# THE CHANGING MARKET FOR HEALTH INSURANCE: OPTING OUT OF THE COST-PLUS SYSTEM

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NCPA POLICY REPORT # 118

SEPTEMBER, 1985

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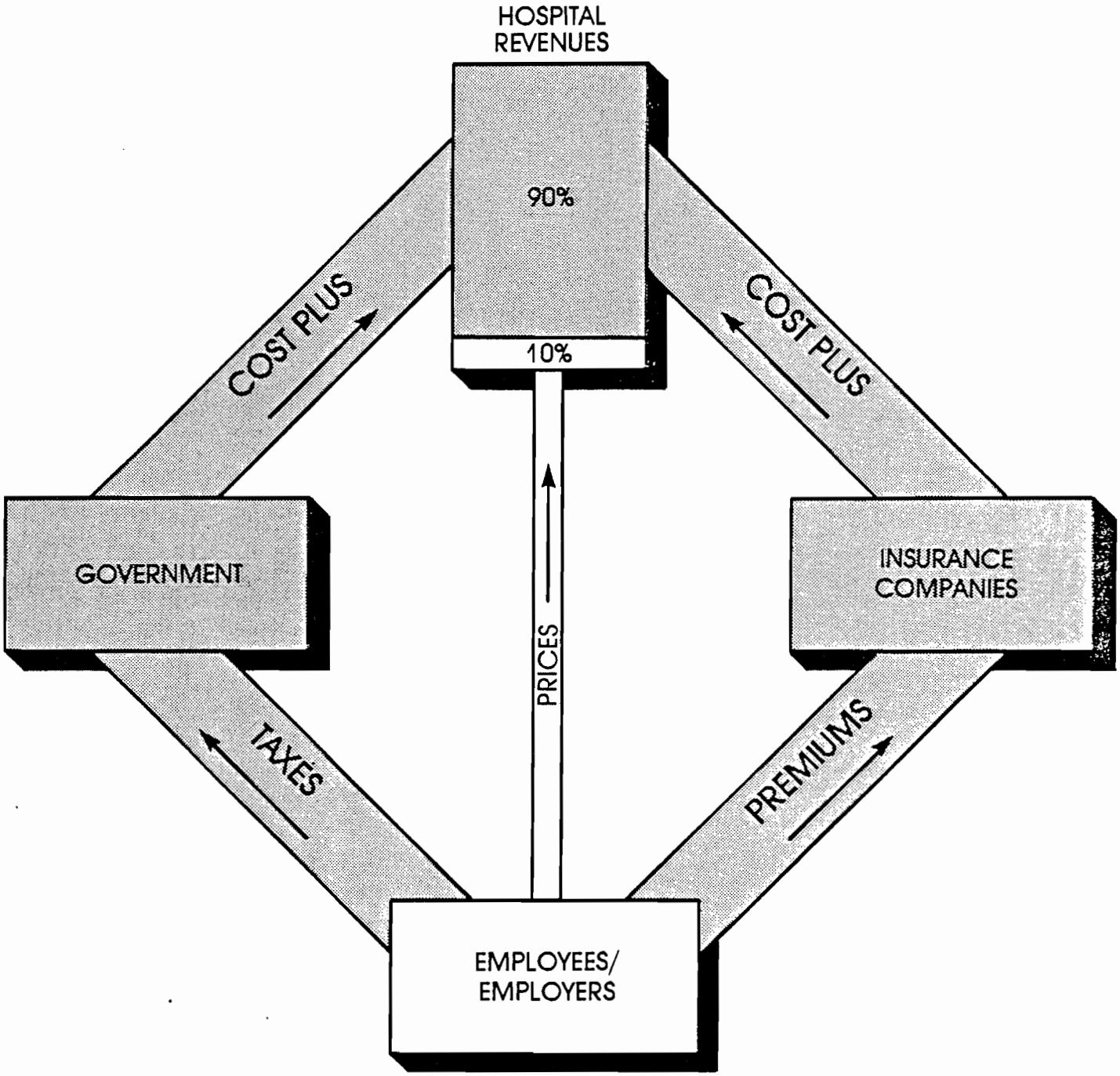
Dallas, Texas 75247

# HOW HOSPITALS GET THEIR MONEY
## (The Cost-Plus System)

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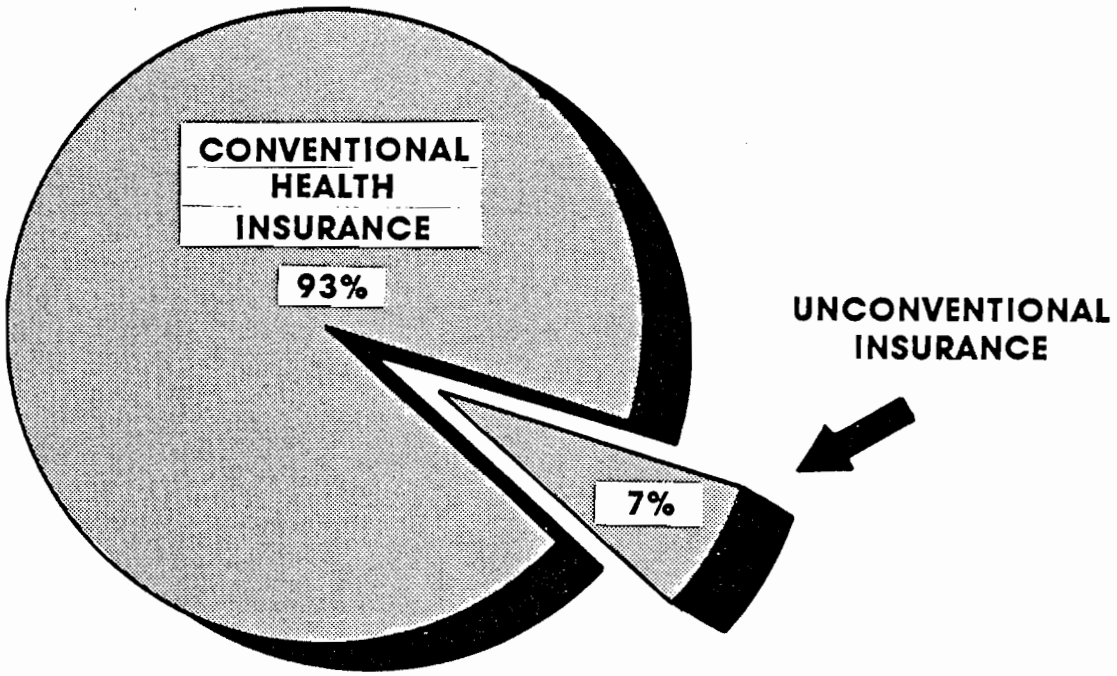
# THE CHANGING NATURE OF THE HEALTH INSURANCE MARKETPLACE

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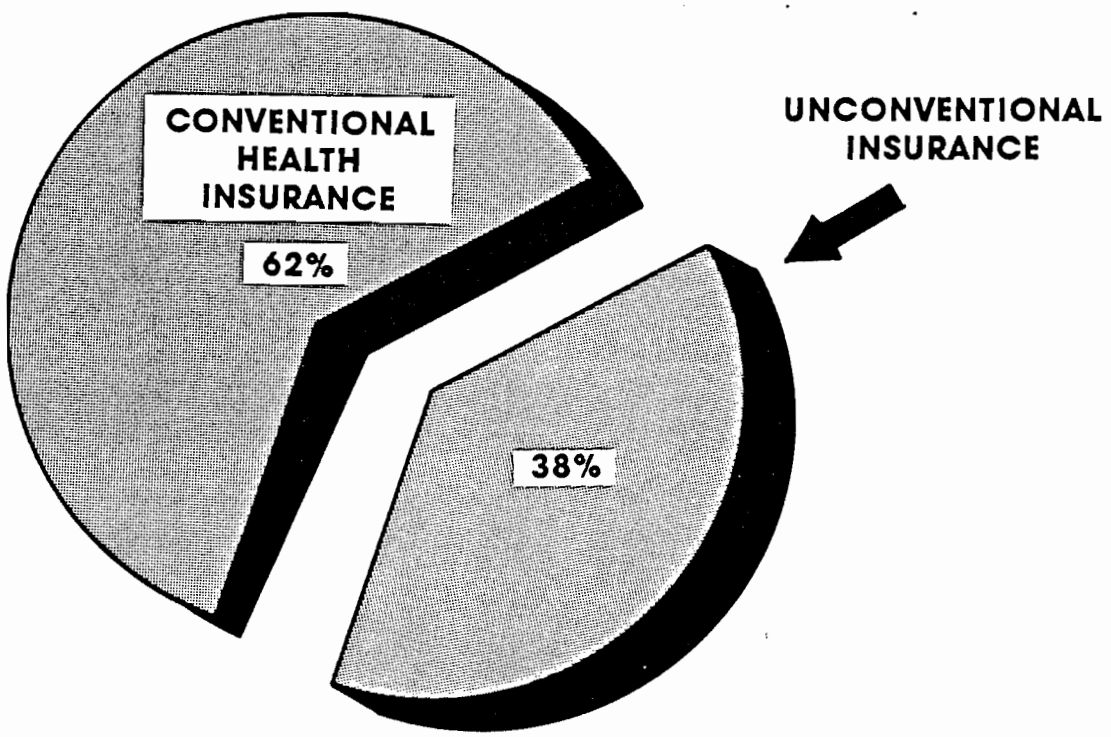


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Source: National Center for Policy Analysis

# I. INTRODUCTION*

This study is based on a few straightforward propositions:

- The American system of paying for hospital care over the last several decades has evolved into a cost-plus reimbursement system.
- This system gives rise to escalating health care costs, because, as in any cost reimbursement system, the recipients of funds find it in their self-interest to increase costs.
- The only way employers and their employees can substantially control the cost of employer-sponsored health care plans is to opt out of the cost-plus system.
- Most of the changes we have been observing in the medical marketplace in the last few years have been attempts on the part of employers and providers of health care to find and exploit alternatives to cost-plus reimbursement, and to rely on competition and the price system instead.
- The evolution of the cost-plus system was not the result of the free market, but of deliberate government policies; the slow dissolution of the cost-plus system is the consequence of recent changes in government policies.
- Sound public policy requires that government remove the remaining barriers that serve to protect the cost-plus system, and allow the market to work.

* The authors would like to thank Jesse Hixon, U.S. Department of Health and Human Services, for many helpful comments and suggestions on this manuscript.

## II. HOW THE SYSTEM EVOLVED

The American system of public and private health insurance, by and large, is designed to insure that hospitals do not go out of business, that they receive sufficient revenues to cover their costs. From the hospitals' point of view, the system has worked reasonably well. Very rarely do we see a hospital go bankrupt and close up shop. Our system of health insurance has managed to insulate hospitals from the potentially fatal risks that competition naturally creates for firms in other markets.

What is good for hospitals, though, is not necessarily good for patients and policyholders. An insurance system designed to make sure that hospitals cover their costs is inherently adverse to the interests of those who are insured. The cost-plus system virtually guarantees that health insurance premiums will go right on rising, because the people who are directly responsible for controlling hospital costs find that the only way they can increase their revenues is by increasing their costs. In this system, it is in the financial self-interest of the providers of health care for costs to rise.

