Controlling the cost of health care: An analysis and a proposal.

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CONTROLLING THE COST OF HEALTH CARE:
AN ANALYSIS AND A PROPOSAL

by

EARL R. WRUCK

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for the degree of
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Chairman, Board of Examiners

Dean, Graduate School

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INTRODUCTION

One of the most pressing issues in the United States is the continued delivery of quality health care at a cost consumers can afford.

Generally speaking, health care consumers continue to expect and receive very high quality health care delivery. Physicians in this country are extremely well trained, and they have easy access to the best medical technology and research. The delivery of health care services is usually quick and efficient, and both heroic and high-tech efforts to save human lives are well publicized. All of these factors help keep consumers expectations high.

However, costs have been rising. Between 1971 and 1982, health insurance and workers' compensation costs increased 245 percent.¹ Employer- and employee-paid health insurance premium costs have been skyrocketing from 25 to 30 percent per year, and in the last four years costs for group health insurance have increased by a staggering 75 percent.²

In 1983, it cost employers $1.09 per employee payroll hour for health-related expenses. That amounted to 11.5 percent of their payroll. To put it another way, it cost employers $2,228 to cover each employee's group health insurance and other health-related costs, such as sick

¹

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leave and medically caused sub-standard job performance.\(^3\)

Employers have found it increasingly difficult to absorb these costs, and the competitiveness of the marketplace has made it progressively harder to continue the practice of passing these costs on to consumers. As an example, each vehicle produced by General Motors carries a built-in cost of $600 for employee health-related costs, while each Toyota carries a built-in cost of less than $50.\(^4\)

The delivery of health care to senior citizens is another area in which costs have increased dramatically. Medicare was expected to go bankrupt sometime in 1986 because methods of reimbursement were based on a percentage of provider cost which did not encourage cost-containment. The 1984 "prospective payment method" of reimbursement does encourage cost-containment, with the result that the bankruptcy threat has been forestalled until after 1990.\(^5\)

As a result of these cost increases, employers and government agencies alike have begun to question and to some extent aggressively control the costs of delivering health care services. In addition to the prospective payment method of reimbursement, private and public sector employers are encouraging the economical use of health services by consumers. This includes restricting the use of some benefits when their appropriateness is questionable, and it also includes replacing some in-house services with
contractual arrangements in which outside individuals or groups provide health care. Finally, government agencies and private sector employers are beginning to use public review and approval of charges as a means of cost-containment.

While these steps may be effective, and even necessary, it often happens that solutions are implemented before problems are clearly understood. With that in mind, this paper offers an analysis of the problem of rising health care costs and a discussion of the various strategies currently in use to control those costs. An outcome of this discussion will be the suggestion of a practical and viable health care cost-containment alternative for implementation by hospitals.

My thesis will be that it is better for hospitals to contain costs by stabilizing them than to shift them to outside agencies. This point is contrary to the view held by government, private employers, insurance companies, and consumers, namely, that health care providers in general and hospitals in particular are the primary source of the cost problem. It is also a point which has received too little attention.
CHAPTER I

ANALYSIS OF HEALTH CARE COST INCREASES

The first thing that usually comes to mind when one asks almost anyone to speculate about the likely causes of rising health care costs is "technology". A few people might mention "the higher costs of malpractice insurance" since it is an item often in the news. While both of these are part of the problem, there are many contributors. Perhaps the most important contributor is the health care consumer himself.

The Consumer's Role

Consumers contribute to rising costs in four main ways. First, many of the things people eat and drink are damaging and injurious to their health. Second, consumers often use health services inappropriately. Third, those who participate in collective bargaining agreements help drive costs up. Finally, non-payment for services rendered is a problem as well.⁶

Many of the medical problems people have are self-induced diseases and injuries which could be avoided if people took more responsibility for their own well-being. Excessive consumption of alcohol leads to nervous disorders, malnutrition, and alcoholism. Drug abuse leads to
chemical dependency as well as to malnutrition and nervous disorders. Tobacco use leads to a host of problems, including heart and respiratory disorders and failure. Improper diet leads to both obesity and malnutrition. Lack of exercise leads to muscle disease, advanced aging, and infirmity. A side-effect of alcohol, drug and tobacco use is that people experience various traumas which result in otherwise avoidable injuries and disabilities. In fact, alcohol, drug, and tobacco use are the basic causes of 60 to 70 percent of in-patient hospital admissions.

Consumers often use the health care delivery system inappropriately by choosing higher-priced services. This includes visiting a hospital emergency room, with its built-in higher cost of operation, in cases where a less expensive visit to a doctor's office could have been scheduled. Consumers are often ill-informed about the less expensive options that are available to them. Also, many of them have the attitude that cost does not matter since insurance companies or the government will pay.

Numerous less-than-responsible collective bargaining agreements have been negotiated between employers and employees. For example, overly generous benefits packages have been given to employees in non-union organizations by employers who are trying to prevent unionization. Insurance costs are less when employees participate financially in premium costs, and health-care costs are less when
employees are involved in preventative medicine programs - but many collective bargaining agreements do not involve such cost-effective approaches. More often than not, the result is so-called Cadillac insurance coverage which includes every condition, either optional or non-optional. This encourages over-use of health delivery services. It encourages over-indulgence as well.

Though there is movement toward wellness and the maximization of good health in this country, a large majority of people will not help themselves by changing their poor health habits, or by participating in wellness programs or activities. These are the ones who most likely need wellness programs the most.

People are also adverse to rationing health care in this country. They assume that rationed health care means that health care will not be available when it is most needed. They also assume it means poorer quality service delivery, and that choices to use delivery services or not is removed from their hands. None of these assumptions are necessarily true. Rationing health care is simply a way of discouraging inappropriate use and over-use of health-care delivery systems.8

The last contribution consumers make to the problem of rising health care costs is the amount of bad debt medical providers end up carrying. This results from consumers often not paying those portions of the bills not covered.
by insurance. Providers normally shift these costs to those who do pay for health services, whether through insurance companies or on their own.

The Role of Insurance Providers

For years commercial insurance companies have designed and sold health insurance policies to organizations and individuals on the basis of consumer appeal, rather than on the basis of encouraging efficient, low-cost use of the health delivery system. Sales of such policies have been, and continue to be, an integral part of the total insurance coverage provided to groups and individuals, and these policies normally provide for high retention amounts and high profit margins as part of the premium. This means the dollars are working for the insurance carrier, and not for the purchaser.

