Originally Processed With FOIA(s): S

FOIA Number: S

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the George Bush Presidential Library Staff.

Record Group/Collection: Donated Historical Materials
Collection/Office of Origin: Frieden, Lex, Collection
Series: Printed Materials
Subseries: Periodicals

OA/ID Number: 52130
Folder ID Number: 52130-010

Folder Title:
"Business and Health: Washington Business Group on Health - April 1986"

Stack: **Row:** **Section:** **Shelf:** **Position:**

BUSINESS AND HEALTH

* XEROX'S BENEFITS MANAGER * EMERSON HOSPITAL'S CEO
* NEW YORK STATE'S COMMISSIONER OF HEALTH . . .

When the leading figures in corporate America, health care delivery, government, and health policy present their new approaches to spiralling health care expenditures, the forum they choose is BUSINESS AND HEALTH. We urge you now to join this circle of innovative professionals as they discuss the latest issues in health care cost management.

Dear Colleague:

Today, the most capable minds in the country are focusing their attention on a single, major problem: reducing our $400 billion a year health care bill without sacrificing quality.

Changes in attitudes, policies, and procedures are already producing cost-effective results. But what are they? How do they apply to your company? And what data, theories, and opinions are available now, laying the groundwork for future changes?

The answers are in the unique monthly magazine--BUSINESS AND HEALTH. Unlike any other publication now available, BUSINESS AND HEALTH keeps you at the forefront of thought and action on health care policy development. Its focus is on the major concepts, facts, and developments that in time yield the major savings we're all after.

A NETWORK OF EXCELLENCE . . .

Every issue of BUSINESS AND HEALTH contains pertinent articles written by top program directors, professors, consultants, legislators, and executives. People such as . . .

(please turn)

- Walter B. Maher, director of employee benefits and health services for the Chrysler Corporation;

- Harold A. Cohen, executive director of the Maryland Health Services Cost Review Commission;

- Carl E. Lindquist, director of employee benefits, United Technologies Corporation;

- Harold S. Luft, professor of health economics-University of California School of Medicine in San Francisco;

- Senator David F. Durenberger (R-Minn.), chairman of the health subcommittee of the Senate Finance Committee

Just as impressive are the readers of BUSINESS AND HEALTH--CEOs, vice presidents, benefits managers, personnel directors, and health program administrators from many of the nation's largest corporations. They rely on BUSINESS AND HEALTH to help them meet the challenge of rising health care costs. Corporations represented by our many readers include:

- Atlantic Richfield Corporation
- Ford Motor Company
- Metropolitan Life
- Proctor & Gamble
- Coca-Cola
- Exxon
- AT&T
- IBM

as well as hospitals, preferred providers, group practices, health maintenance organizations, and other health care providers.

Another valuable resource-available only to BUSINESS AND HEALTH subscribers--is the solid background and experience of its publisher, the Washington Business Group on Health. For over a decade, the Washington Business Group on Health has worked to assure the consideration of business's concerns in health care policy development.

SINCE WE BEGAN PUBLISHING BUSINESS AND HEALTH IN 1983, WE'VE BEEN ABLE TO SHARE THE FOLLOWING STRATEGIC SUCCESSES WITH OUR READERS:

- One large corporation began using nurse practitioners as primary care providers in a corporate in-house health care system, and was able to deliver services with a market value of $978,057 at a cost of just $469,562.

- A coalition of hospital trustees from the private business sector began taking an active role with hospitals, and in their first year helped reduce hospital stays for patients under age 65 from 837 days per year per 1,000 patients to 775, and saved the community $100 million over 20 years by convincing one hospital not to develop a new duplicative prenatal unit.

- One company implemented new incentive and health education programs, and was able to reduce a projected 20% increase in health care expenditures to just 5%.

- A company audit of disability claims led to a self-administered program, and savings of more than $750,000.

- Another company analyzed hospital use for nonsurgical back patients, applied intervention techniques, and reversed a pattern of nonsurgical back admissions that had cost them $1.4 million in one year alone.

These projects are just a small sampling of the thousands of important projects now underway nationally and covered by BUSINESS AND HEALTH so you can apply their techniques to your company and create your own success stories.

In fact--nearly 95% of BUSINESS AND HEALTH subscribers report taking some action based on the information they've read.

But don't just take our word for it. See for yourself! Find out why so many other professionals are finding BUSINESS AND HEALTH such an invaluable forum for discussion of today's pressing health care cost management concerns.

A CENTRAL SOURCE OF EXPERT INFORMATION ON THE MOST CRITICAL PROBLEMS FACING CORPORATE HEALTH CARE MANAGEMENT . . .

If BUSINESS AND HEALTH did not exist, it might be possible for you to elicit equally high-quality information on your own from leaders in the health care field. You could talk to them, follow their comments and programs in the newspapers, ask for copies of their research. But even if you could gather all this information, it would be an enormously time-consuming task.

But BUSINESS AND HEALTH does exist, providing you with a single source of comprehensive, yet concise information geared especially toward the corporate environment.

Featured topics have included second opinions, health care alternatives, and for-profit health care. These and other major subjects are covered from all angles: in cost management, health policy, and coalition reports, regular columns, and interviews, together presenting a variety of ideas, case studies, and data analyses.

BUSINESS AND HEALTH also includes such regular columns as:

- **Washington File** — An overview of legislative actions and federal agency decisions;
- **State Actions** — Developments on the state and local levels;
- **Small Business** — Addressing the specific needs and concerns of smaller organizations;
- **Labor Forum** — What workers are thinking and doing about corporate health care policy.

(please turn)

IF BUSINESS AND HEALTH LEADS YOU TO JUST ONE EFFECTIVE NEW APPROACH, YOUR SUBSCRIPTION CAN MEAN THOUSANDS OF DOLLARS IN SAVINGS TO YOUR ORGANIZATION

Today, the pressure is on health care providers and private industry alike to become more efficient, more competitive. By sharing successful experiences, as well as thought-provoking data and ideas, BUSINESS AND HEALTH helps organizations like yours get more for their health care dollars, maximize the health and productivity of their employees, and strengthen their corporate financial stability.

The rewards can be dramatic, yet the cost for a subscription is modest. What's more, your satisfaction is guaranteed. Review your first issue for 30 days. Read it cover to cover. Share it with your colleagues.

If at the end of 30 days you decide BUSINESS AND HEALTH really isn't what you're looking for, simply let us know. We'll cancel your subscription and send you a prompt and cheerful refund. No questions asked. Keep the first issue with our compliments.

If you cancel your subscription at any future time, you will receive a full refund for all unmailed issues.

Begin your subscription now by returning the postage-paid, preaddressed subscription form enclosed.

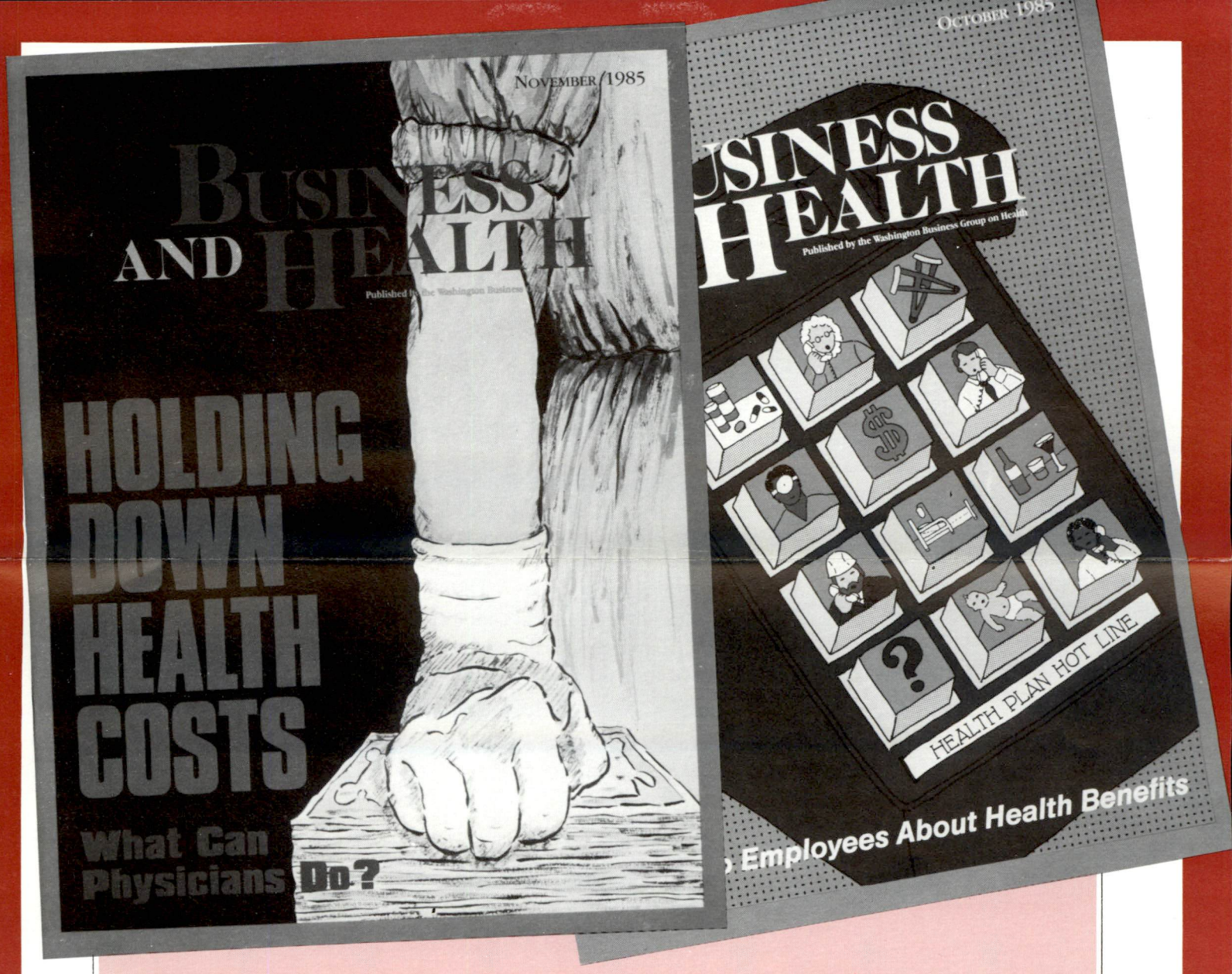
You'll be joining a select group of professionals from diverse specialties, all focusing their abilities on one of the greatest challenges facing business today: containing rising health care costs. Take advantage of their experience and insights by subscribing today to BUSINESS AND HEALTH.

Yours truly,

Willis B. Goldbeck

Willis B. Goldbeck
President

P.S. Subscribe to BUSINESS AND HEALTH today and begin benefiting from the knowledge of the nation's leading health care cost management experts. Just return the enclosed subscription card and we'll promptly begin your 30-day, no-risk, trial subscription. And remember -- the first issue is yours to keep whether you continue your subscription or not.



BUSINESS AND HEALTH

Where America's most respected names in corporate health policy meet

Controlling health care costs is a challenge that reaches into many areas—from government and private business to unions, hospitals and academia. Only **BUSINESS AND HEALTH** gathers the best, most authoritative information, ideas, and case studies from all of these disciplines, and brings it to you in one concise, monthly magazine. If you're involved in health care programs, policy, or delivery, you need the timely, intelligent, focused material that only **BUSINESS AND HEALTH** presents.

Return the enclosed subscription reservation card for your trial subscription now, or call TOLL-FREE 1-800-424-2959 (872-1766 in the Washington, D.C. area.)

Only **BUSINESS AND HEALTH** can bring on the latest discussion of today's health care

The more effectively a business manages its health care investment, the healthier the business...*and* our national economy. Today, health care expenditures represent a startling 11% of the GNP. Costs continue to escalate. And current health care attitudes and policies fall short of improving the general health and productivity of our work force.

Developing programs that work—for employers, employees, and health care providers alike—is a tremendous job that requires the top minds of professionals in many fields. By exposing yourself to their ideas and experience, available only in **BUSINESS AND HEALTH,** you can lead the way for your company.

Bringing featured topics into focus

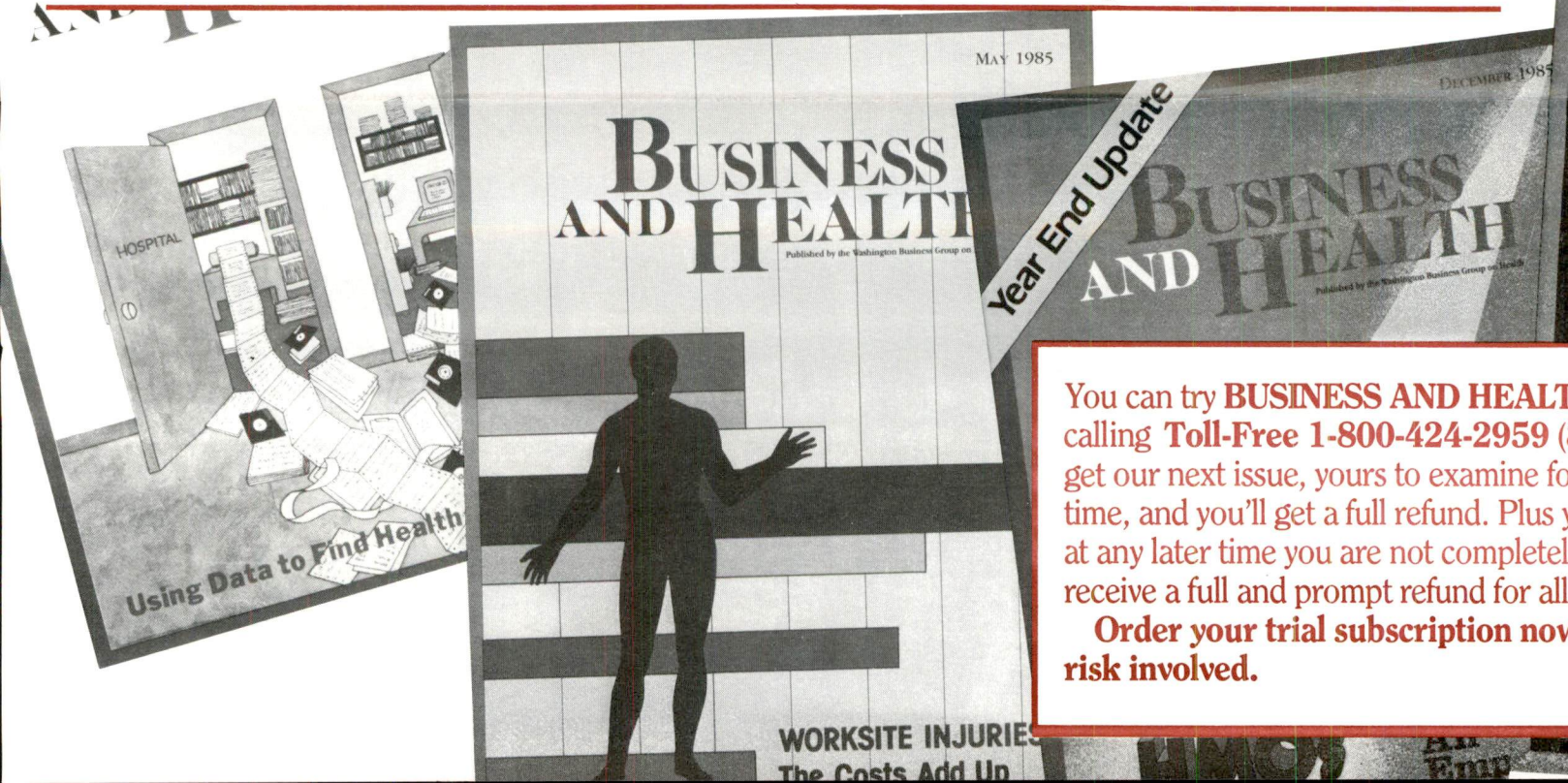
Month after month, **BUSINESS AND HEALTH** concentrates on the most significant issues in health care policy, and views them from a variety of angles.

For every topic, **BUSINESS AND HEALTH** presents concepts, implications, and analyses that will help sharpen your thinking, all written in the plain-English language of business, not policy jargon or medical terms. But significantly, **BUSINESS AND HEALTH** goes beyond the purely theoretical level to the pragmatic, presenting data you can put to work...case studies of programs you can implement...reference lists of articles and studies you can research...top authors you can contact for further information.

Here's just a sampling of how **BUSINESS AND HEALTH** presents multiple levels of discussion on individual topics:

- **Coalitions.** You'll learn what they are and how they can operate. But you'll also read how to form one, and how several existing coalitions have developed programs that have already yielded major savings.
- **Aging.** You'll understand the tremendous impact that both the aging baby boom and long-term care will have on public and private sector institutions. But you'll also read how new ways of evaluating and promoting fitness can help increase a worker's number of years of productive employment and save on retiree health benefits.
- **Wellness.** You'll understand the concepts behind antismoking, exercise, and incentive programs. But you'll also learn the mechanics for developing effective programs of your own, and benefit from the successful experience of others.
- **HMOs.** You'll examine the hidden costs of HMOs and find out how to determine your company's risk using employer specific data. You'll also read about the tremendous leverage the business community has with providers to get the health care it wants at a price it can pay.

Review **BUSINESS AND HEALTH** *for yourself, at no obligation, for 30 days.*



You can try **BUSINESS AND HEALT** calling **Toll-Free 1-800-424-2959** (get our next issue, yours to examine fo time, and you'll get a full refund. Plus at any later time you are not completel receive a full and prompt refund for all

Order your trial subscription nov risk involved.

you up to date policy issues

BUSINESS AND HEALTH is read regularly by nearly 10,000 key decision-makers like yourself. Here are their reactions...

"I have found more useful information between the covers of **BUSINESS AND HEALTH** than any other publication in the field. Every issue adds something to my fund of knowledge about health care."

— W.J. Sheehan
President
Toledo Business Coalition on Health Care

"**BUSINESS AND HEALTH's** comprehensive coverage each month of topical and timely health care issues assists me in my role as a major purchaser of medical care insurance."

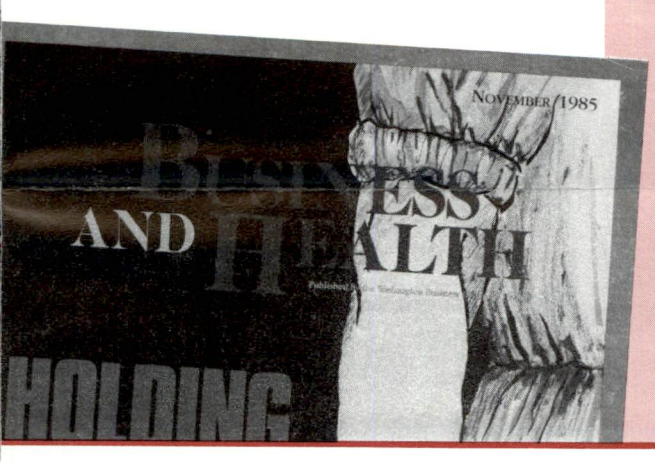
— Jack K. Shelton
Manager, Employee Insurance Department
Ford Motor Company

"Health care coalitions and their members need assistance in understanding community leadership issues. **BUSINESS AND HEALTH** is a tremendous resource for such information."

— James B. Kenney
President
Coalition Development Inc.,/
Executive Director—Minnesota
Coalition on Health Care Costs

"A concise and issue oriented format makes **BUSINESS AND HEALTH** one of the best sources of information on health care management available today."

— James B. Stowe
Vice President of Marketing
The Health Data Institute



TH by simply returning the enclosed card, or by 872-1766 in the Washington, D.C. area). You'll r 30 days. Cancel your subscription within that ou can keep the issue with our compliments. If y satisfied with your subscription, cancel and unmailed issues.
. The investment is small, and there's no

Subscribe now. You won't want to miss these important articles, appearing in upcoming issues of **BUSINESS AND HEALTH**

The Future of Work and Health...Problems of Medigap Coverage...Experiences of a Union Run PPO...Stress Reduction at Work...The Changing Nature of PPOs...Bridging Employer, Provider Concerns...Tracking Quality of Care

BUSINESS AND HEALTH is read by management in America's leading organizations, including:

American Express Co.
American Medical Association
American Pharmaceutical Association
Arthur Andersen & Co.
Atlantic Richfield
Blue Cross Blue Shield
Boeing
Citibank
Coca-Cola
Digital Equipment Corp.
E.I. Dupont & Co.
Eastman Kodak
Exxon
Federal Express
Firestone Tire & Rubber
Ford Motor
General Electric
General Foods Corp.
General Mills
General Motors
Gillette Co.
Hewlett-Packard
Honeywell Inc.
IBM Corp.
John Hancock Mutual Life Insurance Co.
Johns Hopkins University
Johnson & Johnson
Massachusetts General Hospital
Mayo Clinic
Mobil Oil
Motorola
Mt. Sinai Hospital
National Easter Seal Society
Owens Corning Fiberglass
Pacific Bell
Pfizer Pharmaceuticals
Pillsbury Co.
Pitney Bowes
Price Waterhouse
Procter & Gamble
RCA
Sears, Roebuck & Co.
St. Joseph's Hospital
TRW
U.S. Steel
Union Carbide
Xerox

Our readership is growing rapidly. Return the enclosed card now, and join us...

Updating you on the latest developments

BUSINESS AND HEALTH complements its articles on featured topics with important analytical treatments that bring you the latest word on cost management and health policy, as well as practical columns you can count on every month.

In each issue, for example, editor Jane Stein interviews a major figure in health care policy. Here's where you'll get fresh viewpoints from such key leaders as the president of the American Medical Association, AT&T's medical director, Hartford Hospital's chief administrator, the head of the Midwest Business Group on Health.

You'll also appreciate these brief, to-the-point columns:

News Roundup
You'll find quick summaries of late-breaking information on innovative benefit designs and cost containment research, as well as emerging problem areas for health policy.

Washington File
You'll not only learn about today's important laws and regulations, you'll get an inside look at the discussions, inclinations, and problems that are shaping tomorrow's decisions.

Law Notes
Our editors point out the significant trends revealed by individual cases from across the nation.

State Actions
What's happening in your state? Which states are leading the way with aggressive new policies and techniques? Here's where you'll find out.

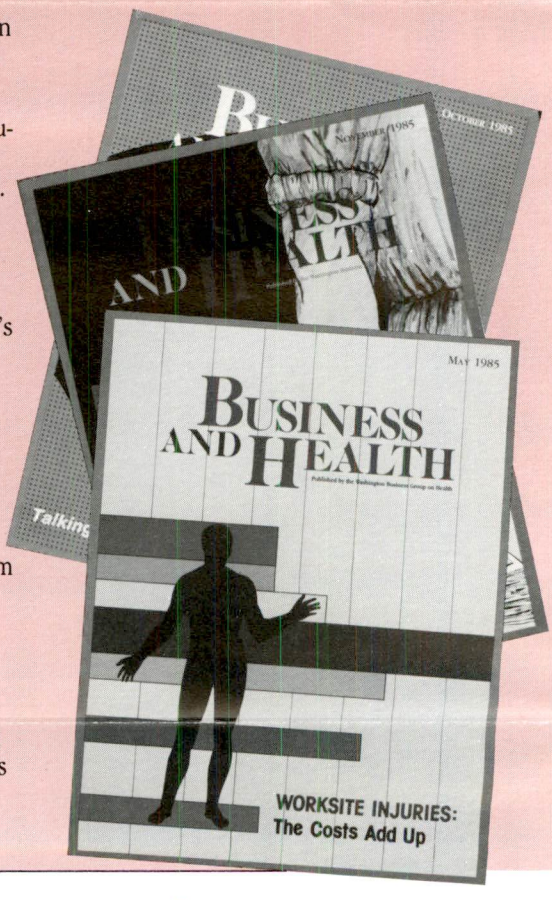
Corporate Culture
You'll read how different management techniques can contribute to your employees' health.

Data Bank
This valuable round up of studies and statistics brings you the latest findings in health care research.

International View
How is Europe's phased retirement program working? Here's where you'll find the answers—and plenty more from around the world.

Personal Perspective
Leaders from business, government, research, and more, share their personal views about health care policy with you—and stimulate new views of your own.

Small Business
Here's where you'll learn about programs that are working for smaller companies, where saving a few thousand dollars is as significant as a Tenneco's saving a million.



To order your trial subscription, return the enclosed card, or call TOLL-FREE 1-800-424-2959 (in Washington, D.C. call 872-1766.)

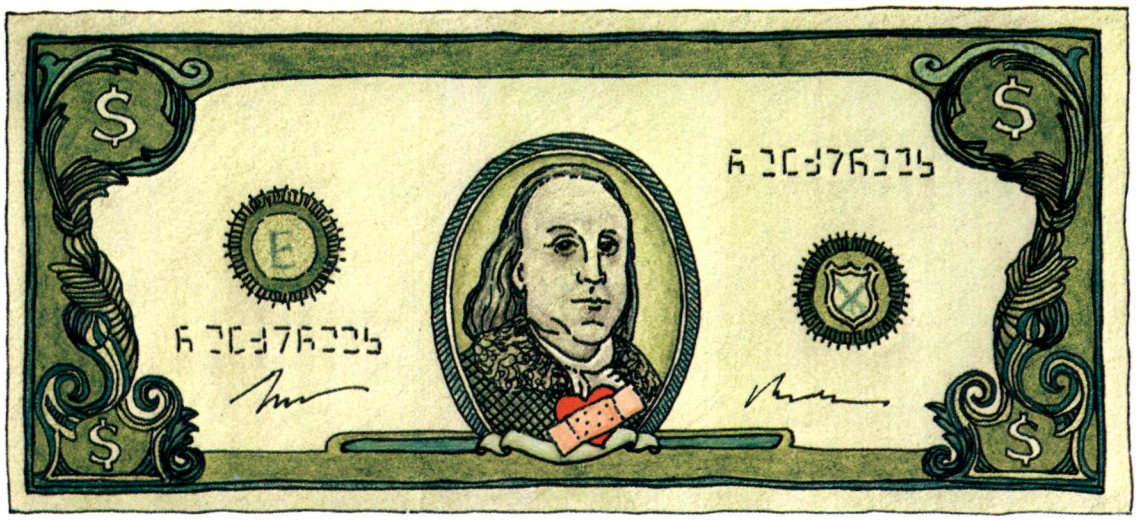
Washington Business Group on Health
P.O. Box 76927
Washington, D.C. 20013
(202) 872-1766 — 800-424-2959

APRIL 1986
$10.00

BUSINESS AND HEALTH

Published by the Washington Business Group on Health

TRANSPLANTS



WHO NEEDS THEM? ◆ WHO RECEIVES THEM? ◆ WHO SUPPLIES THEM? ◆ WHO PAYS FOR THEM?

Washington Business Group on Health

Family Health Programs

AIDS

* Over eighteen thousand men, women, and children have died of AIDS.

* Every state in the U.S. has reported at least one case.

* Worksite rumors have created panic among employees who risk their jobs by leaving the premises in fear of their lives, sue their employers, and further spread the fear of AIDS.

* Employer-employee disputes over hiring, firing, or discrimination can threaten years of community support for the company, and add to the suffering of the persons with AIDS or ARC and their loved ones.

Who Is Taking the Lead in Managing AIDS?

The Washington Business Group on Health has conducted a national search for those who are taking the lead in the management of AIDS and ARC.

We have invited many U.S. employers including Bank of America, RCA, CIGNA, Hospital Corporation of America, and Westinghouse, along with selected employees, family members, community health care representatives, and leading medical and legal advisors to discuss their experiences in managing AIDS and ARC.

AIDS – Employers, Families, and Communities
A National Leadership Conference
May 5 and 6, 1986
L'Enfant Plaza, Washington, D.C.
For more information or to register, call Ellen Menton or Judy Constantino, (202) 547-6644

AGENDA SUMMARY

Monday, May 5, 1986

7:00 p.m. Recognition Dinner and Overview of the AIDS Dilemma. Sponsored by Equitable Group and Health Insurance Company. A Division of the Equitable. Keynote Address: Representative **Henry A. Waxman,** Chairman House Energy and Commerce Subcommittee on Health and the Environment.