In this respect, health insurance contrasts markedly with other forms of insurance. The automobile insurance industry is not organized to insure that auto repair shops remain in business. Indeed, auto repair shops go in and out of business every day. The fire and casualty insurance industry is not organized to insure that builders and home repair firms stay in business. These enterprises also have an uncertain future in the marketplace. Insurers, after all, are supposed to act on behalf of the interests of their clients, the policyholders, and not on behalf of the people who perform repair services in the event of a loss. However, in the market for health insurance the situation is very different.

It was not always so. In the early part of the 20th Century, health insurance was extensively developed in Oregon and Washington, largely as a result of the hazardous working conditions in the lumber, railroad and mining industries. The historical record shows that these insurance companies behaved in much the same way as fire and casualty insurance companies behave today.[1] These early health insurance companies aggressively monitored both prices and medical services in order to keep costs down. Physicians' fees were scrutinized closely. Doctors often were warned about unnecessary surgery and frequently were asked to justify their procedures. Physicians often were asked to explain or justify hospital stays that were longer than the average length of stay for particular procedures.

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1 See Lawrence Goldberg and Warren Greenberg. "The Emergence of Physician-Sponsored Health Insurance: A Historical Perspective," in Warren Greenberg, ed., Competition in the Health Sector: Past, Present and Future (Germantown, Maryland: Aspen Systems Corporation, 1978), pp. 288-321; and Lawrence Goldberg and Warren Greenberg, "The Effect of Physician-Controlled Health Insurance: "U.S. v. Oregan State Medical Society," Journal of Health Politics, Policy and Law, 2 (Spring, 1977), pp 48-78.

All of this began to change with the rise of government regulation of the health insurance marketplace. One of the most important consequences of that regulation was the emergence of Blue Cross and Blue Shield, plans that would soon grow to occupy a monopolistic position in the market.[2] This was done by design. In state after state, the "Blues," as they are known, were given special tax and regulatory advantages not granted to other health insurance companies. These advantages helped shape the entire nature of the market for health insurance. Consider that:[3]

- By 1950, Blue Shield sold 52 percent of all regular medical insurance. Blue Cross sold 49 percent of all hospital insurance.

- For the next three decades, the share of total insurance sold by these two plans never dipped below 40 percent of the insurance market.

Two things are important about this development. First, unlike the early health insurance companies, Blue Cross and Blue Shield never saw themselves as adversaries of the medical community. To the contrary, Blue Cross and Blue Shield plans were largely created and governed by the very institutions whose bills they were paying. For example:[4]

- In 1959, 51 percent of the governing boards of Blue Cross plans consisted of hospital trustees and administrators, and 17 percent consisted of physicians and representatives of medical societies.

- Sixty-one percent of the governing boards of Blue Shield plans were physicians or their representatives; 14 percent were representatives from hospitals.

Not only was there no question of an adversarial relationship, it was generally thought from the beginning that the Blues were created to represent the medical community, not patients. Two experts in hospital finance flatly state, "Blue Cross was founded to save hospitals from financial ruin."![5]

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2 In generalizing about Blue Cross it is important to note that although there is a national Blue Cross organization and although the members typically have very similar views, there are in fact 67 separate, autonomous plans in the U.S., each of which sets its own policies. For most Blue Cross plans, there is a companion Blue Shield plan. Often the two plans work together and share services and billings. In some cases the two plans have merged into a single corporate entity. See Howard J. Berman and Lewis B. Weeks, The Financial Management of Hospitals, 5th ed., (Washington, D.C.: Health Administration Press, 1982), pp 145-173 and pp. 110-121.

3 Sourcebook of Health Insurance Data, 1975-1976.

4 Taken from Medical Economics, June 28, 1965, p. 75.

5 Berman and Weeks, The Financial Management of Hospitals, p. 147.

The second important point about the Blues is the fact that they dominated the market, while any single rival had only a very small share of the market. What this meant was that it was very difficult for a commercial insurance company to adopt reimbursement procedures that differed in any fundamental way from those used by Blue Cross and Blue Shield. If an insurance company with a small part of the market attempted to deviate in a radical way, the medical community could threaten to boycott that company and refuse to treat its patients. Even a company the size of Aetna Life and Casualty, with nearly 12 million policyholders, discovered that it could not fundamentally alter its reimbursement procedures in a way that threatened conventional insurance procedures.[6]

What were the reimbursement procedures adopted by the Blues? In general, they involved very little interference with the clinical judgement of doctors or with the medical decisions made in hospitals. Perhaps of more importance, under Blue Cross hospitals came to be reimbursed in a way that hospitals almost unanimously approved of--cost-plus.

## III. HOW THE COST-PLUS SYSTEM WORKS

Suppose a male patient enters a hospital for a medical procedure. He has a Blue Cross health insurance policy with a $200 deductible and a required co-payment of 20 percent. When the man is released from the hospital, he is presented with a lengthy bill detailing all of the services that the hospital performed and indicating the charge for each one of them. The amount owed by the man is $200 (the deductible) plus 20 percent of the remaining charges.

As our hypothetical patient leaves the hospital, folding his copy of the bill, placing it in his coat pocket, and feeling remorse over the preceding reduction in his bank account, he takes some consolation from the thought that Blue Cross will pay for the other 80 percent of the remaining charges. But the man is quite wrong. What Blue Cross pays may be more than 80 percent of the remaining charges, or it may be less. More to the point, what Blue cross pays is only tangentially related to the bill which our hypothetical patient just put in his pocket.

The amount paid to the hospital by our hypothetical patient is based on the prices which the hospital charges for its services. The patient might have compared these prices with those charged by other hospitals. If he chose a lower-priced hospital, he might have enjoyed the good feeling that he was helping to keep health care costs down and at the same time helping to keep insurance premiums down for his employer and his fellow workers. But again, the man is quite wrong.

What Blue Cross pays hospitals is not based on the prices hospitals charge patients. Under traditional reimbursement policies, what Blue Cross

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6 See Charlotte L. Rosenberg, "He Challenged Aetna's Hard-line Fee Policy--and Won," Medical Economics," September, 1982.

pays is based on hospital costs. These costs may or may not be reflected in the prices hospitals charge. Often they are not. Thus in choosing a lower-priced hospital, our hypothetical patient inadvertently may have chosen a higher-cost one, thus contributing to escalating health care costs and higher insurance premiums--precisely the opposite of his intent!

## Reimbursement Formulas

Table I lists three common formulas used by Blue Cross plans to reimburse hospitals. The most common of these is the "per diem" method. It works like this: Suppose that on the average 30 percent of the patient-days of a particular hospital are accounted for by Blue Cross patients. Blue Cross then agrees to pay 30 percent of the hospital's costs. "Cost" is determined by various accounting techniques, about which there can be much arguing and bickering. Usually a "plus" factor is thrown in to cover the value of working capital and equity capital. Hence, the term "cost-plus".[7]

One does not have to study the per diem reimbursement formula for very long before being struck by the following realization. The one sure way for a hospital to increase its revenues is to increase its costs. Thus, if a hospital adds more beds (even if they go unfilled) or buys expensive equipment (even if it goes unused) it increases its costs, and therefore its revenues from Blue Cross. Conversely, anything a hospital does to decrease its costs also decreases its revenues. Blue Cross, then, pays for hospital care in much the same way as the Defense Department pays for some weapons systems, but without the same rationale.[8]

Two other reimbursement formulas also are depicted in Table I. Like the per diem method, the "department" method and the "combination" method also are cost reimbursement schemes which essentially reimburse hospitals based on the costs they incur. A survey taken in 1976 showed that:[9]

- Among Blue Cross plans using cost-based reimbursement formulas, 61 percent used the per diem method.
- Twenty-five percent used the department method.
- Fourteen percent used the combination method.

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7 For a discussion of this and other reimbursement formulas, see Sylvia A. Law, Blue Cross: What Went Wrong? (New Haven: Yale University Press, 1974) pp. 59-114.

8 The rationale for the Defense Department is that new weapons systems are unique, one-of-a-kind items that are being built for the first time. Exact costs are harder to estimate than for off-the-shelf items. In this case cost-based procurement with competitive bidding is a reasonable policy.

9 Berman and Weeks, The Financial Management of Hospitals, p. 153.

## TABLE I

## HOW BLUE CROSS REIMBURSES HOSPITALS

### PER DIEM METHOD

| | | | | |
|---|---|---|---|---|
| Total Hospitals Costs / Total Patient Days | X | Percent of Patient Days Accounted For By BC Patients | = | Amount BC Pays |

### DEPARTMENT METHOD

| | | | | |
|---|---|---|---|---|
| BC Patient Charges / Total Patient Charges | X | Total Cost Of the Department | = | Amount BC Pays |

### COMBINATION METHOD

| | | | | |
|---|---|---|---|---|
| Total Cost of Routine Services / Total Patient Days | X | Percent of Patient Days Accounted For By BC Patients | + | |
| BC Patient Charges For Ancillary Services / Total Patient Charges For Ancillary Services | X | Total Cost of Ancillary Services | = | Amount BC Pays |

**Source:** Herman Miles Somers and Anne Ramsay Somers, Medicare and the Hospitals: Issues and Prospects (Washington, D.C.: Brookings Institution, 1967), pp. 166-168.

There is some evidence that Blue Cross plans have been moving away from the use of these formulas over the last decade. For example:

- In 1973, 69 percent of Blue Cross plans reimbursed hospitals on the basis of costs, and 31 percent reimbursed based on charges.[10]

- In 1976, 50 percent of the plans reimbursed on the basis of cost and 50 percent reimbursed based on charges.[10]

- In 1983, 28 percent of Blue Cross contracts were cost-based, 59 percent were charge-based and the remainder were mixed.[11]

However, in any charge-based reimbursement system, the charges are required to reflect costs, and these costs are calculated in much the same way as they are in a cost-based system. Because of this, it is probably fair to say that all traditional Blue Cross reimbursement methods are ultimately cost-plus methods of finance.

The cost-plus method of reimbursement is not confined to the private sector. Under the original Medicare and Medicaid programs, the federal government adopted the same payment methods used by Blue Cross (specifically the department method and the combination method).[12] Thus, the two fastest-growing health insurance programs in the medical marketplace also were firmly entrenched in the cost-plus system.

One of the most interesting developments in hospital finance over the last several decades has been the decreasing proportion of hospital bills paid by patients out-of-pocket.

- In 1950, roughly half of all hospital bills were paid out-of-pocket by patients, and half by third-party payers.

- Today, about 90 percent of hospital income comes from third-party payers--about half from private insurance companies and half from government--and less than 10 percent is paid out-of-pocket by patients.

What this means is that only 10 percent of hospital revenue is in any direct and meaningful way connected with the prices hospitals charge their patients. The other 90 percent, for all practical purposes, is cost-plus reimbursement. So pervasive is cost-plus reimbursement that some health economists have gone so far as to conclude that the "prices" hospitals

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10 Ibid., pp. 152-3.