"Consumer appeal" built into these policies include first dollar coverage, or low deductible and co-insurance obligations. These are expensive for consumers, and they are not cost-effective because they provide "Cadillac" coverage. Second, the hospital coverage in these policies is more comprehensive than preventative medicine programs, or out-patient coverage. Third, consumers are attracted to these policies by their coverage of high-cost surgical fees and technical procedures. Finally, these policies include on-demand emergency room coverage.

Until recently, insurance carriers had no good busi-
ness reason to suggest changes. They wrote insurance contracts on a "can't lose" basis instead of being reimbursed by the insured organization for covered health care expenses, administrative expenses, and profit. Insurance companies earned money by investing the premiums they held. Policies for private individuals are normally very expensive, but the risk to the carrier is reduced by pooling those policies with other individual or group policies to minimize potential losses.

Less expensive, viable, alternative health insurance policies have become available recently only because industry, business, and private consumers have become cost sensitive. These policies differ from the ones described above in that they provide for more user cost-participation, demand second opinions, and generally question user need prior to providing coverage.

The Role of Physicians

The average annual net income of the large number of doctors practicing in this country is $110,000. Some physicians privately admit that there is an excess of physicians, but the income potential continues to attract students to medical schools. Other reasons for the excessive number of physicians include the appeal of the profession, lack of competitive forces in the marketplace, and errors in federal planning.

Physicians who earn more than the average include sur-
geons who collect high fees for their services, hospital-based physicians who receive a percentage of total revenues based on the diagnostic and therapeutic radiologic and pathology services they provide, and procedure-oriented internists such as cardiologist, gastroenterologists, and cancer chemotherapists.

In fairness to doctors, it must be recognized that their operating costs include the costs of malpractice insurance. These costs have increased considerably in response to the "sue attitude" which has become so prevalent in today's society. Malpractice insurance currently costs between $20,000 and $40,000 per year.11

Sometimes physicians show no concern for costs, and take no responsibility for them. Sometimes they order unnecessary diagnostic services as a protection against malpractice suits. This practice is commonly known as "defensive medicine." Physicians also contribute to high costs because of poor judgment and the lack of planning. They order out-patient drugs, some of them unnecessary. More legitimate high costs sometimes result from the desire to satisfy scientific curiosity, and from the use of high cost technology to diagnose patients and to save lives.12

In 1981, hospital costs increased by $3.25 billion due to physician-ordered bypass surgery, at the rate of $20,000 per case, and heart catherizations added another billion dollars to costs, at the rate of $3,000 per case. Other
expensive procedures include total hip replacements, cataract surgery (especially lens transplants), renal dialysis, full body CAT scans, and cancer therapy. The large majority of these procedures is necessary, but they do add to costs.\textsuperscript{13}

\textbf{The Role of Hospitals}

Hospitals share responsibility for high health costs partly because of administrative and management decisions made in non-competitive environments. For example, before rising costs became an issue, hospital administrators operated out of the sense that quality health care must be delivered at any cost, as long as income was not affected. Poor purchasing review practices meant hospitals bought expensive equipment which was sometimes outdated when it was bought, or expensive equipment which was under-utilized because it met minimal needs. Finally, the long-term non-competitive nature of the health care industry meant that hospitals serving a common geographic area did not have to cooperate in the provision of services. The result was, of course, that services were often duplicated at consumer expense.\textsuperscript{14}

Two management problems affected costs. First, employees were compensated with no recognition that there was a necessary relationship between efficiency and the effectiveness of their individual efforts. Management did not monitor productivity, and there was little or no employee
performance appraisal. Second, until recently, most hospital management consisted of technicians poorly trained in management skills, or of personnel not experienced in managing under the demands of difficult financial times. Their effectiveness in health care delivery may have been excellent, but their budgetary consciousness was not.\(^{15}\)

Another major way hospitals have contributed to the problem of rising costs has been in areas related to construction, and the largest of these has been that too much hospital construction has resulted in over-bedding. Projections more often than not have been based on hope, rather than on the empirical evidence which shows that there has been a sizable decrease in in-patient hospital utilization. Further, hospitals were increasing "brick and mortar" projects at a time when projections of future income did not support the increasing interest rates charged to finance such construction.\(^{16}\)

Finally, when Medicare payments were a function of the total bill, hospitals had no incentive to pursue any cost containment measures. With the recent advent of Medicare's prospective payment method, however, hospitals have taken another look at cost containment.\(^{17}\) This will be discussed later in this paper.

**The Role of Labor**

Health care is a labor-intensive industry, particularly in hospitals, and wages and salaries have increased
dramatically in the last few years. In part, these increases reflect marketplace considerations. For example, in the late 1970s and early 1980s there was a need to increase wages for nurses. Women, who make up the large share of nurses, were finding out that they could be trained and employed in other professions that paid more and did not require the dedication, compassion, skill, and long, late hours that nursing requires. In order to recruit and retain the nurses needed to meet the shortage health care providers had to pay the price in the form of higher wages. High inflation rates during the same period required higher wages for all health workers, the same as for workers in other industries.

Another marketplace consideration is related to labor union activities. At present, approximately 85 percent of the nation's health care work force is non-union. These workers have generally rejected the union philosophy. At the same time, the nation's major unions have set goals of aggressively attracting membership in the health care industry to offset declining membership in smokestack and other industries. The unions have made inroads, with some contracts resulting in sizable compensation changes. To avoid becoming the next union target, health care providers are forced to offer higher compensation costs and benefits packages.

Finally, the giant leaps forward in technology have
caused an increase in pay scales, in order to recruit and retain the personnel necessary to operate diagnostic and therapeutic equipment.

The Role of Government

The federal and state governments, but most notably the federal government, have mandated a plethora of necessary but also sometimes frivolous regulatory requirements that ultimately result in high costs to health care providers and the consumer served. Those requirements are generally attached to Medicare purse strings, and providers need to comply in order to receive reimbursement or to be considered an eligible provider of health care services. These requirements cover a wide range of subjects, ranging from the quality and quantity of health care services provided to various aspects of the physical plant.

