

HOSPITAL AND HEALTH CARE COST CONTAINMENT
A BLUE CROSS AND BLUE SHIELD OF FLORIDA PERSPECTIVE

There are four questions:

1. What is the problem regarding hospital and health care costs?
2. How can and should the problem be addressed?
3. What is Blue Cross and Blue Shield of Florida doing to address the problem?
4. Given a preferred course for a competitive approach based on diverse initiatives from employers, payors, coalitions, etc., what should the role of the Hospital Cost Containment Board be?

And that is really basically the nature of the outline. I looked up and saw Marie Cowart and Lynn Cambest and realized that they had put up with my impassioned plea regarding competition for the last two years and I promise I won't mention it again. I will be very brief. I do want to start with an understanding because I think that is critical. Now, being last or next to last, maybe these points have been made by others. Health care costs, of course, have risen. That is a problem to the degree that they have risen more rapidly than general income. You can state the statistical measures in a variety of ways - but, in short, the percentage of GNP is large, above 10%, and hospital costs comprise a majority of those costs, and are the most rapidly rising component; and thus, the interest on the hospital side.

Recently, we noted, with interest, a publication on managing health care costs. It tried to take a look at the factors accounting for the growth in expenditures for inpatient care over a ten year period ending in 1981. You can look at these in terms of were they typical of the economy as a whole or were they

unique. (Refers to chart) This shows that if you adjust the prices by the inflation the economy experienced in total, you account for slightly more than half of the increase in expenditures. The remaining part, about half of it, reflects intensity changes and a greater than average increase in the price of goods and services that hospitals purchase. What you have, roughly speaking, is a split between half of health care inflation related to the general economy, the other half related to the nature of the services delivered.

I'm just speaking very broadly about that. We of course, observe significant differences throughout the country in the style and practice of management and in the cost of identical services from the hospital industry. So that tells us that there really are alternatives within the industry, some of which are much more efficient than others. We essentially are looking for systems that will encourage the more efficient approaches. If you look at it from an insurance company standpoint, you see something different than you see in any of the government data. Our premiums reflect both increases in price and use and that is where the employer pays, the federal government pays and the individual buying individual insurance pays. And what we have experienced over the last number of years is significant increases in each and every year up until last year, and they compound with each other in that way, year after year. So in this case, an 11% increase in price and a 10% increase in usage factor related to the number of tests per patient days, for example, produced an increase in cost of 22%. And in fact, in many years we saw numbers like a 15% increase in price and 15% increase in usage; a very large compounding effect. So the employer looked at this, 30-40% increase per year in premiums, whether self-insured or not, and became very concerned over the cost issue.

When you talk about efficiency, there is no measure, of course, that would be perfect in adjusting hospitals for differences. This represents Dade County (refers to overhead) hospital average cost per admission using the Medicare case-mix index to adjust. It shows a range of low to high of \$3000 to \$7000. I think that the reason some of us believe in competition is because we think that there are some things that those folks are doing at \$3100 and \$3400 which, if applied elsewhere, would bring down the cost of care without bringing down the quality of care.

So far as we can determine, in many of these cases there is a very quick and easy explanation of why those costs are different - the variability in costs fail an analysis of differences in case-mix so that you are left with the nagging question that profit margins, and perhaps efficiency as well, are contributing to it.

Let me just make a comment about that. A lot of people say that you have a choice between regulation and competition and the reason that we can't go for competition is that the market is bad. I really don't think that's true. I think the market is very healthy indeed in a couple of ways. First of all, an essential ingredient for these alternative programs is that there be more physicians than there are patients. We have to have physicians concerned about keeping their patients, otherwise, they won't be willing to make changes in their style of practice. It is happening now because there is a surplus of physicians. But, if there had not been a surplus of physicians, it would not have happened. I started working with HMOs in 1968, and if you went to a local medical society and tried to talk about HMOs, they took your head off, and now in 1985, they only operate. That's one of the differences - you do it through selective contracting. I will get into it in a little more detail. As I said, these are thought starters.

But in turn, the market moved very well in that the number of doctors coming out of training programs is perhaps twice what it was fifteen years ago, and that was a deliberate strategy that the federal government modeled to make competition more possible; one of the very few things that the federal government did well in containing costs. They deliberately doubled the output of medical schools as a way of making more physicians available to get them into primary care and to create a more competitive atmosphere.