11 Susan W. Melczer, Hospital -- Blue Cross Contract Provisions, American Hospital Association, July 1, 1983, p. 1.

12 Herman Miles Somers and Anne Ramsay Somers, Medicare and the Hospitals: Issues and Prospects, (Washington, D.C.: Brookings Institution, 1967), p. 168.

charge are little more than numerical artifacts which have little, if anything, to do with the allocation of resources. Somers and Somers state that since hospital "charges now have meaning for only a minority of patients and hospital finances, they have become largely a set of arbitrary statistical factors, instead of a set of prices."[13]

Not only do hospital prices fail to perform the function of allocating resources the way prices do in other markets, under the original Medicare and Medicaid reimbursement formulas hospitals had an incentive to manipulate their prices in order to maximize their reimbusement from the government. Under the department method of reimbursement, for example, the amount paid by Medicare is equal to the total charges to Medicare patients divided by total charges to all patients times total cost. One health economist has shown how a hospital can double its income from Medicare under this method of reimbursement by artifically raising its charges for services typically used by Medicare patients and artifically lowering its charges for services typically used by non-Medicare patients.[14] Moreover, this practice is not considered illegal, or even unethical. It is well-known that hospitals can buy computer programs which show them how to maximize their revenues under the Medicare reimbursement rules.

## Perverse Incentives

It is important to realize that the cost-plus system is antithetical to the market system, a system where prices and competition allocate resources. Frequently, the cost-plus system creates incentives which are the precise oppposite of the incentives created by a market.

One can only wonder what the market for hospital services would look like if it were truly competitive. But it is easy to speculate. When a grocery store discovers that it has ordered a surplus of apples, it tries to get rid of those apples by lowering the price. When a retail firm faces bankruptcy and needs to get cash quickly, it cuts its prices and has a "going out of business" sale. Presumedly, similar sorts of things would happen in a competitive hospital marketplace.

Yet no matter how many hospital beds go empty, we rarely see hospitals advertising cut rate prices on surgery or announcing "going out of business sales" on elective procedures. If prices and competition were allocating resources in the hospital marketplace, a surplus of hospital beds would be great news for consumers. It would mean that prices, and therefore health care costs, soon would tumble. Unfortunately, in today's hospital marketplace, the addition of surplus beds and other unused capacity frequently means just the opposite--that health care costs are going to rise.

The reason for this anomaly is that although prices and apparent competition can be readily seen, what really drives the system is unseen.

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13 Somers and Somers, Medicare and the Hospitals, p. 168.

14 Law, Blue Cross: What Went Wrong?, pp. 78-81.

The prices and the apparent competition that we observe give the impression of a genuine market at work, but the force that really drives the system is cost-plus.

In order to appreciate how very different the hospital market is, consider the results of a recent comparison of hospital costs (that's costs, not prices). The study found that:[15]

- The daily cost of maternity care at some hospitals is more than seven times higher at some hospitals than at others.
- The daily cost of medical/surgical care is more than two and one-half times greater at some hospitals than at others.
- The daily cost of short-term alcoholism treatment is almost five times higher at some hospitals than at others.

The reasons for these cost differences are varied. According to the authors of the study, 130 out of 138 hospitals invested too much in capacity and equipment. Most had too many admitting physicians. But the most important reason appears to be volume. A great many hospitals, it seems, are delivering services at such a low volume that they cannot take full advantage of economies of scale. Table II depicts some widespread differences in costs between high-volume and low-volume hospitals.

How can a hospital continue to stay in business providing a service that is seven times more costly than the cost incurred by a rival? In a genuinely competitive market it couldn't. But the cost-plus system is designed to insure that high-cost hospitals get reimbursed for their costs just as surely as low-cost hospitals get reimbursed for theirs.

The result is a system in which hospitals have very weak incentives to be efficient--to get rid of high-cost services, to take advantage of economies of scale, to specialize in procedures where they are the low-cost producer, etc. The result also is a hospital system in which the nation's annual health care bill is much higher than it needs to be. Indeed, it is a system which rewards and even encourages waste and inefficiency. As Somers and Somers have observed:[16]

> In no other realm of economic life today are payments guaranteed for costs that are neither controlled by competition nor regulated by public authority, and in which no incentive for economy can be discerned.

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15 Thomas Cowing and Alphonse Holtman, "Multiproduct Short-Run Hospital Cost Functions: Empirical Evidence and Policy Implications from Cross-Section Data," Southern Economic Journal, Vol. 49, No. 3, January, 1983, p. 648.

16 Somers and Somers, Medicare and the Hospitals, p. 192.

TABLE II

HOSPITAL COSTS AND HOSPITAL VOLUME*

| TYPE OF SERVICE | HIGH VOLUME Cost per patient per day | LOW VOLUME Cost per patient per day |
|---|---|---|
| Emergency Room Visits | $20.00 (275 Visits) | $32.00 (148 Visits) |
| Medical/Surgical Care | $100.00 (824 Patients) | $255.00 (17 Patients) |
| Maternity | $75.00 (55 Patients) | $540.00 (4 Patients) |
| Short-Term Alcoholism | $50.00 (247 Patients) | $240.00 (--) |

*Based on data from 138 short-term and general care hospitals in New York state in 1975.

**Source:** Thomas G. Cowing and Alphonse G. Holtman, "Multiproduct Short-Run Hospital Cost Functions: Empirical Evidence and Policy Implications from Cross-Section Data," Southern Economic Journal, Vol. 49, No. 3, January, 1983, p. 648.

## Risks To Patient Health

Although our primary focus is on the economic consequences of the cost-plus system, it is worth noting that what is bad economics also frequently is bad for patient health. Numerous studies have shown that when various types of surgery are performed infrequently, not only are the costs of surgery higher but the mortality rate also is higher. For example:[17]

- The U.S. Department of Health and Human Services has judged that for satisfactory results, any hospital performing open-heart surgery should perform at least 200 operations per year.

- Yet 55 percent of U.S. hospitals that perform open-heart surgery perform fewer than 200 surgeries per year.

This problem is not confined to rural areas, where the incidence of surgery is necessarily small. It is also a major problem in large cities where consumers have many choices and where information is more readily available. American Hospital Association data for 1981 show that:[18]

- Annual open-heart surgeries performed in New York City hospitals range from a high of 1,337 (at St. Lukes-Roosevelt Hospital Center) to a low of 75 (at the VA Medical Center in Brooklyn).

- In 14 Chicago hospitals the range is from a high of 926 to a low of six.

- In 10 Los Angeles hospitals the range is from 1,071 to 35; in five Detroit hospitals, the range is from 674 to two.

Some people might be surprised to learn that hospitals with high volume surgery and lower mortality rates do not advertise that fact in order to attract customers. But this practice would be inconsistent with the basic philosophy of the cost-plus system. Hospitals do advertise. But usually that advertising is confined to statements about the amenities offered, the quality of food, and the convenience of location. Almost never is there any mention of comparative mortality rates or patient safety.

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17 Warren Greenberg, "Demand, Supply and Information in Health Care and Other Industries," in Jack A. Meyer, ed., Incentives Vs. Controls in Health Policy, (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1985), p. 100.

18 Ibid., pp. 101-103.

Moreover, the American Hospital Association (AHA) has left no doubt about its desire to discourage such advertising. The AHA's guidelines state that:[19]

> Self-aggrandizement of one hospital at the expense of another may be counterproductive, and, if inaccurate, could lead to charges of libel and claims for damages.

And,

> Quality comparisons, either direct or by implication, between one hospital's services, facilities, or employees and those of another hospital may be counterproductive, libelous, or difficult to present in a firm and objective manner.

## Cost Shifting

In competitive markets, people tend to be charged prices which reflect actual costs. In regulated markets, something different occurs. In virtually every regulated market some consumers end up subsidizing others. For example, in a regulated telephone industry, long distance calls subsidize local calls. In a regulated airline industry, heavily-traveled routes subsidize lightly traveled routes. In this respect, the cost-plus system resembles a regulated market. It is replete with cross-subsidies.

In some cases, the cross-subsidies are overt and direct. For example:[20]

- A 1976 survey of Blue Cross plans found that 30 of them reimbursed hospitals for the bad debts of non-Blue Cross patients.
- The cost of charity care for non-Blue Cross patients was reimbursed by 27 Blue Cross plans.

In other cases, the cross-subsidies are informal and indirect. For example, it is commonly believed that within hospitals, the surgery department subsidizes the obstetrics ward; within emergency rooms, patients with minor ailments subsidize patients with serious injuries; and among all patients, paying patients subsidize charity care.

What is not generally realized, however, is that cross-subsidies are a natural and inevitable by-product of the cost-plus system of hospital finance. Once it is accepted that the de facto purpose of health insurance is to make sure that hospitals receive sufficient revenues to cover their costs, cross-subsidies are unavoidable. Indeed, once it is accepted that the purpose of health insurance is to cover hospital costs and that hospitals shall be free to determine what costs they will incur, the only thing left to argue about is how the hospital bill is going to be divided among the various third-party payers.

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19 American Hospital Association, "Guidelines--Advertising by Hospitals," (Chicago: AHA, 1977), p. 2. Cited in Greenberg, "Demand, Supply and Information in Health Care and Other Industries," p. 100.

20 Berman and Weeks, The Financial Management of Hospitals, p. 153.

This is what gives rise to the recent debate over "cost shifting." In the early years, Medicare and Medicaid officials argued that their payments were being forced up so that payments by private health insurance companies could be kept down. Today, the situation is reversed. Private insurance companies complain that the government's effort to reduce Medicaid and Medicare payments has resulted in their payments increasing. Likewise, many commercial insurance companies argue that Blue Cross' efforts to keep its payments down will mean that their own payments necessarily will go up. Given their premises, this is true. In the cost-plus system, if any one third-party payer manages to reduce its payments, all other payers are threatened with the prospect that their payments will rise to cover the shortfall.

As an example of this attitude at work, consider the pronouncements of the Health Insurance Association of America, an association of private health insurance companies other than Blue Cross plans. According to the HIAA:[21]

- In 1982, $5.8 billion in costs were shifted from Medicaid and Medicare patients to private patients.
- By 1985, that figure will reach almost $12 billion.
- In response, private insurance companies have trimmed benefits and raised premiums by 20 to 40 percent.

In other words, when government's share of hospital costs goes down, the share borne by private insurance companies must go up.

As in regulated markets, the existence of cross-subsidies in the hospital sector creates opportunities for profit-seeking entreprenuers. Surgi-centers come into existence to serve overcharged surgery patients. For-profit emergency care clinics come into existence to cater to overcharged patients with minor injuries. Proprietary hospitals expand to cater to patients who pay their own way and have no desire to subsidize the bad debts or the charity care of others. In this way entreprenuership, innovative ability, and the search for profit tend to eliminate the cross-subsidies.

To the individual consumer in the medical marketplace, these developments are quite welcome because they lead to lower prices. Victims of minor injuries can see their medical expenses cut in half by choosing an emergency care clinic over a hospital emergency room. In the clinic, patients are not being charged for expensive equipment that isn't being used, or for the bad debts or charity care of others. A candidate for surgery can achieve similar savings by choosing a surgi-center over hospital surgery. In

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21 Stanley Wohl, The Medical Industrial Complex (New York: Harmony Books, 1984), p. 188.

the surgi-center, the patient is not being charged for empty hospital beds, for bad debts, for charity care, for the expense of teaching medical students and for dozens of other items that are unrelated to the patient's surgery.