Cost-containment strategies must take these factors into account. The next chapter will address the containment strategies and alternative health delivery systems which government and private industry use in an attempt to contain health care costs.
CHAPTER II

COST CONTAINMENT STRATEGIES

Employers' Approaches

Various measures taken by employers to contain the cost of providing health insurance benefits to employees and their dependents have been widely publicized over the last few years. While these measures are designed to serve the narrower goal of controlling employer costs, they also promise to serve the broader goal of controlling aggregate health care costs. Neither the prevalence nor the effectiveness of alternative strategies adopted by employers to control the cost of their health insurance programs, however, has been adequately documented. No nationally representative data have yet been compiled that would track recent changes in the design of employer group plans.

Nevertheless, private industry surveys indicate that changes in plans designed to control costs are increasingly frequent. Furthermore, these changes may be at least moderately successful in stabilizing employer costs and in raising employee awareness of the cost of their health care. Many experts believe that consumer awareness of health care costs is a critical step toward containing aggregate health care cost inflation.
The variety of changes in insurance plan designs already adopted by employers can be grouped into several categories. The first involves changes that increase employee incentives to use health care more economically. Some of these changes include imposing higher deductible and co-insurance payments for all or some services covered by the plan. Changes also include expanding the scope of covered services to include substitutes for more costly in-patient hospital care, as represented on the following page in Table 1.

Another kind of change specifically restricts the use of some of the services covered by insurance plans. These include requiring compliance with formal review of hospital utilization and same-day surgery requirements, as well as requiring second opinions.

The final category of changes involves re-structuring the delivery of health care services to persons covered by the insurance plans. These include the establishment of preferred provider organizations for the services covered, and the establishment of health maintenance organizations (HMO's).

These changes have all taken place within the framework of existing employer health insurance plans. Outside this framework, some employers have initiated a much more sweeping reorganization of their health insurance benefits. In some cases, this reorganization simply means offering
### Table 1

**FREQUENCY WITH WHICH COST-CONTAINMENT STRATEGIES ARE IMPLEMENTED BY FORTUNE 500 COMPANIES**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percentage of Firms Using Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory (Day) Surgery</td>
<td>82%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>81</td>
</tr>
<tr>
<td>Health Maintenance Organizations</td>
<td>81</td>
</tr>
<tr>
<td>Self-Insurance Programs</td>
<td>80</td>
</tr>
<tr>
<td>Out-Patient Testing</td>
<td>79</td>
</tr>
<tr>
<td>Second Opinions for Surgery</td>
<td>71</td>
</tr>
<tr>
<td>Utilization Review Program</td>
<td>68</td>
</tr>
<tr>
<td>Representation on Hospital Boards</td>
<td>68</td>
</tr>
<tr>
<td>Greater Cost-Sharing</td>
<td>64</td>
</tr>
<tr>
<td>Business Coalitions</td>
<td>59</td>
</tr>
<tr>
<td>In-House Corporate Medical Program</td>
<td>52</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>41</td>
</tr>
<tr>
<td>Wellness Programs</td>
<td>34</td>
</tr>
<tr>
<td>Pre-admission Review</td>
<td>32</td>
</tr>
<tr>
<td>Preferred Provider Organizations</td>
<td>17</td>
</tr>
</tbody>
</table>

**Source**

more than one health insurance plan option to employees, with the understanding that the employer will contribute the same amount to each plan. Other employers have more fundamentally re-organized their health insurance plans within the framework of flexible benefits or "cafeteria style" plans.

Limited experience so far suggests that employee incentives to reduce health insurance coverage in favor of greater cost-sharing are effective in the context of flexible benefits plans. Most employers who have adopted flexible benefits plans have done so to induce employees to share more of the health insurance costs, and therefore take more responsibility for controlling those costs.

This part of the paper describes the design changes in employer plans that have occurred over the last few years. In addition, it describes in summary fashion the operation of flexible benefits plans. It concludes with an examination of existing evidence on the success of alternative measures adopted by employers to control the cost of their own health insurance plans, and, at the same time, the national cost of health care.

**Improving Incentives to Use Health Care Economically**

Design changes in insurance plans that encourage employees to use health care services more economically include raising the level of cost-sharing required by the plan, and changes in the scope of covered services. In-
creased cost-sharing under employer group plans may be achieved by raising deductibles and co-insurance payments for all or some services covered by the plan, as well as by raising employee contributions for their coverage or for dependents coverage under the plan. Because these changes reduce real compensation levels by raising employees' out-of-pocket health care costs, they have been generally resisted by employees, particularly by those with collectively bargained health insurance plans.

Despite employee resistance to greater cost-sharing, many employers report having raised the deductible or co-payment provisions of their group health plans since 1980. One survey of 1,420 employers throughout the United States indicated that approximately one-third had increased the co-payment requirement for coverage of in-patient hospital care.19

Another survey of 308 large employers, conducted by the National Association of Employers for Health Care Alternatives (NAEHCA) indicated that 53 percent had increased their plan's deductible and 25 percent had increased the co-insurance payment required by the plan. In addition, nearly one-third have raised the employee contribution for either their own coverage or dependents coverage under the plan.20

A corollary of increased deductibles and co-insurance payment provisions for hospital care has been the reduction
of first dollar coverage for in-patient hospital expenses. First-dollar coverage pays initial expenses for hospital care, with no deductible or co-insurance payment on the first dollar of care delivered. An annual Health Insurance Association of America (HIAA) survey of new comprehensive major medical plans underwritten by thirty-three major insurers in the United States indicated a sharp reduction in the proportion of new plans that cover initial expenses for in-patient hospital or surgical care. The annual proportion of new plans providing first dollar hospital/surgical coverage since 1980 is presented on the next page in Table 2. In 1982, only 7 percent of all new plans - (weighted by plan size) provided first-dollar hospital/surgical coverage. This rate represents an 81 percent drop since 1980 in the (weighted) number of new plans that provide first-dollar coverage for in-patient hospital or surgical care.

