadelphia College of Osteopathy, because she could at least lay on hands and prevent some suffering and give some bond.

Although medicine in those days was not characterized as being terribly scientific, it was sometimes effective. Some of you know how expensive psychiatry can be. I remember very well something that happened when I was a 6-year-old child and my grandfather was moving to Cleveland to retire. I loved him deeply.

One morning I simply could not walk. My mother called Grandpa in great desperation: "Morris can't walk." This was the era of the scourge of polio, so Grandpa came and looked at me. He carried me to his office, which was not yet dismantled. He laid me on a table and treated me with all kinds of sparks and electrical instruments which, I suppose, really did nothing.

After having done that over my body, he said, "Now you can walk." And walk I did. He knew, though I suppose he had never read Sigmund Freud, that I had a form of hysteria and needed a very powerful suggestion from a very authoritative figure. Medicine in those days did have some healing forms and some healing consequences.

Today, of course, medicine is so different. In the 1940s, medicine was composed of 80 percent general practitioners, or people who called themselves that, and 20 percent specialists. Now the figures are precisely reversed. The care they provide is paid for by third parties and delivered by cohorts to a human body that is parsed, or separated, into all of its components. Physicians render care in an atmosphere where consumerism causes patients to be very suspicious of doctors, and where lawyers are around to sue for malpractice.

### **The Patient As the Common Link**

I would like to speak for a minute about the parsing of the body because, to some extent, it is the heart of the problem we face, at least in the hospital setting and in the case of very sick patients.

When I was being treated for leukemia, I was attended by hematologists, a renologist, a cardiologist, a hepatologist, an immunotherapist, an oncologist, and a psychiatrist. I grew very tired. Everybody was demanding blood samples, and nobody ever asked the others whether they were going to require a blood sample that day. I could not find out, because information was parsed as the body was parsed.



They were all wonderful doctors; otherwise, I would not be here today. But I remember calling them all together, the gray beards and those not so gray, and I said to them, "Look, I'm tired of all this. You're all great, but I want a doctor." And I turned to a woman who was about my age and said, "You're it." She became the doctor and the "filter."

No one else had decided that I needed a doctor. They all thought I had needed the specialists who had parsed my body. Things improved after I designated that woman as my doctor. With her aid and cooperation, I was able to enforce the order that no one was to touch my blood vessels but once a day, so they had better get together the night before and decide how much blood they needed and for what purpose. Beyond that, unless it was an emergency, I was not to be touched.

My blood vessels were wearing out. I knew that pretty soon they were going to go to the scalp, where they sometimes take blood or infuse a baby. I said, "I'm not going to be touched by any of these clumsy doctors or very clumsy interns. I want an intravenous nurse. She knows what she's doing; she does it many, many times every day."

There developed a fine relationship and, I think, a healing relationship. Ever since that time I have known that it is the patient who is ultimately the only person in the world who is able to control costs and ultimately the only person who is able to control quality. You may think otherwise, but let me say this to you:

In the modern hospital setting, the greater the hospital, the more vacations they have and, therefore, the more variety of cohorts. They work 40 hours a week. There are three shifts a day. They have vacations. They get sick. Consequently you are attended by a vast array of strangers in the subsidiary categories.

They do not always read orders. The only people who can monitor the care you receive in such a setting is either you or your family. Now, you may think this is not very likely, but I was in a great hospital. I was supposed to have seven days and seven nights of continuous infusion of Cytosar, amongst many other drugs. At the end of the fifth day, a woman came in to take the needle out of my arm. I said, "What are you doing?" She said, "You've had all you're supposed to have." I said, "Like hell I have. I'm supposed to have seven days." Maybe five days would have been enough, but I was ordered to have seven, so the needle came back in. The next day, she took it out again. Yet it had been only six days.

I cannot tell you the number of times in which quality control really

rested with me and my wife. For example, a bag of platelets which are not matched cannot be put into a patient without first giving the patient Benedryl; the patient would go into shock. Yet I cannot tell you how many times, through my vigilance, I had to remind the hospital staff of that.

### **Improving the Doctor-Patient Relationship**

I have become an extremely wary user of medical service, although I am extremely grateful for it, and I have no doubt that we have the finest medical system in the world. The Japanese may be better in automobiles and the Germans in cameras, but, at its best, our medical system is the greatest. And I was at its best.

But the fact is, the doctor-patient relationship has broken down. The consumer of medicine is not an informed consumer; and with better information he could be a much better source of cost control.

Let me give you this illustration. I have not seen an oncologist in five years, but I went to see an ordinary internist, a marvelous person. I was terribly impressed with him. The other day, he said to me, "Morris, you've got a murmur in your right aortic valve."

I am 67. I said, "What am I supposed to do about it?"

"Nothing."

"Is it going to hurt me?"

"No, I don't think so. It's going to outlast you, anyway."

"Shall I stop doing anything?"

"No, but come back for an echocardiogram in two weeks," he said.

"By the way, have you got a dermatologist?"

"Yes."

"Has he seen that brown spot on your ear lobe?"

"I guess so."

"Better let him see it again."

Now, bear in mind that these doctors know of my relationship to the medical field and my interest in it.

At the end of a week, I called up the internist and said, "I want to ask you a question. It doesn't make any difference to me what that echocardiogram costs. I'm not paying for it, the insurance company is. But I want to know why I've got to spend the time to go down there and get that echocardiogram. Whatever it tells you, are you going to change anything, make any recommendation, or do anything?"

"No."

"Then why in the hell am I having it?"

"Good question. Don't come."

Next I went to see the dermatologist. He looked at my ear lobe and said, "I've seen it. I think it's an angioma, a broken blood vessel, but if your internist thinks . . . ." And he got out his knife.

"Now wait a minute," I said. "I'm going swimming this afternoon."

"Not if I take it out. You're not going swimming for five days."

"Well, now," I said. "That's serious. Can you do a needle biopsy?" I did not have the foggiest idea whether you could or could not.

"No," he said, "but I can stick a needle in it and draw back, and if it's an angioma, as I think it is, it'll disappear."

"Why don't you do that?"

He did; and it disappeared.

Now, if this can happen in reputable places amongst reputable doctors, you can imagine what the costs are to this country as a result of negligence or ignorance or worse. The President's Commission found that 20 percent of hospital days in 1983 were inappropriate, and that 50 to 60 percent of antibiotics administered were not indicated. Of the 75 million x-rays a year, costing \$2 billion, one-third are not needed, and some of them probably are positively harmful. Less than a 10 percent reduction in use of intensive care would save \$2 billion a year. Twenty-five percent of all respiratory care is not needed, representing a total annual cost of \$5 billion. The American Medical Association says that \$15 billion is now spent on defensive medicine each year.

Now, as if all of these concerns are not enough, we know that we have a patchwork system that leaves out enormous numbers of people. One of the President's Commission's enduring monuments is that it stated for the first time that American society has an ethical responsibility to provide all citizens an adequate level of health care without imposing an excessive burden on any. I did not say it was a *right*. I am sure Congress some day will decree it to be a right. But we said it was an ethical responsibility. It was not easy to get a unanimous report to that effect, but we did.

If we are going to have real cost controls, we will need what the President's Commission suggested, and that is a proper relationship between the doctor and the patient. We do not yet have it. For example, take that little document called "informed consent."<sup>2</sup> We got

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<sup>2</sup> Editor's note: Essentially the informed consent document is written consent obtained from a patient authorizing the performance of a specific medical, surgical, or research procedure after the procedure and risks involved have been fully explained to the patient in nontechnical terms and are understood by the patient.

Louis Harris and Associates to do a survey asking people what they thought that document meant. Seventy-nine percent of the patients in a representative sample said that the informed consent document they signed was only for the protection of the doctor; and 55 percent of the doctors agreed.

Eighty-five percent of the patients said they wanted to know the truth with respect to their illnesses, even if it meant the most dismal facts, namely that, as it was phrased, they might be dead within a year.

Seventy-two percent want to make decisions jointly after the alternatives have been explained to them by their doctors; but 88 percent of physicians believe that patients want doctors to choose the best alternatives for them.

When asked what "informed consent" meant to them, 14 percent of physicians mentioned discussing treatment alternatives. Only 9 percent indicated that informed consent had something to do with a patient's making a choice or stating a preference with respect to treatment.

On the question of cost, 70 percent of patients said the doctor has a duty to initiate discussion of the cost of the therapy or treatment. Only 38 percent of doctors say they do.

You will never have complete informed consent between a patient and a doctor. The level of knowledge is so different. But at least that survey shows the gap could and ought to be closed.

## **The Shared Relationship**

Discussion of these relationships, the President's Commission said, is required in a proper ethical framework between doctor and patient. We called it the "shared relationship." Now, we were not crazy enough to think that all patients can understand what some patients can. We were not saying that all doctors should discuss every minutia of what can or will happen. We said the doctor has a responsibility to establish a relationship with a patient and say, "Now, look. These are the alternatives. These are the *probable* effects." The doctor should also *invite* the patient to discuss *the possible*, and then discuss what the effect or probable effect would be of having no treatment at all.

The observational studies conducted by the President's Commission are striking in their findings. In hospital settings, often little or nothing is actually discussed with a patient regarding either alternative treatment or recommended treatment, to say nothing of the cost. Instead, physicians commonly make decisions and proceed to

treat the patients. Ninety-seven percent of those patients, however, say that they should have all the available information they wish, and 38 percent think they are told too little even in the routine case.

They *want* that invitation. But, you see, that invitation requires time that is not generally compensable on a chart. I believe a shared relationship would have a tremendous effect in cutting down the patient's anger, which in turn contributes so much to this dreadful malpractice problem, which is a drag on the system and which also produces false positives, in which tests indicate that a certain condition is present when it is not, to say nothing of defensive medicine.

The shared relationship would be a cost cutter. The President's Commission regarded it as part of therapy. The President's Commission said, and no one has contested it, that the shared relationship should produce better outcomes. It is part of good care. It reduces anxiety and complications during convalescence. Fewer analgesic medicines or days in the hospital are needed. In talking about methods, modes, and things that may be adjusted at the margin, we also ought to talk about the nature of this relationship.

I know how the current relationship got started. We all do. I wonder how many of you know what Hippocrates said about it? "Perform these duties," he said to his young men, "calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him. Sometimes reprove sharply and emphatically and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition." That might have been good ethics in Hippocrates' time—almost anything he told the patient would have been wrong. But that is not true today.

I am not foolish enough to think you can teach people about this relationship in a textbook. I think you need role models. I do not know of anything more important to me than something my great oncologist—and he *was great*—did. When I was lying in bed, he would never stand over me; he knelt by my bed and spoke to me at eye level. And nothing impressed me more than when he thought I was bleeding from the bowel and he did not call the nurse, but instead put on a rubber glove and scraped to stain the slides himself.

I can tell you there is a great difference in the way medicine is practiced by the great healers and the way it is practiced by technicians.

It is also true, I think, that there is far too little attention given to the cooperative relationship between nurses and doctors. They are

rarely trained explicitly to cooperate. When President Carter appointed the commission, it included theologians, doctors, and lawyers, but out of 11 people he did not appoint a single nurse. So when the first vacancy occurred, I went to the White House and said, "Where's the nurse?" We got Carolyn Williams, a professor of nursing at the University of North Carolina, and she made a great contribution.

My main point is that beyond all the health care systems and beyond all the laws and all the methodology, there lies the human factor. That human factor is not just something ethical, kind, and humane. It has an extraordinarily practical impact on the issues being discussed in connection with our changing health care market.

## **XIII. Discussion**

### **How Financing Affects Coverage**

MR. SEIDMAN: I work under Stuart Altman at the Prospective Payment Assessment Commission (ProPAC), and I want to add two points to what he said. The first is that virtually every decision ProPAC makes is under a zero-sum restriction, which means that if we put in more money for pacemakers, for magnetic resonance imaging (MRI), or for whatever it may be, it must be done by subtracting proportionately that amount of money from the rest of the expenditures for the system. Therefore, those decisions become a question of not only whether those things are good in and of themselves, but what has to be reduced in order to add that new expenditure.

The second point is that, to the extent we are dealing with a zero-sum situation in the private sector these days, you have to consider the same thing every time you are talking about, for example, covering something that was not covered before—namely, what is that going to do to the rest of the system?

Related to all of this is the other point Stuart Altman made, that the diagnosis-related group (DRG) system at the present time covers only inpatient care. But the decisions that are made with respect to inpatient care, or what is covered by the DRG system, in effect relate to everything that is *not* covered by the DRG system.

We are seeing that in its worst form in this discharge of Medicare patients “quicker and sicker,” because the facility to which people are discharged is not covered by Medicare or is paid for in part by patients themselves. The same thing is true in the private sector. Something is covered and something else is not covered and decisions that are made with respect to what is covered have an impact on what is not covered. These are very excruciating decisions once you get down to them.

### **Capitation and the Medicare Program**

REP. GRADISON: With regard to the idea of a voucher or capitation system, as one who has been promoting the notion, I think there are two aspects that are very important about such a system.

One is that it should be voluntary. We have already done that. The other is the provision of an element of choice, which is not provided

today, by perhaps requiring that the voucher merely require that the services be actuarially equivalent to those in the Medicare package. The subscribers might prefer larger catastrophic protection and pay a little bit more up front or per day. That is extremely hard to do with government as compared to the private sector. Some specialties and services included in Medicare today might not be included in a competitive environment because they would not be as attractive as other things making the package saleable. We would be under enormous pressure not to change. We are under this pressure not to give the choice that I think private industry is pointing toward.

### ***Quality of Care***

I also want to second the comments about quality. I have been following with enormous interest and trying to learn from the experience of the private sector. Certainly to go the health maintenance organization (HMO) route or the preferred provider organization (PPO) route without building in a very tight method of monitoring quality and being able to make comparisons of the choices being offered to employees is a mistake. We may be saving dollars but not getting the quality of care that people expect.

The individual patient is not in a position to make that judgment. He has a sense of what has happened, what the outcome or the quality of care has been, and of the bedside manner of the particular person who has been helping him. Only the employer, however, or some group larger than a single employer has a sufficient database to make an informed decision about whether this is a good doctor or a quack.

### **Medicare Rates**

MR. MICKEL: Mr. Gradison, do you think Congress is going to get involved in the prospective payment rate-setting this year, as it did last year?

REP. GRADISON: Yes, I do. It is difficult to anticipate what we might come up with, or even to raise this to the higher level of whether we are going to continue to delegate this power to the Health and Human Services Secretary. That is a question we ought to be thinking about—whether we should each year go back and reexamine the numbers, hold some hearings, and try to change the rates, or whether we are satisfied the secretary is carrying this out properly.

The way the federal budget numbers work is interesting. Our budget baseline at the congressional level presupposes the 2 percent in-



crease in DRGs, which is the placeholder. We could come up with 1 percent, which is one-half of a percent better than the administration has offered the hospitals, and still show a saving of the other 1 percent. This is worth more than \$400 million in the first year alone.

There is a lot of room to do things with what you might call—and I would not argue—blue smoke and mirrors. But if we came up with, say, a 1 percent increase instead of the 2 percent, we could then apply the difference toward freezing or greatly reducing the increase in the Medicare hospital deductible and make many people happy, with the exception of the Reagan administration.<sup>1</sup>

### **Changes in Employer Attitudes**

Ms. CARMICHAEL: As we see changes occurring in the health care industry, we are also seeing similar changes occurring in the benefits community. For example, employers are moving away from a paternalistic attitude regarding benefits. There is going to be greater emphasis placed on individual responsibility and control. Xerox and Citibank and a number of corporations took the first step in that direction a few years ago by introducing multiple-option medical plans. At Citibank, we have three options available through a fee-for-service arrangement, plus 38 HMOs. We are moving in the direction of making choices available to employees and letting them decide the type and level of coverage they want.

In response to a question that was raised earlier, we have felt all along that education was an integral part of our cost-containment strategy. To that end, we introduced an employee publication called *Remedies*, which provides our employees with information that would enable them to make choices in the utilization of medical care. For example, one issue of the publication addressed the questions they should ask in exploring alternative types of care. We are also setting up a hotline for employees in crisis situations, to give them access to information that would enable them to work through the system and find the most appropriate type of care.

We also have a staff advisor and employee assistance program to help employees make these kinds of choices. Most of the major corporations are following suit. If they do not have those kinds of programs in place, they are working in that direction.

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<sup>1</sup> Editor's note: For an update on changes in Medicare rates for 1987, refer to the Appendix A postscript.

In terms of the future, more decisions are going to be made by employees rather than by employers. This will change, to some extent, the role of the benefits manager over the longer term. We are already finding ourselves in that situation. Initially we took the position that we did not have the medical expertise to evaluate forms of delivery systems. So when the HMO legislation was enacted and employers were required to make available federally certified or state-certified HMOs, we took the position that we were going to offer all of them as long as there were at least 25 employees within the service area. We wanted to let the employees decide whether they wanted to participate in the HMO or avail themselves of a fee-for-service arrangement. Last year we began reaching the saturation point, in terms of our administrative ability, and actually turned away six HMOs.

That type of situation is going to put the employee benefit manager in a position of having to evaluate, to some extent, what kind of options will be made available to employees. It is a critical issue, and one that may lead us to the medical community for assistance in making that kind of evaluation.

#### ***More on Quality of Care***

I would like to make a couple of other comments. Our concern as an employer is not solely costs. I think the other benefits managers here today would say that quality of care is of equal importance, or even of greater importance. With that in mind, we have started with the case management approach because we feel that it will allow us not only to control costs over the long term, but that it also offers the opportunity to provide quality care. It is our understanding that through these particular techniques the medical practitioners help the employee to seek or be able to obtain appropriate medical care.

I see some of these changes going more in the direction of employees making decisions in terms of purchasing medical care. Ultimately the shake-out will ride on whether or not employees are satisfied. If we have HMOs and nobody enrolls in them because they do not feel that type of coverage can provide them the opportunity for care at an affordable price, then eventually we will end up not offering HMOs. As PPOs begin to develop, we are going to be assessing them and including them in the package of options, providing more flexibility. Again, the central issue is one of customer satisfaction.

MR. MOSER: I work for Southwestern Bell Corporation in St. Louis. We have some 70,000 employees with 23,000 retirees. We have been struggling for some time with how to get a handle on our medical

costs while not diminishing quality. I share the feelings of other employers here that we never have approached a problem of such magnitude without a concern for what is in the best interest of the employees, and I do not think we will begin to now.

Some of the thoughts I have had today as I have listened to possible solutions to the various problems relate to the issue of cost shifting or cost sharing. I have a significant concern with cost sharing. While the Rand Corporation study<sup>2</sup> drew some conclusions as to the effect of cost sharing with regard to shifting the purchasing decision to employees, I agree that 20 percent of the people use 80 percent of the medical services. That is exactly what our internal statistics reveal.

I wonder whether this takes 80 percent of medical purchases out of a situation where it is a financial decision and makes it purely an emotional decision, particularly if the limits on employee out-of-pocket expenses are fairly low, as they are in most plans. What we are left with, then, is a situation where 20 percent of our people do not use the medical plan at all and 40 percent use it a little. So, cost sharing alienates 100 percent of the people and allows us the possibility of influencing only a small percent of our total costs. We looked at that and threw it out as a viable alternative.

Precertification and case management have been represented as being significant cost-containers. I do not necessarily dispute that, except I think that if you control utilization and do nothing with price, the inevitable result is that the price is going to rise. The provisions aimed at controlling utilization that do not attempt to control price are inevitably going to be off the mark.

When we looked at HMO utilization in our system, we also saw some problems. The employees electing HMOs were, for the most part, younger and healthier and tended to be low utilizers of health care. The HMOs based their premiums on those of our group insurance plan—which the insurer later increased to offset the effect of adverse selection, resulting from the loss of lower-risk employees.

The marketplace is moving toward a totally managed medical delivery system, one that provides significant benefit levels, perhaps comparable to what we have today with our basic coverage plus a major-medical override, but with the idea in mind that it would even provide additive-type programs in preventive and wellness areas. We could do that under a managed system with little or no cost impact. As a matter of fact, it is possible, if done properly, to put in effective

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<sup>2</sup>Editor's note: Additional findings from the study are discussed in the Introduction and Background.

quality controls and cost controls and actually save money. That is where I see the market headed.

In the system we envision, we would retain employee choice completely on a service-by-service basis, where the employee could move out of the managed system into a non-network-provider arrangement. But if they did so, that is where the cost sharing or copayment would enter the picture.

### ***Mandated Benefits***

I would like to comment on Rep. Gradison's comments as well. I have a little concern as I see Congress addressing some of these issues, particularly in the extension of medical benefits. I see the legislation moving toward what might be described as an ERISA-fication of welfare programs. ERISA, the Employee Retirement Income Security Act of 1974, was not successful in expanding pension coverage, and a similar movement in the welfare area is going to be equally unsuccessful in expanding the coverage of medical benefits.

We are placing controls on businesses, saying, "You've got to extend coverage, be it post-retirement or post-termination." It is adding more and more to existing plans and not doing anything about promoting coverage in those companies and businesses that have none. That is an erroneous way to move from a policy standpoint.

### ***Long-Term Care***

The final issue I would like to mention is long-term care. The demographics are almost shocking. We have people retiring earlier and living longer and restrictive tax laws on what employers can do to provide coverage for them in non-acute-care settings. You find yourself almost helpless as a benefit planner. I hope that Congress or the administration will examine this area—where we are going to have greater and greater numbers of people having greater and greater needs—because, under current rules and regulations, we are unable to deal with them effectively. As a matter of fact, that has led our company foundation to provide a substantial amount of money to EBRI for the study of this issue.<sup>3</sup>

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<sup>3</sup>Editor's note: EBRI's study on coverage and financing for long-term care is scheduled for completion in the fall of 1987. The Southwestern Bell Foundation, the Atlantic Richfield Foundation, and the American Association of Retired Persons have helped fund the study. For more about long-term care, see Chapter XVI.

## Cost As a Determinant of Quality

Ms. MOON: I want to pose some comments that I do not want to sound pejorative. We have been talking about a change in the basic question we have been asking in the health care area. That is, rather than starting with the question—as we might have done a few years ago—of what it will cost to give us quality health care, we are asking the questions, “How much are we willing to pay, and, within that constraint, what quality of care can we afford?”

It does not happen all the time, and I do not believe that everyone intends merely to save costs. But there has been a shift in the burden of proof of what is needed in moving to a different kind of health care system. The question comes down to cost as the driving force. We have heard that in this discussion in a number of different contexts.

Rather than trying to deny that, it is important to meet the conflict head on. The whole discussion of quality is a critical one. It points out something people have struggled with here today: When you focus first on cost, quality becomes a more difficult problem.

The problems associated with costs are less difficult under a capitated or DRG system, for example. In that kind of system, if you do not care about quality, you can easily cut costs. You simply establish an amount you are willing to pay and the problem is solved. The tough issue is how to have low costs with reasonable quality of care. In many ways this new emphasis is a reasonable one. For example, the point that Stuart Altman made [see Chapter XI] about DRGs helping to discourage costly, ineffective technology illustrates that we can help individuals as well as save costs.