But to those who are firmly entrenched in the cost-plus system, each of these developments is viewed with alarm. Why? Because while these developments may lower prices charged to patients, they are not perceived to lower hospital costs. After all, the cost-plus mentality reasons, all of the hospital's emergency room expenses still have to be paid. So do the expenses for the bad debts, the charity cases, the teaching activities, the empty hospital beds, etc.

Every time a paying patient with an uncomplicated medical problem is drawn out of the conventional hospital system, it is seen as a loss of revenue--revenue which otherwise would have been used to cover fixed costs! Once lost, this revenue must be made up. And who is left to make it up but the third-party payers who fund the cost-plus system. To the cost-plus mentality, anyone who opts out of the conventional hospital system and participates in the new competitive system leaves behind a greater burden to be shared by everyone else who remains in the old system.

The medical marketplace today is characterized by a swirl of competitive, entreprenuerial activity, as providers of health care and employers who fund group health insurance plans search for ways to find and exploit alternatives to the cost-plus system. These activities threaten the foundations of the cost-plus system. For if there is one thing which the cost-plus system cannot do, it cannot exist side-by-side in open competition with a genuine market system. The cost-plus system required help from the government to come into existence in the first place. The old system undoubtedly will require more help from government if it is to survive. That is why defenders of the cost-plus system invariably favor government regulation.

## Blue Cross Is Not The Villain

Although we have been discussing the cost-plus system of terms of the dominant role of Blue Cross, it would be a mistake to believe that Blue Cross administrators bear personal responsibility for the system or that a change in attitude on the part of these administrators would cause the entire system to change. Although there is a national Blue Cross organization, this organization is merely a trade group which represents 67 Blue Cross plans, each administered separately by its own governing board.

There is every reason to believe that each Blue Cross plan is administered by people who respond to economic incentives in much the same way that the managers of any firm respond to incentives. The incentives in the health insurance marketplace have largely been created by government policies. Recent changes in those policies have caused the various participants in the cost-plus system to change their behavior in ways that undermine that system and move in the direction of a competitive market. As we shall see, Blue Cross administrators are responding to these new incentives along with everyone else in the health insurance marketplace.

## THE PUSH FOR GOVERNMENT REGULATION

Since reimbursement is based on costs, the cost-plus system virtually guarantees that costs will rise. Yet there is a limit to what any society will pay for health care. Even without the possibility of large-scale opting out of the system, the cost-plus system from its inception contained a fatal flaw which ultimately would have to be dealt with.

The day of reckoning came less than a decade after the enactment of the Medicare and Medicaid programs. Once the federal government began funneling billions and billions of dollars into the cost-plus system, there was a literal explosion in health care costs. Everyone agreed that something had to be done.

The initial approach was a meat-axe approach. In a nutshell, it amounted to passing laws to try to keep hospitals from spending money. Certificate-of-need legislation required that hospitals get government permission before they built new hospitals, added new capacity, or purchased expensive equipment. Legislation creating Physicians Standards Review Organizations sought to eliminate "unnecessary" surgery and "unnecessary" lengths of stay.

If the history of government regulation teaches us anything, it teaches us that it is extremely difficult to keep people from doing what is manifestly in their self-interest to do. This is true even in areas where the product or service is fairly uncomplicated, such as airline travel or telephone calls. It is even more difficult in a market such as hospital care where it is by no means easy to define the service being rendered. The attempt to keep hospitals from spending money by regulation has failed.

In the late 1970s and early 1980s, the federal government took a series of steps designed to partially opt out of the cost-plus system, or at least to limit its exposure under the system. States were allowed, and even encouraged, to experiment with alternative methods of reimbursement under the Medicaid program. Medicare abandoned its cost-plus reimbursement formulas and instituted a prospective reimbursement system instead.[22] In addition, as we have noted, competition was beginning to make headway in the hospital marketplace.

These developments forced the cost-plus industry to reevaluate the nature of the threat it faced. Increasingly, it became clear that more important than the problem of increasing total costs was the problem of who would bear what share of those costs. The more it seemed clear that the federal government would succeed in limiting its share of the costs, the

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22 Under this system, the diagnosis of a patient is supposed to be categorized by physicians into one of 467 diagnostic related groups (DRGs). Medicare pays hospitals a fixed price for each DRG. In principle, if the hospital can perform the service for less than Medicare's price, it makes a "profit," if the cost is higher than Medicare's price, it incurs a "loss."

greater the danger that Blue Cross, other insurance companies and employer-sponsored health care plans would see their share of the costs go up.

When Medicare adopted the reimbursement formulas used by Blue Cross in the mid 1960s, it did so as a result of considerable lobbying pressure from the cost-plus establishment. Yet by the 1980s the positions were reversed. Increasingly, there are suggestions from the private insurance industry and even from Fortune 500 companies that Medicare's new reimbursement rules should be extended to private health insurance as well.

At first glance, this might seem to be a benign, or even beneficial, suggestion. After all, if Medicare's reimbursement rules seem to be working well for the federal government, why shouldn't private health insurance companies adopt the same rules? And, where people are free to negotiate any reimbursement formula they like, why not negotiate a formula that appears to be working? But this is not what the cost-plus establishment has in mind.

What it has in mind is not the free negotiation of reimbursement formulas in a competitive marketplace. Instead it seeks a system of government price controls designed to discourage, or even eliminate competition--a system which would freeze the relative shares of hospital costs being paid by the various third-party payers. Sometimes called an "all-payers system," in every version the goal is always the same: to prop up and protect by regulation the cost-plus system.

### The Inevitability Of Change

The cost-plus system is destined to dissolve. Even the vested interests who publicly support it privately search for ways to opt out of it. It is doubtful that government regulators are capable of enacting enough rules and regulations to save it. Even if they were, it is doubtful that the public would tolerate it. A system which causes health care costs to consume an increasingly larger proportion of GNP is destined to be replaced.

In the next section we examine methods that employers have taken to partially opt out of the cost-plus system.

## IV. OPTING OUT OF THE COST-PLUS SYSTEM

The burden of the cost-plus system ultimately is borne by individuals. The burden is borne directly in two ways: through taxes used to support government funded health care programs and through private health insurance premiums.

It is sometimes asserted or implied that the burden of the cost-plus system is actually borne by corporations. This view is incorrect. Ultimately, all taxes are paid by individuals, not corporations. In addition, company "contributions" to group health insurance programs as a fringe

benefit are paid as an alternative to the payment of higher wages. What is true, however, is that employer-sponsored health plans are organized and negotiated by employers, not by individual employees. To the extent that a company can succeed in reducing the cost of these plans, it is in a position to pay higher wages to its current employees and offer a more attractive wage package to potential employees.

It is only natural, therefore, to consider the costs of private health insurance in relation to the activities of employers. A recent survey of Fortune 500 companies and the 250 largest nonindustrial companies found that:[23]

- From 1981 to 1983, the average rate of increase in health insurance premiums for these companies was 20 percent.
- Health care costs of these companies amounted to 24 percent of their average after-tax corporate profits.

In what follows, we document some of the actions companies have taken to control rising health insurance costs.

## The Growth of Unconventional Health Insurance

One of the best-known attempts to opt out of the cost-plus system involves opting out of fee-for-service medicine altogether and relying on pre-paid health care, usually through a health maintenance organization (HMO).[24] During the Nixon Administration the use of HMOs in the private sector was encouraged by federal legislation, which overrode state laws that discouraged or even outlawed HMOs, and which required employers to offer employees the HMO option as an alternative to conventional health insurance. In 1962, two percent of all health insurance was accounted for by HMO premiums. By 1983, the HMOs' share of the market had grown to 6.1 percent. This growth, while significant, is not spectacular.

The truly spectacular change (and one that only recently has been documented) is the extent to which employers are bypassing conventional health insurance and relying on self-insurance. In many instances, companies are opting for complete self-insurance. Others are partially self-insuring--self-insuring up to a very large amount then paying a "minimum premium" for outside insurance which becomes effective only if a high-dollar limit is exceeded. In either case, the companies may operate their own insurance program, contract with an independent firm to operate

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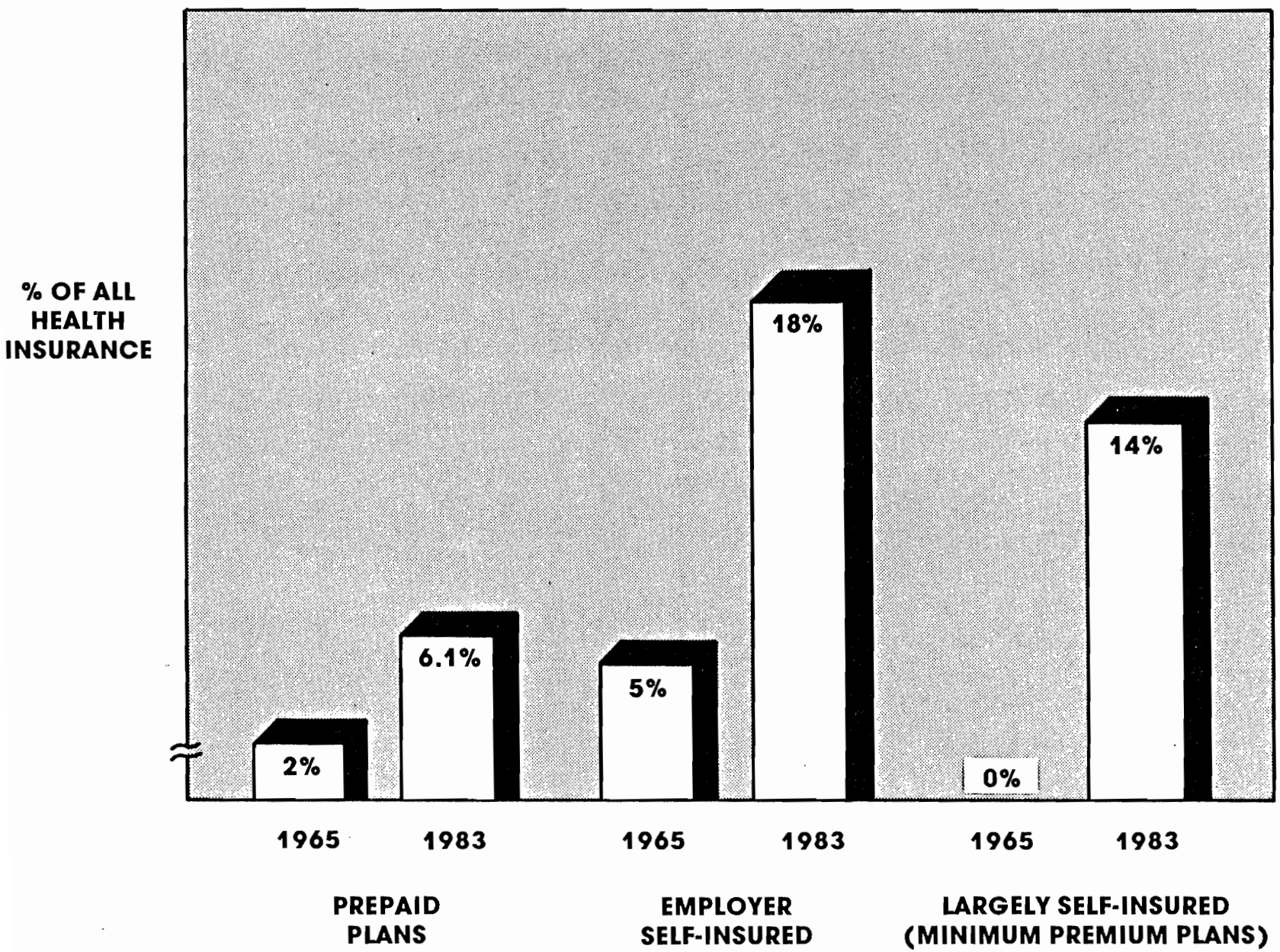
23 Regina E. Herzlinger and Jeffrey Schwartz, "How Companies Tackle Health Care Costs: Part I," Harvard Business Review. July-August, 1985, p. 69.