Changes in the scope of services covered by the plan may be intended to re-direct patient use of health services toward less expensive substitutes for in-patient hospital care. Consistent with this goal, employers have expanded the scope of group health plans to include coverage of home health care services, hospice services, and out-patient hospital care. Out-patient care covered by employer group plans may include pre-admission testing, out-patient surgery, or surgery performed in free-standing surgical cen-
## TABLE 2

DISTRIBUTION OF EMPLOYEES IN NEW COMPREHENSIVE MAJOR MEDICAL PLAN, FIRST-DOLLAR COVERAGE OF HOSPITAL/SURGICAL EXPENSES, 1980-1982

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Employees</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>-</td>
</tr>
<tr>
<td>First-dollar coverage (^2)</td>
<td>36.4</td>
<td>24.4</td>
<td>6.6</td>
<td>-81.0</td>
</tr>
<tr>
<td>Deductible or first-dollar co-payment</td>
<td>63.6</td>
<td>75.6</td>
<td>93.4</td>
<td>46.9</td>
</tr>
</tbody>
</table>

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\(^1\)Includes new comprehensive major medical plans with hospital room and board coverage only, ancillary hospital service only, all hospital service coverage only, surgical coverage only, or all hospital plus surgical coverage. Surgical coverage may include coverage of schedule or actual charges.

\(^2\)Plans that provide first-dollar hospital/surgical coverage require no deductible for coverage of hospital or surgical care and no co-payment on initial expenses for these services.

**Sources**

Health Insurance Institute, New Group Health Insurance Policies Issued in 1980 (Complete Tables). Mimeo, Table 45.


ters. These are often called "same-day surgery" or "day surgery". Coverage of these services is often intended to discourage the use of in-patient hospital care or to discourage protracted hospital stays by equalizing insurance incentives between in-patient and out-patient care.

The HIAA survey of new comprehensive major medical plans indicates emerging coverage of services that substitute for in-patient hospital care. In 1982, 89 percent of all new major medical plans (again weighted by plan size) covered pre-admission tests; 81 percent covered home health care services. Coverage of paramedical testing and hospice care was somewhat less common (44 percent and 13 percent, respectively). However, hospice care coverage is showing growth. Evidence from other surveys of employers (in particular, the 1980 and 1982 surveys conducted by NAEHCA) confirms that all these coverages have become much more common features of employer group plans since 1979.

**Restricting the Use of Benefits**

Restrictions on benefits for the purpose of controlling health plan costs usually apply to the use of in-patient hospital care by plan participants. As indicated earlier, restrictions on benefits covered by the plan may include the requirement that there be compliance with hospital utilization review, the requirement that there be a second or even third opinion, and a requirement for same-
day, out-patient surgery. Although many employers have adopted these benefit restrictions, at present cost-sharing as a method of controlling insurance plan costs appears to be more common.25

Hospital Utilization Review

This kind of review involves assessing the appropriateness of hospital admissions, in-patient hospital services, and hospital discharges. Individual employers or insurers may contract with professional service review organizations (PSRO's) or with peer review organizations (PRO's) to evaluate hospital use.

Hospital utilization review may be conducted prospectively, before hospital admission; concurrently, during the patient's stay; or retrospectively, after discharge from the hospital. Both the prospective and concurrent reviews are highly labor-intensive and costly to conduct, and for these reasons, review organizations often subcontract prospective and concurrent review to the admitting hospital. Critics of the utilization review process have charged that the practice of delegating review to the hospitals compromises its effectiveness.

As a consequence, employers who use utilization review most often use retrospective review. Although retrospective review itself does not limit benefits covered by the plan, it may enable the plan to enforce other restrictions on coverage prior to payment. This form of review probably
exerts a sentinel effect on plan participants, physicians, and hospitals, especially when the employer or insurer is large and well-known to local health care providers. The review protects the cost effectiveness and integrity of the plan. The 1982 NAEHCA survey indicated that 35 percent of the employers surveyed used utilization review; this rate was 10 percent greater than the 1979 rate, as reported in NAEHCA's earlier survey.²⁶

Plan provisions that require a second or third medical opinion before elective surgery are often enforced either by refusing payment for the insured's failure to comply, or by imposing a separate deductible or higher co-insurance payment for expenses related to the surgery. Same-day surgery provisions are intended to eliminate unnecessarily early hospital admissions and the subsequent higher cost of hospital room and board. This provision may uniformly exclude coverage of hospital room and board charges for weekend admissions, unless surgery is scheduled for the following morning.

To date, no survey information has tracked the emergence of same-day surgery provisions in employer group health plans. Second- or third-opinion surgery provisions, however, have become quite common. The 1982 HIAA survey of new comprehensive major medical plans underwritten by major insurers indicated that 84 percent of new plans (weighted by plan size) included a second-opinion surgery provi-
Restructuring the Delivery of Services

Preferred Provider Organizations

A very important development in the effort to control health care costs is the emergence of contractual arrangements between individual or group service providers and some employers (or insurers). These arrangements have come to be known generically as preferred provider organizations (PPO's).

A PPO is a contractual arrangement between providers and buyers of health care services. In some contracts, providers may agree to discount charges in circumstances when buyers use services in excess of volume limitations and when buyers guarantee prompt payment. In addition, providers may cooperate with utilization review that monitors and contains the growth of health service use and plan cost.

As an incentive for plan participants to use the services of the PPO, plan coverage is often greater than for services delivered by other providers. Greater coverage might be achieved by waiving deductibles, co-insurance payments, or limits on coverage for services delivered by the PPO.

The legal status of PPO's has somewhat impeded their development. Several forms of PPO's have been found in
violation of anti-trust laws for horizontal price-fixing (Arizona v. Maricopa Medical Society, 1982) or for being potentially in restraint of trade (Group Life and Health Insurance Company v. Royal Drug Company, 1979). Nevertheless, PPO's have been aggressively developed by some employers and insurers in an effort to control the cost of their group insurance plans.

Apart from these legal issues, and pending their resolution, potential PPO purchasers need to be concerned about two kinds of risks. The first is "quantity risk". The critical question here is, are use-controls sufficient to prevent or minimize excessive volume? Too great a volume of users can wipe out the savings from discounts given to the corporate or government buyer.

The second concern is the "case-mix risk." Does the PPO provide coverage that takes care of all patients? Are control mechanisms in place for referral procedures and the use of subsidiary health care settings, both to deter unnecessary usage but also to ensure that necessary care is extended? Will the buyer have to supplement PPO coverage with catastrophe insurance? Finally, who bears the risk if the case-mix is more weighted toward severe illnesses than anticipated?

Beyond these concerns, the growing popularity of PPO's has created other problems. One is that they have stirred up a good deal of competition. Those providers who were
competing for the same health care dollar began offering large discounts, in some cases such large ones that providers were taking in less money than they spent to cover expenses. The result was a price war in which all the competing providers suffered. In many cases, losses were disastrous, and some providers have backed off from being PPO's. Another problem is that the PPO's non-group customers correctly sense that they are being discriminated against, since they do not get discounts either for business delivered or for prompt payment.