Tuesday, May 6, 1986

* Medical Review: The Virus, The Blood Test.

* Legal Issues.

* Cost, Coverage, and Case Management.

* Employer/Employee Dialogue: Developing Responsible Corporate Policy on AIDS/ARC.

* Coordinating Family and Community Resources for Crisis Diffusion, Education, and Case Management.

* A Case Study of Private/Public AIDS Collaboration. The Business Leadership Task Force of San Fransisco.

* A Case Study of Health Coalition, Employer, and Community Involvement. The South Florida Health Action Coalition.

* Workshop on AIDS: Strategies for Action.

BUSINESS AND HEALTH

April 1986
Volume 3, Number 5

Publisher
Willis B. Goldbeck

Editor
Jane Stein

Associate Editor
Suzanne Viau Klett

Assistant Editor
Lisa Lopez

Contributing Editors
Richard E. Curtis
State Actions
H. Robert Halper
Law Notes
James D. "Mike" McKevitt
Small Business

Editorial Secretary
Gail Jackson

Marketing Director
Marti Campbell

Direct Marketing Manager
Donna Lawton

Circulation Manager
Robert Mello

Art Director
Joan Dall'Acqua

Production Manager
Martha Dahlman

Advertising Manager
Lee N. Mullin

Editorial Board
John Billings
New York City
Merlin K. DuVal
American Healthcare Institute
Jonathan E. Fielding
University of California, Los Angeles
Emmett W. Hines, Jr.
Armstrong World Industries
Patrick F. Killeen
United Auto Workers
G. Robert O'Brien
CIGNA Corporation
John K. Meagher
LTV Corporation
Diana Chapman Walsh
Boston University
Christopher C. York
Citibank N.A.

Published by the
Washington Business Group on Health

Thompson Publishing Group
Business Agent

BPA Membership Applied for 8/85

Cover by Joan Dall'Acqua
Graphs by Lucinda S. Levine

PUBLISHER'S NOTE

Periodically, a society is tested more by the way it manages success than the way it responds to crisis or failure.

Articles in this issue of BUSINESS AND HEALTH depict the dilemmas raised by the emerging technology of transplantation. Well-meaning people are debating the merits of paying for transplants; these discussions are replete with natural prejudices that favor children over equally ill middle-aged alcoholics. Often lost in the emotional and economic pressures of these debates are the realities that (1) the entire discussion is possible only because of great scientific success, and (2) there is no chance that the U. S. will forbid further innovation, no matter what the cost or intellectual anguish.

The transplant issue really is not how or whether to pay for a liver, but rather how to manage innovation. We are challenged far more by the value changes needed to make this technological success part of an equitable national health strategy than we are by the relatively simple economics of that system.

Attaining an affordable unit price and increasing the success rate for various transplants are dependent upon volume, not policy. However, reaching that volume is dependent upon the articulation of a public value that makes organs available except in circumstances where an individual clearly has refused to permit donation of his or her organs. Physicians should not be burdened with responsibilities beyond medical analysis. Family emotion, religion and community standards just cannot be applicable if we are serious about saving lives and enhancing quality of living. In the final analysis, the public, not scientists, politicians nor insurance agents, will decide how the U.S. manages the success of the transplantation opportunity.

Success in reducing the rate of medical care cost escalation and increasing competition in the medical market poses another societal test. It took several decades to learn the price of not encouraging competition or cost management. We now are learning that there is also a price to be paid for our new successes.

The exposure and removal of hidden cross subsidies is real progress. However, success cannot be claimed if it results only in more people being denied care, rather than a reformed system. How we manage progress will say a lot about our values. On a more practical level, it will determine whether or not the positive aspects of private sector competition and cost management are to be retained.

The same energy and resources that have propelled employers from being passive payers of insurance to increasingly sophisticated buyers of medical care now will have to be applied to making our restructured medical system work for all Americans. Continued success demands a dynamic process that continually seeks balance between prudent buying for employers and responsible sharing of costs for the whole community; between investment in short-term acute care and long-term prevention; between support for our hospitals and the need for a much larger long-term care infrastucture; and between the visable drama of substance abuse and the more invidious crisis of generations of mentally impaired youth and unwanted babies.

The point is simple: Either we — purchasers and providers together — achieve a process for the management of success or we will surely find ourselves consumed by a struggle to manage growing failure.

BUSINESS AND HEALTH *welcomes letters from its readers. Please keep them as brief as possible and send them to Letters to the Editor,* BUSINESS AND HEALTH, *229½ Pennsylvania Ave., S.E., Washington, D.C. 20003. The editor reserves the right to abridge letters.*

Effective Health Claims Administration
State-of-the-Art or State of Mind?

By Mark J. Dubinsky
Senior Vice President-Claims
U.S. Administrators, Inc.

There is a range of approaches to effective health claims administration. It can be accomplished with a large cadre of claims reviewers armed with benefit plan booklets, sharp pencils, calculators, claim worksheets, manila folders stuffed with doctor's bills and drug receipts, and clerk typists generating checks and letters.

Or, claims may be handled using the latest in state-of-the-art computer systems, online data retrieval, fully automated benefits computations, electronic telephone response monitoring systems, microfiche retrieval capabilities and laser printed checks, benefit statements, correspondence and reports.

Each of these approaches, and all of the others in between, has its advantages and disadvantages. To one degree or another, however, almost any claims administration organization can get the job done--whether it's operating in the visor and arm-band era or in a high-tech mode--if the *people* doing the work have the right attitude.

The right attitude is the recognition on the part of the individual--and the organization--that the reason most claims have been received for consideration is because someone has been or is sick. The right attitude is one of caring; doing a good job because someone is counting on you. The right attitude is wanting to do it right the first time so that the family has one less thing to worry about. The right attitude is showing a sense of responsibility and a feeling of pride.

But isn't it impossible to put into place the latest high-tech computer systems and still provide a human touch? Isn't caring about the quality of care in conflict with today's emphasis on controlling health care costs? Isn't a concerned and caring attitude a little too "bleeding heart" in the evolving no-nonsense, business-oriented health care delivery system? At U.S. Administrators, we say *"Absolutely* Not" to all three.

The claims management systems at U. S. Administrators represent the latest advancements in technology. Yet, the nature of the system allows claims examiners to take responsibility for entire claims, from start to finish. These enriched responsibilities provide the claims examiner with the opportunity to feel a sense of ownership in the work and to relate to the outcome of the process.

We get involved--with the patient, with the physician, with the hospital. Our professional review staff discusses with the doctor the symptoms and diagnosis, the treatment plan, the prognosis. We make providers and patients aware of alternative modes of treatment to some of the more traditional (and more costly) approaches.

We provide the names of qualified, capable physicians the family can contact to obtain a second opinion concerning most elective surgical procedures. We discuss with the admitting physician the nature of hospital confinements *before* the patient is admitted to insure that hospitalization is the most appropriate treatment. We follow-up both during the hospitalization and after the patient has been discharged to monitor the quality of care.

We also ensure that whatever care we pay for as a health benefits plan administrator is medically necessary and appropriate. U.S. Administrators is effective in managing health care costs without losing sight of the quality care and personal satisfaction objectives of both providers and patients.

Any organization can set up procedures or implement a system to pay health benefit claims. Administrative workflow can be established, benefit parameters can be loaded onto a computer file, bodies can be put in place to go by the book and add up the numbers. But whether the claims operation is turn-of-the-century or state-of-the-art, the people involved must understand the responsibility they have and the ramifications of doing their jobs well, if the objective of the employee health benefit plan is to be achieved.

U. S. Administrators can ensure employers and plan sponsors that their health coverage programs will be viewed as a benefit, not as a burden. We are providing our claims staff, our professional review nurses, and our physician consultants with state-of-the-art systems to assist them. But most importantly, we instill in our staff the necessary state of mind to make it work--for the employee, the employer and the health care system.

U.S. ADMINISTRATORS, INC.

Placing the emphasis where it belongs -- on people.

For further information, contact:
U.S. Administrators, Inc.
3540 Wilshire Blvd.
Los Angeles, CA 90010
(800) 421-2814, Ext. 207

Name: _____

Title: _____

Company: _____

Address: _____

_____

Phone: _____

I am interested in information concerning the following services:

☐ CLAIMS ADMINISTRATION ☐ COST MANAGEMENT SERVICES

- Precertification
- Concurrent Review
- Second Surgical Opinion
- Individual Case Management

USA

BUSINESS AND HEALTH

APRIL 1986 VOLUME 3, NUMBER 5

TECHNOLOGY REPORTS

5 Transplantation: A Public Policy Dilemma **Roger W. Evans**
As organ donations increase, insurers may reassess coverage.

9 Transplants Can Improve Quality of Care **Albert Gore, Jr.**
Choosing the best providers ensures cost-effective care.

11 A Test of Ethical Principles **Gerald R. Winslow**
Transplant advances raise questions of availability and allocation.

HEALTH POLICY REPORTS

18 Financing Options for Long-Term Care Services **Tom Jazwiecki**
Public policy initiatives offer alternatives for elderly care.

25 Medigap Insurance: Pitfalls and Progress **Ron Hagen**
Elderly misperceptions, policy abuses stymie supplemental coverage.

28 ***The Corporate Perspective on Long-Term Care*** **Robert Levin**

31 Are DRGs Affecting Just the Elderly? **Paul A. Kerschner**
Families, providers grapple with ensuring appropriate care.

COST MANAGEMENT REPORTS

38 Impact of Outpatient Surgery **Ronald Lagoe, David Mankiewicz and John Milliren**
Inpatient, outpatient surgery rates combine to give full utilization picture.

41 Tracking Quality of Care in Military Hospitals **Michael J. Mestrovich**
Information gathering system promises cost savings, better care.

INTERVIEW

44 Taking the Side of Patients **Jane Stein**
Patient advocate Anne Coté says access to quality care is a basic right.

COLUMNS

47 News Roundup
BUSINESS AND HEALTH staff

49 State Actions
Marlene Larks

51 Washington File
Frederick C. Lee

52 Law Notes
H. R. Halper/P. Kazon

53 Technology Review
Gloria Ruby

55 Data Bank
BUSINESS AND HEALTH staff

57 Labor Forum
Robert Terruso

58 International View
Robert B. Fetter

60 Personal Perspective
Lex Frieden

BUSINESS AND HEALTH (ISSN 0739-9413) is published monthly, except for January/February and July/August combined issues, by the Washington Business Group on Health, 229½ Pennsylvania Ave., S.E., Washington, D.C. 20003. For editorial inquiries, telephone 202-547-0855. For subscription or circulation inquiries, telephone 1-800-424-2959. In Washington, D.C. call 872-1766.

Copyright © 1986 by Washington Business Group on Health. All rights reserved. Material in this publication may be reprinted with written permission of the publisher and appropriate credit.

Thompson Publishing Group, Inc., Washington, D.C., is the business agent for BUSINESS AND HEALTH. Washington Business Group on Health gratefully acknowledges financial support for BUSINESS AND HEALTH provided by The John A. Hartford Foundation, New York, New York. BUSINESS AND HEALTH is sold with the understanding that the publisher is not engaged in rendering legal, accounting or other professional service. If legal or other expert assistance is required, the services of a competent professional person should be sought. Editorial inquiries, requests for copyright release, unsolicited manuscripts, and advertising inquiries should be addressed to: BUSINESS AND HEALTH, 229½ Pennsylvania Ave., S.E., Washington, D.C. 20003. The subscription rate is $79 per year ($75 prepaid). Single copies are available at $10.00. Subscription inquiries and orders should be addressed to: Mary Scott, Washington Business Group on Health, P.O. Box 76927, Washington, D.C. 20013-6927. Please allow four to six weeks for address changes. Second Class Postage paid at Washington, D.C. **Postmaster:** send address changes to Washington Business Group on Health, P.O. Box 76927, Washington, D.C. 20033.

an analysis based on a variety of nonclinical questions. Once a new technology is regarded as therapeutic, however, coverage on behalf of public and private insurers usually follows. Insurers generally are reluctant to pay for technologies they feel are currently of limited therapeutic value, often arguing that such procedures are in the investigational stage. For instance, insulin pumps are not widely regarded as therapeutic, nor are cochlear implants. Insurers are not particularly enthusiastic about the prospect of supporting research by providing coverage.

Table I
Coverage for Organ Transplantation

Transplant Coverage	Blue Cross/ Blue Shield (%)	Commercial Insurers (%)	State Medicaid Plans (%)
Bone	N.A.	92	N.A.
Bone Marrow	N.A.	100	86
Cornea	N.A.	100	N.A.
Heart	80	85	50
Heart-Lung	72	69	26
Kidney	C	97	96
Liver	84	80	66
Pancreas	52	57	6
Skin	N.A.	97	N.A.

N.A. = not available; C = coinsurance coverage.
Source: Batelle Human Affairs Research Centers

Only recently have a few public insurers decided in favor of coverage for heart and liver transplantation. Kidney transplantation has been a covered benefit under Medicare's end-stage renal disease program since 1973, with private insurers now serving as coinsurers. As shown in Table I, coverage decisions have not been uniform, and administrators of the Medicare program have yet to make a decision concerning coverage of heart transplantation. The program, however, has elected to cover liver transplantation in children with rare congenital abnormalities such as biliary atresia, but such children could receive a liver transplant only if their parents qualified for Medicare.

Transplantation Access

An estimated 64.4 million people have no insurance coverage for heart transplants; 61.2 million individuals are not covered for liver transplants. Therefore, about 27 percent of the U.S. population is without transplant coverage for these procedures. As many as 3,900 people may need a heart transplant and 2,471 may need a liver transplant each year. In a survey of the American Society of Transplant Surgeons, 87 percent of the respondents indicated that ability to pay was a primary consideration in the selection of transplant recipients. As a result, patients without insurance are at a disadvantage in gaining access to transplantation of the pool from which organ donors are derived. Paradoxically, the people most likely to be donors are the least likely to receive a transplant.

Given the current environment of cost containment, it remains unclear how uninsured patients with end-stage liver disease or end-stage cardiac disease can gain access to transplantation. A frequent suggestion is that Medicaid benefits be extended to such patients. Medicaid programs, however, also are under severe economic constraints and, consequently, not all have elected to cover either heart or liver transplants. A recent report by the Intergovernmental Health Policy Project at George Washington University in Washington, D.C., concluded that 32 states and the District of Columbia offer coverage for liver transplants, yet only 24 states and the District of Columbia reimburse for heart transplants. Most disheartening is the fact that there is no assurance that anything will be done to meet the needs of these prospective transplant patients.

The costs of most transplants are high, as shown in Table II, but the aggregate costs of all transplant procedures are severely constrained because of the limited availability of donor organs. For example, given current donor organ procurement efforts, it is unlikely that more than 1,300 donor hearts would be available for transplantation per year. Distributing the costs of these 1,300 potential transplants over the range of all possible payers greatly limits the risk payers incur. A similar situation applies to liver transplantation although, given fewer restrictions associated with liver donation, more liver than heart transplants conceivably could be performed each year.

Thus, the aggregate costs of heart and liver transplantation are not excessive. Total expenditures for heart transplants are between $44.9 million and $116.9 million per year. If Medicare were to limit payment to only currently eligible Medicare beneficiaries, total Medicare expenditures would fall between $2.4 million and $5.8 million per year. These figures are relatively small given that very few, between 35 and 85 beneficiaries per year, would meet the criteria and receive a transplant, given the availability of donor hearts.

This picture could change, however, if the supply of donor organs increases. While a modest increase in donor supply can be anticipated, it is unlikely to satisfy the demand for hearts. Complicating this transplant need picture is the fact that patient selection criteria have been relaxed since 1980. In the case of hearts, the cut-off age has increased from 50 to 55 years, and diabetes is now considered a relative rather than an absolute contraindication. Such changes only mean that more people will be identified as needing a transplant, not that they will get one.

Benefits and Problems

The benefits of transplantation are substantial. In the case of the patient with renal failure, a kidney transplant affords freedom from maintenance dialysis. For heart and liver transplant patients, the benefits are even more profound; these are truly lifesaving therapies. This is not to say that transplantation is a perfect technology. Transplant recipients will, from time to time, experience ill effects associated with long-term immunosuppressive therapy, many of which are directly attributable to the drugs patients must take for the remainder of their lives.

Survival is perhaps the primary benefit associated with transplantation. Unlike in the past, transplant recipients now can expect to live a reasonably long and productive life. For example, it is estimated that 80 percent of all heart transplant recipients will live one year, 50 percent will live 5 years, and more than 25 percent will live 10 years or longer. About 50 percent of liver transplant recipients also will live five years or longer.

Frequently neglected in the assessment of the success of transplantation has been the rehabilitation and quality of life of transplant recipients. Although recipients have problems with their functional ability, their ability to work and their health status, they still compare well with patients undergoing other forms of lifesaving therapy. Arriving at a general statement about the quality of life of transplant recipients is difficult. However, if patient perception — as reflected by their state of well-being — is the benchmark of success, then transplantation must be cast in a positive light.

Legal commentators on transplantation issues have argued that every effort should be made to ensure equitable access to transplantation and that surgeons should be less selective in candidates chosen for transplantation. Yet transplant teams are being challenged on the basis of the cost-effectiveness of transplantation. There is great potential for the cost of transplantation to increase and the net benefits to decrease as patient selection criteria are relaxed. As a result, it seems the transplant team is faced with a real dilemma. Clearly, the goals of cost-effectiveness and equitable access are in conflict with each other.

Political Problems Remain

If it can be shown, as it has, that heart and liver transplantations are as cost-effective as other lifesaving therapies to which Medicare has made a commitment, then it is discriminatory to not extend similar benefits to the therapies in question. In carefully selected patients, heart and liver transplantations have achieved a status equal to that of maintenance hemodialysis, total parenteral nutrition and palliative care of the cancer patient. Using these unfavorable coverage decisions as a method of rationing resources, then, should be stated explicitly as so by its policy makers. Having done so, however, it then becomes necessary to rescind the coverage of technologies that are equal to or less cost beneficial than the technologies that have been denied coverage. This is essentially where the coverage determination process has gone awry. Under tight budget controls, such social injustices can be corrected only with a thorough examination of the coverage determination process in hopes that economic reality can be brought in line with political reality. It is inappropriate to confer upon covered technologies a sacred cow status when economic constraints suggest otherwise.

This public policy dilemma also applies equally to the private insurance industry, although employers often choose among the benefits they would like to offer their employees, thus effectively removing the insurance industry from the direct line of fire. For a price, private insurers generally are willing to offer coverage upon demand. However, this price is reflected in higher insurance premiums passed on to employers who, in turn, can pass them on to employees in the form of increased copayments and deductibles. In some respects, then, insurers are able to place themselves one step apart from policy dilemma described here.

Table II
Estimated Costs of Various Solid Organ Transplant Procedures*

Organ	Estimated Cost Low	High	Average
Heart	$57,000	$110,000	$95,000
Kidney	25,000	45,000	35,000
Liver	68,000	238,000	130,000
Pancreas	18,000	50,000	35,000

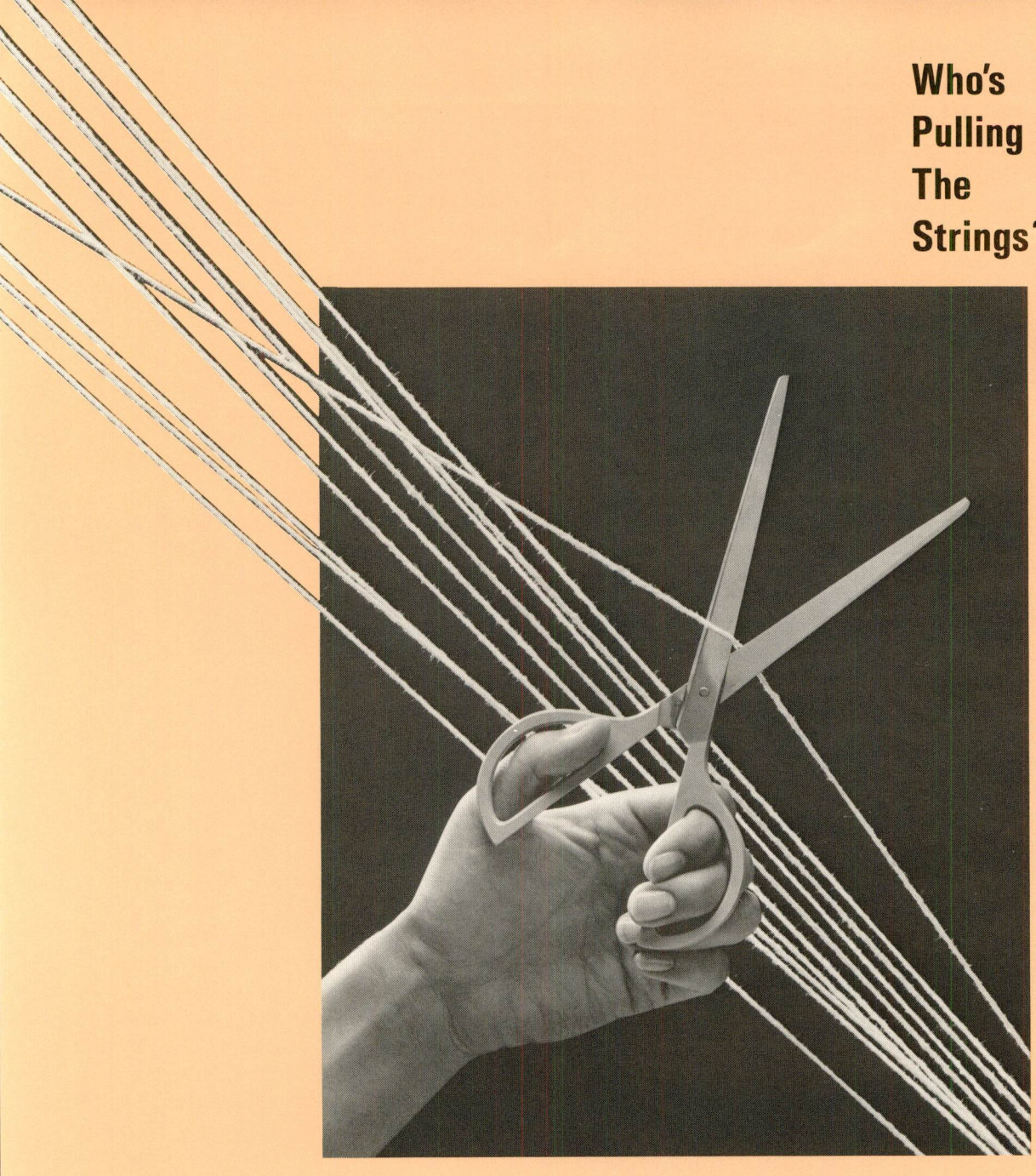
* Total first-year costs.

Source: Batelle Human Affairs Research Centers

In an Oct. 9, 1985, report, the U.S. Department of Health and Human Services (HHS) noted a limit on coverage of heart transplants to only those persons who meet current eligibility criteria. In addition, HHS recommended that reimbursement for heart transplants be limited to only those institutions that met a fairly strict set of criteria set forth in the report, thereby achieving designated status. Given these criteria, the report anticipated that about 10 institutions would qualify during the first year and about 20 the next year. The report concluded further that the "Public Health Service (PHS) now recommends that if the institution and patient selection criteria are applied, cardiac transplantation is deemed not only safe, effective and widely accepted, but also reasonable and necessary." However, only 10 months prior to the completion of this report in a separate document constituting a PHS review of the National Heart Transplantation Study, a very different conclusion was reached. It concluded that coverage of heart transplantation required further analysis of current data and did not support findings that heart transplants are safe or effective and that they result necessarily in a desirable quality of life.

This situation demonstrates that the major issues surrounding heart transplantation have been hardly scientific; rather they are deeply imbued with politics. Unfortunately, there is little reason to believe that the coverage determination process as it now exists within the government is little more than a political slave to the powers that be. Meanwhile, patient lives and well-being remain at risk in hopes that an unyielding environment of economic constraint will conceal sufficiently the key issues or divert appropriate attention away from them. Further, the coverage determination process with its emphasis on distinguishing between experimental and therapeutic procedures must be recognized for what it is — a method to ration health care resources. ■

Who's Pulling The Strings?



Most utilization review programs have strings attached. Cutting through these strings is easy with U.S. Corporate Health Management on your team.

USCHM's comprehensive set of utilization review programs improves quality of care while saving *you* health care dollars.

• *QuickAdmit* — Hospital Preadmission, Admission and Continued Stay Review. Cost-effective. Easy to use. Your employees receive personalized attention from our utilization review professionals — before and during hospitalization.

• *Managed Second Surgical Opinion* — A nationwide panel of 28,000 Board Certified surgeons provides your employees with the information necessary to make an informed decision regarding elective surgery. Alternative treatments are recommended in more than 40 percent of the cases referred for second opinion consultations.

• *Case Management* — The "missing link" in most cost containment efforts. We manage the medical care for long-term and costly cases — those cases which are potentially responsible for half of your health care bill.

• *Bill Audit* — USCHM's prepayment review of hospital bills focuses on medical necessity as well as inappropriate charges. Aggressive screening procedures improve your return on investment. You realize an average savings of four to one on reviewed claims.

It's time to cut the strings. The right utilization review program makes a difference. USCHM also offers a wide variety of health promotion products and services to meet your short and long-term health care management needs.

U.S. Corporate Health Management. Medical professionals in the business of keeping you in charge. *No strings attached.*

U.S. Corporate Health Management

Contact:
Anne Marie Hammond, Vice President
1661 Lincoln Boulevard, Suite 201
Santa Monica, CA 90404
(213) 452-5434

Transplants Can Improve Quality of Care

BY ALBERT GORE, JR.

Choosing the best providers ensures appropriate, cost-effective care.

TECHNOLOGY REPORT

Americans have always demanded the best health care no matter what the price. In the quest for quality, the U.S. spends more on health care than any other nation — some $450 billion in 1985. Americans' top-of-the-line tastes spurred a 200 percent rise in health care spending over the past decade. Employers, private citizens and government have been forced to seek new ways to control health expenditures.

Cost containment and quality care need not be incompatible. In fact, through good planning, common sense and a healthy dose of free enterprise, the U.S. could actually save money by insisting on quality.

Consider the growing success with organ transplantation. Transplants involve highly sophisticated operations using many of the new technologies that make health care so expensive. In the past few years, the number of heart transplants has increased dramatically, from 172 in 1983, to 346 in 1984 and 513 in the first nine months of 1985, according to the federal Office of Organ Transplantation. Yet making important choices about which transplants to perform, and where, can help to ensure that quality care is delivered while holding down costs.

Designating Quality Providers

When Congress passed the National Organ Transplant Act of 1984 proposing to limit the number of centers where transplants can be carried out, it sought to accomplish what it had intended all along — to give the Secretary of the U.S. Department of Health and Human Services (HHS) the authority to restrict Medicare coverage to certain institutions, providers or patients when medical evidence warranted it. If medical experts at the National Institutes of Health (NIH) and the Office of Health Care Technology Assessment find that a procedure is therapeutic only under certain circumstances, then Medicare reimbursement for that procedure should be limited to those cases.

To avoid paying for expensive operations that do not work, many third party payers, including employers and insurers, have taken a similar approach and begun restricting transplants to designated health care facilities that are best equipped to perform these procedures. Institutions seeking permission to carry out these operations first must demonstrate that they have the expertise, the resources and the track record to do so.

Designated facilities are a critical concept in the delivery of transplant services. By controlling the spread of transplant surgery, U.S. society can guarantee access for those who need transplants and will truly benefit from them. At the same time, this approach can assure high quality care and a high rate of success.