On the other hand, under a system whose primary function is cutting costs, constant vigilance is necessary to maintain quality. We still do not have good tools to *measure* quality, however.

Underlying this overall shift in our approach to health care are two other issues. One is the issue of choice, and the second is who will pay. To some extent, reducing choice offers one way of achieving additional savings while potentially maintaining quality of care.

That is certainly one way to go. Such an approach must contend, however, with the very strong desire of people in the United States to maintain choice. The theme set by Morris Abram [see Chapter XII] is that individuals ought to have some choice and that they ought to use that choice responsibly. Greater patient responsibility perhaps represents a way to control costs as well. To what extent are we going to rely upon case managers or professionals to tell us what kind of

care is needed? When do we move from informal choice to the right to make poor decisions regarding health care?

The second underlying issue in our discussion is the question of who will pay. To a certain extent, if you have a zero-sum game, as Bert Seidman was talking about, then the situation degenerates into the federal government saying, "Not us," and the state government saying, "Not us," and the employer saying, "Not us," and the individual saying, "No cost sharing, not us." You then play this silly game of people simply shifting costs from one group to another.

Cost shifting also complicates the question of choice. Also related to who will pay is the question of who is at risk. In this kind of world that I have outlined, I certainly do not want to be one of the disenfranchised, for example, in terms of being uninsured, not being connected with some group, not having Medicare coverage, or not having employer-based insurance. Nor do I want to be disenfranchised by having the kinds of medical care needs that are not well covered—for example, long-term care—because that is one of the things that also falls through the cracks in a world where everyone wishes to shift the responsibility.

There are only two avenues out of this dilemma. One is through information, which was raised today. In knowledge there is power. There is a ray of hope for researchers to make a contribution. Helping physicians determine norms of care requires much research before you can go very far. Individuals cannot hope to know very much until there is some consensus in the medical field about what constitutes "good care," so there is a great need for basic data. This implies a role for government, even in a case-managed, capitated system in which the government is giving out vouchers. Whatever system we move to, there will still be a strong need for government vigilance or at least some provision of basic data.

The second theme is to recognize that there is perhaps no single system that is going to offer all the answers. Instead, there is a need for flexibility. Stuart Altman discussed many of the problems that exist under a very stringent system. My feeling is that elegant systems sound nice on paper, and they sound like they are going to get government and everyone off our backs, but they end up with stringencies and inflexibilities that make them less workable.

### **The Effect of Change on the Market**

MR. GARBER: We are in a period of fundamental change. Consider the growth of health care costs as a percent of Gross National Product

(GNP).<sup>4</sup> In the period 1967–82 it grew at about 4.1 percent of GNP. My calculations indicate that within 300 years medical care costs would consume 100 percent of GNP at that rate of growth. Clearly we had an unsustainable situation. In my cynical view, back a few years ago the more doctors and hospitals one added to the system, the more costs you had, because there was no outside control on any part of the structure.

The most significant thing that has happened, as John Moxley pointed out earlier [see Chapter III], is the change from a provider-dominated system to a payer-dominated system. That is happening today. Many companies have found in the last few years that we have more productive capacity than we need, particularly where we have not been in the competitive market. One of the most serious problems over the next few years in the health care field is what happens to this excess capacity—there clearly is excess capacity among hospitals, and probably excess capacity among doctors. The question is, how do you cut back to the right capacity? Only with a lot of pain, and that is part of our situation.

There are several points I want to make here. One is that we are in a time of great change. The fact is that we do not know how to do this well. We are all fumbling around, trying to find the right things to do that will make the system work as it should—to provide quality care and to provide it economically. We need to have a way of permitting a lot of experimentation to take place, a lot of failures to take place, and a lot of successes to take place in order to find out how to do this right. It is just foolishness, in our complex society, to assume that we can sit at this table, or that Mr. Gradison can sit on the Ways and Means Committee and pass a law, and suddenly the right outcome is achieved.

In my judgment, quality of care will, in the end, be the single most important factor for success. Those organizations and institutions that can provide high-quality care will succeed and those that do not will fail. I believe very firmly in this. The buyers will demand quality care, whether they are employers or government, and they will define a way of measuring it. I was pleased with the discussions that took place today, because they say we are now beginning to develop some objective, useful measures of quality.

Health care will become a very capital-intensive industry. Stuart Altman discussed some of the questions on capital needs and allo-

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<sup>4</sup>Editor's note: Refer to the Introduction and Background for a discussion of the growth of health care expenditures.

cations [see Chapter XI]. The “mom and pop” organization is going to have a tough time in a capital-intensive world. The larger organizations with access to more capital will be successful.

Finally, I would not write off, at this point, what have been called the “intermediaries.” The managed-care component could very well be an intermediary type of function. That means intermediaries must perform a different function than they have been. In the past, intermediaries have been sitting in the middle and passing paper and money back and forth between interested parties. In the future they will have to play a much more aggressive, management-type role to earn their fees and profits. There is a role for them, if they know how to step in and fill it.



## **PART FOUR:**

# **Postscript**

In addition to the issues that form the basis of the preceding chapters, a number of other public policy issues were touched upon. Three major areas of concern are brought out more fully in the following chapters: (1) financing indigent health care, (2) retiree health coverage, and (3) long-term care.

### **Financing Indigent Health Care**

In Chapter XIV, Deborah Chollet explores what has become a growing and far-reaching predicament for health service providers and state and local governments. Uncompensated hospital care, of which indigent care is a portion, rose between 1978 and 1982 at an estimated average annual rate of 10.2 percent, or an average of 4 percent above inflation. Assuming that this real rate of growth has continued, uncompensated hospital care for 1986 would exceed \$8 billion.

Lower rates of private health insurance coverage, apparently precipitated by the redistribution of employment among industries and toward smaller firms, and the erosion of Medicaid eligibility among the poor and near-poor have contributed to an increase in the number of people unable to pay for health care. Increased competition among hospitals for privately insured patients has limited hospitals' ability to shift uncompensated costs to privately insured patients.

The Congress and the states have begun to address the problems of indigent care and access to health care among the growing number of people without insurance coverage. Federal proposals that address these problems commonly involve new regulation of employer plans, including new rules for tax qualification.

This chapter examines the magnitude and apparent causes of the growing problem of financing care for the medically indigent, and the recent increase in noncoverage across the population. Recent federal legislation altering Medicaid eligibility is reviewed, together with recent and proposed federal legislation to expand private health insurance coverage. This chapter also reviews the legal responsibilities of state and local governments to pay for indigent health care and various efforts undertaken by the states to finance indigent care—specifically, state insurance pools and state revenue pools.

## **Retiree Health Insurance**

In Chapter XV, Deborah Chollet and Robert Friedland examine the issues surrounding employers' provision of health insurance to retired workers. Employer-paid retiree health insurance is promised to two-thirds of the full-time employees of medium or large establishments in the United States. Prospects for the continuation or growth of retiree health benefits, however, are uncertain.

At least four factors could discourage establishment of new plans or restrict the benefits of existing plans. First, employers' unfunded liability for retiree benefits is potentially very large. The Financial Accounting Standards Board is considering a requirement that employers disclose these liabilities in their financial reports. Second, the Deficit Reduction Act of 1984 narrowed employer options for funding these liabilities on a tax-preferred basis. Third, recent and expected changes in Medicare are perceived as potentially raising the cost of employer-sponsored plans. Finally, recent litigation seems to indicate that employers may not be permitted to alter retiree health plans once benefit reciprocity has begun.

Estimates suggest that unfunded liabilities associated with employer-sponsored retiree health benefits could be from 4 to 50 times the overall amount employers currently pay each year for health benefits.

This chapter explores these factors and reviews the issues faced by employers and employees. Central to these issues are considerations of prudent financing for retiree health benefits, retirees' rights to promised benefits, and the private sector's role in assisting the elderly to finance catastrophic health expenses in retirement.

## **Financing Long-Term Care**

In Chapter XVI, Robert Friedland studies the problem of how to pay for health and personal care for people who require it on an ongoing basis. An estimated 6.6 million Americans age 65 and older currently need long-term care. As the "baby-boom" generation ages and individuals live longer, the need for long-term care will become even greater. The numbers of older people in need of long-term care are projected to increase to 9.3 million by the year 2000, to 12.9 million by 2020, and to almost 19 million by 2040.

As individuals live longer, they become more susceptible to developing chronic health conditions that require medical assistance over extended periods of time. Long-term care is not covered by Medicare

or most Medicare supplement (Medigap) insurance policies. Such care is expensive and can rapidly deplete a lifetime's savings. Small-sample estimates indicate that nearly two-thirds of older individuals who had been living alone become impoverished three months after entering a nursing home.

Long-term care financing is one of the most serious challenges confronting the United States. The elderly and their families have few alternatives for reducing their out-of-pocket expenditures for long-term care. Most elderly lack sufficient financial resources and private insurance is severely limited. An experiment with financing long-term care through a prepaid health plan has only just started. Residential communities that include long-term care services are expensive and may not be accessible for many persons.

Medicaid has become the only public program financing long-term care, but it primarily covers services rendered in institutional settings rather than home- or community-based services. Medicaid's reimbursement system also creates a variety of market anomalies. In addition, Medicaid eligibility rules require the elderly to be impoverished to qualify for coverage. Yet, unless financing options change, more pressure will be brought to bear on this state and federal program.

## **XIV. Financing Indigent Health Care**

Deborah J. Chollet, Ph.D.

Financing health care for the growing population of medically indigent is a difficult and increasingly urgent problem for health service providers and state and local governments. Between 1978 and 1982, uncompensated hospital care (of which indigent care is a portion) grew at an estimated average annual rate of 10 percent. At this rate, uncompensated hospital care would have exceeded \$8 billion in 1986.

Loss of private health insurance coverage precipitated by unemployment, cutbacks in federal programs that confer Medicaid eligibility, and the erosion of Medicaid eligibility at the state level all contributed in the early 1980s to the growing numbers of people unable to pay for health care. Increased competition among hospitals for privately insured patients has limited hospitals' ability to shift uncompensated costs to major buyers of hospital care.

The Congress and the states have begun to address the problem of indigent care and an array of issues related to the growing population of the uninsured. One such issue is the 1974 Employee Retirement Income Security Act's (ERISA) preemption of state regulation as it applies to self-insured employer health plans.

This chapter examines the magnitude and apparent causes of the growing problem of financing care for the medically indigent and the growing number of uninsured. Recent federal legislation affecting private insurance coverage and Medicaid eligibility is reviewed. The chapter also reviews the legal responsibilities of state and local governments to pay for indigent health care and efforts undertaken by the states to finance indigent care.

### **Uncompensated Care: A Growing Problem**

Financing indigent health care—health care for patients unable to pay—has become a major problem for hospitals and other providers of acute health care. The problem has worsened in this decade due to a convergence of several factors: the loss of private health insurance precipitated by high rates of unemployment during the 1981–83 recession; economic recovery focused in jobs that are less likely to offer health insurance as a benefit; federal cutbacks in programs that

confer Medicaid eligibility; and erosion of Medicaid eligibility at the state level due to declining real levels of qualifying income.

The adoption of prospective payment and capitation by state Medicaid programs and greater competition among providers for private group-insured patients have also contributed to the urgency of the indigent care problem. Preferred provider organizations (PPOs) and negotiated discounts to insurers and employers limit hospitals' ability to shift costs to privately insured patients to finance indigent care and other bad debt. In short, hospitals are confronted with more patients unable to pay for care, while their ability to shift unpaid costs to privately insured patients has been curtailed.

Medicare's past policy of not paying a share of hospitals' uncompensated care (including indigent or charity care) proportionate to hospitals' Medicare caseload also contributed to hospitals' declining ability to shift the costs of charity care to major payers. In 1985, Medicare paid for 29 percent of all hospital care delivered in the U.S., but allowed no adjustment in its fixed, diagnosis-related payments for hospitals' charity care costs. That practice was altered in 1986 with the signing of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA requires Medicare to pay an additional amount for patients discharged from hospitals that serve a disproportionate share of low-income patients, and therefore presumably bear a larger share of the nation's uncompensated hospital costs.

### **What Is Indigent Care?**

"Uncompensated care" as a hospital accounting term encompasses both charity care and bad debt, including bad debt associated with charges not covered by private insurance or Medicare, such as deductibles and copayments. In accounting practice, the distinction between "bad debt" and "charity care" is imprecise; the terms are not used consistently. As a result, measuring the amount of indigent care provided by hospitals is difficult.<sup>1</sup> In general, indigent care is (1) all charity care provided by hospitals, plus (2) the portion of hos-

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<sup>1</sup>"Few hospitals rigorously distinguish between bad debt and charity care, and fewer still are likely to implement the same set of procedures for . . . bookkeeping allocations," as observed in Suzanne Mulstein, "The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options," *Inquiry* 21 (Fall 1984): 219.

With this caveat, Sloan et al. estimated that charity care accounted for only \$1.7 billion of the \$6.2 billion in uncompensated care provided by hospitals in 1982. (Frank A. Sloan, Joseph Valvona, and Ross Mullner, "Identifying the Issues: A Statistical Profile," paper presented at Vanderbilt University [April 6, 1984], as summarized in Mulstein, p. 220.)

pital bad debt associated with care provided to the medically indigent.

Medical indigency is implicitly defined in federal law as "eligibility for Medicaid benefits." In statutory language, the medically indigent are defined simply as the poor or "persons unable to support themselves" (in New Hampshire), as "persons unable to meet the full cost of hospital care" (in Georgia), or in terms of income or eligibility for federal assistance (in Arizona, Indiana, New Mexico, and Oklahoma, for example).<sup>2</sup>

### **How Big Is the Problem?**

Although data on the volume of uncompensated care provided by hospitals are scarce, estimates suggest that the figure is large and growing. Using Gross National Product data, Sloan et al. estimated that uncompensated hospital care totaled \$6.2 billion in 1982, rising between 1978 and 1982 at an average annual rate of 10 percent.<sup>3</sup> The real (inflation-adjusted) value of uncompensated care provided by hospitals rose at an average annual rate of about 4 percent. Assuming that real growth in uncompensated care has continued at the 1978–1982 average rate, hospitals are expected to provide more than \$8 billion in uncompensated care in 1986.

Physicians also provide uncompensated care to patients unable to pay. According to one estimate by the American Hospital Association (AHA), physicians provided \$3 billion in free care in 1982. Assuming that the growth of uncompensated physician services parallels that of uncompensated hospital care, physicians and hospitals together may have provided as much as \$13 billion in uncompensated care in 1986,<sup>4</sup> equal to nearly 5 percent of their projected aggregate gross revenues for the year.

The burden of uncompensated care is unevenly distributed among hospitals. Estimates from states and municipalities indicate that public hospitals bear a disproportionate share of the indigent care burden. For example, Florida's public hospitals provided an estimated

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<sup>2</sup>Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Health Care: Executive Summary," *Access to Care for the Medically Indigent* (Washington, DC: Academy for State and Local Government, 1985), p. 21.

<sup>3</sup>Sloan et al., "Identifying the Issues: A Statistical Profile," as summarized in Mulstein, "The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options."

<sup>4</sup>Donald R. Cohodes, "America: The Home of the Free, the Land of the Uninsured," *Inquiry* 23 (Fall 1986): 229.

12 times as much indigent care (measured as a percent of gross patient revenue) in 1983 as proprietary (profit-making) hospitals provided, and 25 percent more than voluntary (not-for-profit) hospitals provided.<sup>5</sup>

Using AHA's 1982 annual survey data, Sloan et al. concluded that teaching hospitals also shoulder a larger share of charity care and bad debt (relative to their share of total charges) than do other hospitals. In 1982, teaching hospitals provided more than one-third (36 percent) of all uncompensated care provided by hospitals in the U.S., but accounted for only 27 percent of hospital charges. State and local public teaching hospitals (representing 19 percent of teaching hospitals) provided one-half of the uncompensated care delivered by all teaching hospitals. Other uncompensated care was provided by voluntary nonteaching hospitals (42 percent), nonteaching public hospitals (17 percent), and proprietary hospitals (5 percent).

The characteristics of hospitals with higher rates of uncompensated care per total revenues suggest the principal sources of uncompensated care. Based on 1982 AHA survey data, Sloan et al. found higher rates of uncompensated care among hospitals with high percentages of revenue billed to self-pay patients—that is, patients with neither public nor private health insurance coverage. In the South (where Medicaid qualifying income levels are generally lower), hospitals had higher rates of both charity care and bad debt than did hospitals in other regions. These findings suggest that people without private insurance coverage and ineligible for public program benefits are less likely to be able to finance health care. Furthermore, regional patterns in uncompensated care indicate that erosion of Medicaid eligibility standards at the state level may significantly contribute to noncoverage.

The relationship between hospitals' levels of uncompensated care and their service mix suggests the health service use patterns of people unable to pay for either routine or emergency health care. Hospitals with a high proportion of beds in obstetrics, neonatal intensive care, intermediate care, and burn care average higher levels of uncompensated care.<sup>6</sup> Hospitals that obtain a high proportion of their total revenue from outpatient care—primarily emergency care—also average high levels of uncompensated care. Sloan et al. did not find

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<sup>5</sup>Bob Graham, "Florida Blends Competition with Regulatory Safety Net in Landmark Legislation," *Business and Health* 1 (September 1984): 50.

<sup>6</sup>Sloan et al., "Identifying the Issues: A Statistical Profile," as summarized in Mulstein, "The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options."

that higher levels of uncompensated care were significantly related to hospital closings.

### The Problem of Noncoverage

Noncoverage—that is, coverage from neither a private health insurance plan nor a public program such as Medicaid or Medicare—poses an important barrier to obtaining health care. Research evaluating the effect of insurance coverage on health care use has found that levels of health service use among uninsured people are much lower than among insured people, even after adjusting for health status. A study of health care use patterns in 1977 found that people who had continuous insurance coverage throughout the year used nearly twice as many hospital days as uninsured people.<sup>7</sup> Insured people also used 54 percent more physician care than people without insurance. Among people who reported fair or poor health, the disparity in physician use was even greater. Other research has linked lower rates of health service use with higher mortality rates, in general, and higher rates of infant mortality, in particular.<sup>8</sup>

For hospitals, noncoverage signals a substantially greater risk of bad debt. Consequently, many hospitals routinely refer, and actually transfer, patients without insurance or public coverage to other hospitals, usually public hospitals—a practice called “dumping.”<sup>9</sup> Alternatively, hospitals may require a substantial cash deposit from uninsured patients before providing nonemergency care.

Despite professional guidelines intended to avoid transfers that are hazardous to patients’ health,<sup>10</sup> one study of patient transfers from private hospitals in a California community concluded that the practice of transferring unprofitable patients probably in some cases jeop-

<sup>7</sup>Karen Davis and Diane Rowland, “Uninsured and Underserved: Inequities in Health Care in the United States,” *Health and Society* 61 (Spring 1983): 149–176.

<sup>8</sup>M. Grossman and F. Goldman, “The Responsiveness and Impacts of Public Health Policy: The Case of Community Health Centers,” paper presented at the 109th annual meeting of the American Public Health Association (November 1981).

<sup>9</sup>The obligation of public hospitals to accept indigent patients from private hospitals once their emergency condition is stabilized was the basis of a Florida suit (*American Hospital of Miami, Inc. v. Dade County*), appealed to the Florida Supreme Court in 1986.

<sup>10</sup>Board of Directors, American College of Emergency Physicians, “Patient Transfer Guidelines: A Position Paper,” *Journal of the American College of Emergency Physicians* 6 (1966): 10. See also American Hospital Association Bill of Rights and Joint Commission on Accreditation of Hospitals Standard on Emergency Services, both quoted in M.R. Mancini and A.T. Gale, *Emergency Care and the Law* (Rockville, MD: Aspen, 1981), p. 106.



ardized their health.<sup>11</sup> Of 458 consecutive patients transferred to a large California public hospital in 1981, 63 percent were uninsured; 21 percent and 13 percent, respectively, had Medicaid and Medicare coverage. Although one-half of the patients transferred had traumatic injuries, 91 percent had been transferred by private hospitals with full emergency services. Based on reviews of 103 transferred patients' records, the study concluded that nearly one-third of the patients were medically jeopardized by the transfer. Not included among the 33 at-risk patients were five obstetrical patients transferred from the site of the area's high-risk obstetrics center. An earlier study (1970) of 18,000 patient transfers to Cook County Hospital in Chicago indicated that 50 patient deaths had resulted; similar claims have been made about patient transfers to public hospitals in other cities.<sup>12</sup>

In 1986, responding to reports of inappropriate transfers, Congress established rules for hospitals with Medicare beds (Medicare hospitals) regarding their handling of emergency patients, regardless of the patients' Medicare or other insurance status. COBRA requires Medicare hospitals to examine patients with emergency health problems (including women in active labor) and provide treatment to stabilize their condition (or provide for the treatment of labor). COBRA restricts Medicare hospitals from transferring patients until their medical condition is stabilized, and/or until transfer is requested by the patient or transfer is medically indicated because of the availability of superior or more appropriate resources elsewhere. COBRA also defines a protocol for appropriate transfers, requiring that the receiving hospital have available space and qualified personnel to treat the patient, that the receiving hospital agree to the transfer, that medical records be transferred with the patient, and that the transfer itself be handled by qualified personnel and appropriate transportation equipment.

### **Trends in Noncoverage**

The rate of noncoverage across the population has been rising since the mid-1970s and continues to rise. The Social Security Administration estimated that as much as 13 percent of the nonelderly pop-

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<sup>11</sup> David U. Himmelstein, M.D., et al., "Patient Transfers: Medical Practice as Social Triage," *American Journal of Public Health* 74 (May 1984): 494-497.

<sup>12</sup> P. de Vise, "Cook County Hospital: Bulwark of Chicago's Apartheid Health System," *The New Physician* 20 (1970): 394. See also S.J. Meltzer, letter to the *New England Journal of Medicine* 304 (1981): 232; and E. Friedman, "Special Report: The Dumping Dilemma," *Hospitals* 56 (1981): 51-56 (Sept. 1) and 75-84 (Sept. 16).

ulation had no private or public insurance coverage in 1976.<sup>13</sup> EBRI tabulations of the Census Bureau's Current Population Survey (CPS) indicate that about 14 percent of the nonelderly population were without coverage from any source in 1979. That proportion rose to 15.5 percent in 1982, 16.5 percent in 1983, and 17.4 percent in 1984. The number of nonelderly without insurance coverage from any source—private or public—increased nearly 15 percent between 1982 and 1985, to nearly 35 million people.