Here are some statistics about the other approach, regulation. When I first came on the Cost Containment Board, the advocates of regulation said "well, look at Connecticut", so we looked at Connecticut and then Connecticut had virtually all their cases one year overturned by the court for failure to follow the Constitution. And the focus changed, as we sat here the last two or three years and we said, "well, look at Maryland. Its the model". So we looked at Maryland. They had a slightly lower increase in cost per adjusted admission, however, total hospital costs were virtually the same for Maryland vs. the rest of the country. For those of you who travel to Maryland, as I do on business, you would know that the "hot" issue for this year is a proposal, since regulation has not worked in controlling costs, to combine planning and utilization management to give a control agency the authority for all of those. That seems to be one of their major issues this year.

If we break that down a little bit, you see the data like the following. What we have here are the average days per length of stay. We take the states in the country and break them down into ones with mandatory rate setting and those without. Basically, you see what has happened. The hospitals in rate setting states have simply offset the constraints of price by keeping volume of days of care up so as to not affect their revenue. I personally use to work in Delaware

and when rate setting was put into Maryland, it was put in as a request of the hospitals to maintain their revenue base. Similarly, if we look at the trends in the cost per adjusted admission between the two - the states with rate setting are the ones with more severe inflation and they have a higher average level of costs. The trend factors are essentially the same on the cost per admission.

Let us take a look at something that has worked for most hospitals. In October of 1983, Medicare programs went into place. The Medicare programs' reimbursement system destroyed several myths. One that we used to hear all the time - "keep in mind that hospitals don't admit patients, doctors do. Hospitals don't order tests, doctors do. So if we look at hospital charges and revenues, don't blame the hospitals, its the doctors that do it".

Suddenly, you put the hospitals at risk for what the doctors did and behavior changed almost overnight. So low and behold, things came into line dramatically, both admissions and length of stay. The incentive was that the hospital was only going to be paid the fixed dollar amount for patients with a certain condition and if the patient stays longer so as to use more than those dollars that came out of the hospital bottom line, and if the physician ordered twice as many tests, as his brother did for the same diagnosis, that came out of the bottom line also. Over the years there have been all kinds of studies done showing as much as a tenfold difference in the use of services by qualified physicians by patients with the same condition at the same setting. They've just never been held accountable for efficient use of their services.

Everybody talks about staffing. I have been in the industry almost 25 years. I knew many administrators over those 25 years who had never, ever had a reduction

in employment except for cause or inappropriate individual behavior. But the idea that you can reduce your work force in absolute terms in response to business conditions was, for many people, unheard of. The other thing we are seeing is that in many hospitals, but not all, a non-medicare patient receives the same benefits derived from more prudent practice. The physicians did not change the way they practice just for Medicare patients. They changed the way they practice, period. Frankly, my bottom line on my balance sheet shows the benefits of the cost reduction by the hospitals and physicians in response to Medicare. After many, many years of horrible underwriting results, we had a good year last year.

This gets at the alternatives. (Refer to overhead #9) On the left hand side of the chart are the number of days of in-hospital care per 1000 members, that's covered people per year. The difference between National and Florida reflects the fact that the Florida Blue Cross population is considerably older than the National average. Our insured population is still under 65, but we have a very large number of people between 50 and 65. If you look at HMO performance, you find all HMOs, nationally, average around 450 days per 1000. The HMOs that we operate are at 496 days per 1000, while the one we have in Tallahassee is way below that. This is a comparison between HMO and Traditional insurance plans (overhead #10) based on a national study done by the Federal government of a two year period. Look closely at the absolute level, but more importantly, the rate of change. Traditional insurance, during that period, increased in price 49%. HMO coverage nationwide increased 29%. So there is reason to believe that not only are the resources being used more efficiently, with the inpatient hospital care being the one you try to conserve and using outpatient care to offset it, but also once you have that formula, the rate of increase is less.