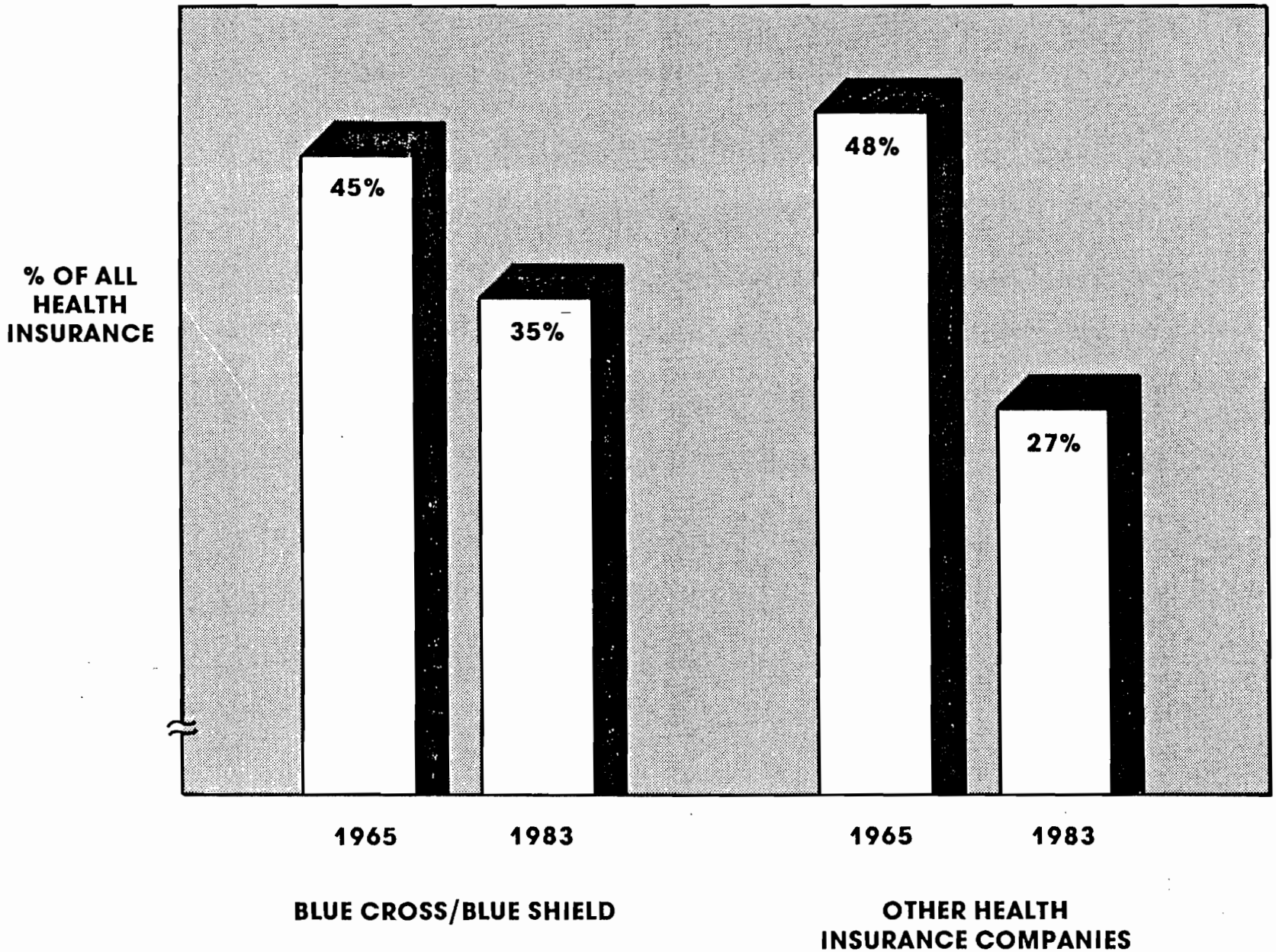
24 The term "health maintenance organization" was either coined or popularized by Dr. Paul M. Ellwood, Jr., the man generally credited with being the architect of the Nixon administration's pro-HMO health care strategy.

# UNCONVENTIONAL HEALTH INSURANCE




Source: National Center for Policy Analysis

## CONVENTIONAL HEALTH INSURANCE




Source: National Center for Policy Analysis

it, or contract with aconventional health insurance company (such as Blue Cross) to handle the program's administration.[25]

As an example, consider an "Administrative Services Only" plan run for an employer by Blue Cross. Under the plan, employees are given Blue Cross cards which are presented to hospitals at the time of treatment. But when Blue Cross gets its bill from the hospital, rather than pay it, it sends the bill to the employer. In this system, all that Blue Cross does is process claims. All bills are paid by the employer, who assumes all of the financial risk under the plan.

As a variation on this idea, consider a "Minimum Premium Plan," also administered by Blue Cross. Under this plan, the employer agrees to pay all bills up to a certain amount--usually chosen to be sufficient to cover the normal and expected health care expenses of the employees. The money needed to cover these expenses is often deposited in a trust fund, which can earn tax-free interest. If the employer's total health care bills exceed the maximum amount the employer has agreed to pay, Blue Cross will make up the difference. Under this plan, the employer is at risk for normal and expected health care costs, and Blue Cross is at risk for anything above that amount. The insurance premium which the employer pays Blue Cross to assume this top-end risk is called a "minimum premium," and it is much smaller of course than the premiums that would be paid to Blue Cross to assume all of the insurance risk.

The extent to which American business has been turning to self-insurance techniques in recent years is startling.[26]

- In 1976, employer self-insurance accounted for only five percent of all health insurance.

- By 1983, 32 percent of all health insurance was accounted for by plans that were either self-insured or largely self-insured.

The growth in self-insurance has come at the expense of conventional health insurance companies.[27]

- Between 1965 and 1983, the Blue Cross/Blue Shield market share dropped from 45 percent to 35 percent.

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25 For a description of these techniques and an explanation of some of the benefits, see Employee Benefit Plan Review, June, 1980, p. 12 ff.

26 Ross H. Arnett, III and Gordon Tripnell, "Private Health Insurance: New Measures of a Complex and Changing Industry," Health Care Financing Review, Vol. 2, Winter, 1984, p. 31.

27 Ibid.

- Over the same period, the market share of other conventional health insurance companies dropped from 48 percent to 27 percent.

Another way to view this change is to consider the extent to which American business has turned to alternative health insurance techniques of all types.[28]

- In 1976, unconventional insurance (defined as pre-paid plans or self-insurance) accounted for only seven percent of all health insurance.

- By 1983, unconventional insurance accounted for 38 percent of all health insurance.

The trend toward alternative forms of health insurance is especially pronounced among the nation's largest firms. Indeed, among large companies, conventional health insurance appears to be vanishing. A survey by the Health Research Institute discovered that:[29]

- Among the 1,500 largest U.S. employers, 83 percent are relying on some form of self-insurance.

- By 1986, it is predicted that at least 92 to 93 percent will be using some form of self-insurance.

But the trend is by no means confined to large companies. In a recent Coopers and Lybrand survey, among companies with fewer than 500 employees, about half are using some form of self-insurance.[30]

Why are companies turning to the self-insurance option? One reason is to get around state laws and regulations which are unnecessarily fueling the explosion in health care costs. For example, in many states legislation requires employers to include in their health insurance plans coverage for items such as alcoholism treatment, the services of podiatrists, chiropractors, clinical psychologists, and psychiatric outpatient therapy. These services can be quite costly. Take psychiatric care, for example:[31]

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28 Ibid.

29 Cited in Meg Fletcher, "More Small Firms Self-Funding Health Plans," Business Insurance, December 10, 1984, p. 12.

30 Coopers & Lybrand, Employee Medical Plan Costs: A Comparative Study (Dallas, Texas: Coopers & Lybrand, 1984), p. 41. Copies may be obtained from Andrea Bailey, Coopers & Lybrand, 1999 Bryan, Suite 3000, Dallas, Texas 75201.

31 Speech by former Secretary of Health and Human Services, Joseph Califano, January, 1984. See "Cost Crisis and Perspectives -- Health Care 1985," Insurance Sales, July, 1985, p. 40.

- In 1973, Chrysler Corporation, which offered only limited employee mental health benefits, experienced 30,000 psychiatric visits at a cost of $800,000.

- In 1978, under a new agreement negotiated with the United Auto Workers Union, Chrysler greatly liberalized its mental health benefits. Total visits jumped to 200,000 at an annual cost of more than $5 million.

In the Employee Retirement Income Security Act (ERISA) of 1974, the federal government exempted companies which self-insure from state laws requiring coverage for items such as those listed above.

Another important provision included in ERISA exempted companies that self-insure from state taxes on insurance premiums. These taxes, imposed on conventional insurance companies, add about two to three percent to an employer's health insurance bill.[32]

Yet another advantage of self-insurance was created by a recent change in the federal income tax law. Employers who establish their own health insurance fund can deduct contributions to those funds, and earn tax-free interest on the amount accumulated. A 1984 survey by The Wyatt Company found that 21 percent of surveyed employers self-insure in this way, up from nine percent in 1980.[33]

Despite these clear financial advantages of self-insurance, we believe that the trend toward self-insurance is far more important than the dollars that have been saved so far. The trend toward self-insurance is important because it is a step toward opting out of the cost-plus system--a step that will become increasingly important in the future.

As we have seen, the cost-plus system at its very worst is a system in which health insurance companies do not aggressively monitor the behavior of health care providers. At the risk of unfair characterization, the system can be described in the following way: Under the cost-plus system, hospitals submit bills and insurance companies pay them. At the end of each year, the insurance company compares the employer's total premiums to the reimbursements the insurance company actually made. If reimbursements are greater than premiums, the following year the employer's premiums are raised. Insurance companies which act in this way are doing little more than processing claims. Thus, one way to look at self-insurance is to view companies as simply formalizing an arrangement that already existed de facto. Under one form of self-insurance, a conventional insurance company

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32 Industry Week, July 12, 1978, p. 115.