The necessary medical criteria have been developed for hospitals that wish to perform transplants and for patients who will undergo them. Following the lead of Blue Shield of California, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) soon will limit coverage of liver transplants to hospitals that perform at least 10 transplants per year and can demonstrate a one-year survival rate of better than 50 percent. For heart transplants, Medicare has proposed that a hospital have three years experience doing at least 12 heart transplants per year, with a one-year patient survival rate of 73 percent and a two-year survival rate of 68 percent. Of the hospitals now doing heart transplants, perhaps only a dozen would meet this tough standard. The Task Force on Organ Transplantation, established by the 1984 act, also has recommended unanimously that transplants be limited to such hospitals designated as meeting rigorous criteria. The National Heart Transplantation Study, conducted for HHS by the Battelle Human Affairs Research

Sen. Albert Gore, Jr. (D.-Tenn.) is the author of the National Organ Transplant Act of 1984 and a member of the congressional Biomedical Ethics Board.

Centers, concluded that the U.S. currently needs no more than 30 heart transplant programs. But there are already more than 70 programs in existence and hospitals are starting new ones all the time.

Cost, Availability Issues

Even though the administration has been slow to recognize their value, organ transplants are a success because they have been required to prove themselves in terms of cost as well as quality. Like many other sophisticated treatments, transplants remain very expensive. But up to now, they have cost comparatively little for each year they add to a patient's life. A heart transplant costs about $23,000 per year of added life.

"Cost containment and quality care need not be incompatible. . . . Through good planning, common sense and a healthy dose of free enterprise, the U.S. could actually save money by insisting on quality."

Organs for transplantation are extremely scarce because their availability is subject entirely to the willingness and permission of potential donors' families. Organ procurement is an area in which the government has always been deeply involved. The nature of the organ shortage — with patients awaiting organs at almost 200 hospitals around the country, and with the urgency of each individual's case constantly changing — requires an efficient system for organ sharing. At congressional hearings on the problem in 1983 before the House Committee on Science and Technology's investigations and oversight subcommittee, experts testified unanimously that organ sharing could best be accomplished by a national computer matching system.

In 1972, Congress had extended Medicare benefits to patients with end stage kidney failure. That decision allowed organ transplantation to flourish and now more than 7,000 lives are improved dramatically each year through kidney transplants. To provide for these cases, Medicare decided in 1973 to support a system of organ procurement agencies (OPAs). That portion of the kidney program has grown to include 110 OPAs staffed by 350 transplant coordinators at a cost to taxpayers of $70 million a year.

In passing the 1984 transplant law, Congress sought to address a problem the federal government had helped create. With the government paying for the organ procurement system, Congress wanted to make sure the system works as well as it possibly could. The transplant law provided for a computerized matching network to help link patients with donors and to distribute organs by recognized medical criteria. The administration has been slow to implement the idea, even though Congress endorsed the program by a vote of 396 to 6. After a long delay, HHS, in February, sent out a request for proposals from vendors to develop the computer system. However, the administration also has proposed to rescind most of a $2.6 million grant program under the law that strongly encourages federally funded OPAs to adopt highly efficient operating and management practices.

Focusing on Technology Assessment

Transplants represent only one aspect of a broader issue, the explosion of new medical technology. In an era of limited resources, Americans simply cannot afford to offer everyone unlimited access to every technology everywhere.

A partnership of public and scientific concerns is needed to make such hard choices. Health care policy making no longer involves just medical questions; it includes many ethical and financial considerations as well. A means for society to guide these critical decisions must be developed. In November 1985, a congressional Biomedical Ethics Board, modeled after the Office of Technology Assessment, was created to lead such discussions. The board is to "study and report to Congress on a continuing basis on the ethical issues arising from the delivery of health care."

Other recently established government entities should help improve the calibre of medical technology assessment (see BUSINESS AND HEALTH, March 1986, p. 56). But medical technologies in this country still confront a hodgepodge of arbitrary and unpredictable decisions. Consider once again the Reagan administration's assessment of heart transplants. At the moment, Medicare will not pay for heart transplants because the administration has deemed them experimental. Yet many hospitals have years of experience in perfecting heart transplants with one-year survival rates approaching 90 percent. Medicare will pay as much as $60,000 to treat pancreatic cancer in a patient unlikely to survive more than six months, while denying another patient comparable reimbursement for a life saving heart transplant. The abuse of the term "experimental" opens the technology assessment system to public criticism.

"Through designated centers, better organ procurement and careful technology assessment, a system can be designed that offers high quality care at a reasonable price."

The choice is ours. Through designated centers, better organ procurement and careful technology assessment, a system can be designed that offers high quality care at a reasonable price. Or chaos can continue to reign, and possibly turn the world's finest health care system into one that is merely the world's most expensive. The sooner we start planning for the future, the better life will be for all of us. ■

A Test of Ethical Principles

BY GERALD R. WINSLOW

Medical advances make transplants attractive, but questions of availability, allocation remain.

TECHNOLOGY REPORT

Organ transplantation and the dilemmas of ethics never were strangers. But advances in transplantation are producing a new set of difficult ethical issues. The focus of the discussions has shifted as organ transplantation has achieved far greater success not only in saving lives but also in providing a more acceptable quality for those lives.

More than three decades have elapsed since the first human-to-human transplants, or homografts, were performed. During that time, a number of ethical questions have been largely resolved. In a society such as the U.S., with its vast cafeteria of moral perspectives, complete resolution of ethical issues should seldom be expected.

In 1954, Richard Herrick received a kidney donated by his twin brother, thus becoming the first recipient of a homograft from a living donor. Then, the ethical questions largely dealt with the justification of last-ditch, experimental procedures. Should patients be asked to consent to such extreme measures? Was it morally permissible to take an organ from a healthy donor? Was not such donation a form of bodily mutilation condemned by centuries of Western moral tradition?

Gradually, these questions have been settled in favor of proceeding with transplantation. Moral philosophers and theologians have argued for the compatibility of organ donation with long held moral principles, such as the principle of beneficence.

As physicians turned more and more to the use of cadaver organs harvested from deceased patients, major questions arose concerning the appropriate criteria for determining that death had occurred and the right procedures for obtaining permission to take decedents' organs.

A significant step toward clarification of these issues occurred in 1968 when the Uniform Anatomical Gift Act was first proposed. According to the act, that now has been adopted in all 50 states and the District of Columbia, a mentally competent person who is at least 18 years of age may will his or her bodily organs for the purpose of transplantation. The act also permits family members to consent to the removal of organs from a deceased person.

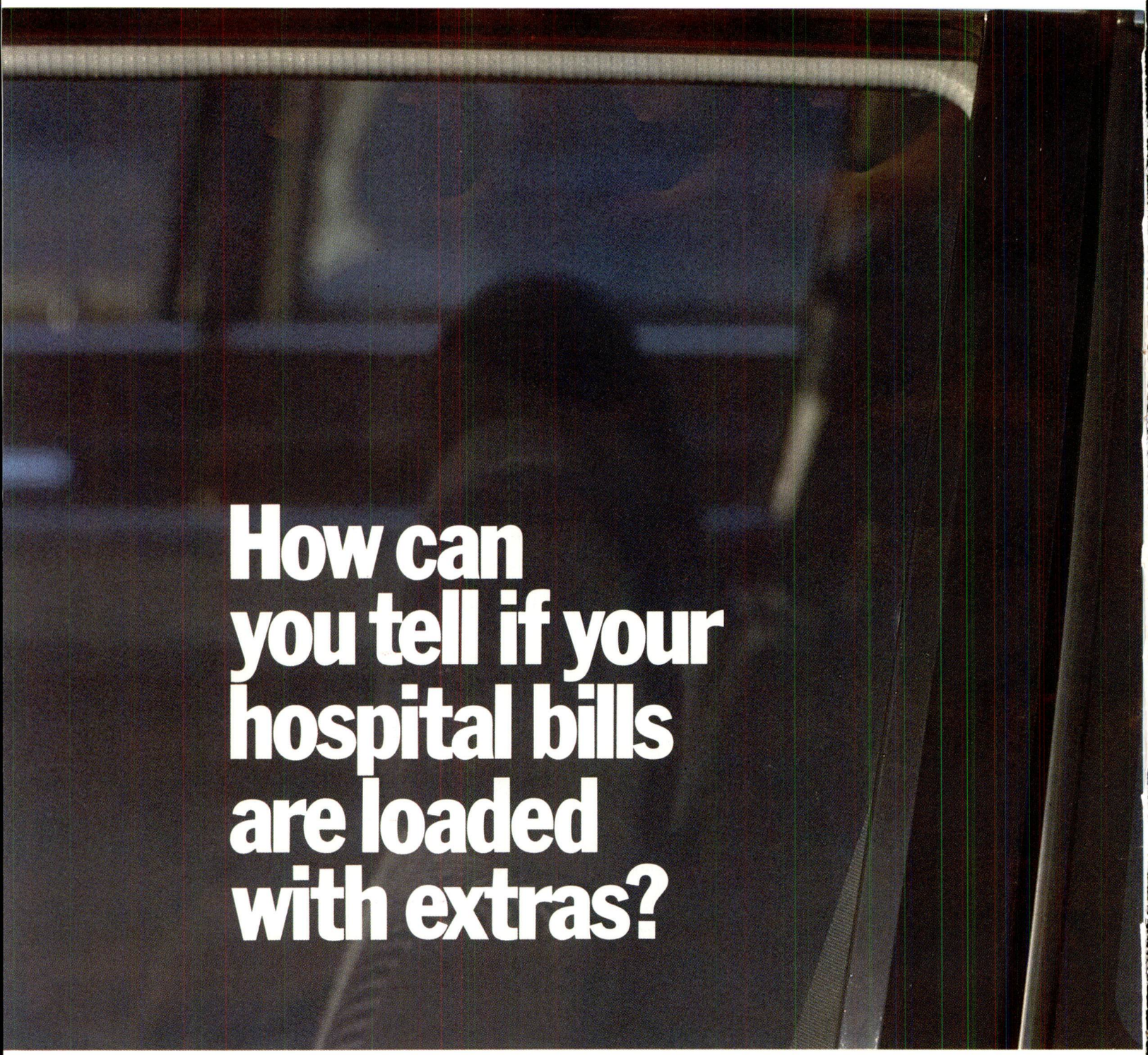
The need to be clear about the time when organs can be taken was one of the primary forces leading to a redefinition of death. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, in a 1981 statement also accepted by the American Medical Association, the American Bar Association and a number of other professional groups, concluded that: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead." An obvious implication is that even if a brain dead person's body is being sustained with a respirator or other mechanical means, that person should be declared dead and all attempts to sustain respiration and circulation should be terminated. Most states have revised their determination of death laws to include brain death criteria.

Clearly, the legal and ethical climate has adjusted to favor transplantation. And medical advances have made the procedure more attractive. But medicine's progress with transplantation also illustrates what appears to have become a recurrent pattern: Modern health care is frequently bedeviled by its own most newsworthy successes.

An Oregon Story

Major ethical questions now coming to the fore are revealed by the story of an Oregon child. Denita Alexander was born in October 1982, the daughter of an unwed high school student who relinquished Denita to the custody of the state. Soon after Denita's birth, her physician determined that she had biliary atresia, a degenerative liver disorder. The condition made her entire body itch

Gerald R. Winslow is a professor of religion at Walla Walla College in College Place, Wash.



How can you tell if your hospital bills are loaded with extras?

90% of all hospital bills contain "extras."

Whether you call them errors or overcharges, they still inflate your hospital bills and your claim payouts.

But when you use Intracorp's auditing programs, our nurse reviewers can eliminate those extras to save up to 10%. Because, unlike many auditors, our reviewers go one step further and determine the appropriateness of hospital stay and treatment rendered.

We pre-screen. You save.

Some auditors review bills indiscriminately. We don't. Intracorp pre-screens each bill so we don't waste money reviewing those that won't produce appreciable savings.

Hospital Bill Auditing the right way. At the hospital.

Simply scanning a hospital bill won't uncover all of the savings. That's why Intracorp goes to the hospital to compare all items on the bill against the patient's chart. Working closely with the business office, we get answers to key questions:

—Were all charges accurate?

—Was everything charged actually delivered to the patient?

—Were all charges applicable to the admitting diagnosis?

—Were all charges covered by the patient's insurance?

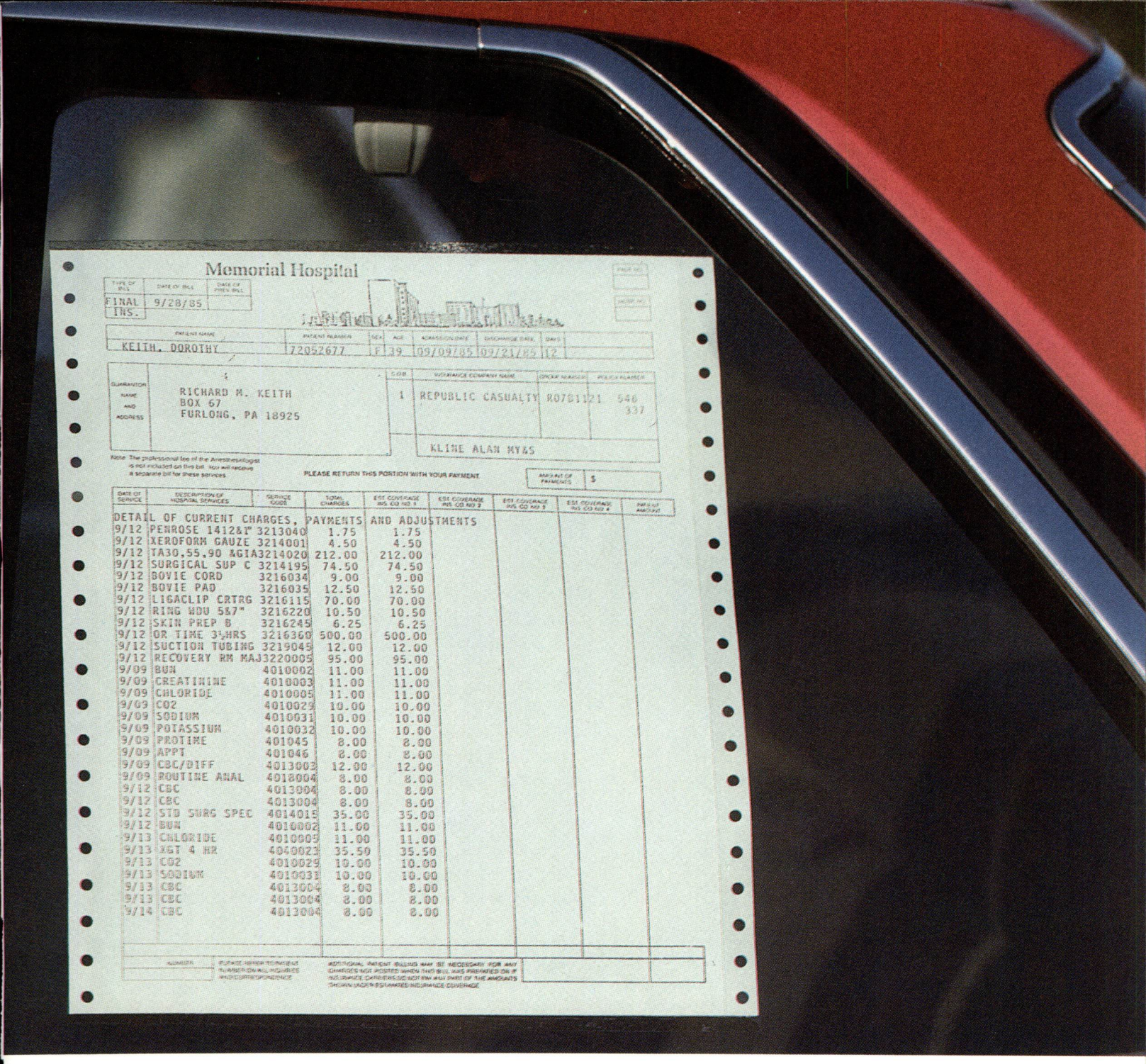
Utilization review takes auditing one step further.

Many auditors stop with a review of billing errors. Not Intracorp. Our utilization review process determines:

—Was inpatient care medically necessary?

—Was the treatment rendered customary for the diagnosis?

—Was the hospitalization period appropriate?



The right people in the right place—nationwide.

Intracorp has an unmatched national presence through its network of over 135 offices coast-to-coast. Using only registered nurse reviewers, our services are performed on site.

Why Intracorp?

Intracorp offers a comprehensive range of auditing services, nationwide. We have a 16-year experience base, and a presence in all major markets. Our professionals know local treatment facilities, procedures and practices, doctors and business staff. These professionals are equally knowledgeable of appropriate medical care and all types of insurance coverage.

This is the kind of expertise needed to read between the lines. And save you up to 10% on your hospital bills.

For more information on how Intracorp can reduce your hospital bills, mail the coupon or call us toll free, 800-345-1075. In AK, HI and PA, call collect, 215-687-9450.

Intracorp

Innovators in cost containment.

Mr. Daniel H. Davis, Senior Vice President
Director of Marketing, Intracorp
985 Old Eagle School Road
Wayne, PA 19087

B&H

Please send me your complete brochure packages on Hospital Bill Auditing.

Name _____

Title _____

Company _____

Street _____

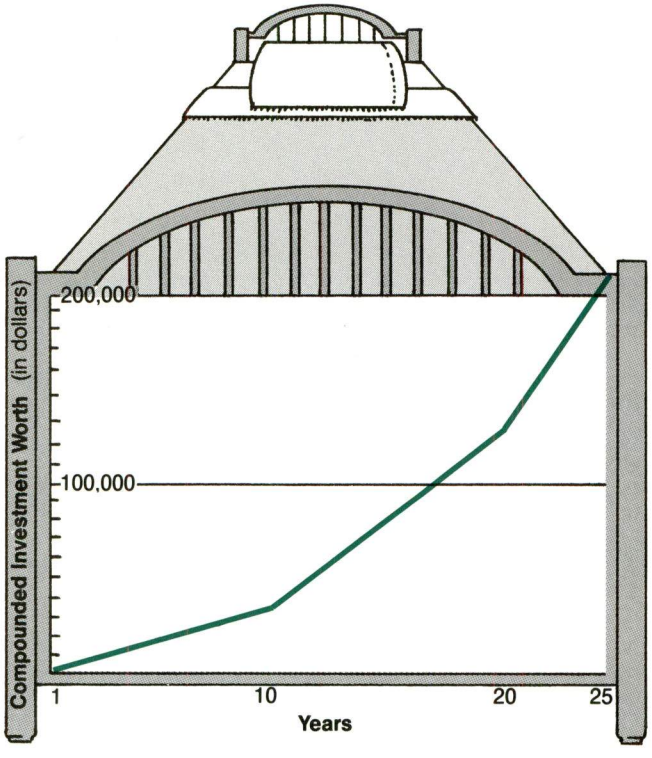
City _____ *State* _____ *Zip* _____

Phone _____ *Ext.* _____

paid upon enrollment. The HMO provides a wide range of acute, preventive and some long-term care services but the S/HMO includes chronic care benefits as well.

While evaluation data are not available on the S/HMO HMO concept, elimination of unnecessary and inappropriate institutional utilization, and ultimately reduction of the fragmentation among provider services and funding sources, are appropriate objectives in meeting long-term care service needs. Emphasis on risk avoidance through selective enrollment by either an HMO or S/HMO, however, could eliminate the effectiveness of either in meeting the long-term care needs of a significant elderly population most in need of protection. Integration of medical and chronic care services has been successful thus far in the United Kingdom and Canadian long-term care programs, where emphasis is placed on not only the institutional care needs but on the utilization of the informal and community care networks. An HMO or S/HMO could provide an effective gatekeeper between the informal and formal care networks. It is this very function that seems most essential, but missing, in the U.S. long-term care system to bridge the gap between formal and informal caregivers while maximizing the efficiencies within each.

Tax-Free Compounding of IRA Funds
(with $2,000 annual contribution at 10 percent interest)



Sometimes referred to as life care communities, continuing care facilities are a combination residential and medical-social environment that encompasses a blend of residential, security and health care services to the elderly and is a form of long-term care insurance without the risks associated with a fixed price indemnity contract. Typical continuing care facilities require an initial refundable or nonrefundable deposit fee and a variable monthly service charge depending on service levels.

Tax Incentives

Thus far, one of the most significant advances in public policies that have and will continue to affect positively the ability of individuals to privately finance future long-term care needs has been the extension of individual retirement account (IRA) eligibility, beginning in 1982, to all individuals regardless of whether they are members of other qualified employer pension plans. The powerful savings incentives in allowing up to a $2,000 income tax deduction for contributions to an IRA will enable individuals to accumulate funds tax free for future retirement use. According to the U.S. Treasury Department, more than 11 million taxpayers claimed IRA deductions on their 1982 tax returns, almost four times the IRA participation the previous year; this represents a significant trend towards greater availability of retirement savings in the future. Almost 13 million taxpayers contributed to IRAs in 1983, and in 1984, the number increased another 20 percent to 15.4 million.

An IRA is not an immediate or short run option for most individuals to meet the cost of chronic care. Tax-free compounding of IRA funds will result in substantial investment growth but it will still require 10 years of $2,000 in annual contributions at 10 percent interest to reach an IRA investment worth of $35,000. In 20 years, that investment could exceed $125,000, and in 25 years it could approximate $216,000 provided the $2,000 contribution is maintained at 10 percent interest (see graph).

However, two IRA statutory requirements pose drawbacks for financing long-term care. Mandating that there is no further deduction for contributions to IRAs after age 70 1/2 while also requiring that an individual must distribute his or her IRA funds beginning at age 70 1/2 — whether needed or not — fails to recognize both the dynamics and the demographics of the elderly nursing home population and could prevent an adequate accumulation of principal in the IRA account. With the average admission age of a nursing home resident over 75 years (and approximately 80 years of age for widowed females who represent a majority of nursing home residents), the mandatory IRA distribution age is several years prior to the typical nursing home admission. Thus, the tax code should be revised to enable an individual to continue contributing to and accumulating IRA funds beyond age 70 1/2, so that individuals accrue personal financial resources until such funds become necessary for support of health care.

Another approach is a health care savings account such as the type introduced as proposed legislation in October 1985 by Rep. D. French Slaughter, Jr. (R.-Va.). The proposal combines both employer funding and a 60 percent federal income tax credit for contributions and is intended to replace Medicare coverage for all health care costs except catastrophic expenditures. While health care IRAs are a reasonable concept for financing long-term care, they should not be developed to compete with the

general IRA, which offers greater income and investment flexibility to individuals. However, a specific purpose health care IRA can be marketed as a viable long-term care financing option and can even supplement a general IRA, if it is designed with the right incentives. This modified health care IRA offers a significant incentive for the beneficiary to purchase some form of long-term care health insurance because it incorporates a substantial tax credit and allows future fund accumulations spent on medical expenses to be excluded.

Another financing option is to allow voluntary copayments to a provider in addition to what the public assistance programs allow for services rendered to a specific patient. To encourage copayments, tax incentives should be targeted to individuals making such payments. By law, providers may not seek or solicit any payments from individuals or families that are in addition to what is reimbursed the facility through the Medicaid program for covered services. However, voluntary copayments for nursing home care were allowed until federal regulations were imposed in 1977 to prevent alleged abuses. The regulations required voluntary copayments from families as a prerequisite for admission to a Medicaid funded facility. Allowing such voluntary payments and tax credits for them not only would alleviate pressure on public programs to increase payments for long-term care in order to maintain adequate service levels, but would encourage families to assist in the financial support of institutionalized relatives and avail long-term care providers to another revenue source that could be used to enhance quality of care.

In addition, the current financial disincentives of federal income tax laws should be eliminated to encourage informal caregiving. For instance, Internal Revenue Code (IRC) section 151 allows a personal exemption for each dependent whose gross income for the calendar year is less than $1,040 for 1985. A disabled individual having a gross income of just $1,040, that is, less than $20 per week, may not be claimed as a personal exemption, even though the family may be the main contributor to the individual's support. Furthermore, IRC section 152 defines the term dependent as one who receives more than half of his or her support from taxpayer contributions. This definition ignores the reality of situations where the taxpayer contributes significantly to the welfare of an aged or disabled person but falls short of the 50 percent monetary requirement.

Another example of disincentives in current tax laws involves the dependent care credit. For tax years beginning after 1981, IRC section 44A allows a tax credit for up to 30 percent of qualifying child or dependent care expenses, which are paid for the purpose of enabling the taxpayer to be gainfully employed. To be eligible for the credit, a taxpayer must maintain a household for certain qualifying individuals — including a spouse or any dependent who is physically or mentally incapable of caring for himself or herself — to whom the taxpayer contributes more than one-half the support. There are three drawbacks to this credit that do not make it conducive to caring for the aged or disabled, or even utilizing adult day care programs. For married taxpayers, for example, the qualifying expenses are limited to the earned income of the spouse with the lesser income. Generally speaking, no credit is allowed if one spouse does not work. Second, taxpayers must contribute more than one-half the support for the individual to qualify as a dependent under IRC 152. Third, linking the credit to the more than 50 percent support requirement under IRC 152 dissuades multiple cooperative arrangements among family members, each of whom may be capable and willing to care for the individual, but only for a portion of the year. Each of these disincentives should be modified to permit the exemption and dependency allowances for the chronically ill and infirm elderly.

"A recent study in Massachusetts . . .concluded that in a sample of elderly persons 75 years of age and older who live alone, approximately 46 percent would spend down to impoverishment after only 13 weeks in a nursing home."

Creative Public Financing

In a 1985 report, the Maryland Governor's task force on Alzheimer's disease and related disorders recommended respite care as a most critically needed service for family caregivers of dementia victims. The report, citing epidemiological data from The Johns Hopkins University and Medical School, pointed out that there currently were 20,000 citizens in Maryland with dementia, two-thirds of whom are institutionalized. The report projected that by the year 2000, there will be 30,000 Marylanders with Alzheimer's disease and related disorders — 20,000 of them in institutions. This projection has tremendous health planning implications because there are currently fewer than 21,000 nursing home beds in the entire state. Ironically, the dilemma of Alzheimer's disease may epitomize the tragedy in U.S. long-term care policy, but it also may provide insight into the solution.

Finding a funding solution for respite care is not an easy task, yet it is probably the most important factor because it ultimately determines when and what type of respite services will become available. This service option could be developed under private long-term care insurance and would appear to be more marketable and less costly than other forms of service benefits. It can also be incorporated as a critical service element within a S/HMO type delivery system because of its linkage to the needs of the informal family caregiver and its potential to control utilization of institutional benefits.

Public funding as a total solution to a catastrophic chronic illness is not realistic from a public policy perspective. Yet given the assumption that families want to help, a Medicaid funded respite care option is a partial but possible cost-effective solution if it is made available before victims become impoverished and if it is targeted specifically to individuals who have:

- A chronic debilitating disease;
- A family support network that is both willing and able to provide informal care for any significant period of time;
- Limited personal financial resources that would be quickly exhausted if institutionalized.

In addition, minimums on age and required levels of expenditures for medical or caregiving needs also could be incorporated into the eligibility requirements for a respite care option. Copayment requirements also could be required to minimize and control fiscal exposure and utilization.

One example of a respite care option feasible under Medicaid can be described as a block time approach. Block time is essentially prearranged, periodic, but extended respite care in an institutional environment, such as a nursing home. It is intended to provide relief to family caregiving by apportioning the caregivers' effort between the informal and formal care networks. It likewise apportions the cost of caring for the victim between the family and the public assistance program, that is, the family absorbs the costs of providing informal care while Medicaid pays or contributes towards the cost of respite care. The amount of block time is progressive in that more respite care time allotments are available to family caregivers as the net worth or financial resources of an individual diminish. It should be emphasized that other noninstitutional forms of respite care easily can be accommodated and made available to families under this time sharing, cost sharing concept.

Catastrophic Coverage Needed

Catastrophic coverage is what Alzheimer's victims and their families need. A form of catastrophic coverage can be provided under Medicaid in the form of a respite care option to family caregivers, but to be effective it must be available before victims are impoverished. Until private long-term care insurance offers a practical policy alternative, Medicaid should offer respite care as a catastrophic insurance policy to families of targeted chronic victims — if only to maintain the future fiscal integrity of this public health care program.