Rates of coverage from various private and public sources in 1982 through 1984 are presented in table XIV.1. Although 1982 was a severe recession year with record rates of unemployment, the reported rate of employer coverage among the nonelderly population was higher than in the subsequent years of significant economic recovery. In 1982, 67 percent of the nonelderly population reported coverage from an employer plan; this rate declined to 65 percent in 1984. In 1984,

**TABLE XIV.1**  
**Number and Percent of Nonelderly Persons with Health Insurance by Source of Coverage, 1982–84<sup>a</sup>**

Source of Health Insurance	1982		1983		1984	
	Number of persons (millions)	Percent	Number of persons (millions)	Percent	Number of persons (millions)	Percent
All persons	195.6	100.0%	197.7	100.0%	200.1	100.0%
Private coverage	148.1	75.7	147.5	74.6	147.3	73.6
employer plan	131.2	67.1	130.3	65.9	130.3	65.1
other plan	24.8	12.7	24.3	12.3	24.7	12.3
Public coverage	25.2	12.9	25.2	12.7	25.6	12.8
Medicaid	15.7	8.0	16.0	8.1	16.2	8.1
Medicare	4.4	2.3	4.3	2.2	4.5	2.2
CHAMPUS <sup>b</sup>	6.5	3.3	6.1	3.1	6.2	3.1
No coverage	30.3	15.5	32.6	16.5	34.7	17.4

Source: EBRI tabulations of the March 1983, 1984, and 1985 Current Population Surveys (U.S. Department of Commerce, Bureau of the Census).

Note: Detail may not add to totals because of coverage from more than one source during the year and because of rounding.

<sup>a</sup>Excludes persons over age 65, agricultural or noncivilian workers, and members of their families.

<sup>b</sup>Civilian Health and Medical Program of the Uniformed Services.

<sup>13</sup>Social Security Administration, "Private Health Insurance Plans in 1976: An Evaluation," *Social Security Bulletin* 41 (September 1978).

employer health plans covered approximately 2 million fewer people than in 1982, while civilian employment rose by nearly 5.5 million workers.

### ***Unemployment and Noncoverage***

Because employer plans are important providers of health insurance coverage, unemployment has commonly been assumed to precipitate loss of coverage among unemployed workers and their families. State statutes requiring employers to offer continued group coverage to workers separated from service apply only to insured plans, since ERISA exempts self-insured plans from state regulation. Among the 23 states that require employers to continue coverage to unemployed workers, the required continuation period averages 29 weeks.<sup>14</sup>

Recent federal legislation, however, now requires all employers that offer health insurance benefits (including those with self-insured plans) to offer workers and their dependents in various circumstances continued access to group coverage. COBRA requires that employers offer workers and/or their dependents continued access to group coverage from 18 months (in cases of layoff or reduced hours) to 36 months (in cases of death, divorce, or dependent children reaching majority age). For nonunion plans these provisions are effective for plan years beginning on or after July 1, 1986. Continuing participants may be required to pay as much as 102 percent of average plan cost. At the end of the continuation period, employers must offer terminated workers and their dependents access to conversion coverage—individual health insurance coverage not contingent on the individual's health status or insurability.

Although COBRA may assure valuable coverage to some workers and their dependents, continuation laws (either federal or state) are probably of greater assistance to short-term unemployed workers and their families than to the long-term unemployed. That is, long-term unemployed workers are more likely to be unemployed from jobs that did not provide health benefits and, therefore, are less likely to be affected by continuation laws. Even among unemployed workers who might have access to continued coverage, the long-term unemployed may be least likely to afford the average cost of group coverage as allowed by COBRA.

Rates of employer coverage among workers by unemployment status are shown in table XIV.2. Reported rates of employer-based in-

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<sup>14</sup>Hewitt Associates, *Continuation of Group Medical Coverage—A Study of State Laws* (Lincolnshire, IL: Hewitt Associates, 1985).

TABLE XIV.2  
**Employer-Based Health Insurance Coverage and Noncoverage from Any Source: Wage and Salary Workers Age 18-64, by Weeks of Unemployment, 1984<sup>a</sup>**

	Number of Workers (thousands)	Total	Fully Employed	Weeks Unemployed			
				Any	1-4	5-12	13+
				Percent with Employer-Based Coverage			
All workers	102,789	77.7%	81.1%	58.5%	63.6%	64.5%	52.7%
full-year <sup>b</sup>	89,816	80.7	84.1	60.2	70.6	68.2	53.3
part-year <sup>c</sup>	12,973	57.3	59.2	49.0	51.9	47.6	43.0
				Percent with No Coverage from Any Source			
All workers	102,789	13.9%	11.4%	28.2%	23.3%	24.0%	32.6%
full-year <sup>b</sup>	89,816	12.4	9.8	27.4	19.4	22.2	32.2
part-year <sup>c</sup>	12,973	24.7	22.9	32.5	29.8	32.2	41.4

Source: EBRI tabulations of the March 1985 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

<sup>a</sup>Data exclude agricultural, self-employed, and noncivilian workers.

<sup>b</sup>Full-year workers are defined as workers who worked or looked for work 35 weeks or more during 1984.

<sup>c</sup>Part-year workers are defined as workers who worked or looked for work fewer than 35 weeks during 1984.

coverage are highest among fully employed workers (81 percent) and decline steadily with increases in the duration of unemployment. In 1984, approximately 53 percent of the long-term unemployed (those unemployed 13 weeks or more) would have had a proximate source of continued employer plan coverage, compared to 64 percent among workers unemployed for one month or less, and 65 percent among workers unemployed for 5 to 12 weeks.

Finally, although short-term losses of health insurance coverage are a generally recognized result of economic recessions, transitional periods of noncoverage may, in fact, be the lesser effect. Economic recession may also generate long-term loss of insurance coverage if unemployed workers move into jobs that do not offer health insurance as a benefit.

This post-recession pattern of relatively rapid job expansion in low-coverage industries is apparent in the years following the 1982 recession. The 1980-84 period shows rapid net job growth in industries with low rates of employee benefit provision, compared to jobs in manufacturing and other industries with characteristically high rates of benefit provision. Industries with below-average rates of employer health coverage (construction, retail trade, business and repair services, personal services, entertainment, and recreation) all showed above-average employment growth between 1980 and 1984 (table XIV.3). Employment in major high-coverage industries (especially in manufacturing and public administration) grew sluggishly or actually declined. Substantial employment gains in some high-coverage industries (transportation and finance) were insufficient to offset the impact of slow employment gains or permanent job loss in other major high-coverage industries.

In 1984, low-coverage industries accounted for 34 percent of total employment, compared to 32 percent in 1980. As a result, the aggregate rate of employer-sponsored health coverage among workers declined. This post-recession redistribution of employment suggests that economic recessions may have an enduring impact on health insurance coverage: economic recovery may not restore coverage to pre-recession levels. Even the generous continuation periods legislated in COBRA would be inadequate to offset a decline in the equilibrium rate of employer coverage among workers.

### **Medicaid and the Poor**

Medicaid is a state-based insurance program for low-income people in specific need categories. By federal law, the elderly, disabled, and

single-parent families with dependent children are categorically eligible for Medicaid benefits. States may define additional categorically eligible groups within federal guidelines (for example, all financially eligible children under age 18 and persons in two-parent families with dependent children where the principal earner is unemployed).

Possibly the most far-reaching legislation affecting Medicaid eligibility since the beginning of this decade was passed in the Omnibus Budget Reconciliation Act of 1981 (OBRA). OBRA altered Medicaid eligibility indirectly by amending authorizing legislation for another federal program that confers Medicaid entitlement—Aid to Families with Dependent Children (AFDC). Subsequent federal legislation has expanded Medicaid eligibility directly, amending Medicaid's authorizing legislation to include new entitlement groups among women and children.

A chronology of legislation since 1980 affecting Medicaid eligibility includes the following:

- Among other provisions affecting AFDC and Supplemental Security Income (SSI) eligibility, OBRA altered the work-incentive provisions of AFDC, reducing payments for earned income, and reduced the asset disregard for eligibility from \$2,000 to \$1,000. OBRA also eliminated states' options to provide benefits for dependent children age 19–21 and restricted eligibility to first-time pregnant women to their sixth month of pregnancy or later. According to the General Accounting Office (GAO), OBRA decreased the national AFDC basic monthly caseload by 493,000 cases and decreased the number of people eligible for Medicaid.<sup>15</sup>
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), among other changes, permitted states to reduce AFDC benefits by prorating shelter and utility costs of shared households and lowered the percentage of erroneous AFDC payments eligible for federal funding, effective in fiscal 1984.
- The 1984 Deficit Reduction Act (DEFRA) expanded Medicaid entitlement to (1) first-time pregnant women who would be eligible if the child were born; (2) pregnant women in two-parent families with an unemployed principal earner; and (3) all financially eligible children under age 5.
- COBRA extended Medicaid coverage to all financially eligible pregnant women in two-parent families.
- The 1986 Omnibus Budget Reconciliation Act prohibits states from imposing a residence requirement that would exclude from Medicaid oth-

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<sup>15</sup>Comptroller General of the United States, U.S. General Accounting Office, *An Evaluation of the 1981 AFDC Changes: Initial Analyses*, GAO/PEMD-84-6 (Washington, DC: U.S. Government Printing Office, 2 April 1984), p. 3.

TABLE XIV.3  
**Total Nonagricultural Civilian Employment, Rates of Employment Growth,  
 and Employer Health Insurance Coverage by Industry, 1984**

Industry	1984 Employment		Rate of Employment Change, 1980-84	Percent of all workers	Percent of Workers* with Employer Health Plan, 1984
	Number of workers (000's)	100.0%			
All workers	101,684	100.0%	6.2%		77.9%
			High-Coverage Industries		
Mining	957	0.9	-2.2		86.2
Manufacturing	20,995	20.6	-4.3		88.1
Transportation, communication, & public utilities	7,358	7.2	12.8		86.7
Finance, insurance, & real estate	6,750	6.6	12.6		84.9
Wholesale trade	4,212	4.1	7.4		82.9
Professional & related services	21,174	20.8	6.7		82.0
Public administration	4,766	4.7	-10.8		87.3
<b>Total, high-coverage</b>	<b>66,212</b>	<b>65.1%</b>	<b>2.6%</b>		<b>85.3%</b>

	Low-Coverage Industries		
Construction	6,665	6.6	7.2
Retail trade	17,767	17.5	9.2
Business & repair services	4,815	4.7	45.3
Personal services	4,174	4.1	8.7
Entertainment & recreation	1,260	1.2	20.3
<b>Total, low-coverage</b>	<b>34,681</b>	<b>34.1%</b>	<b>13.0%</b>
			<b>62.5%</b>

Source: EBRI tabulations of the March 1985 Current Population Survey (U.S. Department of Commerce, Bureau of the Census); and U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States, 1986* (Washington, DC: U.S. Government Printing Office, 1986), p. 404.

Note: Detail may not add to totals because of rounding.

<sup>a</sup>Wage and salary workers with coverage from own employer or as a dependent of another worker. Data exclude self-employed workers.



erwise qualified individuals who live in the state, regardless of whether the residence is maintained permanently or at a fixed address. This provision allows homeless people to qualify for Medicaid benefits.

In addition to meeting *categorical* eligibility criteria, people eligible for Medicaid must meet state-determined *income and asset* criteria. Federal law requires that AFDC eligibility income thresholds be used to determine Medicaid eligibility for the majority of recipients—the nonelderly poor with dependent children. In most states, qualifying income for AFDC, and therefore Medicaid, is set well below the federal poverty standard. No state automatically indexes the level of income below which categorically eligible people become eligible for Medicaid.

Failure by states to fully index qualifying levels of income for AFDC or Medicaid eligibility has resulted in a substantial erosion of those standards relative to the federal poverty standard. In 1975, the average qualifying level of income for AFDC was 71 percent of the federal poverty standard.<sup>16</sup> By 1986, that had eroded to 48 percent of the federal poverty standard. In 1986, one-half of all states set the income standard for AFDC eligibility at less than 47 percent of the federal poverty standard. These data with state-level detail are presented in table XIV.4.

As a result of cutbacks in federal income assistance programs that confer Medicaid eligibility and the erosion of state qualifying income standards, the proportion of the poor who qualify for Medicaid coverage has declined. In 1984, 42 percent of the noninstitutionalized population under age 65 with income below the federal poverty standard qualified for Medicaid coverage (table XIV.5). Even among nonelderly persons with income less than one-half the federal poverty standard—approximately the median qualifying income across states—only 46 percent qualified for Medicaid.

Including the elderly, the proportion of the poor who qualify for Medicaid benefits has declined dramatically during the last decade, from 91 percent in 1976 to an estimated 64 percent in 1984. Estimates of changes in Medicaid coverage rates are presented in chart XIV.1.

Because most persons in poverty are nonworkers, have fragmented employment patterns, or work in low-wage sectors, many of the poor are without health insurance coverage from an employer plan (table XIV.6). Without access to either employer-provided coverage

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<sup>16</sup>Rick Curtis, "The Role of State Governments in Assuring Access to Care," *Inquiry* 23 (Fall 1986): 278.

**TABLE XIV.4**  
**Qualifying Income<sup>a</sup> for AFDC<sup>b</sup> and Medicaid Eligibility in**  
**1986 by State and As a Percent of the Federal Poverty**  
**Standard in 1975 and 1986**

State	January 1986 Income Standard for AFDC Eligibility <sup>c</sup>	AFDC Qualifying Income As a Percent of the Federal Poverty Standard	
		January 1986	July 1975
Alaska	\$8,880	100.3%	99.3%
Utah	8,316	94.0	71.5
California	7,044	79.6	83.1
Wisconsin	6,528	73.8	97.0
Maine	6,432	72.7	78.6
Vermont	6,372	72.0	91.3
Minnesota	6,336	71.6	93.6
New York	5,964	67.4	94.2
Connecticut	5,844	66.0	98.2
Washington	5,712	64.5	89.4
Hawaii	5,616	63.5	121.4
Massachusetts	5,268	59.5	73.5
Colorado	5,052	57.1	61.6
Michigan	5,004	56.5	94.5
Rhode Island	4,908	55.5	78.9
New Jersey	4,848	54.8	87.9
Oregon	4,764	53.8	95.6
New Hampshire	4,668	52.7	87.4
North Dakota	4,452	50.3	80.3
South Carolina	4,428	50.0	50.5
Kansas	4,380	49.5	91.1
Pennsylvania	4,380	49.5	84.0
Iowa	4,320	48.8	83.4
Wyoming	4,320	48.8	68.1
Nebraska	4,200	47.5	79.1
Illinois	4,092	46.2	74.0
Montana	3,984	45.0	57.0
Maryland	3,948	44.6	56.7
South Dakota	3,948	44.6	82.0
District of Columbia	3,924	44.3	68.9
Oklahoma	3,720	42.0	61.6
Idaho	3,648	41.2	85.1
Delaware	3,576	40.4	69.5

(continued)

**TABLE XIV.4 (continued)**  
**Qualifying Income<sup>a</sup> for AFDC<sup>b</sup> and Medicaid Eligibility in**  
**1986 by State and As a Percent of the Federal Poverty**  
**Standard in 1975 and 1986**

State	January 1986 Income Standard for AFDC Eligibility <sup>c</sup>	AFDC Qualifying Income As a Percent of the Federal Poverty Standard	
		January 1986	July 1975
Virginia	3,492	39.5	76.0
Ohio	3,480	39.3	57.9
Mississippi	3,432	38.8	68.4
Nevada	3,420	38.6	55.3
Missouri	3,288	37.2	92.2
New Mexico	3,096	35.0	55.9
Indiana	3,072	34.7	76.3
Florida	3,024	34.2	40.9
West Virginia	2,988	33.8	58.4
North Carolina	2,952	33.4	51.9
Georgia	2,676	30.2	54.8
Kentucky	2,364	26.7	52.5
Arkansas	2,304	26.0	69.5
Louisiana	2,280	25.8	36.3
Texas	2,208	24.9	32.9
Tennessee	1,836	20.7	50.8
Alabama	1,416	16.0	30.6
State average	\$4,240	47.9%	71.4%
State median	\$4,200	47.5%	79.1%

Source: Adapted from Rick Curtis, "The Role of State Governments in Assuring Access to Care," *Inquiry* 23 (Fall 1986), p. 297. ©Blue Cross and Blue Shield Association. Used with permission.

<sup>a</sup>Based on annualized monthly maximum countable income for a family of three.

<sup>b</sup>Aid to Families with Dependent Children.

<sup>c</sup>Depending on how each state calculates AFDC cash benefits, AFDC and Medicaid eligibility can be driven by either AFDC need or payment standards.

or Medicaid, a large proportion of people with family income below the federal poverty standard are without health insurance of any type.

In 1984, 36 percent of all nonelderly poor, as defined by the federal poverty standard, were without health insurance coverage of any type for at least a substantial part of the year. Among low-income people with family income above the poverty line (but within two times the federal poverty standard), higher rates of employer-provided cover-

**TABLE XIV.5**  
**Medicaid Coverage among Nonelderly Persons by Family**  
**Income As a Proportion of Poverty Income, 1984<sup>a</sup>**

Income as a Proportion of Poverty Income	All Persons (millions)	Medicaid-Eligible Persons (millions)	Medicaid-Eligible Persons As a Percent of All Persons
Total	198.1	16.0	8.1%
0-0.49	11.6	5.3	45.8
0.50-0.99	17.0	6.6	38.9
1.00-1.49	17.4	2.0	11.3
1.50-1.99	19.1	1.0	5.1
2.00-2.99	40.1	0.7	1.9
3.00 or more	92.8	0.4	0.5
Summary			
0-0.99	28.6	11.9	41.7
1.0-1.99	36.5	2.9	8.0
2.00 or more	132.9	1.2	0.9

Source: EBRI tabulations of the March 1985 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

<sup>a</sup>Includes all noninstitutionalized persons under age 65, except for persons employed in agriculture or the military, and members of their families.

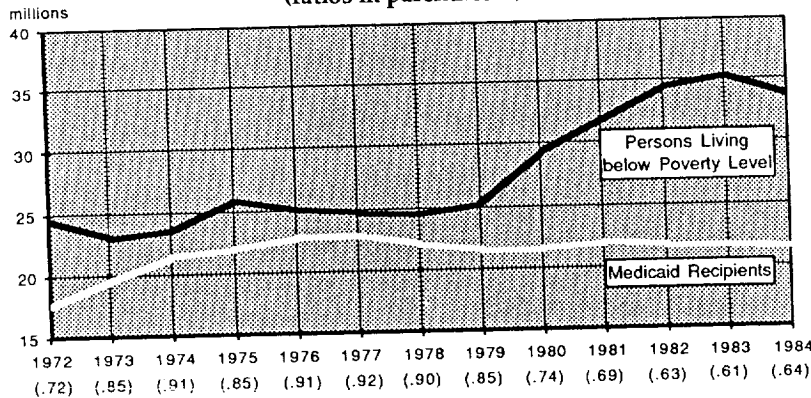
age (52 percent) reduce the noncoverage rate to 29 percent. In aggregate, the poor are more than twice as likely to have no insurance coverage as the nonpoor, despite significant public-sector spending for income assistance and health insurance programs.

### **Public Liability for Indigent Care**

In most states, state or local governments are legally obligated to provide health care for the poor and uninsured.<sup>17</sup> Under these laws, state and county governments may be sued to reimburse health service providers for the cost of treating indigent patients. Court enforcement of these statutes may become more common as hospitals and private-pay patients are less willing to absorb the cost of indigent care. Under such a statute in 1984, the Nevada Supreme Court awarded

<sup>17</sup>Much of the information presented in this section summarizes material presented in Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Care," *Access to Care for the Medically Indigent* (Washington, DC: Academy for State and Local Government, 1985), pp. 13-44.

CHART XIV.1  
 Medicaid Recipients and Persons below Poverty Level, 1972-84  
 (ratios in parentheses)



Source: Marian Gornick; Jay N. Greenberg, Ph.D.; Paul W. Eggers, Ph.D.; and Allen Dobson, Ph.D., "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," *Health Care Financing Review*, 1985 Annual Supplement: 13-59.

a local hospital more than \$300,000 for indigent patient medical care costs in a suit against Washoe County.<sup>18</sup>

Patterns of statutory responsibility differ among states. The state government alone is liable for financing indigent care in 14 states, the counties are liable in 18 states, and towns are liable in 2 states. The responsibility is shared by counties and the state in 5 states, by counties and towns in 4 states, and by towns and the state in 4 states. Three states apparently impose no obligation on any governmental unit for general indigent health care, although all states authorize various levels of government to provide some health and medical services for their residents through the operation of public hospitals or by direct payment for, or contract with, health care providers.

Most indigent care statutes leave substantial discretion to the agency that administers the program. Few expressly define "indigent" or the services that must be covered. The legal obligation of state and local governments to provide for indigent care has been interpreted by many courts so as to preserve administrative discretion. The language

<sup>18</sup>*Washoe County v. Wittenberg*, 676 P.2d 808 (Nev. 1984).

**TABLE XIV.6**  
**Percent Distribution of Nonelderly Persons with Coverage from Selected Sources by Family Income As a Proportion of Poverty Income, 1984<sup>a</sup>**

Income as a Proportion of Poverty Income	Private Coverage			Public Coverage			
	Total	Employer	Other	Total <sup>b</sup>	Medicaid	Medicare	No Coverage
Total	73.7%	65.6%	12.0%	12.0%	8.1%	1.4%	17.5%
0-0.49	14.7	7.3	8.1	48.0	45.8	1.0	39.5
0.50-0.99	28.4	19.7	9.9	42.5	38.9	3.2	33.4
1.00-1.99	62.7	51.6	14.0	12.6	8.0	2.4	29.0
2.00-2.99	81.4	72.9	12.3	6.0	1.9	1.3	15.6
3.00 or more	90.5	83.6	11.9	4.4	0.5	0.7	8.2
Summary							
0-0.99	22.8	14.6	9.1	44.7	41.7	2.3	35.9
1.0 or more	82.3	74.2	12.4	6.5	2.4	1.2	14.4

Source: EBRI tabulations of the March 1985 Current Population Survey.

<sup>a</sup>Includes all noninstitutionalized persons under age 65, except for persons employed in agriculture or the military, and members of their families.

<sup>b</sup>Total public coverage includes civilian insurance coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

of some statutes, however, has accommodated broad court interpretation, obliging the responsible agency to pay for extensive services under the indigent care statute.<sup>19</sup>

### **State Programs to Finance Indigent Care**

Many states have instituted programs in addition to Medicaid that address the problem of indigent care.<sup>20</sup> These programs vary between two models: (1) those that provide health insurance coverage for persons who are uninsured; and (2) those that address the financial burden imposed on providers of uncompensated care.

Programs in the first group include state and local general and medical assistance programs for persons categorically ineligible for federal income assistance or Medicaid. State and local medical assistance programs may cover basic health care expenses or catastrophic care. In 1986, the state of Washington established a commission to develop a pilot program to provide prepaid, capitated health care for the uninsured. Also in 1986, Colorado considered a proposal to help purchase private health insurance for needy persons not eligible for Medicaid.

Recent statutes (in Oklahoma and South Dakota) specifically address payment of providers for catastrophic health care expenses incurred by residents. Other states (Alaska, Maine, Minnesota, and Rhode Island) have long-standing catastrophic health insurance programs. These programs primarily serve near-poor or middle-income persons. Persons served by these programs may have insurance (90 percent in Rhode Island), but have health expenses that exceed the limit of their plan. However, only one-quarter of Maine's program beneficiaries and few of Alaska's catastrophic program beneficiaries have other insurance coverage.