Despite these problems, since PPO's are the newest type of alternative health care delivery system, their cost experiences cannot yet be measured. Ultimately, PPO's may prove useful in setting up price competition for HMO's. Moreover, because they base their rates on an employer's actual experience, rather than on the experience of an entire community, PPO's can be more precise in their pricing than federally qualified HMO's.

**Health Maintenance Organization (HMO's)**

Health Maintenance Organizations are another alternative health care delivery system gaining favor, especially in heavily populated parts of the country. An HMO provides or arranges for comprehensive health care services for members who reside within a specific geographic area. They are member-financed through fixed monthly or yearly fees. Employers affected by the HMO Act of 1973 are
required to offer their employees a choice between HMO's and other insurance, if the employer has received a written request from a federal qualified HMO in the area. They may offer the option even if the HMO is not qualified. An HMO becomes qualified by offering a certain amount of basic health coverage as determined by the U.S. Department of Health and Human Services.

HMO's are both insurers and providers of care. Because they are reimbursed on the basis of fixed premiums, independent of use, they have no incentive to provide excessive services or charges, and they do not place patients in hospitals without real need. Accordingly, most HMO's have far lower hospitalization rates than other benefit plans. These low rates have caused concern about the quality of HMO's care, but there is no evidence so far that HMO's and other plans differ in quality.

The reason for HMO's lower rates of hospitalization is unclear. It might be the result of the greater emphasis put on preventative care for patients, or by a greater number of ambulatory visits, or simply by the innate differences between the people enrolled in HMO's and in other programs. The evidence is inconclusive, but the questions remain important. If HMO's use hospitals less because they are more successful in preventing severe illnesses, they obviously are desirable providers of health care. If they achieve their results merely because those who enroll in
HMO's are generally healthier than those who enroll in other programs, then one can hardly say that HMO's are significantly different from other health care providers.

At present, HMO's require less administrative work than many other health plans because employers have to make premium payments only. There are no insurance claims to be filled out. HMO's are attractive to employees because there are virtually no deductibles or co-payment requirements.

Nevertheless, HMO's represent less than 7 percent of the insured population. In part, the lack of widespread popularity comes from employee's dislike of HMO limitations on choice of doctor, and in part it comes from the fact that HMO costs can be high, as compared to other health plans and delivery systems, because of their comprehensive benefit coverage.

Despite cost reductions achieved by lower hospitalization rates, costs of using HMO's are vulnerable to change for several reasons. First, they achieve their savings by having a large number of healthy subscribers. Because of their complete coverage, they may gain a larger fraction of less healthy subscribers as corporations and governments raise the deductibles and co-insurance features of other health insurance options. If such adverse selection occurs, HMO's will have to raise their premiums for all subscribers in order to subsidize the care of those who
require intensive medical care. Further, their success in dealing with this less healthy population is still unproven.

Second, HMO contracts with hospitals may not contain fixed rates, but rather may require HMO's to share the hospital's financial fortunes. If a hospital has a poor year, the HMO and its subscribers have to absorb the costs. In many areas, HMO's do not have enough influence to persuade hospitals to write fixed-rate contracts, and they lack the capital to build their own hospitals.

Further, many HMO's have no staff or offices of their own. Instead, they contract with physicians to see HMO patients, and the HMO pays a fee-per-visit or a total price per patient. If HMO payments amount only to a small fraction of the physicians' total income, then physicians have little incentive to change their ways of dealing with (and charging) patients. Such HMO's are called "open" because their practitioners see patients who are not HMO members.

Open HMO's often do not share the low hospitalization rates of "closed" HMO's, and they are prone to adverse selection. However, they do offer enrollees a wider and more satisfying selection of physicians and other health care professionals. As a consequence, they seem to have more satisfied users. The "closed" HMO, available only to HMO subscribers, generally have better use experience. They have higher initial costs, however, because they em-
ploy a salaried staff and usually have their own buildings and, sometimes, hospitals. But they are more vulnerable financially than the "open" HMO.

Although many HMO’s claim to have elaborate utilization review and incentive mechanisms, few of them actually have them in place. In addition, HMO’s may wrongly price their services through poor or inexperienced management which is unable to accurately predict the variables affecting HMO costs.

Another problem is that the federal government has removed its grants to HMO’s. Non-profit HMO’s will thus have to rely on loans and cash flow for financing, while for-profits will have to tap the equity market. The future effect on HMO costs from these new sources of capital will surely be to increase them. Further, HMO’s that are federally qualified must have a number of cost-increasing features: comprehensive benefits with limited co-payments and deductibles must be offered. Waiting periods and exclusions must be prohibited.

Despite these problems, Paul Elwood, a consultant for InterStudy, an HMO research group, predicts that 50 percent of the U.S. population will be in HMO’s or PPO’s by 1994. At present, a federally approved HMO is already in place in every state in this country - with the exception of Montana. However, Blue Cross of Montana is presently evaluating the feasibility of developing and mar-
keting an HMO product. An HMO needs a minimum of 40,000 subscribers.

**Flexible Benefits Plans**

A flexible benefits (or "cafeteria") plan is an employer benefits plan which allows some choice among types of benefits or relative amounts of different benefits provided by the employer. To the extent that there is a "typical" flexible benefits plan, it usually includes two or more health insurance plans. They may also include group term life insurance, accident benefits, group legal benefits, dependent care assistance benefits, and a cash of deferred arrangement (the 401(k) plan). Despite regulatory (IRS) uncertainty about the plan elements, the popularity of flexible benefits programs among both employers and employees has generated growth of these plans during the last five years. This growth is expected to continue.

Employer's goals in implementing a flexible benefits program are complex, but they often include strategies like inducing employees to share more of the health care costs covered by the plan; offering employees new, specialized benefits tailored to the needs of a demographically changing work force, with substantially increased total benefits costs; and encouraging employees to elect higher levels of savings, anticipating the need for greater reliance on personal savings for retirement incomes.

One of the problems often encountered with these plans
is the possibility of adverse selection by an employee, for which the employee may attempt to hold the employer liable. (An adverse selection is one in which the benefits chosen by employees may not best meet their individual needs). Another problem is the fluidity and uncertainty of U.S. and state tax regulations affecting the tax status of benefits offered under these plans.