33 Jerry Geisel, "Surveys Find Most Employers Self-funding Health Benefits," Business Insurance, January 28, 1985, p. 10. The funds to which these contributions are made are called Voluntary Employee Beneficiary Associations (VEBRAs), or 501 (c) (9) trusts.

is retained formally to do nothing more than process claims. Under complete self-insurance the company does its own claims processing. In both versions, however, the role of aggressively monitoring health care expenses and influencing how the funds are spent is left with the employer.

Yet the change is important. For even if the change in responsibility is a mere formality it lays the groundwork for more change. When companies control their own health insurance plans, they are in a better position to institute and experiment with other techniques designed to control health care costs.

## Case Study: U.S. Administrators, Inc.[34]

As an example of how unconventional health insurance can help employers opt out of the cost-plus system, take the case of U.S. Administrators, Inc., one of the largest companies in the country administering self-insured health insurance plans for private companies. When a company self-insures, it immediately saves about two to three percent on its health insurance bill by avoiding the payment of state taxes on insurance premiums. But, according to Samuel Kaplan, president of U.S. Administrators, potential total savings are from 10 to 15 times that amount.

How are these savings realized? For one thing, Kaplan says, a typical company can save from six to 12 percent simply by engaging in better auditing and claims review techniques than those used by traditional insurance companies. In addition, companies can save another 10 to 15 percent by employing what Kaplan calls "cost management" techniques. One of the most important of these is comprehensive utilization review--keeping meticulous records to identify doctors and hospitals that overcharge, that are too quick to admit patients, or that keep patients in the hospital too long.

Kaplan's company also engages in other cost containment practices. For example, U.S. Administrators maintains a "hot line" for patients and physicians to call to get prior approval before elective surgery. Physicians are required to describe the diagnosis and state why they think surgery is necessary. Physicians also are asked what they intend to charge for the procedure. U.S. Administrators keeps a record of what other physicians in the same geographical area are charging for the same procedure and frequently will bargain with the physician over the price to be charged.

U.S. Administrators also employs another novel cost management technique. Say a gall bladder operation normally costs about $3,000, and of that amount about $1,000 is the physician's fee. U.S. Administrators reasons

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34 This section is based on author interviews with Samuell X. Kaplan, president of U.S. Administrators, Inc.

that although the physician only gets one-third of the total, the physician has a great deal of control over the other two-thirds. So U.S. Administrators might strike the following deal: If the physician brings in the total procedure for under $3,000, he will get 125 percent of his fee; if the total is over $3,000 he gets only 75 percent of his fee. This arrangement, of course, gives the physician a financial incentive to care about all of the costs he is able to influence through his decisions.

Kaplan is convinced these techniques work. And, he is willing to bet money on it. U.S. Administrators often puts part of its fee at risk, contingent on how well it performs for its clients. Suppose that an employer has been experiencing average health care costs of $1,000 per employee. U.S. Administrators might strike the following deal: If the company manages to reduce the employer's cost to $900 per employee, U.S. Administrators will get its contractual fee plus a percentage of the amount saved. If costs go up above $1,000, then the employer pays only 75 percent of the contractual fee.

Do these cost-cutting techniques threaten to reduce the quality of health care patients receive? Kaplan is adamant on this point. "Good cost management leads to better health care," he says. If patients can avoid unnecessary surgery and unnecessary tests, they also avoid the risks associated with those procedures. Many medical procedures are indeed risky, and it is in the patient's interest to avoid those risks unless there are even greater risks to the patient's health if the procedures are not performed.

## Other Cost-Cutting Techniques

What else can employers do to control the rising costs of health insurance? In this section, we look at some widely used techniques. Following that we look at evidence that the activities of private companies combined with recent changes in government policies are having a major effect on the medical marketplace.

**Contracting Directly With Health Care Providers.** One way of opting out of the cost-plus system is to negotiate directly with hospitals, doctors and organizations which provide health care. When employers engage in these negotiations, they are bargaining over price, not merely reimbursing for costs. The use of HMOs is an example of this behavior. Another example is using a preferred-provider organization (PPO). Under this arrangement, employers negotiate discounts with doctors and hospitals. Frequently, employees share in the savings if they use the services of the designated providers. A recent survey of Fortune 500 companies found that 17 percent are using PPO arrangements.[35]

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35 Reported by MarketPULSE Measurement Systems, Indianapolis. Reprinted in National Committee for Quality Health Care, Annual Report, 1984-1985. Pages unnumbered.

**Increasing the Employees' Share of the Cost.** During the 1960s and 1970s, the trend in employer-sponsored health insurance was toward greater and greater coverage of their employees' health care expenses. Among employees, a "good" health insurance policy was thought to be one which paid for almost everything. Today, this view is quickly vanishing, and is certainly not held by any responsible employer. The 1980s have seen rapid movement in the opposite direction. A Business Roundtable survey of large companies found that in recent years, most of these companies have increased the share of costs borne directly by employees by raising deductibles and co-payments. Among companies surveyed,[36]

- Fifty-seven percent have an annual deductible, and more than half have raised the deductible since 1982.

- Ninety-eight percent require a co-payment of some type.

A major reason for the trend toward requiring patients to pay a greater proportion of health care bills out-of-pocket is that this practice affects behavior. A Rand Corporation study found that people who are fully insured (pay nothing out of pocket) spend 50 percent more on health care than people whose insurance does not cover the first $1,000 of medical expenses.[37]

**Offering Flexible Benefits.** Closely related to the concept of greater employee cost-sharing is the practice of giving the employee a choice between a high-cost health insurance policy (one with low deductibles and low co-payments) and a low-cost plan (one with high deductibles and high co-payments), plus allowing employees who choose the low-cost plan to pocket the savings or apply it to some other fringe benefit (such as a contribution to a pension plan.) The ideal way to structure the option is to allow employees to reap the full financial benefits of choosing the lower-cost plan, or, conversely, to pay the full cost of choosing the higher-cost plan.

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36 The survey covered the health plans of 122 Business Roundtable members (mostly Fortune 500 companies) employing 7.5 million employees and dependents. See Highlights: The 1984 Business Roundtable Task Force on Health Survey, 1985, p. 2. (Hereafter referred to as Business Roundtable Survey.) Copies of the full report, entitled Corporate Health Care Cost Management and Private Sector Initiatives, may be obtained from Douglas L. Cocks, Corporate Affairs Research, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, Indiana 46285

37 Joseph P. Newhouse, et. al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," New England Journal of Medicine, December 17, 1982, p. 1501.

Take PepsiCo, for example. In 1980, the company offered this kind of option to its employees. However, because it "under-priced" the high-cost plan, 65 to 75 percent of PepsiCo employees chose a plan with no co-payment. After reexamining its costs, Pepsico raised the "price" of its high-cost plan to reflect actual costs. After the change more than 50 percent of Pepsico employees chose the lower-cost plan.[38]

A natural extension of this idea is to offer employees a full range of fringe benefit choices, a practice sometimes known as the cafeteria plan. Again, an obvious advantage is that employees come to understand the true costs of the fringe benefits they enjoy. The Business Roundtable survey found that:[39]

- Sixteen percent of surveyed companies offer a choice between high-cost and low-cost health insurance plans.

- Thirteen percent offer cafeteria plans and another 25 percent are considering adding these plans.

**Encouraging Employees To Make Low-Cost Choices.** When individuals make choices in the marketplace, they make choices based on personal costs and personal benefits. Yet in the market for hospital care, as we have seen, more than 90 percent of the cost is paid for by someone other than the patient. This means that when patients make wasteful choices, 90 percent of the waste is shifted to someone else; when patients make choices which result in savings, 90 percent of the savings is realized by someone else. Because of these distorted incentives, many companies are changing their health benefit plans to give employees better financial incentives to make cost-reducing choices, especially in areas where the opportunities to reduce costs are large.

For example, almost any procedure done outside of a hospital is less costly than if that same procedure is performed inside a hospital. (This is particularly true under the current cost-plus system of hospital finance.) As a consequence, many companies now give employees financial incentives to opt for alternatives to hospital ("in-patient") care. The Business Roundtable Survey found that:[40]

- Almost all companies surveyed cover out-patient surgery, and more than 40 percent pay a higher percentage of the bill for out-patient surgery than for in-patient surgery.

- Ninety-eight percent pay for second opinions and 55 percent offer employees a financial incentive to obtain a second opinion.

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38 Herzenger and Schwartz, "How Companies Tackle Health Care Costs," p. 75.

39 Business Roundtable Survey, p. 4.

40 Ibid, p. 3.

**Auditing Claims and Reviewing Utilization.** Most large companies today have a formal procedure for auditing health insurance claims--to determine the accuracy of the claim or the eligibility of the claimant, or to determine whether the service is actually covered by the policy. Most large companies also employ utilization review techniques--to identify unnecessary procedures or inappropriately long hospital stays. With increasing frequency, companies are employing utilization review techniques prior to the time the service is rendered. Many companies require prior approval for surgery. The Business Roundtable Survey found that:[41]

- Eighty-eight percent of companies surveyed audit their health insurance claims.
- More than two-thirds employ some type of utilization review.

The forces of competition are at work here, too. Organizations are offering utilization management to insurance companies as well as to companies which are self-insured. For example,[42]

- For $2 per month per employee, one group of physicians will provide pre-admission certification, concurrent in-hospital monitoring and review, plus discharge planning.
- They report total health care cost savings of 10 to 18 percent for their clients.
- In the case of one client, they reduced inpatient days by 27 percent.

**Promoting Wellness.** Yet another technique for controlling a company's health care costs is to promote preventive measures designed to avoid sickness in the first place. In the Business Roundtable Survey:[43]

- One-third of the companies give new employees screening physicals; one-fourth offer periodic physicals to all employees.
- One-half provide physical fitness programs.
- Forty-nine percent offer employee counseling for alcohol and drug abuse; 30 percent offer counseling for family problems; 29 percent offer counseling for job-related stress.

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41 Ibid, p. 4.

42 "Cost Containment Program: Capital National Bank," Florida Health Network, A Preferred Provider Orgainzation, July 19, 1984.

43 Ibid, p. 5.

## V. THE CHANGING NATURE OF THE MEDICAL MARKETPLACE

The medical marketplace has been shaped from top to bottom by the cost-plus system of hospital finance. It cannot be changed by the actions of a single company. But when many employers engage in the cost-cutting techniques described above, each act is like a small nibble at the foundations of the cost-plus system. The cumulative effect is to set in motion a process of change.

It is interesting how this change is occurring. When a company alters its health benefits policy, it does so because it is in its self-interest to do so, not because it is trying to change the system as a whole. The self-interested actions of one causes others to change. As employers change their behavior, hospitals begin to change their behavior too. So does Blue Cross. So do commercial insurance companies. This is how competitive markets are supposed to work.

Take Blue Cross plans, for example. Blue Cross administrators have not been sitting idly by, watching their market share disappear. They have been responding to changing market conditions by changing their own policies as well. According to a recent publication of the Blue Cross and Blue Shield Association,[44]

- Blue Cross and Blue Shield plans now have 66 HMOs with more than two million members.
- It is expected that there will soon be as many as 40 Blue Cross and Blue Shield PPOs.
- Blue Cross plans across the country are adopting procedures to encourage outpatient surgery, to require prior-approval of hospital admissions to mandate second opinions before surgery, to establish utilization review programs, and to encourage reductions in a patient's length of stay.