State programs that address the provider burden of financing indigent care are varied. Using new discretion under federal law, some states have attempted to raise Medicaid reimbursements to hospitals

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<sup>19</sup>*Welburn Memorial Baptist Hospital v. County Dept. of Public Welfare*, 442 N.E.2d 372 (Ind. App. 1982), was decided under former law, the provisions of which are substantially identical to current law.

<sup>20</sup>Much of the information presented in this section summarizes material presented in Lawrence Bartlett, "State Level Policies and Programs," *Access to Care for the Medically Indigent* (Washington, DC: Academy for State and Local Government, 1985), pp. 54-74; and Intergovernmental Health Policy Project, *State Programs of Assistance for the Medically Indigent* (Washington, DC: George Washington University, April 1985).

that serve a disproportionate number of low-income patients. No more than 10 states have acted to increase reimbursement levels to hospitals serving large numbers of low-income patients, although approximately 20 states have adopted new Medicaid hospital reimbursement systems since the passage of the 1981 federal Budget Reconciliation Act (P.L. 97-35), which authorized greater state flexibility in reimbursing under Medicaid.

State revenue pools are a relatively new approach to resolving the inequitable distribution of indigent care costs among hospitals. For example, Florida, New York, South Carolina, West Virginia, and Wisconsin levy assessments on hospitals to fund pools for the purpose of redistributing the financial burden of indigent care among hospitals. Florida finances its revenue pool by a tax on hospitals' net revenues, supplemented by state general revenues. New York finances its eight regional pools from a surcharge levied on hospital charges. Other sources of funding for state revenue pools to finance indigent care include a levy on insurance premiums (Iowa); assessments on non-hospital health care providers have been proposed in Pennsylvania and Washington state.

Use of the funds in state revenue pools differs. For example, in Florida the funds are used in part to finance Medicaid benefits for the *medically needy*—categorically eligible persons who financially qualify for Medicaid based on their *net* income, after health care expenses. The funds also are used to finance Medicaid eligibility for certain categories of children and pregnant women and to expand outpatient services and primary care coverage.

In six states with hospital rate-setting programs (Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York), an allowance is added to each hospital's rates to help cover uncompensated care costs. These are the only programs that offer hospitals assistance in financing bad debt as well as charity care. In 1985, Massachusetts financed an estimated \$200 million in uncompensated care costs through its hospital rate-setting program; Connecticut expects to finance nearly \$100 million in uncompensated care costs for 1986.

The growing issue of uncompensated care and the uninsured has drawn attention to a wide range of peripheral problems associated with publicly financing health care outside the Medicaid program. In particular, ERISA's preemption of state regulation is being reevaluated as a barrier to effective state financing of indigent care. ERISA narrows the incidence of state law that would tax insurance premiums to finance indigent care, since it exempts self-funded employer plans from state and local taxation. In 1985, 42 percent of



insured workers in larger establishments participated in a self-funded employer plan.<sup>21</sup>

## Conclusion

Uncompensated care accounts for a growing portion of the nation's health care bill. Medicare's adoption of prospective payment, prospective payment and prepayment in state Medicaid programs, and the increasing frequency of negotiated discounts for employer plans limit the ability of hospitals to finance uncompensated care by shifting costs to public and private payers. As a result, indigent patients may be barred from obtaining needed health care, and hospitals that are large providers of indigent care (relative to their total revenues) are put at a competitive disadvantage.

The growing burden of indigent health care is leading state and local governments to look for new ways to finance care and maintain access to health services among the uninsured poor and near-poor. State revenue pools, allowances in hospital rate setting, and state-level capitated insurance plans for the uninsured are options that some states have implemented. These programs offer a glimpse of the type of innovation the future may hold as the need for a financing solution becomes increasingly urgent.<sup>22, 23</sup>

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<sup>21</sup> Employee Benefit Research Institute, "Features of Employer Health Plans: Cost Containment, Plan Funding, and Coverage Continuation," *EBRI Issue Brief* 60 (November 1986).

<sup>22</sup> The author gratefully acknowledges the research assistance of Mona Seliger and the computer programming assistance of Jeannette Hahn Lee, both of EBRI.

<sup>23</sup> Editor's note: An earlier form of the material presented in this chapter was published as *EBRI Issue Brief* 44 (July 1985).

## **XV. Employer-Paid Retiree Health Insurance: History and Prospects for Growth**

Deborah J. Chollet, Ph.D., and Robert B. Friedland, Ph.D.

Employer-paid retiree health insurance is commonly promised to employees of medium or large establishments in the United States. National data from a survey of medium and large firms indicate that in 1985, at least two-thirds of all regular full-time workers participating in health insurance plans were promised health insurance benefits after retirement at age 65. No national data exist to indicate how commonly retiree health insurance is promised to workers in smaller establishments. Available evidence, however, suggests that retiree health insurance for workers in smaller firms is rare.<sup>1</sup>

Employer-sponsored retiree health insurance appears to be predominantly a post-Medicare phenomenon. Although no data track the emergence of retiree health insurance as an employee benefit, anecdotal evidence suggests that few employers provided retiree health benefits in the 1950s. The Medicare debate in the early 1960s, however, brought to the attention of American workers the high cost of postretirement health care relative to the modest incomes of most retirees and probably encouraged demand among workers for retiree health insurance benefits. The advent of Medicare in 1966 dramatically reduced the cost to employers of offering retiree health insurance, since as primary payer Medicare finances a large share of retirees' hospital and medical costs. Employer liability for retiree health care costs, although probably substantial, is secondary to Medicare's.

The acceleration of health care costs in the 1970s markedly raised employers' health insurance costs for active workers and retirees alike. From 1965 through 1985, total spending for health care in the United

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<sup>1</sup>A 1977 Battelle survey, "Employment-Related Health Benefits in Private Nonfarm Business Establishments in the United States" (conducted under contract with the U.S. Department of Labor), provides the only available information on health insurance coverage offered by small establishments. Although the survey did not question respondents about retiree health insurance benefits in particular, responses to a question about continued coverage in any circumstance other than layoffs suggest that small establishments rarely continue coverage for retirees. See Deborah J. Chollet, *Employer-Provided Health Benefits: Coverage, Provisions and Policy Issues* (Washington, DC: Employee Benefit Research Institute, 1984), pp. 57-60.

States rose from \$43 billion to \$425 billion. The cost of hospital care rose three times faster than the cost of other consumer goods and services, increasing more than ninefold from 1965 through 1985. The cost of physician care also grew faster than other goods and services, more than tripling during that period. In 1985, 30.6 percent of all personal health care costs were financed by private insurance, principally by employer-sponsored group plans. By comparison, the federal government financed 30.3 percent, state and local governments financed 9.4 percent, and consumers directly paid 28.4 percent of personal health care costs.

Health care spending by and for the elderly has risen faster than health care spending for any other population group in the nation. From 1977 through 1984, the elderly's health care costs rose nearly twice as fast as those for all Americans.<sup>2</sup> In 1984, per capita health spending for people 65 years of age or over was, on average, two and two-thirds times the total population's per capita health spending.<sup>3</sup>

Because of the rapid increase in health care costs, particularly those of the elderly, employers are focusing on the long-term liability of their obligations to current and future retirees. Historically, most employers did not distinguish between the cost of health insurance benefits for retirees and the cost for active employees. Instead, employers usually measured health care costs in terms of current employees, as a proportion of payroll. Low ratios of retirees to active employees throughout the 1960s and the declining average age of the work force have masked the rising cost of retiree health benefits. Since neither law nor accepted accounting practice required employers to recognize accruing liability for nonpension retirement benefits, many employers did not address the mounting current and potential cost of providing health insurance for retirees.

Growth in the cost of employer health insurance plans, however, has led employers to focus closely on the causes of that growth. In 1985, employer payments for health insurance totaled 5.3 percent of wages and salaries, compared to 5.1 percent in 1982 and 4.1 percent

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<sup>2</sup>EBRI tabulations of data published in Daniel R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," *Health Care Financing Review* 6 (Fall 1984): 1-29, Table 10; and Robert M. Gibson, Katherine R. Levit, Helen C. Lazenby, and Daniel R. Waldo, "National Health Expenditures, 1983," *Health Care Financing Review* 6 (Winter 1984): 1-29, Table 1.

<sup>3</sup>EBRI tabulations of data published in Waldo and Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," Table 12, and U.S. Department of Health and Human Services press release, July 31, 1985.

**TABLE XV.1**  
**Employer Contributions to Health Insurance and As a**  
**Percent of Wages and Salaries, 1950-85**

Year	Health Insurance Contributions <sup>a</sup> (billions)	Health Insurance Contributions As a Percent of Wages and Salaries
1950	\$ 0.7	0.5%
1955	1.7	0.8
1960	3.4	1.2
1965	5.9	1.6
1970	12.1	2.2
1975	25.5	3.1
1980	59.6	4.3
1981	68.8	4.6
1982	80.3	5.1
1983	89.1	5.3
1984	96.9	5.3
1985	104.7	5.3

Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (Washington, DC: U.S. Government Printing Office, July 1986); and unpublished data for years prior to 1982.

<sup>a</sup>Excludes employer contributions to Medicare.

in 1979 (table 1). For firms that offer retiree health insurance benefits, part of this growth is explained by an increase in the ratio of retirees to active workers, a situation that was exacerbated as more workers were encouraged during the 1980-82 recession to retire early.<sup>4</sup>

### Sources of Health Care Financing among the Elderly

With advanced age comes the increased probability of needing medical care. Poor health, in fact, is commonly associated with the decision to retire.<sup>5</sup> Although Medicare is the primary source of health coverage for most retirees, it does not begin until age 65, is aimed at covering acute care, and requires substantial cost sharing. In 1984,

<sup>4</sup>See Employee Benefit Research Institute, "Complementing Social Security: Pensions, Earnings, Welfare, and Wealth," *EBRI Issue Brief* 45 (August 1985).

<sup>5</sup>Eardman B. Palmore, Gerda G. Fillenbaum, and Linda K. George, "Consequences of Retirement," *Journal of Gerontology* 39 (April 1984): 109-116. Also see Shelly Sherman, "Reported Reasons Retired Workers Left Their Last Job: Findings from the New Beneficiary Survey," *Social Security Bulletin* 48 (March 1985): 22-30.

25.2 percent of the health care expenses of those age 65 and over were financed out-of-pocket. The Health Care Financing Administration estimates that the elderly's out-of-pocket expenses in 1984 were \$1,059,<sup>6</sup> or 21.4 percent of median income.<sup>7</sup> Furthermore, this is expected to increase. By one projection, the average elderly household will pay \$2,583 in direct out-of-pocket payments for health care in 1990.<sup>8</sup>

Retirees who are ineligible for Medicare—usually because they are under age 65—have limited options for obtaining health insurance beyond the 18-month continuation period required by federal law if their employers do not offer a retiree plan. Although federal law also requires employers with 20 or more employees to provide access to conversion coverage after the continuation period has lapsed, conversion policies can be more expensive than individual coverage since they do not exclude people with preexisting conditions.<sup>9</sup> Retirees from firms with fewer than 20 employees are not protected by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), which requires employers to provide access to continuation and conversion coverage, although they may be protected by state law if they retire from an insured plan. Twenty-six states require employers to offer conversion policies to employees who retire.<sup>10</sup> These statutes, however, do not obligate employers with self-insured plans, since the Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured employer plans from state regulation. Individuals under age 65 who retire from a job that offered no health insurance plan are not protected by federal or state law.

For early retirees without Medicare coverage, health insurance coverage and out-of-pocket costs may be high relative to income. A Social Security Administration survey of new Social Security beneficiaries indicated that health insurance premiums for those age 62 to 64 averaged 56 percent of Social Security income in 1982. For couples

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<sup>6</sup>Waldo and Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," Table 12.

<sup>7</sup>U.S. Congress, House of Representatives, Select Committee on Aging, Fact Sheet, October 31, 1984.

<sup>8</sup>U.S. Congress, House of Representatives, Select Committee on Aging, *America's Elderly at Risk*, Committee Print, 99th Cong., 1st sess., July 1985, p. 20.

<sup>9</sup>A conversion policy for an individual age 60-64 can exceed \$2,600 per year; an individual policy for a person who does not have a preexisting condition can cost \$1,680 per year. See U.S. Congress, Senate, Special Committee on Aging, *Funding Post-Retirement Health Benefits*, Committee Print, 99th Cong., 1st sess., July 1985.

<sup>10</sup>Blue Cross and Blue Shield Association memorandum, January 1985.

with pension income in addition to Social Security, premiums averaged 35 percent of retirement income.<sup>11</sup>

For retirees over age 65, Medicare is an important payer for health care, particularly for inpatient hospital care. (In 1984, 75 percent of Medicare expenditures were for hospital care.) Medicare in 1984 covered 49 percent of total personal health care expenditures for persons over age 65. Private insurance, by comparison, covered 7 percent.<sup>12</sup> No available data indicate what share of spending for personal health care services was paid by employer-sponsored retiree plans.

### **Types of Employer-Paid Retiree Health Insurance**

Employer-provided health insurance plans for retirees under age 65 are usually the same as those provided to active employees. For those over age 65, employer-provided health insurance plans for retirees are of three general types, defined by their relationship to Medicare.

The first type simply coordinates benefits with Medicare. These plans, called "coordination of benefits" (COB) plans, pay beneficiaries the lesser of (1) the plan benefit calculated without regard to the Medicare reimbursement amount or (2) the cost of covered services minus the Medicare reimbursement amount.

"Exclusion" plans, the second type, subtract Medicare payments before applying deductible and copayment provisions.

The third type, and probably the most common, are "carve-out" plans. Carve-out plans reduce plan reimbursement by the amount Medicare pays. In general, carve-out plans result in the lowest plan cost and the highest beneficiary cost of the three types.<sup>13</sup>

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<sup>11</sup> Social Security data are from the New Beneficiary Survey. For more information see Emily S. Andrews, *The Changing Profile of Pensions in America* (Washington, DC: Employee Benefit Research Institute, 1985).

<sup>12</sup> Waldo and Lazenby, Table 13.

<sup>13</sup> The following illustrates the differences among these methods in plan and beneficiary costs using this hypothetical claim:

The medical expenses covered under the plan are \$1,100, of which Medicare pays \$600. The plan is comprehensive with a \$100 deductible and 20 percent copayment.

- The COB plan, absent Medicare, would pay \$800 ( $.8 \times [\$1,100 - \$100]$ ). However, since covered expenses less the Medicare payment are \$500 ( $\$1,100 - \$600$ ), a smaller amount, the plan pays \$500. In this plan, the beneficiary pays nothing.
- The exclusion plan would pay 80 percent of covered medical expenses (that is, the amount not paid by Medicare:  $\$1,100 - \$600 = \$500$ ), less the plan deductible. In this case, the plan payment would be \$320 ( $.8 \times [\$500 - \$100]$ ). The beneficiary would pay \$180 ( $\$1,100 - \$600 - \$320$ ).
- The carve-out plan would pay \$800 ( $.8 \times [\$1,100 - \$100]$ ), but since Medicare pays \$600, the plan reduces the payment to \$200. The beneficiary pays \$300.

Finally, some plans offer retirees benefits not covered by the active employee plan but may also integrate Medicare coverage in any of the three ways described above. Regardless of their relation to Medicare, these plans commonly cover spouses of retired employees, although spousal coverage may be contributory. Some employers also pay Medicare Part B (Supplementary Medical Insurance) premiums for retirees.<sup>14</sup>

Medicare costs may be affected by the type of retiree plans offered. By minimizing beneficiary cost sharing, COB plans, in particular, may encourage higher utilization of Medicare-covered services. Carve-out plans preserve the cost-sharing incentives of employers' active-worker plans, although they also probably reduce the cost sharing imposed by Medicare.

### **Trends in Employer-Paid Retiree Health Insurance**

Although at least two-thirds of employees in medium and large establishments in 1985 were promised continuation of health insurance after normal retirement, and 71 percent after early retirement, the future of postretirement health coverage is uncertain. At least four major factors may discourage employers from establishing or continuing health coverage for future retirees:

- the prospect of action by the Financial Accounting Standards Board (FASB) to require that employers' unfunded liability for postemployment health and welfare benefits be disclosed;
- current tax law;
- recent and expected changes in Medicare coverage; and
- recent litigation addressing retirees' rights to promised health insurance benefits.

#### ***Disclosure***

ERISA requires that accrued liability in qualified pension plans be funded. Employers receive tax deductions for contributions to qualified pension trust funds; investment income earned by the trusts receives favorable tax treatment. In contrast, ERISA does not require that tax-qualified retiree health and welfare plans be funded. Rather,

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<sup>14</sup>William M. Mercer-Meidinger, Inc., "Understanding the Cost of Post-Retirement Medical Benefits" (New York: William M. Mercer-Meidinger, Inc., May 1985).

employer payments for retiree health coverage are treated as operating expenses for the year in which the benefits are paid.

In a statement issued in November 1984, FASB established employers' responsibility to provide information about postemployment health and welfare benefits as a footnote to their financial statements. In itself, this is not a significant change in accounting practice, since the current costs of these benefits are included in calculating net income. Nevertheless, FASB's position is important in that it requires employers to recognize the current cost of retiree benefits separately from the cost of plan benefits for active workers.

Ultimately more significant may be the issue still under consideration by FASB—whether to require that employers recognize accruing unfunded liability for retiree health and welfare benefits, similar to the way unfunded pension liabilities must be recognized. By most estimates, unfunded liability for retiree health and welfare benefits is large. Based on a nonrepresentative selection of employer plans, the National Association of Accountants estimates that unfunded liabilities for retiree health plans could range from 4 to 50 times the amount that employers are now paying annually as current plan expense. Actuaries who have calculated these costs for clients concur that unfunded liabilities can range from 30 to 50 times the plans' current costs.

Estimates from the U.S. Department of Labor's Pension and Welfare Benefits Administration (PWBA) indicate that aggregate unfunded liability for retiree health insurance benefits may have reached \$98.1 billion in 1983.<sup>15</sup> PWBA estimates that employers would have spent an additional \$6.2 billion more than the \$4.6 billion employers were estimated to have paid in 1985, if the \$98.1 billion liability had been amortized over 20 years. This is an estimated two and one-third times greater than current expenditures using pay-as-you-go financing. Many argue that this is a conservative estimate.

### **Tax Law**

Concurrent with employers' emerging recognition of retiree health plan liability, 1984 changes to the Internal Revenue Code made the prospect of funding accruing liability unattractive. Prior to enactment of the Deficit Reduction Act of 1984 (DEFRA), the tax code defined two tax-favored vehicles for prefunding retiree health benefits: section 501(c)(9) trusts (called voluntary employee beneficiary

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<sup>15</sup>Office of Policy and Research, Pension and Welfare Benefits Administration, U.S. Department of Labor, May 1986, p. 2. (Mimeographed.)



associations, or VEBAs) and section 401(h) trusts.<sup>16</sup> Although no existing national data document the use of these vehicles, consulting actuaries indicate that very few firms used either to fund accruing liability for retiree health benefits. Reportedly, those that did fund these liabilities most often used VEBAs; virtually no employers used 401(h) trusts.

DEFRA discourages the use of VEBAs to fund liability for retiree health benefits in four ways.

- DEFRA establishes limits for deductible contributions to VEBAs. Actuarial assumptions must be based on the current medical plan and cannot include any adjustment for inflation.<sup>17</sup> Under DEFRA, qualified contributions are limited to the sum of (1) benefits paid during the year; (2) reasonable expenses; and (3) a permissible addition to reserves. Without actuarial certification, the safe-harbor limit on the permissible addition is 35 percent of the qualified direct cost for one year.
- DEFRA subjects all investment earnings on reserves held in VEBAs for postretirement medical benefits to the tax on unrelated business income.<sup>18</sup>
- DEFRA imposes a 100 percent penalty tax on any disqualified benefits paid from the funds. Disqualified benefits include any assets reverting to the benefit of employers sponsoring the welfare benefit funds. This means that any excess funds (greater than necessary to cover current-year retiree benefits) cannot be recaptured by an employer.
- DEFRA imposes nondiscrimination rules for qualified contributions to VEBAs. In addition, limits on employer contributions to qualified pension and profit-sharing plans for highly compensated employees (section 415 limits) include contributions for postretirement health benefits.

Many benefit experts consider DEFRA's restrictions on using VEBAs to fund retiree health liabilities prohibitive, given the competing uses of funds—many of which receive preferential tax treatment—within firms. Chart 1 illustrates allowable funding for

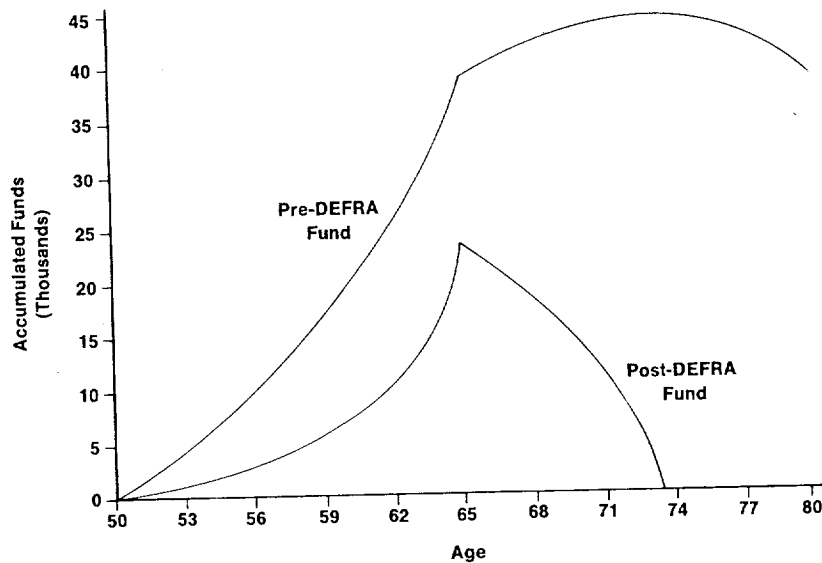
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<sup>16</sup>Technically, the tax-preferred status of VEBAs was not allowed for retiree health benefits, unless the VEBA financed the costs of health benefits for active and retired employees alike.

<sup>17</sup>The new deduction limits imposed by DEFRA apply to contributions paid or accrued after December 31, 1985, in taxable years ending after this date. There is, however, a special transition rule that may be applied for the first four years.

<sup>18</sup>VEBAs used for benefits other than retiree health insurance face a tax on unrelated business income for reserves that exceed the limits specified for that particular benefit fund. The new rules regarding unrelated business income taxes do not apply to income on reserves set aside as of the close of the last plan year ending prior to July 18, 1984.

**CHART XV.1**  
**Comparison of Allowable Funding for Postretirement**  
**Medical Benefits for Employee Age 50**



Source: Buck Consultants.