Any chart I give you on HMO growth would demonstrate dramatic gains. This is Florida HMO enrollment. The solid line going across is actual enrollment (overhead #11). The left hand side represents hundreds of thousands of people. What is relevant is not the absolute number, but the rate of increase. That rate is 100% from 1978 to 1979, 46% in 1980 over 1979, up 18% in 1981 and 41% in 1982. The forecast of 42% for 1983, we believe, has been exceeded. So there is a relatively small number of HMO enrollees, but it is growing at a very, very rapid rate. We see HMO growth in Florida as being absolutely explosive, and we think it is going to expand even further as the Medicare population is more readily enrolled in the program.

Our internal planning has led us to plan on establishing a minimum of ten HMOs throughout the State, based on a forecast of this kind of explosive growth through 1988. We think that our expectations will be exceeded. We have significant enrollment and penetration only in Tallahassee. Our South Florida HMO has experienced a growth rate of about 70% per year, but it is smaller in absolute terms. We just opened one in Jacksonville and will be opening ones in Orlando, Tampa and several other cities in 1985.

Incidentally, one by-product of all this selective contracting is that both the HMO and the PPO added to our need to restructure our own Board; not because we were provider dominated, but because some of the people who wanted to do business with us, because they represented efficient providers in the State, were also on our Board. Consequently, we found ourselves in a potential self-dealing situation. We no longer have any active hospital administrators on our Board. We have two physicians, but they are not active in any of these programs.

What is our strategy? Do we want to penetrate the market with HMOs and PPOs? An interesting thing that is happening which we really did not understand is that as physicians and others see what's happening in the HMO arena they are more willing to consider changes in traditional fee-for-services practices. At the same time, our employees, as they see the cost of care changes in the market, are more willing to change. For example, we offered all our employees a triple option of HMO, PPO or Traditional coverage, which is the same design that General Motors has come up with. He picks the HMO and gets the broadest benefit. He picks the PPO and gets better benefits than he would on the Traditional plan. So he has the three choices. In our case, just under 40% of our people chose the PPO. Just under 20% took the HMO the first time around and a little over 40% chose the Traditional insurance. We experienced immediate significant movement from people into those alternative plans. Beyond that, though, employees in the Traditional become more familiar with things like pre-admission certification because it is going on in the HMO, and physicians become familiar with it, and suddenly we find it installed in Traditional insurance and nobody says anything. Whereas, three years ago, we wouldn't have stood a chance in getting those plans into effect. So in our Traditional program, we now have pre-admission certification for all employees.

We had a meeting recently and were briefing some Legislative people. Insurance companies, one after another, were saying that they had a program that does address utilization. They had never done this before and if they had tried it before, they would have had severe resistance, both from the customer and also the providers of care. So that is really very interesting. Mandatory second opinion is another example.

Summary of our industry (overhead #13). 600 companies are competing - four firms have market shares exceeding 5% - nineteen have market shares exceeding 1% - ten firms account for 59%. These numbers are a bit deceptive because over half the market is self-insured. The nature of the market is one of being highly pragmatic. As one part of the market, you can't tell anybody to do anything. On the other hand, as a good businessman, the hospital administrator would just as soon not lose four or five percent of his hospital's revenue.

We are not going to coerce hospitals very much, but hopefully we are going to build cooperative joint venture type arrangements. One of the strategies that was implicit in the tremendous range in cost that I showed you in Dade County, is that you can identify and work with the more efficient hospitals; you don't have to ask for special deals. You just have to get the patients to go to the more efficient providers which results in significant savings.

(Overhead #14) We think the Board can help by encouraging and facilitating competition. Quality is going to be a hot issue for the next few years. I don't think, though, that there are any good measures of it. I can tell you that in talking to people that are involved in Medicare programs at the level of ongoing hands-on administration, that they consider Florida to be one of the most difficult markets in the country. That probably has to do more with out-of-hospital care, but additionally, it's a very unusual market in the sense that providers have migrated to Florida who had disciplinary problems someplace else. They bring all that background with them. There really are no good reliable means available to measure quality. I was recently visited by a physician who went into research work who was talking about some work he did on one surgical procedure. He said that if you take a look at the mortality rate for patients who have prostate surgery, it's a number like 3 to 6%, who don't have a chance,

based upon measuring how many of the patients died while they were in the hospital. But if you obtain Medicare data and measure how many died within 90 days after the surgery, the number almost triples. So how do you identify and collect the right data to measure quality?