Most of the changes taking place in the medical marketplace are changes which move in the direction of a more competitive market. Why are these changes occurring? One reason is that health care has become more expensive. That gives consumers of medical resources a greater incentive to find ways to economize. A second reason is that the supply of medical resources has been outstripping demand -- more doctors, more hospitals -- largely as a result of government subsidies. This puts greater pressure on the providers of medical services to find new ways of attracting patients. A third reason is that many government impediments to competitive activity have been removed. There is now more freedom to

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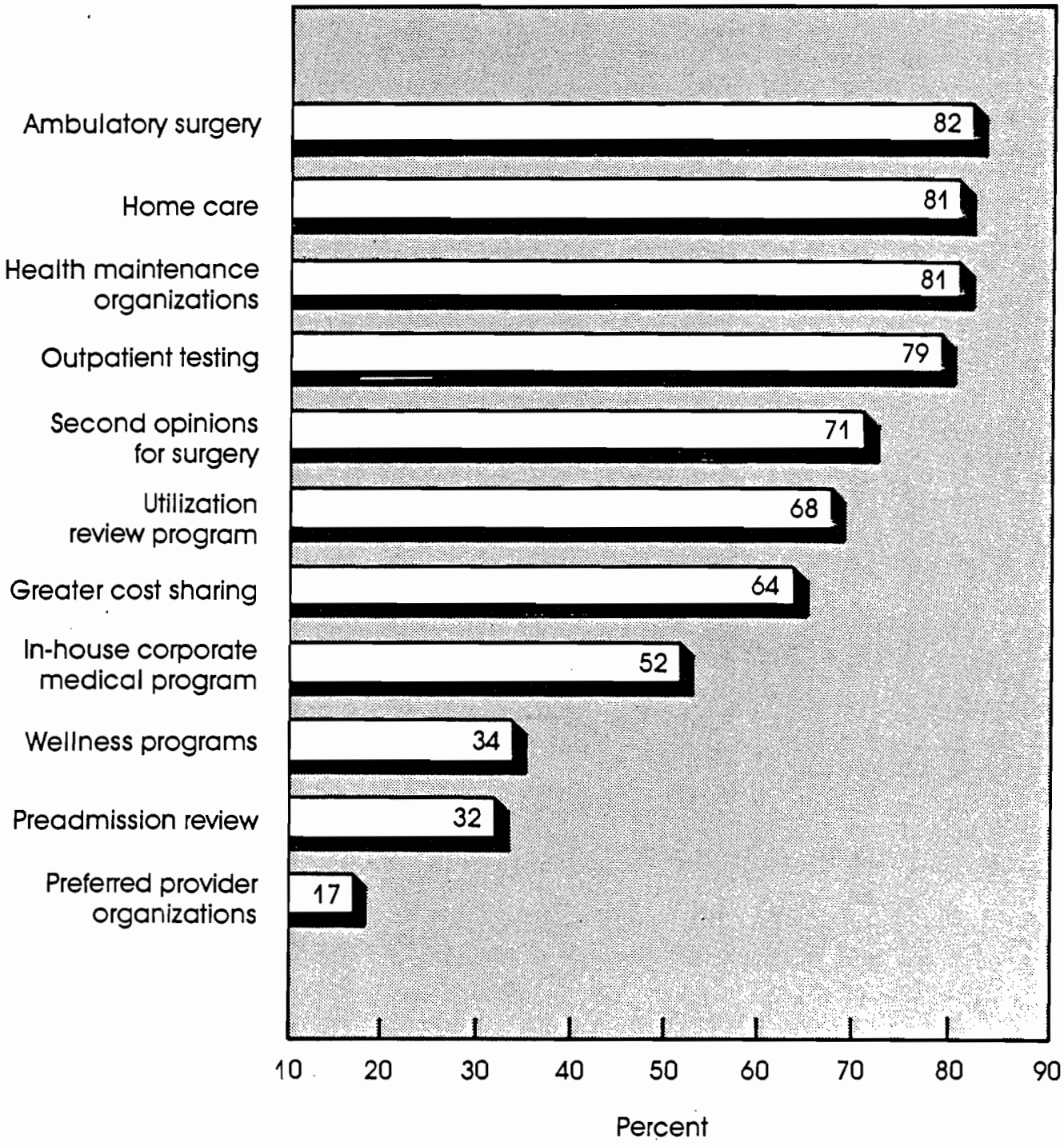
[44] Blue Cross and Blue Shield Association, Questions and Answers On The New Health Care.

## COST CONTAINMENT STRATEGIES OF FORTUNE 500 COMPANIES




Source: Market PULSE Measurement Systems, Indianapolis

Reprinted in National Committee for Quality Healthcare Annual Report, 1984-85.

compete. A fourth reason is the change in Medicare reimbursement rules. No longer is the federal government willing to pay for the inefficiencies of unnecessarily high-cost hospital procedures.

At this point, it is impossible to sort out how much of the change in hospital behavior is due to changes in federal government reimbursement procedures, how much is due to changes made by employers, and how much is due to the competititve pressures produced by the behavior of for-profit hospitals, surgi-centers and other alternatives to hospital care. But there can be no doubt that change has occurred.[45]

- In 1981, the expenses of community hospitals grew at an annual rate of 10.7 percent. Since then the rate of growth has steadily declined to 4.5 percent in 1984--about the same as the rate of inflation.

- After leveling off in 1981 and 1982, the average length of stay in U.S. hospitals began to fall in 1983, and fell at a rate of 5.1 percent in 1984.

- The annual rate of change of hospital admissions also has declined markedly over the last four years. In 1984, hospital admissions fell by four percent.

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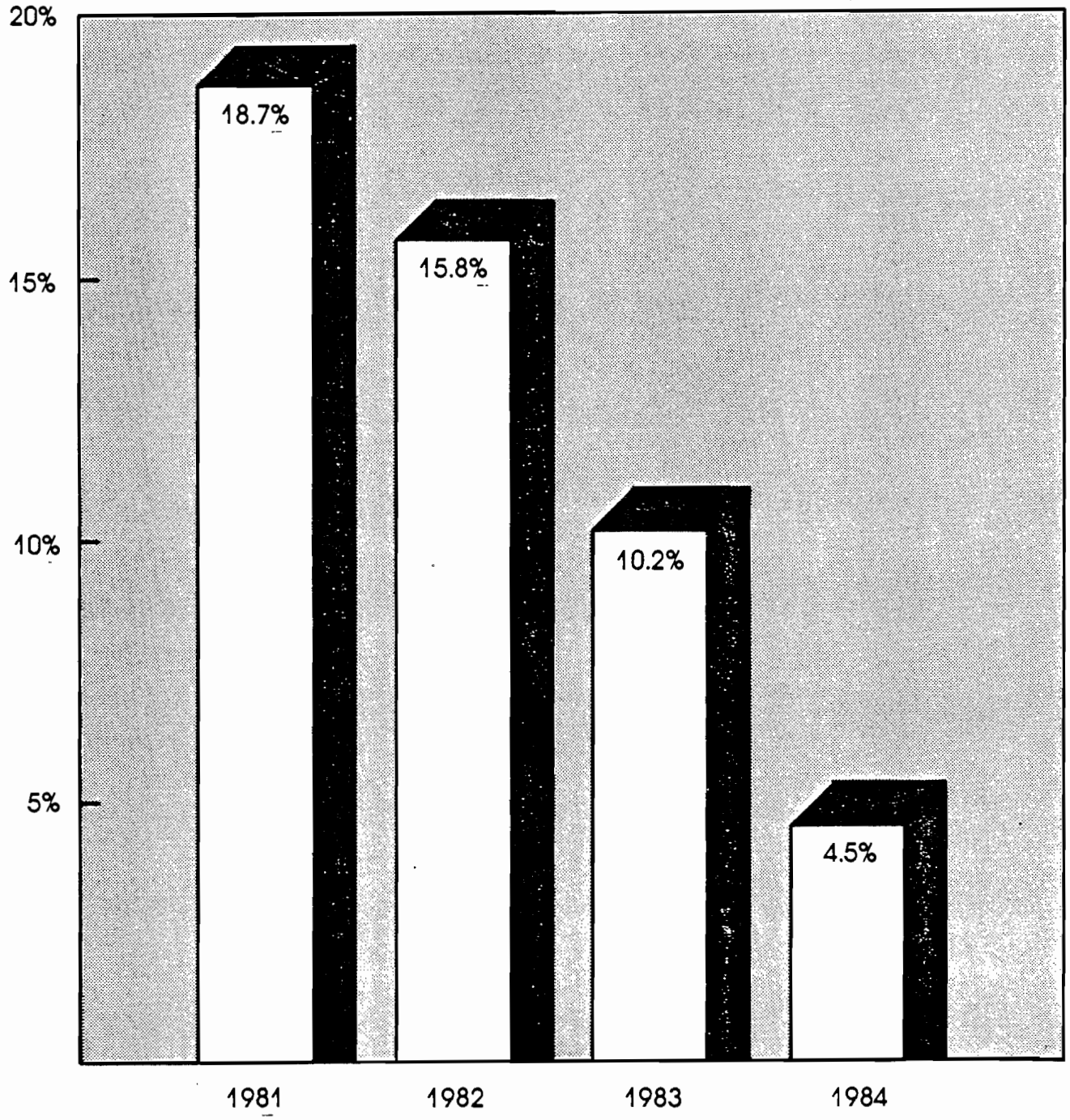
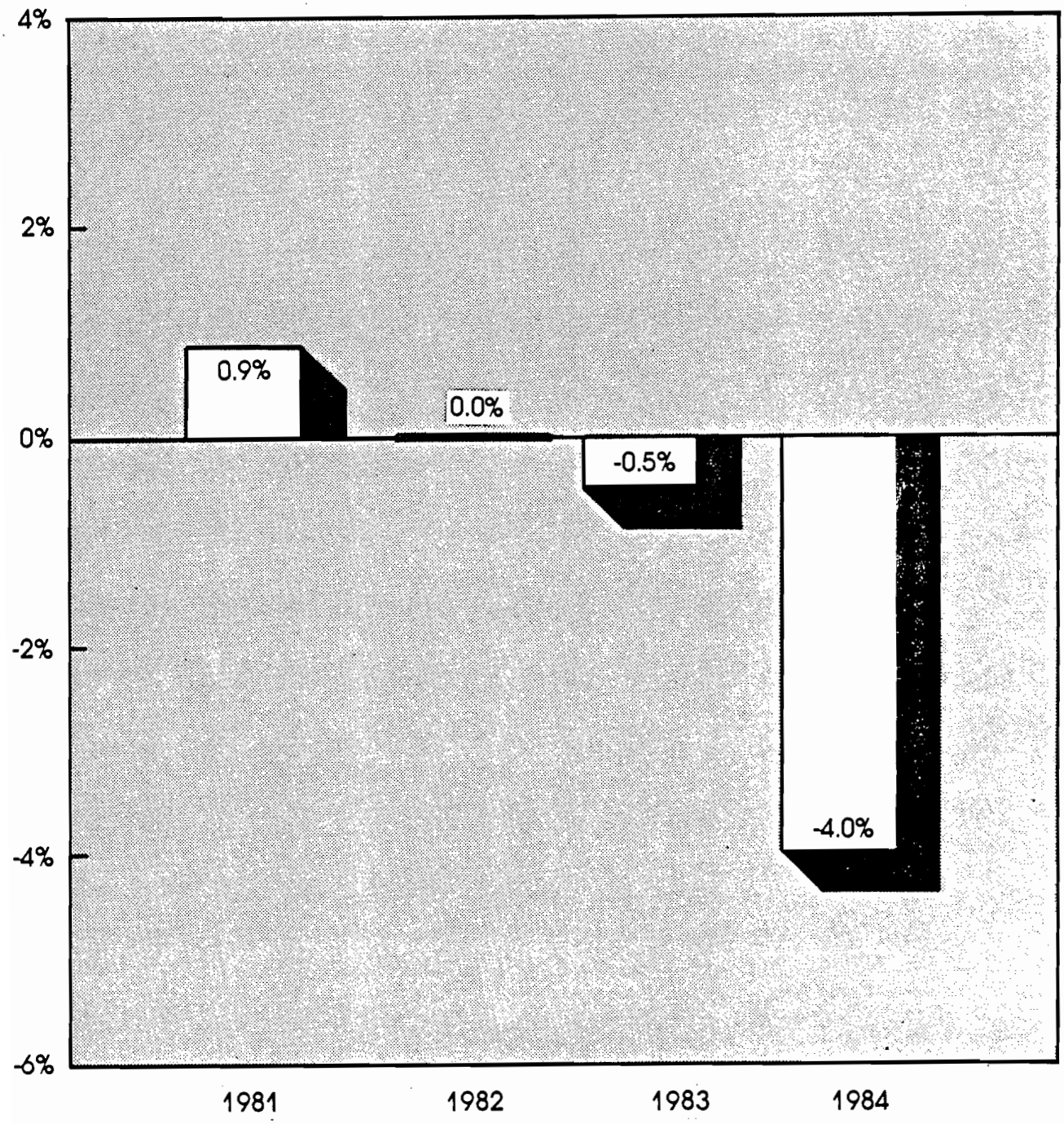
45 American Hospital Association National Panel Survey.