Note: This hypothetical example considers a 50-year-old employee with current annual postretirement health costs of \$600. It is assumed that these costs increase annually by 10 percent and that the fund into which contributions are deposited earns 10 percent annually. In this example, if prefunding had occurred without the limits imposed by DEFRA, sufficient funds would accumulate by retirement at age 65. If prefunding had occurred within DEFRA contribution limits, funds for this worker would be exhausted by age 74.

postretirement health benefits for a hypothetical worker prior to and after DEFRA enactment.

Section 401(h) of the tax code defines an alternative for funding retiree health insurance liabilities. Section 401(h) authorizes (1) tax-exempt employer contributions to health insurance benefits for retirees, their spouses, and dependents, and (2) tax-deferred contributions to retiree death and disability benefits.

No existing data indicate the use of 401(h) trusts. Actuaries report, however, that few firms use them for retiree health benefits. Those that do may limit plan benefits to payment of Medicare Part B premiums.

Prior to DEFRA, employers may have avoided establishing section 401(h) trusts for several reasons.

- The Internal Revenue Code limits employer contributions to section 401(h) trusts, requiring that the benefits paid by these accounts be “subordinate” or incidental to the retirement benefits paid by the employer pension plan. This limit is interpreted as constraining employer contributions to the trust to 25 percent of annual total contributions to retiree benefits, including pension benefits. For most employers, the limit on contributions to 401(h) trusts may be too low to adequately fund accruing liabilities for retiree health, death, and disability benefits.
- Funds contributed to a 401(h) are separate from the rest of the pension plan. This means that excess funds contributed to a 401(h) cannot be used to fund other parts of the retirement plan.
- The nondiscrimination rules applicable to the pension plan also apply to 401(h) trusts. Because VEBAs were not governed by nondiscrimination rules prior to DEFRA, 401(h) trusts may have been a relatively unattractive way to fund retiree health liabilities.
- Benefit consultants had relatively little experience with 401(h) trusts and may have been uncertain about the technical aspects.

Given DEFRA’s restrictions on the use of VEBAs, section 401(h) plans are receiving more attention from employers seeking to fund liabilities for retiree health benefits. However, limits on contributions to these plans and uncertainty about the legislative and regulatory status of any plan established under section 401 may be important factors impeding their use.

### **Medicare**

Recent and expected changes in Medicare are a critical factor in the development of retiree health insurance benefits. Changes in Medicare coverage and reimbursement that shift costs to beneficiaries in turn shift costs to employer-sponsored retiree health plans. Observing the financial status of the Part A (Hospital Insurance) trust fund and the rising public cost of Part B coverage, employers anticipate that Congress will impose additional cost sharing on Medicare beneficiaries. In addition, employers are concerned that Medicare will expand its position as second payer, reducing Medicare obligations for employer-covered retirees in the same way that Medicare has reduced its obligations for workers over age 65 who are covered by employer plans.

Finally, employers are concerned that Medicare’s prospective hospital payment system may increase the cost of retiree health benefits

by further reducing the length of hospital stays, possibly increasing the number of physician visits or use of outpatient services that are covered by employer plans. While Medicare covers the full cost of inpatient services after the deductible for the first 60 days of illness (called a benefit period), Medicare coverage for physician care entails much greater cost sharing. The cost sharing for physician care imposed by Medicare is a major expense for employer-sponsored retiree health plans.

### Recent Litigation

Retirees' rights to health insurance benefits—in particular those not funded during their working careers—have been the subject of numerous court decisions at the federal level. These decisions are based in contract law and generally define retirees' rights to benefits.

Court rulings have addressed the rights of new retirees to health insurance and other nonpension benefits, as well as the rights of current retirees to continued benefits in various instances of plan termination. Recent decisions have affirmed retirees' rights to the benefits promised them, generating some concern among employers that vesting standards for unfunded retiree health and welfare benefits are being defined in common law.

Early court decisions regarding retirees' rights to nonpension benefits, brought under contract law, interpreted their rights conservatively: retirees may be entitled to benefits only while the contract promising benefits is in force and the employer remains in business.<sup>19</sup> The employer may be obligated to provide lifetime benefits to retirees beyond plan termination only if that obligation is clearly assumed in the contract. Furthermore, vesting for retiree health and welfare benefits may not be implicitly defined "outside the contract" in the context of vesting for other retiree benefits, such as pensions.<sup>20</sup>

<sup>19</sup>*Oddie v. Ross Gear & Tool Co.*, 305 F. 2d 143 (6th Cir.) cert. denied, 371 U.S. 941 (1962); *UAW v. Robertshaw Controls Co.*, 405 F. 2d 29 (2nd Cir. 1968); *Burgess v. Kawneer Co.*, Memorandum Opinion No. K77-487 CA8 (W.D. Mich. 1977); *Turner v. Teamsters, Local 302*, 604 F. 2d 1219 (9th Cir. 1979); *UAW v. Houdaiville Industries, Inc.*, Case No. 5-70742, (E.D. Mich.) undated slip op.; *Metal Polishers Local No. 11 v. Kurz-Kasch, Inc.*, 538 F. Supp. 368, 110 LRRM 3319 (S.D. Ohio 1982); *UAW v. New Castle Foundry*, 4EBC 2455 (S.D. Ind. 1983); *UAW v. Roblin Industries, Inc.*, 561 F. Supp. 288 (W.D. Mich. 1983); *Policy v. Powell Press Steel Co.*, Case No. C82-24024, slip op. (N.D. Ohio 1984); *Bomhold v. Pabst Brewing Co.* (No. 83-1327, July 6, 1984).

<sup>20</sup>In *UAW v. Houdaiville* the court found that the continuation of some benefits for which retirees were vested did not implicitly obligate the employer to continue health and life insurance benefits for retirees beyond the termination of the labor agreement. *UAW v. Houdaiville Industries, Inc.*, Case No. 5-70742 (E.D. Mich.), undated slip op.

The precedent established by these decisions placed the burden of proving a continuing right to benefits largely on retirees. Retirees whose benefits were terminated were responsible for proving that the employer breached a bargaining agreement clearly obligating the employer to continue benefits, or at least implying intent to do so.

However, given stated or implied intent to provide benefits to retirees, several decisions interpreted the right to retirement benefits broadly. These decisions have defined vesting for retiree health and welfare benefits as implicit in retirement status, unless otherwise defined in the labor agreement. As early as 1960, *Cantor v. Berkshire Life Insurance Company*<sup>21</sup> established that the employer may not withdraw or terminate the retirement program after the employee has complied with all conditions entitling him or her to retirement rights. Subsequent court rulings have affirmed that opinion.

Other court rulings concerning the continuation of benefits also construed ambiguity in contract language in favor of retirees when evidence of intent was present. In a series of cases since 1967, the courts have obligated employers that promised retiree benefits to continue those benefits throughout the retirees' lifetimes. Generally, these findings have been based on the absence of contract language to the contrary and on evidence of intent. The circumstances of these cases included, variously, contract expiration and corporate takeover or merger.

The inference of intent in these rulings was in each instance drawn from the particulars of the case. Commonly the courts considered both failure of the labor contract to address the issue of lifetime benefits for retirees (or ambiguity in contract language) and management's representations that the benefit would continue for life—including oral statements to that effect.

Reconciling these decisions with more conservative legal precedent, at least one court decision specifically rejected a lower court's presumption that retiree health and life insurance benefits are lifetime benefits, absent express contract language limiting their duration.<sup>22</sup> Similarly, another decision included the following remarks:

...retiree insurance benefits are [not] necessarily interminable by their nature. [No] federal labor policy identified to this court presumptively favor[s] the finding of interminable rights to retiree insurance benefits when the collective bargaining agreement is silent.<sup>23</sup>

<sup>21</sup> *Cantor v. Berkshire Life Insurance Co.*, 171 Ohio St. 405, 171 N.E. 2d 518 (1960).

<sup>22</sup> *UAW v. Cadillac Malleable Iron*, 728 F. 2d 807 (6th Cir. 1984).

<sup>23</sup> *UAW v. Yard-Man, Inc.*, 716 F. 2d 1476 (6th Cir. 1983), cert. denied, 104 S. Ct. 1002 (1984).

Two recent court decisions upholding retirees' rights to continued health insurance benefits have gained particular attention. These cases were brought under ERISA, which governs the funding, vesting, and fiduciary practices of private pension plans. In that these cases were brought under ERISA, *Eardman v. Bethlehem Steel*<sup>24</sup> and *Hansen v. White Farm Equipment Company*<sup>25</sup> are departures from the precedent established earlier under contract law.

In *Eardman v. Bethlehem Steel*, Bethlehem Steel was constrained from modifying its retiree health insurance plans to parallel the benefits offered to active employees under a collective bargaining agreement. Similar to earlier cases where contract language was ambiguous, the court ruling requiring Bethlehem Steel to reinstate benefits strongly took into consideration implied intent. The decision was appealed, and in a later settlement Bethlehem Steel was allowed to establish a substitute "permanent health program" not subject to later modification or termination.

The plaintiff in *Hansen v. White Farm* contested the termination of a noncontributory retiree health plan after a bankruptcy reorganization. The bankruptcy court authorized replacement of the plan with a group plan arrangement financed entirely by participant premiums. Reversing the bankruptcy court decision, the federal district court held that, in excluding welfare benefit plans from the minimum vesting requirements of ERISA, Congress did not intend to permit the unrestricted termination of these plans by employers. Furthermore, the court stated,

...the modern view concerning benefit plans, under which an employer may not invoke a termination clause to cut off the benefits of a former employee who has properly retired pursuant to the employer's requirements, should be adopted as a rule of common law under ERISA.<sup>26</sup>

On April 21, 1986, the Sixth Circuit Court of Appeals overturned the lower court decision and remanded the case back to the bankruptcy court for further clarification of the plan documents to determine if benefits could be terminated. The appeals court decided that Congress exempted welfare benefits from ERISA's vesting, participation, and funding standards, and that ERISA-based "common law" was inapplicable.

In the absence of legislation or further litigation clarifying ERISA's protections for health and welfare plan participants, the precedent

<sup>24</sup> *Eardman v. Bethlehem Steel Corp.*, No. 84-274E, slip op. (W.D. NY Sept. 17, 1984).

<sup>25</sup> *Hansen v. White Farm Equipment Co.*, No. C82-3209 (N.D. Ohio Sept. 20, 1984).

<sup>26</sup> *Ibid.*

set by *Hansen v. White Farm* and earlier cases governs the organization and administration of retiree health insurance plans. These cases suggest a common-law rule for retiree welfare plans: Former employees who properly retire may gain a "vested right" to welfare benefit plans at retirement. These cases suggest that an employer may not terminate the plan or alter its provisions unless the employer has reserved the right to do so and has clearly communicated that right to employees. Ambiguous plan language regarding the employer's right to terminate or alter the plan may be interpreted broadly in favor of retirees.<sup>27</sup>

### Issues in the Coming Debate

In addition to limiting the use of VEBAs for funding retiree health insurance liability, DEFRA mandated the Treasury Department to study possible funding and vesting rules for retiree health plans, similar to the rules now governing pensions under ERISA (a report is expected in fall 1987). Funding and vesting, however, are difficult concepts as applied to service benefits such as health insurance, since the cost of providing such benefits is much less predictable than the cost of providing cash benefits such as pensions.

As with cash benefits, accruing liability for service benefits (measured as the discounted present value of forecasted plan costs) depends on the probability that employees will ultimately qualify for benefits and on the expected lifetimes of retirees. Unlike cash benefits, however, future health insurance costs also depend on the long-term rate of health-care cost inflation, changes in the delivery of health care, and changes in medical technology. Moreover, survivorship rights under a retiree health plan cannot be factored into the benefit payout in the same way that pension plans reduce annual benefits for retirees who elect joint and survivors' benefits. As a result, survivors' benefits

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<sup>27</sup> Editor's note: The termination of retiree health benefits in the voluntary bankruptcy reorganization of LTV Corporation gained congressional attention and may generate future legislation. In the Omnibus Budget Reconciliation Act of 1986 (OBRA), Congress amended the continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to make a firm's entry into Chapter 11 bankruptcy on or after July 1, 1986, an event qualifying any retired employee to continue obtaining employer-sponsored health coverage until he or she (1) dies or (2) obtains coverage from another source. A retiree's spouse may obtain coverage for an additional 36 months.

The second provision, House Joint Resolution 738, established that any company paying retiree medical benefits as of October 2, 1986, that has not had its reorganization plans confirmed by a bankruptcy court, and any companies reorganizing under Chapter 11 after that date, must continue paying benefits until May 15, 1987.

For further information, see Employee Benefit Research Institute, "Employer-Provided Health Benefits: Legislative Initiatives," *EBRI Issue Brief* 62 (January 1987).

can add significantly to health plan costs and make forecasting those costs even more uncertain. Finally, if vesting rules were to allow vesting in more than one retiree health insurance plan, the practical problem of coordinating benefits from multiple plans as well as Medicare would be significant, constituting an additional source of uncertainty in forecasting plan costs.

The emerging policy debate centers on the appropriate and prudent financing of retiree health and other nonpension benefits, as well as the rights of retirees to receive these benefits. While federal rules governing the administration of qualified plans may place funding and reporting burdens on employers—potentially discouraging employers from providing retiree health benefits—such rules may also safeguard promised benefits to workers.

In the coming debate over appropriate rules, however, the current and potential role of employer-sponsored coverage in financing health care for the elderly should also be considered. A larger private system of health insurance for the elderly offers potential advantages and disadvantages compared to a growing public system. Employer plans may be important in protecting early retirees from the high cost of major illness and in ensuring their access to health care. For retirees covered by Medicare, especially those with chronic health problems, employer-sponsored health coverage helps finance substantial out-of-pocket expenses and represents an important supplement to pension income—one that may exceed the value of many retirees' pension plans.

If a larger private system of health insurance for the elderly is to be encouraged, several related issues must be addressed. These include the relative merits of an employer-based system of coverage versus a more individualized system, such as the proposed individual retirement accounts specifically earmarked for the purchase of health care or health insurance in retirement (sometimes called "medical IRAs"). They also include the willingness of Congress and the administration to sustain the near-term revenue loss implied by tax policy to encourage greater private insurance coverage among future retirees. Possible reduction of the fiscal burden of Medicare and Medicaid spending for the elderly, however, is an important offsetting consideration. Possible long-term reductions in public spending enabled by private coverage should be weighed carefully against the near-term cost of aggressive tax policy to encourage private health insurance coverage among retirees.<sup>28</sup>

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<sup>28</sup> Editor's note: An earlier form of the material presented in this chapter was published as *EBRI Issue Brief 47* (October 1985).



## **XVI. Financing Long-Term Care**

Robert B. Friedland, Ph.D.

Financing long-term care is one of the biggest challenges facing our society. The population is aging, with the fastest growth in the age group with the greatest potential for needing long-term care—persons over age 85. The elderly have few alternatives for reducing their out-of-pocket health care costs if they become chronically ill. Many elderly face catastrophic expenses and either spend all their wealth on long-term care or transfer financial assets to others in order to qualify for Medicaid.

This chapter evaluates demographic changes and health care expenditures of the elderly and the risks associated with chronic health conditions. Existing financing mechanisms are explored, as are alternative approaches to long-term care financing. The financing of long-term care is the most fundamental issue discussed. Other concerns, such as the supply of nursing home beds and the reimbursement practices of Medicare and Medicaid, are raised but require analysis beyond the scope of this volume.

Long-term care refers to health and social services that are provided to the chronically ill and functionally impaired. Long-term care includes an array of services provided informally by family, friends, and volunteers and also includes formal services provided, often through institutions, over extended periods of time. These include skilled-nursing care (such as changing catheters or administering medications), physical and occupational therapy, personal care services (e.g., assistance with bathing, dressing, walking, eating, and using a toilet), counseling, case management and coordination, homemaker services (light housekeeping, meal preparation, and shopping), and chore services (heavier tasks needed to maintain a home). Some services can be provided in a variety of settings, including hospitals, clinics, hospices, nursing homes, adult day care centers, and the home.

### **Economic Status of the Elderly**

Americans are living longer, but retiring earlier. In the past two decades, life expectancy for persons age 65 and older has increased. Today's 65-year-olds can expect to live two and one-half years longer than the 65-year-olds of 20 years ago. In addition, labor force partic-

ipation among men age 65 and over has declined substantially, from 33.1 percent in 1960 to 16.3 percent in 1984.<sup>1</sup> Retirement planning has come to play an increasingly important role in individuals' and families' decision making.

Individuals over age 65 have experienced measurable gains in financial well-being. Income among the elderly has risen while poverty rates have declined. In the past 20 years, income among the elderly has risen faster than that of the nonelderly, so that elderly and non-elderly families now have nearly equal levels of per capita income. In 1984, median income among families headed by a person age 65 and older was \$18,215, about \$10,000 less than the median income for families headed by an individual younger than age 65. Median income among unrelated elderly individuals was \$7,296, approximately \$6,000 less than that for unrelated individuals age 64 or younger. By 1983, poverty rates for elderly families had declined to 9 percent from 27 percent two decades earlier. The drop in poverty rates was even greater among single elderly, falling from 66 percent in 1960 to 26 percent in 1983.<sup>2</sup>

However, the elderly are not a homogeneous group. Age and family composition contribute to variations in personal resources. For instance, older people with spouses are, on average, better off financially than those who live alone. In 1982, 85 percent of all married couples had retirement income of \$10,000 or more; only 45 percent of all unmarried individuals reached this threshold. Median annual private pension income for couples (\$4,700) was nearly twice the benefit received by individuals (\$2,417), while median annual Social Security benefits were 53 percent larger for couples (\$7,750) than for individuals (\$5,050).<sup>3</sup> Persons age 85 and older are almost twice as likely to be poor as those age 65 to 74. In 1983, 21.3 percent of persons age 85 and older had income below the poverty level, compared to 11.9 percent of persons age 65 to 74.<sup>4</sup> Furthermore, in 1983, poverty

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<sup>1</sup>For more information on the retirement decisions and wealth of the elderly see Employee Benefit Research Institute, "Complementing Social Security: Pensions, Earnings, Welfare, and Wealth," *EBRI Issue Brief* 45 (August 1985); and Employee Benefit Research Institute, "Economic Incentives for Retirement in the Public and Private Sectors," *EBRI Issue Brief* 57 (August 1986).

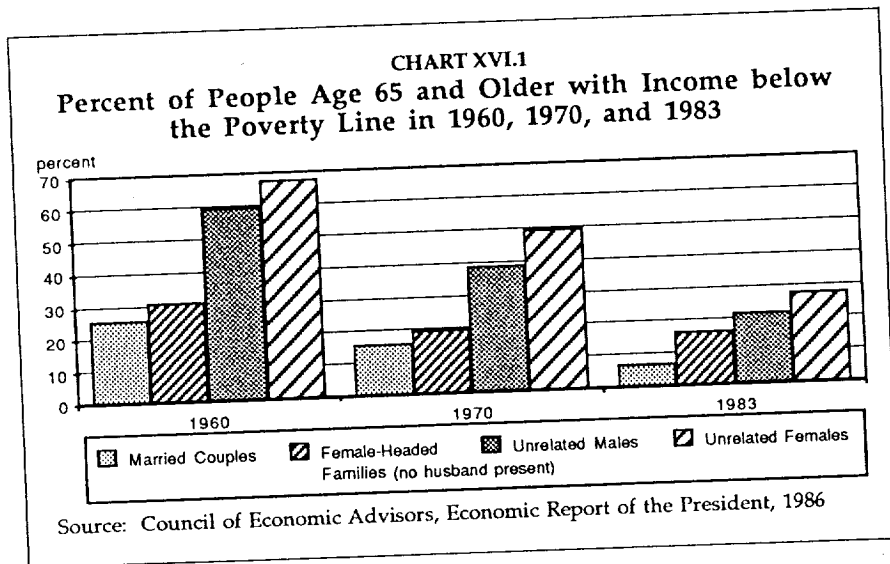
<sup>2</sup>U.S. Department of Commerce, Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1984," *Current Population Reports*, series P-60, no. 149 (Washington, DC: U.S. Government Printing Office, August 1985), Table 15, p. 21.

<sup>3</sup>*EBRI Issue Brief* 45, pp. 5-6.

<sup>4</sup>G. Lawrence Atkins, "The Economic Status of the Oldest Old," *Milbank Memorial Fund Quarterly/Health and Society* 63, no. 2 (1985): 398.

rates among elderly couples were nearly one-fourth the level found among single elderly, and nearly one-third the rate among elderly families headed by females with no husbands present (chart 1).

Compared to the nonelderly population, the elderly are also at greater risk of chronic and degenerative health problems that may lead to institutionalization and eventually to impoverishment. Recent studies have examined the financial risks associated with senile dementia such as Alzheimer's disease.<sup>5</sup> One such Massachusetts study surveyed elderly individuals and families with heads of household age 75 or older. This study found that 46 percent of the elderly age 75 years or older who had been living alone became impoverished within 13 weeks of placement in nursing homes.<sup>6</sup>



<sup>5</sup> Senile dementia is a particularly debilitating condition afflicting an estimated 50 percent of the American elderly who reside in nursing homes. About 15 percent of the elderly not residing in nursing homes are also afflicted. Economic costs in the U.S. associated with senile dementia were estimated at nearly \$39 billion in 1983 according to the National Institute on Aging.

<sup>6</sup> U.S. Congress, House Select Committee on Aging, *America's Elderly at Risk*, Committee Print, 99th Cong., 1st sess., July 1985. The survey was conducted by Harvard Medical School and sponsored by the House Select Committee on Aging. The committee sponsored a similar study conducted by Blue Cross and Blue Shield of Massachusetts. That study, which surveyed persons age 66 and older, found that 63 percent of those living alone would be impoverished within 13 weeks of institutionalization, while couples had a 37 percent risk.

## Demographics of the Elderly

The elderly have been the fastest-growing age group in the United States, increasing both in absolute terms and as a percentage of the total population. At the turn of the century, 4 percent of the population, or 3.1 million people, were age 65 or older. By 1980, this group had grown to 11.3 percent of the population, or 25.5 million persons. By the year 2030, the number of elderly is projected to double again and to represent 20 percent of the U.S. population.

The older population itself is aging. Individuals over age 85 represent the fastest-growing age group in the population. The number of Americans age 85 and older is projected to increase from 2.6 million in 1980 to 13.3 million by 2040, or from 9 percent of the elderly population to 20 percent. Of the 13.3 million "old old" in 2040, slightly more than 30 percent may require some type of personal care assistance.<sup>7</sup>

Substantial advances in medical technology have increased the elderly's life expectancy and changed their prevalent causes of death. Better control of high blood pressure, improved surgical and medical treatment of heart disease, and early cancer detection as well as changes in lifestyle (e.g., decreased smoking and more exercise) have been major factors. Reduced incidence of heart disease and stroke has been especially significant in extending the life span of the elderly. In 1960, the life expectancy of a 65-year-old woman was 15.8 years, compared to 19 years in 1984. The average life expectancy of a 65-year-old man was 12.8 years in 1960, compared to 14.5 years in 1984.<sup>8</sup>

Living longer has meant that chronic health conditions have become major causes of death, disability, and functional dependency. These conditions can afflict individuals for years, impairing their ability to function and necessitating high use of health resources to manage—but not cure—the conditions. Although chronic conditions may include episodes of acute care, the focus of long-term care is to manage chronic problems while maintaining as much of the individual's independence as possible.