Although the idea is probably controversial for a variety of reasons, a national health care lottery is a plausible, viable and painless alternative to the current Medicaid funding crisis. A health care lottery can raise substantial amounts of revenue. Whether federal or state, a lottery can be used to supplement current public expenditures on long-term care. In the case of federal sponsorship, lottery revenues can be earmarked on a per capita basis as current Medicaid monies are distributed, or on an aging population needs basis. While these state or federal lottery revenues can be distributed in a variety of ways to encourage quality long-term care programs, the funding should supplement, not replace, current public health care spending on long-term care. According to the National Conference of State Legislatures, the 18 established lotteries in 1983 (there are currently 23) generated more than $6 billion in gross revenues and approximately $2.4 billion in net revenues. Estimates in 1983 projected that similar lotteries in the remaining nonlottery states, including the District of Columbia, could generate an additional $8 billion in gross revenues and $3.2 billion in net revenues.

The Reagan administration announced in January its intention to propose an insurance plan to cover catastrophic illness for the elderly. Such a program is characterized by increased Part B premiums to Medicare beneficiaries to cover all acute and skilled nursing benefits without limitations. Individuals would be protected from the cost of chronic illness such as Alzheimer's disease through the creation of individual medical accounts (IMAs). This approach would be similar to IRA or health care IRA vehicles except that invested funds would go into a general trust fund instead of an individual's separate trust account. Contributions would commence only after an individual reaches a certain age.

The proposal is a significant step by the federal government in recognizing the need to develop alternative financing for long-term care. The proposal for IMAs does not offer the same state planning advantages as either the general IRA or health care IRA vehicle and may be difficult to market to a younger constituency. Likewise, prohibiting funding contributions until age 40 to 45 may also restrict the accumulation of principal in the trust fund and adversely create greater financial risk.

National catastrophic health insurance under Medicare is an option that needs further consideration. A second, but more politically sensitive option, would be to reconsider means testing Medicare and making Medicare a secondary payer when private health insurance coverage exists in order to create Medicare catastrophic insurance with greater coverage for chronic illness beyond the current skilled nursing benefit. For example, some retirement systems incorporate a basic health insurance benefit that may rarely be utilized because such payments are secondary to Medicare benefits. However, if such private health insurance policies were to become primary payers for basic health care benefits with Medicare catastrophic coverage supplementing them, Medicare could reorient its service benefits towards its original purpose — catastrophic health care coverage for the elderly.

There is no one solution to financing long-term care for the aged and disabled. However, public policy that addresses these financing alternatives will not only encourage the development of greater private financial resources, but also will provide greater incentives for informal family caregivers to continue providing such care. ■

Medigap Insurance: Pitfalls and Progress

BY RON HAGEN

Elderly misperceptions, policy abuses stymie supplemental Medicare coverage.

HEALTH POLICY REPORT

John Marks became concerned last Christmas when his mother told him she could not afford her annual trip from Ohio to visit her grandchildren in North Carolina. After pressing her a bit, he found out why. His mother had been spending $2,300 a year — fully 15 percent of her income — on four health insurance policies aggressively sold to her by an agent from a single company.

The situation of John Marks' mother is typical of the health insurance habits of Medicare beneficiaries, and it is reflective of the continuing — although somewhat abated — sales practices of an aggressive, bordering on fraudulent, nature surrounding the sale of private insurance policies intended to supplement Medicare.

Whereas Medicare was created to ease significantly the financial burden of securing needed health care for most seniors, in 1984, per capita spending for health care of the elderly was $4,202, of which nearly 25.2 percent was out-of-pocket. Medicare picked up only 48.8 percent, and even this contribution varied widely depending on whether or not the Medicare beneficiary was institutionalized.

Elderly Perception Problems

Its ever rising copayments and deductibles as well as greater differences between its reasonable charge determinations and actual provider charges are further compromising Medicare's actual contribution toward meeting the total health care expenses of the elderly, and erasing forever the notion that Medicare by itself is adequate protection. Simply stated, it is not, and this belief is shared by more than 70 percent of Medicare beneficiaries who have purchased at least one private, supplemental insurance policy to fill these gaps in the depth and breadth of Medicare coverage.

Ron Hagen is director of insurance services for the American Association of Retired Persons in Washington, D.C.

As a result, some elderly are making costly purchasing decisions. The pervasive fear among these beneficiaries is that their current coverage is somehow out-of-date and that these new supplemental policies, or Medigap plans, are comparatively superior. Their feelings frequently are accompanied by an almost irrational sense that the more policies held, the more comprehensive and better the coverage. Further, most Medicare beneficiaries today purchase individual coverage and do not have the advantage of the counsel or marketplace leverage of their former employer to counter the confusion engendered by the ever growing multitude of conflicting offers, claims and counterclaims. They often need an honest broker of information, yet hear only the self-interested pleas of sales agents or a variety of endorsed and paid personalities approaching them repeatedly through various media, the most visible being television and direct mail solicitations.

A 1985 study by the American Association of Retired Persons (AARP) illustrates the elderly's perceptions of the depth and breadth of Medicare's coverage vs. that of their Medigap plans, as well as what they or their children will pay (see table). What clearly emerges from these data are the elderly's misperceptions of the extent to which Medicare protects them against a variety of health expenses, most notably those related to long-term nursing and personal care services. For example, 79 percent of the elderly believe that Medicare will cover most of the cost of nursing home care. In reality, however, in 1984, Medicare covered only 1.8 percent out of $32 billion in total cost of nursing home care services (see graph).

One reason for the Medicare gap stems from the Jan. 1, 1986, U.S. Department of Health and Human Services (HHS) increase in the hospital insurance (Part A) deductible from $404 to $492. This increase was due primarily to the new Medicare diagnosis related group (DRG) hospital reimbursement system and its impact on ratcheting down the average length of stay while inversely

average inpatient per diem to which the hospital insurance deductible is tied. As such, a 23 percent increase in the deductible has provided many Medigap insurers the rationale to push their rates even higher since this gap is a primary supplemental benefit and one most typically marketed.

The second gap that older persons must cover is due to the increasing differential between actual charges by the provider to the beneficiary and Medicare's reasonable charge determination, or reimbursement. Some improvements have been forged here, most notably the overall increase in Medicare supplemental medical insurance (Part B) assignment rates as a result of legislative mandates on fee schedules for laboratory services, and Medicare's new participating physician program in which physicians accept assignment on 100 percent of claims. Still, the extent to which this latter development has intimidated physicians and other providers into accepting assignment more frequently is unknown. What is known is that beneficiaries face substantial Medicare shortfalls. For example, in paying for physician services alone, this liability exceeded $2.5 billion in 1984 and this does not even include beneficiary liability for the 20 percent Part B coinsurance.

Percentage of Elderly Misperceiving Who Pays for Nursing Home Care

Perceived Payer	Percent
Medicare	79%
Earnings/Savings	53
Private Insurance	50
Medicaid	17
Children	10
Relatives	2
Other	9
Don't Know	1
Total:	**221%***

* Exceeds 100% due to multiple responses.

Source: AARP/Gallup Long-Term Care Survey

Except in limited circumstances, very few of the Medigap plans, which cost an estimated $6.2 billion in annual premiums, go toward claim payments for outpatient prescription drugs or long-term nursing care for chronic conditions, thus creating a third gap in Medicare coverage. When a non-Medicare benefit is provided, typically it is either severely limited or it involves a benefit with very low utilization. Such marginal benefits improve the look of the benefit package for a very low cost without doing much substantively to enhance Medicare coverage.

Gap Filling Options

Like some other gap filling options older persons have, enrollment in Medigap plans is contingent upon enrollment in both Part A and Part B programs. Seven major options include:

• **Hospital Indemnity Plans.** Although not a substitute for good, comprehensive Medigap policies, hospital indemnity plans may be of assistance to those who wish to be protected against the more incidental expenses associated with hospitalization. Fixed dollar benefits such as a payment of $50 or $100 for each day in the hospital provide no protection against inflationary health care costs, yet at the same time are less subject to frequent and significant rate increases. With their benefits keyed to the number of days spent in the hospital, such plans leave individuals unprotected against big medical bills that do not entail hospitalization. In addition, the fact that hospital indemnity policies are widely advertised and are easy to understand makes them attractive to seniors.

• **Health Maintenance Organizations (HMOs).** These prepaid plans project a sense of security in that the fixed monthly premium covers many of the medical services that are needed. Membership in an HMO, however, may be pricey, especially for an individual over age 65. Not all HMOs permit persons over 65 to enroll; where enrollment is permitted, it may be only during a specified open time. Also, an individual may not live close enough to an HMO to use its services conveniently. Nationwide, approximately 115 HMOs have signed up for risk contracts with Medicare to enroll individual Medicare beneficiaries in their plans. Medicare pays the HMO a monthly fee; members usually supplement that with another fee and have many of their health needs covered. More HMOs have filed applications for risk contracts with HHS and will offer individuals the HMO option this year. Beneficiaries also may have this capitated, prepaid option available to them through a former employer's health benefits plan.

• **Continuation of Employer Group Insurance.** Many people receive health insurance as a fringe benefit where they work; others participate through a multiple employer trust or other voluntary association. Individuals must check with the administrator of their health benefits plan to see if this coverage can be continued after age 65, and if so, under what financial arrangements. In many cases, the coverage can be continued, reduced and/or the premium may increase. In some cases, the new coverage will take the form of a Medicare supplement policy; in others, it may resemble the previous policy. Approximately 40 percent of all retirees currently have some if not all premiums paid for by their former employer. If the group health policy can be continued or converted to an individual one, its coverage and cost can be used as reference points against which to compare other options. In some cases, the preretirement health insurance carrier merely offers retirees the option of converting their plan to an individual policy without paying any portion of the premium. Retirees should keep a close eye on a preexisting conditions exclusion or any other major limitations.

• **Major Medical Plan.** Intended to cover large medical bills, major medical insurance typically has a sizable deductible, such as $500 or $1,000, that must be paid before the insurance company pays anything. This insurance can be used as the sole health coverage, with the individual absorbing the user costs, or can be used in conjunction with underlying coverage, which will pick up some of the smaller medical bills. In many parts of the country,

it is hard or impossible for a person 65 or older to buy major medical insurance. Individual major medical policies, like some Medigap plans, can be heavily underwritten and result in coverage being declined to a significant number of 65-plus persons. A major medical policy may or may not cover Medicare's deductibles and copayments, but if it does cover them, the price of the policy increases. To keep premium costs down, it may be best to use this insurance only as catastrophic coverage, so that any large bills would be covered. The small and medium-sized bills would be split between the individual and Medicare.

• **Medicaid.** In 1984, Medicaid paid some $19 billion, or about 13 percent of the health care bills of people over the age of 65. Eligibility rules and the benefits vary from state to state. In New York, for example, an individual's annual income must be $7,200 or less to qualify for Medicaid. In Alabama it must be $6,048 or less. These figures are for two-person households.

• **No Added Protection.** Some individuals choose to use Medicare as their only health insurance. Since Medicare pays well under half of the average person's bills, this is usually not recommended.

• **Dread Disease Insurance.** This is another limited benefit health insurance policy. Given its exceedingly narrow focus and typically low loss ratios or benefit payout, it can be heavily underwritten and is most often marketed to older persons by addressing their fear of cancer, heart attack or some other serious illness. Several states have prohibited the marketing of this type of policy altogether because it sells itself on people's fears.

Of all these options, the one to watch closely is the development of HMOs and similar capitated, managed care systems for seniors. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1983 for the first time allowed HMOs and other competitive medical plans to go at risk. With relatively comprehensive benefit packages, paperless claims processing, complete assignment of all claims, and the relatively predictable nature of enrollees' monthly out-of-pocket payments, this option is more attractive than the previously described plans. Presently more than half a million Medicare beneficiaries are enrolled in such plans, putting creative, competitive pressure on traditional indemnity insurers and Medigap carriers.

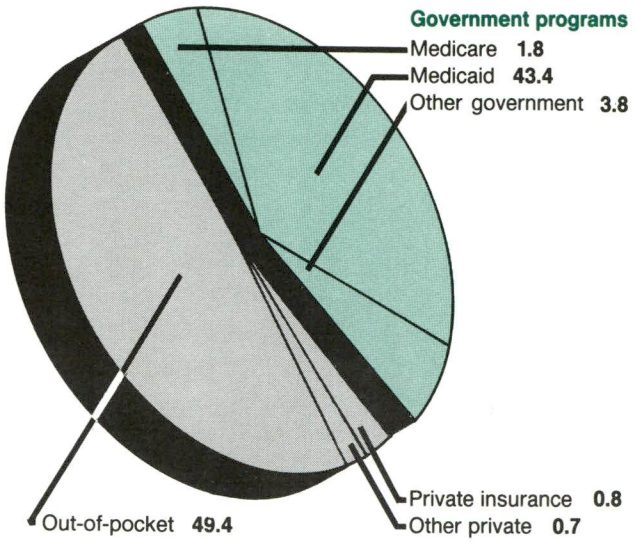
Problems Remain

Despite these options, beneficiaries still face possible marketing abuses and confusion with policy directives. The most notable is perhaps the near fraudulent misrepresentation of a solicitation as an official notice from Medicare, Social Security or the federal government. Such a misleading approach may include an official looking brand name on the outside envelope with words to the effect of "Supplement to 1984 Medicare Benefits, as dictated by federal statute."

Other ploys include the creation of a front organization whose name resembles that of a reputable senior citizens group and, that either through an agent call or direct mail package, gathers survey or research data. This information is then sold with a list of prospects to another insurance company or subsequently used by the generating agent to solicit for a variety of insurance products. Such names may be sold and resold many times.

The manner in which a policy is rated can be confusing. The difference between a community rated plan and entry or attained age rating is frequently not thoroughly explained at the point of sale. This can result in subsequent confusion and consternation as policyholders face what can be significant rate adjustments for renewals based on their age and possibly other factors. It also may be more difficult and risky at that point for individuals to even secure coverage. Clearly, state regulators need to be more demanding of insurers regarding the explanation of how various policies are priced and what the recent and projected loss experience has been.

Source of Funds for Nursing Home Care in 1984
(in percent)



Source: Health Care Financing Administration

Disclosure of policy limitations and exclusions is an area where much progress has been made but where greater regulatory vigilence is probably called for. All too often Medigap buyers guides are merely delivered and not explained by the agent or company. Outlines of coverage, required to be delivered at time of initial solicitation, are potentially helpful but seldom ever fully explained by the agent. Also, it is important that the potential policyholder understands the basics of Medicare and how it works in order to make an informed purchase decision. Insurance agents usually do not know these basics and what gaps need to be filled.

Problems with renewability also abound. Most of these relate to deficiencies in beneficiary understanding of the condition under which their policy will not be renewed. Medigap policies can be guaranteed renewable, conditionally renewable or class cancellable, or even re-

A Corporate Perspective on Long-Term Care

The development of long-term care benefits has been an enigma for many American corporations and has sparked the interest of their employees and retirees. Because these employers are witnessing an unprecedented growth of their retiree populations, many also are experiencing the inadequacy of traditional medical plans in meeting their retirees' long-term needs. Even retirees with generous company pensions are not immune to the high costs of nursing homes and other long-term care services that traditionally have not been included in health coverage.

Employer, Employee Concerns

Company employees also are expressing concern about their future needs and those of their aging parents. The issue of elderly dependents and the difficulties of the working caregiver have increased with the influx of working couples and single working parents. Yet at the same time, companies are becoming more and more concerned about the overall cost of their benefit plans.

Uncertainty about governmental requirements for funding benefit plans and their tax favored status, and the specter of additional state requirements for other benefit provisions are some of the other issues that have given plan designers pause. Several recent court rulings implying that certain retiree benefit provisions are not retractable have slowed employer interest in developing experimental designs, instigating employer fears that any new or experimental additions to benefit plans may be deemed permanent by the courts.

Some employer medical plans, however, already incorporate payment for long-term care in the form of liberal hospice benefits and home health care, and for extended stays — up to as much as 730 days in some companies — in skilled nursing facilities. One major employer, Eastman Kodak Co., provides an actual custodial care benefit, paying up to a lifetime maximum of $6,000 for home based or institutional custodial care. Yet even this unique benefit will only cover a few months of nursing home care.

Often defined in company medical plans as care given for meeting nonmedical personal needs or for assisting in the activities of daily living, custodial care is a source of concern for some plan designers and benefit administrators. In many instances, older patient needs are ambiguous, and in the changing nature of modern medicine, a condition requiring mere custodial care one year may be transformed into an illness responsive to medical treatment the next. For example, Alzheimer's disease is one of these gray areas in corporate medical plans that is categorized — depending on the company plan — as either merely custodial or eligible for medical care reimbursement. Cost saving strategies also come into play as some companies have begun to back off from commitments to long-term care. One midwestern manufacturer, in an effort to reduce costs, recently changed its Alzheimer's coverage categorization from that of a medically treatable illness that has a 730 day reimbursement entitlement, to a nervous or mental disorder with a maximum coverage of 240 days.

New Approaches to Long-Term Care

The following are examples of the kind of steps employers can take to meet the long-term care needs of their employees and retirees:

- **Benefit Redesign.** If accepted by employees and retirees and if deemed legal by the courts, benefit redesign may be an effective means to incorporate long-term care. The benefit packages currently being redesigned at many companies often require increased employee or retiree participation in the payment of coinsurance and deductibles. The trade-off in many cases has been the development of stop-loss coverage for catastrophic care. This type of redesign, which incorporates higher beneficiary payments in exchange for more insured coverage, will be a likely model in the development of long-term care alternatives.

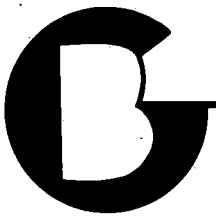
- **Group Long-Term Care Insurance.** Once insurance companies are better able to determine their risk, they will be trying to sell employers on the idea of group long-term care insurance. Current corporate interest is directed toward plans that emphasize employee contributions. Metropolitan Life Insurance Co., Aetna Life and Casualty, and The Prudential Life Insurance Co. are some of the insurers that are researching and developing such plans.

- **Corporate Sponsorship of Long-Term Care Research.** Independent of plan provisions, several companies are funding research and demonstration studies to assist in the area of long-term care. Allied Signal Corporation is one such company. Its studies have supported Alzheimer's research, and future targets include depression, osteoporosis and stroke.

- **Corporate Sponsorship of Informal Care.** Employers are beginning to look at some of the more informal ways in which long-term care needs may be addressed, including the use of existing retiree networks as a source of services for both the retiree population and the parents of current employers. In some companies, retirees already provide services such as home visitation, meal delivery, and respite care for families. These services often are associated with traditional custodial care or may help prevent the need for future custodial care, including institutionalization. Levi Strauss & Co. is one employer that has established a system of retiree coordinators, whereby volunteers are paid a stipend to organize and administer a variety of support services and social activities for fellow retirees.

Corporate interest in promoting retiree initiated, informal care will grow only as companies recognize that self-help and volunteerism can be greatly supported without significant corporate financial contributions. Given a reemphasis on the concept of the corporate family, these types of support programs offer a means of addressing the continuing enigma of providing quality, cost-effective long-term care. ■

Robert Levin, Washington Business Group on Health



GENERAL BENEFITS CORPORATION

IS YOUR FUTURE

Developing *Total Benefit Programs* for employers with *Total* Health Care Cost Controls.

General Benefits Vertically Integrated Data Base System (G.B.D.S.) provides the full range of products, services and consulting for:

- SELF FUNDING PROGRAMS
- FLEX-BENEFIT PROGRAMS
- 401(K)
- NEW *"SEVERITY"* UR/CC PROGRAMS (QUALITY OF CARE)
- DEVELOPMENT, MANAGEMENT, ADMINISTRATION OF ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS
- COMMUNICATIONS
- CONSULTING
- COMPLETE LINE OF SUPPORTING INSURANCE PRODUCTS.

General Benefits JOINT VENTURE with Laventhol & Horwath gives you the advantage to design your benefit program for the 80's and beyond.

Corporate Office
303 Fellowship Road
Mount Laurel, New Jersey 08054
609-235-6200
Southwest Office
3050 Post Oak Drive, Suite 1700
Houston, Texas 77056
713-622-4364
Midwest Office
100 South Prospect Ave.
Park Ridge, Ill. 60068
312-698-1145 or 1146

For more information, mail this coupon or call us at 609-235-6200.
Mr. Elliot Mallon, President
General Benefits Corporation
303 Fellowship Rd., Suite 200A
Mt. Laurel, NJ. 08059

Name:_____
Title:_____
Company:_____
Address:_____
Phone:_____

newable at the option of the company, with cancellation usually coming with 30 days notice. Experts in this area typically recommend the purchase of policies that are either guaranteed renewable or conditionally renewable, with cancellation in the latter case only resulting if the company discontinues the entire group of policies of which a particular individual's is a part, that is, all policies of this type in a particular policyholder's state. Of course the conditions of renewability, with attendant risk selection-retention implications, can have a very direct impact on policy loss ratios and, in turn, premiums.

Policies that are duplicative or overlapping with current coverage present another problem. While relative policy standardization has been achieved, there are enough nuances, twists and turns so that it is still difficult to make comparisons of Medigap plans. There are a great many holes in the aged's knowledge of Medicare and their individual assessment of what risks it may be prudent to seek coverage for. Thus, even with near perfect information there will in all likelihood continue to be a significant number of older persons who will only feel secure with two or three more Medicare supplement plans.

"Insurers. . .continue to underestimate the responsiveness of the elderly as a burgeoning group of prospective insureds anxious to protect themselves against a virtual plethora of remaining gaps in their Medicare coverage."

The financial stability of an insurance company is also of importance to the prospective policyholder. Unless the potential customer has independent knowledge of a company's financial health, that individual should seek an independent assessment of the company's financial status. It may also be advisable, albeit seldom done, to check with the appropriate state insurance department as to the volume and nature of any complaints against a particular company and the final resolution of any endorsement actions.

State regulators and insurers need to delineate more clearly policy limitations and exclusions. Whether it is a preexisting condition exemption, renewability, limitations on the nursing or chronic care benefit, or the circumstances under which rates may be adjusted, this information needs to be more clearly stated in lay terms and displayed or conveyed in a comprehensible format.

Federal, State Reform Efforts

Despite the confusion among the elderly about their Medicare coverage, in recent years there has been a certifiable explosion in information aimed at older persons dealing with Medicare and private, supplemental health insurance. Some states are publishing guidebooks, initiating information forums and peer counseling programs, ranking policies and becoming much more proactive and protective of the health insurance interests of their seniors. For instance, Washington state has developed a supplemental health insurance benefits advisors program to counsel senior citizens making purchasing decisions. Everything from state investigations exposing abuses to public service announcements using local broadcast media are helping produce a more knowledgeable public.

Furthermore, 46 states have adopted the National Association of Insurance Commissioner (NAIC) model law and regulation for Medigap insurance, which provides a blueprint for those states that have limited penalties or no laws governing supplemental policies. In fact, three states have gone beyond these minimum standards and have included additional protection.

Introduced in 1980, the Baucus amendment to the Social Security Act represented one of the first federal intrusions into what has been the exclusive state franchise to regulate the business of insurance. Through this amendment, Congress mandated certain minimum standards to govern the sale of Medicare supplement policies. Additional requirements state that insurance policy administrators now must provide detailed disclosure provisions upon introducing their plans. In addition, they must provide a buyer's guide and an outline of coverage to prospective purchasers. Prior to Baucus, more than half of the commercially available Medigap policies were paying out less than 50 cents in benefits for each premium dollar received.

While Baucus and the multitude of conforming state statutes and regulations it spawned have brought a settling out of the Medigap marketplace, a great deal of flexibility exists within these minimum standards to design and market a wide variety of Medigap plans. Unfortunately, most insurers have not even tested the limits of this somewhat prescriptive framework with their gap filling products. Therefore, the elderly remain to a great degree still at risk for a variety of acute and long-term care conditions that remain largely uninsurable even in the face of unprecedented consumer demand for insurance products that fill a variety of these niches.

Also under the Baucus amendment, anyone convicted of engaging in fraudulent or abusive practices is subject to a fine of up to $25,000 and/or imprisonment for up to five years. These standards apply only to policies labeled "Medicare supplement policies" and not to other types of health insurance policies such as major medical, hospital indemnity, nursing home or long-term care and dread disease.

Insurers and various alternative delivery financing systems continue to underestimate the responsiveness of the elderly as a burgeoning group of prospective insureds anxious to protect themselves against a virtual plethora of remaining gaps in their Medicare coverage. How Medigap insurers respond to this challenge to be innovative and creative will in part dictate the future role of Medigap insurance in an increasingly competitive health insurance marketplace. ■

Are DRGs Affecting Just the Elderly?

BY PAUL A. KERSCHNER

Families, providers grapple with parameters to ensure appropriate care for the aged.

HEALTH POLICY REPORT

There was and is little doubt that the law establishing Medicare, passed in 1965, has been the most far-reaching piece of legislation for the aged since the passage of Social Security in 1935. Indeed, from 1965 to 1975 the program operated with few if any major problems. The most significant criticism voiced by the consumer was the lack of coverage for ancillary services such as podiatry and dentistry, for prosthetic devices such as eyeglasses, and for costs of prescription drugs. Provider complaints were not about reimbursement levels but rather about the amount of paperwork required.

In 1975, however, the health care revolution ran into counter-revolutionary forces in the form of double digit inflation. While the cost of most goods and services was running at 12 percent to 14 percent inflation, health care costs were rising at the rate of 18 percent to 20 percent. The aged were suddenly in multiple jeopardy, their life savings eaten away in savings accounts paying 4 percent to 5 percent interest, and at the same time, their out-of-pocket costs for health care far outstripped their ability to pay. Clearly there were fixed costs that older adults had to meet such as rent and heat; consequently, physician or hospital visits, unless under emergency conditions, were at the bottom of the list of items on which to spend meager resources.

Unlike the environment during the mid-1960s, in 1982 the consumer's voice outweighed the organized opposition from the providers. Yet the costs of providing care also were rising, placing many institutions at financial risk. As is often the case, several states — including New Jersey, Connecticut, Minnesota and California — took action prior to the federal government's intervention, in the form of statewide cost management measures, with New Jersey the case most often cited due to its designation as the first test site for diagnosis related groups (DRGs).

Pressured by these states, Congress and the American public, the Reagan administration moved to implement a cost management system with a prospective payment system (PPS) using DRGs.