The Effectiveness of Plan Re-design

Evidence which measures the effectiveness of alternative plan design changes is scarce. Most research to date has examined the effects of greater cost-sharing on health service utilization and subsequently on hospital costs. This research has uniformly concluded that higher cost-sharing by insured consumers reduces the use of health care services, including the use of in-patient hospital care. It appears that lower hospital use and lower hospital costs result in significantly lower rates of hospital admissions among persons with insurance that requires greater cost sharing for hospital expenses. It is not known whether increased cost-sharing is more effective in containing health plan costs than alternative plan design strategies. The issue has received little attention.

The data collected in the 1982 NAEHCA survey of employers allow a preliminary assessment of the relative effectiveness of alternative changes in plan design intended to control health care costs. By inference, strategies
that are effective in reducing employers' cost of providing health insurance benefits are probably also effective in reducing aggregate health care utilization and cost. The magnitude of the savings, however, cannot be measured with available survey data.

The information provided by the NAEHCA survey must be considered with caution. This data provides only part of the limited published assessments of the relative effectiveness of the various cost control strategies that have been adopted by employers. Nevertheless, the published distributions provide no information about the combinations of strategies used by employers. The good cost experience associated with any particular strategy, therefore, may reflect interactive effects of more than one strategy. Conversely, poor cost experience may reflect the isolated use of a particular strategy, un-reinforced by other measures to control employer health care costs.

Despite this problem, the results reported in the NAEHCA survey are reasonable. On the two following pages, Table 3 isolates factors that contribute most to health care cost controls. The cost experience of employers who have implemented specific plan features is compared with that of employers who have not implemented these features.

Column 3 presents, by plan feature, the difference between the share of employers in each group who experience cost increases which are less than the survey median in-
<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Have Implemented</th>
<th>Have Not Implemented</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added or Increased Amount of Co-insurance</td>
<td>70.0%</td>
<td>32.1%</td>
<td>37.9%</td>
</tr>
<tr>
<td>Covered Hospice Benefits</td>
<td>60.0</td>
<td>54.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Used Outpatient Review</td>
<td>58.3</td>
<td>46.2</td>
<td>12.1</td>
</tr>
<tr>
<td>Covered Outpatient Surgery or Surgical Centers</td>
<td>52.5</td>
<td>27.3</td>
<td>25.2</td>
</tr>
<tr>
<td>Covered Home Health Care</td>
<td>52.2</td>
<td>27.3</td>
<td>25.2</td>
</tr>
<tr>
<td>Used In-patient Review</td>
<td>50.8</td>
<td>45.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Implemented Health Promotion Program</td>
<td>50.7</td>
<td>47.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Required Second Opinion on Surgery</td>
<td>50.4</td>
<td>47.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Covered Pre-admission Testing</td>
<td>48.3</td>
<td>42.1</td>
<td>6.2</td>
</tr>
<tr>
<td>Covered Extended Care Facilities</td>
<td>47.7</td>
<td>39.3</td>
<td>8.4</td>
</tr>
<tr>
<td>Increased Deductibles</td>
<td>40.1</td>
<td>44.9</td>
<td>-4.8</td>
</tr>
<tr>
<td>Increased Amount Employee Pays of Premium</td>
<td>26.1</td>
<td>49.0</td>
<td>-22.0</td>
</tr>
</tbody>
</table>
Table 3 (Continued)

| Added an Optional Low-Benefit Plan | 12.5 | 48.4 | -35.9 |

Source

crease. Where the difference is positive and large, that plan feature is more likely to have been effective in reducing the total cost of the plan. Among respondents that had added or increased the co-insurance required by the plan, 70 percent experienced cost increases that were less than the median cost increase reported by all respondents.

By comparison, only 32 percent of respondents who did not add or increase co-insurance amounts experienced relatively small plan cost increases. Similarly, coverage of hospice benefits was associated with good cost experience. The relatively narrow margin between the cost experience of employers whose health insurance plans covered hospice care and those whose plans did not probably reflects the low frequency of terminal illness and hospice use even among plans that continue health insurance coverage to retirees.

Raising the deductibles, or increasing the level of employee contributions to the plan apparently have been less successful strategies for controlling health plan costs. The reason may be that these increases have been less than either the increase in health plan costs or less than the general inflation rate. Alternatively, employers who have raised deductibles or employee contributions may have done so in order to avoid implementing other plan changes that would reduce health service utilization or re-
direct patient care to less expensive forms or sources of care. The poor cost experience of employers who adopted optional low-benefits plans may reflect adverse selection and a rapid increase in the cost of the more generous plan offered by the employer. The data does not indicate whether the multiple plans were offered in the context of a flexible benefits program, whether other incentives were provided for employees to elect less generous health insurance coverage, or what proportion of employees actually chose the low-option health plan.

In conclusion, changes initiated in employer group health plan design over the last few years have received considerable media attention. However, no nationally representative data have been collected which document the extent of those changes, or their impact. Nevertheless, private industry survey evidence suggests that some employer initiatives may be effective in controlling both plan costs and the aggregate cost of health care.

The changes initiated by employers are notable for two reasons. First, they have occurred in a relatively undramatic, incremental fashion. Second, they have occurred without legislation that would either encourage or require change. In fact, employers have implemented both PPO's and flexible benefits programs in spite of potential conflicts with existing law. Other strategies to control health care cost, such as the governmental implementation of
prospective payment for services for Medicare-eligible recipients and self-funding of employee-provided group health plans will be discussed in the next sections of this paper.

**Governmental Approach**

Title VI of the Social Security Amendments of 1983 established a new payment system for hospitals providing in-patient medical care to Medicare eligible recipients. This change, which was phased in beginning October 1, 1983, has significantly affected the way hospitals are reimbursed for the care of approximately 80 million Medicare-eligible Americans. This change in reimbursement policy may have important implications for private payers, particularly health insurance carriers, employers, and unions that underwrite health insurance for their employees or members.

Under the old approach, all Medicare-eligible health care providers were reimbursed approximately eighty cents on each dollar of medical care delivered. However, Congress and the President found that this approach lacked incentives for providers to operate efficiently, so it was changed to control costs.