## COMMUNITY HOSPITAL EXPENSES
## Annual Growth Rate



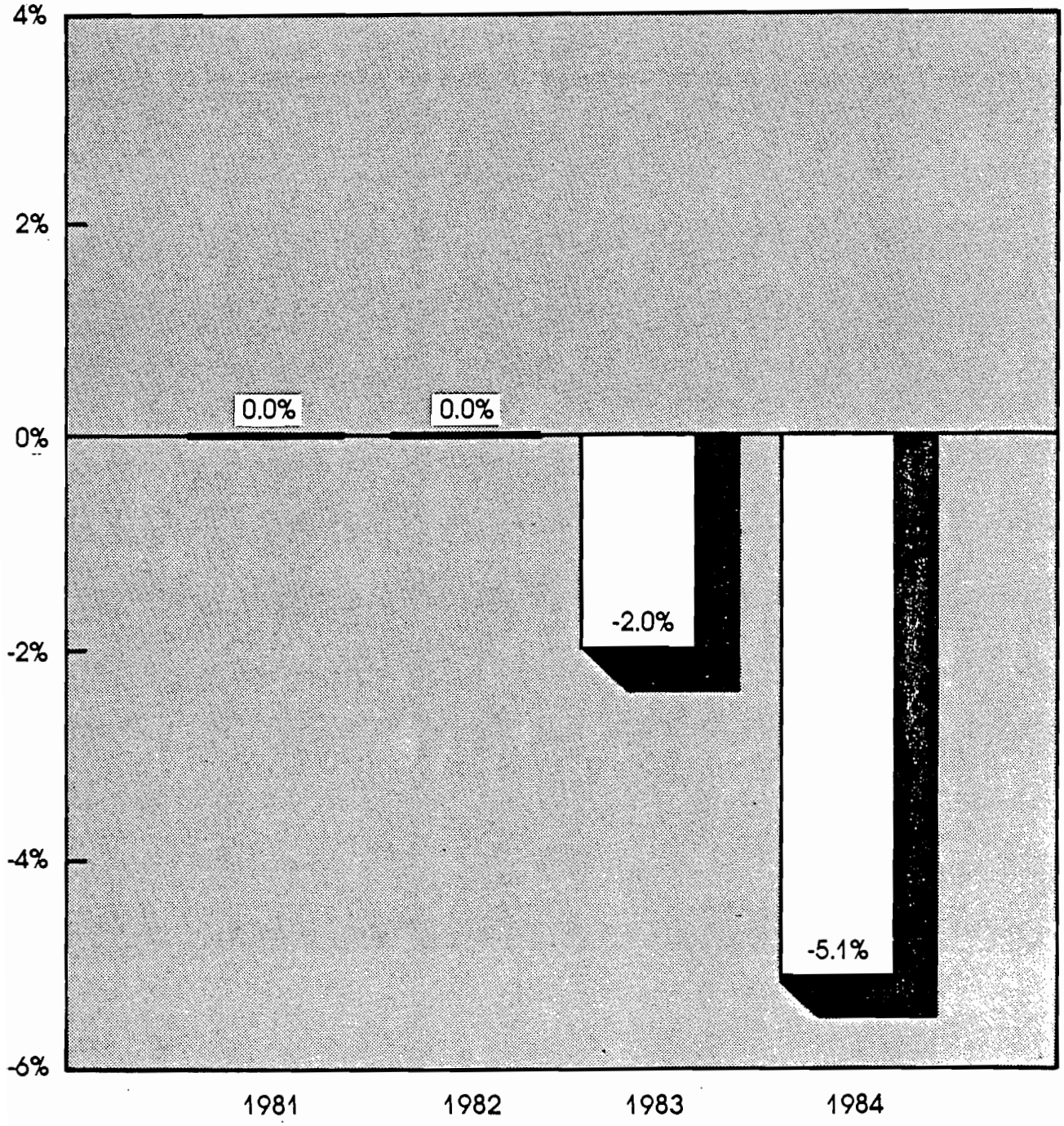

Source: National Center for Policy Analysis

## HOSPITAL ADMISSIONS
## Annual Rate of Change




Source: American Hospital Association National Panel Survey

# AVERAGE HOSPITAL LENGTH OF STAY
## Annual Rate of Change




Source: American Hospital Association National Panel Survey

## VI. WHAT SHOULD GOVERNMENT DO?

The policies of the federal government and of state governments toward the health care marketplace over the last two decades have been schizophrenic. Certain policies have been designed to protect and encourage the cost-plus system. At the same time, other policies have been designed to encourage competition and the development of a free market--these are policies which undermine the cost-plus system.

The cost-plus system of hospital finance, we have argued, is an artificial creation of government policy. It has been bad government policy. It has not served well either the interests of employees and their employers or the legitimate interests of the medical community. Although it largely created the cost-plus system, government should not try to intervene in the market and dismantle that system. All that is necessary is for government to remove existing barriers to competition and allow the marketplace to work. Accordingly, we recommend the following:

1. **Deregulate the health insurance marketplace.** State government policies which give preferential tax and regulatory treatment to Blue Cross and Blue Shield plans have helped give rise to the cost-plus system and have prevented consumers from enjoying the full benefits of open competition for their premium dollars. These policies should be discontinued immediately. In addition, there is no defensible public policy reason for taxing the premiums of traditional health insurance companies, or for requiring coverage for certain types of health care benefits while leaving large companies which self-insure free to go their own way. These policies discriminate against insurance companies and may be preventing them from specializing in the area where they should have a comparative advantage--insurance. In the marketplace, all comers should compete on equal footing and ideally should do so with a minimum amount of government intrusion. State taxes on health insurance premiums should be eliminated along with regulations which impose costs without any corresponding social benefits. Additionally, there appears to be no defensible reason why insurance companies should be required by law to put costly services in their benefit packages when these services are not freely purchased in the marketplace. Markets work best when producers have maximum latitude to make any customer-pleasing adjustments they like to their product.

2. **Retain federal government policies toward self-insurance.** Even if state governments do not follow our first recommendation, the federal government can put pressure on them to do so by maintaining policies that already are a matter of law. Federal policies exempt private companies that self-insure from state taxes on insurance premiums and from state regulation of health benefits packages. As long as these policies remain in place, and as long as the conventional insurance companies continue to lose market share, the political pressure will build to change these state government policies.

3. **Eliminate output controls.** In order for competition to work, entrepreneurs with innovative ideas on how to improve quality and cut costs must be able to freely enter new markets and expand their output to meet consumer demand. Yet, hospital regulations in full force during the 1970s prevented this from happening. Specifically, certificate-of-need (CON) controls required government approval before a new hospital could be built or before an existing hospital could expand its capacity. Moreover, at CON hearings all of the rival hospitals were allowed to present evidence on why an applicant's request for a new hospital or new capacity should be rejected. To see what this means as a practical matter, take the case of Hospital Corporation of America, a company which operates an aggressive chain of proprietary hospitals. In the late 1970s, HCA in some cases spent as much as $500,000 on a CON fight and still failed to get CON approval.[46] Vestiges of CON controls still exist around the country. They should be eliminated immediately.

4. **Eliminate price controls.** When most consumers think of government price controls, they typically think of regulators preventing producers from gouging them with unfair price increases. In fact, in some cases regulation of price achieves the opposite effect--it prevents producers from lowering their prices or increasing quality. The hospital marketplace is a case in point. Following the lead of New Jersey, several states have instituted government regulation of hospital prices. All too often these regulations have the effect of freezing in place the system of cross-subsidies and preventing entreprenuers from exploiting cost-cutting or quality-improving innovations. If competition means anything, it means leaving producers free to exercise one essential right--the right to cut their price.

5. **Resist attempts to reduce the supply of physicians.** Currently, there is pressure to reduce the level of competition among physicians by reducing their numbers. In the mid-1960s the federal government developed an array of programs to expand our nation's capability to train physicians. The benefits of this massive effort are now being realized in the form of increased competition. Yet, America lags behind many western European nations and even some Soviet block countries in the number of doctors per capita. The federal government should resist pressures by special interest groups which promote the notion that we have a "physician surplus." The federal taxpayer has paid for this increase in educational capacity. As long as there are long lines of highly qualified young men and women who seek to become physicians, the federal government should discourage any medical school which receives taxpayer funds from reducing its capacity.

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46 Based on author interviews with HCA officials.

There are other things the federal government can do to cause dramatic changes in the medical marketplace -- moves that will lead to more competition and less cost-plus financing. These involve changing federal tax policies toward health care benefits and medical expenses and changing the way the federal government reimburses hospitals under the Medicare program. The federal government's new Medicare reimbursement program, although advertised as pro-competitive in nature, in fact is unlikely to achieve the hoped-for results. It needs to be changed. These are subjects of future NCPA reports.

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