DRGs Create Repercussions

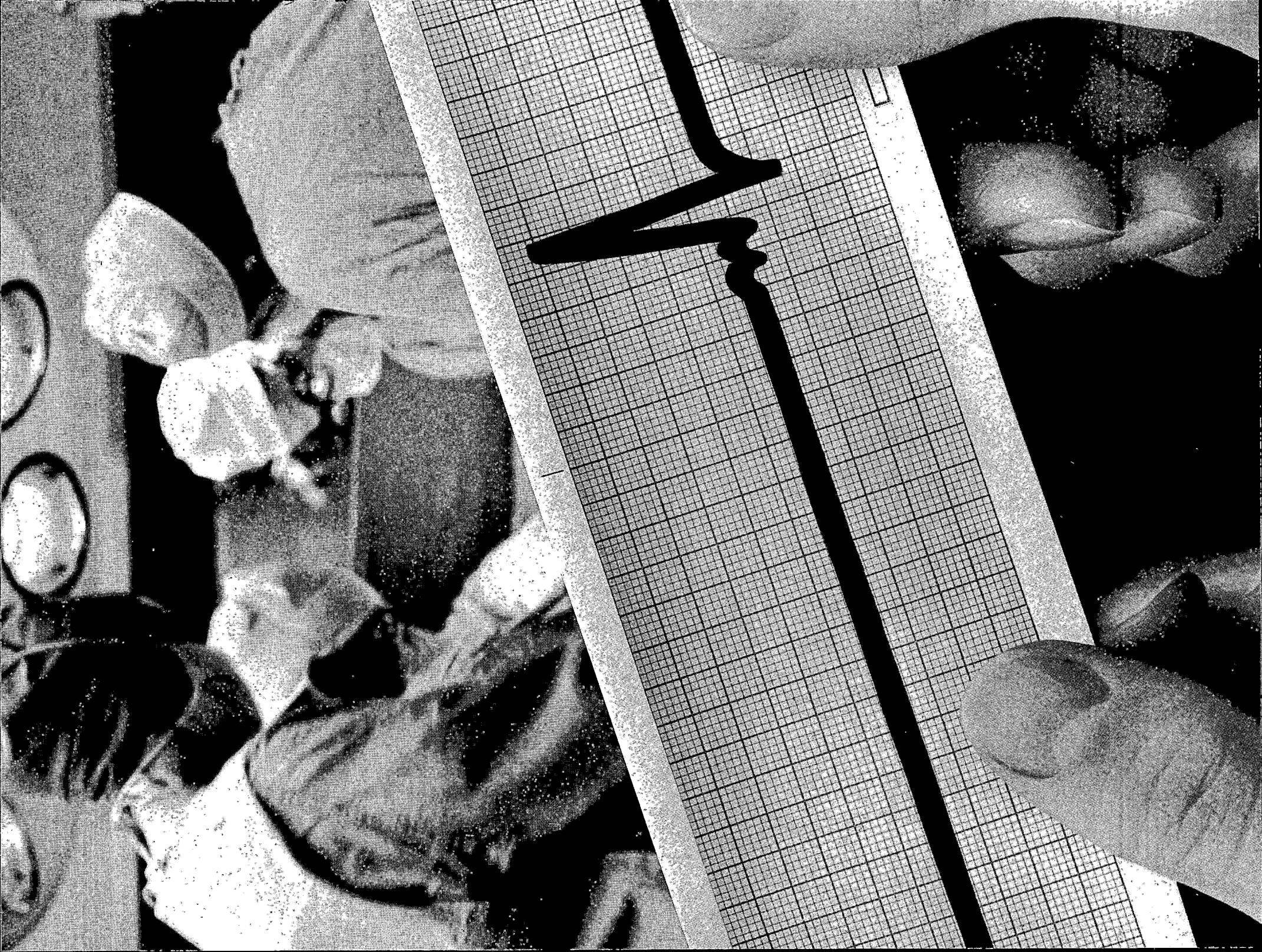
In the two years since the DRG system was instituted in hospitals across the nation, controversy has raged on a variety of fronts, igniting repercussions for skilled nursing homes, home health agencies, private practice physicians and, most significantly, for patients and their families.

The elderly are aware that there is a process out there that attempts, in their view, to limit the time they can spend in a hospital and that attempts to discharge them to a nursing home or home health agency as quickly as possible. Many elderly express concern as to whether their physician will present a good case for their hospitalization, and that once they are admitted, whether they will be treated for other problems that may occur. Their fears also address discharge procedures — whether they will be able to remain in the hospital longer than the DRG allows if their condition warrants it, and whether they will find a nursing home that is appropriate to their needs.

Questions such as these would be anxiety producing in a young and healthy individual; however, one can easily imagine what they do to an 80-year-old woman without a spouse who is in a weakened condition and may be disoriented as a result of her illness, her medication or her fear of the unknown.

In addition to a high level of ignorance as to the admission and treatment process under DRGs, a similar lack of knowledge exists concerning the appeals process, primarily because there is little attempt made by hospital admitting personnel and discharge planners to explain to the patient his or her rights under the appeals process;

Paul A. Kerschner is president of the National Foundation for Long-Term Health Care in Washington, D.C.



The prognosis for health care costs just got better.

With Intracorp Medical Review Services you now have a way to bring new life to your ailing medical claims dollars.

We do it by giving you control over the cost of hospital claims . . . before they occur. By identifying unnecessary hospital stays in advance, you'll be able to save your precious health care dollars for when they're really needed . . . without sacrificing quality of care.

We'll also review each hospitalization request and preset the number of days of inpatient care actually required. Then we'll monitor the stay to make sure that the approved period of hospitalization is not exceeded.

But we don't stop there . . . Intracorp has other ways to save your health care dollars. From providing Second Surgical Opinions that prevent unnecessary surgery, to programs that expedite patient discharge to less expensive—and more comfortable—settings.

And, after discharge we'll review the utilization of all hospital services . . . and the accuracy of all charges, so you'll know exactly what you should pay for. And what you shouldn't.

Intracorp Medical Review Services are provided promptly and professionally by our staff of trained medical specialists, backed by a nationwide network of board certified physicians.

Now in our fifteenth year, Intracorp is the oldest and largest provider of disability management services, offering you the convenience of 135 offices nationwide . . . the experience of over 210,000 cases . . . and the most comprehensive medical review services program available anywhere. The bottom line . . . a healthy reduction in medical costs of up to 20%.

We'll give your medical claims dollars a new lease on life.

To learn more about Intracorp Medical Review Services call us toll free at 1-800-345-1075 (In PA, HI and AK call 215-687-9450), or return the coupon below and we'll send you a complete set of our brochures.

Intracorp

Innovators in cost containment.

B&H

Mr. Daniel H. Davis,
Director of Marketing, Intracorp,
985 Old Eagle School Road,
Wayne, PA 19087

Please send me your complete Medical Review brochure package.

Name _____

Title _____

Company _____

Street _____

City _____

State _____ *Zip* _____

further, little assistance is offered on how it can be initiated. When a family member is under a time crunch to move a patient from the hospital to another setting, the hospital must be proactive in its efforts to inform the family of appeals procedures. Additionally, the Health Care Financing Administration (HCFA) must provide easily understood and accessible information as to the dynamics of the appeals process.

During the current period in society when there is an increased emphasis upon the need to retain or rebuild the American family, the DRG system appears to be placing undue stress on the family unit. The majority of the elderly are single women in their late 70s and early 80s, and are from a generation that reached adulthood during the Depression, had fewer children than at any other time in history, and are at high risk of requiring acute and long-term care services due to their age. As a result of their previously low fertility rate, there is either an absence of an adult child or at best only a single child upon whom the burden of caring for an elderly person falls. In cases where a child does exist, the chances are overwhelming that he or she is in the work force and unable to remain at home to render support.

"Already beset by a public image that somewhat portrays them as second class relative to hospitals, nursing homes were ill-prepared for the onslaught of DRG discharge patients."

Families are not only burdened by the same lack of knowledge about the health care system as that of the patient but are beset by issues of their own immediate family requirements overlaid by feelings of guilt and responsibility towards their parents. Additional problems are posed when the only family support person is an elderly individual, too. While there is always the avenue of the appeals process, too often the need for decision making is so immediate that issues of discharge and transfer overwhelm the family to the point that appeals are overlooked.

Physician, Hospital Concerns

Although physicians are the least affected, they do not escape the impact of the DRG process. In addition, over the past five years, physicians' practices have undergone significant demographic changes. No longer are they seeing predominantly young couples with children, but rather a rapidly graying patient group. This is partially due to the nation's demographic shift and partially due to changes in the manner in which health care is delivered such as through health maintenance organizations (HMOs), which are increasingly attractive to employers and families because of their lower cost and prevention-oriented design.

Unlike the hospital, the physician is often in a better position to know the environment in which the older person resides. He or she may be more willing to seek hospitalization for an older patient if he knows that there is no family present, the spouse is too frail to provide care, or the living conditions are too substandard to allow for recovery or recuperation.

However, if an extended hospital stay is recommended once the DRG runs out, physicians then are concerned about whether this decision will jeopardize their privilege to practice in that facility. Conversely, if a patient dies subsequent to a decision not to hospitalize, the physician is apt to fear a malpractice suit. Although professional ethics are the physician's guide, there are conflicting criteria that enter the picture, including the danger of premature institutionalization.

Hospitals, faced with more empty beds than ever, began to explore the means to help their institutions remain viable while questioning whether they would be held accountable for not admitting costly patients. Their concerns also addressed balancing the hospitalization recommendations of staff vs. attending physicians and determining the feasibility of administrative costs of appealing a peer review organization's (PRO) decision to overturn the hospital's rejection of certain patients.

Hospitals also knew they had to consider the time period for notification of a patient's family as to the need for arranging the transfer of the patient to a public hospital, as well as for giving charity care; further, they knew they had to draw the line in all these instances.

While it is unlikely that hospital administrators or boards of trustees literally review a checklist of such issues, such matters occupy a formidable portion of their daily agenda. Overlying the DRG issue is the desire on the part of the hospital to retain the public's perception of the local hospital as a place to go for high quality, appropriate, and above all curative care.

Skilled Nursing Facility Capabilities

Already beset by a public image that somewhat portrays them as second class relative to hospitals, nursing homes were ill-prepared for the onslaught of DRG discharge patients. They are locked into a reimbursement system such as Medicaid, which in the best of states, New York, pays $82.80 a day, and in the worst, Arkansas, pays only $28.62. Yet skilled nursing facilities remain operating with 90 percent occupancy, with staffing patterns and levels for the chronically ill, and with reimbursement levels more appropriate to residential care. In the meantime, their phones begin to ring as hospitals search for empty beds.

At the same time, nursing homes are faced with the realization that hospitals are paid on the basis of diagnoses whereas the nursing homes are paid on generalized designations of skilled or intermediate care. Further, they are confronted with the decision of whether they can afford to accept a very ill, high cost patient at the Medicare skilled nursing rate and whether they have the appropriate staffing levels and skills to treat subacute patients. Cov-

erage of care is also a question once these patients are stabilized or rehabilitated and their Medicare coverage runs out. Because the majority of these patients are Medicaid eligible, these providers question whether they can afford to continue to provide subacute care at Medicaid rates and wonder what to do about the traditional nonacute chronically ill patients who are backed up waiting for an available bed. Questions also surface about who the responsible party is when the patient is subacute and requires monitoring from the hospital.

Nursing homes, which for so long have been the facility of last resort, are now finding themselves in the position of serving as a way station for patients stuck in that never-never land between acute illness and chronic disease. While most have moved quickly to address the problem in terms of staffing and appropriate equipment, the reimbursement system remains that of the chronically ill model. Nursing homes want to play their part in addressing the needs of the DRG patient but find themselves trapped by conflicting systems of financing, regulation and review.

The home health agency, meanwhile, finds itself in the unenviable position of having to respond to the hospital, the nursing home and the family or patient. While it might be argued that this is in fact the role and responsibility of such agencies, such interactions are taking place within a highly emotional and time constrained environment. The hospital or nursing home is attempting to discharge the patient back to his or her home as expeditiously as possible and under the care of a home health provider. At the same time, the family or spouse is attempting to locate, usually within 24 hours or less, an appropriate home health service. Increasing the pressure on the family and agency is necessary to insure that the patient is certified as eligible for receiving skilled nursing care, for if not, Medicare reimbursement is not forthcoming.

Because of the influx of discharged DRG patients, home health agencies find themselves deciding whether they have sufficiently trained staff to meet the needs of the subacute patient and whether they have to manipulate the system to have a patient skilled in order to provide him or her with home care. These agencies also are looking at whether they can handle emergency requests for service and for handling patients whose intermittent visits are not supplemented with an adequate home environment that will help them maintain good health.

DRG Reformation, Preservation

There are those who believe that the DRG system has merit and is worth reforming and preserving. The system's problems are not a result of the philosophical underpinnings of the concept, but rather are a result of its implementation and monitoring. The following are areas in which the system's problems can be addressed.

- The DRG system must be altered and adjusted to better take into account differences in severity of illness among individuals in the same DRG category. This could be accomplished through a panel of physicians brought together by HCFA.

- Congress and the administration should move quickly to implement a prospective payment DRG system within skilled nursing facilities. It no longer makes fiscal or medical sense to move patients from a disease specific system in an acute hospital to a generalized level of care system within a skilled nursing home.

- HCFA should immediately provide for a PRO presence in skilled nursing facilities and home health agencies to monitor the subacute patient for a limited period of time following discharge from the acute hospital.

- PRO contracts should be revised to reflect the need for quality review as well as utilization review. Such revisions should be accompanied by funding levels sufficient to address and complete their responsibilities under the law.

- HCFA should propose modifications that allow hospitals to extend a patient's stay when no appropriate post-hospital placement can be located or when a patient or family requires additional time to locate such a facility or service.

American Health Care Association

"Nursing homes want to play their part in addressing the needs of the DRG patient but find themselves trapped by conflicting systems of financing, regulation and review."

- Congress should authorize an ombudsman system for Medicare patients in acute hospitals, similar to that found in the long-term care system. Such individuals working for state health departments or departments on aging would have the responsibility to act as intermediaries between the patient and the health care system.

- Every attempt should be made on the part of HCFA to convey to hospitals their obligation to adequately inform patients and families of their appeal rights. This should be accomplished by the hospital in a timely fashion, not at the moment of discharge or worse yet subsequent to discharge.

- Hospitals and nursing homes should be compelled to provide adequate notice to patients and families that a discharge data has been set. Overnight notice should be deemed unacceptable.

While these recommendations are not foolproof, their implementation should go a long way toward reforming the system for the good of patients, families, providers and health care institutions. ■

Ray Charles has a disability. Yet his abilities have enriched us all.

"35 million disabled Americans want the same things you want out of life."

We want to use our abilities to the fullest. We want to participate. That means being able to get in and out of places you want to go if you use a wheelchair; having signs in braille; getting extra help to do the job you really want.

Because this is the Decade of Disabled Persons, the National Organization on Disability urges us all to lend a hand right in our own community.

Let's put our abilities together so all Americans gain.

To find out how you can get involved, call this telephone number now:

1-800-248-ABLE

Ad Council

NATIONAL ORGANIZATION ON DISABILITY

Our Technology Has Captured The World Of Healthcare Data Management

Throughout the healthcare/insurance world, you'll find people managing data and containing costs with state-of-the-art systems and support from Resource Information Management Systems.

QicClaim

Leading Third Party Administrators, Insurance Companies and Employee Benefits Managers have expanded their businesses with the QicClaim Healthcare Data Management System. These organizations are administering health claims promptly and accurately while identifying cost containment opportunities with QicClaim's clear, concise utilization and provider data. Integrated products are also available for: Medical Case Management, Billing & Accounts Receivable, Disability Processing and Prescription Drug Processing.

QicPACE

This revolutionary Program for Alternative Care Environments is enabling Health Maintenance Organizations and Preferred Provider Organizations to grow profitably with a management information services package designed to meet their unique administrative and reporting needs.

QicPACE HMO automates group, staff, IPA or network model Health Maintenance Organizations and keeps them updated with profile and provider comparative reports for detailed performance analysis.

QicPACE PPO addresses the areas of claims payment, provider panel profile reporting, savings reporting and fee schedule management...all areas vital to the success of any Preferred Provider Organization.

Support

It takes more than the right system to capture today's healthcare marketplace. It requires effective training and ongoing personalized service from professionals who know our products and understand your needs. We implement innovations such as our state-of-the-art Technical Resources Center, nationwide cooperative advertising by our users, and more. It is this commitment which has enabled RIMS to encompass the world of Healthcare Data Management.

RIMS

RESOURCE INFORMATION MANAGEMENT SYSTEMS, INC. 312/789-0230

Send me more information on:

- ☐ *QicClaim Healthcare Data Management System*
- ☐ *QicPACE HMO* ☐ *QicPACE PPO*

Name _____

Organization _____

Address _____

City _____ **State** _____ **Zip** _____

Resource Information Management Systems, Inc. Dept. **BH64** • 2015 Spring Rd–Suite 220 • Oak Brook, IL 60521-1811

THE Q TEAM

The Impact of Outpatient Surgery on Hospitalization

BY RONALD J. LAGOE, DAVID A. MANKIEWICZ AND JOHN W. MILLIREN

Variations in inpatient admission rates may reflect outpatient surgery utilization.

COST MANAGEMENT REPORT

Recently, variations in hospital admission rates among acute care service areas have captured the attention of providers and purchasers of health care, including employers. Studies carried out in states in the Northeast and Midwest by John Wennberg of Dartmouth Medical School, Benjamin Barnes of the Harvard School of Public Health and others have identified extensive variations in admission rates for most surgical procedures and medical diagnoses. Much of this attention has focused on differences in per capita admissions for certain surgical procedures.

The differences have been most closely associated with physician practice patterns. Thus, it has been suggested that these variations justify establishing second surgical opinion and preadmission screening programs that focus on avoiding excess hospital admissions for surgery. Moreover, the best approach to reducing these differences over the long term may be increased interaction between purchasers of care and physicians.

It is probably true that some of the variations in hospital admissions could be eliminated through further development of utilization review programs. The whole state of affairs in this area also might be advanced measurably by increased interaction between purchasers and providers of care.

Before undertaking such efforts, however, it might be wise to reevaluate the data on which these activities will be based. Specifically, while research has identified notable variations in hospital admission rates for surgery, inpatient use rates do not reflect total surgery utilization. For instance, a number of the diagnosis related groups (DRGs) identified by Wennberg and the surgical procedure categories identified by Barnes include operations performed on an outpatient or ambulatory basis as well as on an inpatient basis. Procedures such as cataract removals, tonsillectomies, anal operations, hernia repairs and laparoscopies often are done in outpatient settings, at less cost to the payer and greater satisfaction to the patient. In their efforts to ensure that health care will be provided efficiently, employers, insurers, providers and communities should evaluate the role of outpatient services in total utilization on a procedure specific basis.

Outpatient Surgeries in Syracuse

Outpatient surgery generally is provided through two types of programs. Hospital integrated programs make use of existing facilities and staff and usually are operated by the hospital itself. Freestanding outpatient surgery programs have dedicated facilities and staff and may be operated by hospitals, separate corporations, or groups of physicians on a for-profit or nonprofit basis, as with hospital integrated programs. Because they frequently entail substantial capital and other start up expenses, freestanding programs have been slow to develop in many areas. However, it has been projected that by 1990, there will be 832 of these facilities in operation nationally, generating almost 2 million outpatient surgeries a year compared with more than 500,000 outpatient procedures in 1985.

The relationship between outpatient and inpatient surgery utilization for procedures such as those mentioned earlier can be illustrated through an analysis of ambulatory programs in Syracuse, N.Y. Located in central upstate New York, the Syracuse hospital service area has a population of approximately 555,000. Twenty years ago, the consolidation of nine area hospitals into four nonfederal, inpatient facilities with an efficient bed supply of 2.8 per

Ronald J. Lagoe is executive director of the Hospital Executive Council in Syracuse, N.Y. David A. Mankiewicz is assistant to the executive vice president of the Metropolitan Development Association and staff to the Health Care Action Council, Metropolitan Development Association also in Syracuse. John W. Milliren is director of appropriateness review, New York State Office of Health Systems Management in Albany.

1,000 resulted in the development of outpatient alternatives to ease inpatient service constraints. By the 1980s, each of these nonprofit hospitals had the capacity for ambulatory surgery.

Hospital integrated programs were established by Community-General Hospital and St. Joseph's Hospital Health Center. A freestanding program was assembled by Crouse Irving Memorial Hospital, and the medical staff of University Hospital of the Upstate Medical Center also uses this freestanding unit, which is located adjacent to the medical center campus. In addition, University Hospital supports a small volume of outpatient surgery in its operating rooms. Annual utilization of each of the programs at Community-General Hospital and St. Joseph's Hospital Health Center range from 1,500 to 3,000 procedures; the freestanding program, 7,000 to 8,000 procedures; and the University Hospital program, 500 to 1,000 procedures. In combination, these ambulatory surgery programs have supported the ability of Syracuse hospitals to avoid excess admissions while assuring access to care. During 1982, the Syracuse hospital admissions rate of 119 per 1,000 population was considerably below the New York State average of 150 per 1,000 population.

The following table shows the extent of outpatient surgery utilization in two of these programs for selected DRGs that have been identified as having high variation in surgical admission rates.

Outpatient Surgery Utilization by Diagnosis Related Group Syracuse, N.Y., 1984

	Number/Percentage of Hospital Total	
DRG	Freestanding Program*	Hospital Integrated Program**
(39) Lens Operations	793/69.9%	270/55.6%
(59) Tonsillectomy and/or (60) Adenoidectomy	614/96.7	328/97.6
(157), (158) Anal Operations	148/58.3	12/5.9
(226), (227) Soft Tissue Operations	14/21.9	27/38.6
(229) Hand Operations Except Ganglion	106/56.7	97/59.5
(345) Other Male Reproductive System Operations for Nonmalignancies	63/96.9	40/87.0
(361) Laparoscopy and Endoscopy Except Tubal Interruption	119/70.0	38/27.7
(362) Laparoscopic Tubal Interruptions	428/98.8	0/0.0

* Located at Crouse Irving Memorial Hospital
** Located at St. Joseph's Hospital Health Center

This information demonstrates substantial outpatient surgery utilization in a number of different types of surgical procedures. Lens operations, many of which involve removal of cataracts, are an interesting case in point. This form of surgery is one of the five major sources of admission to hospitals under Medicare. The data indicate that, during 1984, the two outpatient surgery programs accounted for more than half of lens procedure utilization at each of the institutions. With its dedicated facilities and staff, the freestanding program was able to accommodate almost 800 procedures, more than two-thirds of hospital utilization in this area.

Tonsillectomies and adenoidectomies provide another telling example of the potential impact of outpatient facilities on surgery utilization. These procedures typically involve large numbers of pediatric cases, reimbursed by Blue Cross-Blue Shield, commercial insurers and employers. During 1984, less than 5 percent of all tonsillectomies and adenoidectomies at each of the two institutions were performed on an inpatient basis.

"In their efforts to ensure that health care will be provided efficiently, employers. . .[and] providers. . . should evaluate the role of outpatient services in total utilization on a procedure specific basis."

Anal procedures, including hemorrhoid removals and other operations, have been another important cause of hospitalization for adults. The data indicated that half of these procedures performed at Crouse Irving Memorial Hospital were carried out in the freestanding program. Anal procedures were not a significant source of utilization in the hospital integrated program.

These data also illustrate the effect of ambulatory surgery availability on two types of orthopedic procedures characterized by highly variable admission rates. Each of the two ambulatory surgery programs was responsible for at least 20 percent of soft tissue procedures performed at the hospitals, including surgical incisions, grafts and repair of numerous tendons and muscles. Each program generated more than half of the institutional utilization for hand operations not involving ganglion. Most admissions in this DRG, which includes numerous bone and tissue repairs, involved young adults.

Other areas where outpatient surgery is an important component of total utilization are procedures involving the male and female reproductive systems. DRG 345 includes a variety of minor, nonmalignant male reproductive system procedures such as biopsies and incisions. Each of the two outpatient surgery programs reviewed accounted for at least 85 percent of institutional utilization for this category. Wennberg identified laparoscopies, both with and without tubal interruption, as having extremely high variation among inpatient hospital admission rates in Maine. In each of these DRGs, the Crouse Irving freestanding outpatient surgery program generated more than two-thirds of the institutional utilization. As a matter of policy, St. Joseph's Hospital Health Center does not perform sterilization procedures on an inpatient or an outpatient basis.

Analyzing Surgery Utilization

This analysis suggests that extensive outpatient utilization may account for many of the differences in hospital admission rates for certain surgical procedures that have been identified in recent research. For example, in Wennberg's analysis of hospitalization for tonsillectomy and/or adenoidectomy (DRGs 59 and 60) in Iowa, a 17-fold variation in admission was identified. In the combined data for the two Syracuse hospitals outlined in the table, a 32-fold variation is demonstrated.

"Syracuse currently is experiencing a boom in outpatient services. . . .The collection of comprehensive outpatient data, which has been a difficult undertaking, has been discussed with local physicians, [insurers] and other organizations."

This type of comparison should not imply that all of the variations in hospital admission rates can be explained through reference to outpatient surgery utilization. A number of the procedures that have been studied, such as major cardiovascular and joint operations, cannot be performed in outpatient settings. Even in cases when outpatient utilization is not appropriate, other aspects of benefits design or physician practice may explain the variations. In other cases, differences in hospitalization rates may result from variations in medical, rather than surgical admissions.

However, the Syracuse analysis strongly suggests that employers attempting to evaluate the use of surgery in their communities should investigate utilization in outpatient, as well as inpatient settings. The information produced by such investigations may fill in gaps in an area's surgery utilization picture and increase the sophistication of benefits design efforts within corporations.

This first step is to acquire adequate utilization data. In Syracuse, the Health Care Action Council, which is the local business group on health, in cooperation with eight regional hospitals and Blue Cross-Blue Shield of Central New York, has created an inpatient data set for businesses. This data set is providing a means of comparing inpatient utilization for Syracuse firms, regardless of who their third party payers are, or whether they are self-insured. It will allow employers to determine how well they are using local hospital resources, to redesign existing benefits packages, and to monitor the impact of cost containment efforts. However, the council also has acknowledged the need to develop outpatient data to encourage the use of more cost efficient procedures and to track the growth of these services. Syracuse currently is experiencing a boom in outpatient services, which while generally supported by the corporate sector, must be evaluated for its cost impact. The collection of comprehensive outpatient data, which has been a difficult undertaking, has been discussed with local physicians, the Health Insurance Association of America and other organizations.

Once acquired, the uses of health care utilization data in addressing outpatient surgery may vary. In areas such as Syracuse, for example, where many types of procedures already are being performed outpatient, local businesses, health planners and providers should cooperate to increase the use of these services. During 1984, the council and the Central New York Health Systems Agency, with advice from local providers, assembled a *Purchasers Guide to Health Insurance.* This document, which surveys a variety of benefits and administrative strategies that promote cost containment, emphasizes that outpatient or ambulatory surgery can produce substantial savings amounting to about one-half of the cost of inpatient procedures. It lists incentives employers can institute to encourage use of ambulatory surgery such as coverage of outpatient procedures at higher coinsurance rates (usually 100 percent), waiver of general policy deductibles for outpatient surgery, and denial of coverage of certain procedures when performed on an inpatient basis. The guide identifies procedures that might be included in this latter category.

At the same time, evaluation of inpatient and outpatient surgery utilization data will indicate that some communities lack sufficient ambulatory surgery capacity. Under these circumstances, businesses, third party payers and providers should work together to develop these resources.

"Two approaches might be taken to outpatient surgery development. . .[establishing] freestanding surgery centers. . .[and] using existing facilities to establish hospital integrated surgery programs. . . ."

Two approaches might be taken to outpatient surgery development. The establishment of freestanding surgery centers, either by hospitals or other providers, offers the potential for greatest utilization. With their dedicated facilities and staff, freestanding outpatient surgery centers can generate thousands of procedures per year in a variety of specialties. However, these facilities involve substantial risks in the form of construction, equipment and other start up costs.

For these reasons, using existing facilities to establish hospital integrated surgery programs may be more feasible. As declining occupancies free up facilities and staff at many institutions, the resources to establish such programs may be increasingly available. Business groups should analyze surgery utilization data for their communities and support the development of programs that best serve their particular needs. ■

Tracking Quality of Care in Military Hospitals

BY MICHAEL J. MESTROVICH

A state-of-the-art information gathering system promises cost savings, better care.

COST MANAGEMENT REPORT

In today's environment of ever increasing costs, health care providers are constantly challenged to deliver the most efficient and effective levels of health care service possible. As custodian of one of the largest health care networks in the world, the U.S. Department of Defense (DOD) is sensitive to both cost issues and those concerning quality of care. During the past several years, incidents of improper or inadequate health care have occurred within a number of military medical treatment facilities. These occurrences have raised questions in Congress, in the DOD, and in the minds of the general public about the quality of care being provided to military beneficiaries at military facilities. As a result, a number of policies and program changes have been instituted by DOD in the last two years to strengthen that quality of care. One initiative that promises great success is an automated support system called AQCESS.

The Automated Quality of Care Evaluation Support System (AQCESS) was developed by the Defense Medical Systems Support Center (DMSSC) through its Tri-Service Medical Information Systems (TRIMIS) program office. The system is microcomputer based and is for use by hospital staff to support the collection of patient and provider information and quality assurance decision making throughout military hospitals.

AQCESS, for example, is being used in gathering data for occurrence screening, that is, retrospective screening of provider-patient encounters for peer review purposes. It facilitates monitoring of problems such as adverse drug interactions in patients, and nonillness related accidents and other incidents occurring during a patient's hospital stay. AQCESS also provides data on credentialing and profiling of providers, and inpatient quality assurance.