The new reimbursement system - called the Prospective Payment System (PPS) - pays for in-patient hospital care according to pre-established rates for each type of discharge. The system is based on Diagnostic Related Groups
(DRG's). The driving force behind the legislative change was hospital costs, which have increased annually at the rate of 17.5 percent since 1979. The new system is geared to provide incentives for hospitals to curb costs, and it rewards efficiency. Under this approach, the Department of Health and Human Services pays hospitals for services according to rates assigned for each of the 467 DRG's.

DRG's were established by researchers at Yale University as a management tool. DRG's are a classification system which standardize hospital resource use according to type. The new legislation is designed to provide a reimbursement level for each DRG. As an example, if the geographic regional average for a hip replacement is $5,000, then the hospital is paid $5,000. If the actual costs are less, the hospital retains the difference. If the actual costs are more, the hospital absorbs the difference. At first, Medicare reimbursed hospitals according to a regional rate, with differentials for urban hospitals versus rural ones. Beginning in October, 1986, Medicare will phase-in a uniform payment procedure, based on national DRG rates, rather than on the nine regional rates which presently exist.

Theoretically, one of the major reasons for this change in payment is to offer cost-control incentives to hospitals. Since a specific DRG will provide a fixed
payment to a given hospital, the incentives for a provider to maximize income will shift. Hospitals will try to become more cost-effective by reducing the length of a patient's stay. But since the new reimbursement system will favor increased admissions, particularly short-stay admissions, there may be an inclination to hospitalize patients who might be as well treated on an out-patient basis. To control this possibility, Professional Review Organizations (PRO's) were established by law. PRO's are required to develop admissions objectives aimed at reducing inappropriate admissions, re-admissions, and cases that can be handled on an out-patient basis. PRO's also will be responsible for reviewing the validity of diagnostic information, the adequacy of care provided, and the validity determinations regarding exceptional individual cases.

If DRG's are found to be a viable cost-effective measure, there is an excellent possibility that the method will be extended to physician reimbursement as well. Other payers will be watching closely to see if the DRG method would work for them as well, since they are not inclined to pay more than Medicare does.

Peter Drucker and several other professional analysts believe that the DRG method is doomed to fail. They believe that Medicare officials will grant so many exceptions that the method's intended effects will become ir-
reparably diluted. Because several White House policy-makers see the DRG system either as too regulatory or as not creating the savings it is supposed to, groundwork has been laid for a more market-oriented voucher system which would provide beneficiaries with a year's medical care from a prepaid plan sponsor. This "capitation concept" will probably be implemented on a limited trial basis in 1986.41

Self-Funded Group Health Plans

Self-funded group health insurance programs have increased rapidly in the last few years. Indeed, a recent study indicated that approximately 80 percent of Fortune 500 companies are self-funded for at least a portion of their health insurance benefits.42

Self-funding means that a plan only pays losses as they occur, up to the limit of the plan or up to the limits of a stop-loss insurance policy which normally takes over payment of claims once limits are reached. Stop-loss insurance is available from a number of reputable carriers.

Self-funded health insurance appeals to employers for a variety of reasons. First, it eliminates pre-payment for liabilities that have yet to occur, and it puts payment on an accrued basis. Next, it reduces the internal costs of the health plan by eliminating the insurance company's administrative overhead. Third, it re-introduces the plan's reserves into the employer's cash flow, or in
other interest-earning investment programs. Finally, properly initiated and implemented self-funding has the potential to stabilize premium rates. The savings which result from the above changes, and the increased potential for fund growth reduces to a minimum the need for increasing premiums.

Though self-funded plans are employers' plans, the day-to-day management and operation of the plan is usually contracted out to an insurance company or to an administrative service organization. Services provided by these contractors include consulting, claims adjudication, report and check preparation, management of difficult or questionable claims from employees, and the preparation of federally mandated documents and submissions.

Self-funded plans reduce costs because they eliminate insurance companies' administrative expenses, profits, contributions to contingent reserve pools, the use of incurred reserves not held by insurance companies, and state taxes (generally). And, in favorable-use years, self-funded plans can earn interest on surplus funds. However, from a cost-containment point of view, a major weakness with such plans is that the administrative service organization (ASO) will reap a sizable profit because of the limited amount of administrative work involved, and ASO's normally are not assertive in combating the pathological causes of disease and injury.
This chapter has analyzed a variety of approaches to the problem of containing the costs of health care delivery, with attention to advantages and disadvantages. In the next, we will analyze an approach to cost-containment which offers advantages for both service providers and service users.
CHAPTER III

A HOSPITAL COST-CONTAINMENT STRATEGY

Marketing New Services to the Consumer

A common feature of most of the health care cost-containment strategies presented in the previous chapter is that either the consumer or the provider must deal with one or more unattractive alternatives. In this chapter, we will consider a hospital cost-containment strategy that has the potential to serve both parties. That strategy is for hospitals to increase their market share by introducing new services into new markets.

A common maxim for business success is that one must find a need and fill it, and do so with excellent quality and service at a reasonable and competitive price. Ideally, everyone stands to win. In the health care business, hospitals and other service delivery systems must learn to move beyond their traditional, self-imposed constraints, and hospitals in particular must become leaders in providing solutions to the problem of rising health care costs.

To the best of their abilities, hospitals must become full health care facilities. This means more than the traditional treatment of injuries and disease; it means
the management of preventative medicine programs, as well as the administration of employer health plans which facilitate such programs. Hospitals must become health centers, rather than just sickness centers.

A number of "health center" services are not part of the normal delivery system provided by typical acute care hospitals. These include Employee Assistance Programs and Wellness Programs.

Employee Assistance Programs (EAP's) are a response to the demonstrable fact that employees with no "handle" on their personal problems are less productive than employees who know their community resources and are encouraged to use them. Equally demonstrable, in-house EAP programs help hospital employees recover earlier levels of productivity. Further, an in-house EAP program can be marketed profitably to other businesses. It is less expensive to restore trained and seasoned employees to earlier levels of productivity than it is to fire them, then hire - and train - new employees.

Wellness Programs are more preventative than restorative. They include activities like smoking cessation, diet control, back care, nutrition, stress management, medical self-care, fitness and conditioning, hypertension management, and health assessment. In some environments, programs even include activities like transcendental meditation.
Other "health center" services not usually associated with acute care facilities include training in home health care and providing administrative services for employer group health plans.