My experience in other states where I worked, such as Michigan, reflects that people don't want to know the cost of education and indigent care because they don't want to fund it any other way. When it comes to writing the ticket to pay for that indigent care you run the risk of people saying, "well, now that you've raised it to a conscious level, I don't like that much of a tax". That is a real public concern, but I don't think that it, in any way, takes away from the need to address the problem.

Whatever we can do to inform the public regarding health care costs, we should do. You know I was quite aggressive in dealing with the two psychiatric hospitals. One of the reasons I was, was that number one, they are not subject to meaningful price competition. They simply have found a niche in the market where there is no price competition. It seems to me that one of the things that the Board can do is to identify, over time, when they see people really under the pressure of market discipline or not. The whole argument in favor of the competitive approach is that there is pressure out there, that is, in fact, much harsher and challenging than any regulatory pressure. If that's not the case, then we have to reconsider our approach. I have a hard time defending competition when a specialty hospital, because of mandated insurance coverage, is able to sell services for a very profitable price. As a member of the Board, I also would like to say a little about "true" hospital costs, where a hospital builds too much or too soon, has a 50% occupancy rate, raises their prices very high compared to other hospitals so that they can pay for that building and at the

same time provides themselves a good profit margin, and then they come into the Board and they say, "well, really the only reason that we're having a problem with prices is that we need more volume".

To go back to my earlier slide, what happens when we get more volume? Our premiums go up, State costs go up, Medicare costs go up. So, for any institution to say the solution to the problem of high cost is more volume is really just measuring one part of the problem; you're not really measuring total cost. That's a concern because if you have excess capacity then people will say, "well, I'll get my average price per admission down by bringing more patients in". But if everybody else has the same number of patients and he just has more, then total cost in the community has gone up. I'm all for competition, but what I'm saying is that if that fellow really felt the heat of competition, he wouldn't have those prices up that high to begin with because he'd be worried about keeping them down so that Gulf Life or American Heritage, Blue Cross or somebody else would contract with them.

One of the Legislators was visiting Jacksonville. Employers and insurers put on a presentation on some of the things that were happening. His concern was that he really wasn't sure exactly what was happening, but he, sure as hell, didn't want to screw it up. It is the most profound change that any of us have seen in our careers. I think it rivals the auto industry dealing with the Japanese cars in terms of forcing change. I really think we do have to allow it to work through. And in the same manner, I'm not exactly sure what the market will look like, but I still think its the right way to go.

I was up in Maryland - I didn't pick that spot by accident - bidding on a large company by offering triple option HMO, PPO, Traditional insurance coverage,

The Maryland insurer said "now just a minute - you want a PPO, here's what the Commission said we should pay a hospital. You pick out the hospital". There were no negotiations at all. You take what the Commission said. I really do think it is important to have that opportunity for negotiations.

Again, some of the major things we see. I think 80% of the population lives close to two or more hospitals. There is reason to believe that the competition can develop in those areas. Coalitions have played a major role in Florida. Cost sharing is a predominant form of insurance. Now frankly, I think that is the most oversold thing there is. You know that's about all we sell. The reason that it is oversold is that if you go back to that hospital that charges \$3000 and another charges \$7000, and you put a \$100 or \$200 deductible and even a 20% co-insurance on it, you find that the insurance plan has masked some of the difference in price between institutions. If you go back to when health insurance got started, it was supposed to help people finance needed care. It wasn't intended to create efficiency because there was the assumption that the nature of the industry was already efficient. Today, of course, historical insurance plans do tend to mask the differences in cost. For example with one UCR claim, one guy charges \$700 and another charges \$1000 which is within the limit the Plan recognizes as a reasonable price. Why is \$1000 reasonable if somebody will do it for \$700? The key is that only recently have consumers been willing to sacrifice unlimited access to delivery systems in order to obtain lower cost. An abundant supply of physicians and beds is essential to the competitive approach in Florida. It doesn't seem possible that all the folks that think they are going to make a hit in Florida can do it. I think there are going to be more people trying than there are going to be ones surviving.

We need your help in supporting the policy previously formulated where competition is the preferred solution to containing costs. We will work with everybody to do our part. Thank you very much.