Michael J. Mestrovich is director of the Defense Medical Systems Support Center, U.S. Department of Defense in Falls Church, Va.

The goal of AQCESS is to improve the quality of the health care delivered to military personnel and their families by capturing accurate patient demographic and clinical record data, organizing the data efficiently, and providing quick, useful reports in all quality assurance functional areas. It includes information security and data management capabilities, and will soon be able to access other DOD medical applications, such as medical records tracking and health benefits verification systems, through its link with the DMSSC communications network.

Meeting DOD Needs

AQCESS was developed in response to a critical DOD need. With the introduction of occurrence screening to act as a quality assurance technique in military hospitals worldwide, a mechanism was needed to monitor large volumes of inpatient visits. The mechanism needed to be uniform throughout military facilities, so that hospital personnel on rotating assignments would not require constant retraining, and to allow militarywide analyses to be based on comparable, standard data.

In summer of 1984, working groups were established within the patient affairs and quality assurance division of DOD's health affairs office to identify functional requirements for the first phase of AQCESS, which is inpatient quality assurance support. The planners realized that while the requirements for such a support system in the military were similar to those needed in the public sector many data elements and specific processes were unique to DOD. For instance, military facilities do not handle private medical insurer claims and therefore admissions and billings requirements are different from those in civilian hospitals. Nor do military hospitals of diagnosis related groups (DRGs), a key data element of Medicare's prospective payment system and often applied in the review of quality of care. Rather, international classification of diseases (ICD) codes serve as the standard diagnostic data element in military medical facilities.

Since no comparable monitoring systems meeting the military's unique requirements seemed available in the civilian community, DOD contracted with two computer firms to develop and implement the system. Close cooperation between TRIMIS and the three uniformed services, the Army, Navy and Air Force, was essential to accelerate the standardization of functional requirements for the system and speed the contract bidding process. In early 1985, contracts were awarded to National Data Corporation Federal Systems Inc. and Digital Equipment Corporation for the project, and development and prototype testing at military hospitals were completed by September 1985. The AQCESS system prototype was tested at three installations: Kimbrough Army Hospital at Fort Meade, Md.; U.S. Air Force Hospital at Langley Air Force Base, Va.; and Naval Hospital in Pensacola, Fla. During the test, a number of issues were raised relating to the software and its functions. However, the changes required did not affect the system's implementation schedule. Worldwide adaptation of the quality monitoring system in all 168 military hospitals was completed last month. The life cycle cost of the $18.2 million system for initial inpatient use was held down by incorporation of previously available DOD software programs where possible.

"The goal. . .is to improve the quality of the health care delivered. . .by capturing accurate patient demographic and clinical record data, organizing the data efficiently, and providing. . .reports in all quality assurance functional areas."

Three-Pronged Information System

AQCESS has the capability to gather data in three major functional areas: patient admissions and disposition; clinical records; and quality assurance. Basic demographic information on each patient including age, sex, occupation and other data is entered into the admissions and disposition module of the system as patients are registered. In addition, the system records data and provides reports on admissions, transfers, patient disposition, hospital bed management and inpatient history, that is, past diagnoses and procedures performed.

The entire AQCESS system was developed with the user in mind. To speed data entry and preclude the need to enter certain information on the same patient more than once, data fields on the data entry screens are prefilled whenever an item of information already has been put into the system. AQCESS also provides patient list searchers to help in locating a patient's record when the complete patient name, family member prefix and Social Security number are not known.

Building on admissions and disposition records, the clinical records module is used to track processing of inpatient illness episodes, patient diagnosis and procedures, and patient record status. It also performs inpatient day computations. Again, computer terminals are located conveniently for the clinical records staff. The entry of diagnostic codes into the system replaced old manual recording procedures formerly performed by these staff members. AQCESS provides a complete dictionary of diagnostic ICD codes to assist system users, and also edits data as it is entered to spot coding errors. These automated aids can save the user time while promoting greater data accuracy by allowing errors to be caught and corrected immediately, thus avoiding tedious error research after the fact.

Not only does AQCESS spot invalid entries, such as impossible dates or incorrect provider names, but the system also edits for consistency, so that male patients are not cited for pregnancy, for instance. When errors are found, AQCESS immediately displays an error message that explains which data field is incorrect or inconsistent. The system user also can use an error explanation feature to obtain more information.

The quality assurance module performs the data sifting and information matching tasks for the hospital quality assurance coordinator. In the area of inpatient occurrence screening, the system is preprogrammed to identify 18 conditions that warrant investigation, and has the capability for each hospital to select up to six more. Preprogrammed conditions, for example, include: patient drug or transfusion reactions; loss of neurological or functional abilities or intractable pain not present at the time of a patient's admission; post-operative patient complications; repetition of invasive procedures during a patient's admission; patient discharges against medical advice; and all patient deaths.

A similar set of nine occurrences have been identified for emergency medical services. Emergency outpatient records are screened for such events as: return emergency room visits; emergency room visits closely following inpatient discharges; emergency room patients seen by a paraprofessional rather than a physician; patients who are dead on arrival or who die in the emergency room; and patients who leave against medical advice.

To review this information, the hospital quality assurance coordinator need only enter his or her password, which allows access to system functions, select inpatient occurrence screening from the menu of options available, and specify the particular information to be displayed. Once the coordinator has used the AQCESS screening lists to identify occurrences requiring follow-up, he or she can review complete medical records on the patients and treating physicians involved and make appropriate referrals for physician peer review.

In addition to occurrence screening, the quality assurance module maintains a log to record inpatient incidents, such as patient falls, visitor altercations or drug administration errors, which could generate hospital policy or procedure changes. Problems identified in these reports are tracked through a problem audit routine until they are resolved. This routine essentially reminds the quality

assurance administrator, via recurring reports, that actions are pending on these problems. Once the final disposition of a problem is determined, the action taken is logged on AQCESS and the problem changes status from a pending to a completed item.

A number of quality assurance reports are available from AQCESS including: a blood utilization pull list, which summarizes blood product use by provider over a specific period of time; occurrence screening lists sorted by providers, hospital departments or by medical specialities; quality assurance audit lists to track the status of given problems; a provider credential renewal list; a procedure-mortality summary by provider for specific procedures; and a profile report on a provider's total patient load. The capability for the quality assurance coordinator to develop ad hoc queries also has been developed recently, which increases AQCESS' flexibility as a tool in this area.

Tracking Provider Performance

The information compiled by AQCESS on each provider within the hospital is used by department chiefs and hospital credentials committees. Each provider profile includes information on credentialing and state licensure renewal requirements, the provider's certification in cardiopulmonary resuscitation, acute trauma life support and advanced cardiac life support, and a record of the provider's continuing medical education, residency and other training. In addition, the profile records information on such adverse incidents involving the provider as validated instances of normal surgical tissue removal from a patient, drug variations, patient transfusion reactions, omissions from medical records, validated patient complaints, malpractice claims filed against the provider and other instances of substandard medical care confirmed by peer review. This profile then is used in evaluating the performance and competency of a health care provider. It is a key source of information for granting renewal of a provider's clinical privileges and will assist a credentials committee in the evaluation of these privileges. Access to this sensitive information — required for hospital risk management programs — is controlled through measures such as user security and a terminal security system. These systems limit data entry and data viewing capability to authorized personnel at terminals in appropriate areas, for instance, so that quality assurance reports can not be viewed at the admissions desk.

In implementing the system, users were provided with on-line AQCESS training programs so that they received rapid hands-on instruction. Supervisors and key hospital administrators received additional training and orientation from the installation and training teams who visited each site. A support center also was set up so that system users and managers could receive continuing help. This multitiered approach to user training has been widely acclaimed by military hospital staff. The new system, highly visible in the hospital during its installation, initially raised some concerns, however. Staff members were not disturbed about the data being collected in AQCESS since most of that information already was in manual files. Rather, they questioned how and where the data would be used. During system installation at each site, a representative was present to answer these questions. Right now, the reports from AQCESS are used only within hospitals. Strong consideration is being given to provider concerns as DOD determines whether and how to extend the use of this information to higher management levels.

Future Developments

AQCESS is an interim step for DOD. Its functions eventually will be accomplished by a Composite Health Care System, a standardized, integrated hospital information support system still under development. AQCESS, then, represents a cost-effective balance between the need for automated quality assurance support in military hospitals now, and a more sophisticated information processing capability that is several years away.

Most importantly, for the first time, military hospital administrators have the ability to review a body of quality assurance and provider information quickly and confidentially without having to thumb manually through numerous files. AQCESS is expected to save hospital administrative staff time; and although it is too soon to know what sort of cost savings will be directly attributable to it, a preliminary economic analysis by DOD estimates a minimum benefit-to-cost ratio of 2.4 to 1.

A number of enhancements are being developed or planned for AQCESS. The diagnostic ICD-9 codes used in the clinical records module have been converted to the ICD-9-CM (clinical modification) format, a change that will provide more details in coding. Business office software will soon be installed so that AQCESS can perform automatic medical services accounting from patient information contained in the system. AQCESS also will soon be linked to automated embossers, which will produce a plastic card for each hospital patient admitted. The card can be used on forms for laboratory tests, special diets and other in-hospital procedures. Interfacing with the Defense Enrollment Eligibility Reporting System (DEERS) is planned, so that the eligibility of patients registered in AQCESS for military medical care benefits can be verified automatically. Linking AQCESS to the DMSSC telecommunications network will allow access to other defense medical applications.

Requirements for outpatient quality assurance support also are being analyzed. Quality assurance management support needs for surgery and anatomical pathology are being investigated, and drug utilization review and infections control are two other functions that could be incorporated within a system such as AQCESS.

AQCESS, then, has been a springboard to generate program enthusiasm at the hospital level. Ultimately, this unexpected benefit may prove to be one of the most important achievements of the system. Hospital staffs know their own needs and problems better than anyone else, and gaining their direct participation in the quality of care program is one of the best ways DOD can work to improve its efficiency and effectiveness in this area. ■

Taking the Side of Patients

BY JANE STEIN

The New York Hospital's patient advocate, Anne Coté, says access to quality care is a basic right.

INTERVIEW

Complaints from patients at the New York Hospital, as at most hospitals in the U.S., run the gamut from wanting a nonsmoking room to refusing treatment.

But according to Anne A. Coté, director of patient services and associate director of the hospital, complaints concerning the quality of care are likely to increase now that length of stay is being predetermined by diagnosis related groups (DRGs) in New York. In preparation for this, the hospital has developed a case management committee that includes two representatives from each clinical department as well as senior administrators.

As Coté discusses in an interview with BUSINESS AND HEALTH, many complaints could be avoided if patients were more aware of their rights and were better prepared for the hospital experience. Hospitals can provide this information to patients once they are admitted, but employers — and other leaders in the community — have an opportunity to do this in advance, she says.

Coté has been with the New York Hospital since 1966 when she joined the staff as a nurse. She has been involved in patient services work there since 1970. Coté is a past president and founder of the American Hospital Association's National Society of Patient Representatives and teaches health advocacy at Sarah Lawrence College in Bronxville, N.Y. The following is an edited transcript of an interview with Coté in her office in New York City.

***Q:* Many states, including New York, have mandated patients rights in one form or another. How does this functionally help patients?**

A: It gives power to a regulatory agency such as the health department to enforce patients' rights, for example, by telling hospitals they must guarantee that patients will have access to certain types of information. But if consumers are unaware that they have rights then all of the regulations in the world are not going to help because it really boils down to individual consumers standing up for their rights or asking the right questions so that they can be entitled to the information that they are supposed to have.

***Q:* What kind of rights are you talking about?**

A: The American Hospital Association put out a patient's bill of rights in 1972, and basically every regulation or voluntary document covers the same issues: respect, dignity, quality of care, quality of life, and specifics such as the right to a nonsmoking room and, in states with access to records legislation, the right to see your medical chart. States without access legislation may say that patients have the right to information contained in their chart, which is very different. Then it is up to the provider to have a mechanism in place so patients can indeed take advantage of their rights.

***Q:* Could you describe the mechanism in place at the New York Hospital to assist patients who have complaints or feel their rights have been violated?**

A: Since 1970, we have operated a patient services program to respond to patients or families about their comments, concerns or complaints about care or service. Patients do not make the distinction between care and service, but the staff does. The staff sees bringing juice, responding to a light or a request for something nonmedical, such as extra linen as service. These are things to make patients' hospital stay pleasant. Care is providing medication and treatment. The staff makes care a top priority and service a lesser priority, and that sometimes gets us into trouble.

Four patient representatives are responsible for staff orientations on patients' rights. For instance, once a month all new nurses get an hour-and-a-half lecture on their responsibility vs. patients' rights including resuscitation, termination of treatment and informed consent. Nonprofessional employees, too, receive an orientation on

Jane Stein is editor of BUSINESS AND HEALTH.

rights. What does informed consent mean to a technician? It might not mean the same as to a physician, but the patient still has the right to know what tests are going to be done, what the steps are going to be.

Once a year we orient the new house staff on patients' rights and what it means to them as physicians so that everyone on board has the same orientation. For the patients we have a booklet that is given out in the admitting office. It also is in the emergency room waiting area and the ambulatory care area so that anybody can pick it up and read it. If they have a question, the number for patient services is on the back. If families or patients are referred to us or if they self-refer, patient representatives will hear the problem or complaint and will investigate it. Sometimes it is a minor complaint, sometimes it is a major complaint.

***Q:* Could you give an example of both a minor and major complaint?**

A: A minor complaint in our terms may not be minor to the patient. In fact, frequently what we consider minor in the scheme of things is what will make or break a patient or family because it is the last straw. They can not deal with not having hot coffee; everything else is irrelevant. Getting lukewarm coffee is driving them nuts. The real story is that everything else is driving them nuts. They are anxious, they are afraid, they are scared to death, and the one thing they can relate to is a meal. The coffee could be scalding and it still might not seem to be hot enough. For someone else, cold food might be considered a minor complaint, but a patient representative would understand that to this patient it is important and would convey this message to the staff.

A major complaint would be a complaint about care, for example, when a patient is dissatisfied with the outcome of a procedure, feels that a misdiagnosis took place or is injured when some diagnostic test was administered. The patient representative would listen to the patient and/or family to get as much information from them as possible because their perspective is going to be key.

Let us say a patient is unhappy about the care he or she is receiving. The patient was told to expect that within so many days or weeks after a certain type of procedure or therapy he or she would be better, but indeed the patient is worse. Now the family wants to know what is going on. The patient representative might do one of several things, including reviewing the patient's chart, talking with the nursing staff and the physicians involved in the patient's care, and figuring out who else needs to be involved. Do we need to get someone from a diagnostic area to meet with the patient and the family to explain, in great detail, the procedure that was done or the outcome? Do we need to get all the consultants in one room with the attending physician to find out what they are saying to the patient? The cardiologist might be saying that the patient is doing well while the renal team is saying the patient is not doing well. Both are correct as they describe their specialty interest but they have to put this information together so the patient understands it.

Frequently it is a family member who brings a problem to someone's attention on behalf of the patient, and the patient representative has to deal with information supplied by the family only. While that works in 90 percent of the cases, there are times when the family is misinformed. The patient is not, but the family is. Then we have to try to get the details from the patient when she or he is not too sick. Sometimes the patient does not want the family to know the whole story.

***Q:* How many patients typically are at the New York Hospital and what percent seek patient services?**

A: We have approximately 1,000 beds and we run an average of 89.9 percent occupancy. Probably a small percentage of the patients admitted seek us out, although my staff will tell you it seems like everybody that comes in the door stops by the office. Quality of care, consent and the termination of treatment issues occupy about 80 percent of our time. We might have one or two termination of treatment cases a week, which can occupy three days of a patient representative's time because he or she has to talk to everybody involved. Sometimes the family is feuding so different factions have to be dealt with.

"A minor complaint in our terms may not be minor to the patient. . . . Getting lukewarm coffee is driving them nuts. The real story is that everything else is driving them nuts. They are anxious, they are afraid. . . ."

Anne A. Coté

***Q:* DRGs were introduced into New York hospitals this year. Do you expect to see an increase in the number of consumer related issues based on a concern about the quality of care delivered under DRGs?**

A: We have not seen problems related to DRGs yet, but I anticipate there will be a few. We did have a woman come in the other day complaining that her husband was being kicked out of the hospital and that we had not done anything about alternate care plans. It turns out that that was not the case. There had been multiple attempts made to try and get her husband into a nursing home, but she would only accept a rehabilitation center. None of the rehabilitation centers wanted him because he was not an appropriate candidate. So, while it surfaced as a premature discharge complaint, in effect it was not. It was related to this woman's inability, understandably so, to accept the fact that her husband could not be rehabilitated anymore and was a candidate for a nursing home.

We have put together a patient case management committee, composed of physicians and administrators, to develop a system so that problems are noticed early

on, even before the patient gets here. The committee will have input into setting up criteria for measuring length of stay. The responsibility for managing the real care of the patient belongs with the physician, and I think that we are going to see some better decision making in terms of what patients should receive. In the past, physicians would order a test because it let them be very thorough. Some of that was defensive medicine, some was just learning which tests should really be ordered. There are some patients who are dying and for whom it is not appropriate to use all available tests. I think the financial issues will prick the ethical ones, and my concern is that decisions be made based on clinical and ethical consideration, as opposed to financial ones.

***Q:* Do you have a lot of patients looking at their hospitals bills and complaining that they were charged too much?**

A: Yes, patients are looking carefully at their bills. The problem with that is that for Blue Cross, Medicaid and Medicare patients, prior to Jan. 1, we were on a per diem reimbursement system. So quite frankly, it did not matter what was on the bill. But this is difficult to explain to someone who says, "I was charged twice for the same test." To us, it was irrelevant. If our per diem rate from Blue Cross was $500 a day, it did not matter what was on a patient's bill because we were still only going to get $500 a day. A patient's first day in the hospital could cost $8,000, but $500 a day is what we negotiated with Blue Cross and that is what we got. And the same thing with Medicare and Medicaid. Patients would read articles in the newspaper about how there are a lot of billing errors in hospitals. They would find an error on their bill and would call up and demand that it be credited. It was a nightmare because it did not matter. Medicare was not going to get money back.

It is a different story for the commercial insurers and self-insured employers because they are paying dollar for dollar. Patients with copayments, because of their out-of-pocket costs, go through their bills and ask us questions. The commercial insurance companies send in their own auditors to go through the medical record and try to match up charges on a bill. They will refuse to pay for certain things if the physician did not write an order for it. In the hospital, physicians give a lot of verbal orders — "Send these bloods off" or "Get a chest x-ray." So there is a lot of back and forth between the commercial companies and our accounting people because a lot of information, especially tests related to emergency situations, does not get transcribed onto the chart.

***Q:* Studies have shown that preoperation patient education can reduce length of stay by more than one day. Why is this so?**

A: Patient education can decrease anxiety. It helps patients if they know what to expect, for example, when they will receive pain medication. Being taught how to cough and give support to an incision, or knowing that there might be some blood in your urine can be important to patients. They can gear themselves up for it. Mental attitude has a lot to do with how people handle any illness.

***Q:* How can hospitals and employers promote better patient education prior to hospitalization?**

A: Preventive education would be best. While I think hospitals have a role, I also see employers as providing that kind of education to their employees. How many workdays are lost every year from people with smoking related illnesses? If there is an employee cafeteria, how much of the food is fried? What kinds of health education materials, if any, does a company provide to their employees? Maybe employers would be willing, at lunch time, to have someone come in once a month and talk about health issues that are important — breast exams for women, nutrition, smoking, vascular problems. A lot of people do not even know that they have early signs of vascular problems that could be managed by medication. Pediatric issues is another important topic to cover. Many employees are parents, and they miss time from work because of a sick child.

***Q:* As a patient advocate, is there a way that you can work cooperatively with employers or with insurance companies that are carrying their health plans so that employees, retirees and dependents are better prepared for a hospitalization?**

A: If a hospital has a preferred provider arrangement with a specific company, that would be the perfect opportunity for various people, not only the patient advocate, to meet with the company's benefits manager, write an article for the employee newspaper, or talk to small groups of employees or supervisors who could then spread the word about patients' rights when they come into a hospital. That kind of education in the community setting is much more beneficial than trying to explain rights to people when they are sitting in the admitting office. All they want to know is: "Where is my room and when is this ordeal going to be over with?" The best time to get any information to anybody is when they are in control of their own environment, either in their own house or in a setting in which they are comfortable, and when they are well or reasonably well.

***Q:* How do you handle being a double agent? You are representing both the New York Hospital and the patients treated in it.**

A: This is a delicate situation to handle. To start off with, there is a tremendous amount of support for the concept of patient services both from the clinical services departments and the administration. People expect us to jump up and down and scream and yell on behalf of the patient, when that is appropriate. The role gets sticky when we are dealing with an issue where a patient has been injured and everyone is convinced that it never should have happened. The only thing we can say is the truth. If we do not know the answer, then we look into the case. As patient representatives, we present our cases to the risk management committee and we fight for the patients. ■

NEWS ROUNDUP

Insurer Lures Retirees with Older Worker Campaign

Employers with large retiree populations may be unaware of a valuable resource that has enabled at least one large company to build a highly reliable backup work force. The Hartford, Conn., based Travelers Companies recently sponsored a recruitment drive not for young, aspiring middle managers, but for retirees. The purpose — to refurbish its five-year-old retiree job bank that has been depleted by heavy company demands for this pool of skilled and capable part-timers.

Of some 700 responses to the campaign, the insurer netted 300 eligible retirees from other companies and another 50 former Travelers employees who chose to become "un-retired," as the company puts it.

The effort demonstrated the strong interest among retirees in continuing to work at least on a flexible basis, notes Abigail Sullivan, Travelers administrator of leadership communications. "We struck a cord," she says, adding that retired physicians, attorneys, engineers, school teachers and retirees from numerous other walks of life flocked to Travelers for the chance to snap up temporary and permanent part-time positions offered through its job bank.

Most of these jobs are clerical or administrative in nature and many offer the opportunity for job training and brushing up on computer and other office skills, she explains. Two pluses to the program are the flexibility it offers to allow for job sharing arrangements and the pay scale, which permits retirees in many cases to make substantially more than the minimum wage. The amount of time retirees may put in as part-timers is capped, however, at 960 hours per year. No other benefits are offered as most participants already are drawing on retiree benefit plans, according to Sullivan. She adds that the Travelers model has been so successful that other employers have been calling the insurer for guidance on setting up similar programs.

It is no accident that Travelers is committed to efforts such as hiring campaigns geared exclusively toward retirees. Back in 1979, the insurer made a corporate decision to adopt aging as a social responsibility issue, says Sullivan. The commitment led to Travelers' "Older American Program," of which the retiree job bank project is a part. Aging "is something that affects every aspect of society," and as an insurer, the company realized that it makes sense for it to be involved in efforts to encourage older people to remain healthy and independent, she notes. For this reason, the company has no mandatory retirement policy; its oldest full-time worker is 78 years old, Sullivan adds.

Crucial to retirees' sense of well-being is their staying active as well as being financially secure, which is where the job bank effort fits in. A preliminary survey conducted by Travelers showed 85 percent of its employees favored coming back to work as retirees, says Sullivan.

Travelers now has several divisions staffed entirely by retirees including the job bank and its office of consumer information. ■

Regulatory Issues Add to State's Malpractice Problems

Reminiscent of New York in recent months, Massachusetts physicians have been curtailing surgery and other medical services to dramatize their objections to a sharp increase in malpractice insurance costs. Unlike in other states, however, the Massachusetts situation relates more to poor planning and a regulatory system that has resulted in unavoidable cost increases for physicians, than to high malpractice awards.

Specifically, the state Division of Insurance's efforts to hold down increases in malpractice insurance premiums along with the state's and Massachusetts Blue Shield's attempts to contain increases in physician payments have contributed largely to the current circumstances. Physicians and insurers both are on the offensive, searching for solutions; the upshot is that employers and consumers most likely will pick up the cost of these solutions.

The problem crystalized last December when the state's Joint Underwriting Association (JUA), which supplies malpractice insurance for the majority of Massachusetts physicians, won a court challenge forcing the state insurance commissioner to permit higher premium rate increases than had been approved for the previous two years. The court decision made new malpractice premium rates retroactive to 1983, meaning physicians in the state are liable for these costs on top of premium increases scheduled for 1986.

On average, a Massachusetts physician faces a bill for retroactive premiums of about $5,300 plus a 1986 premium of $4,700 for a total bill of $9,700. However, for certain high risk specialties, such as orthopedic surgery and obstetrics, malpractice insurance bills are considerably higher: about $54,200 for an orthopedic surgeon and about $47,600 for an obstetrician. Payments for the retroactive portion of physicians' bills are to be spread over a year. But the Massachusetts Medical Society has charged that the payment schedule will be little compensation for the average physician in the state who makes about $90,000 per year compared to slightly more than $100,000 for physicians nationwide. On the other hand, premium increases were frozen for the past several years for Massachusetts physicians who on average spend only about 5 percent of their gross income annually on malpractice insurance, compared to as high as 10 percent of gross annual income for physicians in New York.

What seems to have set off Massachusetts physicians, however, has been that the premium increases follow a wave of legislative battles they have lost recently, says Paula Griswold, health policy director for the Massachusetts Business Roundtable (MBR). The state, for example, has passed laws banning physicians from billing patients for more than the established reimbursement levels not only for Medicare but also for Blue Shield patients. Medicaid reimbursements also have been tightly controlled by the state. The restraint on Blue Shield reimbursements, especially, has hurt physicians since Blue Shield controls 60 percent of the insurance market, notes Griswold.

The medical community has sought to take the current problem of high malpractice costs into its own hands by drafting legislation that would impose a tax on insurers and self-insured groups, the proceeds of which would be used to pay the cost of physicians' malpractice coverage for claims after the first $250,000. Some 250 physicians, mostly in the high risk specialties, also stopped doing surgeries and accepting new patients for a time to call attention to their demands for short-term relief from added malpractice costs.

Both strategies were opposed by insurers and the business community who have since begun discussions with the medical community that have centered on alternatives to ease the financial strain on physicians by possibly restructuring fees schedules and payments for retroactive premiums, Griswold reports.

Blue Shield, too, has stepped in with a plan for placating physicians by proposing to increase physician payments by $25 million over the next 18 months. The program, pending approval by the state insurance commissioner, would adjust physician profiles to compensate for higher malpractice insurance premiums.

Physicians in high risk specialties would receive greater fee increases to match the higher malpractice premiums they face, explains Blue Shield spokesman Paul DiNatale. In obstetrics, for example, the plan calls for increasing the fee for a normal delivery from the current $727 to $927, which would make the fee the same as for a Cesarean section. The added cost of higher physician fees will have to be passed along to Blue Shield subscribers in the form of increased premiums that could add $3 or $4 to the average family rate, DiNatale says.

Nonetheless, there has not been much opposition among employers to the prospect of paying more for health care coverage largely because they are aware of the malpractice insurance situation and the need to resolve it, Griswold of the MBR notes. While there is some speculation that the degree to which Blue Shield and the state have attempted to constrain costs has contributed to the political furor over the malpractice situation, business leaders are prepared to be part of the solution. Particularly when physicians are prepared to cut back their practices, employers "don't want to be buying insurance that does not provide for certain services," she says.

At the same time that discussions have ensued in the private sector, the state legislature is struggling to come up with an equitable solution by early next month to the short-term malpractice situation as well as to forestall a repeat of the problem in the future. One approach, proposed by Democratic Gov. Michael S. Dukakis, involves a comprehensive package of reforms that calls for improving the policing of physicians by the state medical licensing structure, changing the way malpractice insurance premiums are set and imposing certain tort reforms. Although well-crafted, the governor's legislative package would do little to solve the present malpractice problems, Griswold asserts. ■

Passive Smoking: Research Priorities

There is good news and bad news for employers concerned about the health effects of smoking in the work place. While there is still sparse information about just how deleterious passive smoking is, serious efforts are underway in the scientific community to come up with some answers.