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<sup>7</sup>Beth Soldo and Kenneth G. Manton, "Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends," *Milbank Memorial Fund Quarterly/Health and Society* 63, no. 2 (1985): 286–319; Ira Rosenwaike, "A Demographic Portrait of the Oldest Old," *ibid.*, pp. 187–205; and Joan C. Cornoni-Huntley, Daniel J. Foley, Lon R. White, Richard Suzman, Lisa F. Berkman, Denis A. Evans, and Robert B. Wallace, "Epidemiology of Disability in the Oldest Old: Methodological Issues and Preliminary Findings," *ibid.*, pp. 350–376.

<sup>8</sup>U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Health United States, 1985*, Pubn. No. PHS 86-1232 (Washington, DC: U.S. Government Printing Office, December 1985), Table 11, p. 40.

The elderly, especially those over age 85, are at the greatest risk of needing long-term care. The likelihood of needing long-term care services increases with age. In 1977, there were about 13 nursing home residents per 1,000 persons age 65 to 74 and about 216 per 1,000 persons age 85 years and over.<sup>9</sup> Nearly one-third of the population over the age of 85 requires help with personal care, compared to less than 1 percent of the population under age 45. More than 70 percent of those who require help with personal care are over the age of 65. Of the elderly in need of personal care, 2.6 percent were age 65 to 74 while 31.6 percent were age 85 and over.<sup>10</sup>

Most persons requiring long-term care reside within the noninstitutionalized community, but the likelihood of needing institutionalized care increases with age. The 1977 National Nursing Home Survey found that nursing home residents represented 0.3 percent of all persons age 45–64, 1.4 percent of those age 65–74, 6.4 percent of the population age 75–84, and 21.6 percent of those age 85 and older. This survey in conjunction with the 1977 National Health Interview Survey indicated that of those needing personal care assistance in the 65-to-74 age group, 40 percent resided in nursing homes. For those age 85 and over and in need of personal care assistance, 61 percent resided in nursing homes.<sup>11</sup>

### Utilization and Health Care Expenses of the Elderly

On average, the elderly's health care utilization and, consequently, personal health care expenditures are much greater than those of the nonelderly. The elderly averaged 1.75 more visits to physicians' offices per person in 1981, and nearly twice as many hospital discharges per 1,000 persons in 1982, than the population as a whole. The elderly's average hospital stay in 1982 was 2.6 days longer than the national average.<sup>12</sup> Per capita, the elderly spend nearly three times the amount the population as a whole spends on health care. In 1984,

<sup>9</sup>Ibid., Table 55, p. 116.

<sup>10</sup>Pamela Doty, Korbin Liu, and Joshua Wiener, "An Overview of Long-Term Care," *Health Care Financing Review* 6 (Spring 1985): 69–78.

<sup>11</sup>Patrice Hirsch Feinstein, Marian Gornick, and Jay N. Greenberg, "The Need for New Approaches in Long-Term Care," in *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*, conference proceedings, U.S. Department of Health and Human Services, Health Care Financing Administration, Pubn. No. HCFA 03174 (Washington, DC: U.S. Government Printing Office, June 1984), pp. 7–12.

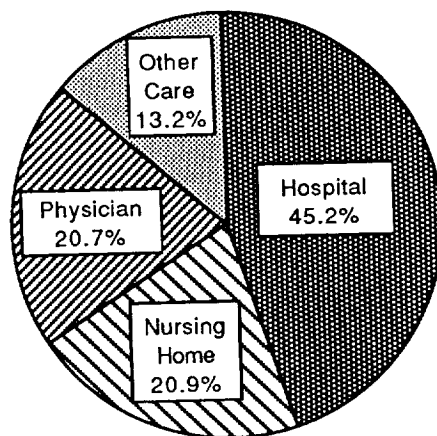
<sup>12</sup>U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Health United States, 1984*, Pubn. No. PHS 85-1232 (Washington, DC: U.S. Government Printing Office, December 1984), Table 44, p. 99, and Table 50, p. 108.

health care expenditures by those age 65 and older exceeded \$119 billion, while the expenditures of those under age 65 were \$267.5 billion. For the elderly, the largest expenditure category in 1984 was hospitals (\$54.2 billion), followed by nursing homes (\$25.1 billion) and physicians (\$24.8 billion); all other care accounted for \$15.8 billion (chart 2).

Nursing home care represents the elderly's second-largest expenditure category, but is their largest source of out-of-pocket spending. Among the 1.3 million elderly persons in nursing homes, about half are covered by Medicaid. More will eventually exhaust their financial resources and become eligible for this program. Private out-of-pocket expenditures financed 50.1 percent of all nursing home care in 1984. Private insurance plans financed only 1.1 percent. Medicaid purchased 41.5 percent of all nursing home care, while Medicare's portion was 2.1 percent (chart 3).

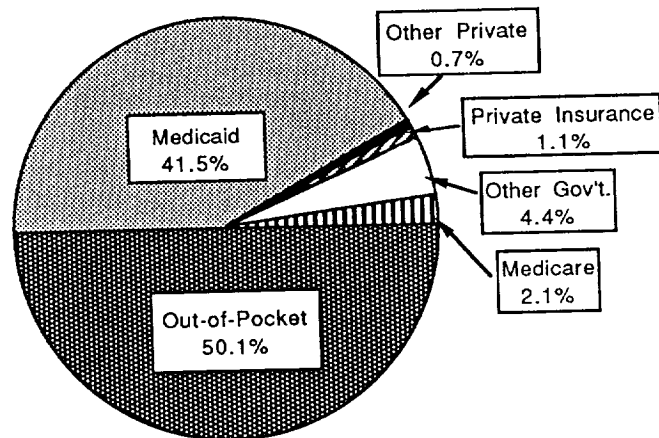
On average, the elderly's out-of-pocket expenses for health care are large and are expected to increase. Out-of-pocket health care expenses excluding health insurance premiums for the elderly in 1984 averaged

**CHART XVI.2**  
**Distribution of Personal Health Care Expenditures**  
**Per Capita for People 65 Years of Age and Older,**  
**by Type of Service, FY 1984**



Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Financial and Actuarial Analysis

**CHART XVI.3**  
**Distribution of Nursing Home Expenditures Per Capita**  
**for People 65 Years of Age and Older, by Source of Funds, FY 1984**



Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Financial and Actuarial Analysis

\$1,059 per person—21.4 percent of the elderly's median income. By 1990 it is expected to average \$2,583.<sup>13</sup>

## Public Financing of Long-Term Care

### Medicaid

Medicaid is the major source of public financing for long-term care. Federal law requires states to cover services provided in skilled-nursing facilities (SNFs) for Medicaid recipients over age 21. In addition, states may cover SNF care for recipients under age 21, the service of intermediate care facilities (ICFs) and ICFs for the mentally retarded (ICFMRs), and institutional care for mental disease for persons under age 21 and for those age 65 and over.

Medicaid has been the fastest-growing component of many state budgets, and long-term care has been the fastest-growing portion of Medicaid spending. Between 1975 and 1980 Medicaid spending for long-term care rose at an annual rate of 17 percent, compared to 15

<sup>13</sup>U.S. Congress, House Select Committee on Aging, *America's Elderly at Risk*, p. 20.

percent for all Medicaid spending. By 1983, Medicaid spending for long-term care was \$15.4 billion, or 48 percent of total Medicaid spending. Nursing home spending was the largest component of long-term care aggregate spending, accounting for over 36 percent of Medicaid expenditures. Nursing home expenditures are ranked within each state as Medicaid's largest or second-largest expenditure category.

In states with Medicaid programs that encompass the medically needy, nursing home expenses are covered once health care costs become greater than an individual's Medicaid-recognized assets. Thirty-one states have incorporated medically needy programs into Medicaid. Over one-half of the people covered by Medicaid in nursing homes were not on Medicaid upon entering but became eligible by "spending down" (depleting) their assets until medical costs exceeded net wealth.

The promise of Medicaid eligibility after depletion of one's assets provides strong incentives for transferring personal assets to others prior to needing long-term care. It is unknown how extensively assets are transferred to receive medical assistance, but tangential evidence suggests that it is not minimal. Attorneys advertise expertise in transferring or sheltering assets to assist families in qualifying for Medicaid. State laws governing asset transfers have grown increasingly strict, regulating asset valuation and lengthening the required waiting period between asset transfer and application for Medicaid benefits.

State and federal inheritance and gift taxes may also encourage the transfer of assets prior to needing long-term care. The effect of Medicaid program incentives and state and federal gift and inheritance taxes are probably complementary, but the relative impact of each is not fully understood.

The absence of private insurance alternatives to Medicaid for financing long-term care further encourages the elderly to seek ways to become Medicaid-eligible. Paradoxically, however, the Medicaid program may make it more difficult for private insurers to market coverage for catastrophic chronic-care costs. Misconceptions about the coverage now provided by private health insurance plans, by Medicare, and by Medicaid, and failure to recognize the risk of high health care costs associated with aging foster a public illusion that the probability of needing long-term care is small and that if it is needed, the financing will come "from somewhere."

The preeminence of Medicaid in financing long-term care has also created some problems in service delivery. Medicaid coverage tends



to be institutional rather than home- or community-based and has encouraged a delivery system that is biased toward institutionalization.

Medicaid's low reimbursement levels and cumbersome system of claims filing have also affected the nursing home market. Facilities that accept Medicaid patients have long queues for admission, while nursing homes that accept only private-pay patients generally have beds readily available. In some areas, however, nursing home beds may become scarce for private-pay patients as states restrict the overall number of new beds in the belief that this action will contain Medicaid expenditures. Flat-rate or cost-based reimbursement, moreover, has encouraged nursing homes that accept Medicaid payment to prefer patients who are the least ill or to over-provide billable services and supplies.<sup>14</sup> These incentives have resulted in instances where too many services were provided to those less in need of institutional care, while not enough services were provided to those in greater need of care.

### **Medicare**

Medicare was enacted in 1965 to finance acute care for the elderly and, subsequently, the disabled. Medicare does pay for some nursing home care, but the level and limits of coverage target post-acute care. Medicare pays only for nursing home stays that begin within 30 days of discharge from a hospital stay of three or more consecutive days. Furthermore, Medicare covers only care provided in skilled-nursing facilities and limits benefits to 100 days per benefit period (spell of illness). The first 20 days of Medicare-paid SNF care require no copayment; after 20 days a \$61.50-per-day copayment is required (increasing to \$65 for federal fiscal year 1987). In 1980, Medicare covered an average of 30 days of skilled-nursing care, much less than the average length of stay of 456 days for all nursing home care.<sup>15</sup>

Medicare also covers an unlimited number of home health care visits. To qualify for coverage, a beneficiary must be under the care of a physician, be homebound, and need part-time, skilled-nursing

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<sup>14</sup>The inability to place Medicaid patients in nursing homes has prompted states to consider alternative reimbursement schemes. One fairly successful arrangement implemented by the Maryland Medical Assistance Program makes payments based on one of four levels of care, although capital costs are still reimbursed based on actual cost. Lack of placement is very costly since it usually means extending the hospital stay, which can be two to four times the daily rate at a nursing home.

<sup>15</sup>Doty et al., "An Overview of Long-Term Care."

care (or physical or speech therapy) on an intermittent basis. The intermittent care requirement, however, has been interpreted by the Health Care Financing Administration as the need for home health care less than three days a week. Home health expenditures are less than 3 percent of Medicare's total costs but are growing rapidly. From 1974 to 1980 the annual growth rate was 34 percent. Doty et al. have estimated that only one-third of this increase was due to price inflation; almost one-half was due to an increase in the proportion of beneficiaries utilizing home health services; 8 percent was because of an increased number of visits per person; 10 percent resulted from growth in the overall number of Medicare beneficiaries. Medicare home health care expenditures doubled from \$722 million in 1980 to \$1.5 billion in 1983, an annual compounded growth rate of 26 percent.<sup>16</sup>

Since November 1983, Medicare also has covered a limited amount of hospice care (care for the terminally ill). In 1986, hospice coverage was made a regular Medicare benefit.

#### ***Other Federal Programs***

Many smaller federal programs together financed 5.6 percent (\$6.7 billion) of the elderly's total health care expenditures in 1984. These programs include nursing home and personal care for elderly veterans provided by the Veterans Administration; home-delivered meals, congregate meals, and some in-home support services financed under Title III of the Older Americans Act; social services financed under Title XX of the Social Security Act; a variety of programs financed through the alcohol, drug abuse, and mental health block grant; and programs funded through the Developmental Disabilities Assistance and Bill of Rights Act. Of this \$6.7 billion, nearly three-fourths (73.2 percent) went to purchase hospital services, followed by nursing home care (16.5 percent), other care (7.9 percent), and physician services (2.4 percent).<sup>17</sup>

#### **Alternative Financing for Long-Term Care**

Recognizing the likely consequences of demographic trends, technological advances in medicine, and a general squeeze on social spending, there has been growing concern over whether resources are

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<sup>16</sup>Doty et al., "An Overview of Long-Term Care."

<sup>17</sup>Ibid.

adequate to finance the enormous cost of long-term care. Many consider the current system of financing long-term care inadequate because the financial burden can be very large relative to retirement income and accumulated wealth. At a cost of \$2,100 to \$4,500 a month, the expense of receiving care in a nursing facility can exceed retirement income, wiping out a lifetime's savings.

The problem, however, is that there is no obvious financing mechanism one can use to help meet long-term care costs in advance of the time they are incurred. Although a private insurance market exists for acute care not financed by Medicare, no comparable market for private long-term care insurance has been developed. A public mechanism—Medicaid—exists, but this is a means-tested program that was not intended to finance the long-term care costs of all elderly.

Approaches to financing long-term care could be purely public, like an extended Medicaid or Medicare program; purely private, by encouraging long-term care insurance; or a mixture.

A purely public approach could be organized in a manner that resembles Medicare. Coverage could be mandatory or voluntary and financed through premiums, general revenues, or both. One advantage of this approach is that participation would be among a broad population at risk of using long-term care; those at immediate risk of needing long-term care would not be the only ones selecting the insurance. To the extent that it is mandatory and/or financed through general revenues, the financial risk would be shared by all. Furthermore, the Medicare model might avoid the stigma of a means-tested welfare program. The disadvantage of this approach is that the benefits structured by the political process may be different from those individuals would choose, potentially producing expensive benefits that may not serve individuals' needs.

Purely private financing would have the free market determine the types of insurance available. The advantages of this approach are that the individual would be free to choose a policy that would complement his or her particular financial and family circumstances. The disadvantage of this approach is that individuals may not adequately assess the risk of needing long-term care. Alternatively, they may wait until retirement to purchase coverage, when the risk of needing long-term care is so high that premiums are prohibitive. If many elderly were unable to afford the insurance, society would be faced with having to decide what to do about individuals who lacked adequate health care.

More than likely, long-term care financing will be addressed as a cooperative arrangement between the public and private sectors. Public

involvement may take the form of assurances or assistance in developing widescale private markets. In addition, the public sector will probably continue to safeguard access to health care by poor elderly.

### **Financing Options**

Many financing alternatives have been suggested. The options receiving the most attention are private initiatives that include private insurance for long-term care, life-care communities, and social/health maintenance organizations (S/HMOs). Some attention has been focused on mechanisms to facilitate personal funding of long-term care, including converting home equity into cash and establishing individual retirement accounts (IRAs) for medical purposes—"medical IRAs." This is not an exhaustive listing of options, nor are the alternatives mutually exclusive. A brief description of the most widely discussed approaches follows.

*Long-Term Care Insurance*—Private insurance for long-term care is available, although not in all states, from at least 13 carriers. An estimated 130,000 individuals were covered as of June 1986. As of the same time, 15 more insurance companies were preparing to enter the market.<sup>18</sup> These policies typically offer indemnity benefits in SNFs (ranging from \$10 to \$50 a day) for three to four years and may also cover custodial and intermediate care, as well as home health care. Premiums are commonly based on age and vary by the indemnity level and waiting period chosen.<sup>19</sup>

The feasibility of developing a private long-term care insurance market is a commercial concern for private insurers, as well as a policy concern for government. Numerous studies of existing policies, many sponsored by the federal government, as well as private market testing have been under way.<sup>20</sup> The Health Insurance Association of

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<sup>18</sup>Health Insurance Association of America, "The State of Private Long-Term Care Insurance: Results from a National Survey," Research and Statistical Bulletin No. 5-86 (Washington, DC: Health Insurance Association of America, 25 November 1986). For more information see Mark R. Meiners and Gordon Trapnell, "Long-Term Care Insurance: Premium Estimates for Prototype Policies," *Medical Care* 22 (October 1984): 901-911; and ICF Incorporated, "Private Financing of Long-Term Care: Current Methods and Resources, Phase I, Final Report" (Washington, DC: ICF Incorporated, January 1985), submitted to Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

<sup>19</sup>Fireman's Fund has the most experience underwriting long-term care coverage. Based on seven years of experience, the company reports that the average policyholder age is 78, the average beneficiary age 83, and the average length of stay in a nursing facility 256 days. See ICF Incorporated, "Private Financing of Long-Term Care: Current Methods and Resources, Phase I, Final Report."

<sup>20</sup>For examples see Meiners and Trapnell and ICF Incorporated. The Prudential Insurance Company of America recently released a test product to a random selection of AARP members in six states.

America has examined this issue and established broad guidelines for putting together a private insurance product.<sup>21</sup>

Estimates based on both existing and prototype policies suggest that many elderly could afford insurance coverage for long-term care. EBRI estimates suggest that long-term care insurance premiums may be less than 5 percent of 1984 cash income for 21 percent of families with a member over age 65 (chart 4).<sup>22</sup> If families had purchased coverage at a younger age, premium levels would have been lower, both absolutely and as a percent of cash income. These prototype policies, it should be noted, do not adjust for any insurance-induced demand—that is, use of services that would not occur in the absence of the insurance coverage. If long-term care insurance increases utilization of services, premiums will increase.

The low rate of long-term care coverage among the elderly population may be related to four factors.

- For the most part long-term care insurance has been sold to individuals rather than to groups, making it more expensive.
- Because of limited actuarial experience and the difficulty of defining some long-term care services, insurers have been very cautious in offering coverage—covering well-recognized, medically oriented benefits; using extensive screening to identify low-risk buyers; and providing partial indemnity rather than service coverage, with high deductibles.
- State regulations vary and in some places may inhibit the development of an affordable insurance product. In many states, long-term care insurance may be regulated as Medicare supplement (Medigap) insurance, mandating the coverage of specific benefits and imposing specific minimums for short-term losses relative to insurers' premium income. While these regulations are intended to protect the consumer, they tend to ignore differences in insurance policies and the event being insured. Long-term care insurance is substantially different from Medigap and may need regulation that accounts for these differences.
- Misconceptions about the scope of coverage from Medicare and supplemental Medigap policies as well as the existence of Medicaid may make it difficult to sell private policies. In a survey of the membership of the American Association of Retired Persons (AARP), 79 percent thought that nursing home needs would be met by Medicare.

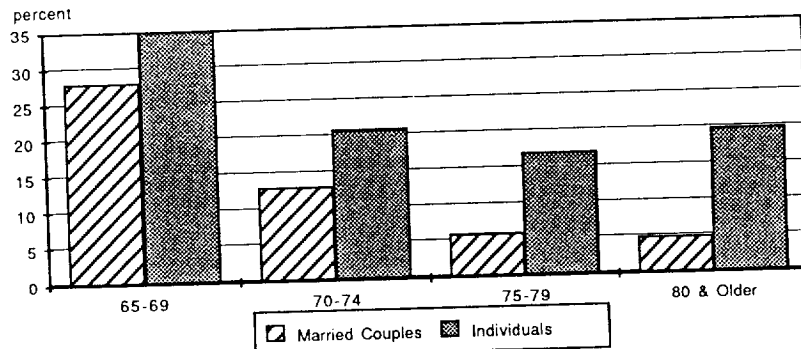
Efforts to remove some of these barriers and facilitate development

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<sup>21</sup>"Long-Term Care: The Challenge to Society" (Washington, DC: Health Insurance Association of America, 1984).

<sup>22</sup>This is based on the estimated premium for a comprehensive prototype insurance policy. See Meiners and Trapnell, "Long-Term Care Insurance: Premium Estimates for Prototype Policies."

CHART XVI.4  
 Percent of Families for Whom Long-Term Care Insurance Premiums  
 Would Be Less Than 5 Percent of Cash Income, 1984 \*



Source: EBRI analysis of U.S. Department of Commerce, Bureau of the Census, March 1985 Current Population Survey

\*Premiums are based on estimates (in 1984 dollars) of a prototype comprehensive policy developed by Mark Meiners and Gordon Trapnell. It assumes an annual premium for an individual age 65-69 of \$761; age 70-74, \$978; and age 80 and older, \$1,304. Premiums for married couples are assumed to be twice these levels.

of private long-term care insurance, however, are under way. Insurance companies are gaining experience in offering this coverage. Federal legislation designed to assist private initiatives has been proposed. Finally, states are examining their insurance laws to be sure that the laws do not discourage the development of private insurance, since they expect private insurance to reduce Medicaid expenditures.<sup>23</sup>

*Life Care Community Centers*—Sometimes referred to as continuing-care retirement communities, life care centers attempt to provide all services a relatively ambulatory elderly person would need from date of entry until death. A typical center has a campus appearance and contains an apartment complex, a dining facility, an activity center, and a nursing-care facility capable of providing skilled, intermediate, and custodial care. Individuals are provided the opportunity to live as independently as they can in surroundings that are secure and geared to an elderly community. For residents with medical problems, home health care or use of the nursing-care facility is provided; hospital care is provided outside the community center. Social activities are included and the centers often have a mechanism for self-governance.

<sup>23</sup> See Mark Meiners, "Long-Term Care Insurance," *Generations* 9 (Summer 1985): 39-42.

Life care residency is typically financed through entrance fees and monthly fees. Some centers affiliated with religious organizations, however, may require assignment of all assets at entry. The monthly fees usually do not cover all medical expenses.

Life care centers are not new in concept, but viewing them as a major means of financing chronic care is. Although many centers have existed for over 30 years, not much is known about them. For example, estimates of the number of care centers in 1979 range from 275<sup>24</sup> to 600.<sup>25</sup> Growing interest in life-care centers has accompanied concern about appropriate protection for residents, since few regulations govern either the financing or the health aspects of these centers. Several well-publicized business failures have heightened these concerns.

In any case, life care centers may not be affordable for many elderly. The cost for a single one-bedroom accommodation may range from nearly \$50,000 (with a monthly payment of nearly \$900) to more than \$80,000 (with a monthly payment of more than \$1,300). Monthly fees for the nursing-home care pose an additional cost.<sup>26</sup> Despite the expense, approximately 1 million to 1.3 million individuals over the age of 75 currently may have sufficient assets and income to enter life care centers.<sup>27</sup>

*Social / Health Maintenance Organizations*—The S/HMO, a concept developed at Brandeis University, extends the HMO acute-care model of case management and prepaid financing to long-term care. The S/HMO is at financial risk for both acute and long-term care services, and therefore has every incentive to encourage the most appropriate utilization of services. Presently four S/HMOs are operating as three-and-one-half-year demonstration projects funded, in part, by the Health Care Financing Administration.