Hospitals must, of course, continue to be prepared to care for and treat the results of injuries and disease while they attack the pathologies behind them with preventative medicine programs. As suggested above, these preventative medicine programs include the initiation and aggressive marketing by hospitals of EAP and Wellness programs to employee groups and to individual consumers.

Though comprehensive national data is not available to support a cost-benefit analysis of EAP and Wellness programs, it logically follows that hospitals have an excellent opportunity to prevent needless injury and disease at a cost considerably less than the costs of treatment.

A regional sample of employee assistance program success published by St. Benedicts Hospital in Ogden, Utah, shows that of the 92 hospitals that contracted for the EAP program in the last three years, 78 percent achieved significant savings by reducing turnover, sick leave, and health care costs.  

Further, a nation-wide survey of organizations with 3000 or more employees indicates that 70 percent of them have some form of in-house EAP and Wellness programs. Sixty percent of these organizations report significant
health cost-containment results directly or indirectly attributable to their EAP or Wellness efforts. The fact that these programs are well received by a large majority of the employees using them is becoming an item of note in these organizations' labor relations efforts.

The implication is that in the long run, EAP and Wellness programs will continue to be cost-effective for organizations and highly beneficial for employees.

**Administrative Services for Self-Funded Group Plans**

Another major service that hospitals do not usually offer is the provision of administrative services for the employer self-funded group plans discussed in the previous chapter. Hospitals have not entered this field because it is comparatively new and because most of them have considered administration of these plans to be the fiefdom of either insurance companies or their ASO's. Also, they have accepted the argument made by insurance companies that administrative responsibilities should be "handled by insurance professionals."

At present, the going rate charged by ASO's is from six to seven dollars per employee per month, for groups of 100 or more. This can produce a gross administrative income of approximately $42,000 per year for an ASO with, say, 500 covered employees. This is expensive, considering that a group of 500 employees normally does not generate more than 600 submissions per quarter. Considering that
it takes approximately 5 minutes of an experienced staff person's time to review each claim, or not more than 200 hours each year per 500-member plan, a large profit is earned on minimum investment. The numbers look like this:

Cost of plan

500 employees x $7.00 x 12 months = $42,000

ASO expenses

2400 average annual claims x 5 minutes
direct labor @ $20.00 per hour = 4,000

Administrative + general overhead = 5,000

Net Income = $33,000

Consider that a for-profit ASO staffed by one claims adjudicator could easily handle eight other group accounts of the same size, or a total of 22,000 claims, an ASO could gross $360,000 per year, and net more than $250,000.

Obviously, that is a large sum. It is also a large opportunity for hospitals. Operating as a not-for-profit ASO, hospitals can provide the same service at a very competitive price. For example, assume salary and benefits for one claims adjudicator at $20,000; equipment, materials, and program costs at another $20,000; administrative and general overhead at $10,000, the hospital price for acting as ASO for nine 500-member self-funded plans would be $50,000.

At that price, each of the nine self-funded plans would pay $5,555 per year, instead of $42,000. The savings
of 86 percent seems irresistible, and the market for hospitals is evident, considering that 80% of Fortune 500 companies self-fund their own plans (excluding catastrophic or stop-loss insurance for large claims or over-utilization). Hospitals which provided ASO services would compliment the cost-containment strategies already built-in to self-funded insurance plans quite nicely.

As an example, a group of hospitals serving major urban centers in Montana is presently planning to set up their own corporation to market and provide wellness programs, employee assistance programs, and ASO services to other organizations, as well as to their own. The primary customers will be self-funded organizations (examples in Missoula would be the City of Missoula, Missoula County, and Bitterroot Motors), but the service will be just as available to those organizations (like the University of Montana) which have conventional health coverage.

The backbone of the hospital-owned corporation will be to provide low-cost ASO services to cost-conscious organizations which want to lower the cost of administering their own health plan, but still maintain quality-control. By providing these services, the hospital-owned corporation will forge a link with the contracting organizations, and that link will be beneficial to all concerned parties.
Conclusion

These options represent an obvious opportunity for hospitals to provide a range of services to consumers which attack the causes of disease and injury, on one hand, and provide considerable savings, on the other. A very competitive marketplace exists, and the potential is enormous. As in any competitive and uncontrolled marketplace, consumers will win because their health care expenses will decrease. Providers will win too, to the extent that they deliver services in the most effective and reasonably priced manner.

The ultimate strategy for containing the costs of health care services is for hospitals to assertively initiate and implement preventative medicine programs. A secondary strategy for hospitals to follow is to provide ASO services both to self-funded and conventional health insurance plans. In thus attacking the problem of rising health care costs from both ends, hospitals would make a major contribution to the benefit of all.
DEFINITIONS

Administrative Costs are the costs to the plan of doing business and processing claims. These costs are not returned to subscribers as benefits.

Co-Insurance or Co-Payment is the portion of the premium that the subscriber assumes.

Contract is the written agreement between the subscriber group and the plan that specifies what each will do. For most practical purposes, it records what the subscriber will pay (premium) and what the plan will pay (benefits) or not pay (exclusions).

Deductible is the amount which the subscriber assumes prior to any payments being made by the plan.

Diagnostic Services are medical care, including the services of the physician, hospital, and laboratory, to determine the cause of illnesses or symptoms. Often hospital diagnostic services are an exclusion because they can be performed just as efficiently elsewhere.

Indemnity Benefits are fixed dollar amounts toward a specific medical treatment or service. These often leave the consumer with monetary difference to pay out of their own pocket.

Paid-in-Full benefits pay the full cost of treatment, though there may be some specific contract limitations.

Pre-Existing-Condition are those existing prior to the effective date of the policy. These are exclusions in many policies, or items available at greater premium cost.

Rider is an addition to a policy which either adds, modifies, or removes benefits.
FOOTNOTES


2University of Montana Center for Continuing Education and St. Patrick Hospital (program sponsors), Health Care Cost-Containment Strategies for Business and Industry, Missoula, Montana, October 10, 1984.

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9Ibid., p. 1.

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11Ibid.

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13Ibid., p. 5.


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21 "Controlling the Cost of Health Care", op. cit., p. 4.

22 Ibid.

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26 Pollock and Stack, loc. cit.

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32 Interview with Randal Cline, Vice-President, James Benefits, Missoula, Montana, July 25, 1984.

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34 Ibid., p. 8.


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