Although no formal studies have been conducted in the U.S. on the health risks involved with inhaling secondhand smoke in the work place, studies have been done that show exposure to tobacco smoke in general increases the risks of lung cancer, bronchitis and other respiratory problems. A study published last September in the *National Cancer Institute Journal* reported that of 134 nonsmoking women who were exposed to a smoking spouse, between 13 percent and 31 percent had a greater risk of lung cancer than those not exposed to a smoker at home.

Over the past few years, employers increasingly have been getting into the act of countering smoke filled offices and making their work areas completely smoke free or designating certain areas only for smoking. A recent example involves Joseph A. Califano, Jr., an attorney in private practice in Washington, D.C., and former secretary of the U.S. Department of Health, Education and Welfare, who has not only called for making his law firm smoke free, but also wants all offices in the 12-story building to follow suit. In addition, just last month Chesapeake & Potomac Telephone companies in Maryland, Virginia, the District of Columbia and West Virginia, instituted a policy whereby an objecting nonsmoker can veto smoking in his or her work area. The policy was implemented in other subsidiaries of the parent company, Bell Atlantic, and now affects 80,000 employees systemwide.

The National Academy of Sciences (NAS) recently held a public meeting on passive smoking to gather information from a number of health policy makers, scientists and representatives from the medical community to present their findings on the effects of passive smoking on health. Requested by the Environmental Protection Agency (EPA) and the U.S. Department of Health and Human Services (HHS), the meeting came on the heels of the U.S. Surgeon General C. Everett Koop's report, "The Health Consequences of Smoking: Cancer and Chronic Lung Disease in the Work Place." In part because of the dearth of scientific information available, Koop said that the public "can expect to see research on exposure to cigarette smoke in the work place."

This should be encouraging news to employers, especially since such sidestream smoke makes up about 85 percent of tobacco smoke in the air, according to Judson Wells of the American Lung Association. Furthermore, John Topping Jr., an attorney in private practice and most recently staff director of the EPA Office of Air and Radiation, notes that there is evidence "that tobacco smoke concentration and health risks may be greater in the work place" than in the home.

A serious technical problem in doing this research was raised at the NAS public meeting by representatives from Georgetown University, the Coalition on Smoking or Health, and the George Washington University Medical Center. Measuring exposure to tobacco smoke in enclosed environments such as the work place, they reported, is not easy because of variations in room size, ventilation and exposure to other pollutants. However, according to Diane Wagener, staff officer of the NAS Committee on Passive Smoking, "the meeting gave us the chance to receive input from nonmembers of the academy and also has generated interest in reviewing existing literature on the effects of exposure to smoke. According to Wagener, the NAS committee expects to complete its report by the fall. ■

Suzanne Viau Klett and Lisa Lopez

STATE ACTIONS

State systems gather more health care data but lack uniformity.

By Marlene Larks

About one-third of states across the country have been maintaining statewide health care utilization data bases for several years. In 1979, agreement was reached on a national level through the National Committee on Vital and Health Statistics about those elements that constituted a minimum hospital utilization data set that would be useful for health policy and planning. This resulted in the Uniform Hospital Discharge Data Set (UHDDS), which consists of diagnosis, procedure and certain demographic data. Although not all states participated in this national endeavor, a substantial data base has since been developed, analyzed and used to assist policy makers in both the public and private sectors.

Impetus for Growth

During the past five years, state governments, data commissions and business coalitions have clamored for sufficient information to study the reasons behind the dramatic rise in health care costs and to develop policies and strategies for achieving cost containment goals. Their need for greater detail about how and why hospitals are used has led many states to pass legislation allowing access to hospital financial and utilization data.

Using these upgraded data bases, a number of states have published reports comparing hospitals within their respective state. But generally speaking, reports identifying individual patients and utilization patterns of providers have not been available to data commissions or state agencies. The widespread use of small area analysis, a method of comparing health care utilization between communities, has sparked interest in identifying providers to study variations in practice patterns and how to influence changes. As a result, some states, such as Colorado and North Carolina, are including language in legislation that allows for collection and analysis of such data.

System	States	Percent Hospitals	Percent Admissions	Percent Population
UB-82	Ariz., Conn., Fla., Ill., Iowa, Md., Mass., N.J., N.C., Tenn., Wash., W.Va.	24	29	28
UHDDS	Calif., Maine, N.H., R.I., S.C., Vt., Wyo.	12	11	14
Unique	Ind., N.Y., Ore.	8	11	11
Undecided*	Colo., Tex.	10	8	8
Totals:		54%	59%	61%

* Represents states that have not yet selected a specific system for data collection.

In March 1985, the Washington Business Group on Health (WBGH) published a report on guidelines for state data commissions that included five recommendations pertaining to creating a data base that includes a record of individual hospital inpatient episodes and eventually other types as well. Such a data base would permit health care analysts to examine the cost and utilization of medical and health care services. One of the recommendations specified in the report was that UB-82, the uniform billing form currently required by Medicare and Medicaid, be used by major insurers and/or hospitals as well, and that certain data elements from the form be included in statewide data bases. The UB-82 claim form includes many of the demographic and clinical data that appear in the UHDDS minimum data set. Data then would be submitted to and analyzed by a health data commission or state agency. At the time the recommendations were published, 7 states already had legislation requiring all payers to use UB-82, and 13 others had empowered state insurance commissioners to implement standardized collection formats.

In some of these states, the sole source of hospital utilization data would be the UB-82 system. This is significant in that UHDDS has long been used by the health services research community as a clinically oriented data base in which selected data are abstracted from a patient's medical record after discharge, usually by trained medical records coding clerks. Often a discharge diagnosis is not entered in the record until lab results are available, which can take several days or weeks following discharge. This approach is said to promote the accuracy, and thus the integrity, of the data.

UB-82 data, on the other hand, are generated by the billing system, and entries to the system are made as services are delivered to the patient, so that at the time of discharge the bill can be submitted for payment. During the claims review process, if the principal diagnosis does not warrant the services rendered, inquiries are made and any discrepancies resolved. This process sometimes takes months. If the discrepancy is in the diagnosis, critics argue, the billing system would not be updated to reflect the changes. Or, if the system was updated, less emphasis would be placed on clinical accuracy once the issue of payment had been settled, they contend. Throughout the health data community, the debate continues.

The Push for Patient Data

Patient utilization data under both the UB-82 and UHDDS approaches are differentiated from institutional utilization data in that they usually include diagnostic and demographic information for each patient. Florida collects aggregate patient utilization data. This means that the total number of patients discharged by some clinical category, such as DRGs, is reported. By its very nature, patient utilization data can be sorted into diagnosis related groups (DRGs), major diagnostic categories (MDCs) or other diagnostic or clinical designations. This is particularly important in determining the distribution or frequency of certain types of admissions. Institutional utilization data is a quantitative measure

Marlene Larks is a service fellow in the user liaison program at the National Center for Health Services Research and Health Care Technology Assessment in Rockville, Md.

of the total number of patients admitted to the hospital, or to services within a hospital, such as surgery.

Since the WBGH issued its recommendations, many new states have begun collecting patient utilization as well as financial data. A survey conducted at the National Center for Health Services Research and Health Care Technology (NCHSRHCT) earlier this year identified states that collect patient utilization data, publish or have the authority to publish reports based on these data, and make these reports available to the public; in all, there are 24. Twelve states are using UB-82, 7 use UHDDS, 3 have unique systems and 2 are undecided about the approach to take to data collection. Many states in the UB-82 and UHDDS groups have enhanced data systems and/or data subsets, making it difficult to conduct comparisons, although most states share a core data set. However, the three states with unique systems are substantially different. New York developed its own system that merges a medical record abstract with a uniform billing system, both of which are specified by the state. Indiana collects discharge abstract data by using ICD-9-CM codes. It analyzes data by average length of stay, preoperative preparation time, and average daily patient charges broken out by routine and ancillary. It further sorts data by payer class and age categories. Oregon requires that each hospital submit an abstract for each discharge, which includes certain data elements, but it does not specify the format to be used. The state then puts the data into a uniform format for data processing.

Focusing on Data Sharing

There is much recent activity on the state health data forefront. For instance, five more states, Delaware, Georgia, Ohio, Pennsylvania and Virginia, have introduced legislation that would mandate collection of patient specific utilization data. Purchasers of health care want patient utilization data sorted by payers so they can develop a utilization profile to be used to construct premium rates, negotiated preferred provider arrangements and establish benefit packages. Delaware, Pennsylvania and Virginia identify UB-82 as the primary source of this information. Georgia specifies that a uniform billing system be used, and Ohio would use UB-82 for federal, state and uncompensated care patients and collect aggregate utilization data for all others. Michigan has introduced legislation that would create a data commission for the purpose of collecting data that would encourage competition. Case mix data, such as how many patients fall into each DRG and average charges for each DRG, are the types of information thought to encourage competition. Nevada, meanwhile, is considering regulatory changes to enable collection of patient specific data, and UB-82 is under consideration. Should these seven states join those listed above, the percent of U.S. hospitals, admissions and population covered would be 70 percent, 79 percent and 80 percent respectively.

Although the following actions do not require complete patient data, either for each discharge or in aggregate, they are examples of the continuing clamor for health care information. In Kentucky, legislation has been introduced that would enable the state to produce a guide to charges for the most frequent diagnoses or procedures performed in hospitals, based upon aggregate discharge data. In Nebraska, a 1985 bill requires hospitals to publish a report indicating the 20 most common procedures and their respective prices. Hospitals, upon request, also must give prospective patients estimates of charges prior to admission. Also last year, a health care cost and access commission in New Mexico published recommendations that included the establishment of a data commission.

Many heralded the introduction of UB-82 as a nationwide data base that would provide more uniformity and detail than UHDDS. Except for Medicare, which is uniform throughout the country, only more detail has materialized; uniformity has not been achieved. Thus interstate comparability of data remains difficult except on an aggregate level, and formation of appropriate standards of health care costs and utilization is hindered. As with UHDDS, UB-82 is developed within each state to meet specific needs.

The NCHSRHCT survey demonstrates that both the UB-82 and UHDDS data bases, with some modification, can fulfill the needs of specific state data systems. Whether UB-82 becomes the standard approach remains to be seen. But clearly the era of statewide patient utilization data collection and analysis is at hand. ■

Health Data Management EXPO 86

THIS NATIONAL CONFERENCE/ TRADE SHOW WILL TEACH YOU.

SEPT. 11-13
HYATT REGENCY
MIAMI, FLORIDA

- Over 100 HDM companies exhibiting.
- 3 days of information exchange.
- New contacts to markets nationwide made direct and in person with the buyers and providers in the cost containment field.

H. D. M.

"DEFINES THE INDUSTRY"

EXPO

INFO: TO EXHIBIT OR ATTEND
MARGARITA S. OSBORN
Show Director
305-448-6242

WASHINGTON FILE

HHS Inspector General sets lead for oversight, accountability of providers.

By Frederick C. Lee

A recent report by the Office of the Inspector General (IG) in the U.S. Department of Health and Human Services (HHS) indicated that hospitals nationwide have benefited greatly from Medicare's prospective payment system (PPS). This study is one more indication that the IG has performed a vital role in health policy formulation, not only for the federal government, but for the private sector as well.

The IG's draft report, which surfaced last December, found that a sample of 892 Medicare participating hospitals in nine states experienced an average profit of 14 percent under PPS. The report indicated that four of every five hospitals examined in the study realized profits. Were these Medicare profits extrapolated to the entire nation, as much as $5 billion in profits would have been generated under the new reimbursement system for U.S. hospitals. The IG's major concern is the federal largesse extended to hospitals under what was meant to be a budget neutral system. These data raise the possibility that the weighing factors for the individual diagnosis related groups (DRGs) on which PPS is based may have been excessive, providing large profits that exceeded what hospitals received under the former cost based reimbursement system.

Inspector General Richard Kusserow's latest study represents one more salient observation by his office on the propriety of the Medicare system. Kusserow has been making a substantial impact through aggressive oversight since he arrived on the scene in 1981. The IG was established in 1976 to reduce the occurrence of fraud, abuse and waste in HHS programs. These programs ran a combined 1985 budget of $318.5 billion. Reported savings due to a myriad of activities initiated by Kusserow have grown from $165 million in 1981 to $3.75 billion in 1984. More importantly, there are savings that accrue to parties other than the federal government. For instance, a recent study on inflated DRG rates should be a caution to private sector employers intending to use the Medicare DRG weights for prospective payment and preferred provider arrangements.

Fraud, Abuse and Accountability

In the area of fraud and abuse, the IG has demonstrably improved the integrity of Medicare. Through diligent efforts to scrutinize improper financial practices aimed at bilking Medicare, the IG has achieved a commendable record. The number of administrative sanctions imposed in fiscal year 1985 grew to 390 from 39 in 1981, a 900 percent increase. Sanctions resulted in the banning of unfit providers from both Medicare and Medicaid.

The IG has injected a great deal of fiscal accountability into Medicare and Medicaid since Kusserow took office. The operations of the IG — in many respects — have taken on a more private sector, get tough orientation. On the issue of hospital bad debts, the IG has questioned the time-worn principle of reimbursing hospitals under reasonable cost principles since PPS is generating profits to offset bad debts. Also, a number of hospitals have taken to waiving copayments and deductibles as an incentive to attract patients. The IG questions why these very hospitals then should be permitted to seek bad debt reimbursement. The IG estimates that the Health Care Financing Administration (HCFA) could save up to $92 million annually by eliminating bad debt payments.

In a similar vein, the IG has sought changes in Medicare capital cost reimbursement. Currently, these costs are passed through by hospitals and reimbursed in a retrospective manner. Medicare has always waived the offset of interest earned on income set aside for future growth or expansion, referred to as funded depreciation. The IG feels there is little need for future bed expansions, which makes this accounting loophole inappropriate, particularly since they cost HCFA $464 million in fiscal year 1984. The IG also has called for an end to return-on-equity payments to proprietary hospitals, which would net Medicare another $200 million a year.

For cataract surgery, the IG has proposed legislation that would make a sizeable cut in the profits being realized by hospitals, ophthamologists and surgeons. The IG found excessive markups and wide variances in payment for cataract surgery depending on the site and associated professional fees. Consequently, the IG has called for a cap on lens payments, a limitation on hospital outpatient facility fees, and a single payment for all professional staff associated with a surgery. The IG estimates that these changes could result in $5.6 billion in savings to Medicare over five years.

Private Sector Implications

The diligence of the IG has repercussions for the private sector. By identifying fraudulent providers, the IG has created a resource available to the public through the Freedom of Information Act that bears some scrutiny. Most unscrupulous providers are equally villainous to their private sector clients, and thus employers should follow the lead of the IG and apply similar restraints on health system abusers. Hospitals that inflate private sector bills by building in unjust capital or bad debt costs, or by charging more for lens implants in the outpatient setting than in the inpatient setting also require the oversight of business.

As an astute analytical resource and concerned fiscal monitor, the IG has brought greater accountability to the billions of federal dollars that pass through the health care system. IG efforts have thus been a model for private sector programs as well as a check on unnecessary waste of taxpayers' dollars. ■

Frederick C. Lee is associate vice president for business development with Preferred Health Care, Ltd. in Katonah, N.Y. He was contributing editor for "Washington File" and former vice president of policy with the Washington Business Group on Health.

LAW NOTES

FTC focuses on protecting health care competition in analyzing mergers.

By H. Robert Halper and Peter M. Kazon

Mergers in the hospital industry, as in other areas of the economy, are relatively commonplace today. But as competition becomes a more significant factor in the health care marketplace, hospital mergers and acquisitions are coming under increasing scrutiny by federal authorities. These agencies are seeking to ensure that developing competition is not undermined by firms acquiring too large a share of local markets.

In October 1985, the Federal Trade Commission (FTC) ordered Hospital Corporation of American (HCA), the nation's largest for-profit hospital chain, to sell two hospitals in Chattanooga, Tenn., which it had acquired as part of its purchase of two other proprietary hospital chains, Hospital Affiliates International (HAI) and Health Care Corporation (HCC). Three months earlier, HCA, in addition, had entered into a consent agreement with the FTC to settle charges that HCA's acquisition of several acute care and psychiatric hospitals owned by the Forum Group, Inc. violated antitrust laws with respect to certain localities. As a result of the agreement, HCA divested itself of one hospital in Midland, Tex., and two psychiatric hospitals in the Norfolk, Va., area.

Acquisition of hospitals by other for-profit chains similarly have been challenged by the federal government.

Chattanooga Case Illustrative

In determining what standards the federal government will apply to future hospital acquisitions, the FTC's lengthy opinion concerning HCA's acquisition of hospitals in Chattanooga in the most illuminating. Prior to its acquisition of HAI and HCC, HCA owned only one hospital in the Chattanooga area. In obtaining HAI, it acquired or managed 4 of the 11 hospitals in the area and several hospitals in neighboring counties. With the acquisition of HCC several months later, HCA obtained another hospital in the same area.

The first step in analyzing any merger from an antitrust perspective is to define the product and geographic markets; that is, to determine the particular product or services that could be adversely affected by a merger and the specific locality in which such effects could be felt. The FTC administrative law judge who initially heard the Chattanooga case defined the relevant product market to include the "cluster of services offered by hospitals" including both inpatient and outpatient services, but excluded outpatient services offered by nonhospital providers, such as freestanding emergency care centers and surgicenters. The FTC accepted this analysis but strongly suggested that in future cases all outpatient services be considered totally separate from inpatient services, since the two are generally not comparable.

In defining the geographic market, the FTC concluded that the proper market for analyzing HCA's acquisitions was the Chattanooga urban area and its suburbs. It determined that hospitals in outlying areas did not operate as a competitive check on hospitals in the Chattanooga area since few physicians held privileges at both outlying and closer in facilities.

The FTC then addressed the question of whether HCA's acquisition of various hospitals could have an adverse effect on competition in the Chattanooga area. When HCA acquired HAI, it also obtained a number of hospital management contracts, including two for hospitals in urban Chattanooga. HCA terminated one Chattanooga hospital contract, however, prior to the suit brought by the FTC. While HCA did not become the owner of the hospitals as a result of these contracts, it did become responsible for the day-to-day operations of the hospitals. In the case of one hospital, HCA also had acquired the land on which the hospital was located and an adjacent office building. Therefore, the FTC concluded, these HCA managed hospitals should be included in calculating the chain's market share.

The FTC determined that HCA's market share had gone from about 13 percent before the merger to more than 26 percent afterward. Further, it noted specific ways in which the HCA acquisitions could have adverse competitive effects. The FTC was particularly concerned that the acquisitions could make it easier for the newly merged firm and remaining hospitals to collude to the detriment of patients or their insurance companies, since the number of competitors had decreased while concentration had increased in the market.

Cost Containment Threat Seen

Among the types of possible collusion cited were: collective resistance to cost management measures adopted by third party payers or alternative low cost payers; diminished advertising and marketing activities; agreements to lower staff-patient ratios or wages and benefits for personnel; and joint opposition to certificate-of-need (CON) applications, which are necessary to build or expand certain types of medical facilities. The FTC also was concerned that HCA's acquisitions could result in anticompetitive pricing behavior if HCA agreed with the remaining hospitals on pricing formulae or other competitive terms.

As a result, the FTC ordered HCA to divest itself of the two hospitals it had purchased and the remaining management contract it had acquired. What is significant about this decision is the FTC's attention to the realities of health care markets, especially the importance of third party payers in the competitive process. The commission was aware of the new, more competitive environment evolving within the health care industry and was unwilling to see the process slowed by the possibility of an anticompetitive merger. ■

H. Robert Halper, contributing editor for "Law Notes," is a senior partner and Peter M. Kazon is an associate in the Washington, D.C., law office of O'Connor & Hannan.

TECHNOLOGY REVIEW

Assistive devices are key to lowering costs, aiding long-term care.

By Gloria Ruby

An increasing number of elderly persons in the U.S., particularly those over age 85, is likely to intensify the demand for health and social services and increase public and private expenditures for formal long-term care services. However, the costs associated with the provision of long-term services can be tempered by improving the functional capacity of older individuals who need assistance because of physical impairment.

The functionally limited elderly include both individuals who become impaired after age 65 and those who were impaired at earlier ages but are now over 65. Both groups are expected to increase. The number in the former group will grow because future medical advances that reduce mortality for the elderly may result in a larger portion of elderly persons living longer with chronic diseases, such as heart disease and osteoarthritis. Functional impairments and the inability to perform basic self-care and home management activities accompany such diseases. The number of elderly who were impaired at earlier ages is also expected to increase in the future as a result of biomedical advances that prolong the lives of developmentally disabled and physically handicapped individuals.

Technological Capability

Numerous technological devices are available to assist both the moderately impaired older population that needs help in preparing food, eating, performing household chores and managing other activities of daily living, and the elderly who have hearing, vision, walking and other impairments. If used appropriately, such assistive devices can provide cost savings for the individual, the employer, the insurer and society. For instance, use of an assistive or rehabilitation device often can reduce or eliminate the need for institutionalization. Of equal importance is the degree of independence the user can retain, which is essential for well-being, particularly as people grow older. For others the use of assistive devices and rehabilitation technologies can reduce the burden of care on family and friends and can further cut the absenteeism rate of employees who are informal caregivers.

These devices include hearing aids, telephones with large numbers on the dials or with large push buttons, battery operated and computerized wheel chairs, unlicensed vehicles such as golf carts, and automated voice technology that enables individuals with limited function to perform a number of tasks. Also there are vision technologies, such as optacoms, a combination minicomputer and a camera that converts printed images into vibrations that strike index fingers enabling poor sighted individuals to "see" through their fingers.

The scientific knowledge with which to develop new types of assistive technologies is increasing. For example, rapidly evolving computer and communications technologies hold tremendous potential. Already monitoring the blood pressure, pulse and heart rhythm of individuals in the home through closed circuit TV or computers enables people to remain safely and comfortably in their own homes without constant need of outside caregivers. These functions also may alleviate some of the anxieties that accompany chronic disease because an individual with a monitoring device is reassured that a physician is alert to his or her symptoms. Future possibilities are even broader, as a result of the advancing rate of computing power and storage capacity and the speed and sophistication of access. Functionally impaired elderly with sensory limitations, such as hearing loss, speech impairment or limited vision and neuromuscular ability, will benefit from smaller and more powerful and natural assistive devices.

". . .Many older people look upon an assistive device as a challenge and an opportunity for a more self-fulfilling life. . . .Almost all. . .want to remain functionally independent. . . ."

Although most of the devices that are available have been developed for the general public or disabled people, they also are or can be applicable to the needs of the elderly. Many may provide only minuscule improvement in functioning; however, they make a substantial difference in self-care ability. For example, an individual with limited use of an arm and hand can continue to feed himself or herself using devices such as splints and special eating utensils, thus increasing independence.

Devices currently available range from the simple and inexpensive to the highly sophisticated and expensive. There are more than 14,000 simple inexpensive devices that can assist with the daily activities of living in the home — bathing, dressing, eating, toileting, walking and getting in and out of bed. These devices include bath tub grab bars, velcro fasteners, suction grippers for jars, canes, lighted magnifying glasses, clocks with flashing lights, switches and controls on extension cords that can be easily reached, and clappers that turn devices on and off.

A variety of costly and sophisticated technology is also obtainable.

Utilization Barriers

The more costly and sophisticated technologies present production, marketing, financing, repair and reimbursement problems. Computers with

Gloria Ruby is senior policy analyst in the health program at the congressional Office of Technology Assessment in Washington, D.C.

large keys, for example, are usually custom-built and costly. Although they would be used for health purposes, these keys are not covered by public or private insurance. The adoption and use of all assistive devices for the elderly is further constrained by negative stereotypes about the elderly and their potential for accepting technological assistance. Some elderly may have several functional impairments, and devices suitable for one impairment may not be usable due to other functional limitations. For instance, an elderly person who cannot walk because of osteoarthritis may not have the stamina to use crutches or a walker because of respiratory or cardiovascular disease. Additionally, cognitive impairment can interfere with the elderly's ability to use assistive devices.

It is important, however, to recognize the heterogeneity of the older population. Older Americans vary widely in their willingness to adapt to assistive devices. Fortunately, many older people look upon an assistive device as a challenge and an opportunity for a more self-fulfilling life. Almost all the elderly want to remain functionally independent or be minimally dependent on people or technology.

Increasing Public Awareness

The appropriate use of assistive devices can delay or eliminate the need for costly institutionalization or extensive formal home care services for some of the elderly who are functionally limited. However, the capacity of such technologies to help individuals who are unable to manage activities of daily living has received relatively little attention from the functionally impaired, formal caregivers such as physicians and other paid medical practitioners, and informal caregivers such as family and friends. The reason for this is that most individuals are not aware of the variety of available devices.

Several initiatives have been devised to increase public awareness of technological devices. For instance, the National Institute of Handicapped Research (NIHR) is evaluating the efficacy, safety and cost of commonly used devices such as wheelchairs and hearing aids. Further evaluative research is the focus of the Veterans Administration's ongoing program in providing devices and rehabilitation services.

Conditions that affect the capacity to use these technologies such as multiple functional impairments, mental problems and psychosocial factors also must be measured. Advertising messages for assistive devices that reach a broader audience and that deemphasize stereotypical images of useless and unattractive disabled persons are another way to increase availability. The public, however, is not the only target of awareness initiatives. Physicians, nurses, social workers, physical and occupational therapists and other service providers also should be made aware of newer rehabilitation devices. Although all have had training in some devices, very few have knowledge of the wide range of available technologies.

Employers can help by informing their employees of sources of information, such as the ABLEDATA, a computerized data base sponsored by NIHR. Already, one public-private effort, the National Initiative on Technology and the Disabled, is working to create a national toll-free telephone network to provide comprehensive information on using technology to assist disabled people. The fundraising efforts by business, represented by an executive coalition of industry leaders, have resulted in more than $1 million. Scheduled to be implemented in two years, the initiative also involves the public sector, which includes the U.S. Department of Health and Human Services, the U.S. Department of Defense and the National Aeronautics and Space Administration.

Another way that business could help increase assistive device utilization is by encouraging insurers to include in their plans payment for such devices as eyeglasses or hearing aids to help the elderly impaired. For instance, many elderly diabetic individuals could benefit from the use of specially constructed shoes; however, because of the high cost such persons may not purchase the shoes. The diabetic can develop gangrene, which usually results in amputation and, thus, costly hospital bills. Further, employers with medical directors can educate these administrators about the availability of assistive devices.

Increased Medicaid, Medicare and public funding would facilitate provision of these devices. Further exploration in these areas will provide a better managed health care system for employers and their retirees. ■

BUSINESS AND HEALTH

Do you need your own copy of BUSINESS AND HEALTH?

Are you tired of waiting for others in the office to route the magazine to you?

Are you worried you may not be seeing every issue?

Don't wait any longer! Send today for your own, personal subscription to BUSINESS AND HEALTH.

Just call TOLL-FREE 1-800-424-2959 (in Washington, D.C. 872-1766) or send in the coupon below to:

Washington Business Group on Health
Computer Center
P.O. Box 76927
Washington, D.C. 20013-6927

☐ YES! Please start my subscription to BUSINESS AND HEALTH for one full year (10 issues) and bill me annually until cancellation.

PREPAY AND SAVE!