The financial success of S/HMOs relies on enrolling members who are similar to the population average in terms of their chronic-care needs. However, since membership in S/HMOs is voluntary, adverse selection is likely to be a problem—that is, those in immediate need of care are most likely to enroll. Current experiments, however, should

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<sup>24</sup>Howard E. Winklevoss and Alwyn V. Powell, *Continuing Care Retirement Communities: An Empirical, Financial, and Legal Analysis* (Homewood, IL: Richard D. Irwin, Inc., 1984).

<sup>25</sup>Fred Frankel, "Life Care Communities: Housing for Both the Active and the Infirm Elderly," *Journal of Property Management* (March-April 1979).

<sup>26</sup>ICF Incorporated, "Private Financing of Long-Term Care: Current Methods and Resources, Phase I, Final Report," Table 9, p. 41.

<sup>27</sup>*Ibid.*, tables 30 and 31, pp. 74–75.

provide enrollment information that might be used in the private development of commercial S/HMOs.<sup>28</sup>

*Personal Resources*—The most important asset of many elderly is home equity. However, the illiquidity of home equity and the importance of a home as shelter create problems in converting home equity to finance large health care expenditures. A forced sale can produce a low return. In addition, persons who sell their homes to finance health care may face major changes at a time when they are physically or emotionally incapable of coping with such change. Home equity conversion—converting home equity into income without requiring the family to leave their home—offers one option for overcoming these problems. Two basic types of home equity conversion are *reverse mortgages* and *sale leasebacks*.<sup>29</sup>

Reverse mortgages provide a stream of monthly loan advances to the homeowner. Repayment of these advances is deferred until the homeowner moves or dies. In the meantime, the elderly homeowner retains the title. Appreciation in the home's value during the loan period typically belongs to the homeowner or family estate. Some reverse mortgages, however, allow the loan grantor to share in the appreciation.

In a sale leaseback plan, the home is sold to an investor; the former homeowner retains the right to rent the home for life. Each month the investor pays the former owner and in exchange receives a rent payment. Upon the former homeowner's death or change of residence, all rights associated with the house belong to the investor. Appreciation during this rental period also belongs to the investor, as does the responsibility of maintenance and taxes.

Only a few private- and public-sector programs facilitate home equity conversions;<sup>30</sup> participation in these programs is negligible, perhaps because of the attitudes many older people have toward sale of their homes and because of regulatory uncertainty. Moreover, potential lenders may be reluctant to enter reverse mortgage contracts without mortgage guarantee insurance. Mortgage guarantee insur-

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<sup>28</sup>For more information see Jay N. Greenberg and Walter N. Leutz, "The Social/Health Maintenance Organization and Its Role in Reforming the Long-Term Care System," in *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*, pp. 57–65. The S/HMO demonstration projects began in January 1985.

<sup>29</sup>Employee Benefit Research Institute, "Reverse Annuity Mortgages: A Viable Source of Retirement Income?" *EBRI Issue Brief* 12 (September 1982).

<sup>30</sup>Bruce Jacobs and William Weissert, "Home Equity Financing of Long-Term Care for the Elderly," in *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*, pp. 82–94.



ance would insure that lenders are not put in the position of requiring the elderly to sell their homes when the loan term has expired. This insurance is not widely available. Finally, uncertainty about federal taxation may foster reluctance to enter a sale leaseback arrangement. Homeowners may be unwilling to relinquish their homes under contracts that are unfamiliar to them; home equity conversions are relatively new and extremely complicated.

In any case, home equity conversion may have little potential for helping one purchase long-term care services. A \$50,000 home, for example, may produce an annuity value of between \$195 and \$475 per month, depending on the conversion plan used.<sup>31</sup>

Establishing tax-preferred savings instruments such as IRAs for medical purposes, known as "medical IRAs," has been proposed as another solution. This approach would allow an individual to defer paying taxes on contributions and on interest earned in the account. Some proposals would provide a tax credit for making contributions to the account; disbursements from the account would not be considered as income for tax purposes as long as the disbursements are for eligible medical expenses and the individual is Medicare-eligible.

Since medical IRAs would be less liquid than regular IRAs, the tax advantages would have to be relatively great to foster their widespread use. EBRI tabulations of the May 1983 EBRI/U.S. Department of Health and Human Services Current Population Survey pension supplement indicate that participation in regular IRAs is not widespread: only 17 percent of workers had IRAs in 1982.<sup>32</sup> Increased tax advantages could outweigh disadvantages associated with restricting medical IRA withdrawals to the purchase of health care. However, for the savings to amount to a meaningful sum, individuals must assess the risk of needing long-term care early in their financial planning.

## Conclusion

On average, the financial well-being of the elderly has improved significantly over the last 20 years. The incidence of poverty among

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<sup>31</sup> ICF Incorporated, "Private Financing of Long-Term Care: Current Methods and Resources, Phase II, Final Report," (Washington, DC: ICF Incorporated, January 1985), pp. 15-24; submitted to Office of the Assistant Secretary for Policy Evaluation, U.S. Department of Health and Human Services.

<sup>32</sup> Emily S. Andrews, *The Changing Profile of Pensions in America* (Washington, DC: Employee Benefit Research Institute, 1985), Table IV.5, p. 82.

the elderly has declined, and the elderly are living longer. But while medical technology and changes in life style are extending life expectancy, the likelihood that the elderly will need chronic health care is growing. Increases in the age-65-or-older population imply an increasing demand for long-term care services and an increasing need to use health care resources efficiently.

The ability of some older individuals to finance long-term care is limited by the type of wealth usually held and by the source of income. Most elderly receive retirement income from fixed annuities and most of their wealth is in the form of homeowner equity. Although financial instruments to convert home equity to cash income are available, few elderly have been willing to relinquish ownership of their homes, even if they retain a lifetime right to continued residence.

In fact, there are strong incentives for the elderly to divest their wealth before long-term care is needed. Federal and state gift and inheritance taxes and the existence of Medicaid provide incentives to bequest wealth before death. Even if assets are not transferred, chances are still good that they will be expended, forcing the individual to apply for medical assistance through the Medicaid program.

Historically, the net result of Medicaid-financed long-term care has been to direct long-term care services and resources to institutional care. Medicaid regulators recently began evaluating alternatives to the institutional and reimbursement biases inherent in Medicaid practices. Over the last few years, state demonstration projects have experimented with expanded home- and community-based services, case-management, and prospective rate setting.

The problems of efficiently financing long-term care exist now. Pressure on long-term care resources will continue to grow as the population continues to age. Solving the problems of financing long-term care and efficiently providing long-term care services will require innovation and the attention of everyone affected—government, providers, and the growing ranks of potential consumers.<sup>33, 34</sup>

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<sup>33</sup>The author gratefully acknowledges the helpful comments provided by Deborah J. Chollet of EBRI and John Rother of the American Association of Retired Persons, and the research assistance of Joseph Piacentini, also of EBRI.

<sup>34</sup>Editor's note: An earlier form of the material presented in this chapter was published as *EBRI Issue Brief* 48 (November 1985).

## **Appendix A**

# **Paying for Hospital Services: Current Federal Policy and Likely Future Options**

Stuart H. Altman, Ph.D.

The change in federal policy for paying for hospital services under Medicare has had a far-reaching impact not only on federal spending but also on private health insurance premiums. Whether it will last or not has been a subject of much discussion of late, both in Washington and in many insurance corporate boardrooms. In this paper, I will argue that the key to continuation of the Prospective Payment Assessment Commission (ProPAC) diagnosis-related group (DRG) system depends on the willingness of federal officials to make important technical changes. This paper will also summarize the major recommendations of ProPAC and why I believe they should be followed by the administration and the Congress. The paper concludes with a discussion of possible alternative options to prospective payment and why such systems also bring potential serious problems.

While Medicare's prospective payment system (PPS) has been controversial since its inception in 1983, few would question that it has the potential for generating the most far-reaching changes in our health care system since passage of the original Medicare law itself. The originators of the plan hoped to develop a system that would control, if not reduce, the rate of Medicare spending while maintaining the quality of hospital care and access to that care by Medicare beneficiaries. To do this, the PPS system pays hospitals a predetermined fixed amount based on the diagnosis of the illness that was primarily responsible for the patient's hospitalization, adjusted for certain characteristics of the patient, e.g., age and sex, and in some instances whether there are complicating factors.

### **Incentives of the New Payment System**

By separating the payment amount from the resources used to treat a particular patient and using as the unit of measurement the complete hospital stay as opposed to the previous Medicare unit—each day of care—the new system substantially changes the financial incentives faced by hospitals. Of particular interest are the incentives

to reduce the length of time patients stay in the hospital and limit the amount of resources and procedures that are used to treat patients during their hospital stay. Both factors have been singled out in the past as "culprits" in the tremendous increases in hospital costs during the 16 years prior to passage of Medicare and Medicaid.<sup>1</sup>

Many students of the U.S. health care system as well as practitioners, however, have become very concerned about the reversal of the financial incentives embodied in this new law. While few would recommend a return to the previous system, which included very few incentives to provide medical care efficiently, they are apprehensive about a system that flips these incentives "on their ear" and puts tremendous pressure on hospitals to provide as little care as possible. Unlike a comprehensive capitated system, which has some of the same incentives, PPS does not include the same marketplace safeguards that are contained in capitated plans. Plans that provide too few services are threatened with the possibility of losing many of their members. There is also the possibility that if an illness is not appropriately treated at the outset, it could cost the plan many more dollars later in the medical cycle. Of course, PPS is not without its own safeguards, which include the ethical commitments of physicians, who still have the same professional and financial incentives to demand the best available treatment for their patients. But for the first time since 1965, a real tug of war could exist in certain situations between the demands of patients or their physician and the financial requirements of the hospital.

One of the strongest arguments made by the Reagan administration in recommending the PPS approach to the Congress was that it would promote competition in the health care system and reduce the regulatory requirements of the federal government. While I believe that PPS does have the potential to foster greater competitive forces than the previous system, many of these are not automatic or self-correcting as they would be in an Adam Smith-type of free market, and they require frequent technical adjustment by government. To a large extent, I believe, the success of PPS in encouraging the efficient delivery of hospital care without causing serious declines in the quality of care will depend on how well these so-called technical adjustments are made.

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<sup>1</sup>Stuart H. Altman and Robert Blendon, eds., *Medical Technology: The Culprit Behind Health Care Costs?*, proceedings of the 1977 Sun Valley Forum on National Health, (PHS) 79-3216 (Washington, DC: U.S. Department of Health, Education, and Welfare, 1979).

## **Prospective Payment Assessment Commission**

Congress, realizing the negative potentials of PPS and recognizing that it and the executive branch could use help in making these technical adjustments, created the Prospective Payment Assessment Commission. ProPAC, as it is called, was mandated by the same law that created the PPS/DRG system and was put in place to evaluate the effects of PPS and minimize any negative consequences. It was to include members knowledgeable about the Medicare program and the U.S. health care system. The initial group of 15 members were appointed by the director of the Office of Technology Assessment in November 1983 and I was asked to be its chairman. The commission's role is to advise the executive and legislative branches of the government on the operation of the PPS and to provide analysis necessary to maintain and update the system. The two primary responsibilities of the commission are to:

- recommend annually to the Secretary of the Department of Health and Human Services (HHS) the appropriate percentage change in the Medicare payments for inpatient hospital care; this percentage change is called the "update factor"; and
- consult with and recommend to the Secretary of HHS necessary changes in DRGs including advice on establishing new DRGs, modifying existing DRGs, and changing the relative weights of the DRGs.

The first requirement, that of recommending an appropriate update factor to the previous year's rate, was to be accomplished by April 1 of each year. This would permit the Secretary of HHS to incorporate the commission's recommendations into the proposed and final regulations that are due by October 1 of each year. The commission has met its deadline for each of its first two reports.

Underlying the substance of the April report is the issue of whether the existing DRG system is an adequate base for compensating hospitals overall and whether there are structural aspects of the DRG system that discriminate against or in favor of specific types of patients or hospitals. If either or both indicate problems it is the responsibility of the commission to recommend appropriate technical adjustments. The commission has also indicated its willingness to consider at times more fundamental reforms if the problems appear serious enough or if previous technical adjustments have been unsuccessful in solving the problem.

## Annual Adjustment in DRG Rates

The mechanism used by PPS to provide hospitals with yearly changes in the payment rate per DRG patient is the annual update factor, which can be defined by the following equation:

$$\begin{aligned} \text{annual update} &= \text{hospital inflation (market basket)} \\ &+ \text{discretionary adjustment factor (DAF)} \end{aligned}$$

It is through changes in this annual update factor that Congress and the administration will decide how much this country is willing to support the continuous growth in the American hospital system or ratchet down this sector, which had been growing two to three times faster than the national economy. While the hospital inflation factor is relatively straightforward and is based on technical estimates of expected inflation for the various resources used by hospitals, the DAF component is complicated and very difficult to measure. In principle DAF is to include a *negative* adjustment for expected or real improvements in hospital productivity and a *positive* adjustment to permit hospitals to incorporate new technological and scientific advances and to assure that the quality of care and access to hospitals is maintained at an acceptable level.

### ***Estimating Inflation***

One issue the commission focused on in deciding the appropriate inflation rate is whether a hospital's market basket should vary by region of the country. The market basket used by the Health Care Financing Administration (HCFA) included the same 18 categories of expenses for all areas of the country. What's more, the same relative weight (or importance factor) was used throughout the United States, except for area wage differences. As shown in table A.1, wages as a proportion of total expenses vary by region as well as whether a hospital is within a major urban area. Other evidence revealed that wage changes also vary by region.<sup>2</sup> Therefore, it seemed important to the commission that separate regional wage factors be maintained.

But what about the other components of expenses? My own view was that some variation in the nonlabor expense categories might be appropriate to assure equity across hospitals. After all, fuel oil is likely to be more important in New England than in the South. A review of the evidence, however, did not support the need for such an ad-

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<sup>2</sup>Prospective Payment Assessment Commission, *Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services: April 1, 1985* (Washington, DC: U.S. Government Printing Office, April 1985), pp. 31-35.

TABLE A.1  
**Relative Cost Weight from Wages by Census Division and Hospital Classification**  
 (1977 base year)

	U.S.	Outlying Areas	New England	Middle Atlantic			South Atlantic			East			West		
				Atlantic	Atlantic	Atlantic	Atlantic	Central	South Central	North Central	South Central	North Central	South Central	Mountain	Pacific
All hospitals	51.74	50.91	54.31	55.25	49.84	53.35	48.52	51.76	48.21	50.30	48.46				
Teaching hospitals		52.35	55.07	56.22	52.03	54.84	50.40	52.51	51.82	52.89	51.80				
Nonteaching hospitals		47.59	53.36	52.99	48.06	51.67	47.58	51.25	46.78	48.88	46.20				
Hospitals in SMSA <sup>a</sup>	52.06	N/A	54.58	55.36	50.05	53.77	48.63	51.89	48.28	50.50	48.57				
bedsize (less than 100)		N/A	50.35	50.39	47.71	49.41	46.27	52.19	44.97	43.97	42.52				
bedsize (100-404)		N/A	55.03	53.57	48.00	52.48	47.34	50.81	46.16	50.97	47.71				
bedsize (405-684)		N/A	55.03	55.66	52.20	53.86	49.39	53.03	51.91	51.06	51.35				
bedsize (greater than 685)		N/A	54.02	58.39	51.81	57.35	52.51	51.62	51.57	45.58	54.49				
Hospitals located in non-SMSA	50.19	50.91	52.43	54.04	49.17	50.87	48.29	51.48	47.96	49.74	47.45				
bedsize (less than 100)		44.18	51.79	50.43	47.59	50.01	47.70	51.59	48.10	49.32	46.86				
bedsize (100-169)		47.91	52.45	53.19	47.66	50.35	48.25	51.01	47.63	49.52	48.12				
bedsize (greater than 169)		52.72	52.77	55.21	50.79	51.68	49.17	51.76	48.08	51.28	47.82				

<sup>a</sup>Standard metropolitan statistical area.

Source: American Hospital Association annual survey, 1977; compiled by Office of Research, Demonstrations, and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services; from Prospective Payment Assessment Commission, *Technical Appendixes to the Report and Recommendations to the Secretary*, U.S. Department of Health and Human Services: April 1, 1985 (Washington, DC: U.S. Government Printing Office, April 1985), p. 33.

justment. A study by Freeland, Schendler, and Anderson, published in 1981, concluded that between 1972 and 1979 no significant differences existed between increases in the national input price index and increases in the regional input price index.<sup>3</sup> A second major conclusion was that to the extent that there were variations in the increase in the market baskets across regions, the primary cause was differences in price changes. Differences in the market basket weights had very little effect. It was this study that provided the basis for HCFA's decision not to include regional variations for nonlabor expenses. The commission was concerned, however, that if overall inflation were to increase sharply above the limited inflation reflected in the 1972-79 period, these conclusions might not hold. For example, when the price of silver went through the roof in the early 1980s, those tertiary care hospitals that use x-ray and other diagnostic testing faced much larger than average price changes. ProPAC, therefore, in its first report recommended an ongoing study to determine if multiple regional market baskets would be necessary in the future.<sup>4</sup>

No easy consensus emerged with respect to the discretionary adjustments. The PPS legislation of 1983 called for a +1.0 percentage point increase to provide hospitals with continued capital for technological and quality improvements. Under a later Deficit Reduction Act this add-on was revised downward by the Congress to +0.25 percentage points for 1985 and a ceiling of 0.25 percent was established for 1986. The Congress left open what those rates should be for future years.

### ***Productivity Factor***

A review of the literature provided little help in sorting out the various influences affecting hospital productivity and what an appropriate technology/quality adjustment should be. With respect to productivity, it was clear to the commission that past experiences were of limited help since the incentives were primarily to enhance perceived quality of care and access, and very limited rewards existed for increasing efficiency of operations or reducing costs. It therefore seemed more reasonable to use the productivity component to "reflect a policy target which encourages the attainment of the highest level

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<sup>3</sup>Ibid., p. 31.

<sup>4</sup>Prospective Payment Assessment Commission, *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services: April 1, 1985* (Washington, DC: U.S. Government Printing Office, April 1985), Recommendation 2, pp. 30-31.



of productivity that is compatible with high-quality patient care and long-term cost effectiveness of the health care system."<sup>5</sup>

Some have questioned whether it is appropriate to penalize hospitals by lowering the price they receive because they have taken actions to increase productivity. The argument has been made that if all the productivity advances led to ultimate price reductions, then there is no real incentive for hospitals to try to become more efficient. I think that argument is fallacious on three grounds. First, if no adjustment in price resulted from these productivity improvements, all we would have done with the PPS system is generate a substantial growth in hospital profits or retained earnings. Some sharing of these productivity advances must accrue to the buyers of care, the government, and the patient. Second, in a competitive marketplace improved productivity is the key mechanism that generates price reductions. Not because each producer wants it to happen, but because each wants to sell more of its expanded product and now can do so at a lower price. Finally, even with such reductions in price, a hospital would still benefit financially from improving the efficiency of its operations. Reductions in price take place only gradually over time and then are based on the average performance of all the hospitals. A hospital that is in front of the pack with such improvements and exceeds the average performance of the group will reap the rewards for a longer time and will see a permanent advantage even after the average price falls.

While the DRG unit of measurement allows the basic hospital product to be relatively standardized, there is still the question of whether the product really begins and ends when a patient enters and leaves the hospital. The PPS system clearly provides a strong incentive to admit patients to the inpatient setting but to shift services out of that setting, both before and after hospitalization. An important and often overlooked aspect of the system is that the initial dollar amounts for each DRG were based on the amount and duration of care provided on average to patients with the diagnoses grouped in that category before PPS started. Shifting of services to other settings may be a very appropriate and desirable outcome, but if no adjustment is made in the payment amount either directly through a recalculation of the costs in all of the DRG categories or through some adjustment in the

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<sup>5</sup>Prospective Payment Assessment Commission, *Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services: April 1, 1985*, p. 49.

annual update factor, then all the savings of such changes will accrue to the hospitals. Therefore, it seemed to us necessary to examine the changing patterns of care including the changing site where the services are provided. Reductions in the average length of a stay in the hospital can reflect a real increase in hospital productivity as well as a change in the hospital product.

Quantitative evidence regarding practice-pattern changes is not easy to obtain. During the initial year of investigation the commission was limited to changes in average length of stay. At the time the commission was reviewing these data they indicated that for the 65-and-older population, average length of stay had declined by 7.6 percent in the first nine months of 1984 as compared to the comparable period of the year before. While such a decline continued a downward trend that has been going on since 1970 (table A.2), the magnitude of the change following the introduction of PPS suggests a clear relation-

**TABLE A.2**  
**Trends in Inpatient Hospital Average Length of Stay**

Year	ALOS <sup>a</sup> , All Patients	Percent Change	ALOS <sup>a</sup> 65+ Patients	Percent Change
1970	7.82%	-3.08%	12.62%	-3.00%
1971	7.66	-1.96	12.22	-3.10
1972	7.56	-1.38	11.74	-3.95
1973	7.44	-1.54	11.40	-2.92
1974	7.38	-0.81	11.31	-0.79
1975	7.38	0.04	11.23	-0.69
1976	7.37	-0.12	11.05	-1.62
1977	7.25	-1.74	10.71	-3.02
1978	7.22	-0.31	10.59	-1.20
1979	7.15	-1.05	10.39	-1.90
1980	7.18	0.47	10.38	-0.09
1981	7.21	0.37	10.36	-0.12
1982	7.16	-0.61	10.13	-2.27
Average (1970-82)	7.37	-0.90	11.09	-1.80
1983	7.02	-2.04	9.68	-4.47
1984 (9 mos.)	6.66	-5.00	8.94	-7.60
1985 (8 mos.)	6.54	-2.10	8.74	-2.90
Average (1983-85)	6.74	-3.10	9.12	-5.00

<sup>a</sup>Average length of stay, in days.

Source: Prospective Payment Assessment Commission, *Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services: April 1, 1986* (Washington, DC: U.S. Government Printing Office, April 1986), p. 14.

ship. Translating this productivity improvement into expected cost reductions required a series of assumptions about the marginal costs associated with reduced lengths of stay. Using the 60 percent factor established in PPS to pay for the added cost of treating outlier [atypical] patients, the 7.6 percent decline in average length of stay resulted in an estimated 4.7 percent reduction in expenses. Using a conservative estimate that 1.0 percent of the reduction in expenses was the result of actual changes in hospital services, the commission concluded that productivity advances permitted hospitals to lower their costs by 3.7 percent without reducing the quality of patient care to Medicare beneficiaries. In an attempt to share these savings with the hospital industry, the commission recommended that the next annual update rate should be reduced by 1.5 percent for productivity and further reduced by 1.0 percent for the product shift. HCFA in its final set of regulations for the 1986 update rate used similar logic and arrived at similar productivity adjustment numbers.<sup>6</sup> But they arrived at a total update rate of 0 percent, because they determined that hospitals had inappropriately inflated the case level of the patients they treated and thereby received an excess in total payments from the government. Congress, after much political "horsetrading" with the administration, provided hospitals with a 0.5 percent increase for 1986. In so doing Congress adopted many of the recommendations in ProPAC's first April [1985] report.

It was clear to the commission that future adjustments would require a better understanding of how these forces really operate, or else hospitals would either reap inappropriate windfalls from PPS or be penalized unnecessarily. In its second April [1986] report the commission continued to use the same basic approach. Although average-length-of-stay reductions in the first eight months of 1985 slowed to 2.9 percent compared to 7.6 percent the previous year, further productivity gains through less use of ancillary tests were observed. In total, the commission concluded that hospitals could reduce their costs by 1.5 percent through productivity gains.

### ***Allowance for Technological Change***

The last aspect of the discretionary adjustment factor is the appropriate positive adjustment for providing hospitals with an allowance for new procedures, techniques, or technologies to enhance the quality of or access to the care they provide. This issue also ties in

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<sup>6</sup>Prospective Payment Assessment Commission, *1986 Adjustments to the Medicare Prospective Payment System, Report to the Congress: November 1985*, pp. 45-59.

with the second major charge of the commission, that of recommending adjustments to the basic DRG structure of the system. Under the previous cost-based system adjustments were instantaneous and complete and required no special mechanism; if some new procedure was considered appropriate, it was considered a covered service and its costs were immediately incorporated into the cost report and ultimately would be paid. Under PPS no such automatic adjustment exists. This is both a strength of the new system and a component that gives critics much to complain about. Left alone, PPS will not pay a hospital any more money for either providing more traditional services to a patient or adding a new service that may be quality enhancing but is cost generating. The \$64 or \$64 billion question is, "How do you maintain this tight incentive to force hospitals and physicians to ask the question of whether the extra test or procedure or day of care is really that necessary and yet assure that, if the answer is truly 'yes,' there will be funds to pay for it?"

The annual update adjustment for technology and quality is supposed to provide some financial cushion to allow the hundreds of small improvements in hospital care to continue, and to leave to a structural change in specified DRGs larger and more targeted changes. As shown in table A.3, after adjusting for hospital inflation and changes in admissions, hospital spending for inpatient Medicare services grew by 2.8 percent a year between 1972 and 1983. A major portion of this so-called "intensity factor" are the funds used by hospitals to buy the quality-enhancing technologies and devices in the past. It also included spending for some items that had very marginal benefits to patient care. Clearly, if hospital spending is to be reduced, some of this yearly "real" growth in hospital spending needs to be reduced. How much a reduction is appropriate is both a technical and a political question. That is, what will we lose by reducing such spending, and are we as a country willing to pay the added cost of continuing to improve the level of medical care? The commission recommended in the first-year update an amount equal to 50 percent of the average intensity factor for the past 12 years, or between 1.5 and 2.0 percent. In the second year annual update, this portion of the technology adjustment was reduced to 0.7 percent, recognizing that the commission was recommending several adjustments to the DRG structure for technology or new medical procedures such as magnetic resonance imaging (MRI) and more complicated cardiac pacemakers, which would add to the total hospital payment amount.

In summary, the commission recommended that the update factor be equal to the estimated increase in the medical market basket plus

TABLE A.3  
**Historical Annual Percentage Changes in Medicare Inpatient Hospital Costs, 1972-83,  
 and Projections for 1984 and 1985, by Components**

Calendar Year	Market Basket			Medicare Admissions			Total	Inpatient Costs Per Admission	Intensity
	Medicare Inpatient Hospital Costs	Hourly earnings, hospitals	Nonlabor inputs	Hourly earnings, hospitals	enrollees per enrollee	Admissions per enrollee			
1972	10.9%	6.8%	4.5%	5.9%	1.4%	1.2%	2.6%	8.1%	2.1%
1973	16.4	5.5	8.0	6.5	6.5	7.1	14.1	2.0	-4.2
1974	23.6	7.7	14.2	10.4	6.2	0.3	6.5	16.1	5.1
1975	22.5	9.9	12.2	10.9	3.4	0.1	3.5	18.4	6.7
1976	19.0	8.2	8.3	8.2	2.9	1.5	4.4	14.0	5.3
1977	17.3	7.1	7.9	7.4	3.0	4.5	7.6	9.0	1.5
1978	14.8	8.4	7.9	8.2	2.7	-1.8	0.9	13.8	5.2
1979	16.4	8.4	11.1	9.6	2.7	2.9	5.7	10.1	0.5
1980	20.3	10.6	12.8	11.6	2.1	2.4	4.6	15.0	3.1
1981	21.6	12.3	11.2	11.8	1.9	1.8	3.7	17.3	4.9
1982	16.1	11.0	7.3	9.4	2.1	1.9	4.0	11.6	2.0
1983	13.0	7.2	4.8	6.2	1.5	3.1	4.6	8.0	1.7
Average	17.6	8.5	7.7	8.8	3.0	2.1	5.2	11.7	2.8
Projections:									
1984	11.8	6.4	4.4	5.9	1.8	2.0	3.8	7.7	1.7
1985	12.5	7.7	4.6	7.1	2.1	2.0	4.1	8.1	0.9

Source: 1984 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, April 1984, Table A1, p. 53.  
 From Prospective Payment Assessment Commission, *Technical Appendices to the Report and Recommendations to the Secretary*, U.S. Department of Health and Human Services: April 1, 1985, p. 51.

-1.0 percent for the discretionary adjustment factor in 1986 and -0.5 percent in 1987. The commission also recommended that a further adjustment be included to the extent that hospitals had upgraded the coding weight for illness after PPS began. The commission felt that such coding adjustments, which are not related to the treating of more sick patients, will generate inappropriately higher payments to hospitals and should be taken back by the government before they are built into the hospital payment base. A major difference with HCFA developed over this issue for the 1986 adjustment as the executive branch sought to reduce the expenditure factor to compensate for such coding "creep" since the inception of PPS. The commission felt the adjustment should be limited to such changes for only the previous year. As of the writing of this paper (May 1986) it is unclear what the administration will do for 1987.<sup>7</sup>

A comparison of the update adjustments recommended by ProPAC for 1986 and the approved HCFA adjustments are shown in table A.4. Shown in table A.5 are the estimated ProPAC adjustments for 1987.

**TABLE A.4**  
**Estimated Increase in Prospective Payment System Payment Amounts for Fiscal Year 1986: Comparison of HCFA to ProPAC Recommendations**

	HCFA	ProPAC
FY 86 market basket increase	4.85%	4.85%
Previous market basket forecast errors	-1.30	-0.57
Policy target adjustment factor (DAF)	-1.50	-1.00
components:		
productivity	-1.00	-1.5 to -2.0
cost-effective technologies	1.50	1.5 to 2.0
product change	—	-1.0
cost-ineffective practice patterns	-2.0	—
<b>Subtotal (market basket + DAF)</b>	<b>2.05%</b>	<b>3.28%</b>
Observed change in case mix	-4.90	-2.00
Real case-mix change during FY 85	0.00	0.80
<b>Total</b>	<b>-2.85%</b>	<b>2.08%</b>
<b>Proposed Increase</b>	<b>0.00%</b>	<b>2.08%</b>

Source: Prospective Payment Assessment Commission, *1986 Adjustments to the Medicare Prospective Payment System, Report to the Congress, November 1985* (Washington, DC: U.S. Government Printing Office, November 1985), p. 19.

<sup>7</sup>Editor's note: The author discusses 1987 PPS rates in the postscript to this paper.

**TABLE A.5**  
**Recommended ProPAC Increases in Prospective Payment**  
**System Payment Amounts for Fiscal Year 1987**

Component		Percentage Change
Estimated market basket increase		4.6%
Correction for market basket forecast errors in previous fiscal year		-0.3
Discretionary adjustment factor		-0.5
scientific and technological advancement	0.7	
productivity	-1.5	
site substitution	-0.6	
real case-mix change in fiscal year 1986	0.9	
DRG case-mix index	0.2	NA
within-DRG patient complexity	0.7	NA
<b>Subtotal (update in standardized amounts)</b>		<b>3.8%</b>
Observed change in case-mix index (adjustment made to DRG weights after recalibration)		-1.0
<b>Total change in DRG prices</b>		<b>2.8%</b>

Source: Prospective Payment Assessment Commission, *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services: April 1, 1986* (Washington, DC: U.S. Government Printing Office, April 1986), p. 19.

If 1987 follows the same pattern as 1986, the administration will use only a limited number of the ProPAC recommendations as far as the update factor is concerned. Congress, on the other hand, is more likely to take the ProPAC recommendations seriously even though it might not accept the bottom-line recommendation. The commission, of late, has been required to defend its update recommendation as politically too high. At the same time some in the medical community feel ProPAC has been too tough in recommending increases less than the overall inflation rate. In commenting on the issue the commission stated in its 1987 report:

In the current environment of fiscal stringency an estimated 2.8 percent increase in PPS payment amounts for fiscal year 1987 may seem unduly high. Hospitals received no increase for the first half of fiscal year 1986, and may receive a net reduction for the second half of the year if the Gramm-Rudman-Hollings deficit reduction act is upheld. The president's proposed budget for fiscal year 1987 estimates a 2.0 percent increase in PPS payment rates. The commission-recommended increase is very stringent compared to historical trends in Medicare payments to hospitals, however. Between 1972 and 1983, these payments averaged about 3 per-

centage points *above* inflation, whereas the commission estimates its recommendation for fiscal year 1987 to be 1.5 percentage points below inflation.

## Changing the DRG Structure

Regardless of the decision on the update factor, providing hospitals with an overall cash allowance for new technologies does not guarantee that desirable new procedures or devices will be bought or used. These funds are ultimately usable for any purpose. Therefore, pressure continues to be placed on making adjustments in specific DRGs or adding new DRGs for a new procedure or device. The issues involved in making a decision on whether to make a structural DRG change and how often are very complex. In most cases a structural change decision is a two-part decision. Is a change medically required—that is, does the new procedure add appreciably to the quality of medical care? If the answer is yes, the next question is, how should the change be made? If a particular procedure is clearly focused on a specific type of diagnosis, a new DRG can be constructed, as HCFA proposed in 1986, for operations involving a bilateral hip replacement as opposed to a single-hip operation. Alternatively, the new procedure can be moved to an existing DRG that closely reflects the new cost of treatment. The system also can be allowed to correct itself through periodic “recalibrations” of the actual costs incurred in treating all DRGs, or by “reweighting” a specific DRG to better reflect the new resource cost which includes the new procedure. An example of the latter is the growing use of intraocular lens implants for the treatment of cataract extractions. During the short period between 1981 and 1983 the proportion of extractions using the more expensive lens implants increased from 58 to 85 percent. The commission decided not to make any specific adjustments in DRG 39, i.e., lens procedures, but rather to allow the change to take place through a recalibration of the resource weights for all DRGs. This recommendation was followed by HCFA and the weight assigned to DRG 39 went up by more than 15 percent.

Two types of technology changes are not so easy to adjust for in PPS and could have long-term consequences in the years ahead. I would like to conclude this paper with a discussion of what we should do with cases where there is more than one procedure or device that can be used to treat the same diagnosis, but where the resource costs are very different, and how we should incorporate into the system new high-cost technologies or procedures that treat many different illnesses but are used only in a select number of hospitals.



## Alternative Treatments for Same Diagnosis

Among the 468 active DRG categories are four that are used for patients with a heart condition that requires a pacemaker implant. Differences in the payment rate of the four DRGs relate to whether the implant is part of more extensive and complicated care, whether it is just focused on the implant surgery, or whether it is payment for an adjustment or replacement of the pacemaker. To complicate the story, there are also four different types of pacemakers, which vary considerably in expense. The current PPS does not recognize any difference in device-cost expense. In 1981, 15 percent of the implant patients used the least expensive "single-chamber nonprogrammable" pacemaker and 6 percent the most expensive "dual-chamber programmable" model. By 1984 these utilization figures were reversed with only 3 percent using the least expensive model and 26 percent the most expensive unit. In 1984, the cost of the most expensive model was almost twice as high as the lowest-cost unit (\$5,171 versus \$2,741). In addition to differences in device costs, there are also related differences in the surgical and physician cost of implantation. Question: How to reflect the changes from 1981 to 1984, and, more importantly, should the DRG price reflect differences in the device costs?

The first part of the question is similar to the intraocular lens issue; the commission ruled the same way (e.g., let recalibration adjust for the changes), but the second part is complicated, with no easy answer. If the DRG prices vary based on the device or resources used in the treatment, then the system has backed into the same set of incentives that existed under cost-based reimbursement. If no adjustments are made and hospitals are paid based on the average of all the potential devices, then for those patients who are treated with the least expensive model the hospital is paid too much, and for those patients implanted with the most expensive model the hospital incurs losses. In part, I believe we want a payment system that forces hospitals and physicians to question whether the most expensive device or procedure is really that necessary. But we do not want the system to so penalize the hospital for a particular type of care that it is compelled to deny such services to some patients who need them and who would, on their own, be willing to pay the added expense. Thus far, neither HCFA nor the commission has come up with an acceptable solution. My own view is that PPS needs a payment mechanism for situations such as this where the hospital has some financial incentive to use the least costly device, but where the losses of using the most

costly device are limited and could be absorbed by the hospital, if it wished, from the technology allowance in its update factor.

One possible mechanism to accomplish this has been suggested by my colleague, Dr. Thomas McGuire, at the Brandeis/Boston University Health Policy Center. That is to divide the hospital payment in two parts—the first would reflect the average resource cost for treating all patients with a similar diagnosis; the second would be tied to the specific resources used to treat that particular patient. In the case of a pacemaker patient, such a revised DRG payment would limit the loss to the hospital that implanted the most costly device to the equivalent of a 12.5 percent coinsurance rate assuming that there were just the high- and low-cost models and each was used with about the same frequency. Such a rate, while high enough for a hospital to question a physician who always used the most expensive device, would still be low enough to permit any patient who needed the more expensive model to receive it. It should be remembered that under current law a patient *cannot* agree to pay the hospital a *supplemental* amount to insure that he or she gets the most expensive model. If the PPS payment is not adjusted to reflect a higher rate for certain procedures or devices, I think pressure will build to allow such supplemental payments. Advocates of one-class medicine will fight against such a move since patients with limited income could not afford to supplement the Medicare payment.

During debate on its 1987 recommendations, ProPAC briefly considered such a proposal and rejected it in favor of requesting that HCFA split the pacemaker DRGs to reflect whether the patient was given a single-chamber or a dual-chamber pacemaker. If HCFA rejects this recommendation and Congress does not overrule, the blended rate adjustment may yet be used for certain types of patients.

### **High Device Costs in Multiple DRGs**

An example of the second problem area is the issue of how to pay for new diagnostic technologies such as magnetic resonance imaging (MRI). MRI is a very expensive technology costing up to \$2 million per machine plus operating expenses. Even at maximum efficiency, the operating expenses alone equal about \$130 per scan. It is likely that an MRI scan could be called for in more than 100 different DRGs, and therefore no specific DRG adjustment is possible. HCFA is proposing that no MRI adjustment be made, and that payments increase gradually through annual recalibration in those DRGs that use MRI scans. Such payments, however, will be available to all hospitals

whether or not they have an MRI and for all patients in those DRGs whether or not a scan was performed. As such, for those institutions that do purchase a machine, the extra payments they receive will be far less than the cost of operating the equipment. Also, for those patients that do receive a scan, the payment level will only pay a small proportion of the added costs of the procedure.

What kind of signals will such a payment approach send to MRI manufacturers and, more importantly, to future manufacturers of expensive medical equipment? As an alternative, the commission has recommended that a specific amount be paid to any hospital that orders a scan regardless of whether it owns the machine. This will focus the payments on those institutions that own and use the machine or those that purchase such tests from other sources. The amounts recommended by ProPAC are rather stringent and assume a machine is used to maximum efficiency. The funds for this MRI add-on would be subtracted from the technology portion of the annual update amount. Critics of this approach argue that this is a major complication to the system and directly rewards only this one technology. While this may be true, we do have to face the much bigger issue that unless changes are made, the PPS approach could force medical equipment manufacturers to cut back substantially on research and development investments in quality-enhancing but costly new medical devices and procedures. Some cutbacks may be appropriate, but it is not clear that Congress wished to freeze our hospital care system with the technologies of the 1980s. Again, this is an issue that deserves much broader debate than it thus far has received. How it is resolved could greatly affect both the efficiency of today's hospital system and the availability of new technologies for our future hospital system.

## **Conclusion**

The prospective payment system adopted by Medicare in 1983 to pay for inpatient hospital claims is a radical departure from the retrospective, cost-based system, which it replaced. The previous system, while modified several times, had been in place since 1965. The major difference between the two lies in the financial incentives they offer to hospitals once a person is admitted as an inpatient. The former system assured a hospital full payment for any approved service, test, or day of care. The opposite is true for PPS. Once a patient is admitted and the likely DRG category is established, the rate of payment is fixed. Any extra service, test, or day of care adds expenses for the hospital but no additional revenue.

A related aspect of the new payment system is that change in the way medical care is practiced does not automatically change the payment system. This is both a major advantage of the new system and a very significant challenge to those responsible for the ongoing operation of the program. In this presentation, I have tried to highlight a sample of the complexity of the decisions that HCFA and the Congress face in trying to keep the Medicare hospital payment system in line with a rapidly changing medical care system.

As you might expect, there are many critics of this new approach to paying hospitals. Some question its basic design and believe that it cannot succeed no matter how thoughtfully it adjusts to its perceived problems. They believe it is based on an inherently flawed approach. Others, myself included, believe that there are many very desirable aspects of PPS which, if appropriately modified, can form the basis of a long-term hospital payment system. Regardless of which camp you are in, PPS is the law of the land and is not likely to be replaced in the immediate future. It is therefore incumbent on all of us to make it work better. By that, I mean it should pay hospitals in total at a level that reflects the attitude of all Americans as to the type and quality of the hospital system they want and are willing to pay for. It should also include the correct structural characteristics to assure that the individual patient receives the appropriate amount and type of care consistent with the cost of that care and the medical benefits they produce.

There are those who believe that PPS should be viewed as an interim transition system to some form of total capitated or Medicare voucher plan. While there is much to commend a capitation system and I believe the current capitation option for Medicare beneficiaries will continue to grow, I do not believe it is a panacea for all the problems raised by PPS. All our current knowledge about how capitated medical plans operate is within a total medical system that has been very liberally funded for new medical procedures and devices and that has sufficient funds from other sources to assure that the system has adequate back-up capacity. Suppose all medical care in the U.S. was delivered by various forms of fixed, capitated plans. Under this condition, could we be assured that our total health care system will receive adequate funds to provide the level and quality of medical care we want? Will such a system provide the right incentives to medical researchers and equipment manufacturers to invest in the research and development needed to keep the quality of our system at the level we want and are willing to pay for? I do not

think we know the answers to these questions. Even worse, I do not even hear these questions being discussed!

### **Postscript**

Since the date of the policy forum, the Congress has made several important decisions affecting future increases in the basic DRG payment rate. With respect to the allowed increase for fiscal year 1987, the Congress accepted much of the logic in the ProPAC report and increased the rate by 1.15 percent. The ProPAC estimate in this paper of 2.8 percent had been revised downward in June because the estimate for inflation was revised downward by the administration. As a result ProPAC, in its June 1986 meeting, recommended a 1.9 percent increase, as opposed to the administration's recommendation of a 0.5 percent increase.

The Congress, in revising upward the administration's recommendation, has indicated that henceforth the target increase for hospitals would be the estimated inflation for hospital goods and services minus 2 percent. The reduction reflects the productivity factor discussed in this paper.

HCFA and ProPAC are still discussing how best to adjust specific DRGs, particularly those that relate to new technological advances in health care. For the most part, HCFA continues to rely on recalibration and the averaging principles as the primary mechanisms for introducing new procedures into the payment structure. ProPAC is concerned that this averaging structure is uneven and could lead to distortions over time as new technologies come on line without adequate compensation. Congress as yet has not focused on this issue. It has, however, instructed the administration not to use the regulation process to implement changes in the DRG payment structure for capital payments.

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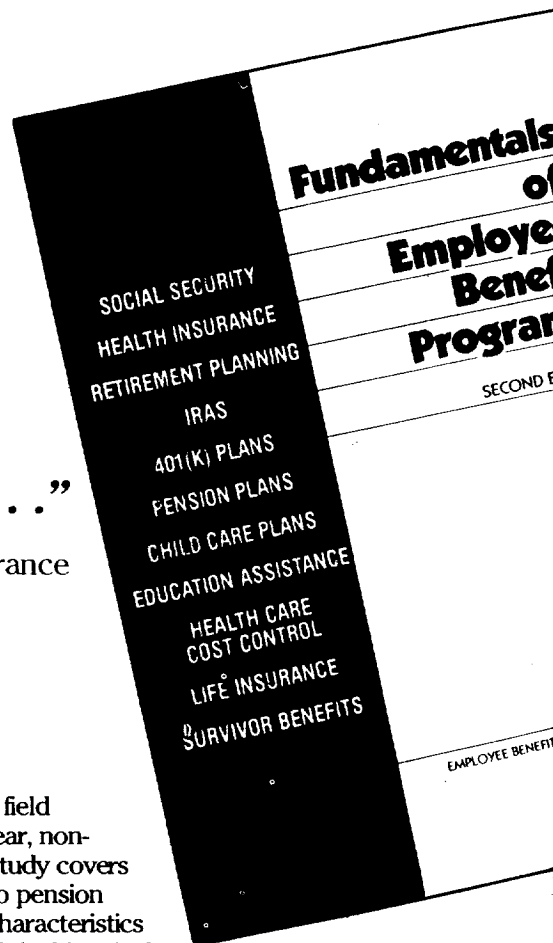
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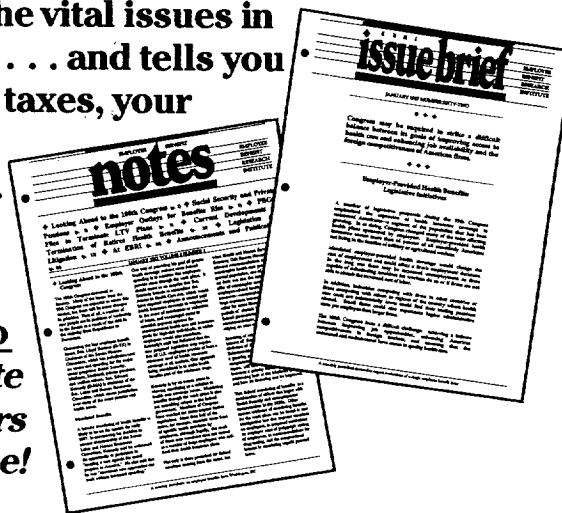
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