☐ Payment enclosed — $75

☐ Bill me — $79

Name_____

Title_____

Organization_____

Address_____

City_____ State____ Zip_____

Telephone (____)_____

Signature_____

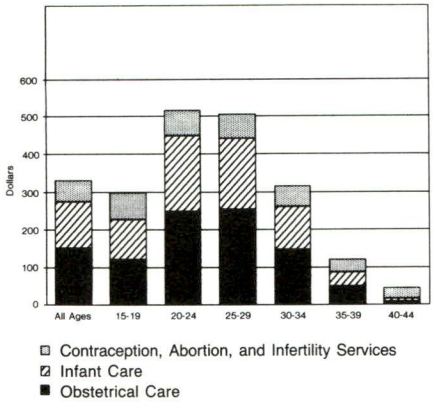
999940

DATA BANK

Hospital Strategies...A factor more and more hospital chief executive officers (CEOs) will be taking into account in strategic planning is the growing role of employers and insurers in reshaping health care, according to a recent hospital industry survey. Of 460 CEOs responding to a 1985 survey by *Hospitals* and Kurt Salmon Associates, 57 percent predicted private sector payers will soon surpass the government in increasing the pressure on hospitals to contain health care costs; only 5.8 percent downplayed private purchasers' influence in this area. Nonetheless, a growing number of hospital CEOs indicated they anticipated the government would be stepping in to help bail them out of the indigent care problem. This was demonstrated by a drop in the number of CEOs believing states would not increase their support to the medically indigent from 51 percent in a similar survey conducted in 1984 to about 33 percent in the 1985 survey. The latest survey also showed that increasing revenues and beating out the competition were primary in the minds of hospital CEOs and they would be exploring several areas of selective expansion with new or renewed vigor. These growth areas include industrial medicine, which is of particular interest to hospitals in the Northeast and Midwest, and women's medicine, reflecting the increasing number of women in the work force, which is being pursued mainly by hospitals in the West, Southwest and Northeast. *Hospitals* 59(24): 69-72, Dec. 16, 1985. ■

Reproductive Health...In comparison to health care spending for other sectors such as the elderly, reproduction related health expenditures are relatively low, concludes an analysis recently published in the *Journal of the American Medical Association*. Authors Victor Fuchs of Stanford University and Leslie Perreault of the National Bureau of Economic Research estimated direct costs for obstetrical and infant care, contraception, abortion and infertility services account for 5.5 percent of total health care spending. This compares to 33 percent of total health care spending that goes to medical care for the U.S. population over age 65. They caution that this does not take into account costs associated with lost work time by pregnant women, adoption or the psychic impact on women of contraception problems and abortion. Still, this indicates that despite media coverage of high costs associated with neonatal care, "reproduction related health care at present is not using a large part of health resources." In fact,

Reproduction Related Expenses per Woman by Age, 1982



Journal of the American Medical Association

the authors estimate, an insurance mechanism if it were to spread the high cost of neonatal intensive care across all babies delivered in a given year would add 10 percent or less to the total cost per live birth. More likely to affect future spending in this area are trends such as a drop in the number of babies born to women of childbearing age, cost containment activities and legal developments. Insurance coverage and reimbursement methods will have a lot to do with spending in areas such as treatment of infertility problems. Moreover, laws governing abortion, contraception and surrogate mothering will be the controlling factor for spending in these areas, they say. *JAMA* 255(1): 76-81, Jan. 3, 1986. ■

Physician Laboratories...As greater numbers of physicians have turned to in-office laboratories to assist in timely diagnosis, concern over the quality of laboratory tests has increased. In at least one state review, nonregulatory incentives such as accreditation standards required for reimbursement from third party payers or clinical society accreditation programs has proved to be inadequate in assuring high quality physician laboratory practices, according to a report published recently in the *Journal of the American Medical Association*. Thus, Idaho moved from its voluntary effort to a combination regulatory and consultation program after a formal study in 1977 showed this approach improved the accuracy of test results and compliance with quality controls by physician laboratories, according to the report. It notes that studies have shown the variability of test results is three to five times greater for physician office laboratories than for hospital based or independent laboratories. Idaho has 144 approved physician based laboratories compared to 47 licensed hospital laboratories and 16 certified independent facilities. In the study, 109 physician laboratories participated in on-site inspections, which revealed that the experience of personnel running the laboratories varied widely. Forty-two of the laboratories had medical technologists and technicians, 90 percent of whom had more than five years of experience; the remainder were supervised by nurses and individuals without formal training, of whom only 57 percent had more than five years experience. This lack of experienced personnel in physician laboratories was found to be linked to lower levels of compliance with quality controls than for technologist supervised laboratories, the report said. Seventy percent of technologist supervised laboratories maintained acceptable quality controls, compared to 26 percent for nurse supervised laboratories and 42 percent for laboratories run by staff trained on the job. The study showed test proficiency levels improved when an on-site consultation program was implemented for physician laboratories. For example, the error rate for urinalysis tests over a six-month period dropped from 8.6 percent to 7.2 percent with this program, and improvements of similar magnitude were achieved in the

error rates for hematology, chemical and bacteriology tests. The report notes that with no federal regulation of physician laboratories, Idaho, Wyoming and Pennsylvania have stepped in with comprehensive regulations designed to protect patients through establishing quality assurance programs for these operations. *JAMA* 255(3):374-382, Jan. 17, 1986. ■

Work Place Hazards...Uncertainties about the cause and effect of work place hazards to male and female reproductive systems complicate employer efforts to ensure a safe worksite, according to a recent report by the congressional Office of Technology Assessment (OTA). Designated as a significant health problem in the U.S., unintentional infertility affects more than 8 percent of couples of childbearing age. In addition, 7 percent of all infants in the U.S. are diagnosed as having various congenital malformations. OTA recognizes, however, that reproductive impairment is difficult to measure, and that the study of reproductive hazards in the work place linking toxic agents to such problems is inconclusive. Further complicating the study, says OTA, are incomplete data on toxic agents and their affects, as well as variations in worker susceptability. Only four agents are regulated because of known harmful effects on adult reproductive capacity or embryo and fetal development: ionizing radiation; lead; ethylene oxide; and dibromochloropropane. According to OTA, other factors causing reproductive impairment in varying degrees are physical factors such as noise and vibration, infectious agents, overexertion, stress and alcohol and tobacco use. OTA asserts that employers can reduce reproductive hazards by employing engineering and exposure controls, education programs and personal protective equipment. In addition to encouraging employers to consider employee protection, OTA suggests that Congress require employers to allow their workers to take a temporary paid leave of absence after experiencing occupational health hazards and that federal or state law add provisions to worker compensation to cover reproductive health or amend existing laws to provide employees the right to pursue tort remedies for uncompensated injuries. OTA also suggests that regulatory agencies be instructed to assume that an exposure is dangerous, even if only a few studies show that this is so. It calls for an amendment to the Occupational Safety and Health Act (OSHA) to allow employees to take action against employers who may be violating regulations. Copies of "Reproductive Health Hazards in the Workplace," (Pub. No. 052-003-01001-1) are available for $15 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. ■

Employed Uninsureds...National surveys indicate that in 1980 more than 9 million persons in the U.S. between the ages of 16 and 64 were employed at least some part of the year yet lacked any kind of insurance. These individuals make up a key group whose uninsured status is ripe for public policy considerations, according to several researchers with the U.S. Department of Health and Human Services (HHS).

Employment Status of Persons Uninsured in 1980

Uninsured Persons	Percentage of Uninsured
Employed all or part of year (16 to 64 years of age)	55.6
Full-time	38.7
Part-time	16.9
Persons not working (16 to 64 years of age)	15.2
Persons < 16 years of age	26.2
Other uninsured persons*	3.0
Total uninsured persons	100

* Includes persons 65 years of age or older and persons with unknown employment status.

Source: National Medical Care Utilization and Expenditure Survey, 1980

Researchers Alan Monheit, Michael Hagan, Marc Berk and Pamela Farley illustrate in their article, "The Employed Uninsured and the Role of Public Policy," published recently in *Inquiry*, that in 1980 the employed uninsured accounted for more than 55 percent of all uninsured persons for one year. Further, the authors assert, uninsured workers tend to be those who are self-employed, those in seasonal jobs or those in low technical occupations in agriculture, construction, sales, repair, personal services, entertainment and recreation. In addition, self-employed individuals are almost twice as likely to lack coverage than wage earners and tend to be poor, with relatively little education. The survey also found that of those workers with private insurance, 70 percent obtained coverage at their work place; 89 percent of the uninsured were not able to get insurance through their employers and 22 percent of the uninsured were not eligible for health insurance benefits that were offered by their company. The authors maintain that policy directives must take into consideration the diversity of the employed uninsured and must consider cost management procedures that at the same time do not pressure employers to terminate marginal workers. They also suggest options that would require employers to make insurance available to all employees, encourage state insurance pools to make coverage available to uninsured workers, and use income tax incentives to promote health insurance purchases. *Inquiry* 22:348-364, Winter 1985. ■

Disabled Black Adults...Less than one in four disabled black adults of working age — or 22.4 percent— are employed, and of the nation's total black working age population, 14 percent have a work disability, according to a recent study, "Black Adults with Disabilities," published by the President's Committee on Employment of the Handicapped. Author Frank Bowe attributes the low number of disabled working blacks to the double discrimination they face: race and disability. According to Bowe, "blacks are more likely than whites to perform physically demanding work that may lead to disability; simlarly, conditions in whites that may be corrected by medical care may, among blacks, persist until they become permanent disabilities." The study also found that 53 percent of disabled black persons are women, primarily because women outnumber men in the general working age population. However, U.S. Census Bureau data indicate that the typical work age, disabled black is single, 42-years-old, unemployed with a 10th-grade education, and has accumulated approximately $3,000 in income from all sources. Bowe also found that almost all such disabled persons have incomes below the poverty line. One positive finding, however, is that of those disabled who did not work but sought employment, 73.5 percent have found jobs. Copies of the report are available at no charge from the President's Committee on Employment of the Handicapped, 1111 20th St., NW, Washington, D.C. 20036. ■

Suzanne Viau Klett and Lisa Lopez

LABOR FORUM

New York City union tries stress reduction to counter job pressure.

By Robert Terruso

In 1979, the New York City District Council 37 opened Med Plan, a prepaid group medical practice housed at the Bellevue Hospital complex and affiliated with New York University Medical School. Med Plan offers its services to the 110,000 union members who include blue-collar and clerical workers, motor vehicle operators, engineers, social workers and nurses aides.

Over the next few years, however, a family practitioner at Med Plan began to notice that a growing number of his patients were being seen for general fatigue, headaches, minor depression and gastrointestinal problems. Numerous tests were performed that failed to provide a cause for the complaints, which resulted in an overutilization of medical services. The physician, in consulting with a social worker about these patients, noticed that all them worked as case aides at local public assistance centers, a highly stressful job that required constant contact with an angry and demanding public.

Needs Assessment

Consequently, the social workers in Council 37's personal service unit, which was responsible for providing social service screening and referrals for union members and their families, developed a stress reduction program as part of the group's efforts to supplement the medical services offered to union members. The purpose of the program, conducted over an eight-week period, was to educate these workers about job related stress and to provide them with techniques and skills to cope better with the stressors encountered in their jobs.

Robert Terruso is associate director of the Personal Service Unit of the Health and Security Plan at New York City's District Council 37.

Twenty-five participants were referred to the program by the family physician at Med Plan. According to the case workers, the problems encountered most often on the job were:

- Overly demanding, sometimes abusive public assistance clients;
- Lack of support from administrators and supervisors who gave little or no consideration to managing case worker responsibilities within a reasonable time frame;
- Insufficient cooperation and support from co-workers.

The social workers were impressed with the caseworkers' awareness of their work roles, responsibilities and how they should conduct themselves with clients, most of whom were on welfare. For example, the aides recognized that those who came to the city for assistance were often in a state of emotional crisis and required a sensitive response. They understood that to get at the root of the problem, they needed to identify individual factors of the entire problem; however, they were not able to implement this knowledge due to the tremendously high number of caseloads they were expected to handle. Frequently, they found themselves verbally and even physically attacked by their clients and consequently responded defensively in their work responsibilities. It came as no surprise, then, that the pressures of relentless supervisory expectations and abusive clients resulted in general medical complaints as well as absenteeism, tardiness and poor work evaluations.

After the needs assessment was completed, a group program was developed for the caseworkers. Approximately 12 to 15 individuals attended the weekly sessions. The social workers responsible for the group enlisted the expertise of the medical staff who examined both personal and organizational issues involved in the caseworkers' problems. The group participants began to realize that they were not alone in what they were experiencing and that others had similar feelings. This realization was the first step in dealing with the problem. They learned to define stress and to identify stress factors at work.

The participants identified inappropriate ways they dealt with job related stress: passively withdrawing from the stressful situation, which slowed their work performance; calling in sick; aggressively arguing with supervisors and co-workers; or refusing to perform assigned work tasks. As a result, the group began to explore productive coping mechanisms. Through the use of relaxation techniques, meditation and exercise they were able to reduce the cumulative effects that a stressful work environment had on their ability to cope. The sessions also emphasized developing skills for dealing with difficult people they encountered at work. They were given specific training in nonviolent crisis intervention, which helped them feel more adequately prepared to deal with agitated and hostile clients.

Program Results

Funded through the union's health and security plan and carried out by the professional social work staff of the union's personal service unit, the stress reduction program was effective in reducing the number of stress related medical problems for this population. The group members brought to their jobs a new perspective. They also helped develop supportive networks, which enabled the workers to more effectively cope with a demanding work environment without feelings of isolation and guilt. In addition to teaching individual coping techniques to the participants, the program was able to respond to the workers' complaints about the stressors in their jobs that were beyond their individual ability to change.

In addition, labor and management met to discuss job and organizational issues. As a result, caseload size was reduced, financial incentives were introduced for additional work, provisions were made for more adequate security for the protection of staff against assault, and a quality of work-life committee was formed to continue to explore ways in which to improve the work environment. ■

INTERNATIONAL VIEW

DRG projects in Europe and Australia fuel new management applications.

By Robert B. Fetter

Interest in diagnosis related groups (DRGs) and their applications has been developing globally since 1977, when the Dutch began working with DRGs for case mix analysis. Based on this research, which demonstrated the feasibility of grouping hospital records by DRGs and their capability to represent Dutch hospital case mix, the Dutch government sponsored a DRG reimbursement experiment in two university hospitals.

Of the 19 countries that are members of the Council of Europe, 17 reported at the council meeting last November that they are conducting DRG projects. Most of these projects are directed toward assessing the availability of DRGs to describe hospitalized patients, and to evaluate their contribution to improvements in the way in which hospitals are financed. In essence, at the heart of these countries' concerns are the escalation and the lack of control of hospital expenditures.

French Style DRGs

The French Ministry of Health initiated in 1981 and scheduled for completion this June the Project for the Medicalization of Hospital Information Systems. The objectives of this project are:

- To experiment with a new system of medical information in a group of short stay hospitals;
- To develop and refine the definition of the *groups homogenes de malades* (GHMs), which are analagous to DRGs in the U.S., using a French data base from these hospitals based on a standard discharge abstract;
- To put in place a statistical analysis system operating on existing French computer systems;
- To refine hospital accounting capabilities to permit uniform cost reports from different hospitals and then to obtain costs by GHM;
- To compare budgets and hospital performance, accounting for different case mix and different costs of treating the same kinds of patients.

Under contract with the French Ministry of Social Affairs, the Health Systems Management Group of the Yale School of Management (HSMG) sought initially, in 1982, to validate the French data on DRGs to determine whether they described diagnosis and corresponding DRG codes as they are defined in the U.S. These analyses demonstrated that this was possible.

As a second major project, the Yale group collected detailed medical data on diagnosis, procedures and demographics on each patient as well as cost data on function and type of service from two French hospitals. Then, utilizing a cost finding model developed for U.S. hospitals, the group produced detailed costs by GHM for the French hospitals. The results were again positive and the French ministry decided to implement its own version of this process.

Charged with the responsibility of developing the software necessary for utilization of the cost finding and budgeting system in all French public hospitals, the HSMG has begun training French personnel to transfer the technology directly to each hospital. It is envisioned that by 1988 each hospital will be able to calculate its costs in detail by DRGs and eventually use the information to better manage its own institution. Further, the use of the DRG system will help the ministry administer the global budgeting system, which was established in France in 1979 and limits the increase in national expenditures for hospital care to the lesser of the actual increase in budgets submitted or the increase in the French Gross National Product. Distribution of the global budget to each hospital is decided by the ministry. In addition, there are plans for the national health insurance program in France to initiate a project this year to evaluate the potential of a DRG case payment system for private patients, about 20 percent of the total hospitalizations.

Management, Planning Goals

With a four-year grant from the Agency for International Development (AID), Boston University is developing a DRG based costing and budgeting system for Portuguese hospitals. HSMG already has completed initial work aimed at producing mappings, or correspondence tables, between diagnostic and procedural coding schemes used in Portugal and ICD-9-CM, a U.S. coding system used to define DRGs. The HSMG has grouped records from 16 hospitals, and demonstrated the validity of DRGs in their ability to explain length of stay. Currently, HSMG is doing detailed cost per case analysis in four hospitals in Portugal by adapting its basic cost model to deal with Portuguese hospital accounting methods. Future work will be aimed at defining a standard cost accounting structure to be used in all hospitals and integration of the cost and budget model with newly developed productivity reporting systems.

The Swedish Planning and Rationalization Institute (SPRI) has initiated a project to evaluate the utility of DRGs in Swedish hospitals. The initial phase includes grouping, case mix analysis and DRG validation. Finland, Norway and Iceland are developing similar project proposals. The main difficulties in initiating such work are in producing compatible mappings for diagnosis and procedure codes. For example, in Sweden, an older U.S. coding scheme — ICDA-8 — is used for diagnoses while surgeries are described by a Swedish code.

There has been sporadic work on DRGs over the last several years in Britain, most of which has been severely limited because specific service information on patients is not routinely kept. In addition, in Britain DRGs are defined in a computer program that produces different results than the U.S.

Robert B. Fetter is professor of operations, research and information services at the Yale School of Organization and Management in New Haven, Conn.

system; consequently, comparative analyses are difficult.

A DRG project is being implemented in Ireland, where hospital budgets are determined by a central health authority and are based largely on the previous year's disbursements, resulting in uncontrolled expenditures and funding inequities. Based on earlier work at Yale with Irish data, a preliminary report has been issued from the Ireland Department of Health assessing the feasibility of assigning records to DRGs. Work is now proceeding to identify several hospitals that will serve as pilot sites for DRG costing and budgeting.

In August 1984, a two-day workshop on the potential applications of DRGs was held in Canberra, Australia. This sparked a high level of interest among a number of states including New South Wales and Victoria, which since have initiated a variety of DRG projects.

The School of Health Administration at the University of New South Wales, for example, is conducting several projects including grouping, case mix analysis and validation of DRGs utilizing data from all hospitals in Victoria. Based on these results and the case mix analysis of data from all Victorian hospitals, the Victorian Health Commission is proceeding to implement DRG costing for all hospitals in the state. There is currently a great deal of activity in several states at the regional and hospital level aimed at understanding better the utility of DRGs to improve the health delivery system, and an experiment has been proposed in New South Wales to evaluate the effectiveness of a DRG based payment scheme for private hospitals.

In all these applications, the central theme is the understanding and control of expenditures for acute care. In some countries, such as France and Portugal, the approach is through changes in the way in which hospitals are managed. In others, such as Australia and Ireland, DRGs are viewed as a mechanism to change the way in which hospitals are financed. Finally, in countries, such as Sweden and Norway, they are viewed as a mechanism to improve the planning for delivery of hospital care. Underlying all of these applications, however, is the desire of the payer both to control the rate of increase in expenditures and to improve the health care delivery system. ■

TOGETHER WE CAN MAKE A HEALTHY DIFFERENCE

With HRM ReviewPLUS℠ people come first.

We'll help your employees by giving them essential information. Information about procedures. Medical necessity. Possible alternatives to hospitalization. The information people need to become better-informed health care consumers.

We even negotiate fees on their behalf.

The ReviewPLUS nurses and doctors on duty at HRM each day are highly experienced. Our ReviewPLUS services cover 1 in every 200 Americans.

And we get results. Our state-of-the-art telecommunications systems, computer technology and comprehensive database make it possible.

But our caring, dedicated people make it work. Call HRM, toll-free, for details and we'll show you how.

Together we can make a healthy difference.

HRM®

Health Risk Management, Inc.
1 (800) 824-3882

PERSONAL PERSPECTIVE

Policies for the disabled must encourage individual productivity, independence.

By Lex Frieden

Unemployment and underemployment of people with disabilities should be of major concern to employers and to public policy makers. A recent report, "Toward Independence," issued by the National Council on the Handicapped, found that only about one-third of the 36 million people who have been labeled as having a disability are employed, another one-third are dependent on public assistance, and the remaining one-third neither work nor receive public assistance. Yet, according to a recent Harris poll, two-thirds of the people with disabilities who are not working would like to work.

It is a disturbing and ironic fact that millions of working age disabled people with employable skills are not working. This is due to a variety of factors, including barriers in the work place, lack of transportation and, perhaps most significant, lack of available health insurance coverage.

Work Disincentives

Of the $60 billion that the federal government spends annually on programs related to disability, less than $3 billion is spent on rehabilitation and education programs specifically designed for employment preparation and independent living. The council notes that most of the remaining disproportionate amount of funds is spent on dependency oriented income support programs.

In addition, many people who now rely on Social Security or other types of public assistance programs for support face the reality that entry level employment in many types of occupations will not provide enough income to meet their basic life necessities. Coupled with the loss of related medical benefits, this predicament creates a major work disincentive. Because they are unable to obtain health insurance at affordable rates or insurance that will cover preexisting conditions, many otherwise employable people with disabilities see no other option but to remain on public assistance.

The council addressed these concerns in its report and made a number of recommendations, including suggestions that persons receiving Social Security disability benefits who choose to go to work should continue receiving their benefits up to a certain level, and that Medicaid coverage should be made permanent for these individuals. The council also recommended the development of cooperative agreements between public and private insurance programs in which Medicaid would pay disability related medical expenses and private insurers would pay for other medical expenses.

Support Services Key

Because of the many barriers to employment for disabled people there is a need for more training and educational opportunities to prepare them for work. The traditional rehabilitative approach is not enough if opportunities to use the skills learned in the process are not available, if the environment is not accessible and if the appropriate support services are not available in the community.

The council is committed to the philosophy of independent living and proposes to encourage the continued development and expansion of programs that are designed to assist disabled people in achieving their goals of independence and productivity.

To live independently in the community, some disabled people need a variety of support services. An individual with a severe physical disability may need assistance with personal care, domestic tasks, transportation or architectural modifications at home or work. People with sensory disabilities may need readers or interpreters to help them better communicate, and those with mental disabilities may need assistance with cognitive tasks such as banking and home accounting.

Perhaps the most important of all support services for individuals who are severely disabled is personal care assistance. Whether such assistance means provision of an attendant for a physically disabled person, a reader for a blind person, or an advocate to protect the interests of an individual with a mental disability, personal care assistance, along with other community based services, can allow people to make their own choices as to where they live, where they work or with whom they associate. Such choices are fundamental and should be exercised by disabled people as well as nondisabled people.

Additionally, the council feels that the Health Care Financing Administration (HCFA) should examine and make recommendations for changing what appears to be an institutional bias in the way program funds are prioritized and spent. Billions of tax dollars are spent each year subsidizing the care of disabled people in nursing homes and other dependency inducing institutions. Many of the people served in these restrictive settings could and would prefer to live more independently in the community if less expensive home care was available to them on a part-time or shared basis. In view of the achievements of independent living programs in helping severely disabled people to live successfully in the community, the provision of comparatively costly institutional care is, in most cases, unnecessary and indefensible.

Disability policy must be viewed from a broad perspective. It must be realized that in order to improve the quality of life for disabled Americans, while minimizing costs and lost productivity, steps must be taken now to begin restructuring the nation's approach to disability policy. Employers and policy makers must begin to encourage independence, productivity and self-sufficiency among people with disabilities, rather than dependence as is done today. The council's report is a blueprint for progress. It provides a useful perspective from which to begin the process of changing public policy toward disability. ■

Lex Frieden is executive director of the National Council on the Handicapped in Washington, D.C.

Coming in Future Issues of BUSINESS AND HEALTH

Social Costs of Caregiving
Carol A. Nowak,
State University of New York at Buffalo

Measuring Quality Care
Arnold Milstein, National Medical Audit

Health Insurance, Japanese Style
Jay Wolfson and Peter J. Levin,
University of South Florida

The Costs of Prevention
Louise B. Russell,
The Brookings Institution

Evaluating EAP Providers
Sheila H. Akabas and Marian S. Krauskopf,
Columbia University School
of Social Work

Experiences of a Union Run PPO
Perry Ciccotelli,
Local 825, Operating Engineers

Arbitration Alternative for Malpractice
Arnold J. Rosoff,
University of Pennsylvania

Bed Reduction in Milwaukee
Jack Needleman and Robert Derzon,
Lewin and Associates, Inc.

A Role for Allied Health Professionals
Patricia P. Bailey,
Federal Trade Commission

Multifaceted Wellness Program
Dave Patterson,
United Methodist Publishing House

Health Capital Policy
Jonathan Brown,
Harvard University
School of Public Health

Cost Implications of Alzheimer's Disease
Robert M. Cook-Deegan,
Congressional Office
of Technology Assessment

The Problems of Pain
Gerald M. Aronoff,
Spaulding Rehabilitation Hospital

Community Rating for HMOs
Harry Sutton,
Towers, Perrin, Forster, & Crosby

Employee Choices Under Cafeteria Plans
Randall P. Ellis, Boston University

Group Benefits for Small Employers
John Polk,
Council of Smaller Enterprises

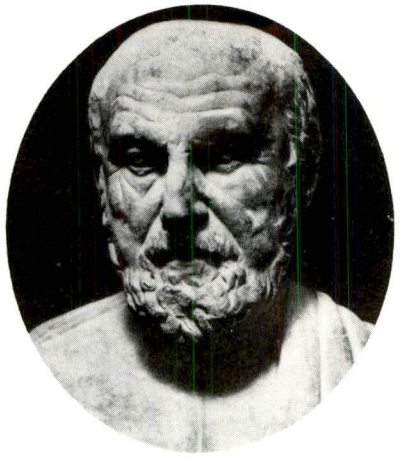
Personal, Societal Concerns about Quality Health Care
Uwe Reinhardt, Princeton University

Indigent Care Strategies
Dennis Andrulis,
National Association of Public Hospitals

Quality: What is Medicare's Responsibility?
Sen. John Heinz (R.-Pa.)

Physician Response to Small Area Analysis
Philip Caper, Dartmouth Medical School

Henry Ford



Hypocrates

The perfect team for your healthcare cost containment program.

Good business. Good medicine.

We believe they go hand in hand. That good medicine is cost-effective medicine. And there should be no dichotomy between innovative quality patient care and fair, tough-minded management of healthcare costs.

But we also live in the real world.

And what we see is many aggressive, one-dimensional cost containment plans that reduce expenses by reducing treatment. Overcare may shift to undercare.

If that happens, the ultimate cost to employers is staggering. Complications and prolonged recuperation. Readmissions. Absenteeism. Lost productivity. Unhappy employees. Maybe even litigation.

So, what's the answer to mixing good medicine with good business?

Peer Review Analysis.

PRA is a private cost containment firm. We consult on state-of-the-art strategies for achieving quality, cost-effective healthcare, including utilization review, quality assurance, and managed care programs. Our clientele: companies, hospitals, unions, insurance carriers, HMOs, third-party claims administrators.

We also offer a comprehensive Patient Review Program which evaluates overcare and undercare within an integrated package.

Our Patient Review Program is modular. You choose the exact services you need to round out your managed care plan. Pre-treatment planning through *Preadmission Review. Emergency Admission Review. Concurrent Review and Monitoring. Return To Work Review* (a PRA first). *Retrospective Review and Analysis. Management Reports.*

The heart of our consulting sevices is the Nurse Reviewer-Physician Advisor team. Managed care works because they're able to communicate about procedures and costs with attending physicians and hospitals. Right *upfront*. Experienced health administrators, researchers, and analysts support the review team. So you always benefit from the best of two worlds: business and medicine.

No question, we're in a unique position to help you contain costs without risking the quality of healthcare you and your employees deserve.

Team up with us. Call or write for our brochure, *Linking quality healthcare and sound business economics.*

The number is (617) 354-8550.

Peer Review Analysis, Inc.

Cost-effective strategies for quality healthcare

©1985 Peer Review Analysis, Inc. 222 Third Street, Cambridge, MA 02142-1132. (617) 354-8550. Managed Healthcare Consulting.